Urology Services Inquiry

Oral Hearing

Day 11 – Thursday, 17th November 2022

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON THURSDAY, 17TH DAY OF NOVEMBER, 2022 AS FOLLOWS:

CHAIR: Morning, everyone. Mr. Haynes, welcome back.
MR. WOLFE KC: Good morning, Chair, Dr. Swart, Mr. Hanbury. I understand there is a petition gathering force and if I couldn't allow for a break at half eleven the petition will be presented, so we will break somewhere between twenty past and half eleven, if that's suitable, Chair. 10:06
CHAIR: Certainly suitable to us, yes.
MR WOLFE KC: Just recapping on a couple of pieces from yesterday, I called out a rogue reference when dealing with the very important Aidan O'Brien perspective, as I think I called it. Let me pull up the reference now, just so that we can do it full justice. It's at WIT-82597. Just for the record, while that's coming up, I called yesterday WIT-82957, so that, if you want to go back to that, anybody, that's where the problem arose. The point I was dealing with was, I had reflected, Mr. Haynes' view that there was a demand capacity mismatch and then I juxtaposed that with Mr. O'Brien's observations that the issues which arose in relation to his practice were inextricably linked to the inadequate system I was working within. So that's the point fully framed. 10:07 10:07 10:08

MR. MARK HAYNES CONTINUED TO BE EXAMINED BY MR. WOLFE AS FOLLOWS:

1 Q. Moving from that, can I pick up with you, Mr. Haynes, just a couple of, I suppose, procedural points that I was dealing with yesterday and, upon reflection, I am not sure I fully bottomed them out with you. One was in relation to the Datix. We saw, I think it was in the context of Patient 102 where you had raised a Datix in connection with an MDM decision that had not been implemented concerning Patient 102. Ultimately, as I think I demonstrated, the processing to stop with a David Cardwell e-mailing Mrs. Corrigan with the instruction that she should speak to the Consultant involved, who we understand to have been Mr. O'Brien. Just in relation to a Clinician completing a Datix or an IR1 such as you did here, can you help us by stepping through what you understand the various parts of a process, either leading to a decision for an SAI on the back of the Datix, or not as the case may be. You fill it in; where does it go? 10:08 10:08 10:09 10:09

A. My understanding it goes, it's within the Datix system, so it's a fully electronic system. It's not a piece of paper passed around. Once the Datix, IR, the Incident Report form is filled in that's picked up by a member of the Governance team, and David Cardwell would be part of that team. There's an initial screen of Incident Reports, because Incident Reporting system is used for a whole manner of things. Some of them can 10:10

be, say, a slip on a wet floor, that sort of thing, and some of them can be Clinical concerns.

2 Q. Yes.

A. There's an initial screen that takes place in terms of the severity and there's an agreed grading system for severity of potential incidents, but also the type of incident in terms of where it then goes. For instance, a ward level incident of a slip on a wet floor would not come to the Incident Report screening that I'd sit on as an Associate Medical Director. There's a screening, if you like, out of those things that are felt to be part of different bits of, if you like, the Trust system, and there's a screening based upon the severity with then brought to the screening are those that are related to Clinical practice and above -- I am going from memory, I think it's above a certain severity level. 10:10 10:11 10:11

3 Q. Yes. Sorry, I just lost it in my hearing. If they percolate up to a level where somebody in the Governance team thinks they should reach, did you say a Screening Committee? 10:11

A. It's a screening -- it's the team so it's Governance, member of the governance, the Assistant Director and the AMDs.

4 Q. Yes. 10:12

A. Yes.

5 Q. Just to be clear, I think you answered it clearly yesterday, but Patient 102, which variously described as a failure to issue correspondence but more

generally, a failure to implement an MDM decision to refer to Radiotherapy, delaying treatment for approximately 12 months, that should certainly have made it to the Screening Committee or the Incident Committee? 10:12

A. I would have thought so, yeah. It would be my view.

6 Q. Yes. Again, just a procedural type issue arising out of that case. You explained yesterday that, to the best of your understanding, this was a case where the MDM decision was for referral to Oncology? 10:13

A. For a direct referral to Oncology which means there should -- in that decision, there's a referral that should be created at the Multidisciplinary Team Meeting to go to Oncology.

7 Q. Yes. The question that spins out of that is, there's various people with jobs to do at MDM, so the Clinician, the treating Clinician would present the case at the MDM? 10:13

A. That's the case in some Multidisciplinary Team Meetings, it's not the case in Urology. In Urology, the Chair on the day of the meeting presents all the cases. 10:13

8 Q. Okay. If the consensus of the MDM is for a referral, and a direct referral as in this case, who holds the responsibility to ensure that the form is completed or the letter is issued to the people who should receive the referral? In other words, presumably the Cancer Centre in Belfast? 10:14

A. The outcome from the MDM is, you typically generate it

live at the time of the MDT, usually by essentially a live transcription from the Chair and annotated by the MDM Coordinator. The MDM Chair checks them and approves them before they are circulated. The direct referral itself is generated, it's my understanding, by the MDM Coordinator, and my memory of that SAI is that MDM direct referral was generated but then there was no record of it having then subsequently been received and therefore the patient didn't get an appointment. 10:14

9 Q. Yes. I think we are going to try to get access to those patient notes and associated notes to work through that process, but, for present purposes, I think that's helpful. 10:15

We rounded off yesterday by considering the case of Patient 93, you will recall, which was, not to put too fine a point on it, a failure of Triage, and we worked through how you e-mailed through your observations in relation to that, and they eventually reached Mr. Young. Before that, chronologically the case of patient 93 appears to have arisen in or about August 2016. In January of that year, you were doing a clinic when you saw a Patient 10 -- just orientate yourself to her -- and you raised a Datix or an IR1, which we can find at PAT, I think it's at three zeros, if not 4 zeros, 51. 10:15 10:16 10:16

Highlight that for me, just the main text.

We can see, Mr. Haynes, just at the bottom of the screen, that you are the reporter, 6th January 2016. This was a case where you were concerned about a number of issues, it appears. I think, judging by the text, you were concerned about the quality, or the accuracy is perhaps a more honest way of putting it, of the Radiology report in respect of this lady, and you highlight in the middle of that text that the patient was referred to the Urology Department on 29th October 2014 for assessment. Then you go on to say that the referral was not Triaged on receipt. Essentially, there were two issues that went forward from that Incident Report and were considered as an SAI review under the charge of, I think, Mr. Glackin; is that correct? 10:18 10:18 10:19

A. Yeah.

10 Q. Was this the first case that had come across your desk or your surgery with a specific problem flowing from a failure to conduct Triage?

A. I think it was the first time I'd noticed that there was a failure to Triage and, as it says on the Incident Report forms, the report is fact rather than opinion, so I haven't put in any thought there. I do recollect that clinic, I recollect many of my consultations with the family. In preparing for the Clinic, I tended to, before turning up to Clinic, look at the patients I was due to see, very much in a planning and preparation for the Clinic. This was a new patient Clinic where we had the ability to get ultrasound scans, we could do 10:19 10:20

flexible cystoscopies, we could do prostate biopsies where needed. I tended to before attending the Clinic put together a quick review of the patients who were coming so that I could give the, if you like, a heads-up to the nursing staff in Clinic that day as to what would be required during that Outpatient Clinic. In that initial review of Patient 10's referral and then looking at the scan, it was apparent to me that the scan report of the MRI did not fit with the reason the scan was requested. As I said, there was a report of two cysts, I think, in the kidney, one at the upper pole, and one at the lower pole, and the MRI report only commented on one of them, which caused me to have a look at the scans myself. Again, my memory is I actually liaised with a Radiology colleague before the Clinic saying I think there's an issue been missed here in this report, this is what I am going to need to get in terms of up-to-date scans. In that review, and when I saw the patient, it was apparent to me that the referral letter itself had not been triaged as well. As I say, the Incident Report is fact and not opinion, but my opinion at that time, and I would maintain it now, is that there was an opportunity that, if, at Triage, someone had spotted the same inconsistency between the reason the MRI was requested and the MRI report, it could have been detected that there was an issue with that report, and actually, potentially, there may be a more significant finding and, therefore, the patient might have needed upgrading

10:21 10:21 10:21 10:22 10:22

from Routine.

11 Q. Yes. You use the word opportunity there. I think that's also the word used by the SAI Review Team when they came to report later that year or early next year. Let me just see if I can find that. If we can go to PAT-00007 in that series? We can see just in that fourth paragraph there, it says: 10:23

"The Review Panel agree that in relation to the patient, the opportunity to upgrade the referral to red flag was lost by the omission of Triage resulting in a 64 week delay to diagnosis of a suspicious renal mass." 10:23

Mr. O'Brien, in his defence, argued that even if this had been triaged by him, he would still have treated it as routine because he would not have seen the problem here on the Radiology report. You emphasise the word "opportunity", as does the Review Team. Does that suggest that what you are saying is that not everyone, not every Clinician in the time available to Triage would necessarily have spotted the problem, but if you had triaged, there was at least a chance, or an opportunity, that the problem could have been spotted? 10:24 10:24

A. Yes. You know, it's an opportunity, that I'd reflect that I'd identified it on a relatively quick review of the referral letters in advance of that Clinic, that would not have been a huge amount different in terms of what I was thinking as to what I would have done at 10:25

Triage of similar referrals.

12 Q. In many respects, I suppose, albeit extremely unfortunate and traumatic for this patient, but in many respects the bigger point is that the failure to do Triage in any case for the purposes of reviewing the GP's designation, is the bigger issue; it's the broader issue affecting the Service and affecting, potentially, any patient coming into the Service on a referral? 10:25

A. Yeah. If, for whatever reason, the condition the patient is being referred to, is referred on at the wrong urgency category, and that Triage process doesn't happen, then the patient will continue on the pathway for the referral category, and in this case that was routine. 10:26

13 Q. It was this kind of discovery in a live case such as this that became, I think I've seen it described as the Index Case, this kind of discovery was to give rise to, in 2017, a rather urgent Lookback across a number of cases from the period '15, '16, to see what else could be discovered in other cases arising out of failure to Triage? 10:26 10:27

A. Yeah. My recollection of the steps that went through is the SAI Panel, as you say which was chaired by Mr. Glackin, identified or confirmed that that referral hadn't been triaged. They then asked the question were any other referrals from that same week not triaged, and identified that there were some other referrals from that week not triaged. That led on to events where a significant number of un-triaged referrals were 10:27

in a filing cabinet in Mr. O'Brien's office, and from there, all of them un-triaged referrals were then triaged effectively late by the rest of the Consultant team through early 2017.

14 Q. I'm going to come, just in the right order, a little later this morning, the SAI arising out of the five patients which you participated in. You were the Urologist participant in that review. 10:28

Just before we move away from that case, that was January '16. You'd also, as we noted yesterday, had the failure of Triage in Patient 93's case, which was later in 2016. Can I just pick you up on something you've said in your witness statement? If we could have up on the screen WIT-53952? If we could just look at 73.6 of your statement. Within this paragraph you are talking about the period after becoming Associate Medical Director and you are saying: 10:28 10:29

"The absence of an induction process or handover for incoming AMDs was also a factor" in the difficulties you faced. 10:30

You say: "For example, it was only after the identification of the un-triaged referrals in 2017 that I was made aware that this had been an issue previously with Mr. O'Brien." 10:30

That is seeming to suggest that it was only after you

had become AMD that you became aware of the issue of a lack of Triage?

A. As I read that paragraph, I think, as I made in my corrections yesterday, I'd made a date error in terms of as I wrote my statement and had put that from my memory it was just after I became AMD that this happened, which was wrong. I actually became AMD in October 2017, but I think the general point I am making within that statement is that it was only after that 2017 period of finding the lack of Triage that I was CD for Surgery and Trauma and Orthopaedics at the time, so Clinical Director at the time, but myself and Colin Weir, who was the CD for Urology, hadn't been made aware through anything that there had been a historic issue with lack of Triage by Mr. O'Brien. As there's been other people's statements, there had been a history of that same issue being picked up previously. 10:30 10:31 10:31

15 Q. The issue of failure to triage on time was, nevertheless, an issue that you were bound to have been aware of more generally, even if it wasn't associated in your mind necessarily with Mr. O'Brien? Let me orientate you a little bit further on this point. If we turn to TRU-274344 on the screen please. Just scroll down. Yes. 10:32 10:33

In late 2014, you are in post just over six months. Martina Corrigan is writing to all of the Urologists in the team and she is saying:

"Please see attached ... 206 outstanding Triage letters on this list" and she is highlighting you will see the longest outstanding is 263 days, and if we scroll down we will see the spreadsheets she attaches to this. Do you remember such an e-mail? 10:33

A. I don't recall it. I'm in the circulation list so I would have received it.

16 Q. Yes. I wouldn't necessarily have expected you to recall receiving this specific e-mail. I suppose the general point is that this is an example added to the two cases that you pick up on and report in association with Mr. O'Brien, that this is an example of, can I suggest to you, a general awareness that Mr. O'Brien wasn't triaging? 10:34

A. I think it points to an awareness that there was Triage that wasn't happening. I'm not sure in that e-mail that it's identified as a single practitioner or multiple practitioners. When I raised the Patient 10 IR1, I haven't identified who hasn't triaged, because I wouldn't necessarily know who that referral letter has been passed to. There was an awareness that evidently some patients were not being triaged. At that time, triage was paper-based, and pieces of paper passing around a hospital can and do go missing. It's not kind of dismissing it but there are other reasons why a paper-based Triage can go missing as well as it being down to an individual failure. You mentioned late triage. I think there's a difference between late 10:34 10:35 10:35

triage and no triage. No triage is not returning it at all, which is very different to returning it a week or two later.

17 Q. Yes. The cases that we've looked at, the Patient 10 and Patient 93, they were examples of no Triage, the Triage wasn't returned? 10:36

A. Yeah.

18 Q. And not then followed up by the system?

A. Yeah.

19 Q. In other words, the default arrangement kicked in and the patients were allocated a place in the waiting list in accordance with the General Practitioner's designation? 10:36

A. Yes.

20 Q. These are examples of early concerns that you were picking up. You are just a year or 18 months in your role at the Southern Trust. One of the other issues that you appear to have picked up and expressed concern about, is the question of whether private patients of Mr. O'Brien were the subject of some form of advantage when it came to the allocation of treatment. Can I refer you to an e-mail you've appeared to have sent in May 2015? 10:36 10:37

If we can up on the screen, please, WIT-54107? 10:37

This is an e-mail from you to Michael. Michael Young is the Clinical Lead in Urology, is that correct? And Martina Corrigan, who at that time was the Head of

Service Urology. You are saying here:

"I feel increasingly uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order usually having been reviewed in a Saturday non-NHS clinic. On the attached total urgent waiting list there are 89 patients listed for an urgent TURP, the majority of whom will have catheters in situ, they have been waiting up to 92 weeks. 10:38 10:39

However on the ward this week is a man ... who went into retention on 16th March" --

That's just a little over two months earlier. 10:39

-- "failed a TROC on 31st March 2015. He was seen in private clinic on Saturday 18th April and admitted with a view to surgery on 27th May."

10:39

You call that immoral. This was a private patient of Mr. O'Brien; is that correct?

A. That's where he had been seen on the Saturday, as a private patient.

21 Q. How did you come across the issue? 10:39

A. In our practice working as Urologists of the week we would do a ward round of all of the inpatients under the care of Urology, so not just individual consultants but every Elective and Emergency admission. In doing

my ward round, I reviewed him on the ward round and, in reviewing his notes in seeing him, the private letter detailing the private consultation from the Saturday was present, and the timings of his attendances in retention and for his trial removal of catheter were also present.

22 Q. Yes. Why did you consider it immoral what was happening?

A. As I have said in the letter, the Service this patient got is what we would have aspire to deliver to everyone, but at the same time as this man got an aspirational level of Service, there were patients in the same situation with catheters in awaiting the same operation for up to 92 weeks. What we had was someone who had, through whatever means, been able to seek private input. His surgery had been brought forward ahead of anyone else on the waiting list. While that patient may well have been distressed with his catheter, our secretaries, then and now, will continually receive contact from GPs and patients who are distressed with catheters who have been waiting on our waiting list. To, if you like, expedited this patient's treatment while the patient waiting 92 weeks, perhaps miserable, perhaps suffering every day, but patiently waiting their turn, it just disadvantages, if you like, the silent sufferer, the man who is just accepting a Service which is not able to deliver treatments in the timescale that the patient would like and we would like, but is accepting that and patiently

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waiting his turn.

