



Oral Hearing

Day 65 – Wednesday, 11th October 2023

Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

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

Gwen Malone Stenography Services

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WITNESS

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MR. JOHN O'DONOGHUE

Examined by Mr. Wolfe..... 3

1 THE INQUIRY RESUMED, AS FOLLOWS, ON WEDNESDAY, 11TH
 2 OCTOBER 2023

3
 4 CHAIR: Good morning, everyone.

5 MR. WOLFE KC: The witness this morning is Mr. John 10:13
 6 O'Donoghue. He proposes to take the oath.

7
 8 MR. JOHN O'DONOGHUE, HAVING BEEN SWORN, WAS EXAMINED BY
 9 MR. WOLFE, AS FOLLOWS:

10
 11 MR. WOLFE KC: Good morning, Mr. O'Donoghue. 10:14

12 A. Good morning, Mr. wolfe.

13 MR. WOLFE KC: welcome to the Urology Services Inquiry.
 14 Thank you for coming to give your evidence.

15
 16 The first thing I'm going to do is put up on the screen
 17 for your consideration, your two witness statements,
 18 one the primary witness statement and the second an
 19 addendum witness statement to correct or clarify a
 20 number of features of your earlier statement. 10:14

21
 22 Starting with your primary statement, it's dated 24
 23 August 2022, and we find it at WIT-50517.

24 A. Yes.

25 1 Q. There's an annotation at the top to reflect the fact 10:14
 26 that you have provided the addendum. So you recognise
 27 that. So let's go to the last page at WIT-50553. You
 28 recognise that as your signature?

29 A. Yes.

1 2 Q. So subject to the revisions contained in your addendum,
2 are you content to adopt this statement as an accurate
3 account of your evidence to the Inquiry?
4 A. Yes.
5 3 Q. Thank you. 10:15
6
7 Then, to that addendum, as I said, received and signed
8 on 3 October of this year, WIT-103266, that's the first
9 page, and then to the last page at 103269. Again, are
10 you content to adopt that as part of your evidence? 10:16
11 A. Yes.
12 4 Q. Thank you.
13
14 I understand from your counsel that there's one
15 additional correction you would wish to make to your 10:16
16 primary statement. Let me bring you to it. If we go
17 to WIT-50528. In the middle of the page, 13.1, you
18 list a number of locum consultants. Was Dr. Fel or
19 Mr. Fel a locum consultant?
20 A. He was, yes. 10:16
21 5 Q. Should he be added to that list?
22 A. He should be. I think I inadvertently forgot to put
23 him in.
24 6 Q. I understand that he came in in July 2020?
25 A. Yes, I think so. 10:16
26 7 Q. And he served until August or September of that
27 year; is that right?
28 A. That's right, yes.
29 8 Q. Thank you.

1
2 If we can go then to WIT-50521. Just to get your
3 career background and academic history on the record.
4 You are currently a Consultant Urologist working at the
5 Southern Trust? 10:17
6 A. That's right.
7 9 Q. You have been in that position from 4 August 2014?
8 A. That's right.
9 10 Q. And helpfully, if we just scroll back up the page, we
10 have your occupational -- if just go above that again, 10:17
11 please. Yes. So you qualified with a Medical Degree
12 out of University College Cork --
13 A. That's right.
14 11 Q. In 1993?
15 A. Yes. 10:18
16 12 Q. Then qualified as a surgeon in Ireland 1997?
17 A. Yeah.
18 13 Q. And completed your urological training in 2013,
19 4 October 2013?
20 A. Yes, in Oxford. 10:18
21 14 Q. We can see then the next stage, I think you took up
22 your first consultant role at Watford?
23 A. Watford General Hospital, yes, I was there for a year.
24 15 Q. We can see that. If we just scroll down to
25 August 2013. We can see it all in order. Yes. So 10:18
26 August 13th at Watford, served there for a year, and
27 then straight over to us at Craigavon?
28 A. Craigavon, yes.
29 16 Q. And you have been there --

1 A. Ever since.

2 17 Q. Uninterrupted ever since. So ten years, give or take?

3 A. Yes.

4 18 Q. We have your job description. We'll just put it up on
5 the screen. I don't intend to interrogate it to any 10:19
6 degree. WIT-50648. It is more for illustration
7 purposes.

8

9 You were appointed on the same day as Mr. Haynes, is
10 that correct? 10:19

11 A. That's right. We interviewed together but I delayed
12 coming because my children were in school and we had to
13 give notice to come.

14 19 Q. Yes, was there a third consultant appointed that day?

15 A. Not that I'm aware. I understood there was two but I'm 10:19
16 not too sure.

17 20 Q. Yes. It's described here, just in the introduction, as
18 a "replacement post". You see in the introduction
19 section. Do you have a sense of who you were
20 replacing? 10:20

21 A. I think that was just generic. I think in the end,
22 because two suitable candidates applied, they created
23 an extra post, so I'm not entirely sure it was
24 a replacement post that I took.

25 21 Q. Did you inherit, coming into post, did you take on 10:20
26 a backlog of patients from the waiting list or how was
27 that -- how was your practice, if you like, in terms of
28 people or patients. How was that assembled for you?

29 A. Well the first two weeks, or first few weeks when

1 I started, I took Mr. O'Brien's operating list, so
2 I got patients that way. I did clinics. I think
3 I must have inherited patients because within a few
4 months of me being there I had somebody waiting I think
5 91 weeks on a waiting list. So I think I obviously did 10:20
6 inherit patients, but I'm not too sure where that
7 patient came from.

8 22 Q. So the moving of the patients was done behind the
9 scenes without --

10 A. As far as I know. I don't ever remember accepting that 10:21
11 patient, but I might be open to contradiction.

12 23 Q. You set out in your witness statement, something of
13 a summary of your job description or the activities
14 that you perform, and let's just take a look at that.
15 It's WIT-50521. Scrolling down to paragraph 5.2. 10:21
16 There you are.

17
18 You set out what your duties and responsibilities
19 include. One in seven on-call, emergencies, admin
20 duties, audit and research, teaching supervision of 10:21
21 undergraduate and postgraduate doctors since 2015. You
22 have rotated to do to Chair the Uro Oncology NBN. You
23 have been Chair of the Patient Safety meeting
24 since October 2021 succeeding Mr. Glackin, isn't that
25 right? 10:22

26 A. That's right.

27 24 Q. You have been Educational Clinical Supervisor to
28 foundation doctors since 2017 and you have been
29 a clinical supervisor to specialist registers since

1 beginning in the Trust in 2014?

2 A. That's right.

3 25 Q. Just working through some of that. Your you're
4 one in seven on-call for urological emergencies, is
5 that something other than performing your role as
6 urologist of the week, or is that another way of
7 saying --

10:22

8 A. That's another way of saying it, so we initially did --
9 we were doing one day a week on-call but I think within
10 a few months of me starting Craigavon in 2014
11 we changed to urologist of the week, so it's roughly
12 one in seven.

10:23

13 26 Q. That's just another way of saying, I am urologist of
14 the week, one in seven weeks, roughly?

15 A. Yes.

10:23

16 27 Q. And during that week I deal with the emergency cases
17 coming in?

18 A. Yes.

19 28 Q. We'll come on and look at aspects of urologist of the
20 week in just a moment or two.

10:23

21
22 Let me ask you this. The Inquiry wants to get to know,
23 I suppose, the context in which you came to work in
24 Craigavon and the environment you found when you came
25 there in 2014 and the particular challenges that you
26 faced. So an easy question, what kind of department
27 did you find when you arrived in 2014? Can you offer
28 maybe, a sense, given your experience in Great Britain,
29 of whether things were done as well here, as compared

10:24

1 to there, and what were the -- what was the resourcing
2 differentials, if any?

3 A. Well I found I was extremely busier than when I was in
4 Watford. As far as I remember, we had 3 or 4 clinics
5 a week which was a lot more than an English urologist 10:24
6 would have done at that time. So I found a huge amount
7 of clinics. The MDM in Craigavon seemed to be much
8 heavier, it was a much heavier load, because I also
9 chaired the MDM in Watford and I found it was a much
10 heavier role in Craigavon. Probably the numbers of 10:25
11 patients, there were quite long narratives on each
12 patients and it was a lot of preparation for the MDM.

13
14 As a Department itself, it was very friendly and I felt
15 I had made the right decision. I didn't know a lot of 10:25
16 these issues had been going on for ten years before
17 I arrived and I had been continuing whilst I was there,
18 but it seemed an extremely friendly department. I came
19 here for, I think, quality of life because I was either
20 going to take a job in London, which I had got 10:25
21 a substantive job a week before I had the Craigavon
22 job, and I turned it down, because I wanted to get
23 Craigavon.

24 29 Q. Your main areas of work are benign, male and female?

25 A. Yes, stones and female urology and voiding dysfunction. 10:26

26 30 Q. Any oncology work?

27 A. Well, yes, because I do the MDM I also do TRBTs. I see
28 prostate cancer patients. So I do oncology as well.
29 I have always done that, even when I was in England, so

1 it hasn't changed.

2 31 Q. How many PAs a week do you dedicate to Your Trust or
3 NHS practice, I understand you have a private practice?

4 A. I have a private practice. It's 12-point-something at
5 the moment, I think it is 12.2. It is over 12 PAs, 10:26
6 I think at the moment.

7 32 Q. That constitutes full-time working as such?

8 A. Yes.

9 33 Q. And built into that, how many theatre sessions would
10 you have per month, if that's the -- 10:27

11 A. It is easier for me to do it per week. So I have one
12 in-patient list, one full day of an in-patient list
13 a week. I do every month, or every five weeks, I do
14 a Lagan Valley list, which is a full day of day
15 patients, which include in the Regional Urology Unit, 10:27
16 and then every five weeks I do half-a-day of a day's
17 surgery list in Craigavon.

18 34 Q. In terms of your personal capacity, as opposed to the
19 capacity of the theatre infrastructure to support you,
20 is that you working at full tilt. Is that you working 10:28
21 at capacity or if there were additional; if there was
22 additional infrastructural support available could you
23 in 2023 be working more? Or, perhaps, could the
24 average Consultant Urologist be working more if
25 capacity was available? 10:28

26 A. I couldn't have capacity for anything else. I'm full.
27 There are no other hours in the day that I could
28 possibly devote to working in the NHS.

29 35 Q. Yes. Is that because the demand for outpatient clinics

1 and reviews is so high, or is what you have just
2 described in terms of theatre commitments, one
3 in-patient list per week to Lagan valley, one every 4
4 or 5 weeks for a list and then a further list, it
5 doesn't, on the face of it, seem like an awful lot of 10:29
6 operating time, but maybe that is the naive layperson's
7 interpretation.

8 A. Well, I do --

9 36 Q. And I'm not -- I suppose I'm not personalising it to
10 you, because you can have whatever other commitments 10:29
11 you wish to have, I suppose. But I'm just, I suppose,
12 standing in the position of a urological consultant, a
13 urological surgeon. Is that not a small amount of
14 theatre relative to what could be done, given the
15 demand for surgical procedures? 10:30

16 A. Well, first of all, operating is only a small part of
17 what a surgeon does. I mean a surgeon has lots of
18 other duties, including clinics.

19 37 Q. Of course.

20 A. So you could certainly increase, to get another 10:30
21 surgical list, you will have to drop a clinic so
22 something else will have to suffer because of that,
23 because there are no other hours in the day for
24 activities. So you do more operating, you drop
25 a clinic. You drop something. 10:30

26 38 Q. Yes. Take us through an average working day for you,
27 an average working week. Obviously you have the M and
28 M, or the Patient Safety Meeting it is now called. You
29 have attendance and chairing of the MDT, the Patient

1 Safety meetings once a month. But in terms of sort of
2 the mean average week, how does it look?

3 A. Well, do you want me to do each individual day and say
4 what I do?

5 39 Q. Yes, briefly. 10:31

6 A. Briefly. So Mondays I would operate all day. Tuesdays
7 I would have a clinic in the morning, the afternoon I'd
8 be at the stone MDT. I would, over lunchtime, do
9 paperwork or do it virtually now. Wednesday mornings
10 I have a clinic. Wednesday afternoons I have my 10:31
11 supervision of foundation doctors. I also do
12 paperwork. Thursday mornings I have a Patient Safety
13 meeting. As well as that I have to get the MDM ready
14 if I'm chairing it, so that has to be done. Thursday
15 afternoons I am at the MDM, and on Friday's I'm in 10:32
16 private practice.

17 40 Q. Yes. Is it a running to stand still environment?

18 A. It is very busy, but I manage it. I mean, I don't sort
19 of hang around and do nothing. I mean there's always
20 things to do. So there's constant results coming in 10:32
21 that have to be signed-off and actioned. So I'm always
22 doing something. And people are always coming and
23 asking me questions. So nurse specialists come and
24 speak to me. So if I'm in the Department, I'm always
25 busy. 10:32

26 41 Q. We'll come on to talk in greater depth about the
27 capacity issues which the Southern Trust has faced,
28 probably throughout your 10-year tenure, but is it
29 a stressful environment because of the challenges faced

1 by the capacity demand problem?

2 A. I don't think it's stressed, because I think I manage
3 it reasonably well.

4 42 Q. But is it a stressful environment?

5 A. I suppose hospital, medicine can be stressful but it 10:33
6 doesn't stress me.

7 43 Q. You obviously work with a team of urological
8 colleagues. Do you get any sense that it is a --
9 whether or not it is manifesting in stress as
10 a condition, do you get the impression that it is an 10:34
11 excessively pressurised environment, one that's
12 unhealthy perhaps, and one that shouldn't be the case
13 in 21st Century public service medicine?

14 A. I, personally, don't find it a stressful, unhealthy
15 environment. I can't speak for my colleagues, but from 10:34
16 observing them they don't seem to be overly stressed.
17 But perhaps that is me not noticing, but you would have
18 to ask them, but they don't seem to be, or else they're
19 good at hiding it.

20 44 Q. The method of working or the model of working includes 10:34
21 the urologist of the week model?

22 A. Yes.

23 45 Q. You have explained that you come into that role, if you
24 like, one in seven approximately.

25 A. Yes. 10:35

26 46 Q. Have you been exposed to any other methods of working
27 in order to cover the emergency intake?

28 A. Well before we went to the urologist of the week
29 we used to do a day a week on-call. In England that's

1 the way we did it. But I think lots of places have
 2 changed to working weekly. It is better for following
 3 patients up and knowing your patients.

4 47 Q. How do you find the urologist of the week model as
 5 a method of working in the context of emergency intake? 10:35

6 A. I think I probably sort of have two feelings about it:
 7 I mean I hate when I'm on-call because it's incredibly
 8 busy but at the same time I think it's the best model
 9 in that, you know, you have continuity of care, you
 10 know all the patients on the ward, you know everything 10:36
 11 that is happening, it's just very busy. But I think
 12 it's the best model, I think.

13 48 Q. Could I put to you some reflections that Mr. O'Brien
 14 shared with the consultant team in 2018. You were to
 15 have -- did have a Departmental meeting. I think there 10:36
 16 was an expectation that management would attend, but
 17 I think I'm right in saying didn't attend.

18 A. Yes, I saw those emails.

19 49 Q. So the document I want you to have a brief look at is
 20 AOB-01904. You can see how it is titled: "Issues of 10:36
 21 concern for discussion at Departmental meeting on 24
 22 September 2018". Just if we scroll down a little bit.
 23 So within "urologist of the week" there's a couple of
 24 points I would invite your comments on.
 25 10:37

26 He sets out in this third paragraph a concern that:
 27
 28 "We, as a team, in agreeing to the urologist of the
 29 week model, agree to include triage in the duties."

1
2 And in due course he came to believe there was a range
3 of perspectives on the concept of urologist of the
4 week:

5
6 "...from that which I expected it to be to being
7 urologist on call and variations in between."
8

9 If we go on to just the next page, we'll come back to
10 this again.
11

12 Scrolling down. Thank you, on further. He has said --
13 just going down to "triage". He has found it
14 impossible to complete triage while being urologist of
15 the week, and he still does. We'll look at triage from
16 different angles as we go on today, but you attended
17 this meeting?

18 A. I must have but I have no memory of it, but I must have
19 attended it, yes.

20 50 Q. So he's spelling out a sense of regret that triage
21 was --

22 A. I was aware, yes.

23 51 Q. -- included within the duties. He reflects that, there
24 seems to be a range of ideas on how it should be done
25 and taking into account his approach, he finds it
26 impossible to complete triage when serving as urologist
27 of the week and it spills into his Friday and his
28 weekends.

29 Just from your own perspective, did you find it

1 difficult to complete triage during the one week of --
2 when you were urologist of the week?

3 A. No, and I think there's reasons why, or my
4 interpretation why Mr. O'Brien found it difficult. One
5 is, I managed to do all of my triage during the week. 10:40
6 I never left the hospital until I had it done and so
7 I started the next day having it cleared.

8
9 Mr. O'Brien, his triage went on certainly for a couple
10 of weeks after he finished on-call. Certainly one of 10:40
11 the reasons, and I noticed that he dictated letters on
12 a few of the patients which were four-pages long.
13 I mean, dictating four-page letters on a triage is
14 going to slow you down enormously. So I think he
15 overdid -- he overcomplicated triage. We certainly 10:40
16 organised scans for our red flagged patients, and
17 I think that's reasonable --

18 52 Q. Just so that we're clear, what was your understanding
19 of what was expected of the UOW in terms of the
20 approach to triage, taking the red flag patient first 10:41
21 of all. What were you to do with the red flag
22 referral, assuming you accepted it was correctly
23 classified as a red flag?

24 A. Yes. So, one, I always did the red flags first. If
25 they had blood in the urine or testicle tumours, or 10:41
26 query testicle tumours, I organised scans. But I also
27 triaged them for a red flag appointment so they would
28 be seen in the very near future. If they had query
29 testicle tumours I saw them within a few days whilst on

1 call, I didn't wait for them to come to clinic.

2 53 Q. If the referral was otherwise than red flag, if it was
3 urgent and routine, assumedly you assess whether it has
4 been properly categorised?

5 A. Yes, because the GP may have -- sometimes GPs call 10:41
6 blood in the urine "urgent" when in fact it is a red
7 flag, so you need to be careful that you are triaging
8 it correctly.

9 54 Q. Yes, and having accepted the classification, were you
10 expected within, if you like, the understanding amongst 10:42
11 the team in terms of how you performed the triage duty.
12 Were you expected to do anything else within an urgent
13 routine?

14 A. We weren't expected to organise scans because otherwise
15 it would just take too long. I mean with a couple of 10:42
16 hundred referrals coming in, you would have to have no
17 other duty than sit there and book scans all the time.
18 So they were booked into the clinic at the appropriate
19 triage, either urgent or routine, unless it was query
20 kidney stones and organise CT urinary tracts. 10:42

21
22 So it was done on an individual basis, it wasn't a
23 carte blanche of which way one did. If the GP said
24 "urgent, query stone in the ureter", or "query renal
25 colic", we would have organised a scan for that. 10:43

26 55 Q. Yes. This is just an initial sorting into the area of
27 triage, I'm going to come back at it from a number of
28 angles but for now that's helpful and thank you.

29

1 Just going back up to the previous -- back up to the
2 top of this page, please. Let me start from the bottom
3 of the previous page so I can get it in context.
4 Mr. O'Brien, in this section of his observations in
5 relation to the method of working when urologist of the 10:43
6 week emphasises that too much is being placed within
7 the domain of the registrar and that is because the
8 consultant is being overall stretched, particularly
9 with theatre, I think is his point.

10 10:44
11 He says it has been his experience that the most common
12 conflict has been when operating makes it impossible to
13 undertake ward rounds. When that has occurred on
14 conservative days the clinical in-patient care has been
15 undertaken by registrars, often with different 10:44
16 registrars on different days with obvious risk to
17 continuity of care.

18
19 The other main concern that he has experienced is that
20 registrars are dealing with many calls for advice from 10:44
21 elsewhere without input from urologist of the week,
22 resulting in the default outcome of having the patient
23 referred to the Department to be triaged by another
24 urologist of the week, 1 or 2 weeks later.

25 10:45
26 Is that how it worked, that the number of emergencies
27 coming in requiring consultant in theatre, was such
28 that the model was being stretched and the patient
29 wasn't getting the quality of care he or she might

1 expect via the consultant?

2 A. It depended on the experience of the registrar. If it
3 was a simple extent insertion, the registrar would go
4 to theatre himself, him or herself and do it, the
5 consultant could continue with the ward round. I think 10:45
6 if the registrar was quite inexperienced, obviously the
7 consultant would have to go to the theatre and do it.

8
9 The fact you are on for a whole week, you know all the
10 patients, so you know which patients you need to know 10:46
11 about and would often catch up with the registrar
12 afterwards and either go and see the patient or sit
13 down and work through a list. But we always met and
14 discussed all the patients and I think that's what
15 a lot of my colleagues would have done as well. 10:46

16
17 with regard to the registrars taking phone calls,
18 I mean that's part of learning for a registrar. That
19 has happened wherever I worked, whether it was England
20 or here. Registrars always take phone calls from GPs 10:46
21 and answer their queries. If there's a query that a
22 registrar can't answer, they would go and speak to the
23 consultant and that's expected.

24
25 I mean what the consultant can't do is be everywhere 10:46
26 all the time. I mean that's, you know, there's no
27 point having a registrar then. Registrars have got to
28 learn as well.

