Urology Services Inquiry

Oral Hearing

Day 22 – Wednesday, 1st February 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

THE INQUIRY RESUMED ON WEDNESDAY, 1ST DAY OF FEBRUARY, 2023 AS FOLLOWS:

MRS. HEATHER TROUTON CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS: 09:56

CHAIR: Good morning.

MR. WOLFE KC: Good morning, Chair.

1 Q. Good morning, Mrs. Trouton. Your statement helpfully offers some reflections on the circumstances in which 10:01 you had to work as Assistant Director and what you describe as the four main concerns that predominated during that period. Could I start by looking at what you say about the staffing concerns in the context of the commissioning expectation? If we turn, first of 10:02 all, to WIT-12034, at the very bottom of the page, please. You say:

"So with regard to whether the staffing levels funded by the Health and Social Care Board were optimal from 10:02 the beginning, my view would be that, on paper, and as calculated they should have met demand practically and taking into account human factors and the wider challenges with staffing and capacity within the Health Service, they were not optimal. My experience of the 10:03 Health and Social Care Board is that they primarily worked within a funding envelope and the Trust were asked to accept what was available from a funding perspective and make the service fit. This was often

challenging."

Scrolling down to the last -- that paragraph, number 9 on that page:

10:03

"The other issue relevant was that the calculations were based on the demand for the Service as it was in 2008 and 2009. The commissioning letter was sent in April '10. The Minister for Health endorsed the new model in March. 10:03

10. And the full service was not implemented with 2013. With a known 10% growth on service demand year on year, by the time the model was able to be implemented, the demand outweighed the new agreed capacity." 10:04

The new service which was introduced really got off the ground on the basis of fairly shaky foundations, is that fair?

A. I think it's fair to say that the modelling that was done around the capacity needed to meet demand, was done when the -- that modelling was done in 2009, which was for a particular obviously demand. We know that demand grows year on year by 10%, and therefore, by the time we got to 2013, when the staffing was secured, the money was secured, the investment proposal template was done, et cetera, et cetera, at that point we were witnessing demand outstripping capacity that was funded. So even the five-Consultant model, probably 10:04 10:04

wasn't enough to meet the demand in 2013.

2 Q. Yes. It's against that background that we might look at the four concerns that you have highlighted.

A. Yes.

3 Q. The first concern you describe, WIT-11995, we are looking at these issues, Mrs. Trouton, because that's the context in which you worked? 10:05

A. Yes.

4 Q. It's also the context in which Mr. O'Brien worked and his Consultant colleagues and within which he was expected to do his job. You have said at paragraph 28 that: 10:05

"I had four primary concerns at the time"

10:05

You address them in detail at question 31, we don't have the time obviously to drill down into them in fine detail but you say:

"The first concern that was a constant for the first four-and-a-half years in this role of Assistant Director was the difficulty the Service had in recruiting and retaining Consultant Urology staff". 10:06

From April 2014 there was a consistent body of five and recruitment did improve to some extent, before that there were three. This difficulty was compounded because there was no funding or limited funding for middle grade staff? 10:06

A. Yes.

Q. You outline, if we go through to WIT-12039, just go back to the bottom of -- yes. You outline the impact of this concern, or the consequences of it, and you say, just scrolling down: 10:07

"The effects of gaps in medical staffing are as follows:"

There were longer waits, pretty much across the board, 10:07 and less than optimum availability of medical staff to see inpatients for ongoing treatment and care. Medical rotas and on-call rotas struggled to meet the working time directive. At H you are saying when you have that kind of background it has a knock-on effect on 10:07 recruitment.

"Having a small Consultant team often with vacancies put additional pressure on present Consultants and the team to provide the patient access that met the 10:08 standard as set by the HSCB."

At J: "There was a Trust dependency in order to meet the demand to retain employed consultants." 10:08

What does "employed consultants" mean in that context? Does that mean bringing them in from elsewhere from the independent sector?

A. No. I think what I meant there to say is when you have

a small body of consultants and a huge demand, I think, you know, you obviously try to hold on to those Consultants, so you try and support and hold on to them to maintain the service that you have, considering it's so difficult to recruit new ones. 10:08

6 Q. Yes. Does that, somewhat perversely, lead the Service to retain -- try to retain staff that they might otherwise seek to shed if they perhaps were not up to standard?

A. I don't think it was an overt calculation as such or discussion, but when you have, I think it's sensible that when you have an abundance of staff and you can, you know, pick and choose, that's a good position to be in. Whenever you don't you support staff that you have, but I don't think it was an overt consideration. 10:09

7 Q. Consideration, okay. And lastly here you say there's lass capacity within the team to take on managerial roles. A second concern that you highlight, going back to WIT-11996 is long patient access times and large volumes of patients waiting for secondary care Urology Services. I think you go on to highlight that, as a result of this, there was really a pressure to prioritise red flag patients? 10:10

A. Yes.

8 Q. And that had the knock-on effect of increasing waits for urgent and routine patients? 10:10

A. That would be right.

9 Q. Of course, you would probably accept that patients who are designated as red flag giving them priority, in the

other camp, if you like, the urgent patients, or indeed some routine patients, who are not designated as red flag, they could have symptoms or difficulties which are not coming to light and they are not getting their treatment, and getting into difficulty because you have to prioritise the red flags? 10:11

A. Yes, that would be the case, unfortunately.

10 Q. Within this context of trying to meet demand, you say at paragraph 33, scrolling down, that:

10:11

"At this time, there were often opportunities for services to avail of additional waiting list funding both for Outpatient activity and Theatre activity. The Urology team would have availed of this opportunity to see and treat patients as their availability allowed. This was paid as additional to the Consultant staff at an enhanced rate and was voluntary." 10:12

You say voluntary in that context; I mean, were consultants placed under a degree of pressure to assist in this way because it was presumably made widely known that the Trust was expected to meet its targets? 10:12

A. I think pressure is the wrong word, but obviously we asked if they would be willing to do additional sessions. It wasn't just the consultants, it had to be matched up of course with the availability of theatre staff, nursing staff, Outpatient staff; so it was a combination of availability across the board to create an additional list. The Consultant would have 10:12

been one element, obviously a key element.

11 Q. Is it fair to say that Mr. O'Brien and indeed Mr. Young, I think, would have undertook extended operating sessions without being paid at all?

A. No. The extended theatre day, if that's what you are referring to, which was later on with the five Consultant model, was part of their contract. 10:13

12 Q. Right.

A. They certainly would have been paid for that as part of their contract. The additional sessions usually took place on a Saturday or other times outside clinics, for example, in the evenings, but not the extended day, it was core. 10:13

13 Q. Is there a sense or is there an understanding that this pressure on a less than optimal team to get through patients, to work extra sessions, has an impact on what would normally be done in a calmer way, such as administration, such as the opportunity to review scan results, that kind of thing? 10:14

A. I don't think so, because the clinics were set up to a certain capacity, that wouldn't have changed, so we didn't try to book additional patients on to clinics. They had their number of news, the number of reviews, so that stayed the same. The same in a Theatre list, it wasn't extra patients put on the Theatre list. You can only do what you can do in the Theatre list, so that would have been the same of level of activity, so no, I don't think so. I think the additional activity would have been completely outside of the core 10:14 10:14

activity, if that makes sense.

14 Q. In terms of the backlogs and waiting lists, primarily affecting those who would have been categorised as urgent and routine, but was there also difficulty in meeting cancer pathways as well? 10:15

A. At times there would have been because it depended on the referral pattern, so if you would have had a particularly high referral pattern in any given week, well that obviously gave rise to a spike in that activity, therefore that maybe was greater than the red 10:15 flag slot capacity, and those times then we had to readjust clinic templates to swap red flags -- sorry, urgent or routines for more red flags. So you followed the delivery based on the referral pattern, which wasn't always static, it could have had its peaks. 10:15

15 Q. Just on that, your third concern, WIT-11998, paragraph 42, was the amount and the extent of the Urology review backlog. Was that really a constant that was never resolved?

A. I think that's fair to say. It improved over the 10:16 years, at times, and then went out again, but certainly it was something I inherited in 2009 and it did continue. We managed -- tried lots of ways to reduce it, manage it, stop it growing, but it did continue right through. It wasn't just Urology, I have to say, 10:16 it would have been other specialties would have had, maybe not as extensive but still challenged with a review backlog.

16 Q. That was identified as a major patient care concern?

A. Well for me certainly, because while the patient had been seen and put under their care pathway, often patients need review to see how that's going, and when they don't get the review of course you are left wondering how they are.

17 Q. The fourth concern that you identify, just over the page, please, at paragraph 43, was the ability to ensure that all patients referred from a GP or by another secondary care Consultant accessed their first definitive treatment in line with the cancer pathway standards. Again, was that a difficulty of numbers exceeding Consultant availability?

A. Yes, it was that, and the cancer pathway necessitates the input from many professionals, so yes, you are seen by the medical team in Urology, but then, invariably, you go for a radiological investigation, that takes time, pathology potentially, back again for -- so it's a pathway, so you depend on a lot of elements being available to work to meet the 31 and 62 day pathway.

18 Q. Yes. So that's overall a picture both sides of the one coin across a number of areas. Demand outstripping availability of resources. Nevertheless, despite that perhaps being obvious to everybody, the Commissioner was a frequent visitor to your office or you to them?

A. Yes.

19 Q. There was a constant pressure to address performance issues and achieve more from the available resources, is that fair?

A. That would be fair. We were always being asked to look

at our efficiency and effectiveness right across the board, yes.

20 Q. You say at WIT-11997, paragraph 38, that there were monthly meetings held with the HSCB in their headquarters, and each Trust collectively and individually had to go through all the waiting time and cancer pathway data. 10:19

"Trusts were held to account at these meetings for their performance and areas of concern were escalated to the HSCB by Trusts regularly." 10:20

That creates a picture, correct me if I am wrong, of an almost constant month-to-month pressure and that, in light of what you said about your four key concerns, appears to have been the predominant concern of your job? 10:20

A. It certainly would have been one of my main focuses over that period of time, yes.

21 Q. In terms of the Commissioner's understanding of the Trust's predicament, was there any sense of providing the Trusts with solutions? 10:20

A. Probably the primary one they would have given would have been waiting list initiative funding, so they would have given additional funding to put on the additional waiting list activity I referred to earlier. That was probably their primary way to assist. 10:21

22 Q. In terms then of Patient Safety and an appreciation of what clinicians were doing in their practice, I think

we'd some reflection from you yesterday that that may not have been optimal because of the pressures on the performance side of the equation. Within your witness statement, if we can turn up WIT-12053, you are setting out here the range of systems and processes used to ensure, review, monitor, learn and improve Patient Safety. They are really governance instruments to focus, as you say, on Patient Safety, but I think if we scroll down through them, for example, you point to audit there. There were some types of audit conducted but you've said in your statement what was not available to you at that time was robust and regular audit of medical record-keeping?

A. That's correct.

23 Q. Audit of patient pathways, audit of patient outcomes? 10:23

A. That's right.

24 Q. Had they been introduced it would have been obviously very helpful. As a list that looks impressive, perhaps, but is it fair to say that if you scratch the surface on governance, you might have found that the system was not as patient-safety focused as it ought to have been?

A. I think we tried to make it so. I, even in my role now, and I think about how can I assure that nursing is good, I will just, if you don't mind, give an example. You think about we need to have the right workforce, they need to be correctly trained, they need to continue with their professional development, you need to have the right number of them et cetera, et cetera,

so you can audit the mechanisms by which you can assure yourself that everything is being done to support the workforce to function properly. Ultimately, you depend on the individual to function as per their code of conduct and their training and everything that pertains to that. But you can audit an awful lot, but it is more difficult to audit individual's practice, and I think that's where we gave up, we didn't have thee data to necessarily audit that, that would have been helpful. 10:24 10:25

25 Q. You presumably accept that there was some data that you ought to have had affecting clinicians --

A. Yes.

26 Q. -- generally. And while it might be appropriate to say as a general principle you would expect well trained professionals to comply with their codes of conduct, it's for the organisation, is it not, to police that and, in the absence of hard data and good intelligence, it's difficult to police? 10:25

A. It is difficult, absolutely. 10:25

27 Q. When Mr. McAllister came into the role of Associate Medical Director in May 2016, April 2016, he wrote to the Medical Director a few weeks after taking up post, on 9th May, and he sets out what he describes as a very disturbing picture of governance risks. Just put that up on the screen, please? WIT-14875. Obviously you have left to your new post a month previously, but are you familiar with that e-mail? 10:26

A. Yes.

28 Q. Yes.
A. Yes.
29 Q. I don't need to go necessarily through all of the items, but just going to the last line of it. He characterises it as basically a very disturbing picture with significant governance risks. Having left the role after eight years of Assistant Director, would you recognise that as a fair description of governance risks? 10:27
A. Some of it, yes, some of it, no. A lot of them absolutely correct, the allocation of junior doctors, the risks within Urology, some of the interfaces, et cetera I would recognise as being absolutely correct. I wouldn't, couldn't necessarily agree with point number 1 around not a good governance function because I believe that we did. I suppose Dr. McAllister is an intensive anaesthetist. My understanding was he was coming from that role of ICU and Theatres, which is a much smaller, well-staffed, intense area, he was coming into a very wide-ranging Surgical Directorate across two hospital sites, across five Outpatient Departments, across many wards and many surgeons in many specialties, so it would have been very difficult. Therefore, he probably did find it, my goodness, huge issues right across. So a lot of it I would recognise and some of it yeah, it was challenging. 10:27 10:28 10:28
30 Q. So what you are reflecting back is that --
A. It was difficult.

31 Q. -- some services are neater and tidier and easier to keep control of matters because the issues are so much fewer in a complex and wide-ranging Directorate such as Surgery. There's always ongoing governance issues to be addressed? 10:29

A. There's 500-plus staff, a budget of 50 million, lots of professionals working together in teams, various teams across two acute hospitals and other hospital Outpatient Departments. It was diverse. It also had its Unscheduled Care pressures to deal with as well 10:29 through our ED Departments, you know, it was Emergency and Scheduled Care, it wasn't just about Scheduled Care, so I think it was a very challenging area that we worked in, absolutely. And a lot of those I can relate to and can remember. 10:29

32 Q. You, in your witness statement, before we go on to look at some of the more specific issues, offer some general reflections about Mr. O'Brien and his practice and the management interface with that. I suppose a good starting point in terms of your view of Mr. O'Brien in 10:30 his practice is set out at WIT-12002. At paragraph 53, please, you say:

"As Assistant Director, the management team, both operational and medical, was familiar with various 10:30 concerns being raised at various times about various consultants across a number of teams. Such concerns were typically raised, discussed and addressed. However, what was different in the case of Mr. O'Brien

was the ongoing challenge to address practices which, despite discussion at all levels within the organisation, and over a period of years, Mr. O'Brien was either unwilling or unable to address consistently. However, it must also be noted that throughout this period Mr. O'Brien did acknowledge and address some of the concerns. Some were addressed on a permanent basis and others intermittently." 10:31

Does that capture, I suppose, your experience of dealing with Mr. O'Brien? 10:31

A. Yes, I think it does. I mean, the IV antibiotics issue was eventually addressed and ceased to exist. Then obviously we all know the Triage issue was intermittently addressed but continued right through the end. So, yeah, I think that's still fair. 10:31

33 Q. Yes. There were always Consultants and more junior clinicians on your radar as being in difficulty or causing difficulties, and Mr. O'Brien was not alone in that respect, but what you are suggesting is that what marks him out as different is that the longevity or the period of time over which concerns arose, different concerns, some resolved or resolvable, and others never resolved, that's what marks him out as being different? 10:32

A. That's correct. 10:32

34 Q. You say that, in terms of management of him, WIT-12147, at paragraph 472, he should have been held to account, you say, and you are here highlighting the issue of Triaging, by the Clinical Lead and Clinical Director,

the AMD and the Director of Acute Service, ultimately the Medical Director, that was the structure within which he ought to have been managed. It was impossible to go out of that structure, you say. Just your reflections on that. Are you pointing out a weakness in management, that's who should have addressed it effectively, and the fact that you reach March 2016 with it not resolved is a management issue? 10:33

A. I think it was a collective responsibility, of which I played my part in that as well, to robustly ensure that patients were safe, and where we knew that there was any risk, I do believe collectively all those people that could have done something should have done something more robust over that period of time, yes. 10:34

35 Q. Yes. You say there were missed opportunities and within your statement you reflect on your own role in this. If we just pull that up for us, please, at WIT-12150. At paragraph 84, you say: 10:34

"While they conclude that the practice of Mr. O'Brien was not appropriate they also raised the issue of missed opportunities by managers to effectively and fully assess the deficiencies in practice of Mr. O'Brien and conclude that no-one formally assessed the extent of the issues or properly identified the risk to patients" 10:35 10:35

Sorry, this is in the context of the grievance outcome.

You say: "I can conclude that on reflection, there were missed opportunities by me and those operational and clinical managers that worked with me and to whom I reported during my tenure as Assistant Director in that period. I sincerely tried to ensure Patient 10:35
Safety through all of my actions at the time as detailed in this statement, however, I now know that I should have done more to better manage and monitor the triage process to ensure that no referral went untriaged and unreturned in the expected timeframe. 10:36
I should not have relied on the clinical assurances given to me regarding Mr. O'Brien's clinical excellence, but undertook a more robust objective investigative process. I sincerely regret that this was not done. As my experience has developed, 10:36
particularly in the last four years in my corporate role, I have learned and have grown in confidence and ability in speaking up against accepted practices which were not conclusive to the best in quality care provision." 10:36

Let's unpack that a little.

In terms of missed opportunities, just before we look at some of the more specific issues that you had to 10:36
address with Mr. O'Brien, what were those opportunities, with the benefit of some hindsight, and why weren't they taken, do you think?

