



Urology Services Inquiry

Oral Hearing

Day 49 – Tuesday, 6th June 2023

**Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)**

Held at: Bradford Court, Belfast

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

Gwen Malone Stenography Services

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Mrs. Noleen Elliott

Examined by Mr. Wolfe KC (cont'd)

3

Questions by the Inquiry Panel

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

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A. That's correct.

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

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

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

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A. That's correct.

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

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

- 1 the patient was discharged and not on any waiting list.
2 He would have said that that was lost then to
3 follow-up, as well as he would have said that he wanted
4 to review the patient irrespective of what the test
5 indicated. So, the fact that they were taken off any 10:03
6 review waiting list, he didn't accept that.
- 7 6 Q. So his approach was what, then, in the alternative?
8 A. The patient was, for instance to take an example, if
9 the patient was sent for a CT scan, the CT scan to be
10 to be done in three months and he would have asked me 10:04
11 to put the patient on the Outpatient review waiting
12 list for review, say, in four or five months, whatever.
13 It would have been a short time after the scan would
14 have been due to be reported on.
- 15 7 Q. Okay. why did he favour that approach? 10:04
16 A. He favoured that approach because the patient was on a
17 waiting list, what he had requested. Irrespective of
18 the scan result, he still wanted to see the patient.
- 19 8 Q. Even if that was unnecessary from a clinical
20 perspective? 10:04
21 A. Whenever the scan -- yes, he would have always wanted
22 to review his patients.
- 23 9 Q. Regardless of outcome?
24 A. I cannot ever remember anybody being discharged from a
25 result if they were already on a review waiting list. 10:04
- 26 10 Q. Did the system work effectively, in your view?
27 A. It had its pitfalls because obviously of the long
28 waiting lists for review appointments.
- 29 11 Q. We will maybe see some of that in a moment. In terms

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

5
 6 "The DARO reports would have been sent out by the
 7 service administrator to the secretaries on an ad hoc
 8 basis for the secretary to validate and return. I
 9 would have had approximately 60 patients on DARO report
 10 (mainly from specialist registrar and staff grade
 11 doctors and some from Mr. O'Brien). Other secretaries
 12 would have had considerably more patients on their DARO
 13 report. Therefore, I believe that management would
 14 have been aware that the SOP for DARO was not fully
 15 implemented by Mr. O'Brien due to the vastly reduced
 16 numbers on Mr. O'Brien's DARO report".
 17

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

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

29 12 Q. Let's just maybe look at that. If we go to a DARO

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

3 A. That's correct, yes.

4 13 Q. 11th May 2016. She is saying:

5
6 "Please see the attached DARO report updated today and
7 filter as appropriate. It is essential that this
8 report is actioned upon receipt and validation
9 confirmed by return email to me by the end of the
10 month. If patients are no longer appropriate for DARO, 10:07
11 they must be reinstated or removed from DARO as per the
12 DARO SOP".

13
14 what is the work exactly you are being asked to do here
15 by validating? 10:07

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

18 14 Q. would it help if we scroll down so you can illustrate
19 it?

20 A. Yes. 10:08

21 15 Q. I think. Yes.

22 A. So you can see there --

23 16 Q. The first two entries are Mr. O'Brien; isn't that
24 right?

25 A. Yes, yes. You can see there the patients are actually 10:08
26 identified with their hospital number. Then over on
27 the last line, it tells you what we were expecting
28 back. In that case it was a PSA that was expected back
29 in May '15. So, what we would have done as

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

11
12 You would have went through and checked the results.
13 If the results was actioned and a letter done, then you
14 would have removed them off the DARO as per the results
15 letter. If there was no results letter done, then you 10:09
16 left that for the clinician. So you would have printed
17 off the result and left it for the clinician to advise
18 on the outcome.

19 17 Q. If a patient has been put up on DARO, you are awaiting
20 the results of the CT scan and if that CT scan comes in 10:09
21 and the clinician actions the CT scan, how would you
22 know about that?

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

- 1 whether it was a discharge, a review, or a... I am
2 trying to think what else there would have been. You
3 wouldn't really have anybody put on a waiting list
4 following that. It would have been review or discharge
5 probably. 10:10
- 6 18 Q. You would use the DARO system in that case to keep
7 track of what has been done in the case?
- 8 A. That's correct. If you need the cooperation of the
9 clinician.
- 10 19 Q. Yes. So if the patient isn't on DARO -- 10:11
- 11 A. Hm-mhm.
- 12 20 Q. -- and the CT scan results come in, and if the action
13 required as a result of the CT scan results hasn't been
14 followed up by the clinician, how would you know?
- 15 A. Well, in Mr. O'Brien's case if the patient wasn't on 10:11
16 DARO, there were obviously on a review waiting list.
17 If the scan came back and there was something untoward
18 or something serious on the scan, Mr. O'Brien would
19 have asked me to arrange an appointment earlier than
20 the expected appointment. So he very regularly would 10:11
21 have asked me to put people as an extra patient on to
22 my PR slots on the review clinics.
- 23 21 Q. That system relies on the clinician advising you
24 whereas the DARO, if you go to the trouble of inputting
25 on DARO, there is a tracked record of a patient; is 10:12
26 that right?
- 27 A. There is but you still need the cooperation of the
28 clinician. I think this is something that has come up
29 on other people's evidence, that the clinician didn't

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

3 22 Q. But if you have the patient on the DARO system, at
 4 least that has the merit of the safety net of letting
 5 people know that something has to happen to that 10:12
 6 patient?

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

9 23 Q. Of course.

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

11 24 Q. And questions can be asked?

12 A. Yes.

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

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

18 26 Q. You were explaining to me how the service could have
 19 used this system to deduce that Mr. O'Brien wasn't
 20 playing ball with it? 10:13

21 A. Yes.

22 27 Q. I fear that I might be jumping ahead into a second
 23 report, just to help you with Mr. O'Brien's total.
 24 Forgive me that; there is no trick in it, it is just my
 25 referencing. If we go to WIT-77866. Just scroll up a 10:13
 26 page. Stop there, please. Mr. Haynes has got 194
 27 cases?

28 A. That's correct.

29 28 Q. I think, off the top of my head, Mr. Glackin might have

1 had more than that?

2 A. 300 odd.

3 29 Q. If you just scroll on up. I don't think we need do it
 4 but if we scroll down slowly down to the end of
 5 Mr. Haynes' list, we can see -- and remember this is a 10:14
 6 report for 2019; isn't that right?

7 A. Hm-mhm.

8 30 Q. No, it may be 2016. I will come go back.
 9 Mr. O'Brien's, scroll down, comes to a total of 73
 10 cases? 10:14

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

18 31 Q. Just help me with that. What entry are you pointing
 19 to?

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

21 32 Q. Yes?

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

23 33 Q. So the right hand column?

24 A. Actually the very last KS.

25 34 Q. That is Mr. Suresh? 10:15

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

29 35 Q. What you are saying in terms of the Trust's knowledge

1 of Mr. O'Brien's departure from DARO is if anybody
2 looking at that was asking himself the question which
3 consultants are using DARO and which aren't, they could
4 do a simple subtraction sum with an awareness of
5 Mr. O'Brien's large practice and work out that 73 is 10:16
6 indeed a very small number?

7 A. Yes.

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

13 A. That's correct.

14 37 Q. We know that Mr. O'Brien was largely - I think you
15 allowed for some exceptions - largely not using DARO? 10:17

16 A. That's correct.

17 38 Q. What do you mean when you say DARO has been validated
18 for these cases if Mr. O'Brien was largely not using
19 DARO?

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

26 39 Q. So, cases that are carried out by or looked at by his
27 registrars or, on occasions, by locums, perhaps by
28 tenured consultants such as Mr. Suresh as a favour or
29 to help out or whatever it was --

- 1 A. It would have been mainly extra clinics put on.
- 2 40 Q. So they would still fall under Mr. O'Brien's name as
3 such, and those were your responsibility to validate in
4 accordance with DARO?
- 5 A. Yes, that's correct. 10:18
- 6 41 Q. Do you think it was entirely clear to management that
7 Mr O'Brien wasn't using DARO, that he was bypassing it,
8 because clearly you are saying on this, results are
9 being validated according to DARO, the report, the
10 central report, albeit with a smaller number, is 10:18
11 showing DARO validations; you have DARO cases under
12 Mr. O'Brien's name. Should you not have been raising
13 with management more explicitly that DARO was being
14 bypassed?
- 15 A. When we talk about validating DARO, for every entry 10:19
16 that was on the DARO, I had to put an explanation in
17 another column for our service administrator. There
18 was a very detailed report went back for the validation
19 of DARO. The service administrator, it would have been
20 very obvious to me that there was a disparity or a 10:19
21 difference in the numbers. Should I have highlighted?
22 I thought, well, it is blatantly obvious there, and it
23 wasn't that there was anything new. There again, I
24 took over working for Mr. O'Brien when he has already
25 been a clinician for years so there was nothing new in 10:20
26 not using DARO.
- 27 42 Q. Certainly by 2019, management are writing to you and
28 others to underline their view that DARO should be
29 used. Let's just look at how that played out. If we

1 go to WIT-22786 and just look at the email at the
2 bottom of the page. It is 30th January. You are one
3 of the recipients, we can see in the last penultimate
4 line of the address column with the email. Collette
5 McCaul, she was the service administrator; is that
6 right? 10:20

7 A. That's correct.

8 43 Q. She is clarifying the process in relation to DARO.

