Urology Services Inquiry

Oral Hearing

Day 69 – Wednesday, 8th November 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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WITNESS PAGE

MR. MICHAEL YOUNG

EXAMINED BY MR. WOLFE 3

1 THE INQUIRY RESUMED ON WEDNESDAY, 8TH NOVEMBER 2023, AS
2 FOLLOWS
3
4 CHAIR: Good morning, everyone.
5 MR. WOLFE KC: Your witness this morning, Chair, is 10:04
6 Mr. Michael Young, and he proposes to take the oath.
7
8 MR. MICHAEL YOUNG, HAVING BEEN SWORN, WAS EXAMINED BY
9 MR. WOLFE, AS FOLLOWS
10 10:04
11 Q. MR. WOLFE KC: Good morning, Mr. Young.
12 A. Good morning.
13 1 Q. We'll start this morning by introducing or
14 reintroducing you to the various statements that
15 you have given, both to this Inquiry and to Dr. Chada's 10:04
16 investigation. And at the end of that process, I'll
17 ask you whether you wish to adopt those statements as
18 part of your evidence to the Inquiry. So, there are
19 several, probably more than most.
20 10:05
21 So, starting with your primary response to the Inquiry
22 Section 21 process, if we go to WIT-51638, that is the
23 first page. You can see that there's an annotation at
24 the top indicating that we've received an amending
25 statement from you in respect of this notice. 10:05
26
27 Then if we go to the last page, we can see that at
28 WIT-51845 -- and do you recognise that as your first
29 statement to the Inquiry?

1 A. I do.
2 2 Q. Subject to those amendments that I'll now bring you to,
3 do you wish to adopt that statement as part of your
4 evidence to the Inquiry?
5 A. I do. 10:06
6 3 Q. Thank you. Then the addendum to which I referred is
7 dated 3rd November. It's WIT-104215 and we, as I say,
8 received that from you on 3rd November, and I'll be
9 bringing you in the course of your evidence to some of
10 these amendments. 10:06
11
12 If we scroll down then to the end, it's five pages
13 through, you recognise that as your signature?
14 A. I do.
15 4 Q. Again, do you wish to adopt that statement as part of 10:07
16 your evidence?
17 A. Yes, please.
18 5 Q. Then a few days before this statement, we received
19 a response to a second Section 21 notice which we had
20 raised with you primarily to cover issues raised by 10:07
21 Mr. Hagen in his evidence to the Inquiry, and we'll
22 pull that up for you now. It's WIT-103604. You'll
23 recognise the first page of that. I'll bring you to
24 the last page then, and your signature -- it's at
25 WIT-103621, as you can see there. Again, time-honoured 10:08
26 question, do you wish to adopt that as part of your
27 evidence to the Inquiry?
28 A. I do.
29 6 Q. Thank you. Then, finally, as part of this exercise,

1 your evidence to Dr. Chada, TRU-00751... Eh, we'll
2 maybe come back to that if we can't bring it up --
3 A. That's okay, yeah.
4 7 Q. But you will recall that you sat with Dr. Chada and her
5 support officer for the purposes of the MHPS 10:09
6 investigation --
7 A. Yes.
8 8 Q. And I understand those sittings were on
9 23rd March 2017 and 3rd April 2017, leading to the
10 production of a statement which you then signed on 10:09
11 5th October 2017. Have you had an opportunity to
12 review that statement in preparation for today?
13 A. Yes. Just the second date of the interview was --
14 9 Q. I understand it was 3rd April?
15 A. 3rd April, that's right. 10:09
16 10 Q. -- 2017. We can bring you to this statement later, if
17 needed.
18 A. Yes.
19 11 Q. But are you happy to adopt the contents of that
20 statement? 10:09
21 A. I am.
22 12 Q. Thank you. Now, we can see from your Section 21
23 statement, Mr. Young, that you qualified from Queen's
24 University Belfast in 1983 and entered urological
25 training after general surgical training, and that 10:10
26 urological training commenced in 1992?
27 A. Correct.
28 13 Q. It took six years and you took up a consultant's post
29 at what was to become the Southern Trust in or around

1 May 1998?
2 A. Correct.
3 14 Q. You stayed in that consultant's post, a consultancy in
4 urology, from May 1998 through until May 2022 when
5 you formally retired? 10:11
6 A. Yes.
7 15 Q. As of today, you continue a connection with the
8 Southern Trust by acting as a part-time or locum
9 consultant -- not locum --
10 A. No, no, I retired at the end of the May '22. I came 10:11
11 back then as a part-time consultant working equivalent
12 of four sessions a week. So that's a substantive but
13 part-time post.
14 16 Q. One can see then, just looking at that time span, that
15 you have had an association with -- just in simple 10:12
16 terms, we call it the Southern Trust but the Inquiry is
17 aware of the various changes in the structure of the
18 Trust and its -- and that kind of thing over the years.
19 But you've had a connection prior to your retirement of
20 24 years with the Southern Trust? 10:12
21 A. It's the same hospital, Craigavon Area Hospital all the
22 way through, yes.
23 17 Q. Yes. That period of time in post hopefully allows you
24 to cover quite a number of the issues which the Inquiry
25 is interested in and, as part of your evidence, I hope 10:12
26 you'll be able to explain to the Panel some of the
27 early developments in the creation and development of
28 the Urology Service, the difficulties that were faced
29 into and may have lingered over the period. We'll also

1 wish to explore your role as a clinical lead and
2 whether that had any particular importance, given the
3 particular issues that the Inquiry is looking at in
4 association with the practice of Mr. O'Brien, with whom
5 you worked for a period of 22 years, and the governance 10:13
6 arrangements around some of those issues.
7
8 So if we look to your witness statement at -- your
9 first witness statement at WIT-51690. You set out,
10 from paragraph 4.3 there, helpfully, your occupational 10:14
11 history. As I've said, you took up a consultant's post
12 in May 1998 at Craigavon, and the job description for
13 that post is at TRU-101601.
14
15 As you explained, if we just scroll down to 5.4 -- 10:14
16 thank you -- that you came into this post with,
17 I suppose, a specialism in stone management; is that
18 correct?
19 A. Correct.
20 18 Q. And as part of your work, the clinical part of your 10:14
21 work involved general and specialist clinics,
22 outpatient clinics, at Craigavon Area Hospital,
23 Banbridge and Armagh, and then subsequently the South
24 Western Acute Hospital; is that right?
25 A. Correct. 10:15
26 19 Q. In addition to that, you had day cases in theatre, both
27 at Craigavon and the South Tyrone Hospital?
28 A. Correct.
29 20 Q. And inpatient operating took place primarily at the

1 Craigavon Hospital, but subsequently, particularly in
2 light of the pandemic developments, in Daisy Hill
3 Hospital in Newry?
4 A. Correct.
5 21 Q. Was there an oncology element to your clinical 10:15
6 practice, or was it primarily a benign condition
7 practice?
8 A. My practice was, from a general perspective, of all
9 things relating to adult urology. It would have
10 covered the benign contingent, but I did have an 10:16
11 oncology interest. I had spent time at the Institute
12 in London -- in Northern Ireland, we didn't have open
13 surgery for prostate cancer -- and I spent some time
14 there training in that specific type of surgery and
15 brought that back home again. So I was exposed to 10:16
16 quite a lot of open surgery from a bladder cancer point
17 of view and from prostate cancer.
18
19 So I did have a broad oncology view of things and
20 certainly for my first ten years in Craigavon doing 10:17
21 open kidney surgery, open bladder surgery and doing
22 radical prostatectomies was part of my field.
23
24 I obviously had an interest in stones, so that ran in
25 tandem. And I ran our ESWL service throughout the 10:17
26 whole period.
27
28 Certainly then after the review of 2009, all of the
29 radical pelvic surgery went to Belfast. I still did

1 the open kidney surgery and I kept that going until
2 more recent times when Mr. Haynes arrived. He had
3 a particular interest in renal surgery, so I swapped
4 my -- I got his stones and he got my kidneys, if you
5 want to put it that way! 10:18
6
7 So in more recent times, my oncology interest certainly
8 has waned to allow me to focus on the stone side. And,
9 certainly from an oncology MDT point of view, I was at
10 the meetings when they were being set up, but due to 10:19
11 the number of clinics that I was trying to cover, I did
12 a Thursday afternoon Outpatients and dropped my MDT
13 attachment to that in 2015.
14 22 Q. Yes. I think that's the helpful point I was going to
15 bring you to. We can see that from the annual reports 10:19
16 associated with the MDT that you had very regular
17 attendance from the establishment of the MDT I think in
18 or about 2010?
19 A. Yes.
20 23 Q. Then looking at the report for 2015/2016, your 10:19
21 attendance at MDT dropped to 14 meetings out of 42,
22 which isn't to suggest that you were a poor attender,
23 it probably suggests that it was around that point in
24 time when, as the number of consultants expanded, they
25 took on the MDT role; is that fair? 10:20
26 A. That's fair. I think I had a lot of other commitments.
27 I didn't have a new patient clinic slot. So that's
28 what was then my Thursday afternoon.
29 24 Q. Just for the Panel's note, that Annual Report for 2015/

1 2016 showing 14 out of 42 meetings attended is to be
2 found at AOB-77912.
3
4 You also make the point that, perhaps self-evidently,
5 in association with the consultant's role, there is 10:21
6 a comprehensive suite of administrative duties to
7 perform, and you set that out at paragraph 5.8, if
8 we just scroll down, and we'll come in due course to
9 touch upon the impact of administration or the
10 potential impact of administration and the growing need 10:21
11 for administration as it developed through your career,
12 how it may have impacted on other priorities.
13
14 You were also, as you explain at 5.12, just scrolling
15 down again, you were also cast in the role as an 10:21
16 appraiser of colleagues' work, the appraisal system
17 coming into play around about 2010 or so. And we can
18 see that you were an appraiser for, amongst others,
19 Mr. O'Brien, for a period of five years, approximately,
20 isn't that right? 10:22
21 A. The appraisal would have covered that five years, yeah.
22 25 Q. And we'll come in due course to look at the role that
23 appraisal played and the approach that you adopted to
24 it.
25 10:22
26 You declare or you notify us through your statement
27 that one of your interests in association with urology
28 was as a director of the charitable company CURE, isn't
29 that right?

1 A. Correct.
2 26 Q. How long were you associated with CURE?
3 A. Well, I've attended the CURE events and everything to
4 do with this over my tenure. I was then asked to
5 become a director at some stage. I don't know exactly 10:23
6 the date, but it would have covered 15 plus years.
7 27 Q. Would you have encountered Mrs. Brownlee through the
8 CURE company and through your duties on CURE?
9 A. My duties, no, but I was aware that she was a founder
10 member and would attend the social events. But as far 10:24
11 as interaction specifically to do with CURE, no.
12 28 Q. The Inquiry has received evidence that Mr. O'Brien had
13 a relationship, a patient-clinician relationship with
14 Mrs. Brownlee, but was also in a position of friendship
15 with her, and certain suggestions have been made about 10:24
16 Mrs. Brownlee intervening on behalf of Mr. O'Brien at
17 various times. Did you have any particular
18 relationship of -- whether professional or friendship
19 -- with Mrs. Brownlee?
20 A. It would have been a friendship, knowing -- from a CURE 10:25
21 perspective, it was very much a social aspect.
22 Mrs. Brownlee was Chair of the Trust and would have
23 been on some of the interview panels for consultants.
24 That would be right. And that was purely work.
25 29 Q. Did she ever engage with you in relation to Mr. O'Brien 10:25
26 and the difficulties that he found himself in?
27 A. No, I don't recollect any conversations.
28 30 Q. Thank you. You were also for, I think, the majority of
29 your time as a consultant also the clinical lead or the

1 lead clinician in respect of the Urology Department;
2 isn't that right?
3 A. From about 2000/2001, yes.
4 31 Q. We will look at that role closely later in your
5 evidence, but just to give us an initial heads-up in 10:26
6 association with it, if we go back to paragraph 1.5 of
7 your statement, WIT-51684, you describe it at that
8 paragraph 1.5 as a role which was service-driven in
9 terms of its organisational responsibilities, which
10 focused upon the urology medical team's daily work 10:27
11 placement.
12
13 So in terms of that role, and, as I said, we will look
14 at it in greater detail later, what were the formal
15 aspects of that role in terms of regular daily or 10:27
16 weekly activity?
17 A. As I say, I saw the job as a service driven
18 organisational need. It was to support our Head of
19 Service, Martina Corrigan. So there was an
20 organisational and a medical aspect and, if 10:27
21 Mrs. Corrigan needed an angle from a medical
22 perspective, she would come to me. Whether that was on
23 a daily or a weekly basis, it was as necessary.
24
25 I think the main role or one of the primary roles was 10:28
26 to do the rota for the whole unit, and that was to
27 define the morning and afternoon sessions for all of
28 the clinical activities in the unit for all the staff
29 from a medical perspective; and then, having defined

1 that, the nursing angle would fill in their slots
2 around that.
3 32 Q. Yes. And as appears from your statement, you have
4 a particular perspective on the, I suppose, on the
5 limits of that role in terms of responsibility. And 10:29
6 that perception or that understanding may not
7 necessarily be shared by others and I want to,
8 I suppose, confront you with that or ask you about that
9 later in your evidence. So thank you for that for now.
10 10:29
11 Just one final point on that. You never had a job
12 description for the clinical lead role; is that
13 correct?
14 A. Never.
15 33 Q. Another string to your bow, as we can just catch there 10:29
16 at paragraph 1.5, was that you held a post as programme
17 director, obviously external to the Trust, for
18 urological trainees in Northern Ireland and,
19 subsequently, you became an educational supervisor when
20 the programme director role ended; is that correct? 10:30
21 A. I was an educational supervisor before and after. It's
22 the Northern Ireland Medical and Dental Training
23 Agency; it's the training programme for all of Northern
24 Ireland. You know, it will have surgery and medicine
25 and, from our perspective, we had a defined urology 10:30
26 training programme.
27 34 Q. You explain, if we just scroll down to WIT-51695 and
28 just scroll to 5.13, you explain that in addition to
29 the list of duties in the programme director's post,

1 the programme director had responsibility for looking
2 after doctors in difficulty. And you have referred us
3 to WIT-51880, which is a document associated with,
4 I suppose, how to manage doctors and dentists in
5 difficulty published by the Agency to which you have 10:32
6 just referred, the Northern Ireland Medical and Dental
7 Training Agency, and I just want to pick up on a couple
8 of strands contained within this.
9
10 It explains that this is a policy which has been 10:32
11 written with a view to defining the procedures for
12 dealing with doctors and dentists in the training
13 grades who are experiencing difficulties within the
14 Northern Ireland deanery, and the policy aims to
15 promote early identification of trainees in difficulty 10:32
16 and to provide a clear structure for identifying and
17 addressing these difficulties.
18
19 And then if we scroll down to Section 3 of the policy
20 or the guidance, it talks about identifying trainees in 10:32
21 difficulty:
22
23 "All possible steps should be taken to identify and act
24 on early signs and symptoms of difficulty. The
25 majority of these are behavioural, but also include 10:33
26 signs of clinical incompetence, for example, poor
27 record-keeping, poor clinical decision-making and
28 judgement, inappropriate referrals..."
29

1 -- etc. And then it goes on to refer to what is
2 perhaps a priority, which is to try to successfully
3 remediate trainees or doctors or dentists in
4 difficulty, and it says that requires an understanding
5 of the underlying problems. 10:33
6
7 I don't want to delve into the document beyond that,
8 but do you see in that guidance some relevant themes or
9 potentially relevant themes in terms of managing
10 doctors who are fully qualified, not necessarily 10:34
11 trainees?
12 A. It moves from one to the other, yes.
13 35 Q. Yes, and highlights, by way of example, some of the
14 things that those responsible for managing trainees in
15 difficulty might have in mind. And, I suppose, one of 10:34
16 the themes is to get to the issue early, to identify
17 things early and get to work on it.
18
19 Were you -- and I might add there's probably loud
20 echoes of this document or the themes of this document 10:35
21 in the MHPS process or framework -- were you familiar
22 with that, the Managing or Maintaining High
23 Professional Standards framework?
24 A. No.
25 36 Q. Let me bring it up on the screen, WIT-18490. I keep 10:35
26 using the word "Managing", but it's "Maintaining" --
27 A. Maintaining, yes,.
28 37 Q. I haven't cleared that in my head after 12 months --
29 24 months! So -- and this is maybe just an initial

1 fact-finding exercise with you -- this document, as you
2 can see, published in 2005 by the Department and was to
3 be used *inter alia* by employers for the purposes,
4 essentially, of managing doctors who are qualified and
5 get into difficulty. Is that something that ever 10:36
6 crossed your desk by way of information, by training,
7 even if you weren't implementing it?
8 A. Yes. I'm sure this has come across my desk, but to go
9 through it on a formal basis was what I meant by my
10 last answer. I haven't had any formal training in the 10:36
11 content of this document.
12 38 Q. The Trust produced its own guidelines as a companion
13 piece to MHPS -- if I could just bring those up on the
14 screen, TRU-83685 -- published in 2010. Again,
15 self-explanatory headline -- 10:37
16 A. Yes.
17 39 Q. We'll maybe go into some of the nuts and bolts of it a
18 little later, but any familiarity with those
19 guidelines?
20 A. Yes, I recognise this as a document. I understand it 10:37
21 was quite a long document.
22 40 Q. These things are all relative!
23 A. Yes!
24 41 Q. But in terms of, yes, you recognise it, we'll come, as
25 I said, later to your role as clinical lead and what 10:37
26 might have been expected of you, particularly in
27 association with Mr. O'Brien, a doctor who arguably was
28 in difficulty.
29

1 Had you any training or working experience of this
2 document?
3 A. I don't remember being taken through this by the
4 hospital management. These things are often sent to
5 you with the expectation that you read them. 10:38
6 42 Q. Yes. Thank you for that. Now, the environment in
7 which you worked for 20-odd years has been, I suppose,
8 the subject of detailed commentary by yourself in your
9 witness statement. I think it's -- I suppose, it's
10 fair and appropriate to explore that a little with you 10:39
11 so that you can provide the Inquiry with, I suppose,
12 the benefit of that context. It was a context which
13 was often challenging for all of the consultants
14 employed within Urology and it does seem at your --
15 reading between the lines in your statement -- that the 10:39
16 foundations for the Urology Service were never quite
17 correct, never strong enough, and that led, perhaps, to
18 difficulties in dealing with the demands of the local
19 populace throughout your career. Is that a fair
20 summary of what you were exposed to? 10:40
21 A. That's a very fair summary. Going back to 2001, there
22 was a Trust recovery plan and, from a urology
23 perspective, we were noticing a 60% increase in our
24 emergency workload. Our referral rates were going up
25 exponentially, and that was in 2001. 10:40
26
27 We then, over the next few years, linked with
28 Mr. Templeton, who was the Chief Executive at the time
29 and had his office on the top floor of the Hospital.

