



# Urology Services Inquiry

## Oral Hearing

**Day 50 – Wednesday, 7<sup>th</sup> 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.

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**Gwen Malone Stenography Services**

I N D E X

P A G E

Dr. Gillian Rankin

Examined by Ms. McMahon

3

Lunch adjournment

107

Questioned by the Inquiry Panel

168

1 THE INQUIRY RESUMED ON WEDNESDAY, 7TH DAY OF JUNE, 2023  
2 AS FOLLOWS:

3  
4 CHAIR: Morning, everyone.

5 MS. McMAHON: Good morning. The witness this morning 10:00  
6 is Dr. Gillian Rankin, a former Director of Acute  
7 Services with the Trust. She is going to take the  
8 oath.

9  
10 GILLIAN RANKIN, HAVING BEEN SWORN, WAS EXAMINED BY MS. 10:00  
11 McMAHON AS FOLLOWS:

12 1 Q. MS. McMAHON: Dr. Rankin, my name is Laura McMahon, I  
13 am junior counsel for the Inquiry. Thank you for  
14 coming along to give evidence today. You have already  
15 given evidence in the form of your written reply to the 10:01  
16 Section 21 notices, and if I could just take you to  
17 those and ask you to confirm that that's your evidence  
18 in written form.

19  
20 The first one is at WIT-15779, and that's Notice 8 of 10:01  
21 2022. That's signed at WIT-15935. Do you recognise  
22 that as your signature?

23 A. I do.

24 2 Q. It's dated 14th June 2022. Do you wish to adopt that  
25 as your evidence? 10:01

26 A. Yes, I do. Thank you.

27 3 Q. We then received an addendum statement which can be  
28 found at WIT-96714, and the signature can be found at  
29 WIT-96721. That's dated 1st June 2023. Do you

1 recognise that as your signature?

2 A. I do.

3 4 Q. And do you wish to adopt that as your evidence?

4 A. Yes, I do. Thank you.

5 5 Q. Thank you. We will look at the second statement

6 shortly. You have added some further information you

7 have recalled in relation to one of the issues we are

8 going to discuss, and we'll come to that.

9

10 Now, you have provided a lot of information in your

11 Section 21 and I suppose that's our fault, we asked you

12 for a lot of information so thank you for providing all

13 the detail that you did. By this stage, the Inquiry

14 has heard evidence from a range of witnesses, some

15 touching on aspects of your evidence. The focus of

16 today will be some key aspects of your statement that

17 are relevant to the governance issues for the Inquiry's

18 terms of reference during your tenure as Director of

19 Acute Services. Really, in global terms, the focus

20 will be on the issues that arose during your tenure,

21 how you became aware of them, how the governance

22 systems operated to make you aware or not, what you

23 then did and what subsequently flowed from that. We

24 will take each item separately.

25

26 Just at the outset, I know that you have retired and

27 you say that you got the documentation that you relied

28 on in the preparation of your statement from the Trust?

29 A. That's correct.

10:02

10:02

10:02

10:03

10:03

1 6 Q. And all the documents were provided to you by them?  
2 A. That's correct.

3 7 Q. Now, you have set out just briefly your background, if  
4 I can just touch upon that. You studied medicine at  
5 Queens; then you had various junior hospital jobs in 10:03  
6 Belfast; then you did your GP traineeship, achieving  
7 your MRCP. After that, you moved into various medical  
8 and social healthcare management roles, leading  
9 ultimately to your appointment as the Interim Director  
10 of Acute Services on 1st December 2009? 10:04

11 A. Yes.

12 8 Q. Until February 2011, in the Southern Health and Social  
13 Care Trust. Then you were made full-time Director of  
14 Acute Services on 1st March 2011 to 31st March 2013.  
15 After that, you then left the Trust, moved to part-time 10:04  
16 consultancy in the NHS in England, and then  
17 subsequently worked part-time with the PHA and HSCB in  
18 a role through 2013 to 2016, and that included  
19 undertaking regional medical workforce planning?

20 A. That's correct. 10:04

21 9 Q. And then you retired in August 2019?  
22 A. I did, yes.

23 10 Q. The job description, which we don't need to go to, for  
24 the Director of Acute Services is at WIT-15949.  
25 I would like to just read some extracts from that to 10:05  
26 set the boundaries of your responsibility at that time.  
27 The job description says:  
28  
29 "The Director of Acute Services will be responsible for

1 the development and delivery of safe, high quality  
2 emergency and elective hospital care within the  
3 Southern Trust. She will lead the strategic planning  
4 of the Trust's Acute Services and ensure effective  
5 multidisciplinary working and the most efficient use of 10:05  
6 hospital beds and other resources. She will provide  
7 clear leadership and oversee the management of all  
8 staff involved in Acute Services. In addition, the  
9 post holder will have a corporate role as a member of  
10 the Trust's senior management team that will include 10:05  
11 helping to shape the Trust's overall objectives. The  
12 Director is responsible to the Chief Executive for  
13 delivery of effective clinical and social care  
14 governance within acute hospital services, including  
15 the successful delivery of agreed patient safety 10:06  
16 programmes, and the reporting of appropriate indicators  
17 to provide assurance to the Chief Executive and Trust  
18 Board. "

19  
20 You also are to ensure high standards of governance 10:06  
21 "including the effective assessment and management of  
22 risk. "

23  
24 And you must "ensure that robust performance management  
25 arrangements are developed and implemented within the 10:06  
26 Directorate".

27  
28 You say at paragraph 5.2 in your statement that you  
29 consider that the job description was an accurate

1 description of the duties of your post?

2 A. Yes.

3 11 Q. Just to give the Panel the context of other players at  
4 the time, if I can put it like that, there has been  
5 some changes in personnel over the years. During your 10:06  
6 time as Director of Acute Services, the Chief Executive  
7 was Mrs. Mairéad McAlinden?

8 A. That's correct.

9 12 Q. The Medical Director was Dr. Patrick Loughran, and then  
10 Dr. John Simpson? 10:07

11 A. That's correct.

12 13 Q. The Director of Performance and Reform was Mrs. Paula  
13 Clarke. The Director of HR was Kieran Donaghy. The  
14 Director of Nursing was Frances Rice. At that time the  
15 Assistant Director of Surgery and Elective Care was 10:07  
16 Heather Trouton?

17 A. Correct.

18 14 Q. And Ronan Carroll was Anaesthetics, Theatres &  
19 Intensive Care Radiology?

20 A. Yes. 10:07

21 15 Q. The AMO -- is that the AMD as well, are they  
22 interchangeable?

23 A. AMD.

24 16 Q. AMD, was Dr. Eamon Mackle -- sorry, Mr. Eamon Mackle,  
25 for Surgery and Elective Care, and Dr. Charles 10:07  
26 McAllister for Anaesthetics and Intensive Care. Now,  
27 the Clinical Directors For General Surgery and Urology  
28 were Mrs. Samantha Sloane, then Mr. Sam Hall and then  
29 Robin Brown?

1 A. That's correct.

2 17 Q. Throughout all of the time, the Head of Surgery for  
3 Urology and ENT was Martina Corrigan?

4 A. That's correct.

5 18 Q. Have I left anyone out? 10:08

6 A. I don't think so.

7 19 Q. Now, you have set out in your statement the general  
8 landscape for governance while you were the director.  
9 I just want to take you through some of those roles and  
10 processes you had in place before we move on, as they 10:08  
11 will hopefully help explain how things actually were  
12 brought to your attention. I promise you you will be  
13 talking more than me subsequent to this, but if we set  
14 out the landscape, we will be on fair ground.

15 10:08

16 We don't need to go to this but at WIT-15830 at  
17 paragraph 32.1 of your statement, it says:

18

19 "The Director of Acute Services was operationally  
20 responsible for the day-to-day safety of patient care 10:09  
21 and the quality of service, and this role was  
22 accountable to the Chief Executive."

23

24 If I can just ask you in relation to the Chief  
25 Executive at the time, what was your interaction with 10:09  
26 Mrs. McAlinden, formally and informally? What were  
27 your lines of communication?

28 A. Formally I would have had regular one-to-one meetings  
29 with her, to which both of us brought issues for



1 discussion. I was formally appraised by the Chief  
2 Executive, of course, and that had a regular review  
3 throughout the 12 months relating to the performance  
4 indicators which had been set for the year.

10:09

5  
6 Informally, I would have had contact with the Chief  
7 Executive, with Mairéad, almost daily, either  
8 face-to-face when we were both at a meeting or when I  
9 was in headquarters and wanted just to have a quick  
10 conversation with her. Or we phoned and caught up on  
11 the activities of the day, often at the end of the  
12 working day, which was often 7:00, 7:30 in the evening.  
13 So, it would have been an unusual day when I didn't  
14 have a degree of contact with Mairéad.

10:10

15 20 Q. In relation to your assistant, Heather Trouton, Martina  
16 Corrigan, can you give us a flavour of what your lines  
17 of communication and lines of interaction with them  
18 were both formally and informally as well?

10:10

19 A. Okay. The beauty of Craigavon hospital is that the  
20 offices where most of the managers are located are at  
21 the front of the hospital on the first floor, just  
22 above the main entrance to the hospital. So, most of  
23 the direct staff that I was working with, all of my  
24 Assistant Directors and many of the Heads of Service  
25 were in the next door office or around the corner. So,  
26 a lot of the communication was people coming to my  
27 office, me going to their office, some of it of course  
28 had to be by e-mail, and during one-to-one meetings or  
29 performance meetings when the whole system needs to be

10:10

10:11

1 present those were face-to-face more formal meetings.  
2 But a lot of the ongoing contact was face-to-face,  
3 informally, in the corridors around the hospital and  
4 along that corridor.

5  
6 Because the suite of offices was situated at the front  
7 of the hospital, it was very easy for clinicians to  
8 call in on their way out or their way in in the  
9 morning, or their way out to the car park.

10 CHAIR: Sorry, I need to interrupt you but you do speak 10:11  
11 rather quickly. Although we don't have a stenographer  
12 present in the chamber, they are trying to get a note  
13 of all that you say. If I could ask you just to slow  
14 down a little bit, please.

15 A. I will do my best. Thank you. It meant that the 10:11  
16 clinicians often would have popped their head around  
17 the door of my office on their way out to have a quick  
18 conversation, to discuss an issue, to pass on some  
19 information or to seek some information. My policy was  
20 always to have an open door, a physically open door to 10:12  
21 my office and to my secretary's office. Everybody knew  
22 my secretary and knew that Emma would know exactly  
23 where I was. If I wasn't physically in the office,  
24 I could be contacted, and obviously could be contacted  
25 any time 24/7, seven days a week, 24/7 by e-mail. 10:12

26 21 Q. So the geographical close proximity, in your view did  
27 that assist good governance?

28 A. Absolutely. Absolutely assisted in governance. There  
29 was a lot of soft intelligence was in discussion.

1 That's often the way hospital systems work. You have  
2 the formal processes but you have also the  
3 conversations that happen through the wards and talking  
4 to nurses and talking to a range of staff, some of whom  
5 you don't necessarily met in formal meetings but you 10:13  
6 make it your business to be out walking in the  
7 hospitals, in both hospitals. I mean, I have to  
8 mention Daisy Hill, of course, here because I would  
9 have tried to spend some time every week in Daisy Hill  
10 Hospital, and the present -- I didn't have an office 10:13  
11 there but I would have arranged meetings and would have  
12 sometimes done formal meetings within the Directorate  
13 from Daisy Hill and videoed into my staff who were in  
14 Craigavon that day. So, we tried to make sure that  
15 there was one of the senior team in Daisy Hill on most 10:13  
16 days.

17 22 Q. You have set out at WIT-15832 - we don't need to go to  
18 that, I am going to summarise it - at paragraph 33.3,  
19 some of the systems you put in place to provide  
20 oversight of clinical and social care governance in the 10:13  
21 acute services when you started?

22 A. Yes.

23 23 Q. We will start at February 2010 and work through. Just  
24 before we do that, you had just started the role. Was  
25 it your view -- did you take an overview of what the 10:14  
26 governance structures were like in place and felt that  
27 you needed to bring about change, or is it usual for  
28 a new director to come in and develop their own systems  
29 of governance to ensure they are aware of all issues?

1           A.    No, it wouldn't be usual to start afresh without  
2                    understanding the existing systems because if they were  
3                    fit for purpose, you would continue and develop those.  
4                    What I inherited appeared to be a once-weekly meeting  
5                    with the Assistant Directors. It was a one-hour                    10:14  
6                    meeting on a Friday afternoon and it covered  
7                    governance, performance, finance, HR, in an hour.  
8                    I felt that Friday afternoon is not the right time of  
9                    the week to have a senior leadership meeting. It  
10                   doesn't give you time to address things promptly                    10:15  
11                   because you are coming towards the end of the working  
12                   week, so the timing of that meeting was not good.  
13                   I felt that to be able to cover all of the issues in  
14                   sufficient depth and understanding, I couldn't cover  
15                   them all within an hour.    10:15  
16  
17                   So, I set up various -- three sets of meetings. One  
18                   was a meeting with the Assistant Directors and the  
19                   associated finance, HR staff from the Medical  
20                   Director's office, where they were bringing information                    10:15  
21                   on our complaints reports, on our risk registers and  
22                   our IR1 reportings. That was a weekly meeting on  
23                   a Tuesday afternoon. That was an in-depth meeting. We  
24                   rotated that. One week it was governance, a detailed  
25                   look at all of the wide range of issues under    10:16  
26                   governance, such as Patient Safety alerts, such as NC  
27                   pods, such as learning letters, our risk registers, the  
28                   recent monthly report on IR1s, complaints, any SAIs and  
29                   their draft reports; looking at progress against actual

1 plans. That was one meeting. A second meeting in the  
2 month was on performance and another meeting was on  
3 finance and the fourth one was probably on HR.  
4

5 Now, to echo that then with the senior clinicians, 10:16  
6 I started in April 2010 an acute clinical governance  
7 meeting. There had been no forum to which the senior  
8 clinical and management staff came together to discuss  
9 governance. Our first meeting, I think, was 16th April  
10 2010. It was set at a Friday morning at 8:00 a.m., at 10:16  
11 a time when all the senior clinicians could be present.  
12 Again, we had a very similar agenda to the meeting that  
13 I had with the Assistant Directors. The whole range of  
14 safety issues were brought to the table, and it was an  
15 opportunity for anyone present to raise issues but also 10:17  
16 provide their views on the range of issues that we were  
17 discussing.

18  
19 The third meeting that I set in place at that stage,  
20 which didn't exist, was a weekly performance meeting on 10:17  
21 a Tuesday morning at 9:00, where I expected all of the  
22 Heads of Service, and Katherine Robinson as Head of the  
23 Referral and Booking Centre and the Assistant Directors  
24 to be present. We met in a small room, there were  
25 often two people to a seat. It was an hour long 10:17  
26 meeting. It was a fast and furious meeting, provided  
27 and supported by the data. Another key person at the  
28 meeting was an Assistant Director from Performance and  
29 Reform, who brought the data that was up-to-date to the

1 previous day, to the Monday. We used that, those  
2 reports, from both the Assistant Director from  
3 Performance and Reform and from Katherine Robinson in  
4 the Referral and Booking Centre then to monitor how the  
5 system was doing against a whole range of metrics. 10:18  
6 That had not been in place before and I don't think the  
7 system had really used the data that was available to  
8 it to inform how we need to work, going forward.

9 24 Q. We have heard from Katherine Robinson about her  
10 intensity of preparation for those meetings and the 10:18  
11 effectiveness of them from her perspective, I will put  
12 it in neutral terms. One of the things that was clear  
13 from Mrs. Robinson was that the focus at that time was  
14 ensuring the data was collated almost concurrently so  
15 that those meetings were as up to date as possible? 10:18

16 A. Absolutely. Absolutely.

17 25 Q. I presume that was the aim for you, to know exactly  
18 what was happening across your division?

19 A. That was exactly the aim, to understand how each  
20 service was performing against the range of metrics, 10:19  
21 whether that was triage, whether that was the waits for  
22 outpatient clinics, for first appointment, whether that  
23 was for review appointments, and to look at the  
24 inpatient waiting times and the day case waiting times.  
25 Those were the broad range of metrics that we looked at 10:19  
26 and to understand, projecting forward within the next  
27 months, three months, where we were likely to be within  
28 the waiting times, given we had the integrated elective  
29 and access protocol which had clear time standards

1 against each of those parameters which we were expected  
2 to meet.

3 26 Q. Were you confident at that time that -- we have looked  
4 at metrics and the way in which data can seem very  
5 one-dimensional but, when you go underneath it, there's 10:19  
6 perhaps a bit of a story that needs to be told. Were  
7 you confident in relation to the data that you were  
8 receiving that you were understanding of any  
9 outstanding issues that were perhaps interfering with  
10 performance metrics? 10:20

11 A. Well, that, in fact, was the benefit of having the  
12 face-to-face meeting and everybody in the room. If I  
13 had just been looking at a cold report, I wouldn't have  
14 understood necessarily the reasons underlying some of  
15 the issues that the data was telling us. By having the 10:20  
16 Head of Service for each of the specialties across all  
17 of medicine, surgery, obs and gynae around the table,  
18 and Katherine Robinson, we were able to delve into some  
19 of those issues. Sometimes they were significant and  
20 had to be taken off the table, and we would have had 10:20  
21 a separate meeting about those to understand what was  
22 happening and to try and get things back on track. It  
23 was a matter of bringing together all of that  
24 intelligence so that we could understand what was  
25 happening and then to take the appropriate action to 10:20  
26 deal with it.

27 27 Q. It may have been in preparation for this introduction  
28 of different ways of looking at governance but you  
29 also, in February 2010, sent an email to the ADs?

1 A. Mm-hmm.

2 28 Q. Asking them to set out the divisional processes to  
3 record IR1s.

4 A. Mm-hmm.

5 29 Q. 10:21

6 "Identify SAIs, share IR1s and SAIs with clinicians and  
7 managers, identify and record actions and lessons  
8 learned, share information with the staff involved,  
9 i.e. complete the feedback loop, please send to my  
10 office by 24th February 2010". 10:21

11

12 was that because you weren't that long in the post; was  
13 that you trying to get a feel for systems in place, or  
14 had there been something that prompted that?

15 A. No, I don't think anything had prompted that other than 10:21

16 an awareness that things were not as I felt they should  
17 be. I was really asking the ADs, two of whom were new  
18 into post, to really look at their systems. As we were  
19 designing the overall Directorate system, that was to  
20 be echoed within each division and then within the Head 10:22  
21 of Service. So, there was a cascade in both  
22 directions.

23

24 There was a real thrust at that stage in the Trust that  
25 IR1s, we perhaps didn't have a culture that every 10:22  
26 incident was recorded on an IR1. So therefore, if it  
27 wasn't recorded it was only a very small group of  
28 people knew about it. Therefore, there wasn't  
29 necessarily learning from it and certainly the whole



1 system didn't learn from it.

2  
3 One of the things we were very keen to do was to gain  
4 people's confidence in completing IRIs. Unfortunately  
5 at that stage, they had to be written and then sent to 10:22  
6 the Medical Director's office to be put on the system.  
7 But the whole thrust was to get IRIs to get completed,  
8 to get them visible, to have the local system where the  
9 IR1 was generated, to look at that and to understand  
10 what the learning was, and then to cascade that back up 10:22  
11 the system so you had information going in both  
12 directions. Very difficult to really get that  
13 motoring, but that was certainly the thrust of what we  
14 were seeking to do.

15 10:23  
16 So, my email to the ADs at that stage was saying, look,  
17 you know how we are now managing ourselves at the top  
18 of the directorate, please now put in your systems with  
19 the same regularity, using the same information but  
20 a deeper dive, and get this working really well, get 10:23  
21 this energised in your system and I want to hear how  
22 you are doing it, because if you didn't ask for the  
23 feedback, you wouldn't necessarily get the feedback.

24 30 Q. It was that feedback and your identification of perhaps  
25 some vulnerabilities in the system, or some 10:23  
26 improvements that might be made, that then led to the  
27 setting up to the two new governance meetings that you  
28 have discussed, the monthly acute clinical governance  
29 meeting on a Friday, and the acute governance meetings

1 which took place monthly?

2 A. Yes.

3 31 Q. With the ADS?

4 A. Yes.

5 32 Q. Was it also an attempt by you to try and standardise  
6 the approach to governance feedback, as you say, both  
7 up and down the systems so that everyone understood  
8 what should trigger an IR1, what it should contain,  
9 what is an SAI, and confidence-build staff to engage  
10 with those processes?

10:23

10:24

11 A. It was absolutely. If you think of the Southern  
12 Trust - this was late 2009, early 2010 - the Southern  
13 Trust had only been a single organisational entity from  
14 April 2007. Prior to that, it was four Trusts, two  
15 acute hospital Trusts and two community Trusts, and  
16 there was still a lot of standardisation needed. So,  
17 a lot of processes were about finding new ways of doing  
18 them, engaging people in determining those processes  
19 but actually then bedding down, implementing and  
20 accruing the learning from those systems.

10:24

10:24

21 33 Q. What was the response from the ADS and the Heads of  
22 Service in relation to these new changes and these new  
23 systems of looking at how things were working? Did you  
24 meet any resistance, or were people keen to embrace new  
25 ways of working?

10:25

26 A. I think there was a mixture of reactions. Some felt  
27 that the old system was fine, and took a little bit  
28 more time and energy required to actually address the  
29 new way of going. Others very, very comfortable going

1 on that journey and welcomed it. As with any system,  
2 you will find the earlier adopters and those that come  
3 along a little bit later, and you've just got to work  
4 with the whole system to get it all there.

5 34 Q. Part of your role, you were also involved in various 10:25  
6 committees in the Trust Board, the Governance Committee  
7 of the Trust Board throughout your tenure?

8 A. Yes.

9 35 Q. Your role was to provide assurances by reporting back 10:25  
10 issues. How often were those meetings held with Trust  
11 Board?

12 A. My recall is that they were quarterly.

13 36 Q. Was it your experience that they were meetings at which 10:26  
14 you could report any issue and speak freely about any  
15 concern around governance, patient safety risk, any  
16 matter that was on your mind?

17 A. Yes. The meeting was supported by reports and papers  
18 which went out before the meeting. So those were  
19 discussed, obviously, but there would always have been  
20 an opportunity to raise an issue that had perhaps 10:26  
21 arisen in the week since the reports had gone out or  
22 the papers had gone out. So yes, they were long  
23 meetings, they were three to four hours long. Of  
24 course, each directorate was setting out their own  
25 report. The span of the range of services that are 10:26  
26 governed by a Trust in Northern Ireland includes not  
27 only acute health but community health, social care,  
28 all the social care problems, the disability problems.  
29 So yes, it's a very wide range of services.

1 37 Q. There's a sense that it could be a lot of papers  
2 presented unless you could filter down the issues that  
3 needed being brought to the Board's attention, at least  
4 the Governance Committee's attention primarily?  
5 A. I am sorry, I don't quite understand what you are 10:27  
6 asking.  
7 38 Q. You had the exercise, your discretion as Director, as  
8 to what made it into the report?  
9 A. Yes. There certainly is an element of that. There  
10 perhaps would have been discussion at the senior 10:27  
11 management team, the senior management team governance  
12 meeting, as to which particular issues from each  
13 directorate needed to go into the report. The Director  
14 obviously had the discretion to add more in but there's  
15 a risk if you overload with too much, you lose sight of 10:27  
16 the key issues. So there's always a balance to be  
17 struck in terms of what goes into all of the reports.  
18 39 Q. And the SMT governance is a way in which you hear from  
19 the Medical Director as well as to two issues arising?  
20 A. Yes. 10:28  
21 40 Q. And the Director of Performance and Reform --  
22 A. That's correct.  
23 41 Q. -- at that point as well?  
24 A. Yes.  
25 42 Q. Now, the Acute Clinical Governance Group; I think you 10:28  
26 were Chair of that group?  
27 A. I was, yes.  
28 43 Q. That was another way in which you could find out  
29 information from various members of staff from the

1 acute governance or acute services --

2 A. Yes, that's correct.

3 44 Q. -- on issues that were outstanding. Again, there were  
4 monthly reports. You also in those meetings received  
5 quality checking assurances from the ADs and the AMD. 10:28  
6 what does that involve, if they are giving you  
7 assurances around their particular areas of  
8 responsibility?

9 A. Well, that would have been the reports that were being  
10 brought to the meeting. It may have been assurances 10:29  
11 around actions coming out of RCAs; it may have been  
12 assurances actions around medicines governance, which  
13 we omitted to mention five minutes ago, another really  
14 important report on that agenda which Dr. Boyce would  
15 have brought to the table. So it would have been -- 10:29  
16 it's a face-to-face assurance as well as the data that  
17 is sitting on the page, and you've really got to do  
18 both.

19 45 Q. We will come to some examples when you sought assurance  
20 from, for example, Mr. Carroll on some of the issues 10:29  
21 arising. You will be able to give the Panel examples  
22 of the correspondence seeking that.

23 A. Okay.

24 46 Q. Just in relation to the line management of raising  
25 governance issues, and we don't need to go to it but I 10:30  
26 am referring to your statement at WIT-15855. I just  
27 want to read this paragraph.  
28  
29 "With the exception of the Serious Adverse Incident,

1 the governance process was taken through the line  
2 management process of managers and clinicians in CD and  
3 AMD roles. Therefore, the Head of Service and Clinical  
4 Director took appropriate action if they deemed the  
5 risk to be moderate to serious. They raised this with 10:30  
6 the AD and AMD, who in turn raised it with myself as  
7 Director. The data on the risk would then be further  
8 detailed and discussed at the service monthly meeting  
9 led by the Head of Service and the divisional monthly  
10 meeting led by the AD and/or both the acute services 10:30  
11 monthly governance meetings with the AMDs and ADs. "

12  
13 It doesn't seem there's any shortage of opportunity to  
14 discuss the issues?

15 A. No. 10:31

16 47 Q. One of the issues that has potentially arisen is the  
17 failure of people to inform each other whether they are  
18 on the clinical side or the operational side of  
19 potential issues or real issues, the issue of  
20 delegation or escalation and that perhaps being seen as 10:31  
21 being sufficient in circumstances.

22  
23 Do you feel that when you were the Director of Acute  
24 Services that there was a greater cross-fertilisation  
25 of information between the medics and the operational 10:31  
26 side so that people had a global view of issues?

27 A. It's very difficult for me to compare what happened in  
28 my time to somebody else's time but I do feel that we  
29 had connected systems. We had connections between the

1 clinicians and the managers at all different levels.  
2 That was part of what I was seeking to ensure was in  
3 place. I think the openness of dialogue, which I am  
4 sure was never as good as it should or could have been,  
5 but there were never any clinical issues that were 10:32  
6 brought to my senior table that I actually didn't  
7 already know about through somebody having  
8 a conversation with me. The benefit of having the open  
9 door policy, having the senior clinicians dropping in  
10 and out, the benefit of walking the corridors, walking 10:32  
11 the wards and spending time with staff to listen. Now,  
12 not every member of staff would have opened up about  
13 things but many did. When you are walking around the  
14 hospital with a cup of tea in your hand, as I always  
15 did - it's one thing I haven't got here, is a cup of 10:32  
16 tea - a cup of tea in hand, it makes a deliberate  
17 statement, 'I want to have a chat'. I know people are  
18 busy and if you find there's something very serious to  
19 talk about, you come back and find a time to have that  
20 conversation. 10:33

21 48 Q. So visibility was a benefit in relationship building  
22 and confidence-building?

23 A. Very much so.

24 49 Q. You were involved with the Urology Review in 2010?

25 A. Yes. 10:33

26 50 Q. That was another meeting that you chaired weekly or  
27 fortnightly with the Urology consultants at that time  
28 and the AMD, the ADs, the Heads of Service, senior  
29 staff from Performance and Reform, and HR and Finance?

1 A. That's correct.

2 51 Q. This was a process by which the development and  
3 agreement around the implementation plan was brought  
4 about over a period, you say, of around 16 months?

5 A. Yes, yeah. 10:33

6 52 Q. You also represented the Trust along with Mr. Young,  
7 who is one of the consultant urologists, and the  
8 Director of Performance and Reform on the Regional  
9 Implementation Project Group set up by the  
10 then-director of the HSCB? 10:34

11 A. That's correct.

12 53 Q. In relation to the Urology Review, that was almost  
13 simultaneous, I think, with your appointment; the same  
14 sort of era?

15 A. That's correct. Yes, it was. 10:34

16 54 Q. Would it be fair to say that you were responsible for,  
17 as Director, in your role taking the reins of  
18 implementing the change that was envisaged by the  
19 Review?

20 A. That's correct. It had been started by my predecessor 10:34  
21 and I followed it on. The Monday evening meetings,  
22 Monday five o'clock meetings, were fortnightly. They  
23 were open meetings always to the three consultant  
24 urologists, the Assistant Director, the Head of Service  
25 and, as you have indicated, other staff from other 10:34  
26 disciplines. The meetings were very clear in terms of  
27 what they were seeking to do. I always created an  
28 agenda for every meeting, every meeting that I chaired  
29 across the Trust. If there were 12 meetings in the



1 day, there were 12 agendas had been sent out prior to  
2 the meeting.