29 56 Q. So you see nothing of concern or nothing controversial

1 in what is being described here, that is the inevitable
 2 outworking of the UOW model and that it doesn't
 3 constitute a deficit in the quality of care going
 4 towards the patient?

5 A. It would occur in any model. So, in other words, 10:47
 6 whether it was one day on-call or whether it was
 7 a week, you know, if you need to go to theatre and
 8 there's a ward round happening, but there's no better
 9 system. I mean if the consultant has to go and you
 10 have got a very junior registrar, of course, you are 10:47
 11 dependent on what decision the registrar makes. But by
 12 meeting the registrar afterwards and having
 13 a discussion, I think you can remedy that.

14 57 Q. I think you have made the point that the urologist of
 15 the week, the consultant is a constant presence during 10:48
 16 the six or seven days, so that is an advantage?

17 A. So always on the end of the phone, always in the
 18 hospital, even in the evenings on a phone. He knows
 19 everything that's happening because he is there for
 20 seven days. 10:48

21 58 Q. Scrolling down to the next paragraph. He makes, that
 22 is Mr. O'Brien, makes a point about ward rounds. Just
 23 so that I understand, the urologist of the week's
 24 period ends on when, a Thursday evening?

25 A. On a Thursday morning. 10:48

26 59 Q. A Thursday morning. The expectation is that the
 27 incoming urologist of the week would meet at early
 28 morning with the outgoing for a ward round?

29 A. That's the way it happened, now we ring each other.

1 Because it's -- it seems to me it is a dreadful waste
2 of time spending four hours on a Thursday morning, so
3 we ring each other, talk about the patients that we're
4 concerned about so that the incoming consultant is
5 aware of what's going on.

10:49

6 60 Q. Yes. Did you have -- in terms of the timing of the
7 urologist of the week rota, did you have a relationship
8 in time with Mr. O'Brien?

9 A. Well, certainly earlier on in the urologist week we
10 were certainly doing ward rounds and we met on the ward
11 rounds.

10:49

12 61 Q. Okay, so --

13 A. Earlier on, in the first, probably year and a half,
14 there were actually ward rounds with the two
15 consultants.

10:49

16 62 Q. So it is a coincidence, perhaps, of how it was arranged
17 but you were taking over from him --

18 A. Yes.

19 63 Q. -- on the Thursday?

20 A. Yes.

10:50

21 64 Q. Yes. And that was for about a year and a half.

22 A. Yes, and we would have done the ward round together.

23 65 Q. He reflects here, there's just a number of points but
24 one which you can perhaps help us with. He says:

25
26 "It has increasingly become a common occurrence for no
27 ward rounds to be undertaken by the urologist of the
28 week over a weekend. It has been reported that one
29 whole week went by in recent months without one ward

10:50

1 round being conducted by the urologist of the week."

2
3 He says, and this is perhaps a point that you can help
4 us with directly:

5
6 "As often as not, I have begun my urologist of the week
7 without hand-over from the previous urologist of week
8 and ended it without the next urologist of the week
9 being present."

10:50

10
11 So I suppose that latter bit might be you?

10:50

12 A. I would disagree with that totally, because I always
13 met him and we discussed the patients. So I would
14 disagree with that.

15 66 Q. Yes. So I think you've said, just to be clear, for the 10:51
16 first year and a half after the introduction of the UOW
17 model --

18 A. Or in until he retired, because he would always follow
19 me, so I would always have met him and discussed the
20 patients.

10:51

21 67 Q. So I think urologist of the week model came into place
22 in late 2014, early '15?

23 A. Yes, within a few months of me starting there.

24 68 Q. Yes, and he retired in July 2020?

25 A. Yes.

10:51

26 69 Q. Is that about five years?

27 A. Yes, so it's probably longer, yes. Yes.

28 70 Q. So you succeeded him on urologist of the week rota?

29 A. Yes.

- 1 71 Q. For five years?
- 2 A. And if there was some reason that I couldn't get to it
- 3 on a Thursday, we would certainly have a phone call and
- 4 discuss the patients.
- 5 72 Q. Did you consider whether it was a phone call or 10:52
- 6 participating in the, if you like, a joint ward round,
- 7 the incoming and the outgoing, that was an important
- 8 patient continuity of care and/or safety mechanism?
- 9 A. But a phone call you can equally talk about the patient
- 10 equally as well, than spending four hours walking 10:52
- 11 around a ward. If it's commoner to do the ward round,
- 12 but if for some reason one couldn't, it was a phone
- 13 call.
- 14 73 Q. Has it now moved to a phone call completely or
- 15 comprehensively? 10:52
- 16 A. Certainly, I think that it is, that it's a phone call,
- 17 yes, and it's equally as effective.
- 18 74 Q. Leaving aside the working of the UOW model and thinking
- 19 back across the 10 years of your career so far at
- 20 Craigavon or the Southern Trust, what has been 10:53
- 21 I suppose the biggest professional challenge for you as
- 22 a urologist?
- 23
- 24 We spoke earlier about whether it was a pressurised or
- 25 stressful environment and you helpfully said, well, you 10:53
- 26 know, it's a busy environment but you don't feel the
- 27 stress. What is the -- is there a constant
- 28 professional challenge that has been in place or
- 29 a regular professional challenge that has been in

1 place?

2 A. I suppose my challenge really is balancing home life
3 with work, you know. It's quite a busy job and so --
4 and I probably haven't perfected by private life yet,
5 but I'm aiming, I'm trying to do that. So I think 10:53
6 that's really -- trying to balance the two because work
7 eats into your private life all the time. You know,
8 you have got lots of results to sort, et cetera. So it
9 pervades your life all the time.

10 75 Q. I think many busy professionals perfect it just a few 10:54
11 weeks before retirement?

12 A. Probably, and I keep saying that I will try, but it
13 is -- I try. Not very well, but I do try.

14 76 Q. I want to move to ask you some questions about the
15 extent to which the 6, 7, the numbers varied, and 10:54
16 we have had evidence that the consultant post, the
17 substantive consultant posts were rarely filled in, if
18 you like, on a permanent basis. Your statement speaks
19 to that as well, the number of locums that have been in
20 place. But I want to explore with you the extent to 10:54
21 which there was good communication within the team, to
22 the extent to which it truly had a team dynamic.

23
24 You've said in your statements, maybe bring it up for
25 convenience, WIT-50535. That in terms of -- scroll 10:55
26 down please. You've helpfully listed within this
27 paragraph I suppose the nature of the communications
28 that take place through meetings in the urological
29 domain. There are planning meetings, weekly

1 Departmental meetings, monthly Patient Safety meetings,
2 weekly uro-oncology MDT, you attend a Regional Urology
3 Reconstructive meeting, and monthly uro-gynaecology
4 meeting.

5
6 So across those types of interaction, what was emerging
7 from that? Did you feel that as a practitioner you
8 were given an opportunity to understand all that was
9 going on in this domain?

10:56

10 A. With regards to waiting lists, et cetera, I was
11 certainly aware. In other words, I was aware that we
12 were finding it difficult to keep up with our waiting
13 lists, or the numbers of patients we had far exceeded
14 our capacity. I wasn't aware of a lot of the issues in
15 the background that were happening.

10:56

16
17 Certainly at our weekly Departmental meetings, and
18 Martina Corrigan was the Head of Service at that time,
19 as far as I remember, I think we were certainly
20 informed of the state of our waiting lists, planning
21 for the future issues, if we were getting a vacant post
22 and who was being interviewed. So I think we were
23 being kept up-to-date reasonably well, yes.

10:57

24 77 Q. Just touching on the Martina Corrigan input. If we go
25 back up through your statement of WIT-50518 at
26 paragraph 1.5. I'm conscious that you said within your
27 statement that you had not been made aware specifically
28 of the IEAP Protocol, the Integrated Elective Care
29 Protocol. Nevertheless, attending at these meetings --

10:57

1 is this the weekly Departmental meeting?

2 A. Yes.

3 78 Q. She would have furnished the attendees with key

4 performance indicators including, as you say --

5 CHAIR: Mr. O'Donoghue, there is water in front of you 10:58

6 if that helps.

7 A. Thank you.

8 79 Q. MR. WOLFE KC: As you say here at the bottom of the

9 page, the KPI included cancer waiting times, the red

10 flag urgent routine waiting times for in-patient, 10:59

11 out-patients and day surgery. I suppose you make the

12 point that being made aware of those indicators

13 presented every month and it allowed you and others,

14 supposedly, to engage with efforts to reduce waiting

15 lists and improve performance. 10:59

16

17 Help us understand that. You're getting the message,

18 one might assume, that there's more coming on to our

19 lists, the position isn't getting any better, in fact

20 the Inquiry observes from evidence received before you 11:00

21 came to us that waiting lists of all varieties were

22 getting worse exponentially over the period. What, in

23 a real sense, were you able to do in terms of

24 engagement with efforts to reduce waiting lists and

25 improve performance? 11:00

26 A. Well, we ran extra lists to try and get the numbers

27 down. We ran extra clinics to try and clear the

28 waiting lists. Certainly in the last few months, the

29 patients -- or last year and a half patients were sent

1 to the independent sector. But at that time we were
2 running extra lists in the clinics.

3 80 Q. Mr. Glackin has offered some reflections upon the,
4 I suppose, effectiveness of the team in terms of
5 participation at these meetings.

11:01

6 A. Yes.

7 81 Q. He said, and if I could just bring his particular
8 witness response up on to the screen, WIT-42307. And
9 he says at 31.2 that:

10 11:01

11 "Mr. Young tried his best to lead the Urology team.
12 However, despite his best efforts Mr. O'Brien,
13 Mr. Haynes and Mr. O'Donoghue frequently failed to
14 attend Departmental meetings or arrived late. All too
15 often I sat across the table from Mr. Young wondering
16 why my colleagues had not shown up. Due to the number
17 of fronts on which the service was failing to deliver
18 (growing waiting lists for appointments and
19 surgery)..."

11:02

20 11:02

21 He cites:

22
23 "...it was difficult to achieve a consensus as to how
24 to move forward without engagement from our
25 colleagues."

11:02

26
27 Specific to you, you're one of a number of consultants
28 who he says didn't attend as regularly as you might
29 have. Is that fair comment?

1 A. If it's there, it probably is. And I think the reason
2 is probably I got pulled in a different direction to
3 sort a problem at the time. Lots of people would come
4 to me with issues and I would end up sorting those
5 problems. 11:03

6 82 Q. I suppose it's, with every situation, you have to work
7 out the comparative priority.

8 A. Yes. So if there is a clinical issue, I would sort
9 that before I would go to the meeting.

10 83 Q. Yes. Did you see any great importance associated with 11:03
11 these meetings?

12 A. No, the meetings are extremely important. But I think,
13 you know -- but there are lots of important things and
14 whatever I was doing obviously I felt was more
15 important to sort than go to the meeting. But the 11:03
16 meeting is exceedingly important. I kind of regret
17 that I was late, but I think I got to most of them,
18 I was probably just late. But it was probably
19 balancing lots of duties, I think.

20 84 Q. Yes. You have talked briefly about the kind of 11:04
21 initiatives that as consultants you would have
22 participated in to try to improve the service, waiting
23 list initiatives, for example.

24

25 Mr. Glackin, in his oral evidence to the Inquiry 11:04
26 reflected upon his experience in Birmingham and
27 Wolverhampton as a trainee and he explained the data in
28 terms of patient numbers and workload was openly
29 discussed along with strategies as to how to manage.

1 He said that in Craigavon, while we have had elements
2 of that at times, it was only within, literally, the
3 last week as he stood giving evidence -- or sat giving
4 evidence in the seat that you're in, but now within the
5 last month, I suppose, he said:

11:05

6
7 "Only within the last month have we had a meeting of
8 this kind where data was presented."
9

10 And he congratulated the person who did it:

11:05

11
12 "It hadn't happened before under Mrs. Corrigan, she had
13 too much on her plate. She was pulled from pillar to
14 post."
15

11:05

16 So I suppose what we're getting from him, and I'm
17 interested in your perspective, rarely before, at least
18 until relative recently, has there been a concerted and
19 thought-through effort to put all of the relevant data
20 on the table and to have a serious conversation about
21 how you, as a team, might better manage the waiting
22 list challenge.

11:05

23 A. Yeah, I'm thinking back to my time in England first.
24 My experience certainly wasn't Mr. Glackin's. I was in
25 Oxford and certainly when I was in Oxford it didn't
26 seem to be -- it seemed to be again extremely busy,
27 long waiting lists, and registrars there weren't party
28 to the workings of Department like Mr. Glackin was
29 exposed to. That's the first point.

11:06

1
2 when I went to Watford one of the consultants there,
3 the Head of Department at the time, and Freddy Banks
4 was trying to organise Outpatients, a bit like the
5 Guy's model which Craigavon also had done in my first 11:06
6 couple of years pre-COVID of having an out-patient
7 where everything is done, patients have their
8 investigations, are seen and either discharged or go to
9 specialist clinics. So that was happening, or the
10 planning for it was going ahead in Watford when I was 11:07
11 there.

12
13 I think Mrs. Corrigan certainly was very busy. I think
14 she had a huge workload. Not only did she have
15 urology, she had I think ophthalmology, ENT. So 11:07
16 I think she was pulled in lots of different directions.
17 But, certainly, I think the information we received
18 more recently is helping us to plan, and
19 we probably didn't have that information before, to try
20 and plan things a bit better. 11:07

21 85 Q. Again, this is maybe a taster session around the
22 capacity issue, and we'll go on and look at it in a bit
23 more detail a little later. But do I take from your
24 answer that you feel that as a team there might have
25 been an opportunity for some better strategy thinking 11:08
26 around the challenges posed by the demand capacity
27 problem which were not taken up, perhaps, because
28 management wasn't able to offer you the support to work
29 it out in this way?

1 A. well, I think there's always room for improvement. I
2 mean I think it wasn't for the want of trying and
3 I think, in fairness to Martina Corrigan, she certainly
4 did her best as well. But I suppose we all could have
5 done better, all of us. 11:08

6 86 Q. Let me move to one of the specific, I suppose,
7 additional duties that you've taken on, which is the
8 chairmanship of the MDM.

9 A. Yes.

10 87 Q. At this point I'm just asking you about the role of 11:09
11 Chair and some aspects of how the multi-disciplinary
12 meeting and team functioned. Later, perhaps tomorrow,
13 we'll look at some of the problems which have emerged
14 from the MDM which, I suppose, emphasised -- not
15 exclusively, but emphasised as a result of the SAIs 11:09
16 that were reviewed in 2020.

17

18 How much work does the chairing of the
19 multi-disciplinary meeting involve?

20 A. For me, personally, I find it takes a lot of time. So 11:10
21 I spend about four hours preparing it before I Chair
22 it.

23 88 Q. Is it always possible to commit sufficient time?

24 A. well, because I do it at home so I'm -- or I've started
25 also getting the patients out on Tuesday, so I start it 11:10
26 on Tuesday. So I do it on Tuesday and do it at home if
27 I get a chance. It takes quite a chunk out of your
28 time, but it is possible. But I do it at home quite
29 a lot.

1 89 Q. Yes. Incorporated within the preparation, is it
2 reviewing letters, results and reports on the NICER?

3 A. Yes. Because the narrative always doesn't give
4 sufficient information. So one has to go back to the
5 original letters to get further information. 11:11

6 90 Q. So there's a patient narrative, that's a background
7 piece. I suppose it tends to be quite immediate in
8 terms of where the case is at?

9 A. Although some -- it does give historical information as
10 well. It depends how -- 11:11

11 91 Q. Is that prepared by the clinician with responsibility
12 for the patient?

13 A. Things have changed. So I think in the last year
14 we now have a pro-forma, so when we submit a patient to
15 the MDM we write a narrative. But there's also 11:11
16 a narrative which I think cancer tracker sort of cut
17 and paste from previous MDMs.

18 92 Q. Do you review imagining as well?

19 A. Yes. If necessary, yes.

20 93 Q. Do you have specific time allocated within your job 11:12
21 plan for preparation?

22 A. I have time but it's not specific time as in it is not
23 a certain time of the day or week, but I have time
24 allocated, yes.

25 94 Q. But does it -- does it adequately reflect the 11:12
26 preparation activity in terms of time that you commit
27 to the task?

28 A. Well it doesn't adequately for me because I spend
29 longer on it. I spend at least four hours trying to

1 get it ready, probably longer.

2 95 Q. So essentially you're using your own free time --

3 A. Yes.

4 96 Q. -- in order to achieve, in quality terms, adequate
5 preparation? 11:12

6 A. Particularly if you have duties all day wednesday.
7 I mean, you have to do it afterwards. That's why I try
8 to get it on Tuesdays, so I can start it.

9 97 Q. In terms of your approach, say, in circumstances where
10 you're not chairing it, do you submit clinical 11:13
11 summaries concerning your patients, or do
12 you alternative perhaps simply submit dictated letters
13 to the cancer tracker?

14 A. You have to now, since the change, you have to fill out
15 the pro-forma. To put a new patient in the MDM you 11:13
16 have to fill out a narrative now for the patient to get
17 discussed.

18 98 Q. You say "now". Has that changed?

19 A. Yes. It's probably in the last year, or probably not
20 even a year. It is a virtual form online, so we fill 11:14
21 it out.

22 99 Q. Yes. What was, if you like, the mischief there, that
23 this change was intended to correct?

24 A. I think it was probably to give a more focused
25 question, so to give a question that you want to ask 11:14
26 the MDM exactly what, you know, do you want this
27 patient discussed for radiotherapy. It is a guide to
28 the person chairing what exactly is your question or
29 whether you want imaging reviewed by your

1 radiologist.

2 100 Q. So it helps to efficiently bring greater focus to the
3 issues concerning the particular patient?

4 A. Yes.

5 101 Q. Has that worked well? 11:14

6 A. I think it works better, yes.

7 102 Q. I suppose it front loads the work or the commitment
8 required to --

9 A. Well, you know exactly, so you know some of them are
10 quite straightforward, but you know what you're looking 11:15
11 for.

12 103 Q. In terms of the operation of the MDM, did you find, and
13 do you find that there's adequate time for discussion
14 of patients during the meetings?

15 A. Yes. We take as long as we need for each patient. 11:15
16 Some patients are faster. It is relatively
17 straightforward. The more complicated ones get longer
18 time.

19 104 Q. We'll go on to look at issues such as quoracy and
20 other, if you like, problems arising out of specific 11:15
21 cases and the governance issues that they identify.
22 But in the time that you have chaired, and you have
23 been chairing since 2015, leaving aside the quoracy
24 issue perhaps, were there any items or problems that
25 were apparent to you as a participant and regular Chair 11:16
26 of the MDM that you felt were looking to be resolved
27 but were never resolved?

28 A. I think it's just the workload that goes into preparing
29 it. I think that's certainly an issue.

1
2 with regard to the actual running of the meeting,
3 I think -- well, certainly now it is much better
4 because there's quoracy. We always now have an
5 oncologist, a clinical and medical oncologist and a 11:16
6 radiologist, most of the time although not always. So
7 it certainly runs better than it did in the past.

8
9 But in saying that, you know, there's only three core,
10 well, four I suppose, four urologists, but we're not 11:17
11 always there if somebody is on-call or away.

12 105 Q. There have been changes recently, we understand, and
13 we'll look at the impact of those changes in terms of
14 the support that is now available to the MDM. Was
15 there ever any unease prior to these recent changes 11:17
16 about the support, whether administrative or tracking
17 that was available to the MDM?

18 A. Well, if you're -- I mean there were issues at times.
19 I think certainly, not always, pathology, patients who
20 have malignant pathology, it's meant to be contacted -- 11:18
21 the trackers are meant to be contacted. I think that
22 always didn't happen. So if that's what you're
23 referring about. But I think that has got better, that
24 has got better as well.

25 106 Q. Well let's just maybe look at that. I suppose my 11:18
26 question was more general than that. But historically
27 has there been a problem in terms of the interaction
28 with pathology for particular patients?

29 A. I personally haven't had problems. I don't know what

1 particular thing you're talking about.

2 107 Q. No, it's just what you have just said?

3 A. I personally haven't experienced -- I've been reading
4 in some of the folders that pathology didn't always --
5 it was probably patients who weren't followed up, it 11:19
6 wasn't passed on to the trackers. And that's something
7 I was reading in the evidence bundles in the last three
8 weeks, but it was not something that I was aware of
9 when I was chairing.

10 108 Q. We'll maybe look at that particular case. I think it 11:19
11 is one of Mr. Glackin's cases where the case was closed
12 down before pathology was discussed. That's not
13 a general concern that was --

14 A. No.

15 109 Q. -- being discussed or was known to the MDT in 11:19
16 real-time?

17 A. I think it certainly wasn't common. I think it might
18 have been a one-off. I think it is not something I was
19 aware of.

20 110 Q. Let me ask you about the patient safety meeting. If 11:19
21 we go to WIT-50523. At 7.2 you explain that this was
22 a monthly meeting.

23 A. Yes.

24 111 Q. You say it was either urology specific or combined
25 surgical directorate, and it was held to discuss 11:20
26 clinical cases of concern and deaths:
27
28 "Learning points were noted. Audits and studies were
29 presented and directives from various NHS sources were

1 noted."

2
3 Just the first point you made there, as the Inquiry
4 understands it, perhaps in the early year or so of your
5 career in Craigavon, the patient safety meeting was 11:20
6 a broad church. It was surgical generally which
7 incorporated urology but there's now a specific urology
8 meeting, isn't that right?