A. I refer there to triage which was my biggest concern,

and we had the escalation procedure in place, which worked to some extent, in that the delays were escalated and Mr. O'Brien was spoken to and we got them back and whatever, but that was me relying on those escalation processes. I note, on reflection, and it's right in my statement, that there was long periods of time whenever there was no escalation and I suppose, and we have reflected on, and again it's really not an excuse but the busyness of my job across lots of different things that I probably relied on that escalation whereas I could have and should have, and knowing his modus operandi, I could have and should have went in to double-check each time that they were coming back in a timely fashion, and taken it upon myself to do that wee bit more proactive look as opposed to waiting until the escalation came through, if that makes sense. 10:37 10:37 10:38

36 Q. Mm-hmm. Obviously you were one tier of management?

A. Yes.

37 Q. There were those on the medical side, as well as your Director who were aware of, if we stick with the example of triage, of course it's not just triage. 10:38

A. No.

38 Q. Do you think would have been supported to take a more robust approach, or indeed do you think it was your role to take a more robust approach? 10:39

A. I have reflected on that. I think it would have been difficult. I think that I needed the support of all those around me to be able to do that. I don't think

I could have gone alone. I believe and experienced many conversations at levels above mine around this, and I know and we have evidence that my Directors had many conversations about the same issues with Mr. O'Brien, and the same approach was taken, seemingly, by everyone. So whether I would have been supported to go off down a road of more intense audits or checking, or whatever phrase you want to use, if I am being really honest, I'm not sure I would have had the support. Capacity would also have been a big issue. The capacity to be able to do that and the people to be able to do that. I genuinely think I would have found it difficult to get the support from medical colleagues and potentially senior management to do that, but I can't say that for sure because obviously I'm reflecting back. 10:39 10:40 10:40

39 Q. Of course. Another perhaps interesting reflection is in terms of the solutions and the culture that prompted what I have described as solutions but ultimately they didn't resolve, WIT-12152. At G, you have said that: 10:40

"I believe that while the Patient Safety concerns were identified relating to the deficiencies in admin management, the team were required to try to work around those deficiencies rather than have the support to require Mr. O'Brien to address them effectively. On reflection, and while that was the culture of Acute Services during my tenure as Assistant Director, I take responsibility for not doing more to fully investigate 10:41

and report on the effects of Mr. O'Brien's administrative practice and ensure that action was taken to preserve the quality and safety of patient care and all its parts."

Again, you are taking your share of the responsibility but you are also -- the Inquiry might consider pertinently explaining that there was a culture within which you had to work, which involved, as you suggest here, trying to work around deficiencies rather than go to the root cause, sort out that root cause and provide a lasting solution. The cultural piece that you referred to, can you help us with that? Where does that come from and what was it? What was the culture?

A. The performance was a huge culture, getting patients seen was a huge culture. I have to say, for whatever reason, there seemed to be a reluctance to deal with Mr. O'Brien at source and expect him to do what was needed to be done. For example, I'm sorry to use triage again but it's just a good example, and I think I said --

40 Q. We are going to hear a lot of that this morning.

A. I am sorry.

41 Q. But you use that example to illustrate your point.

A. Is that okay?

42 Q. That is perfectly fine.

A. It's just that, you know, when I read around some of Mr. O'Brien's statements in my witness bundle, around his desire and probably genuine belief that advanced

triage, that I think he said took at least ten minutes per patient to do and that's what he wanted to do, which he genuinely didn't have time to do and I kind of did a calculation, if he took ten minutes per patient, 100 patients a week you would spend hours and hours doing that, which just is not possible. Every other Consultant accepted that wasn't possible in their job plan, and, therefore, they did what was expected, which was their expert opinion on the GP referral, using that information to upgrade, keep, or downgrade. I think that was widely known, but at no point did anybody say to Mr. O'Brien you may wish to do advanced triage but you can't because it is leaving other patients at risk because they are not being triaged at all. It was a case of a work around and support, you know. So that's what I mean by the culture was to do everything but actually challenge the practice of the Consultant.

10:44

10:44

10:44

43 Q. Yes. You highlighted Mr. Brown's e-mail to you yesterday as illustrative of your point. Thank you for that. In terms of the pressures that you have described when we looked at your four main concerns, that predominated throughout your time or for most of your time, does that provide any form of explanation for why the issues concerning Mr. O'Brien and perhaps other clinicians in terms of quality of output and compliance with rules or expected practice, does that provide any explanation for the absence of, in respect of some issues, conclusive and robust challenge and resolution?

10:45

10:45

A. I don't think -- the demands were obviously significant. I don't think that explains or excuses his lack of attention to his patient, the detail right --

44 Q. First of all -- 10:46

A. Sorry.

45 Q. -- I am talking about the management, the pressures on management to deal with these four main concerns --

A. Yes.

10 46 Q. -- that you identify. Does that explain any lack of 10:46 attention by management to resolving the O'Brien issues?

A. No, I don't think that either. We dealt with many things and many pressures and we dealt with many governance issues, and many doctors and others in 10:46 difficulty, so I know, despite the pressures that management worked in, so no, I don't think so.

18 47 Q. I was next going to go and ask you about the impact of those pressures which you fairly said obviously impacted clinicians. They were asked to do additional 10:47 work. They had more time in theatre perhaps than would have been normal. They had expansive waiting list issues. Does that explain in part, or at all, the issues that you had to frequently chase with Mr. O'Brien? 10:47

A. Again, I don't think so, because those demands and pressures were equally amongst all the other specialties, ENT, orthopaedics, General Surgery, Breast Surgery, it was all for the most part demand was

greater than capacity. In each of those specialties, they did additional waiting lists, et cetera, but I didn't have the same issues with other consultants as we did have with Mr. O'Brien, so I can only conclude that those consultants were able to manage the additional workload and keep their practice safe. 10:48

48 Q. You said in your witness statement that you had minimal involvement in job planning issues and that the primary responsibility for that lay with the Clinical Director and the Associate Medical Director. With regard to Mr. O'Brien in 2011, there was, I suppose, a breakdown in discussions in respect of his job plan. Mr. Mackle, on the one part, and Mr. O'Brien, negotiating that through, and ultimately it went to facilitation. First of all, you were aware of that? 10:48 10:49

A. Probably loosely aware of it, but yes, I'm sure I was aware of it, yes.

49 Q. If we turn to I suppose the outcome of that process, and just ask for your observations on it. TRU-265964. Here, Dr. Murphy, who was the facilitator, is writing to Mr. O'Brien with the outcome. I think at the start of the process, Mr. O'Brien was sitting with something like 15 PAs and taking a stepped approach. Dr. Murphy is reducing it to 12.75, and ultimately to 12 from the 1st March 2020. Is the minutiae of PAs and what consultants are granted for their duties, is that something that occupied your time at all? 10:49 10:50

A. My interest or responsibility, I suppose, so the Commissioner would have expected a certain balance in

a Consultant's job plan, so you were to have two clinics a week, two inpatient theatre list, one-day case list, so that was your output, as such, that was required, and that made up the SAB as we call it, your service baseline agreement activity level. Then, of course, there was a standard PA for admin, on-call, SPA, so those things together made up a job plan. There was an expectation that a Consultant's job plan would be somewhere around 10 PAs, so that's what most people were aiming for. My role, I suppose, was to make sure that the job plan reflected the Commissioner's expectation of clinical activity, and that was kind of my role. So when I looked at job plans, my main focus would have been does it deliver what the Commissioner, and therefore the Trust, needs delivered? The medical management would have been thinking about has it adequate SPA, is on-call, et cetera, into it as well. So that would have been kind of my role. 10:51 10:51 10:51

50 Q. Yes. Here the debate seems to have been primarily around the issue of administration and whether Mr. O'Brien had sufficient time within his job plan for his administrative work. Were you particularly aware of the debate around that or the issues around that? 10:52

A. I don't think I was intimately involved in that debate and the facilitation process that went around that. 10:52

51 Q. Yes. Okay. The issue, scrolling down the page, that Dr. Murphy, arrives at, is that in a context where he is reducing Mr. O'Brien's PAs in respect of

administration seems to be the theme of this. He is telling Mr. O'Brien:

"This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this."

First of all, to what extent did you perceive the issues around triage, for example, retention of patient notes at home, issues around not reading the results of investigations when they were available, to take three examples, to what extent did you perceive those problems -- and you are aware of each at various times -- as being administrative issues that Mr. O'Brien wasn't efficiently dealing with? 10:53 10:53

A. I was aware that he was, I would say, from what I'd heard through Mrs. Corrigan and others, that he chose to embark on using his time to do things that probably he wasn't required to do, or we certainly didn't require him to do. For example, normally when a Consultant creates a Theatre list they choose the patients from the, usually chronological management from the top of the list and bed allocation or whatever, and they give those to their secretary or the scheduler and say, go ahead, please schedule those patients for theatre. My understanding from what I was informed by Mr. O'Brien, he chose to do that himself, and he would have phoned individual patients and 10:54 10:54

discussed with them the ins and outs of when they come in and how they come in and who was looking after their dog when they come in, and that took up a lot of time but that wasn't required. I have noticed, and I am sure we will get on to the notes in the bin issue at some point but again it's referred to in the correspondence in that instance that he spent a lot of time filing and filing notes and re-filing notes and organising charts. It wasn't his responsibility. That should have been delegated to the ward clerk. Whenever you consider whether he had enough admin time or not enough admin time, I think it is important to recognise that we all have to use the time that's given to us productively to do the things that only we can do, and that we use the people and the constructs around us to do what they need to do. So I think my understanding of Mr. O'Brien was, if other consultants, and I manage many of them, certainly work with many of them, not manage them, were able to do their triage, their reading of results, their dictation, their notes, within the administrative time allocated, then I think Mr. O'Brien really needed to think hard about how he used his admin time. 10:55 10:55 10:55 10:56 10:56

52 Q. You have set out a number of examples of where you thought his admin -- or sorry, to put it another way, you have set out a number of examples of where he ought to have delegated admin --

A. Yes.

53 Q. -- type issues? Just to pick up on another example,

you have said in your witness statement, I don't need it up on the screen, but it's WIT-12010, that Mr. O'Brien found it difficult to adjust to the use of digital technology and to embrace the full multidisciplinary team and the collective roles that each played to support him and the Service. How were you aware of that?

A. Well, as I say, I mean, he had a whole time secretary. Interestingly, the Commissioner only funded half a secretary per Consultant, it was meant to be one secretary between two, but each of the Urologists had a whole time, so he did have a good admin support and audio typist. He had the Operational Support Lead Mrs Glennie at his disposal who would have worked with him around the chronological management of his waiting lists. At one point we put in a scheduling team which again would have taken the onus of scheduling out of the Consultant and their secretary's responsibilities, again to relieve them of that duty although Urology didn't want to take up that particular option. There was many sort of things put in place to support, but you did need people to take those opportunities and use them and delegate them. Pre-op assessment is another function that was put in to support the preparation of patients for safe, you know, in preparation for theatre. So there was lots of constructs put in place to support all consultants, including Mr. O'Brien, and many consultants did take them up and use them effectively. You put the constructs in but you need

people to utilise them.

54 Q. Just another piece of correspondence arising out of this job planning and facilitation exercise. Building on what Dr. Murphy had said to Mr. O'Brien about the need to consider changes to his way of working, 10:58
Mr. Mackle wrote to Mr. O'Brien. If we could just bring that up on the screen briefly? WIT-90921. And I called it out wrong. 90291. Yes. So, "subject: Post facilitation to Mr. O'Brien". You copied in. Mr. Mackle quotes what has been written by Dr. Murphy 10:59
and he records that he, that is Mr. Mackle, organised a meeting to discuss the advice and support that the Trust could provide. Mr. O'Brien is said to have cancelled the meeting. Mr. Mackle is concerned that you haven't been able to meet to agree any support and 11:00
he says:

"I would appreciate if you would contact me directly this week to organise a meeting. If, however, you are happy that you can change your working practice without 11:00
need for Trust support, then you obviously do not need to contact me to organise a meeting."

This is 2011. Five years was to elapse before Mr. Mackle sits down with Mr. O'Brien and the issues on 11:00
the agenda, as we will see later today, are triage, are patient notes. Is that something of a cop-out on the part of management? We are ticking the box of inviting you, Mr. O'Brien, to sit down with us. We know you

don't do administration properly and the writing is on the wall in respect of that triage, just to use that example. You are not coming along to meet with us and we will close the issue off by saying, well, we will leave it to you to decide whether you need the help. We can't force you. Is that a fair analysis to place on that correspondence? 11:01

A. Yes. Certainly on the face of it, yes, but I have no doubt that Mrs. Corrigan would have been, because she met Mr. O'Brien on numerous occasions and you can ask her herself, but I have no doubt that Mrs. Corrigan would have followed up and sought to support, as she always did, Mr. O'Brien with his admin practices, meeting or no meeting. 11:02

55 Q. Yes. We will ask Mrs. Corrigan about that, and no doubt we can see -- so, for example, in, I think it's 2014, when your Director, Debbie Burns, intervenes on this issue again, there was the offer of support? 11:02

A. Mm-hmm.

56 Q. No doubt those offers are made frequently; I suppose my emphasis is somewhat different. Can management or should management have compelled changes in practice, recognising that the failure to change his way of doing things was continuing to produce the same unacceptable administrative outcomes? 11:02 11:03

A. I think so, yes. I think what didn't help was the intermittent nature of his compliance. You know, again looking back and seeing it all tabulated in a row, of course, I can accept that? But at the time maybe

naively, but you might have thought we have made a breakthrough, he is doing what he needs to be doing. It was, for a long period of time, there was a performance meeting held every Tuesday morning between 8:00 and 9:00 and the manager of the booking centre would have came to that meeting every week and reported on the number of outstanding triage. So, it was very live for a very long period of time and, as I reflect, it wasn't every week that there was an issue, so there was periods of time, and I think that probably didn't help because you thought maybe we have made a breakthrough and then you went on. Then so many months later back it came again. 11:03 11:04

57 Q. Just to segue into some of the more specific issues, we are on triage, let's stick with it for a little bit longer. I mean, it's fair to say, if we pull up a document at TRU-276737. Yes. You refer to this notebook entry in your witness statement and you speculate a little, but you think it dates from 2009. Would it help you if I put up the explanation from your witness statement first? 11:04 11:05

A. No, I think it's okay.

58 Q. Yes.

A. I kept all my notebooks.

59 Q. If we scroll down. I suppose the point I'm making to you and asking for your observations, is this: Really, from the outset of your role in 2009, and probably before that, the issue of triage and Mr. O'Brien was known? 11:05

A. Mm-hmm.
60 Q. I wonder does this meeting indicate, I suppose, some discussion about how we, that is management, might more robustly address the issue. Just take us through the note, if you would. It starts, helpfully perhaps, with the word "audit", and obviously, what is actually happening. Can you take us through the note? 11:06
A. It's a very long time ago, 14 years ago, but from what I have written it looks as if I'm probably at that point about eight weeks in post, first AD post, so I want to know what is actually happening, get data, because obviously there's a three-week delay, that's what it looks like to me, how many of those referrals were red flag, how long has it been delayed, and then brief Eamon, Mr. Mackle on the data. Then Mr. Mackle was to meet with Aidan. If you could scroll on down. Then if there's no resolving then refer to Dr. Loughran, who was the Medical Director, and Joy, who was the Director of Acute Services at that time. Is there a second page? 11:06 11:07 11:07
61 Q. I think that is the only page?
A. That might be it.
62 Q. I will just check. Yes.
A. I think, again it might be speculation, but there was then the meeting, I think that audit might -- the results of that audit may have been presented to the meeting that there is a note of on 1st December 2009. 11:07
63 Q. Yes. We can go to that. WIT-16551. Just as that is coming up on the screen, I suppose the point here we

are asking you to reflect on is that that note suggests an appropriate way of getting the information, working out what the problem is, how serious it is and quantify it, do we really have a problem here?

A. Mm-hmm. 11:08

64 Q. And then with your arrows, as we saw on the page, escalating through various tiers if it isn't resolved.

A. Yes.

65 Q. This is a meeting, 1st December 2009. We can see that the acting Chief Executive is in attendance with the 11:08 Medical Director, the Associate Medical Director and then the operational team, including yourself.

A. Mm-hmm.

66 Q. I forget what month you said you started?

A. October 2009. 11:09

67 Q. Again you are relatively early in post. In your experience, a meeting including the Chief Executive, focused solely on Urology issues, was terribly unusual, wasn't it?

A. Very unusual. 11:09

68 Q. We can scroll through the agenda and what was discussed. Can you recall thinking it unusual or can you recall why it was set up in this way with the Chief Executive?

A. To me, I probably wouldn't have known back then it was 11:09 unusual because it was my first Assistant Director post, so I was new into that level of management. I probably, at that point, wouldn't have been overly aware. I think potentially the Chief was involved at

this stage because of the desire for the Trust as a whole to secure the Team South model and the expansion, so, you know, it may have been because of that, but I think now, knowing what I know now and all my years of experience, a Chief Executive at an operational meeting was unusual, but I probably wouldn't have appreciated that at the time. 11:10

69 Q. Yes. If we scroll down. The first issue concerns the new model that was to be introduced in the fullness of time, and we are not going to look that today. Under quality and safety, a number of key issues are discussed. There's the IV antibiotics issue that had recently been drawn to the Medical Director's attention and was attracting some concern and investigation, and we will look at that a little later. The action on that, while we are here, just for the Tribunal's eye, in essence a professional assessment from outside of the Trust is to be conducted. Then a second issue under, I think with the sub-title was "quality and safety" it says the triage of referrals, and it's said that it's undertaken by one of the three consultants within the required timescale. One Consultant's triage is three weeks and he appears to refuse to change to meet current standard of 72 hours. It seems that two out of three aren't entirely compliant and one of those two is way out? 11:10 11:11 11:11

A. Yes.

70 Q. Is the one who is way out Mr. O'Brien, to the best of your recollection?

A. To the best of my recollection, yes.
71 Q. You said earlier, if I interpreted your answer correctly, that the meeting which had preceded this with the handwritten note, you think that some kind of audit was conducted and the results are essentially what is summarised there? 11:12
A. Yes, I can only assume so, that it was in preparation for that meeting.
72 Q. You are not aware of an audit report, are you, or anything of that nature? 11:12
A. No, sorry.
73 Q. A third issue, red flag requirements for cancer patients: "One Consultant refuses to adopt the regional standard that all potential cancers require a red flag and are tracked separately. This results in 11:13 patients with potential cancers not being clinically managed within agreed time scales."