23 Q. Have you considered whether, in any of the cases that you have come across where you believe that there's an immoral approach to it, have you considered whether, on clinical grounds, the prompt attention given to those patients could be justified? 10:42

A. Without conducting a Clinical Review of all of the other patients on the waiting list for the same condition and assessing their level of symptomatology and their suffering, I don't know how you can make a fair justification for that patient at better, greater need than a patient you don't know about. 10:42

24 Q. Yes, but if Mr. O'Brien, in knowing this particular patient, takes the view that there are clinical reasons which would justify a prompter approach than for other patients, that's justifiable, is it not, on clinical grounds? 10:43

A. The only reason for knowing this patient's condition is because he's had the means, or whatever, to seek private input. The patient who is at home, silently suffering, who perhaps doesn't know how to access that, perhaps hasn't got the means to access that, doesn't get their needs assessed and is disadvantaged. 10:43

25 Q. Are you suggesting that the appropriate approach here would have been to put the patient on the normal Trust waiting list and take your time before reaching the top, or to suggest, in the alternative, that he takes his medical problem into the independent or private sector and is treated there? 10:43

A. Yeah. My approach to when patients contact my secretary in this same situation, is you typically advise them and the GP of the issues with our waiting list, but that, unfortunately, I have to manage patients chronologically which means I won't be bringing their treatment ahead of someone who has waited longer, but equally I won't bring someone ahead of them who has waited shorter. Also, where patients are distressed, I will also arrange a Clinic Review to discuss this directly with them and work with our colleagues in the Community Continence Team, our Primary Care colleagues and our Clinical Nurse Specialist colleagues to see what measures we can put in place in the interim to alleviate the problems the patient is getting. 10:44 10:44 10:45

26 Q. Just scroll up a little. Scroll up so I can see the last paragraph.

You say: "The behaviour needs to be challenged and a stop put to it" I think that should read. You say you are: "... unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. I would suggest that this needs challenging by a retrospective audit of waiting times/chronological listing and an honest discussion as a team..." 10:45 10:45

Do you know if your suggestion of a scientific audit to assess the extent of this problem was conducted at that

time?

A. Not at that time, to my knowledge.

27 Q. If we scroll up to page 254106?

At the tail-end of the year, some six months later, you are writing again to Mr. Young and Mrs. Corrigan and you have entitled this e-mail "queue jumpers". Is this essentially the same subject? 10:46

A. Yes.

28 Q. Before we get into the e-mail, why are you writing again? 10:47

A. Because once again, as I say in that top paragraph:

"As I have been through our inpatients in preparation for taking over the on-call today have once again come across examples of this behaviour continuing". 10:47

I am taking over as Urologist of the week and I have identified two patients there who have had very short waiting times and been brought in for surgery, having been seen privately. 10:47

29 Q. Just let me see if I can see Mr. Young's response on this. No, I may not have it. I will refer to it maybe later, if necessary. This is the tail-end of 2015. Again, is the problem, as you see it, resolved at that point? 10:48

A. Absolutely not, it's still happening.

30 Q. Okay. Are you aware of any initiative undertaken, either by Mr. Young or by Mrs. Corrigan, to address it?

A. No.

31 Q. Do you receive any feedback at all?

A. Not that I recollect.

32 Q. Again, this is before you take on a managerial role, you don't address it with Mr. O'Brien? 10:48

A. No.

33 Q. Why not? Why would you not take it up with a colleague?

A. As I said yesterday, the awareness, as it were, of the people around Mr. O'Brien and, in general, experience 10:49 of him, I think I said yesterday him being a challenge to challenge. Essentially, a fear of taking it up. Mr. Young had a long working relationship with Mr. O'Brien and, in general, would have -- the reason I escalated it to him in his position of Lead is part 10:49 in that he was Clinical Lead at the time and in, part, that he has that longer working relationship, so his ability or, if you like, his seniority on a level with Mr. O'Brien to challenge it, would have been, I guess, more effective, I felt, than me as a new kid on the 10:50 block.

34 Q. In December of the next year, you wrote a further e-mail on the subject. If we could have up AOB-01300? Scroll down, please. Thank you.

10:50

23rd December 2016 you are writing to Ronan Carroll. Ronan Carroll, remind us, was the Assistant Director within Acute?

A. Yeah.

35 Q. And management of private patients, is that PP?
A. Yes.
36 Q. And non-chronological listing. Can you recall the context in which you are writing this?
A. Essentially I have come across again a patient who has had a short wait from a private consultation to a TURP on an NHS waiting list. At that time, so this is December 2016, this is a point in time where the non-triage has been identified, Dr. Wright is engaged in and involved in issues surrounding Mr. O'Brien, and this is me that this issue should be looked in as part of that overall look into Mr. O'Brien's practice. 10:51 10:51
37 Q. Yes. You are right to say in terms of the chronology of events, this is reaching the point when the Trust is about to make a decision, or has maybe just made a decision, that an MHPS investigation was to be conducted. Are you feeding into that specifically because you have been told that, or how are you orientated to what Dr. Wright, as the Medical Director, is doing? 10:52 10:52
A. I just had conversations with Dr. Wright around concerns about Mr. O'Brien, and, as the last line says, the question I was asking of Ronan Carroll was did I think this should be fed into the overall investigation. 10:52
38 Q. Yes. We know that it was. Let me have your observations, if you will. You saw this as a problem. You saw it as immoral. You saw that essentially patients on the waiting list for years were being

cheated? I see you nodding. You agree with that?

A. Disadvantaged.

39 Q. Disadvantaged. You believed, and Mr. O'Brien has his own perspective on this, but, to keep it at its most neutral, you believed that there was an experienced Clinician breaking the rules, and there were rules, in respect of the treatment of private patients. You seem to be observing that those in managerial positions didn't grapple with it, or at least if they grappled with it, they didn't do it successfully? 10:53

A. Yeah. I mean whether rules or not, I am fairly clear in my thoughts on it. It's just not right. You don't need a rule to tell you it's not right.

40 Q. What does it say about the Governance of this issue at that time as it was implemented or ought to have been implemented by management on both the Operational and Medical side? 10:54

A. It was, at best, ineffective. Certainly, I think it probably illustrates -- you've asked me why I didn't approach it. I suspect that the same, if you like, fear element in terms of challenging Mr. O'Brien existed for the likes of Martina Corrigan and others who were challenged with challenging his practice. As a result, the easier route of essentially allowing things to continue may have happened. 10:55

41 Q. If I could have up on the screen, please, WIT-53932?

In this section of your statement, and again we are still at this earlier phase of your career with the

Southern Trust. What you are reflecting is that Mr. O'Brien had different ways of working compared with others. This is 61.1. It was apparent that many of these were embedded in his working patterns and widely accepted across the Trust as "his way". 10:56

You go on at 61.2 to give an example of the lack of Clinical information, which we have seen in one of the incidents we looked at yesterday. You talk about the voicing of concerns would have occurred during informal 10:57
conversations and within Departmental meetings, including with the Head of Service but, as you observed a moment or two ago, in the context of private patients, the managerial response to this was at best ineffective. Amongst colleagues, that's yourself, 10:57
Mr. Young, Mr. O'Donoghue by this point and Mr. Glackin, I think Mr. Suresh as well -- he left when? In 2016, I think?

A. I can't remember.

42 Q. But amongst colleagues you talk about informal 10:58
meetings. Was there any attempt on the part of the Urology team as a group, the group of people who collaboratively are delivering this Service and who are, no doubt, impacted by these behaviours that you have outlined, was there no challenge coming from the 10:58
group?

A. As I say, it was certainly discussed within meetings. I don't have documented recollections of it but I have included in my statements, I certainly recall when

a discussion about contemporaneous GP letters came up in one such meeting, Mr. O'Brien expressing an opinion that the only two people that needed to know the outcome of the consultation was him and the patient as his justification for why nothing else was needed. 10:59

43 Q. Does that suggest that, however frequently issues were raised with him and he rebuffed the challenge and nothing more was done, it was -- was it a group shrug of the shoulders, that's just Mr. O'Brien and we can't do much about it? 10:59

A. I think we had attempted to let him know our concerns, you know, even to the point of where if we were doing Clinics to see long waiting patients who had been seen by him before, we weren't able to see as many as we might see if we were doing a long waiting list of 11:00 patients in Clinic who had been under the care of someone else because we didn't have the documented decision-making processes leading up to that, that we could quickly review, and so the process of reviewing patients took longer. Did we collectively as a group 11:00 shrug our shoulders? I think I certainly continued -- well, I certainly had raised concerns and I did raise concerns where it impacted.

44 Q. You were, in raising concerns, looking to the systems and Management to take those concerns seriously and 11:00 make appropriate challenge and escalation if the challenge was rebuffed?

A. Yeah. We, as a group, had made an informal challenge of, you know, this is an issue for us.

45 Q. Yes.
A. And it was rebuffed.
46 Q. Just moving through your statement a little and go to 53948. Again, let me just step through this relatively quickly. At 69.7 on that page, you are reflecting upon the fact that Mr. O'Brien failed, from your perspective, to use the support services that were available to him, that he undertook many of the administrative tasks that otherwise would be performed by a secretarial bank. How were you able to observe that? 11:01 11:02
A. He would recount to us how long it took him to organise a planned theatre list because of the time taken to phone patients and check that they were available to come in, and the like. Where the process that others would use would be to identify the potential patients for a theatre list, and our secretaries would do the contacting of patients, the arrangements of times to come in, and the like, the arrangement for transport where required. He was spending time, to my observation, doing jobs that my secretary did for me. 11:02 11:02
47 Q. Moving down the page to 69.8, you make the point that he complained of the number of interactions or inquiries that he was having to deal with from the Primary Care Sector. Your response to that is that the absence of dictated letters to the General Practitioners to tell them about their patients would have addressed that kind of problem? 11:03
A. Yeah, and, as subsequently came to light with regards

cancer patients, the involvement of Clinical Nurse Specialists. If everyone involved in someone's case has a clear record of what the plan is, then you don't get an Inquiry as to what is the plan, and so it can take some of that, them inquiries away. Particularly with regards cancer patients, many of the uncertainties or queries about cancer patients, for me, for instance, would come directly to the key worker through the contact number for the Clinical Nurse Specialist. So, the workload of patient and GP inquiries can be significantly reduced by ensuring contemporaneous correspondence is available to all those involved in care, and patients have got access to the support systems and services that are available for them to be able to contact with their inquiries. 11:04

48 Q. Were you aware at the time, I mean 2014/15, at any time prior to the 2020 SAIs discovering, apparently, for the first time, Mr. O'Brien's failure as it was reported to use Cancer Nurse Specialists or Key Workers in the treatment of cancer patients? 11:05

A. Not that I recollect.

49 Q. Your observation here is with the benefit of that revelation?

A. Yeah.

50 Q. It wasn't obvious to you as a practitioner working within that Service that, as the reviewers in those 2020 SAI cases concluded that there was a failure to use that resource, whereas other practitioners were using that Nursing resource? 11:05

A. No, that wasn't apparent to me. As I have said in the preceding paragraph, it was apparent that there were other resources that he wasn't making use of.

51 Q. But not that one?

A. But not that one. 11:06

52 Q. Just on this page, you deal with the DARO process. I am going to come back to that in a short while. You raise a specific issue at the bottom of that page. If we can scroll down, please, to 69.10? It concerns an issue that you say arose out of a coroner's verdict in 11:06 October 2015, seemingly a coroner's verdict that was unrelated to the Trust?

A. No, not related to the Trust.

53 Q. The issue that arose out of it was a proposed change to regional policy in the context of the surgical 11:06 management of endoscopic issue resection. Was this a fluid management type issue or hyponatraemia type issue?

A. It related to the fluid used during endoscopic resection, as it describes. Historically transurethral 11:07 surgery was performed using glycine as a fluid medium and monopolar diathermy. That, in itself, has long been recognised in Urology to carry a risk of absorption of that fluid, and absorption of that fluid in significant quantities can lead to problems of fluid 11:07 overload, hyponatraemia, and also glycine toxicity, so-called TUR syndrome. The circular related to a patient death following a resection, not in Urology, from a TUR syndrome. The circular referred to newer

technology which had been around for a number of years by this point, which is using bipolar diathermy. Rather than monopolar, using bipolar technology where the fluid medium is normal saline. For want of a better term it, it's salt water. 11:08

54 Q. Yes.

A. While using that normal saline as your fluid medium doesn't takeaway the risk of fluid absorption, it's absorption of fluid with a normal level of sodium and without glycine, so without the risk of glycine 11:08 toxicity, so the risk of patient morbidity related with that fluid absorption is less.

55 Q. Thank you for that background. The issue that you raise -- just if we scroll up a little -- is that a good deal of work was done as a team to examine this 11:09 proposed policy change. It seems what you are saying is, at the end of it, Mr. O'Brien expressed the view that he would be continuing to use monopolar resection and glycine and would not comply with the policy?

A. Bipolar resection, the equipment is very similar to 11:09 monopolar resection, but the way you resect is slightly different. You tend to move your electrodes slightly slower, so there's a slight change in the way you operate with it. Mr. O'Brien expressed a view that it was the equipment, bipolar resection was inferior to 11:09 monopolar resection and therefore he was going to continue using monopolar resection.

56 Q. Why are you telling us about this? Why was it significant in terms of your impression of Mr. O'Brien?

A. To me, as I was reflecting on things completing my Section 21 statement, it brought to me a recognition that perhaps it was illustrative of an approach where Mr. O'Brien was, I have said a challenge to challenge, he was resistant to an external recommendation of changing his practice to an alternative way of practice.

57 Q. He wasn't challenged on this at the time, was he?

A. I don't recall any challenge at the time. I do know, from subsequent conversations with Anaesthetic team members who would have worked with Mr. O'Brien on his theatre list that mitigations recognising that he continued to use monopolar resections, such as regular monitoring of blood sodium during resection, were put in place, recognising that he continued to use glycine as a resection medium.

58 Q. In terms of these gathering impressions of Mr. O'Brien and your clinical experience of the impact of what you have described as some of his shortcomings on your practice and on the patients that you were treating, you are credited by Mrs. Corrigan and Mr. Mackle as creating the context or contributing to the context in which, by the end of 2015 and into early 2016, a decision was made to speak to Mr. O'Brien in order to see if an improvement could be obtained in his practice. Let me just, for the record, open some of those observations.

If we go to WIT-39888. Just scroll down, please. No,

it doesn't appear to be the right reference. Could we try WIT-11783, and if we go to paragraph 122?

This is Mr. Mackle's response to the Section 21, and he says, just at the bottom of that paragraph: 11:14

"Following the changes to the booking of Outpatient referrals I was not made aware of any delays in Triage and it was only the raising of concerns by Aidan O'Brien's colleagues, while performing Validation 11:15
Clinics in late 2015, that ultimately led to the investigation into his practice."

It is the case that when you and Mr. Donoghue took up post, he in the summer of 2014, you were given the 11:15
task, while you generated your own group of patients, to review some of the longer waiters on Mr. O'Brien's review list?

A. Yes. At the point of taking up post we didn't have patients awaiting review specifically. There would 11:15
have been backlogs from previous consultants, so when I took up post I, if you like, inherited Mr. Pahuja, who had left the post, patient waiting list. I would have seen patients that would have been planned for review by Mr. Pahuja, and part of that included taking 11:16
long waiting patients from our colleagues as well.

59 Q. In that process, it seems that you spotted some of the difficulties we've outlined earlier and communicated your concerns to Mrs. Corrigan and Mr. Mackle?

A. Yeah. As I mentioned earlier, we had recognised as colleagues that reviewing long waiting patients of Mr. O'Brien's where there was, perhaps, no correspondence was more of a challenge and took longer and, as a result, the clinic template, the numbers of patients or the time per patient that was assigned was adjusted to reflect that.

60 Q. Did you go to Mr. Mackle as well or was it Mrs. Corrigan reporting to Mr. Mackle?

A. I don't have a clear recollection. I think it would have been a conversation that we would have had about them specific clinics but I don't have a specific recollection about it. 11:17

61 Q. It would appear, at least from what they are saying, that this led to a meeting with Mr. O'Brien in March 2016 that called upon him to address some of these issues and then, by the end of that year, 2016, the MHPS investigation was about to be launched. At that time, running simultaneously with those conversations, was the investigation into the Patient 10 SAI. Into the following year then, you and your colleagues in the team were asked to do some further work in relation to the Triage issue; isn't that right? 11:17 11:18

A. Yeah. So into 2017, we triaged for the first time those referrals that were in the filing cabinet. 11:18

62 Q. As a result of that, a number of cases were identified as being cases that, had they been triaged in 2015 and 2016, they would have been red-flagged, or they ought to have been red-flagged?

