Urology Services Inquiry

Oral Hearing

Day 48 – Monday, 5th June 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE HEARING COMMENCED ON MONDAY, 5TH JUNE 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. I understand, ladies and gentlemen, that there may be an issue about the heating in here. We have the air-conditioning on and we'll reassess just how cool it is at the break. The door is shut, so hopefully the room will cool down substantially from what it was when you all came in first thing this morning. We'll just see what it is like at the break time and see whether we need to take any further steps. Mr. Wolfe. 10:17 10:17

MR. WOLFE KC: Thank you. Good morning, Panel. Good morning, Ms. Elliott. Your witness this morning is Noleen Elliott and she'll take the oath. 10:17

NOLEEN ELLIOTT, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

1 Q. MR. WOLFE KC: Good morning again, Ms. Elliott. I'm going to put up on the screen for you your witness statements. The first of them is dated 28th October 2022, WIT-76306. Sorry, back a page. Let's just correct that for our reference. There we go, apologies for that. That's the first page of your initial witness statement. You can see the note that you have provided us with two further statements or addendum statements, which I'll turn to presently. We can go to the last page, which is hopefully WIT-76362. You'll 10:17 10:18

recognise your signature at the bottom of the page?
A. Yes.
2 Q. That is your first witness statement, subject to the amendments that I am going to refer you to, do you wish to adopt that statement as part of your evidence? 10:19
A. Yes.
3 Q. Thank you. The addendum statement or the first addendum statement of 20th April of this year is at WIT-91961. That makes some minor corrections to your initial statement and refers to some further emails; 10:19 isn't that right?
A. That's correct.
4 Q. If we go to the last page of that, WIT-91962, again your signature. Do you wish to adopt that as part of your evidence? 10:20
A. Yes, please.
5 Q. Thank you. Then received late last week, your second addendum, WIT-96807. The last page, just over the page - scroll down, there we go - and again, subject to correction, do you wish to adopt that? 10:20
A. Yes please.
6 Q. Thank you. The Inquiry is also aware that you provided a witness statement to Dr. Chada as part of the MHPS investigation. We'll just refer the Inquiry to that, WIT-77961. That's the first page. The Inquiry is 10:21 aware that this statement would, like the others as part of that investigation, have followed an interview with Dr. Chada and then this would have been written up for your consideration and you signed it if you agreed

with it?

A. Yes, that's correct.

7 Q. We can see that you signed it three pages further on at WIT-77964. Again, do you recall making that statement?

A. I do. 10:21

8 Q. And is it an accurate statement?

A. Yes.

9 Q. Thank you. Now, I'm going to ask you some questions about your employment history.

A. Mm-hmm. 10:22

10 Q. We'll get into questions then about how you did your job and communication issues in your job this morning. First of all, you explain that you have worked in the National Health Service in various roles since 1987; is that right? 10:22

A. That's correct.

11 Q. When the Southern Trust formed, you took up a role as the clinical audit facilitator in 2007?

A. Yes, we transferred over. I was the clinical audit facilitator in the Legacy Trust and I automatically 10:22 transferred over then to the Southern Trust.

12 Q. Yes. It would be helpful for us just to have your statement on the screen, I'm going to refer to a few aspects of it. WIT-76319. Just scroll to the bottom of the page, please. You're explaining your various 10:23 roles; transferred to the clinical audit department and then to the central reporting department. Just over the page, you then, in 2009, were appointed to a risk management officer role. Was that in the same

department?

A. It was in Governance. That was just due to a restructuring of the governance structure. The job I was in the central reporting didn't exist so they appointed me then as risk manager, risk officer. 10:23

13 Q. In the first of those roles, you were responsible in part for establishing processes for the management of serious adverse incidents within the Datix framework; is that right?

A. Yes. Initially when I worked in the central reporting, 10:23 we would have populated the Datix from handwritten IR1 forms, and also took the complaints from patients over the telephone. Then, when I became the risk management officer, I would have produced reports for the Acute Services Directorate and the divisions within that. 10:24

14 Q. As you explain here, just four or five lines down, responsible for quality assuring adverse incident data inputted into Datix, producing monthly reports, Director and Assistant Directors and heads of service ad hoc reports, for example, pursuant to Freedom of 10:24 Information requests?

A. That's correct.

15 Q. If I can categorise it, was this a back office administrative role or were you engaging with how the SAIs were being conducted? 10:25

A. No. It would have been a back office job.

16 Q. Were you able to get a sense of how the Datix system was reporting, how effective was it for the purposes of addressing concerns?

A. Yes. I would have quite regularly been asked to check Datix for trends, and to check if there was incidents that were cropping up on a particular theme. I would have done that very regularly for the risk manager.

17 Q. Mm hmm. 10:25

A. Obviously at the request of the Director. So, I would have done searches all the time.

18 Q. At that stage - that was within this Trust in any event - early in development of Datix and SAI, you had in part set it up? 10:26

A. Yes.

19 Q. In 2007?

A. Yes. Datix was purchased, as far as I know, whenever the Trusts did amalgamate, so we were the first users of Datix. 10:26

20 Q. Did you see any difficulties or deficiencies in the system at that early stage?

A. No. It was very -- well, I thought it was a very good system. It was very easy to do searches. I suppose because we were in from the start, we got very familiar 10:26 with how to do searches and were quite often asked, as I say, to do such things.

21 Q. In 2011 you moved to another role within Governance, is that right, Patient Safety and Quality Officer?

A. Yes. That was again following another restructuring of 10:27 Governance.

22 Q. If we just scroll down slowly, please, we can see reference to it. You were responsible for the management of the standard and guideline database?

A. That's correct.

23 Q. And you produced data for the six-monthly accountability report to the Trust Board. Was that the mainstay of your role, the standards and guideline database? 10:27

A. There was also the management of medical devices. So we would have, along with the manager, been responsible then for the governance regarding medical equipment.

24 Q. Within the various governance roles that you undertook, was there any interest in governance at that time, and 10:28 this is 2007 through to 2011, was there any interest in assessing risk to patients in any of the work that was performed by you in particular? By that, if there were long waits for patients - and maybe long waits wasn't as much of a problem in those days - was that something 10:28 that the department looked at?

A. Well, when I would have been populating the Risk Register in my role as the risk management officer, yes, there would have been reference made to especially the Outpatient waiting lists. If I can remember 10:28 rightly, urology always was mentioned in those risks, and they would have been on the acute Risk Register. If I can remember rightly, I think that was upgraded to the corporate Risk Register when things started getting progressively worse. 10:29

25 Q. Yes. You moved then in August 2012 into a completely different role; isn't that right?

A. That's correct.

26 Q. Of a consultant secretary in urology?

A. Yes, that's correct.
27 Q. You stayed within urology through to August 2020?
A. Yes.
28 Q. During that period of eight years or so, you worked to a number of consultant urologists; is that right? 10:29
A. That's correct.
29 Q. You've referred to them in your statement. Mr. Connolly, I think, was possibly the first?
A. Yes.
30 Q. That's for a short period of time? 10:29
A. Yes. He then moved to the Belfast Trust.
31 Q. Yes. Then there were some locums and you have mentioned then Mr. Suresh. And then, for the longest period of time, Mr. Aidan O'Brien from August 2014; is that correct? 10:30
A. There was actually the beginning of September. I think it was the 1st or 2nd or 3rd September.
32 Q. Yes.
A. '16.
33 Q. What brought you to that area of work? 10:30
A. I was a full-time secretary with Mr. Suresh. All through my governance employment, I was always four days a week so I really wanted to go back to four days. Mr. O'Brien's secretary, who had fell ill and left the service, was four days, so that's why I transferred 10:30 over to work for Mr. O'Brien.
34 Q. Sorry, I didn't quite mean that. I meant what brought you out of the governance area of work into the secretarial work? What caused you to move into that

area?

A. Well, to be honest, the standards and guidelines role I found was very -- it wasn't very a rewarding job. I was setting up meetings and spending the whole day trying to set up a meeting, for it to be cancelled on the eleventh hour. I was going home manys a night thinking what did I do today that made a difference. So, I just wanted to change.

35 Q. Okay. More recently in September 2020, you have taken up a role as consultant secretary in the breast surgery unit; is that right? 10:31

A. That's correct, yes.

36 Q. I'll ask you something about that towards the end of your evidence. We know, Mrs. Elliott, that various discussions would have taken place with you in relation to Mr. O'Brien's work, and this morning and today is another such opportunity to discuss aspects of his work and aspects of how the Trust systems and arrangements acted in relation to Mr. O'Brien's interface with patients, and you obviously had eyes on aspects of all of that. It is the case, isn't it, that when you have been asked about Mr. O'Brien's work and whether he had shortcomings, or whether he did things in the way that the Trust might have expected, you have become upset and emotional from time to time; isn't that right? 10:32 10:33

A. That's right.

37 Q. I want to ask you about that. Dr. Chada, when she gave evidence to the Inquiry -- can I just bring up on the screen, please, TRA-03644. She recalled when you came

to see her that you were really very anxious about the whole process. She says:

"I think that you had felt that..."

10:34

She felt that you were in a difficult position in terms of divided loyalties and those types of things.

"Doctors and secretaries tend to have a very special relationship and I think it is difficult for secretaries to feel in some way they're, I don't know, just not being loyal. Certainly, the secretary found it difficult."

10:34

Is that right? Do you find it difficult speaking to people about Mr. O'Brien's work?

10:34

A. Not particularly, no. I get emotional because I'm hurt at the way even I was treated just by other people.

38 Q. Yes. Is this in the context of being asked questions about Mr. O'Brien's work?

10:34

A. Yes, partly so. Just the whole process, I find it difficult because I was sworn to secrecy and told not to talk about it, so I felt very isolated.

39 Q. Yes. Just let me understand what that means. So sworn to secrecy, by who?

10:35

A. Well, the emails I got about the MHPS process was highlighted in strict confidential and I wasn't allowed to talk to anybody about it.

40 Q. Yes, and you respected that?

A. I did. Well, I confided in one friend who was outside the Urology Service.

41 Q. Yes. You felt isolated?

A. I did.

42 Q. And unsupported; is that fair? 10:35

A. Yes, I did.

43 Q. Leaving the MHPS aside, as a product of Mr. O'Brien's exclusion from work and his return to work, there was a monitoring arrangement put in place which looked at things such as Mr. O'Brien's approach to triage, his 10:36 approach to dictation, his retention of patient charts. Were you aware of that process?

A. No.

44 Q. You weren't. I want to ask you about that process in terms of (a) whether you were aware - and you say you 10:36 weren't - but in terms of the demands made of you by other people who were aware of it and its impact on you.

Let me start with an email that was sent in 2018. It's 10:37 TRU-279352. Just scroll down. This is 4th December 2018. Colette McCaul, she was the service --

A. The service administrator.

45 Q. Just to be clear, you worked within the Functional Services Department? 10:37

A. That's correct.

46 Q. And she was one of the managers within that?

A. That's correct.

47 Q. Yes. She's attaching backlog reports for urology.

Backlog reports at that time were looking at issues such as typing, dictation, compliance with DARO, that kind of thing?

A. In 2018, yes, I was aware that dictation -- lack of dictation was to be added to that backlog report. 10:38

48 Q. We'll see as we go on this morning, and we'll look at dictation as a standalone issue.

A. Okay.

49 Q. You, I think, would say that you weren't aware until 2017 and beyond that that an absence of dictation or 10:38 dictation yet to be performed was to be included in these reports?

A. That's correct.

50 Q. Yes. Prior to 2017, you weren't highlighting dictation that hadn't been performed; isn't that right? 10:39

A. That's correct.

51 Q. If we scroll on up and we'll see what Mark Haynes says about this. So, he is raising concerns with Colette McCaul about the reliability of these backlog reports. He says: 10:39

"Sorry if my next question sounds awkward and I appreciate I may have asked this before. Could you describe the method by which the information is collated. I can see how you have obtain the waiting to 10:39 be typed information but, for instance, how is the information on results to be dictated and collected?"

He makes a number of points around that, and he says

that he is concerned:
"That the data presented doesn't fit with my impression of practices. I regularly see patients coming into Outpatients with scan results that have been performed often months earlier, requested by someone else, but no results letter or action ever done and no sign-off either on ECR or on the paper copy."

We know that Mr. Haynes concerns in part were related to Mr. O'Brien. Let's just scroll up and see how this develops. Colette McCaul says "We're going to look at this a bit further and the get back to you". She asks for an example of a patient who has come to your clinic but no result letter or action ever done. Mark responds to that. He gives an example of a CT performed on 13th March 2018, reported two days later on 20th March, and then in July a GP letter is brought to his attention. That is his concern, that there has been a delay in processing the dictation of this case.

Then if we scroll up. Keep going, keep going, please. She then -- sorry, Katherine Robinson then replies and she says to Mr. Haynes:

"We've looked into this. We cannot establish if the result ever came back to Mr. O'Brien in either hard copy or email. I thought radiology flagged these up to be looked at; am I correct? I can't find it in Noleen's office. That said, the secretary has a huge

issue with her management ie Colette McCaul and I asking her questions and is extremely upset and feels we are harassing her. I am trying to get through as I don't know how we can possibly get proper info without the secretary helping. The secretary doesn't want to be involved. I suspect like all of us, there is no choice."

This is management within your department talking about your cooperation with efforts to get to the bottom of dictation issues. They are saying that you feel harassed by their questions and that they seemingly can't rely on your input to get to the bottom of it; is that fair? 10:42

A. Well, this is just one of the cases. Like, I was getting phone calls practically every couple of hours. So it is not that this was an isolated case, it was the fact that I was getting so many enquiries and I was telling them the same thing every time, that the results were left with Mr. O'Brien, there was nothing more I could do. So it's not that I wasn't cooperating, it was the fact that -- it was the way I was being asked to do things. Like, for instance, I would have -- they would have sent me an email saying go and check his office and count the charts. You know, it was like as if they weren't giving him any respect, they were treating him very poorly. I thought anyway. 10:43

52 Q. Yes. 10:43

A. It was just the way I was being asked to do things, and this was just one of those incidents. I would have -- I obviously did do a search for that particular result. So it's not that I didn't help them, it's just I was upset at them continuously asking me. 10:44

53 Q. Why were you upset? Were they not, I suppose, in management terms entitled to conduct enquiries to try to get to the bottom of issues such as dictation, and needed your eyes and ears and knowledge?

A. Yes, I accept that. But it was, as I say, it was the way they were conducting the -- asking me the questions. 10:44

54 Q. What was the way that you?

A. Well, they would have said "Is he in his office"? You know, that's the way they would have asked me. "Is he in his office. Go and check how many charts is in his office". That was the literally every other day I was getting these calls until it got -- and like, I knew that the charts weren't moving in his office, there were no different from one day to the next, but you were just constantly being asked. 10:45 10:45

55 Q. So you felt, am I right in thinking, that they were asking you to go behind his back?

A. Yes.

56 Q. And did you feel that that put you in, if you like, a compromising position because you were his secretary? 10:45

A. Yes. Well, I would imagine any secretary would feel the same way as I felt.

57 Q. Yes. There was a meeting between you and Mrs. McCaul

later that year in December 2018. Let's just look at that, WIT-22720. This is 14th December 2018. You asked to see Mrs. McCaul in your office; isn't that right?

A. Well, I think I had a conversation with her and then I got upset, and she said she would come around and see me. 10:46

58 Q. This is you explaining that you can't cope, feeling very harassed by all the questions asked by Mrs. McCaul on the previous Friday regarding Mr. O'Brien. Do you agree that that is the reason for the conversation? 10:46

A. Yes. As I say, I'd got upset on the phone and then she'd said she would come around and see me, yes.

59 Q. She's explaining that you, as Mr. O'Brien's secretary, were the direct link for the information that she was trying to obtain from you, and you explained by response that you were finding it overwhelming and you again use the phrase "harassed". You said you felt that you couldn't do this any more, you might need to go off. You said, according to this note, that you no longer wanted to be involved and if management wanted the information, that they should come and get it themselves, "not sitting in their ivory tower getting us to do their dirty work". Just scrolling down. You had a loyalty to Mr. O'Brien "as her consultant", and you felt that they were "trying to get her", that's you, "to shop him". 10:47 10:47 10:48

Is that an accurate account of what you were trying to

get across?

A. I don't know about the shop him, I don't know where that came out of, but I certainly felt I didn't like the sneaking about behind his back. I don't see why the monitoring couldn't have been upfront. He knew he was being monitored so what was the problem with asking him the questions or being open, instead of saying 'is he in his office, go and check his office when he is not there'. I don't like that style of management. 10:48

60 Q. Mm-hmm. Just so I am clear, did you have a loyalty to him so that you weren't prepared to provide the information, or were you objecting to their requests because of the way the requests were made? 10:49

A. It was the way the requests were made, the fact that it was the sneaking behind backs; I didn't like that. I would provide the information if it was asked, you know, if it was upfront and he knew about it. It was the fact that I was being asked to go behind his back and check things. I didn't agree with that. 10:49

61 Q. As a result of this meeting, did they stop asking you? 10:49

A. They did, yes. Well, on the checking of the office, yes, they did.

62 Q. Specifically, the checking of the office was in respect of charts?

A. Charts in the office, yes. 10:50

63 Q. You say you didn't know about the action plan but the rule was that charts weren't to be taken home, charts weren't to be stored in his office; charts were to remain in his office for the shortest amount of time

consistent with his ability to do the work?
A. Well, I know that now but that was never -- I never knew that was ever an issue, that charts weren't to be held in consultant's office. That was never an issue in my whole time working in urology. 10:50
64 Q. Yes. I think the distinction is they weren't to be stored in his office but the action plan allowed them to be held in the office but for the shortest amount of time consistent with his need to do work on patient charts. 10:51

To cut a long story short, you were unhappy with the way that you were being asked to address this issue, you felt that this would involve you sneaking around behind Mr. O'Brien's back, you raised objection to that 10:51 and your objections were listened to eventually; is that right?
A. That's fair, yeah.
65 Q. A meeting took place on 8th October 2019. I just want to draw your attention to it and ask for your comments. 10:51 It's WIT-34252. If we scroll down to paragraph 560, this is a statement from Mrs. McClements. She's explaining that at this meeting in October 2019, Dr. O'Kane, who was at that time the Medical Director, noted that you had not engaged with the monitoring of 10:52 the action plan, and this required - your non-engagement - required Mrs. Corrigan to go on to the electronic care record to check if notes - I take that to be dictations or records following clinical

episodes - whether they had been uploaded. Now, I should, just for completeness, take you to the note of the meeting she's referring to, TRU-252529.