1 He was easy to talk to, and we would have put our case
2 across. And it actually got to such an extent that our
3 emergency workload was overtaking the system completely
4 and we asked to close the doors for a period of time.
5 10:41
6 We also had outreach clinics that we were meant to go
7 to which then didn't leave anybody on site in the main
8 hospital and we felt that that was an issue from
9 a safety perspective. And it all came to a head,
10 basically, and Mr. Templeton did listen to what we were 10:42
11 saying and he called for an external review of the
12 Urology Services.
13 43 Q. I'm going to pause there because I want to do a little
14 bit of backfilling before we reach the McClinton
15 review, which you talk about at some length, helpfully, 10:42
16 in your statement.
17 A. Right.
18 44 Q. There were, in essence, three reviews that are maybe
19 worth mentioning this morning -- the McClinton; then
20 into a regional review in 2009; and then roundabout 10:42
21 2014, something of a stock take on the regional review.
22 A. Mm-hmm.
23 45 Q. But let me set out, I suppose, the broad thing that's
24 to be divined from your witness statement. It's set
25 out at 1.8. So if we go to WIT-51684, and just down 10:43
26 the page at 1.8, so I suppose this is really a state of
27 the nation kind of description of what you and your
28 colleagues worked in:
29

1 "A theme which has coursed throughout my tenure has
2 been the demand put on the Service from the significant
3 numbers of patients requiring investigation and therapy
4 within a deficit in the healthcare system capacity in
5 terms of both facilities and provision of healthcare 10:43
6 staffing. This has resulted in particularly long
7 urology waiting lists for both outpatient and inpatient
8 assessments. The yet undiagnosed and potential hidden
9 pathology is a distinct concern. For those with
10 a known condition, they suffer from a lack of 10:44
11 intervention."
12
13 And you go on to say later in your statement -- this is
14 paragraph 54.1 -- that during your initial, you said,
15 ten years or so in Craigavon, it was evident that there 10:44
16 was a struggle for the Trust to appreciate the level of
17 need the Urology Department required. And then we have
18 the McClinton review in 2004.
19
20 Just before we unpack why that review was asked for and 10:44
21 what it produced, we should remind ourselves -- when
22 you took up your consultant's role in 1998, Mr. O'Brien
23 was there; he was the sole or single-handed urological
24 consultant, is that right?
25 A. When I took up post, yes. But there had been 10:45
26 a consultant, Mr. Baluch, there. I think I came to
27 replace him, as opposed to being the third person.
28 46 Q. Yes. It was part of the drive that was to come over
29 the next few years, was to try to persuade the powers

1 that be that a third consultant was necessary, isn't
2 that right?
3 A. And potentially more than three, yes.
4 47 Q. Of course. Just in terms of the impact on the two of
5 you coping with what you briefly described as the big 10:46
6 increase in emergency work, in referrals, and that kind
7 of thing, what was it like in terms of pressure?
8 A. You lived in the hospital. It was a one-in-two on-call
9 rota as a consultant. There were registrars, but they
10 did not cover the whole week, so you may be on call 10:46
11 yourself. So that's a one-in-two weekends. Work for
12 week at a time. You did your daytime work -- clinics,
13 theatre -- and then you were on call, and all of the
14 admin and triage to go with that. When your colleague
15 went on holiday, you were on call for two weeks solid. 10:46
16 48 Q. Belatedly, was, I suppose, the weight of those
17 responsibilities recognised with a contract of
18 15.4 PAs -- or 15.6, I think, is the correct --
19 A. Yes.
20 49 Q. -- as an ex gratia payment? 10:47
21 A. That's correct. We did have job plans, but it was all
22 the extras, it was the administration and the on-call
23 and the recognition of that, the one-in-two rota,
24 we felt was important to sort of cover. We didn't get
25 any summer cover. There was no -- in those days, there 10:47
26 weren't any sort of locum consultants coming in to sort
27 of cover the place.
28 50 Q. When you think back now, what I'm trying to explore
29 with you is whether the foundations of this service,

1 this urological service -- which is obviously in
2 a quite different place today than it was in the mid
3 90s when you came along and, just before that,
4 Mr. O'Brien came along to establish the service -- but
5 help us with this: Was urology regarded as some kind 10:48
6 of Cinderella interest or area by those in power within
7 the Trust, or was this sort of struggle to get it going
8 and get it resourced perhaps a factor of the context in
9 which it started? There had never been a Urology
10 Service until Mr. O'Brien came along -- or not formally 10:49
11 one. How do you explain what you go on to describe, or
12 we'll explore with you, the constant struggles?
13 A. Okay. I have to go back further. Mr. Graham was
14 a general surgeon in Craigavon and he had, obviously,
15 a main surgical interest, but he also had a urology 10:49
16 interest. He would have done TUR prostates. I was his
17 registrar at one stage and, from a urology perspective,
18 it was to do sort of TURPs. There wasn't anything
19 else. The TUR -- also bladder tumours -- would have
20 gone to Belfast. So I think urology might have been 10:50
21 thought of as a one-operation service. But as will be
22 known from the top desk is that it's not just all about
23 TUR prostates. And urology then evolved and there was
24 a formal training programme in urology in the 80s, as
25 you know, and Mr. Graham was replaced by a general 10:50
26 surgeon and a urologist, Mr. O'Brien.
27
28 So, Mr. O'Brien would have introduced much more to the
29 overall wing of urology, moving on from the prostates

1 to the likes of bladder tumours and etc.
2
3 So it was then trying to -- and, again, in the 90s, the
4 only urology centre was at the Belfast City Hospital,
5 so probably one of the prime reasons why a unit in 10:51
6 Altnagelvin and in Craigavon opened up was that it was
7 observed that the Belfast service wasn't catering for
8 the whole of NI well enough, and that's why the other
9 places have opened up.
10 10:51
11 But when you have trained urologists going in, you're
12 going to introduce an awful lot more procedures and
13 care, and a lot of work came out of the woodwork, shall
14 we say. So when the GPs realised that a certain
15 condition could be treated more on a local basis, then 10:52
16 I feel that that's when there was an escalation in the
17 number of referrals in principle, and not just having
18 to be sent to Belfast.
19 51 Q. That development, that expansion of need, are you
20 saying -- and certainly you appear to be saying in your 10:52
21 correspondence that there was a slowness on the part of
22 the management, senior management, within the Trust to
23 recognise and resource -- recognise, first of all, and
24 then eventually it was recognised, but then to resource
25 all that came with it? 10:53
26 A. Yes. I don't think that they fully appreciated the
27 range of services that we could have offered. And when
28 the GPs learned about it, there was an increase in
29 volume and I don't think the Trust really had -- had

1 left us to get on with it, basically, but maybe not
2 appreciating the volume.
3 52 Q. Yes. And some of this is reflected in -- sorry, I cut
4 across you?
5 A. No, no, you haven't. 10:53
6 53 Q. Obliged. Some of this is, of course, reflected in the
7 correspondence between you and the Chief Executive, you
8 and the Medical Director in the early noughties. Let's
9 just pull up a few examples of that to illustrate the
10 point. WIT-052068... No, that may not be... That's it, 10:54
11 thank you (52068).
12
13 So you're writing 19th August 2002 to Dr. Liam
14 McCaughey, who was Medical Director at that time. Just
15 in the first paragraph, I suppose, it sets the tone. 10:55
16 You're saying that you have, in previous correspondence
17 and meeting:-
18
19 "...expressed grave concerns about the Trust's
20 provision of services to our urology population and 10:55
21 urology manpower. These two points are closely
22 interrelated, but they are two separate issues."
23
24 And you go on to expand upon that. Waiting times are
25 a big problem. And then in terms of impact on 10:55
26 manpower, you talk about the expectation in terms of
27 the work to be performed is currently far too
28 excessive.
29

1 Just let me go, maybe, to the last paragraph of the
2 letter. The Panel can read this in full, so I'm just
3 picking up on broad brushstrokes, I suppose:
4
5 "The Trust has been aware of our concerns for over one 10:56
6 year."
7
8 And you're saying:
9
10 "I doubt if the Trust has informed the Board of the 10:56
11 same. This may be appropriate in view of the eminent
12 plans."
13
14 "Imminent" plans, maybe.
15 10:56
16 "Since there has been little progress, I am referring
17 this issue back to the LMC..."
18
19 -- that's the local...?
20 10:56
21 A. This is the consultant sort of job pay, basically.
22 54 Q. Okay. So, I suppose this letter contains a flavour of
23 the concerns -- a degree of frustration that the Trust
24 isn't listening or isn't moving fast enough on those
25 two interrelated issues? 10:57
26 A. Correct.
27 55 Q. Just by way of another example, you write then to the
28 Chief Executive a year or so later, 17th
29 September 2023, and we'll find that letter at

1 WIT-52092. And if we just scroll down to the next
2 page, please, and just in the middle of the page, this
3 probably catches in a nutshell what you're saying:
4
5 "Since taking on the lead clinical role several years 10:58
6 ago, we all acknowledge that there were difficulties
7 and shortfalls in the ability to cope with the volume
8 of urological workload."
9
10 You say: 10:58
11
12 "I feel I have put a considerable amount of time and
13 effort into trying to address the urological issues
14 with a fair and logical approach."
15 10:58
16 First, you define the problems using data supplied by
17 the Trust, and, secondly, formats to supply urological
18 provision and national guidelines were presented as
19 a model to the hospital.
20 10:58
21 "Both these presentations were fully accepted by
22 yourself and the Medical Director earlier this year.
23 At this stage, you stated that you would give a written
24 indemnity to cover the urological service status. This
25 would appear to give full support, despite the known 10:59
26 difficulties.
27
28 On this premise, we have been working towards defining
29 an adequate and acceptable way forward."

1 But you say the goalposts have shifted and what
2 you thought, I think, was progress towards a third
3 consultant had not developed in the way that you
4 thought it should. And, at that point, it was decided
5 that there would be an external review. 10:59
6
7 So is it fair to say that progress was very slow?
8 A. Progress was made, but slowly.
9 56 Q. So the next stage, I suppose, was the McClinton review.
10 Mr. McClinton was a Scottish urologist? 11:00
11 A. Mr. McClinton was a senior urologist in Aberdeen, and
12 I knew Mr. McClinton well. He was an endourologist.
13 He was born in Northern Ireland, so he knew the set-up,
14 although I think he did all his training across the
15 water. So he -- and the other aspect to that was 11:00
16 I thought that the Scottish system would have been
17 fairly similar to the urology set-up here in Northern
18 Ireland, rather than what was based in London, for
19 instance.
20 57 Q. You, at WIT-51722, provide us with a summary. Just 11:01
21 scroll down, please, to 15.9. You provide us with
22 a summary of the findings of the review or its
23 recommendations. Let's just scroll down through them.
24 For example, at (c) it's proposed that there would be
25 increased use of available urology nurses. At (d), the 11:01
26 appointment of a third consultant urologist and
27 appropriate support staff. That's something,
28 I suppose, you'd been campaigning for for some number
29 of years?

1 A. Indeed.
2 58 Q. At (e), there is talk of a need to redesign and
3 modernise urology services, and, at (f), investment in
4 creating additional capacity, including inpatient bed
5 and day case capacity. 11:02
6
7 At (i), just moving down, the appointment of a fourth
8 consultant urologist and support staff appointment;
9 and, at (j), dedicated urology specialty nurses.
10 11:02
11 You go on in your statement and we can see in the
12 correspondence that you largely welcomed the
13 recommendations, but then, as we can see, for example,
14 at paragraph 15.21 of your statement, you talk about
15 inertia on the part of the Board and the Trust in terms 11:02
16 of the implementation of the review recommendations.
17 What happened? There was a locum consultant appointed,
18 is that right, and then Mr. Akhtar was appointed, but
19 you never got to a fourth consultant; is that fair?
20 A. I think the inertia referred to the McClinton report 11:03
21 came out in 2004, and we thought it would have been
22 faster, all of those (a) to (j), being at least started
23 on the process. But it took the Trust a while to get
24 the wheels in motion, as such.
25 11:03
26 In saying that, the wheels in motion was, maybe,
27 slightly larger than I was aware of at the time in that
28 they had the Aspen. This was to clear the backlog to
29 a certain degree and we had -- it's an Australian

1 surgical unit that was very mobile and they came to
2 South Tyrone and set up camp, basically, for a good
3 number of months and they tackled our outpatient --
4 sorry, tackled our inpatient surgical lists.
5 11:04
6 So that was going on in the background. And I thought
7 on the second vein that, for our service, that these
8 recommendations would have been started a little bit
9 faster, i.e. in 2004, rather than leaving it to the end
10 of 2005. Sorry, I was being impatient. I was hoping 11:05
11 that they would move faster.
12 59 Q. In concrete terms, what did the service get as a result
13 of the review?
14 A. Yes, okay, so engagement was part of our departmental
15 meetings on a Thursday. We set out to work through all 11:05
16 of the list. It was about redesigning and remodelling
17 what we were putting across. And we set up individual
18 outpatient clinics -- like, a prostate clinic,
19 haematuria clinic, andrology, female. So it was
20 a themed outpatient process. We were engaging with our 11:06
21 nurse specialists. These were senior nurses from the
22 ward. It would be a start to the CNS process,
23 basically.
24
25 So we were designing a nurse-led and also a GP with 11:06
26 specialist interest form of clinics. I was keen that
27 we had this under the one roof principle so that the
28 doctors and nurses were together. They could ask
29 questions -- if the nurses felt they needed a bit of

1 advice, there was a doctor on hand, and that was
2 important. That's where we got our -- we were
3 originally promised the Ramone building, which was part
4 of the main hospital, which would have catered for all
5 our needs, even until today, but there was a closure of 11:07
6 the Skins Department in Lurgan Hospital and they got
7 our space! But the Trust built us a big porta cabin,
8 if you want to put it that way, on the hospital site,
9 just specifically for us, and we named that Thorndale.
10 And it was a specific building just for us. And within 11:07
11 that, that's where we put our service.
12
13 This was a year ahead of the ICATS service that the
14 Department of Health were keen to move to. So ICATS is
15 integrated care. It was that bit between sort of GP 11:08
16 and the hospital site, to try to reduce the number of
17 hospital referrals. But certainly our sort of building
18 of this was just right up the alleyway off the ICATS
19 service and it led to it very, very well.
20 60 Q. Yes. Your answer suggests that although the service -- 11:08
21 although the demand for the service had grown too
22 quickly or quicker than the service could actually
23 respond to, the outworking of the McClinton review,
24 albeit rather tortuous and slower than you and perhaps
25 Mr. O'Brien would have liked, at least for the first 11:09
26 time, perhaps, put in place something that -- something
27 of a framework or foundations from which the Urology
28 Service could begin to thrive. Is that what
29 you thought at the time?

1 A. Yes, and our ICAT service was very good. It did have
2 an output. We had worked out our clinics and volume as
3 appropriate to the number of referrals coming in. And
4 at the same time the surgeon who had worked for Aspen
5 stayed on as -- we then advertised -- we took a third 11:10
6 position as a locum consultant, and that's where
7 Mr. Batstone came from. He had worked for the Aspen
8 team, he was English, and wanted to come home -- it
9 suited well! So he came as the third consultant, as
10 a locum to start with, and then we advertised the post 11:10
11 and Mr. Akhtar got that post.
12 61 Q. Yes, so that was three posts, not four, just to be
13 clear?
14 A. Absolutely. It was three posts. I know that
15 Mr. McClinton here had recommended a fourth post by 11:10
16 2007, but we only got the three posts.
17 62 Q. Yes. Let me move to the regional review. The regional
18 review came in 2009 and, ultimately, I suppose, the
19 headline is it proposed a three-team model, and Team
20 South was to be centred in Craigavon with 11:11
21 responsibility for a population of 410,000, spreading
22 out to Newry and further afield into Fermanagh. Let's
23 look at that briefly.
24
25 You set out at WIT-51699, at paragraph 9.3, some of the 11:11
26 key recommendations. You, just scrolling through those
27 -- I suppose, the headline, again, was the expansion of
28 the service at Craigavon in terms of the number of
29 clinicians who would be employed there. How did that

1 process work out and what was your role in it?
2 A. My role in?
3 63 Q. Your role -- after the review, you took a position in
4 the project steering group for the purposes of
5 implementing the review; isn't that right? 11:12
6 A. Yeah, that's correct. Right, okay. Yes, after the
7 review, they had set out, I think, 21 things to get
8 through and the Trust worked through these
9 implementations. And, as you say, one of these related
10 to the number of new consultants. Our issue there was 11:13
11 a resource issue -- where were they going to be
12 working, number of theatre spaces, day surgery, and
13 clinics. We had to do a fair amount of work to try to
14 make that fit. It got to the stage where we were
15 looking at a three-session day -- morning, afternoon 11:13
16 and evening theatre lists. We only had the one
17 theatre, Theatre 4, sort of allocated to urology, and
18 I was trying to squeeze as much out of that as
19 we possibly could.
20 64 Q. Just on that, and one of the themes that we'll move on 11:14
21 to look at in a moment is the ability of this service
22 to deal with the demand. Given, I suppose, the
23 infrastructural constraints at Craigavon and, indeed,
24 even taking into account some of the sort of satellite
25 hospitals, given the difficulties of recruitment and 11:14
26 that kind of thing, was this proposal, which was
27 implemented for a Team South, excessively ambitious
28 with the benefit of hindsight?
29 A. No, I don't think it was ambitious. It was a good

1 master plan. It took time for us to work through it
2 all and the employment of the extra surgeons took time.
3 There is no doubt about that. There is an original
4 sign-off in 2011, I believe, but, yet, the time it took
5 to get to advertising posts, to have them interviewed, 11:15
6 and then for who we employed to take up post, you know,
7 took right through 'til 2013, I believe.
8 65 Q. Yes, interviews appointed three consultants in late
9 2012 and it was into 2013 --
10 A. -- 2013 that they actually came to work. So there was 11:15
11 a void there of several years. And in the middle of
12 that, I think Mr. Akhtar moved at one stage, so we were
13 actually back down to two.
14 66 Q. Yes. You say in your statement that -- this is
15 paragraph 10.9, if we can go back to that -- but, to 11:16
16 summarise, you're saying that the process didn't
17 achieve its aims and, here, you're pointing to -- I'm
18 just bringing you to the page -- the process didn't
19 achieve its aims, at least, it seems to be, in the
20 short-term in that the roll-out was slow, understaffing 11:16
21 in the unit in medical terms, and as well on the
22 nursing side?
23 A. Yes.
24 67 Q. Is that meaning to suggest that in the short-term
25 it didn't achieve its aims, or are you broadening it 11:17
26 beyond that?
27 A. No, it's very much in the short-term. So we had spent
28 time working through our theatre list allocation. We
29 were looking at our day surgery facilities -- our