A. They met criteria for a red-flag referral, and so we upgraded them.

63 Q. After the break, I think we'll start into looking at that SAI concerning the five cases. If that's a convenient time? 11:19

CHAIR: Yes. So let's reconvene then at 25 to 12.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MR. WOLFE KC: I was dealing earlier this morning with the issue of private patients and I took Mr. Haynes through a couple of e-mails that he had issued, ending with one which he sent to Mr. Young and Mrs. Corrigan at the tail end of 2015, November 2015. I didn't bring you to Mr. Young's response to that e-mail. I don't propose opening it, now but just, for your note, you will find his response at TRU-274504. 11:36 11:37

64 Q. What I want to move to now, Mr. Haynes, is your involvement in the review that, Serious Adverse Incident review that was conducted in respect of the five patients who I indicated had not been triaged and who, upon review by the team of Consultants, it was recognised would have been red-flagged and ought now to be re-graded as Red Flag patients in 2017. There were five Incident Reports raised. Let me just take you to one by way of example. It's to be found at, I will just get this, I wanted to refer you to a Datix for one of these patients. Let me move straight to the SAI report. We will find that at AOB-02225. I'm going to 11:37 11:38

go through some aspects of that, Mr. Haynes. This was a series of cases where the Incident Report was filed in 2017 and the report issues on the 22nd May 2020; isn't that correct?

A. I think that was when it was signed off at the Acute Clinical Governance. 11:39

65 Q. Yes. The issue that arose that concerned each of these five patients is that they hadn't been triaged on various dates in 2015 and 2016. The facts that were established indicated delays to diagnosis and treatment ranging between six and ten months; isn't that right? 11:40

A. Yeah. These were five patients who were upgraded at that Triage that myself and my colleagues did in early 2017 of the un-triaged referrals. They met Red Flag criteria and were upgraded. These weren't the only five that were upgraded. I think there was 24 that were upgraded. Again, just consistent with some things I said yesterday about our use of the SAI process, these were patients who reviewed as -- these had cancer so they had come to harm, but the other 19 who hadn't been triaged didn't have an SAI done but they all were at potential risk of harm because, equally, they could have had cancer. 11:40 11:40

66 Q. Mm-hmm. Again, applying the criteria of yesterday, they could equally have justified SAIs? 11:41

A. Yeah.

67 Q. I am sorry to jump around a little bit. Let me take you to one example of what was said in the Datix. If we go back to TRU-162114. This is a Datix raised

towards the end of 2017 by Mr. Young. It concerns one of the five patients, that is Patient 15. It shows here he was referred to the Urology Outpatients 28th July '16 for assessment and advice on an episode of haematuria, referral was marked Routine by the General Practitioner. The referral was not triaged on receipt. As a result of a Lookback exercise that Mr. Haynes has just referred to, the referral was upgraded to Red Flag and was seen in clinic in day 179, and on day 187 there was a decision to treat, and on day 217 the patient had a confirmed diagnosis of cancer. There has been a resultant six month delay in Outpatient review and recommendation for treatment for a bladder cancer as a result. 11:42 11:42

In broad terms, because we don't have the time, naturally enough, to devote to a full consideration of this SAI review, but the SAI Review Team examined what issues, Mr. Haynes, if you can remember?

A. From memory, the SAI team examined the issue of Triage, so Triage being done or not done, and the impact of that on the patient; the delay in terms of treatment, and considered the harm as well, so what the outcome of that was. They also examined the referral process as well in the patient being referred, and a patient such as this being referred with very clear suspected cancer symptoms but on a routine pathway. Indeed, I think from my memory, this patient had additional risk factors for why he may be likely to have a bladder 11:43 11:43

cancer in the presence of blood in their urine.

68 Q. Yes. If we could bring up the report again, I want to take you straight to the recommendations that emerged. So that's AOB-02225. If we scroll through that to the recommendations section at AOB-02227. The recommendations that were issued were targeted at a number of constituencies. The first concern was directed to the HSCB in relation to the process of referrals, and that was the electronic process. You were recommending to the HSCB that, in their engagement with the General Practitioner Service, improvements would be made in terms of how referrals were directed to the Secondary Care Sector? 11:44 11:45

A. Yeah. Again, using the example of this patient with blood in their urine, suspected cancer referral criteria are relatively straightforward. If you have visible blood in your urine and you are over the age of 45 you meet Red Flag or suspected cancer referral criteria. My recollection is that what we were suggesting is there needs to be a more, if you like, fail-safe way of flagging that patient as a suspected cancer referral that doesn't rely on the GP recognising that, and doesn't rely on a triaging doctor recognising it, because the patient's age and their symptom can be selected and automatically becomes a Red Flag referral. 11:45 11:46 11:46

69 Q. Could I scroll down the page then to the next set of recommendations. There's a recommendation there for GPs in terms of compliance with the NICE standard. In terms of the Trust, you were particularly focused --

just scroll up, please, so I can see all of the Trust. From recommendation 5, bring that up, please.

One of the issues that you raised was that the Trust should examine whether the process of Triage was one that was capable of being performed as part of the Urologist of the week set of duties. Why was that of concern to the Review Team? 11:47

A. My recollection is that Mr. O'Brien, in his input into the SAIs, had raised that as one of his concerns. Again, my recollection is it was noted that while Mr. O'Brien had raised that as a concern, the other Consultants, who also conducted Urologist of the week activity and also had Triage, didn't have the same issue with not doing triage. I would add that that same model of the on-call, the Urologist of the week or the surgeon of the week, or the ENT surgeon of the week doing Triage, exists in many other services in other Trusts as well as within Southern Trust. 11:47 11:48

70 Q. Yes. I will come to Mr. O'Brien's observations in a moment. The process, just so that I understand it, was that he would get a draft copy of this report for his comment and observation, and then it would be signed off as final; is that right? 11:48

A. Yeah. 11:48

71 Q. Okay. Recommendation 7 seems apposite:

"The Trust will develop a written policy for the guidance for clinicians in terms of the requirements of

the Triage process".

Was that a response to the Review Panel's understanding of how Mr. O'Brien triaged?

A. I think it was a response to, or a recognition in the failings of our system. If we want to monitor how individuals are performing in doing a task, we need to have clarity as to what we are monitoring them against, so what the expectation is in terms of timescale -- 11:49

72 Q. Yes. 11:49

A. -- and in terms of output. By output, I mean the outcome of triage. Are we expecting an advance triage or are we expecting a check the category of referral is appropriate?

73 Q. Yes. If you have a Clinician who is doing Triage of a patient in five minutes and is doing certain tasks, and another clinician thinks an additional range of tasks is appropriate during the Triage process and it's taking him longer, the Clinicians need to understand what is expected of them when performing that task? 11:50 What the employer expects of them?

A. Yes, what the minimum expected is in terms of the outcome applied. What you have done with the Triage and the timescale applied and then individuals can, if they elect to do more, they can do more, but they still 11:50 have an understanding of what the expectation is.

74 Q. Yes. We will come to some of the recommendations that you direct to Mr. O'Brien, as I understand it, in a moment, with that thought in mind. Just scrolling --

maybe I should be saying up as opposed to down.

Recommendation 8 is in respect of the default process, and the Review Panel is strongly saying this should be abandoned. By this stage, the signing off of this report, May 2020, it had not yet been abandoned? 11:51

A. I don't recall. I don't know.

75 Q. Has it been abandoned now?

A. I can't say for certainty. I would think so, but I haven't checked that. 11:51

76 Q. Then you make a recommendation for Audit of Clinician Compliance with the Triage arrangements and invited recommendation 10, what's described here as:

"A robust system within which medical management hierarchy can deal with 'difficult colleagues' and 'difficult issues', ensuring Patient Safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Directors and Chief Executives' tables. This needs to be open and transparent with Patient Safety issues taking precedence seniority reputation and influence". 11:52

What was that about? What was that intended to convey?

A. My primary part in that SAI panel was to provide Urological expertise. Within that role, we had made attempts to get someone from outside of the Trust, given my linkage both to the patients and my previous concern, so I did personally, in terms of expressing 11:52

opinion, try and narrow myself to the Urological, direct Urological aspects. My memory of the discussions is this was addressing the fact that, as we have outlined here, this wasn't the first episode of non-Triage for Mr. O'Brien; this had been a recurring issue that just hadn't been successfully tackled. Within the recommendations there's recommendations in terms of expectations and then a monitoring process, and with that monitoring process there needs to be a clear understanding of how that then is escalated and addressed when failure to comply with that happens, and then how that is escalated if an attempt is made to address step one of that process and that fails, there needs to be clarity as to how that moves on to step 2 and step 3, and where communication within the Trust hierarchy occurs with that. 11:53 11:53 11:54 11:54

77 Q. This was an independent-led SAI?

A. Yeah.

78 Q. You were providing your Urological output. Can I suggest you were the person with greatest knowledge of Mr. O'Brien and his practices. To the extent that that recommendation is directed at a difficult colleague, it would seem to suggest, your voice was somewhere in the mix there. Is this an outworking of it's difficult to challenge or it's a challenge to challenge Mr. O'Brien? 11:54 11:54

A. I think it's an outworking of that same conclusion, that same perception, but not just from my view but from the knowledge that the same behaviours had

attempted to be challenged before by others, and failed.

79 Q. If we scroll down then to Consultant 1, who was Mr. O'Brien, isn't that right?

11:55

Recommendation 11 indicates that it's the view of the Panel that he:

"... needs to review his chosen 'advanced' method and degree of Triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner."

11:55

In one of your earlier recommendations directed to the Trust you were reflecting the view that there needs to be clarity by way of a policy in terms of how Triage should be done so that Clinicians are capable of understanding the expectations placed with them. How does that sit, that absence of clarity, with what you are saying to Mr. O'Brien essentially through this recommendation, that you shouldn't do it this way?

11:56

11:56

A. I think that recommendation is saying you need to look at the amount of time that you are deciding to take doing a process, that it's evident that your colleagues don't devote that same amount of time and, in doing so, they are able to do the Triage. The other thing, as in terms of what that process --

11:56

80 Q. Sorry, just before you move on. So you can do the triage. What the Review Panel seems to have arrived

at, in the way you have phrased that, is that there's an importance to actually doing some form of Triage in order to get it done, to get some movement, as opposed to what was understood to be Mr. O'Brien's way of doing it? 11:57

A. Yeah. At a very minimum, Triage is checking that the referral urgency, so Suspected Cancer or Red Flag, Routine or Urgent, is appropriate, and the largest amount of checking there is making sure that the condition described doesn't meet a suspected cancer 11:57 referral criterion, so to upgrade patients. That's at its very minimum. As you move through Triage, you can do a more advanced Triage, as I would have done certainly through this time where, if patients are referred with certain symptoms that will always require 11:58 certain investigations, they can be arranged at that time of Triage. The process I adopted for that was a series of standardised letters, so I didn't spend a significant amount of time in dictating a letter for every individual patient. They were sent standardised 11:58 letters outlining what they had been referred for and what investigation they were going to get, and requesting a scan. That process took longer than that basic, that very minimum, but it didn't take as long as what Mr. O'Brien described where he telephoned every 11:58 patient and effectively did a telephone consultation. So Mr. O'Brien's complaint to the time that Triage took was a direct result of his choice to telephone a significant number of patients and, in doing that, he

was not able to meet the bare minimum Triage for some patients, as identified in the patients who hadn't been triaged.

81 Q. You go on at recommendation 12 to say:

"Consultant 1 needs to fashion his Triage in a way that meets the expected time limits".

Presumably those time limits set out within the EAP set of standards. 11:59

That report, before it was signed off, would have been, as I said earlier, received in draft form by Mr. O'Brien. Let me just touch on some of the things he said, because it would appear that his concerns about what was contained within the draft report weren't accepted by the Review Team, or at least some of them weren't. 11:59 12:00

Let me turn to what Mr. O'Brien has said. If we go to AOB-02284. In the second paragraph he says he believes the singular and significant flaw of the review has been to investigate the failure to Triage Urgent and Routine referrals in isolation of other pressures and Clinical priorities which he believes are evidently more important. He says that he believes these are greater Clinical priorities that cannot be compromised for the sake of Triage as they have been and continue to be. 12:00 12:01

It's back to the point I raised yesterday and drew attention to this morning again, which is, Mr. O'Brien's perspective is very much that, given the frailties of the system that he has to work in, and you have to work in for that matter, Triage cannot be given the importance or the priority for all referrals sent to him that the Trust would like, and that there's a failure to recognise that in the Review Team's findings?

A. I think the Review Team recognise that the pressures of the Service were not unique to Mr. O'Brien, yet the failure to Triage was.

82 Q. If you scroll to the fourth paragraph down, he goes on to say, dealing with your recommendation 6, that you should review the wording so that the Trust would re-examine or reassure itself that it is feasible for the Consultant of the Week to both perform the duties associated with non-red flag referrals and the duties of Consultant of the Week. He goes on to say that:

"I believe it is crucially important that the duties and priorities of the Consultant of the Week and the expectations of the Trust in the conduct of those duties and priorities be clearly agreed and expressed in a written Memorandum of Understanding or similar."

To that point, that had not been achieved?

A. We would have certainly discussed the format of the Urologist of the Week activities, and the way we worked

during that on a number of occasions during the development of the presentation to the Director of Commissioning in late 2014, and on a number of occasions at Departmental meetings and general discussions between each of us. 12:04

83 Q. Is it fair to say that across the Urology team, there were a range of different views about the purpose and, perhaps, the efficacy of dealing with Triage as part of these duties and, in fact, in your observations to Dr. Chada's investigation, I think you described Triage, did you use the word pointless that context? 12:04

A. I think it's nonsense, actually.

84 Q. Nonsense. What did that reflect from your perspective?

A. I think within the text, Dr. Johnston has reflected this thought process. In a process like referral in to Secondary Care, any process works best if the first decision is likely to be right almost all the time. The best process would be a process, as I mentioned earlier as an example, if you are over the age of 45 and you've got blood that you can see in the urine, there shouldn't be any mechanism by which you can be referred on anything other than a Red Flag basis. Using technology available to us and electronic referral forms, then the ideal situation would be that that actually the referral category is right and I don't need to double-check it. What Triage is doing, or one of the things Triage is doing is it's utilising Clinical time in a Service that hasn't got enough Clinical time to check that the referral category is 12:05 12:05

right, rather than using technology and mandated fields to make sure that it's right at the outset. That is where I say I think Triage is nonsense. If we are having to check and you are getting a significant percentage are referred at the wrong category, and that carries a patient risk at the back of it, then surely a better process is one that ensures that it isn't wrong. At various points we would have discussed if any changes could be made to the electronic referral system. We would have used analogies of booking flights. If you were booking a holiday and there was a 5% chance that you booked a flight to the wrong destination it wouldn't be a very effective booking system. The same principle can be applied to referrals. 12:06 12:06 12:07

85 Q. Yes. You, in some sense, shared Mr. O'Brien's frustrations in respect of the process of triaging that confronted you as a busy Clinician. Where you parted with him was that you felt able to comply with the rules as regards Routine and Urgent referrals, whereas he couldn't find the time to do it as part of his duties as Urologist of the Week? 12:07

A. Yeah. While I had a view personally about whether alternative systems could be adopted that made the requirement for this less of an issue, I didn't abandon it as a duty to carry it out, and I carried it out. I also, as I described, adopted strategies to streamline patients' contact with the Department by a form of Advance Triage that was as efficient in use 12:07

of my time as I could make it.