Just scroll down, thank you. This meeting is taking place in a context late 2019 where Mr. O'Brien is said not to have complied with the action plan with regard to the dictation requirement aspect of the plan. There were a number of dictations from clinics in the late summer of 2019 which were found to be outstanding. As I said, as per Mrs. McClements' statement, you can see at number 3: 10:53 10:54

"Martina can only monitor what she is given. his secretary has not engaged. Martina has had to go on to ECR to check if notes are uploaded." 10:54

I wanted to give you the opportunity to respond to that. Is it fair to say that you hadn't engaged with the action plan or the monitoring aspects of it? 10:55

A. I don't think that's very fair. It was the actual counting of notes in the chart that I objected, it wasn't the looking up of details regarding patients. I never refused to look up details on patients.

66 Q. As regards dictation, for example, although you say you weren't aware of the action plan itself, were you feeding information into the system using the backlog reports -- 10:55

A. I was.

67 Q. -- to say when dictation hadn't been completed or was outstanding?
A. Yes. After December '16, I filled in that backlog report fully with the undictated clinics.
68 Q. Yes. 10:56
A. By that time, Mr. O'Brien had started -- in March '17, he had started using the digital dictation so it was very easy for me to populate that.
69 Q. Yes. As regards the action plan, there were several aspects as regards triage by, let's say, 2019 when this 10:56 record which we have in front of us had been written. As regards triage did you have any role to play in terms of reporting failure to complete triage on time?
A. No. The monitoring of triage was done by the Referral and Booking team, so I didn't feel I needed to monitor 10:56 that.
70 Q. In terms of charts in Mr. O'Brien's office, whose responsibility was that after you raised the issue in late 2018?
A. Whose responsibility for counting those charts? 10:57
71 Q. Yes, and for monitoring.
A. I have no idea, I was never told.
72 Q. Yes. As you have said as regards your role in dictation, you were completing the backlog return?
A. I was, yes, albeit very rushed because of the pressures 10:57 of work. So you were sitting with maybe 20 urgent letters to be typed and you got the email to say give us your backlog within a day, it was very hard to prioritise, to not do the actual typing and concentrate

on the backlog. So, sometimes there could have been errors on the backlog but I certainly tried my best to do it as accurate as possible.

73 Q. We'll come to look at some of those reports and the system that was applied in a short period of time. Just to be clear, where it is suggested here that you were not engaging, you think that's an unfair comment to make about you? 10:58

A. Yes.

74 Q. Could I bring you to some meetings that you had in September 2020 after Mr. O'Brien had retired and issues arose in respect of his practice that required investigation. You recall that you were asked to attend a number of meetings in relation to such issues? 10:58

A. I attended one meeting and that was with Katherine Robinson and Anita Carroll; she zoomed in because bear in mind this was in the tail end of the Covid restrictions. Then the second meeting was a telephone call with Melanie McClements. As far as I know, that was it. 10:58 10:59

75 Q. Let me look at that. If we pull up Mrs. Anita Carroll's witness statement, first of all. WIT-21337. At the top of the page, please. Mrs. Carroll records in paragraph 50.2 that: 10:59

"In one-to-one in September 2020, Katherine Robinson shared a note of a meeting with me. The meeting took place on 1st September 2020. Katherine Robinson spoke to Noleen Elliott regarding a complaint received from a

member of nursing staff alleging that Noleen was unhelpful. Katherine Robinson then phoned Noleen, who advised Catherine that she was stressed over the investigation. As Mrs. Robinson felt this conversation did not end well, she contacted Noleen on 2nd September 2020. During this conversation Noleen advised she had changed some data on PAS at the request of Mr. O'Brien, and on the detail of these changes. Katherine Robinson advised she should not be doing this and reminded her that she needed to follow instructions from the line manager. Noleen says she found this difficult as she worked with Mr. O'Brien for a long time and she felt she had loyalty towards him."

Now, I want to look at that statement and the notes that accompany it. I am going to bring you now to the notes relating to that. A note was made by Mrs. Robinson in relation to the 2nd September conversation.

A. Hmm.

76 Q. If we bring that up, it's WIT-22812. Just scrolling down, the 1st September telephone call we've looked at. Then 2nd September. Following the conversation on the 1st, Mrs. Robinson rings you back and says:

"On reflection, I rang Noleen to see how she was because our conversation did not end well the previous day and that she was stressed and she was stressed about the investigation. I advised it was nothing to

do with her but as long as she was doing what she was supposed to be doing, she was okay. She said AOB asked her to change some things and she did. I advised she should not have done this and that she had to do the right thing and also that she should be taking her instructions from her line management team. She said it was difficult because she works so closely with AOB. I said I appreciate that but she still should have advised her line manager that she had, who had to do the right thing or we could not protect her. I reminded her that I had also told her this before." 11:02 11:02

Context: September 2020, management are trying to get to the bottom of the concerns that they had, rightly or wrongly, in respect of Mr. O'Brien's practice. 11:03

A. Yes.

77 Q. And they were speaking to you. Did you tell them that you had made some changes on PAS at the direction of Mr. O'Brien?

A. Yeah. I was really shocked when I saw this in my bundle, because my recollection of what I said that day was that Mr. O'Brien had sent me emails, sort of annually or six monthly, and it would have been asking me to upgrade routine patients that were on his routine waiting list to urgent, and that was simply the change. The reason I highlighted that to her was because you can imagine the waiting list in urology was years long, so if you had a routine patient that was on the waiting list, say five years, and they were upgraded to urgent, 11:03 11:03

that then had an impact on the urgent waiting list. I felt that I needed to let management know that this was why they were being changed. I actually had emailed Sharon Glenny, who was the officer responsible for waiting lists, to let her know that this was happening. So, that's what I was speaking about there. But to me it was nothing untoward, it was normal practice. If there was a patient that symptoms had changed in the course of them being on the waiting list, that they needed then upgraded to urgent, and that was simply what I was referring to there. So, to me that was taken out of context. 11:04 11:04

78 Q. Yes. There is a further note that might assist you in this respect, if we go down three pages to WIT-22816. This is a meeting - you recall, I think, when I asked about meetings a short time ago - that came the next day, the day after 2nd September telephone conversation for which we have just seen the note? 11:05

A. Yes.

79 Q. Here, if we just stay with the first main paragraph, it begins with questions about how long you had worked for Mr. O'Brien, and you advised five years. Mrs. Carroll, Anita Carroll: 11:05

"... recognised the relationship between consultant and secretary but said they needed to discuss with you administrative arrangements and get a clear position on paperwork, admin functions and how things worked, in particular to get a feel for what was stressing Noleen 11:05

and also the fact that she had advised Katherine Robinson the previous day that Aidan O'Brien had asked her to change some things. When asked about this at this meeting, she denied that she changed things but advised she didn't use all administrative processes, in particular the DARO function."

So, again here is a gloss on the notes of 2nd September. If I understand your explanation of what you said on 2nd September, this note doesn't do justice to your explanation either; is that fair? 11:06

A. Yes, but as I say, to me the changes that Mr. O'Brien asked me to do, to me wasn't anything out of the ordinary whereas they were making it out as if I was doing under cover. It wasn't that. It was simply that someone, as I said the routine patient, would end up on an urgent waiting list with a waiting time of four to five years. I didn't see that as being anything that needed any action or... 11:07

80 Q. Yes. I just want to try to understand then where the apparent confusion, or on one view the inaccurate note, if it is inaccurate, has come from. Trying to think through this, you have said to us this morning that the only changes I was making to the PAS waiting lists was in respect of patients who had languished on those waiting lists for a number of years and may have deteriorated or their circumstances may now be worse, and Mr. O'Brien was saying that needs to be upgraded from routine to urgent? 11:07 11:08

A. Yes.
81 Q. 'The patient is now, if you like, in worse circumstances than he or she was four years earlier'?
A. Yes.
82 Q. That's the change that you made? 11:08
A. That's the change I made.
83 Q. Now, you spoke to Mrs. Robinson on 2nd September. Is that how you explained it or did you not explain it at all?
A. I'm not very -- I couldn't remember. I can't remember. 11:08
But obviously it was noted there so it would have been discussed, yeah. It was the fact that I had emailed Sharon Glenny; it was letting them know that this was something I have done and I have checked with management. 11:09
84 Q. You have mentioned Mrs. Glenny a couple of times. Is was that something you were Mrs. Glenny prior to these investigations in 2020?
A. Oh, yes.
85 Q. So, is this something way back in time? 11:09
A. Yes, it was. I think it was 2017.
86 Q. Yes.
A. But it must have been I was prompted, Katherine Robinson must have prompted me to see was there anything that Mr. O'Brien asked me to do that I wasn't 11:09
comfortable with. I don't know what prompted me to mention that. I said the only change I ever made with the PAS was when...
87 Q. So if she's asking you whether you had ever taken an

administrative step on Mr. O'Brien's behalf that you were uncomfortable with, she presumably was asking you was there anything untoward going on. Is that what she's getting at?

A. I don't remember how she asked me but she must have asked me was there anything -- did I ever do anything like change anything on PAS on Mr. O'Brien's instructions. I don't know how it was worded, but obviously -- 11:10

88 Q. Yes. 11:10

A. -- that's whenever I brought that up.

89 Q. Yes. When you get to this note, it's recording you, I suppose, as denying that you ever changed it?

A. Well, I think it was probably the way it was worded there because I wasn't aware that Mrs... I wasn't aware that they knew about this. Obviously whenever that was brought up, I thought there's nothing untoward with what I had done so why are they even discussing that. 11:10

90 Q. The note doesn't record, as I understand this note in front of me at -- just scroll down to get the page number for the record. WIT-22816. This note doesn't go on to explain that the change that you were talking about was the change to patient prioritisation or status, it goes on to talk about the DARO function? 11:11

A. Yes. 11:11

91 Q. "When asked about this issue she denied that she changed things but advised she didn't use all administrative processes, the particular the DARO function".

A. Yes, and that was well known within urology.
92 Q. What you are saying is that Mr. O'Brien, so far as you are concerned, never asked you to take any untoward step or any step that you were uncomfortable with?
A. No. 11:12
93 Q. And you feel that Mrs. Robinson, on 2nd September, has got the wrong end of the stick?
A. Yes.
94 Q. When asked about this on 3rd September, can you help me with the note just in summary, you can't understand the 11:12 note; is that fair?
A. Well, it must have been the way it was worded to me, did I make changes that I wasn't happy with. Well, I didn't, I didn't make any changes that I wasn't happy with. 11:12
95 Q. On the other hand, you are telling them one thing that you are aware of that Mr. O'Brien doesn't comply with is --
A. The DARO.
96 Q. -- the DARO requirement or the DARO process, which, as 11:13 you know, Trust management wanted him to implement but he didn't?
A. That's correct.
97 Q. We'll look at DARO presently. In terms of your relationship with Mr. O'Brien, it was a close working 11:13 relationship?
A. It was, yes. We got on very well.
98 Q. As we have seen, when you were, I suppose, asked to provide information about him to assist the Trust in

understanding his practice, you would say I would have been content to do it but I'm not somebody who runs around behind people's back?

A. That's correct.

99 Q. Because I would feel that that's the wrong thing to do? 11:14

A. Yes.

100 Q. You feel a certain amount of loyalty to Mr. O'Brien in that context?

A. Yes, and as does all the secretaries in the Trust.

101 Q. Yes. To who? 11:14

A. To their consultants.

102 Q. To their consultants. Is it fair to say that loyalty to Mr. O'Brien wouldn't come at the expense of taking steps to protect him when you knew that wouldn't be justified? 11:14

A. No, not definitely. I was loyal to all the consultants I worked for.

103 Q. You would say, as we have seen, that, for example, on dictation when it is explained to you how it was to be done, you always filled in the reports to show when 11:15 Mr. O'Brien hadn't performed dictation?

A. Yes.

104 Q. Mr. O'Brien was asked about your attendance at this Inquiry on the day he was giving evidence. You attended on the day he gave evidence? 11:15

A. I did. I contacted Aidan to ask him would it be okay if I came down the day he was giving evidence, just to familiarise myself, because I was due to come up the next week. It was mainly to let him know that I was

going to attend that day.

105 Q. Why did you contact him to ask was it okay as opposed to, for example, your legal team?

A. I don't know. I suppose in hindsight I should have but that's just what I did. 11:16

106 Q. Yes. At any stage have you discussed your evidence with Mr. O'Brien?

A. No.

107 Q. Not at all?

A. Not at all. 11:16

108 Q. Very well. Now, let's take some time to look at your responsibilities as a secretary to a urology consultant. You helpfully set those out in your witness statement, if we go to WIT-76338. At paragraph 19.1, you describe them. Just scroll down. Over the 11:16 page, please. You have indicated that you worked, did you say five days a week for Mr. O'Brien?

A. No, four days a week. I was off on Mondays.

109 Q. You have explained in your witness statements some early difficulties in settling into the role of 11:17 secretary to consultants?

A. That's correct.

110 Q. Could you summarise those for us?

A. As I say, I was new to clinicals. I had never worked in clinical before so it was all new to me. I shared 11:17 an office with two other secretaries and one audiotypist. I just found it difficult that I wasn't getting the support from the other secretaries and it had to be sought elsewhere.

111 Q. In what way were they failing to provide you with support?
A. They -- I don't mean to be rude but they ostracised me, they just ignored me, and there was a bit of difficulty at the start. 11:18
112 Q. Yes. If we look at your statement. If we scroll down, WIT-76337. Just scroll down. You have explained that across the line managers you have had in this role, some were more supportive than others?
A. That's correct. 11:19
113 Q. What was the problem in lack of support or variable support from line managers in this role?
A. Well, I would have brought my concerns regarding the atmosphere in the office to at that time Jane Scott, and there was face-to-face meetings with her. At one 11:19
time she actually told me that we're not going to let them beat us. But I just said -- tried my best to settle into the role. I would have stayed on to maybe ten o'clock at night to try and learn the job because I didn't want to fail. 11:19
114 Q. Yes. I think elsewhere in your statement you explain that training, in your view, for the job was not all it should have been?
A. No. It was literally an audiotypist with a day -- like, an hour here and there. It was an audiotypist 11:19
that used to work in urology and had moved to ENT, so it was her that done the majority of the training.
115 Q. The Inquiry has heard about various aspects of Mr. O'Brien's practice that gave a rise to concern,

triage, dictation, use of DARO, Outpatients, various things. Taking any one of those, say dictation, did you receive any particular training around how that was to be managed from a secretarial perspective in terms of your relationship with Mr. O'Brien? 11:20

A. Well, in my roles with the other consultants, they would have generally have done their dictation following their clinics, so there wasn't really an issue there. The dictation would have been done in its totality, the whole clinic would have been dictated at 11:21 the one time, and therefore the typing was done for that whole clinic at the one time. The difference in Mr. O'Brien was that he would have dictated the urgent dictation and the routine dictation wouldn't have been done until later, and that was the difference in the 11:21 two roles.

116 Q. Yes. What I'm asking you, you talked about the shortcomings in the training that you received when you entered into the job, what I am saying is that Mr. O'Brien has certain activities that he is expected 11:21 to perform in the administrative clinical arena?

A. Mm hmm.

117 Q. You are his right-hand person in terms of producing product as a result of his activities?

A. Yes. 11:22

118 Q. What I am asking you is was there any training provided to you in order to enable you to understand what your responsibilities were when he had done his bit, or indeed if he hadn't done his bit?

A. I knew what my responsibilities were when he had done his bit. As regards was it my responsibility to chase him up when he didn't do his bit, I wasn't aware that that was my role.

119 Q. Yes. If we scroll down and over the page, you have explained at various points in your statement that the hours that you worked in this role as, in particular, secretary to Mr. O'Brien -- 11:22

A. Mm hmm.

120 Q. -- you were working more hours than you were contracted for quite often in order to get the job done. Is that a fair summary? 11:23

A. That's correct. I would have worked extra hours particularly with Mr. Connolly because Mr. Connolly was a new consultant in the Trust. He was given quite a bit of long waiters and he was doing a lot of extra clinics at that particular time, so there was a lot of work generated there. With me only coming into the post, it was a learning curve and I had to work very long hours just to keep up with his workload. So it wasn't always -- it wasn't just Mr. O'Brien that I worked the extra hours for, it was the other consultants as well. 11:23 11:23

121 Q. There was no additional remuneration for working extra hours unless it was beyond contract? 11:24

A. That's correct. If it was an extra clinic put on the system, yes, we would have got remuneration for that. But Mr. O'Brien would have done a lot of extra work that he obviously wasn't paid for and it wasn't classed

as extra. An example of that would have been when consultants were off an annual leave, we'd have had then a theatre list go astray; Aidan would have stepped up and took on extra theatre sessions. Another example of that would have been his urodynamics. He'd have usually had one urodynamic, half a session a week, which was a Friday, and he would have done all day Friday for urodynamics if Mr. Young happened to be on annual leave. Equally, his urooncology clinic, on a Friday he would have done all day on urooncology should there have been a backlog of patients to be seen. 11:24 11:25

Those were all extra sessions that Aidan did over and above that weren't classed as extra, if you know what I mean, by management. So therefore, I wasn't -- I couldn't class them as extra so I had those extra duties then -- 11:25

122 Q. I see.

A. -- on the back of that.

123 Q. Your secretarial colleagues, did they perform extra duties in the same way on occasion without remuneration? 11:25

A. Not that I'm -- everybody was very secretive within the secretarial, nobody ever talked about what overtime they got. I'm not aware of what overtime people got and what they didn't. 11:25

124 Q. We've heard that perhaps unique among the urologists, Mr. O'Brien had one whole time secretarial support, in other words yourself?

