



Oral Hearing

Day 57 – Thursday, 29th June 2023

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

Held at: Bradford Court, Belfast

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

Gwen Malone Stenography Services

INDEXPAGE

Mrs. Martina Corrigan	
Questioned by Ms. McMahon BL (cont'd)	3
Questioned by the Inquiry Panel	75

1 THE INQUIRY RESUMED ON THURSDAY, 29TH JUNE 2023 AS
2 FOLLOWS:

3
4 CHAIR: Morning, everyone.

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

7
8 MRS. MARTINA CORRIGAN CONTINUED TO BY QUESTIONED
9 BY MS. McMAHON, AS FOLLOWS:

10 10:05
11 1 Q. MS. McMAHON BL: We left off yesterday on the triage
12 issue and I just want to clarify a few points in your
13 evidence and we can move on to some other issues we
14 need to discuss.

15 10:05
16 The Panel have already been taken to an e-mail by
17 Mr. Wolfe, with Mrs. Burns, from Anita Carroll setting
18 out the process to be adopted in relation to default --

19 A. Yes.

20 2 Q. -- triage. For the Panel's note, that is at WIT-98404, 10:05
21 with the process in a diagram form at WIT-98405. You
22 weren't in that e-mail, but it was sent out to all
23 senior individuals --

24 A. It was, yes.

25 3 Q. -- about the process that was to be adopted. Now, we 10:06
26 spoke yesterday about the meeting in February and your
27 subsequent e-mail of March 2014?

28 A. Yes.

29 4 Q. -- which set out that Mr. O'Brien was only to do

1 referred name triage?

2 A. That's right, mm-hmm.

3 5 Q. And I just want to feed what you said back to make sure
4 I've understood it before moving on to the default
5 issue. So, at that point, Mr. Young was to take up 10:06
6 Mr. O'Brien's triage duties.

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

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

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

22 7 Q. I think your evidence yesterday was that he didn't
23 inform his other colleagues about that --

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

26 8 Q. And, subsequently then, Mr. Young stopped doing the
27 triage?

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

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

13
 14 Mr. Young then, without discussion, had returned the
 15 referrals belonging to Mr. O'Brien to the Booking 10:08
 16 Centre to say he was no longer doing it because his
 17 reasoning was they had moved to Urologist of the week,
 18 which was agreed, and everybody had dedicated time,
 19 including Mr. O'Brien, to do the triage.

20 9 Q. So, there was a shift in the landscape insofar as there 10:08
 21 was an opportunity and a time given --

22 A. Yes.

23 10 Q. -- for triage?

24 A. Yes.

25 11 Q. Mr. Young's expectation then was that things would 10:08
 26 revert as expected and each consultant who was a
 27 Urologist of the week would undertake their triage
 28 duties while they were on call for that?

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

1 the Board and that's what was agreed by the team,
 2 including Mr. O'Brien, because there was discussions
 3 coming up to the meeting with the HSCP and that was all
 4 agreed, that they would have time to do the triage on
 5 their Urologist of the week. 10:09

6 12 Q. At that point in September/October, the backlog in
 7 triage that became apparent -- we saw the e-mail
 8 yesterday referencing November 2014, some of the
 9 backlog until that point. Was Mr. Young up to date
 10 with the triage that originally should have been 10:09
 11 allocated to Mr. O'Brien, or when he stopped doing that
 12 in September was there already a backlog?

13 A. He was up to date with the letters for the general
 14 urology, if you like, but with regards to Mr. O'Brien's
 15 named referrals, there was a backlog in that. So, 10:09
 16 Mr. O'Brien's responsibility was the named referrals
 17 and there was a backlog.

18 13 Q. So, even with the ones that were allocated to
 19 Mr. O'Brien being specifically referred to him, the
 20 backlog existed at that point? 10:10

21 A. It did, yes.

22 14 Q. And then that became exacerbated when he took on the
 23 Urologist of the week duty and there became more of an
 24 issue with triage?

25 A. It did, yes. If I can just say too, always, and we may 10:10
 26 come to this, Mr. O'Brien always triaged, albeit it was
 27 late. The issue obviously that came to light in 2017
 28 was that he hadn't triaged. But, up until that, you
 29 know, any of the chasing that would have been done was

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

5 15 Q. I know you listened into Mrs. Burns' evidence in 10:10
6 relation to the default position. Her understanding
7 seemed to have been that although the default was in
8 place to allow people to go on to the list according to
9 the GP's prioritisation, that there was -- it was
10 anticipated that they would ultimately be triaged by a 10:11
11 consultant and, if they needed recategorised, then that
12 would take effect on the list, dependent on what the
13 consultant's view was about the clinical priority. Was
14 that your understanding or was it your understanding
15 that the GP's default was where someone sat on the 10:11
16 list?

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

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

7 16 Q. Just to go back to the essence of the question, really,
 8 which was: Was it your understanding that the GP
 9 categorisation would be the priority the patient was
 10 set at or was it -- 10:12

11 A. Yes.

12 17 Q. Sorry --

13 A. Yes.

14 18 Q. Yes. And so it wasn't anticipated that that would
 15 subsequently be triaged again by you at that point? 10:12

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

26 19 Q. So, your understanding was the same as Mrs. Burns'?

27 A. It was, yes.

28 20 Q. And for the Panel's note, Mrs. Corrigan refers to this
 29 in her Section 21 at WIT-26271 at paragraph 55.5. And

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

4 A. Yes.

5 21 Q. You don't disagree with Mrs. Burns' evidence at all? 10:14

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

23
 24 So, in or around January, I do recall the meeting -- it
 25 was with Heather, Mrs. Trouton; Mrs. Anita Carroll; 10:15
 26 Mrs. Robinson, and myself, and they were basically
 27 asking what we were going to do about the whole thing
 28 about Mr. O'Brien's triage. Now, Mrs. Burns was not
 29 present at that meeting at that time and Anita had

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

3
4 what happened then was I sent down to, as we used to
5 call it, the corner office, down to Mrs. Burns and 10:15
6 asked her to come up and join the meeting. It was a
7 heated discussion, it was a heated debate, and that's
8 where the escalation policy came out of -- but really
9 was to do with Mr. O'Brien at that stage, but then it
10 ultimately moved that there was an Ophthalmology 10:16
11 problem and it was then for all specialties. So, I
12 suppose, that's where the difference is. It ultimately
13 started out with Mr. O'Brien, but this was pre --
14 before Mrs. Burns and I met with him, because it wasn't
15 being resolved. And in between times, Mrs. Carroll and 10:16
16 Mrs. Trouton were doing the escalation, which is the
17 e-mail that you spoke about there, the flow chart.

18 22 Q. It was brought in before Mrs. Burns was aware, the
19 default, is that what you're saying?

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

29 23 Q. And I think Mr. Wolfe took the Panel and Mrs. Burns to

1 the note of your interview with Dr. Johnston?

2 A. Mm-hmm.

3 24 Q. And where you said that the process was developed by
4 you, Anita Carroll and Katherine Robinson, with no one
5 else in the room, and that this would enable you not to 10:17
6 have to monitor triage because it was being done. Is
7 that an accurate reflection, given that you've said
8 that there was still an expectation that, even though
9 the default process was in place, that triage would
10 ultimately be done and a recategorisation applied, as 10:17
11 necessary?

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

1 floor.

2

3 So, the notes don't reflect what happened at all,
 4 because the notes actually say I have told Mr. O'Brien
 5 to triage, which doesn't match up with anything, you 10:19
 6 know, any of the evidence or anything that I've ever
 7 said or understood.

8 25 Q. And when did you get those notes?

9 A. January 2018.

10 26 Q. And did you correct them or send back in and say "These 10:19
 11 are not accurate --

12 A. I couldn't find where I had corrected them or sent them
 13 back, but -- because I've only started to look for them
 14 yesterday after Mrs. Burns' evidence. But I definitely
 15 would have corrected them things if I had of had them. 10:19
 16 And I've never seen a final draft either.

17 27 Q. You understand that one of the focuses for the Panel is
 18 the governance system and processes that allow
 19 decision-making, I suppose, to be tracked back to
 20 origin. This seems to have been a fairly relatively 10:19
 21 important discussion that was going to slightly change
 22 the route by which triage was going to be approached,
 23 and certainly there's some contested evidence now
 24 around what was expected to be done. Do you feel that
 25 decisions like that should be minuted and documented 10:20
 26 and circulated to the individuals, both who are in
 27 charge and whom it's going to affect?

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

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

11 28 Q. You say it was Anita Carroll, Heather Trouton and
 12 Debbie Burns --

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

14 29 Q. Around the default?

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

1 was an omission.