86 Q. If we scroll just to the bottom of the document, conclusions. Let me just see. Keep going, please. Sorry, I don't have a page number for this. Keep going, please. 12:09

In what is a wide-ranging response to the draft SAI review, Mr. O'Brien reaches the following conclusions. He says that he does agree with the recommendations contained in the report with a number of caveats. He 12:09
says he does believe that it is crucially important that recommendation be amended to ensure that the Trust developer a clear, agreed written policy of its expectations -- something you deal with in part of your review. He goes on to say in the next paragraph: 12:09

"I believe that no Consultant Urologist should be expected to concern him or herself with reviewing their conduct of Triage to align themselves with his or her colleagues, especially when the colleagues claim to be 12:10
conducting Triage in a similar manner. That proposal will be replaced, in my view, by a clear, agreed, written policy of what the Trust", to paraphrase, should expect. 12:10

That seems to be a riposte to the recommendation contained in draft to him that he should seek to align himself to how his colleagues, you and perhaps others, were dealing with Triage. You presumably saw that

observation before signing off on the final report. What do you make of that?

A. I mean, essentially you are presented with a Clinician who, the reason the SAIs had happened is because he had not been able to do the Triage of a significant number of referrals, and had not done it and had not alerted anyone that he hadn't done it. What he's saying there, in my interpretation, is, even though that's the case, I'm not willing to change the way I do it to try and meet the time scales the way that my colleagues do until someone tells me exactly what's expected of me. 12:11

87 Q. If we scroll down, finally, to -- just a little.

This Review Report, as I have indicated earlier is delivered finally on 22nd May 2020, a period of some four or five years after the failures of Triage had occurred, and anything between two and a half and three years after some of the Datixes were raised. Within your statement to the Inquiry, you indicate that the Trust is aware of the risk of delay attendant in investigating some of these SAI cases. By any stretch of the imagination, this is a grossly delayed report. Would you agree? 12:12

A. As I have reflected in my statement, the process of an SAI report takes too long, and indeed this one took, as you highlight there, two and a half years. There are often multiple factors into why an SAI report can take so long. Some of them relate to challenges in bringing, often, panel members together for meetings 12:13

around the SAI, with panel members being busy Clinicians who perhaps haven't got the availability to meet as urgently as would be ideal. Some of them relate to time taken to put together a report, or to draw together all the evidence. Within this SAI interviews were conducted with individuals, I seem to recall. I think Mr. O'Brien was at least had some feed in before his comments. There was other, if you like, things that needed arranging that were arranged around clinicians' schedules. Once a report starts to be drafted, that needs to be reviewed again by them same individuals who have busy schedules. For example, within this, I would have had to review the report and, unfortunately, these reports need time and consideration. They are not something you can review necessarily quickly, and sometimes that can take time. Opportunity for comment, as was provided to Mr. O'Brien in this report, was given, and that can take time. I think in this case, while initial suggested deadlines were given, that was pushed back and the comments came back later. The process takes time because of multiple factors that come together to get to the end, unfortunately.

12:13 12:14 12:14 12:14

88 Q. This report obviously is being signed off a month or so before Mr. O'Brien retires. Plainly, the utility of any of the recommendations, not just in this case but in any case where there is gross delay, is blunted the further you get in terms of time away from the adverse incident itself. If the adverse incident has happened

12:15

as a result of questionable practice four or five years earlier, you would agree with me that there is some importance to be attached to promptitude when trying to identify the lessons that are there to be learnt from the questionable practice? 12:16

A. Yeah. I mean, at the very least, the same practice could be continuing.

89 Q. Sorry?

A. At the very least, you know, if you like, at the worst end the same practice could be continuing while the investigative process is ongoing, and recommendations haven't been made. 12:16

90 Q. Yes. If the Inquiry was to think more generally about your experience of the SAI process, dealing with this particular set of circumstances -- we are going to go on and look at some of the other patients in a moment. What would you be suggesting to the Inquiry in terms of the kinds of procedural improvements that could be made to bring a quicker outcome? 12:16

A. Obviously a timescale related to the steps in an SAI report are important, but I've mentioned that some of the factors are actually the availability of the Clinicians. If Clinicians either involved as, if you like, the subjects of SAIs or the Panel members don't have available time in order to conduct them duties, then you inevitably end up in a position where there is delay. You might want, and I'm sure we would all want, at least a first meeting very quickly after the establishment of an SAI, say, within a month, but 12:17

unfortunately, clinical activity would be booked and scheduled up to six weeks ahead of us, so immediately there's a challenge, if people haven't got time, that you can't have your first meeting for at least six weeks. That creates problems. It's availability and time within the Panel members' jobs.

91 Q. What's the solution?

A. I think the solution is either to take the approach of cancelling the clinical activity to facilitate and enable these to proceed at a quicker pace, or to have a designated group of Chairs, SAI Chairs who have fixed availability in their job plans prospectively to conduct that, them meetings and conduct the SAI investigations. 12:18

92 Q. One of the other observations contained in your witness statement in terms of some SAIs that you have presumably been a party to, is the sometime failure to tailor recommendations to the individual circumstances of the Clinician. In other words, if the Clinician is shown by the process to be weak or aberrant in particular aspects of his or her practice, the recommendations should seek to specifically grapple with that. Is that a weakness of the SAI process or some SAI reports that you have experienced? 12:19

A. Yeah, that's my view. Sometimes we can find that within the body of an SAI report it may identify an individual Clinician failing or issue, but that may not be subsequently picked up within the recommendations of the report as a specific recommendation related to that 12:19

individual or Clinician. These reports did have specific recommendations related to the Clinician.

93 Q. In other words, I'm sure you're too modest to say so, but this is the kinds of recommendations tailored to specific organisations and, ultimately, an individual Clinician, is that what you tend to hold up as if not a perfect example but something that gets closer to the concern that you were expressing? 12:20

A. I think if an identified causal factor in the incident that's being investigated is a behaviour or an action of an individual that is not a system-wide behaviour or action, then you need a recommendation that relates to that individual. 12:20

94 Q. Yes. Let me move on to another SAI dating from 2017 that you were part of the Review Panel. It concerns Patient 16. This matter originated as a complaint from the daughter of Patient 16, a lady from whom the Inquiry heard in its June hearings. The concern that she was expressing, on behalf of her father, was the failure on the part of the Urology Service to arrange for the timely removal and replacement of a ureteric stent for her father, a cancer patient. The SAI report is to be found at PAT-000100. 12:21 12:22

Again, Mr. Haynes, you are part of this panel. A green light to proceed with a SAI review was given in April 2017. I'm not sure if it's clear on the face of that document, but this report signed off on 27th January 2020, some nearly three years later, certainly more 12:22

than three years after the incident giving rise to the concern. Again, is that to be taken as just one of those things, a symptom of a process that didn't arrange for the Clinicians participating in the process to be able to devote sufficient time to getting it done quicker?

A. As I say, it's multifactorial. That's one of the factors. This SAI was also chaired by Dr. Johnston externally. I think my memory is it was considered at the same time as the five non-Triage SAIs, is my memory. 12:23

95 Q. Yes. There were several issues in it, but the issue which called attention to Mr. O'Brien's role was in respect of communication coming into him and his secretary seeking an appointment for admission of this patient that was seemingly unanswered or not dealt with. If I can just open the report at PAT-000112, and if we just scroll down. 12:24

Mr. O'Brien in this context was labelled Consultant Urologist 13. This is the issue that directly concerns Mr. O'Brien and it says, second paragraph: 12:24

"There is no evidence of the letters sent to Consultant Urologist 13" -- that's Mr. O'Brien -- "being initialled to acknowledge receipt. The important 26th November 2015 letter from Consultant oncologist 10 to Mr. O'Brien initially requesting change of the stent was stamped on the Craigavon Hospital chart 11th 12:25

December 2015 but there is no Consultant note/signature/handwriting evident on the letter to acknowledge receipt. This calls into question whether Mr. O'Brien was made aware, at that time, that the stent change was required.

"However, there were several e-mail communications received shortly afterwards that should have brought this to his attention. This series of communication issues could be characterised as indicating a lack of acknowledging, reviewing and/or actioning correspondence."

In its recommendations, the Review Team drew attention to this issue of clinicians dealing with correspondence. If we scroll down to page 115 of that series, that's PAT-000115.

Mr. Haynes, help us if you can. Part of the concern of the Review Panel was that the Trust didn't have a system in place which allowed for the proper monitoring of, and actioning of correspondence by clinicians.

A. Yeah. Essentially, despite much of what we do being electronic, means of communication between Consultants within a hospital still tends to be, then and largely now, in the form of paper letters. If a patient is seen by the Oncology team in the Cancer Centre in Belfast and a letter is written to me in Craigavon,

that comes through the post to my secretary. Although on receipt the secretaries would tend to stamp the letter as to when received, there wasn't a process whereby the system knew that that letter had been received. The system knew when that letter had been passed on to, in the example I gave, me, for me to read it, and annotate what action, if any, is required from that. That action may be simply to file it or that may be to carry out something else. There was no monitoring process for when that was returned from me to my secretary for that, if you like, outcome to be noted. That was, if you like, the problem that we had recognised in the process of this SAI. 12:28 12:29

96 Q. The effect in this case of Mr. O'Brien not dealing with his correspondence -- and I will come on to his perspective in a moment. The effect of that was, from the patient's perspective, profound, in the sense that I think it was identified that there was a delay between 26th November 2015 and 29th June 2016 before the stent was removed and, I think replaced, and a degree of pain and suffering associated with that delay and a complicated or more complicated recovery process of the stent and the replacement. I suppose that puts into sharp focus the need for the Trust to have a system of ensuring that Clinicians are responding to correspondence and, if not responding, a provision or an arrangement for that to be spotted, identified and addressed. Has that changed in the interim? 12:29 12:30 12:30

A. I can certainly give example of how it functions in my practice now. That is, upon receipt of a letter my secretary will scan that electronically to a shared folder on a shared drive so it's date-stamped as to when that's received. I will manage that 12:31
electronically using software to annotate my comments, dating my comments, and save it back to the same shared folder, where my secretary is able to take it off and she stores it herself on a hard drive, so there's a clear record of when it's given to me, when I have 12:31
actioned and when it's taken off and actioned by my secretary.

97 Q. Yes. In terms of the outsider, the Trust, a Trust manager, how can they identify that you have perhaps failed to do it for a month or two months or, in this 12:31
case, several months?

A. For me, that would be reliant on my secretary highlighting that I haven't done it.

98 Q. Yes. The system beyond you and your secretary doesn't know until, in this case, the patient's daughter 12:32
complains, or somebody else, perhaps another Clinician, spots it?

A. Or my secretary escalates that I've not done it through her line management.

99 Q. Sorry to cut across you. Is she given that, if you 12:32
like, supervisory responsibility vis-à-vis you? In other words, if you are not doing your job, she has liberty to raise that with her management?

A. My secretary is very aware that I am clearly of the

view that that is her role, and that's a protective role for me as well.

100 Q. Yes.

A. What I was just going to add is that I am aware, and it's currently a live thing, in that an alternative process for the inter Consultants, so inter Speciality referral process that will come through the electronic Triage system on ECR is developed and is due to be trialed in the near future. Indeed, one of the e-mails I have picked up this morning concerns that being trialed within Urology in Southern Trust in the near future. 12:33 12:33

101 Q. I said I was going to look at Mr. O'Brien's perspective on this. If we go to AOB-03494. Just the top of his letter, if we scroll up, please, to 03495. 12:34

What Mr. O'Brien is saying here is that he is acknowledging receiving correspondence in respect of this patient, asking for admission to deal with the stent issue. He says: 12:35

"The subsequent e-mails which I received from" -- his secretary or audio typist, and he gives the dates -- "are typical of requests and enquiries which I have received every day for years from patients, relatives, GPs, MLAs, MPs and personnel in Trust management, regarding dates for admission. For years, I have had approximately 280 patients awaiting elective admission and re-admission. I currently have 228 patients 12:35

awaiting urgent elective admission dating back to August 2014, prior to Patient 16 having first been referred to our Department in March 2015."

He goes on to say: 12:36

"The failure to respond positively to any request for admission is a consequence of the lack of operating capacity provided by the Trust. The failure to respond in any way to every request is additionally 12:36 a consequence of the lack of time provided and available to do so."

There's two features there. He is saying, I don't have the time or didn't have the time, because of the 12:36 frailties of the system within which I was expected to operate, to grant this patient a timely admission. Secondly, although I'm aware of getting these requests for assistance, I don't even have time to deal with the correspondence. Your observations on that? 12:37

A. I think it's notable the period of time. This was 2015/16, and we've already discussed my concerns being raised through 2015 on two occasions, I think it was, about private patients being brought in very quickly after a consultation. Indeed, was it December 2016 my 12:37 e-mail to Ronan Carroll about a routine TURP being brought in after a very short period of time?

I think one reflection is that it appears that he can

respond to private patients' clinical urgency but not a patient he has being contacted about who is also urgent. I do recognise, and I have highlighted it within my statement, the issue of us not being able to meet demand, and I commented yesterday about the impact on patients having delayed changes in dwelling stents or delayed stone management with stents in situ, and the potential risk of an increased or more complicated procedure. There's almost a suggestion in his comment that he'd just managed this change of stent on the same urgency as everyone else on the urgent waiting list, that's not entirely in keeping with how any Urologist manage patients with stents in that require changes. They are planned for changes. The manufacturers recommend changes every six months. We endeavour to meet that. On occasions, we are late, we are not able to meet that, but that's not managing them in a chronological manner with everyone else urgent back to 2014. If that was the case, we'd have every patient with a long term stent being admitted as an emergency with a complication. While I recognise that he may not have had the capacity to manage this patient as urgently as he perhaps would have liked to, to say that he couldn't manage him at all and, at the same time, over that period of time, have patients that I have identified who had short waits for less urgent procedures arguably, who he happened to have seen privately, just doesn't seem to fit together.

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102 Q. If you don't have time within your waiting lists to

address this patient, and if you find that you don't have time to draft a letter, is there another approach that should be taken to alert the wider system to your lack of capacity in respect of a particular patient?

A. Again, and I would have done this myself on occasion where I've been in this almost exact situation of patients who have long term indwelling stents where I haven't got theatre availability, I will communicate with my colleagues and say this patient needs their stent changed and I haven't got any operating space, is there any chance someone can offer a date? 12:40 12:41

103 Q. Presumably, when you see correspondence not being answered for such a long period of time, that reinforces the point that the system needs to develop a way to identify that and challenge it? 12:41

A. Yeah. You know, we all get a significant volume of patient correspondence, we all get a significant volume of e-mail correspondence. As a system, we need to know where that correspondence relates to patients isn't being managed, isn't being actioned. As an individual, I think we also need to be alert and recognise that we need to ask for help and state very clearly not, I'm finding it difficult, but I'm not doing it, if you are not doing it. 12:41

104 Q. Yes. The Inquiry also has to look at these kinds of instances, both this patient, Patient 16 as well as the group of five patients we have just looked at in the triaging context, and Patient 10, the other Triage case, we have to look at these cases in a more rounded 12:42

way to see what those instances were telling or ought to have been telling the Governance arrangements about a practitioner employed doing very important work, had, no doubt, a huge skill set but, for whatever reason, judged by these examples, was struggling to deliver the service which at least the Trust expected him to deliver, and leaving aside the delay issue, because some of these conclusions didn't emerge until 2020 itself, albeit before his retirement, but if you had received the report, or had you produced the report as part of a team with regards to the five non-Triage cases or, to use this different example, Patient 16, what would that have been saying or what that ought to have been saying to the Trust about Mr. O'Brien and his way of working? 12:43 12:43 12:44

A. I think what it said is that he's not on top of this correspondence. There's factors that -- there's an issue here akin to the issues that then became part of the MHPS investigation. If you are, say, not acting on a CT report, it's very similar to not acting on a piece of paper, a correspondence letter. It's, I guess, flagging that there is an issue in this individual's way of work in his practice that is a risk. 12:44

105 Q. Let me turn to a couple of cases that deal with this issue of this CT report. What I mean by that is that we can see dotted across this narrative that on a number of identified occasions, and of course there could be other instances not identified, not least for the Inquiry but also for the Trust, where, with regard 12:45

to patients for whom Mr. O'Brien has some element of management responsibility, there are investigations, they are sitting in report form to be accessed and they are not accessed on time or sometimes at all. Is that something that's familiar to you? 12:46

A. That's a factor in some of the patients within the subject matter, or the patients within the list here that we are considering. It's the same factor as I had highlighted in some of the concerns that I have raised.