9 A. I might be wrong. I think since my time, unless I've
10 got it wrong, it was always urology specific and joint 11:21
11 surgical. I think it was before my time it was just
12 general surgical or a big surgical meeting. I think it
13 was always urology specific since I've been there.

14 112 Q. Yes, and the one you're expected to attend is the
15 urology specific? 11:21

16 A. Well, you are expected to attend both.

17 113 Q. Okay.

18 A. They alternate. So I think the combined meeting is
19 quarterly and the rest of the time it's urology.

20 114 Q. Now, you've said there that clinical cases of concern 11:21
21 are discussed as well as deaths, and we've had evidence
22 from Mr. Glackin already, many of the deaths in Urology
23 are to be expected and that the real discussions are
24 around those that maybe have a question mark around
25 them. Learning points were noted. 11:22

26
27 I suppose the Inquiry is anxious to understand what, in
28 terms of learning, actually happens. So to take an
29 example, and in the context of stents, I'll take you to

1 a particular example later this morning, but help us
2 with this: A complaint or the outcome of an SAI review
3 or a death, or a morbidity case, is discussed at
4 a Patient Safety meeting and learning is noted amongst
5 its members as you indicate here. The learning 11:23
6 I suppose is described by the person, the clinician
7 presenting the case, this is what we learned from this
8 case and this is what we really should be doing in the
9 future, might be one way of phrasing it.

10
11 But how does what is discussed at the Patient Safety
12 meeting translated into real practical effective
13 action, what is the join between the PSM meeting and
14 what's discussed there and what needs to happen?

15 A. Well, one, it all goes back to the Clinical Governance 11:23
16 team. It is disseminated to various people, management
17 plus the Urology team. You are probably talking about
18 stents that have been left in too long. But things
19 have changed for the better to try and -- as a result
20 of that, so stents are not dwelling too long or 11:24
21 excessively long in patients.

22 115 Q. We'll come to the stents one in a moment. I don't want
23 to claim your thunder too early on that. But can you
24 help the Inquiry with another example of how the
25 learning that is noted in this forum you said goes to 11:24
26 the governance team. But if something requires, if the
27 learning is that this requires a change of approach, it
28 may require resources, it may require training or
29 equipment, how is that change delivered and who ensures

1 that it is delivered?

2 A. well, if it requires equipment we aim to get the
3 equipment. I mean if we need equipment or if we need
4 training, we access the training. I mean I'm speaking
5 generally rather than a specific case. But if the
6 outcome was that Doctor So-and-so should get further
7 training, he or she would go and find that training.

11:25

8 116 Q. who superintends the action that is required, whose
9 responsibility does that become?

10 A. I would have thought if a directive came from the
11 Patient Safety meeting that once the doctor got the
12 training he ought to report back to the Patient Safety
13 meeting. I think that's how I would see that it would
14 happen.

11:25

15 117 Q. Because one could get the impression at looking at some
16 of the incidents that arise, whether it's -- I don't
17 know, the need for sign-off of diagnostic
18 investigations, perhaps preoperative assessment,
19 perhaps the stenting issue.

11:25

20
21 You see these on the agenda of PSM across different
22 incidents over an expanse of years. The same issue or
23 a similar issue is arising and it is discussed and, as
24 you say, learning noted. But, in fact, conscious that
25 accidents can happen, or shortcomings can occur with
26 the best will in the world, but you don't perhaps get
27 the impression that the learning is translated into
28 effective curative action at the earliest opportunity.
29 Is that a fair comment?

11:26

11:27

1 A. No, because if you talk -- well, probably things happen
2 slowly. But if you talk about sign-off, and I'm
3 talking about what happens now. So, obviously, what
4 happens now is as a result of SAIs and problems in the
5 past. I mean without exception we all sign-off results 11:27
6 now on NICER. Every two weeks we get a little tally of
7 how good or bad we are doing. So if we haven't
8 signed-off for a week or so, we're green or red or...
9 So from that point of view I think it does translate
10 into how we're doing. But it takes a long time. These 11:28
11 things don't happen overnight. So probably from when
12 the problem originally was noticed, which was several
13 years ago to now, but now we're doing it right.

14 118 Q. Yes. Yes. Again, I'm holding a lot of "we'll do this
15 later" into the air. We'll look at sign-offs 11:28
16 specifically, but it is a useful example to, I suppose,
17 illustrate the point that you've just made. You're
18 essentially saying, I'm conscious that there have been
19 multiple incidents of sign-off problems, of failures on
20 the part of clinicians to sign-off and patients have 11:28
21 got into difficulty because of that. We know that, you
22 know that. And, I mean, if we start -- and as I say,
23 I'll go into the detail of this later, if we start
24 with, you know, any of the -- some of the SAIs we've
25 looked at, but it's only in 2021, 2022, where you, as 11:29
26 A Trust, arrive at a solution where Mr. Haynes is
27 sending you a monthly chit saying, if you have 50
28 sign-offs outstanding, in your case -- go to the
29 example later -- I know you've been on holiday, but

1 please sort that out. So there is now a governance
 2 safety net in place. But it shouldn't take that long,
 3 should it?

4 A. It probably shouldn't. In an ideal world it shouldn't
 5 take that long and I suppose it should have been sorted 11:29
 6 faster.

7 119 Q. Yes. What I'm sort of poking at a little here is, I'm
 8 asking you a question I suppose about the effectiveness
 9 of the patient safety meeting. It is an ideal forum or
 10 opportunity to corral the problems and identify the 11:30
 11 learning. But I'm anxious to, I suppose, take your
 12 view on whether that is sufficient if there is
 13 a disconnect between that and the implementation of the
 14 solution?

15 A. I suppose the patient safety meeting can make 11:30
 16 recommendations and inform the appropriate people, but
 17 it can't police it. In other words, you know, if
 18 something is sorted, it can come back to the Patient
 19 Safety meeting. But I don't think the Patient Safety
 20 meeting is well enough resourced so that -- you know, 11:30
 21 I'm doing it now, so I can't go and chase up all the
 22 time that something is being done. You know, I depend
 23 on people to contact me and say "we have now done
 24 this". But I don't have either the time or the
 25 resources. 11:31

26 120 Q. In terms of -- I mean, one can imagine that those
 27 clinicians attending the Patient Safety meeting are in
 28 a good position to articulate, I suppose, their
 29 concern, their alarm, their worry about any issue of

1 practice that comes there. Are there listening ears in
 2 terms of those on the governance and/or management
 3 side? Are they present at the meeting so that they can
 4 hear this alarm, worry, if that's how it is to be
 5 characterised in terms of any particular clinical
 6 issue?

11:32

7 A. Yeah, and very often a Head of Service comes to the
 8 Patient Safety meeting. We now have audit people at it
 9 as well. You know, we have a good turnout of medical
 10 professionals, nurses, doctors, at the meeting. So it
 11 is a good forum for discussion, discussing concerns.
 12 I think it is effective, albeit slowly effective. But
 13 it is, things do change ultimately. Maybe not as fast
 14 as we would like, but they do change.

11:32

15 121 Q. You took over the role of Chair from --

11:32

16 A. Mr. Glackin, yes.

17 122 Q. -- Mr. Glackin in 2021. Can I just offer you
 18 a reflection or a series of reflections that have come
 19 through him. I'll read them out. It's not word for
 20 word but it's reflective of his sentiments. He said,
 21 this is WIT-42299 at paragraph 17.3, that Clinical
 22 Governance has been neglected. At WIT-42289, paragraph
 23 7.5, that support for clinical audit has been
 24 insufficient. He has said that:

11:33

25
 26 "No one person has held responsibility for quality
 27 assurance for urology services and the degree to which
 28 individuals engaged with Quality Improvement was
 29 variable."

11:33

1
2 Now, touching on the issue of clinical audit which goes
3 to, if you like, quality assurance, what about that?
4 He seemed to be thinking that the degree to which audit
5 was supported as part of Patient Safety and into the 11:34
6 Patient Safety meeting was poor. Quite often audits
7 would be performed unilaterally by the clinician for
8 their own purposes, but really they weren't fit for
9 purpose, they didn't complete the audit loop, as he
10 described it. Has audit been poorly supported 11:34
11 historically for Urology and has that changed?

12 A. Well what has changed from when he wrote that, so we
13 can talk about it now. So as I said, the Audit Manager
14 comes to our meetings. We have a programme of audits.
15 We ensure that the registrars all have audits. 11:35
16 We ensure that they present the audits and, in fact, at
17 our next Patient Safety meeting one of our registrars
18 in Leicester is presenting on Teams, so we ensure that
19 it's not just an audit that is actually presented. So
20 he is presenting in a week's time. So it is much more 11:35
21 robust. And I think because the audit Department are
22 professional, they ensure it is done properly.

23 123 Q. Okay. So what is the importance of their now
24 attendance at the Patient Safety meeting?

25 A. That it is done in a professional way in that they are 11:35
26 now -- everybody doing audits, they have to register
27 the audits so that the Audit Department is aware of
28 that, they have forms to fill out. We chase them,
29 I chase them constantly to ensure that they are

1 presenting them. It is not just doing, forgetting all
 2 about it, I make sure that they present at our meetings
 3 now. And they get a certificate at the end of it so
 4 they can put it on their CV if they are going for
 5 interviews. So it is all done more professionally now 11:36
 6 and it is done for the entire team, so they present in
 7 front of the entire Patient Safety meeting.

8 124 Q. Are there, if you like, current clinical concerns that
 9 have recently been the subject of audit?

10 A. The audits that they're doing are audits of - not 11:36
 11 things of concern - although I think one of the audits
 12 they're looking at how good we are at consenting, and
 13 that's the one that's going to be presented next week.

14 125 Q. Does that encompass pre-theatre assessment and what
 15 goes into that into in terms of conversations? 11:37

16 A. No. He's looking at the quality of the Consent Forms.
 17 In other words, are we informing the patients of all
 18 the -- how well we're informing the patients of
 19 potential complications they may suffer from
 20 a procedure, how good or bad we are at doing that. 11:37

21
 22 So that's one of the audits. So there is a national
 23 audit, the one the Registrars are doing, and that's of
 24 TRBTs, which is resectional bladder tumours. That's
 25 a UK-wide audit. That hasn't been presented yet 11:37
 26 because it's UK-wide and we're waiting on the results
 27 of that. But we have contributed to that.

28 126 Q. So in terms of the improvement or the support of and
 29 participation in audit, you're reflecting a positive

1 change?

2 A. Yes, I think it's got better. Certainly from what
3 I hear from people on the ground, they are much happier
4 with the involvement of the Audit Department at the
5 Patient Safety meeting. In fact I have e-mailed the 11:38
6 manager just the other day to make sure that she is
7 coming to our Audit Meeting, our Patient Safety meeting
8 next week.

9 127 Q. As I pointed out, Mr. Glackin had concerns about the
10 support for audit. We have heard from the Acute 11:38
11 Governance Team, the Governance Coordinator, that audit
12 had suffered, audit within acute generally and you
13 might say urology specifically had suffered because of
14 resource issues. How would you characterise how poor
15 it was before the recent changes? 11:39

16 A. Yes. I would agree with Mr. Glackin. I mean certainly
17 there was no people -- I think registrars picked topics
18 where -- just picked topics. It wasn't, as far as
19 I know, agreed with anyone, and it was really just
20 a sort of a way of getting a study done whilst they 11:39
21 were in their six-months or a year. So I think it is
22 on a firmer footing now and I think it will contribute
23 to improvements overall and they will be repeated, as
24 audits are, to see that there are improvements in the
25 various things that we are auditing. We're going to 11:39
26 complete the audit cycles.

27 128 Q. Yes, can I just ask you briefly about the support that
28 you receive as Chair of the Patient Safety meeting.
29 Are you paid, in a sense, for taking on this role?

- 1 A. I think I get point-4 or something of a PA for it.
- 2 129 Q. Does that reflect your activity?
- 3 A. No, because I have to do everything myself. So from
- 4 booking the room to typing the programme, to organising
- 5 everything. So I do everything, plus taking the 11:40
- 6 Minutes. I get one of the nurses to take the list of
- 7 names who are attending because I can't do everything.
- 8 So I'm not supported in that sense, I have to do
- 9 everything myself.
- 10 130 Q. So you receive little or no administrative support? 11:40
- 11 A. Yes. Apart from the audit side, the Audit Department,
- 12 but the rest of it I do myself, yes.
- 13 131 Q. In terms of attendance at the Patient Safety meeting,
- 14 we note from your appraisal documents back in 2017, and
- 15 again in 2018, that the appraiser is pointing out that 11:41
- 16 your M and M attendance has been low but you're an
- 17 active participant when you attend and you need to
- 18 improve that, and you recognise that you needed to
- 19 improve it?
- 20 A. Yeah, I think it's obviously 100 percent now because 11:41
- 21 I'm chairing it. I think, again, I was probably either
- 22 on-call or various issues, if you are on-call you can't
- 23 be at it. So I think they were probably the reasons.
- 24 132 Q. Is compulsory attendance a requirement for all levels
- 25 of staff? 11:42
- 26 A. It is compulsory but if somebody is on-call they
- 27 obviously can't get to if they are busy. If they are
- 28 not busy they will come to it, but if they're busy in
- 29 theatre they can't come to it.

1 133 Q. who polices that?

2 A. I take all the names and I submit it to the Clinical
3 Governance Department so they're aware of everybody who
4 attended. So that goes into their appraisal, obviously
5 their attendances.

11:42

6 MR. WOLFE KC: I want to move on, after a short break
7 perhaps, to look at management arrangements, then we'll
8 look at capacity issues in more detail.

9 CHAIR: we'll come back at 12 o'clock, everyone.

10

11:42

11 (Short adjournment - 11:42 a.m.)

12

13 CHAIR: Thank you, everyone. Mr. wolfe.

14 MR. WOLFE KC: Before we look at some of the further
15 tools or instruments of good governance, I just want to
16 ask you some questions about, if you like, management
17 responsibility for governance.

12:01

18

19 You've said, if we can have up on the screen please,
20 WIT-50536 at paragraph 32.1. You've said overseeing
21 the quality of services in Urology was within the remit
22 of the Consultant Urologists and the Head of Service.

12:01

23

24 Then, scrolling down, I suppose by difference or by
25 contrast, in relation to the Clinical Governance of the
26 profession of those services, you said that overseeing
27 Clinical Governance was the responsibility of the
28 Clinical Director, the Associate Medical Directors and
29 the clinical Lead. They're obviously all on the

12:01

1 medical side or the professional side. Was there
 2 a role in overseeing clinical governance for the
 3 professional managers, as such, I'm thinking in
 4 particular the Director of Acute and the Assistant
 5 Directors?

12:02

6 A. Perhaps I didn't say that, yeah, absolutely. I mean
 7 I think Ronan Carroll was an Assistant Director and
 8 Martina and the Director above them are all responsible
 9 for ensuring that Clinical Governance is achieved.

10 134 Q. When you use the phrase -- maybe you are using our
 11 phrase back to us -- about the oversight of Clinical
 12 Governance and the responsibilities that fell to the
 13 people you have identified, and I take it those to be
 14 the current, whereas when you wrote the statement, the
 15 then current --

12:03

16 A. They were at that time. It's different now.

17 135 Q. Obviously the Inquiry is familiar with the post-holders
 18 before that. But what did you see as falling within
 19 the oversight of Clinical Governance?

20 A. I think Patient Safety, certainly, is important. I
 21 think if patients suffer any untoward events, it's
 22 certainly something they will take up and pursue, that
 23 it is identified what the problem is, or at least it is
 24 reported to them what the issues are. So I think
 25 Patient Safety. Also Patient Safety in its audits
 26 aspects and that would include, obviously, waiting
 27 lists and patients waiting in a timely manner for
 28 surgery. I mean other issues would come into Clinical
 29 Governance. Obviously paperwork and summing-up

12:03

12:03

12:04

1 results, doing letters. All of that, all are issues
2 that can result in injury to a patient.

3 136 Q. Yes. I suppose if you put a distinction between the
4 role of the consultant providing the service and the
5 people you've identified as having oversight
6 responsibility for Clinical Governance, the
7 practitioners deliver the service, so it's for the
8 people that you have identified here in Clinical
9 Governance terms to ensure that the service is being
10 delivered safely?

12:04

12:05

11 A. Yes, to facilitate the service and enable the
12 practitioners to work. So, obviously, that would be
13 providing clinics, ensuring that things are ultimately
14 done correctly.

15 137 Q. If things weren't being done correctly, would you
16 expect these people, these post-holders would be active
17 then in pursuing the shortcomings in practice, whether
18 it was a particular practitioner's approach to the
19 delivery of a service, or any particular aspect of his
20 or her practice, as well as, I suppose, bigger issues
21 or macro issues in association with the infrastructure,
22 perhaps, or the ability to deliver?

12:05

12:05

23 A. Yes. They should have used all the tools at their
24 disposal to do whatever they needed to correct the
25 problem or stop issues happening.

12:06

26 138 Q. You have explained in your statement that your
27 immediate point of contact, depending on the issue, on
28 a day-to-day basis would be either Martina Corrigan or
29 Mr. Young; is that right?

1 A. Yeah, so if I had issues I would have spoken to either
2 of those or both of them.

3 139 Q. If you had concerns about how a colleague, a medical
4 colleague or a nurse, or whoever the member of staff
5 might be, would you approach Mr. Young? 12:06

6 A. I certainly would have started there. I think as it
7 got higher up you'd probably loose track -- I'm not the
8 entirely sure -- but I would start with Mr. Young and I
9 would see what I should do about it.

10 140 Q. How did you perceive or understand his governance role 12:07
11 and how did that work out in terms of activities or
12 expected activities if an issue arose?

13 A. Mr. Young certainly had a clinical role. I thought he
14 was more management, although I know he said he didn't
15 so he mustn't have had, but I would have looked at him 12:07
16 as a management-type person if I had issues that needed
17 to be sorted.

18 141 Q. Yes. Let me just put his perspective --

19 A. Yes, I think he said --

20 142 Q. -- on the screen, because I think you are alluding to 12:07
21 it. Let's just get it precisely. We start with
22 WIT-51748, paragraph 29.1. He characterises his
23 clinical lead role as well as his consultant role as
24 being service roles as opposed to management posts. He
25 says as a senior doctor, there's a responsibility to 12:08
26 ensure your patients, and patients in general terms,
27 have a high standard of care provided in a safe
28 environment. He outlines a series of systems and
29 structures that helped him obtain some assurance

1 regarding Patient Safety.

2
3 Then, if we go to -- and I suppose the emphasis here is
4 he doesn't see his role as being management in nature.

5 If we go then back in his statement, WIT-51696. If 12:09
6 we go to 6.3, please. He reported, he said, to the
7 Clinical Director of Surgery and Director of
8 Acute Services. This role, again, he uses the phrase
9 "was a service post". He was not responsible for
10 individual team members but was a coordinator of 12:09
11 activities for the Urology team members. He may have
12 coordinated activities, such as Departmental meetings.
13 The role did not manage or have responsibility for the
14 overall running of the Urology Unit per se. It did aid
15 the Trust management structure if asked for clinical 12:10
16 direction.

17
18 Do any of those extracts jar with your perception of
19 what the role of clinical lead was or should have been?

20 A. Well, honestly, my impression was different than what 12:10
21 his was. I did think it was a management role. I'm
22 obviously wrong. It depends what you define,
23 "management", but you know if you are coordinating, you
24 are managing. If I had issues with -- if I wanted
25 a new piece of equipment, I would first talk to him 12:10
26 about it. So he may have been on the lower level of
27 management, but my impression was it was a management
28 role of sorts rather than a Urologist treating patients
29 and that's it. But I'm obviously wrong.

1 143 Q. Well, you may not be. We'll test that out with
2 Mr. Young in due course. But it was certainly your
3 understanding as a participant in this urological team
4 that your first port of call, if there was a problem,
5 would be either Martina Corrigan, if it was 12:11
6 a particular kind of problem, or it would be Mr. Young
7 and you would be expecting them to either signpost you
8 to a resolution or, indeed, resolve it for you?

9 A. Yes. I wouldn't have gone straight to any of the other
10 people, no. 12:11

11 144 Q. Yes. You wouldn't, for example, have gone to
12 Mr. Suresh or Mr. Haynes back at that time.

13 A. No, because they were on a similar level to me, so no.

14 145 Q. So, for example, if you had a concern, and I know you
15 did have a concern about a particular practitioner, you 12:12
16 would go to Mr. Young in the first instance?

17 A. At that time, yes. Yes.

18 146 Q. In terms of how you personally assured yourself that
19 Clinical Governance was being done properly, if we just
20 pull up WIT-50536, you refer at 33.1 to how you assured 12:12
21 yourself. You assured yourself that:

22

23 "Clinical Governance was done properly by engaging with
24 the pillars of clinical governance, and in particular,
25 active participation in the PSM, participation in the 12:12
26 MDMS."

27

28 You set the types of MDMS out there.

29

1 "Attendance at educational meetings and training
2 courses and engagement in audit."

3
4 You go on at paragraph 26.1, or back at paragraph 26.1,
5 to say that discussion of cancer patients at MDM and 12:13
6 actioning MDM decisions is another feature of your
7 efforts to sense that governance was being done
8 properly.

9
10 In terms of that assurance, you're speaking here about, 12:13
11 I suppose, whether there were adequate structures in
12 place bringing together the relevant people providing
13 you with the relevant information, is that what
14 you mean?