A. I did see that, yes.

125 Q. And that the other urologists had 0.5 whole time equivalent. Mr. Mackle, for example in his evidence, and I don't need to bring this up on the screen but it is WIT-11770 at paragraph 93. Is that the case, that 11:26 the other urologists lived off half the whole time equivalent secretarial support and Mr. O'Brien had one whole time secretarial support?

A. Certainly not in my time. There were five or six secretaries - I am trying to think - and out of them, 11:27 so Mark Haynes, Mr. Haynes, Mr. O'Donoghue, Mr. Suresh and Mr. Young had one whole time equivalent secretary. Mr. Glackin, his secretary done 32 hours out of 37, so it would have been probably about 0.85 whole time equivalent. And then I was 0.8, which was 30 hours, as 11:27 a secretary for Mr. O'Brien.

Now, in the course of 2018, the audiotypist working in urology was upgraded for one day a week to a personal secretary role for the Monday that I was off. I would 11:28 say for about six months during 2018, he would have had one whole time equivalent until she then left and moved to another job, another full-time secretary role post.

126 Q. Just so I can understand this, you are saying that Mr. Haynes and Mr. O'Donoghue, for as long as you know, 11:28 had one whole time?

A. And Mr. Suresh.

127 Q. And Mr. Suresh. Mr. Glackin had somewhat less than that?

A. 32 hours I think she worked.
128 Q. And Mr. O'Brien --
A. 30 hours.
129 Q. -- had less than Mr. Suresh, Mr. O'Donoghue and less than Mr. Haynes? 11:29
A. Yes.
130 Q. Except for a period of six months or so?
A. It was about six months the audiotypist was upgraded to a secretary for the Monday, for the one day a week that I wasn't there. 11:29
131 Q. Yes. Leaving aside that six-month period, was Mr. O'Brien required to bring all his administrative needs to you or did he have access to audiotypists, for example, outside of your support?
A. Well, but the audiotypist generally would have -- well, this girl that was upgraded was an audiotypist, so she would have covered me on the Mondays I wasn't working. But Aidan would have tended to have kept the administrative work to when I came back on the Tuesday. 11:29
132 Q. Yes. 11:30
A. Unless it was something very urgent, he very seldom would have asked that audiotypist to have carried out any scheduling or anything like that that was over and above typing and so forth.
133 Q. You are describing the period after you came to Mr. O'Brien in 2014? 11:30
A. Mm-hmm.
134 Q. Did you understand his administrative needs prior to your taking up the role?

A. Well, his previous secretary, certainly Monica was four days a week. For how long, I'm not sure when she started that. I think she might have been full-time and then reduced her hours but I'm not sure when that was. 11:30

135 Q. If we could look at some other aspects of Mr. Mackle's comments. Go to WIT-71447. At paragraph 37 he describes Mr. O'Brien as slow to embrace technology. He can recall that at one stage, Mr. O'Brien's secretary used to have to print out emails, and he 11:31 didn't have a computer in his office.

Did Mr. O'Brien have a computer in his office when you took up your role?

A. He did, yes. 11:31

136 Q. He says that rather than dictate a short note to his secretary, he was known to write longhand. Is that how you received your --

A. No.

137 Q. -- work from Mr. O'Brien before the digital dictation 11:31 came in?

A. No. We would have communicated quite regularly by email was our main source of communication. So, he would have emailed me requests.

138 Q. To dictate? 11:32

A. No, it would have been usually administrative things like putting people on waiting lists.

139 Q. Yes, we'll come to that. But in terms of --

A. Dictation?

140 Q. -- dictation, how did he?
A. It would be on tape.
141 Q. He would communicate by tape?
A. Yes. Up until 2017.
142 Q. After that, what way did he work? 11:32
A. He was trained up on digital dictation in March of '17, and he used digital dictation thereafter.
143 Q. Mr. Mackle records that he was slow to utilise it, Mr. O'Brien was slow to utilise it. Was that your experience? 11:32
A. It wasn't evident to me that he was any slower. I shared an office with Mr. Young's secretary and I can't remember exactly when Mr. Young started to use digital dictation but to me it was around the same time. I didn't think that Aidan was the last person. 11:33 Certainly that didn't occur to me, that he was slow to embrace technology.
144 Q. You have referred already to Mr. O'Brien's approach to dictation, he would do the urgent and leave until later the non-urgent, and we'll look at that in a bit more 11:33 detail. That was a contrast with other consultants of whom you had experience?
A. Yes.
145 Q. Was there any other contrasts between Mr. O'Brien's approach and the approach adopted by other consultants 11:33 with whom you were familiar in terms of his administrative or clerical practice?
A. He would have been very thorough. I would say he was one of the most thorough consultants I ever worked

with. He always arranged his own inpatient elective lists and then he would have asked me to send for the patients, but he organised that himself. Whereas with Mr. Suresh, who I'd have worked for for the longest time, he would have sat down with me and we'd have looked at the inpatient list, and he would have -- it was a different ways of doing things. He would have said 'oh, we'll have that man and that man' and so forth. But Mr. O'Brien done that himself, usually over the weekend. So whenever I'd have come in on a Tuesday, he would have sent me the list of the patients he had rang over the weekend for admission the following Wednesday. 11:34 11:34

146 Q. Yes. Now, you have said in your statement, just if we could bring it up, how you saw your role. It's WIT-76340. At paragraph 21.1, you say: 11:35

"I believe my role was as a facilitator for the operational clinic aspect of the Urology Service. I provided support for the consultant to ensure the smooth running of his work and ensuring work was kept up-to-date where possible." 11:35

Would you agree with me that in your role, communication was a very important aspect of your work; you needed to communicate with a range of people to get the job done, as you describe, in facilitating the operational and clinical aspect of the service? 11:35

A. Yes. I would have been in contact with the MDT

coordinator, with nurses, with theatre staff. You know, I would have sent mostly by email. There was very little actually telephone conversations with other staff. But yeah, I would have communicated quite a bit by email with other professionals. 11:36

147 Q. We just in ease of the Inquiry's note, we can see in your statement at WIT-76339, just back a page, we get a flavour at 20.1 of the types of liaison, communications maybe, that you had with the service administrator. That's most recently Mrs. McCaul; is that right? 11:37

A. Our current one would have been Orla Poland. As you can see, there was a quite a few staff changes. So I can't remember, I am sorry --

148 Q. Yes.

A. -- whenever the exact times. 11:37

149 Q. That's an example of who that person is. Mr. O'Brien was somebody who would have been in regular contact, you say on a daily basis, by phone and email?

A. Yes.

150 Q. You would have had face-to-face contact with him at least twice weekly. His office was approximate to yours; isn't that right? 11:37

A. Yes, it was just across the corridor.

151 Q. Yes. You went to Urology team monthly scheduling meetings? 11:37

A. That's correct.

152 Q. You had liaison with clinical nurse specialists?

A. Mm hmm.

153 Q. On a daily basis, you explained?

A. Yes.
154 Q. With the specialist registrars?
A. Yes.
155 Q. And other consultants. Just scroll down. Also liaison with the cancer tracker -- 11:38
A. Yes.
156 Q. -- and the patient assessment team booking office staff. I think you have mentioned that you would have had informal meetings with your fellow secretaries. Just scrolling back up, informal meeting with the... 11:38
A. Well, there would have been those ad hoc staff meetings.
157 Q. Yes. Informal staff meetings.
A. They were very irregular.
158 Q. Okay. Not very often at all? 11:38
A. No.
159 Q. Was there any opportunity to meet with your secretarial colleagues to share perspectives?
A. Very little opportunity. The most of those -- I think two of those meetings were actually to actually 11:39
introduce a new member of staff, as in a new service administrator. To me, that was the reason behind the meeting as opposed to a meeting with us. But I feel there should have been more engagement between the service administrator and the secretaries. 11:39
160 Q. Yes. We see that in your statement in a number of places as one of your reflections on your career working in this part of the Trust.
A. Mm-hmm.

161 Q. What would that have looked like for you, greater connection with the service administrator? What way should that have been taken forward and for what end? What did you think was missing?

A. I think there was an ignorance from the service administrator to how busy the secretary actually was. I think they were adding more work and more work without realising how fast and how demanding our jobs were. 11:39

162 Q. Did you see an increase over time in what was expected of you? 11:40

A. Very much so, yeah.

163 Q. And what do you put that down to?

A. Well, certainly whilst working with Mr. O'Brien, just his extra work that he undertook created extra work for me. Also the triage. And whenever the e-triage came on board, there was a lot of extra work generated from that. So there was different factors that created extra work. 11:40

11:41

Then we lost a lot of audio support. Whenever I started working in Urology, I think there was three audiotypists and that ended up as one. It's not even a one full-time, it's one part-time. That's the way it was when I left the service. We had one part-time audiotypist. 11:41

164 Q. We know that in January 2017, it was discovered, or at least it was catalogued, that Mr. O'Brien hadn't completed dictation on, and the numbers vary depending

on who you are asking. But arguably several hundred clinical episodes hadn't been dictated, or had been dictated, some had been dictated relatively recently to that point in time. But at a certain point in time, there were 61 clinics for which there were no outcomes. 11:42
Did that not in a sense reduce your work if Mr. O'Brien wasn't dictating when he should have been?

A. I don't think that's particularly correct. It was 61 clinics that the outcome sheet --

165 Q. Let's leave that detail to the side and we'll come back to that. 11:42

A. Okay.

166 Q. But would you agree with me that Mr. O'Brien wasn't dictating in a timely fashion, or at all with some patients, for a long period of time? 11:42

A. Yeah, there was dictation outstanding, yes, but that's not to say that he wasn't dictating at all. He was dictating.

167 Q. I don't argue with you on that. What I am asking you is if he's not dictating, does it not reduce your work? 11:43

A. Not necessarily because we have the clinics that the registrars are doing. You have the flexible cystoscopy lists, which was one every fortnight, that the registrars did as well. There was other work.

168 Q. Of course, of course. Your colleagues in the secretarial pool have consultants who are dictating all of their clinical episodes, Mr. O'Brien's not dictating all of his clinical episodes; does that not reduce in part the work that you were doing? 11:43

A. Well, you could argue and say Aidan's letters tended to be longer than the other consultants. The majority of Mr. O'Brien's letters would have been one to two pages, whereas I saw other consultants' letters and they would be about four lines. So there was a difference there in the length of the dictations that Mr. O'Brien would have completed. 11:44

169 Q. You were a port of call at one point in time for a period of time in respect of Mr. O'Brien's failure to triage, or tardiness with regard to triage? 11:44

A. Yes.

170 Q. Again, did that create work for you which, if he had been doing the job as expected, ought not have troubled you?

A. Minimal. Whenever I would have got an email on triage or whatever, I would have forwarded that to Aidan if he didn't already have it. Or if it was a single triage, I would have printed the triage that was attached off and left it on his desk. 11:44

171 Q. So, that was a minimal demand on your time? 11:45

A. Yeah, it was. I didn't really take anything to do with the monitoring of those. That was already done by the Referral and Booking Centre.

172 Q. Yes. Now, I want to look in a bit more detail at some of the groups who you had to communicate with as part of your role. Shall we take a break now? 11:45

CHAIR: We'll break now, ladies and gentlemen.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Right. Can I just check with everyone before we start again if they are content with the temperature in the room, or is it still a little hot for people? If you feel very uncomfortable, please feel free to take off your jacket, ladies and gentlemen, if it gets too uncomfortable. Mr. Wolfe?

MR. WOLFE KC: Hello again, Mrs. Elliott. I am going to ask you some questions now just so we can get a better understanding of how the mechanisms of communication worked in order to get things done for patients, whether that's benign patients, cancer patients, and your role within all of that. You have explained, I think I've touched on already, that you had daily liaison with the cancer nurse specialists?

A. The clinical nurse specialists.

173 Q. Sorry, I had the wrong term, regarding booking biopsy appointments and treatment for patients in Thorndale?

A. That's correct.

174 Q. You liaised with the cancer tracker on a weekly basis regarding red flag patients. You had daily liaison with the booking office, just to take some examples.

All of these kinds of communications to get things done for patients, were they as straightforward and routine as they perhaps ought to have been or did you encounter difficulties in how the system worked?

A. No, they were all very straightforward and routine, yes.

175 Q. Yes. In terms of communications with secretaries in other departments, perhaps a referral is going from Mr. O'Brien to another department or vice versa, was that again something that worked well?

A. Yep. All new referrals would have went to the Referral and Booking Centre. If it was to another speciality, yes, they all went to there apart from the red flags. If there was a new red flag to another speciality, that would have been sent to the red flag team, but it was at all done by email. 12:03 12:04

176 Q. Yes. No great difficulty with the systems of communication on that?

A. No, not at all.

177 Q. To help us understand how Mr. O'Brien organised his day case procedures, as I understand from what you have maybe said already he would look at his list, identify the patients who he thought had priority or ought to have priority, identified them for you, and then what comes next? 12:04

A. He would have identified the patients on his own. Like, I wasn't involved or I didn't assist him in that, he did that himself. He would have rang those patients and organised their admission. As I said before, that was generally done over a weekend. He would have then e-mailed me the list of patients that had agreed to attend. It was very straightforward, I would have then just sent out the letter. Sometimes, especially with the inpatient elective list, he would have specified if someone was on a blood thinning product and asked me to 12:04 12:05

highlight on the letter when they were to come off that. So, he would have already discussed that with them but he would have asked me then to put that on the letter as well, just for...

178 Q. Did you have to make contact with the booking office for the purposes of theatre or was that all done by Mr. O'Brien? 12:05

A. No, the booking office would have been the Outpatient appointments. The booking office had nothing to do with the elective inpatient. 12:06

179 Q. Who takes the step of arranging the procedure then?

A. The list, the actual theatre list?

180 Q. Yes.

A. Yeah, I would have generated the theatre list. That would have been sent to the ward. If it was 12:06 inpatients, it would have been sent to day surgery for the day surgery list, and to all other relevant staff, for example, the pre-assessment nurses. There was a whole raft of people that got that list. Then it was put on the TMS waiting list, which is the theatre 12:06 management list. So, that was done by myself as well.

181 Q. Was there any central control or allocation when it came to patients to be selected for theatre or any other procedure?

A. No. Each consultant had their own specific list, so 12:07 there was no central list. Mr. O'Brien had his own waiting list, Mr. Young had his own and so on.

182 Q. Was it your responsibility to contact patients when arranging flexible cystoscopies?

A. Yes, they would have generally more patients. You would have 10 to 12 patients on a flexy list. I would have rang the patients and organised a time that suited them.

183 Q. Again, that was patients identified for you by Mr. O'Brien and then you following up and making the contact? 12:07

A. He generally would have given me extra patients so that if it didn't suit a particular patient, then I had a reserve if you know what I mean, to fill up the list. 12:08

184 Q. What was the purpose of making that contact? Was it simply to tell them to come in?

A. Well, that, and I was able to give them a time that suited. For instance, if it was a patient from Enniskillen driving 60 odd miles, I wouldn't have give them a 8:30 appointment, I would have tried to organise a time that would have suited them. Also, because you're dealing with an elderly population, a lot of them couldn't drive so they needed family to take them to the appointments. To me, it was very beneficial in those terms, that you were able to give them a time that suited them. 12:08 12:08

185 Q. In terms of patients contacting you, were there scenarios where patients needed to get in contact with Mr. O'Brien but you were the person who, if you like, fielded the call? Were you the recipient of calls from patients? 12:09

A. Yes. All consultants' secretaries took the calls for their consultant. That was just the way it was set up.

You would never give out, or I certainly never did give out Mr. O'Brien's personal mobile number to anyone.

186 Q. Was your contact details as Mr. O'Brien's secretary provided to patients, or did they just phone in to central administration and are directed to you? 12:09

A. Some would have came in through the switchboard but a lot of Aidan's patients would have been long-term patients that obviously had the number. The number would have been on the clinic letters or any results letters that went to patients. 12:10

187 Q. Can I put a couple of scenarios to you. If patients were phoning in distressed, they are on the waiting list, did Mr. O'Brien facilitate you with a message to be given to such patients, a fixed message to be given out to patients, or how were such calls fielded? 12:10

A. So, I would have received the call from the patient and if it was just a general query on where am I on the waiting list, that was addressed by myself. We were actually given a narrative from management to say to patients about the extremely long waiting lists and we 12:10 would get to them as soon as we could. But if it was a patient ringing regarding a change of symptoms, a deterioration in their symptoms, I always emailed that information to Aidan.

188 Q. Mm-hmm. 12:11

A. And no, I generally would not have got a reply back. If the patient had asked me to speak to Mr. O'Brien, I would have put their details, their telephone number on the email and basically left that up to Aidan if he

wanted to follow that up or not.

189 Q. Yes. You've spoken in your statement at WIT-76337 that you could field maybe 20 calls per day give or take, and you put that down as a consequence of the long waiting list. If we just scroll down to 17.3. There you are. You believe that this build-up of calls was as a result of growing waiting lists? 12:11

A. Very much so, yes.

190 Q. Is this, are you suggesting, really an increase over time to this large number per day? 12:12

A. Well, I'd say even when I started working with Aidan, his waiting list never really changed. There was never -- there wasn't really an increase, it was always -- there was as big a waiting list when I started as when I finished. But a lot of them would have been stent queries, where people had stents in and they were in pain, and ringing up about that and when they were going to be brought back in to have their stent removed. A lot of them would have been not necessarily the long waiters. It would have been those sort of patients. 12:12 12:12

191 Q. I'm going to look at stents in a moment. Just in terms of the variety of calls that you could get, some were what's my position on the waiting list, and the Trust had essentially handed you a narrative to explain the position. Where it was patients who needed an answer, whether because their symptoms had developed or their disease progressed -- 12:13

A. Mm-hmm.

192 Q. -- or, for example, a stent case, those are questions you would have set out for Mr. O'Brien generally by way of email?