106 Q. Yes. 12:46

A. Indeed, had been a factor in concerns raised prior to me starting in Southern Trust, as we heard last week.

107 Q. If we go to the case of Patient 92. You raised an Incident Report on 12th March 2019. If we just pull that Incident Report up. It's at TRU-162123. We can 12:47 see, again just what I have said there, you are the reporter, it's being raised on 12th March 2019. Let me just read from the narrative. This was an inpatient admission between 29th November '17 and 7th December '17. There was to be a follow-up CT renal 12:48 in three months. The CT was performed on 13th March 2018 and reported on 20th March 2018, showing suspected renal cancer. There was a GP referral four months later on 17th July 2018. There had been no review and no follow-up after the CT scan. The patient, that is 12:48 Patient 92, subsequently underwent surgical treatment of the renal cancer. To cut that down another way, this was one of Mr. O'Brien's patients. He had directed that a CT scan of the kidney would be

arranged. That was conducted in the Radiography Department and reported on promptly, and the scan report showing suspicion of renal cancer was there to be read but it wasn't read. No action was taken until a GP, fortuitously, wrote in, red-flagged the patient and the situation assumedly was recovered. Is that your understanding of what happened in summary?

A. Yes. The patient was in as an emergency with an upper urinary tract infection and a CT at the time had showed an abnormality which showed could be infection which related to inflammation or could be a cancer, and a CT scan was recommended. That was requested and performed in March, and reported as a renal cancer.

108 Q. The Serious Adverse Event report commented on the absence of a process to ensure the actioning of investigation results. If we could just open that report at TRU-41198? I think if we go to 90, please. Sorry. Go back to TRU-41198.

The first recommendation, Mr. Haynes, is that:

"The Trust is to review its current processes of communicating, recording and signing off suspected cancer diagnosis to patient's Consultants. The Trust is to consider a system in which results can be communicated to referring Clinicians and electronically signed off by the referring Consultant."

Is that the kind of facility or system that, had it

been in place, might have addressed the issue in this case?

A. That system is available for use. I can't recall when it became available, but I think at the time of this SEA it was available. It's certainly a system that I utilise myself and that is whereby, on the electronic care record, there's a tab for sign-off, on to which appears any report or result which has been requested by me when the report is made available. If a reporting Radiologist reports a CT scan now and that's confirmed, so signed off by him as complete, him or her, that, then, appears on my sign-off list on NIECR so I can assess it straight away. In my working practice, I work daily making sure I keep on top of them results coming in, and so if that result shows an abnormality, in this case I would have arranged for an Urgent Outpatient Review to see the patient, to inform them of the result and, subsequent to that, would have arranged staging an MDT discussion of treatment options. That system exists. I think the bigger thing is the engagement of clinicians in the systems that do exist. As a team -- 12:53 12:54 12:54 12:54

109 Q. Let me come to the DARO system in a moment.

A. Yeah.

110 Q. You made an observation at an earlier point about the absence of, in some SAI reviews that you are familiar with, the absence of directed Consultant specific recommendations. Here is perhaps an example of this. In this case, presumably it would have been helpful for 12:55

a recommendation to have been made for the attention of Mr. O'Brien to access, read and action investigation results that were ordered by him in respect of his patient?

A. And monitor that it's happening. 12:55

111 Q. Yes. This wasn't a new type of incident or a new type of shortcoming on the part of Mr. O'Brien, according to the Trust. In 2010, there was a case concerning Patient 95, clearly before your time, but I would just wish to have your observations on it. Patient 95 was 12:56 the case of a swab retained in the cavity following surgery, and Mr. O'Brien was the surgeon.

For the Inquiry's reference, there was an SAI report that dealt with the case and it failed to make any 12:57 recommendation in association with the reading and actioning of CT reports.

If we can open TRU-259876, and just so that I can see the bottom of it, please. 12:57

This is an e-mail from 25th July 2011, the year after the SAI review had reported in Patient 95, Mrs. Trouton is writing to the Service and saying:

12:58

"I know I have addressed this verbally with you a few months ago but just to be sure, can you please check with your consultants that investigations which are requested that the results are reviewed as soon as the

result is available and that one does not wait until the review appointment to look at them."

Isn't that precisely the same concern that we've observed in Patient 92's case? 12:58

A. Yeah.

112 Q. A CT report available for the treating Consultant to review and action if necessary, but not being seen by that treating Clinician?

A. The safety net being the patient coming to clinic when they come to clinic in the context of a Service with a significant capacity demand, mismatch and long waits for Clinic, and therefore, in such a situation, that patient's scan may not be reviewed for a significant period of time. Indeed, it's echoed in later SAIs such as Patient 5 as an example I can just pull from the top. 12:59 12:59

113 Q. Yes. We will come to that in a moment. I just want to look at the remainder of that e-mail trail just before lunch. If we can go back, just scroll down. 12:59 Mrs. Trouton has written, let me see the response to that. Go down to 75. And 74. Okay.

Mr. O'Brien has evidently been informed of Mrs. Trouton's expectation in respect of the reading of results, and he writes in response to that and comments that -- I will read it all out: 13:00

"I write in response to the e-mail informing us that

there is an expectation that investigative results and reports are to be reviewed as soon as they become available and that one does not wait until patients' review appointments. I presume that this relates to Outpatients, and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons".

He sets out a series of questions, and in the middle of that, he asks: 13:01

"How much time will the exercise of presentation take? Are there other resource implications to the presentation of results and reports for review?" 13:01

A series of questions, and he says he believes that these need to be addressed.

Just pausing there. I pointed out earlier Mr. O'Brien's perspective is within the system that he has to operate in, how can he possibly find the time to deal with that? The better approach from his perspective is to review the results at the time of the Clinic when the patient is coming in for review? 13:02

A. I think it's a complete abdication of responsibility for carrying out the action for patients under your care. It's interesting he asks whether he's to review all results and reports relating to patients under his or her care, irrespective of who requested them. 13:02

I would never ask that question as a Consultant, whether it's a trainee, whether it's a non-Consultant career grade, whether it's a Clinical Nurse Specialist who requests an investigation on a patient under my care; I'm the responsible Consultant. From memory, but I believe the GMC duties of a doctor has comment on responsibilities of Clinicians to look at results of investigations of patients under their care. Essentially and to say, I know -- I mean, knowing the system we work in, I know I'm not going to be able to see patients in the time that I should, but I'm not willing to look at any results because the system should enable me to see them and they don't in the time that I have asked for, and if it can't it's everyone else's fault and whatever falls out of that is nothing to do with me; it's not a viewpoint that I could share or ever understand. 13:03 13:03 13:03

114 Q. Yes. Let me just finally, before we break for lunch, if we can go one page up again to TRU-259873. We have on the 26th August 2011 an e-mail from Eamon to Gillian. Eamon is Eamon Mackle, the Associate Medical Director and he is writing to Gillian Rankin, who I think, from memory, is the Medical Director at that time? No? 13:04

A. I think Director of Acute Services. 13:04

115 Q. Director of Acute Services. Thank you. What Mr. Mackle is saying:

"I have been forwarded this e-mail by Martina" --

Martina Corrigan, and that's Mr. O'Brien's -- "and I think it raises a governance issue as to what is to happen to the results of tests performed on Aidan's patients. It appears that at present he does not review the results until the patient appears back in Outpatients Department." 13:05

We will have to speak to Mr. Mackle to see what was done with that Governance conundrum, but, judged by what you were seeing with Patient 92, you've referred as well to Patient 5, which was one of the 2020 SAIs. I don't know if you can remember the facts off the top of your head, but Patient 7 is -- others can correct me if they think I am wrong -- but appears to be another failure to action results and follow up. Albeit of a different kind of case, Patient 90, which was reported just before the Patient 92 case, Patient 90, you may recall, was a death following surgery. One of the observations of the SAI team in that case was that it was indicated in 2016, via a CT scan, that there was a requirement for an echocardiogram and that was not actioned, nor was there a formal preoperative assessment that might have spotted that issue prior to Mr. O'Brien taking the patient to theatre. 13:05 13:06 13:06

13:07

After lunch, I will maybe return to some of the governance aspects that flow from that collection of similar cases, but I think now would be a suitable point. Ten minutes ago might have been a suitable

point!
CHAIR: Given what might have been suitable ten minutes ago we will not sit again until ten past two.

THE INQUIRY ADJOURNED FOR LUNCH 13:07

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone. Mr. Wolfe.
MR. WOLFE KC: Good afternoon. Chair, if you feel that 14:11
a break is required at any point, just let me know. I don't intend to break but I realise that would be selfish, perhaps. The likelihood is that what I'm regarding as, sort of, scene-setting evidence, this first phase of Mr. Haynes' evidence is unlikely to 14:11
conclude today, just looking at what I have to get through. I suspect another half-day will be required, probably the longer half of the day, the morning half of the day as opposed to the evening half of the day. I have mentioned that briefly in passing to Mr. Lunny 14:11
on the way in. I haven't had a chance to discuss diaries with Mr. Haynes. I know that, as a surgeon, it may not be possible to make the 13th, but that's what our thinking is, and it can be discussed with his legal team after today. 14:12
CHAIR: Yes. I mean obviously, Mr. Haynes, we are aware of your commitments and if we can accommodate you we will. Obviously we have a job to do too, so if we can work together towards a mutually agreeable date,

that would be better.

MR. WOLFE KC: Okay.

MR. HAYNES CONTINUED TO BE EXAMINED BY MR. WOLFE AS FOLLOWS:

116 Q. Just before the break, we were looking at the issue of sign-off, that is the Clinician should be seeing the result of an investigation and looking at it and taking necessary action. We have looked at some cases where that hasn't happened with Mr. O'Brien. It did mention briefly, and I just want to look at the recommendation in the case of Patient 90. If we could bring up TRU-161146. 14:12 14:13

The first recommendation is:

"The Trust should develop and implement guidance for clinical rough sign-off with a monthly audit of sign off to be presented to the governance forums." 14:13

I just want to check that I understand that. It's seeming to suggest that, at that time, there wouldn't have been guidance to Clinicians in respect of Clinical results sign-off, but going forward, the Review Team appear to want to see that, and they also want to have a process of audit in place so that the system knows where Clinicians are not looking at their results and not signing off and actioning. Is that a good layman's interpretation of what's going on there? 14:13 14:14

A. Yeah. As I commented on a previous question in, I think, relation to the letters coming in, or it might have been Triage. If we want to monitor performance

against something we have got to have clarity as to what the standard is we are monitoring against and how that is then interpreted, audited or monitored, and then how that is escalated when non-compliance occurs.

117 Q. Okay. Was it unclear to Clinicians that the early reading of results and actioning, if necessary, in light of those results, was that unknown to Clinicians? 14:14

A. I think it's apparent from my views that I've expressed that an understanding that you have a responsibility is certainly there with most of us without having to have that what's expected written down, but it's also apparent where you have issues arising out of not doing that, that for others that understanding or recognition, or acceptance of a responsibility for that aspect of work doesn't appear to be within their work and practice. 14:15 14:15

118 Q. Yes. It's obvious as this, isn't it: If you have gone to the trouble to instigate a CT scan to rule in or rule out a disease, particularly in the area of cancer where you can have aggressive cancers progressing quite quickly, it would be plain daft to leave those results sitting in the ether for three, four, five months, or whatever it might take, in a context where the waiting list for reviews are, to put it mildly, less than generous. Really, it's a matter of common sense for a Clinician to look at them as soon as possible? 14:16 14:16

A. It certainly is for me. As I have said, my understanding is that the GMC is clear that it's our responsibility to action results of investigations we

request.

119 Q. We have seen in this brief potted history of the cases that have come to this Inquiry's attention, 2010 with the stent retention, 2018 in the case of Patient 90, 2018 again with Patient 92, and then the two cases in 2020. What does it say about the Trust's arrangements, if this issue with this practitioner is known about in 2010 causes Mr. Mackle to say this is a Governance issue, look at how Mr. O'Brien is protesting this with a series of questions, and then the issue comes up again and again, again and again, the system isn't grappling with it, is it? 14:17 14:17

A. No.

120 Q. It's the same issue in different clinical or different factual contexts all the way along this ten-year period? 14:18

A. These are cases, as you've suggested under reporting before, these are cases we know about where there has been significant findings on the scans. Alongside these will also be lots of patients who didn't get the result of normal scans or scans without a significant finding until their review appointment, which may have been many months or even years later. 14:18

121 Q. In terms of the system, I'm a Clinician, I am routinely not checking the results for my patients, has that been grappled with today, November 2022? Is the system now aware, via electronic process or audit, if this kind of thing is happening in Craigavon today? 14:18

A. Within Urology, in my role as Divisional Medical

Director for Urology Improvement, we have a weekly audit, exactly as described there, where we have a report generated as to how many outstanding results are awaiting sign-off by the Consultant Urologist. I've developed that in a red, amber, green format so results that are less than two weeks old, results that are two to four weeks old, and results that are over four weeks old. I know that within Urology, we have a system working where all of the Consultants are working utilising the electronic sign-off and the print -- or the result yesterday, the result last week is the only outstanding results are less than two weeks old, so I know that, within Urology, we have developed that system, and I've started speaking across the other Divisional Medical Directors as to how that can be translated across into other Specialties. 14:19 14:20 14:20

122 Q. Yes. I think the Inquiry might accept that sometimes it's more difficult to develop a system-wide solution, you know, that goes through, no doubt, numerous committees and numerous obstacles before you get a solution at the other end, but it's perhaps easier to devise an individualised bespoke solution, so if you know that a particular Clinician is falling foul of the rule that you described earlier as sort of get to these things promptly, then it should be a straightforward matter of including that as part of a monitoring arrangement? 14:20 14:21

A. Yeah. So if you are monitoring arrangements, particularly if you are monitoring arrangement for the

example of results mandates an engagement with that electronic sign-off, getting reports on a weekly basis, which is exactly what I am getting, of an individual Clinician and essentially filtering that Excel file for signed off or not signed off, is a straightforward monitoring process. 14:22

123 Q. But it wasn't done?

A. That wasn't done.

124 Q. You speak in your statement about a system called DARO and I have stopped you several times from talking about it; now is your chance. Let me just orientate you. Your witness statement at WIT-53948, paragraph 69.9. I am going to bring you to Mr. O'Brien's e-mail presently, but just explain to us, if you can, DARO. What, in the context of what we have been talking about, how does DARO assist or detract from this issue? 14:22 14:23

A. In terms of results, or any process in healthcare, we hear about Swiss cheese and essentially where problems happen, often patients have fallen through holes at multiple steps. In terms of monitoring or getting results, there is a potential that I may not get a result that was requested on a patient under my care on the electronic system. If, for instance, a junior doctor selects the incorrect Consultant, or there are two Mr. Haynes and they select the other Mr. Haynes then that result might come to another Consultant. If step 1 of my process for managing results fails, then I need a second step and a third step and, I have described the DARO process there as a safety net 14:23 14:24

process. The electronic system for me and my colleagues in Urology is our first step of that process. In addition to the electronic results, for Radiology, for instance, and for Pathology, the result is printed and sent to our secretaries as a paper result, and our secretaries are able to check whether we've actioned that against, has it been signed off on ECR. Then a third is what if that piece of paper doesn't reach our secretaries, goes missing, then that's where the DARO process comes in. If a patient has seen me in clinic and I have requested a CT scan, then my secretary will add that patient to the DARO list as awaiting a CT result. Each month, my secretary will check against that DARO list if them patients have had the CT done, has it been reported and has the report been actioned, and then take them off that. It's a safety net within that, if you like, I have just described a three-step or a three-point process. 14:24 14:25 14:25

125 Q. Yes. We can see, if we open an e-mail from a Mrs. McCall at WIT-55864. She is writing on 30th January 2019 to what I take to be to a number of members of staff, including a Noeleen Elliott who is Mr. O'Brien's secretary. Are these medical secretaries in the main? 14:25

A. Yes. 14:26

126 Q. Yes. She is writing in order to explain, so far as I can see, the DARO system and how it should be used. She's saying that:

"If a Consultant states in the letter 'I am requesting CT," et cetera and will review with the result'. These patients all need to be DARO'd first, pending the result, not put on a 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 so patients are not missed. Not always does a hard copy of the result reach us from Radiology so we cannot rely on a paper copy of the result to come to us. 14:27

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." 14:27

So your description of a fail-safe mechanism, use DARO and you keep track of the CT result? 14:27

A. Yeah.

127 Q. Further up the page towards the top of WIT-55862 -- sorry, at the bottom, at the bottom, Mr. O'Brien replying to Ms. McCall, and he says that he has been: 14:28

"... greatly concerned, indeed alarmed, to have learned of this directive which has been shared with 'him' out of similar concern."

