



Urology Services Inquiry

Oral Hearing

Day 73 – Monday, 4th December 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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I N D E X

WITNESS
MR. DAVID CONNOLLY

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1 THE INQUIRY RESUMED AS FOLLOWS ON MONDAY, 4TH DECEMBER
2 2023

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4 CHAIR: Good morning, everyone.

5 MS. MCMAHON: The witness this morning is Mr. David
6 Connolly, who's a consultant urologist and he wishes to
7 take the oath.

8
9 MR. DAVID CONNOLLY, HAVING BEEN SWORN, WAS DIRECTLY
10 EXAMINED BY MS. McMAHON AS FOLLOWS:

11
12 1 Q. MS. MCMAHON: Good morning, Mr. Connolly. My name is
13 Laura McMahon and I am junior counsel to the Inquiry.
14 I'll be taking you through your evidence this morning.

15
16 The context of your evidence is that you worked as
17 a registrar and a urology consultant in Craigavon at
18 various times. And you've provided us with a reply to
19 the Section 21 notice we served on you. And we can
20 find that at WIT-41966. You'll just see your name at
21 the top of that. It's dated 7th June 2022. Notice
22 Number 60. And if we go to your signature at the end
23 at WIT-41997, we'll see a signature there. Do
24 you recognise that as your signature?

25 A. It is.

26 2 Q. It's dated 1 August 2022. And do you wish to adopt
27 this statement as your evidence today?

28 A. I do.

29 3 Q. Now, I'll ask you some questions about your statement.

1 I'm going to work through it and just identify some of
2 the issues that you have addressed that the Panel may
3 be interested in. But I wonder, just before we do
4 that, could you summarise your education and your
5 career path to date?

6 A. So, I studied medicine at Queens. I graduated in 1999.
7 I did my GH0 year in the same hospital. I then went
8 straight into basic surgical training, which was for
9 three years. When I finished that, I did a year as
10 a staff grade in general surgery in Causeway Hospital.
11 And then I went into research in 2004. That was in the
12 City Hospital and in the Cancer Registry in Queen's.
13 So that was in 2004 to 2007.

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15 During that period of 2004 to 2007 I also did locum
16 nights in Craigavon and in the City Hospital as a
17 registrar. I then interviewed and was appointed to
18 higher surgical training in urology in Northern
19 Ireland, which started as ST3 in August 2007. And that
20 was in Craigavon, for a year. And then I rotated round
21 through the City Hospital, Altnagelvin Hospital and the
22 City Hospital, and then I did a fellowship year in the
23 Monash University Hospital in Melbourne for a year.
24 That was a fellowship in endourology, primarily stone
25 surgery, and laparoscopy.

26
27 Then I was appointed to Craigavon as a consultant in
28 September 2012. And I left Craigavon in March of 2013
29 to join as a specialist endourologist in the City

1 Hospital, and that's my current post.

2 4 Q. Thank you for that. And just if I can summarise, for
3 our purposes, the relative time periods and you can
4 confirm if that's correct. You were a locum registrar
5 in Craigavon from 2004 to 2007?

6 A. Yeah.

7 5 Q. Then you started your higher training in urology,
8 August 2007 to August 2008?

9 A. Yeah.

10 6 Q. And then you were a consultant in urology in Craigavon
11 from September 2012 until March 2013?

12 A. Correct.

13 7 Q. Thank you. I just want to look at your statement now
14 and set out the lines of management and your role while
15 you were at Craigavon. If we go to WIT-41966,
16 paragraph 1.1 and 1.2. So you say:
17
18 "I started in Southern Health and Social Care Trust as
19 a consultant urologist in September 2012 and left to
20 join the Belfast Health and Social Care Trust in March
21 2013. This was my first consultant job and was always
22 going to be a short term appointment for me, as
23 I planned to move to Belfast Health and Social Care
24 Trust. As a new consultant, I only had a basic
25 knowledge of the processes behind running a consultant
26 practice, managing a rapidly expanding service and the
27 governance structure of a health trust."
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29 At paragraph 1.2 you say:

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"I was a standard core urologist with responsibilities as outlined at paragraphs 5 to 8. I did not take on any other management roles, nor did I get involved in the long-term planning for the unit, as within a few months my consulting colleagues knew that I was leaving."

Just in relation to your plan to move to Belfast, when you took up the post, did you know you were going to move on relatively quickly?

A. Yeah.

8 Q. And what was the reason behind that?

A. So, when I was in Australia, I was in communication with the team in Belfast City Hospital, I was aware that a new job was going to be starting, which I'd hoped would've started in August 2012, that I would've been able to come back to. But the post wasn't ready to be advertised at that stage, so I applied for jobs both in the Ulster, Altnagelvin and Craigavon. But no matter where I was appointed to, it was only going to be for six months, because my plan was always to work in Belfast Trust in a specialist endourology role.

9 Q. And what was attractive about that specialist unit for you? Was it your area of expertise or planned expertise?

A. Yeah. So in all the other Trusts, that you were a core urologist, which meant that you dealt with all of

1 urology and then you had a limited role in your
2 subspeciality. In Belfast, because it was a larger
3 unit with more consultants, then I would primarily be
4 doing my subspecialty near enough all of the time. It
5 was also much closer to home, so it would save me
6 driving.

7 10 Q. Now, you mention as well in that paragraph this was
8 your first consultant post.

9 A. Mm-hmm.

10 11 Q. And you say:

11
12 "I only had a basic knowledge of the processes behind
13 running a consultant practice."

14
15 In 2012 was there any training for new consultants in
16 how to run a consulting practice, or was it very much
17 on the job training, that you learned as you went along
18 from your peers?

19 A. I think certainly as you're training in urology - and
20 I'm sure this is the same in other specialties - that
21 you do reading about the practical theoretical part of
22 the job and then you have your apprenticeship part of
23 the surgery, which is doing the operations. So the
24 main focus of my training was knowledge and practical
25 experience and to become competent in the operations
26 that I would need to do.

27
28 The actual running of a consultant practice was
29 something that was hardly talked about, to be honest.

1 Now, it may well have been that when I got to my final
2 year in ST7 that that would've been part of my sort of
3 training to finish off so that I would be -- sort of
4 that would be part of it. But I was in Australia, so
5 therefore I may have missed out on that. But
6 I certainly felt that whenever I started my first
7 consultant job, I knew how to treat urology problems,
8 I knew how do the operations, but in terms of actually
9 being a consultant, there was major gaps in terms of
10 running a practice that I had.

11
12 So, for example, I can remember starting in
13 Southern Trust and being contacted by the outpatient
14 manager to say what my outpatient template was going to
15 be, and I had never heard of an outpatient template, I
16 didn't know what that meant, so I had to ask the other
17 consultants, what do you do?

18 12 Q. So, from the administrative side of your role, it
19 really was learning on the job as best you could?

20 A. Yeah, you knew that you had triage to do, you knew that
21 you had discharge letters to do, you knew that you had
22 outpatient clinics and letters to do, you knew that you
23 had to have the whole results and background behind
24 that and that you had to be able to run that
25 efficiently. But it was very much left to you and your
26 allocated secretary to work out the practicalities of
27 how that would run.

28 13 Q. And in relation to governance - we'll talk about the
29 specifics of governance at the time in a little while -

1 but in relation to governance and structures and your
2 understanding of governance around 2012, was there any
3 specific training around that, or were you informed in
4 any way that these are the processes that you follow
5 should anything happen?

6 A. Well, you know during your training that there are
7 governance structures that are within a unit and within
8 a Trust; you know, so there's audit, M&M, IR1, critical
9 incidents. But in terms of the practicalities of how
10 that all works in the background, I had no idea, to be
11 honest.

12 14 Q. If we fast forward to now, you're a consultant at the
13 City now; what's the situation like for new consultants
14 coming into posts? Do you know anything about that?
15 Is there much of a difference? Can you inform us about
16 whether processes are perhaps more comprehensive at
17 this stage?

18 A. Well, I think that we, as a group of consultants, as
19 part of the training, do try and involve our ST7 senior
20 registrars as part of that. And I'm a clinical
21 supervisor and education supervisor for the higher
22 trainees, so that would be part of what I would see as
23 my role, is to train them in terms of how to run
24 a practice, not just the knowledge and the operations.
25 So it would be part of that. And, you know, for
26 example, the ST7s in Belfast, we would bring them to
27 our business meetings so they would see what happens
28 with the management and what happens to how the unit is
29 run outside of just audit and M&M that they would be

1 involved with through their training.

2 15 Q. And is that something you've undertaken with the other
3 consultants on a local basis or is that something
4 formalised by the Trust, where's there's an expectation
5 that there is a gradual easing of a registrar into a
6 consultant's post so that they know all of their roles
7 and responsibilities?

8 A. There's no formal guidance that I'm aware of that you
9 do as a consultant for your higher trainees to get them
10 involved with that side of thing. It's something that,
11 probably because we have experience of starting, not
12 really knowing how it works, to try and not have them
13 in the same position.

14 16 Q. The Inquiry has heard evidence in relation to
15 administrative practices that perhaps have impacted on
16 patient care and perhaps risk; do you think, given what
17 you've said, that it would be beneficial for new
18 consultants to have some sort of formalised, structured
19 training around what's expected of them and from them
20 in relation to their role?

21 A. I think that, you know, even within my current
22 practice, that the registrars that I supervise, that
23 they have their own aspects of admin that they have to
24 do. And I keep a very close eye on that and I make
25 sure that they develop good practices in terms of
26 signing off their letters in terms of doing the results
27 and actioning things that need to be actioned within
28 a reasonable timeframe.

29 17 Q. I suppose my question's perhaps a little bit broader

1 than being specific to your assistance that you
2 provide. Do you see any merit in the Trust having
3 a formal or a structured approach to new consultants to
4 allow them to understand exactly what's expected from
5 them in their role, as regards, for example,
6 administration, discharge, the processes by which they
7 engage with wider ancillary staff within the Trust?

8 A. So, again, when I started in Belfast Trust, that there
9 was a programme of training as a junior consultant.
10 But that only happened after I was appointed and then
11 it was, I think it was like one day of training per
12 month for the first six months - I think it was called
13 the CLIME sort of training, C-L-I-M-E. I can't
14 remember what that stands for. But that was sort of
15 part of being a new consultant, how you were introduced
16 to the governance structures and how the Trust expected
17 you to run your practice. But certainly, bringing that
18 into higher training so that when they start that they
19 have a better idea of what's expected I think would be
20 beneficial.

21 18 Q. Now, your line manager, when you worked in Craigavon,
22 was Michael Young?

23 A. Yes.

24 19 Q. And that was during your time both as a registrar and
25 as a consultant - because he was clinical lead at the
26 time?

27 A. He was always the clinician lead, as far as I remember.

28 20 Q. And you worked with Martina Corrigan as well?

29 A. Yes.

1 21 Q. And during your time you were responsible, together
2 with the other consultants, for the training of two of
3 the urology registrars, Derek Hennessy and Matthew
4 Tyson?

5 A. Yeah.

6 22 Q. Now, if you go to paragraph 7.2 at WIT-41972, you speak
7 to the way in which you would've dealt with any issues.
8 You say:

9

10 "Any issues relating to clinical care, patient safety,
11 administration and governance would have been raised
12 with my clinical lead, Mr. Young. I do not recall ever
13 having any such as issues that I had to discuss with
14 him."

15

16 Was that during your time both as a registrar, the
17 early days of your training as a registrar, as a locum
18 registrar, and as a consultant, you never had cause to
19 raise any concerns with Mr. Young, or indeed anyone
20 else at Craigavon?

21 A. No.

22 23 Q. And again, at WIT-41966, paragraph 1.5, you say
23 formally in your statement:

24

25 "I was not aware of any issues or concerns with any
26 staff members or the urology unit management during my
27 time in Southern Health and Social Care Trust. I was
28 aware of my line managers and who to report concerns
29 to, if they had been identified. I first became aware

1 of issues with Mr. O'Brien and with the SHSCT Urology
2 Service in a telephone conversation with Mr. O'Brien."

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4 which you have outlined. And if we perhaps go to
5 paragraph 53. I'll give you the reference for that.
6 WIT-41990. And just before I read this paragraph in,
7 have you had the opportunity to listen in or read any
8 of the press reports about the Inquiry, the issues that
9 have arisen that we've been discussing over the last
10 while?

11 A. Just what I've read in the evidence and what I've seen
12 in the news, nothing more.

13 24 Q. So that's how you found out about the issues that we're
14 discussing?

15 A. Yeah.

16 25 Q. You say at 53.1:

17
18 "I was not aware of any concerns regarding Mr. O'Brien
19 when I was employed at SHSCT."

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21 And at 53.2 you say:

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23 "I first became aware of potential issues when I was
24 speaking to Mr. O'Brien after he retired. I believe
25 this was in late July or early August 2020. He
26 informed me of his perceived poor treatment by SHSCT
27 after his retirement at the end of a telephone
28 conversation about one of his SHSCT patients who he had
29 planned to refer to BHSCT for a metallic stent.

1 Mr. O'Brien was aware that this patient was a family
2 friend of mine and he did not want his care being
3 delayed with his retirement. He was also aware that
4 I had already been helping the patient understand his
5 illness and make decisions regarding his treatment with
6 Mr. O'Brien. He advised that he had a verbal agreement
7 with SHSCT that he would return to work on a part-time
8 basis after his formal retirement. When he contacted
9 SHSCT to arrange his return, he was advised that SHSCT
10 did not want him to return to work, as he had an
11 outstanding grievance against Trust management. He
12 felt this was unlawful and he advised that he planned
13 to sue the SHSCT. Mr. O'Brien informed me that he
14 believed that SHSCT began an investigation into his
15 clinical practice after he brought an unfair dismissal
16 against SHSCT."