Can you recall that issue?
A. I don't particularly recall that issue, and obviously 11:13 we did then have the cancer tracker service that came into place that was a separate stream of referrals in. They didn't go to the booking centre, they went directly and, therefore, irrespective of whether this Consultant didn't agree or not, that was the process 11:13 put in place, so that resolved.
74 Q. That resolved. Then the chronological management of lists for theatre.

"One Consultant keeps patients' details locked in desk and refuses to make this available. Current breaches of up to 24 weeks which may or may not include urgent patients while non-urgent vasectomies are booked for two weeks after listing". 11:14

Can you remember that issue?

A. No, I can't really remember, but it was probably due to thinking about the schedule and chronological management, meeting waiting times, et cetera.

75 Q. Was that Mr. O'Brien's issue? 11:14

A. I would assume so but I can't say categorically, it would be unfair.

76 Q. Very well. Then the action around those points. It describes a written approach with the interim Director to take the lead. Is that across all of those three 11:14 issues, including triage --

A. I would assume so.

77 Q. Then: "If there's no compliance, further written correspondence to be drafted on issues of lack of conformance with triage" -- and obviously the red flag 11:15 issue went down a different stream eventually -- "clearly setting out the implications of referral to NCAS if appropriate clinical action not taken."

I think you have reflected that you were a stranger to 11:15 NCAS and indeed the MHPS process until relatively recently?

A. Mm-hmm.

78 Q. It's obviously mentioned there, I assume mentioned in

the meeting?

A. Mm-hmm.

79 Q. That didn't penetrate with you, did it?

A. No. I can only reflect, I'm sitting at a meeting, probably for the first time, with the Chief Executive, the Medical Director, the Director of Acute Services, and the conversation was probably at that level and I probably didn't fully appreciate or probably it wasn't described to me what NCAS was or where it's at. That's all I can suggest. 11:15 11:16

80 Q. Yes. Okay. You and your Director and the medical management left that meeting knowing that process had been agreed to deal with more of a focus on triage. So it's correspondence not simply from the Head of Service but somebody higher up the hierarchy in terms of the Director. An initial letter, a follow-up letter, and if it can't be resolved, then consideration of NCAS? 11:16

A. Yes.

81 Q. Which, unpacking that, might have meant a review or an assessment of performance issues. It's not specified here but that's a service that NCAS can offer. NCAS doesn't ever feature in any of the follow-up correspondence over several years, notwithstanding that the issue which was audited here, reported to the Chief Executive. 11:17 11:17

A. Yes.

82 Q. Can you explain how that gets lost?

A. I can't. I really can't. I don't even recall this correspondence, but when I read it as part of my bundle

I was thinking you know, the names there were the very senior Dr. Loughran, Medical Director, Ciaran Donaghy, Director of HR, and Dr. Rankin, Director of Acute, with a plan at that point, so I am not sure where it went awry. Then I wouldn't have been party to all correspondence or all thought processes when it came to Mr. O'Brien. I wouldn't have been party necessarily to all correspondence or discussion when it came to Mr. O'Brien or other consultants. 11:18

83 Q. What that reveals is that at no point did your Director sit down with you or the Medical Director, Associate Medical Director, and they had a clear steer from the Chief Executive's meeting that we need to move or at least consider approving the NCAS-led initiative; that discussion never happened in your presence? 11:18 11:19

A. Not that I recall, no.

CHAIR: Mr. Wolfe, might this be an appropriate time for a short break?

MR. WOLFE KC: Yes, sorry. Twenty past 11. I didn't see the clock. 11:19

CHAIR: Twenty-five to 12?

MR. WOLFE KC: I am obliged.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:29

CHAIR: Mr. Wolfe.

84 Q. MR. WOLFE KC: Mrs. Trouton, when you reflect back on that meeting two months after you came into post, you set out a clear process on the back of what appears to

have been some form of mini audit, that the Directorate knew exactly how to get to grips with this, knew what process to deploy but it simply wasn't done?

A. That's how it looks on reading the notes of that meeting. 11:38

85 Q. I suppose when we reach that kind of conclusion, we look for explanations and sometimes they are hard to articulate, but, doing your best to articulate an explanation, what might it be?

A. I know this has been said before but the general impression was that Mr. O'Brien was a brilliant Urologist, a really patient-centred clinician and, therefore, his attributes outweighed his choices or idiosyncrasies, whatever word you want to use, when it comes to admin practices. I think in general, the 11:38 11:39 general consensus was, he was a good clinician. I remember reflecting, I often said in the day, this was the genuine belief -- once you got into see Mr. O'Brien, that was good, it was the process of getting in to see him that was difficult. That was the 11:39 genuine understanding of his practice during those days.

86 Q. Then before we leave triage altogether, I just want to work through three other issues with you. One is the issue of assistance or help from Mr. O'Brien, and 11:40 I want to have your response or comments around that. I want to go back to the medical management approach to this and have your final thoughts on that. Finally, I want to ask you something about the default

arrangement that has been characterised.

Dealing with the issue of assistance, if we could bring up -- this is 2013, so fast-forwarding a number of years, I suppose, from 2009, and the issue of triage has ebbed and flowed. It's a recurrent issue, to use your term. 26th November 2013, TRU-276905. At the bottom of the page, the issue is missing triage, Martina Corrigan is writing: 11:41

"Please advise. This is holding up picking patients for all clinics as these letters came up from triage. I know this will need to be escalated early this week if not resolved." 11:41

Mr. O'Brien's response, just moving up the page, is to apologise that he has fallen so far behind in triaging, says: 11:42

"However whilst on leave, I have arranged all outstanding letters of referral in chronological order so that I can pass them to the CAO". 11:42

That's --

A. Central Administration Office? Maybe booking centre. 11:42

87 Q. "... via Monica in order beginning tomorrow. I know I have fallen behind particularly badly except for red flag referrals which are up-to-date, and I do appreciate this causes many staffing consideration, and

frustration and all have been patient with me, I can assure you that I will catch up but I am determined to do so in a chronologically ordered fashion."

Acknowledgement that he's behind, preparedness to catch up starting soon. 11:43

A. Mm-hmm.

88 Q. Mr. O'Brien's reflections on that are that -- I will just bring it up on the screen. WIT-82562. At paragraph 468, he says with reference to the November e-mail: 11:43

"I was sorry I was behind in triage and had arranged to catch up", that's what he said. His reflection is -- surely the response to that should have been: "To provide adequate time to carry out the tasks within my job plan rather than simply raise the issue, know the cause was overwork yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave." 11:44 11:44

His reflection is that the Service knew that he wasn't coping, but either failed to diagnose that or diagnose solutions for that for whatever reason. There was never any occasion, was there, where the Service, and you, as Assistant Director, and the Director, sat around a table to try and identify solutions? 11:45

A. I think certainly there was various parts, so I think somewhere, certainly in Mr. Akhtar's day he did the red

flags in totality to take some of the load off the other two clinicians. You will have seen that Mr. Young, on occasion, came in to do the triage just to help out. You will go on to see shortly after that, I think February '14, where Mrs. Burns meets him and says you only have to do named referrals, which are the very small proportion, by the way. But as I reflect, and I know Mr. O'Brien has alluded to the fact that one PA isn't enough for his admin time, but when we look back to when he was on 15 PAs, he had 3.75, I believe, for admin time. As we have just discussed, triage was an issue in 2015 when he was in 15 PAs. He also has alluded to the fact that while he agreed that triage would be done during Consultant of the Week, and that proved to be impossible for him, that only came into effect I think in 2013/'14, maybe, and triage was an issue before that. So, it doesn't seem to be, no matter how much admin time you would give Mr. O'Brien, he chooses to use it in a way that doesn't meet timely triage, and I think that was an underlying issue right throughout. Even when he does have his named referrals only, which is the very small proportion because most come into the Service as opposed to a named clinician, he still struggles with that small amount. It didn't seem to matter what attempt was given to support, there wasn't a consistent change. 11:45 11:46 11:46 11:47 11:47

89 Q. I know, in fairness to the perspective that you are providing that at the time when Mrs. Burns reached agreement with him that he would only deal with named

referrals, she appears to have asked him to give consideration to what admin support would assist him. Maybe just pull that up so that we have it. TRU-282019. 21st February. This is at the end of a process. We will actually go back to the start of the process in a moment and we will see how it works out. She is reflecting to Mr. Mackle and Mrs. Corrigan and Mr. Young that she'd had a very helpful meeting with Mr. O'Brien yesterday. Mr. O'Brien has agreed to not triage new referrals with the exception of those named to himself. He is also to think about if any additional admin support would assist him. Michael Young is told: 11:48 11:48

"I know this might place an additional burden on the rest of the team but appreciate you accommodating." 11:49

This is one of these workarounds, and I have reflected to you Mr. O'Brien's complaint that there was a failure on the part of the Service to address his capacity issues, and what this seems to suggest is that Ms. Burns engaged with him to see what further help could be provided to him on the admin side, while reducing his burden by only passing named referrals to him. 11:49 11:49

A. Yes.

90 Q. Are you aware of any approach to you or anyone else from Mr. O'Brien seeking specific administrative support --

A. No.

91 Q. -- around this issue?

A. No.

92 Q. The next issue, going back to the start of this sequence, that I wish to address with you, is this: It concerns the workarounds, and you drew our attention yesterday to an e-mail you received from Mr. Brown, where he said to you: "I would prefer the approach to be how can we help". We looked at that and I don't need to bring that back up. You then become engaged with Mr. Young and Mr. Brown around that issue. Let me just have up on the screen, please, TRU-277038. Just at the bottom of the page if I can look at that. Michael Young has clearly spoken to Aidan and you are thanking him for that. What you are saying to both them is: 11:50 11:50 11:51

"Robin and I had a conversation about this this morning and the only solution we see if it is unlikely that Aidan will change practice is for triage to be no longer go to him. I appreciate this will put an increased burden on yourself, Tony and Mr Suresh but it is just too critical to leave it as it is. I believe you have already agreed to do this for the general triage, Martina informs me, which is great and much appreciated." 11:51 11:52

We can leave it there and scroll up, up the page. Just on that, again as a manager in this context, you are

talking about taking out of Mr. O'Brien's work plan or workload, I should maybe more properly say, a piece of work that is legitimately within it rather than a challenge to his failure to do it, and your solution is to put it on his colleagues. Is that a fair characterisation? 11:53

A. I have just had a discussion with Mr. Brown, the Clinical Director, so obviously I am reflecting on that discussion. I can only reflect that the outcome of that discussion negated any attempt to deal with Mr. O'Brien's practice, and, therefore, we were left with, well, if we're not going to deal with his practice, and I have said it's too critical to leave as it is, I can assume the only other option open to us was then he doesn't do it at all, then that's protects the patients. I can't remember but I think it's inferred in the e-mail, so I think that's the conclusion we must have came to with the Clinical Director. 11:53

93 Q. Is it appropriate to interpret this conversation as you, on the operational side, looking to medical management to resolve this, it being their responsibility to resolve it, and you pointing out the only alternative that occurs to you, if they are not prepared to resolve it in some other fashion? 11:53 11:54

A. It probably wasn't as black and white as that. It probably wasn't me saying, Mr. Brown, you need to resolve this, if you don't I will have to. I don't think it was that. It was probably more of

a conversation about what we can do.

94 Q. Yes. The response that you received from Mr. Young is perhaps a rather terse one?

A. Mm-hmm.

95 Q. It's something of a rebuke to you. It's essentially saying we haven't signed up for taking over the triage, and you have expected this issue to have been completely resolved within a matter of a few days. I suppose the cheap response to that might be, I would have expected it to be resolved over the course of five years by this point. But more constructively, as we can see develop, this matter is escalated to your Director and the outworking of that is conversations with Mr. O'Brien leading to a decision that he would only deal with triages specifically referred to him, or referrals specifically sent to him. Is that your --

11:54 11:55 11:55

A. That looks like the sequence of events, yes.

96 Q. Again, in terms of the characterisation of this, there was a failure to think more widely about the difficulties that might lie beneath this ongoing issue, to think more widely about the practice of Mr. O'Brien. Is that a reflection you share with hindsight?

11:56

A. With hindsight, of course.

97 Q. Is it a case, from an operational perspective that, in terms of your powers, you can only identify the issue, suggest solutions, but ultimately it's for medical management to take more robust action?

11:57

A. There are solutions that operational management can offer, admin solutions, support, whatever, but where

our powers probably ceased was the fundamental mind-change of practice of a Consultant, and that's really where you need peer pressure. My reflection, as I have dealt with consultants over the number of years, is that practice largely changes whenever the peer group together exert that pressure to change practice. It rarely comes from a manager exerting pressure to change practice, if that sounds -- it's usually peer pressure, Consultant, medical evidence, expertise, a new way of thinking, new medical ways of doing things. It's rarely from a management perspective. 11:57 11:58

98 Q. In terms of the solution that was arrived at by Debbie Burns, was that discussed with you in advance?

A. No.

99 Q. Do you know why specifically you arrived at a solution or an accommodation whereby he would only address named referrals? 11:58

A. No. No. Other than maybe she thought it was a pragmatic solution but I really don't know.

100 Q. Is it wholly connected, do you think, with his apparent inability or lack of capacity to deal with a bigger number of referrals? 11:59

A. I'm not sure you could make that direct correlation considering he was challenged way back in 2006, 7, 8, 9, when referrals were less it still was an issue, so I absolutely agree that as referrals increased, of course the workload increases, but I don't know if there's a direct correlation considering his previous practice. 11:59

101 Q. It is the case that, notwithstanding this accommodation, triage continued to be an issue, and one further, accommodation may not be the right word in this context, but in order to ensure that patients who haven't yet been triaged make it on to the waiting list, a device was constructed whereby the patient would go on to the waiting list using the referrer's classification? 12:00

A. Yes.

102 Q. And the expectation would be that if that classification was to change after triage, then the position on the waiting lists or the appropriate waiting list change would be made, is that a -- 12:00

A. That's correct. My reflection, I believe, was that, at that point in time, the waiting times were relatively short, not as short as we would like them but relatively short, and it became a problem where, if patients weren't even registered on the waiting list, then they were missing out by a number of weeks getting on, the thought process was at least if they were registered they would be on the waiting list, that clock would be started at least. There was never any expectation that that negated Mr. O'Brien or anyone else not doing the triage. Indeed everybody else continued to do the triage. The escalation process continued. So it was more of a backstop as opposed to a different approach. 12:01 12:01

103 Q. Thank you. Again, notwithstanding the change in terms of what was sent to him -- and just to clarify, when he

was Urologist of the Week, is it your understanding that, in that capacity, he only received the named referrals?

A. Yes.

104 Q. Is it your understanding that that accommodation, whereby he only received the named referrals, continued? 12:02

A. I was under that impression.

105 Q. Yes.

A. I wasn't aware that -- I know now it stopped at a certain point but I wasn't aware that there was -- it certainly wasn't a conscious decision to rescind that. 12:02

106 Q. Do you know when it stopped?

A. I don't, but I think it went on for a number of months but at some point I think it maybe stopped but I wasn't aware of that. 12:02

107 Q. Could I draw your attention to something said by Anita Carroll in the context of the default arrangement? TRU-277196. Leanne Brown is sending to Anita Carroll, copying in a number of others, a list of outstanding triage. My note tells me at that point it's a list with 29 in it. I am not quite sure if I can prove that to you, but just the point I wish to make to you is at the top of that page then, top of 196. So, it's said by Katherine Robinson: 12:03 12:04

"As you can see, these have all been chased several times. Due to the lengthy target now these patients are not due appointments yet. When they are, we are

going to be booking without a triage result."

That's essentially an outworking of the default arrangement. It's Anita Carroll's comment "don't panic" to you. "As you know we are going with the GP triage anyway". 12:04

In the context where we haven't had triage back on these 29 patients where you are chasing for some months, and we know that within a clutch of triage cases, whether urgent or routine you could find error and the need for upgrade. Does the use of the term "don't panic" in that context belie a misunderstanding of what's happening here? 12:04

A. I think she probably knows that I would have probably have panicked, which is probably why she said "don't panic." 12:05

108 Q. Was there appreciation that simply putting a patient on the, if you like, default list, is akin to avoiding triage if triage isn't done? 12:05

A. Yeah, there was definitely an appreciation that this was not a get-out clause for not doing triage, and that's why it continued to be escalated. Katherine Robinson did exactly the right thing.

109 Q. In terms of Mr. O'Brien's communication of his issue, did you ever hear him say that, following the introduction of the Urologist of the Week concept, that he found it impossible to complete the triage of urgent and routine referrals? 12:05

A. No.
110 Q. That wasn't said to you?
A. No, not that I recall.
111 Q. Mm-hmm. I think the distinction is, he never said "I am not doing it" but did you ever hear a reflection that he found it impossible or exceedingly difficult? 12:06
A. No, no, I didn't. I mean, interestingly, only he would have known that he was accumulating referrals. He didn't come, as far as I'm aware, he certainly didn't come to me. He may have went to Martina or others, but he didn't come and say look I have accumulated a hundred referrals, I am struggling to get them done, can I get help? It was always we caught on from the escalation process and approached him, but I don't ever recall him coming and saying "I'm struggling with this number of referrals. I appreciate it's not good. I appreciate I need to get it done. What am I going to do?" So that, as I recall, didn't happen. 12:07 12:07
112 Q. We will look later at the fact that, come the end of 2015, and into early '16 when you and Mr. Mackle are approaching Dr. Wright, that the number of outstanding triage had grown to several hundred, I think. 12:07
A. I think it was 277 maybe at that point.
113 Q. Yes. Another issue that you were caused to grapple with, and the Service was caused to grapple with, was the fact that patient notes were taken home by Mr. O'Brien. If I could just have up on the screen your statement in relation to that. WIT-12007. Here at paragraph 66 you set out here the risks, as you saw 12:08

them, from both an information governance perspective and impact on other clinicians when notes are not available. The Trust, at that time, had no particular guidelines and no method to specifically track where notes have gone, is that --

A. Yeah, there was a very -- it was a simplistic tracking mechanism put into place, I think, during that time, where notes were tracked out to a specific office, but we didn't have anything as sophisticated as to know whether they had gone off the premises or not. 12:09

114 Q. It's not that there was no system, there was a rather cumbersome or clunky system?

A. Yes. It was very much dependent on notes being signed in and signed out of various offices or clinics.

115 Q. The issue seems to have been a regular feature of life. 12:10
It seems to have arisen particularly loudly in 2013 and a system was developed of formulating an incident form or an IR1 --

A. Yes.

116 Q. -- around missing notes. Can you recall that? 12:10

A. I think it was a case of formalising, but that was effectively something that shouldn't have been there because our Medical Records Department should have been able to locate any set of notes on the premises.
I think it was a case of let's formalise it, and when 12:11
you find an incident where the notes aren't available, you can't locate them well that becomes a Datix.