He says that:

"The purpose of, or the reason for, the decision to review a patient is indeed to review the patient.

The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.

The investigation may be of varied significance but it is still the Clinician's decision to review the patient. One would almost think from the content of the process that Ms. McCall has sought to clarify, that normality of the investigation would negate the need to review the patient, or the Clinician's desire or need to do so.

One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for the review as requested, or are those patients not to be reviewed at all?"

So a series of rhetorical questions. Then he goes on to give an example down the page. He makes the point that secretarial staff are being consulted in relation to this as opposed to Consultants, who, he says, should be consulted. You then come in on this because presumably Mrs. McCall has directed your attention to the reply?

A. I was copied in by Mr. O'Brien to the reply, I believe, along with my colleagues.

128 Q. Okay. If we go to WIT-55862. Are we on that page? Mr. Haynes, your response is to push back against what Mr. O'Brien is saying. First of all, how did you interpret what he was saying? He was asking a lot of questions. He was suggesting that it's really a matter for the Consultant to decide when a review should be listed or should be notified to the system, and that the DARO process, as described by Mrs. McCall, shouldn't interfere with the Consultants' autonomy on these issues? 14:30 14:31

A. If you look at the DARO process as described by Ms. McCall and apply that to Patient 92, who we covered before, who had that CT scan, that follow-up CT scan in March, if she had been on the DARO list, at the end of March that list would have been able to be checked. The fact that she had had a CT scan showing a kidney cancer would have been picked up and she could have been offered a Red Flag appointment at that point, as Ms. McCall has indicated in her e-mail. The plan that was in place for that patient, where she wasn't on the DARO list, meant that she sat in a review backlog waiting to come to Clinic for the urgency of the report to be noted. Mr. O'Brien's approach to it, to me, fits again with my comment earlier of an abdication of a responsibility to have a system, or engage in a system to review results of patients -- of scans of investigations that you have requested on patients. 14:31 14:32

129 Q. I take it that, to your knowledge, he didn't use DARO at all?

A. DARO is not utilised by the Consultant; it's our secretarial team use the DARO process. It happens for me and for most -- well, to my knowledge, all my colleagues, by our secretaries, with investigations that results are identified that we haven't found through our other processes being flagged up to us by our secretaries when they do that check of the DARO list. 14:32 14:33

130 Q. The fact that she, the secretary, in conjunction with Mr. O'Brien, wasn't using that fail-safe, was that known?

A. It is evident from that correspondence that Mr. O'Brien and his secretary didn't feel that they should apply the DARO process to the patients under the care of Mr. O'Brien. 14:33

131 Q. What's your understanding of the rationale for that?

A. I can only repeat the rationale he's put in his e-mail, that is he'd already decided that if the patient needed a review appointment, they should be waiting for a review appointment, they shouldn't be on another list. He seems to have not accepted that that review appointment might not be for many years, and that patient may sit for many years with an un-actioned potentially abnormal scan. 14:33 14:34

132 Q. This provides further evidence to you, as his Associate Medical Director, of a Clinician not willing to conduct his practice in accordance with the expectations of his

employer?

A. Yeah.

133 Q. The question is: And yet, it's not monitored, this aspect -- I know we will go on in a moment to look at some of the aspects of his practice that were monitored, but the actioning of results was not something that was monitored even though there were clear indicators that would give rise to a suspicion, perhaps a strong suspicion, that this was a part of practice that he didn't, for whatever reason, wish to engage in? 14:34 14:35

A. At this time, the MHPS report had come out, I think at the end of 2018, within the return to work there was a monitoring process, but I don't believe it covered this aspect of his work, no. 14:35

134 Q. No. I wonder would this kind of knowledge, this kind of world view of how I am to address the results of investigations, whether it fell to you, with his Clinical Director, to challenge that, given that it was known and subjected to monitoring for compliance? 14:36

A. As you say, I addressed it directly with him at that time in my reply, but I also escalated it to the Medical Director at the time in the subsequent forwarded e-mail, given that, at that time, as I say, the MHPS monitoring, that process was still ongoing and that process, in terms of the Oversight Group from that, didn't involve me. I escalated it to the team who were in the Oversight Team by escalating it to the Medical Director. 14:36

135 Q. To your best knowledge, again, nothing was done to monitor that aspect of his practice?
A. To bring this into that process, not that I'm aware of.
136 Q. Yes. Because, as you know, there were two further cases to be discovered in 2020? 14:37
A. Yeah.
137 Q. In terms of an abdication of responsibility, if you're passing it up the line to the Medical Director's Office because you aren't to get involved with monitoring issues, is that an abdication of responsibility on the 14:37
part of the Medical Director's Office or those charged with monitoring him?
A. Without knowing what was done with receipt of that, I don't know whether that was considered by the Oversight Team in terms of that MHPS outcome. 14:37
138 Q. We know that two cases weren't caught in any form of net, and I'm just wondering whether you were aware of whether a net had been created for the purposes of catching?
A. I wasn't aware of any additional monitoring being 14:38
brought in with regards this. I'm sure we will get to the Backlog Report and concerns that I'd escalated with regards to the Backlog Report. On the face of it, that Backlog Report included a report of the numbers of
results awaiting action for each Consultant, and so it 14:38
was within that Backlog Report, it's possible that there was a belief that that Backlog Report was adequately monitoring this aspect of practice.
139 Q. We will come on to look at what was being monitored

through that action plan in a moment. One other point that you make, you make it specifically in relation to Patient 92 and it's concerning -- I will not bring it up on the screen unless you need it. You make the point that one of the frailties of the SAI and the consequentials of the SAI process is that action plans do not get implemented quickly enough, that there's delay and I suppose you'd call in aid the delay in Patient 92's action plan as being in some sense critical in allowing other cases of a similar nature, a similar shortcoming, to proceed undetected. Is that a problem within the Southern Trust in particular, in your experience, in terms of getting recommendations moved into the action plan stage and then out into the implementation stage? 14:39 14:40 14:40

A. I've made that comment without knowing that, in 2010, with that retained swab, there was a similar issue previously as well.

140 Q. Just to interject, the problem, in 2010, was they didn't even make a recommendation in terms of that practice. It was left locally to management to make a comment about it. It was supposed to be a Governance issue to be taken forward but -- 14:40

A. Yeah. In Patient 92, there was a patient who had a scan result that didn't get any action and had a delay in her treatment potentially as a direct impact of that. Actually, enacting or bringing about either monitoring of an individual or, as you have mentioned, a system-wide change in terms of how all Clinicians 14:41

manage results and are monitored against results, has taken time and potentially, well specifically with Mr. O'Brien, time passed from that point, and other patients had the same issue happen.

141 Q. Yes. I spoke this morning about the delays. There's delays with action plans. There's delays in getting SAIs completed. I should have drawn to your attention an observation which Mr. O'Brien makes in his correspondence to your Review Team as part of the SAI in connection with Patient 16, I think. I will just check that. 14:41 14:42

If we could have up on the screen, please, PAT-000122. This is 28th October 2019, an e-mail from Connie Connolly to Mr. O'Brien. You will remember that this SAI started life in 2017, and she's writing to Mr. O'Brien and saying to him: 14:43

"I would be grateful if you could read over the reports". 14:44

I suspect this is both the Patient 16 report and the five patients' report which are being considered at the same time, albeit separately.

She is asking him to respond within two days on the back of an investigation that's taken three years to complete. What was driving this? Was Patient Safety driving this, or was there a sense of embarrassment 14:44

that we'd better get this report out quickly because I think Patient 16's daughter had gone to the Ombudsman in relation to her complaint? Mr. O'Brien has a point, first of all, doesn't he?

A. That's a very short timescale that he's been given. I don't recall being involved in a discussion of what was a reasonable deadline to expect. 14:45

142 Q. You would accept that if Patient Safety was being taken seriously, albeit that there may well be many mitigations for the delay, Patient Safety is rather lost in the discussion if it's taking three years to produce an outcome? 14:45

A. As I've said and reflected in my statement, the time taken for the SAI process is too long.

143 Q. Each of those incidents that we have looked at over the past two days has been reported, albeit in some cases, such as Patient 92, the SAI report isn't to emerge until after the MHPS investigation. They were all in the system, some have reported, not all have reported, MHPS is underway, and you have an opportunity to contribute to the MHPS process as a witness. I don't want to take you through all of your statement, but I just want to touch on some parts of it. 14:46 14:46

You provide a witness statement to Dr. Chada's investigation in May of 2017. If we could just bring that up. It's at WIT-55704. Talk me through the process of this. Do you go and meet Dr. Chada and she asks you some questions and then this is written up as 14:46

a statement for you to sign?

A. I think that was the process, from memory, yes.

144 Q. Yes. I just want to step through it rather quickly. You deal with many of the issues we have covered over the past day or so in your evidence. At paragraph 8, for example, I think that's a reference to the case of Patient 10, which you discovered in January 2016. You deal in some detail with the Triage issue. At paragraph 17, you go on to deal with situations where notes are not available to you because, I think you are suggesting, Mr. O'Brien has them at home or in his office. So I think you refer to two patients, one of whom might be Patient 103, I think, that we discussed yesterday. 14:47 14:48

Scrolling down to paragraph 22, you are dealing with the issue of dictation. That's from the South West Area Hospital there appeared to be no dictation, no outcome sheets and no notes brought back. You go on at paragraph 23 to say: 14:48 14:49

"It appeared to me to be accepted practice that a senior member of the team did not do dictated outcomes from clinics." 14:49

That speaks to, I suppose, a wider knowledge within Urology Services that this was something he didn't do. It was well known?

A. That was my impression.

145 Q. Then you go on to say:

"Many people knew Mr. O'Brien stored notes at home but there was no action taken. It was also accepted that Mr. O'Brien would transport files in his car from Clinics and then would have these at home."

"We have created this issue".

What did you mean by that? 14:50

A. So the Servicing for Fermanagh patients in the Team South model was provided from the Team South which was Southern Trust, and so for the clinics for patients in South West Acute Hospital, which is part of the Western Trust their notes were Southern Trust notes. The mechanism developed for getting Southern Trust notes to the clinics in South West Acute Hospital in Western Trust was that they were transported there by the Consultant, so they were in the car of the Consultant and taken to Clinic, and then transported back by the Consultant. Living, if you like, in between South West Acute Hospital and Craigavon Area Hospital, it was only natural that Mr. O'Brien would not drive past his house at the end of a day to go to Craigavon to take the notes back but would stop at home. It would be appropriate for him to not leave them notes in his car overnight and take them into the house because of the attendant risks of them going missing from the car. When I have said "we have created this issue", what I'm

referring to is we've created a system that relies on Mr. O'Brien and Mr. Young, who also did clinics in South West Acute Hospital, to transport notes to and from the hospital.

146 Q. Yes. Presumably it was also a feature of this that he needed to retain the notes if he hadn't dictated? 14:51

A. That's what I assume is why he didn't return them, because he had actions outstanding from the clinic that needed doing.

147 Q. Six months after making this statement, you assume the role of Associate Medical Director. Is it fair to say that, by this stage, given your knowledge of Mr. O'Brien as set out in this statement and your knowledge of these incidents, that you considered him to be a Patient Safety risk? 14:52 14:52

A. I had concerns, as I've documented in the concerns I've raised, about many aspects of his practice, which all translated into Patient Safety issues.

148 Q. Yes. Did you regard him as a Patient Safety risk?

A. I wouldn't have raised them concerns if I didn't, so, yes. 14:53

149 Q. There was in place an action plan with a monitoring component, which we will look at in a moment. By the time you became Associate Medical Director at the end of that year, you've told us that you weren't aware of that monitoring plan? 14:53

A. The monitoring plan which was developed when he returned to work in early -- in 2017, was developed, and I was unaware of that having been developed.

150 Q. Yes. You will recall our discussion of your job description yesterday, you had a responsibility for the safety and capability of your medical workforce, that was your contractual responsibility to the Trust. They had given you this job description to comply with and you had to provide assurances back into the Medical Director's Office in respect of the matters contained within that job description, including the safety of medical practice. You are deprived of the information in respect of a monitoring plan. You don't even know it exists? 14:54 14:54

A. No.

151 Q. You, nevertheless, have a concern that Mr. O'Brien is a Patient Safety risk. How can you conduct your medical safety role as AMD if you have that opinion of him and, for all you know, there's nothing in place to monitor his continued performance? 14:55

A. While I was not aware of the monitoring, I was aware that a MHPS process was underway. I was aware that that process had been taken on with the Medical Director and there was other clinical managers involved in that. Rather than me not being aware of there being anything, I was aware that there was a process that was, to my mind, managing the concerns that had been raised, or should have been managing the concerns that I'd raised about Mr. O'Brien. So, if you like, within the Surgery and Elective Care Clinical team, Mr. O'Brien was separate and, to me, to my mind being managed through that process regarding the concerns 14:55 14:56

I had with regards Patient Safety and not being managed directly by me through that.

152 Q. I know, and we will come to look at it presently, that at some point, and you can maybe help us specifically with regards to when that point arises, but at some point you do become aware of the action plan and the monitoring component. Can you think of any good reason why you wouldn't have been notified of that monitoring plan or monitoring arrangement as soon as you became AMD, even if you're not to be involved with the monitoring? Surely you need the assurance, the specific assurance of knowing what's going on with regard to a clinician who, to your mind, is a Patient Safety risk? 14:56 14:57

A. I think it would have been best if I had been aware as soon as I became AMD as to what and how the monitoring was undertaken, as it would have potentially led to me raising my concerns about the synthesis of the data that was being used to monitor his performance against the requirements of that return to work monitoring process. 14:57 14:57

153 Q. We will go on to look at, you did have concerns about the reliability of the data. I have some other questions to direct to you about the adequacy of the plan itself. Before we reach that stage, the MHPS report emerged and reached Dr. Khan's office in the middle of June 2018. After some consideration, he produced a determination in October 2018. Let's just look at the findings that Dr. Khan reached. If we can 14:58

pull up WIT-55697. Here we have his determination. Have you ever been given a copy of this?

A. I have, yeah.

154 Q. At what point were you given a copy?

A. I don't specifically recall. 14:59

155 Q. But it was in the context of your role as AMD?

A. It was at a later point, is my memory, than when it came out.

156 Q. Just as we step through this, you can see his various observations. There are clear issues of concern about 15:00 Mr. O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients, numbered at 783, and actual harm to at least 5 patients. 15:00

Just scroll down. It says:

"As a senior member of staff Mr O'Brien had a clear obligation to ensure managers within the Trust were 15:00 fully and explicitly aware that he was not undertaking routine and urgent triage..."

Then he sets out various recommendations that he feels ought to be taken forward. 15:01

If we look at WIT-55701. I want to start, Mr. Haynes, there's a recommendation within this report from Dr. Khan that the investigation has highlighted issues

regarding systemic failures by managers at all levels, both clinical and operational within the Acute Services Directorate. The report identifies that there were missed opportunities by managers to fully and address the deficiencies in practice of Mr. O'Brien. No-one assessed the extent of the issues or properly identified the potential risks to patients.

It goes on at the bottom paragraph:

15:02

15:03

"In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes."

15:03

When you did see the report, I assume you observed that recommendation. What it speaks to is a failure on the part of management, at various levels, to effectively engage with the information that was in front of them with regard to Mr. O'Brien's shortcomings and, assumedly, to a failure to provide him with the support necessary to change or, alternatively, to take steps if he wasn't prepared to change. Did that stand out to you when you read it?

15:03

15:04

A. It stood out to me as reinforcing an impression that I'd commented on, if you like, in my statement to the MHPS investigation, commenting that much of this,

I think, was recognised as his way or accepted practice.

157 Q. That failing, if you like, on the part of management, was familiar to you? Take an example, we looked at it this morning, you raised the issue of private patients on at least three occasions, at least three occasions that we saw in writing, but it was your sense that nothing was being done? 15:05

A. It's my sense that that got tackled as a result of the MHPS investigation, or at least the initial return to work monitoring plan, which, to my knowledge, beyond that point it didn't happen again. But it took until then for it to be tackled. 15:05

158 Q. We have also observed the multiple examples of the system being aware that Mr. O'Brien wasn't actioning the results of investigations, the CT reports, but, again, management, albeit having that knowledge, would not have appeared to have engaged with the issue. 15:05

In terms of that recommendation, we know, the Inquiry knows that it wasn't taken forward until the middle of 2020. Did you make any suggestion or issue any direction, to the best of your recollection, in relation to that aspect of Dr. Khan's findings? 15:06

A. As I say, it was at a much later date that I became aware of the report and the recommendations within the report. I can't specifically remember the dates, but my understanding of that report in having not received it initially, would have been that that was being taken 15:06

forwards elsewhere. So while I may have recognised it, I may not have, and I evidently didn't, chase up to ask has that been done?