A. Yes, that's correct.

193 Q. And leave him to follow it up? 12:13

A. Yes. If a patient had rang more than once, I usually done a search on my email trail, found the previous email and then would have continued on the email trail, you know, if it was about that same patient to let him see that the patient had been ringing more than once. 12:13

194 Q. Mrs. Corrigan, for example, and maybe some others, reflected in part of their evidence that Mr. O'Brien carried out tasks such as the scheduling patients for theatre which should have been passed to you to do. I'll just bring it up on the screen so that we have 12:14 exactly what she said. TRU-00747. This is her statement to Dr. Chada. At paragraph 17, just so we can see that, please. Generally reflecting upon Mr. O'Brien's attention to detail, his letters could be pages long. In terms of the scheduling of patients, 12:14 she says:

"Schedules his own patients and phones them personally to arrange for them to come in for a procedure. This is something his secretary should be doing. I am aware 12:15 of conversations with patients where Mr. O'Brien would discuss the care of animals while the patient was in hospital."

The impression given there was an excessive attention to detail, contacting patients to arrange their entry to hospital when other clinicians would be delegating that to the secretarial resource so that the clinician could better use his time for other activities. 12:15

Do you recognise the contrast in practice between Mr. O'Brien and others in this respect?

A. Yeah. Well, as I said before, Mr. O'Brien did ring his patients himself. But certainly in my previous roles, 12:15 I have never scheduled without the consultants picking the patient himself. So, as regards the scheduling, a secretary has -- I have never been scheduling on my own without the input of the consultant.

195 Q. It's the piece after that I'm most interested in. 12:16

A. Yes. Well, as I said before --

196 Q. When you were with Mr. Suresh, would he have contacted the patients to go into the ins and outs of coming into hospital or was that left to you?

A. That was left to me after the patients were selected 12:16 for the list.

197 Q. Yes.

A. The only thing I would add to that was that Aidan would have done that scheduling in his own time generally on a Saturday or a Sunday. So, it wasn't impacting on his 12:16 working time in the Trust.

198 Q. How do you know that?

A. Because patients would have -- whenever I would've rang them or they would have been in touch, say if I would

have rang them after the procedure to book a results appointment, they were very complimentary of Mr. O'Brien and said he was a decent man and he rang me at twelve o'clock on Saturday or ten o'clock on Sunday night, and they felt special because they felt as if a consultant was giving them preferential treatment. You know, they just felt as if 'imagine a consultant ringing me on his own time on the weekend'.

199 Q. Yes. But other consultants were doing their dictation during that period? 12:17

A. I don't know what other -- well, other consultants --

200 Q. Is that not the point, that while Mrs. Corrigan is highlighting that Mr. O'Brien is doing activities that really could have been delegated to you, like other clinicians, other aspects of his practice were falling behind? He was using his time, as she would suggest, unwisely. What I am asking you is did you see that in his practice? 12:18

A. Not his working time. He did it in his own time. Were they expecting him to do his dictation then in his own time? I don't know. If it had been during his working time, yes, I would have said that would have impacted on his working load but it was the fact that he was doing that in his own time at the weekends. 12:18

201 Q. I see. Now, can I ask you about two specific patient scenarios that the Inquiry has heard something about and just get your perspective on it. You have in front of you a cipher list. Patient 16. The daughter or family of Patient 16 wrote a complaint to the Trust on 12:18

5th December 2016. In a nutshell, Patient 16 had a stent inserted in March 2015 before the onset of chemotherapy treatment, which finished in November of that year, at which point it was indicated that his stent should be revised or would be ready for revision. The family's complaint - and they have given evidence to the Inquiry through Patient 16's daughter - their complaint in part was in relation to what they regarded as failures of communication in the ensuing six months before his stent was revised on 28th June 2016? 12:19 12:20

A. Mm-hmm.

202 Q. I just want to orientate and refer you to the findings of the serious adverse incident that reviewed that matter. If we could have on the screen, please, PAT-000110. If we just scroll down, please, it says that, if you pick up there: 12:20

"The last dose of chemotherapy was given on 8th October and the letter to Consultant Urologist 13", which is Mr. O'Brien, "was sent on 26th November." 12:21

If you scroll down, the review had some difficulty in assessing whether Mr. O'Brien received that letter. It goes on to say:

12:21

"So there is no evidence that he received and/or acknowledged the letter."

Scrolling down. An email was sent to Mr. O'Brien on

30th September indicating that the patient was on a waiting list for 15th October, and the patient's daughter rang. "There appears to be no record of a response to this email".

12:22

It then goes on:

"On 4th March", this is 2016 now, "an email to Mr. O'Brien's secretary indicated the patient had requested a date to come in for removal of stent. There was no apparent action taken at this time".

12:22

Over the page, please. It says, the third paragraph:

"On 10th May 2016, a further email sent to Mr. O'Brien from his secretary informing him that the patient rang the office and asked for an appointment to have his stent removed. There's no apparent action taken at this time."

12:22

12:23

Then eventually, end of June, the patient is contacted and brought in for stent revision.

I suppose the questions that arise out of that from your perspective, whether this case or generally, do you recognise a pattern here of the patient's family ringing in raising the concern with you, two or three times in this case, and no apparent response from Mr. O'Brien? Does this fit into the scenario you

12:23

described earlier that the patient would phone or contact you and you would then e-mail Mr. O'Brien?

A. That's correct, yes.

203 Q. Yes.

A. And I would have -- because there was three episodes here, I would have brought the patient's name up on my email search and I would have sent the subsequent, next email on on the back of the previous email. 12:23

204 Q. In that kind of scenario, do you do any more than simply draw Mr. O'Brien's attention to the further contact with the family? 12:24

A. That's all. That was all I would have done, yes.

205 Q. Do you have any role to play in trying to expedite admission or prioritisation for the patient?

A. No. 12:24

206 Q. For example, could you contact the department in the hospital dealing with admissions to ensure that this patient is seen to, or does this have to come through Mr. O'Brien?

A. All elective care comes through the consultant. I'm not aware of any secretary scheduling patients over and above the consultant's approval. 12:25

207 Q. If we could go to the evidence of the patient's family member herself. TRA-00118. Just in the middle of the page, the family member is saying: 12:25

"The communication from ourselves. Both dad would have rang and I rang and whatever and you never got a response to that. You know, the message was relayed

obviously but no one, the secretary didn't come back to say, 'well, the consultant, you know, he's on a waiting list, he will be seen in a couple of months. In the meantime maybe you should try this'. So it was that lack of reciprocation of communication which was particularly upsetting."

I am sure on a human level, you could understand how that was. Do you have any understanding of why Mr. O'Brien wouldn't have been dealing with your emails raising these issues as quickly as the family would have liked? 12:26

A. I can only say that there was numerous patients in the same boat as this particular patient. It was a case of demand outstretching the resources. So once I passed it over to Mr. O'Brien, I assumed then that he took it on board and escalated where needed. That certainly wasn't a role that the secretary would have done. 12:27

208 Q. There appears to be no facility or provision within your relationship with Mr. O'Brien to arrive at a situation where he's communicating to you a message to be given back to the family, at least in this case and maybe I shouldn't extrapolate beyond this case. You have described a situation where you do your bit, you send the message on and it's up to him. A better scenario would have been if you were supplied with a reply from Mr. O'Brien so at least you could assure the patient or their family that they have not been forgotten about and there will be action? 12:27

A. Yes. Well, Mr. O'Brien would have tended to have spoken directly to patients in these circumstances and that's how I saw these sort of queries, that Mr. O'Brien would have got in touch with the patient. But he'd never came back to me and said 'will you ring the patient and tell me them X, Y or Z', he would have done it himself. So, I never expected a reply back asking me to speak with a patient and tell them when they were going to be seen; he would have done that himself. 12:28

209 Q. Could I draw your attention to the recommendations that emerged out of that serious adverse incident. If we go to PAT-000115. Just at the bottom of the page, please, just zoom into that. Recommendations 2 and 3 in particular I would seek your observations on. It says: 12:29

"The Trust should develop written policy or guidance for clinicians and administrative staff concerning writing clinic or discharge letters to ensure all clinical teams or clinicians directly involved in the patients' care are copied into the correspondence, especially if they are referred in the letter." 12:29

That recommendation arises out of the confusion that occurred at a stage in the case in terms of whether Oncology and Urology were on the same page in terms of what needed to be done. Correspondence wasn't necessarily going to the right place, or at least there was uncertainty as to whether it was going to the right 12:30

place. Do you know whether the Trust has since written policy or guidance for clinicians and administrative staff in this respect?

A. I don't recall anything regarding that, no.

210 Q. Recommendation 3 says: 12:30

"The Trust will develop written policy or guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff. This 12:31 guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned, receipt acknowledged, reviewed and actioned in an appropriate and timely manner."

12:31

Again, have there been any developments around that?

A. I have no recollection of any guidance being issued since this.

211 Q. Go back to the particular circumstances of this case. When you emailed Mr. O'Brien, and maybe for other cases 12:31 as well, would you have even had an acknowledgment to say what he was going to do, even if he wasn't giving you a message to carry back?

A. No.

212 Q. Do you agree that a requirement for that kind of thing 12:32 would be helpful to patients?

A. An acknowledgment that he received it?

213 Q. And a message to carry back to patients as to what might happen next?

A. Well, I suppose it would have kept me in the loop but I assumed that he was contacting the patients. I suppose, yeah, it would have been a point of keeping me in the loop as to what was happening.

214 Q. Yes and, of course, that's an important part of it. But I'm actually cutting right through this to the important people in the scenario -- 12:32

A. The patients.

215 Q. -- who are the patients, who are kept in the dark for the better part of six months before treatment arrives having corresponded at least three times, according to the SAI, if not more, if the patient's evidence to the Inquiry is correct. They are in the dark. You are kindly taking the emails and the telephone calls and passing them on but you are getting nothing back? 12:32 12:33

A. I take your point, yes. It was leaving the patients in the dark.

216 Q. In terms of this serious adverse incident report and its recommendations and lessons to be learned, you're obviously a player or a protagonist in the various communications that took place? 12:33

A. Mm-hmm.

217 Q. It's not to say that you were at fault in any way, you did your job in receiving the messages and passing them on. Did you ever yourself receive any indication, first of all that there was an SAI review, and, secondly, that there are lessons to be taken from that review in terms of how we handle this case? 12:33

A. No. This particular one, no. Or any SAI.

218 Q. That's what I was going to ask. In respect of this case, did you know there was a SAI?
A. No, but Aidan did ask me a question regarding the initial Oncology letter. I think it's this case.
219 Q. It is, yes. 12:34
A. Where it was date stamped but not signed by Mr. O'Brien.
220 Q. Yes.
A. And it was filed.
221 Q. So only through that kind of question? 12:34
A. I knew, yes, because he started asking me the question where this -- how this happened.
222 Q. But you're telling the Inquiry that the Trust didn't sit down with you --
A. No. 12:35
223 Q. -- or your fellow administrative staff or secretarial staff to say, listen, there is lessons to be learned from this kind of scenario?
A. No.
224 Q. Could I bring you to another stent case and the name of 12:35 this patient is Patient 84. He wrote a letter of complaint to the Trust on 19th September 2016. If we just bring up, please, PAT-000200. Just scroll down. Yes. His scenario was that he had a stent inserted in Easter of 2016 and his expectation was that it would be 12:36 removed within six weeks. It wasn't removed within that period. He had two emergency admissions during August of that year when he fell ill, and I think there was at least a risk of septicemia, if not septicemia,

in the case. What he says about communication in that case is set out at the bottom of this page. If we just scroll down, please. He was worried about his severe signs and symptoms so he contacted Mr. O'Brien's secretary and asked could he speak to Mr. O'Brien or a member of his team for some medical advice and to discuss the symptoms. He goes on to say: 12:37

"... as I was concerned something was wrong. Unfortunately, the secretary said I would not be able to speak to anybody in the medical profession but I should contact my GP and that she would send an email to Mr. O'Brien. I felt my issues were not being taken seriously and I was being neglected." 12:37

He goes on to say that he recontacted you, having spoken to his GP, and you told him that he was on a waiting list for stent removal but the information was not available. He was again informed that an email would be sent to Mr. O'Brien. So, he goes on holiday and things are getting worse. Just scrolling down, please. He says that: 12:38

"Upon return from holiday I phoned the secretary again expressing concerns. Again the same response, she would send an email to Mr. O'Brien who would phone me directly and let me know when the appointment was arranged". 12:38

He goes on in the last paragraph:

"In desperation for knowing I was unwell, I had to continue making calls to the secretary but I would made to feel like a nuisance and never actually got to speak to a medical professional or get an appointment for surgery."

That's an indication of his experience when he came to give evidence to the Inquiry. I needn't bring it up on the page but it is TRA-00088-89, he described his sense of being fobbed off by his contacts with you and with the Trust. Is that again a scenario you recognise, a patient starting off seeking information, you e-mail Mr. O'Brien, his situation deteriorates, you are again e-mailing, keeping Mr. O'Brien in good contact with what's going on -- 12:39 12:39 12:39

A. Yes.

225 Q. -- but Mr. O'Brien isn't coming back to you to give a message back to the patient? 12:40

A. That's correct. I've checked up on this and the first two contacts this patient had with me was regarding his holiday to Spain. He basically -- it was a case where he was concerned about having the stent in whilst on holiday. 12:40

226 Q. Yes.

A. If I can remember rightly, the third contact was actually his wife attending my office, because she was a member of staff and she had came into the office, and

I had said to her that I would e-mail Mr. O'Brien. That was just prior to his -- that was when she had told me about the episodes of infection, but there was certainly no mention of deterioration or anything in the two previous correspondence -- 12:41

227 Q. Yes.

A. -- with the patient.

228 Q. Yes.

A. But, yeah, it was the same case. I would have e-mailed Mr. O'Brien as soon as I got those calls and that day 12:41 of the attendance in the office by his wife.

229 Q. Yes. Would you accept that the patient had good reason to feel that he was being fobbed off?

A. I wouldn't say fobbed off. I see there where it mentioned that I said that he couldn't speak with the 12:41 clinician. I would never have said that, I would have said that a clinician was not available. Because clinicians generally didn't sit in secretaries' offices, they were on the busy ward. Unless it was something really urgent, they wouldn't have time to 12:42 take telephone calls from all the people that would have rung in. So, the best thing for me to do there was to e-mail Mr. O'Brien, and that's what I did.

230 Q. Again, when you look at an example like that in this further stent scenario which, as you have indicated 12:42 already, already was a particular cause of communication into you and into the hospital, can you recognise in that scenario a better way of dealing with things with regard to the patient?

A. You mean going back to the patient and telling them that we have you on the waiting list?

231 Q. Yes. Well, let me hear it from you. We have a number of patients who have given evidence to the Inquiry of putting communication into Mr. O'Brien's office, you're fielding the call in whatever level of discomfort or distress or worry, and nothing is coming back the other direction to give them, at least in a timely fashion a basis to relieve their concern. Can you see in those scenarios a way of doing things better, and in your experience what would that look like? 12:43 12:43

A. I don't know because to me, you can't promise someone something that you can't deliver. There was no point in me saying yes, you'll be admitted within a month when we don't know if that was achievable because obviously red flags took priority. I would prefer to give no information than the wrong information, so that was the reason. I would never have said yes, you'll be admitted within one months, two months or three months because nobody knew because of the demands on the service. But I take your point that, yes, patients want answers but it's very difficult to give them an answer that you can't stand over. 12:43 12:44

232 Q. Whether it's Mr. O'Brien or any other clinician, in a scenario where you are putting the grievance or the concern to the clinician in following your job description, should something come back to you or through another process to ensure that the patient is acquainted with what's going to come next and when, or 12:44

do you not see that as important?

A. Well, if we're speaking about Aidan, I would have assumed Aidan would have contacted the patient, or that that was the general thought process. I am trying to think back to Mr. Suresh, if I would have got a similar call, I can't even remember, if he would have came back to me and asked me to communicate with the patient. I'm not sure. 12:45

233 Q. I'm not asking you now about what happened because we know in the two scenarios I have presented to you that you didn't get a message back. 12:45

A. No.

234 Q. What should fill that gap? Should consultants or clinicians generally be expected to provide you with an answer to communicate back? 12:45

A. In the ideal world, yes, but when you're working with a service that you can't give an answer, because nobody knew what red flags were coming through, and stents tend to have been pushed back to accommodate red flags. That seemed to have been the general flow of things, that stents were sort of second in priority to red flags. So, it was very difficult to give a definitive time of when someone was going to be brought in. 12:46

235 Q. But these patients don't even seem to have received a message that we haven't forgotten about you? 12:46

A. I know, I take your point. I would have tried to reassure them on the phone to say you're on the waiting list and we will be in touch as soon as we've got a date. That was all I could -- that's as much

information I could give.

