Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 73 of 2021
Date of Notice: 20th September 2022

Witness Statement of: Leanne McCourt

I, Leanne McCourt, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order. The Inquiry is aware that you have previously been provided with a questionnaire. If you replied and wish to rely on that questionnaire in reply to any question, please attach that questionnaire as an Appendix to your reply to this Notice and identify the section on which you rely. However, you are encouraged to provide answers that are as full as possible, including further details or information not contained in your questionnaire.**

1.1 Throughout this narrative, I will refer to my questionnaire and have included this document in my folder of attachments.

1.2 I began my career in Urology when I qualified as a staff nurse in September 2006. I took up a post as a Band 5 staff nurse in 2 South Urology (Craigavon Hospital) until April 2010.

1.3 This post included such duties as:

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NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: [redacted] Personal information redacted by the USI

Date: 10/11/2022

those patients requiring a keyworker. In my experience, certain consultants would have sought more keyworker input than others would. I do not know why some individual consultants adopted this approach more than others. I do recall Mr O'Brien stating in general conversation to me, "Keyworker, what is this Keyworker role?". I do not recall the specific date or who else was in the vicinity at the time of this conversation. When he arrived to do his clinic, I had said to him that I was available as keyworker for his clinic. In my opinion, his response was verbalised in the context of a condescending tone, I was "taken aback" and do not accurately recall my response. Consultants were aware of the importance of the keyworker role as per Kate O'Neill's email from June 2017 (*please see. 1. Sister Charge Nurse Band 6 Job Description, 37. Keyworkers email to Sarah Ward and Wendy Clayton, 38. Presentation overview of keyworker activity and 39. Email from Kate O'Neill re keyworker).* It is also listed within the Nican Clinical Guidelines document 2016. *Please see:*

35. Macmillan CNS impact brief, 21. NICaN Clinical Guidelines 2016 and 36. V2 Urology Cancer MDT Operational Policy 2020

50.2 I would like to put this response in context.

50.3 Whist I was employed as a Clinical Sister in Thorndale from April 2017-March 2019, the focus of my position was not that of a keyworker, although it did comprise a limited part of my role. *Please see:*

1. Sister Charge Nurse Band 6 Job Description, 37. Keyworkers email to Sarah Ward and Wendy Clayton, 38. Presentation overview of keyworker activity and 39. Email from Kate O'Neill re keyworker

50.4 I have also included an email with figures that I had kept of my keyworker activity as well as a presentation I delivered at a Urology Morbidity and Mortality meeting (I am unsure of the date). *Please see 35. Macmillan CNS impact brief, 21. NICaN Clinical Guidelines 2016 and 36. V2 Urology Cancer MDT Operational Policy 2020*. It should also be noted that the working pattern of the CNS, influenced which Consultant Clinics she covered.

50.5 Keyworker figures for one CNS are as follows:

a.

July 2017- 26th Feb 2019 (worked as clinical sister and so keyworker was not a central part of my role)	Number of patients
AJG (Glackin)	4

From: ONeill, Kate
Sent: 16 June 2017 11:51
To: O'Brien, Aidan; Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Jacob, Thomas
Cc: McMahon, Jenny; McCourt, Leanne; Young, Jason
Subject: RE: Issue raised at the Thorndale Unit Meeng t oday

For all Consultant colleagues:

Following discussion at the above meeng t oday, can we ask that all paen ts who require the input of a Key Worker would be offered the opon t o meet with the appropriate member of staff on the day. Paen ts have informed us of the benefit of meeng with the s taff member and it makes it much easier for them to make contact via telephone should/when any queries arise.

For all paen ts who require intravesical treatments it is so useful as Janice/Kate Mc Creesh can often provide the necessary informaon, ans wer queries and indeed offer the commencement date of treatment in agreement with the paen t. It also allows them to idenf y issues in relaon t o eg. Transport concerns etc

Thanks for your ongoing support in improving the paen t experience.

Regards,
Kate

1.15 Additionally, I will summarise the governance meetings I attended and my understanding of the governance structures within the Southern Health and Social Care Trust within questions; 15,18, 19 ,20,21 and 29.

1.16 Regarding governance concerns and learning from these, I can truthfully say, that prior to this process I was only aware of what I have included in my answer to question seven. I feel it is regrettable that it has taken a root cause analysis into a review of a serious adverse incident and then a public inquiry for me to become aware of issues that were longstanding and previously known about Mr O'Brien's practice. I have expressed my views on this within questions 56-61. *Please see:*

3. Root Cause Analysis report 2021

1.17 I also feel compelled to express how privileged I feel to work within the current team of urology nurses, consultants and Head of Service. As a team, we strive to make a difference to our patients in challenging times, with some excellent examples of innovation and teamwork. These current proceedings have been very difficult for the team and I hope it will strengthen our resolve to learn from this, move forward and ensure this can never happen again. We must also remember the patients and families involved and this should be our motivation to provide safe, effective and evidence-based care.