1 outpatient facility, as I mentioned, was Thorndale --
2 the principle being all being under the one roof.
3 There was a fair amount of discussion with the higher
4 authorities in that we had a pathway that we wanted to
5 go down in how we delivered the Urology Outpatient 11:17
6 Service. As I say, we had the experience of the ICAT
7 service before hand -- nurse-led, doctor-led, and
8 investigations. I did spend a lot of time with the
9 team then and drew up a second outpatient facility, now
10 named Thorndale Mark II, but it was really trying to 11:18
11 define the amount of work that needed to be done, the
12 number of rooms required to make that happen. I had
13 several sort of master plans, from a very
14 straightforward outpatient design to one that was,
15 well, had all singing and dancing activity in it with 11:18
16 outpatients' rooms, consultants' and secretaries' rooms
17 all in the one area so, you know, you're all under the
18 one roof principle. And we sort of settled for
19 something in the middle, which is our Thorndale
20 Mark II. And when I learned that they were accepting 11:19
21 what I was trying to put across, I sort of knew that we
22 were heading in the right direction. It's right next
23 to this orthopaedic suite, so I think it all got built
24 at the same time.
25 11:19
26 So we had worked out how many rooms we needed, and
27 we got how many rooms we needed, and that was built
28 around this time and it's still our facility at the
29 moment that we work from. So there's five consulting

1 rooms and then two investigative rooms. One was for
2 flexible cystoscopies and urodynamics, and the other
3 one was an ultrasound room. And our clinic design at
4 the beginning was that you could come to a clinic and
5 have an ultrasound or your TRUS prostate biopsy on the 11:20
6 same sitting, but it was all under the one room -- the
7 one floor space.
8 68 Q. Yes?
9 A. So that took time to put across, it took time to build,
10 but it's what runs currently. 11:20
11 69 Q. Yes, but at 10.6 you make the point, if we just scroll
12 back, that in terms of the plan to centralise services
13 at Team South for this population, that there was an
14 overestimation of the actual workload that was
15 possible. Has that been, I suppose, a design fault 11:21
16 that has permeated the service since the attempt to
17 implement this back in 2014, and in part explains why
18 the service has been forever chasing its tail in being
19 able to meet demand?
20 A. Yes. These were my -- these were my sort of 11:21
21 calculations of what was needed. At this time, the
22 Department of Health had a S.A.B.A; it was a contract
23 of a volume of work that you were meant to get through.
24 And I sort of knew that the way our clinics were, that
25 we would never be able to attain that level. And 11:22
26 I felt that we were still short of what we were able to
27 provide. And, on top of this, there was still
28 a backlog. So we were never starting with a clean
29 slate. We were always, as you say, we were always

1 chasing our tail. But we were chasing our tail on two
2 fronts -- one, that there was already a backlog there
3 and I felt that, maybe, we were -- that the expectation
4 of what we were trying to put across was still going to
5 fall short of the mark. 11:23
6 70 Q. There was a stock taking in or about 2014 that looked
7 at how the service had fared since the implementation
8 of the internal review recommendations. And, as you
9 point out, some of the recommendations were only just
10 freshly implemented so, by the time of the stock take, 11:23
11 the additional consultants had just come into place.
12 Some of them, Dr. Connolly and I think Mr. Pahuja,
13 didn't stay very long and they were replaced,
14 ultimately, with Mr. Haynes coming in and
15 Mr. O'Donoghue coming in? 11:24
16 A. So here we have a service that was starting -- new
17 blood come in, new blood leaves very quickly. So,
18 again, we were on the back foot fairly consistently and
19 still stuck with three consultants. It was only then
20 when, as I say, when Mr. O'Donoghue and Mr. Haynes 11:24
21 arrived that the service has been stable at that
22 number. So we were short of consultants.
23 71 Q. Yes. And it was your sense, I think, as reflected in
24 your statement, that really the Trust was much too
25 slow, for whatever reasons, to make the necessary 11:25
26 recruitments?
27 A. There's potentially two angles to that. One, there's
28 a slowness in the Trust to re-advertise a post. They
29 always wait until somebody leaves before they

1 advertise, instead of when somebody hands in their
2 notice that you would expect maybe an advertisement
3 goes out at that stage. So there's always a delay
4 between somebody leaving -- or there's a delay between
5 somebody saying they're leaving and somebody arriving, 11:25
6 and that's been extended.
7
8 Our issues have also been in recruiting people. We
9 have had advertisements go out and have either had no
10 applicants or applicants that were not at a level that 11:26
11 we would have wanted.
12 72 Q. I think you make the point, this is at paragraph 16.3
13 of your statement, at WIT-51728, that from -- it was
14 only at August 2014 that -- this is paragraph 16.3 --
15 it was only from August 2014 that you had a complement 11:26
16 of six consultant urologists. But then Mr. Suresh left
17 in October 2016, so that there's only been a brief
18 period throughout the last ten years or so when the
19 service has had its full complement of, I suppose,
20 tenured as opposed to locum consultants in place? 11:27
21 A. I think you could count that length of time in months!
22 73 Q. And, more seriously, what have been the consequences of
23 that or the implications of that in that period of time
24 for the service?
25 A. Well, if you don't have a consultant there, you're not 11:27
26 going to have output. That consultant's work is then
27 moved to the other consultants to take on board,
28 potentially. So there is ever-increasing demand.
29 I mean, each year goes by that there's increasing

1 referrals done to the system, but, yet, the people that
2 are offering the output are predominantly surgeons and,
3 if somebody leaves, somebody else either has to -- has
4 to pick up that slack. That slack has been picked up
5 from an emergency perspective, but not on the elective 11:28
6 side. So our emergency inpatient work would have been
7 covered, but the increasing demand was not getting --
8 I think it's fair to say that all the consultants work
9 very hard. All of their clinics are full. Our
10 theatres are full to as maximum as we can. Maybe, 11:29
11 coming back to my sort of monthly rota plan is that,
12 during that -- we have a meeting once a month to
13 actually cover the rota for the month that I mentioned
14 earlier and, at that meeting, although there's a basic
15 plan for the months laid out, we then would have to 11:29
16 find the spare slots. In other words, if somebody was
17 on leave, somebody was on call, their theatre list
18 would be free, in theory, and we then, as a team,
19 instead of letting those theatre lists go, we would
20 shift our own workload around to take up that slack. 11:30
21 It may have meant that we dropped something else or
22 we moved our SPA to a different time, but the team were
23 there and maxed as much of the theatre space as
24 possible. But, yet, it's hard to sort of keep up with
25 the extra work coming through. 11:30
26 74 Q. Could I, just before we break, look at two other points
27 around staffing? It wasn't just the consultant grade,
28 it was the staff grade as well where there were
29 difficulties. You, I think, helpfully created

1 a table -- I think it was your work -- at WIT-52261 --
2 which sets out, I think, pretty -- was that your work?
3 Maybe not. It sets out, in any event, fairly
4 consistent or persistent vacancies from 2009
5 through 2022, although some improvement, it seems from 11:31
6 around about 2018. Can you briefly speak to what this
7 is telling us in terms of vacancies and the
8 implications of a shortfall in the staff grade?
9 A. Okay, so our Outpatient service, our ICAT service we
10 were talking about that works in Thorndale were run by 11:32
11 our clinical nurse specialists and staff grades.
12 Dr. Rogers there, you see on the top line, he was a GP
13 with a specialist interest in urology. We then had
14 a series of staff grades, as you see, from 10, 11 and
15 12 there. They were primarily to help in the 11:32
16 outpatient arena and they would have had clinics on
17 their own, obviously under our wing and supervised,
18 but, you know, they were having an output. They would
19 have helped out with the flexible cystoscopy lists etc.
20 11:33
21 So those clinics are all set up and would be sort of
22 running for a year, and if they were coming and going,
23 there was nobody to fill the void. It was at a level
24 at that stage that our nurse specialists wouldn't have
25 been at that precise level to have covered the area. 11:33
26 So this was a distinct void of sort of clinic output.
27 75 Q. There was also a gap in the nurse specialist number for
28 a considerable period of time, it seems. I think the
29 target was, arising out of the various reviews, was to

1 reach five, but that number wasn't achieved until in or
2 around 2019/2020?
3 A. Yes, I think this was an employment thing. I don't
4 think it was a turnover of staff, it was the
5 advertisements and employment and the ability to 11:34
6 recruit into the post became a challenge. So, all in
7 all, our sort of middle grades and our nursing volume,
8 there was a significant void there for a five-year
9 period, say.
10 76 Q. Another feature impacting or causing a difficulty in 11:34
11 the service's ability to impact on demand was theatre
12 availability?
13 A. Theatre availability is on two fronts. One, there are
14 only so many theatres in Craigavon, of which we are
15 assigned to one. And if, say, there's six consultants 11:35
16 trying to share all that, that's -- we're all
17 scrambling for the same space is number one.
18
19 The second impact is the winter pressures and the
20 staffing. The nursing staffing facility had a high 11:35
21 turnover as well, more from people retiring. So our
22 winter pressures, for instance, just to give an example
23 is not just closing down at Christmas time because the
24 hospital is full. I mean, our winter pressures were
25 getting as far as April at one stage, where there was 11:36
26 a 30% cut in the theatre list allocation. Now, that's
27 a substantial amount of lists that are being cancelled.
28 MR. WOLFE KC: Yes. I think, with the Chair's leave,
29 we'll maybe take a break now? We'll return then and

1 look in a little more depth at the consequences of the
2 implications of the context that you've just painted
3 and what staff sought to do about it and its impact on
4 staff. So we'll take that up after the break.
5 CHAIR: Okay, we'll come back, ladies and gentlemen, at 11:37
6 five to twelve.
7
8 THE INQUIRY ADJOURNED BRIEFLY AND THEN RESUMED, AS
9 FOLLOWS
10 11:37
11 CHAIR: Thank you, everyone.
12 77 Q. MR. WOLFE KC: So, Mr. Young, you've painted a picture
13 very clearly of, I suppose, the resource deficit,
14 particularly in terms of staff, across consultant staff
15 grade, as well as nursing, married with resource 11:55
16 difficulties to some extent, in any event, in terms of
17 theatre provision.
18
19 You say in your statement on a number of occasions
20 that, in essence -- if we could, perhaps, pull up 11:56
21 paragraph 16.6 at WIT-51729 by way of example of -- so
22 you're saying that this shortfall in the expected
23 numbers of consultants results in a deficit of
24 provision in overall output of FCE. Does that stand
25 for "Finished Consultant Episode"? 11:56
26 A. Correct.
27 78 Q. And is the period of continuous care provided to an
28 admitted patient with one consultant as the healthcare
29 provider?

1 A. Yes.
2 79 Q. So that's one of the deficits. It has led, as you
3 explained here, to outpatient elective surgery episodes
4 and hindered target achievement potential. You go on
5 to describe reduced productivity, disjointed patient 11:57
6 care, new personalities having to be engaged and
7 integrated and learn the systems.
8
9 Elsewhere in your statement -- for example,
10 paragraph 17.4, if we could just scroll down -- that 11:57
11 the shortfall in consultant number, this is WIT-51732,
12 the shortfall in consultant numbers have had
13 a significant impact in terms of backlog and that has
14 never been adequately addressed, either by the Trust or
15 the Department. And the consequence of this is both in 11:58
16 terms of volume, that is the overall number of patients
17 needing to be seen, and the timeliness with which you
18 can reach those patients. And then this log-jam effect
19 you describe as having an impact in terms of hidden --
20 you say hidden oncology, but, more generally, there's 11:58
21 a hidden pathology across all categories of patient?
22 A. Yes.
23 80 Q. Indeed, I think, as we'll see in a moment, the
24 priority, perhaps necessarily, had to be given to
25 oncology patients, and it was the other patients who 11:59
26 couldn't be treated as urgently or policy dictated
27 wouldn't be treated as urgently where the real concern,
28 perhaps, existed?
29 A. Our system is a red flag, urgent, routine. Obviously,

1 the red flag refers to the oncology workload. It would
2 come to the top of the list of being treated, at the
3 expense of what's classified as routine. Routine would
4 be the benign side of the fence. And, in urology, the
5 actual risk of infection is high and men with catheters 12:00
6 in, stones, still classified as routine or urgent, are
7 left to a certain degree at the expense of the oncology
8 work.
9 81 Q. Obviously, I hope, it is the responsibility of the
10 Department, the Commissioner and the Trust 12:00
11 collaborating to provide the resources so that you
12 could, as clinicians, deliver as against the demand
13 that you were facing. Did you get a sense as clinical
14 lead or simply wearing your consultant's hat as to what
15 was being done to meet the demand that was clearly 12:01
16 reflected in the waiting lists across all of the
17 indices? And we previously opened those waiting lists
18 and I don't think we need to do it again today. What
19 was your sense of what was going on to assist you
20 clinicians to deliver an adequate service? 12:01
21 A. Well, if we -- there's going to be inpatient, but
22 there's going to be -- there's going to be theatre
23 cases and there's going to be outpatient work, okay.
24 There was always going to be difficulty finding extra
25 theatres. To buy a theatre costs millions of pounds. 12:02
26 That wasn't going to be an option, particularly. The
27 Trust did do waiting list initiatives where we would
28 have maybe not so much had lists in the evening time,
29 but there were lists on Saturdays. They employed the

1 independent sector to take on extra work as waiting
2 lists, but again this was ad hoc, dependent on
3 a financial budget to pay for it. It didn't run on
4 a regular basis and, as I say, it was on an ad hoc
5 account. Same for outpatients. 12:02
6
7 I think most of the work in previous times was looking
8 at the theatre lists, as opposed to the outpatient
9 list. In more recent times, the independent sector has
10 been brought in to look after the outpatient arena, 12:03
11 but, again, that's, from my knowledge, only of a recent
12 event and is more consistent, whereas before it had
13 been all very much ad hoc -- going back to this 2015
14 area.
15 82 Q. Yes. Given this context where, as a group of senior 12:03
16 clinicians, you are recognising that there are a large
17 number of patients in your constituency in the local
18 populace who are realistically not going to be seen for
19 a long period of time if nothing changes and that
20 creates morbidity, inevitably hidden, perhaps, because 12:04
21 until they present as an emergency in extremis -- was
22 this creating real-world dilemmas for you as a team of
23 urologists or, indeed, in your individual practice?
24 A. It will have been in all our practices. We all have
25 a general urology interest, so we will be looking after 12:04
26 all the patients on our waiting lists. This level of
27 waiting list length, both in volume and in time, is
28 certainly -- was, certainly, known to the Trust and the
29 Department of Health. They had been told. I mean, the

1 figures are on paper that they collect themselves. So
2 it doesn't take us to tell them the volume. The actual
3 nature of the outcome of that is that patients that
4 were of a routine nature were then coming in on an
5 emergency list, as such, and were being looked after 12:05
6 that way, and, with that, an emergency admission takes
7 much longer to look after in terms of time than an
8 elective case that might have been done as a day case.
9 So there was a bed occupancy effect with that elective
10 lot of patients now becoming emergencies and taking 12:06
11 longer to address. So it all had a knock-on effect.
12 83 Q. In terms of your own practice, were you often thinking
13 or sometimes thinking, "Well, I could mitigate the risk
14 by doing X, but that's going to have an impact on my
15 ability to do Y in terms of my responsibilities that 12:06
16 generally fall within my practice and, therefore, I'll
17 prioritise X but it's going to lead to slippage in
18 aspects of my other work" -- was that a dilemma that
19 ever confronted you?
20 A. That confronts you all the time, yes. Choosing your 12:07
21 cases for a theatre list, if you're from -- for
22 instance, from my perspective, from stones, I'm going
23 to try to choose patients that I identify are at higher
24 risk than another group. But knowing that the other
25 group is also still at risk, you have to do a bit of 12:07
26 juggling. So I may do three or four ureteroscopies as
27 opposed to doing one sort of PCNL, which is -- which
28 takes -- I mean, sorry, a PCNL is a stone that involves
29 the whole of the kidney. And, also, we know that that

1 group of patients are at increased risk of loss of
2 kidney if it's left for an excessive period of time.
3 But I would have had to sort of balance that up against
4 a stone that's in a ureter that's causing obstruction
5 that is higher risk of causing a septic episode, coming 12:08
6 in as an emergency, potentially needing to go to ICU.
7
8 So, yes, we would have had to choose. A man who has
9 a catheter in -- again, increased risk of sepsis --
10 you're more likely to give him a date above somebody 12:09
11 that still needs the same operation but is not having
12 a catheter in. So, yes, there is an element of having
13 to pick and choose, and definitely an onus on us to be
14 sort of making that choice. Is that the question
15 you're asking? 12:09
16 84 Q. Yes. And is there another element to it as well, or
17 perhaps not, in, for example, volunteering to
18 participate in a waiting list initiatives or doing more
19 theatre sessions --
20 A. Oh, right, okay. 12:09
21 85 Q. Would that potentially impact, for example, on your
22 ability to progress the administrative side of your
23 practice and lead you to not doing it or delaying in
24 doing it?
25 A. By -- sorry, I don't... 12:10
26 86 Q. So, there's only so many hours in a day. You have your
27 standard work plan --
28 A. Right, okay. Yes, sorry, I understand now.
29 87 Q. Sorry.