117 Q. Was a decision taken at a certain point not to formalise it, in other words to stop using the Datix?

A. Again, I don't recall that being a decision.
118 Q. Did you, at any point, specifically speak to Mr. O'Brien about this issue?
A. Yes. I think I did, yes.
119 Q. You say, just to pull up an example, TRU-276837. The issue is being raised with you, and if we look at the whole context you would see that staff, to use the vernacular, are being given the runaround to try and track notes, and it comes up to you and you say: 12:11 12:12

"I need to talk to Aidan about this."

It may not have been this occasion but you have a recollection of speaking to him?
A. Yes. 12:13
120 Q. More than once?
A. Not frequently, no. It wouldn't have been me frequently, but I think I remember, bizarrely, talking to him outside a lift on the third floor, or second floor where his office was, about his notes, probably about other things but notes were there, and he promised he would bring them back. To be fair, when he was asked about a specific set, I'm sure Mrs. Corrigan had regular conversations, he would have brought him back. I don't think any of us fully understood the extent of his note collection at home, because we thought they were revolving and rotating in and out as opposed to being held at home for very long periods of time because he would have brought them back. But yes, 12:13 12:13

he was spoken to about it by me.

121 Q. Do you understand now or do you have your suspicions now about why he was retaining so many notes at home?

A. I genuinely don't know why anyone would need to keep 300-plus sets of notes at home. You can only work on any number of patients at any given time. Even now, even now, I am baffled by why he would need to have so many notes at home. 12:14

122 Q. If he wasn't doing the dictation of outcomes following clinics, would that provide an explanation why? 12:14

A. Possibly.

123 Q. Not one you would agree with perhaps.

A. No, because you are supposed to dictate at the end of every clinic, and some people dictate at the end of every patient in every clinic. Even if he did decide, no, I'm going to do it at home, you would be doing it that week, that month. If you think that you do one or two clinics a week, seeing eight patients, that's 16 patients a week, it would take him a very long time to accumulate 300 sets of notes. Even if you did want to do your note-writing at home, it's hard to understand why you would not try and do it relatively contemporaneously. 12:14 12:15

124 Q. The problems caused by it are several. Let's take a look at a particular example that you became aware of. TRU-259403. This concerned -- I think I have a rogue reference. I am not sure I will be able to correct it now, I will come back to it. The concern felt -- try TRU-259043? Yes. We have taken out the 12:15

name of the patient. If you need to know the name of the patient --

A. That's okay.

125 Q. Scroll to the bottom of the page, please. Anita Carroll is telling yourself and Alana Gibson that she will be responding to the complaint from this patient, but she's going to share the following information that she's received on this. The patient attended with Mr. O'Brien on 11th October 2011 and was put on the waiting list. He was then cancelled and moved to Mr. Young and is back on Mr. Young's waiting list. One of the health record members was doing a search and asked Mr. O'Brien about the issue as he had attended with him three years earlier. Mr. O'Brien was able to confirm that the chart was at his home and he would bring it in the following day. She explains that, as a result, health record staff have spent several hours looking for the chart, and a patient and a relative have felt concerned enough to write in a complaint to Mr. Poots, who was then the Health Minister, and Mairéad McAlinden, the Chief Executive of the Trust about health records and inability to provide a chart. That may be untypical of the implications of this shortcoming, but it's an example of the kind of difficulty that arises for patients and staff if charts aren't available? 12:17 12:17 12:18 12:18 12:19

A. Yes. It's obviously an extreme because it's three years, obviously, but, yes, it is a typical example.

126 Q. Again, come March 2016 it's an issue, and I suppose

a further example of the inability of management to eradicate the problem?

A. Yes, yes.

127 Q. Is an explanation for that failure to recognise that it was an issue that required more emphasis because of the patient risks inherent in the practice weren't fully appreciated? 12:19

A. I mean, I did appreciate the risks, as you can see. I suppose I think, again looking back, it was more a case of genuinely didn't fully appreciate neither the extent nor the length of time the patient notes were in his home and we thought it was a case of there for a few days, maybe a week, back again, more out, more in, more out, more in, and some, I think back then before NICAR, it wouldn't have been unusual for notes to have gone home and back again. It was just the length and extent that was very unusual. 12:20 12:20

128 Q. Can I ask you about the review backlog issue?

A. Yes.

129 Q. There was a meeting on 9th June 2011, and just bring the note of the meeting up. It's TRU-281949. These are the issues and actions arising from the meeting. You attended the meeting with Mr. Brown. Scrolling down to "review backlog", you are to meet with him to discuss a way forward. What was the issue around the review backlog that you were struggling with? 12:20 12:21

A. It was probably multifactorial, but we looked at the review backlog to sort of see was everyone on the backlog needing a review? So that's the first place

you start. I remember, I don't know if it was at that stage or not, but setting up meetings with GPs, local GPs, with the Urologists to look at review patterns or the need for reviews. For example, when somebody comes in for a vasectomy they would, at that point, got a review, and the conversation may well have been well look, you don't need to take a patient back to a review for that, they can be discharged and go to their GP if they have any issues. So I facilitated a series of meetings between the Urologists and GPs to see around review practices to reduce the number of Consultant reviews. Another piece of work that was done was when you are admitted as an emergency patient to the ward you may well be discharged not by the Consultant but by the junior members of staff who, maybe not knowing, would have automatically generated a review. There was lots of different ways, and this was some of the conversations no doubt I and others had with Mr. O'Brien, was around how we can ensure that only the reviews that were absolutely needed to be at an Outpatient appointment with Mr. O'Brien were there, and we tried to find other pathways for others that didn't need to be there. I think that was probably some of the work that we went off to do. 12:22 12:22 12:23 12:23

130 Q. Was that an intervention that was welcomed by Mr. O'Brien and his colleagues? 12:23

A. It was hard going again. The meetings with the GPs weren't straightforward. There was quite a reluctance to -- from my recollection, a reluctance to relinquish

care to the GPs. Quite paternalistic and thinking only they could review, so that was harder going. The junior doctor piece what we did was, we asked the ward sister to just check and review with the junior doctor whether a review would be necessary from her knowledge base. So there was a few interventions put in, but no, it wasn't plain sailing.

131 Q. Was this a case the clinicians resenting the suggestion that there were other ways of doing this, that indeed it was from a commissioning perspective and a waiting list perspective, necessary to come up with these ideas? 12:24

A. I think there was a resentment that potentially their clinical judgment was being questioned. You know, certainly if they put down a review, we were potentially questioning the real need for that, so I think they found it difficult to accept that challenge. 12:25

132 Q. Come March 2016, it's one of the issues on the letter that we will come to, but why was the issue still prevalent, at least in terms of your dealings with Mr. O'Brien, at that point? 12:25

A. Some of the review backlog problem was generic, which wasn't pertaining particularly to Mr. O'Brien. The bit that pertained particularly to Mr. O'Brien was, again, back to that lack of engagement around creative thinking, around reducing or using other people, other pathways. I mean some of the general surgical teams, for example, were saying that their senior nurses or 12:25

specialist nurses could potentially validate lists or review patients, whereas that would have been an anathema to Mr. O'Brien.

133 Q. From his perspective he is thinking patient care and his expertise being required in that interface? 12:26

A. I can only presume he felt only he could do the reviews.

134 Q. Just on this document, could I scroll down, please, to the bottom of the page, please? It's recorded at item 8: 12:26

"Discussion regarding the leadership requirement of all senior staff inclusive of consultants to give confidence to all ward Department nursing staff regarding patient care and to take action to improve patient management rather than projecting a negative 12:26 and critical attitude within the clinical team."

Was that comment directed at Mr. O'Brien's behaviours?

A. I would assume so, since it was in his letter, yes.

135 Q. Yes. Can you recall what the context was? 12:27

A. Truthfully, vaguely. I vaguely recollect it being reported that his behaviour at ward level, being critical generally of the Service in front of nursing staff and others, you know, and in front of patients, I believe, as well, was just not conducive to trying to 12:27 create, and it wasn't that the criticisms were felt to be a genuine whistle-blowing type issue, it was more just a general negative, critical leadership that wasn't conducive to good patient service. But

generally it's a very vague recollection, to be really honest.

136 Q. The IV antibiotic management of LUT patients was something that crossed your desk?

A. Yes. 12:28

137 Q. As I understand it, you weren't involved in all of the transactions and conversations around it?

A. No. No, I was probably involved in being aware of the monitoring of the protocol and procedure that was eventually put in place by Sam Sloane CD at that time, 12:28 and the microbiologist to oversee and scrutinise the appropriateness of the patients; more that element towards the end of it.

138 Q. As you reflected earlier, this was one of those issues that was eventually resolved by contrast with some 12:29 other notable issues? What do you put the ability to resolve that matter down to when efforts to resolve other issues didn't succeed?

A. I think, on reflection, when it was overtly clinical, it was absolutely clinical. I think that the spotlight 12:29 or pressure from external sources such as Dr. Diane Corrigan, who I think was PHA at that point, asking the Medical Director, Dr. Loughran, for a response, I think the reflections of Mark Fordham as well, expert, again that clinical -- back to the 12:29 clinical challenge again so Dr. Diane Corrigan was a medical doctor, from my understanding. It's back to the peer, peer challenge, overtly clinical, external scrutiny, seeking a response, then I think that was

probably the factor in making sure that it was eradicated.

139 Q. There were, at least according to some of the correspondence, apparent slips and missteps before final resolution. Can I just seek your reflections on one of those. TRU-281944. Mr. Mackle is writing to Mr. O'Brien, copying you and others in, on 15th June 2011. By this stage a protocol had been established -- 12:30

A. Yes.

140 Q. -- for the management of patients who might be under consideration for IV antibiotic therapy. That involved, or ought to have involved, so far as I understand it, the bringing of the case before the Clinical Director? 12:30

A. Yes. 12:31

141 Q. And a microbiologist?

A. That's correct.

142 Q. A discussion would ensue and an appropriate decision made. Mr. Mackle reflects serious concern here that Mr. O'Brien hasn't recalled a conversation at a meeting the previous Thursday, he says: 12:31

"At that meeting, I informed you that if you wanted to admit a patient for pre-op antibiotic or for IV fluids and antibiotics that a meeting had to be held with Sam Sloane" -- that's the Clinical Director? 12:31

A. That's correct.

143 Q. "And a microbiologist and this prerequisite was non-negotiable. You have also been given this in

writing following a previous meeting with Dr. Rankin and myself. I now find that you initially planned to admit a patient this week without having discussion with anyone and then when challenged you only spoke to Dr. Rajesh Rajendran, would you please provide me with an explanation by return." 12:32

Obviously copied into that, were you aware of this issue at the time, this apparent breach or what has been interpreted as a breach of the protocol? 12:32

A. Probably because there was that sort of escalation process in place by the nursing staff, so they would alert us if anyone came in that hadn't gone through the process. So I'm sure it was. On reflection, that's June 2011. 12:32

144 Q. Yes.

A. Nearly two years post, I think it shows how difficult it was. It was a constant challenge to watch and monitor and challenge, and -- yeah.

145 Q. I mean, obviously peace broke out at the end and so far as we are aware, there were maybe one or two episodes after that, but when you think about it, how do you reflect on the fact that although the rule is clearly established in 2010 and the protocol is clearly established in 2010, that this issue takes several years before it finally beds down. I must add Mr. Young in this context as well? 12:33 12:33

A. Yes. I think it just shows the -- I am trying to find the right word -- disregard maybe is not, but certainly

maybe disrespect for protocols, rules, pathways that are put in by whoever, whether it's peers, management, BAUS, whatever, there appears to be a disregard from Mr. O'Brien to those protocols or regimes, yes.

146 Q. You spoke yesterday about the autonomy -- 12:34

A. Yes.

147 Q. -- clinicians, in your view, attracted or commanded, whereas we've heard much said about multidisciplinary team working, which, I suppose, in theory, should dilute autonomy in certain contexts. Has 12:34 multidisciplinary team working bedded down more effectively in more recent years as compared to more than a decade ago --

A. I think it is --

148 Q. -- in the Trust? 12:35

A. I think it is. From my observations now, back then MDM meetings, for example, morbidity and mortality meetings, would have been Consultant only, medical staff only, whereas now much more prevalent certainly in the smaller M&Ms you would have nursing staff and 12:35 AHP staff and maybe pharmacists there as well, so there is a more general multidisciplinary approach to patient care. Back then it wouldn't have been as well developed.

149 Q. The system, as it existed there, seemed to allow for 12:35 the opportunity of clinicians disregarding the rules that were handed to them?

A. Yeah.

150 Q. Is that a fair characterisation or is this kind of

behaviour exceptional, in your experience?
A. It is. You know, Mr. Mackle reflected yesterday, the personality particularly of surgeons, and quite rightly and for good reason is one of courage. You know, you don't operate on somebody without a certain level of courage to do that. So those personality traits lend themselves to taking decisions and going with it. 12:36
I think, my observations through medical school as well you are taught to assess and decide and go with what you think. So when you get to Consultant level, and certainly if you think about consultants of that era were very autonomous or felt they were very autonomous in their practice. Mr. O'Brien, for example and there was others that I encountered along the way, who, for all the reasons, felt that they knew exactly what they were doing and their care was best for their patient. 12:37
I think what I see laterally in medical circles is a much more collegiate way of working, a much more protocol-based, much more clinical pathway based, which has obviously been researched and evidenced and most clinicians, and clinicians work very hard, most doctors will adhere to those because that keeps them safe as well, so it keeps patients safe and it keeps them safe. 12:37
Then, of course, there are, as with everything in life, there is a scale, and some people are early adopters of new technology, new ways of thinking; others fall in very quickly behind with their peers, and then there's others that struggle, and I think Mr. O'Brien probably was in the category where he really struggled to let go 12:38

of his personal way and go more with peer approaches and evidence. If that makes sense?

151 Q. Thank you. Another issue that you had to deal with at or around this same time, arose out -- and I'm not entirely sure you were aware of it -- of an SAI concerning a retained swab. The context for that is that there was a scan report which pointed to a problem in the patient's cavity, which, it would appear, Mr. O'Brien didn't read in a timely fashion, albeit he was working in a context, back then at least, whereby the radiographers weren't specifically pressing an alert button, and by that I mean making a phone call or specifically directing the clinician to the problem. The issue was how do we address clinicians who do not read the results of investigations in a timely fashion, and it's an issue that you picked up. Did you pick up the issue on the back of the SAI outcome in that case? 12:38 12:39 12:40 12:40

A. I can't recall if it was directly related to the SAI. I didn't recall it but when I looked back through my witness bundle and doing some research it was again picked up by Dr. Diane Corrigan, who wrote to the then Debbie Burns who was in her post of Assistant Director for Governance and copied in, I think it was Dr. Simpson at the time and Dr. Rankin, to say she had noticed there was a missing recommendation in the SAI report and asked the Trust what was being done about that. I was unaware that that was all going on in the background, but then it did come to my attention, of course, through Dr. Rankin, whereupon I was asked to -- 12:40 12:40

152 Q. Just to --
A. Sorry.
153 Q. That's helpful. I will assist you by putting up the relevant e-mails.
A. Yeah. 12:41
154 Q. If we could start at TRU-276807. This is July 2011. I think the incident concerning the retained swab is 2009. The SAI reported the following year in 2010. Dr. Diane Corrigan would have had knowledge of the SAI in her HSCB public health role? 12:41
A. Yes.
155 Q. As you have correctly said, the SAI didn't contain any recommendation around the need to read investigation reports in a timely fashion. You have written, copying Heads of Service is the top line? 12:42
A. That's right.
156 Q. Including Martina Corrigan in Urology. This is of general import?
A. Yes.
157 Q. It's not just Urology. 12:42
A. Yes.
158 Q. You are copying in the Associate Medical Director and the Clinical Directors.

"Dear all, I know I have addressed this verbally with 12:42
you a few months ago but, just to be sure, can you please check with your consultants that investigations which are requested that the results are reviewed, as soon as the result is available and that one does not

wait until the review appointment to look at them."

So, a reminder. Let's see how that develops by going back up the page. Martina Corrigan is writing to her consultants, and I think she simply is forwarding your note, and just scroll down: 12:43

"Please see below for your information and action."

Then Mr. O'Brien receives that, I think in July it was and he is writing in August. He raises a series of questions that you can see and, amongst those issues is the resource implications of being able to do that. That was drawn to your attention, isn't that right? 12:43

A. I think Martina sends it on to Mr. Mackle, but I'm sure I was still aware of it. 12:44

159 Q. Yes. Let's just move it on?

A. Because it was brought to my attention.

160 Q. Mr. Mackle, copying you in?

A. Yes. 12:44

161 Q. Saying: "I will need assistance when replying to this". Then it comes to Dr. Rankin's attention.

"Gillian, I have been forwarded this e-mail by Martina. I think it raises a governance as to what happens to the results of tests performed on Aidan's patients. It appears that at present he does not reviewed until the patient appears back in Outpatients Department." 12:44

Then finally Dr. Rankin writes to you and Mr. Mackle, and she says to you:

"Heather, I wonder if when you are meeting three surgeons regarding speciality interests this whole area of how results are read when they arrive rather than waiting for review appointment could be discussed. Secretaries need to be given a brief as to what is expected of them and this would need discuss and agreed. Perhaps a protocol for secretaries is needed when there is not currently a system in place which I hope is not more widespread. Can I leave it with you until I return?" 12:45 12:45

First of all, your observations on Mr. O'Brien's list of questions within which, I suppose, it's not unfair to say, he is objecting to the proposition that he should read the results immediately in the current circumstances within which he works, and he is pointing to a lack of resource and raising other questions besides. In other words, he might be thinking in principle this is a good idea, but how am I going to do it until you resolve these other issues? Is that a valid point? 12:45 12:46

A. First of all, he was the only person that came back. I think most other clinicians would have been reading the results anyway. If you don't mind going to the list of questions, would that -- just a wee bit. If you think about some of the obvious answers to the 12:46

questions that he asks. Thank you very much.