15 A. I felt when I wrote that, that I had interacted with 12:14
16 all these various aspects of Clinical Governance.
17 Whether I was getting all the information, how
18 effective they were, is a different matter, but at the
19 time I wrote that I felt that I did everything
20 I possibly could to assure myself that I engaged with 12:14
21 everything. As the GMC says, that I was a good doctor,
22 so that I did everything I could.

23 147 Q. In terms of the systems that were in place, you've
24 said -- can you just scroll down to paragraph 35.1,
25 please. There it is there: 12:14

26
27 "It seemed to me that everyone was engaging with the
28 Patient Safety meeting, attending the MDM."
29

1 And from what you understood, having yearly appraisals,
2 all useful forums to ensure that good clinical
3 governance is in place. And you say you felt reassured
4 that safe systems were in place to protect patients.
5 You go on to talk about your approach to results, et 12:15
6 cetera, and there's another action on your part to
7 promote Patient Safety.

8
9 what I want to ask you about is your sense that you
10 were reassured that safe systems were in place. As 12:15
11 a practitioner, did you have any sense of being
12 supervised, scrutinised, in terms of the work that you
13 delivered, the actions that you took in relation to
14 patients?

15 A. well, in that if I caused a problem to a patient, I was 12:16
16 aware that that would be discussed, either at
17 a mortality or morbidity, so that would be
18 investigated, so I was aware that that would be
19 policed.

20 12:16
21 I was aware that, you know, that I was policed that
22 I was seeing -- although it was pre-booked for me, that
23 I was seeing a certain number of patients in clinic.
24 That I was -- I think probably, I'm not sure, probably
25 in those days, I think it's -- I don't think paperwork 12:16
26 results were policed that closely, as far as
27 I remember, I can't remember. But I think they --
28 I think the word there is "seemed". It seemed, rather
29 than me actually knowing.

- 1 148 Q. I quite take the point that if your actions, or actions
2 of a colleague led to disaster, or led to injury, you
3 would expect to be held to account, because that's
4 a very visible evidence of something that has perhaps
5 gone wrong. But you make the point that at that time 12:17
6 I was aware that there wasn't any great scrutiny of
7 results sign-off. You probably, if you had thought
8 about it, would you have recognised that while systems
9 were in place to spot that, triage wasn't being done,
10 it wasn't always being done in a timely fashion. 12:18
11 ultimately enforcement action around that was less than
12 optimal.
13
- 14 You would, as we'll see when we look at some of the
15 other incidents that arose, you would have seen that 12:18
16 a failure to dictate, following a clinical encounter,
17 wasn't particularly well-monitored and due, and
18 Mr. Haynes, for example, I suppose stumbled upon it
19 isn't the right word, but you became aware of it as
20 opposed to some system of superintendence or governance 12:18
21 becoming aware of it. Just some examples to set
22 against your view that you felt reassured.
23
- 24 Do you now, upon reflection, see holes in either the
25 system of governance and/or the appetite for enforcing 12:19
26 good governance when problems were identifiable?
27 A. Absolutely. I mean sitting here now, I can't say I was
28 happy with -- I could be happy with how things were
29 done then. I suppose, with regard to results, because

1 in those days I wasn't signing results in NICER,
2 I depended on my secretary who has been with me a long
3 time and is very diligent, and she made sure I had all
4 the paper copies and ensured that they were all
5 signed-off. So I was dependent upon a good secretary. 12:19

6 149 Q. Yes. I've noted your evidence in relation to the
7 secretary and I want to cover that when we go to look
8 at sign-off as a specific item.

9
10 But as it happens, the next issue that I wanted to 12:20
11 briefly explore with you was the role of the secretary
12 more generally. I have noted from your addendum
13 statement that at one point in time, did you say 2016,
14 you realised or it was pointed out to you, perhaps,
15 that your secretary was performing her role on 12:20
16 a point-5 full-time equivalent and that needed
17 increased?

18 A. Yeah.

19 150 Q. And that was achieved without difficulty, was it? You
20 secured the extra resource? 12:20

21 A. It took a while. One is, I discovered that new
22 consultants were only getting half-time secretaries,
23 which I found difficult to reconcile that my workload
24 would be any less than, say Mr. Young's who had
25 a full-time secretary. And my secretary was constantly 12:21
26 complaining about her workload, you know, she was
27 half-a-day answering the phone and numerous patient
28 queries and then she had half-a-day of typing.
29 I didn't want to lose her. So that's why I -- I think

1 I must have went and spoke to Orla Cunningham about it.
2 I don't think I emailed her, I spoke to her.

3
4 But they must have responded because there were
5 subsequent emails which I didn't see, but they're on 12:21
6 the bundle where Orla and Katherine Robinson said that
7 they came to the realisation that it wasn't enough for
8 a consultant to have a half-time. So they obviously
9 did take cognizance of what I said. I don't know how
10 long after trying to sort it out that it actually 12:21
11 happened. It probably took quite a while. But people
12 eventually...

13 151 Q. Let me just go to your description of the role of your
14 secretary. It's at paragraph 17.2. If we go back to
15 WIT-50530, at 17.2. Let me see if there's anything 12:22
16 above that. Yes. You say that your secretary:

17
18 "Mrs. Robinson provides indispensable administration
19 support. As well as typing, they direct patient
20 queries to the appropriate person, help keep waiting 12:22
21 lists for theatre updated, ensure GP queries are
22 answered and generally provide a supportive role to the
23 consultant."

24
25 You go on and expand to say that: 12:22
26

27 "They ensure that MDM patients are booked into clinic,
28 help organise theatre lists and ensure that results are
29 acted on. I find it is important to have good

1 communication channels with the secretaries to ensure
2 an effective service."

3
4 Then you give the names. Your current secretary is
5 Mr. Daly, is that right? 12:23

6 A. No, Mr. Daly was my first secretary, I've had two and
7 Mrs. Robinson is my current one.

8 152 Q. I see, sorry, actually I have read that wrong, thank
9 you. You placed the secretarial role as, in a sense,
10 pivotal in the good and efficient management of your 12:23
11 practice?

12 A. Yes. My secretary likes to see me several times
13 a week. So I go to her office and we sit down and
14 we discuss various issues.

15 153 Q. So it's very much face-to-face? 12:23

16 A. It's face-to-face. I don't do virtually, so I go to --
17 I obviously speak to her on the phone, but she likes to
18 see me as well. So we do it face-to-face.

19 154 Q. Yes, what would, very broadly perhaps, what would be
20 the nature of the questions or the issues that you 12:24
21 would need to work through when you go to see her in
22 these stand-out meetings during the week?

23 A. So one: If she's had any phone calls from patients or
24 GPs we'll go through those, or any letters that come in
25 that she wants me to act on quickly, we'll deal with 12:24
26 that.

27 155 Q. Just maybe as we go through them I might have
28 a question or two. Park that one. A patient or a GP
29 might be phoning to say "when am I to be seen" or "I've

1 got a complication" or something like that?

2 A. Yes.

3 156 Q. So the communication from the secretary is: Here's the
4 problem. I need to communicate back to the patient.

5 A. She would ring, if there was a phone call, she would 12:24
6 ring the GP or ring the patient with my answer.

7 157 Q. So it's a task you feel comfortable delegating to her.

8 A. Well yes, because she's been doing it -- unless it was
9 something I needed to do myself. But if somebody rings
10 up to say "can I stay on my certain tablet", fine, she 12:25
11 would ring and say "Mr. O'Donoghue said you can stay on
12 your tablet", so that kind of stuff. But if I needed
13 to speak to the patient I would do, or if she wasn't
14 comfortable to do it.

15 158 Q. Working through, what else might be... 12:25

16 A. And so it's changed now, but she would have had
17 patients -- we would do our theatre lists and we
18 would -- there would be always patients that I would
19 feel that she would keep an extra -- patients that
20 needed to be done soon, TRBT, et cetera, and then 12:25
21 patients with stents. We would try and do that, take
22 those off chronologically or on clinical need. So we
23 would organise our list for the next month.

24 159 Q. Just on that, would it be your approach to delegate to
25 your secretary, if you like, the contact with the 12:26
26 patient to say: You're coming in or you're likely to
27 come in in the next three weeks, the letter will be
28 coming your way soon, that kind of thing?

29 A. Yes. I never rang the patient saying come in for

1 whatever. I delegated it. So I picked the patients
2 and it was sorted out. I didn't do that side of
3 things.

4 160 Q. Again, what else might typically arise during these
5 face-to-face?

12:26

6 A. If a result, a paper result had come into her again,
7 they're on ECR now, but if a paper result came in
8 she would -- she got lots of results, but if it had
9 come from X-ray that I needed to act on it, although
10 I would have got an email from X-ray anyway, she would
11 bring my attention to that, that it was something
12 I needed to act on it.

12:27

13 161 Q. So she would be in, in a sense, highlighting that this
14 one is pressing. It may not be pressing because you
15 have it under control, but it is an extra safety net?

12:27

16 A. I always dictate letters on all results and still do.
17 So if a result didn't -- wasn't dictated on, she would
18 make sure that I was dictating on it, that I had acted
19 on it. So she was another mechanism to try and make
20 sure that everything was dealt with and she was very
21 good at it, or she is very good at it.

12:27

22 162 Q. Anything else that might be typical of conversations at
23 these regular meetings?

24 A. At the time she was finding it difficult and she needed
25 more time. I mean that was -- I acted on that, when
26 she spoke to me about it. You know, if I needed MDM --
27 MDM patients, we get a list of MDM patients who need to
28 be seen in clinic and she will book them into the
29 clinic. If she feels she hasn't enough space we will

12:27

1 discuss how we will get those extra patients into
2 a clinic to be seen in a timely manner, fashion.

3 163 Q. If it was ever to arise that you had neglected to make
4 a referral or take the recommended action arising out
5 of the MDM, would it be -- would that come within your 12:28
6 understanding of her job description to address it with
7 you?

8 A. I don't know if it comes under the job description, but
9 certainly she would -- now I do the referrals as soon
10 as I see the patient, so I don't think it is an issue. 12:28
11 So in other words, I see the patient and I make the
12 referral just after they have left the room, so it is
13 not something I will leave. But if I didn't do
14 something, she would certainly let me know. Referrals
15 aren't an issue because they are always done. 12:29

16 164 Q. Is it your understanding that, if you have an
17 understanding, and you may not, that your consultant
18 colleagues generally use their secretarial support in
19 the same way that you do or is there any -- do you have
20 any understanding of dramatically different styles or 12:29
21 approaches?

22 A. I'm only surmising really because our secretaries
23 are -- now they're all in one room, but they're spread
24 apart. So I don't -- I concentrate on my own work,
25 I don't check on what other people are doing. 12:29

26 165 Q. Plainly any of the activities that the secretary
27 performs, or many of the activities that the secretary
28 performs, particularly in terms of communication with
29 patients or communication elsewhere in the hospital,

1 could be performed by you but you're comfortable in
2 delegating or allocating those tasks?

3 A. well, because I'm only one person, you know, I have to
4 delegate. I don't have the time to be doing every
5 single thing myself and I know she's competent. If she 12:30
6 wasn't, I wouldn't let her do it. So she's competent,
7 I need to delegate to be effective. I couldn't
8 possibly do everything myself.

9 166 Q. Yes. Do you see this secretarial role as being a tool
10 or an instrument of good governance? 12:30

11 A. well for me, I call her a "PA". I mean I don't know
12 whether she is officially because I think she is more
13 than a secretary, you know, she does lots of things for
14 me. I don't know will whether she officially would
15 come under that umbrella. But certainly for me she 12:31
16 ensures that the paper results are acted on, that
17 letters are done. So, yes, I think she is, but I don't
18 know whether officially she would or not.

19 167 Q. Just to be clear, I was making that point in terms of
20 -- directly in terms of Patient Safety. Your 12:31
21 description would suggest that she provides support
22 that adds to or reinforces the systems that you may
23 have personally or professionally, in terms of how you
24 do your job, but her role reinforces that on your
25 description? 12:31

26 A. Yes, she provides a back-up for me. Now, if I don't
27 see her because we -- she send me PDFs with queries
28 from telephone calls. So yes, I think she puts
29 everything in front of me.

1 168 Q. Yes. We'll come later to look at an Incident Report
2 that you raised in respect of an MDM decision which
3 you understood, I think, had not been implemented by
4 Mr. O'Brien or there had been a delay in relation to
5 it.

12:32

6 A. Yeah.

7 169 Q. We'll come to the specifics of that in a moment.
8 I just want to ask you about the Serious Adverse
9 Incident review process, which is prefaced by the
10 incident reporting mechanism or Datix and look at those 12:32
11 as tools of governance.

12
13 To what extent over the past ten years have
14 you directly used and encountered incident reporting
15 into serious adverse incident reviews? I ask that 12:33
16 question in separating it from your exposure to them
17 through the Patient Safety meeting, and clearly,
18 completed reviews come on to the Patient Safety meeting
19 agenda and are discussed. So that's the question?

20 A. I certainly use them and I am certainly using them 12:33
21 more, particularly if I find a stent that's been in too
22 long, I certainly will do an IR1 so that we're aware of
23 it. I have done perhaps not as many as I should do,
24 well "should do", I have done several over the years.
25 But perhaps I should have done a lot more but I can't 12:33
26 give you details on them. They were not, obviously,
27 serious. They were probably operational measures on a
28 ward. I think I did one -- once a patient, I was
29 concerned about fluid balance management on a ward and

1 I did an IR1. That's one that comes to mind, but
2 I don't know what came of it.

3 170 Q. Yes. Well I think that's, I suppose, one of the points
4 that I wish to explore with you. The responsiveness of
5 the system in terms of telling the informant, you being 12:34
6 the informant in that context, what has happened, what
7 is the outcome. Let me come to that in a moment.

8
9 You said, maybe, over the years, "I could have used the
10 instant reporting mechanism more than I did". Your 12:34
11 caveat being that they weren't terribly serious
12 incidents. What was the culture around that or the
13 understanding of when you should be using it. Were you
14 encouraged to report incidents when they arose,
15 particularly where they affected Patient Safety? 12:35

16 A. I don't know if anybody -- remember anybody saying "you
17 must do this". Perhaps as you go through your career
18 you're aware that if you see something that's not
19 right, it must be reported. But I don't think anybody
20 said you must report -- not like now, you must do 12:35
21 a Datix on this. It is just something instinctive. In
22 other words if it is not right, you should report it.

23 171 Q. You're not suggesting this was A Trust where, if you
24 like, the requirements for reporting were regularly
25 emphasised or publicised. You know, there wasn't an 12:35
26 effort to create a culture of, if you like, utilising
27 that system to bring forward shortcomings in practice
28 or in service?

29 A. It's difficult to say. I don't think we are constantly

1 reminded about it. Perhaps the Trust assumed that we
2 would do it because we knew the system was there. But,
3 yes, I think nobody was concerned about policing us,
4 I think.

5 172 Q. Is there a sense that it was cumbersome system or an 12:36
6 awkward system, time-consuming system to use to put the
7 complaint into the pro-forma that we've all seen that
8 comes with the IR Datix arrangements?

9 A. I preface this by saying I'm not using it as an excuse:
10 Certainly I thought it was cumbersome, it wasn't user 12:37
11 friendly. I suppose the other thing was, as you
12 said, you didn't get feedback. It went into a black
13 hole and that was it, you never heard of it again,
14 unless it turned into an SAI or something. So that
15 probably might have been an issue as well. 12:37

16
17 If you knew that you were reporting something and you
18 got something back and it said -- but when you just
19 report something and never hear about it again, there
20 probably isn't the impetus to keep doing it. But 12:37
21 that's not a justification for not doing it. That's my
22 thoughts as I'm sitting here.

23 173 Q. Yes. I suppose if you've gone to the trouble of
24 opening your eyes to and realising that there's
25 a concern or a problem there and you make the effort to 12:38
26 put that in writing by engaging with the system, you're
27 saying it would make sense to obtain a letter back or
28 a quick email back periodically saying, yes, your
29 concern is credible or correct, and this is the steps

1 we're taking and, ultimately, that's are the steps we
2 have finally taken and these are the conclusions
3 we have reached?

4 A. I think the system would be better. Then you would --
5 I think people would sort of think, well, something is 12:38
6 going to be done about this. So, yeah, I think the
7 system would be better if there was an outcome sent
8 back to the person who reported it.

9 174 Q. I haven't noted your participation in any SAI reviews.
10 Is that fair? 12:38

11 A. Not then, I have more recently but not at that time,
12 no.

13 175 Q. You may, nevertheless, have been conscious of SAI
14 reviews taking place affecting concerns or interests
15 within Urology, because they would ultimately be 12:39
16 reported into the Patient Safety meeting.

17 A. Yes.

18 176 Q. Have you anything in terms of reflections to offer the
19 Inquiry in relation to how you perceived the SAI review
20 system to operate? I'm thinking in terms of both its 12:39
21 timeliness or the expedition of its processes which the
22 Inquiry may have observed can be excessively long in
23 some cases. I'm also thinking in terms of what emerges
24 at the other end, in terms of recommendations and
25 action planning, and whether they have a particularly 12:40
26 effective process for implementation.

27 A. Well, I suppose the fact that I've done a few SAIs in
28 the last year, I sort of know how they work. I think
29 certainly they involve several meetings. I think

- 1 there's quite detailed discussion on the events that
 2 occurred. There's good support from the manager who
 3 sort of coordinates all these SAIs.
- 4 177 Q. Just to be clear, have you served as a Chair or a lead
 5 clinician on an SAI? 12:40
- 6 A. Yes, in the last year.
- 7 178 Q. We have heard about, I suppose, the difficulties of
 8 combining a busy clinical practice with trying to move
 9 forward with what might be a complex SAI review, you
 10 know, in terms of finding the practical things, about 12:41
 11 finding the time to marry several diaries and get that
 12 work done. Is that something you have experienced?
- 13 A. It can be and lots of emails go back and forth. If
 14 you're trying to get 5 or 6 people together, it can
 15 take quite a while to get everybody, to coordinate 12:41
 16 everybody to get them to meet.
- 17 179 Q. Because presumably there's an understanding that if an
 18 SAI is to be, I suppose, worth anything, it's got to do
 19 its work relatively efficiently so that learning
 20 emerges at a time relatively proximate to the incident. 12:41
- 21 A. Yes, although it can take quite a while, ultimately,
 22 for these SAIs to end. Probably because of, one,
 23 getting everybody together for a several meetings over
 24 a few months and, two, is to gather evidence and
 25 information on the events. 12:42
- 26 180 Q. Presumably you regard delay, even unavoidable delay in
 27 the context of how they are currently run, as being
 28 regrettable?
- 29 A. Absolutely. I mean in an ideal world I would like it

1 all to be sorted very quickly. I mean, a delay --
 2 obviously one learning at the end or actioning them, so
 3 the longer it takes to get to that point, the longer
 4 the same event can happen again, I suppose.

5 181 Q. Yes. Have you seen or thought about any solutions or 12:42
 6 potential solutions to get around these systemic delays
 7 that tend to punctuate reviews?

8 A. I'm not entirely sure how you can get 5 or 6 people
 9 with busy careers, you know, to meet quickly. Because
 10 it's quite complex. Apart from, you know, everybody 12:43
 11 dropping an activity on a certain day, but then that
 12 probably eats into clinical activity. So I think it's
 13 a difficult one.

14 182 Q. In terms of, as I say, at the end of it, when you have
 15 recommendations leading to an action plan, do you think 12:43
 16 that there is work still to do in terms of the
 17 implementation of action plans?

18 A. You mean as in a result come from an SAI and then sort
 19 of action, change something?

20 183 Q. What is the procedure, as you understand it, for 12:44
 21 translating the recommendations of the action plans
 22 into practice?

23 A. Well my understanding is first, it comes before the
 24 Patient Safety meeting and the outcomes are discussed
 25 at that point and the recommendations are reviewed. 12:44
 26 And depending on what the recommendations are, I can
 27 action those. If it's either to inform somebody or try
 28 and change, you know, something. For example,
 29 antibiotics before theatre. That's a simple one. It

1 wouldn't be an SAI because we all do that for most
2 things, but if it was, you would change, you would
3 introduce that.

4 184 Q. We'll look, as I think I mentioned earlier, at how the
5 managements of stent issues seemed to take a long time 12:45
6 over several visits to Patient Safety meeting to
7 perhaps arrive at something of a solution. We'll come
8 to that.

9
10 Let me turn to appraisal briefly. You have explained 12:45
11 at paragraph 29.1 of your statement that you're
12 appraised every year with revalidation every five
13 years.

14 A. Yes.

15 185 Q. The appraisal encompassed a Personal Development Plan, 12:45
16 and that plan was discussed every year to assess if it
17 was achieved and then a new one formulated. If we look
18 at paragraph -- sorry, let's go to WIT-50540. You
19 said -- this is, I suppose, by way of example,
20 a typical performance objective might be, in your case, 12:46
21 developing green light (inaudible) service and
22 developing a supervisory role for junior doctors.

23
24 You go on to say, just scrolling down and speaking from
25 your perspective, you had an appraisal every year and 12:46
26 you found it immensely useful in that it allowed you to
27 reflect on past performance and plan for the future.
28 You used appraisal as a way of improving your
29 performance and job planning occurred yearly,

1 encouraged discussions on planning weekly and monthly
 2 job activities. We'll come to job planning briefly in
 3 a moment.