1 A. Okay. Yes, coming back to that business of running the
2 rota, we try to max out as much as we could of theatre
3 space, so you would take that up. That time that you
4 are taking it up, you are then offloading to
5 a different time. So, yes, it adds, undoubtedly, to 12:10
6 the work that you do Monday to Sunday. So, yes.
7 88 Q. Take, for example, Mr. O'Brien. I understand that
8 between 2012 and 2016, he performed 112 additional
9 elective operating sessions over and above what would,
10 I suppose, be expected of him. Would that -- would you 12:11
11 recognise that there's almost an inevitability in
12 prioritising those patients in order to, perhaps,
13 mitigate the risk of them becoming more unwell, and
14 perhaps they're unwell already, that that will
15 inevitably impact on the performance of other duties? 12:11
16 A. When you take on these extra time slots, it's clearly
17 done that you can cope with doing the extra. For
18 instance, you were talking about a waiting list
19 initiative on a Saturday -- this is all about your
20 choice of whether you want to or can do. But this is 12:12
21 in addition to what you do; it is not to displace what
22 you were already assigned to do.
23
24 Maybe just following on that exact point and coming
25 back to the rota that we were talking about -- sorry, 12:12
26 I know I'm talking about the rota a fair wee bit, but
27 it's quite important, this meeting. For instance, if
28 we knew that somebody was on leave or on-call and their
29 theatre lists were free, when going through all of

1 this, if I had observed that somebody was trying to
2 take on too much, then I would have politely said,
3 "I think you're doing too much" -- and specifically you
4 comment Mr. O'Brien here -- he would say that,
5 "Look, I would like to do this extra -- extra, extra" 12:13
6 and on several occasions I've said, "Look, Aidan,
7 I think you're trying to cover too much this week" and
8 I would give it to somebody else. So, you know --
9 89 Q. That was your role as clinical lead trying to get
10 a sense of all of these moving parts and -- 12:13
11 A. It's very much trying to get all the cogs lined up.
12 But, you know, if I saw somebody was -- and the Trust
13 gave out these extra lists or extra sessions, but they
14 were asking, they weren't telling. So, you know, they
15 would say, "Look, here's an extra list, can anybody 12:14
16 take it?". It wasn't sort of saying, "Right, here
17 we are, we're going to divvy all these out between..."
18 -- that's not the approach that they got. So they --
19 the Trust said "Here's extra -- do you want to do it?",
20 it's up to you whether you wanted to do it or not. And 12:14
21 then, even within that, if it was at the departmental
22 meeting, if I had seen somebody was trying to do too
23 much, I would say "I don't think that's a good idea."
24 90 Q. So, to summarise it, you appear to be saying that it`s
25 implicit and sometimes made explicit in the transaction 12:15
26 or the conversation around the extra work that you are
27 accepting it on the basis that you will be able to
28 manage the other aspects of your practice that still
29 need to be done and to manage it in a timely fashion?

1 A. Yes.
2 91 Q. Briefly, it appears that -- we looked at a couple of
3 examples just now -- that the staff of consultant and
4 nursing, and no doubt others, were not afraid of making
5 noise and drawing attention to the imperfections of the 12:15
6 system and its impact on the safe delivery of care and
7 its impact on patients; is that something you found
8 yourself giving voice to or did you leave that to
9 others?
10 A. I think we all contributed to the same conversation. 12:16
11 92 Q. Mr. Haynes, for example, if we briefly look at a piece
12 of correspondence from him, AOB-01811 -- here, he is
13 writing to the Director of Acute Services,
14 Mrs. Gishkori, in May 2018. In essence, it's an
15 expression of concern that serious patient safety 12:17
16 issues are flaring in the Urology Department,
17 particularly in terms of the resource available for
18 inpatient theatre waiting lists. And he makes the
19 point in the third paragraph there that it is the
20 clinically urgent cases that are at a significant risk 12:17
21 as a result of ongoing -- primarily ongoing reduction
22 in elective capacity.
23
24 He was to write subsequently to yourselves as a group
25 of urologists suggesting -- this is in October 2019 -- 12:17
26 suggesting the completion and submission of IR1 forms
27 for any patient who has waited for an excessive period
28 of time.
29

1 Did you have any sense that the Trust were approaching
2 these issues -- and maybe it was a responsibility that
3 goes beyond the Trust, but primarily the Trust because
4 they were the deliverer of the service, but was there
5 any sense that the Trust had a plan or a framework that 12:18
6 focused on the issues that you and your colleagues were
7 bringing to them, or was it, just to complete the
8 sentence, was it very much piecemeal or a band-aid
9 approach in the sense of waiting list initiatives every
10 so often, that kind of thing? 12:18
11 A. It's that kind of thing. It's the Trust were aware of
12 this, they were aware of the downturn in the sort of
13 theatre capacity. I mean, there's the 30% I mentioned
14 earlier. I think they didn't know how to cope with
15 that because the Trust was already running at maximum 12:19
16 efficiency, as far as they could see. They/we were
17 thinking of alternative ways to try to address the
18 issue. It's not that they were trying to sweep it
19 under the carpet, if you want to put it that way.
20 I think the Trust were aware of the level of concern, 12:19
21 both from us saying it and them seeing the actual
22 numbers. But it was how do you address the problem?
23 And, again, that maybe comes full circle to the sort of
24 waiting list initiatives and thought processes of how
25 this can be done or tackled, shall we say. And I think 12:20
26 the options of outsourcing the problem was the line to
27 be taking, rather than the investment in the service.
28 But investment in the service comes from higher up than
29 the Trust itself. That is, undoubtedly, a Department

1 of Health problem. If we need extra theatre space, the
2 Trust isn't going to build the extra theatre space.
3 It's going to be at a much higher level than the Trust
4 to be able to supply that.
5 12:21
6 I think our figures -- I mean, everybody will talk
7 about theatre utilisation percentages and I feel ours
8 are pretty good. I mean, it's never going to be 100%,
9 but we've undoubtedly tried to use every spare minute
10 that we have to provide, but, yet, still, the "in" is 12:21
11 vastly better than the "outs", I'm afraid. So there's
12 just not enough floor space or theatre time to do that.
13 Is that what you're asking?
14 93 Q. Yes. And I suppose it crystallises in your statement
15 where you say that this shortfall has never been 12:22
16 adequately addressed by the Trust or the Department --
17 A. Can I maybe just answer that a little bit? Again,
18 there has been the backlog and what you have existing.
19 So, if you, again, have a clean slate and run an
20 efficient service, you know, it's going to appear much 12:22
21 better. But, again, with an inherited backlog of
22 patients that then become sick and take longer to do,
23 it's not just adding to the equation, it is multiplying
24 the time required to look after it.
25 94 Q. I'm interested in your thoughts in relation to those 12:22
26 patients languishing on waiting lists. Your statement
27 speaks to the hidden morbidity. These patients
28 eventually, in some cases, come in *in extremis* and, as
29 you've said, that's much more difficult and

1 time-consuming to manage as compared with addressing
2 their needs in a more timely fashion before the
3 emergency happens --
4 A. Yeah.
5 95 Q. Was there any active initiative to, if you like, keep 12:23
6 an eye on those patients before it became an emergency,
7 or were no such initiatives conceived?
8 A. I don't think there was any initiatives actively
9 targeting them, although there were initiatives to --
10 sorry, on a global term. There were initiatives for 12:24
11 patients who had a catheter in to be outsourced to the
12 independent sector. So, "yes" to that part of the
13 equation. So there was specific targets and, again,
14 ad hoc. So, yes, there were some targets, but not --
15 there wasn't an active role in reviewing everybody. 12:24
16 There's a problem there. Are you going to review
17 somebody or are you going to see a new patient who also
18 has an active problem? So they all have an active
19 problem. The new patients being referred in and
20 a review patient, they all... 12:25
21 96 Q. Yes. As you say in your statement, life within this
22 Urology Department has, I think you say, always been --
23 your words -- "an uphill struggle" and "Change has been
24 slow and underfunded" and that's set out in
25 paragraph 76.1 of your statement. But I think within 12:25
26 your statement it's only fair to point out that there
27 had been positive developments. It's not all doom and
28 gloom?!
29 A. Yeah!

1 97 Q. You say, if we go to paragraph 39 of your statement --
2 so it's WIT-51765. So you set out in paragraph 39
3 a number of, I suppose, the more significant
4 developments which helped to modernise and, I suppose,
5 make more proactive the Urology Service and exploited 12:27
6 those valuable human resources that were available to
7 you, particularly on the nursing side, but not
8 exclusively so. In particular, you refer to the
9 one-stop clinic principle. I'm not sure if I see it
10 there -- yes, of course. And that's assisted with 12:27
11 presumably bringing timely interventions and also
12 quality interventions to patients in need?
13 A. Okay, now, this comes back to our Thorndale unit and
14 our building a urology ambulatory unit. As I say,
15 we had experience of this with the original ICATS 12:28
16 service, which was a small building. You know,
17 we needed the extra floor space. Again, appreciating
18 our small numbers of team members, the importance of
19 having them all under the one roof, making people's
20 time efficient, having a doctor/nurse term available, 12:28
21 rather than trying to go and find somebody -- you know,
22 you're all in the one unit and you can ask a question
23 quickly. It's taken time to get our nursing staff up,
24 as you say, to a high standard from a CNS point of view
25 -- before they would have helped out at a prostate 12:29
26 clinic, and now the CNSs are doing the biopsies. But
27 having the safety net of them being in the same arena
28 and floor space as everybody else around, it made them
29 feel safe that they were doing it, from their aspect.

1 And from our aspect as the clinician, we felt safe that
2 we were nearby if they needed to ask us something.
3
4 So the one-stop clinic principle is the advanced
5 version of the old ICATS service, in principle. So we 12:29
6 were, again, trying to get the maximum from the people
7 that were available, albeit small numbers, but getting
8 them trained up to such a level that allows everybody
9 else to do something else. So we were being on an
10 initiative ourselves, telling the Trust this is a good 12:30
11 way to go. Same as the Urologist of the Week -- the
12 principle of that was to come out of sort of daytime
13 work to be on call to do the ward round. It took a
14 little bit of time to, maybe, persuade the Trust that
15 the Urologist of the Week was a good idea because 12:30
16 they didn't see clinical output! But the sell point
17 there was if a consultant was doing the ward round, it
18 was more efficient in bed turnover, for instance. So
19 trying to make beds so that somebody else could come
20 into it. 12:31
21
22 But coming back to the one-stop clinic here, it's that
23 it's meant to be one stop. The person coming into the
24 clinic is being seen by the team, which could be the
25 consultant or the nurse, and in the Thorndale, as 12:31
26 I said, there were two rooms; one was for urodynamics
27 and flexible cystoscopies and the other room was an
28 ultrasound room. So, on the day, the patient would be
29 seen, would have an ultrasound, could have a flexible

1 cystoscopy, and investigations -- potentially see
2 a nurse as well and for a follow-up. So there was
3 a plan -- at some of the clinics, the patients could
4 have had their TRUS prostate biopsies at the same
5 sitting. So we were trying to be as efficient with the 12:32
6 throughput as possible.
7 98 Q. Your statement also charts positively the developments
8 around stone work, which, obviously, you have
9 a particular interest in, so that Craigavon has emerged
10 as the regional centre for ESWL stone therapies. 12:32
11 A. Yeah.
12 99 Q. And the particular importance of specialist nurses in
13 that context?
14 A. Yes, again, I've run the stone service -- it opened
15 September 11th, 1998, and when I arrived there was four 12:33
16 grey walls and a big box in the corner, and I said,
17 "Right, here's what you want to do with this space."
18 So the space was for our ESWL machine, but I had a
19 clinical space where I ran a clinic at the same time.
20 Again, it was a one-stop clinic right from the word go. 12:33
21 So, again, we had a clinic, a nurse, an
22 ultrasonographer, and the principle ran well for the
23 volume that we had originally.
24
25 As time went by, the volume increased and I realised 12:34
26 I wasn't keeping up to speed with the volume. So
27 we embarked on a fresh start and looked at all the
28 various aspects of a patient coming with stones all the
29 way through, and we redesigned the process. Now,

1 again, that, for the first decade or so, was me, but
2 with the investment of extra staff members, has been an
3 absolute must. We have a staff grade for the service
4 and a clinical nurse specialist all working in the
5 system. So, as I say, we had taken the stone 12:34
6 department apart and have sort of rebuilt the process,
7 and now we have a stone MDT -- well, it's a stone
8 meeting, to be precise, and it runs on a weekly basis.
9 And all the patients -- where we had patients waiting
10 weeks to be seen, now they're all discussed on a weekly 12:35
11 basis.
12
13 There's always a bit of give and take in this in that
14 my stone outpatients, to start with, it was patient in
15 front of you, going through all the options on a verbal 12:35
16 basis and the information -- the nurse was there, the
17 radiographer was there, but it took so long. Whereas,
18 now, to improve the thing, it's that our stone meeting
19 is, basically, all the team discussing cases and the
20 patients have a letter, basically, informing them. But 12:36
21 it has speeded up the process.
22 100 Q. I suppose another development that one can see being
23 explained through your statement is, I suppose, the
24 expansion, and stones being one example, the expansion
25 of the nursing expertise and the embracing of nursing 12:36
26 within Urology Service -- perhaps it's the wrong word,
27 but the greater professionalisation or expansion of
28 nursing?
29 A. Yes. Taking two examples here, (1) is outpatients in

1 Thorndale, and (2) is at our stone meeting -- I've
2 always had a staff nurse at the level -- a staff nurse
3 at the stone meeting, but it was very much from
4 a nursing perspective of dealing with the patient,
5 doing bloods -- whereas, now, moving on with the higher 12:37
6 grades from a CNS point of view is that a lot of review
7 patients are coming back to our nurse-led clinic for
8 a certain sort of level of stone follow-up, which then
9 has given the consultant more time to spend on -- and,
10 again, on a timely basis -- to get the patient seen of 12:37
11 the more complex, the more sort of complex cases.
12 101 Q. You explain in your statement -- maybe, if we pick up
13 WIT-51743 -- at 26.1, you describe an ethos within the
14 Urology Service which has been to encourage nurse
15 training in the advancement of their careers. And you 12:38
16 go on at 26.2 to say that -- I suppose, an approximate
17 distinction -- there are two groups of specialist
18 nurses, one on the cancer side, the specialist cancer
19 nurse, and, on the other side, a specialist urological
20 nurse, with a little overlap, as you put it. In terms 12:38
21 of your involvement or engagement on the cancer nurse
22 side, you explain, if we just scroll down, at 26.3,
23 that your own clinic for oncology patients -- and just
24 to put a date on that, is that a clinic for oncology
25 patients that you continue to maintain even after you 12:39
26 cease to become a formal member of the MDT?
27 A. Yes. I have a review clinic -- well, it was Friday
28 afternoon. And that review clinic -- my actual set-up
29 is a new patient clinic. It's all new patients.

1 I have a stone patient list, all stones -- that's
2 second. And the third was a review clinic. And my
3 review clinic involved standard review patients. It
4 had two to three urodynamics patients on it. And then
5 there would be an oncology review component and also 12:40
6 any, as my secretary calls it, protected slots for the
7 oncology patients discussed at the MDT.
8 102 Q. Yes. And picking up on that within your statement --
9 so MDT on Thursday. If one of your patients is
10 discussed, he or she will come to you on the Friday or 12:40
11 perhaps the following Friday by the time you get
12 correspondence out?
13 A. Yeah.
14 103 Q. It's the involvement of the cancer nurse specialist
15 that we're interested in now -- 12:41
16 A. Oh, right.
17 104 Q. -- and you describe that here. If the oncology cancer
18 nurse specialist was not available due to work
19 rostering or leave, then a senior staff nurse took over
20 this role. If the CNS was not available, the patients 12:41
21 were given contact details and vice versa. And then
22 you go on to say that with the employment of additional
23 CNS staff in the recent years, there has been
24 a significant improvement in the provision of oncology
25 CNS to cover clinics. And the CNS would work in 12:41
26 partnership with yourself and, if they are not
27 physically in the room with you at the time of the
28 consultation, then you specifically ask for their
29 presence at the end of the consultation, and you

1 explain why.

2

3 What is the importance from your perspective in terms
4 of practising this way with direct, I suppose,
5 involvement of the CNS with the patient at the same 12:42
6 time as consultation, if circumstances permit?
7 A. Yes, now, as I say, my clinic was on a Friday
8 afternoon. The CNS cover wasn't full. And I had Nurse
9 Campbell, who was a senior nurse sister in the
10 Outpatients, and she would be running the clinic at the 12:42
11 same time and, generally speaking, didn't have time to
12 be in the room with me for the full consultation. But
13 I found, actually, that this worked well because I had
14 the opportunity to go over the patient's information
15 twice. So I consulted with the patient and then, at 12:43
16 the end of that procedure, I would have Dolores come
17 into the room; I would introduce the patient/Dolores in
18 the same way, and then I would say -- I would then go
19 over the whole thing again with them, with both Dolores
20 and the nurse -- so that's Dolores and the patient. So 12:43
21 that gave the patient again a second synopsis of the
22 situation. We would then give the appropriate patient
23 pamphlet. There's a pamphlet that we gave to the
24 prostate cancers where we wrote in the pamphlet what
25 the score was, what the treatment plan would be. So 12:44
26 that gave the patient a second synopsis of what we're
27 trying to put across, and also then Dolores was in the
28 wing of knowing what was going on and she would take
29 a record of what was done and then would have time to

1 spend more holistic time with the patient outside of
2 the room while I am on to the next patient.
3 105 Q. And just the other part of my question, in terms of the
4 benefit or the importance of having specialist nursing
5 involvement, what is that doing for you and what is it 12:45
6 doing for the patient?
7 A. Well, while I'm putting across the doctor aspect to it,
8 the nurse can back that up, but there is also the
9 holistic aspect to their care. It gives the patient
10 an opportunity to talk to a second individual -- 12:45
11 sometimes talking to the nurse rather than talking to
12 the big doctor about something! So it gives the
13 patient a little bit more time to ask a question. But
14 I think it's very much the holistic angle to it. And,
15 also, it's a bit like a lot of things, it's only when 12:46
16 you go out of the room that you think, oh, I should
17 have asked that question, or said that.
18
19 So the nurse would give the patient the phone number
20 and card, basically, of contact point with the specific 12:46
21 understanding that "Look, here's -- if you have any
22 more questions, here's how you make early contact."
23 And, as I say to patients, there's not such a thing as
24 a silly question. It's probably the most important
25 question to be asked all afternoon, because it's what 12:46
26 they don't understand and want to know a bit more
27 about. Is that what you're asking?
28 106 Q. Yes. And if I could just broaden that out, is there an
29 expectation -- and maybe it would be on an exceptional