2 30 Q. What you've described seems to be quite a piecemeal way
3 of communicating that everyone knows a bit of the
4 picture, but nobody seems to have an overall view,
5 would that be fair? 10:22

6 A. That's very fair, yes.

7 31 Q. Having heard Mrs. Burns and the other evidence so far,
8 is there anything else you want to say about the triage
9 or the default triage process, or do you think you've
10 covered your understanding of it? 10:22

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

13 32 Q. I just want to ask you a couple of questions about the
14 non-dictation issue. Generally, you have covered that
15 in your statement at WIT-26264 and, if we could go to 10:22
16 WIT-26265 at paragraph 54.14, I just want to read this
17 paragraph out -- just go back. So you say -- the
18 paragraphs:

19

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

22

23 -- you say:

24

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

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

12
 13 It became apparent that despite it being raised with
 14 Mr. O'Brien formally in March 2016, this didn't improve
 15 and, in January 2017, before his return to work, 10:24
 16 Mr. O'Brien revealed to me that there were 668 patients
 17 who had not had a dictation dating back to 2014, which
 18 is in line of when this was brought to my attention."

19
 20 Now, I just want to ask you about that. You have 10:24
 21 mentioned in this the number of patients who didn't
 22 have a clinic letter on the Patient Centre system.
 23 Now, is that the way in which the clinic letter had
 24 been done, is marked on the system, or if you could
 25 just explain what it was that they noticed? 10:24

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

1 would have went in and read the last clinic letters.
 2 So, it would have been clinic letters, but also would
 3 have discharges was added to that system. What I mean
 4 by that was they, basically -- I had given them a list
 5 of patients in the review backlog, and basically then 10:25
 6 what they would have done was went in and looked at the
 7 last letter. But what they were coming back to me to
 8 say was that there were no previous letters, so they
 9 couldn't make a decision without actually having to see
 10 the patient, which was then impacting -- because 10:25
 11 obviously they're able to do that online exercise
 12 whenever sort of it nearly suited them, you know, sort
 13 of because they were doing it as additional if -- to
 14 help us out. So they could have done it in an evening
 15 or a Saturday because they didn't need to see the 10:26
 16 patient, whereas, what they were finding was, because
 17 they didn't have it, they were coming back to say "We
 18 need to see the patient."
 19 33 Q. So they had to go into the system in order to realise
 20 the letter wasn't there? 10:26
 21 A. Yes.
 22 34 Q. The system didn't preemptively indicate the absence of
 23 letters?
 24 A. No, no. Nor does the new system. The NIECR wouldn't
 25 tell you that either. 10:26
 26 35 Q. We mentioned yesterday about the bi-weekly reports on
 27 outpatient activity. Was that a report that could have
 28 possibly captured the absence of dictated letters or
 29 was it not built into that system?

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

2 36 Q. You said now this system's changed, the NIECR?

3 A. Yes.

4 37 Q. What is the position now in relation to referral -- by
5 the time you'd left in relation to referrals? Was 10:26
6 there a way of capturing that information that you can
7 inform us about or --

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

18

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

26 38 Q. So, it's in a trial period at the moment?

27 A. It is, yes.

28 39 Q. But that could potentially, if it was adopted by the
29 Trust, remedy that issue?

- 1 A. Yeah, it will be adopted by the Trust. It's a regional
 2 project that they've been working on for a number of
 3 years, and I think that's possibly why there's been no
 4 investment in the likes of the Patient Administrative
 5 System because this is coming. It's going to be 10:28
 6 paperless -- for all disciplines -- social worker,
 7 AHPEs... I don't know enough detail about it, but I do
 8 know there's a lot depending on it.
- 9 40 Q. I can ask Mrs. O'Kane about that when she comes back.
 10 She can give us the most up-to-date information? 10:28
- 11 A. Yes.
- 12 41 Q. Just the other thing I wanted to ask you about in that
 13 paragraph was that -- you stated at the bottom of that
 14 paragraph, if I can go back to it:
 15 10:28
 16 "It became apparent that despite it being raised with
 17 Mr. O'Brien formally in March 2016, this didn't improve
 18 and, in January 2017, before his return to work,
 19 Mr. O'Brien revealed to me that there were 668 patients
 20 who had not had a dictation dating back to 2014." 10:28
 21
 22 Now, just what were the circumstances under which
 23 Mr. O'Brien told you about that and gave you that
 24 figure? Because I think you had a meeting with him on
 25 9th January, which Mr. O'Brien recorded? 10:29
- 26 A. That's right, yes.
- 27 42 Q. -- or was recorded?
- 28 A. Yes, that's right.
- 29 43 Q. You weren't aware that it was being recorded?

1 A. No.

2 44 Q. The Panel's note of the transcript is at AOB-56018 to
3 AOB-56032. There doesn't appear to be a mention of
4 numbers or an indication of that sort of figure. But
5 just to give that context, do you recall?

10:29

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

10:30

10:30

17 45 Q. So, the majority of those had already had letters
18 dictated?

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

10:30

10:31

1 didn't.

2 46 Q. So, just to break that down slightly, the number that

3 you've put in that paragraph was a number you

4 subsequently gathered information about. It wasn't a

5 number given to you by Mr. O'Brien? 10:31

6 A. No. No.

7 47 Q. And Mr. O'Brien would say that out of those 668, all

8 but 189 patients had had correspondence dictated. Does

9 that ring any bells with you?

10 A. The number doesn't, no. And, I suppose, the only thing 10:31

11 I will say is I know in Mr. O'Brien's evidence he did

12 mention our meeting and the 668 patients, from what I

13 can recall, so that number is still --

14 48 Q. I don't think the 668 -- it's the what was done at that

15 point -- 10:32

16 A. Yes. Yes.

17 49 Q. Again, it's just obviously Mr. O'Brien has a different

18 narrative around what was actually dictated?

19 A. Yes, and I appreciate that.

20 50 Q. I just wanted to see if that rang any bells with you? 10:32

21 A. No, it doesn't. There was a lot of numbers and figures

22 around that time with regards to -- we had the

23 un-triaged letters and we had the undictated and then

24 we had the private patients. So we were running at a

25 fast pace, so... 10:32

26 51 Q. Now, I just want to move on to the key worker issue for

27 oncology. You had said in your Section 21 - we don't

28 need to go to it - the first one at WIT-26267 that you

29 had only been made aware of the allegation that

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

4 A. I have, yes.

5 52 Q. And they dispute that they were not permitted or denied 10:33
 6 access to --

7 A. That's correct.

8 53 Q. -- Mr. O'Brien's clinics. And you were interviewed by
 9 Dr. Hughes for the SAIs and, in the course of that
 10 interview, you had indicated to Dr. Hughes that you'd 10:33
 11 worked in the Southern Trust for 11 years and, during
 12 that time, Mr. O'Brien never recognised the role of the
 13 Clinical Nurse Specialist and, for the Panel note, that
 14 interview is at WIT-84355 and 84356, and that was an
 15 interview with Mr. Hughes and Patricia Kingsnorth on 10:33
 16 18th January 2021. Now, given the variance in that
 17 evidence, November 2020 and then leading on, the
 18 Inquiry sent you a subsequent Section 21 to ask for
 19 clarity and what I want to do know is just highlight to
 20 the Panel your explanation for some of the issues. 10:34
 21 Just, also, by way of context, the notes that were kept
 22 in relation to some of the SAI interviews and meetings,
 23 I don't think there was any expectation from anyone
 24 that they would be verbatim, but they were deemed to
 25 reflect accurately the contribution from those who were 10:34
 26 interviewed, and that's been questioned by some of
 27 those who gave information to Dr. Hughes and Patricia
 28 Kingsnorth and some of the other note-takers, whether
 29 those notes accurately reflect their contribution.

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

8
9 "It was my impression that Mr. O'Brien didn't recognise
10 the potential value of having a nurse with him at 10:35
11 clinics generally. I do not recall all the factors
12 which led me to forming this impression of Mr. O'Brien,
13 but I believe it was influenced by things like the
14 following:

15 10:35
16 When the two Clinical Nurse Specialists attended
17 meetings and made suggestions about the services -
18 examples could have been changing appointment slots for
19 the clinics so that there were not too many people in
20 the room; equipment suggestions; suggestions regarding 10:35
21 training for the other nurses in the unit and so on -
22 Mr. O'Brien, whilst he would have listened, never got
23 involved in these conversations or showed any interest
24 in taking forward their suggestions and I, therefore,
25 personally felt that he didn't value the role that they 10:36
26 held.

27
28 This was not an impression formed, I believe, as a
29 result of a single meeting, but one that developed over

1 time between approximately 2009 and 2015."

2

3 Under heading 1 that Mr. O'Brien never involved them in
4 his oncology clinics, you say at 1.3:

5

10:36

6 "The CNS team expanded in about 2014 with two temporary
7 Band 6s being appointed, Janice Holloway and Dolores
8 Campbell - see my previous Section 21 Statement No. 24/
9 2022 at WIT-26197 to 26198. Kate and Jenny had plans
10 and suggestions for these two new appointments,

10:36

11 including having additional staff to support all
12 clinics. It was during conversations with both CNS,
13 Kate and Jenny, that they would have mentioned that
14 this was for all of the consultants, although not as
15 much for Mr. O'Brien as he rarely had a nurse in
16 attendance at his clinics.