17
18 So that provides the context for your contact with
19 Mr. O'Brien. Did he mention anything in the call about
20 the issues that are subject to this Inquiry, about the
21 specific complaints in relation to him and the general
22 governance within the trust?

23 A. No. It was that the Trust had started looking at his
24 practice in very great detail because he was
25 bringing -- because he was going to sue them for
26 unlawful dismissal. That's the only thing he said to
27 me.

28 26 Q. And you time this call to late July or early
29 August 2020.

1 A. Yeah.

2 27 Q. Did you have any contact with Mr. O'Brien subsequent to
3 this call?

4 A. No.

5 28 Q. If we go to WIT-41973, paragraph 9.1. And this is
6 a paragraph in relation to the Integrated Elective
7 Access Protocol. We've heard a lot of evidence around
8 this. At paragraph '9.1 you say:

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10 "I was aware of the Integrated Elective Access Protocol
11 (hereafter IEAP), most probably from Mr. Young and
12 Martina Corrigan. I do not recall if I was ever given
13 the full document or signposted to it on the Trust
14 intranet. I was informed from an early part of my
15 employment (September or October 2012) that the main
16 focus of the IEAP in the urology unit was trying to
17 decrease the waiting times for all patients so that the
18 target times were met. As a new consultant in a new
19 post, on a practical basis this meant taking the
20 longest waiters from other consultants' waiting lists
21 and operating on them. I was aware of the importance
22 of reducing waiting times and of ensuring no patients
23 were waiting longer than the agreed target times for
24 their planned out-patient review or surgical
25 interventions."

26

27 Now, the Integrated Elective Access Protocol sets down
28 timeframes for treatment. And as a new consultant, was
29 it the case, as you didn't have a list, or a patient

1 list, did the longest waiters go to you, or what was
2 the process at that time when you started in Craigavon?

3 A. Yeah, so most of my outpatient clinics would've been
4 seeing new patients. So they would've been whoever
5 were the longest wait patients waiting to be seen, sort
6 of urgent or routine. Because at that stage I didn't
7 have a operating waiting list, my operating theatres
8 would've been with other patients, or other
9 consultants' patients, and they would've been given to
10 me by Martina through Mr. Young and Mr. O'Brien.

11 29 Q. And they were allocated to you, you took those on. And
12 did they stay as your patients or did they go back to
13 the original consultant? Were they transferred to you?

14 A. I can't remember. I think they were probably
15 transferred to me because I operated on them, then
16 I would've followed them on thereafter.

17 30 Q. Do you have any recollection around the target time set
18 out in the IEAP and whether patients that you dealt
19 with had exceeded those target times at that point?

20 A. There was numerous patients that were waiting longer
21 than the targets. And that was the main focus of
22 Martina and the Trust management, which was to try and
23 sort of meet those targets as best they could. Like,
24 it was unrealistic at the time, based on the patients
25 had exceeded the target and the capacity within the
26 unit, but they would've just taken the longest waiters
27 and then give them to me and the other two new
28 consultants to see whether or not we were able to get
29 close to or meet the targets.

1 31 Q. And when you joined as a consultant in 2012, you were
2 aware of these target times at that point - you've
3 mentioned that Mr. Young and Martina Corrigan probably
4 made you aware of that. But prior to that, when you
5 were there as a locum registrar during 2007/2008, did
6 you have any awareness around waiting times or long
7 lists or anything like that at that time, was that on
8 your radar?

9 A. Well, you always would've known that waiting times were
10 excessive. But in terms of actual targets and the
11 practicalities of how the Trust were meeting them
12 targets, I wouldn't have been involved.

13 32 Q. I suppose I'm trying to get to the sense of, given you
14 were there for three different time periods over
15 a period of time, every time you went back - 2004 to
16 2007, then back as your training 2007 to 2008, then you
17 came back as a consultant in 2012 - did you have any
18 sense that things were seemingly worse?

19 A. No.

20 33 Q. So the target times in 2012 that you were experiencing
21 as a consultant, they weren't a surprise to you?

22 A. I wouldn't have been that aware of the waiting times
23 when I was a registrar, because the lists would've been
24 booked by the individual consultants. You know,
25 whenever I started as a consultant, the waiting times
26 were above target - well above target - but compared to
27 now, they're not bad. So, at that stage I didn't think
28 it was excessive. And my expectation, given the fact
29 that they had went from two consultants to five

1 consultants, that we would actually, by working
2 together, be able to meet those targets.

3 34 Q. And did you have a sense that management had an
4 expectation that it would be urology consultants who
5 would work together to meet the targets or try and
6 bring some of those patients in to reduce waiting
7 times?

8 A. Yeah, so --

9 35 Q. Was the onus on you as the urology consultants?

10 A. So we would've had a meeting once a month where we
11 would've went through the whole theatre lists for the
12 following month in terms of who was doing the lists, if
13 someone was on holiday or someone was on leave or doing
14 something else, that someone then would've been
15 allocated to backfill that list so all available lists
16 were covered all of the time. So that's the way the
17 unit would've ran. And then -- so, for example, if
18 I had taken on one of Mr. Young or Mr. O'Brien's lists,
19 that they then would've said 'Right, I need three
20 prostate operations done, these are my ten longest
21 waiters, can you choose three of them?' And I would've
22 then looked at the cases and then chosen the cases that
23 I was happy to operate on.

24 36 Q. So there was that flexibility among the consultants to
25 try to get people off the list who'd been waiting
26 excessive times?

27 A. Yeah. So, I don't know how Mr. Young and Mr. O'Brien
28 did t, but they would have sent me a list of patients
29 to say 'Can you operate on these patients?' And then

1 I would've looked at them and I would've said 'Yes'.

2 37 Q. Do you have any recollection or any view on whether
3 you felt, at the time, Urology was adequately resourced
4 to meet the targets?

5 A. I think there was, and I mention in the statement that
6 there was, an expectation amongst the team that our
7 capacity was going to increase, because they had moved
8 from two consultants - well, previously three
9 consultants - up to five consultants and, therefore,
10 the operating time, the theatres that we had available
11 to us, the clinics we'd available to us, the
12 diagnostics we had available to us would be increasing
13 in line with the number of consultants that had been
14 appointed and, therefore, the waiting times were going
15 to come down. And the expectation was it may take
16 a period of time, a year or two years, but that we
17 would be able to get the unit running on
18 a self-sustaining basis so we would be able to meet the
19 targets the majority of the time.

20 38 Q. And was that still the expectation when it came around
21 to March 2013 and you'd moved to Belfast, was it still
22 going that direction?

23 A. Well, I know the extra lists hadn't materialised at
24 that point, so Urology were not being given the
25 resources that we felt we needed to be able to meet the
26 targets from the Trust. But, again, getting a theatre
27 list and making that active takes a long time. You
28 know, obviously you need a theatre available. Most
29 Trusts do not have free theatre space - you know,

1 basically because the theatres are already used by
2 other specialties. So, in order for Urology to be able
3 to access additional theatre capacity, then that
4 required a lot of work from the Trust to be able to get
5 that theatre up and running and us to be able to
6 utilise it. So it was always an expectation that this
7 would take a long time, and that I wouldn't be involved
8 with it, because as I said, I was always going to be
9 moving on.

10 39 Q. Now, was there any sense from your perspective during
11 that time that general surgery or other surgeries were
12 prioritised over urology?

13 A. It certainly would've been Mr. O'Brien's belief that
14 urology was treated badly compared to general surgery
15 and other subspecialties of general surgery and that
16 that had been a longstanding problem within Southern
17 Trust.

18 40 Q. And was that your perception for the short period of
19 time you were there? Did you share that at all?

20 A. I didn't have enough info -- you know, like, I don't
21 know, I didn't know how it was between 2008/2012 and
22 how it changed after I left, so it's hard for me to say
23 yes or no.

24 41 Q. You've mentioned it in your statement - perhaps we'll
25 just go to that paragraph. WIT-41992. That's
26 paragraph 62.1. You say:

27
28 "I cannot recall the specific details, however I do
29 remember that Mr. O'Brien had longstanding concerns

1 regarding the perception or support of Urology by the
2 general surgical management in SHSCT. This would have
3 been discussed informally during conversations at break
4 times and during meetings with the whole consultant
5 team about the restructuring of Urology services.
6 There was no specific patient safety concerns raised,
7 it was more about the perception of, and resource given
8 to, Urology compared to other services. Specifically,
9 I recall that he did not have a good relationship with
10 Mr. Eamon Mackle, Associate Medical Director. I recall
11 that Mr. O'Brien felt that Mr. Mackle did not take
12 Urology seriously and would always make decisions that
13 prioritised general surgery over Urology. "

14
15 Do you have any recollection of any specific examples
16 that you may have heard or were aware of where
17 Mr. O'Brien indicated that he thought general surgery
18 was given a priority over urology?

19 A. As I said, this was just conversations at break time
20 over coffee. But, you know, for an example,
21 Mr. O'Brien told a story of when he first was appointed
22 to Southern Trust in '92 or whenever that was, that on
23 the interview panel was the Chief Executive and
24 a number of the consultant surgeons and after he'd been
25 appointed, he was brought back into the room to
26 congratulate him and go through how it happen and he
27 was asked how many urologists he thought Southern Trust
28 needed and I think he said five or six and they laughed
29 at him.

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So, even from when he started, he knew that he was in a very minority position at that stage, a single consultant running the whole of the urology service, and that he obviously didn't feel that urology was an important part of the surgical management of Southern Trust. Now, obviously that was back in the early '90s, when urology was, right throughout Northern Ireland, a very sort of fledgling specialty. But even as we expanded from two consultants to five consultants, that there was still that perception that we were a lesser specialty and that, you know, even though there were massive waiting time problems and that urology continues to be one of the worst waiting list problems in Northern Ireland, that we do not get the resources that other specialities get.

42 Q. Do you think the impact of the urology restructuring around that time, just before then and leading into the time that you joined, do you think that seemed to make things better or worse for at least the perception of the urologists in Craigavon?

A. It improved things. Because as I say, they went from a team of two to a team of five. We also then were restructuring ourselves to take over the urology catchment of Fermanagh, so we were taking over going to Erne Hospital at that stage, or SWAH. And that would've been part of then the Southern Trust's urology, so it covered a massive geographical area from Fermanagh across to South Down, so it covered a very

1 large population. And it was then a more sustainable
2 unit, because obviously, if you're dealing with a unit
3 of two people, if one person gets sick, it's almost
4 unsustainable.

5
6 So it certainly improved the belief that this was
7 a proper urology team that would be sustainable going
8 forward. And it was a very exciting time in the unit -
9 you know, that they were opening up the Thorndale unit,
10 which was a one-stop clinic for doing sort of
11 diagnostics all at one time and there was a lot of
12 planning went into it. And, like, even amongst the
13 managerial staff, the consultant staff and the nursing
14 staff, it was an exciting time, that you sort of
15 thought 'we're actually going to make this work', you
16 know? And I'm sure Aidan probably felt at that time
17 that he was getting the service that he envisaged was
18 needed back in 1992.

19 43 Q. You did have cause to send an email yourself about the
20 general surgical list, the emergency list. If we just
21 go to that. Just as an example of, perhaps you can
22 explain if there is tension, but just an example for
23 the Panel. AOB-06264. And if we just move down to the
24 bottom e-mail, first of all, from you, sent on 25th
25 November 2012. And you've copied in the other
26 consultants. The subject is "emergency lists". And
27 you say:

28
29 "Hi, was anyone aware of the way that emergency lists

1 are now running? What I was told is the surgeon of the
2 week reviews the list and prioritises it, giving time
3 limits that the cases need to be performed in (1 hour,
4 4 hours, 12 hours, 24 hours etc.). I did not receive
5 any communication about this as far as I know, but it 11:31
6 appears to have been implemented from last week.

7
8 I have just had a case bumped down the list without any
9 communication from the surgical team (bilateral
10 ureteric stones with hydro). Luckily she is not septic 11:31
11 and renal function is okay. But when I went down I was
12 told that their case had to be done within four hours,
13 so got prioritised.

14
15 Just slightly annoyed that this seems to have happened 11:31
16 without any input from the other specialties which also
17 use the emergency list.

18 David."

19
20 Mr. Young then replies to you the next day, 26th 11:31
21 November 2012, and he says:

22
23 "What exactly is this? Completely unaware of this.
24 Will investigate.

25 MY" 11:31

26
27 So that seems to be an example when your case was
28 bumped for another case that had been assessed as of
29 greater urgency; would that be fair from what you've

1 written?

2 A. Yeah.

3 44 Q. But the issue is that youse weren't informed or
4 consulted on this process for allocation of emergency
5 list?

11:31

6 A. So, there's a general etiquette in terms of how an
7 emergency list works in every hospital that I've worked
8 in, which is that the most urgent life-threatening
9 cases go first and then when they're finished, then
10 everything else is done in chronological order

11:31

11 depending on who booked first. But it may well be
12 cases that aren't immediately life-threatening but are
13 still urgent, which I presume this case from the
14 general surgical team was, because they felt it needed
15 to be operated within four hours. So the etiquette

11:31

16 would be that the general surgical team would phone me
17 and say, you know, 'We have to go ahead of you because
18 of this case'. And I would've said 'That is no problem
19 at all'. But what happened - and obviously this
20 happened without any discussion with Mr. Young or with

11:31

21 any of the urology team - is that the general surgical
22 team in Craigavon implemented a system whereby the
23 surgeon of the week, who is a general surgeon, would
24 look at the list and they would then prioritise the
25 cases, not knowing any of the clinical history of the

11:31

26 individual cases, and then they would say which gets
27 most priority. And, you know, whilst everybody tries
28 to be fair, you will tend to prioritise your own case.