1 basis, but is there an expectation that the nurse, the
2 specialist nurse, would have the wherewithal to ensure
3 that everything is being done, if you like, properly,
4 perhaps in accordance with what the MDT had recommended
5 and to ensure that choices are being fully explored and 12:47
6 explained with the patient and maybe to put their hand
7 up and say, you know, "Mr. Young, this perhaps needs
8 done", and thereafter to ensure that the pathway to be
9 pursued by the patient is being appropriately followed?
10 A. So there's two questions in that -- 12:47
11 107 Q. Yes.
12 A. First -- sorry, the first is: Has all the information
13 been put across? Yes, I think there is an onus -- if
14 the specialist nurse has been to the MDT and you know
15 what the outcome of that's meant to be -- has that been 12:48
16 discussed? Yes. How can that be found out? That can
17 be either in the room at the time of the full
18 consultation, or, for instance, in my case, if they are
19 not in the room, it is discussed at the summary of
20 the -- at the end of the consultation. Sorry, that 12:48
21 would have been my practice. So, for instance,
22 somebody who is coming in with prostate cancer and they
23 have been offered either surgery or radiotherapy, you
24 know, this would be said in front of the nurse "I have
25 discussed with Mr. X and Y -- here's the information 12:49
26 leaflets to go with both of those", and "Mr. X may want
27 to discuss a little bit more of this with you outside",
28 and if there's any holistic care packages to add to
29 this, that's what it is. So, yes, the CNS does have

1 the opportunity to -- or, well, should have the
2 opportunity -- yeah, should have the opportunity to
3 have known what was discussed, whether it is the
4 complete conversation or has a good summary of it, then
5 I think that's fine -- 12:49
6 108 Q. And a rather more pedestrian question -- sorry for
7 cutting across you --
8 A. That's okay.
9 109 Q. Go on ahead. You finish.
10 A. Sorry, I forgot the second question! 12:50
11 110 Q. I think in the care pathway that followed, I think
12 you've part answered it, that nurses do have
13 a responsibility or at least an opportunity for input
14 to ensure that the care packages are properly explained
15 and are followed up? 12:50
16 A. Explained and followed up -- so, explained, as I say,
17 so there are several pamphlets available for each
18 condition. This is an opportunity to actually go
19 through it with them afterwards. As far as follow-up
20 is concerned, my understanding is that the CNS, you 12:50
21 know, is at the end of a phone if the patient has
22 something further to question.
23 111 Q. Back to my pedestrian question then, the nuts and bolts
24 of moving from MDT to knowing that the patient is
25 coming in to consultant with you, how is it 12:51
26 choreographed that the nurse is at the door of your
27 clinic to see the patient, whether in the room or after
28 the consultation has taken place? Is there a formality
29 to the allocation of the nurse or is it simply, as

1 you've explained -- I think you called her Dolores --
2 was the constant, was on duty at the same time, and an
3 expectation developed?
4 A. The nurse would know the oncology patients attending
5 the clinic. I mean, mine, it was a protected slot. So 12:52
6 at a precise time spread out through the afternoon to
7 give everybody enough time -- probably enough time to
8 give the nurse time to discuss afterwards -- so mine
9 had a protected slot. Now, I'm speaking for myself
10 here. That was my practice because for the full 12:52
11 afternoon, you know, I may have 10 to 12 patients with
12 urodynamics reviews, but the oncology patients got
13 a protected slot time and the nurse would have known
14 the cases that were on the protected slot and, at the
15 end of it, if they didn't, they were invited in for 12:52
16 the -- so I always had the nurse in the room at some
17 time discussing the case.
18 112 Q. Thank you for that.
19 A. Does that answer it?
20 113 Q. That's helpful. If I could bring you to TRA-05379, I'm 12:53
21 drawing your attention to a comment that one of the
22 Cancer Nurse Specialists, Kate O'Neill, made. So it's
23 Q. 415. So this is in the context of prostate biopsy in
24 relation to your practice. And it's not the context in
25 which we just immediately discussed, which is coming to 12:53
26 see you after the MDT. And what she says -- she's
27 asked the question:
28
29

1 "Q. Was that just a little bit of resistance to nurses
2 taking on that role or was it something else?"
3
4 And if I can just go straight to the point -- you can
5 read the first few lines: 12:54
6
7 "So, my feeling for it at that time was it just took
8 Mr. Young that wee bit longer to engage with it."
9
10 That's the CNS involvement with it. 12:54
11
12 "My way of assisting that process was to ensure that I
13 audited the services that I was providing and presented
14 those audits at either departmental meetings or patient
15 safety meetings to ensure that my clinical work was
16 robust and safe."
17
18 She goes on to say to the extent that there was -- it's
19 the questioner who uses the word "resistance", I think,
20 my learned junior -- 12:55
21
22 "Q. ...is it dissipated entirely?
23 A. Oh, it's gone and it didn't delay anybody..."
24
25 -- does that resonate with you, that there was a bit of 12:55
26 a slowness to engage with nursing on the prostate
27 biopsy?
28 A. Oh, the word "resistant" is wrong. I have been very
29 encouraging of nurses to be involved in all our

1 practices. If I can maybe go back even to the original
2 ICAT service, the Department of Health asked me
3 directly why am I asking for two CNSs when they are
4 only offering one, and I said because the service needs
5 two. I wish I had asked for four, but I said two! And 12:55
6 the two ended up as Kate and Jenny, and they have
7 stayed throughout. So, no, I -- and, again, the
8 principle of having Thorndale I and Thorndale II,
9 everybody under the same roof so that there's a safety
10 net -- that if the nurse wants to ask the doctor 12:56
11 something and the doctor wants the nurse involved in
12 something, it's everybody is there. So there has been
13 nurse education in this. I have been fully supportive
14 of nurses getting involved in everything.
15 12:56
16 Now, prostate biopsies was fairly new. I don't do
17 prostate biopsies. It's my colleagues have been doing
18 it. And when this was set up, it was the one-stop
19 clinic, so the other consultants may have done their
20 prostate biopsies on those occasions but, for myself, 12:57
21 and I think for Mr. O'Brien as well, who didn't do the
22 biopsies, is that our radiology colleagues came in and
23 did that. So I had no objections to the nurses taking
24 on all of these roles; I just wanted to make sure that
25 they felt safe doing it. So there's a distinct -- 12:57
26 okay, there might have been an air of this coming
27 across -- I just wanted to make sure that the nurses
28 felt safe doing the procedure and were well supported
29 in doing it.

1 114 Q. So if there was a perception of delay or slowness, you
2 would explain it on the basis of building competency
3 and confidence in the process?
4 A. Yes. Whether the biopsy was done by the clinical nurse
5 specialist or the radiologist, I wasn't concerned. My 12:58
6 concern was to make sure that they felt sort of
7 comfortable doing it. And if that came across the way
8 it's been put across here, then I apologise if it came
9 across that way. But I have been very supportive
10 throughout my time of clinical nurse specialists. We 12:58
11 have, undoubtedly got an excellent benign side of the
12 service. Jenny runs our urodynamics; I have been fully
13 supportive of her doing that all on her own. And the
14 flexible cystoscopies, Patricia now does on her own.
15 You know, so I have been more than supportive of 12:59
16 clinical nurse specialists taking on the role. So it
17 may have been a perception at the time, but I just
18 wanted to make sure that they felt safe.
19 115 Q. Could I eat into our lunch break just for another three
20 or four minutes to close on nursing? 12:59
21
22 I hope you've had the opportunity of reading the root
23 cause analysis reports resulting out of the nine SAIs
24 that were raised for review of Dr. Hughes and
25 Mr. Gilbert in 2020. One of the points that they 12:59
26 focused on, and perhaps one of the more significant
27 points, was that across the nine cases that they looked
28 at, and they all involved Mr. O'Brien as the main
29 practitioner, is that they found that in the nine

1 cases, none of them, none of the patients had access to
2 a cancer nurse specialist. Did you have any sense that
3 Mr. O'Brien's engagement with cancer nurse specialists
4 differed from yours? You've described yours earlier as
5 one of engagement where the nurse was available on 13:00
6 every cancer case that came through your clinic.
7 A. Every MDT, not the reviews.
8 116 Q. Yes, every new diagnosis --
9 A. No, I wasn't aware. I hadn't heard.
10 117 Q. It's not something you ever discussed with him? 13:01
11 A. No, I didn't discuss that with Mr. O'Brien.
12 118 Q. In terms of the usage that should be made of cancer
13 nurse specialists, was that ever the subject of
14 discussion -- perhaps, reinforcement -- at departmental
15 meetings? 13:01
16 A. Ehm...
17 119 Q. I'm not asking you about a specific meeting, I'm just
18 asking you to cast your mind back -- or, in the
19 alternative, was it not something that appeared as an
20 issue of concern or controversy? 13:01
21 A. It wasn't raised, as far as I was concerned, at
22 a departmental meeting.
23 120 Q. You have said at paragraph 26.6 of your statement, just
24 for the Panel's note, that you considered that the
25 nurses -- that the Specialist Nurses in Urology 13:02
26 communicated effectively and efficiently. They could
27 raise concerns with the consultant team without any
28 feeling of being pressurised. Does it surprise you
29 that no one came to you to raise any concerns about

1 Mr. O'Brien's practice with regard to specialist
2 nursing?
3 A. I wasn't aware that there was an issue. Or it hadn't
4 been raised to me.
5 121 Q. I put the question in that way knowing that Mr. O'Brien 13:03
6 will have a different perspective. The perspective I'm
7 putting to you is the one that emerged from the SAIs,
8 for the avoidance of doubt.
9 A. Yeah.
10 122 Q. But, again, across your colleagues in Urology, amongst 13:03
11 the consultants this wasn't an issue that arose? To
12 put it simply, was it your expectation that everybody
13 would see the benefit of engaging with the cancer nurse
14 specialists?
15 A. Absolute assumption that it was important. I mean, 13:03
16 when the NICaN was set up at the beginning, when there
17 was a review statement of this made in 2014 -- I don't
18 know the precise date of the document -- there was
19 clear information there to note the importance of the
20 Clinical Nurse Specialist in the role of the cancer 13:04
21 care and their involvement, both on a holistic basis as
22 well as...
23 123 Q. And, again, for the avoidance of doubt, and we're
24 talking here about cases in 2019 and 2020, by that
25 stage would resources or resource factors offer any 13:04
26 explanation as to why nurses may not be used with
27 particular patients emerging from MDT?
28 A. It would be the number of CNSs available.
29 I've mentioned already sort of Fridays I had a staff

1 nurse, as opposed to the full CNS. So the actual
2 numbers of CNSs weren't at an adequate level to start
3 with. There should have been more. There was -- my
4 understanding is they had advertised for two posts that
5 remained unfilled. I think it might have been an 13:05
6 advertisement issue, or there might not have been the
7 standard expected. I don't know exactly the reasons.
8 But the fact was there was meant to be more CNSs
9 employed, but they were inadequate in number for
10 a variety of reasons. 13:06
11 124 Q. But, I suppose, if, for whatever reason, the nurse
12 isn't available on the particular day or clinic, the
13 important point would it be to ensure that there was
14 contactability between the patient and whatever nurse
15 it might be? 13:06
16 A. Yes. For instance, coming back to my scenario, is that
17 Dolores would hand over the information to Kate to
18 actually follow through. Is that what you're asking?
19 MR. WOLFE KC: Yes, indeed. Thank you for that. It is
20 now ten past one. 13:07
21 CHAIR: I think we'll come back again then at ten past
22 two, ladies and gentlemen. See you then.
23
24 THE INQUIRY THEN ADJOURNED FOR LUNCH
25 14:09
26
27
28
29

1 THE INQUIRY RESUMED, AS FOLLOWS, AFTER LUNCH
2
3 CHAIR: Thank you, everyone. Mr. Wolfe?
4 125 Q. MR. WOLFE KC: Good afternoon. I want to spend the
5 next short while, Mr. Young, looking at the area of 14:09
6 accountability and governance in broad terms,
7 encompassing, I suppose, relationships and
8 communication between different levels of management,
9 and encompassing your role as clinical lead and how you
10 saw that and how others may have saw that, and also 14:09
11 looking at some of the tools of governance that you've
12 dealt with in your statement, including audit, patient
13 safety meeting, and issues around data and what could
14 be understood from the data that the Trust routinely
15 collected. 14:10
16
17 Now, let's start with some, I suppose, basic
18 understandings. At page WIT-51763, if we could have
19 that up, you discuss clinical governance. Clinical
20 governance, you say, was overseen primarily by the 14:10
21 Director of Acute Services and, in your time, that was
22 Dr. Rankin.
23
24 "It was, for a short time, Mrs. Burns and
25 Mrs. Gishkori, and the associated management team." 14:11
26
27 By that, did you mean assistant directors?
28 A. Yes.
29 126 Q. And:

1
2 "This would have been shadowed by the higher management structure and the associated medical directors."
4 What do you mean by that?
5 A. There is a medical channel, as I took it, as the 14:11
6 Medical Director -- the AMDs and then the Clinical
7 Directors. Then I saw running, maybe, in tandem to
8 a degree, from an organisational point of view, is the
9 Acute Services like Dr. Rankin, and then the associate
10 member. 14:11
11 127 Q. When you refer to "clinical governance" -- and I
12 sometimes think people say that word and use that
13 phrase and it's a common understanding, but what do you
14 mean by it? Is it a broad -- are you using it broadly?
15 A. It is a broad term. Sometimes it's hard just to put it 14:12
16 in a complete nutshell, but it's how the organisation
17 sort of runs itself, I suppose, and feels safe about
18 what it's doing.
19 128 Q. So it's that area directed to patient safety?
20 A. Yes. 14:12
21 129 Q. Does it encompass, in your view, I suppose, how
22 clinicians are supervised and held to account? Some
23 people might refer to that -- Dr. Simpson, I think,
24 refers to that as professional governance, but are you
25 including that within this broad definition? 14:13
26 A. It's a broad term, yes.
27 130 Q. Yes. And we also see references to some of what I've
28 called the tools of governance, such as M&M, data
29 collection, SAI, Datix. They're all encompassed within

1 that, is that how you would think of it?
2 A. That's how I would think of it, yes.
3 131 Q. You go on here just to -- there's, perhaps, an answer
4 to my question -- clinical governance, I think you're
5 saying, would have encompassed the patient safety 14:13
6 meeting, along with the medical lead for this meeting.
7 The lead clinician role, you say, was:
8
9 "...service-driven and the assurance for governance
10 responsibility would have been as with that of the 14:14
11 other consultants."
12
13 You use the term, the active term "responsibility" and
14 you're equating the lead clinician role in terms of
15 responsibility for clinical governance as being the 14:14
16 same as for other consultants -- as with other
17 consultants?
18 A. Yes, I am taking it that the lead clinician is a fellow
19 consultant working alongside his peers, his or her
20 peers. 14:14
21 132 Q. At various places in your statement -- paragraph 37.3,
22 for example:
23
24 "The lead clinician role was service-driven and the
25 assurance for governance responsibility would have been 14:15
26 as with that of other consultants."
27
28 Sorry, that's just what we have here.
29 A. Yeah.

1 133 Q. Another example:

2

3 "My role in clinical governance was as a doctor in the
4 position of being a consultant. This involved
5 mentoring junior staff and providing a continuous high 14:15
6 standard of care for patients."

7

8 So that's paragraph 7.3 of your statement. Then
9 paragraph 38.4:

10 14:15

11 "My specific governance role in the unit I regarded as
12 maintaining the work schedule for the whole medical
13 team and, as such, was operational. Assurance of
14 governance was as a hospital consultant, but the
15 responsibility of governance lay with management 14:15
16 structure and the Medical Director's team."

17

18 So, again, you're placing yourself as having no
19 additional responsibility for clinical governance as
20 compared with your fellow consultants; is that fair? 14:16
21 A. I regarded my element of higher sort of governance and
22 management to be at a low level in that sort of ranking
23 of seniority that you've just raised. So I felt that
24 I was, if I can maybe use the phrase, the captain of
25 the team, potentially, but I was working alongside my 14:16
26 peers and with them. I wasn't having a direct
27 responsibility for them, and that's what I was trying
28 to get across. So I'm working as a doctor, I'm working
29 as a consultant, working alongside my colleagues.

1 I may have been the one to try to gel the situation as
2 part of the team, maybe.
3 134 Q. Let me put something else that you said and see if this
4 underscores the point that you're making. If we go to
5 paragraph 55.9, which you'll find at WIT-51790, you say 14:17
6 at this point that:
7
8 "The Medical Director system from 2007 onwards with
9 regards to my role as lead clinician was generally one
10 directional. If there was an issue, the Medical 14:18
11 Director would liaise with me directly or more likely
12 through the Acute Service Leads. This was infrequent
13 with specific reference to urology. The Medical
14 Director's office does, however, issue general patient
15 safety documents on a frequent basis and the principle 14:18
16 of 'office door was always open' applied if a physician
17 wanted a conversation. As lead clinician, if I noted
18 a governance issue, it would be raised first with the
19 Head of Service and/or Director of Acute Services of
20 the time." 14:18
21
22 Does that last sentence help us to understand your
23 words as "captain of the team" or, perhaps, first among
24 equals, you did perceive of the role as having one to
25 communicate to, for example, Mrs. Corrigan or to 14:19
26 a clinical director if you saw a governance issue arise
27 that needed attended to?
28 A. Yes, that would have been my first port of call.
29 135 Q. So is that over and above the responsibility of a, if

1 you like, run-of-the-mill consultant -- if there is
2 such a thing -- it's hard to imagine!
3 A. Don't say that!
4 136 Q. No, strike that from the record! So you are sitting
5 above the normal fray, are you not? 14:19
6 A. I agree the head is above the parapet a little bit on
7 that front, yes.
8 137 Q. Let me put some other perspectives to you and you can
9 tell me if you think they fit. Richard Wright was the
10 Medical Director from the second half of 2015, taking 14:20
11 over from Dr. Wilson -- sorry, Dr. Simpson. If we go
12 to WIT-17857 at paragraph 31.1, and he explains his
13 role. He was the Executive Director primarily
14 responsible for clinical governance matters as they
15 related to doctors. And he explains the blurring of 14:21
16 the boundaries with the operational or the service side
17 in that in the case of Mrs. Gishkori.
18
19 He goes on to say that the role of responsibility for
20 clinical governance was delegated through the line 14:21
21 leadership structure to the Associate Medical Director,
22 through the two Surgical Clinical Directors, then
23 through to the Urology team, and, finally, to
24 consultants and other medical staff, including
25 trainees. There was also a shared governance 14:21
26 responsibility through the Associate Medical Director
27 team across the specialities, the Trust specialities --
28 CHAIR: I think you've left out the most important word
29 there Mr. Wolfe, it was the - team lead.