4
 5 The reflection part of appraisal you found useful. 12:47
 6 I suppose it might depend on the approach or character
 7 of the appraiser, but were you at all challenged by the
 8 exercise? If something was understood as not being
 9 quite right in your practice, there was a shortcoming,
 10 however modest, would you expect the exercise to bring 12:47
 11 that to your attention and put you on your guard, if
 12 you like, to deliver improvement?

13 A. Well, I think I've had about four appraisals since I've
 14 been in Craigavon. So I've had four different
 15 appraisals. I mean appraisal to me is very important, 12:48
 16 as you can see from there. I achieved everything
 17 I planned to do on my PDP the year before, so I didn't
 18 feel concerned that I wasn't achieving what I wanted to
 19 do. Challenged in the sense of -- because I had
 20 achieved everything, I didn't feel that I was going to 12:48
 21 be challenged from that perspective. Perhaps, as you
 22 said earlier on, when I was in Craigavon my attendance
 23 at M and M was less than desirable and so I was
 24 probably challenged to improve that, think of ways to
 25 get to the meetings more often. So I suppose... 12:48

26 186 Q. In theory at least, and that's perhaps a practical
 27 example, albeit, I suppose, a modest shortcoming and
 28 you have given the mitigation or the explanation for
 29 it, you would have been tied up perhaps as urologist of

1 the week and couldn't attend, or whatever the
2 explanation might be.

3
4 But are you saying in theory, at least, it's your
5 understanding that the appraisal, the annual appraisal 12:49
6 session had the potential to allow the appraiser to
7 challenge shortcomings in practice?

8 A. Yes, I mean the appraisal process is quite
9 comprehensive. It goes on for an hour and a half, two
10 hours. Certainly my appraisal explored all the domains 12:49
11 on my appraisal. If there was any complaints, they
12 certainly would have broached that. But in general,
13 I probably hadn't a lot of negatives in my appraisal,
14 I think.

15 187 Q. Could I bring you to a reflection from Mr. Glackin 12:50
16 around the appraisal mechanism. If we go to WIT-42316.
17 If we go to the top of the page. He expresses the view
18 that the appraisal process has morphed from
19 a confidential reflective exercise in professional
20 development between two professionals which, elsewhere 12:50
21 in the statement he welcomes and, like you, found
22 extremely useful, but it has, as he says, morphed into
23 a formulaic capture of documents, such as reflection on
24 complaints, records of continuous professional
25 development, through evidence a recommendation for 12:51
26 revalidation by the Trust's responsible officer. In
27 other words, I think he agreed with my
28 re-characterisation that that is either bean counting
29 on box ticking. I forget the metaphor I used. But

1 I think the point he's making is quite clear.

2
3 Has that become your experience, that there has been
4 a change in the character of the process, or do
5 you still remain relatively content that it is 12:51
6 a positive experience?

7 A. Well, I can probably only speak from my experience. I
8 mean there certainly is where you're collecting all the
9 documents, but they're essential because they're
10 evidence of engaging in various activities to support 12:52
11 your practice. I mean, I have had confidential
12 discussions, I've reflected with my appraisers, and so
13 it hasn't been my experience. Perhaps I had a good
14 experience, but it -- and I found it -- and I put a lot
15 of work in and, as a result of that, I try and achieve 12:52
16 everything that I've set out to do for the following
17 year. It does set -- it does give you a focus of where
18 you want to go. So I found it useful.

19 188 Q. Have your appraisers been external to Urology?

20 A. One of them was internal, it was Mr. Young, but the 12:53
21 other three them were external. One in Radiology, A&E,
22 and aesthetics, so I've had four.

23 189 Q. Is there something, if you like, to be preferred from
24 using a person from another discipline to conduct the
25 other? 12:53

26 A. I think it is probably a good idea in that they can be,
27 certainly, more objective. You know, if I'm
28 a colleague of yours, I mean you mightn't be as hard on
29 me as perhaps somebody else might. I'm only surmising.

1 190 Q. Yes. Thank you for that. Just briefly before the
2 lunch break, you don't say much about it in your
3 witness statement, but job planning, you've explained,
4 I think I read it out a short time ago, it occurred
5 annually and incurred discussion on planning and 12:54
6 weekly/monthly job activities.
7

8 I suppose your experience of it, if we can set that,
9 set it in the context of the demands pulling on the
10 Service. So you've -- you are one of a number of 12:54
11 clinicians that make up the capacity, with your nurse
12 colleagues to deliver services, and you have this
13 demand sitting out here looking at you for delivery.
14 Do you think that the job planning process adequately,
15 or at all, takes into account the pressures on the 12:54
16 Service from that demand?

17 A. I suppose job planning is done in the context of the
18 practitioner and what he or she can deliver, not
19 necessarily taking what the Service needs. But we all
20 have different requirements, different things that 12:55
21 we do outside the Trust, and so it probably would be
22 exceedingly complex to try and mould it all into a job
23 planning for one Service, I think.

24 191 Q. I'll maybe come back to that. But tell me about your
25 experience of a typical job planning conversation, 12:55
26 whether it is done in a meeting or by email. Is it
27 reduce or reducible to 'these are my activities' and
28 'in my experience this is what I have to do and have
29 been doing for you, the employer', 'this is what I can

do and please provide me with sufficient PAs to allow me to continue to deliver'. Is it that kind of conversation, I suppose, sometimes a battle to achieve in your job plan what you think you deserve?

A. I don't think I ever had a battle about my job plan. I mean it hasn't been a difficult situation for me. You know, I've job planned in the last few months and it's a discussion, it is a two-way discussion, and there's a mutual agreement. So I personally haven't had difficult conversations on job planning. 12:56

192 Q. Just back to your previous answer about how complex it might be to try to engage in what might be regarded as group or team job planning with a view to measuring what's available and better directing what's available in terms of human resource to meeting the demand. Is that a concept -- and I hope you understand how I'm describing it -- team job planning, is that a concept that, insofar as you're aware, within the Trust is somewhat alien? 12:57

A. It's a great concept. I'm not too sure how it would work because we all work different PAs, we work different days. You have infrastructure requirements so you can't necessarily -- I think there's so many variables feeding into it, I think it would be very difficult, but it sounds good in theory. 12:58

193 Q. Mr. Young, who will come to give evidence in 3 or 4 weeks, he has said in his statement, I'll give the reference, WIT-51783 at paragraph 52.3. He describes the process of job planning, in his experience, as

1 "haphazard until recently".

2
3 At paragraph 52.7, I think the point he's using to
4 explain the haphazardness is that "consultant activity
5 was not being recognised". He says that at 12:59
6 paragraph 52.7. He says that it has taken a long time
7 for job planning to reach the level it should have.
8 You seem to have experienced an uncontroversial,
9 unproblematic process through job planning?

10 A. Perhaps I'm not a controversial person! There are 12:59
11 certain activities that aren't recognised, you know,
12 and which are becoming recognised which we do, like
13 dictating virtual PSA results.

14
15 But, no, I've found it always -- perhaps I'm 12:59
16 a relevantly junior consultant -- well, not now, but
17 I was once upon a time -- and it worked reasonably well
18 for me, I think. And I could certainly, if I disagreed
19 with it, I think I would be listened to.

20 194 Q. who has been your, if you like, partner in the job 13:00
21 planning process, is it typically the Clinical
22 Director?

23 A. So my last job planning, Mr. Haynes actually, and Wendy
24 Clayton.

25 195 Q. And before that, Mr. -- 13:00

26 A. Probably, in fact it was, I think.

27 MR. WOLFE KC: Thank you for that. We can, subject to
28 the Chair, take a break for lunch now.

29 CHAIR: Yes. We will come back again at 2 o'clock,

ladies and gentlemen.

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON
ADJOURNMENT

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Mr. O'Donoghue.

196 Q. Let me look, for the next short while, at some of the
ways demands of capacity affected the Urology Service,
what was done about it by way of initiatives, what
couldn't be done, and how the staff felt about it.

If I could start with your witness statement. You have
set this in the context of the difficulty in recruiting
both senior and junior staff. WIT-50527. You say at
12.1 that:

"Urology Department always had difficulty recruiting
doctors, both junior doctors and consultants, despite
actively recruiting on many occasions. Consulting
positions were filled by several locums."

We saw this morning the list of them that you provided:

"On occasions urologist of the week shifts were covered
by the substantive consultants in a locum capacity."

1
2 what does that mean? Does that mean if the scheduled
3 consultant couldn't do it for whatever reason, you
4 would have to step in?

5 A. So, in other words, the on-call, for example, was one 14:02
6 in seven, so we all do our own week on-call and if
7 there's only four of us, well there's three weeks that
8 have to be covered, or if there are five of us, two
9 weeks have to be covered, so that's done on a locum
10 capacity. 14:02

11 197 Q. This recruitment issue, I suppose, had an impact on
12 clinical activity:

13
14 "As clinic sessions were cancelled with the consultant
15 doing the locum on-call, junior doctor positions proved 14:02
16 difficult to fill due to the lack of interest or
17 inadequately experienced doctors. This particularly
18 impacted during on-call, and on occasions, the
19 consultant had no junior support. The Trust was
20 supportive and did all in its power to assist by going 14:03
21 out to locum agencies to look for junior support."

22
23 Are you in a position to diagnose, I suppose, why the
24 recruitment issues were there? Was it a shortage of
25 doctors with urological interest? 14:03

26 A. There's lots of reasons. One is from the point of view
27 of registrars, there's only a certain cohort of
28 registrars in Northern Ireland, which is controlled
29 UK-wide, I think it is 10 or 12. So unless they come

1 off training when a job is advertised, they're not
2 appointable.

3
4 Two, is certainly registrars from across the water,
5 Northern Ireland is sort of considered abroad and so it 14:03
6 is very hard to attract new consultants from England
7 unless you have a particular reason, like I wanted to
8 come to Northern Ireland. Mr. Haynes, I think had
9 family ties. And then attracting consultants from down
10 South is impossible because the differential salary, 14:04
11 we're just not competitive.

12
13 And the other reason, I think, is because a lot of
14 the -- a lot of registrars these days have an interest
15 in oncology and big operations, robotics. So Craigavon 14:04
16 doesn't have big operations, as in oncology operations
17 and robotics, so you're only attracting doctors who
18 have an interest in benign surgery to some extent. So
19 the other reason it is difficult to -- and there's also
20 a shortage of consultant urologists UK-wide. I don't 14:04
21 know about worldwide, but certainly UK-wide. Bigger
22 hospitals like Addenbrooke's, et cetera, have
23 difficulties recruiting, so I think it is even more
24 acute for us.

25 198 Q. We'll obviously look in a moment at the impact on 14:05
26 patients, but you, as a consultant grade urologist, if
27 there's no junior or staff grade urologist available to
28 work alongside you or behind you, what are the
29 implications in practical terms. You talked about

1 absence of support for on-call and that kind of thing.
2 what does that actually mean in real terms?

3 A. That was more of a problem, really, certainly in the
4 first year when I came to Craigavon. We had a shortage
5 of juniors so and we ended up very much doing on-call 14:05
6 on our own without junior support, which was incredibly
7 difficult. That only happened on a few occasions but
8 certainly I found it far from enjoyable with no junior
9 support.

10 199 Q. what does that mean? Can you spell it out for us -- 14:06
11 A. well it means that you take all the calls --

12 200 Q. when you should be in bed, you're in hospital?
13 A. No, no, it means that during the day all the calls that
14 a registrar would take, you take. So you're rang every
15 few seconds by GPs. You're covering theatre. You're 14:06
16 covering the wards. You're covering. You're
17 supervising F1s. So everything is under your control,
18 so it's quite difficult. There's a lot of territory to
19 cover. It happened only a few occasions but too much
20 even just being a few. 14:06

21 201 Q. You say, I think this is particularly in the context of
22 oncology, if we go to WIT-50537, paragraph 34 at the
23 top there. You talk about the targets, and that's in
24 the cancer domain, isn't it?

25 A. Yes. 14:07

26 202 Q. You go on in the last sentence to say:
27
28 "In conjunction with the Head of Service and other
29 Urologists, if patients were not reaching their

1 targets, they were given earlier dates for
2 theatre/clinic with one of the other consultant
3 urologists."
4

5 So is this a factor of the staff shortages that targets 14:07
6 were sometimes missed. I think we have the percentages
7 somewhere.

8 A. It's one of the issues. I mean, you know, if you have
9 less doctors to see patients and they're coming in at
10 the same rate, you're going to get a buildup, so yes. 14:07

11 203 Q. What does that mean, they were given earlier dates with
12 other consultants?

13 A. So if a patient was due to see me but my waiting list
14 was too long, somebody else would -- they would see
15 somebody else who had more availability. 14:07

16 204 Q. Yes. Is it the case that perhaps self-evidently, that
17 the priority went to cancer patients and not the --
18 certainly not the routine and often not the urgent?

19 A. Cancer always got precedence over everything else
20 because of these targets as well. 14:08

21 205 Q. I'll show you some documents in a moment, but that it
22 would be wrong to suggest, would it, that urgent benign
23 cases were not without risk if they sat on the waiting
24 list?

25 A. Yes. No, benign cases can also come to harm. I keep 14:08
26 mentioning stents, but stent patients can certainly
27 come to harm.

28 206 Q. Yes. I think you deal with this in the extract I want
29 to read to you. If we go to WIT-50528, 13.3 at the

1 bottom of the page, please. You say, as another
2 species of the problem or another aspect of the
3 problem:

4
5 "Staffing problems made it difficult to provide an 14:09
6 elective clinical service. If one of the substantive
7 consultants had to cover locum urologist of the week,
8 his elective clinical activity was cancelled."

9
10 So that's the knock-on effect of what we saw earlier: 14:09

11
12 "This impacted on the waiting list. In my opinion
13 there was no risk to patient care, as red flag patients
14 were always treated first, although it did cause
15 a delay in treatment of urgent and routine patients. 14:09

16
17 The delay in treatment would have posed a risk to
18 patients, for example, ureteric stents patients were
19 often left in longer than three months as it proved
20 difficult to treat the patient sooner." 14:10

21
22 Just scroll back 3 or 4 lines. You say:

23
24 "In my opinion, there was no risk to patient care as
25 the red flag patients were always treated first." 14:10

26
27 So no risk to them.

28 A. As in that they got treated, certainly, in a timely or
29 almost timely fashion.

- 1 207 Q. It's maybe not entirely clear in how it is expressed,
2 but you do come back and say there was a risk for
3 benign patients, and in particular, you are using the
4 example of ureteric stents?
- 5 A. But there were other benign, patients with long-term 14:10
6 catheters, although they probably -- urinary catheters,
7 although they probably didn't have the same risk as
8 patients with stents.
- 9 208 Q. I think we'll probably stumble across it in one of the
10 SAIs that I'm going to refer you to, but would you just 14:11
11 articulate for us the risk associated with leaving
12 stents in beyond the optimal date for removal or
13 replacement?
- 14 A. Well, if a stent is removed after one month, the risk
15 of sepsis is about one percent. The longer it goes on, 14:11
16 the higher the risk. So it is a risk of sepsis and
17 encrustation of a stent as well which means the stent
18 ends up with stones at either end of the stent and that
19 makes it a much more complicated and difficult
20 operation to remove the stent. 14:11
- 21 209 Q. Yes. I can't remember off the top of my head, we heard
22 from a patient directly, and indeed, the daughter of
23 a patient who had come through that process of, on the
24 one part encrustation with a patient who also had
25 cancerous comorbidity, and another patient who had 14:12
26 a delay and then was admitted with sepsis and became
27 very ill, he had repeated admissions?
- 28 A. It also impacts -- even if it doesn't affect their
29 lives, it affects their quality of life. Stents cause

1 a lot of symptoms. About 80 percent of patients with
2 stents will get symptoms.

3 210 Q. I want to suggest to you, and I think you'll agree that
4 the problem associated with getting stents removed in
5 a timely fashion was both well-known and prolonged in 14:12
6 terms of arriving at a solution?

7 A. Yes.

8 211 Q. We'll look at a number of instances of how it was
9 talked about. What was the problem? Do you put it
10 down solely to; we don't have enough resource to bring 14:13
11 these patients in in a timely fashion?

12 A. Not entirely. That's certainly one of the reasons.
13 I think another reason, which I kind of had only
14 learned about certainly in the last few months, is how
15 patients were coded. We had booking forms where 14:13
16 we booked patients for stent removal and ureteroscopy,
17 and it wasn't always coded that they had a stent in
18 place, much to our surprise. So it wouldn't have been
19 apparent on the database that they had a stent in.
20 That has changed and there are now only two codes, 14:13
21 stent or not a stent. We put in the date that the
22 stent has gone in and we get -- there's a monthly list
23 of patients who have stents so that we're aware of
24 those patients.

25 212 Q. Has that been resolved, the coding issue? 14:14
26 A. It has.

27 213 Q. Has the resourcing issue been improved?
28 A. Well, in -- well, there are lots -- I mean one is,
29 we've sorted in lots of ways, we try and avoid putting

1 stents in, or if we put stents in, we put so-called
2 "stents on strings" which are stents you can pull out.
3 So unless we really have to put in a stent we put in a
4 stent.

5
6 We do primary ureteroscopy which is an operation to
7 remove the stone on acute presentation, that tries to
8 obviate the risk of having a stent in place as well.
9 So lots of little ways of trying to -- then we also try
10 and privatise patients with stents as well.

14:14

14:15

11 214 Q. Yes. I'm going to show you some examples of how
12 a stent problem was talked about against the background
13 of the solutions or partial solutions that have come
14 about now. So if we go to AOB-73717. Scroll down to
15 the bottom of the page, please. This is May 2015 and
16 Mr. Suresh reports to Mr. Glackin, Mr. Glackin wearing
17 his Patient Safety meeting hat:

14:15

18
19 "I have seen a couple of patients recently with
20 'forgotten stents', with no mention about the stents in
21 the discharge letter. I have filled in Incident Forms.
22 We can discuss about this issue in the next governance
23 meeting, please, particularly about the need for stent
24 registry."

14:16

25
26 This maybe touches upon the coding or administrative
27 issue. It may not be precisely coding, but it's, 'oh,
28 we've forgotten' or it hasn't been adequately recorded
29 so it's not known about. Does that accord with what

14:16

1 you now know? Perhaps you knew something of this at
2 the time?

3 A. It's not just Craigavon, I think this is probably
4 a worldwide problem. But we tell patients
5 ad nauseam to, one, do letters on every patient who has 14:17
6 -- or tell registrars to do letters on every patient
7 who they treat in theatre. Probably because we're
8 going on about it so much as well, to mention that
9 stents in place. I would hope things are better now.
10 That's a big, that's a big red flag. I mean, that 14:17
11 shouldn't happen. That's inexcusable.

12 215 Q. Just scroll up the page and get Mr. Glackin's response.
13 He says:

14
15 "I would be most grateful if you can present these 14:17
16 cases formally so that we can share learning and plan
17 some action points. Please let me know the dating
18 codes associated with the cases."

19
20 He suggests the next meeting. This, it arose out of a 14:18
21 number of cases, we understand that Patient 136,
22 probably on your list in front of you, you may or may
23 not know the Patient's name. It is towards the back of
24 your sheets. That is who we are thinking about or at
25 least that's who we know about in the context of an 14:18
26 incident at that time. Because as you can see at
27 WIT-50465, Mr. Suresh puts this matter into an Incident
28 Report and he says:

29 "Patient was wait-listed for removal of ureteric stent

1 on 17 November 2014. This request was registered in
 2 the book in Stone Treatment Centre. A booking form was
 3 also filled of the same but it was overlooked."

4
 5 So maybe it is slightly different from how it was
 6 described in his email:

14:19

7
 8 "Patient had to have the stent in unnecessarily too
 9 long."

14:19

10
 11 Then if we go down four pages to 50469. Just scroll
 12 down. There's an outcome recorded, yes, stop there,
 13 please.

14
 15 "It was discussed at Urology Departmental and
 16 Governance meetings and the new process agreed that all
 17 patients that have a stent fitted need to be added to
 18 a waiting list with a planned date to come in."

14:19

19
 20 It seems far from rocket science that this should be
 21 the process applicable to stents given the safety
 22 issues that arise if they are forgotten about. I think
 23 you came close to saying it is a never event, or maybe
 24 it is not characterised as such but --

14:19

25 A. It should be a never event, you know, there's no excuse
 26 for it.

14:20

27 216 Q. Yes, it is fairly fundamental.

28 A. Yes.

29 217 Q. So the investigation completed 7 September 2015. You

1 would have thought, well, leaving aside the resourcing
2 issues that, you know, remained a feature of life at
3 Southern Trust, that that part of it has been
4 corrected. Do you know whether it was?

5 A. I mean, I know I did it because I've always been 14:20
6 obsessed about stents, but I don't know whether --
7 I assume people did, but I can't speak for anybody else
8 or what registrars did because lots of people fill out
9 forms. But, you know, I think there had been stent
10 issues after that date so obviously -- 14:21

11 218 Q. I suppose what you are saying is that there was
12 a process in place, the fact that we had further stent
13 issues would tend to suggest that it wasn't always
14 complied with and not necessarily well-policed?

15 A. Well, you can have a date to have the stent out but if 14:21
16 you haven't got capacity in theatre, and that's
17 probably a lot of the problem, you know, if you said
18 remove the stent in 4 to 6 weeks but you can't get
19 somebody in for 4 to 6 weeks because you have got all
20 the bladder cancers, et cetera, so that's certainly 14:21
21 probably an issue. Because I use about BAUS, British
22 Association of Urological Surgeons, I use their -- they
23 had a stent register, which is now defunct, and I had
24 to use that myself to try and keep track of stents.
25 But, in the end, I found it didn't work. And lots of 14:22
26 other places in the UK were using various registers to
27 try and keep it in track. But the BAUS one didn't work
28 for me, it was too slow. I was getting numerous emails
29 back every week of lots of stents and it just didn't

1 work. Obviously it didn't work for BAUS because
2 they've got rid of it now.