3  
4 The regional review was very clear in terms of what it  
5 was seeking to do for Urology in Northern Ireland. All 10:35  
6 three units were expected to meet the same demands of  
7 certain metrics they had set out. So that was our  
8 challenge, to take our Urology Service through each of  
9 those different parameters and to get agreement before  
10 we could then set out our implementation plan for 10:35  
11 discussion and approval with the Health and Social Care  
12 Board.

13 55 Q. Now, you say in your statement - again we don't need to  
14 go to this - just for note, it's WIT-15811 at paragraph  
15 16.6: 10:36

16  
17 "The main issues were a combination of a lack of  
18 sufficient resources and a less than optimal use of the  
19 existing resources. The discussions with the Urology  
20 Service improved the use of resources in many ways, but 10:36  
21 during my tenure the service was still on a trajectory  
22 of improvement in this regard."

23  
24 Is that in terms of the implementation aims, or was  
25 that your understanding of the provision of Urology 10:36  
26 generally?

27 A. No, that was in relation to the implementation. We had  
28 to work very, very hard to get agreement on the range  
29 of metrics, things like admission on the day of

1 surgery. There had been a longstanding -- as with many  
2 surgical specialties, patients would be admitted the  
3 day before, and we were now moving to a scenario that  
4 unless there was a medical reason for the patient to be  
5 pre-admitted the day before for assessment for further 10:37  
6 tests, most patients would now be being admitted on the  
7 day of surgery. That was quite a significant change.

8  
9 The issues in relation to the number of procedures  
10 which we were undertaking as inpatients that we needed 10:37  
11 to change to day cases, that was a very significant  
12 change that had to be made over this time. There were  
13 quite a lot of changes that we were taking the  
14 urologists through that perhaps had been around before  
15 the regional review but the changes had not been made. 10:37

16  
17 The thinking about the management of outpatient clinics  
18 and the amount of time that a new patient should  
19 warrant within a clinic setting, and a review patient  
20 and the new-to-review ratio. What is interesting, the 10:37  
21 new-to-review ratio had been an issue for the Health  
22 and Social Care Board prior to the implementation of  
23 the regional review. Prior to 2007, 2008 when there  
24 was this structural change within Northern Ireland, we  
25 had four commissioning boards. Most people took the 10:38  
26 view that was three too many and we moved to a single  
27 commissioning board. The single commissioning board  
28 had to embark upon a process of standardising across  
29 Northern Ireland to prevent the inequity of post-code

1 lottery and post-code access. One of the things they  
2 had done was to look at all of the specialties within  
3 the acute sector, and to look at national guidance on  
4 what new-to-review ratios there would be within  
5 Outpatient clinics. So, there would have been guidance 10:38  
6 from the Royal College of Physicians, or from BAUS in  
7 relation to urology, or from the Royal College of  
8 Surgeons. The board adopted national guidance in  
9 relation to each specialty and we were required then to  
10 implement that. 10:38

11  
12 So, I had brought the Clinical Lead for all of the  
13 specialties into those meetings with the board and we  
14 had already embarked on a process of moving each of the  
15 specialties to a new-to-review ratio. Most specialties 10:39  
16 were absolutely fine. One or two were resistant; those  
17 two was a medical specialty and urology. The medical  
18 specialty, we took a little bit longer but we got them  
19 there. In urology, that was a really difficult problem  
20 to get them there. Of course, if you are not adopting 10:39  
21 the correct new-to-review ratio, you are building up an  
22 increased new-to-review backlog and making a greater  
23 rod to deal with later. So, our new-to-review ratio in  
24 urology in the Southern Trust was greater than the  
25 peers in Northern Ireland; that was set out in the 10:39  
26 regional Urology Review. We had some elements to work  
27 with.

28 56 Q. You speak about --

29 CHAIR: Again, if you could, just try and remember to

1 slow down a little bit. We are trying to get a note,  
2 as well as the stenographer getting a transcript.  
3 I know it's very difficult but if you can just try to  
4 slow down a little bit, please. Thank you.

5 57 Q. MS. McMAHON: I get reminded of that frequently as well 10:40  
6 so we are both in the same boat. That's probably why I  
7 am not saying anything. It seems fine to me.

8  
9 One of the things you referred to in your statement is  
10 the issue of the capacity gap, that the Trust had 10:40  
11 agreed there was a capacity gap?

12 A. Yes.

13 58 Q. Could you just explain what that means and in what way  
14 the Trust established that?

15 A. Okay. The capacity gap is a concept that is usually 10:40  
16 agreed with the Trust as the provider and the Health  
17 and Social Care Board as the commissioner. Trusts can  
18 often talk about a gap but until it is agreed and set  
19 out with a commissioner, it's not an agreed position.  
20 It is where the population requirement for a particular 10:40  
21 specialty is greater than the resources that you have  
22 to provide care for that need. That capacity gap could  
23 be insufficient consultants in the specialty; it could  
24 be due to insufficient theatre capacity and theatre  
25 nurses and anaesthetic staff to be able to run all the 10:41  
26 inpatients. It could be a whole range of things. But  
27 in terms of urology, it was around the numbers of  
28 consultants and also the middle grade staff, because we  
29 had serious gaps in middle grade staff as well, which

1 contributed to the overall pressure within the service.

2 59 Q. If I can just feed your answer back to you to make sure  
3 that I understand it. The Commissioner wants a certain  
4 service and the Trust said well, if you want that, this  
5 is what's needed to meet that, is it as simple as that, 10:41  
6 and therefore we require greater access to staff or  
7 funding? Is it done that way?

8 A. Well, the simplicity of the statement implies that the  
9 Trust is using all the resources optimally, and of  
10 course we know that that was not the case. The Trust 10:42  
11 has an absolutely key responsibility to make sure that  
12 against the norms that are set for the Trust, be those  
13 from the Commissioning Board or be those from outside,  
14 within the national scenario, the Trust has  
15 a responsibility to make sure that whatever resources 10:42  
16 we are given for that specialty, we are using those.  
17 That comes down to things like your Outpatient clinic  
18 and how many new patients and how many review patients  
19 you were seeing in your Outpatient clinic; how many  
20 patients are being operated on as a day case as opposed 10:42  
21 to an inpatient, because all of these have direct  
22 impacts on the use of our resources.

23 60 Q. In order to establish if resources were being used  
24 optimally, were the consultants engaged in the process  
25 of establishing what the capacity gap was? Is that 10:42  
26 something that they would be asked about and consulted  
27 on, I suppose? Would they be aware of that or is it  
28 much more high level?

29 A. I can't speak for the time before me because

1 I inherited the regional review as a done deal, shall  
2 we say. It was published in, I think, April 2010 and I  
3 had started meetings with the consultants from January  
4 2010, I think. All of the work establishing what the  
5 capacity gap was at that stage had been done prior to 10:43  
6 me coming into post, so I can't say whether the  
7 consultants had been involved at that stage.

8  
9 I think going forward, though, the metrics that we  
10 looked at in terms of the numbers of patients on the 10:43  
11 PTL, the Patient Targeting Lists, the number of  
12 patients who were waiting to have an operation, the  
13 number of patients who were waiting for day cases, the  
14 number of patients who were waiting for urodynamics,  
15 the numbers of patients waiting on the outpatient list, 10:44  
16 and the review backlog, all of that would have been  
17 known to the consultants because that was the crux of  
18 the conversations to have with them. Martina would  
19 have brought the most up-to-date position so that we  
20 were using that data on the table at those Monday 10:44  
21 evening meetings to talk about the need for change.  
22 They were our evidence to bring, they were the  
23 consultants' evidence. You would usually use that in  
24 the discussions with the consultants to say how are we  
25 going to handle this? what do we need to do? what's 10:44  
26 the process doing this and the time scale? who is  
27 going to do what? So, we brought that to the table for  
28 those discussions on a Monday evening.

29 61 Q. You have mentioned the consultants were concerned about

1 obviously staffing and their ability to meet the  
2 demand?

3 A. Yes.

4 62 Q. We don't need to go to it but for the Panel's note at  
5 WIT-15811, at paragraph 17.3 and 17.4 of your  
6 statement, you give an example of receiving an email  
7 from Mr. Young. Your paragraph says:

10:44

8

9 "In relation to junior staff, I received an email on  
10 6th August 2010 from Mr. Young Clinical Lead for  
11 Urology regarding junior staff and the need to clarify  
12 the funding for same and specifically for the action  
13 plan for urology."

10:45

14 A. Yes.

15 63 Q. You detail your response.

10:45

16

17 "My action in response to Mr. Young was to request the  
18 Head of Service to clarify the budget position before  
19 proceeding. This was the corporate requirement across  
20 all services due to the budgetary constraints imposed  
21 on the HSC by the Department of Health at this stage.  
22 No post would proceed to recruitment without a clear  
23 funding position and agreement by SMT scrutiny that the  
24 post would proceed to recruitment."

10:45

25

26 So, you responded to that by asking that the proper  
27 lines of securing that that post would proceed were  
28 followed through Mrs. Corrigan?

29 A. Yes. That specific request was in relation to a

10:45

1 clinical fellow. I think the date of that  
2 correspondence is germane in that that is the  
3 changeover of the junior doctors. I think probably  
4 that meant that we had a gap in a specialty registrar  
5 in the service. We had not been given the number of 10:46  
6 trainees for which there was funding, and that was  
7 Mr. Young quite rightly asking the question about could  
8 we appoint a clinical fellow who would work part-time  
9 within the service for the unit and would have  
10 a part-time research role. I just needed to establish 10:46  
11 that the funding for the clinical fellow was in the  
12 service; I think Mr. Young was quite clear it was.  
13 I just needed to establish that it was before we could  
14 bring that through for approval and go to appointment.

15  
16 There was always a struggle to maintain the middle  
17 grade staff within urology, partly because at that  
18 stage my understanding was it was a national training  
19 programme and we didn't always get the number of  
20 trainees that we should have had. 10:46

21 64 Q. The Inquiry has heard evidence of staffing difficulties  
22 within urology, which appear to continue currently?

23 A. Mm-hmm.

24 65 Q. Mr. O'Brien would certainly raise his concerns around  
25 the adequacy of the staffing in order to meet clinical 10:47  
26 demands and to carry out good clinical practice?

27 A. Mm-hmm.

28 66 Q. Was that a familiar theme during your tenure, that the  
29 consultants and medics within urology felt that they



1 just couldn't meet the demand and were overstretched?

2 A. I think that statement is true. I mean, the Regional  
3 Review said we should have had five, a five-person  
4 team, and we had three. But we had to set out our  
5 implementation plan and the detailed job plans to 10:47  
6 deliver against the full activity that the  
7 Commissioning Board had set out before we could get  
8 approval to proceed to recruitment, and that became  
9 a very lengthy process. So, therefore, we had no  
10 permission in the system to increase our consultants 10:48  
11 until we got to that point. But we also had, as I have  
12 alluded to, gaps in middle grades which exacerbated the  
13 pressure. We had a seven-session ICATs doctor. ICATs  
14 is a service which is usually staffed by GPs with  
15 specialty interests who will take some of the workload 10:48  
16 from the consultants against an agreed specified list  
17 of symptoms or diagnostic categories. Unfortunately,  
18 our ICATs doctor who had seven clinical sessions was on  
19 long-term sick leave, and so that meant that instead of  
20 that being a potential route to review many patients, 10:48  
21 those patients who needed to be reviewed who could have  
22 been reviewed by the ICATs doctor then had to remain  
23 within the consultant review list. That was a theme  
24 throughout my whole tenure. So, we lost seven sessions  
25 a week, which was a very significant number of 10:49  
26 sessions.

27  
28 Then, when you don't have a full complement of staff in  
29 training, you have difficulties again because if you

1 have a specialist registrar with you at an Outpatient  
2 clinic, you can increase the numbers of patients.  
3 Okay, you have a teaching workload to do but you can  
4 usually increase the number of patients being seen,  
5 usually on the review side within an Outpatient clinic, 10:49  
6 and that wasn't the case. So yes, staffing pressures  
7 were an issue all throughout.

8  
9 I think at one stage we did appoint a consultant locum,  
10 who stayed with us for a short period. I know that in 10:49  
11 2012, one of the three consultants decided to return to  
12 England. So, we had a gap for I think of the order of  
13 three or four months. We were -- and I think had  
14 appointed a locum at that stage but we were already  
15 within the recruitment process to move the three-person 10:50  
16 team to a five-person team. So, the consultant gap was  
17 small number of months. I know it was still  
18 a significant impact but it wasn't a prolonged period.  
19 I strove very, very, very hard in every specialty to  
20 keep our consultant posts full. It was a real theme to 10:50  
21 make sure that we had all of our posts filled across  
22 both hospitals and that any necessary gaps were as  
23 short as possible.

24 67 Q. You do say in your statement at paragraph 28.5 that you  
25 spent "considerably more time with the Urology 10:50  
26 clinicians than the clinicians in any other specialty  
27 in acute medicine across a range of over 16 specialties  
28 across both hospitals."

29 A. Yes, that, in fact, is true. That's because of the

1 Monday evening meetings. If you have a fortnightly  
2 meeting with consultants over 16 months, that is a lot  
3 of time. The meetings were all at least 90 minutes and  
4 often there was the informal conversation after the  
5 meeting, so you wouldn't really be leaving the room 10:51  
6 until 7:00. That's two hours every fortnight, so that  
7 amounts to a lot of time.

8 68 Q. You also speak to the difficulties in bringing about  
9 change in behaviours --

10 A. Yes. 10:51

11 69 Q. -- in order to meet targets and performance metrics. I  
12 will just read what you say at paragraph 29.5. For  
13 note, it is at WIT-15822.

14 CHAIR: Call some of this up because I think it's  
15 easier for the witness and us to follow when you are 10:51  
16 reading it out.

17 70 Q. MS. McMAHON: "The issues of changing the behaviour of  
18 the consultant team to meet the required new-to-review  
19 ration of patients, and new clinic templates in  
20 Outpatient clinics to increase the day case rate and 10:52  
21 lower the inpatient elective workload and to meet the  
22 BAUS guidelines were exceptionally difficult. Whilst  
23 agreement may appear to have been reached on one of  
24 these issues at one week's meeting, there was  
25 retrenchment from this position at the following week's 10:52  
26 meeting. It was unusual to require weekly meetings for  
27 such a long period of time to reach agreement on such  
28 issues. It was also unusual for the Director to have  
29 to formally write to each consultant setting out the

1 the requirements for change tailored to each  
2 individual's practice."

3  
4 Just in relation to the last sentence, how often would  
5 you have had to write formally to consultants to set  
6 out the requirements again of what they needed to do? 10:52

7 A. I don't think I wrote to any other consultant across  
8 all the specialties. We achieved the changes that we  
9 needed to achieve, both in relation to outpatient  
10 new-to-review ratios, but also in new pathways for 10:53  
11 patients from the Emergency Department through to  
12 specialties and vice versa. All of those changes  
13 across the many ranges of specialties and many changes  
14 to reform and modernise were achieved without final  
15 resort to a written letter to the consultant. 10:53

16 71 Q. Would that have been something -- we will go to an  
17 example now of one from Heather Trouton to Mr. O'Brien.  
18 If I can go to AOB-00255, dated 1st July 2011. You  
19 will see it's to Mr. O'Brien from Heather Trouton and  
20 the subject is "Issues and actions from meeting held on 10:53  
21 9th June 2011".

22 A. Yes.

23 72 Q. I just want to read this out. It says:

24  
25 "Following our discussions on Thursday 9th June 2011, 10:54  
26 please see following a summary of our discussions and  
27 agreed actions. Dr. Rankin outlined the Trust  
28 requirement for updated job plans to be completed prior  
29 to end of June 2011. Dr. Rankin also placed a meeting

1 in the context of the Regional Urology Review and the  
2 necessity of demonstrating the provision of an  
3 effective, efficient and productive Urology Service if  
4 further funding was to be secured from the Regional  
5 Board. This productivity was also set in the context 10:54  
6 of the SBA capacity modelling exercise under way for  
7 all specialties across all Trusts."

8  
9 The second point is about job planning.

10 10:54  
11 "Mr. O'Brien to submit current breakdown of activities  
12 to Mr. Mackle for planning into updated job plan as per  
13 Trust action for all consultants Trust-wide to agree an  
14 updated job plan by the end of June 2011".

15 10:54  
16 That was subsequently submitted on Thursday 16th June.

17  
18 The review backlog:

19  
20 "Heather Trouton to meet with Mr. O'Brien to discuss 10:55  
21 the way forward in managing the review backlog in  
22 a timely manner. Heather Trouton to set up meeting.  
23 Also to ensure that responsibility is taken to manage  
24 all Outpatient appointments in such a way as to only  
25 review those who clinically require review and thereby 10:55  
26 reduce the formation of a review backlog unnecessarily.  
27 A discussion was also had regarding appropriate  
28 communication with patients who have had their review  
29 appointment delayed due to the current backlog or

1 review appointments". I presume that is "of review  
2 appointments"?

3 A. Yes.

4 73 Q. A mention of an issue we will come on to speak about.

5

10:55

6 "Patient admission for surgery: Patients are not to be  
7 brought in the days prior to surgery for IV fluids and  
8 IV antibiotics without discussion with and agreement  
9 from both Ms. Sloane as Clinical Director and the  
10 consultant microbiologist. All patients are to be  
11 brought in for elective surgery on the morning of  
12 surgery, with the exception of the very complex patient  
13 who requires essential inpatient management prior to  
14 major surgery."

10:56

15

10:56

16 Then we have urodynamics consultant input.

17

18 "It was agreed following discussion that Mr. O'Brien  
19 would require 20 minutes per patient to review the  
20 results of the urodynamics studies and agreed/provide  
21 a management plan for each patient. This would be  
22 factored into workload but does not require a full  
23 dedicated urodynamics session."

10:56

24

25 Then there was a note on pooled lists.

10:56

26

27 "There was an agreement on the need to manage all  
28 day-case patients in a chronological manner and to  
29 support Mr. O'Brien in managing the chronological

1 booking process. Sharon Glenny, the Operational  
2 Support Lead, and Andrea Cunningham, Service  
3 Administrator for Urology, will contact Mr. O'Brien to  
4 discuss support input required".

10:57

5  
6 The cancer pathway:

7  
8 "Discussion was had around specialist interest within  
9 Urology with regard to Outpatient time required to see  
10 day 4 cancer patient. It was agreed a 30 minute slot  
11 would be required.

10:57

12  
13 "Discussion regarding the leadership requirement of all  
14 senior staff inclusive of consultants to give  
15 confidence to overall department nursing staff  
16 regarding patient care and to take action to improve  
17 patient management rather than projecting a negative  
18 and critical attitude within the clinical team.

10:57

19  
20 "I would appreciate if you would advise if the above is  
21 an accurate reflection of discussions had and actions  
22 agreed or if any amendments are sought."

10:57

23  
24 Is that a document you are familiar with? Have you  
25 seen that?

10:57

26 A. Yes, I have.

27 74 Q. would you have seen that before it was sent to  
28 Mr. O'Brien?

29 A. Yes, yes.

1 75 Q. May I take that to mean that you agree with all of the  
2 contents that were put in it; it was reflective of  
3 issues that needed to be discussed at that time?  
4 A. Yes.

5 76 Q. Just in relation to the point 8 where there's mention 10:58  
6 of the leadership requirement of all senior staff  
7 inclusive of consultants to give confidence and to take  
8 action to improve patient management rather than  
9 projecting a negative and critical attitude within the  
10 clinical team, was that something that you had direct 10:58  
11 experience of?  
12 A. No. I'm trying to remember what caused that to be part  
13 of the conversation. My recall is hazy but I think  
14 there had been some examples of just negative  
15 discussions within the ward. All staff have 10:58  
16 a responsibility, but especially senior staff, in terms  
17 of keeping the system buoyant. If there are negative  
18 issues around discussing those, opening those up for  
19 discussion and getting them resolved and moving on. So  
20 there must have been something that had happened, 10:59  
21 otherwise we probably wouldn't have had that discussion  
22 in there but it's a very carefully worded paragraph.

23 77 Q. Some of the issues we will look at shortly when we look  
24 at your hand-over on your first day in role specific to  
25 Urology, and to Mr. O'Brien. This is dated halfway 10:59  
26 through your tenure, July 2011?  
27 A. Mm-hmm.

28 78 Q. Would you agree that some of the first day themes seem  
29 to still be an issue?



1 A. Yes, some of them are still there but many of the  
2 themes are being managed appropriately but it's just  
3 a useful time to remind. I mean, the pooled list is an  
4 interesting one there. We had already put a process in  
5 place with Mr. O'Brien, who had always scheduled his 10:59  
6 inpatients list himself, but I had put a process in  
7 place fairly early in 2010 that Sharon Glenny as OSL,  
8 and Martina Corrigan, sat with Mr. O'Brien to make sure  
9 that we had patients being booked in chronological  
10 order for their inpatient episode. 11:00

11 79 Q. Just from discussion around the culture and the mood in  
12 relation to change, if we could bring up WIT-15872.  
13 I may have got the wrong -- I think I have the wrong  
14 Bates number, with the Chair's indulgence I will maybe  
15 read from my own and get the correct reference. 11:01  
16 Hopefully you will recognise this paragraph.

17  
18 "On reflection, while there was a significant demand  
19 pressure on the Urology Service, there was a general  
20 resistance to change in clinical behaviour in the 11:01  
21 service. Nonetheless, when change was required in  
22 order to implement improvements for patients and to  
23 implement Team South Urology as part of the Regional  
24 Review of Urology, two consultants did make these  
25 changes in their personal behaviour. However 11:01  
26 Mr. O'Brien did not always make the changes required  
27 and there were times when change was agreed and  
28 implemented for a period of time before he reverted to  
29 the previous behaviour. He therefore was unable to or

1 chose not to amend his behaviour."

2

3 15782, thank you. There it is at paragraph 1.12. I  
4 don't know whether you want to read that again, or  
5 having read it out to you --

11:02

6 A. That's fine.

7 80 Q. Was that something that persisted during your period in  
8 post, a resistance to change or, as you say, perhaps an  
9 inability to change?

10 A. Resistance or inability. Certainly that was a theme 11:02  
11 throughout, and particularly in the Monday evening  
12 meetings, that an issue for change might be agreed and  
13 perhaps that was then retrenched or rescinded the  
14 following meeting. In terms of making changes in  
15 clinical behaviour, whilst help was offered, there was 11:02  
16 a resistance to making that change. I think the only  
17 thing that was requested was additional secretarial  
18 time. There was no other help sought in thinking about  
19 how he could change his administrative processes to  
20 free up time for clinical work, which is primarily what 11:03  
21 his job was around, the relevant administrative  
22 processes to undertake the clinical requirements of the  
23 job.

24 81 Q. Both you and Mr. Mackle met with Mr. O'Brien on  
25 occasion to discuss issues. You have detailed one of 11:03  
26 those at WIT-15827, at 30.2A. If we look at the  
27 paragraph just preceding that, you can see that. You  
28 will see the question there about informal meetings  
29 within Urology. You say:

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"Virtually all meetings with Urology staff regarding patient care and safety were scheduled meetings due to the need to identify a suitable time which did not impact on the consultants' clinical schedules. These meetings were scheduled with the urgency required and all out detailed responses to other questions. The only two informal meetings that I can recall are detailed below".

11:04

11:04

Then you detail both meetings. If I could just look at 30.2A.

"A meeting at my request as Director, Mr. Mackle as AMD and Mr. O'Brien Consultant Urologist. The meeting took place at the end of the working day after Mr. O'Brien had completed his main theatre list. I had been notified that day that Mr. O'Brien had not been triaging his red flag referrals and was travelling to the BAUS conference in Barcelona the following day. Mr. Mackle and myself impressed on Mr. O'Brien the requirement and importance of triaging red flag referrals. The permission to attend the conference the following day was refused unless the red flag referrals were triaged before travelling the following day. This resulted in red flag referrals being triaged and Mr. O'Brien travelled to the conference. I have no notes of this short discussion which took place on late April 2010. The red flag referrals continued to be

11:04

11:04

11:05

1 triaged appropriately for a period of time. The  
2 approximate timing of this meeting with Mr. O'Brien was  
3 confirmed to me by Mr. Mackle."

4  
5 Now, that was obviously a meeting that you felt you 11:05  
6 needed to be at in order to move the matter forward?

7 A. Yes.

8 82 Q. I think that was a conference ultimately Mr. O'Brien  
9 wasn't able to attend because of the ash cloud?

10 A. The ash cloud, yes. 11:05

11 83 Q. But would that have been a pretty draconian response,  
12 to tell a consultant he couldn't attend a conference  
13 unless he did his triage?

14 A. Yes. I don't think that response -- I don't think any  
15 other consultant had that kind of response. But we 11:05  
16 were trying to impress on Mr. O'Brien the importance of  
17 this. There were times when he did agree with it, and  
18 there are certainly a couple of letters where

19 Mr. O'Brien has written to Mr. Mackle and myself  
20 confirming that he will triage red flag referrals 11:06  
21 within the appropriate waiting times. There were times  
22 where we did get him to do that but we could not be  
23 confident that he would continue to triage within the  
24 appropriate time. That's why we had to have a very,  
25 very tightly managed weekly system of understanding 11:06  
26 where the red flag referrals and the urgent and the  
27 non-urgent referrals were within the Urology Service,  
28 and particularly when Mr. O'Brien was surgeon of the  
29 week.

1 84 Q. what was your feeling about the fact that the threat of  
2 a sanction like that seemed to elicit a positive  
3 response from Mr. O'Brien? I know you mentioned  
4 earlier you weren't sure if he was unwilling or unable  
5 to bring about change but on this occasion it seems to 11:07  
6 have been successful?

7 A. Yes. It certainly resulted in the referrals being  
8 triaged, but not in a sustainable way to be doing that,  
9 you know, of an evening after a whole day theatre list.  
10 But it certainly was giving him a message, this is 11:07  
11 important and it has to be done. But he knew at that  
12 stage that we were monitoring him, and it was out of  
13 that monitoring that we were able to identify that the  
14 red flag referrals were not being triaged.

15 85 Q. Now, you mentioned the second meeting was at your 11:07  
16 request?

17 A. Yes.

18 86 Q. "I had been hearing from several people that  
19 Mr. O'Brien did not appear to be himself. He was  
20 operating in theatre that day and I left a message for 11:07  
21 him, please come and have a chat with me on his way out  
22 of the hospital after completing his theatre list. At  
23 around 6:00 p.m. Mr. O'Brien joined me in my office.  
24 I said there were people concerned about him and I was  
25 therefore concerned for his welfare. I asked if there 11:08  
26 was anything which I could help him with or did he need  
27 to talk to anyone in the Trust or seek help with  
28 Occupational Health? He said he did not need help and  
29 was very surprised at the approach from me but thanked

1 me for it. I have no notes of this meeting and cannot  
2 date when it took place, except that it was likely to  
3 have been after the period of weekly/fortnightly weeks  
4 with the urologist to agree the implementation plan  
5 with Team South Urology. "

11:08

6 A. Mm-hmm.

7 87 Q. Now, had someone come to you to bring your attention  
8 that Mr. O'Brien didn't appear to be himself?

9 A. That's correct, and I think that exemplifies the  
10 openness of the communication within the system. I  
11 don't recall who had mentioned it to me, it may have  
12 been Mr. Mackle, but obviously there was a sense in  
13 theatre because this was Mr. O'Brien's all day theatre  
14 list, his main theatre list, that he didn't seem to be  
15 his usual self. So, that had come to my attention.

11:08

16 You, of course, are concerned for all members of staff;  
17 their welfare is partly your responsibility. I was  
18 very pleased that he did respond to my message and came  
19 up to see me, and we sat down and had a conversation.  
20 But he was not prepared to -- I mean, whether there was  
21 anything significant worrying him, I don't know, he  
22 didn't allude to it. But we had, as always, a very  
23 civilised conversation, and he thanked me for it and  
24 left. There was a 10, 12, 15-minute conversation and  
25 that was all.

11:09

11:09

11:09

26 88 Q. Mr. O'Brien has, and will again I'm sure when he gives  
27 evidence, raised many issues around the lack of  
28 support, the lack of resources, the pressures he was  
29 under as a consultant clinician in the Trust, and his

1 belief that he was unable to carry out his tasks  
2 because he wasn't being properly resourced in various  
3 ways. Did he ever come to you specifically for help in  
4 relation to issues around resources? Did he come to  
5 you directly, or were those indications of concerns 11:10  
6 brought via him and the other consultants?

7 A. Mr. O'Brien never approached me directly about  
8 resources. The only approach directly that I can  
9 recall was from Mr. Young in relation to the filling  
10 the clinical fellow post. There certainly would have 11:10  
11 been no direct approach to me from Mr. O'Brien. I  
12 mean, I think that this meeting after his theatre list  
13 was the only occasion that I met Mr. O'Brien on my own  
14 during the tenure of my post.

15 89 Q. The previous meeting with Mr. Mackle was another 11:10  
16 meeting, and other meetings were in relation to more  
17 wider group of system-wide --

18 A. Yes, absolutely. There would have been other members  
19 of staff present.

20 90 Q. I just want to bring your attention to a transcript of 11:10  
21 a meeting Mr. O'Brien had with Dr. Johnston, if we can  
22 go to AOB-56323. We might need to go to the first  
23 page, if we go back a few pages. This is not a meeting  
24 you were at?