162 Q. Thank you.

A. Thank you. Is there a consultant to review all the results? Yes. Are all results to be reported irrespective of their normality or abnormality? Yes, particularly abnormality. Are they to be presented in the review and paper? Back then it was probably paper. Who is responsible? The secretary. Will the reports be presented with the charts? If you wish. 12:47

12:47

The questions were quite simple to answer. "How much time will the exercise of presentation take?" Basically the secretary gets the results back, they sets them as Mr. Mackle reflected yesterday in which whichever form the Consultant would like them, and the Consultant looks at the result and goes normal, normal, normal, abnormal, need to do something. A lot of those questions had, for me, very obvious answers. He talks about the time taken. For me, he had to look at them at some stage, so he had to spend time looking at them at the Outpatients appointments, so what was different looking at them in his office? They were just questions that were, to me, convoluted and unnecessary. Sorry. 12:47 12:48

163 Q. Just by your answer, you think that the premise of the intervention is vital and important that results should be read promptly? 12:48

A. Yes.

164 Q. Was there external governance covering that area or if

governance isn't the right word, was there an expectation in the literature, in the health sector, that prompt review of results would be important?

A. I think, and maybe I am being too simplistic, but if you ask for an investigation, you would, most expectedly, want to know the result of it. I think it is implicit that if you seek an investigation, you would look at the results. I don't think you needed governance protocol to cover that premise. 12:49

165 Q. Clearly there was some pushback here. 12:49

A. Mm-hmm.

166 Q. Dr. Rankin is inviting you to handle the issue. You were due to speak to the three clinicians to talk about speciality issues. Was further work done on this issue? 12:49

A. Yeah. I can't recall the conversation with the three clinicians, I genuinely can't, but I do know that there was further work done, and I do know that there was a scoping exercise across all consultants and their secretaries to ascertain what their process was for reading results. I do know that there is a report somewhere there in the system to say what that looked like. In each and every case, including Mr. O'Brien's secretary, reported back when the results were got, she attached them to the chart, she set the chart on his desk and either he or his Registrar would have signed off those results. That was a pretty consistent theme that came back from all the surgeons and their secretaries that that was the process. That scoping 12:50 12:50

was done in the December of that year.

167 Q. I will just bring up that, TRU-164392.

A. Yes.

168 Q. This is you writing to Margaret Marshall?

A. She was the Head of Governance for acute at that time. 12:51

169 Q. You are attaching responses received so far?

A. Yeah.

170 Q. I'm not sure if the responses lie behind that, but what was the conclusion reached as a result of this process?

A. The conclusion was that every Consultant and their 12:51 secretary had a process whereby, simply, when they come back they were set in front of the Consultant, in some shape, make or form, and they would have looked at them, them or their Registrar.

171 Q. The issue flares again in general, I suppose, in 2016, 12:51 so far as we can establish. If we could bring up on the screen, please, TRU-277936. You are writing -- there had been several SAIs, I don't think those SAIs relate to Mr. O'Brien in this context?

A. No. 12:52

172 Q. It's a more general issue --

A. Yes, yes.

173 Q. -- that you are concerned about:

"We are writing to remind all consultants that it is 12:52 their personal responsibility to check and sign all urology and pathology reports to assure that no serious results are missed. Any concerns regarding the process of how these get to your attention should be raised

with your secretary in the first instance."

A. Mm-hmm.

174 Q. Is it the case, Mrs. Trouton, that although this issue was raised in 2011, and you wrote, carried out this scoping exercise, there was nothing put in place to audit compliance with what appears to be a fairly common sense obligation? 12:53

A. No. No, there wasn't. But off --

175 Q. Or even an alert system using technology, for example?

A. Again, back then, technology wasn't as strong a feature, we were still doing paper copies of things. But, no, I don't recall putting in a process whereby we would have intermittently or snapshot audit of results being read and acted on. Sorry, didn't. 12:53

176 Q. Does that, upon reflection, seem excessively trusting of busy clinicians, to be kind, that they would carry out the job expected of them? Where is the safety net in that system? 12:53

A. I think, again on reflection, a large body of thought is, you know, what does a normal Consultant do, what do nine out of ten consultants do or 9.9 out of 10 Consultants do, and the practice was generally very robust. So the thought process of going back in and checking probably wasn't as thought through as it could have been and should have been. Is it being done now? Probably technology enables it much easier to be done now than going back and doing an audit. In hindsight, of course, it would have been helpful. Would the capacity have been there to do it is another question, 12:54 12:54

who would do it? I'm not saying it shouldn't have been done it, but again the capacity, who was going to do it, how we were going to do it. You could do a snapshot audit this week and something falls through the net next week, yeah, but yes, it would have been helpful, absolutely. 12:55

177 Q. I ask these questions from the perspective that, in 2020, Dr. Hughes conducts a series of SAI reviews and, from his perspective, and there are other perspectives on this, he sees two cases; one where a CT scan is apparently not actioned for eight months, revealing metastatic spread, and a second case where there's a significant delay in actioning a pathology output. Did anybody think to ask Mr. O'Brien, on the back of his e-mail in 2011, apparently pushing back against what you might regard as orthodoxy, "are you going to change your approach?" 12:55 12:56

A. I am sure that question was asked, and I think if you look at the scoping template, Mr. O'Brien's secretary did give the assurance that the results were put in front of him or the Registrar, so that gave an assurance that the process was there. How you act on the result is up to the Consultant. You see it, you read it, and you take action. 12:56

178 Q. Was there an expectation within the system, whether written down or informally, that the medical secretary should report to their line management departures from the norm or departures from the expectation? 12:56

A. I think I recall some memo or protocol whereby the

secretary is required to alert if there are any issues or concerns, sorry, I don't know the reference but I'm pretty sure that was part of it.

179 Q. In 2016 when you had to write again on this issue, was that how it was left, with that e-mail, no change in the system? Because the interpretation that might be placed on the several SAIs is that these shortcomings had gone undetected until an adverse incident occurs? 12:57

A. There certainly was the discharge awaiting results process that was put in place where the secretaries were to hold a record and it was coded as DARO against it so that patients wouldn't get lost in the system and that the investigation result had to come back, had to be a decision made on it before the secretary could discharge that person either as in discharge them completely, discharge them on to a review, you know, Outpatient appointment or theatre. So there was a process put in place for the secretaries and there most definitely was a case where those were being held until actioned. So again that was felt to be another fail-safe mechanism to ensure that patients weren't forgot about. 12:58 12:58 12:58

180 Q. We heard evidence from Mr. Haynes, and I don't have the e-mails to show you, that Mr. O'Brien and his secretary didn't use the DARO system? 12:59

A. And I was unaware of that.

181 Q. You are unaware.

A. Sorry.

MR WOLFE KC: It's coming up to one o'clock, I was

going to move on to another topic but I think will we break now?

CHAIR: 2 o'clock?

MR. WOLFE KC: Thank you.

CHAIR: Can I just ask, I see the person who I assume is Mr. Wright present, do you expect to be much longer with this witness? 12:59

MR. WOLFE KC: I expect that given that you will have questions for this witness, and I probably have another 90 minutes or so to go, that it's unlikely that we will take Mr. Wright today. I would hope to complete him tomorrow. 12:59

CHAIR: Just in ease of Mr. Wright, if he wishes to stay this afternoon, that's absolutely fine, we are not pushing him out the door, but if he has other things to do which he wishes to attend he is certainly not going to be dealt with then today. 13:00

MR. WOLFE KC: I don't like surprising you but perhaps over lunchtime people could think about whether a slightly earlier start might be feasible tomorrow. It may not suit you and if so -- 13:00

CHAIR: We will certainly discuss it over lunchtime and see whether it's feasible.

MR. WOLFE KC: If it's feasible amongst everybody else we might have consensus on that but we can discuss it after lunch. 13:00

CHAIR: Okay. Thank you. Back at 2:00 then, ladies and gentlemen.

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon. 14:02

182 Q. Could I pick up, Mrs. Trouton, just on two discrete points before I get back on my intended path. This morning, you were giving some evidence in relation to Mr. O'Brien's job plan.

A. Mm-hmm. 14:02

183 Q. We exchanged some discussion in relation to PAs and I think it was at page 42, or thereabouts, of the transcript -- we don't need to bring it up, just for the panel's note -- you reflected an understanding that Mr. O'Brien had something like 3.75, was the expression 14:03 you used, PAs, and it was your understanding, as I heard your answer, that that related to administration. Can you tell us where you have got that from? What is your understanding of the specific figures of PAs for administration? 14:03

A. I think I read that somewhere in all my witness bundle, it was certainly 15, as you know, originally, in total, and I read somewhere that the additional were admin, but I could be wrong, it wouldn't have been my area of expertise. 14:03

184 Q. We looked at a document when you were in the chamber I think maybe yesterday, it could have been last week, and I will just bring it up. AOB-00131. This was Mr. Mackle writing to, from memory, Mr. Carroll.

I could be wrong. No, Mr. Gibson.
A. Yes.
185 Q. As you can see, "Dear Simon", as he writes this there are already 3.87 PAs of admin time in his current job plan. Certainly, Mr. Hanbury was asking questions of 14:04
Mr. Mackle about that yesterday. Would it surprise you to know that Mr. O'Brien's analysis of his PAs for admin work was generally -- he would assert that it was generally less than one per week. In other words, he
disagrees with any suggestion that he had 3.75, as you 14:05
said this morning, or 3.87, as is contained in that letter, and we looked at Dr. Murphy's letter this morning as well. Have you any thoughts on that? Was he as low as one PA per week for admin, or is that
something you don't have a view on? 14:05
A. One PA for admin would be, in my reflection, recollection, normal, and I think he was on one PA.
186 Q. You think he was?
A. For admin in his new job plan.
187 Q. In other words, after Dr. Murphy's introduction? 14:06
A. After Dr. Murphy's --
188 Q. After the facilitation?
A. Yes.
189 Q. Thank you. But prior to that?
A. I don't know prior to that, other than what I read in 14:06
that note that is on the screen. As I said before, job planning wouldn't have been a key part of my role.
190 Q. Yes. We will hear undoubtedly from other witnesses on that and from Mr. O'Brien.

A. Yes.
191 Q. Just another discrete issue, if I can, before going back to the incidents. You reflect in your witness statement about your understanding of Mr. O'Brien's referral to, or not as the case may be, of nursing staff in the cancer context. If I could just bring up what you have said about that. It's at WIT-12121. And paragraph 397, please. You say:

"Knowing what we now know regarding the practice on occasions of Mr. O'Brien not referring patients on for treatment post diagnosis nor referring patients with a cancer diagnosis to the specialist cancer nurse for support with follow-up, I would have to say that the extent of the issues in this regard were not properly identified at the time."

Do you have a specific understanding of the obligations in the context of the Urology Cancer MDT for referral to the cancer nurse? 14:06 14:07 14:07 14:08
A. I know now, yes. I know that it was part of the key worker role, and certainly now in the bigger specialist nurse pool that there currently is, I'm aware of that.
192 Q. Yes, yes.
A. Yeah. 14:08
193 Q. In the context of the SAI reports that were performed by Dr. Hughes under his leadership in 2020, he points the finger generally at Mr. O'Brien for failing to make the referral. Is that where this piece of evidence

from you comes?

A. I think so, yes.

194 Q. Let me refer to you this document, WIT-84545. This is the Trust's protocol which was extant at the time when these SAIs arose. It provides that: 14:09

"It's the joint responsibility of the MDT Clinical Lead and of the MDT core nurse member to ensure that each Urology cancer patient has an identified key worker and this is documented in the agreed record of patient 14:09 management. In the majority of cases the key worker will be a Urology Cancer Nurse Specialist."

The point I am asking you about is; would you have had knowledge of that when you wrote your or did your 14:09 knowledge contained in your statement derive from your understanding of what the SAI reviews were saying?

A. The latter.

195 Q. Okay.

A. Because when I was probably AD in 2009 and beginning of 14:09 '16, the key worker, there was only two, I believe, specialist nurses back then. The team didn't evolve until after that, so I was probably referring to the SAIs, yes.

196 Q. Just before lunch we were looking at the issue of the 14:10 obligations of clinicians to review the results of investigations, and I think I concluded on that aspect.

Could I ask you about pre-operative assessment? As

I said earlier, your witness statement identifies recurrent issues with respect to Mr. O'Brien, we have looked at some of them, and also what might be regarded as singular issues or issues that came up not very often.

A. Mm-hmm.

197 Q. In 2015, I think you have told us that an issue to do with pre-operative assessment was drawn to your attention. If we could just look at what you have said about that. WIT-12126, and bottom of the page, paragraph 416A at the bottom:

"Singular issues noted to have included the following" and you have explained:

"Not referring patients for pre-operative assessment in a family fashion or at all. This was brought to my attention in November 2015 for the first time."

It's not an issue that came across your desk apart from this one incident, with Mr. O'Brien?

A. Yeah. I don't recall it to be a regular thing that came across my desk, no.

198 Q. I think we looked at the documentation in association with that yesterday, with Mr. Mackle. I can bring it up on the screen for you. TRU-277929. I will just work backwards through this e-mail chain. The bottom of the previous page, so it's somebody called Rachel Donnelly writing to Mary McGeough. Mary McGeough is

responsible for theatres?
A. Head of Theatres.
199 Q. The issue concerns Mr. O'Brien's theatre list. It says the list was sent to someone on Friday out of the five patients three have not been pre-oped, and that leads to certain consequences. If we scroll up, please. The concern from Mary is she is asking this to be investigated, you are copied into the e-mail. They are now in a position where they are unable to bring these three patients to theatre because of the absence of pre-op in the time available to him. Is that what you understood to be the problem? 14:13 14:13
A. Yes, yes.
200 Q. She asks: "Have all of these patients been seen somewhere other than at his Outpatient clinic." Do you know what she is getting at there? 14:14
A. I don't know what she's getting at, but at Outpatient clinic, part of the, it's my understanding and remembrance, whenever you are listed for surgery you are automatically referred to pre-op assessment, so that's the process. But it wasn't unusual for consultants to see patients in their own office. I am not talking about Mr. O'Brien specifically, I'm talking generally. Some consultants -- 14:14
201 Q. Do you mean privately or within the NHS system? 14:14
A. No, not privately, within the NHS system. They may come back for results, for example, and they may need to come back for results outside of an Outpatient clinic if they are particularly urgent, or maybe bad

news had had to be given or something like that. I think she was probably referring to that more than anything.

202 Q. Did you investigate it? Just scroll up. You ask a question: "Have you the lists for this?" I am not sure it's taken much further by e-mail? 14:15

A. Probably looked at the lists when they were listed, et cetera, et cetera. It wasn't that unusual because pre-op assessment, I can't remember what year it went in, but it did go in certainly as a service during my time. But if patients had investigations that had come back or that were needed to be operated on quite quickly, it wasn't completely unusual for a decision to be made relatively short between the decision to operate and the actual theatre list if the urgency was thought to be sufficient. Therefore, it wouldn't have been that unusual for the timescale to be not -- because not everybody was taken off a chronological waiting list, sometimes something happened that you needed to be operated on pretty quickly. 14:15 14:15

203 Q. Can I ask you about private patients. You have said in your witness statement, WIT-12127, that periodic concerns regarding listing patients, Mr. O'Brien had seen privately as Outpatients but referring to NHS for surgical treatment and listing these patients in a short time frame, when noted and asked regarding the short waiting time for surgery, Mr. O'Brien would always have had a clinical justification for the short wait. This concern arose at various times throughout 14:16

your tenure as AD.

Mr. Mackle seemed to think that you had addressed Mr. O'Brien on occasion in relation to this issue. Is that right? 14:16

A. It was usually Martina. It was usually Ms. Corrigan that would have challenged the decision, yeah.

204 Q. Do you have recollection of challenging?

A. I have no recollection personally. That's not to say I didn't, I just can't recall. 14:17

205 Q. How would the issue escalate to Martina, who would be --

A. So Mary McGeough, the Head of Theatres, on occasion and it wasn't very frequently, would have -- because she had a scheduling meeting, and she would have pointed 14:17 out that there were patients on the theatre list a short time from decision to operate to the theatre list itself. Again, if that was for a cancer patient that would not have been unusual, but if it would have been for more of a routine procedure that was more 14:17 unusual, so she would have pointed it out periodically. Then most regularly Martina would have asked Mr. O'Brien and he would have had a very robust clinical explanation for why the patient was on the list. 14:18

206 Q. Mm-hmm. The fact that Ms. McGeough is looking at this and noticing it, does that suggest that there is some message from the organisation to someone like her to be on the lookout for abuse of NHS facilities?

A. If there was I wasn't aware of it. I wasn't aware of any specific instruction to look out for that.

207 Q. You now know that, pursuant to the MHPS investigation, the question of the unfair advantaging of private patients was looked at in the context of Mr. O'Brien's practice. Prior, even, to that, Mr. Haynes had raised issues with both Ms. Corrigan and Mr. Young. I just want to ask you about that. The raising of these issues by Mr. Haynes, was that drawn to your attention? 14:18

A. No. When I saw those e-mails in the bundle, that was for the first time, as I recall. The language was strong, and I am sure if I would have seen it, I would have remembered. 14:19

208 Q. Let's just look at some of the language. WIT-54106. This is the second of the interventions by Mr. Haynes. He is referring back to June 2015. In fact, I think his e-mail was May 2015, but leaving that wrinkle aside, he is writing again about the ongoing issue, as he describes it, of patients on waiting lists not being managed chronologically and, in particular, private patients being brought on to NHS lists having significantly jumped the waiting list. He says: 14:19 14:20

"As I have been through our inpatient preparation for taking over the on-call today I have once again come across examples of this behaviour continuing". 14:20

He gives specific patient examples which we will redact in due course. He says:

"I have expressed my view on many occasions. This is immoral and unacceptable."