29 45 Q. And would that have been a system introduced that

1 would've affected other specialties as well as urology?
2 A. It would've been every speciality that would've used
3 the emergency list. But the surgeon of the week is a
4 general surgeon, so no matter who the speciality was,
5 the general surgeon was making the decision in terms of 11:31
6 which cases went first in the emergency lists. And
7 again, this was obviously introduced by the general
8 surgical team and Urology and I presume no other
9 specialty were actually told about it until it was
10 already implemented. 11:31

11 46 Q. Mr. Young has said "I will investigate". Did you ever
12 get any feedback from him about what the outcome of his
13 queries on this issue were, or did anything change
14 after that, or did it happen again?

15 A. I believe the system continued, but I don't know the 11:31
16 outcome of the thing. So I think this system was in
17 place in Craigavon for a period of time, but I think
18 the outcome of the investigation with Mr. Young was
19 that this is how it's working now.

20 47 Q. And is there anything in this example - I know it's one 11:31
21 email 11 years ago - but is there anything in this
22 example that would support any perception that urology
23 perhaps was the poor relation within the surgical
24 structure in Craigavon?

25 A. Well, I think if you look at what happened, inferring 11:31
26 from what I've written in the email, is that general
27 surgery implemented a system without discussing it with
28 urology that clearly was going to impact on how the
29 urology service was going to run. So, to me, that's

1 disrespectful.

2 48 Q. Now, when you were the consultant at Craigavon, your
3 secretary was Noleen Elliott?

4 A. Correct.

5 49 Q. And she was appointed to you when you started off. And 11:31
6 she was already working with Mr. O'Brien at that point,
7 is that your recollection?

8 A. No, I think Noleen started and she was my secretary.
9 I don't believe she worked with anybody else at that
10 stage. 11:31

11 50 Q. And had she started long at that point in 2012, do you
12 recall?

13 A. No, she was new as a medical secretary as well.

14 51 Q. And given you were both relatively new to the post, how
15 did you go about developing your working relationship 11:31
16 as regards your admin duties?

17 A. I can't honestly remember it being an issue. It was
18 just basically we sort of said 'Right, this is what
19 we need to do. This is how we will run it'. Again,
20 Noleen would've been in an office with other 11:31
21 secretaries, so we probably asked, you know, how do
22 other consultants do it and what way do they run it and
23 then we kind of just followed suit.

24 52 Q. In relation to notes, the Inquiry has heard evidence in
25 relation to notes being kept away or located where they 11:31
26 may not expect to be; did you have any recollection
27 that there was an issue among other consultants around
28 keeping notes or taking notes away or having access to
29 notes? Did you yourself experience a problem with

1 that?

2 A. So, this was pre-electronic care records, so therefore,
3 everything was in the paper notes. So if you had to do
4 a discharge letter or if you had to do a result letter,
5 that would require you getting the paper notes to be 11:31
6 able to do that. So, everybody had, like, a filing
7 cabinet that notes were kept in and I was aware of
8 a section that I had that were notes that needed
9 discharge letters, I had a section that were notes that
10 needed results letters and then I would've just taken 11:31
11 my time to go through each of those and to do a letter
12 and when I finished with the letter, the notes would've
13 went back to Noleen to go back to file.

14 53 Q. So when you finished that, it was Ms. Elliott who sent
15 it back then to -- 11:31

16 A. Yeah.

17 54 Q. -- where the notes were kept at that time?

18 A. Yeah.

19 55 Q. In relation to your dictation after clinics, what was
20 your process at that time starting out for you to get 11:31
21 those tapes back and for letter to be dictated, what
22 was your system?

23 A. So, again, during training there were two different
24 ways that I seen it being done. The first and the most
25 common way was that when you saw a patient in 11:31
26 Outpatients, you dictated the letter immediately onto
27 a tape. And then you did that for each patient and
28 then at the end of the clinic you would have put the
29 tape into an envelope and written on it "Mr. Connolly's

1 outpatient clinic, 1st January". And that would've
2 went to the outpatient team or the clerk at the front
3 of Outpatients and they would've sent that with all of
4 the notes back to my secretary to get the letters
5 typed.

11:31

6
7 The other way which was done, primarily in Vascular,
8 from what I remember, was that because the clinics were
9 very busy, with a very high turnover, that they asked
10 you to do your dictation all at the end. So you
11 would've held onto all of the notes in the room and
12 then when all of the patients were seen, you would've
13 went through and then dictated all of the letters at
14 the end of the clinic. I personally disliked that,
15 because, you know, many vascular or many urology
16 patients have similar problems and, therefore, you
17 know, I wouldn't have been able to remember the
18 intricacies of each of the notes. So I always dictate
19 the letter after I see the patient.

11:31

11:31

20 56 Q. And did you ever find yourself falling behind with
21 dictation?

11:31

22 A. So, that would've happened at the time. So I would've
23 sign the patient, dictated the later, put the notes to
24 one side and moved on the see the next patient. So the
25 outpatient dictation always would've happened at the
26 time and always would've finished by the end of the
27 clinic.

11:31

28 57 Q. So, based on your workload, it was manageable for you
29 to be able to do that, either at the time or at the end

1 of the clinic, without falling behind?

2 A. Oh, it was just part of your clinic time is that you
3 had time built into that so that you would be able to
4 do your dictation as part of seeing the patient. It
5 was considered part of your allocated four hours, is 11:31
6 that you had that time to see the patient and dictate
7 on them and book whatever investigations or procedures
8 they needed.

9 58 Q. And at the time that you were there in 2012, was triage
10 part of your role? 11:31

11 A. It was.

12 59 Q. And what way was it carried out when you started your
13 post at Craigavon?

14 A. So you would've got paper triage letters from GPs or
15 from A&E or from other consultants and that would've 11:31
16 went to a central appointments and they would've then
17 date stamped it and sent it to individual consultants
18 for triage. Because there were five of us, it would've
19 been split between the five of us. I don't remember
20 how that they chose, I assumed it was just, you know, 11:31
21 evenly sort of given to all of the consultants. Like,
22 I don't honestly know how it happened, but I knew that
23 every day I would get a folder that had a number of
24 triage letters in it and then it was my job to triage
25 those. 11:31

26 60 Q. And again, was that something that you ever weren't
27 able to do because of your other commitments, or was it
28 something, a bit like your dictation, you just factored
29 into your working day?

1 A. You generally would've done it around what else you had
2 done. So, you know, you can't do it at clinic, because
3 clinics are busy and there's patients there all the
4 time, but, for example, in theatre it would've been
5 fairly common that you bring your triage down to 11:31
6 theatre and, therefore, when you were waiting for
7 a patient to be put to sleep, that you would have 10/15
8 minutes and you would be able to triage some of the
9 letters. And then if you didn't have time to do that,
10 then you may have done it at the end of your working 11:31
11 day. And it would've been not uncommon that I would've
12 stayed on late to finish off admin tasks that I didn't
13 want to leave behind.

14 61 Q. Do you have any recollection of Ms. Elliott or anyone
15 else having to chase you up for dictation or triage or 11:31
16 for the location of notes? Did any of those things
17 happen when you were there?

18 A. As I said, I was just started. I was trying to make an
19 impression.

20 62 Q. Best behaviour, you were on your best behaviour? 11:31

21 A. You know, I didn't want to sort of, like, fall behind.
22 So it was never an issue. But as I said, like, you
23 never had enough time for admin. And I still don't
24 have enough time for admin and I regularly stay on at
25 the end of a working day in order to make sure that 11:31
26 it's all done. But, you know, the admin roles you have
27 are very important, so I would make sure that I did
28 what was allocated to me.

29 63 Q. I just want to read into the record your comments on

1 what you considered was the organisation's efficiency
2 of the unit at WIT-41994, paragraph 67.2 of your
3 Section 21 reply. It starts at 67.1. They both cover
4 the same issue, but I'll read both of them in.
5 WIT-41994. The system's just having a Monday moment. 11:31
6 Perhaps if I just can read this while we're waiting for
7 the system to heat up.

8 CHAIR: Sure.

9 64 Q. MS. McMAHON: At paragraph 67.1 you say:

10 11:31
11 "When I started at the Urology unit SHSCT, I felt it
12 was a good unit with good working relationships between
13 staff members, including consultants, trainees, nursing
14 staff, both ward and their specialists, secretaries and
15 unit managers. The unit had significant backlogs and 11:31
16 waiting times and this would have taken time and effort
17 from all staff to organise and resolve. With the
18 expansion of consultant numbers and the upcoming
19 rebuilding of a dedicated urology one-stop clinic,
20 there was a lot of goodwill and excitement about the 11:31
21 future of the unit. In the intervening years, I and
22 a number of other staff members have moved on and
23 I understand there has been difficulties with
24 recruiting and retaining full-time staff. The SHSCT
25 have advertised on a number of occasions for 11:31
26 substantive consultant urologists and have not
27 successfully appointed anyone. I suspect that this has
28 led to increased pressure on the remaining staff and
29 the services have become stretched and pressurised.

1 I expect that this has likely led to worsening
2 interpersonal relationships between individual
3 consultants, admin staff and management. It also
4 leaves less time for the usual governance structures to
5 work robustly. With COVID, these problems have
6 exacerbated the underlying issues, so that the service
7 now has difficulty managing even its core work. "

11:31

8
9 At paragraph 67.2 you say:

10
11 "At the time, I felt it was a well run unit, with good
12 engagement and organisation between the medical staff
13 and management. Like other units I have worked in,
14 there were appropriate formal processes of risk
15 management, clinical governance and Patient Safety.
16 Any issues tended to be managed informally and almost
17 on an ad hoc basis. There was, however, very little
18 structure to governance meetings and there tended to be
19 no agenda and the meetings were not minuted. Any
20 patient safety issues, complaints and incidents tended
21 to be managed by the individual consultants involved.
22 Therefore, there was the potential for a lack of
23 independence or oversight. This is not an exclusive
24 issue with SHSCT and I suspect this was normal practice
25 at that time. Indeed, it is only since the Dr. Michael
26 Watt case in Belfast Trust where I have seen this
27 change, so that these governance processes are now more
28 formal and documented with independent oversight. "

11:31

11:31

11:31

11:31

1 I just want to pick up a couple of issues in those
2 paragraphs. Obviously, you've already reflected in
3 your evidence that you felt things were improving,
4 there was a greater capacity of staff at that point,
5 but you've also highlighted information that 11:31
6 we've heard previously about the staff recruitment and
7 retention, and that seems to have been a problem within
8 Urology generally, I think. Is that still your
9 experience or is there a greater capacity now for being
10 able to attract the right staff and to keep them in 11:31
11 post?

12 A. No, it's still a problem in the majority of Trusts
13 that -- like, Northern Ireland is a small place,
14 urology is a small specialty; there are only a limited
15 number of people who want to come and work here. And 11:31
16 the vast majority of those are trainees that come
17 through. At present, there are vacancies in all of the
18 Trusts bar one. And therefore, for every trainee that
19 comes off the top of training, they have three or four
20 job opportunities that they can choose between. So 11:31
21 we're all fighting for the same trainees and we all
22 have the same issues in terms of being able to attract
23 people.

24
25 Obviously, with Craigavon, they had specific issues - 11:31
26 you know, primarily that they were a small team and
27 that people like myself and Mr. Pahuja, who were
28 appointed - and as I say, at the time there was an
29 expectation that the unit would become self-sustaining

1 within a period of a few years - but I left, Mr. Pahuja
2 left. And, therefore, whenever that happens, you have
3 a prioritisation of work. So, emergencies always are
4 priority, followed by red flag cases, followed by
5 urgent cases, followed by routine cases. When you have 11:31
6 two or three vacancies, it means more of the emergency
7 work falls onto the in-house consultants, more of the
8 red flag work falls onto the in-house consultants, so
9 even the urgent stuff waits and the routine stuff just
10 doesn't get done. So, therefore, it's just a 11:31
11 self-fulfilling prophesy, that it just keeps going on
12 and on. And that makes the life more difficult for the
13 current consultants. And, therefore, if they see an
14 opportunity of a job elsewhere when there are vacancies
15 elsewhere, then they may well choose to leave it. And 11:31
16 there was a period of time where I and other consultant
17 urologists in Northern Ireland had concerns about the
18 viability of Craigavon as a unit going forward because
19 of its inability to attract new consultants.

20 65 Q. And as you say, the knock-on effect of that is that the 11:31
21 system gets squeezed more and more. And you've hinted
22 at the potential for interpersonal relationships then
23 to degrade?

24 A. Yeah. As I say, your focus always goes onto
25 emergencies and red flags. And the red flags were a 11:31
26 massive thing - so, obviously that's for possible
27 cancer cases - so, so much of your time and energy is
28 put into that, that a lot of the standard work -- and,
29 you know, if you don't specialise in cancer, as I

1 don't, then that puts a lot of pressure, because, you
2 know, Mr. O'Donoghue, for example, in Craigavon, his
3 subspecialty interest is in female urology and
4 reconstructive urology, which is a benign problem;
5 whenever he is doing emergencies and red flags, he 11:31
6 doesn't get to do any of his subspecialist interest.
7 So, I can understand why - like, I appreciate he's
8 still a consultant there - but I understand why he may
9 not be happy with that situation. And that's reflected
10 in other Trusts as well. 11:31

11 66 Q. Now, you've mentioned that the issues tended to be
12 managed informally around governance and almost on an
13 ad hoc basis. Now, I appreciate it was 2012, but what
14 do you mean by that? Have you any examples you could
15 give us in relation to that, how you know that to be 11:31
16 the case?