25 A. No. 11:11

26 91 Q. But there's some reference to you in the meeting and  
27 I just want to ask you about it. The first page is  
28 AOB-56314. You will see the date at the top, it's  
29 11th June 2018. What this is, Mrs. Rankin, is

1 a transcript of a recording of a meeting, a recording  
2 made by someone who attended the meeting. Mr. O'Brien  
3 was at the meeting accompanied by his son, Michael  
4 O'Brien, with Dr. Johnston and this is a transcript of  
5 it.

11:12

6  
7 If we can go back to 56323, just down to line D.  
8 I just want to read this extract to you and let you  
9 comment, if you wish. Dr. Johnston says:

10  
11 "Yes, according to many of the staff, there was  
12 difficulty and not always only difficulty with  
13 yourself. It was cropping one with Urology was  
14 particularly bad I understand, and it occurred on  
15 occasions with some of the consultants, that they had  
16 particular difficulty getting you to agree and to do  
17 this triaging of the non-red flag cases. That's how we  
18 would describe them. If these patients were not to be  
19 triaged by you because it was time consuming, what was  
20 going to happen to them? Mr. O'Brien: Before the  
21 default went in. Dr. Johnston: That's what I am  
22 talking about, the default in the past. Mr. O'Brien:  
23 Prior to the default? Dr. Johnston: Yes, prior to  
24 that. It went on for many, many years. Gillian Rankin  
25 had various meetings with you, I understand, to try and  
26 get you to triage them and you... Mr. O'Brien: I  
27 don't recall having one single meeting with Gillian  
28 Rankin about it. Dr. Johnston: She clearly remembers  
29 some quite difficult meetings with you"

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Mr. O'Brien: She had difficult meetings with me about the number of people we, and with my colleagues, terrible meetings, but I am not going into that detail but I don't have a memory.

11:13

Dr. Johnston: She didn't go into any detail either, just to let you know, but she did describe them as very difficult.

Mr. O'Brien: They were difficult and contributed significantly to our third colleague leaving."

11:14

We have just gone to a couple of meetings that you say you had with Mr. O'Brien, one was with Mr. Mackle, and there were no notes of those meetings

A. No.

11:14

92 Q. You would say to that that it's not true that you didn't have meetings with Mr. O'Brien about triage?

A. Oh, there's many, many notes of meetings on record, and often written correspondence after those meetings, which evidenced that we did discuss triage with Mr. O'Brien formally on many occasions.

11:14

93 Q. We have just used the one in your statement as an example of that with Mr. Mackle?

A. Yes.

94 Q. Because of the recollection about the conference and the potential sanction. That is the example.

11:14

A. Yes.

95 Q. Chair, I wonder if we could take a break at the moment?

1 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

2  
3 96 Q. MS. McMAHON: I just want to briefly look at the review  
4 backlog issue and the plan around that. That can be  
5 found at WIT-15803. You have set out your role in the 11:31  
6 process at paragraph 13.3(a). I will just read this  
7 out.

8  
9 "The director was responsible operationally for the  
10 reduction in the review backlog. Most actions were 11:31  
11 undertaken by the surgical division. Some evidence of  
12 actions taken to address the issue by the director  
13 was..."

14  
15 Then firstly: 11:31

16  
17 "To explore the interface with primary care to seek new  
18 review pathways where clinically safe to review  
19 patients in primary care. This could reduce the number  
20 of patients being reviewed in secondary care. This was 11:32  
21 subsequently followed by a small workshop involving the  
22 consultants and a group of GPs to discuss three to four  
23 clinical pathways which have been drafted for  
24 discussion."

25  
26 Now, do you recall those workshops? would you have  
27 been in attendance at those?

28 A. Yes, I think I was.

29 97 Q. Was the idea behind those to gain understanding as well

1 as buy-in into the process to try and reduce the  
2 backlog of reviews?

3 A. Yes, it would have been. I mean, perhaps a little bit  
4 of context in the background here. In my previous role  
5 in the Trust as Director of Older People and Primary 11:32  
6 Care, I had pointed an Associate Medical Director,  
7 a GP, into that role into Older People and Primary  
8 Care. Dr. Beckett was very well-connected to the GPs;  
9 he had long played a leadership role in primary care  
10 across the Armagh and Dungannon, one of the historical 11:33  
11 legacy Trusts. So, I knew that, having worked very  
12 closely with GPs and met most of the GPs across the  
13 totality of the patch during that post of Director of  
14 Older People and Primary Care, I knew that we could  
15 have a conversation with them about developing pathways 11:33  
16 for patients on the discharge from hospital, which  
17 would reduce the reviews. So, yes, it was an open  
18 conversation to bring the GPs to the table. Then we  
19 would have had processes with the GPs committee and  
20 other committees in the area to take those to a wider 11:33  
21 agreement with GPs and then to start to implement them.

22 98 Q. For the Panel's note, the minutes of the Urology  
23 Primary Care meeting of 17th June 2010 can be found at  
24 WIT-26620.

25  
26 Then, the second point in relation to your actions:

27  
28 "The evaluation of specialities against the review  
29 backlog checklist was sought by myself from each AD.

1 The response from the AD or SEC on 3rd August 2010 is  
2 attached and it states that the discussion in the  
3 division identified compliance with a lot of the  
4 suggestions or audits work in place to provide some of  
5 the information. It did provide some new food for  
6 thought." 11:34

7  
8 So, this was a collective learning about the best way  
9 to achieve your ultimate goal of reducing the backlog?

10 A. Yes. Yes. Yes. 11:34

11 99 Q. If we go down to point 5 on that minute, on the next  
12 page:

13  
14 "It also included a formal discussion and subsequent  
15 letters to each consultant regarding the new-to-review  
16 ratios for their patients. The data published in the 11:34  
17 Regional Review identified that the new-to-review  
18 ratios for consultants in the Southern Trust were  
19 higher than their colleagues in other Trusts. This  
20 therefore was a contributing factor to the review 11:35  
21 backlog and needed to be addressed. After discussion  
22 with the consultants at a Team South project team  
23 meeting, letters were sent to each consultant".

24  
25 what that seems to illustrate is that the consultants 11:35  
26 were aware both of the reasoning behind the need to  
27 adopt new ways of approaching this, and also  
28 expectations on their clinical practice in order to  
29 bring about this change?

1 A. That's correct. The fact that I was -- I took the  
2 action of writing to the consultants meant that I felt  
3 I hadn't got sufficient agreement. The agreement and  
4 the movement to the new Regional Review ratio was  
5 agreed with two consultants and subsequently 11:35  
6 implemented, and that is evidenced in the performance  
7 data. But Mr. O'Brien would not accept this, even  
8 though the new-to-review ratio that was which had been  
9 adopted by the AUS, the national urological society.  
10 It may not have been the most up to date or it may have 11:36  
11 been about to change but, at that point in time, the  
12 Commissioning Board had adopted that very reasonably as  
13 the metric to be met, and that was why we were using  
14 that with the three consultants.

15 100 Q. You go on to say in your statement: 11:36  
16  
17 "There were periodic improvements in the review backlog  
18 in Urology but it just wasn't possible to sustain  
19 those".

20 A. That's correct. We certainly -- it was very closely 11:36  
21 monitored. We were fully aware of the risk of having  
22 a huge backlog in review patients. The Board, the  
23 Commissioning Board, were aware of the risk and we  
24 sometimes were able to get funding for a certain number  
25 of extra review backlog clinics to see an agreed number 11:36  
26 of patients. All sorts of reasonable approaches were  
27 taken to reduce the review backlog, but really very  
28 difficult when you have, inside the system, you have  
29 a consultant who is contributing to the size of that

1 review backlog by not adopting the correct  
2 new-to-review ratio. It was quite clear in the  
3 regional report that the Southern Trust were out of  
4 kilter with their peers in Northern Ireland, let alone  
5 their national peers. Within the Southern Trust we 11:37  
6 were able to move two consultants to the new review,  
7 which then was fine, but we were not able to move  
8 consistently Mr. O'Brien. There was times when he  
9 moved to a new system and then he reverted to the  
10 previous behaviour, and that was a characteristic 11:37  
11 throughout the journey.

12 101 Q. You have set out some of the possible reasons why the  
13 improvement wasn't able to be sustained at WIT-15805,  
14 paragraph 13.4 onwards. I just want to read these out.  
15 You say: 11:37

16  
17 "From memory, my recall is that there were periodic  
18 improvements in the backlog in Urology but it was not  
19 possible to sustain these. This was in part due to the  
20 following factors: 11:38

21  
22 1. Increasing demand which was greater than the  
23 service could treat."

24 A. Correct.

25 102 Q. "2. Insufficient clinic sessions available to review 11:38  
26 all those patients in the backlog given that the three  
27 consultants were working full-time and working  
28 additional in-house sessions at weekends, evenings, to  
29 treat patients needing day case or inpatient surgery."

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Just those first two. The two seemed to be more focused on availability of staffing and resources to meet the demands?

A. Yes. Those were certainly issues at the time, yes. 11:38

103 Q. Number 3:

"Insufficient progress was made on some of the actions required to fully address the backlog. An example of this was that both Mr. Young and Mr. Akhtar agreed to amend their clinic templates but Mr. O'Brien refused to amend his clinic templates in October 2010. The clinic templates for all three consultants were amended to reflect the BAUS guidance with effect from mid-November 2010. However, Mr. O'Brien's clinics started to overrun by two hours for each clinic and this was not a sustainable position for the associated nursing and support staff needed at each clinic. The result was that the number of new patients per clinic for Mr. O'Brien was then reduced by two new patients. This meant that Mr. O'Brien saw five pure new patients each week than if he had adopted the BAUS guidelines for clinic templates, and the number of reviews required would have reduced if he had agreed to move from his ratio of one-to-two from four, and to adopt the BAUS guidelines of a new-to-review ratio of one-to-two."

So, the crux of that paragraph is that Mr. O'Brien's own individual way of working or inability or refusal

1 to engage with the suggested approach of BAUS that was  
2 adopted by the Trust actually resulted in an increase  
3 -- or decrease in capacity to deal with patients?

4 A. It did, yes. The BAUS guidance was required of us from  
5 the Commissioning Board; it wasn't that the Trust had 11:40  
6 decided to do this. This was part of the regional  
7 implementation, that across the three teams within  
8 Northern Ireland we would all follow the same guidance  
9 so that patients had all the same access to services no  
10 matter where they lived in Northern Ireland. 11:40

11 104 Q. Was the guidance time-limited in there was -- was it  
12 a 10-minute or 15-minute slot for patients?

13 A. I think the first clinic appointment for a patient was  
14 20 minutes, and review, it may have been 10. I mean, I  
15 am not sure on those details but that sort of order. 11:40  
16 20 minutes for a first patient and 10 for a review.  
17 The day four cancer patients required a longer slot.

18 105 Q. For the follow-up review for someone who may have  
19 a tumour or some form of cancer, a 10-minute slot,  
20 would there be an argument from a clinician's 11:41  
21 perspective that that is perhaps inadequate?

22 A. I think when you are talking to a cancer patient at the  
23 point of diagnosis and talking about the preferred  
24 treatment plan, that's the day four cancer patient who  
25 needed a longer slot, which was agreed. I think that 11:41  
26 was in the minutes of the meeting that Heather Trouton  
27 had chaired that we looked at just a few minutes ago.  
28 But those, the 20 minutes and the 10 minutes, those are  
29 prescribed nationally. Those are what all the



1 specialties would be doing. It means you need to be  
2 very organised in terms of the approach you are taking  
3 to the patient, and keeping notes throughout that.

4 106 Q. And were the other clinicians able to adhere to those  
5 time slots? 11:41

6 A. They were.

7 107 Q. You have mentioned in that paragraph that the clinics  
8 overran by two hours. This obviously had a knock-on  
9 effect to other support staff as well if they were  
10 running late? 11:42

11 A. Mm-hmm.

12 108 Q. Did you see those clinics running late or how did you  
13 come to have that information about the lateness of the  
14 clinics?

15 A. Oh, that was brought to me by Martina Corrigan. 11:42  
16 I think this was an afternoon clinic, possibly in  
17 Banbridge. Instead of having a finish at 5:00, it was  
18 finishing at 7:00. The nursing staff had not been  
19 rostered to be there at 7:00 and may have had other  
20 commitments to go to. The support staff, the reception 11:42  
21 staff and administrative staff that are always present  
22 at a clinic, they were not rostered beyond that. So  
23 certainly all the staff would have stayed on on an ad  
24 hoc basis, very willingly, there was a great culture of  
25 wanting to do the right thing, but it was not possible 11:42  
26 to do that on a sustainable basis. So, it came to me  
27 through Martina at that stage.

28 109 Q. Just in relation to timeframes and staffing in order to  
29 meet the capacity envisaged by the implementation plan

1 of five consultants, there was a submission that the  
2 Team South implementation plan to the Health and Social  
3 Care Board in November 2010, and the approval to  
4 proceed came in July 2011?

5 A. Mm-hmm. 11:43

6 110 Q. Then there was undertaking a process to develop the job  
7 plans for the consultants, for the five consultant  
8 model, and that took several months?

9 A. Yeah.

10 111 Q. Was that negotiation and discussions with the other 11:43  
11 consultants or was that more of a HR issue?

12 A. No, that was discussions with the consultants.  
13 I wasn't personally directly involved in those  
14 discussions around the job plan. I wouldn't have been  
15 involved in job planning discussions. My role was to 11:43  
16 make sure that all of the information on the activity  
17 to be delivered was available. The fact that that had  
18 been agreed now with the Health and Social Care Board  
19 meant that we had agreed the activity for Outpatients,  
20 for day cases, for inpatients. So, that now needed to 11:44  
21 be turned into the job plans for the five-person model.

22  
23 I think, probably from memory, we already had an  
24 outline of those five job plans ready but there was  
25 still an ongoing discussion about subspecialty 11:44  
26 interests and how those would be handled. For  
27 instance, Mr. Young always dealt with the stones and he  
28 did lithotripsy. There were other subspecialties that  
29 we needed to handle within the five-person team, and so

1 that needed separate discussions that Mr. Mackle would  
2 have been involved in with HR and Performance Reform in  
3 terms of the data around the activity.

4 112 Q. who would have taken the lead? If it wasn't you, who  
5 would have taken the lead in those discussions with the 11:44  
6 consultants?

7 A. It would have been Mr. Mackle.

8 113 Q. Mr. Mackle. Now, you got the final approval in July  
9 2011 but the five consultant model job plans were  
10 signed off only in March 2012. Is that an unusually 11:45  
11 long period of time or does the process normally take  
12 that long to get to the point where you can actually  
13 recruit?

14 A. The process does take a long time but I think that that  
15 was inordinately long. I think part of the pressure 11:45  
16 there was the pressure the consultants were under  
17 running the service. They were almost doing additional  
18 in-house waiting list clinics in the evenings and on  
19 Saturday. They didn't do any on a Sunday; that was  
20 quite clear, I'm very happy. 11:45  
21

22 Consultants had been asked would they do additional  
23 theatre sessions and evening clinics, and it was their  
24 choice to pick those up. So, I suspect that had been  
25 a very busy winter which had contributed to the 11:45  
26 pressures but it did take longer than you would have  
27 hoped, longer than we had hoped. Of course, once the  
28 job plans are agreed with the consultants internally,  
29 there's then an approval process with the Health and

1 Social Care Board. We've then got to go to the  
2 specialty adviser for Urology, who was Mr. Patrick  
3 Keane at this stage, so you've got to get them back.  
4 So, there are various hoops you have got to go through  
5 before you can actually get to advertising for those 11:46  
6 new consultant posts.

7 114 Q. Given that the full implementation plan could not be  
8 brought to fruition until the five consultant model was  
9 in place --

10 A. Yeah. 11:46

11 115 Q. -- did that cause you any sense of frustration?  
12 I think it wasn't in place by the time you left.

13 A. A considerable amount of frustration because my sense  
14 was that there would be considerable motivation from  
15 the three consultants internally to actually get this 11:46  
16 agreed and out to recruitment as quickly as possible,  
17 because the money could be not be pulled down against  
18 the new consultants until they were agreed. That  
19 motivation didn't appear to be aligned in the way that  
20 I thought it might have been. 11:46

21 116 Q. Now, IEAP and performance targets were also part of  
22 your role. You do say in your statement that this  
23 predated your appointment, this process?

24 A. Yes.

25 117 Q. But its requirements by the time you took up post had 11:47  
26 been implemented, and your belief was that each  
27 consultant was clearly aware of the requirements of the  
28 IEAP?

29 A. Yes.

1 118 Q. And the timeframes and the metrics. That goes back to  
2 what we spoke about earlier when you talked about  
3 getting the information back on what the targets and  
4 the performance metrics were?

5 A. Yes, that's correct.

11:47

6 119 Q. Would it be your view that the IEAP placed a primary  
7 obligation on the Trust to ensure that the service was  
8 sufficiently staffed and resourced to enable the  
9 consultant to triage referrals? Do you think the  
10 burden was on the Trust to properly resource a system  
11 that they put in place, or performance metrics that  
12 they wanted to achieve?

11:47

13 A. That wasn't the system that we were working in and  
14 I suspect it's not the system we are working in today.  
15 The system is a joint system between the commissioner  
16 of the services against the population need with the  
17 provider providing the services. So, the Trusts at  
18 that stage now - my memory is very clear - the Trusts  
19 would have not had the permission to appoint  
20 a consultant to any specialty without the express prior  
21 permission of the Commissioner. In fact, there were  
22 instances where individual Trusts went out to appoint  
23 a new consultant for a specialty that they felt was  
24 under considerable pressure, and they were asked to  
25 pull that appointment because it would not be funded by  
26 the commissioner. Trusts on occasions went out to fund  
27 -- to appoint a consultant on nonrecurrent funding,  
28 which of course meant that you would be looking for  
29 recurrent funding from the Commissioner but if the

11:48

11:48

11:48

1 Commissioner had not approved that before going to  
2 recruitment, the Trust would have been asked to pull  
3 the recruitment. So, it was a very tightly controlled  
4 environment in terms of resources at that stage.

11:49

5  
6 We were also at that stage taking efficiency savings  
7 out of the service, so each Trust had a percentage  
8 reduction within its overall budget. That, of course,  
9 filtered down to directorates. So, whilst we were  
10 seeking to improve the quality of service, seeking to  
11 deliver against all of the targets that were set out  
12 for every specialty, we were also taking funding out of  
13 the system. It was a very, very difficult triangle to  
14 square, or to, you know, put around. Very difficult.

11:49

15 120 Q. Was it your view that the staff in place at the time,  
16 the numbers and the way in which the structures were  
17 set up, used at their optimum, were sufficient to meet  
18 these performance metrics? Or did you think that there  
19 was an argument that there had been a push of  
20 responsibility on to the consultants to meet these  
21 targets when they already felt overstretched with their  
22 clinical duties?

11:49

11:50

23 A. No, there was no specific push on to consultants at  
24 all. There was a recognised capacity gap but I think  
25 when you recognise that there was a 98% increase in  
26 urology referrals over a six-year period, which  
27 included daytime when I was in post, that's a very  
28 considerable rate of increase. I think the Regional  
29 Review, when I reread it very recently, indicates that

11:50

1 they had estimated what the projections would be, but  
2 they recognised that might not be entirely how it  
3 worked out because they were moving some of the  
4 procedures from Urology to general surgeons, and there  
5 were some unknowns in the system. It almost implied 11:50  
6 that they would have to look and see, once they had  
7 implemented this, whether there was sufficient capacity  
8 in the system. So, I think it was known that certainly  
9 at that time with the three consultant model, there was  
10 insufficient capacity. All of the agreements to run 11:51  
11 additional clinics and theatre sessions was with the  
12 agreement of the Board because they funded it  
13 non-recurrently. Also, to place contracts with the  
14 private sector for an agreed range of procedures. We  
15 always agreed the range of procedures in there. 11:51

16  
17 Those were only done with the agreement of the Board.  
18 When the backstop, as we called it, the waiting time  
19 for particular, whether it was inpatients or day cases  
20 or Outpatients, when that backstop moved, that was with 11:51  
21 the agreement of the Commissioner. When we couldn't  
22 meet the IEAP time standards, that backstop went out to  
23 maybe 17 weeks and sometimes to 36 weeks. We were  
24 being judged against our performance of those new  
25 backstops. Those recognised that there was a capacity 11:51  
26 gap, but that was recognised as a joint approach  
27 between the Commissioner and the provider, the Board  
28 and the Trust.

29 121 Q. The IEAP was, of course, the framework against which

1 the framework of all services, not just urology, were  
2 being assessed?

3 A. Yes, that's correct. Urology would not have been the  
4 only specialty that was not meeting the specific  
5 targets in IEAP, there were other specialties, but 11:52  
6 I think urology certainly was one of the ones with the  
7 greatest mismatch between demand and capacity.

8 122 Q. Just before we are both told off again, maybe we can  
9 both slow down and then we won't lose a stenographer  
10 this week. But you will be glad to hear we have worked 11:52  
11 our way to your first day in the job, so I am going to  
12 look at 1st December 2009 to see what the specific -  
13 that's a more general landscape of what you inherited -  
14 but the specific issues. You set them out at  
15 WIT-15780, at 1.2. You say: 11:53

16  
17 "Issues in relation to the Urology Service were raised  
18 with me on my first day in post, i.e. 1st December  
19 2009. This was to a meeting chaired by the Chief  
20 Executive which alerted me to the current and ongoing 11:53  
21 issues the Regional Review of Urology had reported but  
22 was not yet signed off by the Minister. The  
23 development of the implementation plan for Team South  
24 Urology had commenced, and I subsequently chaired  
25 a weekly/fortnightly meeting with the consultants 11:53  
26 involved to get agreement on the implementation plan  
27 and its implementation."

28  
29 If we move on to WIT-15820. 28.3, sorry.



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"Specific meetings were not held on a regular basis".

You have identified this as an outlier meeting but it sets out the issues you were informed about on 1st December 2009.

11:54

"... meetings on a range of governance issues chaired by the Chief Executive with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services," which was your post at the time.

11:54

"The range of issues on the agenda included: Demand and capacity and the need to optimise the use of clinical sessions, quality and safety, the Medical Director to discuss with Mr. Fordham seeking an urgent professional opinion on A, the appropriateness and safety of the current practice of IV antibiotics; B, triage of referrals and one consultant refusing to meet the current standard of triaging within 72 hours; C, red flag requirements and one consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately; D, chronological management of theatre lists for theatre with one consultant keeping patients' details locked in the desk.

11:54

11:54

11:55

"Action agreed that if there was no compliance,

1 correspondence would be sent regarding the implications  
2 of a referral to NICAS if appropriate clinical action  
3 was not taken."  
4

5 Now, they were the general issues that were brought to 11:55  
6 your attention. Was this information from the Chief  
7 Executive or was it from the Medical Director at the  
8 meeting? Can you recall the way in which the  
9 information -- was it just on an agenda and it was  
10 discussed generally, or did someone actually speak to 11:55  
11 a narrative of these issues at that point?

12 A. I don't recall the specifics of the meeting as to who  
13 was speaking to each issue. I'm sorry, I don't have  
14 that recall. It is first day, and baptism of fire.

15 123 Q. It certainly seems to be a very specific list of issues 11:56  
16 and we move on to the detail of some of that. Just in  
17 relation to point B, where it says "triage of referrals  
18 and one consultant refusing to meet the current  
19 standards of triaging within 72 hours", was that  
20 a reference to Mr. O'Brien, do you know? Did you know 11:56  
21 at that time or...

22 A. Almost certainly that was in reference to Mr. O'Brien.

23 124 Q. Was there any suggestion that rather than him refusing,  
24 that it was his view that he just simply was unable to  
25 meet referrals within 72 hours due to other competing 11:56  
26 clinical demands? Was there any context to that  
27 sentence at the meeting, or it was simply put forward  
28 as a refusal?

29 A. I don't recall, I'm sorry.

1 125 Q. The issue in relation to the chronological management  
2 of theatre lists for theatre, with one consultant  
3 keeping patients' details locked in the desk, that  
4 sentence, I'm not sure if the first part of the  
5 sentence explains the second part or how they sit 11:57  
6 together, the alleged locking of patients' details in  
7 a desk with the chronological management. I know it's  
8 a long time ago but what was your understanding of the  
9 point that was trying to be made by that issue?

10 A. I think the understanding that I took away was that 11:57  
11 Mr. O'Brien, in personally scheduling his theatre  
12 lists - in other words, nobody else was involved - he  
13 was therefore scheduling patients potentially out of  
14 chronological order. All the other surgeons would have  
15 met with a member of the team; there was the 11:57  
16 Operational Support Lead, there were secretaries, and  
17 most other surgeons would have done that with somebody  
18 else and they would have worked through the PTL, the  
19 Patient Targeting List and taken off the longest  
20 waiters to ensure that they had the right case mix for 11:58  
21 a theatre session, be that a four-hour session or all  
22 day eight-hour session. Obviously, neither surgeon can  
23 make that determination; you have to get the right mix  
24 of operations to make the best use of that time in  
25 theatre. That's my understanding of what that point 11:58  
26 was about. I then set about setting in a new system.

27 126 Q. Just on one analysis, the locking of patients' details  
28 locked in a desk would seem to be good protection. You  
29 are disagreeing with the context of that?

1 A. Yes. No, no, absolutely not good protection. It  
2 should not have been locked in a desk and should have  
3 been available to the system and known about in the  
4 system, so that if the patient was consulting any other  
5 specialty, that they would have been available to them. 11:59

6 127 Q. Was there any suggestion behind that, that notes had  
7 been needed to be available and weren't?

8 A. No, none at all at that stage.

9 128 Q. If we go to WIT-15871, you list the specific issues in  
10 relation to... 15781. Those are the general issues in 11:59  
11 urology, and these are the specific issues then that  
12 you --

13 A. Yes.

14 129 Q. -- were aware of from day one, I think.

15 A. No, some of those -- that is a list of all of the 11:59  
16 issues that I encountered during the tenure, so they  
17 would not all have been known about on day one.

18 130 Q. Well, they provide some context to the wider, more  
19 generic issues and some specific issues that were  
20 brought to your attention with the Chief Executive? 12:00

21 A. Mm-hmm.

22 131 Q. Was that your official hand-over, that meeting? Was it  
23 specifically for you as a new person in post?

24 A. I don't know. I don't know what the reason was for  
25 calling the meeting. It just happened perhaps to be on 12:00  
26 my first day, but it certainly meant that I was briefed  
27 about the issues I was dealing with. I also knew I had  
28 the support of everybody around the table.

29 132 Q. At paragraph 1.7 you've summarise the issues that you

1 were aware of during your stewardship.

2  
3 "The specific issues in relation to Mr. O'Brien related  
4 to the need to change behaviour in relation to some  
5 clinical practices and some administrative practices. 12:00  
6 The range of issues included triage of red flag  
7 referrals, i.e. referrals of people with potential  
8 cancer and non-urgent referrals; B, the scheduling of  
9 patients for surgery without due regard to urgency in  
10 chronological order; C, the surgical operation of 12:01  
11 cystectomy; D, the use of IV antibiotics for  
12 inpatients; E, referral of patients requiring  
13 prostatectomy or cystectomy to the Belfast Trust, and  
14 the implementation of the regional MDM  
15 multidisciplinary meeting to discuss each patient with 12:01  
16 cancer and agree their treatment; F, service capacity  
17 gap which impacted on the waiting time for patients for  
18 Outpatients clinics, day case surgery, inpatient  
19 surgery and review Outpatient appointments, and  
20 breaches of the 31-day and 62-day standards for 12:01  
21 patients with diagnosed cancer; G, failure to retest  
22 results when received and before filling the patient  
23 notes, irrespective of whether the patient has an  
24 Outpatient appointment booked; disposal of some patient  
25 notes and information in the bin of a consultant's 12:02  
26 office. "

27  
28 They are all specific to Mr. O'Brien?

29 A. Yes.

1 133 Q. Now, if we can go to WIT-15820 and paragraph 28.3(b).  
2 Now, after your initial meeting on 1st December where  
3 your brief was handed over, you had a meeting with  
4 Mr. Young?  
5 A. I did. 12:02

6 134 Q. Was that just you and Mr. Young or was there anyone  
7 else at the meeting?  
8 A. No. Dr. Loughran as Medical Director was present at  
9 the meeting, and Mr. Mackle as the Associate Medical  
10 Director for Surgery. I think there were the four of 12:02  
11 us. I am not sure that Heather Trouton was at the  
12 meeting.

13 135 Q. You also had a meeting on the same day with  
14 Mr. O'Brien?  
15 A. That's correct. 12:03

16 136 Q. You describe that at paragraph C at WIT-15821.  
17  
18 "The 7th December meeting. Follow-up meeting with  
19 Mr. O'Brien, Consultant Urologist, after the 1st  
20 December meeting. The key points of discussion and the 12:03  
21 necessary actions are set out with agreed actions by  
22 Mr. O'Brien to review current patients waiting to  
23 determine if urgent or routine, to put all urgent  
24 patients on to immediate lists and other immediate  
25 actions with key staff." 12:03  
26

27 Was that the first time you had met Mr. O'Brien?  
28 A. Yes, it was.

29 137 Q. Given the list that you had been made aware of on

1 1st December about urology, did you reflect those  
2 matters of concern to him at that meeting and indicate  
3 that things needed to change, or what was the tone?  
4 A. That would have been my recall. What I would have done  
5 would have been created the agenda for the meeting on 12:04  
6 7th December as the agenda that we had had for the  
7 meeting with the Chief Executive on 1st December. It's  
8 enough work to do without creating new agendas. So  
9 that would have been the request to Emma, to set that  
10 out as the agenda for the 7th December meeting and to 12:04  
11 go through all of those issues.