236 Q. Could I broaden this out into stent cases more generally. An issue arose in June 2020 which I want to take your views on. AOB-02989. Just scroll on down, please. This is an extract from a referral letter or communication more generally that Mrs. O'Kane, Dr. O'Kane, entered into with the General Medical Council in respect of the circumstances which she understood were revealed to the Trust in June 2020. It says as regards the patient administration system and record keeping: 12:47 12:47

"In an email dated 7th June 2020, Mr. O'Brien put forward a list of ten patients for inclusion upon a surgical waiting list. On the booking paperwork, some of these patients appear to have been to diagnosed with stents requiring treatment. There was concern that the patients appear not to have been added to the Trust waiting list for revision of indwelling ureteral stents in a timely fashion. This raised concerns that other patients might not also have been added to the Trust waiting list for revision of their stents in a timely fashion. Delay in this procedure increases the risk of in patient morbidity. It appears that months have gone by since they were recognised as requiring further procedure or investigations and they have not been processed in the interim. 12:48 12:48 12:48

"The specific concern was that there had been a failure

to adhere to standard administrative processes following stenting and as a result these patients would be unduly delayed, not dealt with chronologically but potential lost to follow-up until they presented as emergencies." 12:49

I want to ask you generally what is your understanding of the administrative process that should have been followed by a clinician when they diagnosed or decided that a patient would require a revision of their stent? 12:49

A. Well, these generally were patients that were already admitted under an emergency and then the stent would have been inserted, so they would have been coming from the ward. Generally on the day before their discharge, Aidan would have emailed me the full details of when 12:49 the patient was to be put on the waiting list, what they were to be put on for, and the urgency. I would have received that email the day before they were discharged and inserted on the waiting list as per Aidan's instructions. 12:50

237 Q. So at the point of discharge, recognising that there is to be a stent revision in the future, you would have been told of that by Mr. O'Brien?

A. Yes. He emailed me religiously. Then the chart would have came to me after that when the patient was 12:50 discharged.

238 Q. Yes. Where would you place the patient in terms of a waiting list?

A. They were put on the waiting list as per Aidan's

instructions, which was the day of discharge.

239 Q. Right. They would go on to the PAS Trust waiting list?

A. That's correct, yes.

240 Q. And you did that?

A. Yes. 12:50

241 Q. Are you aware of any patients not having been added to the Trust waiting list for revision of their stents?

A. No. No, never.

242 Q. That has never happened?

A. Never. 12:51

243 Q. If we scroll on down.

A. Can I add that it was never under Mr. O'Brien, but there would have been occasions whilst working with the other consultants that the discharge summaries that the junior doctors would have filled in sometimes didn't always list that the patients were returning for a stent removal, and the secretary would have picked it up on the operation notes. So, that did happen prior to working for Mr. O'Brien but never whilst working for Mr. O'Brien. 12:51 12:52

244 Q. How do we understand the two cases that we have just looked at in terms of the administrative procedure that was to be followed with them? We have looked at Patient 84 and we have looked at Patient 16. So, if Patient 84 is discharged at Easter -- 12:52

A. Mm-hmm.

245 Q. -- you would have been told about that?

A. I would have been e-mailed by Aidan.

246 Q. Yes. You would have been told that he required stent

revision?
A. Yes.
247 Q. And would he enter on to the waiting list then at that point?
A. Yes. It would have been removal of stent or change of stent. We always -- I would have always put the removal of stent as the first procedure so that it flagged up on the waiting list, because those would have had to have been brought back in a timely fashion, or tried to. 12:53
248 Q. So it's a matter then from the waiting list for Mr. O'Brien to identify a convenient point or an appropriate point, taking into account other demands on theatre --
A. Yes. 12:53
249 Q. For the removal or revision?
A. Yes. Yes.
250 Q. In terms of two patients that Mrs. O'Kane is referring to here, do you know about those patients?
A. I took this very serious. Sorry. When this hit the headlines, I actually was very annoyed about this because it is the role of the secretary to put people on the waiting list, and when I read this in the headline news, I felt it was that I had done wrong. So, I investigated it fully and no patients were not on 12:54 the waiting list. All ten patients were on the waiting list at the time that they were supposed to be.
251 Q. Yes. Were you asked by the Trust about those cases?
A. No, never. I just took it on myself, I wanted to check

up for myself because I knew it was a role that I had undertook.

252 Q. Yes. How did you become aware of the problem?

A. When it hit the headline news.

253 Q. Did you discuss it with Mr. O'Brien? 12:55

A. At the time, yes, because we were both very shocked.

254 Q. So what came first, the headline news or the discussion with Mr. O'Brien?

A. The headline news.

255 Q. Then how did you discuss it with Mr. O'Brien? How did it come about? 12:55

A. Well, I knew the ten patients because it was the ten patients that he had copied me into the email for the urgent bookable list. Now, bear in mind this was in the middle of Covid, so these were ten patients that Aidan had highlighted needed to be seen. So I knew exactly what ten patients the headline news was referring to. I went back on all my information to see where they were and I got all ten on the waiting list. 12:55

256 Q. Yes. Mrs. O'Kane goes on in this document to say that because of concerns, a lookback or a consideration was given to whether there were other patients who fell into this category. It says here of the total of 147 patients who had emergency procedures, 46 patients with stents were reviewed and five patients in total were identified as delay due to failure to adhere to standard administrative processes. Were those cases drawn to your attention? 12:56

A. No. I don't know what that means.

257 Q. Is it possible that the Trust has a different view about what standard administrative processes means as compared to the arrangement that you had with Mr. O'Brien?

A. I don't know what they are talking about there with standard administrative processes. 12:56

258 Q. But the process that you work with Mr. O'Brien was that --

A. It was very robust because he was very, very particular about his readmissions. I would say more so than any other consultant. 12:57

259 Q. Very well.

MR. WOLFE KC: It's coming up to one o'clock if we maybe break.

CHAIR: Again, two o'clock. 12:57

MR. WOLFE KC: Very well.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone. 12:58

MR. WOLFE KC: Good afternoon, Mrs. Elliott.

Continuing with our theme of looking at the various communications that you would have had in the course of your job. We've looked at how you have communicated with colleagues in certain respects, with patients. I now want to ask you about communications with management, particularly in the context of where you have might have concerns about clinical practice or 14:02

aspects of clinicians' work. If we start with what you say about governance, WIT-76340. At 21.2:

"Regarding governance, I believe everyone is responsible for governance and when I felt there was an issue that needed addressing, I would raise this with my service administrator or consultant." 14:03

You gave a couple of examples. I won't use the name of the clinician concerned but you raised a query with a consultant when you were concerned regarding the quality, the content of the letters generated. Over the page. You spoke to Mr. Haynes about this issue and he asked you to take certain steps. You raised an issue with your service administrator regarding a patient, and you explain that. 14:03

You, therefore, didn't have any difficulty within your role in terms of raising issues when you felt they needed to be addressed? 14:04

A. No.

260 Q. Regarding Mr. O'Brien, did you ever raise any concerns about his practice?

A. No. Regarding the undictated clinics?

261 Q. Regarding any aspect of his practice. 14:04

A. Not to my knowledge, no.

262 Q. When you think about that now, did you have concerns that you think you ought to have raised about his practice?

A. Well, the concern regarding the undictated clinics, I would have raised those with Mr. O'Brien himself. He always assured that it was the non-urgent, the routine dictation that was outstanding and there was nothing to worry about. So that was the reassurance I got there. 14:04

263 Q. Mm hmm.

A. I can't think of anything else that I would have been concerned about, apart from just long waiters and patients contacting me about their concerns, but those were raised with Mr. O'Brien. 14:05

264 Q. When he wasn't dictating on all of his clinics, you were concerned enough to raise it with him?

A. Yes.

265 Q. But not outside of him. He gave you an assurance and that satisfied you? 14:05

A. It did, yes.

266 Q. When he wasn't coming back to you when patients had phoned in to you one, two, three, maybe more times and were requiring answers, was that something you should, with the benefit of at least hindsight, have brought 14:05 elsewhere?

A. I don't know because I understood the pressures that he was under as a clinician in getting all the patients seen on a timely fashion. It was something that the Trust was well aware of, that there was long waiting 14:06 lists and there was a lot of pressures to get patients seen --

267 Q. Yes.

A. -- in a timely fashion. That wasn't something unique

to Mr. O'Brien, it was something in the whole of the Urology Service, that there was problems getting people seen in a timely fashion.

268 Q. I get the context, what I am talking about is failing to communicate with patients. You would have known that he has failed to communicate with one of the examples I gave you because you're getting a third email on the issue, and you have rationalised that that's not something I need to bring to anybody's attention because he can't help it? 14:06

A. No. I didn't see that as being anything that management could address.

269 Q. Why not?

A. Because we hadn't got the answers. No one had the answers. 14:07

270 Q. Had nobody within the Trust the ability to go back to this patient or either of the patients to give them an explanation?

A. Well, I was giving them an explanation, that there was a long waiting list and there was other priorities. 14:07 You know, I would have said that on my telephone call with the patient, so there was nothing really more to add to that or I didn't feel there was anything more I could add to that.

271 Q. In terms of the IR1 process - you are obviously 14:07 familiar with it, the Datix arrangements from your previous work - did you ever fill in a Datix with regard to any issue when you were a secretary in Urology?

A. No, I didn't.

272 Q. You have said in your witness statement, if we just bring it up, WIT-76358, at 39.2:

"While working in the Urology Service, staff were not actively completing instant report forms for any concerns they may have. Instead staff raised their concerns through the service administrator. I'm not aware if IR1s were completed by the service administrator. I feel the reporting of concerns or incidents should all be reported through Incident Reporting on Datix." 14:08 14:08

Your view is that incidents or concerns should be reported using Datix? 14:09

A. Yes, but I was doing what other staff did, basically. Our management, the service administrators and Katherine Robinson, would have emphasised that if there was a problem, they needed to know. So, that was the first point of contact and then they would have obviously taken it further. So, that was just sort of the way the staff worked in Urology, and I just did the same, I didn't step outside the box. 14:09

273 Q. Did anyone tell you not to complete a Datix?

A. No, nobody said not to but I just did what everybody else did. 14:09

274 Q. And by everyone else, you are referring to your fellow secretaries?

A. Other secretaries, yes.

275 Q. How do you know that's the way they worked? Is that something you discussed amongst yourselves?
A. Well, we worked in the same office, the offices were all shared offices, so yeah. But also the --
276 Q. How would that kind of thing come up? Explain to me how you would get into a situation where you're speaking to your fellow secretaries about the circumstances in which a Datix might be completed but you weren't going to do it. 14:10
A. I don't think the "Datix" word was ever mentioned as far as I am concerned in Urology. I had the experience of Datix but I don't believe the other secretaries did. 14:10
277 Q. Yes.
A. So they would have raised their concerns with their service administrator and then that's why I just did the same. I think probably they were ignorant to the system. 14:10
278 Q. But I'm struggling to understand, you're telling me that your fellow secretaries didn't use Datix?
A. Well, as I say, I don't ever remember the word "IR1" or "Datix" used in the office. 14:11
279 Q. Yes.
A. And we were encouraged to let management know if there was something that we were concerned about, so I just continued then to do that. 14:11
280 Q. Yes. But what I am trying to get to --
A. Sorry.
281 Q. -- you said while working in Urology, staff were not completing instant report forms. Is it fair to say you

are basing that assumption on the fact that the word "Datix" was never used in your presence?

A. Yes, it's probably an assumption. But it's... I think it's probably something that secretaries should be trained on. 14:12

282 Q. Mm hmm.

A. It was just basically their ignorance to the system.

283 Q. Yes. You can't think of any circumstances when it would have been appropriate for you to use Datix, or can you? 14:12

A. Oh I could have used Datix, yeah. First of all, the first point of call was to your service administrator. Now, in fairness I had said that I wasn't aware of IR1 forms being completed. When I was preparing for this, I did get to see that there was emails where the 14:12 service administrator would have came back and said that an IR1 was raised.

284 Q. Yes.

A. So again --

285 Q. They were raising them, for example, in relation to 14:12 Mr. O'Brien retaining notes at home?

A. No, not specifically that. Other concerns I would have raised. I can't remember the specifics but it would have been -- for instance, one of them might have been that wrong patient chart used at clinic. 14:13

286 Q. Okay.

A. It would have been those sort of clinical type incidents.

287 Q. Now, I want to ask you more specifically then about the

whole issue of backlog reporting and delayed dictation and your view of it.

A. Mm-hmm.

288 Q. I am particularly interested in the systems that were in place governing that area and whether the systems were well used by the Trust generally, and indeed by yourself. You would appreciate, wouldn't you, that following a clinical episode or clinical interaction, the clinician has to record that? 14:13

A. Yes. 14:14

289 Q. It's important that certain people will know what is in the clinician's mind following that clinical episode. So, for example, the general practitioner may need to be aware of what's happening to his or her patient?

A. Yes. 14:14

290 Q. There might be a need to put the patient on a waiting list?

A. Yes.

291 Q. So, the dictation of the clinical episode might need to cover that. There might be various people who need to hear from the consultant after the clinical interaction; is that correct? 14:14

A. That's correct, yes.

292 Q. In your experience with other consultants, would they have been routinely dictating after each clinical episode? 14:15

A. They would, yes.

293 Q. And Mr. O'Brien was different?

A. He was different, yes.

294 Q. He, I think as you explained earlier, dictated what he explained to you as the urgent matters?
A. That's correct, yes.
295 Q. His explanation was that while there might be other dictation, it fell into a non-urgent category? 14:15
A. That's correct.
296 Q. And he would dictate that later?
A. Yes. That would be on some clinics. This didn't happen on all clinics.
297 Q. Yes. 14:15
A. I think it's important to point that out.
298 Q. Yes. Let's see how that worked. If we pull up onto the screen, please, WIT-77963, at paragraph 19. This, of course, is your statement to Dr. Chada. You say at 19: 14:16

"On occasion I would have mentioned to Mr. O'Brien about typing for his clinics. Mr. O'Brien didn't do a clinic letter for every attendance but he would put all information into one long letter at the end of the 14:16
episode of treatment. When asked if Mr. O'Brien kept the patient's GP informed during the course of a treatment process, I advised that in some cases I don't believe he would have written to the GP until the end." 14:16

Do you recall saying that?
A. I do recall saying that.
299 Q. Do you recognise a problem in not keeping the GP informed after a clinical interaction?

A. Oh, yes, but this sort of fizzled out as time went on. I wouldn't have said that this would have been an ongoing problem well into my tenure with Mr. O'Brien, it was more or less just at the start I noticed this. But things started to improve where there would have been a dictation for every episode.

300 Q. For how long was that a problem, to your estimation?

A. You see, I covered Mr. O'Brien's secretary for a couple of months prior to me actually taking up post with him, so I think it was basically more back at that time that I would have noticed this. It was basically because of the length of his letters, and the letters would have very clearly paragraphed out each attendance. So, it would have been back maybe to a couple of previous consultations. But as I said, that tended to fizzle out whenever I did take up post with Mr. O'Brien. 14:17 14:17 14:18

301 Q. So it wasn't a problem after September '14?

A. I couldn't tell you exactly when but I noticed things changing.

302 Q. If we go back a little -- sorry, further on in your statement, WIT... I'm going to your other statement, I beg your pardon, your statement to the Inquiry, WIT-76360. At 42.1 you say: 14:18

"Regarding undictated clinic letters, I was aware this was a growing problem for Mr. O'Brien during 2016. Mr. O'Brien reassured me that the urgent dictation was completed and it was routine dictation that was outstanding." 14:18

Did you understand that distinction?

A. Yes.

303 Q. What was routine dictation?

A. It would generally have been a patient who was discharged from the service, like would have been for their consultation and discharged. Or people that were maybe to be added to the routine waiting list, which was years long. I appreciate that they weren't added in a timely fashion but whenever they would have been added, it would have been backdated to the date they were seen, so it wasn't that they were disadvantaged. 14:19 14:19

304 Q. Did you ever come across patients who hadn't been added to the waiting list who were disadvantaged?

A. Not that I can -- well, no. Well, apart from there was one urodynamics patient that was tied up in the backlog that was dictated during Mr. O'Brien's sick leave. But it was a patient to be put on for urodynamics so there would have been maybe a slight delay with that patient's admission. 14:19 14:20

305 Q. And was there --

A. As regards inpatients, no, they would have been routine. As I say, the routine waiting list was years long. Like I mean four or five or six years, I can't remember exactly at that point in time. 14:20

306 Q. And he wasn't dictating for those?

A. Well, those would have been in that route, what he called the routine dictation.

307 Q. Yes.

A. Would have been people that would have been added to the routine inpatient waiting list.

308 Q. Yes. What was your understanding of why they weren't being done?

A. Due to lack of time. They would have been generally the SWAH clinics, the South West Acute Hospital clinics. That was an all-day clinic, morning and afternoon. Mr. O'Brien would have been slow to dictate those historically. 14:20

309 Q. Yes. 14:21

A. Simply because of capacity.

310 Q. Yes. But you were plainly fully aware of the issue by 2016; you knew there was a problem?

A. It was an issue when I took up post in '14.

311 Q. Yes. There was a growing problem by 2016? 14:21

A. I started noticing other clinics then joining that list of incompleted. I should say incomplete clinics as opposed to undictated clinics, because I think the word "undictated clinics", it sounds as if none of them were dictated. So, it was incomplete clinics. 14:22 I noticed, yes, in early '16 there was other clinics being added to that list.

312 Q. Why were you raising it with him?

A. Because I wanted my work all tidied up and completed.

313 Q. You would have known how many patients Mr. O'Brien was due to see at SWAH on whatever day of the week. Was it a Monday? 14:22

A. It was a Monday, yes.

314 Q. Yes. You would have expected, as a general rule, to

have seen -- if he had seen ten, you would have wanted to see ten dictations?

A. Yes, but the dictations would have came to me, been drip-fed to me, so I wouldn't have got ten dictations all in one go. You could have got two one day, three the next. It could have went over a long period of time and, therefore, very hard to monitor. 14:22

315 Q. Yes.

A. Plus at that time when I took up post, there was an audiotypist working in another building, in a standalone building and Mr. O'Brien would have brought dictation to her to complete, so I wouldn't have had a full picture of what dictation was outstanding. 14:23

316 Q. Yes. But the gap in dictation was sufficiently obvious by 2016 that you raised it; you knew there was a problem? 14:23

A. It wasn't that I raised it, it came to the service administrator's attention because of one of the dictations that Aidan had done whilst off on sick leave. So, I'll try and explain. 14:24

317 Q. We'll come to that in a moment. Was it only by late 2016 that you saw a problem, or when did you get this assurance from Mr. O'Brien?