17 A. Well, I suppose I can't remember any occasions where
18 these things were formally discussed at any of the
19 meetings where there were any issues raised with
20 individual consultants. Now, I appreciate from 11:31
21 evidence that other people have given that there were
22 issues in the background that I wasn't aware of, you
23 know, and from a governance perspective, that this
24 tended to happen as, you know, a corridor conversation
25 or a coffee break at theatre where, you know, someone 11:31
26 may mention something to the Clinical Director or the
27 Associate Medical Director but wouldn't make a formal
28 complaint or raise a formal issue, it's sort of more,
29 you know, 'This might be something you want to know

1 about'. You know, that's kind of what I mean, is that
2 it was -- you know, there was very little in terms of
3 formal structure to it, it tended to be more 'well, you
4 better let the CD know that this might be an issue so
5 that they can go and talk to the individual consultant 11:31
6 so they can stop that practice', as opposed to it being
7 raised through a formal channel, you know, such as poor
8 performance.

9 67 Q. And now that you know some of the issues, because of
10 the Inquiry, do you think they were issues 11:31
11 you shouldn't have been made aware of or it would've
12 been beneficial to know about at that time?

13 A. Well, I think that there was a perception that there
14 were ways that Aidan was dealing with cases that
15 would've been different to other consultants and that 11:31
16 would have been accepted, you know, as a 'well, that's
17 how he's always run it and, therefore, that's how he's
18 continued to run it', as opposed to that formally being
19 challenged through the clinical lead with Mr. Young or
20 Mr. Mackle or Mr. Brown. 11:31

21
22 But again, I don't know whether any of those issues
23 were ever raised directly with Aidan in sort of 2007 or
24 before. But there is the potential that, had they
25 been -- if some of the issues that -- probably the way 11:31
26 to say it is that if that was happening now in Belfast
27 Trust, that that would be dealt with in a more formal
28 way.

29 68 Q. So that's the difference between then and now, is there

1 would be a form formalised structure?

2 A. I believe so. But as I said in the statement, I don't
3 believe Southern Trust in any way was different to
4 Belfast Trust/Western Trust at that time, I think
5 that's just how things were done, is that it tended to 11:31
6 be done on an informal way where, if you had concerns
7 about a colleague, you would go to your CD and you
8 would say 'I don't like the way that he's doing this'
9 and then the CD would go 'Oh, you're probably right'
10 and they would talk to the consultant and say, you 11:31
11 know, 'Somebody has raised a concern about this. You
12 probably shouldn't be doing that'.

13 69 Q. You said in that paragraph as well that any Patient
14 Safety issues, complaints and incidents tended to be
15 managed by the individual consultants involved. And 11:31
16 I know you've said a moment ago that you don't think
17 the Southern Trust was any different from other Trusts
18 in relation to the way ad hoc governance was applied.
19 Would that be the same for that sentence, would most
20 trusts have operated in the same way at that time? 11:31

21 A. Yeah. So, as I said, if there was an issue with an
22 individual consultant's performance, that that would've
23 been dealt with just with that individual consultant by
24 either CD usually. So it wasn't have been -- you
25 wouldn't have had other consultants really being 11:31
26 involved with the process, you know. And therefore,
27 you lose some independent oversight, because -- and,
28 like, you know, if you look at the structure where you
29 had us as standard consultants and then Mr. Young as

1 the clinical lead and then Mr. Brown as the clinical
2 director, Mr. O'Brien, Mr. Young and Mr. Brown worked
3 together for 20 years, you know, so therefore, they
4 knew each other personally. And it's more difficult to
5 then formally discipline someone if you know them
6 personally. It just, it can create a lot of ill
7 feeling within the unit.

11:31

8 70 Q. And perhaps it's more difficult to even challenge
9 someone, rather than discipline them, if those
10 relationships exist?

11:31

11 A. Absolutely. And, you know, obviously when you have
12 Mr. Young and Mr. O'Brien were the only two consultants
13 for a long period of time, that they needed to have
14 a good working relationship, because they were
15 completely depend on each other. Because if
16 Mr. O'Brien wasn't in the Hospital, Mr. Young was the
17 only urologist and, therefore, everything that happened
18 fell onto him. So you needed to have good working
19 relationships. And, therefore, having Mr. Young and
20 then Mr. Brown as the clinical lead and Clinical
21 Director when there was a dependence on each other
22 probably isn't -- has potential for things to be dealt
23 with in an informal way because you know them
24 personally and you want to keep everything smooth.

11:31

11:31

25 71 Q. Now, you've mentioned in your statement some of the
26 structures in place for governance at that time and
27 I just want to read out those particular references.
28 At WIT-41979 at paragraph 26.1 you say:
29

11:31

1 "As this was my first consultant post (and I had not
2 planned to stay in the unit on a long-term basis),
3 I did not have a good grasp of the clinical governance
4 struck and processes at the time. On appointment,
5 I believed that the Trust governance structures were 11:31
6 already in place and I was happy to fully engage with
7 them. I was aware of the unit's M&M meetings, grand
8 ward rounds, audit meetings, complaints management,
9 critical incident reporting (IR1) risk management and
10 MDT (and appraisal had I stayed longer). This provided 11:31
11 me with reassurance that patient safety and minimising
12 risk were an important part of the unit's standard
13 work. "

14
15 Then if we go to WIT-41981 at 32.1, you say: 11:31

16
17 "I believe that I had individual responsibility for
18 ensuring that I was providing good quality care for my
19 patients. This would have been assured through the
20 Trust's governance structure, such as IR1s, complaints, 11:31
21 audit or M&M meetings and the risk register, for
22 example. This would have been overseen by my clinical
23 lead, Mr. Young, and my Service Manager, Martina
24 Corrigan. I do not recall any issues regarding the
25 quality of care that I provided being raised during my 11:31
26 time in SHSCT. I was never aware of any issue with any
27 of the wider Urology service. "

28
29 You say later on at 37.1 that you cannot comment on the

1 efficacy of any of those systems, as you weren't
2 personally involved with them.

3
4 Then at WIT-41983, at paragraph 39.1 you say:

5
6 "Had any issues been raised, I would have expected
7 these to be discussed during the dedicated governance
8 day (Thursday), either around the discussions during
9 the grand ward round, during the lunchtime meetings or
10 during the cancer MDT. There were also ad hoc meetings 11:31
11 between the consultant team to discuss the proposed
12 service changes which would have provided a further
13 opportunity for concerns to be raised. I never asked
14 for, nor was I provided with, any assurances regarding
15 the quality of urological care under any consultant." 11:31
16

17 Now, just in relation to that, the Thursday, you've
18 described it as governance day, was that the
19 opportunity then, you feel, for both you to raise any
20 governance concerns, but also for any governance 11:31
21 concerns arising within the unit, for you to be
22 informed of those?

23 A. Well, I'll say that it was a day where standard
24 clinical work was stopped, so there were no operating
25 lists, there were no outpatient clinics, so it was 11:31
26 expected that all of the consultants, all of the
27 trainees, the senior nurses, would do a grand round of
28 all of the patients. And that was an opportunity where
29 you could discuss patients' care and it was an

1 opportunity to ask questions of the treating consultant
2 team what was happening and what options, maybe, they
3 had for treating patients differently. The meeting at
4 lunchtime, again it was a scheduling meeting or it was
5 a meeting about -- it was like a business-type meeting 11:31
6 where you were then talking about the running of the
7 unit. And in the afternoon it was the cancer MDT. And
8 each of those, you had the opportunity of raising any
9 issues that you felt you weren't happy with how the
10 unit was being run. 11:31

11 72 Q. If we go to WIT-41987. At paragraph 47.9(ix) you say:

12
13 "I trained with Mr. Glackin and Mr. Pahuja and
14 I consider them to be my contemporaries. I would have
15 been comfortable raising clinical concerns directly 11:31
16 with them. Mr. O'Brien was my supervising consultant
17 both when I was a locum registrar in Craigavon in 04 to
18 2007 and when I started my higher training in urology
19 (Urology ST3) 2007 to 2008. I would not have felt
20 comfortable going directly to Mr. O'Brien if I had 11:31
21 concerns, as he only knew me when I was very junior and
22 inexperienced and we did not have time to build
23 a stronger relationship before I left. In any event, I
24 did not have any concerns to raise."

25
26 Now, you worked then with Mr. O'Brien; as you say, you
27 were a registrar at the time.

28 A. So when I was a locum between 2004 to 2007, so
29 I would've done nights on call and weekends. So

1 Mr. O'Brien would've been the consultant on call for
2 a third of those. And then my first role as an ST3
3 when I started proper urology training, that it
4 would've been him, Mr. Young and Mr. Akhtar were the
5 three consultants that were supervising me at that 11:31
6 stage.

7 73 Q. And did you work in surgery with Mr. O'Brien during any
8 of those periods. Were you in theatre with him?

9 A. Yeah, yeah.

10 74 Q. And did you have any view of his ability as a surgeon 11:31
11 or sense of the culture in theatre when he was there?

12 A. Mr. O'Brien was technically a very good surgeon.
13 I learned an awful lot from him. I still believe how I
14 do a TURP, a prostate operation, a lot of what I do is
15 how Mr. O'Brien did it. And he was a very careful, 11:31
16 slow, meticulous surgeon who done things in a very
17 stepwise way. So I learned the steps from him and
18 I probably still do the operation very similar to how
19 he did it. The same thing with open surgery; he was
20 a very careful, meticulous surgeon who took his time 11:31
21 and did everything, in my view, by the book, how it
22 should've been done.

23 75 Q. Did you have cause to call Mr. O'Brien in when he was
24 on call during those periods, weekends and --

25 A. On numerous occasions. As I said, 2004 to 2007, 11:31
26 I hadn't even started urology training, so I was very
27 much a junior who could do very little on my own, so
28 any time a patient would've had to go to theatre,
29 I would've expected, certainly in the first few years,

1 that the consultant would've been there with me.

2 76 Q. And the urology consultants, there was never any
3 difficulty, they came in from home and --

4 A. None at all.

5 77 Q. -- when you contacted them, they responded to that 11:31
6 appropriately, in your view?

7 A. Absolutely. They were very supportive.

8 78 Q. We'll go to WIT-41996. And at paragraph 71.1 you say:
9

10 "In hindsight, I do not think the governance 11:31
11 arrangements were fit for purpose. I did not
12 appreciate this at the time, as this was my first
13 consultant job and the processes in SHSCT appeared to
14 be similar to other units I had worked in during my
15 urology training. As a result, I did not raise this as 11:31
16 a concern. As outlined in my answer to question 67,
17 this was my experience of all the units I worked in
18 during my urology training and as a consultant until
19 the last five years or so. I have noted within Belfast
20 Trust in the past five years that governance procedures 11:31
21 have become far more formalised, the recording and
22 documentation of issues and the independent oversight
23 of these has greatly improved. I suspect this relates
24 to lessons learned from the Dr. Michael Watt case."
25

26 Just before we look at what has improved, when you say
27 "In hindsight, I do not think the governance
28 arrangements were fit for purpose", is that based on
29 what you know from the Inquiry or is it on reflection

1 now as a more experienced consultant looking back?
2 A. I think it's both. That, as I said, that in
3 Every Trust I worked with, the structures were there,
4 you know, sort of -- so, M&M, audits, complaints, IRIs,
5 that was there. But it was dealt with in a very 11:31
6 informal way between the individuals and, you know, it
7 was probably done in a way to not raise issues, you
8 know, so that things would sort of return back to
9 normal as long as no patient harm was done. And,
10 therefore, it would've been dealt with informally 11:31
11 between the individual consultant and their CD and it's
12 not something that probably would've involved the rest
13 of the of the team and a lot of the learning then may
14 not have been shared.
15 11:31
16 As I say, the individual issues with Aidan's practice,
17 I was completely unaware of as a registrar and then
18 even as a consultant, that there were issues going on
19 in the background that were never discussed at any of
20 the formal meetings that I was at. And I presume, 11:31
21 therefore, that that was being dealt with in-house
22 between Mr. Young, Mr. Brown as the CD and then
23 Mr. Mackle as the MD. But me, as a another consultant
24 in the unit, would not have been aware that those
25 issues were happening. 11:31
26 79 Q. Now, you've mentioned in that paragraph recording,
27 documentation and oversight, independent oversight, has
28 improved within the governance procedures in the
29 Belfast Trust and you mention the Dr. Michael Watt

1 case. Can you tell the Panel in what way they've
2 improved, or what's your experience of what has been
3 enhanced, perhaps, as a result of that?

4 A. Yeah, so probably from around 2015/2016 there's been
5 a massive change in the culture, where everything is 11:31
6 far more open and far more transparent in terms of
7 what's going on with individual consultants and with
8 the processes. There's now, each specialty have
9 a dedicated governance lead who's paid to do that job.
10 So it isn't just that you have the CD and it's part of 11:31
11 their role; that you have a person who's individually
12 responsible for the governance issues; in our unit that
13 there's a weekly meeting between the management team
14 and the governance lead so that all issues are dealt
15 with very rapidly, so that these types of things aren't 11:31
16 able to just go on for months and years without ever
17 being addressed.

18
19 As part of my appraisal, I get a document sent to me
20 that tells me, as well as my activity and 11:31
21 morbidity/mortality, it tells me how many complaints
22 I've had, what the individual complaints are, it tells
23 me any IR1 that either I've completed or another person
24 has completed that involves me and any litigation that
25 the Trust has about me, that I get advised of all of 11:31
26 this. And the expectation is, as part of my appraisal,
27 that I will reflect on each and every one of those
28 incidents and then record that and that will be part of
29 the appraisal discussion with my appraiser. My

1 appraiser is also completely independent from urology,
2 so therefore, they are not a friend of mine or someone
3 who is able to kind of just go 'Ah, don't do it again,
4 David', that they're someone who's independent and part
5 of the appraisal team, not someone who'd be directly 11:31
6 affected by my performance.