12 138 Q. At that meeting was there any pushback from  
13 Mr. O'Brien, or explanations as to what his version of  
14 the issues were from a clinician's perspective? Did he  
15 try and explain why, for example, he wasn't able to 12:04  
16 meet some of the targets?

17 A. I think it was a strange meeting in a way, and I think  
18 the notes of that meeting reflect that, which I would  
19 have done, because not only are you usually chairing  
20 the meeting but you are also taking the notes and 12:04  
21 sending out the note afterwards. There were a lot of  
22 different issues raised, which I think the note of the  
23 meeting reflects, which I hadn't expected. As I say,  
24 this was my first encounter with Mr. O'Brien. We must  
25 have discussed all the issues set out in the Chief 12:05  
26 Executive meeting, but the note reflects a range of  
27 other things that were also brought in. It wasn't  
28 necessarily a meeting of minds at that stage.

29 139 Q. I think I have written down the reference to the note

1           incorrectly so I will not be able to go to it just at  
2           the moment unless someone can give me the correct  
3           version. I normally rely on Mr. Lunny to have the  
4           answer. We will come back to the note of that.

12:05

6           It was certainly six days into your role as Director of  
7           Acute Services and you were straight in meeting  
8           Mr. O'Brien and Mr. Young?

9           A. Yes, that's correct.

10 140 Q. At WIT-15799 you set out a further list, down the  
11           bottom, please. Paragraph 12.7 "Evidence of Additional  
12           Meetings and Actions" regarding the Urology Service  
13           meeting the IP Performance Targets. The email sent in  
14           pursuance of that. This seems to be an issue that you  
15           were on top of, if I can use that phrase, to try and  
16           bring about the change that was required in order to  
17           meet the targets?

12:05

18           A. I was certainly very much aware of it. Because we were  
19           seeking to modernise and to make the considerable  
20           changes to implement the Regional Review, it did have  
21           my personal attention. Obviously there were a lot of  
22           actions done within the system through the Assistant  
23           Director, Heather Trouton, and through the Head of  
24           Service, Martina Corrigan, and also the clinicians, but  
25           at that stage in my sense in the past, and with also  
26           a new assistant director, I felt that we needed to work  
27           this together. So yes, it did have a lot of my  
28           personal attention, just to ensure that things were  
29           done in the way they needed to be done and in the time

12:06

12:06

12:07



1 scales that they needed to be done.

2  
3 There were many demands on our attention at that stage  
4 and this could very easily have gone off our radar and  
5 that would not have been a useful place to be. This 12:07  
6 needed to be kept on the radar in focus until we got to  
7 certain points of agreement and got things implemented.

8 141 Q. If we just go to point D on the next page. It's just  
9 an example of one of the meetings on 9th June 2011  
10 where you chaired a meeting with Mr. O'Brien, 12:07  
11 Mr. Mackle, and Mrs. Trouton to discuss a range of  
12 issues, including performance to meet the requirements  
13 set by the HSCB for Team South Urology, the review  
14 backlog, patient admission for surgery, urodynamics,  
15 pulled lists and the cancer pathways. You have 12:08  
16 attached that.

17  
18 Even at this remove, it seems that many of the issues  
19 that were first-day problems continued to require your  
20 attention in order to try and get them resolved? 12:08

21 A. Well, things like the review backlog, we were putting  
22 in actions to address that but we never got the review  
23 backlog completely contained. That would have been  
24 miraculous if we had.

25 12:08  
26 Patient admission for surgery. That's presumably  
27 patient admission on the day of surgery, we were moving  
28 in that direction. But all of things are processes,  
29 they are not something that happens overnight. So, it

1 would have been considering the process of where we had  
2 got to and what more needed to be done; were there  
3 particular cohorts of patients for particular  
4 procedures which were still being brought in the day  
5 before and why was that? There would have been  
6 discussions to try and understand what was happening.

12:08

7  
8 Urodynamics. I think my recall around that was the  
9 number of patients in a session taking place in the  
10 Thorndale Unit. It never seemed to me that we fully  
11 utilised the fact that we had the Thorndale Unit, so  
12 that would have been a conversation.

12:09

13  
14 Pooled lists. Whilst the right thing to do, I'm not  
15 sure we ever got all three consultants to agree to  
16 a pooled list. There were occasions when if one of the  
17 consultants had a consistently longer waiting list, we  
18 agreed cohorts of patients could move from that  
19 consultant's list to another consultant's list. That  
20 could have been in all the directions across the three  
21 consultants, not only specifically Mr. O'Brien.

12:09

12:09

22  
23 The cancer pathway was always a point of discussion.  
24 We continued to have small numbers of breaches along  
25 the 31- and 62-day pathway and we were working on  
26 actions to address that, such as the one-stop  
27 haematuria clinic and the one-stop prostate clinic  
28 which then were implemented later on in 2011 to try and  
29 remove the breaches in the pathway. So, that was

12:09

1 always in discussion. I wouldn't say that they had not  
2 been addressed, they were in the process of being  
3 addressed and some had been addressed.

4 142 Q. They were still a work in progress?  
5 A. They were still a work in progress, absolutely. 12:10

6 143 Q. Mr. Lunny has risen to the challenge and come up with  
7 the reference for the meeting. So, it's at WIT-11852.  
8 This is the note of the meeting on 7th December?  
9 A. Yes.

10 144 Q. You will see present was Dr. Loughran, the Medical 12:10  
11 Director, Mr. Eamon Mackle, AMD, you and Mr. O'Brien,  
12 we will just go through the notes. Are these notes  
13 subsequently sent to other attendees to confirm their  
14 accuracy, or is this --  
15 A. Oh, yes. They are sent out as a draft for anybody to 12:10  
16 come back to amend and then go out. Absolutely.

17 145 Q. The key points of discussion.  
18  
19 "1. The Trust expects in line with the NI Integrated  
20 Elective Access Protocol that all patients will be 12:11  
21 treated by clinical priority and chronological order.  
22 Those patients on Mr. O'Brien's lists as clinically  
23 urgent may not be clinically urgent. No agreed process  
24 in place for the consultants and junior staff on what  
25 is urgent and routine. If juniors designate as urgent 12:11  
26 wrongly, the patient status is not amended to routine.  
27 Agreement to review whether urgent or not by Monday  
28 14th December."  
29

1 And that was to be actioned by Mr. O'Brien.

2

3 Are you aware was that actioned by Mr. O'Brien, those  
4 particular steps to review the categorisation?

5 A. That would have been reviewed because otherwise it 12:11  
6 would have come up during performance meetings. That's  
7 really about an individual consultant-led team agreeing  
8 what the criteria are for juniors in terms of their  
9 decisions of putting patients against a routine or an  
10 urgent list, designation on a waiting list. 12:12

11 146 Q. To ensure uniformity of approach in the categorisation?

12 A. Yes. That was usually consultant led.

13 147 Q. "Number 2. Agreed to put all urgent patients onto  
14 immediate list. Action Mr. O'Brien".

15

12:12

16 Again, was that something that was recurrent at future  
17 meetings or that was deemed to have been done at the  
18 time?

19 A. I don't know that that was done at the time because  
20 I put the process around Mr. O'Brien that he did not 12:12  
21 schedule his lists himself. I had the Operational  
22 Support Lead, Sharon Glenny, and either Martina  
23 Corrigan or one of the theatre schedulers would have  
24 met with Mr. O'Brien to schedule his list. That was an  
25 ongoing process throughout my ongoing tenure; I didn't 12:12  
26 relinquish that.

27 148 Q. I just missed your last sentence there.

28 A. I didn't relinquish, I step down that process during my  
29 tenure in post.

1 149 Q. There was a change in approach then?  
2 A. There was a change in approach.

3 150 Q. The scheduling would be not so much centralised but --  
4 A. All the other consultants scheduled their theatre list  
5 with somebody else, who then took it away to actually 12:13  
6 implement it. Mr. O'Brien was the only surgeon who did  
7 the scheduling of the Patient Targeting List himself  
8 and so, therefore, we had no visibility at the point in  
9 time of who he was scheduling. And that's where this  
10 comment relates to. So, I put a process around him to 12:13  
11 support him in the process of scheduling but to make  
12 sure that the longest waiters within the urgency  
13 category were those that were being taken first.

14 151 Q. Just while we are on that, the scheduling of patients,  
15 you say Mr. O'Brien did that on his own. Was he 12:13  
16 supported in that role by a scheduler?  
17 A. He should have been but he was refusing that support,  
18 as I understand it at that time.

19 152 Q. The new arrangements to standardise the procedure  
20 around the scheduling of patients, was that something 12:14  
21 that was adopted by other consultants in Urology?  
22 A. I don't think there had been a problem in terms of the  
23 other consultants.

24 153 Q. Was it your understanding that it was only Mr. O'Brien  
25 who allegedly didn't schedule the admission of patients 12:14  
26 in chronological order?  
27 A. That is my understanding, yes.

28 154 Q. It was your understanding then that once this system of  
29 chronological scheduling was asked to be adopted by the

1 consultants, that it was actually implemented and you  
2 were assured of that, that that process was in place,  
3 save for concerns around Mr. O'Brien?

4 A. Yes, I was assured of that. The Tuesday morning  
5 meetings, performance meetings, each head of service 12:15  
6 had their PTLs, and they were then monitoring them in  
7 detail because they knew they were going to be asked  
8 about them the following Tuesday and the following  
9 Tuesday and the following Tuesday to make sure that the  
10 patients were being taken off the Patient Targeting 12:15  
11 List in chronological order according to their  
12 designation of urgency.

13 155 Q. Just for the Panel's note, you say at your statement at  
14 WIT-15872 (g):  
15  
16 "The systems put in place were successful as they 12:15  
17 removed the sole control of scheduling of surgery from  
18 Mr. O'Brien and ensured the rules were applied".

19 A. Yes.

20 156 Q. Point 3, back to the notes, the minutes of 7th 12:15  
21 December.  
22  
23 "Current problems perceived in system: Patients are  
24 getting letters of offer from IS".  
25  
26 IS is? 12:16

27 A. Independent sector.

28 157 Q. "Even though they have already received an in-house  
29 appointment. Clinical management plans are not

1 accurately put on PAS. Example, flexi cystoscopy  
2 planned for annual review is booked for three months.  
3 Suggestion of separation of dictation and onward  
4 management booking, action review and process mapping  
5 of systems", which is something that was Heather 12:16  
6 Trouton's responsibility?

7 A. Yes.

8 158 Q. Now, this seems to be some aspect, it could be said, as  
9 breakdown in communication among different systems.  
10 Would that be fair to say? 12:16

11 A. Yes. There were always difficulties in terms of  
12 patients going out to the IS in the early days, about  
13 which patients were going out and confusion. We worked  
14 very hard on streamlining that and I think towards --  
15 you know, the farther we went on, the better the 12:17  
16 systems got. It's not good for patients to receive an  
17 in-house appointment and then get a letter that they  
18 are going to the IS and to be confused as to which  
19 appointment do I attend.

20 159 Q. Again, it was about communication systems as well as 12:17  
21 efficiency of the service provided?

22 A. Yes. Yes.

23 160 Q. Was that review and process mapping of systems carried  
24 out by Mrs. Trouton?

25 A. Yes, it would have been. I mean, I don't recall the 12:17  
26 details of it but we would have known in the system if  
27 that hadn't happened because the problem would have  
28 still been there.

29 161 Q. The way in which you have set up the governance

1 feedback loop to you, it seems that you probably would  
2 have been made aware one way or the other that that  
3 hadn't been done, or the problems were persisting and  
4 needed it done again?

5 A. Yes. I mean, my system of having one-to-one meetings 12:17  
6 with the Associate Medical Directors and the Assistant  
7 Directors, and those were always monthly but might have  
8 been weekly or fortnightly, depending on the urgency of  
9 issues that were being addressed. Those flexed  
10 depending on what was on the agenda but I would always 12:18  
11 have had a copy of this in my file for that individual  
12 to then go through the progress against the actions  
13 that were in there so that things were always tracked.  
14 If needed, they then came out into the directorate  
15 governance meeting with the ADs, or the directorate 12:18  
16 governance meeting with the AMDs and ADs. There was  
17 a linkage between all of these things, they didn't  
18 stand alone.

19 162 Q. It sounds as if the systems you developed were flexible  
20 enough to meet either immediate concerns or things that 12:18  
21 required long-term planning and implementation?

22 A. Yes. Yes, they had to be.

23 163 Q. Number 4 on the 7th December note of the meeting:

24  
25 "Pooling of lists is acceptable if patient consents and 12:18  
26 is aware they may be treated more quickly by another  
27 surgeon. Need to agree who has clinical responsibility  
28 post-operatively for regional surgeon or operating  
29 surgeon".



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That was to be actioned by Mr. Mackle and urologists. That was a case of if people wanting to be seen quicker, they would get whatever surgeon was available for them?

12:19

A. Yes. Yes.

164 Q. The issue then was the post-operative. was that also something that doesn't seem to have recurred as an issue?

A. I am not sure that we got to the point of pooling lists, except for occasional situations which I alluded to a few moments ago, where if one waiting list was considerably longer, we agreed a cohort of patients for a particular procedure to move from one surgeon's list to another. I don't think we genuinely got to a single pooled list that we then took the longest waiters off on all occasions.

12:19

12:19

165 Q. That would have been something that would have you needed buy-in from the consultants as well; that needs to be driven from them?

12:19

A. Yes.

166 Q. That's reflected in the last line:

"The urologists need to agree which patients' conditions can be put on a pooled list. Action urologists and Heather Trouton".

12:19

would it be fair to say whether someone can be put on a pooled list is dictated a lot by their clinical

1 presentation as well as their pathology, really?

2 A. It depends on a range of things, not least what the  
3 procedure is that's to take place within theatre. I  
4 mean, I may be wrong but I don't think we got to  
5 a truly pooled list in Urology during my time. 12:20

6 167 Q. Point 5 on the 7th December notes.

7

8 "Red flag system: The NI standard is the patients with  
9 potential cancer are tracked by the red flag system to  
10 ensure they are seen within designated time scales. 12:20

11 This system is not used at all at present, mainly on  
12 principle because the system is blunt and does not  
13 create the degree of clinical priority across all red  
14 flags, nor does it reconcile with non-cancer clinically  
15 urgent. The use of red flag is mandatory and reflects 12:20  
16 clinical evidence, NICE and NiCaN. Agreement to  
17 develop a subdivision of red flags for use in  
18 speciality. Action Mr. Mackle and urologists."

19

20 would those comments about the red flag system and the 12:21  
21 bluntness of it in relation, in particular it seems, to  
22 non-cancer clinically urgent, is that feedback from  
23 Mr. O'Brien at that meeting or was that already an  
24 issue that was just being brought to that meeting with  
25 him? 12:21

26 A. I don't know whether that had already been recognised  
27 in the system but that was being brought by Mr. O'Brien  
28 to this meeting. He did not agree with the red flag  
29 system which had been implemented by the Commissioning

1 Board in Northern Ireland.

2  
3 It was never a perfect system and lots of people had  
4 issues with it that GPs could refer patients with a red  
5 flag when there is a consultant who read the details of 12:21  
6 the referral, they decided that they felt that the  
7 parent was not a red flag but they were not able to  
8 downgrade it. So there were occasions when there was  
9 certainly a feeling across many specialties that the  
10 red flag system was overloaded, but that wasn't in our 12:22  
11 gift to change. The gift that we had was to implement  
12 the red flag system that the Board had set up.  
13 Mr. O'Brien always had a different view of that red  
14 flag system.

15 168 Q. Was it within your gift to develop a subdivision of red 12:22  
16 flags for use in Urology, I presume?

17 A. No, no. I mean, I am surprised that that is there  
18 because we did not follow through on that.

19 169 Q. Do you think there was a general confusion about the  
20 use of the red flag system, given the apparent 12:22  
21 reasoning as to why one size didn't fit all; it  
22 continued to make suffer from individual  
23 interpretation?

24 A. No. I think my note may be slightly confusing but, you  
25 know, that I can accept. The red flag system was very 12:22  
26 clear: If a GP referred a patient on a red flag, that  
27 was a red flag and the acute secondary care system had  
28 to respond clearly as that patient was a red flag. It  
29 was black and white, except it was a red flag,

1           apologies. But there was no confusion in the system,  
2           the red flag was a red flag. It was only if, through  
3           diagnosis or through investigation and biopsy it was  
4           proven not to be a red flag, it was only at that point  
5           then it was not a red flag. 12:23

6 170 Q. You don't have any recollection of the existence or  
7           practice of a subdivision?

8           A. I was aware that Mr. O'Brien wanted to have his own  
9           subdivision but it was not one that was practised in  
10          the Trust. 12:23

11 171 Q. You can see that the note suggests that there's an  
12          agreement for that?

13          A. I do see that but there was never work done on that  
14          that I'm aware of. In the light of day when I look at  
15          that and when I thought about it, we wouldn't have 12:23  
16          followed through on that.

17 172 Q. Number 6:

18

19                 "Need to clarify what POA goal signifies against the  
20                 patient on the waiting list and whether if a patient is 12:24  
21                 not medically fit for procedure, the clock stops".

22          A. Yes.

23 173 Q. Again, that's trying to standardise what the codes mean  
24          in relation to actual practicalities of treatment?

25          A. Yes, yes. A POA was very new at that stage and we were 12:24  
26          working through the process, and this was just  
27          a refinement that needed to be put in place.

28 174 Q. Number 7 relates to pre-op assessment: "Needs review  
29          as patients can be called unnecessarily."

1 A. Well, that's in relation to patients being called if  
2 their surgery is not within three months. Their pre-op  
3 assessment has to be within three months of the date of  
4 their surgery, so you have got to put the potential  
5 date of surgery on the POA assessment so they are not 12:24  
6 called and then they have to be called again, which is  
7 not useful to either the patient or the system.

8 175 Q. There is a window for the pre-op assessment and it  
9 can't be repeated?

10 A. There is, yes. 12:25

11 176 Q. Number 8, just a sentence on its own. "Confidence in  
12 Trust destroyed due to ward reconfiguration".

13 A. Yes.

14 177 Q. Just a sentence hanging at the end of the notes, nobody  
15 has to action that. I am just wondering the origin of 12:25  
16 it and maybe a bit of context to why that finds itself  
17 in the notes.

18 A. It was obviously brought to the table by Mr. O'Brien  
19 and it was a theme that was running through the Urology  
20 consultants at that stage. My predecessor had 12:25  
21 undertaken a bed audit, in other words looking at the  
22 occupancy of beds in what was designated as a separate  
23 Urology ward, and looked at the reasons why patients  
24 were in bed - were they emergency admissions, were they  
25 elective inpatients - and looked at their lengths of 12:25  
26 stay. I suspect that that had been a requirement to  
27 undertake in the workup to the Regional Review of  
28 Urology.  
29

1 The results of that bed audit had showed that there  
2 were more beds in the single-designated Urology ward  
3 than were actually required. So, a ward  
4 reconfiguration had taken place which meant that the  
5 Urology beds and the ENT beds were brought into the 12:26  
6 same physical space. The urologists were not content  
7 with this. It had been implemented several months  
8 before I came into post and I had had no role in it,  
9 but it was certainly still a subject of conversation.  
10 In fact, Mr. O'Brien and Mr. Young, and I think 12:26  
11 probably Mr. Akhtar as well, wrote to me in January  
12 just a few weeks after this, talking about the  
13 unsafety, lack of safety because of the ward  
14 configuration. We met them with the Medical Director  
15 to understand concerns and to care about any clinical 12:26  
16 issues which they felt had arisen that were causing  
17 this perception of a lack of safety.

18 178 Q. If we could maybe look at some of the issues that the  
19 surgeons did raise with you at this point. If we go to  
20 WIT-15919. The question is asking about concerns that 12:27  
21 Mr. O'Brien may have raised. You say:

22  
23 "To my knowledge Mr. O'Brien raised a total of concerns  
24 across three occasions regarding patient care and  
25 safety during my tenure in post. Two of these concerns 12:27  
26 were raised by Mr. O'Brien in response to requests from  
27 myself as Director of Acute Services regarding clinical  
28 behaviour. There was one concern regarding patient  
29 safety raised by the three consultant urologists,

1 including Mr. O'Brien. This was raised in a letter on  
2 18th January 2010."

3

4 I think this is what you have just referred to?

5 A. Yes. 12:28

6 179 Q. "The concerns are detailed below, along with the action  
7 taken in response". I just want to set these out.

8

9 Point A:

10

12:28

11 "I received a letter sent on 18th January 2010 from  
12 three consultant urologists, including Mr. O'Brien,  
13 outlining concerns regarding the potential appointment  
14 of a locum consultant urologist in order to help  
15 address the urgent list of patients awaiting surgery. 12:28  
16 The letter also raised the issue of compromised  
17 inpatient care and safety as a result of the recent  
18 ward reconfiguration".

19

20 That chimes again with the note from the meeting? 12:28

21 A. Mm-hmm.

22 180 Q. "The action taken was an immediate meeting held by the  
23 Director on the day of receipt of the letter. The  
24 meeting involved all three consultant urologists,  
25 Mr. Mackle, AMD, myself and, from memory, Dr. Loughran. 12:29  
26 Each of the issues was discussed and actions agreed as  
27 set out below. In relation to the appointment of  
28 a locum consultant, a range of measures to address the  
29 long waits for theatre were agreed, which would ensure

1 that no patient was waiting longer than 16 weeks at the  
2 end of March. This required the surgeons working  
3 additional hours and, on the basis of this agreed  
4 position, the Trust agreed to cancel the locum  
5 appointment.

12:29

6  
7 2. In relation to the compromised inpatient care and  
8 safety as a result of the recent ward reconfiguration,  
9 the recent correspondence from Dr. Loughran, Medical  
10 Director, regarding the process of clinical incident  
11 reporting was discussed, and consultants advised to  
12 identify concerns over safety. Consultants were  
13 requested to immediately report any cases whereby  
14 patient safety was compromised so that urgent action  
15 could be taken. The letter of 20th January 2010 sent  
16 to the consultant urologists after the meeting also  
17 stated: "We would further appreciate if you could let  
18 Dr. Rankin know when you have submitted the required  
19 forms so that she can ensure a speedy response."

12:29

12:30

20  
21 Did you get any --

12:30

22 A. No.

23 181 Q. No. "B. Re referral triage and amending clinic  
24 templates to reflect new-to-review ratios. The letter  
25 from myself to Mr. O'Brien dated 22nd October 2010  
26 indicates a previous related letter from myself and  
27 Mr. Mackle to Mr. O'Brien to which Mr. O'Brien had  
28 replied on 27th September 2010. While the initial  
29 concern was not raised by Mr. O'Brien, the

12:30



1 correspondence identifies the concerns which he  
2 continues to hold with regard to implementing certain  
3 aspects of the implementation of the Team South  
4 Urology. These are set out below."

12:31

5  
6 In your letter of 22nd October 2010, the following  
7 points are made. This is your reply. So, you made:

8

9 "1. A commitment to triage referrals within a week and  
10 red flag referrals within a day, conditional on the  
11 cohort of consultants being sustained."

12:31

12 A. Mm-hmm.

13 182 Q. Now, that was an agreement then --

14 A. That was Mr. O'Brien agreeing to commit to triage of  
15 referrals within a week and red flag referrals within  
16 a day, assuming the cohort of three consultants  
17 remained in place.

12:31

18 183 Q. Thank you.

19

20 "2. Refusal to amend clinical practice to undertake  
21 new appointments in 20 minutes and review appointments  
22 in 10 minutes."

12:31

23 A. Yes.

24 184 Q. Again, that was not moving on the appointment  
25 timeframes that were set down --

12:32

26 A. Yes.

27 185 Q. -- by BAUS?

28 A. That's correct.

29 186 Q. "Lack of undertaking to reduce new-to-review ratios to

1 one to two as an interim step through clear discharge  
2 pathways with primary care".

3 A. Mm-hmm.

4 187 Q. "4. We are willing to ask you to reconsider the issues  
5 which have been in discussion over many months. Please 12:32  
6 confirm by Thursday 28th October your agreement to  
7 amend the clinic templates".

8

9 Then you attach the letter. So your recollection, that  
10 is that once again, there was a tension between the 12:32  
11 expectations of the service --

12 A. Yes.

13 188 Q. -- and the requirements that other consultants,  
14 certainly in relation to the time slots, triage and the  
15 amendment of the templates, had already adopted? 12:32

16 A. They had agreed to adopt them. I think we implemented  
17 them in November, hence why my seeking a response from  
18 Mr. O'Brien by the end of October, because we had  
19 agreed that we would implement them in November of  
20 whatever year that was, 2010 or 2011. 12:33

21 189 Q. I am just going back to the year. 22nd October 2010?

22 A. Yes.

23 190 Q. Do you remember was there any response to that? Was  
24 there a particular indication that there wouldn't be  
25 any movement on these issues, or was it anticipated 12:33  
26 that there had been some understanding that Mr. O'Brien  
27 would be expected to adhere to the same standardised  
28 approach as other consultants in certain respects?

29 A. I don't recall anything further from Mr. O'Brien, and

1 I think it was at that stage that we went ahead and  
2 implemented the new clinic templates, the new clinic  
3 times, in November 2010. That, I think, then was when  
4 we found that the afternoon clinic in Banbridge was  
5 overrunning by two hours.

12:34

6 191 Q. I will just read the rest of this, even though I am  
7 going to take you to something slightly out of  
8 sequence. I am going to take you to some letters that  
9 Mr. O'Brien has exhibited where he has identified some  
10 issues. They are 2010 and I see this paragraph moves  
11 on to 2011. If you bear with me, I won't lose my  
12 place.

12:34

13  
14 "On 25th August Mr. O'Brien sent an email to the Head  
15 of Service regarding the request to read test results  
16 when they were received".

12:34

17  
18 In fact, I am going to go against what I have just said  
19 because I am going to be coming on to the test results  
20 issue, so we will double park, if you can forgive me --

12:35

21 A. That's all right.

22 192 Q. -- and we will go to some of Mr. O'Brien's letters.  
23 AOB-02010. There's a digit missing in that. Let's go  
24 to the reply to see if it includes the original letter,  
25 WIT-17487. This is a letter from you and Mr. Mackle?

12:35

26 A. Yes.

27 193 Q. We go back up, dated 20th January 2010. You have  
28 received a letter from them on 18th January --

29 A. Mm-hmm.

1 194 Q. -- outlining your concerns about the consultant  
2 urologist?

3 A. Yes.

4 195 Q. The first part of the correspondence is at AOB-00138.  
5 Sorry to jump about. The documents are held in  
6 different files so we just want to make sure the Panel  
7 are aware of the original letter. This is dated 18th  
8 January 2010 and it's to you?

12:36

9 A. Yes.

10 196 Q. And it's from Mr. O'Brien. This is a correspondence  
11 from Mr. O'Brien to you. We will stick with this and  
12 see where we go.

12:37

13 A. Okay.

14 197 Q. This is Mr. O'Brien setting out his concerns. To put  
15 it in context, Mr. O'Brien has provided us with his  
16 correspondence to the Trust detailing his concerns and  
17 obviously the Panel want to engage with that as well.

12:37

18  
19 "Dear Dr. Rankin, it is with shock and disbelief that  
20 we learned from you on Monday 11th January 2010 that  
21 the Trust had appointed a locum consultant urologist  
22 without any consultation with us and without our  
23 participation in due process of appointment. It  
24 remains for us incredible and untenable the excuse that  
25 one of us could not be contacted when the appointment  
26 was apparently made during the third week of December  
27 2009. In addition, we can only conclude that the  
28 failure to inform us until Monday 11th January 2010 was  
29 with intent rather than oversight.

12:37

12:37

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Previous appointments of locum consultant urologists have always been conducted in consultation with, and with the active participation of, us in the due process of the construction of job descriptions, advertising, shortlisting and interviewing. This involvement has proven to be an indispensable component in the time-honoured method of ensuring that any appointee is qualified and adequately experienced for the post with the ultimate objective of ensuring, so far as is possible, patient safety, and our collective experience and awareness of the manner in which the Trust has made this appointment is unprecedented. Our concerns regarding the manner of appointment..."

12:38

12:38

12:38

Then he goes on to make comments about the appointee, alleged appointee.

If we just move on down towards the end, the general thrust of that is the appropriateness of the individual for the post. He says:

12:39

"As urologists we find ourselves unable to support the Trust's appointment and incapable of advising the Trust on this deployment. During the past year and despite our expressed concerns, the Trust proceeded with its ward reconfiguration resulting in compromised inpatient care and safety, as feared. In addition to significantly diminishing the specialist status of our

12:39

1 department, compliance with the loss of radical pelvic  
2 surgery as proposed by the Regional Review of Adult  
3 Urological Services similarly has the potential to  
4 compromise patient care and safety and will certainly  
5 diminish the status of our department further. The 12:39  
6 capacity to provide enhanced urological services in the  
7 future is entirely dependent upon the ability to  
8 recruit and retain specialist staff, and that is  
9 entirely dependent upon the attractiveness of the  
10 department's current status at any point in time. We 12:40  
11 would earnestly request that the management of the  
12 Trust seriously reflect upon its actions and proposals  
13 before any prospect of a future has been completely  
14 eliminated. If it is the case that only a general  
15 surgeon can be appointed, we fear that we may have 12:40  
16 already arrived at that point."