159 Q. Because if there's no managerial bulwark to address shortcomings or if it has inadequacies that haven't been addressed, then there's a risk, at the very least, that the shortcomings of the past will simply be replicated? 15:07

A. Mm-hmm.

160 Q. The part of the report that was directly concern you or, if implemented, might have directly concerned you, is at WIT-55699. Just at the top of the page Dr. Khan sets out his view: 15:07

"That in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practices and management of his workload an action plan should be put in place with the input of PPA or NCAS, the Trust and Mr. O'Brien for a period of time agreed by the parties". 15:08

"The action plan should be reviewed and monitored by Mr. O'Brien's Clinical Director and Operational Assistant Director within Acute Services, with escalation to the AMD and Operational Director should any concerns arise. The CD and Operational AD must provide the Trust with the necessary assurances about Mr. O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient 15:09

related administrative duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time."

There's a number of aspects to that, but it is the case, is it not, that none of that was taken forward? 15:09

A. My understanding is that after the issuance of that report, Mr. O'Brien raised a grievance with the process and, as you state, them recommendations were not taken forward at that point while the grievance process ran. 15:10

161 Q. You are not suggesting that the instigation of a grievance process would have prevented the Trust from monitoring the activity of a Clinician who was causing concern?

A. My understanding, and as I've commented on with regards to how that monitoring was being done, the monitoring arrangements that were instigated in early 2017 on return to work continued during that process. It wasn't that no monitoring happened, but the monitoring continued from a Trust perspective in the same way as it had done since early 2017. 15:10 15:10

162 Q. Yes. This recommendation from Dr. Khan was calling for a new action plan with monitoring, one that, to quote him, "must address any issues with regards to patient related administrative duties". We will obviously speak to Dr. Khan in due course, but he seemed to be contemplating a revised plan that might indeed be broader, go into areas of administrative duties in connection with patients that weren't perhaps caught by 15:11

the earlier plan. When you saw this, saw a role for you within it, did you ask questions wearing your AMD hat about why aren't we doing this?

A. As I have said, I can't remember specifically today when I saw this. My memory is it was much, much later in this process, coming well into 2020 that I became aware of and saw the whole report. By this point, concerns were still being raised and taken forwards at that time. We didn't have, as you say, a specific action plan wasn't developed but there were additional concerns being raised. 15:12 15:12

163 Q. Just so that the Inquiry has it as clear as it can. This report, signed off by Dr. Khan, presumably goes to the Medical Director's office and whoever else needs to see it, but although you are the senior man in terms of Governance within the Surgical and Elective Care part of Acute with responsibility for Urology and with responsibility for this Clinician, you don't get to see it at all until 2019/2020. It's not even discussed with you? 15:12 15:13

A. I'm aware that he's been presented with the MHPS report, but I'm not aware of the content of.

164 Q. It doesn't require hindsight and all that we are aware of now, this should have been an important moment to sit down with the report of Dr. Chada, the determination that emerged from it, from Dr. Khan and for discussion between you and the Medical Director and perhaps Dr. Khan to work out what needs to be done, what can be done, notwithstanding the grievance? 15:13

A. Yeah, there was an opportunity there where a more comprehensive action plan could have been developed that may have picked up issues that were found at a later date.

165 Q. Yes. You've acknowledged that you had the concern that this was a Clinician who presented as a Patient Safety risk. You have confirmation of that from all that you are aware of through the Incident Reports, the MHPS report. Was there not a suspicion that there must be, or at least there may be, more hidden in a dark place that's yet to be exposed, that we ought to be going looking for, that the MHPS report is perhaps only the tip of the iceberg? 15:14 15:14

A. Certainly reading the MHPS report and the comments within there, not only about the ways of working but also about the insight demonstrated, should have raised a flag that there would be other concerns within practice, and other concerns that needed addressing. 15:15

166 Q. The action plan that was in place, if we could turn it up, please, at TRU-00732. 15:15

CHAIR: Sorry, Mr. Wolfe, while that's being called up I am just wondering if people require a break or if they are content to sit on. I see from Mr. Lunny --

MR. LUNNY KC: I am perfectly content to sit on but one observation I would make the break does facilitate, even if it's only five minutes, it allows us an opportunity sometimes to speak to Mr. Wolfe to say there's another page on that e-mail, for example, that you should perhaps bring up, rather than leave it to 15:16

the 13th December or phase 2, as it were.
MR. WOLFE KC: Okay.
CHAIR: Is this an appropriate point then, Mr. Wolfe?
MR. WOLFE KC: Yes.
CHAIR: Okay. Let's say ten minutes, Mr. Lunny. 15:16

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe, just before you start, I don't think we should sit any later than half past four, in ease of 15:27
Mr. Haynes and everyone else. I think it's been a long enough day.
MR. WOLFE KC: I think we are coming back on another occasion, I may even stop shortly after 4:00, if that's okay. 15:27
CHAIR: That's fine. Thank you.
MR. WOLFE KC: I don't hear any dissent.
167 Q. We have up on the screen, just show the witness the first page of it, please. This is the Return to Work Plan with monitoring arrangements following a meeting 15:27
on 9th February 2017. That's at the very start of the MHPS process, Mr. Haynes. Clearly, by that stage, you weren't in your AMD role and you would not have been cited on that, I rather suspect. You've told us, I think, that you first became aware of the action 15:28
plan, and we will go to the e-mail presently, but it appears to be towards the end of 2018, about a year after you took up the AMD role, but we will look at that. What I want to ask you about in this sequence is

about your view of the adequacy of the plan going forward from a position in October 2018 when MHPS is reported. You are not, you say, familiar with the outcome of maps at that point. With those caveats in mind, could we scroll down and just look at the various aspects. 15:29

Concern 1, at the bottom of the page, was in respect of patient referrals, in other words Triage:

15:29

"All referrals received by Mr. O'Brien will be monitored by the Central Booking Centre..."

The standard against which Mr. O'Brien will comply, at the top of the page, is that "all referrals must be completed by 4 p.m. on the Friday after Mr. O'Brien's Consultant of the Week ends. Red Flag referrals must be completed daily." 15:29

Does that seem an adequate standard to hold the Urologist of the Week to, in this case Mr. O'Brien? 15:29

A. I think it's an adequate aspiration. I think if I were writing that, I would allow a caveat for a particular -- you could have a particularly busy day where you may not get to this. You may have a day where you are called in through the night previously and, therefore, don't perhaps meet that Red Flag completed daily because of fatigue and workload. 15:30

168 Q. Yes.

A. You have to have a caveat recognising that where it's attached to an unpredictable emergency workload, there has to be some tolerance.

169 Q. Yes. Scrolling down to concern 2, which is the retention of notes in office or in home. 15:30

"The standard to be applied is that Mr. O'Brien is not permitted to remove patient notes off Trust premises. Notes tracked out to Mr. O'Brien must be tracked out to him for the shortest period possible for the management 15:31 of a patient. Notes must not be stored in Mr. O'Brien's office. Notes should remain located in Mr. O'Brien's office for the shortest period required for the management of a patient."

15:31

Again, does that seem reasonable and comprehensive?

A. It seems reasonable. To me, either explicitly within it or behind this needs to be a process for how notes are to be taken to the Clinics in South West Acute Hospital. 15:31

170 Q. Yes. Concern 3 then is issue of dictation. It says:

"All clinics must be dictated at the end of each clinic/theatre session via digital dictation. This is already set up in the Thorndale Unit and will be 15:32 installed on the computer in Mr. O'Brien's office and on his Trust laptop. This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the

Assistant Director of Acute ... to ensure all outcomes are dictated.

An outcome/plan/record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient who did not attend as there must be a record of this back to the GP."

Again, does that seem both reasonable and comprehensive, or if you were writing this with the benefit of what you know now, would you extend it? 15:32

A. It seems reasonable. With the benefit of hindsight I would extend it. As we perhaps found later, while there may be the required number of dictations at the end of a clinic session, that didn't always mean that there was a letter done on every patient. So there needed to be a second step where the patients themselves, their record was assessed to check that there was a letter on every patient attending. I think that in terms of monitoring it, I think there should have been a greater involvement in the person closest -- 15:33

171 Q. Let me see what's over the page, it doesn't appear to -- it provides for a report via digital dictation. Is that check? 15:34

A. Essentially that was a manual check of is there a dictation on the digital dictation system for the number of patients who attended. The staff member closest to this within the Trust is always going to be

the secretary doing the typing, and there isn't a role within this of that reporting. As I described earlier, with regards my practice and my secretary as a safety mechanism for me, should be reporting if I'm not doing something and that would apply here. 15:34

172 Q. Yes. This Concern 3 appears to have its context in the dictation of Outpatient outcomes, or Outpatient encounters. Therefore, given what was known by the date of the report of MHPS or, in the alternative, given the kinds of suspicions that might have arisen in 15:35 light of the outcome of MHPS, should this kind of monitoring of dictation have been broader than simply Outpatients?

A. I think the monitoring of his activity should have been much broader and included the other aspects that we've 15:35 identified, like the results.

173 Q. You could think of many examples?

A. Yeah.

174 Q. You could think of, given what we know from 2020 and indeed some of the SCRR cases that have been reported 15:35 into the system; the complaint, at least from the Trust perspective, and I realise Mr. O'Brien may not share it so I will put it in these terms. There appear to be a suspicion on the part of the Trust that he wasn't dictating following Multidisciplinary Meetings? 15:36

A. You wouldn't necessarily dictate after Multidisciplinary Team Meetings, so the CAP system which is the system used to record Multidisciplinary Team Meeting discussions and outcomes generates an

automatic letter to GPs. We wouldn't always be dictating a letter for every patient discussed at a Multidisciplinary Team Meeting. Many of them outcomes would be to bring a patient back to clinic and it would be at that consultation where you would expect a letter or a referral to be dictated. I think one of the concerns about the Multidisciplinary Team Meetings as well as the not dictating the letters on the consultations, is the not following through the recommendation of the Multidisciplinary Team Meeting in the subsequent consultation. 15:36 15:37

175 Q. If you follow through the recommendation that should give rise to a dictated letter, shouldn't it, in terms of the referral? I mean, it's perhaps a slightly different point, I will grant you that, but it's of the species. 15:37

A. The consultation, irrespective, should generate a letter, and that letter should detail the action that should either match the Multidisciplinary Team Meeting or provide a reasoned explanation as to why it doesn't match that Multidisciplinary Team Meeting and that may be a patient choice that they decide they don't want to follow that recommendation. 15:37

176 Q. Yes. I suppose under the broad heading of administrative-type actions with impact on Clinical practice and Patient Safety, you, or Dr. Khan more particularly, could have imagined, at the end of 2018, a range of different administrative actions who were not-too-distant cousins from the kinds of shortcomings 15:38

exposed by the MHPS report, which should have found their way into an improved monitoring arrangement?

A. Yeah. If you are not dictating after a clinic, then there's 668 patients without an outcome formally dictated there are described there, could one of them have required a referral to another Speciality? 15:39

177 Q. Yes. If you were to have sat down, or Dr. Khan and others were to have sat down and developed a new action plan, it would have had similar pillars to this but it would have had a broader remit in terms of the areas of Administrative/Clinical practice that were worthy of scrutiny? 15:39

A. A broader remit and perhaps a clearer mechanism by which that is going to be monitored that's ensuring the actual intended outcome is monitored. 15:39

178 Q. Yes. The fourth Concern, over the page, concerns private patients and it refers to the Trust's private practice policy. It goes on to say that:

"The scheduling of patients must be undertaken by the secretary, who will check the list with Mr. O'Brien and then contact the patient for their appointment. This process is in keeping with the practice established within the Urology team." 15:40

15:40

That was the monitoring provisions and the standards which Mr. O'Brien was to be measured against. They, as you understand it, continued in place from February '17 all the way through to his retirement in July 2020. Is

that right?

A. Yeah.

179 Q. You've said in your witness statement -- just for the record, I don't need to bring it up -- at WIT-53944, it's paragraph 66.1, that you were not part of the monitoring of Mr. O'Brien after MHPS. I think you have earlier explained that the indication that you shouldn't be involved came through the Medical Director at one point in time, Dr. Wright, but by this stage, I think, the end of 2018, Dr. Khan had assumed the role in an acting capacity, and the post of Medical Director was then to shortly pass on to Dr. O'Kane in, I think either the late part of '18 or early '19. Were they all similarly content that you would stay outside the formal role of monitoring? 15:41 15:42 15:42

A. I don't recall a specific discussion about my role within that monitoring plan that was there.
Dr. O'Kane, when she took over as Medical Director, very quickly involved me to a much greater extent in discussions and planning around the monitoring and oversight of Mr. O'Brien. 15:42

180 Q. Yes. I'm interested in that distinction. You said you weren't involved in monitoring, but the Medical Director brings you in and you have a degree of involvement, which I hope to illustrate briefly before we finish today. What is the distinction that's being drawn? I can see through this e-mail correspondence that you're frequently made aware of deviations from the monitoring plan and frequently commenting, but not, 15:43

as it might appear, taking any particular managerial steps; is that fair?

A. When I was commenting on the action plan, my understanding of the escalation within there was it escalated through to Dr. Khan as the Case Manager. Where I was commenting on the shortfalls of what I saw was being utilised for monitoring, I was escalating that through to Dr. Khan, who, as I understood it, was the Case Manager for this.

181 Q. One of the concerns that seems to be oft repeated in the e-mails is a concern about the reliability or, perhaps, the robustness of the data being relied upon, particularly in or around the issue of dictation. If I could just draw your attention to and have your comments on an e-mail I think you sent as far back as June '17 before you became AMD, WIT-55743. You are responding to the fact that Marie Evans has sent around something, I think it's called a Backlog Report, and your concern appears to be that this doesn't provide a true reflection of the extent of dictation activity on the part of Consultants feeding through to their secretaries. It gives a false impression. First of all, have I correctly diagnosed the problem, and what was it that was preventing the real picture from emerging using the backlog reports? 15:44 15:44 15:45 15:46

A. So my specific concern related to results, so scan results much like we have covered earlier, and how the column which was results to be dictated was being populated. We've covered that I had a suspicion,

a concern that Mr. O'Brien was not on top of his administrative processes, and yet what I saw in the Backlog Report was very often a report of no results to be dictated. I had multiple concerns with that. First of all, I didn't have a clear understanding of how that number was being generated; what were our secretaries being told to look at in order to generate this results to be dictated number? I had a very clear idea as to how my secretary was doing it, but I didn't have an understanding as to what instruction had been given to the secretarial team in terms of how that number was to be populated, and I guess the purpose of that report. I also had a concern that, in sending this round, seemingly giving us assurance that everything was okay, that our secretarial teams would somehow be culpable through perhaps a lack of guidance or a lack of understanding as to the importance of the Backlog Report in a broader scheme of things, they'd somehow be responsible for under-reporting activities not happening. What I was trying to ask was how are we generating this number? Is it a re-produceable number? Are the people who are providing this report aware of the importance of accurate data? Without them things being clear to me, and potentially to those who are generating it, how can this report in any way be a reliable monitor of anything? 15:47 15:47 15:48 15:48 15:49

182 Q. Your focus in this context, and you can see that, you are raising the alarm in a very particular context. What if a disaster happens and the data being produced

shows everything in the garden is rosy, it would be a dark day for those providing the data I suppose is what you are saying, so let's get it right. Do these Backlog Reports have a read across to other areas of dictation? 15:49

A. They include not only results -- the Backlog Report serves, I guess, a number of purposes. Some of the purposes it serves relate to a Clinician's actions, so the results to be dictated, Clinics to be dictated, discharge notes to be dictated. Some of them relate to 15:50 secretarial and typing, so staff workload, so letters to be typed, so there's a dictation done but it's not typed. In order to use that in any way to monitor workloads, pressures, performance, each column we need to have a clear understanding as to where we get that 15:50 data from and who is providing that data.

183 Q. I introduced that issue for your comment before looking at the next two years up to 2020, because it's my understanding that that Backlog Report, in substantial part, was the focus of Mrs. Corrigan's attention when 15:51 monitoring Mr. O'Brien's dictation output?