10:37

17

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

10:37

10:37

29

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

6
7 The handwritten 18th January 2021 meeting notes were
8 provided to me by the Trust on or about 11th May 2023,
9 having recently been located, and I confirm that they
10 are now attached to this witness statement." 10:38

11
12 So just stopping there for a second, you point out that
13 the handwritten note didn't have the word "oncology"
14 but the typed did, that's your point on that.

15 10:38
16 Paragraph 1.5:

17
18 "Of course I now reflect and accept that had I thought
19 about the matter in more detail, I would likely have
20 realised that this approach by Mr. O'Brien might have 10:38
21 included the nurse's cancer key worker roles. However,
22 I believe I was, perhaps, less conscious or less
23 sighted as to this aspect of their work for a number of
24 reasons, including, I believe, that I did not attend
25 MDT meetings and because of cancer, as opposed to acute 10:38
26 services role, in respect to these."

27
28 You were then asked at (b) to:
29

1 "Identify to whom you are referring at the meeting when
2 you say that some of the Clinic Nurse Specialists would
3 have asked to be at clinics but Mr. O'Brien never
4 included them, dealing how, when and in what
5 circumstances you came to be told or made aware of this 10:39
6 information?"

7
8 And you answer at 1.6:

9
10 "The nurses that I am referring to are Kate O'Neill, 10:39
11 Jenny McMahon and, laterally, Leanne McCourt and Jason
12 Young. I can confirm that I have no evidence of dates
13 and times, but I believe this would have been mentioned
14 to me occasionally during casual conversations about
15 various aspects about the running of the unit if I had, 10:39
16 for example, just called in to see how things were with
17 them and the staff."

18
19 So I think the thrust of what you're saying at that
20 point is no one ever made a complaint or an allegation 10:39
21 specifically; it was something that you picked up from
22 comments that were made, would that be fair?

23 A. That's fair, yes.

24 54 Q. The extract then we gave you from the meeting with
25 Dr. Hughes was, as follows, at paragraph 2: 10:40

26
27 "Dr. Hughes asked if anyone expressed concerns about
28 excluding nurses from the clinics. Martina advised
29 that two of the Clinical Nurse Specialists did report

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

10:40

7
8 And we've asked you to name the two nurses and you say
9 at paragraph 2.1:

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

10:40

12
13 And at paragraph 2.2, you say:

14
15 "I should clarify in this regard that I do not recall
16 the nurses saying they regularly challenged
17 Mr. O'Brien. I note in this regard that this word does
18 not appear in the relevant part of the handwritten
19 notes - first page, 9th and 10th lines of text up from
20 the bottom of the page."

10:40

10:40

21
22 So, again, that's a difference between the typed
23 version -- the word "regularly" appears to be added in
24 the typed version, it's not in the handwritten.

10:41

25
26 Then you're asked at (b):

27
28 "Please provide the details of how and when they
29 reported the details you provide in this paragraph. If

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

3
4 I can confirm that this was never formally reported to
5 me. It was occasionally but not regularly mentioned to 10:41
6 me conversationally and in passing and in the general
7 terms referenced to my answer at paragraph 1 above. As
8 Dr. Hughes has recorded as observing in the notes, we
9 all became habituated to Mr. O'Brien's practice and
10 while still periodically discussed the issues with each 10:41
11 other, I can confirm that to my knowledge there was
12 nothing formally raised in writing about the matter. I
13 am, therefore, unable to provide dates or further
14 details of these conversations.

15
16 (d) What, if anything, did you or anyone else do on
17 receipt of this information?"

18
19 And you say at 2.4:

20
21 "I believe that I mentioned this matter during general
22 conversations with Heather Trouton, Ronan Carroll and
23 Mr. Mackle, as well as the Clinical Directors,
24 Mr. Colin Weir and/or Mr. Ted McNaboe, but did not do
25 anything else with this information." 10:42

26
27 If I can just ask you there did anyone that you
28 mentioned it to do anything about that information that
29 you know of?

1 A. Sorry?

2 55 Q. Did anyone that you mentioned this matter to that
3 you've listed in that paragraph do anything, that you
4 know of?

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

6 56 Q. If I could go to two pages on, paragraph 4 -- for the
7 Panel's note, it's at WIT-94944. And we've given you
8 an extract at paragraph 4 where Dr. Hughes reiterated
9 -- this is a note from the meeting:

10

10:42

11

12

13

14

15

16

17

18

19

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

10:43

20

10:43

21

22

23

24

25

26

27

28

29

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

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

10:43

1 review or audit of files of patients of Mr. O'Brien.
 2
 3 4.2. I should clarify in this regard that I believe
 4 that when Dr. Hughes asked 'At no stage were specialist
 5 nurses allowed to share patient care with Mr. O'Brien?' 10:44
 6 and I replied, 'Yes' - second and third full paragraphs
 7 on WIT-84356 - my response was in relation to what had
 8 come to light during the previous months from
 9 approximately Autumn 2020 when issues relating to MDT
 10 recommendations not being actioned were coming to 10:44
 11 light. I believe that this is supported by the
 12 handwritten note of the meeting, which on its second
 13 page in the 6th line of text down from top of the page,
 14 includes a reference to MDT recommendations not being
 15 followed through (agreed MDT not followed through), 10:44
 16 followed shortly thereafter, 8th and 9th lines down, by
 17 Dr. Hughes' question: At no stage were specialist
 18 nurses allowed to share care with them? I interpret
 19 the reference to 'them' at the end of this question to
 20 be a reference to the relevant MDT patients whose 10:44
 21 recommendations had not been actioned or followed
 22 through. In the typed version of the note, 'them'
 23 appears erroneously to have been replaced by
 24 'Mr. O'Brien'. My answer was, I believe, in respect of
 25 the relevant MDT patients." 10:45
 26

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

1 nine SAIs or the outcome that had been --

2 A. Yes.

3 57 Q. -- the analysis that was being undertaken by Dr. Hughes
4 at that point?

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

6 58 Q. Paragraph 6 at WIT-94948:

7

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

13

14 And you say:

15

10:46

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

24

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

26

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

29

1 You say:

2

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

6

7

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

9

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

13

14 And you say:

15

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

21

22 At paragraph 8.2, you say:

23

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

27

28 8.2.1 The third full paragraph of the second page of
29 the typed meeting notes WIT-84356 records that I

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

16
17 8.2.2 The fifth full paragraph on the second page of
18 the typed meeting notes with 84356 records 'Martina
19 advised that during MDT on occasions there were issues
20 raised about Mr. O'Brien and at times these were 10:48
21 escalated to the AD or AMD.' I think that the
22 reference to MDT here may be mistaken as I would not
23 have attended it. I note in this regard that the
24 relevant exchange between myself and Dr. Hughes appears
25 to have been captured between the 12th and 17th Hynes 10:48
26 of text on the second page of the notes. It is clear
27 from the 15th line that I was referring to our team
28 meeting and not to MDT."
29

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

4
5 At paragraph 5.2.1 at WIT-94947, you have sought to 10:49
6 amend the notes when you're asked about the accuracy of
7 them, given what you've said in your statement and then
8 the copy of the notes from Dr. Hughes.

9
10 "I believe upon reflection and upon considering both 10:49
11 the typed and handwritten notes of 18th January that
12 both paragraphs are inaccurate and require revision, as
13 follows . . ."

14
15 -- so I'm going to read it out. You will see what's 10:49
16 been underlined, which is what you've added in --

17 A. Yeah.

18 59 Q.

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

1 response to Section 21 Notice No. 7 of 2023 at Question
2 1 thereof, the broad issue of Mr. O'Brien's non-use of
3 nurses and Clinical Nurse Specialists was mentioned to
4 me a number of times by nurses in the years prior to
5 2020 and I ought, upon reflection, to have appreciated 10:50
6 the potential cancer key worker issue as a result."

7
8 So that's the clarity provided by that Section 21.
9 Then if we could go -- you put in another addendum
10 witness statement which starts at WIT-98544. I just 10:51
11 want to tie the points all up together so the Panel has
12 a picture.

13 A. That's fine, yes.

14 60 Q. This is dated 23rd June 2023. And you, in reference to
15 that notice, you make some corrections at WIT-98546. 10:51
16 And the background to this is that -- did you listen to
17 Patricia Kingsnorth's evidence?

18 A. I did, yes.

19 61 Q. And the evidence indicated that she had both provided
20 and spoke about e-mails between you and her and the 10:51
21 note of that meeting, actually, had been sent to you.
22 You had seemed to correct the typed version to reflect
23 your involvement in the meeting, and now it's been
24 brought to your attention you wanted to set the record
25 straight for your evidence to the Inquiry and because 10:52
26 we've read out what was apparently wrong with the typed
27 notes, I just want to read out your explanation --

28 A. That's fine, yes.

29 62 Q. -- as to why you said that.