3 219 Q. How does it work in practice, if you like, at the point
4 of selection of patients for the procedure, the removal
5 procedure? So you have Mr. Smith, not a real name, 14:22
6 obviously, on your list for stent removal. You use
7 a register to keep track of it, of the patient --

8 A. I was using, not now.

9 220 Q. I get you. And you know that stent ideally should be
10 removed or replaced in 12 weeks or whenever it might 14:22
11 be.

12 A. Yes.

13 221 Q. But it doesn't happen. Can you, as the clinician for
14 that patient, be active around that or do you schedule
15 him or does somebody else override that scheduling? 14:23

16 A. No, I think as much as I could, as far as I remember,
17 I tried to schedule the patient but they were coming in
18 at a very fast rate. You know, it was like
19 a waterfall. So I could schedule as much as I could,
20 but I could never keep up, as in, clear them every 14:23
21 week.

22 222 Q. Is it left to you to make the decision that that man
23 must be shunted in to four weeks' time or whatever?

24 A. It was then. Now we have a scheduler. So I think
25 we're having pools lists so it's not the same issue. 14:23
26 It's a common list now. So I think that certainly will
27 help to alleviate that problem. But at that time
28 we all had our own lists and we were managing them
29 ourselves.

1 223 Q. So in that sense you were playing the old -- you were
2 cast in the role of playing the all-powerful one --
3 I don't want to say "God". But you had to make
4 decisions between that patient and that patient for
5 priority purposes?

14:24

6 A. As in stents were the ones -- apart from the bladder
7 tumours -- the stents, we were trying to do as many as
8 we could, plus various cancers.

9 224 Q. If we move to just an extract from a Patient Safety
10 meeting four years later on 19 July 2019. TRU-387331.
11 This is the first page of the Minutes for this. I see
12 you're not in attendance, but let me take your view on
13 what this may be reflective of. If we go on to the
14 next page, please, still at the top of the page.

14:24

15
16 It would appear that a complaint has come in in
17 relation to -- we have the HNC number and we know the
18 name but we know nothing more of the background than
19 that. It is just by way of example of the state of the
20 nation, if you like, the state of the Service in
21 relation to the stents:

14:25

22
23 "The case highlighted the need for the operating
24 surgeon to make a plan for the removal of a ureteric
25 stent at the time of the insertion. All agreed that
26 the surgeon placing the stent is responsible for
27 auctioning the removal in a timely planner. There is
28 no agreed trust protocol in place for this scenario.
29 Various suggestions were made as to how to manage this

14:26

14:26

1 situation, but no consensus was reached at this
2 meeting. Further work is needed."

3
4 It is very plain language and maybe gives us a sense of
5 the problem. So if we reflect, this is coming four 14:26
6 years after the last one. There may be others in
7 between. This doesn't intend to be an empirical survey
8 of all of the stent issues that came before the Patient
9 Safety meeting. But you would, presumably, say that,
10 contrast with this surgeon's practice, you had at least 14:27
11 within your practice an understanding of the need to
12 put good administration and forward planning around
13 stent removal.

14 A. I had a pious aspiration to remove a stent within a
15 certain time period, but that didn't always happen 14:27
16 because of various pressures. But the intention was
17 there, but one couldn't always do that.

18 225 Q. The implication here is that this operating surgeon
19 hasn't made a plan. That may or may not be true. But
20 do you think that there was enough information within 14:27
21 Urology Service system at that point to emphasise the
22 need for careful and planned stent management?

23 A. Absolutely. I mean they're obviously talking there
24 about -- when you do the procedure, do the urethoscopy,
25 put a stent in and you should write whatever date you 14:28
26 want the stent remove, I think that's what they're
27 implying. I mean as Urologists, you know, we're
28 constantly aware of that. So I don't think that's
29 something new for -- the issue, I suppose, is that if

1 there was a registrar, a new registrar -- and I don't
 2 know what date this was -- had come, or even
 3 a registrar who was doing a locum, they may have put
 4 a stent in, they don't know the protocols, and that's
 5 where issues may creep in. Because we have lots of 14:28
 6 locums coming in, doing on-call for us, and it may have
 7 been a stent that was put in perhaps, hypothetically,
 8 it could easily happen.

9 226 Q. Perhaps the point is, as highlighted here, is that
 10 there was no protocol when, in fact, given the problems 14:29
 11 that there were around stents, there ought to have been
 12 a protocol?

13 A. It is, I think the problem is, really, when you get
 14 somebody coming in for 24-hours or 12-hours to do
 15 a procedure, you know, apart from the consultant who is 14:29
 16 aware that the registrar is doing the procedure and
 17 saying "make sure you do" whatever, if he doesn't that,
 18 the locum registrar may not know what to do.

19 227 Q. I'm conscious that you weren't there at this meeting,
 20 but it talks about no consensus being reached in how to 14:29
 21 manage a situation like this. Is it not obvious how
 22 a stent, if they're talking here about stent
 23 replacement, is there not a sort of -- an obvious set
 24 of core values that should be applied to a situation
 25 like this? 14:30

26 A. You can say that, but it's not sorting the problem. In
 27 other words, you know, you can say at the meeting,
 28 "we must remove this stent in six weeks" and you can
 29 write that somewhere, but that's not sorting the

1 problem because it will not be removed in six weeks.
 2 So you can write it, but, you know, with the numbers
 3 coming through, it doesn't make any difference. So
 4 I think from reading between the lines they were trying
 5 to think of a different way or being more inventive to 14:30
 6 try and sort that problem.

7 228 Q. Perhaps that explains why no protocol was developed?

8 A. Because it is easy to say "we'll give a date", but
 9 that's meaningless because you won't be able to reach
 10 that date. 14:30

11 229 Q. But there is a recognisable standard, isn't there?

12 A. There is, but again, it is pious aspirations. If you
 13 have more coming in than capacity, it soon gets out of
 14 control. You know, there is more water running into
 15 the bucket than going out of the bucket. 14:31

16 230 Q. Is this area of stent replacement an area where you, as
 17 a clinician, would candidly recognise that the service
 18 within which you were employed was failing to comply
 19 with the standard or stent management?

20 A. It was failing, yes. That's why I tried to deal with 14:31
 21 different ways of getting BAUS stent register and try
 22 and get ways myself to try and keep track of it.

23 231 Q. And it was placing patients at risk?

24 A. Absolutely, patients at risk.

25 232 Q. We can see, if you turn up Patient 91's case. I think 14:31
 26 you should be familiar with Patient 91, if you just
 27 check his name by reference to the number and we'll use
 28 the number throughout our discussion about him. If
 29 you go to WIT-33314. This is the SAI record or report

1 in association with Patient 91. We can see if we just
2 go forward just to confirm for myself that my note is
3 right. If we go through to WIT-33321. Yes, we can see
4 that the report was approved on 11 October 2019, which
5 is about a year and a half after this patient came in
6 to difficulty and died during the replacement, or as a
7 result of complications arising out of a stent process.

14:33

8
9 If we go then to WIT-33315, under "what happened".
10 Just park it there for a moment. We can see that this
11 is a case where a stent was placed in or about 4
12 March 2018, but he was not admitted - scrolling down -
13 he wasn't admitted until 18 May for urethroscopy and
14 laser. He was a patient with comorbidities, but he did
15 not emerge well from the operation. Part of the
16 difficulty here was the preoperative assessment. There
17 was a failure to conduct, I think, a midstream urine
18 analysis prior to surgery.

14:34

14:34

19
20 If we scroll down, please, we can see that the stent
21 was placed. His condition deteriorated
22 post-operatively and despite efforts he sadly passed
23 away.

14:35

24
25 If we could go to the recommendations at WIT-33320.
26 Particularly scrolling down the page and looking at
27 recommendations 3 to 6. Recommendation 2 deals with
28 the preoperation assessment issue. But 3 to 6,
29 I think, in particular deal with the need to improve

14:35

1 the service's approach to stenting. It says at
2 recommendation five, for example:

3
4 "All patients who have ureteric stents inserted for
5 management of urinary attract stones should have plans 14:36
6 for definitive management within one-month, unless
7 there are clinical indications for a longer interval
8 treatment and where patients wait longer than the
9 intended time for definitive treatment with ureteric
10 stent in situ, should be reported on the Trust Datix 14:36
11 system."

12
13 I know you made the point that, let's not have
14 a protocol, or it wouldn't make sense perhaps to have
15 a protocol if we can't deliver on the time limits, but 14:37
16 here the recommendations are, it's planned for
17 one-month removal and if that test is failed, it goes
18 up the system by way of an Incident Report.

19 A. Absolutely. The other issue there, which is probably
20 just as important, probably more important, I think 14:37
21 this man failed to get to his preoperative assessment,
22 so I don't know if he had the procedure without an MSU.

23 233 Q. I think he did.

24 A. That's the real -- I wouldn't do a ureteroscopy on
25 somebody with a stent without an MSU, certainly I mean 14:37
26 now because of the risks of sepsis.

27 234 Q. Yes?

28 A. Particularly this chap because he had sepsis before, he
29 had E.coli, so I would be very concerned about just

1 bringing somebody like this in, somebody with multiple
2 comorbidities and operating on him without making sure
3 that he was free of bacteria.

4 235 Q. The case itself gives rise to --
5 A. So there's lots of issues there. 14:38

6 236 Q. -- many concerns and issues --
7 A. I think there's more than one.

8 237 Q. I think the one that I am focused upon at the minute
9 is, a stent goes in 4 March, doesn't come out until 18
10 May. I think the sense of it here was it should have 14:38
11 been out within a month?

12 A. But this is probably not the worst, I mean, you know,
13 a stent that goes in in March and comes out in May, it
14 might seem very long, but it's actually not that bad.
15 I think the main issue there is the microbiology. You 14:38
16 know, two months, okay, it's longer than a month, but
17 it is not really worrisome.

18 238 Q. Generally?
19 A. Generally I think two months isn't bad. It is the
20 culturing before theatre and treating appropriately I 14:38
21 think is probably a lot of the reason why this
22 gentlemen suffered not a very good outcome.

23 239 Q. Is the "not too bad" analysis nevertheless reflective
24 of perhaps an indictment of a system that's prepared to
25 acknowledge that, if we can get a patient seen within 14:39
26 12-weeks, nevertheless they're going to have a risk of
27 sepsis, but "not too bad" is nevertheless worrying?

28 A. No. I think the person doing the operation should have
29 cancelled the patient. I mean, I wouldn't have

1 operated on that patient with no MSU. I wouldn't have
2 taken the risk.

3 240 Q. Yes. The broader point is, and it comes to you in
4 a Patient Safety meeting context, remember this report,
5 it's produced a year and a half after the incident
6 in October 2019.

14:39

7
8 If we go to WIT-33309 we can see that Mrs. Clayton is
9 writing to you on 21 September 2021. So it's two years
10 after the SAI report is issued:

14:40

11
12 "I attach SAI Action Plan on this patient. Can the
13 following points be discussed at the next Patient
14 Safety meeting? Is that the right forum."

14:40

15
16 It has Item 5 and 6 of the document that I have just
17 shown you. We go, just to close the circle, if we go
18 to TRU-387892. You're chairing this meeting. The
19 second page, if we just scroll down. This is the
20 meeting of 13 October 2021 and we can see there; sorry,
21 I wasn't looking at the screen. If we scroll down a
22 little further to Section 10.

14:41

23
24 I think we understand that one of those items under
25 "shared learning" relates to Patient 91 and it's the
26 one 19.08.21 on the left-hand side. It says obviously
27 the seven recommendations in the SAI were discussed.
28 Then there is, amongst the attachments, a copy of the
29 action plan for Patient 91. What's less obvious is the

14:41

1 nature of the discussion and how the issues were
2 addressed and if solutions were reached. Obviously
3 2021, 6 years after Mr. Suresh troubled Mr. Glackin to
4 put a series of stenting cases, perhaps it's
5 a different set of factual issues in that one, but what 14:43
6 has been done by the stage it reaches you, or what do
7 you do to try and get stenting better?

8 A. Well, I remember discussing this patient. So it wasn't
9 just the stenting, it was having the MSUs before the
10 procedure as well which we felt was important in this 14:43
11 particular case. The fact there was no MSU, I think
12 that was the one that we really concentrated on.

13 241 Q. Okay, so the absence of MSU is a cardinal sin in that
14 context. But, equally, I think it's a point Mr. Haynes
15 makes in correspondence with management in 2018, the 14:43
16 delay in managing this patient back into the system for
17 delivery of stent removal or replacement or whatever it
18 was, was not helpful. So has your Patient Safety
19 meeting, in the context of this case, and you were
20 particularly told to look at Recommendations 5 and 6, 14:44
21 did it grapple with that delay issue?

22 A. We were all made aware that we should submit data if
23 the stent has been dwelling more than one month. So
24 all the recommendations were discussed. They weren't
25 written there, but they were discussed. 14:44

26 242 Q. So back to the top of where we started: In terms of
27 solutions to the stent delay issue, clinicians are
28 being taught to look more imaginatively at whether
29 a stent is required and, if it is required, to assess

1 whether a stent with a string can be used?

2 A. So if it's appropriate, yes.

3 243 Q. But there will be cases where it is not, and I suppose
4 what the Inquiry wishes to understand, because we've
5 seen quite a number of stent cases, and that is why I
6 am spending so much time on it, what can you say about
7 today, October 2023, that could re-assure the public
8 that they're not going to get into difficulty with
9 indwelling stents staying in too long and being
10 forgotten about by clinicians who don't have it on
11 a management plan?

14:45

14:45

12 A. Well, as I said, we're probably putting in less stents
13 because if we're putting in stents with strings, the
14 cohort of patients that are waiting for stent removal
15 is less. We are doing, as I said, primary
16 ureteroscopy. So if it's feasible we're treating the
17 stone when the patient comes in acutely, rather than
18 putting a stent in and bringing them back at a later
19 date for treatment of that ureteric stone.

14:46

14:46

21 Three is, a recording is better in that we now have two
22 codes, a code whether there's a stent in or whether
23 there's a stent not. So we are aware on the database
24 that a patient has a stent in situ. We have
25 a scheduler appointed in the last few weeks who now
26 takes pools lists and so -- or pools the patients. So
27 the next person with availability will get that
28 patient.

14:46

1 Our correspondence; so I do and my colleagues, so when
2 we do our letter from theatre, we document that there
3 is a stent in place, and that's always documented. I'm
4 sure that the registrars do that as well. Our Waiting
5 List Form is done at the time of theatre. It's an
6 online form now, or the "green form" that we keep
7 talking about, it is now online and it is done and sent
8 to the secretary at the time, after the operation, and
9 it's marked clearly that there's a stent in place and
10 the date it was put in. And we're acutely aware of it
11 as well. We do Datixs if the stent has been in more
12 than a month. So we have lots and lots of ways to try
13 to prevent it happening.

14:47

14:47

14 244 Q. Thank you for that.

15
16 It is a obvious point to make, it is not meant to
17 prolong the agony, but it does seem to take a long time
18 to get to at a place where there are solutions to make
19 governance of Patient Safety more effective. Take this
20 example: It is on the agenda more regularly than the
21 few examples I have pulled up for you and we started
22 this conversation in the context of looking at the
23 impact of human resource deficits but, as we can see,
24 it's more than just a shortage of consultants.

14:47

14:48

25 A. Yes. No, it has taken us a long time to get to this
26 level. But you know, if you look at the urology
27 literature going back years you will always find
28 articles on the forgotten stent, the stent that is
29 indwelling too long. So it is a problem that has

14:48

1 plagued urologists for a long time.

2 245 Q. Yes?

3 A. Perhaps it has plagued us more than other Departments,
4 but it is a problem that has been around for a long
5 time.

14:49

6 246 Q. Yes. Returning to the theme of capacity issues more
7 generally, you spoke this morning briefly about
8 initiatives to try to improve the capacity problem or
9 to address the capacity problem. From time to time
10 there were waiting list initiatives. It was the use of
11 the private sector.

14:49

12
13 You talk in your statement about specialist nursing and
14 what specifically trained or specialist trained nurses
15 can bring onboard to help address problems by,
16 I suppose it would be wrong to say "by filling gaps",
17 but by providing services that maybe historically
18 consultants and senior medical staff would provide.
19 Can you help us on that and what you have seen over the
20 course of your career at Southern Trust?

14:49

21 A. Well I think we are quite lucky in Craigavon. We have
22 got five Clinical Nurse Specialists and two more who
23 are in-training now. They have a lot of extended
24 roles. So we have one of the nurses, two of the nurses
25 actually do prostate biopsies. We have two nurses who
26 can do flexible cystoscopies, we're training them up.
27 We have a nurse who does urodynamics. One of the Nurse
28 Specialist is taking prostate cancer for surveillance,
29 and another one has an interest in kidney cancers,

14:50

14:50

1 small renal masses.

2
3 So they're all providing, and they're all well-trained,
4 and they interact with us constantly so if they have
5 any queries they can speak to us. So they're doing 14:51
6 jobs that we probably, as consultants, would have done
7 previously and it has certainly enabled us to treat
8 more patients.

9 247 Q. Yes. I think if we pull up WIT-50532. I think what
10 you just said is encapsulated within that 14:51
11 paragraph 23.2 and into 23.3:

12
13 "Specialist Nurses are experienced trained nurses and
14 are instrumental in reducing unnecessary hospital
15 admissions and readmissions, reducing waiting times, 14:52
16 freeing up a consultant's time to treat other patients
17 and, most importantly, being able to help, educate and
18 re-assure patients on how best to manage their health
19 conditions."

20 14:52
21 I suppose the Inquiry is interested to explore whether,
22 given, perhaps, the unavoidable demand for urological
23 services, whether the response on the part of the
24 service itself, whether at ground level, through the
25 consultants and the nurses, or whether at management 14:52
26 level, in terms of the organisation of services,
27 whether adequate and perhaps imaginative thinking is
28 being brought to bear on the need to arrange the
29 services in the best possible way to get as much out of

1 it, as much out of the resource as can be reasonably
2 done.

3
4 In terms of nursing, after that long preface, in terms
5 of nursing, do you think that enough has been done to 14:53
6 expand the use of that -- I hate using the word
7 "resource" to refer to valuable staff members, but do
8 you think that that is being developed, that part of
9 the available service is being developed, or do you see
10 untapped potential? 14:53

11 A. Well, I think Craigavon is lucky, it has all these
12 trained nurse specialists. They're difficult to get,
13 to get somebody of that level of training. I think
14 we're probably amongst the best in the UK from the
15 point of view of having specialist Nurses doing all 14:53
16 this. I think we're certainly up there amongst having
17 so many experienced trained specialist nurses who can
18 do so much.

19
20 We're continuing to grow the team. We're continuing to 14:54
21 expand their roles and they are very happy to do that
22 because it gives them more roles as well. So there's
23 room for growth. I think they have been a valuable
24 resource and hugely important to our Service.

25 248 Q. You also talk within your statement about the 14:54
26 modernisation of the Service. This is referencing
27 several years ago when a series of, I think you
28 described as modernisation initiatives took place.
29 Maybe just to touch upon some of those. WIT-50534 at

1 28.2, scrolling down. So you describe, and this is
 2 shortly after you joining the Trust, a plan is
 3 developed and brought to fruition to modernise the
 4 Urology Department, both medical and non-medical
 5 managers work well to make this happen. Developments 14:55
 6 included electronic referral systems for GPs and an
 7 online platform for GPs to ask questions on clinical
 8 cases and the developments of a Urology one-stop
 9 clinic.

10
 11 I suppose some of those developments were intended on
 12 the one part, perhaps, with the GP platform, is that
 13 intended to kind of quash demand or diminish demand in
 14 terms of patients having to come to see you?

15 A. That was the plan. In other words, to answer the GPs 14:55
 16 query and give them a solution and hopefully avoid
 17 a referral coming into the system and that's still in
 18 use.

19 249 Q. The one-stop clinic is presumably intended to ensure
 20 more efficient throughput of patients? 14:56

21 A. Yes, the one-stop clinic probably was at its height,
 22 which was pre-COVID, it worked very well. It was
 23 something similar to what started in Guy's. It doesn't
 24 really work in the same way now. There isn't
 25 a one-stop clinic as such like we used to do 14:56
 26 previously. That was an effect of COVID.

27 250 Q. I'm not sure I entirely follow why if it was working
 28 well, COVID intervenes in the sense of I suppose
 29 limiting interactions between people?

1 A. It's to do with space. There's been an internal change
 2 in the whole Department, how the Outpatients is run
 3 with regard to nursing experience. So what the
 4 one-stop clinic meant was that patients came in, they
 5 could have a flexible cystoscopy on the day, have an 14:57
 6 ultrasound, if necessary have prostate biopsies.

7
 8 Now we see the patients, but they don't necessarily
 9 have their flexible cystoscopies on the day because
 10 there are other specialties also using the rooms in the 14:57
 11 Department. Geomedicine come in on a Thursday, so
 12 they're using two rooms. As I said, the trained cohort
 13 of nurses, they come from other Departments. There
 14 isn't the same experience, you need experienced nurses
 15 to help with flexible cystoscopies, et cetera. 14:58

16 251 Q. I suppose one can infer from that that that's impeding
 17 progress in terms of getting patients through the
 18 system?