A. That's my understanding, within the Backlog Report it was included a column for clinics to be dictated.

184 Q. Yes. I think that was her focus, on clinics being dictated. As we observed earlier, if you were 15:51 rewriting that action plan, it would have a lot broader than that. Leaving that to one side, we will see that it at various points in the period after October 2018, you come in with observations about the reliability of

the data. At various points then, Mrs. Corrigan is communicating with you, and other members of the management team, pointing out deviations from the action plan observed by her on monitoring. Starting even before the MHPS report issues, so 23rd January 2018. If we could pull up very briefly TRU-275133. If we look at the bottom of the page first. Vicki Young is telling you, amongst others, the Red Flag Appointment team have brought to her attention there are seven referrals dating back from 18th January '18 that need to be e-triaged and would it be possible to get those done today? 15:52 15:53

Then scrolling up, you speak through this e-mail to Martina Corrigan: 15:53

"Do you need to have a word?"

You say before that: 15:53

"I did 3 or 4 from the 18th yesterday." Were they your own? Was that your own workload catching up?

A. The way e-triage works is when you open the system, they are not assigned to a single Consultant. They will appear for Urology on every Consultant Urologist's ECR if they open the e-triage. I presume on that day I had either been on to the system because I was Urologist of the Week, or I was on to the system to check if any had specifically been assigned to me. If 15:54

a referral comes into the Urology Department and it's a patient who I have seen before or have some knowledge of, then my colleagues can assign that to me and my name appears next to it, it doesn't disappear from the system for other people but my name is there for me to look at it. Periodically, during a normal working week I will have a check of the Triage system to see if any have been assigned to me.

185 Q. Where you say there "do you need to have a word?" directed to Martina Corrigan, what's that suggesting? 15:54 15:55

A. I presume it's do you need to have a word with, I presume, Mr. O'Brien, about -- to catch up with it. There is another, if you like, slight quirk of the system, in that, if a patient needs registration on the system, the referral letter doesn't appear on the e-triage system the minute the GP presses refer on the clinical communications gateway, which is the system that the referral is generated on. I don't fully understand what the process is, but there can be a process, there is a process that's needed sometimes for some patients before that can translate then over to the e-triage system and on ECR. There are occasions where a referral letter might have been sent, and it will still be dated the 18th, but it doesn't appear on the system until that process in the background has happened, and then it will come up but still with the date of the 18th. 15:55 15:55 15:56

186 Q. Thank you for that. If you are right and if this is a slippage from the action plan arrangements, it's

coming to you via Mrs. Corrigan or via the coordinator, and you are pushing it off to Mrs. Corrigan. It doesn't seem to be going to Dr. Khan, who, as Case Manager within the MHPS and the associated monitoring arrangements, is the person who should be getting the deviations? 15:56

A. I don't think this e-mail at the bottom from Vicki Graham is, in fact, generated as part of the monitoring at all. It's been written to all of the consultants working at the time. Martina Corrigan isn't included in that circulation. Vicki Graham worked within our cancer team, and so she was working within that role and saying that there were Red Flag referrals and just raising it to us as a team in general. 15:57

187 Q. Yes. My point, sorry, maybe inelegantly expressed, is, if there is slippage from the standard that Mr. O'Brien is expected to comply with, with respect to Triage, Mrs. Corrigan obtains that information from the Red Flag team and if she's satisfied that there has been a deviation, she will be escalating it to Dr. Khan. Is that what she should have been doing with this information? 15:57 15:57

A. That's my understanding. My understanding is also that there was -- I mentioned when we talked about that return to work monitoring, that there needed to be some caveat for a busy period of on-call, that expecting everything to be done all the time, while an aspiration for it to be done within a day is reasonable, there needs to be a caveat of, if you like, a slightly 15:58

extended deadline if there are issues. My understanding is that there was a caveat introduced that altered that expectation from the original to a slightly, you know, not leaving it for a number of weeks but giving a few days' leeway for recognising busy periods would affect ability to maintain.

188 Q. Okay. So the suggestion have a word is, find out what's going on here?

A. Yes.

189 Q. And emphasise the need to get it done? 15:58

A. Yes.

190 Q. Okay. The next occasion when Triage remains an issue is a week later, and I wonder is it part of the same sequence of events. If we can go a few pages further on to TRU-275138. Is there 1st February e-mail on 15:59 down? Yes. This is Mr. Carroll's response, just above that.

CHAIR: Mr Wolfe, it looks as though Mr. Haynes has forwarded the original e-mail to Mr. Carroll, who then contacts Ms. Corrigan and says do we need to speak 16:00 about this. Is that interpretation fair?

A. That's what I could see from the scan up and down. I forwarded it on to Mr. Carroll and Mr. Carroll has said to Martina, we need to pick this up on Monday.

191 Q. MR. WOLFE KC: Yes. And they schedule a meeting? 16:00

A. I didn't catch that as we scanned up.

192 Q. If we can turn then to WIT-55772. Here again you are part of the team being advised by Vicki Graham that there are quite a few Red Flag referrals that are

outstanding dating back to the 4th October (36 in total).

Again, how would you have responded to that as the AMD? Is that something that you would refer to Mrs. Corrigan? 16:02

A. As I have said, within the team on the Triage everything appears there for us to see. What I don't know is who was on-call at that time and I don't know what the busyness of the on-call at that time was. 16:02 Generally, these sorts of e-mails we would endeavour as a team to try and pick up and get things done. Indeed, certainly from a personal perspective, and recognising that workloads during an acute week do vary, I didn't follow Mr. O'Brien on an on-call week, but if my 16:02 colleague the day before had had a busy day and there were referrals waiting to be triaged, I would have picked them up and done them when I came on, if I was able to.

193 Q. During that period of time Mrs. Corrigan was absent 16:03 from work for personal reasons, and an issue came to your attention about the absence of monitoring during her period away from work. If we can bring up the e-mail at TRU-258911. On 18th October, it was indicated to the system that Mr. O'Brien has 16:04 accumulated a large backlog of dictated letters, a large number of charts in his room. Mr. Weir is saying that he hasn't seen the review and results of recommendations into his practice but he is assuming he

is in breach of the findings and he is asking Dr. Khan how he should proceed. Just go up the page. Mr. Gibson is employed in the Medical Director's Office, is saying to Mr. Carroll:

16:05

"What is most concerning here is that there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties.

If he has a Backlog of Clinic letters and discharges going back to June, have these arrangements fallen down?" 16:05

The next e-mail up, please. Mr. Carroll, somewhat tersely, says: 16:05

"I think you are stating the obvious. With Martina having been off since June, the overseeing function has not taken place and the day-to-day activities was overlooked, but we need to understand why the dictation has gone out, this could explain the volume of notes or there may be some other reason." 16:06

Then Mr. Haynes replies to Mr. Carroll:

16:06

"According to Simon" -- Simon Gibson, that is -- "there were monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties..."

You make the point that you have been making earlier:

"I wasn't one of these interested parties, neither from Colin's e-mail was he, or Michael from his." 16:06

That's Michael Young.

"So if the Clinical Lead in the Service, the Clinical Director and the Associate Medical Director weren't, 16:07 I'm not sure who was.

I can only assume, given the Trust's previous failings in tackling behaviours in this case, the arrangements were robust, regularly monitored at multiple levels and 16:07 had clear back stops for sickness so that it wasn't reliant upon only Martina?"

Just to unpack that a little. That's you telling Mr. Carroll that, if I have got the tone right, you are 16:07 not best pleased that you weren't informed of what the monitoring arrangements amounted to, or that they even existed?

A. I think it's me saying that it's not clear to me who was involved, what them arrangements were and, as I've 16:07 suggested, it appears that they've been reliant on one individual, which is an inherent weakness in the plan that had been made.

194 Q. Yes. But surely there's also saying that I should have

been involved, I should have been at least told of the existence of these arrangements?

A. Or absolute clarity as to who was told and where that fitted within the existing management structure.

195 Q. You set that against the background, as you put it very candidly, of the Trust's previous failures to engage in ineffective monitoring and the need for the monitoring going forward to be robust. If it's dependent upon one person and not picked up upon by others in her absence, are you saying that you struggle to see how it could be considered to be robust? 16:08 16:09

A. I think, as I have said previously, if you haven't got clarity as to how monitoring is being performed, how the data that's being utilised for monitoring is being obtained and clarity as to who and how and where cover provides, then you haven't got a robust process. If your robust process involves someone doing the monitoring themselves without a clear description that can be picked up by someone else in their absence, then your process has an inherent frailty. 16:09 16:09

196 Q. This is the 18th October 2018. MHPS has just reported, or is about to, in the sense of Dr. Khan's determination. As we have observed earlier, it provided for the development and formulation of a new action plan, and you have explained that that wasn't, at that point, known to you. But knowing that there was this monitoring plan in place as a result of these e-mails that had come to you, is that the point where you sourced the extant action plan and got to know what 16:10

it was doing?

A. I don't have a recollection, but clearly I've expressed significant concerns in the way monitoring was being undertaken.

197 Q. But you don't have a recollection of doing anything specifically to bottom out how this was being done and what was being monitored? 16:11

A. I think I've asked in that e-mail -- well, I haven't asked but I've made a statement to Ronan, who was involved in the monitoring process, that I'd concerned about how that process was being undertaken and how robust it was. I can't recall what followed that e-mail. 16:11

198 Q. There certainly wasn't a step into the arena of looking at the extant action plan and reformulating it in any way to make it better? 16:11

A. I don't recall that.

199 Q. I will put it another way. This was an opportunity, given your responsibilities as AMD, to have, now that you're informed of it, to say, well this isn't good enough, look at what we know about Mr. O'Brien. We should expand this action plan and associated monitoring into other areas; the point is, that wasn't done? 16:12

A. Yeah. I think I've said that, but I haven't taken it that step forwards. 16:12

MR WOLFE KC: Okay. I think, Chair, this would be a convenient point.

CHAIR: Just because we won't see you until a later

date, Mr. Haynes, if you don't mind we would have a few questions that we'd like to ask you now, and hopefully we will not keep you much longer beyond the half past four. Mr. Hanbury, maybe I will ask you to go first this time. 16:13

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

MR. HANBURY: Thank you for coming. I have just got one question about the MDT process, the MDM process, the preparation, your Department had a arrangement that one of the clinicians would take on the preparation, the preparation and the mop-up afterwards, which is quite intensive and time consuming. Why did you do that rather than everyone sharing the work out on the day? 16:13 16:13

A. So, other MDTs would have processes where the clinician who has seen the patient presents the patient, and one of the inherent weaknesses in that is if a clinician isn't present then a patient's care doesn't get discussed. From before I worked in Southern Trust there was a working pattern within the Urology Multidisciplinary Team Meeting where that wasn't the process that was utilised, but the Chair of the meeting presented the cases, which meant that patients would pass through the Multidisciplinary Team Meeting, whether or not the Clinician who had seen the patient was present. That landing on the shoulders of a single 16:13 16:14

person is a significant workload and so, with the expansion of the team, and particularly given, say, my interests which have always been on an Oncology bent that we made a decision to rotate that Chair responsibility so it reduced that workload, so each of us took it in turns to take that on. When Mr. O'Donoghue joined us in August that became us taking it on on a sort of rotational one in four basis. 16:14

DR. SWART: You have described quite clearly taking on the AMD role when you had very extensive clinical responsibilities, including outside the Southern Healthcare Trust, and it's obvious that was a considerable challenge. What was it that motivated you to want to take that role on at that time? 16:15

A. I think it's the same thing that motivates many of us who make decisions to take on additional roles outside of our, if you like, our core Consultant responsibility, and that's a desire to work to improve, and improve both the working arrangements and the Service received by patients. So that's the desire. 16:15

200 Q. You also said that you didn't have any induction or handover. Was any support offered to you by the Trust at the time you took the role on?

A. I don't recall.

201 Q. Did you ask for any? 16:16

A. Probably not.

202 Q. I'm specifically thinking of whether you thought it would be a good idea to go and talk to the Medical Director about mentoring or any other senior colleague

input?

A. I was Clinical Director at the time so I had met the Medical Director on a number of occasions through that.

203 Q. Yes.

A. I had, if you like, a direct line into the Medical Director already at that point. 16:16

204 Q. Did you have any discussions with other AMDs and CDs about the challenges of this combination of clinical responsibility and managerial role, and did you come up with any ideas about things that would improve the situation for you? 16:16

A. I don't recall any specific conversations about that.

205 Q. Another thing you talk about is this tension, which is clearly very real in terms of being a colleague in Urology and being AMD at the same time. Again, did anybody talk to you about how you might want to handle that in the circumstances you found yourself in? 16:17

A. No.

206 Q. Okay. Just lastly, you talk about the desire to make improvement. You describe some improvements in your own practice, which would have general application across the Trust in terms of the quality improvement in processes, I am talking about results and also some of your Triage. Do you feel as AMD you were empowered to kind of spread those improvements or that you had access to quality improve resource? What's your stance on that? 16:17

A. We had access to quality improvement resource and, within the evidence bundles we had an adept fellow join

the Trust and do a project on the Stone Service within Urology, so we had access to quality improvement projects. In terms of them patterns of working, we would have communicated regularly just within the Consultant team as to how and what we were doing and, you know, I am, in the context, an early adopter, so once I was aware of the existence of something I looked to take it on, and tried to encourage people to take it on. If we look at, like, the sign-off and results, that is included in a number of SAI recommendations and that would have been discussed at Acute Clinical Governance, and I was a strong proponent of this being rolled out and taken on by teams across the Trust. Unfortunately, from many there was often a resistance to this, seeing it as a significant increase in workload, and not necessarily believing my perspective that it made it easier. 16:18 16:18 16:19

207 Q. Are you telling me you felt more barriers than empowerment at that particular point?

A. I think the barriers were people not wishing, individuals not wanting to change the way that they did things, yeah. 16:19

208 Q. Okay.

CHAIR: Thank you. I suppose mine is less of a question and more of a comment. I find it surprising, we have talked about the delay in reporting on SAIs, the whole purpose of an SAI investigation is to learn and to learn quickly and to improve Patient Safety, and I found it surprising that there was no 16:19

deadline set for delivery of an investigation. You described how it was difficult to find time for the team to get together to discuss matters. In my experience of other professions, and I speak obviously of the legal profession of which I would know best, but often meetings such as that would take place outside the working day to ensure that they happened and that they happened in a timely way. Was that never an option? 16:20

A. Of course that's an option, but I think, if I look at my own practice and we look at the e-mail we had up yesterday from late 2018, I detailed that I was already using significant portions of time outside of the normal day to do activity. From a personal perspective, you are almost deciding what do you stop, and that's where the earlier question as to, do I have any recommendation comes. If we want to get this done by a deadline, then we've got to decide what we don't do to enable everyone to be able to attend. What are we going to stop to make sure that every member of this panel is present next Wednesday morning for a meeting? 16:20 16:21

209 Q. Or Wednesday evening?

A. Or Wednesday evening, yeah.

210 Q. I suppose was any consideration given to putting into place locums to cover the work to allow you get the SAIs done in a timely fashion? 16:21

A. I have touched on the challenge in terms of locum appointments within my statement. As I have said in the statement, while, on the face of it, it can seem

a straightforward solution, it can often end up actually creating more work than the problem that they have solved.

CHAIR: Thank you, Mr. Haynes. We will, unfortunately from your point of view, see you again. Thank you for attending both yesterday and today. 16:21

MR. WOLFE KC: Just one final point. I drew attention to the complaint, I think, registered by Mr. O'Brien when he was afforded only a couple of days to reply to the SAI concerning Patient 16. I think it's fair that I refer you to -- I don't need it brought up on the screen but just for your note -- an e-mail series starting at PAT-000119, which I think indicates that certainly while he was initially given a very short time frame to respond, and that came in the context of a three-year interval before it made its way to him, he was given, I think, several weeks to turn around his response in full, to put that in for fairness. 16:22 16:22

I think what I will engage with Mr. Lunny and his team to see when we can get Mr. Haynes back to us. Probably half a day or a little more than that, I wouldn't imagine a full day. 16:23

CHAIR: Very well. We are not due to sit again to hear further evidence until the 29th, so we won't be sitting next week, and I will see you all again then on 29th November. 16:23

THE INQUIRY THEN ADJOURNED TO 29TH NOVEMBER 2022