1.18 I would also like to note, that I have listed occasions within this document (questions 48+50) where I found Mr O'Brien to be condescending in tone, but this was not always the case. If I needed advice from him, he was professional and forthcoming. When I was a junior staff nurse, he would have taken time to explain things and help me to learn. He was very dedicated to care of his patients and I would describe him as "kind and caring" to his patients in clinic. I recall one such time where I was present when a life-changing diagnosis was given to a young man. Mr O'Brien offered to drive him to the oncology appointment he had arranged for him later that day as he was concerned the young man was distressed and shaken.

1.19 This process is difficult and discordant for me as there was the consultant I knew to be kind and caring, albeit arrogant and condescending at times and then there was the consultant mentioned within the Root Cause Analysis report and the findings that have now led to a Public Inquiry.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider

7.9 I also had concerns regarding two of Mr O'Brien's patients from late 2019 to mid-2020. Patient details have been redacted to preserve confidentiality. *Please see:*

10. Mr O'Brien emails

7.10 I had concerns regarding the timeframe of Mr O'Brien's clinical letters being available on ECR as it made the keyworker role more difficult. I also had concerns about delayed referral for additional treatment. If I had not been physically in the room with the patient for the appointment I would not have been party to what had been discussed if the patient had then contacted me with a query.

7.11 The queries noted below are in relation to scan appointments or oncology referrals/appointments of two patients.

Patient 125

7.12 03/03/20 – email from patient regarding further clinical appointment with Mr O'Brien. As the letter from previous appointment on 20th Feb was not on Electronic Care Record (ECR), I was unable to advise the patient and signposted him to Mr O'Brien's Secretary Noleen Elliott.

7.13 I also noted that I did not see a referral to Oncology on ECR for consideration of radical treatment – I emailed Noleen regarding this. To the best of my recollection, I did not receive a response. MDM outcome from 6/2/20 was referral for radical treatment.

7.14 11/03/20- emailed Oncology Secretary – no referral received.

7.15 11/03/20- discussed issue with Mr Haynes (Consultant Urologist/Divisional Medical Director) and emailed him the details.

7.16 17/03/20 - Letter of referral dictated by Mr O'Brien to oncology, typed 17/3/20. This concerned me as the outcome from MDM (6/2/22) was referral to clinical oncology, with the referral not being completed until 3 weeks after the patient had been reviewed. In my experience, the consultant normally completes the required referrals directly after (or as soon as possible) reviewing the patient. I am unsure if this referral was prompted due to involvement by Mr Haynes.

7.17 10/04/20- Oncology appointment for patient.

7.18 4/12/2021- Letter to patient re Lookback Exercise stating, “No issues of clinical concern have been identified and your current plan is completely satisfactory.”

Patient 101

7.19 16/12/19- phone call to Thorndale Unit from patient enquiring re CT scan. To the best of my knowledge, I had not been previously been introduced to this patient as a keyworker. The Clinic letter from 13/12/19 had not been typed. I checked SECTRA (radiology system) and did not see a CT scan ordered. Emailed Mr O’Brien and he replied stating he had now requested the CT. Outcome from MDM 28/11/19 was: “for review by Mr O'Brien to request CT C/A/P and consider early referral to Oncology.”

7.20 11/03/20- emailed Oncology Secretary – no referral received.

7.21 11/03/20- discussed issue with Mr Haynes (Consultant Urologist/Divisional Medical Director) and emailed him the details.

7.22 16/04/20- phone call from patient asking for his recent PSA blood test result and enquiring about radiotherapy appointment.

7.23 I did not see a referral letter for radiotherapy on ECR and so emailed Mr O’Brien (cc secretary Noleen Elliott) enquiring. To the best of my knowledge, I did not receive a response.

7.24 11/07/2020- referral letter on ECR to oncology

7.25 14/07/2020- Phone call from patient telling me his PSA has increased to 20. Also informed me he was telephoned by Mr O’Brien on Saturday and told to change his hormone treatment to injections and that he had been referred to Oncology.

7.26 07/08/2020- Oncology appointment for patient

7.27 4/12/2021- Letter to patient re Lookback Exercise stating, “No issues of clinical concern have been identified and your current plan is completely satisfactory.”

7.28 From the patient perspective, I am satisfied that they received their definitive treatment. However, I do feel that the two patients involved could have endured more anxiety than they ought to have due to the prolonged referral time. From my perspective, I feel I could have been better informed regarding what had or had not been done about my concerns.