A. I had got the assurance all the time. I constantly, every time he would have come into the office, I would have said 'any word on the dictation from the SWAH clinics', and he would say 'oh yes, I'll see what I can do'. Just the pressures of work, and I was very aware of the pressures of work knowing what time I was 14:24

getting emails from Mr. O'Brien.

318 Q. Yes.

A. In the early hours of the morning.

319 Q. Yes. So, it was not. You didn't feel the need -- even though you saw that dictations weren't coming back to you in the numbers that ought to have been, you didn't see the need to escalate it beyond Mr. O'Brien, you didn't see the need to raise it with your service administrator? 14:24

A. No, because I got the assurance from Mr. O'Brien that it was routine dictation. 14:25

320 Q. Yes. But if I may say so, he is the one in default, isn't he --

A. He is, yes.

321 Q. -- he is the one who has to keep the dictation up to date. There may be good reasons to explain why he hasn't. It's a point we'll come to in a moment in a different way but he's reassuring you about his own default; do you see a problem in that in terms of governance? 14:25

A. Yes, but can I go on to say that there is another mechanism that the management knew. You're probably going to come to that.

322 Q. Let's come to that by degrees. Let me start with this: You have mentioned already that there was a known problem going back to 2014 when you started work? 14:26

A. Mm-hmm.

323 Q. Let's look at how that maybe emerged. If we go to WIT-91971. At the bottom of the page, Conor Murphy is

writing to Marie Loughran on 4th November 2014, and he's explaining about the use of DARO quality monitoring reports?

A. That's correct.

324 Q. You are familiar with those? 14:26

A. This was a new concept that came in shortly after I took up post with Aidan.

325 Q. Does it help to identify for the system where there is missing attendance and disposal records?

A. Yes. Well, outcomes, outcomes/disposals. It's the same thing. 14:27

326 Q. Yes.

A. Yes.

327 Q. If a clinician hasn't provided for an outcome in a case, this system should spot that; is that it? 14:27

A. That's correct, yes.

328 Q. The point being made by Conor Murphy is that if that step isn't performed by the clinician, if the outcome isn't provided for, after six months that clinic disappears off the system? 14:28

A. That's correct.

329 Q. It isn't picked up by the system.

A. It falls off the patient centre system. This is the reason why a secretary is unable -- after six months you are unable to see what letters were dictated and what weren't. This was why I could never give an exact number of what dictations were outstanding. 14:28

330 Q. Yes.

A. Because you'd no mechanism for doing that. However,

this report gives you the exact numbers.

331 Q. Yes. Well, we'll come to that. If we just scroll up the page. You contribute to this; it's copied on to Conor Murphy's, it's copied on to you and Elizabeth Troughton. You say: 14:28

"I've attached the report with my action recorded. Unfortunately Mr. O'Brien has not given me the outcomes for the Enniskillen clinics. Therefore, I am unable to complete." 14:29

A. Yes.

332 Q. You're writing that to Marie Loughran. Was she your systems --

A. She's actually the same Marie Evans. She got married, 14:29 so she is Marie Evans. She was the service administrator at that particular time.

333 Q. What are you telling her in specific terms in relation to Mr. O'Brien's work?

A. Well, the exact same information I told them in 2016, 14:29 the outcome sheets were not available for those two clinics. I think there was two Enniskillen clinics on that list. The normal practice was Mr. O'Brien would have given me the outcome sheet when he had completed the dictation for that clinic. So whenever the outcome 14:29 sheet was missing, I knew that there was dictation still outstanding. So this here is a report which lists the patients that the clinic outcomes were outstanding. So, therefore, the patients that were

dictated on, the outcomes were already done for them from the clinic letter, but it was the non-dictated clinics or non-dictated letters that were outstanding.

334 Q. You had to complete something called a backlog report. Let's look at an example of one from 2014. TRU-164942. This is shortly after you have started working for Mr. O'Brien. We can see what it is asking you across the top of the table. "Discharges awaiting dictation", you've entered in 31 dating back to May. That's May '14, so it's a total of 31? 14:30 14:31

A. Yes.

335 Q. "Clinics awaiting typing" and you have said nil. "Results awaiting dictation", 12. You have left "validated" blank, and approximately ten lever arch files to be filed. You say under "any other relevant information", "a large amount of back filing which was here when I took up post with Mr. O'Brien". 14:31

What this table doesn't include is information regarding missing dictation from clinics; isn't that right? 14:32

A. That's right, yes.

336 Q. Subsequently you do provide that information, for example in 2017 and 2018 and '19. Why didn't you include it in this table when it might have been obvious to you, would it not, that this system wanted to know what was going on in terms of demands on secretarial staff and typists? 14:32

A. Well, I believe this backlog report was a secretarial

backlog report, and the purpose of that report was to let management know where there was pressures on typing and filing so that they could distribute the audiotypists appropriately. So, if one secretary was sitting with 100 letters to be typed, the audiotypist would have been allocated to that particular secretary. So, that's how I saw this report. I did not see it as being a backlog of a consultant's work. It was just that was the way I was told this report was, the reason it was sent to me for. 14:33

337 Q. But if the consultant has dictation outstanding which has to be done, surely this service needs to know that that work is going to come in to the system and has to be performed by a secretary or an audiotypist in due course; did you not understand that? 14:33

A. Well, that was on the 3D report. I felt that this here was a functional support report as opposed to a Urology report. It was just that's how I saw this as being, a secretarial report and not a holistic report for all Urology Services. 14:34

338 Q. Let's look at the steps that you took towards the end of 2016. If we go to TRU-255967, Katherine Robinson is reporting to Anita Carroll, "see the attached list".

"This is a list of clinics that Mr. O'Brien has not dictated on and hence no outcome to some of these patients. There is a risk that something could be missed so I am escalating to you although I know that a lot of the time Mr. O'Brien knows himself what has to 14:35

happen with patients. Unfortunately this was not highlighted on the Backlog Report."

We have just looked at an example of what a backlog report looks like. 14:35

"The secretary assumed we knew because there has always been issues with this particular consultant's admin work from our perspective. As learning from this the discovery, I have asked all secretaries to provide this 14:35 information on the Backlog Report so we fully understand the whole picture of what is outstanding in each speciality. The secretary also advised that at present Mr. O'Brien is working is some of his backlog admin report as he is off recovering." 14:36

Just scroll down. Underneath this email is the list that you sent forward. Scroll down. This is your email, 15th December. 14:36

"Please find attached list of clinics with no outcomes completed as per 15th December 2016."

Then beneath that again is the 61 clinics that featured as part of the MHPS investigation. When you are saying 14:36 no outcomes completed --

A. It should have been actually "no outcome sheets". So, the word "sheets" was missing off that email.

339 Q. It wasn't used?

A. I just omitted it. I don't know why. It is just an error.

340 Q. You said no outcomes completed?

A. No outcome sheets completed. As I said, Mr. O'Brien completed the outcome sheet at the end when he had finished the dictation on the clinic. 14:37

341 Q. Let's understand the distinction you are now making. You have said no outcome sheets completed is what you should have said. Just scroll down.

A. No outcomes means no outcomes for any of the patients. 14:37

342 Q. What you have said is "no outcomes completed". What would the reader of that understand?

A. Well, that was following a telephone conversation, so...

343 Q. So "no outcomes completed" means no dictation completed for those cases? 14:37

A. Well, that would, yes, but it actually should read "no outcome sheets".

344 Q. Yes, I understand. I know you keep saying that.

A. It's an error I -- 14:37

345 Q. I am trying to appreciate the distinction.

A. But Mrs. Robinson would have been aware of what I meant on the telephone conversation.

346 Q. So if you were saying no outcome sheets, what does that mean? 14:37

A. The difference being no outcome sheets means that the clinic wasn't completed. That wasn't to say that there was already letters dictated on that clinic. As I say, the urgents and the red flags would have been dictated

so it was the routine typing that was outstanding.

347 Q. Yes. What you are saying in real terms is of those 61 clinics, you hadn't received outcome sheets?

A. That's correct.

348 Q. You had received dictation for some of the patients who would have been seen within each of those clinics? 14:38

A. That's correct.

349 Q. But you hadn't received dictation for all?

A. That's correct.

350 Q. It would be wrong to say that 61 clinics were not dictated, what you are saying is that parts of those 61 clinics had not been dictated? 14:38

A. Yes.

351 Q. And you weren't in a position at that point to say how many? 14:39

A. I couldn't. I had no way of knowing.

352 Q. Yes.

A. There was no mechanism for me. Because the clinic dropped off the Patient Centre System after six months, you had no way of bringing that up again, apart from that 3D report. 14:39

353 Q. Yes. Apart from the email which we have just looked at from, I think it was September 2014 when Mr. Conor --

A. Murphy.

354 Q. -- Murphy had written and you had responded. 14:39

A. Yes.

355 Q. That was, so far as I can see on our papers, your only intervention to point out that clinics weren't being dictated; is that fair?

A. Yes. There were subsequent reports sent and I would have emailed Mr. O'Brien listing the clinics that were outstanding. But yes, I didn't respond back to the service administrator, nor was I asked from them to clarify why these clinics were on that list. 14:40

356 Q. If we take a look at what Mrs. Carroll says about your role in this respect. If we go to WIT-21302, at 24.9 she said:

"This incident demonstrated that the secretary was not following standard process. The standard process to be followed is that a consultant holds his clinic and dictates a clinic letter to the GP on every attendance on a timely basis. I would have expected that Noleen Elliott, Mr. O'Brien's secretary, would have been 14:40 14:41 following up with her consultant Mr. O'Brien to advise that he had not dictated on clinics. Also I would have expected that when she was aware of delays in dictation, she would have brought that to the attention of her service administrator, Andrea Cunningham. If 14:41 this had happened, this would have been apparent on the backlog report and would be visible to myself", and those others she mentions.

Do you accept that criticism, that this was an aspect 14:41 of your role that you should have been performing?

A. Not really, no. As I said I looked -- I believe that that backlog report was a secretarial backlog report. I was never told that I was to highlight the backlog of

a consultant on that backlog report. There was that mechanism of that 3D report that was already in the system for the service administrator to see what was outstanding.

357 Q. We'll come to that, what you call the 3D report, in just a moment and we'll look at it in a bit more detail. Is it not fair to suggest that an altogether more visible way of bringing it to the attention of the service that there is a problem in dictation is through your good offices? Is that not a much more visible and immediate way of identifying that a clinician, for whatever reason, isn't providing timely dictation? 14:42 14:42

A. I think it is because I always knew that management were aware of this. It wasn't -- it was nothing new when I took up post with Mr. O'Brien. 14:43

358 Q. That might well be right.

A. It has always been the case, so I wasn't going to come in and start report, report, report. It wouldn't have sat well with me working for a clinician who management knew there was issues regarding dictation, for me to start reporting to this, that and the other. 14:43

359 Q. Was that part of the problem for you, that while you recognised that there was a shortcoming in Mr. O'Brien's practice or in his ability to comply with the understanding around dictation, that you felt as his personal secretary it would be seen as disloyal or -- 14:43

A. Well, to me I was there to facilitate and not to start and cause problems. Look, I would have dictated --

I would have typed the dictation as soon as it arrived with me. There was never any delay in that.

360 Q. What if the problems which flow from slow dictation are causing problems for other people - patients, the Trust itself in terms of its understanding of where patients are at. If that's causing a problem, why do you not feel it's within your responsibility to draw that out? 14:44

A. Well, I was getting the assurance from Mr. O'Brien that there was nothing. It was routine dictation.

361 Q. So you now know that patients, they well be small in number, suffered harm as a result? 14:45

A. I am not aware of that, no.

362 Q. Well, you have explained that there was one case, and I think you may have referred to two cases --

A. There was one. It was a urodynamics case. 14:45

363 Q. -- where the patient should have been seen 12 months earlier?

A. Not, 12 months earlier, no. Not 12 months earlier.

364 Q. Let's not argue about the precise --

A. It's that one urodynamics case. 14:45

365 Q. Yes.

A. Yes.

366 Q. I'll try and pull up the reference as we go and we can look at it. You refer to the availability of another system, what you call the 3D system, to give the same information to the Trust as you are being criticised for not providing? 14:46

A. That's correct.

367 Q. Let's just look at that. If we go to your second

addendum statement where you refer to this, I think for the first time. WIT-96808. At paragraph 4, this is what you're correcting, you're saying originally Mr. O'Brien had dictated on the urgent dictation.

14:46

"These undictated letters were flagged up on the Backlog Report. Mr. O'Brien went on sick leave in late October 2016 and during his recovery in November and December 2016, he started to address this backlog."

14:47

Where you say that these undictated letters were flagged up on the Backlog Report; is that correct?

A. No, that was post December '16.

368 Q. Yes. Okay.

A. So it was just I got that -- 14:47

369 Q. So prior to that --

A. Prior to that, they weren't, no.

370 Q. You then changed this and provide the following explanation:

14:47

"Mr. O'Brien had dictated on the urgent dictation and continued to address this backlog until he went on sick leave in November '16. These undictated letters were flagged up on the data quality report. Outpatients with no attendance, outcome disposal recorded." 14:48

You then refer us to that, and we'll look at that now. Then you say:

"During his recovery from surgery in November and December 2016, Mr. O'Brien continued to work through the backlog in dictation."

Clearly nothing in your backlog report to flag up the issue, what you are saying is the Trust should rather have looked to this other document, the data quality report. 14:48

Let's pull up that report for the period April 2015 to February 2016. Let's just go to the first page of the report to start with, WIT-76376. I choose this page just so that the Inquiry can see the headings at the top of the table. This document runs to several hundred pages; isn't that right. 14:48 14:49

A. That's correct.

371 Q. It takes the reader across a number of different clinics which are provided by the Trust.

A. That's correct.

372 Q. It's not just urology, as we can see from the examples here. This report does what in terms of helping the Trust to understand what's outstanding? 14:49

A. It's basically saying that this is the patient episodes that haven't been disposed or the outcomes had not been completed on. These patients -- I think that one does actually identify the patient with the case note number at the end. So all of these patients, outpatients or episodes are sitting opened but not either added to a waiting list, discharged, or on for a review 14:50

appointment. As you say, it went on to hundreds of pages.

373 Q. Yes. If we go to urology entries, which are about 300 pages further on, just to illustrate the point that it is a lengthy document. If we go to WIT-76603, we can see that a number of urology consultants are mentioned. If we go, for example, to the first O'Brien entry. If we go to the fifth column, we see the coding or the abbreviation AAOBU1. Is that an Armagh? 14:50

A. That's an Armagh clinic. 14:51

374 Q. So that means Mr. O'Brien has gone out to a satellite clinic in Armagh.

A. Yes, and that would --

375 Q. Is that the date of the clinic sitting beside it then?

A. No, two columns over is the date of the clinic. The date beside is the date they were referred in. 14:51

376 Q. Okay. 2nd November 2015 is the date of the clinic?

A. Yes.

377 Q. The fact that it appears in this report tells us that the clinical episode is still open; it hasn't been closed? 14:52

A. The outcomes haven't been completed.

378 Q. Yes. By outcomes completed, that means the patient either hasn't been -- steps have not been taken to discharge the patient or a step has not been taken to add him to a review list or any other kind of list? 14:52

A. Yes.

379 Q. To take another example. If we go down, we find an entry alongside Mr. O'Brien's name for 6th November,

the first, 6th November 2015. The entry is CAO UDS?
A. That's Craigavon urodynamics clinic. There was generally three patients on that clinic, so that's all three.
380 Q. There was a urodynamics clinic on 6th November 2015, and again the episode hasn't been closed? 14:53
A. No.
381 Q. So the outcomes are still outstanding?
A. Yes.
382 Q. This data relates to the period from April '15 through to February '16; is that right? 14:53
A. As far as I know. I'll take your word for it.
383 Q. This system of cataloguing outstanding clinical episodes, you say, didn't rely on you to tell the Trust that Mr. O'Brien was not completing his dictation? 14:54
A. Well, it was robust enough to know that the episodes weren't closed for whatever reason. It could have been a delay in typing or a delay in dictation.
384 Q. Yes. It didn't tell the reader what was going on in SWAH, in the South Western Hospital? 14:54
A. Subsequent reports included SWAH. I don't think SWAH was on this particular one for whatever... Obviously whoever done the searches for this didn't include SWAH in the search. The data quality department.
385 Q. So this report couldn't be relied upon by the Trust to know that he wasn't completing his SWAH clinics in a timely fashion -- completing his clinical outcomes in a timely fashion? 14:54
A. From SWAH?

386 Q. Yes.
A. But subsequent reports did include SWAH. I don't know -- this one not didn't include SWAH but other reports that were received, I think maybe the first one, remember it had two SWAH clinics on it, the very first data quality report that came through. I don't know, for some reason this one didn't but the others did include SWAH. That was something outside my control. It was the data quality people who populated this report. 14:55
387 Q. What you are saying is that this system, properly used, could have been availed of by Trust management to interrogate or question the issue of why a clinic or a patient attending a clinic hadn't received an outcome?
A. Yes. 14:56
388 Q. Hadn't received a disposal?
A. Yes.
389 Q. You would say that, as I understand your evidence, there was no need for you to be telling the Trust that Mr. O'Brien wasn't dictating because the Trust had this system at its disposal and ought not to have required you to be informing on Mr. O'Brien? 14:56
A. Yes. Well, I did -- do you remember, going back to that email I had sent Marie Loughran where I had said that Mr. O'Brien hadn't given me the outcome sheets for the two Enniskillen clinics, and that was on the back of this report. 14:56
390 Q. Yes. Why, having done that at one point in time in 2014 told the system, told the service Mr. O'Brien

isn't dictating on SWAH or isn't doing it quickly now enough, why didn't you continue with that?

A. I don't know. Probably just the pressures of work and I knew that everybody knew. I think I have said in my statement that it was common knowledge. So therefore, I -- the information was there for managers to see. I didn't need to tell them where to look for it.