1 A. Yes, please.

2 63 Q. So I just want to read -- the heading of this section
3 is "Section 21 Notice No. 7 of 2023 dated 5th May
4 2023."

5 10:52

6 Paragraph 2:

7
8 "I can confirm that I have now seen the e-mail exchange
9 and attachments exhibited to Patricia Kingsnorth's
10 addendum witness statement of 2nd June 2023, WIT-96809, 10:52
11 WIT-96827. In light of this, I would offer the
12 following additional evidence:

13
14 I had not recalled this e-mail exchange when preparing
15 at relatively short notice my statement of 12th May 10:53
16 2023 in response to Section 21 Notice No. 7 of 2023. I

17 have no reason to doubt that this exchange occurred and
18 I accept that I must have added to the draft typed
19 minute of 18th January 2021 meeting prepared by
20 Mrs. Kingsnorth and sent to me on 24th January. I 10:53

21 believe that I made the additions to the typed minute
22 without access to Mrs. Kingsnorth's handwritten meeting
23 notes, which I only saw for the first time after 5th
24 May 2023 when preparing my 12th May 2023 statement and
25 without any notes of my own from 18th January 2021 10:53

26 meeting. I believe that all of these events, i.e. the
27 18th January 2021 meeting and the 24th to 25th January
28 2021 e-mail exchange, occurred at a time when I was
29 particularly busy with my day-to-day work, it being the

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

8
9 Where there is any conflict or discrepancy between
10 Patricia's handwritten note of 18th January 2021 10:54
11 meeting and the final typed note of the meeting of 25th
12 January 2021, I would place more reliance on the
13 handwritten note."

14
15 A. Yeah. 10:54

16 64 Q. Anything else you want to say about that or does that
17 cover everything?

18 A. No, that covers everything.

19 65 Q. Thank you. while we have this witness statement in
20 front of us, the issue also came up with Fiona Reddick 10:54
21 around the recruitment of a cancer nurse specialist, in
22 particular, rather than CNS and the protracted period
23 of time that had been taken to recruit. Now,
24 Ms. Reddick gives some evidence around the securement
25 of funds from Macmillan about the posts. You have also 10:55
26 indicated prior the paper I think you sent to
27 Mrs. Burns advocating for nurses to fill those
28 specialist posts. So, there is a little bit of
29 conflict about the history of it but I think that the

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

3 A. That's correct, yes.

4 66 Q. -- CNS, at least. There was an expectation under the
 5 Cancer Regional Guidelines for nurses specific to
 6 oncology, but that those figures weren't met until
 7 2020?

10:55

8 A. That's correct, yes.

9 67 Q. And what you've helpfully done, and this is information
 10 that Mrs. Reddick won't have seen because it's just
 11 been provided by you last week, is set out a timeline
 12 for the Panel as an exhibit to the statement, the
 13 timeline and supporting documents for recruitment of
 14 Urology Clinical Nurse Specialists. The timeline
 15 starts at WIT-98549 and it goes through to WIT-98552.
 16 Now, that's your version of events and it hasn't been
 17 put to anyone else, but the timeline sets out the
 18 attempts that were made and the difference in, perhaps,
 19 approach from the Cancer Services and from Urology
 20 Service in trying to secure nurses?

10:55

10:56

10:56

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

25 68 Q. I don't want to go through the timeline in any detail
 26 -- the Panel have it for their consideration and, if
 27 anything arises from it that they feel need clarified,
 28 we can approach the relevant individuals.

10:57

29

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

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

6 69 Q. Now, there is some evidence in that table about what
 7 could be viewed as potential conflict of opinion or
 8 difference of opinion about job descriptions and the
 9 Panel will have heard evidence around Jenny McCourt and
 10 the appointments and whether she should -- 10:57

11 A. That's right.

12 70 Q. -- have been appointed as a CNS and the job was changed
 13 and it seems from some of this narrative that
 14 Mrs. Reddick did get involved in trying to assist in
 15 the job description and, because of a lack of 10:57
 16 consensus, there was a -- not a downgrading, I don't
 17 mean to put it like that, but there was a
 18 re-configuration of the posts that Jenny McCourt and
 19 Jason Young eventually took up?

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

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

17 71 Q. So I think Mrs. Reddick had indicated that there
 18 sometimes could be a tension between the expectation
 19 from the Cancer Services and what services they wanted
 20 to ensure were provided and perhaps some other 10:59
 21 services, such as Urology, where the Clinical Nurse
 22 Specialist, as you say, can be allocated to benign --
 23 it's not just specifically oncology?

24 A. That's correct, yes.

25 72 Q. And sometimes that tension -- and that's, perhaps, an 11:00
 26 example of that where two competing demands or
 27 expectations result in everyone getting a little bit of
 28 something, but nobody really getting what they need?

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

1 that time. [Short pause]. So I think the Panel have
 2 seen this particular e-mail -- it's from Mr. O'Brien --
 3 and then, if we go back up, that was sent to you
 4 about the -- do you need reminding of that --
 5 A. No, I do know that e-mail. 11:02
 6 80 Q. "When were we supposed to read them..." --
 7 A. Yes, yes.
 8 81 Q. And you'll see that that was sent to you, but also
 9 Eamon Mackle is in that as well and Heather Trouton.
 10 Eamon Mackle writes to Gillian Rankin copying you in 11:02
 11 where he specifically said:
 12
 13 "Gillian,
 14 I have been forwarded this e-mail by Martina and I
 15 think it raises a governance issue as to what happened 11:02
 16 to the results of tests performed on Aidan's patients.
 17 It appears that at present he does not review the
 18 results until the patient appears back in OPD."
 19
 20 Just go back up -- it's 26th August. So that is an 11:03
 21 e-mail trail from 2011. Your knowledge said 2020.
 22 Does that indicate that this issue either fell off your
 23 radar or you didn't hear anything more about it or can
 24 you give us some background as to what might have
 25 happened around this time? 11:03
 26 A. I know now why this has happened and it's as a result
 27 of the Inquiry, it's as a result of the retained swab
 28 SAI. And I think that is probably one of the feelings
 29 I feel, on reflection, is, you know, this happened, but

1 I've never heard tell of the retained swab until
2 2022/2023. I think, with regards to this, it was more
3 to do with the fact of Mr. O'Brien was bringing the
4 patients back to review them with results. He was
5 still reviewing the results, as opposed to not looking 11:04
6 at them. He was still looking at them and saying "I
7 want to see the patient back."

8
9 what happened in 2020 was that it would have appeared
10 that he hadn't done anything at all with the result, 11:04
11 and, I suppose, that's why I had said that in my
12 Section 21. It was more to do with -- this was -- he
13 wasn't saying he wasn't reviewing them, but he was
14 saying he wouldn't do anything with them until the
15 patient was back in front of them, whereas the other 11:04
16 consultants, even back in 2011, their view would be if
17 a result was normal, they'd just write to the patient,
18 whereas Mr. O'Brien wanted to bring the patient back
19 and tell them there was a normal review. And if you
20 have a review backlog, there would have been easier 11:04
21 ways to address it.

22
23 So, I suppose, the difference with that one and with
24 the result in the admin exercise that I did in 2020 was
25 I never thought he wasn't reviewing them, whereas it 11:05
26 felt that he didn't review the results electronically.

27 82 Q. But you can see by this e-mail --

28 A. Absolutely.

29 83 Q. -- that it seems to have been the same issue?

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

4 84 Q. would that have fallen under your remit to deal with
5 something like this, or would you have expected that to 11:05
6 be something the medics dealt with?

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

8 85 Q. There is another e-mail, just for the Panel's -- I'll
9 take you to it but just for note in sequencing, it's at
10 TRU-276807. It's an e-mail of 25th July, Heather 11:05
11 Trouton -- 25th July to Trudy Reid, Louise Devlin and
12 to you. It copies in Mr. Mackle, Robin Brown and
13 Samantha Sloan:

14

15 "Subject: Results. 11:06

16

17 Dear all,

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

24

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

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

5
 6 "Dear all,
 7 Please see below for your information and action."
 8

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

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

14 86 Q. And you actually asked Mr. Mackle to help you with the
 15 reply to that e-mail to Mr. O'Brien?

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

17 87 Q. And, for the Panel's note, that is at AOB-00280. Just
 18 a different reference.

19 88 Q. In relation to the Bicalutamide issue, that wasn't
 20 something that you knew about until October 2020 and
 21 that was as a matter of issues arising. How did you
 22 come to know about that?

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

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

11:09

6 89 Q. There has been some evidence given around the
 7 difficulty people might have with forming a proper view
 8 of what was going on by the fact that information
 9 wasn't shared, and that's obviously a clinical, a
 10 specific clinical issue. Do you think there's merit in
 11 people at senior management knowing all of the issues
 12 that are being looked at or analysed or potentially
 13 causing difficulty so that people know the extent of
 14 problems and can take more informed decisions?