9
10 "If a consultant states in the letter I am requesting 10:21
11 CT, bloods etc and will review with the result, these
12 patients all need to be DARO-ed first pending the
13 result ... and not put on the waiting list for an
14 appointment at this stage. There is no way of ensuring
15 that the result is seen by the consultant if we do not 10:21
16 DARO. This is our fail safe to patients are not
17 missed. Not always does a hard copy of the result
18 reach us from Radiology etc so we cannot rely on a
19 paper copy of the result to come to us.

20 10:22
21 "Only once the consultant has seen the result should
22 the patient be then put on the waiting list for an
23 appointment if required, and at this stage the
24 consultant can decide if they are red flag appointment,
25 urgent or routine, and they can be put on the waiting 10:22
26 lists accordingly.

27
28 "Can we make sure that we are all following this
29 process going forward".

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

3 A. That's correct, yes.

4 44 Q. You didn't reply to it directly yourself?

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

8 45 Q. Yes. But you didn't tell your management I am between
 9 a rock and a hard place here, which instructions do I
 10 follow? 10:22

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

14 46 Q. Certainly the email from Mr. O'Brien - just let's
 15 scroll up, please - might suggest that. Thank you. 10:23
 16 Just down a little bit. Mr. O'Brien responds to
 17 Ms. McCaul. What Mr. O'Brien writes is:

18

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

22

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

24 A. (Witness nodded).

25 47 Q. You suggested you had a similar concern to him. What 10:23
 26 was that concern that you had?

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

- 1 day, his DARO would have been sitting with 300 odd, and
2 if he wasn't going to action it, where did that leave
3 me?
- 4 48 Q. Okay. You had no particular concern about the DARO
5 system itself, your concern was how am I going to 10:24
6 operate it if Mr. O'Brien doesn't cooperate with me?
7 A. Yes. Well, there is pitfalls with the DARO as well,
8 and historically people have been sitting on DAROs for
9 years before clinicians sign them off.
- 10 49 Q. So again that -- 10:24
11 A. That has been happened in surgery, yes.
- 12 50 Q. That is not a pitfall of DARO, is it?
13 A. It is a pitfall of the system of the way it's managed,
14 I suppose.
- 15 51 Q. It is a pitfall of the clinician not actioning? 10:25
16 A. But that did happen.
- 17 52 Q. Yes, yes. Nobody is suggesting that DARO can compel a
18 clinician to take the action. DARO is a safety net
19 which allows the system to have visibility on the
20 patient so that the patient doesn't get lost? 10:25
21 A. They are not lost but they are not sitting on a review
22 waiting list. So, they are sitting in a no man's land.
- 23 53 Q. Until the clinician takes action?
24 A. Exactly. If the clinician doesn't take action, the
25 patient doesn't be treated. 10:25
- 26 54 Q. The alternative is as Mr. O'Brien practised, which is
27 to take it out of the DARO system and manage it
28 according to his approach, which was, as you conceded I
29 think earlier, which was at risk of the patient being

1 lost?

2 A. It is not at risk of a patient being lost, it is at
 3 risk of the patient being seen in a timely fashion due
 4 to the long waiting lists. If the waiting lists
 5 weren't so long, everything would have worked fine. It 10:26
 6 was just the fact that he had such long waiting lists.

7 55 Q. The purpose Mr. O'Brien writes of the reason for the
 8 decision to review a patient is indeed to review the
 9 patient.

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

17
 18 He is making the case, as I think you outlined earlier,
 19 that these matters should stay with him; he should have
 20 control of the leavers in terms of when and for what 10:27
 21 reason the patient should be seen?

22 A. That's correct, yes.

23 56 Q. He sets out further concerns.

24
 25 Mr. Haynes is brought into this debate. If we scroll 10:27
 26 up. He explains that the process is now a urology
 27 process but a Trust-wide process. It is intended in
 28 light of the reality that patients in many specialties
 29 do not get a review at the time intended and many cases

1 take place years after the intent to ensure that scans
2 are reviewed and in particular unanticipated findings
3 actioned. Without this process, there is a risk that
4 patients may await review without a result being looked
5 at. There have been cases (not urology) of patients' 10:28
6 imaging not being actioned and resultant delay in
7 management of significant pathologies. As stated, this
8 is a Trust-wide governance process that is intended to
9 ensure there are no unactioned significant findings.
10 There is no risk in the process described". 10:28
11

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

14 A. He did, yes.

15 57 Q. Did he change his approach? 10:29

16 A. No, he didn't.

17 58 Q. Did he show you Mr. Haynes' explanation?

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

19 59 Q. All right. So, was there any debate between you and
20 Mr. O'Brien about the difficulty you faced? You had 10:29
21 instructions from your service administrator to follow
22 a particular process, and Mr. O'Brien, notwithstanding
23 his knowledge of what the Trust was saying back to him
24 through his Associate Medical Director, Mr. Haynes, was
25 that explained to you at all? 10:30

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

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

11 60 Q. You would have, as the ultimate check, inquired into
 12 whether action had been taken by Mr. O'Brien or by the
 13 testers, by the radiology or pathology?

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

25 61 Q. If the result has come in and you have marked it as 10:32
 26 essentially transferred over to Mr. O'Brien, would you
 27 have taken any steps after that?

28 A. No.

29 62 Q. So, you wouldn't be in a position to know whether

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

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

9 63 Q. Anything that didn't get back from results remained on
10 the shelf? 10:33

11 A. Yes, yes, that's correct.

12 64 Q. Katherine Robinson, in her account to the Inquiry -- if
13 we could just go to the WIT-60388. She says at 28.4:

14
15 "The issues with use of DARO were frustrating and 10:33
16 worrying. The secretary spoken to on at least two
17 occasions to say that she should be following the
18 instructions from her line manager and not the
19 consultant regarding administrative processes.

20 Although I have a log of these interactions, I do 10:34
21 acknowledge that it is difficult for in the management
22 of consultant secretaries is not easy due to the
23 relationship of being managed by a different group of
24 people. On this basis the issue was escalated to Mr.
25 Haynes, the clinical director and this was reinforced. 10:34
26 The secretary then did comply".

27
28 Let's just look at that, first of all. Were you spoken
29 to on two occasions or at least two occasion to the

1 best of your recollection?

2 A. Yes. That would have been one of those meetings that I
3 would have spoken with Katherine Robinson and the
4 workaround was organised. To say that "the secretary
5 did comply", it was not with the DARO, it was the 10:34
6 workaround.

7 65 Q. Right. So, you're confident DARO wasn't used by
8 Mr. O'Brien, the workaround was you to keep visibility
9 on the movement of the charts --

10 A. Yes. 10:35

11 66 Q. -- as results came in or if they didn't come in?

12 A. That's correct.

13 67 Q. Could I bring you to a document that we looked at
14 yesterday, WIT-22816. This is the note of the meeting
15 where, as we explained yesterday, as we looked at 10:35
16 yesterday, you were asked whether you had changed some
17 entries on Mr. O'Brien's behalf. You tried your best
18 to explain your understanding of that. You were asked
19 about the DARO function, and you explained that you
20 didn't use - that is Mr O'Brien and yourself - didn't 10:35
21 use all administrative processes, in particular the
22 DARO function. You go on to say that:

23

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

1

2

An example is recorded there.

3

4

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

10:36

5

6

A. That's correct.

7

68

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

8

9

Is that his office?

10:36

10

A. That is the secretary's office.

11

69

Q. Your office.

12

13

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

10:37

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

10:37

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26

A. Yes.

27

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

28

29

1 December - top of the page - 2019. It was reported on
 2 11th January 2020. He explains, going to the second
 3 paragraph, that you would have retained this patient's
 4 chart in your office to awaiting the report of the CT
 5 scan; is that right? 10:41

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

8 73 Q. So that chart would have been sitting on the shelf and
 9 you would be waiting on the result coming from
 10 radiology; is that right? 10:42

11 A. Yes, that's correct.

12 74 Q. But the results in terms of the system, Mrs. Elliott,
 13 do they come to you by email?