19 A. I suppose a lot of the patients we're seeing at the
 20 moment are red flag prostate patients and bladder 14:58
 21 cancer anyway, so they will have their procedures soon.
 22 Some of them are seen in the independent sector, quite
 23 a lot of them are going to the independent sector at
 24 the moment and they are seeing a lot of patients for us
 25 and doing flexible cystoscopies as well. 14:58

26 252 Q. It is the impact on the routine and urgent patients
 27 that is, I suppose, on one view of the statistics,
 28 a cause for concern. Maybe just to put this in the
 29 context of the figures, of the stats. If we go to

1 TRU-98238. Thank you.

2 A. These are obviously reviews.

3 253 Q. Yes. These are the waits to a consultant-led first out
4 patient appointment, it's the legend at the top says.
5 I am just struggling to see a date for when it applies. 15:00
6 Yes, there, we can see it, it's 16 May 2016. We can
7 see that. If we just scroll across we can see that
8 there are a total of 2,743 waiting, anything between 0
9 and 52 plus weeks. But those in the 52 plus weeks
10 category stands at 420. 15:00
11

12 I'm going to just check to see if it is the next page.
13 Scroll down to the next page. These are the figures
14 for 2017 and we can see that the waits are now
15 totalling 2,600 with a reduction compared with the 15:01
16 previous year in those waiting more than 52 weeks to
17 213. I don't have the reference to this, I'll check it
18 later and give it out.
19

20 But in September 2021, the numbers waiting more than 15:01
21 a year had gone up massively to 3,683. Is that
22 something that surprises you for this cadre of
23 patients, those awaiting a first out-patient
24 appointment?

25 A. Well, there are obviously "urgents" and "reviews" and 15:02
26 I wasn't aware of the numbers. But as I say, a lot of
27 these patients have now gone under the independent
28 sector anyway, so they're being seen. I suppose --
29 I keep mentioning COVID, that 2017.

- 1 254 Q. I suppose the point I'm making, I haven't got the
 2 reference for you to bring it up on the screen, but
 3 what I'm saying is that by 2021, for the same cadre of
 4 patients, in other words those waiting on
 5 a consultant-led first appointment in Outpatients, the 15:02
 6 number of those waiting more than a year has gone up
 7 massively to more than three and a half thousand?
- 8 A. I think during COVID I didn't see any urgents, I saw
 9 just red flags. So between MDM patients coming back to
 10 be seen at review, because they were the only review 15:03
 11 patients, MDM patients, and new red flags, they were
 12 the only patients we were managing to see. So I think
 13 that's probably the reason why the numbers have gone a
 14 way up with regard to urgents, and routine, and new
 15 patients. 15:03
- 16 255 Q. We can see, perhaps, similar increases across other
 17 indices, number of patients waiting on a Day Case
 18 waiting list. If we go to TRU-98245. These are
 19 figures for 2016. Those waiting more than 52-weeks is
 20 241. 15:04
 21
- 22 If we go to 98251, TRU-98251. So that figure of 241
 23 waiting more than 52 weeks for in-patient or day case
 24 has now grown exponentially up to 1321. Is that all
 25 related to COVID, the bounce in these figures? 15:04
- 26 A. Putting it simplistically, because that's what I'm
 27 doing, I think it certainly is. I can't see what other
 28 variables, there probably are other variables, but
 29 certainly I would have thought COVID, because

1 we weren't doing any day surgery, any routine day
2 surgery at all, so I can see why those numbers went up.
3 TRPs suffered, TRPs are outlet surgeries for benign
4 prostate, I think they suffered. So anything that
5 wasn't cancer, I think, suffered because of COVID.

15:05

6 256 Q. Yes, but the figures for any of these cadres of
7 patients weren't particularly healthy even before
8 COVID?

9 A. No. They weren't healthy before, but they were even
10 worse afterwards.

15:05

11 257 Q. Yes. So, as I suggested to you, 241 patients waiting
12 more than 52 weeks for a day case in 2016 is not what
13 you would want?

14 A. No, not in the slightest. But again, a lot of these
15 are now going to the independent sector for patients
16 needing bladder outlet surgery. We have new technology
17 and if they are suitable we do that with something
18 called "Rezum" which is a treatment for prostates. It
19 wasn't there when these patients were listed for
20 prostate surgery. If they are suitable, we certainly
21 put them to Lagan Valley to have that procedure done
22 there. You can do a lot more with that patient with
23 Rezum than you can for a TRP because it is a day
24 procedure.

15:06

15:06

25 258 Q. Just before we move on to see what the view of the
26 staff was and your colleagues was in relation to
27 waiting list problems, just going back to the reference
28 I needed to give you for 2021 for those waiting for
29 a first outpatient appointment. The reference is

15:06

1 TRU-98244.

2
3 You have, I think, through your statement at WIT-50562,
4 provided us with some statistics. We can see on this
5 top table that there are 4,011 patients on a new 15:07
6 outpatient waiting list as of 1 August 2022. Then
7 below that actually, if we go across, WIT-50564, we can
8 see these figures broken down across per consultant.
9 If we look at the first table, which is the review
10 outpatient backlog, we can see that as of 15:08
11 August 2022 -- just scroll down so we can see the full
12 table. Thank you -- there's a total of 1,372 on that
13 list as of August '22.

14
15 You have, relatively speaking, quite a significant 15:08
16 review backlog. It's topped only by Mr. Young. The
17 obvious point to make I suppose is you're primarily
18 a benign consultant, that's an inelegant expression,
19 and the others are --

20 A. And that's the explanation, also because I go to the 15:09
21 uro-oncologist MDM, Mr. Young doesn't. So I get all
22 the oncology patients coming back and I've been seeing
23 those for the last -- things have improved since
24 August, but I've been seeing all the MDM patients back
25 rather than benign cases. So I've been seeing nothing 15:09
26 for the last year and a half, only oncology patients.

27 259 Q. Have you been drawn into that as a consequence of --

28 A. Well, no, because I'm a core member of the uro-oncology
29 MDM. That's why I see the oncology patients as well.

- 1 So whilst I have a specialist interest in benign
 2 urology, I obviously also do some oncology. And that's
 3 why these patients have suffered, because they have
 4 gone on the long finger.
- 5 260 Q. So the side effect of you being necessarily brought 15:10
 6 into oncological practice is that nononcology patients
 7 suffer these waits.
- 8 A. Yes.
- 9 261 Q. Again that is a resourcing issue, is it?
- 10 A. Things have got slightly better since August because 15:10
 11 the registrars have come back into clinic, whereas they
 12 weren't before. When a registrar is with me in clinic,
 13 they are now seeing benign patients, benign review
 14 patients. So hopefully -- but I'm still seeing a lot
 15 of MDMs. 15:10
- 16 262 Q. Mr. O'Brien's name appears on that list, somewhat
 17 unusually, perhaps. He departed practice in July 2020.
 18 Do you understand why his name is set against?
- 19 A. Yes, my understanding is that they were Mr. O'Brien's
 20 patients, but as they are picked up by Mr. Haynes or 15:11
 21 one of the rest of us, they then change over. So
 22 they're on his name but they'll slowly drift over to
 23 one of us.
- 24 263 Q. Do they stay under his name, do they, until their
 25 review date occurs? 15:11
- 26 A. Either Mr. Haynes or one of us, one of the other
 27 consultants will take them over.
- 28 264 Q. I appreciate that.
 29

1 Just for comparative purposes, if we bear in mind that
 2 your review list, albeit improved from July, still
 3 stands at 408, for the reasons you explained. If we go
 4 back to 2015 to perhaps see the change in context, in
 5 its fullest context. If we go to WIT-50567 and scroll 15:12
 6 down we'll find that you, Mr. O'Donoghue, had I think
 7 it is totalling out as 42?

8 A. But if you can see, I have a patient going back to
 9 December 2013 and I wasn't even there then so...

10 265 Q. I suppose I want to get an insight into it. Do 15:12
 11 you have this sense that your review, as well as your
 12 in-patient and your day case list, do you have that
 13 constant sense that these things are increasing in size
 14 and you have no real control of it?

15 A. Well, I'm hoping that as my registrars are now seeing 15:13
 16 my benign reviews, and hopefully if we get some new
 17 consultant, that I won't be seeing as many MDM patients
 18 and then I can start seeing my reviews. Because
 19 I would like to get the numbers away down.

20 MR. WOLFE KC: Yes, I wonder would it now be convenient 15:13
 21 for a short break.

22 CHAIR: we will take a 15-minute break and come back at
 23 half-past-three.

24
 25 (Short adjournment - 3:13 p.m.) 15:13
 26

27 CHAIR: Thank you, everyone.

28 MR. WOLFE KC: If we could have up on the screen,
 29 please. WIT-50524. At paragraph 8.1, Mr. O'Donoghue,

1 you explain that you strived to provide, along with
2 Mr. Young, and no doubt other of your colleagues, to
3 provide an excellent and efficient service for
4 patients. How was that possible in terms of the
5 excellence and efficiency of delivery. How was that
6 possible when you see the state of the waiting lists
7 and what lay behind the waiting lists?

15:33

8 A. I think on reflection, "efficient" is probably a bad
9 choice of word. Excellent, in my eyes, I provide the
10 best service I could, so I think it was excellent in
11 that sense, but "efficient" perhaps shouldn't be in
12 there.

15:33

13 266 Q. I suppose there's two ways of reading that. As you
14 suggest, you did your level best to provide an
15 efficient and excellent service but the service itself,
16 in terms of its efficiency and excellence was okay for
17 those who got in the door, but it wasn't by any other
18 definition an efficient or excellent service if you're
19 waiting for more than a reasonable period?

15:33

20 A. Absolutely. I did my best with what I had, but I think
21 if you were looking at it objectively, it certainly
22 wasn't efficient. But I worked hard or I do work hard.

15:34

23 267 Q. Yes. You have explained to us that there were these
24 recruitment issues and the Trust worked, as best it
25 could, to try and fill the void with locums on the
26 consultant end. Ultimately, you know, there are
27 insoluble problems or at least problems that are
28 difficult to get around on the recruitment side.

15:34

1 You have reflected to us the efforts on the part of The
2 Trust to innovate to some extent with the modernisation
3 programme, and you gave examples of that, and the
4 expansion of nursing services and the scope of nursing
5 practice. Still and all, we're left with waiting lists 15:35
6 the size of which we've just explored and no doubt the
7 impact of COVID has been far from helpful.

8
9 I want to ask you about another area of delivery which
10 seemed to be impervious to change and that was the 15:35
11 extent to which Urology Services or Urology
12 practitioners were able to access theatre. We can see
13 in the papers, for example, if we take up at WIT-54680.
14 Mr. Haynes -- just at the top of the page, yes -- he's
15 writing to Mrs. Gishkori. The date is May 2018. He is 15:36
16 expressing:

17
18 "...serious Patient Safety concerns for the Urology
19 Department regarding the current status of our
20 in-patient theatre lists and the significant risk that 15:36
21 is posed to these patients."

22
23 He reflects in the second paragraph about the impact of
24 the winter planning. He says in the third paragraph
25 that: 15:37

26
27 "The clinically urgent cases are at significant risk as
28 a result of this."
29 Moving down to the next paragraph he cites the case of

1 Patient 91, I assume, who had died, and he describes
2 the delay which, as we all know and accept, was part of
3 the problem, not the whole problem, but the delay in
4 removal of the stent. He goes on to conclude that:

5
6 "Unless immediate action is taken by The Trust to
7 improve waiting times for Urology, urological surgery,
8 we are concerned that another potentially avoidable
9 death may occur."

15:37

10
11 So he's laying it on the line. He goes on and reflects
12 that:

15:37

13
14 "The private sector has a role to play in managing the
15 problem, but the Trust needs to find a solution from
16 within."

15:38

17
18 He concludes by saying he would stress that:

19
20 "Without immediate action to start treating these
21 patients there will be further adverse patient outcome,
22 death from sepsis, which would potentially not have
23 occurred if surgery had happened within an acceptable
24 timescale."

15:38

25
26 Do you remember as a team of consultants having
27 conversations of that type, particularly pertinent to
28 you, perhaps, because of your central focus on benign
29 urological conditions?

15:38

1 A. Yes. I mean it is an issue, one, our theatres last
 2 year were having a problem with recruitment of nurses,
 3 theatre nurses, so that impacted on theatre
 4 availability. Certainly the winter pressures. You
 5 know, if there's flu or -- and we have quite an elderly 15:39
 6 population, that impacts on the bed availability in the
 7 hospital. But in saying that, again, Lagan Valley,
 8 which has taken away the urethroscopies, not all, but
 9 those fit for day case surgeries, so we have put
 10 urethroscopies in there. So that has certainly helped. 15:39

11 268 Q. Is that a recent initiative?

12 A. I think I have been going there about the last 8 or
 13 9 months. So I think it is certainly within the last
 14 year, it is the Regional Urology Day-Case Centre. So
 15 patients who are fit for day surgery could have 15:39
 16 urethroscopies, can have green light lasers of
 17 treatment of their prostate Rezum. So that has made
 18 a difference.

19

20 Daisy Hill, we now operate there as well, or some of us 15:40
 21 do, so we can try to do cases there. So we're
 22 certainly looking at ways to try and take cases away
 23 from Craigavon, those who are fit. Obviously the very
 24 sick ones have to be done in Craigavon.

25 269 Q. Yes. If we just scroll up to WIT-54678. So 15:40
 26 Mr. Haynes -- I should just say in fairness, Mr. Haynes
 27 is writing again, but in fairness to Mrs. Gishkori she
 28 has replied to the email that I had just read through
 29 and we can see, for example, at the top of the page

1 there:

2
3 "Dear Mark, prima facie, it looks like the death of
4 this gentlemen could have been avoided."

5
6 Then she talks about bringing it down through the SAI
7 process and is communicating it. The issues raised by
8 Mr. Haynes, she is communicating them through both to
9 Shane Devlin, Chief Executive, as well as Dr. Khan,
10 then Acting Medical Director. So everybody in, if you 15:41
11 like, the senior management chain is alerted to
12 Mr. Haynes' concerns.

13
14 Mr. Haynes, if we just scroll up the page again, he's
15 writing back again. I suppose the thrust of this email 15:41
16 is to demonstrate that, comparatively speaking, there
17 is an apparent disadvantage being visited upon
18 urological patients so that those waiting, those urgent
19 patients waiting, are 596, and "weeks waiting is 280".
20 I assume that means that chronologically that's the 15:42
21 maximum wait on the list?

22 A. I would have thought so, yes.

23 270 Q. It is perhaps stand-out by comparison with other
24 specialities both in number and length of wait. So
25 there's 596 patients, orthopaedics at 200 is a distance 15:43
26 behind but it's the best of the rest of them.

27
28 So he uses this email to convey the message, if
29 we scroll down, please:

1
2 "Consideration needs to be given as to how the clinical
3 risk associated with such significant waiting time
4 disparities across specialities should be managed. As
5 highlighted in his previous email, amongst the Urology 15:43
6 cases are patients where there is well-documented
7 increased risk associated with longer waiting times."
8

9 He asks for a meeting at some point and says:
10

11 "From a urology team perspective, I think it would be
12 helpful to meet with the consultant team."
13

14 He declares your availability as a team for a meeting
15 in June. 15:44
16

17 Do you remember any intervention by senior medical
18 management sitting down with you as a team to
19 interrogate what lies behind these figures and to
20 attempt to grapple with devising solutions? 15:44

21 A. I'm trying to remember what happened, whether
22 we temporarily got some theatre space from another
23 speciality. In the back of my mind I'm thinking that
24 we did but I can't categorically say that. But
25 certainly there would be a disparity, although you're 15:44
26 looking at -- you're not comparing like for like. You
27 know, 200 orthopaedic operations would be much bigger
28 than -- you know, you're comparing numbers rather than
29 length of a procedure.

1
2 But in saying that there is quite a disparity, but
3 I can't remember whether we got theatre space or not
4 from another specialty. I think we did.
5 271 Q. You think you did? 15:45
6 A. I think it was Gynae.
7 272 Q. Was it short-term as opposed to a --
8 A. It's not a permanent, well it wouldn't be permanent.
9 If we did get it, it was short-term, but I can't give
10 you the time period. 15:45
11 273 Q. As opposed to a proper structural fix?
12 A. Yes.
13 274 Q. Perhaps my comparison is somewhat unfair and not
14 precise enough, but was there any sense on the part of
15 yourselves as a team of Urologists that 'we need more 15:45
16 access to theatre'?
17 A. No, we're always wanting more access.
18 275 Q. Yes?
19 A. You know, that's not just that time. We're constantly
20 looking for more access. I mean we're always asking 15:46
21 for more access.
22 276 Q. Was there a sense as well as wanting more access that
23 other disciplines were achieving more access or better
24 access than urological patients?
25 A. I don't know whether they were getting more access. I 15:46
26 mean, their waits were less but I mean that's probably
27 just a reflection of referrals that come into the
28 specialty. Perhaps some of the specialities have
29 a smaller operation so they can work through them a lot

1 faster.

2 277 Q. We can see, if we take it to the next year, October
3 2019, that Mr. Haynes is still on, for quite proper
4 reasons, is still on this initiative of advocating on
5 behalf of urological patients for more time in theatre. 15:46

6
7 So if we go to WIT-55757. He's writing to Mr. Young
8 and copying the Head of Service and the Assistant
9 Director in, as well as the rest of the urologists. He
10 is reminding you of what, presumably, you were acutely 15:47
11 aware of:

12
13 "The waiting lists for patients are considerable. This
14 results in them being admitted as emergencies within
15 particular urosepsis and these could be avoided with 15:47
16 timely elective surgery. Going forwards we should
17 submit an IR1 Form for any patient who has waited
18 longer than a time we consider reasonable for elective
19 treatment and is subsequently admitted as an
20 emergency." 15:48

21
22 I think he leaves it to individuals to reach a view on
23 what is reasonable. Arising out of all of that, in
24 terms of limited or less than optimal theatre access,
25 which is what Mr. Haynes is saying, given the demand on 15:48
26 the service, what was the block here as you understood
27 it?

28 A. The block, as in to get patients in in a timely
29 fashion? I think its multi-factorial. I think it's

1 needing more theatre space. It's sheer numbers that
2 need to be treated. There's certainly two that would
3 come -- two reasons that would immediately come to
4 mind. Sorry, I think a large number of patients,
5 something would be -- and whilst we were working our
6 way through them, they never made -- never seemed to
7 make a huge impact on the waiting list.

15:49

8
9 You know, we're talking about benign cases there. So
10 the red flag TRBTs would have always taken precedence
11 on those. So there will always be, so we would have
12 never had just fully benign lists because of the need
13 to try and get the red flags done all the time.

15:49

14 278 Q. You speak in your statement about working together with
15 line management to pursue common objectives as a team
16 to ensure the best possible care is provided for
17 patients. I think you say that you considered that:

15:50

18
19 "Medical and nonmedical managers work well in Urology
20 and the Department ran effective."

15:50

21
22 At paragraph 28.1. Perhaps, in focus, that's
23 a reference to Mr. Young and Mrs. Corrigan, for
24 example.

25 A. Yes.

15:50

26 279 Q. Do you think that Urology, as a service, was well
27 supported and well looked after in terms of securing
28 resources so that clinicians could pursue excellence
29 and efficiency for their patients by senior management?

1 A. Well I think, you know, one could always do with more
2 resources. But having the money to buy things doesn't
3 necessarily, you know, you need people as well. You
4 know, The Trust tried to recruit. So you can't do an
5 operation without a surgeon.

15:51

6
7 I suppose subsequently they have, you know, employed
8 the IS. There are Urologists coming from Manchester
9 now. So they are thinking of ways to try and get the
10 numbers through. They're also sending patients to the
11 IS for private surgery. So some patients have gone to
12 Dublin for TRPs. Some patients have gone to Dublin for
13 urethroscopy. Patients have had TRPs in Belfast.

15:51

14
15 So they are trying, spending lots of money now, but
16 perhaps that didn't happen back -- I mean that's going
17 back to 2000-and -- certainly a few years ago. What
18 we're doing now has only been going on for the last
19 year or so.

15:52

20 280 Q. Mr. Glackin makes the point -- and this is at
21 paragraph 31.1 of his statement, WIT-42307, 31.1. He
22 says that in his opinion:

15:52

23
24 "...senior managers did not work well with Urology.
25 Engagement with the Department by Clinical Directors,
26 Medical Directors, Assistant Directors and Directors
27 For Acute Medical Services was very limited and
28 infrequent, in my experience. I do not know how much
29 job planned time they had allocated to management

15:52

1 activity."

2
3 So that may be a factor in the degree to which they
4 engaged. But it does seem, if we just use Mr. Haynes'
5 correspondence as a means of litmus testing this. He, 15:53
6 presumably with the knowledge of the team, is clearly
7 dissatisfied on behalf of patients, that not enough is
8 being done to break this theatre capacity impasse. You
9 say that more recently they have come up with
10 initiatives, Daisy Hill, Lagan Valley, thinking a bit 15:54
11 more imaginatively.

12
13 Upon reflection, would you tend to agree with
14 Mr. Glackin, indeed Mr. Haynes, that not enough energy
15 came down from senior management to recognise the real 15:54
16 risks for patients here?