11:09

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

11:09

11:09

11:10

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

6
 7 And, as you said there, I would never have heard of
 8 Bicalutamide until this happened. So, that probably
 9 came from MDT. So we needed somebody clinical to be
 10 bringing that back to us. 11:10

11 90 Q. There was also an issue about the waiting lists,
 12 patients being added to that, or not, in the case of
 13 Mr. O'Brien. Were you involved in that at all in
 14 collating information around that?

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

28 91 Q. I just want to ask you, just slightly out of sync, but
 29 just to get your explanation on it so that we know what

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

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

9 92 Q. And we'll see -- just go on, please -- we'll see an
 10 e-mail from Heather Trouton 22nd October 2015 to you 11:12
 11 and Eamon Mackle and it's in relation to a Datix
 12 incident report, number W45991, where she's asking does
 13 this need screened. And then if we go to -- sorry, we
 14 just see your answer at the bottom after that is -- on
 15 21st October 2015, you reply, saying: 11:13

16
 17 "I will check tomorrow. I don't think so but I will
 18 let you know."
 19

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

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

25 93 Q. I thought that was a different chain, but do you want 11:13
 26 to go back to that?

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

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

5 94 Q. -- an answer to Heather? 11:14

6 A. An answer to Heather. Sorry, yeah.

7 95 Q. Well, I suppose the question is really on this --

8 A. Yes, sorry, yeah.

9 96 Q. It was just -- no, that's fine.

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

13 97 Q. I've read out the reply to the wrong e-mail! Well,
 14 thanks for pointing that out. But if we look at this
 15 particular thing, the issue just -- it's just really 11:14
 16 for process, understanding process?

17 A. Absolutely, yes.

18 98 Q. And you'll see the second box down, 11/12/2015, and the
 19 sender is David Cardwell. Who is David Cardwell?

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

22 99 Q. And the connection with the previous e-mails is simply
 23 that this is the same complaint issue?

24 A. Yes, yeah.

25 100 Q. So the body of the message says -- this is a feedback 11:14
 26 message from David Cardwell. Incident form reference
 27 is w45991, and the feedback is :

28

29 "Hi Martina,

1 Helen Forde has asked me to send this to you with the
2 following message, W45991. I think it should go to
3 Martina Corrigan as it said there was no correspondence
4 for the appointment. So it wasn't that the secretary
5 didn't type it. I think it was that it wasn't 11:15
6 dictated, so that would need to go to Head of Service
7 for Urology to discuss with consultant."

8
9 And then it says:
10 11:15
11 "Regards, David Cardwell."

12
13 So, you will know from listening to the evidence that
14 the Panel are interested to understand the way the
15 systems work when they are triggered. 11:15

16 A. Yes.
17 101 Q. This is a Datix IR1 was filled in. And it has gone
18 through the system to David Cardwell. It seems to have
19 had an initial filtering so that a view is taken on
20 what the issue is, the factual accuracy of it, it 11:15
21 seems?

22 A. Yes, mm-hmm.
23 102 Q. -- and also what should be the next steps. So, this is
24 the potential of seeing something closed, ultimately --

25 A. Yes. 11:16

26 103 Q. -- after arising from an IR1. So, Helen Forde has
27 indicated what she thinks should happen next?

28 A. Yes.

29 104 Q. And it's for you to do that?

1 A. That's correct, yes.

2 105 Q. So can you pick up the story from there? What happens
3 then? Or do you recall this at all?

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

16 106 Q. Now, the dictation issue had arisen in 2014, raised by
17 Mr. Haynes and Glackin and O'Donoghue.

18 A. Yes.

19 107 Q. So this was a year later. The dictation issue would
20 have been -- would you have known about it at that 11:17
21 point, 2015, that it had been an issue since the
22 previous year?

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

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

3 108 Q. So, this -- so, if I'm right in what you're saying, it
 4 is issues had been raised in 2014, but this was the
 5 first time the Governance systems had been triggered 11:18
 6 through Datix IR1 on the dictation issue?

7 A. Yes.

8 109 Q. And the result of that was that you were to speak to
 9 Mr. O'Brien, but you didn't?

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

11 110 Q. And does that potential remedy that's suggested in
 12 that, does that result in IR1 or that Datix being
 13 closed?

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

1 off nearly too early.

2 111 Q. So would Mr. Cardwell's role in this be really as a
3 conduit between the --

4 A. Yes.

5 112 Q. -- individuals who could provide him the information. 11:19
6 He populates, but he's not a decision-maker, is he?

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

15 113 Q. Spoken to, yeah. 11:20

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

18 114 Q. So the close of the loop is the feedback of what should
19 be done, rather than what's done?

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

26 115 Q. I just want to finish up one more section before we
27 take a short break, if that's okay with you and the
28 Panel?

29 A. Yes.

1 116 Q. It's just your view on Mr. O'Brien's return to work in
 2 2017?
 3 A. Okay, yes.
 4 117 Q. We don't need to go to it, but for the Panel's note
 5 it's at WIT-26315. Now, you say that you don't think 11:20
 6 Mr. O'Brien should have been allowed back to work so
 7 soon and you refer to that as being a mistake. One of
 8 the reasons why is you say that there were issues that
 9 weren't considered and you didn't think his Return to
 10 Work Plan was a proper plan to manage him. 11:21
 11 118 Q. Now, one of the examples you give is that the
 12 monitoring arrangements that were put in place for his
 13 return focused on the gaps in his outpatient dictation
 14 and outcomes, but they completely ignored his
 15 administrative responsibilities towards patients who 11:21
 16 came in as emergencies or as a day case. Now, that
 17 knowledge of what you say is a lacuna in the area that
 18 Mr. O'Brien was to be monitored in, was that something
 19 that came to you later on, or were you aware at the
 20 time that there was a gap in relation to those 11:21
 21 particular patients?
 22 A. It came to me later on, because obviously when I did
 23 the admin exercise, I discovered that these were two
 24 areas. But at the time of -- it's a bit like, and I
 25 know we'll probably go to it, the admin review, it 11:22
 26 should have been wider. It was too confined. The view
 27 was -- in my view at the time, I remember saying if
 28 there's one area he's not performing in admin wise, I
 29 wonder are there other areas? But he came back just

1 with them four areas, as opposed to wider, and I think
2 there should have been a step back and think exactly
3 that -- you know, I wasn't the only one. I wasn't
4 involved in the Return to Work, apart from it was
5 presented to me to do the monitoring on. So I'd no
6 feedback in it. 11:22

7
8 So, that was the reason it came later and in my sort of
9 view was that I was -- sort of what my thoughts were,
10 which I didn't openly discuss, was, was correct. 11:22

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

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

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

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

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

18 121 Q. So it might have benefitted from more collective --
 19 A. Absolutely, yes.

20 122 Q. -- view on the appropriateness of the Return to Work 11:25
 21 Plan to see all the potential weakness areas and make
 22 sure that there was sufficient monitoring of that?
 23 A. That's right, yes.

24 MS. McMAHON BL: Chair, I wonder if that was a
 25 convenient time? 11:25
 26 CHAIR: Is ten minutes enough, Mrs. Corrigan?
 27 THE WITNESS: Yes.
 28 CHAIR: we're just going to take a short ten-minute
 29 break.

1 THE WITNESS: That's fine.

2

3 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

4

5 123 Q. MS. McMAHON BL: Mrs. Corrigan, we just have a couple 11:37
 6 more topics to cover, you'll be glad to hear, perhaps.
 7 The first one of those, I just want to ask you about
 8 Mr. O'Brien's retirement --

9 A. Okay.

10 124 Q. -- the issues around that. Did you have any 11:38
 11 involvement in the decision-making around that at all?

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

22 125 Q. You weren't consulted about his part-time employment or
 23 you didn't have discussions with anyone?

24 A. No, I didn't, no.

25 126 Q. I just want to ask you a couple of things people 11:38
 26 mention in their statements --

27 A. Mmm.

28 127 Q. -- just to get your view on it. I think the first one
 29 is probably uncontroversial, given what we've talked

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

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

11 128 Q. And I don't know whether you heard the evidence of
 12 Melanie McClements?

13 A. I did, yes.

14 129 Q. She indicated that -- did you get a chance to --

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

16 130 Q. I think just the point is that she indicated that you
 17 had said to her that the 2019 breach was the first
 18 breach of the plan?

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

25 131 Q. Just for the Panel's note, Ms. McClements' evidence on 11:40
 26 that is TRA-06645, line 18, to TRA-06646, line 6. And
 27 also at TRA-06714, line 29, to TRA-06715, line 8. So
 28 you think there's been, perhaps, a misunderstanding?