14 A. No, by post.

15 75 Q. By post. 10:42

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

20 76 Q. This is a patient who had a history of renal cancer and 10:42
 21 the scan is pointing up a concern that he may have
 22 metastatic disease of the prostate, and suggesting, as
 23 Mr. O'Brien observes here, the need for further
 24 evaluation and the need for perhaps bone scan. So,
 25 that is something for him to consider. 10:43

26

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

- 1 A. Yes. They would have been date-stamped. They wouldn't
2 have been recorded on any database or anything, they
3 were just date-stamped.
- 4 77 Q. On a hard copy you put a stamp?
5 A. Yes. 10:43
- 6 78 Q. With a date on it, okay. Then do you move the chart
7 into Mr. O'Brien's office or how does it work?
8 A. No, it would have been moved then to the "results with
9 Mr. O'Brien to see" shelf.
- 10 79 Q. Within your office? 10:43
11 A. Within my office.
- 12 80 Q. If these results are written up or recorded on 11th
13 January, do they reach you fairly promptly after
14 that --
15 A. Yes. 10:44
- 16 81 Q. -- in the normal way?
17 A. Normally they would have been the same week. Within a
18 week at least.
- 19 82 Q. If you put them on the results received shelf or "for
20 Mr. O'Brien to see" shelf, how does he get to know then 10:44
21 that you are holding a set of results that he has to
22 see?
23 A. The result was left on his desk. So the result went,
24 the paper copy of the result --
- 25 83 Q. Oh I see. 10:44
26 A. -- went to his office.
- 27 84 Q. So you continue to hold the chart?
28 A. Yes.
- 29 85 Q. He gets the result?

1 A. Yes. Now bearing in mind this was whenever Aidan
 2 didn't want any charts in his office because he was
 3 being monitored for the number of charts in his office.
 4 86 Q. well, if he needed to check back on the chart to see a
 5 fine detail or whatever to remind himself of something, 10:45
 6 was the chart was close at hand, you were holding it?
 7 A. It wasn't really relevant in 2018 because NIECR was
 8 operational by then so all information would have been
 9 there.
 10 87 Q. So, I think the paper copy of the result is now with 10:45
 11 Mr. O'Brien within presumably the day you receive it?
 12 A. Yes, the same day, unless I was on leave or the post
 13 was held, you know, not opened.
 14 88 Q. But it would be date-stamped, so that would be the day
 15 it would go? 10:45
 16 A. To his office, yes.
 17 89 Q. Yes. Then it is on his side of the court to action?
 18 A. Yes.
 19 90 Q. Now, if he anticipated reviewing that patient in
 20 January, what would you expect the next step to be from 10:46
 21 him to you?
 22 A. He would have either e-mailed and asked me to put the
 23 man on the next available clinic, or it would have been
 24 hand written on the result, 'please book this man to my
 25 Friday oncology clinic' or whatever. So there was 10:46
 26 either an email back to me or the result came back to
 27 me with a hand written note on it.
 28 91 Q. Just returning to what Mr. O'Brien says about this.
 29

1 "My secretary had retained Patient C", or service user
2 C - we call him Patient 5 - "hospital chart in her
3 office to await the report of the CT scan so this chart
4 would be available for his intended review in January.
5 She transferred the chart with the report of the CT 10:47
6 scan to my office on some unspecified date following
7 receipt of the report".

8
9 Can I just ask you about unspecified date. Do you know
10 what that means? 10:47

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

12 92 Q. If we obtained the report, would we see a date on it?
13 It should be date-stamped?

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

20 93 Q. Yes. Where he says "as she did not track the transfer 10:47
21 of the chart from her office to mine, it has not been
22 possible to determine when it occurred", what you are
23 saying is your approach is not to transfer the chart,
24 it is to transfer the report?

25 A. Yes. 10:48

26 94 Q. The report will have a date stamp on it?

27 A. That's correct.

28 95 Q. And that will be the date that you would place it in
29 his office, place it on his desk.

1 He says:

2

3 "It is probable that it was during February 2020 due,
 4 once again, to my not being able to review SUC during
 5 January 2020 due to the inadequacy of outpatient review 10:48
 6 capacity. In fact he still remained on the list for
 7 review at my oncology review clinic in June". And I
 8 think that should say 20 20 and not 2019?

9

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

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

23 96 Q. As regards this particular case, you didn't receive any
 24 follow-up instructions from Mr. O'Brien?

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

27 97 Q. Help me with the rationale that is set out here, if you
 28 can. Mr. O'Brien is saying it is probable that the
 29 chart came to his office during February due to him not

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

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

5 98 Q. If the results are available within days of them being 10:50
6 reported on 11th January, was it Mr. O'Brien's habit,
7 to the best of your understanding, to review results
8 quickly, or did he tend to wait until he had a review
9 clinic arranged or review appointment arranged for the
10 patient? 10:51

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

17 99 Q. On a case such as this, results have come in, he wants
18 to review him in January. How would that review be set
19 up? who would make the arrangements for that?

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

28 100 Q. The result has come in; he wants to review him, it
29 suggests here. He has, if you like, the role or the

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

4 A. That's correct.

5 101 Q. Are you interpreting that as saying he simply didn't 10:53
6 have the space to fit this patient in?

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

14 102 Q. Do you have visibility on the needs of the patient in a 10:53
15 situation like this? This patient had suspicion of
16 metastatic prostate cancer, he needed a bone scan; that
17 didn't come to light and wasn't actioned until July or
18 August 2020. This was obviously a period of some
19 destabilisation within the Trust with COVID,
20 Mr. O'Brien retired and the circumstances around that. 10:54
21 But in general, if we can look at it perhaps, where a
22 review isn't possible because of the capacity reasons
23 that Mr. O'Brien is suggesting there, and you agree
24 with that, what happens in the meantime for a patient
25 where the scan results are saying further action is 10:54
26 required, this patient may have cancer?

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

- 1 certainly did not have the time to chase up every
2 single result and see that it was actioned.
- 3 103 Q. If that patient had been on DARO, the service would
4 have had visibility of the fact that results had come
5 in from radiology; isn't that right? 10:55
- 6 A. That's right, yes.
- 7 104 Q. And would have had visibility that those results hadn't
8 been actioned because the case still remained on DARO?
- 9 A. Yes. So our service administrator -- the narrative,
10 should that person have been on DARO, how I would have 10:56
11 validated that DARO would have been "result with Mr.
12 O'Brien to see and action". Now, that happened on a
13 regular basis but our service administrator never came
14 back to say why has this not been actioned, so I'm not
15 sure whether it would have went anywhere. All right, 10:56
16 it would have been noted on the DARO but whether those
17 sorts of things were ever actioned, I am not concerned
18 -- I am not convinced that they were.
- 19 105 Q. Before leaving this, can I ask you two more questions
20 in relation to this area? When results come in, is it 10:57
21 any part of your function to plan something, to make a
22 quick assessment from a non-clinical perspective of how
23 urgent a case might be?
- 24 A. Well, unless it really jumped out at you, we would have
25 generally just read the conclusion. We certainly 10:57
26 hadn't time to sit and read all the results. It was
27 very, I have to say ad hoc as to what time we had to
28 read. We are not clinicians, so not all things I
29 suppose that were red flag or of concern were

1 highlighted by the secretary.

2 106 Q. In terms of the cancer tracker, would you have any
3 engagement with the cancer tracker when results came
4 in, particularly where results suggested an unexpected
5 course or a serious course for a patient? 10:58

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

7 107 Q. Or in Patient C's case, where there had been a history
8 of cancer and this was a situation where there was a
9 suspicion of metastatic disease from the primary.

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

13 108 Q. Yes, but what I'm saying is regardless of whether the
14 patient is on a tracking system, if you as the
15 secretary see something untoward in the result, do you 10:59
16 have any role - I am thinking here from the perspective
17 of an additional safety net - to get the thing moving
18 with the cancer tracker?

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

20 109 Q. You had no role in that respect? 10:59

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

23 110 Q. Can I leave that area and ask you about your role in
24 respect of private patients. Mr. O'Brien had a private
25 practice; is that right? 10:59

26 A. Yes, a private outpatient practice.

27 111 Q. And he saw patients in his own home?

28 A. That's correct.

29 112 Q. You have said in your witness statement at WIT-76345

1

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

4 A. That's correct, yes.

5 116 Q. We had a brief look at that yesterday, and you 11:02
6 suggested in your statement to Dr. Chada that there was
7 a typo in respect of --

8 A. The chart requested.

9 117 Q. The chart requested.

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

15 118 Q. Although you know perfectly well that Mrs. O'Brien is 11:02
16 the liaison person quite often in respect of private
17 patients; that is why you are writing to her?