1 MR. WOLFE KC: Yes, sorry, I appreciate that, and thank
2 you. So he's making the point -- I've left out the
3 most important word -- so he's making the point that he
4 saw the clinical lead or the team lead role as part of
5 this supportive arrangements delegated from him through 14:22
6 this chain of command, which included your post. Is
7 that an acceptable way of viewing it?
8 A. That is an acceptable way of doing it, but if I can
9 maybe add to that, I was not instructed through a job
10 plan or anything what was actually required of 14:22
11 a clinical lead. I've subsequently read it and it says
12 it's a taster for entering into a sort of management
13 role. So I do accept that if you are the lead, that
14 there is slightly more involved in that than just being
15 a consultant. 14:23
16 138 Q. I think the document to which you allude in terms of it
17 being I think you said a taster role --
18 A. Well, apparently, it's a taster role if you wish to
19 take it further along...
20 139 Q. Let's just look at that in context. The document 14:23
21 you're alluding to is the Medical Directorate
22 Structures. We have it as a draft document and it's
23 WIT-55855. So we have this document and if we could
24 scroll in to -- just open it -- go down seven pages,
25 please, to 6-2 in the sequence. 14:24
26
27 I wonder, Chair, is it going to be possible to turn the
28 heat off? Maybe not? It's extremely hot where I'm
29 standing.

1 CHAIR: Mr. Murphy, would you, maybe, nip into the
2 office, please, and see if that can be done remotely or
3 if someone needs to come in to do it?
4 140 Q. MR. WOLFE KC: So, within this document, there's
5 a reference to the speciality lead. You make the point 14:25
6 "I've never received a job description" and
7 we certainly haven't seen one for the role of
8 speciality lead. And the nature and scope of the post
9 is sketched out here. It is a post required to bolster
10 medical management capacity and ensure coordination 14:25
11 within a specialty. So implicit in that -- "bolstering
12 medical management" seems to mean adding support to the
13 medical management?
14 A. Yes.
15 141 Q. On accountability, you will account managerially and 14:26
16 professionally to the clinical director of the
17 division. At various points that was Mr. Brown,
18 Mr. McNaboe, and Ms. Hall.
19 A. Mr. Hall.
20 142 Q. Mr. Hall? 14:26
21 A. Mr. Hall. It was Mr. Hall and Mr. Weir.
22 143 Q. You used the phrase earlier:
23
24 "The post of specialty lead is a taster role for those
25 who want to try medical management out. The post may 14:26
26 become a stepping stone to a wider management role or
27 may prove to be as much as the post-holder wishes to
28 take on for a longer period."
29

1 So you stopped at that rung in the ladder. You didn't
2 use it as a stepping stone to elsewhere --
3 A. Correct. I didn't want to climb up the management
4 level.
5 144 Q. Yes. In terms of the role, were you remunerated for 14:27
6 it?
7 A. Yes. I was given 0.5 PA.
8 145 Q. Did that adequately reflect the time that you devoted
9 to the responsibilities of the role?
10 A. I don't think so. 14:27
11 146 Q. Were you supported administratively or otherwise in the
12 role?
13 A. My secretary did any typing that I needed.
14 147 Q. In terms of, if you like, training for the role,
15 support in that direction, did you ever receive any 14:28
16 specialty lead specific training?
17 A. No. I trained myself and to what I thought was needed.
18 148 Q. Were you given any guidance as to what might be needed?
19 A. No. But I also wasn't told that I was doing something
20 wrong, if you know what I mean -- if I was going up 14:28
21 a wrong pathway, that's what I'm trying to say.
22 149 Q. Over the years -- and it was 20, approximately, years
23 for which you held the role --
24 A. Yes.
25 150 Q. -- did anybody at any point press the pause button with 14:28
26 you and say "You're doing this particularly well, but
27 you're not doing this particularly well"? Any meetings
28 of an appraisal-type nature focusing on specialty lead?
29 A. No.

1 151 Q. Just going back to some of the other perspectives on
2 it, let me bring you to Mr. Simpson -- and I think I've
3 referred the Panel to the reference and I don't think
4 I need to bring it up, WIT-25712 -- at paragraph 25.1
5 of his statement, he said the Associate Medical 14:29
6 Director, with the support of the two clinical
7 directors and the lead clinician had particular
8 responsibility for clinical governance. Maybe that
9 puts it further than you would like?
10 A. It is. That's the Medical Director's perspective of 14:30
11 what I did.
12 152 Q. Mr. Mackle, bringing his statement up, WIT-11749, at
13 paragraph 42 he talks about the difficulties and the
14 pressures he found in the AMD role, and he goes on to
15 say: 14:30
16
17 "Heather Trouton, the acute directors, and myself
18 relied on the assurance of Michael Young and Robin
19 Brown that there were no clinical concerns. The
20 current system is such that an AMD has to rely on the 14:31
21 CD and lead clinician to supply accurate assessments on
22 the clinicians in their team."
23
24 My words, not his. But, in a sense, he's suggesting
25 that to enable him to do his job properly in this 14:31
26 delegated chain, he needs you and the Clinical Director
27 to be his eyes and ears. Is that another reasonable
28 perspective?
29 A. I think that is very, very reasonable. Often, the lead

1 clinician will be the first of the team that you're
2 going to go and speak to. I think that's fair.
3 153 Q. On the Clinical Director side, Mr. Brown, WIT-17527, at
4 25.1 he refers to:
5 14:32
6 "Day-to-day clinical management would have been carried
7 out by the lead clinician, Michael Young, and any other
8 team member to whom they delegated tasks, such as the
9 MDM lead."
10 14:32
11 And he goes on to say:
12
13 "During my tenure, Michael Young would have reported to
14 me or Eamonn Mackle..."
15 14:32
16 -- he uses the term "reported" --
17
18 "...to describe lines of communication rather than the
19 exchange of actual reports."
20 14:32
21 And he doesn't recall any concerns raised by you. So,
22 again, that phrase "day-to-day clinical management"
23 carried out by you, is that another adequate
24 characterisation of the role?
25 A. The role was the day-to-day running of the unit. I, 14:33
26 maybe, come back to the rota that I would have
27 mentioned earlier. I would have known where everybody
28 was meant to be. If somebody rang in sick, I then
29 would be on the ground to try to move the cards around

1 the table to get that sort of clinical activity
2 covered. And this day-to-day -- so the clinical
3 management was very much inter-related to the Head of
4 Service, Martina Corrigan, to make the unit run on
5 a day-to-day basis. 14:34
6 154 Q. You illustrate the point by reference to a very
7 practical activity --
8 A. Yes.
9 155 Q. -- ensuring that the service can run. But did the
10 day-to-day clinical management, was it broader than 14:34
11 that? Was it ensuring that the clinicians, if you
12 like, were behaving themselves or, if they had any
13 difficulties, sussing that out and reporting it perhaps
14 upwards?
15 A. Yes. It primarily related to our junior staff or the 14:34
16 likes of staff grades, if there were issues.
17 156 Q. But did it not apply also -- we'll look at some of the
18 examples later this afternoon, but did it apply also,
19 in your view, to your peers?
20 A. I found the role of -- I found that part hard. As 14:35
21 a lead clinician, the non-interpersonal ways of running
22 a unit I found very easy. I felt it hard to deal with
23 a peer-to-peer issue because I felt I was one of the
24 same team. So any comments I would be making on that
25 front would have been as a consultant-to-consultant 14:35
26 sort of level.
27 157 Q. Yes, as opposed to you being a manager --
28 A. Yes.
29 158 Q. -- with authority?

1 A. Ehm, I take the word, that last word, "authority" --
2 I agree with being captain of the team, if you want --
3 159 Q. Sorry, somebody coughed and I lost the word --
4 A. If you are being the captain of the team, it is putting
5 you at a slightly higher sort of level, but you are 14:36
6 working with the team. So any report on that line
7 would have been as a consultant. I do accept that this
8 role had a slightly higher level than just
9 a consultant, right, I do accept that. But it is the
10 word in the ear of Mr. Brown and Mr. Mackle is that the 14:36
11 lead may be the person they do come to first.
12 160 Q. Yes. I wonder is your slight awkwardness or discomfort
13 around this reflected in something Mrs. Corrigan has
14 said, if I can ask your comments on this -- if we go to
15 WIT-26304 and at I think it's paragraph E, she's 14:37
16 reflecting some learning arising out of, if you like,
17 all of this. She says:
18
19 "In my opinion, another area that I consider should be
20 taken into account with respect to learning is the need 14:37
21 for a clear management structure of medical staff. For
22 clinical staff, they need to know who this is and what
23 authority they have as their accountable..."
24
25 -- and I think that should say "manager". 14:38
26
27 "It is my observation that there wasn't a clear line of
28 accountability of management while I was in post. So
29 whilst the consultants were directly accountable to

1 their responsible officer, the Medical Director,
2 I believe that they were unsure who was responsible for
3 managing them on a day-to-day basis. Whilst there was
4 a clinical lead, Mr. Young, and whilst I believe it was
5 understood that he should be managing the rest of the 14:38
6 urological consultants, Mr. Young never had an actual
7 job description outlining what this should entail and,
8 from my recollection, only got 0.5 of a PA to be the
9 clinical lead, so I don't believe that he ever felt
10 that this was his role, although this would be 14:38
11 a matter best addressed by him."
12
13 And here we are! It's set up for your comment,
14 I think. She's speaking in tolerably clear terms, but,
15 to paraphrase, is she echoing something of what you've 14:39
16 just recently said, that, really, you didn't accept
17 that you were the manager of these collection of
18 Consultant Urologists in the kind of sense that she's
19 describing -- that is with authority, telling them to
20 pull their socks up if they needed to pull their socks 14:39
21 up, and...
22 A. That's spot on. It's a small group. It's a small
23 team. It's very important to get on to make the
24 thing -- to make the work gel, to make the whole as a
25 unit gel. So it's hard if it's -- if you're put on the 14:40
26 spot. If someone needs to be put on the spot, that's
27 fairly obvious, but, you know, I felt a bit pressurised
28 on that front and I thought it was an unfair ask, if
29 you want to put it that way.

1 161 Q. Yes. Plainly, you took the role on in or about 2000,
2 give or take?
3 A. Yes.
4 162 Q. It's in much different-looking shape than it was in
5 2014 when you have five or six consultants, albeit for 14:40
6 a short time, as we discussed earlier.
7 A. Yeah.
8 163 Q. Do you feel that the expectations that came with the
9 job changed throughout that time?
10 A. Well, like most things, they change as they move on. 14:41
11 I mean, I saw the role as a service-driven, sort of
12 organisational job. I would have represented the unit
13 at such things as our THUGS Committee -- that's our
14 theatre users group! So I would have represented our
15 unit for that to report to the Committee on what we 14:41
16 wanted from Urology, and maybe backwards from that
17 Committee to the rest of the team. I saw my role as
18 leading on if there was any sort of major sort of
19 project to get through, that would have been -- for
20 instance, actually setting up the ICATS service on the 14:42
21 2009 process of how we're going to get this into the
22 unit; I sought -- there was the saline resectoscope
23 issue -- I sort of took charge in trying to process
24 that, to make it happen, and maybe facilitated the
25 departmental meetings. But, again, that was trying to 14:42
26 get people to get round the table. And, again, I might
27 have sort of managed the staff grades in a little bit
28 more detail, albeit that the staff grades contract,
29 their next in charge was actually the CD, I believe; it

1 wasn't me.
2 164 Q. Yes.
3 A. Although I took control of it.
4 165 Q. Yes. And, in many ways, your pre-empting -- I'm not
5 criticising you, by any means -- some of the bigger 14:43
6 ticket items we'll explore through your evidence to see
7 how they managed and to see how they both reflected on
8 your role and how what they say about, I suppose,
9 governance in general.
10 14:43
11 Just before I leave what Ms. Corrigan has said, and
12 it's up on the screen, she adds the sentence that she
13 felt or she feels it was unfair, in any event, to have
14 peers attempting to manage peers, as these were their
15 colleagues and it was hard to hold them to account when 14:44
16 they were of the same grade. So I think that's echoing
17 at the very heart of your discomfiture --
18 A. Yeah.
19 166 Q. Yes, you were happy, if you like, to take on
20 activity-based projects -- the resectoscope being an 14:44
21 example we'll, maybe, look at later for other reasons,
22 but much more difficult to grapple with
23 under-performance, for example, on the part of a peer,
24 and that's not something you felt you should have been
25 asked to do and you weren't comfortable doing it when 14:45
26 you were asked?
27 A. I wasn't comfortable, yeah. I think a lot of these
28 issues are, you know, at a higher level to try to sort.
29 167 Q. And it would appear, reading between the lines of

1 Mrs. Corrigan's statement, albeit that is a matter for
2 the Panel to read between the lines, but she would
3 appear to have recognised your discomfiture. But
4 it didn't, as we will shortly see, prevent or alleviate
5 the demands that came your way to address issues, 14:45
6 particularly in the context of Mr. O'Brien, isn't that
7 right? You were expected to roll your sleeves up and
8 come up with, if you like, short-term solutions or
9 immediate solutions?
10 A. I was asked, yes. 14:46
11 168 Q. Yes. I think just to bring you back just finally on
12 this area, I think this probably encapsulates what you
13 thought of the role. If we go to WIT-51780, at 49.1
14 you say:
15 14:46
16 "The lead clinician role is service-based and did not
17 have a direct responsibility for other consultants
18 other than a working relationship alongside them as
19 colleagues on a daily basis and offering support and
20 advice." 14:47
21
22 So the distinction I think you're drawing there is
23 between some of the service-based activities -- getting
24 the rota right; if there's a new development such as
25 resectoscope, let's get that pushed through -- but when 14:47
26 it comes to direct responsibility for what consultants
27 are doing in their day-to-day practice, I will speak to
28 them, I will offer advice, I will convey messages from
29 wider management, but it's not my direct responsibility

1 to manage them -- is that it?
2 A. I feel that's right.
3 169 Q. In terms of your own accountability as -- perhaps, both
4 as a consultant and as a clinical lead, on day-to-day
5 matters you explained you reported to Mrs. Corrigan? 14:48
6 A. Yes. This would have been from a medical perspective,
7 or her asking me about operational issues that she
8 needed addressed from a medical perspective.
9 170 Q. In terms of relations between consultants and
10 operational or service managers, you've said that, 14:48
11 following the regional review in 2009, the medical and
12 administrative managerial structure appeared more
13 structured, as compared to what went before.
14 A. Yes.
15 171 Q. This is paragraph 32.1 of your statement. What did 14:49
16 you mean by that, by "more structured", and is that
17 a good thing?
18 A. It's a good thing. Before the change between the
19 Hospital and the Trust, the system was the Chief
20 Executive, Mr. Templeton, who had his office on the top 14:49
21 floor, and then there was the Medical Director below
22 that, and that ran the Hospital. And then when it
23 became the Trust, then there was increased -- so,
24 levels. The Trust was getting bigger, it needed more
25 hands to look after it. And that was my understanding 14:50
26 of the addition of the extra levels.
27 172 Q. How did that structure assist you, either -- that
28 greater structuring, how did that assist you as either
29 a consultant or wearing your clinical lead hat?

1 A. I must say I had a very good relationship with
2 Mr. Templeton, who was the Chief Executive. We did
3 have our times together and arguments about how the
4 service should go, but that was a direct conversation
5 to the top brass, shall we say. 14:50
6
7 With the new introduction, then that was to the Acute
8 Service lead, and then the likes of the AMD would have
9 been more of where you took the high-end points to to
10 get dealt with, as we did with going through the 2009 14:51
11 service review. And then on a day-to-day basis of
12 levels, it was -- my first port of call was the Head of
13 Service. And if that then needed to -- if she needed
14 to take it higher, then she would have taken it to the
15 Clinical Director and the AMD level. 14:51
16 173 Q. Yes. So you say in your statement that since 2009 --
17 this is paragraph 54.2 -- maybe bring it up on the
18 screen, please -- it's WIT-51785 -- and at 54.2, you
19 say:
20 14:52
21 "Following the 2009 review, I felt my role as lead
22 clinical was very much supported by the immediate line
23 management system of heads of service and clinical
24 directors covering urology. They had been supportive
25 and deeply involved in all the projects our department 14:52
26 have put forward."
27
28 I think you allude to a bit of pain before things
29 settle down, and on several occasions in your witness

1 statement you refer to a difficult period in your
2 engagement with Dr. Rankin in trying to implement the
3 various aspects of the regional review.
4 A. Yes. But I think you were asking what was the sort of
5 chain of command that I would have gone through to take 14:53
6 something forward, and that's exactly what, yeah.
7 174 Q. Yes. So just reflecting on two points, the first point
8 is that, post 2009, there was an unsettling period that
9 you reflect in your statement in terms of relationships
10 with Dr. Rankin, I think, primarily, were you felt she 14:53
11 wasn't taking on board your suggestions for the good of
12 the Urology Service. And I get the sense that it was
13 a rather bruising period?
14 A. We were all trying to make our point.
15 175 Q. Yes. 14:53
16 A. But there was open -- there was open dialogue. I mean,
17 it's not that everybody went quiet. I mean, it was
18 a very constructive approach to the whole thing. I
19 mean, the 2009 review had as -- I think either 21 or 23
20 things to actually get through, and we sort of 14:54
21 worked -- we worked through those. Some were easy,
22 some weren't. We were trying to put across our case.
23 The Trust was following the lines of the Department of
24 Health and used the -- the Department of Health had
25 a very fixed view on how many patients that they wanted 14:54
26 you to see at a clinician, and the Boyce document from
27 2000, ten years before, had a structure to it. In the
28 meantime, we had the ICAT service. We had seen that
29 the outpatient sort of set-up for a consultant, they

1 were seeing the more complex cases and, therefore, it
2 took slightly longer to get through. As part of the
3 review they said, "Look, go back and sort all of this
4 out that suits your arena." Now, the arena for Belfast
5 is -- it's one big city. We live in a rural area, so 14:55
6 we have Outreach Clinics. Travelling to the southwest,
7 for me that was 150 miles round-turn drive in a day.
8 So all of those things had to be incorporated into the
9 equation.
10 14:56
11 Our sort of day surgery unit, it wasn't a day surgery
12 unit, it was a morning surgery unit. The patients had
13 to go out at lunchtime for the afternoon patients
14 coming in. It didn't have X-ray screening -- you know,
15 so we couldn't take our stone kit. So there was lots 14:56
16 of things that maybe fitted one unit that doesn't fit
17 the other. But as part of our understanding of what
18 they were trying to tell us is "Go make it fit", and
19 maybe that's where Dr. Rankin and I -- we had
20 conversations, if you want to put it that way! 14:56
21 176 Q. I think just for completeness, because it's on the
22 record and you may feel the need to comment on it -- if
23 you don't feel the need to say much more than you've
24 already said, then so be it. Mr. Mackle, who was part
25 of those conversations, alongside Dr. Rankin, you on 14:57
26 the other side of the table, perhaps Mr. O'Brien and
27 other colleagues, he says at paragraph 64 of his
28 statement:
29