7 80 Q. In relation to learning from incidents that have
8 happened or complaints, is there a way in which you
9 receive feedback even if you're not directly involved
10 in the incident, that there's some learning fed back 11:31
11 formally to either the individual clinicians, the
12 general consultants within the unit or more broadly?
13 Is there structure for that feedback?

14 A. Yeah. So, currently, as part of our monthly M&M
15 meeting, that we discuss all of the IRIs or potential 11:31
16 SAIs that are currently live within the unit. So our
17 service manager comes to the end of that meeting and
18 we go through with the governance lead the outstanding
19 IRIs or SAIs and what we need to do then as a team in
20 order to meet the recommendations of any SAIs. 11:31

21
22 There's then also sort of specialty-specific local
23 and -- or trust-wide and regional learning letters that
24 go out. So, you know, if there's a specific issue to
25 urology then that will go to the urology teams in all 11:31
26 of the different Trusts, or if it's a more general
27 thing, you'll get an email that'll have a learning
28 letter on it.

29 81 Q. And the governance improvements that you've outlined

1 there, do you know if they're specific to the Belfast
2 Trust, or is there any feedback from the Department
3 that there's an expectation that certain procedures
4 will come into play given issues that have arisen from
5 past cases?

11:31

6 A. I'm not involved with other Trusts, so I don't know.
7 But as I say, I would've thought that the learning from
8 the urology inquiry will have been regional and will
9 not be just specific to one individual specialty, it
10 would be expected that everybody will then form
11 a similar process.

11:31

12 82 Q. I want to look at WIT-41995 at paragraph 70.2, where
13 you speak about Mr. O'Brien. And you say:

14
15 "In my time working with Mr. O'Brien, I found him to be
16 very similar to other older consultants that I had
17 worked with during my training. He had a wealth of
18 experience and was technically a very good surgeon. He
19 was a good teacher and was very patient with trainees.
20 His patients were very fond of him, even to the point
21 where they preferred to see Mr. O'Brien personally
22 instead of other consultants or trainees and they
23 respected his opinion above all others. He did,
24 however, have idiosyncrasies to his practice that I did
25 not understand. As a new consultant and having
26 recently passed the FRCS urology exit exam, I was very
27 guideline and evidence-focused and I practised as
28 closely to what I had learned during my training as
29 possible. Mr. O'Brien had changed his practice based

11:31

11:31

11:31

1 on his experience and anecdotal cases."

2
3 Then you go on to give us some examples at 70.3. And
4 there are two examples in this paragraph. The first
5 one relates to IV fluids and the second one to BCG 11:31
6 therapy. So I'm just going to split the paragraph
7 slightly and read the first part. You say:

8
9 "For example, Mr. O'Brien (and Mr. Young and
10 Mr. Akhtar) used to regularly admit patients with 11:31
11 recurrent urinary tract infections to the urology ward
12 for 5-7 days to be treated with intravenous antibiotics
13 and fluids. I never saw this in any guideline, but
14 accepted that this was the standard practice in the
15 unit which predated my time. I felt that I was never 11:31
16 going to change this practice in the short time that
17 I was planning to stay in SHSCT, but I was not going to
18 practise in the same way."

19
20 Now, just stopping there for a moment. That issue in 11:31
21 relation to intravenous antibiotics and fluids seems to
22 suggest that that was an issue that came to your
23 attention when you went back as a consultant in 2012,
24 or were you aware of it --

25 A. Oh, no, when I was a registrar. 11:31

26 83 Q. When you were a registrar.

27 A. It was far more apparent then, because I would've been
28 doing the ward round and seeing these patients.
29 Obviously, as a consultant, they would've been admitted

1 under the other consultants, so I wouldn't have been
2 involved with their care. So it was mainly I note this
3 as a registrar between August 2007/2008.

4 84 Q. I took that to be the case, given you'd said you were
5 only going to --

11:31

6
7 "I was never going to change this practice in the short
8 time that I was planning to stay."

9
10 I took that to mean as your consultancy post --

11:31

11 A. Oh, sorry, yes.

12 85 Q. -- but in fact you had noticed it in the years prior to
13 that?

14 A. Yeah. And I can remember conversations with other
15 registrars and the research registrars at that stage,
16 who would've been in Craigavon before me, about this
17 practice. And I believe there had been previous audits
18 or discussions about this and that even though there
19 was no evidence behind it, it was ingrained practice in
20 the unit and that it was not going to change.

11:31

11:31

21 MS. McMAHON: I wonder if I could just stop there,
22 Chair. I believe there's a problem with the case note,
23 it hasn't been working for a while, so perhaps it would
24 be a convenient time?

25 CHAIR: well, yes, I think it's an appropriate time
26 then to take a break. We'll come back at 25 to 12.

11:31

27
28 SHORT ADJOURNMENT

29 CHAIR: I believe the technical difficulties have been

1 resolved, so hopefully they'll stay that way.

2 86 Q. MS. McMAHON BL: Yes, smooth sailing, hopefully.

3

4 Just before the break, Mr. Connolly, we'd spoken about
5 the IV, intravenous antibiotics and fluids issue and 11:34
6 we'd looked at paragraph 70.3 of your statement. Now,
7 you'd said something you'd noticed, I think you said,
8 both when you were there as a registrar and later on as
9 a consultant, is that right, for the purposes of the
10 transcript? 11:35

11 A. So, it would've been -- I first identified that when
12 I started as a registrar, as an ST3 in August 2007,
13 that this was common practice that once or twice
14 a month a patient would've been admitted for a five to
15 seven-day course of IV fluids, IV antibiotics. 11:35

16 87 Q. And why did you consider that to be unusual, if you did
17 consider it to be unusual at that time?

18 A. Because the patients tended not to be acutely unwell.
19 This was a planned admission, so this isn't someone who
20 has come through A&E, is septic, with high temperatures 11:35
21 and high inflammatory markers, that these were patients
22 who were clinically well and were a planned admission
23 to the ward on a timetable, so that they would have it
24 three times a year - I don't remember exactly what way
25 it worked. But again, it was the same people that you 11:36
26 would've seen every three or four months that would've
27 come in to have this course of fluids and antibiotics.

28 88 Q. You've mentioned clinical markers that would've perhaps
29 indicated the need for IV antibiotics and fluids and

1 these patients weren't exhibiting those markers; was
2 that something you ever discussed with either
3 Mr. O'Brien, Mr. Young or Mr. Akhtar, who you said used
4 this practice of regular admission?

5 A. No, again, the administration would've been arranged by 11:36
6 the consultant and there would've been a plan in place
7 for them and I would've followed the plan.

8 89 Q. Was it something that other registrars noticed or was
9 discussed at all? Were you aware of anyone else --

10 A. No, as I said, that whenever I started and this 11:36
11 practice was ongoing, it was discussed by registrars
12 and by the clinical fellows and I was advised that this
13 practice had been looked at previously and there was an
14 audit done, I don't remember which registrar did the
15 audit, but there was a audit done sometime between 11:37
16 2004/2007 which showed there was no clinical benefit to
17 this. But the practice was ingrained and that audit,
18 despite having negative findings, was never --
19 it didn't change practice.

20 90 Q. Just for our understanding of the reasons behind why 11:37
21 a registrar might undertake an audit, could you set
22 that out, why that might happen in practice?

23 A. Yeah, so it was part of your training, was that you
24 were expected to perform an audit or a quality
25 improvement project at least once a year. And that 11:37
26 usually would be under the supervision of one of the
27 consultant team. And the way it would tend to be is
28 that you would -- something that you were interested
29 in, or a practice that you saw within the unit that you

1 felt could do with improvement, that you would then see
2 what the practice was, how it was being measured, you
3 would then look at it, see if there was any national or
4 international guidelines in terms of what we consider
5 the gold standard, you would then collect the data to 11:38
6 see how the unit's practice compared to the
7 international standard and then you would recommend
8 changes based on that. And then once the changes were
9 implemented, you would then re-audit it, you know, six
10 or 12 months later to see whether or not the changes 11:38
11 made any clinical impact.

12 91 Q. And are those audits usually published or are they
13 internal documents? What's the status of that sort of
14 work?

15 A. So, again it would be normal for that to be presented 11:38
16 to the whole team as part of your monthly M&M audit
17 meeting. And that would be just like a PowerPoint
18 slide and a team discussion about it and then any
19 changes that were needed. But again, the M&M meetings
20 were not minuted, so no one would've kept a record of 11:38
21 what was discussed or what the outcome of that was. If
22 the audit was a good quality audit and could
23 potentially change clinical practice, then that's
24 something that you could've put forward as an abstract
25 for a meeting, such as the Irish Society of Urology, 11:39
26 that audits would be presented at that, or then if it
27 was very good, then you may be able to get that
28 published in a journal.

29 92 Q. And you say there was an audit carried out at some

1 point between 2004 and 2007 by another registrar?

2 A. Yeah. Again this is going on memory, but I believe
3 that whenever I sort of talked about this, to say 'why
4 is this happening' and 'Has no ever one ever looked at
5 this', I was advised 'It has been looked at before, 11:39
6 it's been shown it doesn't make any difference, but it
7 sometime happens'.

8 93 Q. And for a registrar to do an audit like that, would
9 they need buy-in from the consultants? would they need
10 their engagement? Or is it autonomous work which is 11:39
11 done at that stage?

12 A. So you would have a supervising consultant, but
13 generally the whole team would be aware that the audit
14 was happening. Because it's a lot of work, there's
15 a lot of data collection on lots of different patients, 11:39
16 and particularly at that stage, because it was paper
17 notes, it would've been a matter of getting all of the
18 notes put together to be able to get all the
19 information to put an audit together. So it was a lot
20 of work. And, like, it would be very unusual that 11:40
21 somebody would object to an audit. Like, it was just
22 standard that if someone decided they were going to do
23 an audit, that it would just go ahead.

24 94 Q. And would it be usual for an audit's outcome or
25 findings to perhaps be disregarded or not taken on 11:40
26 board?

27 A. It depends on the audit and what the findings were. As
28 I say, I wasn't involved in the audit or the findings,
29 I was just advised, when I sort of was in Craigavon as

1 a registrar, that 'There's no point in trying to audit
2 this or to look at it, because it's not going to change
3 the practice of admitting these patients'.

4 95 Q. If an audit was done, as you say you were informed it
5 was, and the finding was that the practice as you 11:40
6 witnessed it wasn't clinically beneficial to patients,
7 would that be, in your view now, a significant enough
8 finding for the practice to be reviewed?

9 A. Well, you would hope that if you were doing something
10 as a practice and then an audit showed that it didn't 11:41
11 help, that you would then personally review your
12 practice to decide whether that's something that
13 you should continue to do.

14 96 Q. Was there any indication that it was harmful to the
15 patients or carried any element of risk? 11:41

16 A. No. Like, the patients would've received intravenous
17 fluids that they didn't need, because they could eat
18 and drink and, therefore, there's no benefit to them
19 getting intravenous fluids. They would've had bloods
20 done to check for fluid overload or low sodium levels. 11:41
21 But that was never an issue, basically because the
22 amount of fluid they're getting was not excessive, that
23 their body wouldn't be able to just pass out. They
24 would've been getting regular doses of antibiotics,
25 usually Gentamicin. Gentamicin does have side effects, 11:41
26 but again, the doses, I can't remember exactly, but
27 they were low dose that they were being given, it
28 wouldn't have been a full therapeutic dose. So the
29 antibiotics that they were getting, at the level they

1 were getting, the risk to an individual patient was
2 very low, but there would've been a community risk to
3 resistance, because you were giving antibiotics in
4 a person who doesn't clinically have an infection that
5 needs them.

11:42

6 97 Q. Now, you'd mentioned in your statement earlier,
7 we talked about, that you didn't have any difficulty
8 speaking to, for example, Mr. Young as your clinical
9 lead and you felt well supported. Would that have been
10 an example of an issue that you may have gone and
11 spoken to him about, just to get some clarity from
12 a clinical standpoint?

11:42

13 A. I believe Mr. Young also admitted patients for IV
14 fluids and antibiotics, so I didn't see any point in
15 talking to him about it.

11:42

16 98 Q. Now, the other issue that you mention at paragraph 70.3
17 is the BCG issue. And if I could just back to that
18 paragraph. It's on the screen. In the second part of
19 that you say:

20
21 "Similarly, he did not like using intravesical..."

11:43

22
23 Is that, am I saying --

24 A. Into the bladder. Intravesical.

25 99 Q. "... intravesical BCG therapy for high risk, non-muscle
26 invasive bladder cancer and preferred mitomycin
27 therapy. I was informed (I do not recall if this was
28 by Mr. O'Brien himself or someone else) that
29 Mr. O'Brien had a patient soon after BCG was first

11:43

1 introduced that developed a small capacity, poorly
2 function bladder as a side effect of the BCG treatment
3 and since that time he did not likely using BCG. I did
4 not have this experience and continued to advise BCG
5 for my patients. Over time, there may have been the 11:43
6 opportunity for me to challenge some of the differences
7 between our practices, but I never felt this was
8 a realistic prospect during my short tenure at
9 Craigavon Area Hospital."

10
11 "BCG" stands for...

12 A. Oh...

13 100 Q. ... Bacillus - if I can say this correctly - Bacillus
14 Calmette-Guérin therapy. And it's the same BCG
15 we get at school? 11:44

16 A. Yeah, for TB vaccination, correct.

17 101 Q. And what's the benefit of that, or the use of that in
18 your practice, just for our understanding?