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

19 119 Q. That was a not infrequent transaction between you and 11:03
20 her?

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

25 120 Q. And Mr. O'Brien had a private patient typist who did 11:03
26 all of the typing in respect of his private work; isn't
27 that right?

28 A. That's correct.

29 121 Q. And that was Mrs. Hanvey?

1 A. Miss Hanvey.

2 122 Q. Miss Hanvey, I beg your pardon. She worked within the
3 Trust as a secretary in her own right?

4 A. In urology, yes.

5 123 Q. Obviously the private patient work was additional to 11:03
6 her day job; is that right?

7 A. That's correct.

8 124 Q. Could I ask you about TRU-296740. This is 24th
9 September 2018, and the query is in relation to private
10 patient typing. You have said, "I have attached letter 11:04
11 which were on G2"; that is the digital dictation
12 system?

13 A. That's correct.

14 125 Q. "I note that you actually saw this patient privately 11:04
15 and wonder if these should be on your private patient
16 letterhead paper instead. There were no recent
17 episodes on PAS for me to link this to. Can you please
18 advise".

19

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

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

4 A. Yes.

5 126 Q. -- in September 2018. This has been typed up, this is 11:06
6 the result of that private consultation being typed up
7 by you. So, you appear to be concerned that you are
8 typing up the outcome of a private patient encounter;
9 is that right?

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

12 127 Q. What was your concern and tell us how it was
13 clarified?

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

- 1 privately in the interim was because he was a neighbour
2 of Mr. O'Brien's, or he lived very close to Mr.
3 O'Brien, so it was out of just courtesy that he had saw
4 him in his own home when he was experiencing
5 difficulties during his long wait on the waiting list. 11:08
- 6 128 Q. So, your concern that you were typing up a private
7 patient episode was resolved by Mr. O'Brien telling you
8 that what, in fact, had transpired was a NHS remote
9 telephone conversation?
- 10 A. Yes. 11:08
- 11 129 Q. Was that recorded as such?
- 12 A. As far as I am aware, yes. I would have had to have
13 opened up and attached that then to an open episode,
14 outpatient episode.
- 15 130 Q. This patient has obviously been seen for flexible 11:08
16 cystoscopy and urodynamic studies within three weeks of
17 him being seen by Mr. O'Brien remotely by telephone in
18 September. You have explained that there were no PAS,
19 no PAS episodes to link this case to when you were
20 typing this letter; was that unusual? 11:09
- 21 A. As I say, I didn't appreciate that he was on the
22 waiting list for surgery. When someone is put on the
23 waiting list for surgery, they don't generally have an
24 outpatient episode open as well; it is either one or
25 the other. They are either coming in for surgery or 11:09
26 they are coming in for review. It was because
27 Mr. O'Brien wanted to reassess this man's symptoms
28 because he was on the waiting list for so long that
29 that episode, outpatient episode, had been to be

- 1 reopened to enable him to do this.
- 2 131 Q. How does Mr. O'Brien arrange a remote telephone
3 engagement with a patient on the NHS when his previous
4 interaction with him in 2016 had been private? How does
5 that come about? 11:10
- 6 A. That would have been done -- we would have done that
7 retrospectively. So, the clinicians would have rang
8 patients. There was never -- I know there are some
9 consultants where they set up virtual clinics. So, the
10 secretary sets the clinic up and then the patients know 11:10
11 they are going to be rang on such and such a day at
12 such and such a time. But that didn't happen in
13 urology. The clinicians would have rang the patients
14 and then we would have set up the episode after,
15 retrospectively. 11:11
- 16 132 Q. So, this is an Outpatients remote conversation?
- 17 A. Yes.
- 18 133 Q. Mr. O'Brien presses on with that and then he tells you
19 about it and you record it retrospectively; is that
20 right? 11:11
- 21 A. Yes, that's right. This was a new concept that sort of
22 came in and then was increased, the usage was increased
23 during COVID. Virtual clinics were only really
24 starting to come in in the latter stages just before
25 COVID hit. 11:11
- 26 134 Q. Are you saying that this patient had been on the
27 waiting list for cystoscopy since when?
- 28 A. I can't remember because there was actually another --
29 there is another email from my service administrator

- 1 saying that this man was never put on the waiting list,
2 and it is the same man because it went that far back.
3 Whenever you have someone on the waiting list quite a
4 while, there are -- whenever you go into PAS, you can
5 only see about six episodes. Sometimes you have to 11:12
6 scroll down maybe three or four pages before you get
7 the actually waiting list episode.
- 8 135 Q. Were you able to find him on the waiting list?
9 A. Oh yes, he was on the waiting list, yes, but it was, I
10 don't know -- this was '18. I have a funny feeling it 11:12
11 would have been 2014. I am not 100% sure but I think
12 it was 2014.
- 13 136 Q. Yes.
14 A. I don't know, did Mr. O'Brien refer to it at the
15 beginning of the letter? 11:12
- 16 137 Q. Let me scroll up.
17 A. Maybe it was '16. I think he referred to this man is
18 on the waiting list. Maybe not.
- 19 138 Q. By the end of '15, or by April '15, he reported
20 significant improvement and then in '16 he reported 11:13
21 recurrence of former symptoms. Scroll down. Then he
22 prescribed medication. Scrolling down.
- 23 A. If you notice there on the bottom of that first page,
24 he had said there - scroll up, please - "he would be
25 better served". Yes, so last paragraph there, "I 11:13
26 advised that he would be better served by his prostate
27 resected". So, it could have been September '16 there,
28 according to that.
- 29 139 Q. Your concerns that this was a private patient episode

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

2

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

8

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

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

16 140 Q. Right.

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

19 141 Q. Help me with this. If we go to your amended statement
 20 at WIT-96807 and if we scroll down, please, you're 11:15
 21 explaining it at answer 2. Just scroll down a little
 22 bit further. Your first answer in your original
 23 statement is set out first.

24 A. Hm-mhm.

25 142 Q. You said: 11:16

26

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

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

7
8 You say you want to change that. You have added:
9 "However if the patient(s) Mr. O'Brien had seen
10 privately were not on the PAS waiting list, I was able 11:17
11 to check on the chart tracker on PAS to see when the
12 patient's chart was tracked to Mr. O'Brien PP filing
13 cabinet by Leanne Hanvey. This was the date I used to
14 put the patient originally seen as a private patient on
15 to the NHS waiting list". 11:17

16
17 Can you help us to understand the distinction that you
18 are drawing here?

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

25 143 Q. Okay. I think that maybe we were confused. I was 11:18
26 asking whether you had a role in putting patients
27 moving from the private into the NHS onto the waiting
28 list and preadmitting them. Is that what you are
29 describing here?

1 A. Yes, sorry.

2 144 Q. That when a patient had been indicated for a procedure,
3 your role kicked in at that point?

4 A. Sorry, could you please repeat that? Sorry.

5 145 Q. When a patient originally seen by Mr. O'Brien as 11:19
6 private --

7 A. Yes.

8 146 Q. -- was moving into the NHS for a procedure --

9 A. Hm-mhm.

10 147 Q. -- you had a role at that point? 11:19

11 A. No.

12 148 Q. No. What are you describing here?

13 A. It was whenever I was preadmitting, so when Aidan gave
14 me the theatre list for his next theatre session and
15 the patient wasn't on the waiting list, this was 11:19
16 whenever I checked the tracking of that chart and
17 determined that it was a private patient. Then, I
18 needed a date to add that patient to the waiting list.
19 Because I had no way of knowing when the patient was
20 seen, I - and I know it now to be wrong - I used the 11:19
21 tracking date that that chart was tracked to
22 Mr. O'Brien's PP cabinet as the date of the patient
23 going on the waiting list. I now know that to be
24 incorrect.

25 149 Q. Why is that incorrect? Let me put a scenario to you. 11:20
26 Mr. O'Brien sees a private patient on a Saturday and he
27 decides that the patient should come in for a
28 procedure, and he takes a view on the priority of that
29 patient.

1 A. Hm-mhm.

2 150 Q. He will then contact you; is that right?

3 A. No, he never -- no. As I say, I did nothing. I had
4 nothing to do with his private practice.

5 151 Q. Okay. The private patient is moving to the NHS, he is 11:20
6 an NHS patient, he needs a procedure.

7 A. Hm-mhm.

8 152 Q. You have to pre-admit that patient for that procedure;
9 no?

10 A. Only when he is being preadmitted, which isn't at the 11:21
11 time of the consultation. You never would have a
12 patient coming to see him on a Saturday and put on the
13 following Wednesday. So there was always a time lapse.

14 153 Q. The patient is coming in for the procedure within the
15 next month or so? 11:21

16 A. It is not. It would never be months.

17 154 Q. Would it not?