29 A. Perhaps, yes.

1 132 Q. Her evidence was that had she known there'd been prior
 2 breaches, then her response would have been different?
 3 A. And, I suppose, just to say on that, I actually
 4 probably never had any conversations with
 5 Mrs. McClements over the pre-2020, as such, about 11:41
 6 Mr. O'Brien because I would have felt that wasn't my
 7 position to do that -- it would have been Mr. Carroll
 8 -- because he had his one-to-ones with Mrs. McClements.
 9 So I would have assumed that it was him would have
 10 discussed, you know, return to work and breaches and 11:41
 11 things like that. And I don't actually recall actually
 12 talking about the July '19, personally, but obviously
 13 I'm not arguing it didn't happen but I don't recall it.
 14 133 Q. So, would it be fair to reflect your evidence as saying
 15 that Mrs. McClements should have been told about the 11:41
 16 issues around Mr. O'Brien, just not by you?
 17 A. Absolutely, yes.
 18 134 Q. Siobhán Hynes, also -- we don't need to go to this, but
 19 at her witness statement at WIT-42079 to 42080 at 23.1
 20 and 23.2 said that she wasn't aware of any deviations 11:42
 21 and that you had told her there was just one in 2018?
 22 A. Yes.
 23 135 Q. Again, what do you say in relation to that?
 24 A. On reflection of that, I -- look, Mrs. Hynes would have
 25 been copied into the deviations pre that and my only 11:42
 26 thought of why I said that was it was when she asked me
 27 about the breach, they were trying to prepare the final
 28 MHPS and I was aware that she was aware of the ones
 29 before and I just said that there had been nothing in

1 2018. That's the only reason why, because, again,
2 Mrs. Hynes was very much involved in all the breaches.

3 136 Q. And there were breaches in 2018, including when you
4 were --

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

6 137 Q. -- and when you came back?

7 A. And when I came back, yes.

8 138 Q. So there were quite a few?

9 A. Yes. What date was that?

10 139 Q. She just refers to 2018. 11:43

11 A. Oh, right, okay.

12 140 Q. I can take you to them, but we took a note of them the
13 last time.

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

18 141 Q. I suppose, just to reflect that there were more -- her
19 evidence is that she didn't know?

20 A. And I -- pardon? 11:43

21 142 Q. Her evidence was you had said there was just one in
22 2018?

23 A. Right, okay.

24 143 Q. And that isn't right?

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

1 144 Q. There were two then when you were off, two during that
2 period?
3 A. Yes.
4 145 Q. And then the others were before or after?
5 A. After, in 2019 then. It was September 2019. 11:44
6 146 Q. And 2018 --
7 A. And '18, yes.
8 147 Q. Now, Helen Forde says in her statement -- again, we
9 don't need to go to it -- at WIT-61202 at
10 paragraph 41.1 that she believes that you should have 11:44
11 raised the issues in a formal way. Now, the formal way
12 would appear to be through the Datix. That was one of
13 the formal ways it was available. And the Panel have
14 evidence that some of the issues were raised that way.
15 A. Yes. 11:44
16 148 Q. What other formal way may you have raised the issues
17 that you gained knowledge about from 2009 through?
18 A. I'm not sure was Mrs. Forde talking about just the
19 charts or was she talking about everything in general
20 -- 11:44
21 149 Q. I think her knowledge was based mostly on the charts?
22 A. Yes, and I suppose they were raising the Datixes and it
23 was on quite a number of people's radars, apart from
24 myself. So, I would have had conversations -- like,
25 obviously we've seen the e-mails from Mrs. Burns and 11:45
26 Mrs. Trouton with regards to trying to address it. So
27 I'm not sure how else I would have raised it formally,
28 because I did speak to my line managers about it, and
29 the clinical teams.

1 150 Q. Not just the charts issues, but all of the issues that
 2 you became aware of --

3 A. Yeah.

4 151 Q. Do you feel that you did everything that you could to
 5 draw them both to the attention -- well, number 1, to 11:45
 6 deal with them at your level, if possible, and also, as
 7 much as you could, to draw them to the attention of
 8 people who may be able to do something about them?

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

19

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

28 152 Q. Now, Ester Gishkori in her evidence -- I'll just give
 29 you the reference, TRA-06786 and TRA-06913, line 4 to

1 TRA-06914, line 6, she said that she had a sense that
2 Mr. O'Brien was more or less complying during her
3 tenure -- now, her tenure was August 2015 to April
4 2020. would that reflect that you hadn't spoken to
5 Mrs. Gishkori about the issues that arose during those 11:47
6 years?

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

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

24
25 "So, they were all having meetings outside of my 11:48
26 knowledge completely."

27
28 was there either a deliberate or an inadvertent
29 decision taken to exclude Mrs. Gishkori from meetings

1 where the issues were discussed?

2 A. Not that I'm aware of. And I suppose them meetings, as

3 I said yesterday, it was with Dr. Wright and Mr. Mackle

4 and Mrs. Trouton. I wasn't actually at them meetings

5 either. And, I suppose, unless she's talking about the 11:49

6 March 2016 meeting, as you know, I was asked to step in

7 at the last minute because Mrs. Trouton wasn't

8 available. So, I don't know if that was discussed with

9 Mrs. Gishkori or not. But it wouldn't have been

10 appropriated for her to be, I don't think, you know, it 11:49

11 was Mr. Mackle and then I was accompanying Mr. Mackle

12 because of previous issues with Mr. Mackle being on a

13 one-to-one with Mr. O'Brien.

14 154 Q. So, again, she should have known about the issues, just

15 not from you? 11:49

16 A. Not from me.

17 155 Q. Now, what was referred to in evidence with

18 Mrs. Gishkori, the softer landing approach that was

19 adopted in September 2017 when Mrs. Gishkori and Colin

20 Weir and Mr. McAllister tried another tack to get 11:50

21 Mr. O'Brien to comply with some of the expectations,

22 were you aware of that approach that was being taken at

23 that time?

24 A. Not aware of anything.

25 156 Q. Did you subsequently become aware of it because of the 11:50

26 Inquiry or did you know about it before then?

27 A. No, only subsequently because of the Inquiry.

28 157 Q. Given that you had been an original drafter, although

29 not the decision-maker around the letter in March that

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

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

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

18 A. I do agree with it, yes.

19 159 Q. I want to move on just to the admin review. And I know
 20 you heard Mrs. McClements' evidence on that and we 11:51
 21 established a timeline in considerable detail through
 22 her evidence. There's no need to repeat that. She
 23 accepts that the GMC query for an update about the
 24 admin review -- independent admin review, as envisaged,
 25 following the MHPS recommendation, that focus on that 11:51
 26 was triggered by the GMC request in August 2019. The
 27 first mention of you in the timeline was 31st July 2020
 28 when Stephen Wallace shares the Terms of Reference with
 29 you and others?

1 A. Yes.

2 160 Q. And for the Panel's note, that's TRU-292694. We had
3 looked at what your role was or had you been given a
4 role or was there an expectation on you that, in some
5 way, you would undertake this review. What's your 11:52
6 version of that?

7 A. Well, the original discussions on Terms of Reference
8 were I was to have no original role in it. And then
9 the independent aspect of it with Dr. Donnelly and
10 Dr. McCullough was that I was the person that they 11:52
11 would come to to seek out information from. So I was
12 their point of contact, which was agreed by the
13 Oversight Committee. And they obviously shared their
14 first draft with me and I shared it on with the
15 Oversight Committee. 11:53

16 161 Q. And did you have any contributions to those drafts?

17 A. No, I had none at all.

18 162 Q. Are they the drafts recently that have been provided
19 recently to the Inquiry?

20 A. No, that was the number 1 draft -- I had no involvement 11:53
21 with that at all.

22 163 Q. I think there were 14 versions?

23 A. There are 14 versions, yes.

24 164 Q. Are they all from the two doctors tasked with it?

25 A. No, not at all. Version 1 was from them and, from then 11:53
26 on, the Oversight Committee asked that we revisit,
27 because it wasn't covering it. I will say from the
28 outset that I was -- I never seen the determination of
29 the 2018 and all that was ever shared with me was two

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

13
 14 Looking at it now and on reflection, first of all I
 15 should never have been involved and, secondly, the 11:54
 16 remit of it was Urology from the Terms of Reference --
 17 that should never have been. When I had the report,
 18 the full report shared with me as a result of the
 19 Inquiry and read it, I knew that the exercise that was
 20 carried out was not the right exercise at all. Really 11:55
 21 and truly an independent person should have been
 22 somebody totally from outside the Trust -- for example,
 23 the Leadership Centre. So, yes, my hands are all over
 24 it, but I was doing it for -- I think I was directed
 25 wrongly in the sense of, again, it's back to -- first 11:55
 26 of all, I don't say no, a big fault of mine; but,
 27 secondly, the fact of my admin background, along with
 28 Mrs. Carroll and Mrs. Robinson, that it ended up on my
 29 table.

1 165 Q. So, to summarise your view on that, it was neither
 2 independent --

3 A. No.

4 166 Q. -- nor robust, nor reflective of the MHPS
 5 recommendation?