He goes on to say: "The HSC board can see it when they look at our service, and any of our good work is undone by this. Can you advise me what action has been taken since I raised this?" 14:20

So a senior clinician raising a concern with operational and medical management about what he perceives to be an abuse of the system by a fellow senior clinician. That's pretty serious stuff, isn't it? 14:21

A. Absolutely.

209 Q. It should have reached your desk? 14:21

A. I would have thought so. In saying that, that is November 2015, I believe.

210 Q. Yes.

A. That might have been yet another trigger to the discussion then that ensued with Dr. Wright, December/January. I genuinely can't recall, I certainly don't remember seeing those e-mails, but the timing would be such that it may be yet another trigger for the referral. 14:21

211 Q. Apart from anything else, placing a non-clinician such as Ms. Corrigan, relatively junior management -- 14:21

A. Middle, I would say.

212 Q. Middle. She's not in a position to effectively place a challenge on this issue?

A. No.
213 Q. It shouldn't have been left to her?
A. No, it needed to be a peer challenge by somebody who would understand and be able to effectively discuss the rights and wrongs, pros and cons of listing somebody within that short space of time, as per their clinical presentation. 14:22
214 Q. The issues that we have looked at, I think you have said in your witness statement that there was no reflection of the concerns raised regarding delays in patient triage, retention of notes at home, the issue of patient-centre recording, which we are going to look at. None of that reflected in governance minutes or discussed at governance meetings? 14:23
A. No. Rarely any singular practitioner would have been discussed. In fact, it wouldn't have been discussed at a group meeting. 14:23
215 Q. Is that because of the sensitivities around identifying a specific individual in association with shortcomings?
A. Yes, yes. 14:23
216 Q. It was more often a one-to-one?
A. Yes.
217 Q. Informally and rarely recorded?
A. Yes.
218 Q. The risk register provides a particular function of governance -- 14:24
A. Yes.
219 Q. -- within the organisation as a whole. Anita Carroll I think, was it suggested to you that as regards, for

example, the retention of the notes at home, as we now know, is that something that should be considered for Risk Register, and your answer to that, TRU-277895, is that you will consider the Risk Register, although with that, you are supposed to address the risk and eliminate it. This is down to a personal way of working which seems impossible to stop. 14:25

Two points: This wasn't really a Risk Register issue, is that your view? 14:25

A. That's my view. It was impressed on us by Dr. Rankin and others that the Risk Register was for more systemic issues and with a plan to address and eliminate and take off and then new risks come on, and it was a live Risk Register. This was an individual's way of working. I didn't have an issue systemically with notes at home across the patch and I didn't think it was appropriate to -- in fact, it wouldn't have been appropriate to put Mr. O'Brien's personal way of working on to a Risk Register. 14:25 14:26

220 Q. Two points on that: I suppose the systemic issue with the structural issue was the inability of the systems, as then imagined and implemented, to effectively trace the whereabouts in a timely fashion of the medical records? 14:26

A. There was a system in place of tracking, but it wasn't sophisticated enough to track outside of the hospital. So it wasn't a bing, bing, or an alert system or as we might have a Wi-Fi system or whatever, and probably, at

that stage, it wouldn't have been available either, so we probably had the best system that we could in place at that time, it just didn't cover this particular issue.

221 Q. The second point is this: It seems impossible to stop, and I'm sure, when you think about that, you would recognise that you couldn't have meant that literally. It was possible to stop if the right kind of strategy was adopted and the right, I suppose, level of robustness was brought to the piece? 14:27

A. Yes.

222 Q. That was part of the thinking for going to Dr. Wright in 2016, is that right?

A. That would be correct, yeah.

223 Q. You have said, to go to your witness statement again at WIT-12008, paragraph 68, that it was in the context of discovering that Mr. O'Brien wasn't completing dictation on clinics that you went to Dr. Wright. I just want to look at that. First of all, can you recall how this, what I take to be a new issue, came to your attention? 14:27 14:28

A. I believe it came to my attention because in 2014/'15 we'd established an expanded team of Urologists, Mr. Haynes being one of them. They didn't have, is my understanding, a review backlog because they weren't there long enough to have one. They then started to review some of Mr. O'Brien's patients and when they started to do that in 2015, they discovered gaps in his record-keeping. That was reported through to 14:29

Ms. Corrigan, who reported it through to myself and Mr. Mackle. Around the same time, we had the issue of the triage having slipped significantly again, and although I can't recall it being a key issue, we have Mr. Haynes' e-mail around the private patient issue. So there's a lot that kind of came together of new issues around that end of 2015, collective.

224 Q. Were these new issues, as you describe them, were they qualitatively any more significant than what you had to address over the period of several years before that? 14:30

A. I think so. I mean, I think any clinician of any profession knows that good record-keeping is really important, and to discover vast gaps in record-keeping was, to me, a different level of admin issue.

225 Q. We don't see on our papers at least, so far as current searches go, any repetitive evidence of this problem that you allude to, this issue of patient notes not being properly attended or, to put it more specifically, review outcomes from clinics not being properly attended to. Is there any reason for that? Did a report come up or was it just word of mouth? 14:30 14:31

A. No, I think it was genuinely the concerns expressed by the new consultants, who now were having access, for reason of their workload, to see those notes.

226 Q. I will draw your attention to one example which I think we looked at yesterday with Mr. Mackle. If you go to TRU-258494. You will note the name of the patient, bottom of the page, 14th July 2015. Mr. O'Brien's secretary is being asked about an attached referral 14:31

concerning that patient to be forwarded to Mr. O'Brien and an outcome is to be advised. If we can slowly scroll up, please. We are now in August and there's been no answer from Mr. O'Brien.

14:32

"Does this patient require a review or is it just for information?"
"Said the patient was seen in June."

It's now October. The patient has not been discharged 14:33
or reinstated for a review following last attendance. Please advise of Mr. O'Brien's decision in the attached referral. Is the referral for information or urgent or routine review? It's now November, no response to the queries. 14:33

It says: "No follow-up has been arranged". Now late November: "Can you check the outcome sheet to see if he needs reviewed, discharge, please?" In the next e-mail it said: "This Consultant does not use clinical 14:33
outcome sheets. The clinic decision is outstanding" and it's now December.

Martina Corrigan asks for a discussion with Mr. Young and he replies, indicating that he is not concerned 14:34
necessarily about the patient's condition, but he says that the patient and the GP are out of the loop and the options are to put it back into Mr. O'Brien's review clinic or send an e-mail to Mr. O'Brien asking for his

outcome of the consultation, and if no response then the patient to be added to one of his clinics.

When you speak about this issue that the clinicians conducting backlog validations, are doing, this isn't a backlog validation? 14:34

A. It doesn't seem to be, no.

227 Q. But is this similar to the kinds of issues that were being brought to your attention?

A. Yes. I didn't see that series of e-mails at the time, but yes, it would have been similar, obviously no record of next steps. 14:35

228 Q. Perhaps stating the obvious, but what kind of consequences can that shortcoming produce? What would be the potential impact for the patient? 14:35

A. Well a gap in their plan, so whether they needed reviewed, a treatment, surgical intervention, discharge, there's a gap.

229 Q. In terms of the process of bringing issues together and discussing them, by this stage your Director had changed, it's now Esther Gishkori, from I think June 2015 or thereabouts? 14:35

A. Yes.

230 Q. The Medical Director had changed. It's now Dr. Wright, from, again, the middle of 2015. Was the changing of the guard in either of those positions impact or a factor on bringing the issues together and trying to get more formality or structure around them? 14:36

A. I believe I recall, on discussing it with Mr. Mackle,

the latest issues that had arisen towards the end of 2015, that it might be opportune with the new Medical Director in place, with fresh eyes and maybe a fresh approach, to bring these issues to the new Medical Director. I obviously brought them to Mrs. Gishkori as well. 14:37

231 Q. Yes.

A. Yeah.

232 Q. You met with Mrs. Gishkori in December of 2015. If we just bring up a note of that. TRU-277934. Just that top section. We can see the date. It's a one-to-one with Esther. Is this your note? 14:37

A. Yes, that's my note.

233 Q. It is. Mr. Mackle not in attendance is this, is that right? 14:37

A. No.

234 Q. Is this part and parcel of how you and Mrs. Gishkori worked your responsibilities, there were periodical meetings to discuss latest developments and issues?

A. Yeah. We would have seen each other informally a lot and at meetings a lot, but monthly one-to-one, yes. 14:38

235 Q. Was this you bringing Mr. O'Brien's issues to her attention?

A. Yes.

236 Q. You have highlighted Urology, AOB charts, that's the retention of charts at home? 14:38

A. Yes.

237 Q. "No patient centre letters"?

A. That's the latest issue, yeah.

238 Q. And "triage"?
A. Yes.
239 Q. A plan is recorded, a letter one month to improve?
A. Yeah.
240 Q. Can you say what that means? 14:38
A. I think probably what had happened was Eamon and I had discussed this. I believe he went off to talk to the Medical Director. I probably went off to talk to Ms. Gishkori. I was probably advising her that we believed we needed to do something more robust, put 14:39 a plan in place, make it more formal with a letter and seek improvement. I was probably asking was she supportive of that approach.
241 Q. There was to be a meeting with Dr. Wright on 11th January, I think you recall it as? 14:39
A. That's right.
242 Q. You attended that?
A. I attended it, yeah.
243 Q. At that meeting Dr. Wright advised you and Mr. Mackle to put the concerns in writing to Mr. O'Brien and 14:39 request an action plan to address them.
A. Yes, that's right.
244 Q. In terms of that meeting, first of all, can you recall it with any clarity?
A. I do recall it, yes. 14:40
245 Q. We have looked at 2009 and the Chief Executive meeting and we saw a handwritten note produced by you, speaking about the audit of triage issues. To the best of your recollection, is this the first, sort of, sit-down

formal meeting with a senior medical manager in the intervening period to try to get to grips with the difficulties faced and posed by Mr. O'Brien?

A. The normal interface with the Medical Director would usually have been either with the Associate Medical Director or the Director for Acute Services, so I can't say whether there were intervening meetings, but this was the first meeting, as I recall that I was at that was with the Medical Director around this specific issue, yes. 14:40 14:41

246 Q. At that time, in terms of more local management on the medical side below, obviously below Mr. Mackle, Mr. Young was obviously still Clinical Lead?

A. Yes.

247 Q. Mr. Weir had replaced Mr. Brown as Clinical Director, is that right? 14:41

A. I am not 100% sure --

248 Q. Or is that a bit later?

A. I think that was later.

249 Q. Okay. Had you, in dealing with these issues with -- now dealing with them with Mr. Mackle, why was he coming into it at this stage against the background of what you had previously said, he had taken a back seat because of allegations made or apparently made or brought to his attention in 2012? 14:41 14:42

A. I think because it wasn't the same thing, it was different, it was definitely more serious, and Mr. Mackle was always there in the background. This wasn't a meeting with Mr. O'Brien in the first

instance, this was to take advice from the Medical Director, which I am sure Mr. Mackle worked closely with, so I think it was felt appropriate that it was Mr. Mackle and myself and the Medical Director who met.

250 Q. Can you remember who, and maybe it was more than one person, decided that this was now more serious, as you are describing, more serious, as I think you have described, because we have got this new issue that was qualitatively different, other things hadn't gone away, I think, in terms of what you were told around that time about triage, there was a significant collection of a couple of hundred plus outstanding triage. How did it achieve this elevation into more serious or to be regarded as more serious? 14:42 14:43

A. I think it was the actual issue itself, but I think another factor was that we now had consultants in Mr. O'Brien's peer group that were obviously willing to speak up and willing to say this is not normal, this is not acceptable, this is not what we would expect as a group of consultants. I think that injection of new people probably really helped and assisted in, and was something new. I think that was probably a factor as well. 14:43 14:44

251 Q. Did you field complaints or did you even engage in conversations with these new consultants pointing to the difficulties? 14:44

A. No, they wouldn't have came to me; they would have gone to Mrs. Corrigan.

252 Q. I think you reflect in your statement that, with the

smaller group of consultants, the peer challenge wasn't there. It was certainly less obvious and perhaps less effective, but when it had grown five members in the Consultant team, these new and younger consultants were willing to challenge peer practice and that made a difference. You say that at WIT-12146, just for the panel's note. Can you help us more with that dynamic? Was it a question of, from your perception, Mr. Young, Mr. O'Brien, Mr. Suresh growing up together in the service and being perhaps the same age band broadly, a cosier relationship there and these new kids on the block, if you forgive the expression, being less respectful of bad ways of doing things? 14:45 14:45

A. I think again nothing is ever simplistic, it's multifactorial but certainly Mr. Haynes had worked in England. He had worked outside of the Northern Ireland system and had expectations of practice that he brought in to the team. I think once he built up his confidence, confidence as a member of that particular Urology team he began to notice and be courageous enough to say this isn't acceptable. Just like anything, I suppose Mr. O'Brien's maybe influence was diluted in a bigger team rather than a team of three. That's me reflecting back on what that might have been. I wasn't in that team so it's hard for me to say. 14:46 14:46 14:46

253 Q. In advance of going in to see Dr. Wright, did you meet with Mr. Mackle to strategise, if you like, and that's maybe a grander express than what you were thinking, but did you have an objective in going to Dr. Wright in

terms of what needed to be done and how you were going to explain that to Dr. Wright?

A. I suppose my objective was, strategise is probably too strong a word, but my objective was to take a different approach, a new formality, seek Medical Director support to do something different to bring to his attention the latest issues, but also to set the latest issues in context with the previous number of years, and Dr. Wright was relatively new in post so he did need to be brought up to speed because it was within the context of everything that happened before, it wasn't an isolated incident, and it was really just to bring it to the Medical Director's attention and seek his guidance. 14:47 14:47

254 Q. Mm-hmm. To the best of your understanding, was this Dr. Wright's first engagement with these issues; in other words, the difficulties posed by Mr. O'Brien's practice had not been brought to his attention prior to this? 14:48

A. I can't say for sure because I wouldn't have had a lot of direct interaction with any Medical Director. It may have came across his table, but it probably was one of the first times certainly it came across his table, I would imagine. Eamon might have mentioned it to him in a one-to-one previously, I really don't know. 14:48 14:48

255 Q. In terms of the gravity or the scale of the problem and its consequences for patients or potential consequences for patients, how was that described to Dr. Wright?

A. I suppose, as I have tried to describe it here, the

issue around triage and the potential to miss an upgrading, the issues of notes and unavailability for other clinicians, obviously the gaps in record-keeping, the dangers with review back -- just the usual, just as I would have explained it to you, I explained it, as did Mr. Mackle, to Dr. Wright. 14:49

256 Q. Was it placed on the footing of a patient harm or patient risk issue?

A. I would say yes and a professional practice issue, both. 14:49

257 Q. I mean it's probably difficult to recall precise words, but the Patient Safety or patient risk, was that implicit in your view, or was it made explicit?

A. I really can't recall how, whether it was implicit or explicit. I genuinely can't. But the issues were discussed in full. 14:50

258 Q. Do you think, given the nature of the issues that you were raising with him, that the patient risk for potential harm arising out of such shortcomings was obvious? 14:50

A. I think so.

259 Q. In terms of what was concluded at the meeting, you have said you went away with -- essentially the plan was to produce a letter to Mr. O'Brien and to meet with him. In terms of the oversight of that process as it had been agreed at that meeting, did you expect Medical Director input going forward in terms of oversight of what would be done, or even in terms of input with regard to Mr. O'Brien, or was this going back to the 14:51

Directorate for you to take forward?

A. I think the expectation probably was, in the first instance, for the Directorate to formalise the concerns with Mr. O'Brien, seek his adherence to a different way of going, monitor that, and then, I would presume, refer back to the Medical Director to say look, we met January, we did what the plan was, it hasn't been successful, what next? That would have been my anticipation of events. 14:51

260 Q. But that wasn't spoken out loud? 14:52

A. No.

261 Q. No. It was, here's the plan, you guys get on with it, and the expectation would be in the normal course, if it worked, great, no need to report back; if it didn't work, you knew where his office was? 14:52

A. Yes, I think that's fair to say.

262 Q. Yes. Again, in terms of MHPS, which we all know about now, this wasn't, at least explicitly through Dr. Wright put on an MHPS footing? This wasn't articulated by him as a preamble to something that could come down the line in terms of an MHPS process? 14:53

A. No, I don't recall MHPS being discussed at that meeting.

263 Q. In terms of other assistance, was Human Resources discussed as being a relevant and helpful input at this stage? 14:53

A. Not that I recall, no.

264 Q. Zoe Parks, who was Human Resources with responsibility for the medical side, is that --

A. That's correct.
265 Q. She has reflected, and I paraphrase here, that at a moment like this when you realise that really something has to be done because there are obvious shortcomings in practice, you really ought to have brought in HR expertise and reflected on what we are, as a team, trying to do here, and part of that would have been to take a deeper or perhaps broader examination of all of the potential issues. That, clearly, wasn't suggested? 14:54
A. No.
266 Q. And wasn't done. You proceeded to the meeting ultimately with Mr. O'Brien on the basis of the issues that you knew about?
A. Yes. 14:55
267 Q. Can I ask you for your reflections on those observations from Ms. Parks. Do you think back at that moment and think, really, if we'd thought more carefully through this, we needed to get a fuller and better understanding of what was going on here before moving to the meeting, or do you think, in the alternative, that a meeting on the basis of what you knew at that time, was an inevitable and urgent step? 14:55
A. I think how we felt at the time was some of the issues were well-evidenced over a number of years. The latter issues, I believe we had enough knowledge, evidence, examples, to at least bring it to, first of all, the Medical Director's attention and then obviously Mr. O'Brien's attention. I think after so many years 14:56

of that we have gone through today, of very little, only encouragement and support, I felt this was a real opportunity but it was the start of something, not the end of something, and it was the start of something that was more formal. Again, sorry, I was unaware of the MHPS process, but I certainly felt this was something that was at a higher level, and it was the start of a process as opposed to a one-off.