18 A. Well, not to my knowledge, no.

19 155 Q. Well, take that as the scenario. How do you arrive at
20 a waiting list date for that patient? 11:21

21 A. Right, I'll give you the scenario. So, Mr. O'Brien's
22 --

23 156 Q. Just in terms of what you are describing here, you have
24 the chart coming back into the private patient cabinet;
25 isn't that right? 11:22

26 A. Yes, by Leanne Hanvey. I had nothing to do with the
27 tracking of that chart. So, I needed a date to put
28 that patient on the waiting list. I hadn't time to run
29 around the hospital looking for Mr. O'Brien to find out

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

5 157 Q. Okay. If that was a mistake on your part to use the 11:22
6 date when the patient's chart arrives in the private
7 patient filing cabinet, if that was a mistake, what
8 should the date have been?

9 A. The date the patient was attended for consultation.

10 158 Q. What consultation? 11:23

11 A. Private consultation.

12 159 Q. That should --

13 A. Of which I didn't know.

14 160 Q. If the patient had seen Mr. O'Brien four weeks earlier,
15 six weeks earlier, and a decision had been made that 11:23
16 that patient should go for a procedure, that is the
17 date you should have used?

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

21 161 Q. What you were finding with many patients who had their
22 origin in his private practice was that there was no
23 record on PAS, on the PAS waiting list?

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

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

5 162 Q. You have said that your approach is wrong, or was 11:24
6 wrong?

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

9 163 Q. When did you come to that view?

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

13 164 Q. Who told you you had taken the wrong approach?

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

15 165 Q. In terms of your training in respect of the handling of 11:25
16 private patients or advice given to you by the Trust in
17 respect of private patients, can I draw your attention
18 to this brief guide for administrative staff? It is
19 TRU-165872. This was sent to administrative staff and
20 shared with secretaries in 2014. It is a very brief 11:26
21 one-page document. Just scroll down. What you need to
22 do, it says you need to "Ensure the status of private
23 patient is recorded on the PAS system".

24

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

26 A. I don't, no.

27 166 Q. Were Mr. O'Brien's private patients recorded on the PAS
28 system as private patients?

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

- 1 or?
- 2 167 Q. well, I can only use the language in front of me.
- 3 A. I don't understand it. "Please ensure the status of
4 private patient is recorded"; I don't know what that is
5 referring to. 11:27
- 6 168 Q. Is the patient on the PAS system; if he or she is
7 private, that should be labelled as such?
- 8 A. You see, once the private patient came in under the
9 NHS, they were an NHS patient, they were no longer a
10 private patient. So I don't understand that because 11:27
11 they were no longer a private patient and they were
12 treated equally to other patients.
- 13 169 Q. So, there is no method on the PAS system to record
14 alongside the patient's name that they are a private
15 patient? 11:28
- 16 A. well, if they were attending a private consultation
17 they wouldn't be on the PAS system.
- 18 170 Q. But if they are coming into the hospital, for example,
19 from the Republic of Ireland, they are a private
20 patient? 11:28
- 21 A. I'm not aware of that.
- 22 171 Q. No.
- 23
- 24 "For booked patients with a Republic of Ireland
25 address, ensure the patient is recorded as private on 11:28
26 PAS", to take that example.
- 27 A. I don't remember ever anybody from the Republic of
28 Ireland being on my books.
- 29 172 Q. So you know, I suppose the broad question is this: Are

- 1 you saying that you are not aware of any method to use
2 the PAS system to label the patient as a private
3 patient?
- 4 A. Not at that time, no. The only time I would have said
5 somebody was transferred over to the private sector was 11:29
6 whenever there would have been an episode opened and
7 they would have been seen privately, then you would
8 have said attended AOB privately and closed down that
9 episode.
- 10 173 Q. If we look at WIT-96807 and if we scroll down to 11:29
11 paragraph 3, please. In terms of your role in dealing
12 with private patients coming into the NHS, you have
13 explained how you came by using the chart hitting the
14 cabinet as the date for waiting list purposes, and you
15 have said, I think, that that was wrong? 11:30
- 16 A. Hm-mhm.
- 17 174 Q. You have said at paragraph 3; "then there was the
18 introduction of the transfer status form" and you are
19 not sure of the date?
- 20 A. Well, this was post inquiry -- or and post MHPS 11:30
21 process.
- 22 175 Q. Could I just draw your attention to the following
23 documents briefly. If we go to TRU-267692. This is a
24 copy of a transfer status form, the transfer of private
25 patients to NHS status. It is contained at Appendix 4 11:31
26 of a guide relating to paying patients, which was
27 introduced in 2016. The Inquiry has material which
28 shows that the private patient transfer form in one
29 shape or another was in operation from at least as far

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

7 A. Yes, that's correct.

8 176 Q. Did you see them coming through your office?

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

13 177 Q. So, describe the circumstances in which they would have
14 been used, as you understand it.

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

26 178 Q. Prior to you starting to see these forms after the MHPS
27 investigation, prior to that what was the method used
28 by Mr. O'Brien to move the patient from private into
29 NHS?

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

4 179 Q. How would the system have known that the patient was
 5 transferring his or her status? 11:34

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

7 180 Q. Did you understand that the regulation of this area
 8 required the Medical Director's office to give approval
 9 to the transfer?

10 A. No. No. 11:34

11 181 Q. That wasn't something you were aware of?

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

18 182 Q. Just looking at one of the principles set out in the
 19 form, or in the guidance, if you go to TRU-267673, it
 20 says that... just go over the page, sorry. Where a 11:35
 21 change of status is required, the form we have just
 22 looked at must be completed and this has to go to the
 23 medical director for approval.

24
 25 Just go back to the previous page. There it is. 11:36
 26 4.4.1.

27
 28 "A patient seen privately in consulting rooms who then
 29 becomes an NHS patient joins the waiting list at the

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

3
4 I am thinking back to the period before you became
5 aware of the transfer of status form. In your role, 11:36
6 were you able to ensure that when a private patient
7 comes in to the NHS, that he or she joined the waiting
8 list at the same point as if her consultation had taken
9 place in the NHS?

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

15 183 Q. The date you used, the more recent date, if you like, 11:37
16 you are concerned that that would give the impression
17 that a private patient had been advantaged --

18 A. Yes.

19 184 Q. -- in some way?

20 A. Yes. 11:37

21 185 Q. Do you have a means of ascertaining or satisfying
22 yourself that private patients hadn't been advantaged?

23 A. Sorry?

24 186 Q. Are you able to ascertain from your position that
25 private patients weren't advantaged? 11:38

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

- 1 that.
- 2 187 Q. The position would perhaps be susceptible to inquiry if
3 the date had appeared on the PAS system, in other words
4 if the waiting list system had been used. But you were
5 finding in many of these transfer cases that you 11:39
6 couldn't find patients on the waiting list?
- 7 A. That's correct.
- 8 188 Q. Just briefly then to conclude, Mrs. Elliott. Some of
9 your reflections contained in your witness statement
10 refer to the extremely long waiting lists. I think you 11:39
11 say that your main concern in urology was these
12 extremely long lists, there was not enough capacity to
13 deal with the workload and therefore patients suffered.
14 You talked about how you had been, I suppose, taught
15 coming up in the Trust, particularly in your governance 11:40
16 roles, that we should be aiming for a gold standard, as
17 you describe it, but that wasn't deliverable as time
18 went on. Is there anything more you want to say about
19 that?
- 20 A. I think there seems to be a bit of a disconnect in what 11:40
21 governance inspired to do and what is actually
22 happening. It is just not achievable to have that gold
23 standard.
- 24 189 Q. One of your reflections as well is that management
25 needs to engage more with the workload. Was that a 11:40
26 disconnect as well?
- 27 A. Very much so, yes.
- 28 190 Q. What could they have done about it, do you think? What
29 should they have done about it?

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

3 191 Q. This is on the administrative side?

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

7 192 Q. You have reflected in your statement at WIT-76358 that
8 the move to the Breast Service, I suppose, has led to
9 an improvement in your working environment and you find
10 it to be a more effective service. What are the 11:41
11 differences that you are observing from a position as a
12 medical secretary in that service by contrast with the
13 Urology service?

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

15 193 Q. Could you give us one example of how things work better 11:42
16 and are better for patients because you're able to do
17 your job as a secretary in a better way to work?

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

23 194 Q. Okay. I have no further questions for you. The Chair
24 will speak to you.

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

28 A. Okay.

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

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

3
 4

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

5
 6

12:00

THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:

7
 8

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

10 195 Q.