17  
18 That is signed by Mr. Akhtar, Mr. Young and  
19 Mr. O'Brien. The signatures are not on that but it is  
20 sent from them on their behalf? 12:40

21 A. Yes.

22 198 Q. That's a document you have seen. I presume it arrived  
23 to you?

24 A. Yes, absolutely. It's a document you receive and your  
25 heart falls to your shoes when you receive it and you 12:40  
26 know you have to respond very, very quickly. That's  
27 why I held a meeting with the three consultants on the  
28 day that I received that letter, on 18th January. The  
29 outcome of those discussions was sent back to them on

1 20th January so I moved very, very quickly.

2

3 I would totally agree with a lot of the sentiments in  
4 that letter. I genuinely do not recall who had been  
5 responsible for appointing a locum. If the locum was 12:41  
6 appointed in the third week of December, I can't think  
7 it would have been me because I only had been in post  
8 from the beginning of December, so it may have been  
9 happening and it may have concluded in the third week  
10 of December unbeknown to me. 12:41

11

12 I would totally agree with them that they should and  
13 must, of course, be involved in that process because  
14 only they can make an assessment of whether the  
15 candidates who are available have the suitable 12:41  
16 training. So, there's no issue about that point.

17

18 The failure to inform them of that later on in January,  
19 that was certainly an oversight as opposed to intent.  
20 I will never forget that Christmas and New Year, my 12:41  
21 first Christmas and New Year working in the Acute  
22 Services with the pressures and having to come in on  
23 Sunday 3rd January to cancel all elective work for the  
24 Monday because we had no beds in the hospital, they  
25 were all full of emergencies. So, I have a very, very 12:42  
26 clear recollection of that period within a few weeks of  
27 taking up posts, so that was certainly an oversight.

28

29 As a result of the letter and the conversations with

1           them, we immediately pulled the appointment of the  
2           locum, offered to go out again to get a locum, but you  
3           can see from the note of the meeting and my letter to  
4           the surgeons that they then presumably offered and  
5           agreed to do additional work internally, and that was 12:42  
6           the conversation. Now, that was never something that  
7           was required of any consultant, any specialty. When we  
8           had funding for waiting lists initiatives, WLIs, as we  
9           call them, that offer was made to all the consultants  
10          and there were many picked it up and many said I can 12:42  
11          only do this particular session in the week, or I can  
12          do the second and fourth Saturdays, or I can do  
13          whatever and we would have accommodated all of that.  
14          There was never any compunction on any surgeon to do  
15          that. I see from this correspondence that they offered 12:43  
16          to do additional sessions to treat a certain number of  
17          patients on the list who needed to be treated, which  
18          presumably had been the driver of bringing in a locum,  
19          which predated me.

20 199 Q.    which meant then the locum didn't need to be appointed 12:43  
21           because the capacity had increased internally?

22          A.    Yes, I immediately stepped it down because (A) they  
23           were dissatisfied so it was never going to work; but  
24           (B), as they were saying the person who had been  
25           offered the job, was not appropriately qualified. 12:43  
26           That's not a step you take, I mean somebody has to be  
27           qualified to do the job. If they haven't the urology  
28           experience, then they can't be appointed into a urology  
29           job.



1 200 Q. Just a phrase you used there, "they were dissatisfied  
2 so it was never going to work", is that reflective of a  
3 mindset or a culture amongst medics where you have to  
4 get their agreement to implement any change?

5 A. I think if you are bringing a new member into a small 12:44  
6 team of three people and you are bringing a fourth  
7 member in, unless they have credibility within that  
8 team, it's going to be very, very difficult to make it  
9 work as a full working team. It's purely about the  
10 credibility of the experience that the person brings to 12:44  
11 the job.

12 201 Q. Now, there's mention in the letter of the ward  
13 reconfiguration which resulted in "comprised inpatient  
14 care and safety as feared". Now, you had said  
15 previously that you hadn't received anything back about 12:44  
16 concerns about patient safety. What did you understand  
17 that to mean there?

18 A. Well, at the meeting that I held on the day I received  
19 this letter, I, of course, raised it, and I think  
20 Dr. Loughran was with me at the meeting because it was 12:44  
21 still so early in my days of tenure in this post that  
22 I felt it would be important to have the Medical  
23 Director. We often co-worked meetings. There was  
24 a real trust in the Trust that could you co-work any of  
25 these scenarios with colleague directors if you were 12:44  
26 concerned. This obviously is very concerning when you  
27 have a consultant body and a specialist in a specialty  
28 area talking about comprising inpatient care and  
29 safety. We asked about examples of what had caused

1 them to write this and no examples were forthcoming at  
2 the meeting. Otherwise, I would have reflected that in  
3 my response to them, and I don't recall any being --  
4 any specific examples being made.

12:45

5  
6 we then asked, as is revealed in my letter to them,  
7 that they would immediately, if they did have a concern  
8 about any particular patient, they would raise an IR1  
9 but also alert my office, leave a message with my  
10 office and I would be looking at that IR1 immediately  
11 and discussing with them what the issue was and seeing  
12 what needed to be done. If I had received any examples  
13 of unsafe care where safety was comprised, I would have  
14 been actioning that. It wouldn't have been me alone,  
15 it would have been me with Mr. Mackle or the Chief  
16 Executive as needed, there was an absolute focus. If  
17 there was a demonstrable lack of inpatient safety and  
18 care, we would have acted on that, without a doubt.

12:45

12:46

19 202 Q. So you had the meeting on 18th January and then the  
20 written reply was the 20th?

12:46

21 A. 20th January, yes.

22 203 Q. That was the reply we had previously seen, Chair. If  
23 you'd like me to bring you back to give you a note,  
24 it's WIT-17487. I am having that confirmed that the  
25 letter of 18th January 2010 is the one that we just  
26 took you to in your statement at 64.1(a). We have gone  
27 through the detail of it, not the actual physical  
28 letter, but the Panel have that note.

12:47

29 A. Yeah.

1 204 Q. Just in relation to other issues that were brought to  
2 your attention, I wonder if we could go to WIT-51785.  
3 This is from Mr. Young's Section 21, where he says:  
4  
5 "Following the 2009 review, I felt my role as lead 12:48  
6 clinician was very much supported by the immediate line  
7 management system of Heads of Service and Clinical  
8 Directors covering Urology. They have been supportive  
9 and deeply involved in all the projects our department  
10 have put forward. In the immediate period following 12:48  
11 the review, it was my opinion that Dr. Rankin, Director  
12 of Acute Services, although chairing our steering  
13 group, was not as supportive of our department's  
14 personal thoughts on the recovery plan. This is my  
15 personal opinion as she did not fully follow my 12:48  
16 suggestions. I had thought her approach to appointing  
17 three consultants on one day unwise in 2012, and  
18 especially in the way the interview panel had been  
19 constructed. She also did not agree to the Outpatient  
20 clinic template we had suggested at the time which 12:48  
21 actually did ultimately become our template.  
22 Subsequent directors of Acute Service were supportive."  
23  
24 I just wanted to draw your attention to that reflection  
25 of Mr. Young in relation to his engagement with you. 12:49  
26 Were any of those concerns from him articulated to you  
27 at the time?  
28 A. No, I'm not aware of this. I suppose my response would  
29 be that when you are seeking to make quite considerable

1 change to working practice, that is an inevitable  
2 consequence. As I was leading that change and very  
3 visible, I would be the focus for that, but that's the  
4 way the system works.

5  
6 The issue appointing three consultants in one day  
7 unwise in 2012 and the way the interview panel had been  
8 constructed, I had no control over that. That was in  
9 the control of the -- that was the Trust policy on  
10 appointing consultants. The panel was constructed by  
11 HR to appoint the consultant, and the Chair of the  
12 Panel was usually the Chair of the Trust or  
13 a designated non-executive member of the Trust, so I  
14 had no role in that process. I was a member of the  
15 panel, invited to be, so any discussion in terms of  
16 varying the panel members or the approach would have  
17 been with HR.

18 205 Q. Do you think the extent to which you liaised with the  
19 clinicians was sufficient, was appropriate?

20 A. Well, the liaison with the clinicians would have been  
21 at that weekly/fortnightly meeting during that  
22 prolonged period of 16 months. We then would have  
23 reviewed our progress against the review  
24 implementation, such as that meeting that we looked at  
25 half an hour ago that Heather Trouton had written the  
26 note of. That was in June 2011. We would have met  
27 with the consultants for specific reasons subsequent to  
28 that. I mean, the second half of 2011 into the first  
29 part of 2012 was around the job planning because

1 everything else in the implementation plan was in place  
2 or being put in place and was work in progress. As I  
3 say, the second half of 2011 and the early part of 2012  
4 were the discussions with the medical staff and with  
5 the consultants about job planning, about which 12:51  
6 I wasn't directly involved. As we have already alluded  
7 to, those were quite protracted discussions.

8 206 Q. Just for the Panel's note of other concerns that were  
9 raised, we have already gone over the issues. It's  
10 Mr. Weir's concerns regarding ward reconfiguration 12:51  
11 raised in 2009. That can be found at AOB-82229.

12  
13 Now, we will go on to look at the Trust governance  
14 documents as they informed the Trust Board when we look  
15 at the issues that arose and how they were reflected to 12:52  
16 the Board, okay. Just in relation to the specific  
17 concerns raised by Mr. O'Brien and others, those  
18 specific concerns weren't reflected in the Trust  
19 governance documents. You've stated that in your  
20 witness statement at WIT-15924, paragraph 67.1, where 12:52  
21 you have said:

22  
23 "The specific concerns raised by Mr. O'Brien and others  
24 were not written down in Trust governance documents. I  
25 am unable to give an explanation for this. However, it 12:52  
26 would not have been usual practice at that time to  
27 record such specific issues as raised by Mr. O'Brien in  
28 Trust Board or directorate risk registers. These risk  
29 registers generally identified risks which existed

1 across a range of systems in the Trust or across a full  
2 directorate. The specificity of risk would more likely  
3 be identified in divisional risk registers. This may  
4 have been the position on the journey of recording  
5 risks at that time and may have subsequently been  
6 further developed. "

12:53

7  
8 we have taken one example of a risk that was raised in  
9 relation to patient care and safety in the ward  
10 reconfiguration, and in the letter it mentioned the  
11 removal of the radical pelvic surgery to Belfast.  
12 There was a suggestion that that would comprise patient  
13 safety, but your evidence to the Inquiry is that no one  
14 ever brought any manifestation of those alleged patient  
15 safety issues to you, or they were never evidenced when  
16 you asked for them.

12:53

17 A. I think there are possibly two issues there. One is  
18 the specific risk that Mr. O'Brien had raised. I would  
19 have expected those to have started on the service  
20 specific risk register with Martina, then for  
21 discussion of that process and come up with a system.

12:54

22  
23 Obviously, the other balance to that is the paper that  
24 went to Trust Board specifically around some of the  
25 issues. We will come on to that later, as you have  
26 indicated.

12:54

27  
28 The other issue in there about prostatectomy, that was  
29 a requirement within the Regional Review, and also from

1 the guidelines which NICA<sup>n</sup>, the Northern Ireland Cancer  
2 Network, had set out and agreed, in 2008 I think, in  
3 the Urology group, of which Mr. O'Brien was a member,  
4 I understand, and then subsequently became Chair of.  
5 So, that clinical guidance was set within Northern 12:54  
6 Ireland, was adopted by the Regional Review for the  
7 implementation of urology, and so should not have been  
8 a surprise to any of the urologists working anywhere in  
9 the system in Northern Ireland. It had been agreed  
10 that radical pelvic surgery, including prostatectomy 12:55  
11 and cystectomy, would move to the Belfast Trust at an  
12 agreed time when they had the resource to handle the  
13 increased referrals, because they obviously needed to  
14 build their capacity in terms of consultants and  
15 theatre time, et cetera, to prepare for that change. 12:55

16 207 Q. That decision to move the radical pelvic surgery was  
17 done after a review was undertaken. The decision was  
18 made after that to centralise, I think, to centralise  
19 it to Belfast due to the nature of the surgery and the  
20 apparent rarity with which it was being performed. 12:55

21 A. That was the issue. NICA<sup>n</sup> had set out that -- NICA<sup>n</sup>  
22 guidance had set out in 2008 that radical pelvic  
23 surgery for malignant reasons would move to Belfast.  
24 The numbers of cystectomies being undertaken in the  
25 Southern Trust was of the order of two to four per 12:56  
26 year. That wasn't defined by one surgeon; that could  
27 have been all three surgeons doing one cystectomy per  
28 year. By this stage, in the surgical world in the UK,  
29 it was becoming quite the norm that you did not

1 continue to operate and to undertake a procedure if you  
2 were only doing one per year. That was not deemed to  
3 be sufficient. In some surgical specialties, there  
4 were some requirements for surgeons to be undertaking  
5 25 of a specific procedure in a year to maintain their 12:56  
6 skill and expertise and be able to continue providing  
7 that. This was a thrust from the Board, quite  
8 correctly, that that kind of major surgery would move  
9 to the Belfast Trust.

10  
11 The timing of the move of cystectomies, for benign 12:56  
12 reasons, moving to the Belfast Trust, coincided with  
13 the end of the review of the benign cystectomies.  
14 There was not an explicit link made that I was aware of  
15 but there certainly was a time coincidence there, which 12:57  
16 was rightly done.

17 208 Q. The consultants at the time in Urology, were they  
18 consulted about the move, or do you understand the  
19 nature of their engagement around the decision of that,  
20 or was it not necessary for that to take place? 12:57

21 A. Mr. Young was on the steering group. Mr. Young sat  
22 with me and the Director of Performance and Reform as a  
23 full member of the regional steering group at which  
24 that decision was taken. In fact, the notes of the  
25 meeting in November 2010 came out saying that it had 12:57  
26 been agreed that all benign cystectomies would move to  
27 the Belfast Trust. Mr. Young, on reading those  
28 minutes, it went back to the Chair of that group, Beth  
29 Molloy, Assistant Director in the Health and Social



1 Care Board; the late Beth Molloy. Mr. Young went back  
2 to Beth to say that he didn't remember it being agreed  
3 that cystectomies for benign reasons would move to the  
4 Belfast Trust.

5  
6 I think Beth's action then was to talk to Mr. Mark  
7 Fordham, who was the independent urologist appointed to  
8 be part of the review. Mr. Fordham's reply, if I  
9 recall, was to say that there no specific guidance on  
10 this but he would expect, and would expect a patient to  
11 expect, that somebody who was undertaking a cystectomy  
12 would be doing enough of them during the year to  
13 maintain that skill.

14  
15 Unfortunately, there was no formal correspondence from  
16 the Board at that stage to underscore the fact that the  
17 decision had taken the decision that the regional --  
18 the steering group had taken the decision that the  
19 cystectomies for benign reasons would move.

20 I identified confusion in our system in the summer of  
21 2011, and I wrote the letter that I always regard  
22 for-the-avoidance-of-doubt letter, benign cystectomies  
23 for benign reasons no longer occur in Craigavon; all  
24 those patients are to be referred to the Belfast Trust.  
25 That might explain some of the confusion around it.

26  
27 But we got it clarified and there were patients who  
28 were referred very, very urgently for prostatectomy and  
29 cystectomy for malignant reasons. I think the speed of

1 that happening was what surprised Mr. O'Brien and  
2 Mr. Young, the fact that patients who had been booked  
3 for surgery were moved to the Belfast Trust even after  
4 they had been booked. In the correspondence that  
5 Heather Trouton at my request was having with Beth 12:59  
6 Molloy, the Board, on the timing of this, Beth was on  
7 leave at the time and Dr. Corrigan replied on behalf,  
8 and her email was explicit - move these patients ASAP -  
9 not even spelt out - move these patients ASAP, and by  
10 the end of the day those patients had been referred. 12:59  
11 In fact, one patient had their surgery earlier in the  
12 Belfast Trust than they would have had with us. All  
13 five patients who were referred were seen within a week  
14 in the City Hospital in the Belfast Trust. So, all  
15 patients were correctly seen and served appropriately. 13:00  
16 209 Q. The next part I would like to move on to is how the  
17 information around the concerns and that issue in  
18 particular were communicated to the Board. I just  
19 notice the time, so it might be...  
20 CHAIR: So back again at two o'clock then, everyone. 13:00  
21 Thank you.

22  
23  
24  
25  
26  
27  
28  
29

THE INQUIRY ADJOURNED FOR LUNCH

1 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

2  
3 CHAIR: Good afternoon, everyone.

4 210 Q. MS. McMAHON: Just before I move on to the topic  
5 I discussed with you before lunch, one of the other 14:00  
6 governance oversight metrics I wanted just to ask you  
7 about, if you have any knowledge of, is the clinical  
8 audit as a governance tool.

9 A. Yes.

10 211 Q. Do you have any knowledge of what methods of clinical 14:00  
11 audit there were in your time and how you became aware  
12 of any issues arising from those?

13 A. Clinical audit, as I recall, and the support for  
14 clinical audit, was handled/managed through the Medical  
15 Director's office. I recall asking at some stage, I 14:00  
16 don't recall when it was, but I recall asking had there  
17 been and were there any ongoing audits in Urology, and  
18 I think I was told there weren't.

19  
20 I then undertook to see if there were any national 14:01  
21 audits going on through BAUS or any other professional  
22 organisation in relation to Urology at that stage, and  
23 there weren't and so I wasn't able to follow through on  
24 that. We as a Trust had always wanted to participate  
25 in national audits, and I have many examples where we 14:01  
26 did participate: The Sentinel Stroke Audit, the  
27 Fracture Neck of Femur Audit, Emergency Department  
28 ICNARC for Intensive Care. So, we had many examples of  
29 where we did contribute to national audit so that we

1 could measure ourselves against our peers across the  
2 United Kingdom.

3  
4 The results often of those audits came to Trust Board.  
5 I can remember Dr. McAllister presenting very proudly 14:01  
6 the ICNARC results to a meeting of the Trust Board  
7 because we were holding our head with the best of the  
8 UK intensive care units. So, I was disappointed not to  
9 be able to find a tool that we could use within  
10 Urology. So, I cannot recall any results of audits 14:02  
11 from Urology coming to me, or being made aware of them.

12 212 Q. The way in which any clinical concerns would have come  
13 to your attention, was that through the Clinical  
14 Director or the Medical Director? were they at  
15 meetings they were identified? 14:02

16 A. They could have come through that route, they could  
17 have come through an informal route. You have to be  
18 able to have the formal systems, but obviously the  
19 ability to listen when things come to you through  
20 different routes, which they often did. That was the 14:02  
21 best of a system, to have both the formal routes and  
22 the informal routes.

23 213 Q. One example of that may be the use of IV antibiotics?

24 A. Yes.

25 214 Q. which occurred during your time? 14:03

26 A. Yes.

27 215 Q. If we look at your statement at WIT-15876. That begins  
28 at paragraph 50.9. I am just going to read out the  
29 context of this before asking you a couple of

1 questions.

2 A. Mm-hmm.

3 216 Q. Your statement says:

4

5 "The concern regarding the use of IV antibiotics was 14:03  
6 raised with me by the Chief Executive at the meeting  
7 held on 1st December 2009", and we have previously seen  
8 the notes of that.

9 A. Yes.

10 217 Q. "The use of IV fluids and IV antibiotics have become 14:03  
11 part of local urological practice for the treatment of  
12 recurrent UTIs over many years and had been identified  
13 in spring 2009 during an audit of bed usage. It was  
14 considered to be unusual."

15

14:04

16 Just if I could stop you at that point. Considered to  
17 be unusual by the person reporting it to you or  
18 considered generally among the medics who brought it to  
19 your attention that it was unusual?

20 A. "Unusual" is maybe not the correct word there. I think 14:04  
21 it's my word in terms of writing my statement. I'm not  
22 sure it was taken from anywhere.

23 218 Q. That's fine. I will go on.

24

25 "At that time, the Trust discussed with the clinicians 14:04  
26 involved and subsequently took expert advice. The  
27 therapy was deemed not to be evidence based. About 35  
28 patients were in the cohort at that stage and it was  
29 agreed that each member of the cohort would be reviewed

1 with a view to ceasing IV therapy. When I came into  
2 post, the cohort had reduced considerably to  
3 approximately ten patients. The Commissioner had  
4 sought assurance that this treatment had ceased and  
5 that no patient had central venous access required for 14:05  
6 the injection of the antibiotics."

7  
8 The actions taken were as follows:

9  
10 "Request a further review of the cohort of patients by 14:05  
11 the consultants in order to cease the practice. B,  
12 implement a process which required the consultant  
13 urologist to discuss a patient in respect of whom they  
14 wished to prescribe antibiotics, and the Clinical  
15 Director and the consultant microbiologist. This 14:05  
16 process would ensure that no patient was prescribed IV  
17 antibiotics inappropriately".

18  
19 Then you have referenced an email of 6th July 2010 from  
20 the Head of Service to the Director, which was you: 14:05

21  
22 "... an update on those patients still receiving IV  
23 antibiotics identifies that none of these patients had  
24 been discussed with the Clinical Director and  
25 consultant microbiologist". 14:05

26 A. Mm-hmm.

27 219 Q. "In terms of assurance that these processes were or  
28 were not working, regular information on the cohort of  
29 patients previously receiving IV therapy was reviewed

1 and any recent use of IV therapy highlighted. It was  
2 then checked if the decision to treat with this therapy  
3 had been taken jointly in discussion with the Clinical  
4 Director and the consultant microbiologist."

14:06

5  
6 Then you attach an email of 24th August 2010 which  
7 identifies the patient cohort, and the position of this  
8 cohort as at July 2010 and updated for August 2010.

9 You say:

10  
11 "The list showed that both Mr. Young and Mr. O'Brien  
12 had continued the practice of IV therapy in both those  
13 months. The number of patients treated with IV therapy  
14 in July was 13. Mr. O'Brien treated nine patients and  
15 Mr. Young treated four patients. In August it was  
16 three patients; Mr. O'Brien treated two patients and  
17 Mr. Young treated one patient. The number of patients  
18 treated using IV therapy had reduced but was still  
19 continuing."

14:06

14:06

20  
21 Then you say in paragraph E:

22  
23 "On 2nd September, as an outcome of the meeting held  
24 the previous day, the Medical Director wrote to the  
25 Director of Acute Services seeking assurance that the  
26 practice of treatment with intravenous therapy had  
27 stopped completely. The Director of Acute Services  
28 wrote to the two consultant urologists on 2nd September  
29 2010, inviting both consultants to attend a meeting

14:07

14:07

1 with" yourself "and Mr. Mackle regarding the practice  
2 with three patients. "

3  
4 You then sought an updated position on 2nd September  
5 2010 on patients receiving IV therapy prior to meeting 14:07  
6 with the consultant urologists. That meeting then  
7 subsequently had to be cancelled. You haven't been  
8 able to find the note of the subsequent meeting with  
9 the consultants but you confirm that you wrote to  
10 Dr. Loughran on 14th September following the meeting 14:08  
11 with them to say:

12  
13 "Here are the documents Mr. Mackle and I used to  
14 discuss with Mr. Young and Mr. O'Brien separately last  
15 Thursday. You may wish to use in your correspondence 14:08  
16 to Dr. Corrigan. "

17  
18 The issue there was a practice that was identified as  
19 not being clinically required or clinically approved,  
20 and a process was put in place that should that 14:08  
21 practice wish to be carried out on a particular  
22 patient, that there would be some level of oversight  
23 and engagement with both the Clinical Director and the  
24 microbiologist?

25 A. That's correct. 14:08

26 220 Q. Was that process put in place by the Medical Director  
27 in collaboration with you, or was this entirely  
28 a medical problem to be sorted out by the medical  
29 management?



1 A. I think we implemented -- we discussed it and agreed  
2 the approach jointly. It was very much a joint  
3 approach. At that stage, the Trust were doing a lot of  
4 work on antibiotic stewardship and there were  
5 antibiotic ward rounds being introduced in specific 14:09  
6 wards. One of the actions was to move quite quickly to  
7 introduce the antibiotic ward round by Dr. Damani into  
8 the urology ward. But there was some consultants who  
9 didn't want to be told which antibiotic to prescribe  
10 for patients and were less inclined to take the advice 14:09  
11 of the consultant microbiologist in the Trust, a very  
12 imminent consultant of national and very international  
13 repute. We were very fortunate to have Dr. Damani on  
14 our staff at that stage. So no, it was a joint  
15 approach by Dr. Loughran and myself. 14:09

16 221 Q. The issue at that time was not just in relation to the  
17 type of antibiotic prescribed but the route by which it  
18 was administered?

19 A. Both of those, the type of antibiotic and the fact that  
20 it was being given IV, which sometimes meant specific 14:10  
21 access had to be created to enable that to happen.

22 222 Q. Do you have any knowledge of any risk assessment that  
23 was undertaken at that time in relation to the benefits  
24 of giving people the treatment that they were receiving  
25 from Mr. Young and Mr. O'Brien to stopping that? Was 14:10  
26 that something that you know or might have assumed that  
27 the clinicians involved in assessing this practice  
28 would have considered?

29 A. I have no knowledge of that. I mean, I was aware that

1 it was a long-standing practice that had been practised  
2 within the Urology Unit in Craigavon Hospital.

3 I understand that a letter had been published in  
4 relevant Urology journals. Quite clearly, the advice  
5 and guidance from the Commissioner to the Trust prior  
6 to me taking up post was that this was not an  
7 evidence-based practice and should not continue.

14:10

8 223 Q. You have just mentioned that the practice was  
9 referenced in a Journal of Infection in 2011. I will  
10 bring you to that. It's at WIT-82743.

14:11

11  
12 Now, you are trained in practice as a medical  
13 practitioner as well. I won't claim to have any  
14 particular knowledge about this but the Journal of  
15 Infection 2011 where this was being published, this is  
16 published by way of a letter?

14:11

17 A. Okay.

18 224 Q. So you can see on the right-hand side, Vincent Koo,  
19 Michael Young and Aidan O'Brien. Now, that's been  
20 submitted to the journal and been published. Were you  
21 aware of that at the time?

14:12

22 A. No, completely unaware of it. This is the first time I  
23 have seen it. Of course, a letter is not  
24 a peer-reviewed substantial evidence-based piece of  
25 research that would be accepted in today's world,  
26 albeit this was August 2011. It's a letter. Quite  
27 clearly, you know, there's information there.  
28 I haven't read the article so I don't know what it's  
29 actually saying.

14:12

1 225 Q. But it's a presentation of information rather than, as  
2 you say, a peer-reviewed --

3 A. Yes, that's correct.

4 226 Q. -- piece of scientific research that's been undertaken  
5 and the results reported. The results are reported 14:12  
6 there but it's in a different format than perhaps you  
7 as a medic might expect?

8 A. Yes, it is. Necessarily being from one unit, it will  
9 have a relatively small cohort of patients. To be  
10 evidence-based, you would usually be looking at a much, 14:13  
11 much larger cohort and multi-centre trial to produce  
12 something that was evidence-based and therefore moving  
13 into routine practice.

14 227 Q. Now, as regards the success of the systems that were  
15 put in place to try and rectify this, you refer to 14:13  
16 that, if we can go back to WIT-15883 at paragraph G.  
17 You reflect on the system. You say:

18

19 "The system and agreement with the consultants put in  
20 place was largely but not completely successful. The 14:13  
21 number of patients who were subsequently treated with  
22 IV therapy were of the order of one or two per year.  
23 Mr. O'Brien required repeated reminders of the process  
24 to be followed, such as the meeting chaired by myself  
25 on 9th June 2011 involving Mr. O'Brien". 14:14  
26

27 Then the issues and actions from the meeting on 9th  
28 June are set out in a memo of 1st July from Heather  
29 Trouton. We have seen.

1 A. Yes.

2 228 Q. Was it your understanding that clearly based on that,  
3 there was a resistance to adopt the new process that  
4 had been put in place, presumably as clinically  
5 appropriate but also as a safety valve? 14:14

6 A. Yes, there definitely was resistance and it was very  
7 difficult to completely eradicate this. I think by the  
8 autumn of 2010, we had it largely eradicated. We put  
9 in place a couple of strands of work. One was the  
10 multidisciplinary approach involving Dr. Damani and the 14:14  
11 Clinical Director, of whom there were three in  
12 succession who handled this. We also, aligned to that,  
13 asked the ward to identify to Mrs. Corrigan if they  
14 knew of a patient who had a planned admission for IV  
15 antibiotics. So, that became an action that was put in 14:14  
16 place so we were aware then if there was a planned  
17 admission and we could then take appropriate action to  
18 ensure that there had been a multidisciplinary  
19 discussion and, if not, there was one put in place.

20 14:15  
21 The other main action that we put in place was a new  
22 pathway agreed with Mr. O'Brien and the other two  
23 consultants, that there would be a community pathway  
24 for oral antibiotics which then the patients went  
25 through. 14:15

26  
27 Set against that, part of the dilemma here was that  
28 some of these patients had actually become dependent on  
29 this as a treatment that they actually phoned looking

1 for. So, we had to be very careful about handling  
2 that. The process of the community pathway using oral  
3 antibiotics was successful in adopting that, but I know  
4 that one of the subsequent breaches after that --  
5 I think I have knowledge of two breaches after this 14:15  
6 particular period of time, and one of those was  
7 a patient who actually wanted to come in, and we had to  
8 work very hard to handle that situation.