19 A. So if the patient, after the initial treatment where
20 the bladder tumour is removed, if they then have 11:44
21 a six-week course - so, once a week they will attend,
22 they'll have a catheter put in their bladder, the BCG
23 will be instilled into their bladder, that will stay
24 within their bladder for one to two hours, they will
25 then pass it out and they will go home. And they will 11:44
26 do that once a week for six weeks. And then they will
27 go on to a maintenance programme of between one to
28 three years, during which time that they will come up,
29 usually sort of on a three-monthly basis, to have

1 further courses of the intravesical BCG. And the
2 principle behind it is that by having the induction
3 course and the maintenance course, that you decrease
4 the likelihood that the cancer will recur and the
5 cancer will then progress to muscle invasive disease, 11:45
6 which is far more serious and more life-threatening.

7 102 Q. So you've recounted anecdotal evidence of Mr. O'Brien's
8 dislike for that, or perhaps caution around it and as a
9 result of that reference to that issue, the Trust, as
10 part of their Lookback Review undertook an audit of 11:45
11 patients in relation to this particular issue and have
12 replied to the Inquiry. And I just want to detail that
13 response. It's at TRU-320011. Just for the Panel's
14 note, this was an audit by Mr. Mark Haynes, the outcome
15 of which is dated 24th November 2023. And I just want 11:45
16 to read out, given this issue has been raised, this
17 paragraph. It says:

18
19 "With reference to the concern raised with regard to
20 Mr. O'Brien's use of intravesical BCG treatment for 11:46
21 patients with high risk non-muscle invasive urothelial
22 cancers of the bladder, the existing Lookback Review
23 cases have been interrogated. A single case of high
24 risk non-muscle invasive bladder cancer was identified
25 where BCG treatment was not offered. For this patient 11:46
26 there was clinical justification for the decision to
27 not offer BCG. Therefore, to date the Lookback Review
28 has not identified any concerns regarding the offer of
29 BCG treatment to patients with high risk non-muscle

1 invasive bladder cancer.

2

3 As BCG treatment for high risk non-muscle invasive
4 bladder cancer is given after initial diagnosis and
5 resection TURBT and that, following retirement, Mr. 11:46
6 O'Brien's patients' case has been continued by the
7 remaining members of the Southern Trust urology team,
8 we do not have any concern that there is an ongoing
9 patient concern regarding this group of patients not
10 currently receiving appropriate management. 11:47

11

12 Mr. Connolly references the risk of functional side
13 effects of BCG therapy, in particular in the long term
14 bladder function/symptoms factor into decision making
15 for patients and may be a clinical reason why BCG 11:47
16 treatment is not offered. In order to receive BCG
17 treatment, patients need to retain the BCG in their
18 bladder for up to two hours. Patients who are unable
19 to do this, either because of incontinence or severe
20 urgency symptoms, would not be suitable for the 11:47
21 treatment. In addition, patients' bladder symptoms can
22 become worse during the course of BCG treatment.

23 Approximately one-third of patients do not complete
24 three-year maintenance BCG programmes, with the
25 majority of these being because of worsened bladder 11:48
26 symptoms.

27

28 Risk of persistent bladder pain, sometimes leading to
29 bladder removal, is quoted as 1:50/1:250 in the patient

1 information leaflet produced by BAUS for patients
2 receiving BCG treatment. Patients are counselled
3 regarding these risks when their treatment options are
4 discussed with them. Unfortunately, some patients do
5 develop intractable bladder symptoms, as described by 11:48
6 Mr. Connolly, as a result of BCG treatment and they
7 subsequently require surgery to remove their bladders
8 to manage these symptoms.

9
10 We have considered the guidance for bladder cancer 11:48
11 management which was available during the time which
12 Mr. Connolly was a consultant in the Southern Trust in
13 order to ascertain if the assertion by Mr. Connolly can
14 be evidenced in the treatments received. At this time,
15 NICE guidelines had not been published. They were 11:48
16 first published in 2015. The available guidance for
17 multi-disciplinary teams at this time has been produced
18 by BAUS in January 2013, which recommends intravesical
19 BCG and maintenance 1 - 3 years and references the
20 European Association of Urology guidelines for bladder 11:49
21 cancer.

22
23 A significant factor which has occurred on a number of
24 occasions over the past decade is disruption on
25 availability of BCG supplies. This was an issue during 11:49
26 the time period 2012 to 2013. There has been
27 a worldwide problem and has meant that at times of
28 unavailability of BCG, patients were not able to be
29 offered this treatment and delivery of maintenance BCG

1 for patients has been interrupted and, therefore,
2 suboptimal. Supplies of BCG during periods of
3 disruption have been intermittent and variable, meaning
4 we have not been able to clearly identify dates between
5 which BCG was unavailable. " 11:49

6
7 Then at TRU-320013, the second paragraph, beginning:

8
9 "Despite the NICE guidelines not being published until
10 2015, in order to assess the care of patients with 11:50
11 non-muscle invasive bladder cancer treated in
12 Southern Trust during the time period when Mr. Connolly
13 worked as a consultant in Southern Trust, we utilised
14 the audit tool published alongside these guidelines.
15 Unfortunately, the data output from this audit did not 11:50
16 provide sufficient insight into the care provided to
17 patients with high risk non-muscle invasive bladder
18 cancer to be able to assess Mr. O'Brien's utilisation
19 of BCG for patients with high risk non-muscle invasive
20 bladder cancer and the concerns raised in 11:50
21 Mr. Connolly's statement.

22
23 This audit did enable us to identify those patients who
24 were first diagnosed with high risk non-muscle invasive
25 bladder cancer in the 2012 - 2013 and 2013 - 2014 11:51
26 financial years and a subsequent review of all of these
27 cases was undertaken with regard to the offer of
28 intravesical treatment and the MDM recommendations
29 given at the time.

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A total of 38 patients were identified with a diagnosis of high risk non-muscle invasive bladder cancer on their initial TURBT. Of these, seven patients were upstaged to muscle invasive disease on resection TURBT and one patient was found to have metastatic disease on staging. A further three patients had severe significant comorbidities and were managed with palliative intent. The remaining 27 patients were potentially eligible for BCG treatment. A total of nine consultants who worked in the Southern Trust Urology Department during this time period managed these patients. Mr. O'Brien was recorded as managing five of these patients." 11:51

Then the report, for the panel, provides details of the treatment offered to each of those patients. 11:52

Then if we move down below the table, and the summary of that: 11:52

"From the data collected over this time period, there is therefore no evidence that patients under the care of Mr. O'Brien during this time period were less likely to be offered BCG management in the management of their high risk non-muscle invasive bladder cancer than patients under care of the rest of the urology team." 11:52

It goes on just at the last page, at TRU-320015, and

1 the audit includes:

2

3 "Of note, during the process of this review, concern
4 has been identified regarding the management of one
5 patient (who is now deceased) with metastatic/muscle 11:52
6 invasive disease and this has been flagged to The Trust
7 Lookback Team for further assessment. This concern is
8 not in relation to intravesical treatment."

9

10 And it's signed by Mr. Haynes, consultant urologist, 11:53
11 24th November 2023.

12

13 So that was a piece of work undertaken by the Trust
14 simply to have a look back to see if that issue was
15 prevalent and the information that they have and those 11:53
16 are the conclusions of that.

17

18 I just want to ask you a couple of other issues that
19 have been raised through the Inquiry to see if you have
20 anything you can assist us with. 11:53

21

22 You've mentioned about the clinical nurse specialists
23 in the unit --

24 A. Mm-hmm.

25 103 Q. -- in Urology and you work very well with them. For 11:53
26 the Panel's note, that is at WIT-41877 and the relevant
27 paragraphs are 22.1, 22.2, 23.1 and 24.1.

28

29

1 In summary, you have said that they were excellent and
2 they had very advanced practice at that time. And also
3 we've heard since then, obviously they have -- the
4 developments and the work that they have undertaken has
5 seemed to be quite progressive within urology, more 11:54
6 roles falling to the cancer nurse or the clinical nurse
7 specialist.

8 A. Yeah.

9 104 Q. Is that the experience in the Belfast Trust? Is there
10 a parallel in expertise? 11:54

11 A. We are years behind the specialist nurses in Craigavon.
12 When I was in Craigavon - so that was ten years ago -
13 the specialist nurses were training to do diagnostic
14 flexible sigmoidoscopies and training to do prostate
15 biopsies. That process is currently happening within 11:54
16 Belfast Trust, where the clinical nurse specialists are
17 just being trained now. So the CNSs in Southern Trust
18 were being trained ten years ago and I presume have
19 been working independently doing those two diagnostic
20 procedures which in the past would have been done by 11:55
21 consultants for many years.

22 105 Q. And did you have experience of working with the cancer
23 nurse specialists in clinics for new diagnosed patients
24 or review patients?

25 A. Yeah, so there would've been, both for prostate cancer 11:55
26 and bladder cancer there would've been a results clinic
27 where you would've seen patients, usually in the
28 Thorndale unit, because it's sort of quieter and you
29 were able to take time with the patients there. And as

1 part of that results exercise, the Clinical Nurse
2 Specialist would've sat in with you, would've been
3 there when you gave the patient the news about their
4 cancer diagnosis and would've been the first port of
5 call for any questions that they would've had. So the 11:55
6 nurses would've come in with a little, like a booklet
7 that would have information on prostate cancer or
8 bladder cancer and they would've given that to the
9 patient at the end of the consultation and they
10 would've give them their contact details so that if 11:56
11 they'd any more questions, that -- like, when you give
12 patients a diagnosis of cancer, a lot of the time they
13 do not remember a lot of the details you gave them
14 thereafter. So the nurses had a very important role to
15 be able to be a first point of contact if they had any 11:56
16 further questions coming back. And the nurses in
17 Southern Trust were excellent.

18 106 Q. And did you have any problems accessing the Cancer
19 nurse specialists when you needed them to come into the
20 clinics or you needed them to provide information to 11:56
21 patients?

22 A. No, these were all planned clinics, so I would've known
23 in advance that the CNS would be there.

24 107 Q. Do you remember if there was ever an issue with any of
25 the other consultants having access to, or utilising, 11:56
26 the cancer nurse specialists?

27 A. Not that I was aware of. As I say, there may well have
28 been times where, because of leave or other issues,
29 that there may not have been a CNS at every single

1 results clinic, but it would've been normal practice
2 that they would've been there had they been available.

3 108 Q. You've stated that the nurses were also there for the
4 MDTs, they attended the MDT, the general meetings.

5 A. The cancer CNSs did. 11:57

6 109 Q. In relation to MDT and the way in which it worked at
7 the time you were in Craigavon, if you were to -- if
8 the MDT were to agree, or recommend a course of
9 treatment for a patient and you then felt that that
10 treatment should perhaps be changed or wouldn't follow, 11:57
11 you didn't think the recommendation was suitable for
12 the patient, was there a process by which you revisited
13 that with the MDT or was that something, as
14 a clinician, you could independently take a decision on
15 and move forward with your course of action? 11:57

16 A. So, in the Southern Trust, I was at MDT every week that
17 I was there, so therefore, my patients would've only
18 been discussed at MDT when I was actually at the
19 meeting. So I would've been part of that consensus
20 discussion and writing the decision of the MDT. So it 11:57
21 would've been very rare that the MDT decision would not
22 have been what I, as an individual, felt was the right
23 course of action. Because had it have been different,
24 I would've challenged it at the time. So it would be
25 very rare that the MDT outcome would differ to what 11:58
26 I would want to do as an individual.

27 110 Q. Were you aware that there had been any variations in
28 MDT recommendations from other consultants?

29 A. I wasn't at the time, but obviously I am now.

1 111 Q. And what would be the procedure if you were to want to
2 change a course of treatment that had been recommended
3 by the MDT as a clinician? what would you do?
4 A. Well, as I say, when I moved to Belfast Trust in end of
5 March 2013, I no longer was involved with cancer 11:58
6 treatment or MDT, so I'm not at MDT. So, some of my
7 patients will go to MDT and the MDT discussion happens
8 without me being there and then the results of the MDT
9 will come back. Most, the vast majority of the time
10 I would follow the recommendations from MDT, because 11:58
11 it's usually the right thing to do. There have been
12 a small number of occasions where I have disagreed with
13 the outcome of the MDT and my belief is usually because
14 I know the patient very well, I've been caring for
15 them, I know all of their history and all of the 11:59
16 results. The MDT might see 50 or 60 patients in three
17 hours, so they have five minutes to discuss a case, so
18 they may not have picked up all of the information that
19 I know. So had that been the case, then it would be my
20 normal practice to then refer them back to the MDT, 11:59
21 giving them the additional information to state why
22 I felt that the original recommendation was not, in my
23 view, the best treatment course for that patient.
24 112 Q. So you would be referring it back with justification
25 for why the recommendation is perhaps not the best 11:59
26 route and what you consider to be the best route?
27 A. Yeah. So, you know, at the MDT there are numerous
28 different consultants from numerous different
29 specialties, but in simple terms, I do an operation to

1 burn kidney cancer or upper tract TCCs - transitional
2 cell carcinomas - that nobody at the MDT does, so
3 I will occasionally get recommendations from the MDT
4 for me to laser a cancer, which I know is wrong. So,
5 therefore, I will write back to the MDT and I will say 12:00
6 'I appreciate that you've recommended this, but because
7 this does not fall into the criteria for this
8 operation, I do not believe this is the right
9 treatment'.

10 113 Q. So there can be a two-way conversation with that based 12:00
11 on your particular expertise, your knowledge of the
12 patient and it's just a matter of letting the MDT know
13 about that and the reason for alteration of the
14 recommendation and then the treatment plan moves
15 forward? 12:00

16 A. Yeah.

17 114 Q. The issue around Bicalutamide 50 has also come up for
18 the Panel, we've heard evidence in relation to that.
19 Is that something that you would prescribe,
20 Bicalutamide in any format? 12:00

21 A. So, as I say, I don't treat prostate cancer any more,
22 but I would still diagnose prostate cancer when
23 patients attend my clinic. So, Bicalutamide 50 can be
24 given for two reasons. The most common reason is when
25 you're about to start formal androgen deprivation 12:01
26 therapy. So you would treat them with LHRH analogue.
27 When you give someone an LHRH analogue, that increases
28 their level of testosterone, which could, for a short
29 period of time, allow the prostate cancer to progress.