391 Q. We have received evidence from Mrs. Robinson in respect of this issue. I'll give the Panel the transcript references, I don't need to bring them up on the screen. It's TRA-05189 through to TRA-05196. Thinking back to the Backlog Report that we have looked at, and we'll look at some more recent examples of it, she is saying while there isn't a specific column on that table to address clinics awaiting dictation, that was nevertheless an issue secretaries should have known to report to add that information in to the table. You don't accept that? 14:57 14:57 14:58

A. I didn't think of it at the time, no.

392 Q. In 2016/early 2017, were secretaries told to include that information in the Backlog Reports? 14:58

A. Yes.

393 Q. And did you do so?

A. I did, yes.

394 Q. We can just look at a couple of examples of that. If we go to WIT-77951. You use the far right column to complete an entry for 25th May 2017, this "also see attached list of clinics with no outcomes completed". 14:59

A. That was the list that was given to them in December

'16, so those outcomes, to my knowledge, were never done by May '17.

395 Q. Okay. In 2019, WIT-77995. Not that. If we try TRU-77995? Thank you. So again, you use the middle column at the bottom "awaiting dictation" -- 15:00

A. Mm-hmm.

396 Q. -- to convey the message that there were 16 patients awaiting dictation from a clinic in September '19, and again six from 27th September '19. That was how you started to use the system after being told, the Trust 15:01 might say reminded, of the need to do this from early 2017; is that fair?

A. That's correct, yes.

397 Q. You have mentioned that, when we looked at the outcome report for the Backlog Report, I should say from 15:01 May 2017, that you were including as an attachment to it those clinics that hadn't been dealt with by the end of 2016 are the ones you referred to in your December 2016 email?

A. Yes. 15:02

398 Q. It was your understanding that even by that point in time, May 2017, these matters had not been dictated or completed. Why were you raising that point?

A. Because there was a further five to six months' delay in those outcomes being done. I was aware that 15:02 Mr. O'Brien had given the Trust the outcome sheets, so I couldn't understand why those outcomes weren't completed as soon as those were received by the Trust.

399 Q. Do you now appreciate that those patients' cases were

the subject of consideration by other urologists and that they worked up what had to be done with those patients who hadn't been completed?

A. I didn't know at the time, no. I didn't know what was happening those patients. 15:03

400 Q. And why should you have known?

A. Well, that was my work. Completing the outcomes of the clinics was part of my work and that was taken off me.

401 Q. Right. In a sense, you were chasing them or seeking an explanation? 15:03

A. Well, I thought my management needed -- in fact, I got an email from Katherine Robinson in, I think it was February '17, asking me if I had the outcomes done, so she wasn't even aware that I didn't get the outcomes. So, I had to put her right and say those outcome sheets 15:03 were never sent to me, they were sent to the admin office and I was totally unaware as to what was happening with them. So my line management didn't know what the process was.

402 Q. You have said in your statement, if we just bring it 15:04 up, WIT-76360 at 42.1 - scrolling down - that you were appreciative or appreciating that Mr. O'Brien was working through the backlog --

A. Mm-hmm.

403 Q. -- during his sick leave, and you said with maximum 15:05 effect . What did you mean by that?

A. Well, I was conscious that he was off on sick leave and still he was doing 10 to 15 letters a day. He would have been bringing the charts into my office late on in

the evening. So, whenever I would have come in the morning, those charts were sitting on my desk with the dictation completed. Even though I had a locum that was backfilling his sick leave, I then had this additional work. So I was happy to get that work all completed.

404 Q. Then you go on at 42.2 to say:

"This was all halted in late December 2016 by management, I'm not sure who was directing this, and Mr. O'Brien was subsequently suspended from his duty as a consultant urologist." 15:05

Then you talk about the investigation being initiated.

A. Mm hmm. 15:06

405 Q. You say this backlog in dictation remained until at least May and June '17, and you were never informed if the dictations in clinical outcomes were ever completely dealt with.

"I feel that Mr. O'Brien should have undertaken this workload and I should have been allowed to complete the administrative work associated with it." 15:06

So, you appear critical of the suspension of Mr. O'Brien, the MHPS investigation and the fact that this work was taken off you and Mr. O'Brien; is that what you are saying? 15:06

A. Well, at that particular time in January, I didn't --

I wasn't aware that Mr. O'Brien was suspended. I was actually told --

406 Q. I think the proper word is "excluded"?

A. Excluded.

407 Q. My fault. I used the word "suspended" but it is "excluded". 15:07

A. Sorry. I was sent an email from Martina Corrigan to say that Mr. O'Brien was having an extended sick leave period. That was the reason I was critical of the system because that was part of my work that was taken off me and I couldn't understand why. 15:07

408 Q. But you are writing this statement --

A. Afterwards.

409 Q. -- many years later?

A. Yes. 15:07

410 Q. You are saying "I feel that Mr. O'Brien should have been allowed to get on with this" . Do you accept that by the end of 2016, notwithstanding Mr. O'Brien's efforts during his sick leave to get to grips with the outstanding clinics, that there was still a substantial number of cases outstanding? 15:08

A. I never knew the total amount until obviously later. I didn't know whether it was 10, 20, 30. I had no idea how much dictation was outstanding.

411 Q. What you knew was that there were 61 clinics that had some element of outstanding work; isn't that right? 15:08

A. Yes.

412 Q. Yes.

A. Well, it was reduced, I think, by the time it hit the

end of December.

413 Q. Yes.

A. Because he was working at it. So it was 61 at the beginning of December --

414 Q. We can quibble this down, Mrs. Elliott, but let's get on. When you wrote the email on 15th December, you were aware of 61 clinics with some element outstanding; isn't that right? 15:08

A. Yes, that's correct.

415 Q. Why are you complaining that you weren't and Mr. O'Brien weren't able to complete that work when you know that there were clinics outstanding for almost two years in terms of the completion of them? 15:08

A. I think probably the reason I was so annoyed was the fact that there was a further five to six months. So, those patients were not seen to or addressed for a further five to six months. If those outcome sheets had have came to me, I would have had those done within a week. 15:09

416 Q. Yes. 15:09

A. It was the fact that they were sitting for a further five to six months, I couldn't understand why the Trust would have let that happen.

417 Q. You referred us, I think earlier, to a particular case that you identified where there was a problem caused for the patient by a lack of dictation and a lack of action on Mr. O'Brien's part. Can we just draw your attention to that, please. It's WIT-77963. At paragraph 21 you tell Dr. Chada: 15:10

"I recently had to request a chart from the Head of Urology office for another clinic. When I received the chart, I noticed that the patient should have been put on the waiting list for urodynamics studies. This patient was originally seen in June 2016 and should have been on urodynamics waiting list. As the waiting list was shorter than some others, this patient could have had the procedure by the end of last year if he or she had been put on the waiting list." 15:10 15:11

Mr. O'Brien saw the patient June '16?

A. That's correct.

418 Q. Should have put the patient on the waiting list at the end of the clinical episode. In other words, he should have dictated that night or the next day? 15:11

A. Mm-hmm.

419 Q. You're writing a statement in 2017 and reflecting that you have only just noticed that this patient should have been on the urodynamics waiting list, so that patient has suffered some harm in not getting his or her treatment in a more timely fashion? 15:11

A. Yes. The waiting list for urodynamics would have been about eight to 12 months.

420 Q. What you are saying is this patient -- 15:12

A. It was much shorter, yes.

421 Q. -- would have been seen by the end of 2016?

A. Yes. Well, as I say, maybe six to 12 months. As I say, the waiting list for urodynamics was shorter

than that of inpatients.

422 Q. Yes. Mr. O'Brien had assured you that all urgent cases had been dealt with in terms of dictation?

A. Yes.

423 Q. Is this not a case of urgency? 15:12

A. Urodynamics wouldn't have been classed as an urgent procedure.

424 Q. But you're not saying it's okay for this patient to have slipped through the net and awaited several months at the very least more than should have been the case 15:13 for his intervention? Are you saying this is an acceptable way to have dealt with this case?

A. What do you mean an acceptable way? An acceptable way in that it wasn't dictated and he wasn't put on a waiting list? 15:13

425 Q. Yes.

A. No, it wasn't acceptable.

426 Q. And this could have been avoided with timely dictation?

A. Timely dictation. Plus if the outcomes for those undictated clinics had been given to me in January '17, 15:14 I would have had this man on a waiting list. He had to wait a further five months, five to six months. It was May/June before they'd done the outcomes.

427 Q. Yes. Mr. O'Brien should have done it in June. If the Trust had studied the paperwork and actioned it, it 15:14 could have been done in January?

A. Mm-hmm, yes.

428 Q. When you were speaking to Mr. O'Brien about these matters and he was assuring you that his urgent stuff

was done, his non-urgent stuff could wait, would that explanation have covered a case like that? Would that have satisfied you?

A. Probably not.

429 Q. Did you ever ask him to confirm that nobody was going to come into difficulty or to harm or would be excessively delayed by his inaction? 15:15

A. There would have been the odd email where patients would have rang in to see where they were on the waiting list, and I would have forwarded an email to Mr. O'Brien to say the patient was on the phone, they are expected to be on a waiting list but the dictation wasn't done. So, there would have been those odd occasions where the patient would have contacted me. But that was very rare. It was rare, like. 15:15

430 Q. Yes. Could I move on and look at the issue of triage with you, and GP referral letters. You have explained in your witness statement that when you joined Urology Service, the triage letters were forwarded to the consultant through you, through the secretary? 15:16

A. That's correct.

431 Q. There was a change in that process in November '14 into the early months of 2015 --

A. Mm-hmm.

432 Q. -- when the Urologist of the Week system was introduced. Let's just look at how that worked and I am particularly interested in how the systems worked. If we look at TRU-294285, this would be, would it not, a fairly typical transaction in terms of chasing 15:16

triage. Alannah Coleman, is she from the Referral and Booking Centre?

A. That is correct, yes.

433 Q. She is writing to you, 14th October 2014.

"Outstanding triage from Mr. O'Brien, please have these returned as soon as possible".

Then you would e-mail Mr. O'Brien?

A. That's correct. 15:17

434 Q. Is that the way --

A. Well, I probably didn't e-mail them all but when it was a list like that, I would have e-mailed. If it was individual triage letters, I usually printed them off and left them on his desk with the other triages. 15:17

435 Q. Yes. If, as we have seen in certain scenarios, there is repeat emails to you --

A. Mm-hmm.

436 Q. - 'chase this, do this, it is outstanding three months or whatever', was your formula the same? 15:18

A. Yes, those would have been printed off and left on Mr. O'Brien's desk.

437 Q. When you are getting these repeat communications about outstanding triage and you are printing off the email and leaving it for him, was that to your mind an 15:18 effective system for addressing delayed triage?

A. Well, I had no other way of addressing it. I found printing the email off and leaving it was the best way.

438 Q. Yes, but how effective was it in your view in terms of

getting a timely response?
A. Well, probably when there was numerous printing off and leaving, probably no, it wasn't very effective, but I didn't take any responsibility to the monitoring of those. It was just I was leaving them for him to do and that was my input into the triaging.
439 Q. Yes. In terms of your role, we have seen it perhaps already with patients phoning in, you are leaving emails with triage, you are leaving emails, at any point did you seek to engage in conversation with Mr. O'Brien about those issues? 15:19
A. Oh, I would. If he had have come into the -- when he came into the office, I would have usually highlighted something like that, but that was as far as it went. I would have said there is a -- especially if patients rang, did you get that email about such and such; and he would have said, yeah, he would take it on board. There would have been interaction, yes, about particular things that I was concerned about. 15:19
440 Q. What was your memory of the kinds of responses that you would get around the triage issue from Mr. O'Brien? 15:20
A. I didn't really take much... What would you say; I didn't follow up on triage because I knew that was being monitored by the booking office. I was basically passing on what was given to me and I left everything else up to the booking office, between them and Mr. O'Brien. And the red flag office obviously for the red flag referrals. 15:20
441 Q. Just so we understand it, after late '14/early '15, how

did the system change in terms of chasing up with Mr. O'Brien? If pre '14 you were expected to follow up, what was the system after that?

A. After that the triage -- the appointments people would have left all the triage letters down in the Thorndale Unit, which was a building where the clinics were held, the urology building. That would have been for the Consultant of the Week. Whatever Consultant of the Week was on, they were left in a basket in the office in Thorndale. So, the secretaries would have had less interaction regarding triage. That was the same for the red flag triaging. 15:21 15:21

442 Q. So the follow-up, if there needed to be follow-up, for delayed triage was the responsibility of the red flag people, or, if it was routine or urgent, the referral and booking centre? 15:22

A. Mm-hmm.

443 Q. You did, it seems, receive some correspondence to try to encourage you to chase up even after that time. If we look at, for example, WIT-77945. This is 13th September 2016: 15:22

"Please see the list of current missing triage. If possible could this be returned as soon as possible." 15:22

Obviously Mr. O'Brien is copied in as well. Are you being expected to chase this?

A. Not to my knowledge. I don't think it's a secretary's duty to chase triage. Just due to work pressures, we

just had not the time to do that.

444 Q. So as far as it went, as far as you are concerned, it was just to ensure that Mr. O'Brien was aware of it?

A. Yes. As long as I saw he was copied into that, I didn't need to act on that. 15:23

445 Q. Could I give you another example, TRU-294453. This is a little earlier in 2016. Alannah Coleman - we'll not use the patient's name obviously, maybe you would remember it - is saying to you: 15:24

"This is my fourth time chasing a response to the attached referral. I will leave this for you to sort out."

Was that a referral for triage? 15:24

A. It was. That would have been an example of one of the ones, when it was an individual patient like that, I would have printed that off and left it on his desk with the rest of his post. So, the fact that it was the fourth one, then you can see I e-mailed him then after the fourth one. 15:24

446 Q. Yes.

A. But the other earlier ones would have been printed off and left on his desk with the post.

447 Q. Yes. I mean, it's probably obvious to the Inquiry that Mr. O'Brien's travails with triage were longstanding and that the system and its management knew about it? 15:24

A. Yes.

448 Q. Did anyone within management ever approach you to

invite you to be more proactive with Mr. O'Brien to try to encourage earlier responses?

A. No. I don't know how a secretary can encourage any clinician to do anything different than what he is doing. 15:25

449 Q. Yes.

A. You know.

450 Q. Did you think it unfair that this was being placed across your desk on repeated occasions, more notably pre-2015, to follow up with Mr. O'Brien, or did you just see it as -- 15:25

A. I didn't think it unfair. Like, as I said, I actioned anything I got. I left it on his desk.

451 Q. Yes.

A. But as regards trying to encourage anybody to do anything, I don't think that was a secretary's job to stand over him while he done it. 15:25

452 Q. Martina Corrigan has reported in her statement to Dr. Chada - I don't need to bring it up but it's TRU-00748 - that when she spoke to Mr. O'Brien in January 2017, he directed her to his filing cabinet, and in the third drawer of the filing cabinet there were, she counted, 783 - the number isn't terribly significant - a sizeable number of referral letters dating back to June 2015. 15:26 15:26

Did you know that those referral letters were in his filing cabinet?

A. I knew there was post. It was actually in his drawer

of his desk. I knew there was stuff there but I didn't interfere with it. I didn't know what it was.

453 Q. Did you know that he wasn't triaging by and large normal -- sorry, routine I should say, and urgent referrals? 15:27

A. I knew there was a delay in him triaging them. I never understood that he didn't triage. I knew that he hadn't, he said he hadn't the time to do the triage, but it wasn't that he didn't do any.

454 Q. What's your current understanding? 15:27

A. I think he still did some but not all of.

455 Q. So he did the red flag?

A. Well, definitely the red flags were. Albeit there may have been a slight delay in the return of the red flags but they were generally done in a timely fashion. But 15:28 it was the routine and the non-red flag, the routine and the urgents, that I knew there was a big backlog.

456 Q. Were they not available to be observed in his office?

A. Well, as I say, I knew there was stuff in that drawer but I didn't interfere with anything that was put away 15:28 in his drawer because that wasn't for me to start going through.

457 Q. If you had been aware that he wasn't triaging at all on routine and urgents, would that have been something that you would have raised? 15:28

A. No, because the booking office were monitoring his triaging. I didn't think it was a responsibility of me to monitor triaging, it was already being done in the booking office.

458 Q. The issue of the storage and management of patient records was another issue which you would have been familiar with as secretary for Mr. O'Brien. We know that nearly 300, approximately 300 charts were returned from his home in 2017 . Again, would you have had an awareness that a significant number of charts tracked to Mr. O'Brien were not kept in hospital but had been brought to his home? 15:29

A. Yes, I was aware that there were charts in his home because I frequently had to ask him to bring charts in that were required for other clinics. 15:29

459 Q. Yes.

A. And that was happening on a very regular basis.

460 Q. Had you any sense of the scale of it?

A. Not the scale, no. I knew the outstanding -- you see, it all ties up with the outstanding dictation, well, the most of it, because the most of those charts at home were from those undictated clinics, the SWAH clinics. 15:30

461 Q. Yes. 15:30

A. I would say at least half of them were probably SWAH charts -- or not SWAH charts, Craigavon charts belonging to SWAH patients.

462 Q. Yes. There is obviously policy governing the handling of and the safeguarding of patient files. I just want to draw this to your attention and seek your response. If we go to TRU-164900. This is the policy - you can see its lengthy title - Policy for the Safeguarding, Movement and Transportation of Policy Clients, SWAH 15:30

Trust Files and Other Trust Media Between Facilities". This particular iteration is dated 2012. Is that something that you would have had a working knowledge of as a secretary with responsibility for handling patient charts? 15:31

A. No, because I would never have had charts in my possession removed to another facility. It wasn't something I would have been familiar with, no.

463 Q. But you were responsible for holding charts in your office; isn't that right? 15:32

A. In my office?

464 Q. Yes.

A. Yes, but that was on the Craigavon site.

465 Q. This policy is broader than the movement of charts. Could I ask you this: Had you any training in data protection issues, data management issues? 15:32

A. Yes.

466 Q. Safeguarding of patient charts?

A. We would have done, as part of the induction -- well not, induction, corporate training, there would have been modules on data protection. We would have had to complete those as part of our KSF. As regards, that would have been like a training module we would have done on data protection and the handling of charts. 15:32

15:33

But as regards this policy, I don't ever remember seeing it.