268 Q. Yes. Because obviously you were going to this meeting with what turned out to be four issues. Private patients wasn't part of that at this point? 14:56

A. Yes.

269 Q. It came into the process much later and after your time?

A. Yes. 14:57

270 Q. But, as we have observed this morning, there had been other issues, some of which were resolved. You got pushback on some issues, none of which, if you had reflected, would have given you much confidence, perhaps, if you joined the dots together, that this was necessarily a safe practitioner. So at what point, if you thought about it, would you have had an opportunity as a next stage to do something deeper or wider by way of exploration of all aspects of his practice? 14:57

A. I suppose as things transpired from 2015 on, there was definitely opportunities there, I think, to look in more detail. Following the discovery of patient centre or record-keeping, for example, which was relatively new, there was an opportunity there to delve much 14:58

deeper into that. But as I said, I expected the meeting with Dr. Wright and the subsequent letter and plan to be the start of that exploratory process, as opposed to the end point.

271 Q. Just looking back again, Dr. Wright's perspective, if we could have it up on the screen, please. WIT-17865. At 39.4, he says: 14:58

"In retrospect I believe the issues of concern that related to Mr. O'Brien had been managed for too long exclusively within the Directorate on an informal basis. Once it became clear that the measures put in place were not proving as effective as they might have been, I would have expected that this would have been shared more forcibly at an earlier stage." 14:59 14:59

Is that something you would agree with?

A. I think as Dr. Wright wrote that, he probably was reflecting maybe on his term. I think if you look at the evidence we have seen today and other days when you think back to the note of 1st December 2009 meeting when the Chief Executive and Medical Director were there, when Dr. Loughran dealt with numerous issues that were escalated to him over the period of time, when the Director of Acute Services no doubt had interface, as did the Associate Medical Director, with other Medical Directors, and we have seen Dr. Corrigan has certainly included Medical Directors in her correspondence, I think it is unfair to say that it was 14:59 15:00

kept exclusively within the Directorate. I think it definitely made its way out of the Directorate.

272 Q. In terms of appetite for challenge, if we just scroll down to the next page, please, at paragraph 42.2, please. He says in his opinion with hindsight it seems 15:00
that there was significant data available regarding many of the key issues. As he sees the issue, the main factor was a reluctance to formally address the issues identified rather than any lack of data. Your reflections on that? 15:01

A. I think it would be difficult not to agree with that.

273 Q. Yes. Although, in fairness, certainly there were some issues that were tackled formally and head on, notably the antibiotic issue?

A. Yeah. 15:01

274 Q. The meeting with Dr. Wright, you didn't record it; you appear to be a note-taker as we have seen, but that meeting wasn't recorded by anyone, it seems?

A. It mustn't have been because I did keep all my notebooks, as I do, and I had no note of that 15:01
particular meeting, sorry.

275 Q. The meeting with Mr. O'Brien doesn't take place until the end of March, I suppose three months, four months perhaps --

A. Yes. 15:02

276 Q. -- if you work from December, since there had been, I suppose, a consensus between yourself, Mrs. Gishkori and Mr. Mackle that something more formal had to be done, obviously Dr. Wright's meeting in early January?

A. Yes.
277 Q. Can you explain the delay in getting to the meeting stage on 30th March?
A. I genuinely can't. I see Mrs. Corrigan had a draft of the letter done on 18th January. 15:02
278 Q. Yes. She writes I think TRU-277940.
A. I can only assume that following the draft -- sorry. I will wait until it comes up.
279 Q. Yes. She is apologising, thinking she has delayed and she is getting it back within a week of the meeting? 15:03
A. Yes.
280 Q. She put into it presumably information, we don't have that draft, as far as I'm aware?
A. No.
281 Q. But information around the extent of triage backlog at that point, et cetera. It's 16th March by the time you're getting back to her. That's not to say nothing is happening in the meantime, but was anything happening in the meantime? 15:03
A. I find it difficult to recall, but I would assume I went through the original draft, the initial draft, we probably redrafted it a couple of times just to get things correct, and then it looks as if I was waiting on Mr. Mackle for his views, and eventually obviously I got Mr. Mackle's views on 16th March and then thought by that stage, the data is probably out of date, need to refresh the figures as to what exactly it looked like in March, and then we were ready to send after that. 15:04 15:04

282 Q. You, judged by your note, I think TRU-277941, you met -- well, it says Esther and Eamon, you were at the meeting as well, this is your handwriting?
A. Yes, it's my handwriting.
283 Q. "Need to get letter to AOB this week"? 15:04
A. Yeah.
284 Q. Does that reflect on impatience on the part of Ms. Gishkori to get on with this?
A. Yes, or me.
285 Q. Or you. Okay. But you can't help us in terms of why the delay? 15:05
A. I genuinely can't. It could have been, it probably was a conglomeration of I am on leave, Mr. Mackle is on leave, waiting on people coming back. The usual things. It wouldn't have been intentional. 15:05
286 Q. If we go to the letter, please. I think it's TRU-282022. Just bring the letter up now. Do you think you had some hand in the drafting as well?
A. Realistically, Martina probably drafted the bulk of it and I probably changed bits or not changed bits, is usually what happened, yeah. Sorry. 15:06
287 Q. Just bring the letter up. In terms of the meeting and what you and Mr. Mackle wanted out of it, I mean, I assume in big-picture terms you wanted Mr. O'Brien to follow your path or the expected path around each of these four issues? 15:07
A. Yes.
288 Q. But in terms of making that happen, what was the thinking? How was this going to be achieved, either at

the meeting or using the letter or a combination of both?

A. I think my thought process was, it was formalising some of the issues that we had been encouraging and supporting over the years, and it was formalising it in a way that says: this is not acceptable practice. We need you to change and start complying with the way that you are expected to. Our expectation was that, at least, would prompt a conversation, would prompt a seriousness that maybe hitherto hadn't transpired and, as I said before, it was the start of a process as opposed to here you go, expected to be followed up. 15:07 15:08

289 Q. Obviously you weren't at the meeting. Do you know why you weren't?

A. I really don't. Again, it could have been, we would probably have been working around Mr. Mackle's job plan, so the times when he would have been free to have a meeting were probably fewer and farther between, if he was doing his clinic and his practice, and it just could have been that I wasn't available at the times that he was available, probably something as simple as that. 15:08 15:09

290 Q. Do you think in terms of the milestone nature of the meeting, the availability of somebody at Director level or Assistant Director level, in combination with the Associate Medical Director, might have carried a bigger punch or do you think that's a neutral issue? 15:09

A. I think for Mr. O'Brien the bigger punch would have been Mr. Mackle, and the less -- it would have been

perceived that myself or Mrs. Corrigan would have been there to support as opposed to lead the conversation, I would imagine.

291 Q. In terms of next steps, the letter was, on Mr. Mackle's account, handed over? 15:10

A. Mm-hmm.

292 Q. He sketched out the four issues without slavishly reading the letter. He doesn't think that he discussed any assistance or support that could be made available, but he thinks that he left Mr. O'Brien with the clear understanding that he was to take the letter, reflect upon it, and as it says in the letter, address the issues with a plan. You left for pastures new shortly thereafter? 15:10

A. Yes. 15:10

293 Q. You now know what happened?

A. Yes.

294 Q. Nothing happened until August/September?

A. So I believe, yes.

295 Q. What was your understanding of what should have happened next in the event of no response from Mr. O'Brien? 15:11

A. It would have been my understanding that if a plan was sought, then we should have expected a plan. If, within a month, that plan hadn't been received, I would have expected it to be followed up with Mr. O'Brien for his plan. 15:11

296 Q. Yes. We know that the letter contains no specific or explicit timetable and we know that there's no

reference to any next step or any hint or suggestion of a sanction in the absence of compliance. Do you think that that kind of material really ought to have gone into it?

A. Yes. In hindsight and knowing what happened it certainly would have been helpful, yeah. 15:12

297 Q. You would have expected a next step to be implemented if a plan wasn't received within a month. Mr. Carroll took over the role from you?

A. Yes. 15:12

298 Q. Did you share that expectation with him, do you think?

A. Yes, as part of the handover it definitely would have featured, yes.

299 Q. The issue of Mr. O'Brien and this discussion would have featured -- 15:12

A. Yes.

300 Q. -- but would you -- again it's perhaps difficult with the years that have passed to be specific, do you think you might have said really, we ought to give this another month and then act, or would you more likely have -- to have left the next step and the timing of it to his experience? 15:13

A. The letter -- I probably handed over to Ronan, it probably would have been a bit of that week, of the letter, the letter being on the 30th, I probably would have handed over to Ronan the week coming up to the 30th, probably would have said to him this is letter is going to Mr. O'Brien, shared with him the discussion with Dr. Wright, the general plan, general direction of 15:13

travel, whether I specified one month, I can't say, or whether it was this is the start of it, it's going to him and it will need followed up, I genuinely don't know. But I do know, from what I have read in the witness bundle, that I believe Mrs. Corrigan did e-mail Mr. Carroll around the end of April to say, and that would lead me to think that certainly from Martina and I's perspective we had thought of a month. 15:13

301 Q. Okay, thank you. But coming from the Medical Director's perspective, he is writing in late August to Martina Corrigan wondering what has gone on. 15:14

A. Mm-hmm.

302 Q. Again, I wonder to what extent this meeting, and given the deficiencies of the letter and the absence of follow-up, do all of those ingredients suggest that this was, let's get this meeting done and at least go on the record as having tried something; in other words, a box-ticking exercise before we leave to different jobs? 15:14

A. No, that certainly wasn't my objective with the letter. It genuinely was an attempt, with the latest information that we got coming through, to deal with this much more formally. It was just, as I said yesterday, it was a bad timing. It might have been bad timing that we all -- and of course when I moved on, as far as I was concerned there was continuity because Mrs. Gishkori was still there, Ms. Corrigan was still there, Mr. Mackle was still there, I literally moved office around the corner, so I believe there was still 15:15 15:15

continuity.

303 Q. Post meeting, did you discuss what had happened with Mr. Mackle?

A. I don't believe I did. I literally started my job -- that meeting was on 30th March, started my new job on 1st April and I was immediately into a whole raft of new challenges with Maternity and Radiology and Pathology, which is areas I have never managed before, so I was in a very steep learning curve. 15:15

304 Q. Can I ask for your reflections on MHPS more generally? I am conscious that you have said that even as you provided a statement to Dr. Chada in the summer of 2017, you didn't appreciate that it was an MHPS investigation. I'm sure we don't need to bring it up on the screen, but the second paragraph of your statement is explicit in saying that you are giving this statement pursuant to that MHPS process. When you think about it, could you really have been so unaware of the process? 15:16 15:16

A. Yes, yes. I remember going into meet Dr. Chada, probably in the middle of a very busy day because this was 2017, I was already now fully in maternity and midwifery and all those other things. I was brought in to give my recollections and answer the questions around what was probably a year ago previous to that, and I answered the questions to the best of my ability, and probably didn't start to delve into the MHPS process as a process. 15:17 15:17

305 Q. I will just bring it up to the screen to maybe make the

point a little clearer. I know there are various tracked versions of your statement but this is common to all of them. TRU-00795. Paragraph 2. It says:

"I have been asked to provide this witness statement in respect of an investigation into concerns about the behaviour and/or clinical practice of Mr. Aidan O'Brien, Consultant Urologist, being carried out with the Trust guidelines for handling concerns about doctors and dentists and Maintaining High Professional Standards Framework." 15:18 15:18

That is a pro forma set of words which appears in all of the statements?

A. Yes. 15:18

306 Q. Was the process of giving the statement attending in an interview format, answering questions?

A. Yes.

307 Q. Then your answers were arranged for you in this structure? 15:19

A. Yes.

308 Q. You were asked to review it?

A. Yes.

309 Q. You made some changes and sent them back in with an e-mail in 2017, which I didn't explicitly mention yesterday but the Panel will be aware that you corrected at the time? 15:19

A. I corrected.

310 Q. How, when you paid so much attention to your statement

so as to make changes, did you not appreciate, in light of paragraph 2, that whether you knew what the process was in its minutiae and how it was to be conducted, how did you not appreciate that it was, as it says here, an MHPS investigation? 15:19

A. Probably because it was a generic statement, so when I was going through my statement, I was focusing on the accuracy or not of the reflections in the statement of what I said. I wasn't focusing on the generic introduction to the statement. 15:20

311 Q. You have said, in terms of reflecting now on whether MHPS would have been of any benefit to you, had you known about it, you have said, and we touched on this a little yesterday:

15:20

"Operational managers at all levels, not just Director level, need to be trained in the content of this framework. I believe it would strengthen the governance process around MHPS."

15:20

You have also said that: "The involvement of NCAS would have been helpful from an earlier point, they would have provided an external lens through which to view the concerns raised."

15:21

Any other reflections on what it might have meant for you as a manager in a practical sense had you been aware of MHPS and the Trust's own local framework for dealing with medical performance?

A. I think it would have strengthened my -- armoury is the wrong word, but certainly it would have been a tool that I could maybe have suggested that we use and been able to put it out there and say there is a framework, there are the services of NCAS, I do think they would be useful, I certainly could have asked the question. 15:21

312 Q. You say that one recommendation you would suggest to this Panel would be, in terms of the conduct of MHPS, a level of independence outside of medicine. WIT-14834 is the reference for that. What was your concern there? What prompted that suggestion? 15:22

A. I was as a nurse, I'm very aware of what we do within nursing. We obviously do have, we do support our nurses. We have the capability process, we have the disciplinary process, we have referral to NMC but there's a lot in between. I think it's useful to get the normal processes of other professions to challenge and constructively challenge and question and be like a benchmark on -- like other professions, whereas if you look at the MHPS guidelines it is completely doctor-led, so the investigator is a doctor, the Case Manager is a doctor, it's up to the Medical Director, Chief Executive is in there as well, non-executive director. But if in any profession, any profession, if it's closed and there's no external lens that other people do it differently or think differently about conduct or practice then, it can, like any profession, become blind-sided or really snow-blind within their own profession. So I think maybe there's having 15:22 15:23 15:23

benefit, in the same way we now know there's benefit in the multidisciplinary team all contributing to patient care.

313 Q. Thank you. Two final points. The Terms of Reference for the MHPS investigation caught within it the performance of management in its super-intendance or overview of Mr. O'Brien's actions over that period with which we have been concerned. Did you appreciate, when being interviewed, that your actions as a manager were under scrutiny within the investigation? 15:24

A. Probably not overtly when I was having the interview, but I probably wasn't surprised that anybody looking back over that long period of time felt that there were opportunities to do things earlier and that management should have picked those up. 15:25

314 Q. The criticism that emerged from MHPS, that there were systemic failures at all levels of management across a range of issues in its dealings with these issues, was that conclusion drawn to your attention on a formal basis? 15:25

A. No.

315 Q. There was a recommendation or a determination, to use the language of the process, from Dr. Khan, who was the Case Manager within this process, that there should be an independent review of management actions in this context. Were you interviewed or spoken to in the context of that review? 15:25

A. No. The first time I recall seeing that report even, was as part of my preparation for this public inquiry.

316 Q. That, rather, suggests that you didn't know that a review had been undertaken until you saw the output of it?

A. Yes, that's right.

317 Q. In circumstances where you accept, very candidly, that you might have done things better and differently, but where no doubt you think that you could have been better supported in how you attempted to do your job around this, presumably you would have liked to have contributed to such a review? 15:26

A. Yes, I would have. It would have been good to know. I know that, you know, on reflection I know I am so sorry that the patients ended up with deficits in their care, I really am, but I can honestly say we tried very hard. 15:27

318 Q. Okay. Thank you, I have no further questions for you. Thank you.

CHAIR: Mrs. Trouton, I am going to hand you over to my colleagues first of all and they will have some questions for you. 15:27

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

MR. HANBURY: Thank you very much. I have specifically nursing angle questions you might be relieved to hear. Urologists, as a specialism, rely a lot on nursing specialist care. I would say we really can't practice without them. We have heard a lot of examples of good 15:27

practice in Craigavon, particularly with the prostate biopsies and some recognised, good leadership amongst some of the nursing side and that should be recognised. I just have one or two questions. I will start off on the sort of benign side of practice. In urodynamics, which is a bladder pressure test, in most departments that's primarily run by specialist nurses on their own. 15:28

A. Yes.

319 Q. They do it very competently, and in part of that preparation we see that Mr. O'Brien actually had a urodynamic session as part of his job plan which surprised me. What are your thoughts about that? 15:28

A. We always felt that he didn't need to have. We felt that the nursing were capable and competent of doing urodynamics. One of Mr. O'Brien's challenges back to us that he was needed to be there to interpret the results and come up with a plan of care, so that was a feature of my time with Mr. O'Brien, that he would have wanted to be involved even though we felt he didn't need to be involved. 15:29 15:29

320 Q. Okay. It seems a shame since he would have had the chance to do something different?

A. Absolutely.

321 Q. Okay. Moving on the same line of specialist nurses doing a little bit more, we have heard of a massive need with the Outpatient backlog review. In many departments the specialist nurses will run lower tract symptoms clinics, various things, both at the main site and at peripheral clinics. That didn't seem to happen 15:29

a lot, I wondered why not, in your view?