1 So what you do is that you give them Bicalutamide 50mg
2 for 14 days before you give them the dose of the LHRH
3 analogue.

4
5 So that is the only time I ever prescribe 12:01
6 Bicalutamide 50mg. It is also used further down the
7 line when the patient becomes resistant to LHRH
8 analogues. Then you would add in Bicalutamide to give
9 them maximum androgen blockade. But I don't do that
10 any more, because I don't be seeing them at that stage. 12:02

11 115 Q. So you wouldn't, and you've never prescribed
12 Bicalutamide 50 as a monotherapy?

13 A. No. As a monotherapy with the expectation they will
14 get an LHRH analogue 14 days later.

15 116 Q. So as a dual therapy then with the expectation of 12:02
16 something else?

17 A. Yeah, correct.

18 117 Q. I've covered all the areas from your Section 21 and
19 your evidence generally that I wanted to cover. Is
20 there anything else that you would like to say or want 12:02
21 to draw attention to that might assist the Panel?

22 A. No, I'm grand.

23 MS. McMAHON BL: well, I'll hand you over to the Panel
24 then, who have their own questions, but thank you.

25 CHAIR: Thank you, Mr. Connolly. I'm going to ask 12:02
26 Mr. Hanbury, first of all, if he has any questions for
27 you.

28
29

1 MR. CONNOLLY WAS THEN QUESTIONED BY THE PANEL,
2 AS FOLLOWS:

3
4 118 Q. MR. HANBURY: Thank you very much for your evidence.
5 I've just got a few clinical things. You mentioned 12:03
6 about the lack of main theatres, particularly for
7 urology, and the need to do additions, especially on
8 Saturday mornings and the waiting list initiatives.
9 I wasn't quite sure, were you expected to do that?
10 Were you asked to do that? Did everyone do extras? 12:03
11 What was the --

12 A. So it was above your job plan, so there was no
13 compulsion to do it. But because the waiting times
14 were so bad and we were given -- well, we were offered
15 every Saturday in theatres, that we basically had 12:03
16 a rolling rota, so everybody took their turn.

17 119 Q. Okay. And that was all day on the Saturday?

18 A. It was all day Saturday, yeah.

19 120 Q. And what would you do, typically the long waiters or
20 would there be red flags and -- 12:03

21 A. No, all long waiters.

22 121 Q. All long waiters?

23 A. Yeah.

24 122 Q. And did you think that was a good use of time or...

25 A. We had no other way of treating the long waiters. And 12:03
26 therefore, if we did not have elective sessions during
27 the normal working week, to me, again, it's probably
28 not a cost effective way of treating the patients,
29 because obviously it's additional sort of payment to

1 the consultants, to the anaesthetists and to the
2 nursing staff, but it freed up theatre capacity that
3 you were able to treat six or eight patients that
4 otherwise wouldn't have been treated.

5 123 Q. On the same subject of sort of inadequate theatre 12:04
6 capacity, if you like, you mentioned that you had
7 a discussion with Mr. Brown about restructuring theatre
8 rotas. What was that about?

9 A. So, as part of -- it wasn't just to do with theatre
10 rotas, it was to do with the whole way that the unit 12:04
11 was working. Because having went from two consultants
12 up to five consultants, we were starting to do theatre
13 sessions in Daisy Hill, I believe, and because we were
14 taking over Fermanagh, that we were doing clinics and
15 diagnostic sessions down in Enniskillen, so there was 12:04
16 an expansion in the availability of what we were
17 getting, but not in Craigavon, which obviously, if you
18 need to do in-patient operating, then it has to be at
19 that stage on the Craigavon site, because we didn't do
20 that elsewhere. 12:05

21 124 Q. So did you do any day surgery in other places or --
22 A. There was a day surgery unit in Craigavon, but it was,
23 I believe there was one list a week of circumcisions
24 type thing, just very straightforward day cases. But
25 -- 12:05

26 125 Q. So that was one a week for the whole unit, or for
27 yourself?

28 A. I believe it was one list a week for the whole unit,
29 but honestly I can't remember.

1 126 Q. Okay.

2 A. I just remember doing it as a registrar. But I don't
3 remember, as a consultant, doing it.

4 127 Q. And did you do anything more technical in day surgery?

5 A. No. 12:05

6 128 Q. I mean, obviously, as an endourologist now, you'd
7 presumably do quite a lot of your stone surgery,
8 ureteroscopy there. Was there a move to do that more
9 as a day facility?

10 A. The day unit in Craigavon was a very small building off 12:05
11 the main hospital, it was not well equipped and it was
12 not very useful, to be honest. Like, it was
13 inguinoscrotal surgery and that's pretty much it.

14 129 Q. Okay. So there wasn't a move to do more technical
15 things there in your short time there? 12:06

16 A. No.

17 130 Q. Okay, thank you. I suppose on the subject of theatre
18 capacity, you make some mention about trying to get
19 people in to have their stents removed on flexible
20 cystoscopy lists. Was there a problem with that? Did 12:06
21 you have a regular weekly cystoscopy list? How did
22 that work?

23 A. You would have had a weekly list of flexible
24 cystoscopies but that would have been mainly for red
25 flag haematuria patients. The stent removals would 12:06
26 have been fitted in on an ad hoc basis so. It wasn't
27 anything that was formalised in terms of: This is when
28 you will get your stent out. This is your two slots at
29 the start of a list to remove stents. I can't remember

1 that ever being a formalised way; it was more it was
2 just put onto a waiting list.

3 131 Q. So who did the scheduling for what was going to go on
4 that list? Did your secretary do that or that was the
5 done by endoscopy? 12:07

6 A. I honestly don't know. I presume it was done by the
7 waiting list office.

8 132 Q. You mentioned outreach services. I`m just interested,
9 you did regular clinics at South Tyrone; is that right?

10 A. So when I was there as a registrar, there would have 12:07
11 been an outreach clinic in Banbridge in South Tyrone
12 and in Armagh. Then, whenever I started as
13 a consultant, we were also then going to Enniskillen
14 and to Daisy Hill.

15 133 Q. How did you think they worked, in general terms? In 12:07
16 terms of efficiency and support?

17 A. It was a standard clinic. You turned up, the notes
18 would have been there. You would have seen 12 new
19 patients. You would have then dictated your letters,
20 stick the tape on to the front of it, and then went 12:08
21 home.

22 134 Q. Sure, I accept that. I was more getting at other
23 things that we do in clinics, usually flow rates, this
24 kind of thing. Did you have simple diagnostics there?

25 A. No. It was a room that you went and talked to 12:08
26 a patient and examined a patient. There was no flow
27 rates, there was no availability of bladder scanners,
28 there was no cystoscopies. It was just a room that you
29 discussed a patient, which is why there was a move to

1 seeing all the new patients through the Thorndale unit,
2 which was going to be a one-stop with all of that
3 additional equipment so that that you were able to --
4 you know, if you needed a cystoscopy, if you needed
5 a bladder scan or a rectal scan, you could do it there 12:08
6 and then. But that was only in the Thorndale unit, it
7 wasn't in any of the outreach clinics.

8 135 Q. If you wanted to follow up someone with lower track
9 symptoms, you actually couldn't do a flow rate in an
10 outreach clinic? 12:08

11 A. No.

12 136 Q. Thank you.

13

14 List planning. One characteristic at Craigavon seems
15 to be you organised the lists with your secretary 12:09
16 rather than the waiting list facility or offices, and
17 in your evidence there was a huge Excel spreadsheet
18 full of a few hundred people and "please choose so
19 many". That included quite a lot of radiological
20 things like cystogram and embolisation. Were you 12:09
21 expected to negotiate that with radiology?

22 A. I don't remember that at all.

23 137 Q. You don't remember.

24

25 Also on that were numerous vasectomies. You've gone 12:09
26 through the waiting list. Did you query why ultra
27 routine things were even being considered to be done in
28 that time when people were waiting years and years?

29 A. Well, I presume it is because from a Commissioner and

1 Board perspective, that a patient waiting a vasectomy
2 is the same as a patient waiting a TURP. You know,
3 therefore, it is one person who has been waiting for
4 years, therefore they were interested in having no
5 patients waiting past a prolonged period of time. 12:10
6 Therefore, if the person who is waiting beyond the
7 target was a vasectomy, then you would have been asked
8 to do a vasectomy.

9 138 Q. But was there any challenge at managerial level? why
10 are we doing these when our symptomatic patients need
11 doing, yet patients... 12:10

12 A. The booking of the lists would always have been
13 ultimately the consultant's responsibility and
14 decision. So you wouldn't have chosen a vasectomy even
15 though it may have been on the list of potential people 12:10
16 to do.

17 139 Q. Thank you.

18
19 Also, I was interested that there was one of your
20 attachments which said you suddenly had, I think it was 12:10
21 a cancellation, so you said, Listen, I have an hour's
22 space, and that e-mail went out to about 18 different
23 people. Was it an efficient way? Could you not say to
24 just your secretary, I'll choose one or two people and
25 get them in. I didn't understand why so many people 12:11
26 had to know that you had an unexpected slot.

27 A. As I say, I wouldn't have had a personal waiting list,
28 you know, so I wouldn't have anybody there, so,
29 therefore, it is very much we have a day to get

1 a patient in. If anybody has a patient who's ready to
2 go, just let me know. That's why I would have involved
3 the other consultants and their secretaries, because
4 they may well have had patients that they were going to
5 book in three or four weeks that were suitable to come 12:11
6 in at short notice and, therefore, as opposed to that
7 slot being wasted, you would have treated somebody.
8 But I wouldn't have my own waiting list, I just
9 started, and that's why it would have been like anybody
10 at all. 12:11

11 140 Q. So is that a good way to run a waiting list, do you
12 think? In the other places you've worked, has that
13 method between a consultant and a secretary been the
14 default position or not?

15 A. At present I have my personal list of patients I know 12:12
16 are suitable to come in as cancellations. Therefore,
17 if that same situation happened, I would say to our
18 scheduler, any of these three people have said they can
19 come in, can you get them in. You know, there have
20 been times in our unit where the same thing happens, 12:12
21 you get a cancellation 24 hours in advance and you say,
22 I will literally operate on anybody, just get me
23 somebody who will come into the slot.

24 141 Q. Just one more question about -- we look at BCG in a lot
25 of detail, but that obviously struck you as -- did that 12:12
26 come from an MDT meeting, MDM meeting, that you were
27 there and you witnessed this debate or was it
28 challenged or how...

29 A. Again, this preceded me becoming a consultant. So when

1 I was a registrar this was still -- I was aware that
2 Mr. O'Brien did not like using BCG. Again, as I said,
3 I'm not sure if Mr. O'Brien said that himself or this
4 was just said to me by one of the other registrars,
5 that he doesn't like using BCG and, therefore, the
6 likelihood is that he will offer Mitomycin instead of
7 BCG. 12:13

8 142 Q. Just one other thing. One of your emails about being
9 bounced down on the emergency list. That is something
10 that would irritate a lot of surgeons, that we see. 12:13

11 Did you feel that part of the problem there was that
12 there was no CD who was a urologist and you had a lead
13 clinician, so the person you went to didn't perhaps
14 have enough clout in the system to make changes?

15 A. Well, the CD was a general surgeon with a special 12:13
16 interest in urology. Although he was based in
17 Daisy Hill Hospital as opposed to Craigavon, so he
18 wouldn't have been directly involved with that but,
19 again, reading by email, this was a decision that was
20 made by the general surgical team as to how they wished 12:14
21 to run the emergency lists in Craigavon. And that did
22 not involve other specialities, including urology.
23 Although, obviously, Mr. Young as the clinical lead
24 hadn't been advised that this change was happening, so
25 until I booked the case on and this happened, I wasn't 12:14
26 aware this change had been made. I don't know where
27 the discussions happened, from a general surgical level
28 why they made that change and who agreed it, but it
29 obviously did not involved other specialities.

1 143 Q. Yes. And it obviously irritated you, and you heard
2 nothing back, and that is not good?
3 A. Yes. You know -- but when you have been bumped and you
4 haven't been advised you have been bumped and no one
5 explains why you have been bumped... 12:14
6
7 Everyone knows that when you get that phone call, you
8 invariably say yes. Because, you know, if a vascular
9 surgeon rings you up and says, "I have an aneurism
10 coming", absolutely no bother at all. 12:15
11 144 Q. I totally agree with that. But, actually, you raised
12 it through the formal channels, got nothing back,
13 despite the fact that your CD was a general surgeon and
14 a urologist and you should have had an answer, would
15 you not agree? 12:15
16 A. Yes. Again, it wasn't part of the email, but I believe
17 we did get an answer and the answer was: This is what
18 we are now doing. You know, it wasn't as it --
19 145 Q. But that's not a discussion, that's an instruction.
20 A. That was that the general surgical team decided this 12:15
21 was the way the emergency list was running and we can
22 just accept that because the decision is already made.
23 146 Q. Does that happen in Belfast?
24 A. You know, the emergency -- urology, unfortunately, has
25 very few true emergencies bar a torsion and a trauma. 12:15
26 You know, that we frequently, in the Royal, which is
27 where I now do my emergencies, we get bumped by other
28 specialities for numerous reasons. So it is a very
29 frustrating specialty to treat emergencies in because

1 we regularly get bumped. But in the Royal I would
2 always get phoned by the other specialty to tell me
3 that they have an emergency and, as I said, it's just
4 protocol and good manners.