467 Q. This didn't come across your desk?

A. No.

468 Q. That will help expedite matters if we just briefly touch on some aspects on it, and we'll see if these kinds of principles or policy standards ever came your direction in another way. If we can go over the page, please, and we can see the guiding principle. 15:33

"The aim of the policy is to ensure that staff safeguard all confidential information while travelling from one facility location to another during the course of their working day". 15:33

Scrolling down:

"The guiding principle is that staff working within health and social services have an ethical and legal 15:34 obligation to protect the information entrusted to them by users of the services. Staff must notify their line managers immediately on the suspicion of loss of any confidential information. The line manager must then notify the Information Governance Team of any loss. 15:34 Managers must ensure that staff are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect ensuring the safeguarding of confidential information." 15:34

Would those kinds of guiding principles have been broadly within your knowledge during your time as a secretary?

A. Yes, they would.

469 Q. So if there was a suspicion of loss of any confidential information, that was a matter to be raised with line management?

A. Yes, that's correct. 15:35

470 Q. Is that something you ever had occasion to do as secretary for Mr. O'Brien?

A. Never, no.

471 Q. Did you ever have occasion to be concerned that notes had been lost? 15:35

A. No.

472 Q. I am going to explore that with you by reference to some emails in a moment. Before doing so, can we go to TRU-164906. It says at paragraph 8, if we can just look at that, it's dealing with the transport and 15:36 storage for domiciliary visits. If we just go to the last bullet point. Obviously, Mr. O'Brien didn't do domiciliary visits but it says:

"Staff should not normally take health client records 15:36 home. Where this cannot be avoided, procedures could be in place to safeguard that information effectively. If records are being held by staff members home overnight, then they must be kept in a secure place. The responsibility for the records is held by the staff 15:36 member."

Did you consider it in any way inappropriate that numbers of patient records were being held at

Mr. O'Brien's home, as it appears, routinely?

A. Yes. It's not normal practice, if that's what you are asking, but it was something that historically went on with Mr. O'Brien. I knew management knew it, so there was no point in me raising any concerns because management were aware of it.

473 Q. And which management do you say was aware of it?

A. Well, I knew Martina Corrigan knew the charts were at home, and she was the Head of Service.

474 Q. You have said in your witness statement to Dr. Chada, if we can bring it up, TRU-00790, at paragraph 11, please. You are confirming that all notes tracked to Mr. O'Brien were not stored within the Trust. You said: 15:37 15:37 15:38

"It's widely known within the Trust that Mr. O'Brien has notes in his house".

Then you explain the process. 15:38

"Leanne Hanvey types Mr. O'Brien's private patients work. Mrs. O'Brien would e-mail her looking for charts. Leanne would pull the charts and leave them in Mr. O'Brien's office. The notes would be tracked out to Mr. O'Brien's private patient cabinet in his office but the notes wouldn't be there." 15:38

So, the situation was that a non-Trust employee, Mrs. O'Brien --

A. I actually think that that's maybe a typo. I think it's a typo. I don't know why I would have said Mrs. O'Brien there. I'm sorry.

475 Q. Is it not the case that Mrs. O'Brien frequently would have contacted you? 15:39

A. She would have contacted me, yes, about -- well, I would have contacted her rather than her contact me if a patient rang in requesting a private appointment.

476 Q. Yes. Is it not the case that she would have also --

A. I don't know. I wouldn't know there because it would have been Leanne Hanvey that would have got that request, not me. I didn't deal with any of Mr. O'Brien's private work. 15:39

477 Q. Explain the typo for me. You are saying it shouldn't be Mrs. O'Brien who e-mailed looking for charts? 15:39

A. As I say, I don't know who would have e-mailed looking for the charts. I just assumed it would have been Mr. O'Brien.

478 Q. Are you sure it's a typo, Mrs. Elliott?

A. Hold on. Can I read it again, please? 15:40

479 Q. You can, take your time.

A. I honestly don't know because I would never have had sightings to those emails to know whether it was Mr. or Mrs. O'Brien, because Leanne didn't work in the same office as me. So, I don't know who requested the chart. Irrespective, the chart would have been pulled and left in the filing cabinet in Mr. O'Brien's office. 15:40

480 Q. Mm hmm, and the notes would be tracked out?

A. They were tracked to the PP cabinet.

481 Q. In his office?
A. In his office.
482 Q. Yes.
A. That was like a holding place for him. He would have came and took those charts home. 15:40
483 Q. The system is told one thing, the charts are in his office in a private cabinet but, in fact, you and others knew --
A. They were at home.
484 Q. --perfectly well that that's not what they were tracked to, they were somewhere else? 15:41
A. Well, at that time there was no tracking code for anyone's home; there is now. But at that particular time, there wasn't a tracking code for Mr. O'Brien's house. That was the best way of knowing that that was in Mr. O'Brien's house. If it was in that cabinet and wasn't there, it was in his home, if that makes sense. 15:41
485 Q. That's in a sense distorting reality, isn't it? There may well not have been a feature in the system to record that patient notes are at home but isn't it the case that patient notes should not have been routinely at home, and certainly not for longer than overnight? 15:41
A. I accept that but, as I say, that was totally out of my -- that was nothing to do with me because I didn't -- I made it clear at the start that I was having nothing to do with the private practice and I didn't. 15:42
486 Q. Yes. But it was an issue --
A. I was aware of.

487 Q. You knew that notes were coming from records through Mr. O'Brien's office to his home?
A. Yes.
488 Q. You would have realised that that was not appropriate?
A. Well, it wasn't normal practice. 15:42
489 Q. Yes. Did you ever challenge him in relation to this?
A. No.
490 Q. The emails that form part of the disclosure around your work paint a picture, I don't know if you would agree with me, of sometimes chaos and confusion and practical 15:43 difficulties ensuing from trying to find patient notes, sometimes in urgent circumstances, and they are either at home, Mr. O'Brien's home, and they are known to be there?
A. Mm-hmm. 15:43
491 Q. In some cases there is confusion, and he disputes it that they are there. Was it a chaotic situation owing to this practice?
A. Well, it was an extra duty. I don't know if it was chaos because usually the chart could have been sought 15:43 within a day. But it was extra work, yes.
492 Q. Let's just look at some of the examples. AOB-00483. If we chart from the bottom of the page, please, a patient was to be seen by Dr. Convery but the chart was tracked to Mr. O'Brien in the Thorndale Unit. 15:44

"When the record was looked for, the secretary said she thought Mr. O'Brien had that chart at home and she would ask him to bring it in for the appointment at

9:00 a.m. that morning. The chart didn't arrive in records and Dr. Convery refused to see the patient without the chart. Pamela went to speak to Dr. Convery and asked if he would see the patient as she had got as much information as she could for the appointment. Mr. O'Brien's secretary is off that day." 15:45

This is probably before your time?

A. It is, yes.

493 Q. "He'd brought it in but taken it over to the old Thorndale Unit to have a letter typed. Pamela then went over that there that morning and got the chart and then brought it to Dr. Convey, who informed Pamela that he was going to write to Debbie about this." 15:45

If we scroll up, we see that Anita Carroll becomes involved and then, above that, Debbie Burns is asking did the patient get seen. 15:45

"I think if we can't agree with him, John Simpson", that's the Medical Director, "needs involved". 15:45

And so it goes on. I mean, plainly management were aware of such issues back before you became engaged with Mr. O'Brien? 15:46

A. That's correct.

494 Q. Did you see any particular efforts by management to try and nip this situation in the bud?

A. No.

495 Q. Another example of a patient being inconvenienced, or potentially inconvenienced, we can see at TRU-297194. Just scroll down to the bottom, please. Mr. O'Brien writing to you, Mrs. Elliott, November 2015, referring to, we'll just call him "patient". The patient is described as currently the longest urgent waiter on CURWL. What waiting list is that? 15:47

A. That's Mr. O'Brien's in-patient waiting list.

496 Q. Mr. Haynes had reviewed him in June or July 2015, that's four or five months earlier, with a view to doing his procedure. 15:47

"He was unable to commit to doing so as his chart was not available to him with the findings of urodynamic studies done in January 2014. I had his chart at home with the intent of discussing the findings with Mark. In the interim, Mark has arranged to have to urodynamic studies repeated tomorrow. I thought that I still have the chart at home but I do not have. I cannot recall bringing it into the hospital though it is possible that I did so. Please ascertain whether it is available." 15:47 15:48

This again a situation, Mr. Haynes isn't able to intervene in the case without a chart, Mr. O'Brien thinks he has the chart at home, can't find it there, and he is asking you can you assist to find it; he can't remember bringing it back into the hospital. 15:48

A. Mm hmm.

497 Q. Does this --
A. I can't remember anything about that case, I am sorry.
498 Q. You didn't raise it as a suspicious lost file?
A. Well, obviously it must have turned up. I don't know. Was that in my pack? 15:48
499 Q. I can't say for sure.
A. I don't remember seeing that. I don't know what the outcome of that was but obviously the chart was found. I am not aware of it remaining missing.
500 Q. Were there any charts that remained missing, to the best of your knowledge? 15:49
A. Well, I know from my pack there was 13 missing or supposedly missing.
501 Q. Those 13 charts were raised with Mr. O'Brien at the start of the MHPS investigation. Did Mr. O'Brien raise those with you? 15:49
A. He would have asked me to invest -- to look into it and see were they in the office. I would have done searches of the office. Whenever I would have looked through the PA system, the majority of the cases had no urology episodes. So I think it was a mistracking. A lot of them were before my time -- 15:49
502 Q. Yes.
A. -- but I think it was just a mistracking of charts.
503 Q. Yes. Let's look at a small number of further examples. If we look at TRU-297184. Just before we go there, I am being alerted to a note in respect of the last case I think we looked at. If we go to TRU-297196. Sorry, it was at the top: 15:50

"Checked the filing and this patient's chart is not there."

You may have no recollection of this one. In circumstances where there is suspicion that a chart may have been lost, as we showed you at the start under the general principles in that policy document -- 15:51

A. Mm hmm.

504 Q. -- a report should be made to management. No report made by you; is that fair? 15:51

A. That's fair, yes.

505 Q. Should a report have been made if you didn't find it?

A. I wasn't aware that a report should have been made with not having sight of that policy. 15:51

506 Q. Yes.

A. No, I didn't do -- I wouldn't have done anything about that.

507 Q. You would have left it to Mr. O'Brien to sort out?

A. Yes. 15:51

508 Q. If we go to TRU-297194. Sorry, wrong reference, TRU-297184. I beg your pardon. If we start at the bottom of the page, please. This is October 2015. Just scroll up. Mr. O'Brien has said: 15:52

"I brought a patient's chart to the clinic this morning. However, I do not have at home the charts of two other patients. Whilst it is possible that they are both in my office in the hospital, I think it is

more probable that one is with cancer tracker records and the other is with Records."

Then later that day Mr. O'Brien writes to you and says -- or the next day, I should say, 16th October: 15:53

"I am now eating very large amounts of humble pie, seeking forgiveness. I had entirely forgotten that the file of the first patient had come to see me privately in July '15 and I now have brought in his chart. I had 15:53 also forgotten that the second patient's chart had been requested for a private appointment but I did see him at a clinic and I have brought in his chart as well. Sackcloth for the rest of the day. Aidan." 15:53

Does that again point up that there was a degree of chaos in terms of the traceability of these charts? You, as the secretary, were aware that patient charts were being taken home?

A. Mm-hmm. 15:54

509 Q. They could have remained there for long periods of time and then, when they were needed, there was usually some delay, maybe only a day but usually some delay, and in some cases Mr. O'Brien didn't know whether he was coming or going in terms of whether he had the charts 15:54 or not, as displayed by this colourful email?

A. Well, this email was literally only hours behind the first email.

510 Q. Yes.

A. So I would have -- when I would have come in the next morning, I would have had both those emails on my inbox.

511 Q. Yes.

A. So he corrected himself literally within an hour from his first email. So, it wasn't that there was a day of me not knowing where these charts were. 15:54

512 Q. What we're doing for illustrative purposes, Mrs. Elliott, is pointing to some interesting examples of mismanagement of patient charts. I suppose what it comes to with you is, as his administrative secretary, medical secretary, knowing that patient charts were being used in this way, is there anything more you should have or could have been doing to address the problem which was created? 15:55 15:55

A. I don't feel that I needed to report any of this activity because it was widely known by management already.

513 Q. You had no responsibility to challenge Mr. O'Brien in respect of it, not least because it was a breach of the policy to keep notes at home, charts at home for lengthy periods of time, or, in the alternative, because it was putting you to difficulty? 15:55

A. I know but -- well, I wasn't aware that it was breaching any policy because I didn't see the policy. As I say, he has been keeping records at home for years and years before I was his secretary, and management knew about it. So I didn't know what I was supposed to do or who I would have escalated that to when it was 15:56

already known.

514 Q. I explained earlier this morning the various aspects of the Return to Work Plan, which you didn't know anything about on your evidence but which covered the aspect of patient notes, patient charts. If I could just bring you to the return to work monitoring plan so you can see it. It's TRU-00733. If we go through to concern 2, just down a little bit, please. It said, and this is now 2017. 15:57

"Mr. O'Brien is not permitted to remove patient notes off Trust premises. Notes tracked out to Mr. O'Brien's must be tracked out to him for the shortest period possible for the managements of patients. Notes must not be stored in Mr. O'Brien's office. Notes should remain located in Mr. O'Brien's office for the shortest period required for the management of a patient." 15:57

I think I outlined that to you this morning. Just on that aspect of the action plan, in the summer of 2017, management detected significant quantities, I think up to 90 files but a significant quantity of patient charts in Mr. O'Brien's office? 15:58

A. Mm-hmm.

515 Q. They convened a meeting at which this issue was discussed. I want to seek your observations on Mr. O'Brien's response to this concern. If we go to AOB-56211, and if we just scroll down to (g) on the left-hand margin, please. He's explaining that I don't 15:58

want the charts at all because -- sorry, because "I don't know why charts are coming to my office at all. There's no need for them to come into the office".

If we go over the page, please, and go down to (f), it records Mr. O'Brien saying:

"I was told by the secretaries actually that they are told that's what they have to do by their line managers"; in other words, bring charts in to Mr. O'Brien's office in certain circumstances.

Do you recall the rule, as you understood it, or the practice as you understood it in 2017? 15:59

A. From the outcome? I wasn't aware that they were monitoring the charts or there was a rule that charts weren't to be in the consultant's office. I was never made aware of that.

516 Q. What were the circumstances, if any, that you would bring charts into Mr. O'Brien's office? 16:00

A. The majority of the charts would have been from his DARO report, and that would have been -- we had a locum consultant who done a lot of extra clinics and it was a DARO report that was generated out of that. Because those weren't clinics that Mr. O'Brien done, I would have habitually attached the chart with those results when they went in. So, some of them would have been those, some of them would have been clinics that were 16:00

awaiting dictation. Then there was charts in pigeonholes. For governance reasons, there would have been other various reasons why charts were there. If it was an M&M discussion or maybe even a litigation case, there would have been charts in the office; if Mr. O'Brien had to provide a report for a litigation case. So, there was various reasons why the chart was there.

517 Q. Were you in position to observe whether the turnover of those charts, in other words how quickly they moved in and out, was achieved? 16:01

A. No, I was never made aware of that.

518 Q. Clearly you've said that you weren't made aware of the requirement of the action plan that charts should stay in the office for as short a time as possible? 16:01

A. No.

519 Q. You weren't made aware of that?

A. No.

520 Q. In terms of the questions that you were asked in 2018 in terms of keeping an eye on what was going on, and we looked the first thing this morning at your concerns about that -- 16:02

A. Mm-hmm.

521 Q. -- what was the question posed to you with respect to those activities? What were you being asked to do? 16:02

A. It was as I said. I would have got a telephone call, 'is he in his office, go and count the charts in his office'. There was no explanation as to why they needed to know that. That's why I was annoyed, because

I was asked to do something that I didn't know why they needed that information or what was the purpose of getting that information.

522 Q. Clearly this meeting took place between Mr. O'Brien and Mr. Carroll and Mr. Weir, and they had this discussion about the charts, and Mr. O'Brien is saying it's the secretary who is bringing the charts in to me. Did that situation lead to a conversation between you and Mr. O'Brien in terms of the need to change or address this practice? 16:03

A. Yeah, he would have said to me don't be bringing any more charts into my office. I then, through Mrs. Robinson, she had told me in future then whenever a result came in, that I kept the chart in my office and put it on a separate shelf and tracked it to result for Mr. O'Brien to see, and the chart was retained in my office with the result going to his desk. So, that was my safeguard that Mr. O'Brien had seen that result. 16:03

523 Q. Yes, okay.

16:04

Chair, it's coming up on 4:05. Certainly standing in his heat from my perspective, it certainly feels like a long day and it may feel like a long day for Mrs. Elliott on the receiving end of my questions. Can we park events for today and reconvene in the morning? Probably another hour, hour and a half on my part, and I know that you all will have some questions. 16:04

CHAIR: That's fine by us. I just see there is a note you are being handed that you might want to address

before we rise for the day.

MR. WOLFE KC: I understand this is saying that we need confirmation that we're sitting tomorrow so we can get stenography set up. There is always a risk of a spillover into the morning.

CHAIR: We stated that we be going into tomorrow whenever this week was being timetabled or the revision of the timetable was arrived at. Unfortunately, I'm sorry, Mrs. Elliott, but we're going to have to see you again in the morning. Hopefully you will be away by lunchtime at the very latest. Thank you.

So ten o'clock? Does ten o'clock tomorrow morning suit everyone? Thank you.

THE INQUIRY ADJOURNED TO 10:00 A.M. ON TUESDAY, 6TH JUNE 2023