1 "A long, drawn out process. We were met by three
2 urologists with a lot of suspicion..."
3
4 -- "objective", I think, is the word he used --
5 14:57
6 "...obfuscation and obstruction to the process and to
7 the aims of the project."
8
9 Your response might be what you've already said, that
10 you had a particular understanding of the service that 14:57
11 was required for your own locality?
12 A. We had our ideas of where it was going to go. We knew
13 that we needed a new sort of Thorndale unit. I think
14 I said earlier that when I knew we were going to get
15 the new floor space, I knew we were heading in the 14:58
16 right direction. I can understand sort of Mr. Mackle's
17 comments.
18
19 It didn't help our side from a perspective is that the
20 year before all of this, or within the same year, our 14:58
21 Urology ward was disbanded. Now, we took a bit of
22 grievance to that, but I understand that the Trust
23 needed to cut beds. I think this was a financial
24 reason. I don't know fully behind it, but it often --
25 I'm sure that's exactly what it is, it was a financial 14:58
26 reason that the Trust were told to cut X amount of
27 beds, and it just happened to be ours. And in the
28 middle of this then, we were having a Urology review of
29 trying to expand beds -- trying to sort of gel the

1 Urology Unit. So there was a wee bit of give and take
2 here.
3
4 But I think, maybe, some of us were a little bit more
5 vocal than others. I know it's saying here that he's 14:59
6 saying "us" being as three, but certainly I think it's
7 reasonable to say that Mr. O'Brien wasn't so keen on
8 all the changes that were coming. I did agree with
9 him, because we had to agree as a unit of where we were
10 wanting to go. But I think some were more akin to it 14:59
11 than others. Is that enough?
12 177 Q. Thank you. And the second point which you were going
13 to major on and which I had asked you, in fairness, was
14 in terms of, post 2009, you say you felt very much
15 supported by immediate line management, and here you 15:00
16 site the Head of Service, Mrs. Corrigan, and the
17 various clinical directors with whom you worked who
18 covered Urology. In --
19 A. Could I add to that?
20 178 Q. Yes. 15:00
21 A. I know I had my initial grievances with the likes of
22 Dr. Rankin, but I know that she was trying to get us
23 over the line to get an efficient, effective approach,
24 and I do understand her role and was, indeed, very
25 grateful that she stuck with us, shall we say, and did 15:01
26 get that. But, yes.
27 179 Q. In terms of the support that you felt from the
28 immediate line management -- Mrs. Corrigan, Mr. Brown,
29 for example -- where was that or how was that

1 manifested? In what kinds of activities did you feel,
2 as the clinical lead, that you were receiving this
3 support?
4 A. Mr. Brown was a surgeon in Daisy Hill who had a urology
5 interest, so he was maybe a bit off site, but he would 15:01
6 certainly come up on a regular basis. It might have
7 been once a week or -- well, he probably came up a
8 little more frequently than that, but as far as
9 interaction... We could chat easily. He did the
10 urology in Daisy Hill, so he would interlink with us on 15:02
11 a sort of clinical ground, as well as from an
12 administrative point of view. The interaction with
13 Mrs. Corrigan was -- her office was on the top floor
14 and was easily accessible. It would have been phone
15 calls: "Can you help with this?". There was a lot 15:02
16 more done on a verbal basis than necessarily going on
17 to the computer.
18 180 Q. I'm interested in, as you seem to be describing, the
19 helpful and constructive dynamics of these
20 relationships because -- and I know it is likely to 15:02
21 have been a very small part of the history of this
22 urology service, but when we go on to look at how
23 triage was managed and the problems with that, how
24 patient charts at home was managed, how the dictation
25 issue was managed, these are the people, these are the 15:03
26 managers who are part of the conversation with you,
27 particularly Mrs. Corrigan. And given what you say are
28 the constructive and helpful and supportive attributes
29 of these people, we might bear that in mind when trying

1 to search for explanations as to why the issues that
2 I've just mentioned were not resolved as readily as
3 people might have liked. So we'll come to that in due
4 course.
5 15:04
6 Can I just ask you about be how the Urology Service did
7 its business in terms of communication and working
8 through issues. There was a monthly rota meeting and
9 there was a weekly departmental meeting. The
10 departmental meeting was held on a Thursday lunchtime 15:04
11 or thereabouts, is that correct?
12 A. Yes.
13 181 Q. And you've explained that these meetings -- this is
14 paragraph 38.3 of your statement:
15 15:04
16 "These meetings were designed to give team members an
17 opportunity to discuss and raise any point they wished.
18 These meetings may have had an agenda but often would
19 include pressing issues a consultant would like
20 discussed. They were often not minuted but it was an 15:05
21 opportunity for one of the team with the Head of
22 Service to take issues forward."
23
24 I get a sense from what you're saying that during
25 Mrs. Corrigan's era, they were not as well structured 15:05
26 as they are now under Mrs. Clayton. And I don't know
27 whether that was intended as a criticism, but just as
28 a -- maybe just as a reflection of a style of approach?
29 A. It's a fair comment, yes.

1 182 Q. And in terms of these meetings, you've said, for
2 example, that you used it as a portal to discuss
3 a range of issues, and we'll see later including
4 triage. But did they ultimately fizzle out in terms of
5 the commitment of consultants to attend them? 15:06
6 A. Ehm, "Yes" is a very straight answer to that. But
7 maybe to expand on it, if possible, Thursday mornings
8 were defined as a non -- as a clinical time -- we used
9 to have an X-ray conference, ward round, and then in
10 the afternoon there was the MDT. So, in theory, 15:06
11 everybody should have been on site on a Thursday lunch
12 time. We all had our own sort of clinical things and
13 we could have been like sort of ships in the night
14 during the week, but, you know, Thursday lunchtime
15 seemed a good time to have a meeting, as we did once 15:07
16 a month for the rota meeting.
17
18 So, on a monthly basis, there was a rota meeting, and
19 then the other three weeks it was a departmental
20 meeting. The departmental meeting would have been in, 15:07
21 like -- like, school term-time, if you want to call it
22 that way -- we would run for a couple of months and
23 then have a break. So that was the set up. So that
24 was the opportunity that I was trying to set aside for
25 people to come round the table. 15:07
26
27 Now, the departmental meeting had success on occasions,
28 and fell apart on others. The successful occasions
29 were when there was a Trust issue coming to us to try

1 to sort -- for instance, the setting up of the ICATS
2 and the saline. So if there was a Trust issue -- or
3 especially the 2009 review, you know, that was well
4 attended whenever we got our nurses around the table
5 and sorting out the care pathway. So that was a good 15:08
6 opportunity.
7
8 The third set is where we, as a urology department,
9 were wanting to address something that we would put to
10 the Trust, then those, we found, weren't as productive 15:08
11 because they didn't have an outcome. The only -- for
12 instance, the -- well, maybe the good ones were the
13 topics on sort of paediatrics and we had discussions on
14 mitomycin -- that's drug treatment into the bladder.
15 So the Trust wanted us to go to set up a paediatric 15:09
16 unit in Daisy Hill, so, you know, that was a structured
17 meeting with the team around the table. There were
18 some had been trained in paediatrics and others
19 weren't. So that team went off to try to sort it out.
20 15:09
21 But we all sort of realised as time went out that, you
22 know, our output from it wasn't particularly productive
23 and some members didn't attend as well as they should
24 have. But the point about Thursday lunchtime was that
25 they were meant to be free. That's what I'm getting 15:10
26 at.
27 183 Q. You sent out an e-mail in November 2019 reflecting that
28 you had expressed concerns about the lack of
29 departmental meetings. You said:

1
2 "We haven't met properly in about a year."
3
4 Mr. Glackin, in his evidence to us, reflects that,
5 quite often, he found himself and yourself sitting, 15:10
6 waiting, waiting, and waiting for colleagues to attend,
7 and here he names Mr. O'Brien, Mr. Haynes, and
8 Mr. O'Donoghue as either poor attenders or late
9 attenders. And although you did your best to lead the
10 Urology team, he reflects that due to the number of 15:11
11 fronts on which the Service was failing to deliver, he
12 said it was difficult to achieve a consensus without
13 the engagement of colleagues. Is that fair comment?
14 A. That's a fair comment.
15 184 Q. Can you explain this malaise that it fell into? 15:11
16 A. I think we spent time -- we did spend time talking
17 about topics, but getting them over the line eventually
18 was hard -- again, unless there was a specific agenda
19 of the Trust, and I've mentioned two there.
20 185 Q. Yes. We've discussed earlier your sense of discomfort 15:11
21 if cast in the role of having to challenge peers about
22 shortcomings or perceived shortcomings in their
23 practice. Assumedly, this would be the wrong kind of
24 meeting to do that directly?
25 A. I think so, yes. And although we -- well, it was 15:12
26 a good opportunity to get people around the table,
27 rather than having individual conversations. I think
28 an individual conversation can be more challenging than
29 if you had a group of people together in a room. It

1 was the opportunity to have an open conversation
2 amongst colleagues. So if there was something that was
3 annoying us, you know, that's what we would do.
4 I mean, an example of a challenge there would have
5 related to Mr. O'Brien's sort of letter-writing and 15:13
6 triage, I must confess. That was brought up as a team
7 talking together rather than just one person talking,
8 you know, one-to-one. It's, maybe, a team approach to
9 trying to address an issue. So that might be an
10 example of informally meeting around a table trying to 15:13
11 sort a problem out, or at least talking about it or
12 bringing it out into the open.
13 186 Q. So what you're saying is in the context of triage, and
14 we can see from some of the material that's been put
15 into the Inquiry that -- including your witness 15:14
16 statement -- that around triage there were
17 conversations -- you can tell me how frequently --
18 about seeking to define what was meant or what was
19 expected by advanced triage, and we'll look at that
20 specifically a little later -- 15:14
21 A. Yes.
22 187 Q. But is that the kind of thing that you're referring to?
23 A. That's exactly the thing I'm trying to refer to. And
24 I'm trying to think of another example of where one
25 person did something or two people did something and 15:14
26 the other two or three didn't. Anyway, I have to think
27 about that one.
28 188 Q. Okay. Just a few other items in, I suppose, the broad
29 governance arena. You were an attendee, as was

1 expected of you, and I suppose all of the consultants
2 and medical staff, of the Patient Safety meeting. It
3 was led, certainly from 2015, by Mr. Glackin?
4 A. Yes.
5 189 Q. You reflect, I think, in positive terms that -- this is 15:15
6 paragraph 29.4 of your statement -- that:
7
8 "During the last ten years, these meetings have been
9 mainly involving the individual units, with a quarterly
10 joint meeting." 15:15
11
12 So individual units must mean the Urology Department,
13 and then there was a bigger quarterly meeting for
14 surgery?
15 A. Yes. 15:15
16 190 Q.
17 "This approach allowed detailed, appropriate, focused
18 discussions on individual unit issues and significant
19 learning points from other departments could be
20 distributed via the joint meeting." 15:16
21
22 So in terms of the individual or specific urology
23 meeting -- led, as I say, by Mr. Glackin and
24 subsequently led by Mr. O'Donoghue -- what was the
25 virtue or merit of that meeting in governance terms? 15:16
26 A. You were discussing patient care. It was -- at the
27 beginning, there was very much a focus on mortality
28 cases -- maybe not so much on the morbidity angle --
29 and we would have had audits. Now, from a mortality

1 perspective in urology -- and, I mean, I think it was
2 a hospital thing, that you had to have a mortality
3 meeting, but most of the urology deaths were relating
4 to sort of hospice type -- it was end of care, it
5 wasn't particularly anything coming up that was 15:17
6 unusual, shall we say. Obviously, there were some,
7 but, I mean, they were addressed. It has progressed
8 that we're now discussing the morbidity that's going on
9 in much more detail and much more time. That has
10 proved to be much more productive. 15:17
11
12 How was that picked up? At the beginning, we used to
13 have a ward book that we'd write cases down. With
14 time, you might tend to forget what they were, so if
15 they were written down in the book we could come back 15:18
16 to it. And the other major one to the Patient Safety
17 meeting would have been the likes of audits. We
18 probably could have been doing more audits. The audits
19 were done by the registrars because, as part of their
20 training, they would have had to have done one or two 15:18
21 audits per year. So that's what they did. So if you
22 only have two registrars, you're going to get two
23 audits -- in theory. That's a broad term to the
24 occasion. We would have had more done but that was --
25 that's what the Patient Safety meeting... 15:19
26
27 An observation that I've made in the last couple of
28 months is that it's all been discussed the other way
29 round. We, for instance, our last audit meeting

1 we had, we started with the audits performed. Then
2 we discussed the morbidity, and that took most of the
3 meeting. And we discussed the mortalities at the end,
4 which all sailed through. And that was probably one of
5 the best audit meetings from our department that we'd 15:19
6 been at. There was very open chat. The consultants
7 were there, the registrars were there, and the nursing
8 staff were all involved. And instead of getting tired
9 at the end of the meeting, we had the interesting stuff
10 at the beginning! 15:20
11 191 Q. There was a sense reflected primarily, I think, by
12 Mr. Glackin in his evidence, but even going back before
13 that to those in the Acute Directorate on the service
14 side I suppose bemoaning the reduction in support and
15 resource for audit because of probably around 2015/'16 15:20
16 and the years around that, the Trust, it was suggested,
17 was having to find resource savings, and support for
18 audit and quality assurance were the casualties, or
19 casualties amongst others. Is that a perspective that
20 you recognise? 15:21
21 A. Yes. It's much more structured and supported now by
22 audit teams. Before, my understanding is that you ran
23 the show yourself, practically.
24 192 Q. Yes. In terms of the connection between the issues
25 discussed at a Patient Safety meeting and the reform or 15:21
26 remediation steps that are required around the issue
27 being discussed -- take, for example, and we'll come to
28 your audit which you conducted with Mr. Hiew -- is that
29 how you pronounce him? -- in relation to stone

1 management and stenting, that issue, just to take that
2 example, was on the agenda -- the issue of stent
3 management was on the agenda across multiple M&M or
4 Patient Safety meetings over several years, generated
5 by Datix or incident reports and the occasional Serious 15:22
6 Adverse Incident.
7
8 So the issue is known, widely known among the
9 consultant body, and coming back and coming back and
10 coming back, but nothing, it appears, being generated 15:22
11 on the other side of the line in terms of solutions.
12 I take that as by way of an example that we could
13 broaden to other issues or incidents. Was there
14 a disconnect between, if you like, the talking shop --
15 we recognise the problem -- and then the ability to 15:23
16 provide a solution?
17 A. I feel that the Patient Safety meeting had a better
18 output/outcome potential to address an issue rather
19 than our departmental meeting, for instance. So, yes,
20 instead of talking, having the audit to back up what 15:23
21 you are trying to put across was good, and it was the
22 Patient Safety meeting that had that opportunity. So
23 it was the opportunity of collecting the facts. Now,
24 you can take the facts to the Trust to say "Look,
25 here's the information, here's what we have to do" -- 15:24
26 it is then up to the higher management to try to make
27 it all happen. It's possible to try to drive it but,
28 you know -- yeah, it's always good to have a solution
29 in mind to help the Trust take it further.

1 193 Q. Can you think of, in governance terms, how that gap, if
2 it is a gap, can be addressed or improved upon by
3 reference to any clinical example, or can you suggest
4 a clinical example where the deficit in practice or the
5 shortcoming has made its way from discussion and 15:25
6 awareness-building at the Patient Safety meeting across
7 the line into the practical action?
8 A. Can I use my stone example?
9 194 Q. Yes?
10 A. Okay. There are several types of stents -- (1) you 15:25
11 leave in overnight, (2) is a stent on strings, (3) will
12 be the stent that's been left in for a period of
13 a couple of weeks to let something settle down, and (4)
14 is a stent that's put in because you want to bring the
15 patient back to do further work. Having realised that 15:26
16 patients were having difficulty getting back to have
17 their stents taken out within that month, there are
18 stents that have strings on them now and the string
19 comes to the exterior. So instead of having to come
20 back and use a cystoscopy slot to take the stent out, 15:26
21 these patients with strings come back between five and
22 seven -- well, we try to aim for five days after the
23 procedure. Patients often take out their own stent and
24 may send us a photograph to prove that they have pulled
25 it out. But having identified that patients were 15:27
26 having difficulty getting back, the stents on strings
27 helped them get back within the week.
28 195 Q. So what was the process -- maybe call it a governance
29 process that gets you from discussing the problem,

1 presenting the problem at Patient Safety meeting, to
2 that -- presumably, that isn't a solution for every
3 patient, but it helps,
4 A. No, it's not, but it helps. Well, we, as a unit, had
5 to find this is a problem, and we have a solution to it 15:27
6 and the solution is that.
7 196 Q. Another aspect of the problem is for those patients who
8 have had a stent installed without a string, there were
9 a series of cases -- no doubt, you're aware of them --
10 for example, Patient 91 mentioned in the document in 15:28
11 front of you, Patient 16, Patient 136, these were all
12 stent cases. I suppose -- I'll give you those numbers
13 again -- 16, 91, and 136 -- and perhaps the names don't
14 all mean... None of them mean anything to you?
15 A. Mmm, just the one, I think. 15:29
16 197 Q. Patient 91 was a case where there was a number of
17 factors in play, but the patient died post-operatively
18 -- co-morbidities, but there was a delay in bringing
19 him in to hospital for removal of the stent, and there
20 was a failure to do an adequate pre-operation 15:29
21 preparation in terms of a mid-stream urine test to test
22 for infection. But an aspect of all of these cases is
23 the -- we know that this patient has a stent; we know
24 that he needs it removed to prevent risk of
25 encrustation and potentially sepsis and those kinds of 15:30
26 problems --
27 A. Yes.
28 198 Q. But, as I say, a number of these cases where the
29 patient isn't being managed to the removal slot at an