5 MR. HANBURY: Thank you. That's what I wanted you to
6 say. Thank you very much, Chair. 12:16

7 CHAIR: Thank you. Dr. Swart.

8 147 Q. DR. SWART: I'm quite interested in something that
9 you've alluded to a few times, which is the changes in
10 the Neurology Inquiry. I think you have, in my view, 12:16
11 correctly stated that it's not just the structures of
12 governance which are in place in most hospitals, it is
13 the way they work together, the way governance is
14 functioning, and you described improvements in the way
15 that functions since this Inquiry. 12:16

16
17 Can you tell me, in terms of your specialty and your
18 consultant discussions what the impact of that inquiry
19 was on the way you talked about things in your
20 department? Because, in addition to having 12:17
21 a governance lead and so on, it's the way people talk
22 to each other about things which may not be easy to
23 measure. What impact did it have on you and your
24 colleagues, just from a personal perspective?

25 A. It has been a process. It didn't just happen in 2016, 12:17
26 like suddenly this is what we're doing, and this came
27 in and this came in and this came in and it has been,
28 over the past two or three years. And I think that
29 when you get that document as part of your appraisal

1 that has all of this information on it that, to be
2 honest, in the past I wouldn't have been that aware of.
3 You would have dealt with individual complaints,
4 etcetera, but you wouldn't really have had it all
5 sitting in front of you. And I think, with the 12:17
6 development of the governance lead, that all of these
7 things are now in the open.

8 148 Q. Do you have more conversations with your colleagues
9 about some of them? I mean there's the formal
10 appraisal, obviously, but there's also -- what do you 12:18
11 feel you can talk about or can't talk about? Is there
12 any change in that in terms of actually telling people
13 about the things you are worried about, for example, as
14 opposed to assuming everything you do is right?

15 A. I think the big difference is openness and it being 12:18
16 more formal and recorded. It is very much that you are
17 in a room and you're talking about these things and
18 everybody feels that you can talk about it and you can
19 challenge it.

20
21 I remember an example that one of the consultant 12:18
22 anaesthetists came to our M&M meeting because the ACU
23 team were involved with the case and, at the end of it
24 saying how impressed he was by how we spoke to each
25 other. Because it is very much you just talk about it. 12:18
26 There was very little sort of fear or, you know, like,
27 "Oh, I don't want to upset him". The gateway is just
28 you talked about it. And everybody accepted we all
29 make mistakes. If you are a surgeon, you will have

1 complications. But to be able to talk about those
2 complications and get advice from your colleagues and
3 learn from them, that's...

4 149 Q. Do you think, for example, you would definitely be
5 aware if one of your colleagues was doing things 12:19
6 entirely differently, was, say, really not keeping up
7 with things in terms of the admin, would you know about
8 that on a day-to-day basis? Is it that open?

9 A. No. I think it's very difficult to know exactly what
10 happens in a consultant practice. We've had recent 12:19
11 experience in Belfast where consultants have left for
12 various reasons and, as part of my role as one of the
13 clinical leads, I will be overseeing the transfer of
14 their cases to other consultants. And, as part of
15 that, all of the results that were going to one 12:19
16 consultant after he left then came to me. And you get
17 a great insight into, then, how other consultants run
18 their practice. You can get "I can't believe that they
19 were doing that".

20 150 Q. So one of the things you can do to try to mitigate that 12:20
21 is try to have objective measures of quality of
22 outcomes, and so on. That isn't that easy always. Has
23 there been any move towards asking each specialty to
24 develop a kind of simple quality of outcome scorecard
25 of some kind perhaps based on some National Audit 12:20
26 metrics? So, for example, if it was a stroke service,
27 you would have five or six things that are recognised
28 as best practice. You could just monitor those; you
29 don't have to be regulated. If you monitor these

1 things for consultants, they tend to want to try to
2 make it better. Is there anything like that being
3 developed at the Belfast Trust or any plans to do that,
4 just so you've got a bit more of what I would call
5 assurance rather than reassurance? 12:21

6 A. Not that I'm aware of. You get a lot of information as
7 part of your appraisal in terms of admissions,
8 discharges, length of stay, complications, but --

9 151 Q. Do you get complication rates information?
10 A. Not by specific -- 12:21

11 152 Q. Or compliance with guidelines information?
12 A. No.

13 153 Q. Do you think that would be helpful?
14 A. It would be very onerous to put together, but it would
15 be helpful. 12:21

16 154 Q. So in terms of culture, you've talked about the open
17 and transparentness which has been developing. As you
18 say, it is not an overnight thing. When you moved from
19 Craigavon to Belfast, did you find a difference in the
20 cultural atmosphere or did you think it was much the 12:21
21 same?

22 A. It was the same. Again, as during my training, you
23 know these processes existed but it was very -- you
24 know, at a different level. You weren't involved.
25 Even when I became a consultant in Belfast, the 12:21
26 processes existed, I knew you filled out your forms,
27 you were involved with them, but it was still very much
28 done on an informal ad hoc basis. If there were any
29 issues it would have been dealt with in the background

1 by the CD and the individual consultants, as opposed to
2 it being recorded anywhere.

3 155 Q. So, for example, audit, quite a number of people have
4 told us that at the Southern Healthcare Trust there
5 wasn't enough investment in audit. I don't get a sense 12:22
6 that there was a regular discussion in departments as
7 to which audit should be prioritised, when they should
8 be reported, how they would be supported, what measures
9 were particularly interesting. Was that the same at
10 the Belfast Trust as it was in Craigavon? 12:22

11 A. So there would have been an audit department but the
12 audit department would have been there to advise you in
13 terms of how to run the audit. In terms of what you
14 actually audited --

15 156 Q. No, I'm talking about the priority of what -- 12:22

16 A. Apparently not. It was -- a registrar would have
17 chosen to do the audit, discussed with the consultant.
18 That would be the audit, whether that was something
19 needed in the unit or not.

20 157 Q. If I were to ask you how would a member of the board 12:23
21 get assurance that consultants in the hospital
22 generally were following best practice guidelines, do
23 you think there's any mechanism currently or in the
24 past that would say, yes, we've got the guideline,
25 we've looked at it, and we use the audit tool once 12:23
26 a year, or whatever? Is that anything that you've ever
27 seen in practice?

28 A. Without taking a random sample of outpatients, then
29 I can't see how --

1 158 Q. But there hasn't been a programme as far as you're
2 aware?

3 A. No.

4 159 Q. Okay.

5

12:23

6 Huge recruitment problem, clearly. Huge waiting list
7 problem. Lots of reports in the past. And you mention
8 the look at urology in 2009. At this point in time,
9 are you aware that there's any kind of strategic plan
10 for urology for Northern Ireland that is revisiting all
11 of this to bring it together? 12:23

12 A. Yes. So, again, during COVID there were a number of
13 meetings between the senior leads within each of the
14 Trusts in terms of how we were going to restructure
15 ourselves. And it was a very useful thing. Because, 12:24
16 in the past, each unit would have been competing with
17 each other and very much would have been, you know
18 "them and us". I think with COVID that there was a far
19 more openness to work together and far more openness to
20 be able to travel between Trusts by individual 12:24
21 consultants.

22

23 So, again, probably around 2020, 2021, we had a meeting
24 in Lagan Valley between all the different Trusts and
25 we put on paper how we felt we should structure 12:24
26 ourselves. Then, about a year or so ago, then we were
27 advised there was going to be a GIRFT review. We were
28 very happy with that because it was likely to formalise
29 what we felt was the right way forward. And then the

1 GIRFT review happened and it was published last week
2 and it basically --

3 160 Q. I've seen that.

4 A. It formalised what we discussed in a meeting two years
5 ago, which was how we felt that the region should work. 12:25
6 It didn't do everything that we thought was needed but
7 it certainly gave a formality to it, that it wasn't
8 just a group of consultants trying to sort stuff out
9 for themselves, this actually was the right thing to do
10 for the whole region. 12:25

11 161 Q. I've had a look at that report. Clearly GIRFT is
12 a well-recognised programme in England and it has been
13 adapted to look here. Is that, as far as you're aware,
14 been given a formal status in terms of helping it to
15 happen and taking it forward with ongoing discussions? 12:25
16 I'm just trying to sense what you are aware of as
17 a urologist working in a very pressurised system in
18 Northern Ireland?

19 A. A lot of the changes are underway and were underway
20 already. I am now back working in Southern Trust doing 12:26
21 complex stones, having left 13 years ago to do complex
22 stones. They are all now being centralised there. So
23 that is happening. The ESWL service is happening.
24 There are parts to the GIRFT review that will take
25 a lot more changes and a lot more resource. 12:26

26 162 Q. That's kind of what I'm hinting at.

27 A. Ultimately that will come down to the politicians and
28 to the --

29 163 Q. That is my question to you, really. Who do you feel is

1 leading that? You've described the consultants coming
2 together, the Trusts coming together, do you feel there
3 is a political mandate for this now to happen and do
4 you have a clear sense of how that is being supported
5 by, say, the Chief Medical Officer's Office and Public 12:26
6 Health, and the Commissioners? Is that clear to you?

7 A. I think that everybody, both in urology and in general,
8 know the direction of travel. We've had the Donaldson
9 report, the Compton report, Bengoa report -- numerous
10 reports that have said what needs to happen. I don't 12:27
11 know that Stormont in itself will actually make that
12 happen because they've had 15 years before it collapsed
13 to make it happen, and it did.

14 164 Q. What do you think would make it happen? I'm just
15 interested as a clinician in the service. 12:27

16 A. I would like Chris Heaton-Harris to close down numerous
17 A&Es. That's what I think would help. You know,
18 because the political parties will not do that because
19 of the outcome that would be in their own
20 constituencies. Whereas someone who wouldn't have the 12:27
21 same political back -- what's the word? -- blow-back
22 from it then could make that decision. We've seen it
23 happen in terms of other things, that the politicians
24 can't agree to do it and therefore you need someone
25 from Westminster to make that decision for them. 12:27
26

27 Personally, I believe that what needs to happen with
28 the Northern Ireland Health Service is that there are
29 far too many acute units, far too many A&Es, that some

1 of those need closed. And I don't believe, even if you
2 have a health minister and Stormont up and running,
3 that that decision will be made. In my view, the only
4 way that will happen is if Westminster say, Right, you
5 are spending far too much on health, you need to make
6 your system more efficient, and the way to do this is
7 to close down this, this, this, this and this. 12:28

8 165 Q. I think that's an interesting perspective. I think,
9 looking at this from the point of view of the Urology
10 Inquiry, touches on all of these issues: what happened 12:28
11 to the Donaldson report, the Bengoa report, what is
12 going to happen next. However, I think what you've
13 said to me is, partly as a result of pressures, partly
14 as a result of learning to work differently during
15 COVID, and certainly assisted by the GIRFT report, 12:29
16 there is the backbone of a plan which, if properly
17 implemented and taken forward in what I would call
18 a delivery plan as opposed to an aspiration, would
19 assist greatly, in your view, in taking urology and, by
20 implication, other specialties at the same approach 12:29
21 further? Is that what you're saying?

22 A. It certainly will improve things. At the minute there
23 are pressures in every urology unit and we have to work
24 together in order to improve that. The progress that
25 has been made in Craigavon with the complex stone 12:29
26 service, it shows that if you have the right people
27 involved and the right resource behind it, that you can
28 actually create an exceptional service. I honestly
29 believe that's what it will be. There's no reason why

1 the other aspects of urology and other specialities
2 could not do the same thing if they had the same
3 support and the same resource put into it.

4 DR. SWART: Thank you. That's all from me.

5 166 Q. CHAIR: Thanks, Dr. Swart.

12:30

6
7 Just a couple of things from me. When you worked in
8 the SWAH clinic, were the notes brought to you or did
9 you ever have to bring the clinic notes yourself to the
10 hospital?

12:30

11 A. I never did the SWAH clinic. The SWAH clinic was
12 Mr. O'Brien.

13 167 Q. You didn't have any involvement there and you wouldn't
14 know whether a clinician had to bring the notes
15 themselves and then bring them back themselves? Just
16 the other clinics, they were delivered to you?

12:30

17 A. The way it was sorted out was the people who lived on
18 the east side of Craigavon tended to do the Banbridge.
19 The people that lived on the west side of Craigavon
20 tended to do South Tyrone. It was easier for them to
21 go there and get home.

12:30

22 168 Q. Clearly Dr. Swart was talking to you about the GIRFT
23 report and what is likely to happen in future, but you
24 talked also about the Neurology Inquiry and the
25 recommendations that that made and that the processes
26 had changed in Belfast Trust as a result. I just
27 wondered, if you had to pick one thing that has helped
28 you in your practice generally as a whole, what do you
29 think that would be?

12:31

1 A. The governance report that I get as part of my
2 appraisal.

3 169 Q. Okay.

4 A. Because, basically, it tells me everything that has
5 happened, you know, and it's all there on paper. 12:31
6 Therefore, you know, it's -- in simple terms it means
7 that the Trust knows all about this, and I know about
8 it, and therefore we are able to reflect on it and
9 change. Whereas, you know, I don't know what the Trust
10 were aware of in terms of, you know, my complications, 12:31
11 my M&M, my complaints. Like they're obviously aware of
12 them, but, you know...

13 170 Q. Was this not something that was provided to you
14 previously for your appraisal?

15 A. No. It would have been something that I was expected 12:31
16 to gather myself and then provide that to my appraiser.
17 But, you know, you try, obviously, to collect it all.
18 You can't be sure that it is fully 100 percent there.
19 And then if you looked at it, if you wanted to hide
20 something, then you just wouldn't declare it. 12:32
21 CHAIR: Thank you. That's very helpful. Thank you
22 very much Mr. Connolly. I think that concludes your
23 evidence.

24

25 We're due back tomorrow at 10 o'clock. Thank you. 12:32
26

27 THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 5TH
28 DECEMBER 2023 AT 10:00
29