9 229 Q. There's an example of an email around a further breach,  
10 if we go to TRU-259913. 14:16

11 A. Yes. That's the breach I was referring to.

12 230 Q. So that's the patient I think you are referring to?

13 A. Yes.

14 231 Q. And this is an email from Mr. Mackle sent 30th January  
15 2012 to Sam Hall, copying you in and Martina Corrigan, 14:16  
16 "IV antibiotics". I will read it without referring to  
17 the patient:

18  
19 "Dear Sam. I have been advised that a patient may have  
20 been admitted last week by Mr. O'Brien and under his 14:16  
21 instruction was given IV antibiotics, necessitating  
22 a central line to be inserted. I have checked with  
23 Dr." -- named the doctor -- "and he advises me no  
24 discussion took place prior to administration of  
25 antibiotics. I would be grateful if you could formally 14:17  
26 investigate this and advise me of your findings."  
27

28 This was a period of time, it seems, almost a year and  
29 a half or a year and four months following the initial

1 alert over the practice. Then I think there were quite  
2 rapid recommendations that the new pathway and approach  
3 had to be adopted?

4 A. Yes. Yes.

5 232 Q. How difficult is it from a governance perspective to 14:17  
6 deal with an individual, whether it's Mr. O'Brien or  
7 anyone in the Trust, who seeks to, or by his actions,  
8 circumvents systems in place to ensure that there's  
9 a standardised approach to clinical care, or at least  
10 their actions trigger the appropriate response? 14:18

11 A. It really is very difficult because some systems are  
12 electronic and automated and you can use the ability to  
13 alert when something is going to happen or has  
14 happened. I am sure we will come to some of those  
15 scenarios. Some of the other systems, when you don't 14:18  
16 have the ability to have electronic flag, they are  
17 human systems, and human systems always have the  
18 potential for failure so they can never be completely  
19 foolproof. But you expect people working in the Health  
20 Service to automatically understand about safety and to 14:18  
21 learn whenever there are processes going on which are  
22 not in the best interests of patients as seen by most  
23 of the world. So, it is difficult managing somebody  
24 who has a view that whatever they are doing is the  
25 safest thing, despite the rest of the world disagreeing 14:19  
26 with that.

27 233 Q. Was there ever any consideration of sanctions or any  
28 action in relation to a clinician who is not following  
29 what the Trust have said the process should be?

1           A.    When we come to the cystectomy issue, as I am sure you  
2                    will, there was a screening of a performance concern at  
3                    that stage, so there was a formal process at that  
4                    stage. I don't think we took any action after this  
5                    particular episode in relation to the IV antibiotics,           14:19  
6                    given that we had eradicated it, with the exception of  
7                    this breach. That's a contradiction in terms,  
8                    I appreciate that. But the cohort had moved into  
9                    a community and oral antibiotic route, with the  
10                   exception of this patient. My recall of this patient           14:19  
11                   was that she had phoned and was looking for this  
12                   treatment, which made it very, very difficult.

13   234   Q.    You have just mentioned the cystectomy issue and the  
14                    review, the MHPS review, of that particular process.  
15                    Could you just give us the background to that as you           14:20  
16                    recall it?

17           A.    Yes. My recall is that the Trust received a letter  
18                    from Dr. Corrigan, a physician in public health  
19                    medicine in the PHA but aligned to the Southern area.  
20                    And Diane had been undertaking -- she had noticed           14:20  
21                    a higher rate of cystectomy for benign reasons in the  
22                    Southern Trust in comparison to the other Trusts in  
23                    Northern Ireland. The order of cystectomies at that  
24                    stage was, I think from memory, two to four per year  
25                    but that was greater than had been expected. She           14:20  
26                    brought that to Dr. Loughran's attention. I think on  
27                    the day that we received that letter, Dr. Loughran and  
28                    myself and Mr. Mackle met to discuss the appropriate  
29                    approach. I think also Kieran Donaghy, the Director of

1 HR & Organisational Development was present.

2 235 Q. He was. We can actually go to that paragraph on your  
3 statement, if it helps your memory. WIT-15872,  
4 paragraph (b). I think this was an immediate meeting  
5 on 1st September -- 14:21

6 A. Yes.

7 236 Q. -- that was held.

8 A. That's correct.

9 237 Q. This is where you set out the concern raised by the  
10 Commissioner? 14:21

11 A. Yes.

12 238 Q. A letter was sent. Then the next paragraph is the  
13 meeting that you are referring to?

14 A. Yes, that's correct.

15 239 Q. I will just read this paragraph: 14:21

16

17 "The immediate step taken was a meeting held on 1st  
18 September between Dr. Loughran, Mr. Mackle, Mr.  
19 Donaghy, Director of HR & Organisational Development,  
20 and myself. At this meeting, it was agreed that 14:21

21 a formal independent review of the appropriateness of  
22 the treatment of cystectomy was required. The action  
23 determined was to commence a local review in line with  
24 the guidance provided by the document Maintaining High  
25 Professional Standards in the HPSS. This process 14:22

26 included a case note review of each patient who has  
27 undergone a cystectomy in the previous ten years.  
28 Mr. Young and Mr. O'Brien would have been informed of  
29 the meeting. They were to be met by myself and



1 Mr. Mackle in the next few days to discuss both the  
2 review of cystectomies by an independent assessor, and  
3 the parallel at that time was the use of IV therapy".  
4

5 You have said in paragraph 3 there:

14:22

6  
7 "The terms of the local review, the review brief, into  
8 the incidents of cystectomies was set out in a document  
9 to formalise the document, the review process, in order  
10 to share with Mr. Young and Mr. O'Brien".

14:22

11  
12 Just to be clear, this MHPS review is not an  
13 investigation into any individual at this point. This  
14 was an MHPS guidance document review into a practice?

15 A. That's correct.

14:23

16 240 Q. Is that right? Then you say at 4:

17  
18 "The review brief was shared with Dr. Corrigan as  
19 requested by the Chief Executive, and both Mr. Young  
20 and Mr. O'Brien were kept informed of the process."

14:23

21 A. Mm-hmm.

22 241 Q. One of the points I was going to bring you on to but we  
23 will discuss it now:

24  
25 "The Trust Board were informed of the screening of  
26 a performance concern through a written confidential  
27 briefing in September 2010, and this was presented to  
28 the confidential section of the Trust Board by the  
29 Director of Acute Services."

14:23

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Do you recall how long that process took to review the cystectomy, the ten-year look at patients?

A. Yes. I think Mr. Mackle undertook a case note review initially and then determined that, as he was not a urologist, the process needed to be undertaken by a urologist. I think Mr. Marcus Drake was appointed.

14:24

242 Q. Mr. Drake?

A. By memory -- from memory, I think we had an initial verbal report in March, the following March, but the final written report, I think, came the following summer.

14:24

243 Q. Do you understand that Mr. Drake, did he speak to the consultants concerned, Mr. Young and Mr. O'Brien, or indeed any of the Urology consultants?

14:24

A. I don't know whether he did. I suspect not. I think it was purely a case note review. Because of the numbers of patients on the issues around patient notes, it had to be arranged that Mr. Drake came over to Craigavon to actually do that case note review on the spot as opposed to notes being sent over to him. So it took a while for him to free diary and to come over and to do that.

14:24

244 Q. So this would be something you informed of as it progressed rather than you being involved in?

14:25

A. Yes, yes. I was not involved in the process other than setting up, agreeing the review, and then making sure that people were kept informed and then acting on the results of the review.

1 245 Q. I take it perhaps from your answer, given your slight  
2 distance from the actual carrying out of the review,  
3 you don't have any knowledge of whether Mr. O'Brien or  
4 Mr. Young, or any of the consultants, were informed  
5 that this was being carried out in line with MHPS 14:25  
6 guidance?

7 A. They were certainly informed; I would have been  
8 involved in that part. As I have said in my statement,  
9 the review brief would have been given to them, so they  
10 were fully aware of that. I don't recall how they were 14:25  
11 informed about the outcome of it the following summer  
12 but that, I'm quite sure, would have happened.

13 246 Q. Do you recollect the outcome of the review by  
14 Mr. Drake?

15 A. Yes, Mr. Drake, I think, used the words that "supported 14:26  
16 but indeterminate", it was kind of a middle ground,  
17 which didn't say it shouldn't have been done but didn't  
18 say that all of... It was an unusual way, perhaps, of  
19 setting it out. The decision-makers in this process,  
20 though, were through Mr. Mackle, as the Associate 14:26  
21 Medical Director to the Medical Director.  
22 Dr. Loughran, on the basis of the report from  
23 Mr. Drake, decided to close the case and wrote to  
24 Dr. Corrigan accordingly.

25 247 Q. Where does this sit, this review, with the decision 14:26  
26 about the radical pelvic surgery being moved to  
27 Belfast? Was that in around the same time, did one  
28 influence the other, or what was the understanding at  
29 that point?

1 A. I have no knowledge of them both being collected but  
2 when I look back at the timeline of all of this  
3 happening, quite clearly the Regional Review had made  
4 the decision in November 2010 that all cystectomies,  
5 all radical pelvic surgery was to move to Belfast when 14:27  
6 Belfast had the capacity to take the patients. There  
7 was the confusion that I alluded to earlier around the  
8 --

9 248 Q. Benign?

10 A. -- pelvic surgery for benign conditions, and we sorted 14:27  
11 that out by the following summer. We got Mr. Drake's  
12 report I think in the July of that summer, and in the  
13 September we were instructed by Dr. Corrigan to move  
14 the prostatectomies and cystectomies that had just been  
15 booked - I think it was about the third week in 14:27  
16 September - they were transferred to Belfast ASAP, i.e.  
17 that afternoon. So there was a time coincidence of  
18 those coming together. Dr. Corrigan would have been in  
19 receipt of Mr. Drake's report. It was heard in Beth  
20 Molloy's absence who told us to refer patients ASAP in 14:28  
21 September. There may well have been a link but I was  
22 not aware. It's only when I look back at the time  
23 scales and put the timeline in that I realise that  
24 there was a coming together on the timeline.

25 249 Q. Was there an understanding or was it ever discussed 14:28  
26 whether cystectomy was included in the overarching  
27 definition of radical pelvic urology surgery?

28 A. Well, I'm not a urologist but the meeting of the  
29 regional steering group in November 2010, according to

1 the minutes that were sent out, took the decision that  
2 all cystectomies, for benign or malignant reasons,  
3 would move to Belfast. Mr. Young wrote to Beth Molloy  
4 to say that he did not recall a decision being taken  
5 around cystectomies for benign reasons; he did not  
6 agree with that and didn't think the decision had been  
7 taken that cystectomies for benign reasons were being  
8 moved to Belfast. An opinion was sought from  
9 Mr. Fordham, who was the independent urologist on the  
10 Review Team. Mr. Fordham responded to say that whilst  
11 there was no guidance, he would expect that patients  
12 would expect to have their surgery undertaken by  
13 somebody who was doing sufficient of these in an annual  
14 basis.

14:28

14:29

15  
16 There appeared to be doubt around that in our system  
17 later on in the middle of 2011, so I wrote formally to  
18 all three consultants saying for the avoidance of  
19 doubt, all cystectomies, for benign reasons and  
20 malignant reasons, are to be referred to the Belfast  
21 Trust, and then that's what happened, to include all of  
22 the malignant radical pelvic surgery in September  
23 because the Belfast Trust were now in a position to  
24 accept them.

14:29

14:29

25 250 Q. We can see the briefing note then that you sent in  
26 relation to this setting that out at TRU-259524. It's  
27 a briefing note of September 2010. This is to the  
28 Board?

14:29

29 A. Yes, that's correct.

1 251 Q. The "Clinical Issues in Urology Services Briefing Note  
2 to the Trust Board, Confidential".

3  
4 The background on the IV fluids and antibiotics, we  
5 have already gone through. You are updating the Board 14:30  
6 in relation to that. The indication is there are still  
7 some patients, in the last paragraph, being treated,  
8 "but the cohort has reduced considerably" it says in  
9 that. Then the next line is a background to the IV  
10 antibiotics and central venous access. The background 14:30  
11 then on the cystectomies. So there are three issues in  
12 relation to this going to the Board?

13 A. Mm-hmm.

14 252 Q. You have said that the current action in relation to  
15 the cystectomies is: 14:31

16  
17 "In line with guidance from the National Clinical  
18 Assessment Service, the Trust has commenced a process  
19 of screening with the file of each patient who has  
20 undergone cystectomy in the past 10 years will be 14:31  
21 reviewed by the Associate Medical Director for Surgery  
22 and Elective Care, and professional advice of a UK  
23 urologist with direct knowledge of this field will be  
24 sought as required. Our report of the screening review  
25 will identify if no further action is required or if 14:31  
26 a more in-depth analysis is required. Each of the two  
27 surgeons has been informed of this screening in  
28 discussion and in writing."

29

1 Then a further update on that is on the Regional  
2 Urology Review. You say:

3  
4 "One of the requirements of the implementation of the  
5 review is that all radical pelvic urological surgery is 14:32  
6 moved to the Belfast Trust. This now explicitly covers  
7 radical pelvic surgery for both malignant and benign  
8 conditions and the Trust is in a discussion currently  
9 with HSCB and Belfast Trust regarding each individual  
10 case during the transition period." 14:32

11  
12 I think that's just about almost two pages, that  
13 update, which covers four of the major issues in  
14 Urology at that time, or four of the issues that you  
15 felt it was necessary to bring to the Board's 14:32  
16 attention.

17 A. Mm-hmm.

18 253 Q. Would you be the decision-maker as to what goes into  
19 these briefing reports or would some others come to you  
20 and say I think the Board need to know about this? 14:32  
21 what's the process behind that?

22 A. I think it had been agreed with the Chief Executive  
23 which areas I would cover. The draft of this report  
24 was sent to the Chief Executive prior to it going  
25 formally into the Trust Board papers. There is a real 14:33  
26 dilemma for Trust Board papers and the four members of  
27 the Trust Board in terms of reading all the wealth and  
28 depths of material which comes to the Board. I think  
29 at that stage we were looking to make sure that the

1 Trust Board were aware of the issues and they had all  
2 the information. But something like this would have  
3 been discussed in more detail at the Governance  
4 Committee of the Trust Board, the quarterly meeting  
5 that we talked about earlier. Obviously this was  
6 a paper that was in Trust Board papers and so any  
7 question could have been asked which I would have  
8 endeavoured to answer. Quite often there was quite  
9 a lot of discussion about these things immediately  
10 after the presentation.

14:33

14:33

11 254 Q. would there be discussions around patient risk or  
12 safety? would those sort of conversations arise, given  
13 the myriad of issues that have been brought to the  
14 Board's attention? what was the appetite for  
15 discussing patient risk at those meetings?

14:34

16 A. Oh, the appetite for discussing patient risk was centre  
17 table, absolutely centre table. There was no issue  
18 about that.

19  
20 I mean, some of the other issues in relation to the  
21 Urology Service were not known about at this stage, at  
22 this point in time. It's only after September 2010  
23 that some of the other issues became apparent. But,  
24 no, the appetite for patient safety issues was very,  
25 very -- was absolutely centre stage. The Trust Board  
26 Governance Committee would have started at ten o'clock  
27 in the morning and sometimes didn't finish until two  
28 o'clock in the afternoon. It was a really serious  
29 meeting and you had to be very prepared. I mean,

14:34

14:34



1 Katherine Robinson talked about being prepared for  
2 meetings with me at 9:00 on a Tuesday morning. Boy,  
3 was I prepared for the Trust Board governance meeting.  
4 You know, I went in armed with all of my papers and  
5 files and everything in my head. They were serious 14:35  
6 meetings that you could be quizzed and integrated about  
7 a range of things, and I didn't usually like to be  
8 found wanting in terms of information in response.  
9 I think Katherine Robinson shared that view, she didn't  
10 want to be found wanting as well. 14:35

11 255 Q. It seems in the lead-up to this you had gained  
12 assurances along the way that would be reflected in  
13 this note, so I presume that is in preparation for the  
14 Board's questioning --

15 A. Yes. 14:35

16 256 Q. -- of Patient Safety issues or are there any concerns  
17 you might have around patient risk?

18 A. Yes.

19 257 Q. And conversations of that type did take place?

20 A. Oh, yes. They did take place, yes. 14:35

21 258 Q. Just for the Panel's note, there's another update for  
22 the Board on 25th November 2010. The Trust Board  
23 confidential briefing note of November 2010 is at  
24 WIT-12603. Maybe we will go to that one, actually.  
25 WIT-12603. 14:36  
26

27 This one is after the previous one, the previous note  
28 that we saw, the review of patients on IV fluids and  
29 antibiotics.

1 "The clinical review and development of a management  
2 plan for patients which excludes routine IV fluids and  
3 antibiotics has been led by Ms. Sloane, Clinical  
4 Director for Surgery and Elective Care. The review has  
5 been completed for 13 patients. It has been decided by 14:36  
6 the Clinical Review Team to undertake a review of the  
7 whole original cohort of patients and it will take  
8 several more weeks to complete this. No patient in the  
9 cohort now has a central venous line".

10 A. Mm-hmm. 14:37

11 259 Q. Just move down, please. Again, the review of  
12 cystectomies, the update on that:

13  
14 "The clinical review of the records of the small cohort  
15 of patients who have had surgical removal of the 14:37  
16 bladder is underway by Mr. Mackle, AMD Surgery and  
17 Elective Care. This will be completed in the next few  
18 weeks".

19  
20 And the Regional Urology Review, the update is: 14:37

21  
22 "Transfer pathway of patients with urological cancer  
23 requiring radical pelvic surgery or radiotherapy has  
24 been agreed. All patients are now being transferred to  
25 the regional urology centre in the Belfast Trust". 14:37  
26

27 That follows on from the previous note?

28 A. Yes, it does. I mean, that last sentence, actually  
29 looking back on it, that was not the case. Obviously

1 the Belfast Trust were not yet in a position in  
2 November 2010 to accept patients. They only were  
3 accepting them from late September the following year.  
4 But that was obviously my understanding at that stage  
5 but it transpired to be not the actual specific  
6 timeline.

14:37

7 260 Q. Before we move on to the MDMS and the centralisation of  
8 some of the meetings around that and the difficulties  
9 with that, I just want to bring your attention to  
10 something that Ms. Sandra Hewitt had said in her  
11 witness statement at WIT-62007. She is referencing the  
12 material that was given to the Board. She is a Board  
13 governance --

14:38

14 A. Board secretary in my time.

15 261 Q. Board secretary for governance?

14:38

16 A. Yes.

17 262 Q. So she was responsible for getting the papers together  
18 and the information ready so that the Board had the  
19 information in time for their meetings and were  
20 informed. Paragraph 43.1. She says:

14:38

21  
22 "I think the clinical and social care governance  
23 arrangements were not fit for purpose in that more  
24 connection was required with the corporate governance  
25 arrangements. As referenced in 41.2, the only  
26 information that was escalated and shared with Trust  
27 Board about clinical concerns in Urology was from two  
28 briefing papers Dr. Rankin provided on IV fluids and  
29 antibiotics and cystectomies in 2010. In my view, the

14:39

1 relevance and depth of information that was escalated  
2 and shared with the Trust Board members did not provide  
3 them with robust assurance that concerns had been  
4 addressed, nor enable them to make any informed  
5 decisions. I did not have any concerns specifically 14:39  
6 and therefore would not have raised them."  
7

8 Your evidence seems to be that those papers were the  
9 gateway into which you could have been interrogated on  
10 the substance of what you had written. 14:39

11 A. Yes.

12 263 Q. The actual attendance at the confidential and then the  
13 wider Board meetings --

14 A. Yes.

15 264 Q. -- was where you were stress-tested as to your 14:39  
16 assurances that you could give the Board; would that be  
17 fair?

18 A. That's a very fair assessment. Of course, I suspect  
19 that Sandra's comments referred to the Trust Board  
20 meeting. They don't reference the Trust Board 14:40  
21 governance meeting, which was a subcommittee of Trust  
22 Board, where there was a much, much deeper dive into  
23 the range of governance issues, much greater detail.  
24 From recollection, that Trust Board Governance  
25 Committee at that stage was chaired by Ms. Brownlee as 14:40  
26 delegated by Mrs. Balmer, who was Chair of the Trust.  
27 That's the visual that I have in my mind.

28 265 Q. That's the order of post-holders?

29 A. Yes.

1 266 Q. You mentioned the capacity of Belfast to undertake the  
2 responsibilities, I suppose, for the radical pelvic  
3 surgery following the review?

4 A. Yes.

5 267 Q. I just want to go to something you said in your 14:40  
6 statement at WIT-15884. It's paragraph C. At  
7 paragraph A you've said what we have already discussed,  
8 that the surgery would move. At the end of paragraph  
9 A, the second-last line, you said:

10

14:41

11 "This process of referral to another clinical unit  
12 within a specialty is usually undertaken through the  
13 regional MDM process, where a patient is discussed and  
14 a collective decision recorded and implemented. The  
15 receiving consultant or clinical unit has therefore  
16 agreed the referral of the patient".

14:41

17 A. Yes.

18 268 Q. So if it had been the case that if it was required that  
19 the patient would be transferred to the Belfast  
20 clinicians, then that would be done through the normal 14:41  
21 having a conversation about it and deciding if that  
22 referral was appropriate?

23 A. That's correct.

24 269 Q. Then at paragraph B you have said:

25

14:41

26 "The members of the MDM are necessarily the consultants  
27 in the specialty, radiologists presenting the  
28 diagnostic test results, pathologists presenting on the  
29 pathology of the malignancy, the oncologists setting

1 out the chemotherapy and radiotherapy required for the  
2 patient before and after surgery. All these  
3 specialities required to be present for an effective MDM  
4 process. The MDM process also discusses the discharge  
5 of the patient back to the original Trust for follow-up 14:42  
6 care."

7  
8 Then paragraph C:

9  
10 "After the regional decision was taken to move all 14:42  
11 radical pelvic surgery to the Belfast Trust, there were  
12 difficulties setting up the regional MDM process  
13 through the Belfast Trust. This was due to the lack of  
14 a consultant oncologist for the Urology Service at that  
15 time within Belfast. The Southern Trust set up the 14:42  
16 local MDM to test systems and prepare for linkage with  
17 the Belfast Trust."

18 A. Mm-hmm.

19 270 Q. Was that one of the reasons why there was a delay in 14:43  
20 the transfer over of the radical pelvic surgery, or is  
21 that incidental to that; is that just another  
22 operational issue that had clinical impact?

23 A. I'm not sure whether there was a linkage. There may  
24 well have been a linkage there, because it certainly  
25 was a very difficult time for the Belfast Trust because 14:43  
26 I think they appointed an oncologist who then didn't  
27 take up that particular role with those particular body  
28 tumour groups, moved to a different role and then they  
29 had to appoint somebody else. There certainly was

1 a very long lag period from when we were being asked to  
2 set up an MDM and being asked to effectively link  
3 through to the Belfast Trust. I suspect that that did  
4 contribute to part of the delay in referring patients  
5 but I'm not completely sure on that. 14:43

6 271 Q. The Panel have heard evidence around the difficulties  
7 with staff retention in various disciplines --

8 A. Yes.

9 272 Q. -- and the impact that has on the MDM, and this is  
10 going right back to 2010? 14:44

11 A. Yes. We also had a shortage of consultant  
12 radiologists. We had several radiology consultant  
13 posts vacant at that stage, as had most of the NHS in  
14 the UK. That has since been addressed by significant  
15 increase in specialist training numbers in the 14:44  
16 specialty.

17 273 Q. I think you have said in your statement as well that  
18 the issues regarding the presence of an oncologist from  
19 the Belfast Health and Social Care Trust attending the  
20 MDM continued until the end of 2011. For the Panel's 14:44  
21 note, that's at WIT-15887.

22 A. Yes.

23 274 Q. I want to move on to the retained swab issue. Just for  
24 general note for the Panel, it's dealt with at  
25 Dr. Rankin's statement at WIT-15890 to 15892. You have 14:45  
26 dealt with in that statement and you have revisited it  
27 in your addendum statement. I think it may be easier  
28 if I read the part of your addendum statement.

29 A. Okay.

1 275 Q. The reason why this might be better chronologically is  
2 because you have interspersed your original narrative  
3 with new material. If I just go to the new material or  
4 just go to the old material, we don't get the full  
5 picture. I'm afraid I am going to have to read this 14:45  
6 out and then everyone will have your evidence on that,  
7 if that's okay?

8 A. Okay.

9 276 Q. That's at WIT-96714. So, in reference to this issue,  
10 you say: 14:46

11  
12 "A significant clinical incident occurred regarding the  
13 retaining of a swab after surgery on 15th July 2009  
14 which was only identified when the patient was admitted  
15 as an emergency in July 2010. A post-operative CT scan 14:46  
16 was undertaken in October 2009 as planned and  
17 identified an abnormality. Although not identified as  
18 a retained swab, one of the differential diagnosis was  
19 recurrence of the patient's cancer. A root cause  
20 analysis review of the case was required and 14:46  
21 undertaken. The final report of the RCA was taken to  
22 SMT in December 2010. The RCA identified that due to  
23 a backlog in Outpatient reviews, the patient was not  
24 seen in Outpatients for the 12 months after surgery, at  
25 which stage he was admitted as an emergency." 14:47

26  
27 This is the lady who came in for an operation and had  
28 the CT scan; subsequently presented herself at A&E with  
29 abdominal pain?



1 A. Yes.

2 277 Q. And the retained swab issue was identified and removed?

3 A. Yes.

4 278 Q. Your involvement in this is around the report and the  
5 RCA? 14:47

6 A. That's correct.

7 279 Q. A report was prepared.

8

9 "A draft of the report had been shared with the  
10 Commissioner as required and this resulted in a letter 14:47  
11 from Dr. Corrigan to Mrs. Burns, AD for Clinical and  
12 Social Care Governance, on 14th November".

13

14 That should say 2011. You were right the first time, I  
15 have been informed. 14:47

16 A. That's correct.

17 280 Q. It was incorrectly changed but you were right the first  
18 time. In this letter, Dr. Corrigan states:

19

20 "The report records that it was the practice of the 14:48  
21 patient's consultant urologist not to review laboratory  
22 or radiology reports until patients attended for their  
23 Outpatient appointment. I believe this highlights an  
24 area where the Trust would have considered action to be  
25 appropriate. I am writing to ask whether this issue 14:48  
26 has been taken forward, for example by considering  
27 whether there's a need for a formal Trust policy, such  
28 as review of all test results by medical staff before  
29 filing, whether or not the patient is awaiting

1 Outpatient review."

2

3 So two issues that emerge from this are the issues  
4 around reading results and what became known as DARO?

5 A. Yes.

14:48

6 281 Q. I think DARO was -- is that your invention or your  
7 suggestion?

8 A. Well, I don't know whether I coined the acronym but  
9 discharge awaiting results was certainly a standard  
10 operation procedure that I introduced as a result of  
11 this because as soon as I received the draft report in  
12 October 2010, before it was submitted to SMT governance  
13 and on to the Board, I already started to take action  
14 to address the issue.

14:48

15 282 Q. You then go on to say:

14:49

16

17 "While the draft report was formally shared with  
18 Dr. Corrigan resulting in her letter of 14th November  
19 2011, the issue of medical staff reviewing test results  
20 before filing, whether or not the patient is awaiting  
21 an Outpatient appointment, was understood by the Trust  
22 as a clinical risk and as learning from the RCA prior  
23 to the receipt of this letter. The Trust took the  
24 necessary action to understand the current practice of  
25 medical staff in each specialty. In the Directorate of  
26 Acute Services this was to discuss and assess the risk  
27 in each specialty through discussion with the  
28 consultants at specialty meetings."

14:49

14:49

29

1 This was as a direct result of the report?

2 A. Yes.

3 283 Q. The Panel can find a copy of the SAI report, and this  
4 is Patient 95, at WIT-17471.

5

14:50

6 So, you got a copy of the first draft -- a draft of the  
7 report first came to you in October 2010?

8 A. That's correct.

9 284 Q. Was it you or others who decided there were two  
10 immediate actions required as a result of this initial  
11 report?

14:50

12 A. I think it was myself.

13 285 Q. So, the first action, you said, was:

14

15 "To set out an operating process for Radiology staff to  
16 implement. A notification of urgent reports to the  
17 referrer or cancer tracker was written and implemented  
18 in early November 2010. On 20th November 2010, the  
19 Head of Urology Services assured the Medical Director's  
20 office on request that the notification of urgent  
21 reports to the referrer or cancer tracker had been  
22 implemented and is in operation."

14:50

14:50

23 A. Mm-hmm.

24 286 Q. Can you just explain what that process you put in then  
25 was?