1 appropriate pace?
2 A. The appropriate -- yes. I will maybe take you to the
3 fourth reason for having a stent in, and that is
4 a stent that's in that needs inpatient care because
5 there's something else that needs to be done -- you may 15:30
6 need to repeat ureteroscopy, for instance. So that's
7 a slightly different picture to, maybe going back to
8 the last example, is we used to use a flexible -- well,
9 we do use a flexible cystoscopy to take out the stent,
10 so you need a slot on the flexible cystoscopy list and, 15:31
11 as part of that outcome then, we tried to reserve
12 a slot on the flexible cystoscopy list so that those
13 patients could come back. So that was an outcome of
14 the audit.
15 199 Q. Yes, your audit, I should say -- 15:31
16 A. Yes, but --
17 200 Q. Let me just introduce your audit. It's at TRU-396077.
18 Sorry, I hope I'm not confusing things. I think just
19 to reiterate and emphasise, the point I'm making to you
20 is that in terms of the adequacy of a Patient Safety 15:32
21 meeting in terms of a governance tool, we are seeing
22 and we have observed seeing cases, some of which
23 I've mentioned to you, using stents, as an example,
24 coming into discussion in this forum. It
25 oversimplifies it to say it's the same problem every 15:32
26 time, but it's a species of the same problem,
27 management of stents. And my question ultimately
28 becomes if governance is to be more than a talking
29 shop, it needs solutions to a problem that's oft

1 repeated in practice. And I hope you're going to tell
2 me that your audit with Mr. Hiew, which was
3 commissioned in 2018/2019 looked at this area, isn't
4 that right?
5 A. Yes. It's looking at the stents that can be removed 15:33
6 easily and on a day patient point of view.
7 201 Q. You looked at a cohort cases through 2017 and 2018 and
8 then December 2018 to February 2019 and you came up
9 with three proposals for change, I think. If we just
10 briefly glance at those -- TRU-396090 -- so a checklist 15:33
11 for stent removal on strings:
12
13 "Improved logistics in removing stents with flexible
14 cystoscopies using a pooled list."
15 15:34
16 And the question:
17
18 "How can we improve stents at a realistic timeline?".
19
20 Was there an answer to the final question, which I 15:34
21 suppose is at the core of our governance concern here?
22 A. The issue is getting a slot to take out -- to get out
23 the stent. It needs an attendance at a day surgery
24 list, which is already full of check cystoscopies for
25 the likes of bladder cancer and other investigations. 15:34
26 They've always tried to get as many onto a list as
27 possible and if you leave one or two slots free, that
28 becomes an under -- an observed under-utilisation of
29 the slots. But, again, having the likes of this audit

1 done, it helps to prove that it is a necessary -- and
2 from a volume perspective, it would be used. It is not
3 just the odd case here and there.
4 202 Q. We've heard some evidence already from Mr. O'Donoghue
5 about the use of Lagan Valley for an aspect of this 15:35
6 work. Am I right in my recollection there?
7 A. Absolutely.
8 203 Q. Yes.
9 A. Again, it is finding the availability of an output
10 agent and, undoubtedly the recent Lagan Valley day 15:36
11 surgery has undoubtably revolutionised what we're
12 doing. We were talking earlier this morning about lack
13 of theatre space. You know, this is -- where we only
14 had one theatre in Craigavon, this has been a major
15 improvement. I know we can talk about COVID and how it 15:36
16 has restricted activity, but certainly COVID has
17 reinvented the wheel in terms of where we would be
18 operating. I mean, it was maybe instrumental in
19 getting us to move to Daisy Hill, the Health Minister
20 engaging to get Lagan Valley as a day surgery unit -- 15:37
21 a day surgery, all day -- it's an all day session.
22 I said earlier this morning about our Craigavon day
23 surgery, that it was only the morning. The patients
24 had to go home. There was no opportunity to do any
25 stone work. 15:37
26
27 So we've shifted a lot of inpatient work towards a day
28 surgery arena so that these patients who are operated
29 in the morning can stay all day and go home at

1 tea-time, where we didn't have that before. Is that
2 answering your question?
3 204 Q. Yes. Just to finish on this piece, I mean it may seem
4 to the Panel that, looking at the number of cases that
5 have come through around stent management -- indeed, 15:38
6 we've heard from I think at least two patients, or the
7 family of one and another patient directly affected by
8 what he was describing as his stent mismanagement -- it
9 does appear as if it's, in terms of volume, a
10 significant problem. It has happened many times and it 15:38
11 may appear to the Panel on the evidence that it has
12 been a particularly impenetrable problem or a problem
13 that has been hard to grapple with --
14 A. Yes.
15 205 Q. -- is that right, in your experience? 15:38
16 A. So, yes, to -- when somebody comes in with a stone and
17 they have a stent put in, okay, then it's a matter of
18 getting them a date to come back for their surgery.
19 Now, we were trying to get patients coming back within
20 the month, as per the Griffin report, and when you try 15:39
21 to get somebody back within the month, you have to know
22 that you have a theatre list in a month's time. So
23 coming through the circle to the monthly sort of rota,
24 knowing who's around, and also the theatre list
25 availability only becomes available three or four 15:39
26 weeks -- I'm going -- it's not so bad now, but I'm
27 maybe going back over the last couple of years -- that
28 that theatre list only came out three or four weeks
29 before the month was meant to start. So, in other

1 words, if we had our departmental meeting on the last
2 Thursday of a month, that rota is for the month ahead.
3 So, in other words, this is the month of November, so
4 at the end of November, the last Thursday in November,
5 we would have a departmental meeting which would 15:40
6 then -- a rota meeting which would define the theatres
7 available in January. So you're already a month out.
8 So you can't really sort of schedule. And part of a
9 lot of these audits that I was doing here I went away
10 from and said "Right, I'm going to put Patient X onto 15:40
11 my theatre list in one month's time", to find out
12 either that was already full, there were oncology cases
13 to do, or there wasn't a list available to me because
14 it had been taken away. So it is hard to schedule that
15 far ahead in the old system. So it is -- you're 15:41
16 talking about the key words of capacity and demand --
17 the demand for the theatre space to get these people in
18 was short of the mark.
19 206 Q. Thank you.
20 A. So it's a volume thing. 15:41
21 MR. WOLFE KC: Okay. Chair, I see it's a quarter to
22 four. I've probably overshot the mark slightly. Do
23 you want to take a short break now and continue to half
24 --
25 CHAIR: How long do you think you'll be today, 15:41
26 Mr. Wolfe?
27 MR. WOLFE KC: If we sit to, maybe, twenty past or half
28 four, if that's --
29 CHAIR: Very well, we'll take 15 minutes then, until

1 four o'clock.
2 THE INQUIRY ADJOURNED BRIEFLY AND THEN RESUMED, AS
3 FOLLOWS
4
5 CHAIR: Thank you, everyone. 15:59
6 207 Q. MR. WOLFE KC: Good afternoon again, Mr. Young. If we
7 could start with your statement again at WIT-51697, at
8 paragraph 7.2 you're reflecting again on governance.
9 You set out, I suppose, what might be regarded as
10 a pretty traditional view in terms of governance in 16:00
11 urology.
12
13 "As a clinician, it means following GMC guidance of
14 safeguarding high standards of care by maintaining
15 competency and revalidation, monitoring of risk and, if 16:00
16 a concern is identified, to respond promptly and
17 manage."
18
19 You say:
20 16:00
21 "Mechanisms need to be in place to provide quality
22 assurance for accurate, timely and reliable data that
23 can derive constructive information for continuous
24 improvement or identifying concerns."
25 16:00
26 In your experience, whether as a consultant or as the
27 clinician lead, were there sufficiently robust
28 processes in place to provide reliable data in this
29 context of improvement and risk?

1 A. I think the introduction of the Datix system in
2 principle is a good mechanism of identifying problems.
3 An issue with the Datix system, I find, is that it can
4 be a bit on the cumbersome side to fill in, but that's
5 a process thing. But as part of identifying issues, 16:01
6 I think it has an important part to play, whereas
7 before we had the Datix, it was hard to amalgamate
8 enough sort of information to identify a trend.
9 208 Q. Yes?
10 A. It's how the Datixes are then put together to get the 16:02
11 trend -- I'm afraid, I don't know, I'm not part of the
12 screening mechanism or knowing how a Datix works
13 further down the line. I'm afraid I don't know enough
14 about that.
15 209 Q. Have you ever seen fit, whether as a group of people 16:02
16 looking at any particular issue or as an individual
17 wearing your clinical lead hat, perhaps, ever seen fit
18 to ask for the generation of a report using Datix data?
19 A. I'm glad you asked that question because I haven't seen
20 a report. It seems to be information going in and the 16:03
21 only thing that you see coming out are individual sort
22 of cases, as opposed to a trend being seen. So
23 I haven't -- I've wanted to ask that question,
24 actually, of, you know, can there be an annual
25 appraisal or an annual sort of statement of what comes 16:03
26 out of Datix. Now, unless that is coming, I don't
27 think I have seen it. I may be wrong.
28 210 Q. You have, if we pull up WIT-51780 of your statement, at
29 48.1 -- and, generally, these systems -- I think you're

1 referring, if we scroll up a page, and there's
2 a reference to Datix and SAI and that kind of thing,
3 yeah, and root cause analysis. So I think what you're
4 saying here is that as distinct from patient --
5 individual patient-type data, and you've referred to, 16:04
6 in an earlier part in your statement, to the data to be
7 derived from NIECR and Patient Centre, which is, in
8 turn, to be derived from information sitting in patient
9 cancer pathways, radiology and lab reports, outpatient
10 and inpatient records -- those kind of things are 16:05
11 fairly individual?
12 A. Those are defined entities for each patient --
13 211 Q. Yes?
14 A. -- but not -- the NIECR is a document about an
15 individual patient and all their records on it, but 16:05
16 doesn't track beyond that.
17 212 Q. So, by contrast, you're saying here that Datix, at
18 least, allows you the potential to identify trends.
19 You say, for instance:
20 16:05
21 "If there are repeated Datix reports on patients
22 admitted with sepsis and this group of patients are
23 identified to be overdue a surgical treatment, this
24 produces a trend report."
25 16:06
26 That wasn't something you used for your audit on
27 stents, for example?
28 A. No, that was to identify the people -- "No" is the
29 answer to that question.

1 213 Q. You say:
2 "Albeit the triage issue had already been identified,
3 I believe that the Datix system would have highlighted
4 the point by the booking system at an earlier stage and
5 flagged to the governance team in charge of this 16:06
6 system, which is an independent system to the booking
7 office."
8
9 Just on that point, we know that a number of Datix were
10 raised in relation to the failure of triage. We had 16:06
11 Patient 10's case raised as an incident report in
12 January 2016, and then Mr. Glackin took on the SAI
13 review. And then into 2017, Patients 11 to 15 where
14 the subject of an SAI review following a Datix, and
15 that review was taken forward by Dr. Johnson, an 16:07
16 external, with Mr. Haynes at his side or as part of his
17 team.
18
19 The point I wanted to raise with you arising out of
20 what you just said there was that is it worthy of 16:07
21 comment that until 2016 when Mr. Haynes raised the
22 Datix in connection with Patient 10, that it would
23 appear that nobody else had seen fit to raise an
24 incident report, a Datix, in connection with the
25 failure of triage? 16:08
26 A. Yes, it would have taken -- I suppose, people should
27 have filled in more Datixes for these events. It's
28 whether somebody fills a Datix in for each event --
29 214 Q. I think the point you're making here, and let me put it

1 in these terms, is that we know that triage, in
2 association with Mr. O'Brien, were not good bed
3 fellows, for reasons that we can explore. The issue
4 went way back and, yet, so far as we are aware --
5 I stand to be corrected -- the January 2016 was the 16:09
6 first time the Datix system was used to point to this
7 problem?
8 A. It seems to be, yes. But, in saying that, the Datix
9 was to identify a trend. If you're specifically
10 looking at the triage issue, that trend was already 16:09
11 known. Is that what...
12 215 Q. It was already known, but, in a sense, using the Datix
13 system, I think you would agree with me, puts it at
14 a level of an expression of concern --
15 A. At a higher level, yes. 16:09
16 216 Q. -- which might lead, handled properly, to exploration
17 of the issue and a set of recommendations and an action
18 plan?
19 A. Yes, I understand your question. Yeah, that's correct.
20 217 Q. You go on to say: 16:10
21
22 "The Datix system, I believe, did define the trend in
23 the inappropriate dosage of the prostate cancer drug
24 being described."
25 16:10
26 Is that a reference to bicalutamide?
27 A. Yes, that's my understanding. The Datix system,
28 I believe it defined the -- that's what I was led to
29 believe, that that's how it came to the fore a bit

1 more. That was my understanding.
2 218 Q. Who gave you that understanding? It's certainly the
3 first time I think we've seen it expressed in those
4 terms, that the factor that would appear to have, at
5 least in terms of what the Inquiry has heard so far, to 16:11
6 have informed the world about the bicalutamide issue
7 was the SAI cases in 2020 --
8 A. Did the SAIs not originate from a Datix, in theory?
9 219 Q. Okay, so --
10 A. It's my understanding -- I may have misinterpreted, but 16:11
11 my understanding was that this had originated from
12 a Datix. I may be wrong. I believe -- I may be wrong.
13 220 Q. Okay, I take your point -- that clearly the nine SAIs
14 in 2020 into 2021 originated with a Datix?
15 A. Yeah. 16:11
16 221 Q. Okay. So, I suppose, more generally then in terms of
17 the use of data within urology, you say at paragraph
18 14.1 that performance indicators were regularly drawn
19 to your attention, including occupancy rates, length of
20 stay, day cases, waiting lists and surgery. And these 16:12
21 would be brought along to departmental meetings and
22 discussed. Was there, more broadly than that, was
23 there data used to examine, I suppose, the quality of
24 care being experienced by patients?
25 A. In what terms do you mean by...? Sorry. 16:12
26 222 Q. An inpatient has, post-theatre, has recovered well, has
27 left hospital within the expected period, or has come
28 back to hospital with a theatre-related or
29 a procedure-related morbidity -- timeliness in terms

1 of being seen, being treated, those kinds of -- in
2 theatre, time in theatre, that kind of thing?
3 A. There is a percentage readmission rate produced.
4 I suppose, it's the efficiency of the admission on the
5 day of surgery -- the, as you say, sort of lengths of 16:14
6 stay, and a percentage of that -- is there a sort of
7 outlier -- and readmission rates is quite a point
8 that's put on some of these CLIP reports. Those sort
9 of references that you were doing is that each
10 individual surgeon gets their sort of CLIP report at -- 16:14
11 well, at some time of the year, it's usually May time
12 -- and it outlines where the individual surgeon is on
13 the scale of things. So you will see where sort of you
14 are in comparison to your peers and in comparison to
15 the elite or whatever. 16:14
16 223 Q. Yes. So thinking about data and how it was used within
17 Urology, if we have a doctor in difficulty, and we'll
18 come on to look at some of the issues that emerged in
19 association with Mr. O'Brien's practice, do you think,
20 on reflection, that there's greater opportunity or 16:15
21 there's more opportunity which hasn't been tapped into
22 to use data to shine the light or to help to shine the
23 light on shortcomings in practice?
24 A. Yes, I suppose there are, but it depends what sort of
25 data you are collecting. So, you know, if you're going 16:15
26 to use an example of admitting on the day of surgery,
27 if you're an outlier there, is that a major issue, or
28 are you going to pick a topic that's going to identify
29 a problem? That's really where you stand.

1 224 Q. We'll come on to look at appraisal, perhaps, tomorrow.
2 In theory, as I understand it, you, the appraiser, and
3 the appraisee, was supposed to be supplied with
4 incidents, complaints, perhaps SAIs -- although there's
5 a little uncertainty about that and maybe you can help 16:16
6 us with that. But in terms of that kind of
7 information, call it data, if you will --
8 A. Yes.
9 225 Q. Was that all readily available to you in your role as
10 appraiser? 16:17
11 A. Appraisal is as good as the information that is
12 supplied.
13 226 Q. Of course.
14 A. Yeah. And it's -- now, my appraisal system was -- my
15 appraisal training in 2009 or '10, around that time, 16:17
16 was very much focused on getting the appraisee to
17 engage with the procedure and to get the -- to get all
18 the boxes filled in, if you want to call it boxes. In
19 other words, to have the information supplied to
20 complete. Now, that information is predominantly 16:18
21 supplied by appraisee. The Trust system supplies the
22 CLIP report, as we talked about, and that's a measure
23 of your activity in numbers and efficiency. The Trust
24 supplies your training passport and it supplies
25 "Complaints and Incidents", is the term used. 16:18
26
27 Now, the training passport is your sort of mandatory
28 training events -- like, the fire lecture, training if
29 you've -- well, in more recent times, it includes

1 hyponatremia, for instance. There's a list of things
2 to go, including lifting and back care. So there's
3 a list of things that vary in importance, basically.
4
5 And the third thing that I -- well, then you're meant 16:19
6 to include your job plan and, say, the Trust supplies
7 a Complaint and Incident form. I am not aware of any
8 SAIs in that or the IR1 activity being reported by the
9 Trust. Now, this appraisal period, the time is between
10 '10 and '15 is mainly when I did people's -- 16:20
11 227 Q. What is meant then when you say that complaints and
12 incidents are supplied?
13 A. Yeah, so this is if the Trust has received somebody
14 that has sort of written-in complaining about something
15 and it's attached to a individual -- it may not be the 16:20
16 individual that they're complaining about, but it's
17 just that the patient happens to be that consultant's
18 case -- it goes to them, and they give a complaint and
19 an outcome of the complaint. The incident is something
20 similar and, to be honest, I don't know where the 16:21
21 incidents have come from. They certainly didn't appear
22 to be on an IR1-type sort of level.
23 228 Q. Okay, so it's not an incident in the sense of an IR1 or
24 a Datix?
25 A. That's what I'm trying to put across. 16:21
26 229 Q. Yes? In fact, that is what I'm putting across to you,
27 is that it's not the IR1. So that -- now, I'm not
28 certain of the exact dates of when SAIs and sort of
29 Datixes came out as a document. You may have to help

1 me on that one.
2 230 Q. Okay.
3 A. But, you know, it's certainly going back to -- in the
4 old days, the SAIs were called "root cause analysis",
5 if I remember. So they might have a slight change in 16:22
6 the name.
7 MR. WOLFE KC: Okay. I was going to move on to another
8 topic, but I think with only five minutes to go, it
9 might be best starting afresh tomorrow.
10 CHAIR: Yes, I think we've all had a long day, not 16:22
11 least of which this witness! So we'll see you again
12 tomorrow then, Mr. Young, at 10 o'clock. Thank you,
13 everyone.
14
15 THE INQUIRY THEN ADJOURNED UNTIL THURSDAY, 9TH NOVEMBER 16:22
16 2023 AT 10:00A.M.
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