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

12:00

12:01

18 A.

Mr O'Donoghue's secretary. Towards the end there was a
 19 lot of change. Mr O'Donoghue's secretary, and then
 20 Mr Tyson's secretary who replaced Mr. Suresh. So,
 21 there was -- at the end there was four secretaries in
 22 the one office.

12:01

23 196 Q.

I mean, you mentioned the atmosphere. You could
 24 discuss operational issues with the other secretaries
 25 for advice and what would you do with this and what
 26 would you do with that. Did those sort of
 27 conversations happen?

12:01

28 A.

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

- 1 197 Q. Right.
- 2 A. I moved offices whenever I went to work for
3 Mr. O'Brien.
- 4 198 Q. That was the one you ended up with, that was a sort of
5 helpful and supportive atmosphere? 12:02
- 6 A. Very much so.
- 7 199 Q. Was it? Okay, thank you. You mentioned working four
8 days a week but presumably the audiotypist didn't
9 really pick up much of the Monday queries. Did you
10 have to pick up five days' worth of work in four days? 12:02
- 11 A. Yes. Well, apart from the short period of time in 2018
12 when the audiotypist was upgraded to a secretarial post
13 for about six months before she then got a secretarial
14 post in another speciality. But she was very good and
15 would have done a lot more administrative work on the 12:02
16 Mondays. But that, as I say, was for a short period of
17 time. Then the audiotypist that replaced her when she
18 left would have just took messages. So, I would have
19 got a raft of messages when I came in on Tuesday
20 morning for me to contact patients. 12:03
- 21 200 Q. So she had taken messages but not actually done
22 anything about it?
- 23 A. No.
- 24 201 Q. What about when you were on annual leave, for example?
- 25 A. Annual leave the other secretaries would have covered. 12:03
26 We all had to cover each other.
- 27 202 Q. All right. Thank you. You said interestingly
28 yesterday how could a secretary encourage the
29 clinician? I think you can do that quite well but it

- 1 needs face-to-face. There seemed to be a big culture
2 of e-mailing rather than discussion face-to-face; is
3 that a fair observation? You said you saw Mr. O'Brien
4 sort of twice a week but he was in, say, four days a
5 week, and your offices were very close? 12:03
- 6 A. That's correct but he very seldom was in his office.
7 Well, obviously he had the clinic activity and those
8 clinics were all held in the Thorndale unit. He had
9 his all day theatre list. He usually would have come
10 up maybe midday on his theatre day; just pop in more or 12:04
11 less. A lot of these, the popping into like the
12 office, was like a courtesy pop in. As regards
13 one-to-one and face-to-face consultations, there were
14 very limited.
- 15 203 Q. If I could just draw you on that. The popping in, that 12:04
16 is a good opportunity for you. Would he say how's
17 things, is there any worries, any nasty results type of
18 thing?
- 19 A. Yes. For instance on the undictated clinics,
20 periodically I would have said 'any chance of you 12:04
21 sorting those clinics out'. That would have been my
22 chance then, you know, to have, I suppose what you
23 would say encouraged.
- 24 204 Q. But then also if you had had a worrying result, for
25 example, that you had picked up or jumped out as you 12:04
26 say, would you say actually do you mind having a look
27 at those two, for example. Is that something you did
28 regularly?
- 29 A. Yes. Sometimes if there was something that jumped out,

- 1 I would have actually went down to the clinic, to the
2 urology clinic down in Thorndale if I thought there was
3 something that really needed his immediate attention.
4 That was done on a regular basis, especially on a
5 Friday because I knew I was going to be off on the 12:05
6 Monday. He always had his oncology clinic on a Friday
7 so I quite often attended that clinic with urgent
8 issues.
- 9 205 Q. Okay. All right, I will come back to that one. Just a
10 few questions on the surgical admissions. You said 12:05
11 most of the information came in via email. Was there
12 an actual form or a card that the clinicians would
13 write out and submit to you in paper form, or was it
14 all done electronically? What was it?
- 15 A. Right. So, if a patient -- the Trust policy is that if 12:05
16 a patient is added to a waiting list, there is a green
17 form filled out. That is for the purpose of the
18 pre-assessment unit, so that they could then pre-assess
19 the patient and all the information would be on that
20 form regarding if they were on a blood thinner or if 12:06
21 they were diabetic and so forth.
- 22
- 23 Mr. O'Brien didn't normally use those green forms, or
24 he very rarely used the green forms.
- 25 206 Q. What would happen with the green form if it was filled 12:06
26 in, would that come to you or a central wait list?
- 27 A. It came to the secretary and then the secretary would
28 have sent it down to the pre-assessment unit.
- 29 207 Q. Then would the patient be pre-assessed there and then

- 1 or with respect to the upcoming operation?
- 2 A. Well, it depended if they were red flag, they would be
3 pre-assessed as soon as possible. If they were on a
4 routine waiting list, there was no urgency. But there
5 would have been a case where people were pre-assessed 12:07
6 even though we knew they would not be coming in for
7 that surgery for years. So, that gave that patient
8 sort of a false hope that they were going to be
9 operated on fairly soon. So that was like a fault in
10 the system that caused a lot of extra phone calls to 12:07
11 the secretary.
- 12 208 Q. Okay. But then say the green form had not been filled,
13 then the pre-assessment people wouldn't know that
14 various things needed done?
- 15 A. No, they would have known because they obviously were 12:07
16 able -- once someone was put on the waiting list, it
17 obviously fired up on their system.
- 18 209 Q. Right. Okay, I see.
- 19 A. The purpose of the green form was regarding any extra
20 information as in the blood thinning products, 12:07
21 diabetes, and those sort of bits of information that
22 were relevant for the pre-assessment department.
- 23 210 Q. All right. So, for example, if someone needed a urine
24 test before a ureteroscopy or a stent change, that
25 would be on that green form? 12:08
- 26 A. No. Mr. O'Brien would have organised that on the
27 pre-assessment note that he gave me. So, he would have
28 sent me the email with the people that were to be
29 pre-admitted, and on that he would have had

- 1 instructions for the ward staff. Say, for instance, a
2 patient, as you say, was coming in for the afternoon
3 session, he would have either brought them in the day
4 before if they needed tests done the day before, or he
5 would have brought them in early morning and asked the 12:08
6 ward staff to do those tests prior to him going down to
7 theatre.
- 8 211 Q. Right. That brings me on to my next question. He
9 would e-mail you with a list of case for his operation
10 list, for example the main session, what would roughly 12:08
11 the interval have been between then and the theatre
12 list? would it be the following week or month?
- 13 A. No. It was normally was -- he would have done it at
14 the weekends. Say I got it on the Tuesday, it would
15 have been for the following wednesday, so the wednesday 12:09
16 week.
- 17 212 Q. So roughly 10 days?
- 18 A. Roughly 10 days.
- 19 213 Q. All right, which is fine for simple tests. Say if a
20 patient needed something more sophisticated, like to 12:09
21 see a consultant anaesthetist or if it was high risk,
22 for example, how was that dealt with?
- 23 A. Aidan would have sorted that out himself with the
24 anaesthetist, or he would have liaised then with
25 pre-assessment. 12:09
- 26 214 Q. Was that enough time to get that?
- 27 A. Yes. He would have been very proactive in preparing
28 patients for his theatre, and that wasn't always
29 involving me.

- 1 215 Q. I accept that. We have heard from one of the
2 anaesthetist in this Inquiry that they needed a
3 reasonable amount of time to plug patients into
4 clinics. Perhaps 10 days is pushing that a bit, or you
5 couldn't comment on that particular aspect? 12:10
- 6 A. No.
- 7 216 Q. But roughly 10 days or so?
- 8 A. Roughly.
- 9 217 Q. Thank you. Another thing is that you organised the
10 admissions for the local anaesthetic procedures like 12:10
11 flexible cystoscopy, urodynamics.
- 12 A. That's correct.
- 13 218 Q. Was that because the Thorndale unit didn't have
14 administration or support?
- 15 A. No, those flexis, those would have been the check 12:10
16 flexis. They were done in our Day Procedure Unit which
17 is a separate building from the Thorndale.
- 18 219 Q. My question is more general in that were there other
19 people helping with this administrative load or --
- 20 A. It was always the secretaries. 12:10
- 21 220 Q. -- were you responsible for every single procedure?
- 22 A. Yes.
- 23 221 Q. So, there was really no further administrative
24 assistance in --
- 25 A. No. 12:11
- 26 222 Q. -- day surgery, Thorndale, and you have already said
27 about main unit. Thank you.
- 28 A. No. The secretary done all the pre-admitting.
- 29 223 Q. Also, I was surprised. Radiology, say it had a

- 1 nephrostomy change or something like that, usually they
2 have their own admin systems; why did you have to do
3 that?
- 4 A. It was always the case, I have never known to be any
5 different. They would have let us know when to bring 12:11
6 the patient in and we done the arrangements or set up
7 the arrangements with the patient.
- 8 224 Q. That is enough on that. Filing. On your evidence, you
9 said sometimes there was Lever Arch files full of six
10 or 10 files full of results of filing. What were they, 12:11
11 were they like routine bloods or X-rays or is that a
12 mixture of everything?
- 13 A. That was filing that I inherited when I took up post.
14 It was a mixture of oncology letters. I would have
15 taken the oncology letters out and tried to address 12:12
16 them because at that particular time, the oncology
17 letters weren't on the NIECR system. We tried to work
18 through it. There was people brought in to try and
19 address back-filing, but to limited effect.
- 20 225 Q. Okay. Thank you. The results, you have already 12:12
21 explained a lot about that. Going back to an abnormal
22 CT scan, for example, and Patient 5, where a decision
23 has been made and you have the charts, Mr. O'Brien has
24 the abnormal result, and then he would write on it or
25 e-mail you. What were the sort of options he could 12:12
26 have given you? For example, an urgent appointment on
27 Friday afternoon oncology?
- 28 A. Yes. It mainly was to make an appointment. He would
29 have specified when.