14:51

26 A. Yes, the CT scan for the patient who the RCA was  
27 written about, the radiologist had identified there was  
28 something odd on the investigation but didn't actually  
29 contact the referrer to say there's something strange

1 here, I don't know what it is but there's something  
2 strange here.  
3  
4 what this procedure was about was that the person who  
5 was reporting the investigation in Radiology was 14:51  
6 required, if there was something untoward identified in  
7 the investigation that could be cancer or recurrent  
8 cancer or something very serious, they were required to  
9 make contact with the referrer or the cancer tracker so  
10 that the result did not sit unnoticed and unread in the 14:51  
11 system. So it was a push action, if you like; the  
12 radiologist, or a radiographer on their behalf, making  
13 a link back to the referring clinician or to the cancer  
14 tracker.

15 287 Q. So it was a way of flagging up? 14:52  
16 A. It was a way of flagging up, yes.

17 288 Q. So it wouldn't just wait until a next review or perhaps  
18 an audit review?  
19 A. Yes.

20 289 Q. Now, do you recall that the findings and 14:52  
21 recommendations of the RCA looked at the method by  
22 which the nurses accounted swabs during the surgery?  
23 A. Mm-hmm.

24 290 Q. And that that was a responsibility of the scrub nurse?  
25 A. Yes. 14:52

26 291 Q. And that there had been some lack of clarity around the  
27 method they undertook; is that your understanding?  
28 A. Yes, yes.

29 292 Q. They made recommendations in that regard?

1 A. That is correct.

2 293 Q. I just want to take you to WIT-17471. I will take you  
3 to the report. This is the findings of the RCA and we  
4 will look at the recommendations. We don't need to go  
5 into the detail of this, it's the governance issues 14:53  
6 that arose as a result of this, but I just want to ask  
7 you about it. It says "Conclusions, Recommendations  
8 and Learning", WIT-17481. It said:

9  
10 "The method of recording swabs which were temporarily 14:54  
11 used in the patient cavity that day in theatre is  
12 inconsistent. A standardised protocol for the counting  
13 and recording of all swabs across all theatres needs to  
14 be implemented urgently. The responsible scrub nurse  
15 in this case is unclear because there were two scrub 14:54  
16 nurses. When the scrub nurse hands over to another  
17 scrub nurse, he/she should sign off the current state  
18 of swabs in use and used. The first post-operative  
19 scan of 1st October 2009 was not reviewed at routine  
20 follow-up because there was no follow-up for 12 months 14:54  
21 due to the length of the Urology Outpatient Review  
22 waiting list. The Urology waiting list for  
23 post-operative follow-up needs to be cleared. Several  
24 abdominal X-rays were performed on the patient  
25 re-admission but the swab was missed by several 14:55  
26 doctors. This was presumably because they had never  
27 seen a retained swab on a radiograph before previously.  
28 This case should be presented with the radiographs at  
29 surgical and medical morbidity and mortality meetings

1 to demonstrate the appearance of a retained swab."

2

3 Just on down then, it set out the local  
4 recommendations:

5

14:55

6 "All swab and instrument counts must be interruption  
7 free and, where possible, the same circulating nurse  
8 completes the count. Swabs that are temporarily used  
9 in patient's cavity must be recorded on the white board  
10 and struck through when removed until operation

14:55

11 complete. The record must not be rubbed out. As far  
12 as is operationally possible, the same nurse should  
13 remain as the scrub nurse for the entire operation.

14 Signing off of swab status must take place by the swab  
15 nurse if there is a change-over. It needs to be

14:56

16 recognised and reaffirmed that time is required at the  
17 end of the operation" - I presume that's "for" - "the  
18 scrub nurse to ensure that all swabs, instruments and  
19 equipment are accounted for. Where possible and  
20 practical there should be a surgical pause before wound  
21 closure. The findings of the RCA will be presented at  
22 the next Radiology Peer Review discrepancy meeting."

14:56

23 A. Mm-hmm.

24 294 Q. "Presentation of case with radiographs at Radiology  
25 surgical and medical M&M". "Reduction of urological  
26 outpatient follow-up waiting times."

14:56

27 A. Mm-hmm.

28 295 Q. The other recommendations seem very fact-specific and  
29 context-specific. I know there was a mention at the

1 delay and review may have been as a result of the  
2 outpatient follow-up waiting times, but do you recall  
3 if there was any action taken as a result of that last  
4 recommendation from the RCA?

5 A. Specifically in the waiting times? A review? There 14:57  
6 was ongoing action happening at that stage. We were  
7 already working on specific action plans and we had  
8 specific meetings around the review backlog. I think  
9 somewhere in my witness statement and associated  
10 papers, there is a clear action plan with maybe eight 14:57  
11 or ten actions around the review backlog, things like  
12 one of the Clinical Nurse Specialists reviewing the  
13 actual cases, and in agreement with the consultants,  
14 some patients could be discharged, some could be  
15 reviewed by the nurse, some could be referred back to 14:57  
16 primary care. So, there were a range of various  
17 actions going on in relation to the review backlog and  
18 those continued.

19  
20 I mean, there possibly was a six-monthly review of 14:58  
21 those actions to see what more we could add into them.  
22 One of those actions was the workshop with GPs. That  
23 was one of the actions on a review backlog action plan,  
24 to see and get agreement with the consultants as to  
25 which patients could be more quickly be discharged into 14:58  
26 primary care with, of course, the proviso that they  
27 could be referred back if there was any concern and  
28 they would be seen very quickly.

29 296 Q. The second issue that then emerged from this was the

1 DARO?

2 A. Yes.

3 297 Q. You referred to that in your addendum statement, if  
4 I could just pick up again where I left off. It's  
5 WIT-96717. We have looked at the first one, which is 14:58  
6 the issue around the triggering of the result, the  
7 anomaly. The second one, I will read what you have  
8 said:

9  
10 "The second immediate action was undertaken through the 14:59  
11 Administrative and Clerical Staff Review, which was  
12 commissioned by SMT and the Trust in 2010, which  
13 provided the vehicle to set out a new standardised  
14 process for discharge awaiting results. In order to  
15 undertake the administrative and clerical review, I set 14:59  
16 up a project board for Acute Services, chaired by  
17 myself with a project manager assigned from within  
18 Acute Services. Heather Trouton as AD for SEC  
19 undertook a key role. This resulted in many variances  
20 in administrative processes across the Legacy Trust 14:59  
21 being standardised through a process mapping exercise  
22 involving clerical staff from all parts of the Acute  
23 Services Directorate. There were five different  
24 hospital or community clinic locations where  
25 consultants provided Outpatient clinics. As these were 14:59  
26 across three Legacy Trusts, standardisation of  
27 processes was of key importance. One of the areas  
28 which had an initial focus was to develop a standard  
29 operating procedure for administrative and secretarial



1 staff to manage results in the context of discharge  
2 awaiting results. This was signed off and first  
3 implemented in November 2010 with workshops involving  
4 all clerical and administrative staff. This SOP was  
5 reviewed in November 2011, and again reviewed and a 15:00  
6 revised version was implemented in October 2012. An  
7 additional action taken through the administrative and  
8 clerical review was to develop a specific SOP for  
9 secretarial and typing staff regarding the management  
10 of results. That was implemented in October 2011." 15:00

11

12 You go on to say:

13

14 "The AD for Surgery and Elective Care sent an email on  
15 25th July 2011 regarding the issue to all Heads of 15:00  
16 Service for further assurance after previous discussion  
17 that test results were being read as soon as the  
18 results were available. The Head of Service for  
19 Urology sent this email to the consultant urologists on  
20 27th July 2011, and this resulted in an email response 15:01  
21 from Mr. O'Brien on 25th August 2011. In this email,  
22 Mr. O'Brien raised eleven points regarding the  
23 potential impacts of reading the test results when they  
24 were received. This resulted in an email from  
25 Mr. O'Brien being forwarded to the AMD, Mr. Mackle, who 15:01  
26 raised this with myself, identifying a governance issue  
27 as Mr. O'Brien does not review the results until the  
28 patient appears back in Outpatients. A conversation  
29 followed with Mr. O'Brien without success in terms of

1 changing his clinical behaviour. The email sent by  
2 myself to Mr. Mackle, the AD and Head of Service, on  
3 8th September outlines a high level plan as I was going  
4 on summer leave. The AD replied to state she would  
5 look at the processes in other specialties in order to 15:02  
6 present current working processes in other areas should  
7 the need occur."

8  
9 Then the additional text you have put in is:

10 15:02  
11 "I continued to raise the issue of not reading results  
12 when received with the AMDs. Heather Trouton, as AD  
13 for SEC, at my request, in an email of 8th September  
14 2011, undertook a scoping exercise of the baseline  
15 position across all divisions in Acute Services. This 15:02  
16 scoping exercise identified that in the main, results  
17 are read in a timely manner, although variances in how  
18 this has been done have been highlighted. This was set  
19 out in the Trust letter of response to the HSCB in late  
20 2011 regarding the request for assurance and a policy 15:02  
21 for the review of results when received. The detailed  
22 results of this scoping exercise set out the practice  
23 of each surgeon was sent by Heather Trouton to Margaret  
24 Marshall, copied to myself on 30th September 2011."

25 15:03  
26 Then in September 2012, you wrote again to the Acute  
27 Services Assistant Directors stating:

28  
29 "Despite all the efforts, these procedures have not

1           been implemented. I have no evidence on what  
2           information I have received to state this. I requested  
3           the ADs to urgently review and implement in their  
4           division, and stated that we would be auditing charts  
5           to see what is happening. On 26th September 2012, 15:03  
6           I received assurance from Ronan Carroll, AD for Cancer  
7           Services, Anaesthetics, Theatres and Radiology, that  
8           the DARO SOP has been implemented and staff workshops  
9           undertaken. "

10  
11           I read that out, it sets out the chronology of attempts  
12           to get this process that was agreed implemented. It's  
13           clear from what you have written that the HSCB were  
14           also pushing for an assurance?

15           A. Yes. 15:04

16 298 Q. Just so I understand the way in which the HSCB becomes  
17           engaged in looking for assurances, once they know that  
18           the Trust has gone to undertake a process of  
19           introducing an SOP for a certain issue, do they become  
20           then active in following that up, or is it possible 15:04  
21           that they also require the Trust to introduce certain  
22           measures that they then seek reassurance on? which  
23           direction does it flow in?

24           A. I think if the Trust had not indicated that they were  
25           taking measures, the Board would require you to take 15:04  
26           those measures. There would be no doubt about that.  
27           I think the fact that we had set out the actions that  
28           we were really taking, and of course there would be  
29           a lot of informal conversations about this, in addition

1 to the formal correspondence that you've seen in the  
2 bundles. Dr. Corrigan would have been fully aware of  
3 what we were undertaking. I mean, she would have been  
4 meeting our staff in various different meetings and  
5 would have been fully aware of what was going on. 15:05

6 299 Q. It's clear that almost two years later, September 2012,  
7 there's still a push to get this fully implemented.  
8 It's clear that the staff have been informed and  
9 workshops have been undertaken. Was that a source of  
10 frustration for you, that you were still having to seek 15:05  
11 assurances periodically, given that the report was  
12 written in 2010?

13 A. I think it's the sort of situation that you would  
14 always want to be seeking reports on assurance. I  
15 mean, the system was largely working the way it should 15:05  
16 do. It wasn't perfect; there certainly was at least  
17 one outlier.

18  
19 The thing that I really wanted to get in place, which  
20 really trumped all of those other processes, which were 15:06  
21 key, but the most important thing was the electric  
22 radiology system being able to red-flag an alert. The  
23 radiology system that we were using was the regional  
24 radiology system. For regional read slow progress,  
25 because if you needed to get an amendment very quickly, 15:06  
26 it was very difficult to introduce a development of  
27 a software system that you needed very quickly. It was  
28 very, very difficult to influence a regional system to  
29 get that change in place. My understanding now, from

1 the papers I have seen in relation to the Inquiry, my  
2 understanding is that that change did come into place  
3 before I retired from post.  
4

5 The change that I was looking for was the facility to 15:07  
6 have an alert in the Radiology system when a consultant  
7 had not read -- a consultant or the appropriate doctor  
8 who had ordered the test had not read the results of  
9 that test, and you could set the time scale in which  
10 you want that set. That could be a week after the 15:07  
11 results were published. We also had to be able to  
12 write a report to be able to get that information from  
13 the system. By automating it in that way, you then had  
14 an absolute visibility of who was reading the results  
15 and in what time scale. You then had a mechanism to 15:07  
16 have a report evidence on the table with which you  
17 could have then a very straight conversation with a  
18 consultant or a specialist registrar from their  
19 trainer, or a staff doctor, or whoever was looking --  
20 whoever was ordering the investigations. 15:07

21  
22 That was coming in as I was retiring but, for me, that  
23 was the most important development that I wanted to see  
24 in place. The rest were processes to manage patient  
25 safety until -- which would continue, but I also wanted 15:08  
26 this electronic change in the Radiology system.

27 300 Q. You mention that then at paragraph E of your addendum  
28 statement?

29 A. Yes.

1 301 Q. where you have said halfway through:

2

3

4

5

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29

"The Trust undertook the implementation of the reporting process for laboratory, i.e. blood test results. In relation to the need for report from the regional urology system, a software upgrade was sought through the BSO, Business Services Organisation, to enable such a report to be made available. From memory, the facility for a consultant to tick a box when they read a Radiology result was made available in 2012."

That's information you received from Mr. Mackle.

"A report on which results had been left unread was then feasible", but you don't recall that being available during your time?

A. No. I didn't ever see a report, no.

302 Q. I just want to take you to the SOP for discharge awaiting results, WIT-96725. This was formalised in November 2010. At 96726, the next page, paragraph 3 at the top of the page, it says:

"If a patient is awaiting results prior to a decision regarding follow-up treatment being made, they must be recorded as discharge (DIS) on the system and not added to the Outpatient waiting list for a review."

Then if we look at 96732 on the same document under the

1 title "Management and Monitoring". It says at the top:

2  
3 "Please note a patient must not be added to the  
4 Outpatient waiting list if they are awaiting results  
5 and no decision has been made regarding their review  
6 date." 15:10

7  
8 Is it your view that a patient should not have been  
9 placed on DARO if the consultant had already decided  
10 that the patient required review in December 2010, 15:10  
11 irrespective of the result of the investigation  
12 performed before then? In other words, if the  
13 consultant had already considered that a review was  
14 necessary irrespective of the outcome of the result,  
15 that they should not be placed on DARO. Is that your 15:10  
16 understanding of how DARO operated?

17 A. Yes. I think the consultant has to read the result and  
18 then determine the review time scale, particularly when  
19 we had great difficulty being certain about the review  
20 date, given the review backlog which all the 15:11  
21 consultants were aware of. One of the things that is  
22 absolutely key in this standard operating procedure is  
23 that when the results are read and the decision is made  
24 as to when to review the date that they are put on the  
25 waiting lists for review, is the date of the 15:11  
26 investigation, not the date when the secretary or the  
27 administrative person is actually doing the work on  
28 PAS.  
29

1 So that's a key thing in there. The patient does not  
2 lose their place on the waiting list for review because  
3 they are put on the DARO list. Their review  
4 appointment is dated from the date of the investigation  
5 which the consultant ordered, and so they don't lose 15:11  
6 their place. That's absolutely key and important to  
7 the understanding of this particular standard operating  
8 procedure; the patient is not disadvantaged in any way.  
9 The only thing it is advantaged is their results are  
10 reviewed and seen. 15:12

11 303 Q. So they don't fall off?

12 A. No, they don't fall off and they are not lost in the  
13 review backlog. That was the whole purpose of this, to  
14 make sure that these patients are visible on a list so  
15 that that list can be viewed by consultant, reviews can 15:12  
16 be checked, but the patient is not losing their place  
17 in the ordering of the review backlog or the review  
18 process.

19 304 Q. You finish your last part of your addendum statement,  
20 and I will just read this out, it's just a small couple 15:12  
21 of lines:

22  
23 "I do not have evidence to state whether the systems  
24 were successful in rectifying the problem as they were  
25 only being implemented late in 2012", just prior to 15:12  
26 your retirement?

27 A. Yes. That relates to the development of the Radiology  
28 system having the ability to have an alert that  
29 a result had not been read by the consultant or



1 referring doctor. That's purely in relation to that  
2 statement. The DARO was working clearly long before  
3 that, and the process to guide secretaries around the  
4 management of results.

5 305 Q. You also were Director of Acute Services at a time when 15:13  
6 there was an issue around Mr. O'Brien placing notes in  
7 the bin?

8 A. Yes.

9 306 Q. I don't think you were involved in any part of that  
10 process? 15:13

11 A. No, no.

12 307 Q. And that was a governance concern that was triggered by  
13 an ancillary member of staff identifying that issue?

14 A. Mm-hmm. Yes, yes.

15 308 Q. Were you content the way in which that process was 15:13  
16 dealt with?

17 A. I was.

18 309 Q. You were aware of it at the time and the steps that  
19 were taken to seek to address it with Mr. O'Brien?

20 A. Yes. The steps that were taken were the usual steps 15:13  
21 that would be taken within the Trust's policy for  
22 disciplinary issues. So, the policy was followed and i  
23 was content. I was aware it was happening and made  
24 aware of the result, but other than I had no  
25 involvement. I couldn't have or shouldn't have. 15:14

26 310 Q. For the Inquiry's note, that is in Dr. Rankin's  
27 statement at WIT-15892 to 15893.

28

29 we have referenced the times at which you let the Trust

1 Board know of the issues. I just want to give the  
2 Panel a note of some entries that were made on the risk  
3 register of similar issues during your tenure. They  
4 were recorded. Just let me find my notes.

15:14

5  
6 On the Directorate Risk Register, the Panel will find  
7 reference to the cancer performance risk, with the  
8 highest risk in Urology. The actions were an  
9 escalation policy, action plans drafted, meeting with  
10 Urology team and working towards one-stop clinics is on 15:15  
11 the register at WIT-16415. That's noted as risk 2991.  
12 You are looking for it on 26th May 2011.

13  
14 Then at WIT-16417, noted at risk 3166 on 25th June  
15 2012, there's a note that says:

15:15

16  
17 "Urology access waiting times increase from 36 weeks  
18 for inpatients and day cases. At this point 36 weeks  
19 was the agreed backstop position", and you note with  
20 the Health and Social Care Board. "First ICATs 15:16  
21 appointment increased from 17 weeks currently being  
22 addressed via approval to go to the independent sector.  
23 Appointment of new consultants."

24 A. Yes.

25 311 Q. A further example of the risks on the Directorate Risk 15:16  
26 Register is at WIT-16417. That's noted at risk 3191 on  
27 3rd September 2012. It says:

28  
29 "62-day cancer performance. Trust fails to meet

1 performance standard due to increase in red flag,  
2 capacity issues, inability to downgrade and regional  
3 issues."

4  
5 The action is: "Daily monitoring of referral of 15:16  
6 patients on 62-day pathway, escalations to Head of  
7 Service, AD, when patients do not meet milestone on  
8 pathway. Monthly performance meetings with AD, Head of  
9 Service, and escalation of all late triaging, with  
10 actions to develop one-stop pathways for haematuria and 15:17  
11 prostate cancer."

12  
13 The final note of the divisional risk register this is  
14 for SEC and CCS, WIT-16427. That's risk 2943 on 7th  
15 April 2011. 15:17

16  
17 "Urology cancer pathway delay. Action: 1st October  
18 2011, one-stop prostate clinic commenced. 6th October  
19 2011, one-stop haematuria clinic commenced. 23rd  
20 January 2012, one-stop prostate clinic fully 15:17  
21 operational."

22  
23 Just again for the Panel's notes, when Urology didn't  
24 meet the IEAP requirements, the service performance was  
25 also discussed at the SMT monthly governance meetings 15:18  
26 under the guise of the performance report --

27 A. It certainly was.

28 312 Q. -- which went to the Trust Board?

29 A. And it also was discussed at the Trust Board governance

1 meeting as well, and in the monthly Trust Board  
2 performance report.

3 313 Q. Reference to the performance report to the Trust Board  
4 on 29th April 2010 can be found at WIT-16014,  
5 WIT-16023, and WIT-16042. A further performance report 15:18  
6 to the Trust Board, dated 27th May 2010, to be found at  
7 WIT-16089, WIT-16098, and WIT-16117.

8  
9 You say in your statement at paragraph 37.16, I think  
10 it was you that brought the never event -- 15:19

11 A. Yes, that's correct.

12 314 Q. -- idea or process or procedure, whatever way you want  
13 to frame it, I think to Northern Ireland. It hadn't  
14 been existing in the Trust prior to that?

15 A. No, that's correct. NHS England had a concept of 15:19  
16 identifying a list of never events, which included  
17 a section on never events in relation to medication.  
18 That was taking learning from all of the significant  
19 events that had happened across the -- well, NHS  
20 England, presumably. That was not in usual -- that was 15:20  
21 not in use in Northern Ireland but it seemed to me, as  
22 I was seeking to develop the clinical governance  
23 approach in the Southern Trust and to deepen the  
24 understanding, that will be a useful tool to introduce  
25 within the Acute Directorate and to then use that to 15:20  
26 help with our learning. Not that I wanted to have any  
27 never events, because they are really a list of very,  
28 very significant events such as wrong sight surgery,  
29 wrong limb surgery, significant medication being given

1 through the wrong route; things which usually result in  
2 catastrophic consequences.

3  
4 I discussed it with each of the AMDs at my one-to-ones  
5 with them. They all agreed, and I took it through our 15:20  
6 Acute Clinical Governance process in the Acute  
7 Directorate. I took it to SMT governance and it was  
8 approved there. That was my usual route of having  
9 discussions with individuals, first of all, and then  
10 taking it through the Acute Directorate processes, 15:21  
11 clinical processes, and then taking it to SMT. It, of  
12 course, was approved at that stage, that was  
13 a formality. Then we introduced it, so that was used  
14 subsequently.

15 315 Q. Just for the Panel's note, the email with confirmation 15:21  
16 of the adoption of that is WIT-16983.

17  
18 Now, just a discrete issue with you in relation to  
19 Mr. Mackle. Mr. Mackle, I don't know if you listened  
20 to his evidence at all? 15:21

21 A. I listened to some of it, yes, yes.

22 316 Q. You will remember Mr. Mackle, it was indicated to him  
23 that he had been bullying Mr. O'Brien --

24 A. Yes.

25 317 Q. -- in that wider context. Mr. Mackle refers to this in 15:21  
26 his statement at WIT-11773. That's not the correct  
27 page number. 11769, thank you. Go to paragraph 92,  
28 just to give you the context. I will read out:

29

1 "In 2012, I am unsure of the exact date, I was informed  
2 that the Chair of the Trust, Mrs. Roberta Brownlee,  
3 reported to senior management that Aidan O'Brien had  
4 made a complaint to her that I had been bullying and  
5 harassing him".

15:22

6  
7 None of that is accepted but this is Mr. Mackle's  
8 statement.

9  
10 "I was called into an office in the administration  
11 floor of the hospital to inform me of the accusation. 15:23  
12 I was advised that I needed to be very careful where he  
13 was concerned from then on. I recall being absolutely  
14 gutted by the accusation and I left and went down  
15 a corridor to Martina Corrigan's office. Martina 15:23  
16 immediately asked me what was wrong and I told her of  
17 what I had just been informed. In approximately 2020  
18 I truthfully had difficulty who informed me. Martina  
19 Corrigan said I told her at the time that it was Helen  
20 Walker, AD for HR. I now have a memory of same but 15:23  
21 can't be 100% sure if that is correct. I recall having  
22 a conversation with Dr. Rankin, who advised that for my  
23 sake I should step back from overseeing Urology, and I  
24 was advised that Robin Brown should assume direct  
25 responsibility. I was also advised to avoid any 15:23  
26 further meetings with Aidan O'Brien unless I was  
27 accompanied by the Head of Service or the Assistant  
28 Director."  
29

1 For the Panel's note, Martina Corrigan speaks to this  
2 issue in the same terms in her statement, WIT-26313.

3

4 Do you recall this conversation with Mr. Mackle?

5 A. I do, yes.

15:24

6 318 Q. Just to give us an idea of the proximity in time, had  
7 he just been informed of this allegation when he spoke  
8 to you or it was a day later, or do you have any  
9 recollection of when in time you were told by him about  
10 it?

15:24

11 A. I don't recall exactly when it was but because he was  
12 quite clearly not himself and was very pale, he was not  
13 his usual bubbly self with lots of information, I think  
14 it must have been the same day.

15 319 Q. Did he come to your office or how did it come about  
16 that he told you this?

15:24

17 A. He came to my office. I can see him standing in my  
18 office.

19 320 Q. Was it specifically to tell you this; he hadn't got  
20 a prearranged meeting or anything?

15:25

21 A. No, no.

22 321 Q. You feel he made his way there because of --

23 A. Yes. Yes, he did.

24 322 Q. Do you recollect the words that he used or the phrases  
25 he might have used to tell you what had just happened  
26 or what had happened recently?

15:25

27 A. No, unfortunately I don't recall the specific words.  
28 I recall having the conversation and I recall advising  
29 him as to what action I would suggest that he takes,

1 and I can recall him being visibly upset, but I can't  
2 recall where he said he had received the information  
3 from or --  
4 323 Q. Or who had --  
5 A. -- or who had said it to him at all. I don't have that 15:25  
6 recall. I can recall saying to him -- Mr. Mackle was  
7 the Associate Medical Director to whom the Clinical  
8 Directors linked, and they were in a sense his ears and  
9 eyes and feet for the various specialties across both  
10 hospitals. At that stage, Robin Brown, the senior 15:26  
11 surgeon in Daisy Hill, was the Clinical Director for  
12 surgery across both Daisy Hill and Craigavon. But  
13 Daisy Hill and Craigavon are 22 miles apart, so what  
14 usually happened on a day-to-day basis was that because  
15 Mr. Mackle was present in Craigavon, if there was 15:26  
16 something bubbling that he could deal with very  
17 quickly, he dealt with it and would have informed  
18 Mr. Brown that it had happened and what he had done  
19 about it, which saved Mr. Brown often the journey and  
20 therefore the time. 15:26  
21  
22 All I said to Eamon was, pull back, don't play the CD  
23 role in Craigavon, your CD is Mr. Brown and Mr. Brown  
24 knows the urologists of old, surely Mr. Brown should be  
25 dealing with the day-to-day urology issues, and if you 15:26  
26 do need to meet with Mr. O'Brien, because I am sure you  
27 will need to in the future, you will always have to  
28 have some conversations, just make sure that there is  
29 somebody else present, whether it is Martina Corrigan,



1 Heather Trouton, myself, somebody else. That would be  
2 the usual advice you would give somebody so that was  
3 how I left it.

4 324 Q. Did he indicate to you where the source of the alleged  
5 allegation came from? Did he mention Mrs. Brownlee to 15:27  
6 you or anyone else?

7 A. I can't recall specifically. I now know that but I  
8 don't know whether I now know that because I now know  
9 it or it was said to me at that stage. I think  
10 probably it was said to me at that stage. I'm not 15:27  
11 going to be cast iron about it but I think it was said  
12 to me at that stage.

13 325 Q. Did that allegation ever emerge in your time? Did  
14 anyone ever approach you about it; was it ever  
15 formalised in any way that you can recall? was there 15:27  
16 any discussions between you and anyone else --

17 A. No.

18 326 Q. -- around that? Did Mr. Mackle ever raise it again as  
19 an issue?

20 A. No, I don't think he did. I can't recall. I mean, 15:27  
21 there was nothing further around that. There was no  
22 further discussion around bullying. I would have had  
23 conversations with him, I am sure, at one-to-ones in  
24 relation to how Mr. Brown was getting on handling the  
25 general surgical issues on the Craigavon site, but 15:28  
26 there was nothing specific in my memory that I can  
27 offer.

28 327 Q. Did you have any concerns from a governance perspective  
29 that Mr. Mackle stepping back from overseeing Urology

1 would result in less oversight generally, or  
2 a reduction in - I think you have referred to soft  
3 intelligence - that sort of information feeding its way  
4 back to various people? Were you concerned at all  
5 about that?

15:28

6 A. No, because he wasn't stepping back. Essentially he  
7 was still the AMD for Urology, he was just not also  
8 acting as the Clinical Director for Urology. It didn't  
9 stop soft intelligence because the fact that Mr. Mackle  
10 was a working surgeon in the system and was continuing  
11 that. Eamon wasn't the only person from whom I got  
12 soft intelligence, there was soft intelligence coming  
13 from a range of sources. So no, I had no concerns at  
14 all because Eamon was still the AMD, all we were doing  
15 was giving the Clinical Director their rightful place  
16 in terms of the Urology Service. Michael Young worked  
17 to Robin Brown and Robin Brown, then in terms of the  
18 Clinical Lead, the Clinical Director to the AMD.

15:28

15:29

19 328 Q. You have also mentioned that he might be advised to be  
20 accompanied by the Head of Service or the Assistant  
21 Director from the non-medical side if he was meeting  
22 Mr. O'Brien?

15:29

23 A. Mm-hmm.

24 329 Q. Were you ever aware that either of those two  
25 post-holders attended meetings with Mr. Mackle and  
26 Mr. O'Brien as a result of Mr. Mackle's review on this?

15:29

27 A. I mean, I suspect that there would have been ongoing  
28 meetings routinely that Mr. Mackle would have been  
29 present about general things, but I have no knowledge

1 of anything specific after that. I mean, that was in  
2 2012 and I retired in 2013. So no, I have nothing that  
3 I can add into that particular narrative.