11:55

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

11:56

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

11:56

16 A. I know, yes.

17 168 Q. For the Panel's note -- you may not have got to them
 18 yet -- they are TRU-166332 to TRU-166788. We don't
 19 have to go through the 14 versions, you'll be glad to
 20 hear but --

11:56

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

22 169 Q. You need to bring a sleeping bag! But, yeah, the point
 23 you have made is a general point in relation to all of
 24 them in the versions?

25 A. Yes.

11:56

26 170 Q. And the Panel has already heard evidence in relation to
 27 that.

28

29 Now, you talk about what went wrong in your opinion

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

4
 5 You acknowledge some of your own failings. You say 11:57
 6 that Mr. O'Brien's personality was strong and
 7 challenging and he wore people down. The issue over
 8 lack of respect for non-clinical managers -- and we've
 9 touched on that in relation to Mr. O'Brien. He was a
 10 mentor to people -- and then there was a potential 11:57
 11 reluctance to engage --

12 A. Yes.

13 171 Q. It was a close-knit team in Urology. Nothing had been
 14 done for years about him so people stopped raising the
 15 issues and became complacent. You query in your 11:58
 16 statement the outside interest of Mrs. Brownlee, who
 17 was the Chair?

18 A. Yes.

19 172 Q. And, in that regard, the suggestion is that he was --
 20 they were friendly? 11:58

21 A. Yes.

22 173 Q. And what did you feel then that that engendered in
 23 others or made people think?

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

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

5 174 Q. So, it wasn't anything said by Mr. O'Brien, but what he 11:58
 6 did say indicated that he had a direct line of
 7 communication?

8 A. Yes, yes.

9 175 Q. Mrs. Brownlee, in her reply, to some of the evidence is 11:59
 10 somewhat critical of you in saying well, if you
 11 believed that she was behaving improperly you should
 12 have taken action, effectively, and what do you say in
 13 relation to that?

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

20 176 Q. And for the Panel's note, Mrs. Brownlee's comments in 11:59
 21 that regard are at WIT-90894 to WIT-90896 and that
 22 particular reference is at paragraph 48.

23
 24 The other thing you say about what went wrong was that
 25 issues would resolve for a short period of time but 12:00
 26 would re-emerge. If things had been escalated earlier
 27 that it might have prevented patients coming to harm?

28 A. Yes.

29 177 Q. You also say there was a failure to address the fact

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

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

A. Yes.

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

What do you mean by that?

A. Again, it's an -- and I was interested, Mrs. Burns's 12:01
view on this in comparison to Dr. Boyce's. So, for example, we would have received a complaint in and it would have went to the Complaints Department and then it came to the Head of Service to deal with it. Now, you might have lots of people to try and coordinate. 12:02

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

1 likes of the Datixes. So, to close them off as opposed
2 to just having -- David's brilliant but David's looking
3 after all of us, you know, so he's lots of Datixes that
4 are coming in and that he's having to try and make sure
5 everybody -- whereas, if we had our dedicated 12:03
6 divisional governance people, which they now have moved
7 towards as a result of the SAIs, I think that would
8 have been very helpful.

9 182 Q. You also mention that there needs to be a clear
10 management structure as there's no line of 12:03
11 accountability for clinicians?

12 A. Yes.

13 183 Q. Would it be more that there is a line of accountability
14 but that it wasn't actioned properly?

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

1 184 Q. Now, you said you thought you did everything you could
2 at the time to try and move things along as the issues
3 came to your knowledge. Others have accepted that they
4 made mistakes in evidence to the Inquiry. Do you feel
5 that you made any mistakes? 12:04

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

22

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

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

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

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

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

29 THE WITNESS: Thank you.

1 CHAIR: Mr. Hanbury.

2

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

4

5 186 Q. MR. HANBURY: Thanks very much for your evidence. You 12:07
6 will be pleased to know you have answered a lot of my
7 questions already. I have a few clinical and easy
8 things to go through.

9

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

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

1 187 Q. And that's true throughout the other urologists too?

2 A. Oh, absolutely. And to be fair to Mr. Young, he's been

3 looking for this for years because of this very reason.

4 So, I'm aware now -- and I suppose that's one thing I

5 will say when I said about the babysitting of 12:09

6 Mr. O'Brien, one of my sort of bugbears is that my job

7 should really be to improve. I never had time to

8 improve. So, I suppose now that I've stepped out and

9 somebody else is in and they don't have this added,

10 they're putting in improvements that I would have liked 12:09

11 to put in.

12 188 Q. Okay. Just on that theme. There seemed to be a

13 relatively short time between decision to operate and

14 actually getting someone in. Again, was that something

15 particular to Mr. O'Brien or is that true of other 12:09

16 urologists too? We've heard one or two problems about

17 pre-assessment?

18 A. Oh, yes, pre-assessment. No, it was mostly Mr. O'Brien

19 that they would have raised the issues with. Now, red

20 flags, obviously, is different, but as soon as the 12:10

21 patient had been seen they would have been sent to

22 pre-assessment. But, no, Mr. O'Brien, because of the

23 delay in him doing his paperwork it didn't get to

24 pre-assessment in time. Whereas the other guys they

25 literally will complete the paperwork in the clinic and 12:10

26 send the people round to pre-op, so at least they have

27 their initial consultation done at that stage.

28 189 Q. I see. Thank you.

29

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

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

13
14 So, we did a lot of work on that to try and improve
15 that start and finish times, the productivity. 12:11

16 190 Q. And was there any particular difference between
17 consultants or did you not look at it from that point
18 of view?

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

29 191 Q. Moving to outpatients, just a couple of things.

1 obviously, this has evolved over the years and
 2 one stops, these were all new patients?

3 A. They were, yes. There nine --

4 192 Q. Roughly --

5 A. Nine new patients, yes. 12:11

6 193 Q. Thank you.

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

12 194 Q. Okay. And then for the follow up, the consultants
 13 would run separate follow-up clinics?

14 A. They did, yes.

15 195 Q. And how many, generally, would be seen then? 12:12

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

20 196 Q. Also on this, you mentioned in your statement that the 12:12
 21 outreach clinics are somewhat less efficient and i
 22 noticed that there were sometimes a late start a SWAH?

23 A. Yes.

24 197 Q. What was your view about outreach clinics in general. 12:12
 25 Do you think they were a good use of time?

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

1 very difficult because we're two different Trusts.
 2 But, obviously travel was built in to the job plan.
 3 So, the clinics didn't start till 10:00 and really
 4 finished at 4:00. To have a consultant out of the
 5 system for that length of time to only see that handful 12:13
 6 of patients was not productive. And just to add, this
 7 is a comment, I know from the CNS, Kate O'Neill, she'd
 8 said about the outreach clinics. The agreement was
 9 there was no be red flags in Enniskillen, same as South
 10 Tyrone, but Mr. O'Brien would have identified patients. 12:13
 11

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

20 198 Q. There are new developments in lots of surgeries and we 12:13
 21 have a problem with hyponatraemia in urology?

22 A. Yes.

23 199 Q. And that was obviously topical in Northern Ireland for
 24 other reasons.

25 A. Yes. 12:14

26 200 Q. You mentioned some of the urologists were sort of keen
 27 to go to saline TURP?

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

- 1 very set that he was to go and remain doing what he had
2 to do and there was peer pressure on him to move
3 because of the hyponatraemia. It was actually because
4 of a gynae case in Belfast. So --
- 5 201 Q. But the other urologists were more accepting of the new 12:14
6 technology?
- 7 A. Absolutely. And we trialed quite a bit of equipment
8 and all and we did it during the time when Mr. O'Brien
9 would have been if theatres as well.
- 10 202 Q. Again, on the subject of sort of new things, were you 12:14
11 involved in the sort of out-of-region referrals for
12 cases? I'm thinking --
- 13 A. I was, just before I left my post, yes. We would have
14 had the prostatectomies. Now, it wasn't us, it would
15 have been the Southern Trust patients would have been 12:15
16 sent to Cambridge.
- 17 203 Q. Right.
- 18 A. And we also had --
- 19 204 Q. That was for?
- 20 A. For prostatectomy. 12:15
- 21 205 Q. Radical prostatectomy?
- 22 A. Sorry, radical prostatectomy, yes.
- 23 206 Q. I suppose I was thinking more for benign work, the
24 laser type of prostatectomy. That was seen not to be
25 available, but it might now. But was there a time when 12:15
26 it was referred out?
- 27 A. Yes. It would have been referred out, yes, but it
28 wouldn't have been that many and it would have been
29 more regional discussion. So, the region, what they

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

7 207 Q. Okay. One other thing on the cancer side, penile
 8 cancer, there was something about referrals to English
 9 units, particularly Manchester. Was that something
 10 that was happening? Did that come on your radar? 12:16

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

17 208 Q. Prior to that, if a clinician wanted to refer --

18 A. Yes.

19 209 Q. -- then there is no problem?