- 1 226 Q. With a time scale, for example?
- 2 A. Yes.
- 3 227 Q. Then you would have gone ahead and made that
4 appointment; is that correct?
- 5 A. I made the appointments for all the oncology reviews. 12:13
6 That was done by the secretary, not the booking office.
- 7 228 Q. Thank you. But obviously you were directed to do that
8 in whatever time scale?
- 9 A. Yes.
- 10 229 Q. Was there another option for you to flag that up to 12:13
11 re-discuss on MDM?
- 12 A. No, we never heard.
- 13 230 Q. So what was the mechanism?
- 14 A. It was --
- 15 231 Q. If he had had an abnormal report that he wanted to 12:13
16 discuss at MDM, how would that happen?
- 17 A. Mr. O'Brien himself, the clinician, would contact the
18 cancer tracker to be added to the MDM.
- 19 232 Q. Right. That would be done by e-mail, would it?
- 20 A. I am not too sure because we weren't -- the secretaries 12:14
21 weren't involved in referrals to MDM. I am not sure
22 how he did that or how any consultant did that.
- 23 233 Q. All right. Just on that same theme then, for example
24 an abnormal pathology report in one of the other
25 patients, it really doesn't matter which one. That 12:14
26 piece of paper, if he had wrote on the report 'to
27 discuss it at MDM', that wouldn't come through you,
28 that would have to be done by Mr. O'Brien or the
29 clinician?

- 1 A. Yes.
- 2 234 Q. Okay. Thank you. You mentioned the triage letters
3 from Urologist of the week. Often that was up to an
4 extra 60 letters is what you wrote?
- 5 A. That was where you would say Aidan did advanced triage, 12:15
6 where he would have requested scans and then the letter
7 was generated to be sent to the patient to keep them
8 informed of what their next appointment would be, i.e.
9 the scan.
- 10 235 Q. So that was informing the patient what was happening. 12:15
11 Did the other urologists do that as well?
- 12 A. As far as I am aware, yes.
- 13 236 Q. They wrote to patients. Thank you.
- 14 A. In some cases, if it was routine or an urgent, if it
15 wasn't red flag in other words, he could have started 12:15
16 them on a treatment plan knowing that they wouldn't be
17 seen for years potentially. So, he could have started
18 them on like an antibiotic or a low dose antibiotic for
19 those non-red flag patients.
- 20 237 Q. Okay. Thank you. You mentioned about the stents. 12:15
21 Again, this is related to admissions and sort of
22 distressed patients phoning in, a couple we have heard
23 from you. Were you aware of the sort of difference of
24 the types of stents or the reason that people have
25 stents? Either routine change, or a stone potentially 12:16
26 blocking the kidney which needs a ureteroscopy and a
27 laser. They are two quite different scenarios.
- 28 A. It was never explained to us, we were like self-taught.
29 You got to know as time went on. Those sort of things

- 1 were never explained to secretaries.
- 2 238 Q. Okay. I suppose the next question is the patients who
3 had the regular stent changes, like one of the SAI
4 cases, they are done roughly every six months. How
5 would that appear to Mr. O'Brien as someone who needed 12:16
6 their stent changed at a particular month, say six
7 months after it had been put in?
- 8 A. So, the descriptor on the waiting list episode would
9 have been change of stent and then the date, like
10 October '15 or whenever it was due. So that would have 12:17
11 appeared then on the waiting list list, you know, of
12 patients.
- 13 239 Q. Is that on a paper list or is that electronic? How
14 would have Mr. O'Brien have seen that?
- 15 A. The waiting lists were produced by management every 12:17
16 month, or bimonthly maybe, but Mr. O'Brien would have
17 kept his own waiting list. I produced the waiting list
18 from the patient centre or the PAS system.
- 19 240 Q. And that is hard copy or electronic?
- 20 A. I would have printed that off for him. He would have 12:17
21 requested it periodically.
- 22 241 Q. So, he was aware of who was overrunning and who was...
- 23 A. Yes.
- 24 242 Q. Okay. Thank you. That is all I have. Thank you.
25 DR. SWART: I wanted to ask you a few things really 12:17
26 about working in the office and getting all these phone
27 calls from patients. It is very, very obvious that
28 with these long waiting lists, people who are going to
29 be ringing and I think you said you had a lot of phone

- 1 calls. Did you have a set way for the telephone to be
2 answered if people weren't in the office? Was that set
3 up in a way that there was always someone to take a
4 phone call from a patient, or did you have an answer
5 phone, or how did you do that? 12:18
- 6 A. There would have been an answer phone but when I was
7 off on a Monday, the calls were always transferred.
8 They would only have been put on answer phone for meal
9 breaks.
- 10 243 Q. Were all those calls picked up then at the end of each 12:18
11 period?
- 12 A. Yes. As soon as you would have returned to the office,
13 you would have checked your answer phone.
- 14 244 Q. How did you feel about people ringing up and saying, 'I
15 feel terrible, I am on this waiting list and nothing is 12:18
16 happening'? How did you feel about that? Can
17 you just go through how you dealt with it in terms of a
18 pattern so that you could cope it?
- 19 A. The usual thing was, first of all, to check that they
20 were on the waiting list, and then it was to advise 12:19
21 them of the length of the waiting list and that we were
22 trying our best to get them seen as soon as possible.
23 If they were to say to me that their symptoms had
24 deteriorated, then that is when I would have involved
25 Mr. O'Brien and e-mailed. 12:19
- 26 245 Q. When you told them, what was the reaction usually like?
27 If you said, you know, you are on a waiting list, this
28 is the length of it, did they get cross with you or
29 would they get upset, or what happened?

- 1 A. Yes, you had various different emotions coming from the
2 patients.
- 3 246 Q. Were you given any guidance as to how to deal with all
4 of this?
- 5 A. Not really, no. 12:19
- 6 247 Q. I know you said that you e-mailed Mr. O'Brien a few
7 times. We know from reading patient complaints
8 generally that this is a problem, quite a big problem,
9 within the Trust and probably in another hospitals.
10 Quite a lot of the patients feel that they are being 12:20
11 fobbed off generally. I am not talking now
12 specifically about this situation.
- 13
14 what is your view, having done this for quite some time
15 and had these people ringing up, what is your view on 12:20
16 how that should be dealt with?
- 17 A. I don't know how to deal with people when they are on
18 such long waiting lists.
- 19 248 Q. How do you think people could possibly assess how much
20 their symptoms have deteriorated, for example? Was 12:20
21 there any way other than sending an email to
22 Mr. O'Brien for you? What options do you think you
23 had?
- 24 A. The options was for them to -- we were told to send
25 them back to the GP. 12:20
- 26 249 Q. Did you do that quite often?
- 27 A. Oh yes. We would always have said if you have symptoms
28 that you need addressed, go first to your GP but I will
29 let Mr. O'Brien know. So, there was always that

- 1 narrative, that you advised them to first of all seek
2 help from their GP.
- 3 250 Q. In effect, did you have some patients who rang up
4 repeatedly?
- 5 A. Oh yes. 12:21
- 6 251 Q. When they are on their third or fourth time ringing up,
7 what kinds of things did they say to you?
- 8 A. Well, a lot of it was frustration. It was frustration
9 too on my part because there was nothing we could do.
10 I think they accepted that, that it was out of our 12:21
11 hands.
- 12 252 Q. Was there ever a time, for example, when you could
13 liaise with some of the nurses or someone else to talk
14 to them, because a lot of them would have had quite
15 clinical complaints, I would think, and they would need 12:21
16 someone to talk to. Were there any discussions about
17 how that might be managed within urology, as far as you
18 were aware?
- 19 A. We were never actually advised that we had the nurses
20 there for a backup. That was never something that I 12:21
21 was aware of, and I don't believe any of the other
22 secretaries ever transferred to the clinical nurse
23 specialist.
- 24 253 Q. What do you think; do you think that would have been
25 helpful? 12:22
- 26 A. Well, I know now that that is expected and, yes, it
27 would be very helpful. But at that particular time,
28 those clinical nurse specialists were up to their eyes
29 with work so they didn't need patient calls as well.