20.5 Task and Finish Group Meetings. Established August 2021, to action the outcomes of the Urology SAI Recommendations 2021. Initially these meetings happened monthly, they are now less frequent. I was nominated to be a representative from the Urology CNS team. Below is an example of an attendance record from a meeting that occurred on 08/11/2021:

20.6 Dr Shahid Tariq (Co-Chair),Ronan Carroll Assistant Director (Co-Chair),Barry Conway, Assistant Director, Martina Corrigan, Assistant Director, Mary Haughey, Cancer Service Improvement Lead, Amie Nelson Head of Service, Wendy Clayton, Head of Service Chris Wamsley, Head of Service Clair, Quin, Head of Service, Sarah Ward, Head of Service, Tracey McGuigan, Lead Nurse, Paula McKay, Lead Nurse, Leanne McCourt, Clinical Nurse Specialist Urology, Matthew Kelly, Clinical Nurse Specialist, Janet Johnston, Social Worker Fiona Sloan, Family Liaison Officer, Catherine English, Head & Neck Cancer Nurse Specialist, Jane Scott, Acting Operational Support Lead ATICS/SEC

20.7 A Red, Amber, Green table (RAG) was used to detail and show progress for tasks needing to be actioned and the person/group of people allocated to do this. This would be included within the minutes of the meetings and circulated via email.

20.8 Urology Cancer MDT Business Meeting Biannual meeting held after MDT meeting. Attended by Urology Consultants, Radiology Consultant, Pathology Consultant, Urology Cancer CNS's, Macmillan Service Improvement Lead, HoS and MDT coordinator. A copy of the Operational Policy is circulated prior to the meeting, with attendees invited to comment. Topics such as ongoing/upcoming audits, update on various services within urology, e.g., provision of nurse-led services and red flag waiting times were also tabled for discussion. Minutes were circulated and ongoing themes discussed at subsequent meetings.

21. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

21.1 Within my Urology role, there are a number of processes and procedures relevant to my role. These consist of both SHSCT policies and external guidance from professional bodies.

21.2 SHSCT policies are located on SharePoint and include:

a) Nursing and Midwifery Accountability and Assurance Framework. This was developed to ensure there are clear and effective lines of accountability and assurance for the professional governance of the

Leanne McCourt doesn't feel he valued the Nurse Specialists. She recalled him asking her in the kitchen what the role of a Nurse Specialists was. He didn't understand the role if a Nurse Specialists.

Dr Hughes advised the Nurse Specialists was signed off in 2016. He advised the reason for Nurse Specialists are for patients. He advised he needs to know if it was a deficit because of work or this particular doctor.

Jenny McMahon said she had a very different experience. She advised she was not sure why MrO'B didn't invite CNS into the room and feels this is a question MrO'B needs to answer. She advised MrO'B spoke very highly of CNS. She recalls MrO'B having review oncology on Friday but she wasn't asked to attend.

Dr Hughes confirmed he had asked MrO'B this question. He asked if it is reasonable to say resources were made available.

Jenny McMahon said yes they would have been made available if support was need on the day but advised nurse specialists were not invited to attend appointments.

Kate O'Neill advised the period during 2019 MrO'B only seen reviews, she asked Martina Corrigan if this was decided.

Martina Corrigan advised no. MrO'B decided to do this himself.

Kate O'Neill advised reviews changed to Tuesdays. She recalled MrO'B contacting her to help with cath etc.

Leanne McCourt agreed MrO'B would approach her to arrange prostate appointments.

Kate O'Neill advised if there was no nurse available other staff was available to assist.

Dr Hughes advised referrals were not made and no numbers given out even though resources were available.

Jenny McMahon felt MrO'B was very supportive of Nurse Specialists.

Dr Hughes advised there are 9 patients in the review and they were not referred to Nurse Specialists and 3 have died. He advised families were not aware of Nurse Specialists. He feels Nurse Specialist should be imbedded.

Jenny McMahon agreed contact details should have been given. She conceded there may not have anyone available on the day but patients should have been given contact details.

Kate O'Neill advised at MDT Nurse Specialists should have been present or available. She advised there was an audit done from March 2019 to March 2020, 88% was given Nurse Specialist contacts.

Dr Hughes asked Kate if she would send the information to him. He advised he wants to be able to say resources were available but patients were not referred. He feels this is a patient's choice whether or not to avail of the support of Nurse Specialists.

Jason advised he worked with MrO'B and his experience was entirely different. He said he may not have been in the room but would have been introduced after but with MrO'B he would not have had as much input. He said MrO'B may have given contact details in the

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by USI
E-mail: Personal Information redacted by USI