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

- 1 210 Q. Two more very short points. Job planning, I know you
2 weren't involved much in there but when Mr. O'Brien
3 took on it's NICaN role and the Chair of the MDT, those
4 are quite time-consuming roles. Did he give up
5 anything else? 12:17
- 6 A. No, he didn't.
- 7 211 Q. And how was that fitted?
- 8 A. He was asked to give you up, you know, he was -- like I
9 was at conversations where he was advised to give up
10 stuff but he never did. 12:17
- 11 212 Q. So, if he wanted to have given it up, that would have
12 been no problem from your point of view?
- 13 A. Yes.
- 14 213 Q. Thank you. Just the very last thing. You mentioned
15 late starts to ward rounds. That was prior to 12:17
16 Urologist of the week?
- 17 A. It was, yes.
- 18 214 Q. When Urologist of the week started, was there a problem
19 there from any of the urologists?
- 20 A. None of the urologists, no. Except Mr. O'Brien didn't 12:17
21 usually turn up at half eight for the ward round,
22 everybody else would have been there, probably even
23 from earlier. So, not that I'm aware of, I'm saying
24 that, but that was never brought to my attention.
25 12:18
- 26 The sources used to be, like I have always had good
27 working relationships with the regs and the sisters and
28 the nurses on the ward. And it would have been coming
29 them.

1 215 Q. Right. So, you wouldn't be able to say when he turned
 2 up?
 3 A. No.
 4 MR. HANBURY: Thank you very much.
 5 CHAIR: Dr. Swart? 12:18
 6 216 Q. DR. SWART: I just want to ask you a little bit about
 7 the meetings you had with the Consultant Urologists
 8 talking about triage, if there were any such meetings,
 9 particularly did you have any chance to sit down with
 10 them and discuss things like the risk to patients of 12:18
 11 not triaging or abusing the default system, or any of
 12 that sort of thing? Was there any general discussion
 13 with a certain body?
 14 A. Not for the new patients. The triage was more
 15 discussions on the long waiting times that ultimately 12:18
 16 happened. But we would have had quite a lot of
 17 discussions about the review backing and the risks on
 18 that. But not for triage, no.
 19 217 Q. Not for triage?
 20 A. Not for triage, not for new patients. 12:19
 21 218 Q. Why? I mean there is clearly a risk if you've got this
 22 very long process?
 23 A. Yes, I agree. And I would have brought performance
 24 figures to -- we tried to do once a month we would have
 25 had a performance meeting. 12:19
 26 219 Q. So they knew there were delays?
 27 A. Yes, they knew there were delays. What I would have
 28 done was the red flags, how many red flags were
 29 received, what the waiting times is. Same for the

1 routine and urgent.

2 220 Q. Mm-hmm.

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

5 221 Q. And the risk for the review patients, what were the 12:19
6 kind of discussions you had on that? Were there any
7 ideas forthcoming about how to assess all these people
8 waiting? What was the conversation like?

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

17
18 There was a stage, we would have always done admin
19 revalidation because obviously, as I said yesterday,
20 people coming off for various reasons. 12:20

21
22 There was a directive from the Department of Health
23 where they had asked that there all the patients be
24 contacted and asked did they want to remain on the
25 waiting list? We had to put a stop to that in Urology. 12:20
26 I do know it continued in other specialties and it was
27 as a result of an e-mail from Mr. O'Brien. But to be
28 fair, Mr. Haynes was the same view. So, really what
29 had happened was a patient of Mr. O'Brien's had been

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

12:21

5
 6 Then I kept saying, 'But we need something else.' But
 7 the problem is we just didn't have the capacity to see
 8 the patients.

9 222 Q. So at that time, you know, what was the culture of
 10 medical management in Urology? We heard quite a lot
 11 about the Trust and some of the problems, but how did
 12 it feel to you? Did you feel that the clinical lead
 13 was taking charge of this and saying, 'Actually, we do
 14 have to do something, we need help.' Or was there a
 15 sort of helplessness? What did it feel like to you?

12:21

12:21

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

12:21

12:22

25
 26 To be fair to Dr. Wright and Dr. O'Kane, when they both
 27 came along I wouldn't have known their predecessors at
 28 all. When they came along I brought them to the teams
 29 they asked to be brought to and they listened to what

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

3

4 If they did have issues, no, they didn't put it any
 5 further than me.

12:22

6 223 Q. Did you get the feeling that any of them felt, say if
 7 your Clinical Lead and the Clinical Director that they
 8 felt that were in charge, that they were managing the
 9 doctors? Or did you feel that the managing of the
 10 doctors went over to the operational side? What did it
 11 feel like?

12:22

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

12:22

16

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

12:23

12:23

29 224 Q. That's a sort of almost an operational role?

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

6 225 Q. Now that you look back on that, I think you reflected
 7 that this is a bit of a problem. How much has that
 8 changed as a result of some of the things that have
 9 happened or has any of it changed or what's happened
 10 since, do you think? From your perspective? 12:24

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

14 226 Q. Sometimes you can look at it --

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

20 12:24

21 I think the fact that they've released Mr. Haynes to do
 22 some improvement, definitely there's a -- looking in
 23 there's definitely a sea change and Mr. McNaboe would
 24 have been filling - he would have been ENT 0- he would
 25 have been filling that part of Mr. Haynes's role. He 12:24
 26 still copies me into everything so I do know there's a
 27 lot of things going on

28 227 Q. Just one small thing. The notes at home actually
 29 turned out to be quite a big issue, quite an important

1 issue?

2 A. Yes.

3 228 Q. Not only because of the issue itself but because of
4 what it signified?

5 A. Yes. 12:25

6 229 Q. However in simple terms it's an information governance
7 breach?

8 A. It is, yes.

9 230 Q. Quite a serious one and it kept happening. What was
10 your mechanism for raising information governance 12:25
11 breaches specifically? Was it just through IR1s? Were
12 you asked by the Trust to make a note of all of your
13 information governance issues? What support was there
14 for all of this because it's quite a big area in health
15 now. So, why did that the filter up anywhere as 12:25
16 actually this is a problem?

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

20 231 Q. But were you asked specifically -- 12:25

21 A. No.

22 232 Q. -- for each department to sort of consider these
23 things?

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

29 233 Q. It comes down to say. 'Tell us what's happened'?

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

4 234 Q. That's a common one?

5 A. Yeah. 12:26

6 DR. SWART: sadly. Thank you very much.

7 THE WITNESS: Thank you.

8 235 Q. CHAIR: Mrs. Corrigan, just a couple of things that I
 9 want to get clear in my head about some of the evidence
 10 you gave us. Yesterday you talked about patients 12:26
 11 coming in the night before and that this was causing
 12 difficulties when Mr. O'Brien was Urologist of the
 13 week. If I've got this right, and correct me if I've
 14 got it wrong, is what you're saying that while he was
 15 urologist of the week he was adding patients on to the 12:27
 16 list from his own list that he kept?

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

23 236 Q. And as the Urologist of the week he should really only
 24 have been dealing with the emergencies?

25 A. Yes. 12:27

26 237 Q. I just wanted to be clear that I got that right in my
 27 head.

28 A. Yes.

29 238 Q. The other thing, one of the things we know that

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

8 A. Yes.

9 239 Q. And I think you weren't there?

10 A. I wasn't. 12:28

11 240 Q. We have a transcript of what happened up until the
 12 coffee break. But the issue that was going to be
 13 discussed after the coffee break was triage?

14 A. Yes.

15 241 Q. And were you at that meeting, first of all? 12:28

16 A. No, I wasn't. I was still off on [REDACTED]
 17 [REDACTED]

18 242 Q. You can't help us really --

19 A. No.

20 243 Q. -- about what was discussed among the consultants? 12:28

21 A. I can't.

22 244 Q. We can ask them in due course.

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

1 strange one at the time when I read it.

2 CHAIR: Thank you very much. Thank you for coming
3 along for the second time. Hopefully we'll not have to
4 have you back. Just in case I won't make any definite
5 promises but thank you. 12:29

6 MS. McMAHON BL: I would draw your attention to one
7 final reference from Mr. Lunny. We don't need to go to
8 it but it's just for the transcript and your note,
9 WIT-42163, and that's an e-mail exchange between you
10 and Mrs. Hynes where you're updating her on the 12:29
11 breaches. So, there's a bit of detail in that e-mail
12 which shows that you set out what the position was at
13 that point. I just want to make sure that's on record
14 and the Panel can look at it if they wish.

15 THE WITNESS: Okay. 12:29

16 CHAIR: Thank you, ladies and gentlemen. We've
17 finished early at the end of term and I'm sure, like
18 the rest of us, you're all looking forward to the
19 summer break. We won't be back again for hearings
20 until 12th September but you'll be well aware that 12:29
21 there will still be work going on in the background in
22 the meantime.

23
24 I hope you all get a well earned break over of the
25 summer holiday and see you all again in September. 12:29
26 Thank you.

27
28 THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 12TH
29 SEPTEMBER 2023