- 1 You know, they were under-resourced as well.
- 2 254 Q. The other time you spoke to patients was when they were
3 going to come in for their operations, and you said you
4 would be sometimes advising them on some of their
5 treatments like blood thinners. Did that generate any 12:22
6 conversations with them where you were supposed to be
7 giving them advice, because you are not trained in
8 blood thinners. Can you describe how that was for you
9 and whether you had any difficulties with that?
- 10 A. No, I had no difficulties because Mr. O'Brien made the 12:22
11 first phone call. He arranged the people, the patients
12 to come in. He would have only asked me to remind the
13 patient to come off the blood thinner on a specific
14 day.
- 15 255 Q. They didn't ask you any questions about that? 12:23
- 16 A. No, because he had already that all explained in his
17 first telephone call.
- 18 256 Q. Now that you are with the breast team and it feels like
19 night and day, as you described it, what do you think
20 is responsible for the different culture in that 12:23
21 department? I know you feel you have more support; is
22 there anything else that you have noticed that is
23 different about the way that department works?
- 24 A. It works the same way but it is under less pressure.
- 25 257 Q. Specifically, though, you told us that in the breast 12:23
26 team you went to the multidisciplinary team meetings.
27 Did you feel there was less of a hierarchy in the
28 breast team in terms of everybody recognising the
29 importance of everybody in the team?

- 1 A. Yes, there is certainly more use with the clinical
2 nurse specialist; they play a big part in the breast
3 team. As I say, I attended the MDM and it means that
4 you are very aware of outcomes.
- 5 258 Q. What is the situation when the patient is ringing up 12:24
6 there?
- 7 A. Less patients ringing because they are seen within two
8 weeks. The turnover is extremely fast.
- 9 259 Q. Even so, you said a few things that indicate that the 12:24
10 relationship with management, as you call it, wasn't
11 fantastic. Who do you regard as management? Who is
12 management? Do you mean the service administrators and
13 people down that end? Do you mean the senior
14 management of the hospital?
- 15 A. Well, the service administrators and then up to 12:24
16 Katherine Robinson. Yes, that is who I see as my
17 management.
- 18 260 Q. And that is where you feel that it wasn't very helpful. 12:24
19 Do you think the Trust as a whole creates an atmosphere
20 where all the staff feel valued?
- 21 A. Not particularly, no.
- 22 261 Q. Why do you feel that? What do you think the source of
23 that is? I am sure they wouldn't set out to be like
24 that.
- 25 A. I don't know how to describe or why it has went that 12:25
26 way. I think everybody is just running about chasing
27 their tail and nobody has time for anybody.
- 28 262 Q. Yes, okay. Thank you very much. That is all from me.
29 CHAIR: I have only a couple of questions for you.

- 1 Just in terms of the clinical nurse specialists, we
2 have heard that certainly in the nine SAIs, there were
3 no key worker or clinical nurse specialist assigned to
4 those patients. Can you assist us at all. We know
5 that Mr. O'Brien did have some patients who had a key 12:25
6 worker assigned. Can you assist us with how that
7 happened; how a key worker was assigned in some cases
8 and not others?
- 9 A. No. I wasn't aware that key workers needed to be
10 assigned to cancer patients. This was all new to me. 12:26
11 I never heard the word "key worker" ever used when
12 working in urology.
- 13 263 Q. What about clinical nurse specialist or any other
14 terminology, but somebody that that patient could ring
15 up other than you to get help if they felt they needed 12:26
16 it?
- 17 A. I wasn't aware of that. I knew the clinical nurse
18 specialists were there and they did their role in
19 biopsies and urodynamics, helping with urodynamics, but
20 it was like as if that was their role. We were not 12:26
21 aware that they needed to be involved.
- 22 264 Q. When you say "we", we know that other clinicians did
23 use the clinical nurse specialist in that way as a key
24 worker, so clearly presumably his secretary might have
25 been aware? 12:26
- 26 A. I am not aware that the secretaries I shared the office
27 with were aware.
- 28 265 Q. It wasn't something that was discussed?
- 29 A. I've never heard the word "key worker" ever used.

- 1 266 Q. Just in terms of the DARO system, you said that
2 Mr. O'Brien always wanted to have a review of his
3 patients and that is why he didn't use the DARO.
4 Essentially what you are telling us is if a result came
5 back and the result was all clear, there was really no 12:27
6 need for that patient to be on a waiting list; isn't
7 that correct?
- 8 A. That's correct, yes.
- 9 267 Q. So that patient being on the waiting list was then
10 holding up someone else on the waiting list, in effect? 12:27
- 11 A. But Aidan would have made the -- he would have put them
12 on for a review irrespective of the result.
- 13 268 Q. Do you see my point? If he is having a review slot for
14 someone who really doesn't need it, and a quick phone
15 call to say your tests are all back and they are clear, 12:27
16 you are good to go, someone else could have had that
17 slot on the waiting list?
- 18 A. That's right but to me that is not a secretary's call.
- 19 269 Q. No, no, I am not suggesting it is. What I am saying to
20 you is that the DARO system was set up to ensure that 12:28
21 those people who actually needed a review appointment
22 were getting it. Would you accept that?
- 23 A. Well, Aidan would have used the DARO for those people
24 that he knew was going to be discharged, albeit one or
25 two patients; like, it wasn't vast amounts. But no, if 12:28
26 a clinician says he wants to review, the secretary has
27 to adhere to that. I can't comment on whether one
28 patient deserves a review and another doesn't. It is
29 not something I can comment on.

- 1 270 Q. Just in expanding on that a little bit, am I right in
2 understanding that you did not feel that it was ever
3 your role to challenge Mr. O'Brien?
- 4 A. No, I never would have challenged him.
- 5 271 Q. And whatever he told you to do, you did? 12:29
- 6 A. Yes.
- 7 272 Q. Thank you very much, Mrs. Elliott.
- 8 MR. HANBURY: I've just one more on the theme of the
9 results. We have heard in the Inquiry where things
10 didn't go so well, but were there times that, say, 12:29
11 negative results, as the Chair just said, were dictated
12 on and you did letters so that patients were then
13 advised? So, when you said Mr. O'Brien did use DARO
14 sometimes --
- 15 A. Oh yes, yes. Those patients would have been -- 12:29
- 16 273 Q. -- and the CT came back and it was fine, for example,
17 what would happen? Was there a letter?
- 18 A. Yes, he would have discharged the patient. Now, that
19 was very rare.
- 20 274 Q. Okay, but would he dictate a letter to the patient -- 12:29
- 21 A. He would.
- 22 275 Q. -- to say it is fine?
- 23 A. He would. But that was very rare, I am saying one or
24 two patients maybe a month. It was very rare.
- 25 276 Q. Thank you. If, for example, on the DARO system, say 12:30
26 for a prostate cancer follow-up, and the clinician says
27 I want to see you in six months' time and we will have
28 a PAS test beforehand, under the DARO rules would you
29 then have to see the PAS result and then decide?

1 A. Yes.

2 277 Q. But then if there is a huge backlog, that patient might
3 wait for six months to come back?

4 A. Yes, that's correct.

5 278 Q. So it didn't -- 12:30

6 A. It didn't speed up the review appointment.

7 279 Q. So you ended up -- I mean, was the whole idea of
8 follow-up by letter, is that what the... reading
9 between the lines.

10 A. Sorry? 12:30

11 280 Q. Maybe it is an unfair question. If a patient waited a
12 huge length of time even having had the results, there
13 is still a problem, isn't there?

14 A. If it was a very high PAS, Aidan would have addressed
15 that. If they had have been on the review waiting list 12:31
16 to be seen in six months and the PAS came back high, he
17 would have asked me to escalate that appointment and he
18 would generally have said put him on my SWAH clinic for
19 such and such a date. So, he did expedite a lot of
20 appointments because of high or untoward results. 12:31

21 281 Q. As you say, the onus is then on the clinician to make
22 that call?

23 A. Yes, yes.

24 282 Q. Thank you.

25 CHAIR: Thank you very much. Thank you, Mrs. Elliott. 12:31
26 I am sure you will be very relieved to know that we
27 have finished asking you questions. It is not quite
28 lunchtime but near enough. Thank you.
29

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

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

12:32