4 330 Q. I think we have got to the stage of your learning.  
5 Just before I say that, I just want to ask you about 15:30  
6 job planning and appraisal. Have you any involvement  
7 in that, the objectives for consultants or setting any  
8 --

9 A. No.

10 331 Q. You had no involvement in that? 15:30

11 A. None.

12 332 Q. That short-cuts another page.

13

14 If we look at your learning and reflections that you  
15 have set out in your witness statement at WIT-15928, 15:30  
16 69.1, you say:

17

18 "On reflection, and setting out the range and number of  
19 issues in urology Services, I believe that the  
20 following is clear: The service was under considerable 15:31  
21 pressure due to increasing referrals and was

22 insufficiently resourced to meet the catchment  
23 population needs. The long-term absence of the ICATs

24 Urology doctor contracted for seven sessions per week,  
25 contributed to the consultant pressures as they had to 15:31  
26 see all referrals in Outpatients. There was also

27 additional pressure due to the consultant clinical  
28 behaviour of Mr. O'Brien which meant that smaller  
29 number of patients were seen in each Outpatient clinic

1 and more patients were reviewed that consultant peers  
2 would review. There was also little appetite in the  
3 service to agree protocols with primary care to review  
4 certain cohorts of patients. There was poor  
5 professional practice, which had been long-standing. 15:31  
6 It proved to be very difficult to get engagement with  
7 Mr. O'Brien to change his behaviour. When changing his  
8 behaviour was agreed, the specific behaviour was not  
9 always sustained and he would revert to previous poor  
10 practice. An example of this was when Mr. O'Brien 15:32  
11 agreed to triage referrals within the required time  
12 standards. It became apparent subsequently that this  
13 change in behaviour was not sustained and required  
14 regular checking."

15  
16 You were asked about what you were considered to be the  
17 learning in terms of governance. At paragraph 70.1,  
18 WIT-15929:

19  
20 "There are several points of learning from a governance 15:32  
21 perspective which are set out below. When a service is  
22 under pressure with insufficient resources to meet the  
23 population need for a prolonged period, it might be  
24 reasonably assumed that the risk level within the  
25 service may increase. 15:32

26  
27 B. A service under pressure to meet population need  
28 may have little appetite or space for the development  
29 of implementation plans and then implementing this

1 change. However, it could reasonably be assumed that  
2 most services and the senior staff in those services  
3 would welcome the opportunity for growth of the service  
4 and improvements in services for patients.

15:33

5  
6 C. Systems to collect data to provide the full  
7 functionality required to identify staff behaviour and  
8 provide the required reports to monitor this behaviour  
9 are not always available at the point in time when  
10 needed. "

15:33

11  
12 You reference the regional Radiology system.

13  
14 "D. Governance systems which require action on behalf  
15 of all staff, for example, being open about concerns or  
16 completion of clinical incident data on the Datix  
17 system take time for staff to be trained, time for the  
18 processes to become embedded, and time for staff  
19 confidence to use them to build. This process is  
20 a journey of improvement for a large organisation  
21 rather than an overnight change.

15:33

15:33

22  
23 E. It is difficult to monitor all consultant  
24 behaviour. If there is evidence of agreed changes in  
25 behaviour not being sustained, then additional action  
26 should be considered, particularly where this involves  
27 what might be regarded as required clinical consultant  
28 behaviour, especially when this is outside the accepted  
29 normal behaviour of peers. "

15:34

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29

Then when you were asked do you think there's a failure to engage with the problems within Urology Services, you say:

"I believe that there is a failure to engage fully in the following ways: There was resistance to change in clinical behaviour; resistance to change was the general sense in the Urology Service. However, when change was required in order to implement improvements for patients, two consultants did make these changes in their personal behaviour. Examples of changed behaviour are changing clinic templates, and the new-to-review ratios to reflect BAUS guidance; setting up the local MDM multidisciplinary meeting in preparation for the regional MDM; agreeing new patient pathways such as one-stop clinics. These two consultants also undertook additional work, such as triaging on behalf of Mr. O'Brien when he failed to cooperate in undertaking this process in the required time standards. Mr. O'Brien tested the new clinic templates and his clinics regularly overran by two hours. He was therefore unable or chose not to amend his behaviour in Outpatient clinics."

15:34

15:34

15:35

15:35

15:35

Then you go on to say:

"It is difficult to state what could have been done differently within the Trust without reference to

1 outside professional bodies to change the behaviour of  
2 a single consultant who was resistant to change and  
3 refused to acknowledge that there was a requirement to  
4 work within a clinical system, where the Department,  
5 the Commissioner, and the Trust had set out the  
6 parameters".

15:35

7  
8 Then you give the examples of some of the standards  
9 that would have been anticipated to be adhered to. You  
10 say at the last sentence there:

15:36

11  
12 "However, perhaps earlier action may have been  
13 appropriate in seeking an external assessment of  
14 competence to practise."

15:36

15  
16 We have discussed most of the other issues where you  
17 are making practical suggestions that have been brought  
18 out by the examples that we have relied on?

19 A. Yes.

20 333 Q. Is there anything else in your statement that you wish  
21 to speak to, or any other issue that you feel needs  
22 addressed that we could look at, or anything you would  
23 like to add generally to your evidence at this point?

15:36

24 A. Thank you for the opportunity but I think you have  
25 provided me with the opportunity of setting out all of  
26 the things that I wanted to say. Thank you.

15:36

27 MS. McMAHON: I have no further questions.

28 CHAIR: Dr. Rankin, I think we should have a short  
29 break before you are questioned by my colleagues and

1 myself for a short period of time, hopefully. Let's  
2 come back at 3:55 then.

3  
4 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

5 15:56

6 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL  
7 AS FOLLOWS:

8  
9 CHAIR: I am going to ask Mr. Hanbury, first of all,  
10 I think he has a few questions for you.

15:56

11 334 Q. MR. HANBURY: Thank you very much for your very clear  
12 evidence, I just have a few clinical things.

13  
14 Going back to the Regional Review and the five  
15 consultant model, you expressed some, I think,  
16 frustration that the job descriptions and the plans  
17 come through or the sort of process of advertising  
18 didn't come through as quickly as you would have hoped.  
19 Is that a correct interpretation?

15:56

20 A. Yes. I think the five person job plans took a long  
21 time to gain agreement of. They had been in high level  
22 discussions for quite a long time until the summer,  
23 I think, of 2011, but it took through the winter,  
24 I think, to get final agreement on the detail of all of  
25 those five job plans.

15:57

26  
27 That time, of course, included the approval from the  
28 Commissioning Board and approval from the special  
29 adviser Paddy Keane. So, there was those two other



1 hoops, of course, have to be gone through. Perhaps in  
2 hindsight it wasn't such a long period to actually get  
3 that in place, but we were then able to move to  
4 recruitment, I think, in March 2012.

5 335 Q. So that wasn't necessarily a criticism of the local urologists, it's all the loops together? 15:57

6

7 A. No, it is all the loops together. Obviously you are  
8 very keen, once the Board had agreed and the funding  
9 was there, you were very anxious to get to the position  
10 of being able to move to a position of a five 15:57  
11 consultant model in place and ease the pressure on  
12 three existing consultants, so it was in that  
13 generality.

14 336 Q. One or two other things from that sort of modernisation agenda that you had then. The flexible cystectomies 15:58  
15 and how many there were on the lists, do you remember  
16 any numbers there approximately?

17

18 A. I wouldn't recall the numbers, no. I mean if I was in  
19 conversations I would have recalled, 10, 14. I can't  
20 remember. I may be mixing that up with scopes. 15:58

21 337 Q. It was in double figures, not single figures?

22 A. I am not too sure about that. Perhaps I shouldn't  
23 quote any numbers at all because I am very unsure.

24 338 Q. On the same theme, the Outpatient clinic templates and the sort of one-to-two. Do you have any recollection 15:58  
25 of numbers there; is it one-to-two and working out the  
26 20 minutes and 10; was it sort of four new and eight  
27 follow-up, or five and ten and/or six and 12?

28

29 A. The detail, I am sure, is in the papers but I wouldn't

1 be sufficiently sure to quote that.

2 339 Q. Okay. You mentioned clerical support for admission  
3 processes, particularly with admissions; a four-person  
4 unit. We heard yesterday from Mr. O'Brien's secretary  
5 there didn't seem to be a lot of secretarial admin to 15:59  
6 help admit flexible cystectomies and urodynamics and  
7 that seemed to rely on the secretary some years later?

8 A. Yes.

9 340 Q. Was that something that you felt had improved?

10 A. Well, the situation was that the Trust of part of the 15:59  
11 efficiency savings across the whole of the Health and  
12 Social Care sector driven from the Board, was we had  
13 too many admin and clerical staff. I think there  
14 wasn't a fundamental understanding of how important  
15 admin and clerical staff are to the running of the 15:59  
16 system and the roles that they play. There was  
17 definitely a thrust to reduce the number of admin and  
18 clerical staff. In fact, the link of one consultant  
19 having 0.5 whole time of a PA was driven by the  
20 Commissioner. We actually had to make an allowance to 16:00  
21 grant Mr. O'Brien a full-time secretary because we  
22 recognised that he needed it, and I funded that from  
23 within the Acute Directorate budget so there was an  
24 overall requirement to reduce.

25  
26 That was one of the drivers for the admin and clerical  
27 review which the Trust corporately set out and which we  
28 have talked about this afternoon, that I chaired  
29 a group to look at the admin and clerical review 16:00

1 processes. I suppose there was a grain of truth in  
2 terms of what the Commissioner was saying because there  
3 had been an amalgamation of 19 organisations into the  
4 five Trusts, four plus the Ambulance Trust, so there  
5 may have been a degree of duplication. The review that 16:00  
6 I was doing within Acute was to look at standardising  
7 those processes and see where we had duplication, where  
8 we had doing the same sort of thing but lots of  
9 different ways, which is never useful because then if  
10 somebody is moving around, they don't know which 16:01  
11 process they are following. There was a grain of truth  
12 in it but it did result in perhaps paucity of admin and  
13 clerical where there might have been some.

14 341 Q. Thank you. Moving on. Just one question about  
15 national audits. There were national audits going on 16:01  
16 for things like nephrectomy and percutaneous day  
17 surgery, and national prostate cancer, which was  
18 actually not BAUS, it was the Royal College of  
19 Surgeons. We heard from Mr. Haynes that there was  
20 a sort of negative impact on that for information 16:01  
21 governance, although that came from central... Were  
22 you aware of any --

23 A. No.

24 342 Q. -- negative influence from the higher Trust Board --

25 A. Not in my time. There was always a very, very positive 16:01  
26 embracing if there was a national audit, we will  
27 participate.

28 343 Q. And national audits were happening in other  
29 specialties?

1 A. Yes. We participated in the Sentinel Stroke Audit, in  
2 the Fraction Neck and Femur national database, in the  
3 ICNARC, the intensive care database. The renal  
4 dialysis unit, we had had been contributing to that for  
5 a very long time. The renal dialysis unit was in Daisy 16:02  
6 Hill. So yes, there was a real thrust that if there  
7 was an opportunity to be peer-reviewed and to  
8 contribute to national audit, we were doing that. We  
9 would move resources around to provide the staff, the  
10 information staff, to actually gather the data to 16:02  
11 contribute to the audit.

12  
13 There were also GI audits, I can't remember whether it  
14 was Crohn's or whatever. There were consultants who  
15 were keen to lead those because it was the right thing 16:02  
16 to do, to measure yourself against your peers across  
17 the UK.

18 344 Q. Thank you. Just got one more question, if I may. It's  
19 the retained swab case. Obviously the first thing that  
20 went wrong then was a wrong swab count. We sort of 16:03  
21 glossed over that but, in the RCA, there was an  
22 observation that there were two methods of counting  
23 swabs?

24 A. Yes.

25 345 Q. And there was a change over, which is not unusual in 16:03  
26 a long urological operation, cystectomy and nephrectomy  
27 together. That is understandable, there was a change  
28 of personnel.

29 A. Yes.

1 346 Q. Did you receive reassurance back from the Theatre  
2 Directorate that that counting problem was solved?  
3 A. Yes. Each RCA or SAI or process to investigate an  
4 action -- an incident, had an action plan set out and  
5 with onerous time scales against each action. They 16:03  
6 were not signed off until I had assurance that all of  
7 the actions were in place. Those RCAs would have  
8 routinely been on the agenda for the Acute Clinical  
9 Governance meetings until people were perhaps fed up  
10 with them. But unless the actions were assured and 16:04  
11 signed off and implemented, then they wouldn't come off  
12 the agenda.

13 347 Q. Thank you. That's all.  
14 DR. SWART: These are quite general questions so  
15 hopefully you won't need any figures for them. You 16:04  
16 clearly put a lot of emphasis into developing the  
17 governance structure?  
18 A. Yes.

19 348 Q. You have described that, and some of our witnesses from  
20 later times have referred to that. What was still on 16:04  
21 your to-do list that you would have liked to have done  
22 if you could have done something that you thought was  
23 important? You have mentioned the national audits, and  
24 clearly there was a paucity of data?  
25 A. Yes. 16:04

26 349 Q. But is there anything else in that line that you saw in  
27 terms of desirable?  
28 A. I think the journey that we were on in terms of  
29 embedding the culture of if an incident occurs,

1 recognise it as an incident, discuss it, report, let's  
2 learn from it.

3 350 Q. Yes.

4 A. That learning process, and making sure that the culture  
5 was around learning from an incident as opposed to 16:05  
6 let's hide it, we don't want to know about it or own up  
7 to it, that journey of opening the culture was  
8 a journey in progress. That's a really, really  
9 important organisational journey. That's what the core  
10 thrust of the corporate review of clinical and social 16:05  
11 care governance was about. I am sure you have heard  
12 about that and seen the documents around that. That  
13 was absolutely the core of what we were seeking to do.  
14

15 As you well know, it takes a long time to change 16:05  
16 a system. That required all of the staff working day  
17 in, day out in the wards and outpatients in every which  
18 part of the hospital to embrace that culture, to  
19 recognise. I mean, there were still times when  
20 a senior leader, a senior clinician would come to me 16:06  
21 and say, 'by the way, I quietly want to tell you this  
22 has been happening for a long time, nobody has been  
23 prepared to own up to it but did you know', and you go  
24 gulp, deep breath time, 'right, what do we need to do'?  
25 So that's -- 16:06

26 351 Q. In that vein, a lot of people, mainly I think after  
27 your time, had said that there was a very big emphasis  
28 on performance and that data for performance was looked  
29 at very carefully, but that there wasn't much robust

1 data to cover quality issues other than when things  
2 went wrong, and that, therefore, one didn't necessarily  
3 know, for example, if cancer peer review standards were  
4 not being met, or if people weren't following policy,  
5 or if people weren't using best Royal College guidance. 16:06

6  
7 was that something you recognised in your time and did  
8 you have any views on that?

9 A. All that data was there. All the cancer review  
10 documents were there, again with clear action plans. 16:07  
11 All the RQIA inspections, announced and unannounced,  
12 were clear, they were always in Trust Board papers,  
13 they were in my directorate governance papers, the  
14 action plans against them were in directorate  
15 governance papers. 16:07

16 352 Q. I am talking more if you were asked what's the quality  
17 of clinical outcomes in Urology, would you have data to  
18 look at?

19 A. No, I wouldn't have at all. whilst we as a Trust  
20 joined CHKS and we engaged in the process of 16:07  
21 contributing our data to CHKS, I think in my time it  
22 only got to maybe a divisional level, it didn't get to  
23 specialty level. There was a process of cascading,  
24 cleaning and assuring the data. Certainly I think  
25 there was a basket of 23 metrics that we were measured 16:07  
26 against, and we rated highly in the UK against that,  
27 but those were largely around performance and that's  
28 maybe where the perception has come from.

29 353 Q. I think that is what they said.

1 A. Yes.

2 354 Q. They said this is performance.

3 A. Yes. The audit of clinical practice and having an  
4 audit against that either locally or nationally, no,  
5 I felt that was a gap. 16:08

6 355 Q. It also comes across that quite a lot of the things  
7 that were in place during your time were dependent on  
8 very robust chairing of meetings, having a vision,  
9 a lot of personal energy?

10 A. Yes. 16:08

11 356 Q. How much of it was very dependent on that? Were you  
12 able to hand that over to your successor in a state  
13 where they understood how much you had kind of given  
14 your heart and soul to it? Just my perception; it  
15 might not be quite right. 16:08

16 A. Yes, you are right, you are right. There was a lot of  
17 personal energy, and 12-hour days were the norm. My  
18 successor knew the system inside out; had been  
19 a healthcare practitioner in the system and had grown  
20 up in three different roles within the system and she 16:08  
21 then took on the role. Unfortunately, my last day,  
22 31st March or 30th March, she was involved in a car  
23 accident and when she took over, she was actually in  
24 a bed in the hospital as a result of that car accident.  
25 So, therefore, hand-over was not quite as it might have 16:09  
26 been.

27

28 The files were there. My secretary, who is in the  
29 room, now fulfilling a different function, had all of



1 the files. I left a pile of files that were  
2 specifically for reference in terms of the following  
3 system. My successor knew all of the meetings that  
4 I would have put in place, was fully aware of those  
5 having been in different roles and contributing to 16:09  
6 those meetings. But certainly the Urology file was in  
7 that file, that pile of files, for her reference, with  
8 the invitation from me that I would happily meet with  
9 her at any stage to have that face-to-face discussion  
10 and hand-over. 16:09

11 357 Q. I mean, the reason I asked it is that some of the  
12 meetings you put in place weren't necessarily  
13 continued, and it was more in a general governance, you  
14 know?

15 A. Okay. 16:10

16 358 Q. Having put all that in, and I've had experience of this  
17 myself, it's usually dependent on it being sustained?

18 A. It is.

19 359 Q. And you know that.

20 A. Yes. 16:10

21 360 Q. The other thing that comes through, I think, through  
22 a variety of sources is that the Trust is very large?

23 A. Yes.

24 361 Q. It has a very broad span of control?

25 A. Yes. 16:10

26 362 Q. There are lots of tensions around that in terms of what  
27 gets to the Board and who has time to do what.

28 A. Yes.

29 363 Q. Also, the issue of what the role of the Commissioner is

1 versus what the role of the provider is, and who really  
2 bottoms out the strategic planning and the key  
3 decisions. would you agree that seems to be a tension  
4 from your experience?

5 A. It has always been. The flavour of Northern Ireland, 16:10  
6 where you have integrated Health and Social Care,  
7 whilst it has many, many, many advantages for patients,  
8 or should have - it doesn't always work out that way -  
9 but patients, people, clients, whatever you want to  
10 call them - they are people at the end of the day - 16:11  
11 there are inherent difficulties in --

12 364 Q. So, the system?

13 A. And the reconfiguration of the 19 Trusts into the  
14 Trusts as they are today meant that some of those  
15 difficulties are internal to the Trust as opposed to 16:11  
16 between Trusts.

17 365 Q. Yes.

18 A. And what funding goes where and who gets preferential  
19 treatment when the pressure is really on, what goes  
20 where, how do you equate adoption of children or 16:11  
21 safeguarding of children with the newest treatment of  
22 patient with such-and-such, it's a really, really,  
23 really difficult circumstance --

24 366 Q. My question was really just around that. How do you,  
25 as a provider, then really fight your case with 16:11  
26 commissioners for more funding when you have so many  
27 things to pipe for that aren't really equivalent in  
28 terms of your ability to assess are more risk to  
29 patients and families?

1 A. Yes.

2 367 Q. Because in England, there's sort of emphasis on  
3 everything must go this way?

4 A. Yes, yes.

5 368 Q. Has it caused more benefit, has it resulted in more 16:12  
6 benefit? This is just a general view in terms of your  
7 experience of trying to manage in a provider. Or has  
8 it caused more tension?

9 A. I think coming from the professional background where I  
10 have been, I haven't been in clinical work since the 16:12  
11 middle 1990s, so I had been a director in the Northern  
12 Ireland Health Service for the guts of 20 years, and my  
13 sense is that the overall result is benefit.

14 369 Q. Yes.

15 A. But because there is the opportunity to provide 16:12  
16 something really special and really important for  
17 people at their time of need - and that can work very,  
18 very well in an integrated way - but it does provide --  
19 it does cause a lot of tension at commissioning level  
20 and at management in Trust level in terms of how do you 16:12  
21 balance all of those competing priorities. It is  
22 a difficulty.

23 370 Q. Because we see some of this in this Inquiry in terms of  
24 the difficulties, and also clearly the tension between  
25 money and quality? 16:13

26 A. Yes.

27 371 Q. And so it goes on. In dealing with the specific  
28 urology issues now, and particularly with Mr. O'Brien,  
29 on your very first day in 2009, one of the mentions is

1 if this doesn't get better, let's get a proper plan  
2 with NCAS. Fast-forward to the end of everything and  
3 there's never been a practitioner intervention.

4 A. Yes.

5 372 Q. Even more than that, I quite can't see a serious 16:13  
6 attempt to actually sit down with Mr. O'Brien and  
7 indicate the depth and breadth of the problems and put  
8 a support plan in. would that be an unfair comment, or  
9 is that something that you recognise from your time,  
10 that that wasn't done? 16:13

11 A. I think that's something that I recognise. When I look  
12 over the range of issues, with the benefit of hindsight  
13 --

14 373 Q. That helps a lot, of course.

15 A. It does help a lot, absolutely. The retrospective 16:14  
16 scope in this particular case shows you the timeline of  
17 what was going on and where, and the multitude of  
18 issues. I suppose --

19 374 Q. why is my question really. why?

20 A. I don't know why. We didn't stand back and take that 16:14  
21 long look. We should have.

22 375 Q. Do you think it was anything to do with lack of  
23 engagement with the medical hierarchy, which has since  
24 been sort of highlighted as possibly medical hierarchy  
25 working separately from operational? Or was that 16:14  
26 something that was not there in your time?

27 A. I don't know. I mean we did work very, very closely  
28 together.

29 376 Q. I realise that.

1 A. There was no doubt there was a great deal of co-working  
2 and cooperation. Whether it was to do with the general  
3 busyness of the fact that everybody was dealing with so  
4 many issues across the range of services, I can't  
5 really say why that didn't happen. I think it should 16:14  
6 have happened when I look back now and I see the range  
7 of issues, and perhaps that should have happened. I  
8 mean, we would have had many informal conversations  
9 about the Urology Service, and the consultant in  
10 particular. It's not that it wasn't known and wasn't 16:15  
11 in discussion.

12 377 Q. No.

13 A. But nobody said right, let's put this all down on the  
14 table, let's look at this in the round and see what we  
15 need to do. 16:15

16 378 Q. Who should have? Whose job was that, do you think?

17 A. It would have been a combination of the Medical  
18 Director and myself. Either one of us could have said  
19 'time to do this'.

20 379 Q. Yes. 16:15

21 A. And neither of us did.

22 380 Q. Okay. Thank you very much.

23 CHAIR: I just have a couple of questions. One of the  
24 documents that we looked at earlier today was the  
25 letter of the consultants in response. I think it was 16:15  
26 January 2011, maybe, 18th January, about the ward  
27 issue.

28 A. Yes.

29 381 Q. I just wondered, the onus was then put on the

1 consultants, well, bring us evidence of how patients  
2 are being harmed. I just wondered did anyone think to  
3 go and talk to the ward staff, the nursing staff or  
4 anyone like that? was there ever any discussion?

5 A. I think that would have been done informally 16:16  
6 automatically and we would have known if there were  
7 issues. If the nursing staff were raising issues about  
8 safety, we certainly would have heard about those.

9 382 Q. So, if I am reading you right then, are you saying that  
10 you were really challenging the consultants to prove 16:16  
11 what they were saying?

12 A. Yes, because if they were raising issues of safety,  
13 they had to give us evidence of what they were talking  
14 about. I couldn't manufacture the evidence. There was  
15 nothing sitting in the IRIs, there was nothing sitting 16:16  
16 in Datix because I had went and had a look at that. I  
17 had no evidence which indicated that there was a lack  
18 of safety.

19 383 Q. There was no soft intelligence coming your way from  
20 anyone else? 16:17

21 A. No. I was only six weeks into post at that stage so  
22 I hadn't had time to start gathering the soft  
23 intelligence hugely. It's the sort of thing that  
24 develops once you have built those relationships with  
25 people. There was nothing in the formal system at all. 16:17  
26 Yes, you are right, it was a challenge back to the  
27 consultants, and it was a genuine challenge back, that  
28 if they had brought that evidence or that indication  
29 that they were alluding to, we would, of course, take

1 an action on it. I mean, I don't know what that action  
2 would be because I don't know what the issues would be.  
3 You cannot raise an allegation like that without  
4 substantiating it with evidence, and no clinician who  
5 really means business will raise that. They will come 16:17  
6 with the evidence and say I am worried about patient  
7 care because look at this, look at this, look at this;  
8 okay, let's get into deep conversation about this and  
9 see what we can do.

10 384 Q. Okay. One other thing: You were asked by Ms. McMahon 16:17  
11 about the conversation you had with Mr. Mackle about  
12 this allegation of having being the cause of bullying  
13 Mr. O'Brien?

14 A. Yes.

15 385 Q. Do you recall any conversation with Mr. O'Brien himself 16:18  
16 where you were told by him that he wasn't to have any  
17 more -- or you said he wasn't to have any more dealings  
18 with Mr. Mackle? Do you remember anything?

19 A. No.

20 386 Q. I am just going to tell you, you may or may not be 16:18  
21 aware if you are following the Inquiry proceedings,  
22 that Mr. O'Brien recorded a number of meetings that he  
23 held?

24 A. No. The only meeting I had with Mr. O'Brien on his own  
25 was when I had heard that he wasn't himself in theatre 16:18  
26 and I asked him to call up with me after theatre. That  
27 was the only occasion that I met Mr. O'Brien on his  
28 own. I do not recall any occasion when Mr. O'Brien  
29 sought to meet with me. He didn't usually seek to meet

1 with me.

2 387 Q. I am not even suggesting that he did. I am just going  
3 to read a couple of extracts. There was a meeting on  
4 7th February 2017 that Mr. O'Brien had. This was when  
5 he was going through the MHPS proceedings in 2017.

16:19

6 A. Okay.

7 388 Q. He had a meeting with the NED, the non-executive  
8 director, who was assigned to him for the purposes of  
9 the MHPS. He said in the course of that meeting,  
10 because we have the transcript of it:

16:19

11

12 "Yes, I sought and obtained an assurance from  
13 Dr. Rankin and from Eamon Mackle himself, particularly  
14 from Dr. Rankin, that I would have had no more dealings  
15 or meeting with him because I was on the point of a  
16 breakdown as a result of his treatment over a period of  
17 years."

16:19

18

19 You don't recall anything like that?

20 A. Oh, no, and I think I would recall that.

16:19

21 389 Q. Yes. Mr. O'Brien gave evidence to the Inquiry and he  
22 said he had a number of -- he was invited, to put it  
23 politely, or summoned to a number of meetings with you  
24 and Eamon Mackle over a period of time:

25

26 "From 2010 up until -- I can't remember when this  
27 relates to. They were anything but. They were not  
28 pleasant. They were brutal. Being told that I had to  
29 obey my political masters, having allegations fired at

16:20



1           you. "

2

3           Now I am assuming he is talking about the meetings  
4           about Team South and the setting up?

5           A.    I presume so.   Yes.

16:20

6 390 Q.    Is that your recollection of these meetings?   Was  
7           brutal a fair description, to your mind?

8           A.    No.   The meetings -- all the meetings that I held with  
9           clinicians, managers, staff, all had an agenda at the  
10          meeting.   They were conducted politely, with respect,  
11          every meeting.   I wouldn't tolerate any different  
12          behaviour.   There would have been straight talking, but  
13          I suspect that if you are being asked to change so much  
14          of your clinical behaviour and you don't agree with it,  
15          you are going to use -- you are going to reflect on  
16          those meetings as perhaps brutal or difficult.

16:20

16:20

17

18          But no, the meetings -- I mean the meetings, there was  
19          quite a large cohort of people around the table with  
20          the three consultant urologists, myself, Mr. Mackle,  
21          Heather Trouton, Martina Corrigan, somebody from HR,  
22          somebody from Finance, somebody from Performance; a big  
23          group but all with a single focus of actually  
24          developing the implementation plan.   But as we know,  
25          Mr. O'Brien didn't agree with a lot of the parameters  
26          of that plan and didn't want to change his behaviour.

16:21

16:21

27

28          So no, there was nothing untoward in any of those  
29          meetings.   They would all have been conducted politely

1 and with respect. Perhaps we disagreed about things or  
2 we didn't get the agreement that we needed, but there  
3 was nothing. I can recall no difficult altercations.  
4 Certainly I wouldn't have any raised voices in the  
5 meeting, anything like that. I would call a halt to 16:21  
6 the meeting and call out that behaviour.

7 CHAIR: Thank you.

8  
9 You will be glad to know I have nothing further I want  
10 to ask you, Dr. Rankin. I know you were scheduled to 16:22  
11 come again tomorrow morning, but you will be relieved  
12 to hear we don't need to hear from you tomorrow  
13 morning. So, thank you for your time.

14  
15 10:00 tomorrow morning, then, ladies and gentlemen. 16:22

16  
17 THE INQUIRY WAS THEN ADJOURNED TO 10:00 A.M. ON  
18 THURSDAY, 8TH JUNE 2023