A. So certainly in my time, and I know it's changed now but we had two specialist nurses and one did focus on cystoscopy. She was trained in cystoscopy and that was very, very useful. Now the other girl she did something else -- sorry, I can't remember exactly because it's a long time ago. We had two and they both focused. So yes, you are right, we tried with the capacity that we had to allow and train and support our nurses to do much, much more. Again, it was later on whenever Mr. Haynes and new consultants come in, we were much more supportive of nurse development but again, it was a bit of a battle and a challenge in the early days to get the nurses recognised as able to do more. 15:30 15:30 15:31

322 Q. Was there sort of resistance from the Urologists in encouraging that or not?

A. I don't know if it was -- no, I don't think it was complete resistance. Of course, with any nurse extending her practice, certainly until she's trained and competent, it does take the supervision of a doctor or a Consultant, and again, that takes both time, effort, whatever. So I think it was genuinely a combination of things, capacity of the nurses themselves, capacity of the consultants to oversee training, treat and assess, and maybe a wee bit of resistance. 15:31 15:31

323 Q. Okay.

A. Yeah.

324 Q. Thank you. Just one short question on pre-op assessment, we have already touched on that and I asked Mr. Mackle about that too, he was very happy with the whole set-up from a general surgical point of view. We have seen one or two poor surgical outcomes where the pre-assessment didn't happen or there was something missed out and it seemed to me the sort of precipitative nature of theatre scheduling might be one of the -- what would your comments be there, it was nurse led? 15:32

A. The pre-op assessment was nurse-led although there was, as Mr. Mackle said yesterday, for very complex patients, some of the anaesthetists would have been involved for very complex, but it was largely nurse-led and obviously at different tiers. So somebody like me going for a pre-op assessment, it was very much a self-assessment if I wasn't on any medication, was I healthy to the next level where I had some comorbidities, and obviously the next level was anaesthetists. 15:33

325 Q. Was there recognition where critical steps were left out, like not having a urine test for sternum operation that people would say listen, we can't proceed. Did that come from the nursing side or very much left up to the Urologist/anaesthetist? 15:33

A. I genuinely don't know the answer to that question, which side it came from. Sorry.

326 Q. Okay. Just a couple of small things on the sort of cancer side. I mean we heard from Dr. Hughes and

Mr. Gilbert's report that those nine patients that they looked at, there wasn't an allocation of a specialist cancer CNS and we have had some pushback from Mr. O'Brien's side about the allocation and I'd just like to -- spent a lot of time on MDMs. I mean when a patient is discussed and an appointment is scheduled to come back and see any clinician in a clinic fairly soon afterwards, we know from the quorate analysis that the cancer CNSs attended about 98% so they were always there. Why could they not pick up that particular patient and transmit that information to their colleagues? There doesn't seem to be a robust mechanism for allocation? 15:33 15:34

A. Yes. Why did they wait for the referral to come instead of picking it up is really your question? Again, I can't answer that. It really would be conjecture from me to answer that. Sorry. 15:34

327 Q. Thank you. It seems in a way that the cancer nurses didn't seem to be involved in the follow-up clinics, again there was a big need for more capacity; was that something that wasn't encouraged again, from your point of view, from the Urology medical staff or again was that a capacity -- number of -- 15:35

A. Again, up until 2016, the capacity within nursing was extremely small so we just had the two and maybe somebody had come in in training. It probably was a capacity issue when I was involved in Urology, and then as the team grew into I think it's a five-nurse model at the moment, then obviously capacity would take 15:35

more on increased to ten more clinics et cetera, et cetera. Probably a combination of capacity more than anything else, I would imagine.

328 Q. Okay. Thank you. So last question, if that's all right, just about the ward. We heard earlier on the Urologists, like many around the country, lost their dedicated ward. 15:35

A. Yes.

329 Q. What effect did that have on retention and recruitment of ward staff specifically? 15:36

A. For the most part, they stayed. While the ward itself, as would have been there as in Ward 2 South would have been there before the ward reconfiguration, and while that disappeared, the ward team themselves continued in their entity, albeit that they shared with ENT. Again, 15:36 back then, when we were starting to bring patients in in the morning of surgery that shortened length of stay so we didn't need as many beds. Then with advances in technology and patient length of stay was decreasing post-operatively that decreased, so when that 15:36 calculation was done urology had a full ward of 36 beds which was no longer required because it was full of medical patients a lot of the time, therefore to create the new elective admission ward, which meant people could come in on the morning of surgery and be 15:37 guaranteed a bed and hopefully home that night, that reduced length of stay which meant then that we could combine ENT and Urology into one ward, but that still meant that they still had their entity, albeit they

shared it with ENT, so it probably, they did lose a wee bit, they definitely lost that sense of a whole ward environment to themselves, but we still managed to retain the nursing staff, largely.

330 Q. Thank you that's all the questions. 15:37

DR. SWART: I have got some general questions and some specific ones that have got mixed up, so I apologise for that. Quite early on you made almost a throwaway statement that there's a hierarchy and obviously you have to adhere to the hierarchy. What do you mean by 15:37 that? Why do you think that's so important or why was it important to you? What's your thinking about that?

A. Again, back to 2009-2016, it was expected that if I had an issue of concern I would escalate to my Director of Acute Services and if it was felt it needed to go 15:38 anywhere else, he or she would take it somewhere else, but that wouldn't be for me to bypass them to take it somewhere else, does that make sense?

331 Q. Okay. Did you have a good understanding of when they took things to a higher level or was there sort of 15:38 a kind of a ceiling you didn't know much about?

A. Yeah. Sometimes I was involved. Many times I probably wasn't involved. I wouldn't have been involved with the Director of Acute Services in connection with the Medical Director or Chief Executive, so therefore 15:38 I wouldn't have been involved in those conversations.

332 Q. If you then take something like, you correctly identified the review backlog as a serious safety issue, and I think you know we can all see that?

A. Yes.
333 Q. Did that go on to your Risk Register as a safety issue?
A. Yes, because the review backlog was a pretty generic issue, it went on to the Risk Register.
334 Q. How far did that go in the Trust? Do you know whether it made it on to the Trust Risk Register, for example? 15:39
A. At that stage I genuinely don't know.
335 Q. Another thing which has been apparent to us is that the serious incident process, the implementation and actions tended to be devolved to the Director as far as we can see. What's your view on how effective that was in terms of following through on all those recommendations and making sure they closed -- how well did you feel able to do that given the workload that you were covering? 15:39
A. Not as able as we would have liked with the workload.
336 Q. Did that have any Trust-wide oversight, as far as you are aware?
A. Probably not, probably there was oversight into how many SAIs were open and not complete, but not probably into has it been implemented, have all the recommendations been implemented, no. 15:40
337 Q. We have also heard, both from Shane Devlin and Marie O'Kane, that there are a lot of changes that are actually in the process of being made, is the impression, I get. Things are changing. You are now in an Executive Director role, how have you seen that play out in terms of governance, for example? 15:40
I understand there's a weekly governance meeting and so

on?

A. I think in general there's been quite a significant investment in our governance team, and that's both corporately and at Directorate level, so that sheer manpower, for want of a better word, has increased. 15:40
The reporting mechanism is definitely stronger, and that's through the Governance Committee, through the Trust Board. We are about to embark on a completely new set of meetings, of which I will be co-chair with the Medical Director, and one of them I will be 15:41
co-chair with the Director of Social Work and then there's another one and another one, but one of those is around Patient Safety which will bring all of those Patient Safety together to that meeting. The other one is regulation and standards, and the third one is 15:41
probably more generic as I'm thinking general health and safety, whatever.

338 Q. Can you see that will be better?

A. I think that will be better because that will give Executive Director oversight into all the Directorates 15:41
with various reporting mechanisms, and I think then rather than a huge amount of information going to Governance Committee, it will be able to be interrogated better at the smaller steering group meetings and then more intelligent data be fed up into 15:42
the Governance Committee and Trust Board, so I think would be helpful.

339 Q. Again on this sort of theme, you have mentioned the word "clinical assurance" about the practice of Aidan

O'Brien, and it's been mentioned in other contexts as well, but as I hear it, it appears to be clinical reassurance?

A. Yes.

340 Q. Would you agree with that differentiation or not? 15:42

A. Yes, I would.

341 Q. There doesn't appear to be a set of outcome metrics by which you can judge each service?

A. There certainly wasn't then, and I think that piece is still very much in development. 15:42

342 Q. If we come then on to information governance, is there a Trust protocol or was there a Trust protocol that said that a Consultant should not be keeping records at home?

A. I believe there was, although I couldn't put my finger on it or give you a date of when that was. 15:42

343 Q. During the course of the Inquiry, we have heard quite of a few instances where this has posed a serious risk to patients.

A. Yes. 15:43

344 Q. The unavailability of notes, I mean it's difficult to say precisely where they are, but there was a patient operated on in the private sector, who had an operation proceed without any clinical notes and it was a Southern Health care Trust patient and we haven't 15:43 seen results of any investigation as to why that happened. What would you have done as the Director in your service if that had happened in the operating theatre at Southern Healthcare Trust, where a patient

comes and there's no notes, should that operation have their operation?

A. In my opinion, no, because I mean, operations by the definition is usually or can be a risky procedure, so you would need to know the history of that patient. 15:44

345 Q. When that happened should that not be reported as an incident?

A. Absolutely.

346 Q. The fact that it wasn't, is clearly problematic in your view? 15:44

A. Yes.

347 Q. If that wasn't reported. The raft of information governance issues extend across notes at home, the operating without -- and generally a lack of staff awareness, so my question to you is, how aware were 15:44 people about the clinical risks from everything associated with patient information and information governance?

A. I think there was an awareness, because there was the obvious risk if you didn't have information. I think 15:44 with GDPR and much more emphasis on information governance over latter years, it is most definitely strengthened, and I don't think it -- I would be surprised if it was as, I think it's much more robust now. 15:45

348 Q. Similarly, you talked about assurance, about protocols and things.

A. Mm-hmm.

349 Q. Is there any evidential assurance that people are

following protocols, clinical protocols at the moment and was there then?

A. Probably not then. I think that as audit is growing and our clinical audit team is slowly but is growing and there is more audit into patient outcomes, I think that is stronger. Could I say that it is all-encompassing? Probably not.

350 Q. We have talked a lot about the X-ray review issue, just briefly on that. I don't think you knew then, in 2007 the National Patient Safety Agency issued an alert on this subject to say that basically people who are under investigation should look at them, which you did refer to in your evidence as a basic duty, but this was done because results were missed. In Northern Ireland the RQIA did a paper on this in 2011 and it states that all Trusts had implemented this alert. Clearly that's not entirely true because things fall through it and it's a difficult area, but you also refer to an electronic system that's been brought in now. Are you aware whether the Trust has been able to use that electronic system to actually do something when they see people aren't signing off results on it? Because I have seen some reports with percentage sign-offs and things like that. Is it, as yet, a useful system so that it can flag up when things aren't looked at? 15:45 15:45 15:46 15:46 15:46

A. It would be remiss of me to talk intelligently about that because, in this role that I'm in the Nursing Director role, it isn't something that I am awfully familiar with. But I am given to understand that it is

certainly providing much more transparency into whether results are being signed off or not.

351 Q. Because I think nurses are also on the requesting list?

A. Absolutely, yes.

352 Q. Yes. 15:47

A. Certainly a mechanism now that we didn't have back then.

353 Q. The whole data you have already referred to but do you think, now that you look back on it, if you had regular data provided to a meeting that actually gave you 15:47 numbers about triage and dictations and all of that, that would have been much better than waiting for escalations?

A. Yes.

354 Q. Did you have those discussions? 15:47

A. Yes, and we did have that. As I alluded to during my evidence, when Dr. Rankin was Director of Acute Services she did request that morning to come every Tuesday morning to the performance meeting. Then when those meetings disappeared then that mechanism 15:47 disappeared. You are absolutely right, instead of waiting for the escalation if there would have been a proactive monitoring, which did happen during those times but obviously fell away, it would have been much more useful. 15:48

355 Q. Just finally, a lot of reference to culture in everybody's evidence and people define it in different ways, a kind of tend to define it by the way things are done around here type of thing. Who sets the culture?

A. I think the culture is set whenever action is taken against a standard that is a high standard and there is seen to be follow-through. I would say that the senior management team sets the standard. The Executive Director sets the standard. The Operational Director set the standard. Then there is follow-through whenever those standards aren't met. I think there are various aspects of culture. There is the aspect of a high -- when I say performance I mean good patient outcomes. There's also the culture of good staff involvement, patient involvement, respect, civility, multi-disciplinary working. I think culture transcends across all those things and you have to get the culture right in all those aspects. I'm not saying it's easy but it's certainly up to the senior management team to set that culture. 15:48 15:49 15:49

356 Q. Do you think with all the downside that comes with an Inquiry also you now have an opportunity to send a new message about culture? Does it provide some light for you or can you not see it that way? 15:49

A. It has been challenging, I think, on everybody involved. There's no point pretending it hasn't. It has. I think the Trust is genuinely using this experience as a real opportunity to change both the culture, the governance systems. I mean certainly as a Director of Nursing, I oversee, I am professionally responsible for 5,000 plus staff, nurses, midwives, I can't be personally involved on each of those on a daily basis. I am very mindful when I do interact 15:50

with one of them I always leave the conversation with, if you ever need to raise something, please come to me and open my door. I know your line management is the first port of call, I absolutely get that, but please, please come to me if there's anything. You know, I've learned so much, even through this public inquiry, and having the opportunity reflect back, hard though it has been, to reflect back and it will change my practice and I hope it will change the practice of many. 15:50

DR. SWART: Thank you. 15:50

CHAIR: I won't keep you much longer. It's good to know we are doing some good before we even get to the end of our work. A couple of things that occurred to me when you were giving your evidence, just about the backlog initiative and getting funding for that and asking people to do extra clinics and extra operation lists and so on. I just wonder what -- I mean, obviously there was this drive from the Commissioner to get the lists down, and we hear all the time in the media about the waiting lists, particularly in Northern Ireland and how bad they are, so these initiatives, while they are welcome and certainly welcome for the patients involved, I just wonder how welcome they are for the professionals, particularly where you have a small, already stretched team and what thought is given to the effect on the professionals in terms of asking them to do all of the extra work? 15:51 15:51 15:51

A. It's not sustainable. These initiatives work in short bursts. They will never address the fundamental

under-resourcing of healthcare in this province and across the UK. My experience over the years is, even when money is available, you can't switch on activity with money; you need the trained professionals, in the right numbers, across a lot of disciplines, to have any real effect. It would be better if there was a real workforce plan that addressed the workforce challenges, because even as we sit in 2023 there are not a queue of doctors and nurses sitting to waiting to take up jobs. So it's a very short term, in my view, strategy, and will never fundamentally fix the problem. 15:52 15:52

357 Q. I suppose if I can be a little more specific. In your experience and that's certainly the very general --

A. Sorry.

358 Q. I am not being critical at all, it's very helpful, but it's a very general view. I am curious on the ground did you ever, when you went to any of these professionals, did they ever say sorry, I can't, I am not doing it, I am burnt out? 15:53

A. Absolutely. There was a number of clinicians who did very little because their work-life-balance was more important, they had families, of course. Then there were others who wanted to for various reasons, whether it was dedication to their patients, the hospital, financial incentive, I don't know, but absolutely, it was always -- when I said it was voluntary, it really was voluntary. It wasn't mandatory, and lots of clinicians did say no, thank you. 15:53 15:53

359 Q. That's interesting. Can I bring up a totally different

subject and you will be glad to know this is the last thing I am going to ask you about. Communication and we have seen a lot of e-mails. We have seen the letter which was prepared. You had an input into that letter and you and Martina Corrigan, you say, would have had an expectation of what you would have anticipated to happen. I am talking about the letter obviously of March 2016. You had an expectation on both your parts as to what the next steps would be. That isn't written down in that letter, that's not communicated to the recipient of the letter so how was he supposed to know? 15:54 15:54

A. I think the last paragraph, it was -- I can't remember the term used, but was it an immediate response or some phrase like that, which I get is loose.

360 Q. To come up with a plan? 15:54

A. I suppose what we were trying to do was put the marker down in the sand, at least that was a step forward, with the expectation that we would -- that either Mr. O'Brien would come back or we would go back to him in a relatively short period of time. 15:54

361 Q. I suppose I want to tease that out a little bit more because this is the first time in all of these dealings that something -- I mean it's been described by Mr. Wolfe as a milestone in the dealings with Mr. O'Brien -- 15:55

A. Yes.

362 Q. -- in getting him to do what was required. Given that it was such a milestone, and it was the opportunity to put these things down formally in writing, I just am

curious to know just what the thought processes with that letter were? Was it just a matter of getting something down on paper so he knows we are being serious or do we need to spell out in terms for him what the consequences are if he doesn't now do something more? 15:55

A. I think, in my view, my thought processes, that would have -- those -- okay, so we have set out the letter, we have set out our expectations, we have set out our expectations for a serious plan to address, if then, down the line, that didn't happen, which obviously it didn't happen, then I think you were into the consequences of, okay, so you've been given an opportunity, you haven't taken that opportunity or engaged in discussion about that opportunity, so, therefore, the next step is, this is the sanction or whatever way you want to call it. I think that was the next step, in my head. 15:55 15:56

363 Q. I think maybe there is a -- I mean, it comes back to communication and it's one thing you knowing what is the plan, as it were, and it's another thing communicating that to Mr. O'Brien. 15:56

A. Yes.

364 Q. Certainly in terms of the meeting that took place, I know you weren't able to attend that and Ms. Corrigan attended in your place, but from what we heard yesterday from Mr. Mackle that meeting was short? 15:56

A. Yeah.

365 Q. There was no real discussion. It seems to be these are

the things you need to look at, and he takes the letter and it's folded up, and then there's a dispute from Mr. O'Brien's perception what happened at that meeting and he said what am I supposed to do with this? And he got a shrug. So there's a dispute as to what happened, 15:57
there's no record of that meeting as to what happened other than obviously Mr. O'Brien's word, Mr. Mackle's and we will hear from Ms. Corrigan in due course. But even on Mr. Mackle's account it was let's get this done and dusted with and out of there as quickly as possible 15:57
is the impression I was left with. I mean I know you weren't able to attend it and that may have been just scheduling issues, but had there been a discussion with Mr. Mackle as to how that should have happened or how?

A. I don't think there was a strategy, you know, you are 15:57
going to the meeting and this is what you will say. I think, in my head, it was the formality of a meeting in the first instance with three people in it, the formality of the issues written down, the formality of asking for a plan, in my head would have been 15:57
explicitly made clear during that meeting, and if that didn't happen, I can't -- but that would have been I suppose the thought process going into that. As I said, it was the start of a process, that wasn't the end point by any stretch of the imagination. 15:58

CHAIR: Mrs. Trouton, you will be glad to know I have nothing else I am going to ask you this afternoon. Just to say thank you very much for your time both yesterday and today. We do appreciate, you know it is

a challenging process here in front of us is not easy, we do recognise that but we do need to hear from as many people as we can and get to the bottom of some issues. Thank you very much.

A. No problem and I genuinely hope we are able to make things better. 15:58

CHAIR: Mr. Wolfe, certainly myself and the Panel will willing to sit at half past nine tomorrow if that is suitable to the Core Participants? I don't see any dissent from the ranks so half past nine tomorrow morning, then. Mr. Wright. 15:59

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 2ND FEBRUARY 2023 AT 9:30AM