17 A. Absolutely. I mean -- you know, if what we're doing
18 now was done several years ago, you know it may have
19 changed things somewhat. When I was referring to
20 getting on with managers, I was probably talking to 15:54
21 Head of Service, Martina Corrigan, higher up than that
22 I certainly had no, or very little, if no engagement
23 personally with any of those people.

24 281 Q. Yes. Have they any visibility in any meaningful sense
25 for you as a consultant? 15:55

26 A. For me personally, no.

27 282 Q. Obviously you've referenced these initiatives, Lagan
28 valley, Daisy Hill, you have operating space there for
29 patients that are fit to go there. Do you get a sense

1 that over your ten years in-post, the ability of the
2 service to deliver for patients within the catchment
3 area has improved, has it got worse, or is it more or
4 less the same?

5 A. It's still the same because our referrals are going up 15:55
6 ten percent a year as well. So referrals haven't
7 stayed static. I mean if that stayed static, you could
8 probably would see a difference, but everything is
9 increasing, so it's hard to say. We're doing more
10 imaginative things. We're extending ourselves more. 15:56
11 But there's more coming into the system as well.

12 283 Q. I want to turn now and for the next half-hour to your
13 understanding and awareness of what The Trust has
14 identified as "practice shortcomings" in association
15 with Mr. O'Brien. I suppose I want to start, and we 15:56
16 can test it, test your view as we go along. But we'll
17 start with a reflection you've shared within your
18 statement at paragraph 67.1. So if we go to WIT-50550.
19 At point 76.1 you're asked:

20
21 "Having had the opportunity to reflect, do you have any
22 explanation as to what went wrong within Urology
23 Services and why?".

24
25 Your answer is: 15:57

26
27 "On the basis of the information presently available to
28 me, I don't think anything went wrong with the Urology
29 Service. In my experience issues arising within the

Service are dealt with effectively and efficiently.

Ms. Martina Corrigan identified that a number of referrals had not been triaged by Mr. O'Brien. The missing referrals were found in Mr. O'Brien's office, triaged by the Urology Consultants and the patients needing urgent treatment seen in clinic quickly. Most of the referrals now for triage are online, so an issue like this is unlikely to occur again." 15:58

If we scroll down the page and set alongside that reflection to paragraph 70.1. You are asked:

"Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, explain what could have been done differently, et cetera." 15:58

You say:

"No, I don't think mistakes were made by either me or others in handling the concerns identified. When concerns were identified, such as the failure to triage referrals or failure to follow through on MDM recommendations, systems were put in place to protect the patients." 15:59

Those reflections, Mr. O'Donoghue, perhaps jar up against the facts apparently accepted by The Trust that

1 certain of what they say were shortcomings in the
2 practise of Mr. O'Brien, triage, failure to dictate,
3 keeping patients' charts at home, just to stick with
4 the items that were scrutinised as part of the MHPS
5 investigation. Those matters were known about for, in 15:59
6 some cases, many years, triage, for example, and yet
7 your analysis is nothing went wrong, the Trust spotted
8 it and dealt with it.

9 A. Yes. well, with regard to the triage issue, it was
10 only in the last three weeks I discovered because -- 16:00
11 from reading the witness bundles, the triage issue was
12 in 2009, 2011, the one we're talking about. So
13 I wasn't aware there were triage issues, although
14 I suppose I did notice when I was on-call, because
15 I followed him, that there was always triage waiting 16:00
16 for me as well from his week that I ended up doing.

17
18 So I suppose it was a bigger problem than I realised
19 when I was -- the triage I was thinking of was the
20 large set of triage that was discovered in his office 16:00
21 whilst he was ill. So that's the first point.

22 284 Q. So in summary, when you wrote this last summer you were
23 unsighted on the extent of the knowledge --

24 A. -- on the triage issue. It was just the one triage
25 issue. As I said, it was only in the last three weeks 16:01
26 I discovered there were other problems.

27
28 The dictation, that was something I was aware of and
29 I had noticed that within the first week of joining

1 Craigavon because I did Mr. O'Brien's theatre list,
2 because I had no patients of my own, and I noticed
3 there were no letters in the notes. And it took a long
4 time to work out why they were on the theatre list, so
5 I was quite frustrated. So that's the first inkling 16:01
6 I had that there was something going on with regard to
7 dictation.

8 285 Q. That would have been in 2015, perhaps?

9 A. As in August, my first week, first, second week.

10 286 Q. Oh, right, back in 2014. 16:02

11 A. '14, because I did his lists. Patients were coming to
12 theatre with no letters.

13 287 Q. Yes?

14 A. So that's probably the first point I became aware there
15 was some issue. I think I was new in the job, so it 16:02
16 wasn't something I was really going to action, although
17 I didn't...

18 288 Q. We will look at those in a bit more forensic detail in
19 a moment. Then there were the 2020 issues that
20 emerged, I suppose off the back of the Serious Adverse 16:02
21 Incidents Reviews.

22 A. Yes.

23 289 Q. They related to conduct in association with the
24 multi-disciplinary team and the care pathways in
25 association with oncological patients. 16:02
26

27 In asking this question and to foreshorten it, can
28 I assume that you know some of the themes that emerged
29 from those SAIs?

1 A. Yes, and I think when I was writing that they were only
 2 becoming available to me. So certainly I don't know if
 3 I was aware, you might correct me, certainly whether
 4 I knew the Bicalutamide issue or not when I was writing
 5 that.

16:03

6 290 Q. So to the extent that systems were in place, systems
 7 were in place to spot triage not being done, it would
 8 appear to be well-known?

9 A. I was aware of that.

10 291 Q. Yes, but your characterisation of no mistakes having
 11 been made, is that something you're wishing to reflect
 12 further upon now and articulate in a different way?

16:03

13 A. Well, maybe articulate in a different way because
 14 I think lots of people tried to rectify it, not
 15 effectively. Whether that was a mistake or just they
 16 had a lot of pushback. But, I mean, you know, over the
 17 years lots and lots of people tried to get him to do
 18 this, tried to get him to do dictation, et cetera, and
 19 it didn't happen, or to get him to triage.

16:04

20
 21 I mean it seemed, when I was reading the evidence, it
 22 seemed to be a recurring theme over the last 20 years.
 23 So whether that was -- I suppose the error was that
 24 somebody didn't make a stronger effort to have it
 25 corrected, to have all those ways of doing things
 26 stopped, or not doing things.

16:04

27 292 Q. Let's just work through the timeline then. You say in
 28 your Section 21 response that as, a Consultant Body you
 29 were informed at your weekly meeting with regard to the

1 triage issues in January 2017. Maybe just bring that
2 up on the screen. WIT-50545, paragraph 53.2. You also
3 describe who was in attendance at that meeting.

4 A. Yes.

5 293 Q. A couple of points: Can you recall Mr. Carroll and 16:05
6 Mr. Weir being in attendance at that meeting?

7 A. I can't, but they may have been, but I can't.

8 294 Q. Yes. In terms of what you were told at that meeting,
9 it seems it appears to be limited in scope to the
10 triage issues. We know that, or we understand that as 16:06
11 a group of clinicians you were deployed to conduct,
12 I suppose, a clean-up operation or a tidy-up operation
13 around the triage that hadn't been done.

14 A. Yeah, yeah.

15 295 Q. But there were also issues in relation to a failure to 16:06
16 dictate outcomes from clinical encounters or clinic
17 encounters. Was that problem rehearsed to you at this
18 meeting?

19 A. I don't remember it being discussed but that's not to
20 say it wasn't. I obviously was aware that he wasn't 16:06
21 very good at his dictation and that when he did dictate
22 he did exceedingly long letters which rarely got to the
23 point. But I wasn't aware if it was discussed at that
24 meeting.

25 296 Q. Whether or not you remember it being discussed at that 16:07
26 meeting, is it the case that as part of the "clean-up",
27 as I have called it, the tidy-up, in the months that
28 followed, that you and your colleagues were looking at
29 cases where there hadn't been dictation?

1 A. Yes. The paperwork was quite poor and it turned out --

2 297 Q. This is not the triage cases, this is another set of

3 cases?

4 A. Yes, going through the notes to see what was happening.

5 298 Q. Yes. Just scrolling down, you said at 35.3, your 16:07

6 understanding was the triage letters which had not been

7 triaged were found in a filing cabinet in his office.

8 You're not aware of the reasons why his office was

9 searched and was not aware over what period this triage

10 covered. 16:08

11

12 The use of the word "searched", is that your

13 understanding of what you were told took place or could

14 you have been informed that Mr. O'Brien himself

15 directed Mrs. Corrigan to the location of the referral 16:08

16 letters in his office?

17 A. Well, I think "searched" might be a poor choice of

18 word. I know subsequently, again from reading the

19 evidence in the last few weeks, that Mr. O'Brien

20 directed Mrs. Corrigan to go to his office. But if 16:08

21 I was aware, if I had been told about it at that time,

22 it didn't stick in my memory.

23 299 Q. Just to push that a little further, have you been under

24 the impression until relatively recently that perhaps

25 implied by the use of the word "searched", have 16:09

26 you been under the impression that Mr. O'Brien had

27 hidden these letters away and hadn't informed anybody

28 as to their presence?

29 A. Yes, I think that was my impression. I didn't realise

1 that he had told Mrs. Corrigan. I thought -- again,
2 I may have been told, but I didn't remember that she
3 went to the office and found these. But that's
4 obviously incorrect.

5 300 Q. Yes. I think the impression, or the correct position
6 in fairness to everybody, Mr. O'Brien and
7 Mrs. Corrigan, is that she accepts that she was told
8 that these letters would be found in a particular
9 place, in perhaps a filing cabinet, I forget, but
10 within his office?

16:09

16:10

11 A. And that's what I sort of realised in the last few
12 weeks.

13 301 Q. Yes. As I think you've acknowledged already, you did
14 have a degree of knowledge prior to this January 2017
15 meeting, that triage and Mr. O'Brien were uncomfortable
16 bedfellows.

16:10

17 A. Yes.

18 302 Q. At least in terms of the triage of routine and urgent
19 cases; is that right?

20 A. In that it landed on me, because I followed him.

16:10

21 303 Q. I think we touched upon this briefly this morning, how
22 did you arrive at the view that he was having
23 difficulty, or at least there was a difficulty in
24 completing what was expected of him by the conclusion
25 of his Urologist of the week period?

16:11

26 A. This was before he was given -- this was a way before
27 he got the following Friday in which to complete his
28 triage. So it would have been, really, from when
29 I started. So the triage was kept in Thorndale in an

1 inbox, in a tray, and it was always waiting, sitting
2 there, when I started on the Thursday.

3 304 Q. So you should come in to an empty box?

4 A. Yes.

5 305 Q. Is that right? 16:11

6 A. Yes.

7 306 Q. But what you were finding was referrals that hadn't
8 been completed by Mr. O'Brien?

9 A. Yes.

10 307 Q. Did they fall into all categories or were they 16:12
11 predominately urgent and routine?

12 A. I can't remember. I assume they were urgent and
13 routine, but I actually don't know.

14 308 Q. Yes. And was this a --

15 A. I can't remember. 16:12

16 309 Q. Was this a weekly occurrence with few exceptions or was
17 it --

18 A. It seemed to be a recurrent issue because I was always
19 following him on-call and I found it quite irritating.

20 310 Q. You found it irritating because -- 16:12

21 A. Because it was --

22 311 Q. -- it was a bad start to the week for you, you were
23 picking up --

24 A. Yes, I had referrals, his triage, plus all the stuff
25 that was coming in for me. 16:12

26 312 Q. Yes. Did that irritation trigger conversations with
27 either Mr. O'Brien or, for example, Mr. Young?

28 A. I can't swear. I possibly had informal conversations
29 with people. who, in particular, I had those informal

1 conversations, I can't remember. But I obviously did
2 moan to people because of the irritation it caused me.
3 I probably didn't say it to Mr. O'Brien. No,
4 I wouldn't have said it to Mr. O'Brien, I think.

5 313 Q. Why was that? Why would you not think to say to the 16:13
6 person apparently creating the problem?

7 A. Perhaps I should have, but I just didn't. Perhaps
8 I dodged the issue and sort of did them most of the
9 time. I think I might have left a few for him. Maybe
10 I did direct them, I can't remember whether I directed 16:14
11 him to some of them. My patience was probably wearing
12 somewhat.

13 314 Q. Is it possible that this is a case of new consultant on
14 the block, against experienced consultant, and there's
15 an element of deference in avoiding confrontation? 16:14

16 A. I probably had respect for him because he was a senior
17 consultant. I didn't know all these triage issues had
18 gone on previously. Perhaps I avoid confrontation at
19 times and I thought "I'll get on with it". But my
20 patience was wearing thin after a while. 16:14

21 315 Q. Is it possible that what was left for you to attend to
22 had come down quite late on the Wednesday evening so
23 that he wouldn't have seen them. Is that an
24 explanation?

25 A. It could be for some of them, but I doubt for a lot of 16:15
26 them because it was more than a little pile. There
27 seemed to be a reasonable number at times.

28 316 Q. If you're correct and Mrs. Corrigan's evidence is
29 I think uncontroversial in terms of her finding

1 a significant number of untriaged referrals in
2 Mr. O'Brien's office, having been pointed in that
3 direction by Mr. O'Brien, the situation would appear to
4 be: He is doing precious few urgent or routines by his
5 own admission and they are being placed in his office. 16:15
6 You are doing some of the urgent and routines that have
7 come in on the Wednesday, presumably?

8 A. Yes.

9 317 Q. Is that your --

10 A. Probably definitely on the Wednesday. 16:16

11 318 Q. It's clear, and the Inquiry has seen the correspondence
12 and heard about the conversations between Mr. Young,
13 for example, and Mrs. Corrigan, that the difficulties
14 around triage were a regular topic of correspondence
15 and discussion for quite a period of time before you 16:16
16 joined up --

17 A. Yes.

18 319 Q. -- and subsequent to that. Were you not, whether as an
19 individual or a team member attending the weekly or
20 monthly Departmental meetings, were you not privy to 16:16
21 discussions around what Mr. O'Brien was and wasn't
22 doing in triage?

23 A. As far as I remember I wasn't aware of the extent of
24 the problem with triage that had been going back ten
25 years before I joined. But at the same time I may have 16:17
26 mentioned it at the meetings, I don't know whether
27 I did or not, about the triage. I probably did moan
28 about it because I did find it very irritating. So
29 I doubt very much I would have kept it to myself.

- 1 320 Q. I suppose, in addition to that, do you recall any
2 attempts on behalf of the team, on the part of the
3 team, I should say, or on part of the Team Leader, if
4 I can call Mr. Young that, to try to interrogate the
5 reasons for the difficulty, which I think was perceived 16:17
6 on the part of Mr. Young as being a slowness in
7 delivery of triage, whether or not he understood that
8 there was a failure of triage. We can ask him?
- 9 A. You mean a slowness of Mr. O'Brien triaging or slowness
10 of -- 16:18
- 11 321 Q. I mean there is different strings to the evidence this
12 Inquiry has received. Some people have said and will
13 say, I understand that we assume that Mr. O'Brien was
14 just slow in getting it back, whereas the clear picture
15 is that, in fact far from being slow, he was simply not 16:18
16 doing it in terms of urgent and routine.
- 17
- 18 So my question to you is, I suppose, whatever the
19 problem was being regarded as, whether slowness or not
20 doing it, why was that not, and perhaps it was, was 16:18
21 that a topic of conversation amongst you as a team with
22 Mr. O'Brien?
- 23 A. I don't think it was. I think probably part of the
24 problem with regard to me was I was doing them, so they
25 weren't lying around. I think the issues came to 16:19
26 a head and I sort of things came out. Those triage
27 were found in his office and he was given the Friday
28 afterwards, after on-call, to enable him to do that
29 triage. I think part of the problem was the depth he

1 tried to do the triage.

2
3 As I said earlier today, I mean I've seen some of the
4 letters he dictated whilst on-call and they were
5 four-pages long of no paragraphs, just continuous
6 narrative. I think if you tried to do that kind of
7 long letters, I don't know how many hundred come in
8 a week, it's impossible. I don't think of any benefit
9 because nobody can read those letters. They're just
10 too long, too unfocused.

16:19

16:20

11 322 Q. I'm keeping my finger on, if you like, the state of
12 knowledge and what was done with that knowledge just
13 for the moment. So you had a discrete piece of
14 knowledge that he wasn't doing the wednesday, if I can
15 describe it in those terms, because you were left
16 having to do them.

16:20

17
18 You are not giving us any indication of recollecting
19 that Urology Consultants as a team at meetings attended
20 by Mr. Young and Mrs. Corrigan were an opportunity used
21 to address Mr. O'Brien's shortcomings, whether to
22 provide support or challenge, but to at least address
23 the issue?

16:20

24 A. Yes, because I'm not -- well I don't know, I may have
25 said it casually rather than formally. So I don't
26 think it was discussed at the meeting as an actual
27 problem where there could be a solution to it. But I'm
28 trying to remember back and it's not something
29 I expected to have to reproduce, so I can't remember

16:21

1 exactly, but...

2 323 Q. Given your understanding of the Patient Safety
3 implications for not looking at urgent and routines,
4 the whole point of the exercise being to see whether
5 the general practitioner has got it right, because 16:21
6 lurking in there could be a real risk for a patient who
7 is being referred as routine, but in fact the proper
8 categorisation is red flag and what have you.

9

10 Given that risk, do you find it surprising that you 16:22
11 certainly had no memory of any stand-out discussions
12 around this which might have been used to either
13 support or challenge Mr. O'Brien?

14 A. Yes, I think in hindsight -- well, one is I obviously
15 did the ones that were lying, so they weren't an issue, 16:22
16 so I triaged them. But I think in hindsight I probably
17 should have made more of a formal complaint, I mean
18 particularly knowing now what had happened.

19 324 Q. You have said in your statement, if we go to WIT-50551
20 at 69.1. You were asked whether there was a failure to 16:23
21 engage fully with the problems within Urology Services.
22 You have chosen to answer that question by reference to
23 Mr. O'Brien and you say:

24

25 "Yes, I think there was a failure to engage with 16:23
26 Mr. O'Brien with Urology Services. Mr. O'Brien failed
27 to triage urology referrals and he failed to refer a
28 patient from the uro-oncology MDM to another patient
29 (sic).

1
2 sticking with the triage:

3
4 "With regard to his failure to triage, he should have
5 let the Head of Service know that he was struggling to 16:23
6 complete the triage. I'm not sure if the failures to
7 triage could have been picked up sooner as the
8 referrals at the time were hard copies."

9
10 I suppose a couple of points around that. It is quite 16:23
11 clear going back, I think it was to the year you were
12 appointed, but earlier in the year, the then Director
13 of Acute, or Acting Director of Acute, Mrs. Burns, sat
14 down with Mr. O'Brien and had the discussion about his
15 difficulties around triage. It was agreed that the 16:24
16 Team would take care of triage for a period of time and
17 ultimately Mr. Young took it onboard to do it himself.

18
19 So there was clear knowledge within the system of his
20 struggles. We can see also, if we open WIT-33280, that 16:24
21 if we go to Mrs. Trouton's email in the middle of the
22 page, 10 March 2016. She's telling the then Acting
23 Director, Ronan Carroll, he was Acting Director within
24 another branch of Acute Services at that time, that it
25 was her understanding that: 16:25

26
27 "There is an area of Urology where delays can occur in
28 triage and this is in train, although not easy to sort
29 out. So in the meantime we've agreed the process in

1 Urology, where, if the referrals are not returned in
2 the preferred timescale, then they are booked according
3 to the GP category. The wait for "routine" and
4 "urgent" in Urology is such that a longer triage for
5 urgents and routines is okay.

16:25

6
7 Red flag referrals are booked and seen within two
8 weeks, the gap therefore is in the case where the
9 Consultant may upgrade to red flag during the triage."

16:25

10
11 She agrees that:

12
13 "It does need to be sorted out to ensure that every
14 referral is triaged in a timely manner, it gave ever
15 referral the opportunity to be upgraded, if
16 appropriate."

16:26

17
18 So what the Trust had put in place is something that
19 has been called a "default arrangement". The evidence
20 appears to suggest that this was done, not necessarily
21 particularly with Mr. O'Brien in mind, but he was
22 certainly, his actions around triage were certainly
23 a factor in moving to default. The default system
24 worked by way of simply adopting the GPs'
25 classification and applying the patient to the
26 appropriate waiting list in light of that
27 classification, if the referral didn't come back from
28 triage. Did you know that such a system had been put
29 in place?

16:26

16:27

1 A. No, I didn't, because I think it is a very unsafe
 2 system. whilst you might get away with the vast
 3 majority of the referrals, appropriately categorised by
 4 the GP, you do see referrals that are inappropriate.

16:27

6 As I said, you know, blood in the urine, categorised as
 7 urgent or PSA, elevated PSA, sent as routine. So
 8 I think -- personally I think it is a very unsafe. If
 9 I had known about it I probably wouldn't have agreed
 10 with it or certainly would have voiced my discontent.

16:27

11 325 Q. But you didn't know about it until when?

12 A. You're probably going to turn up one with my name on an
 13 email but --

14 326 Q. I'm not?

15 A. -- I actually became aware of it, again, reading the
 16 evidence in the last few weeks. So it's not something
 17 I was aware of.

16:28

18 327 Q. I suppose you would make the point it didn't apply to
 19 you because you dealt with your triage in a timely
 20 fashion.

16:28

21 A. Yes, but at the same time I would have certainly
 22 expressed that, as I said, my discontent that I think
 23 it's a wrong decision to triage on the basis of what
 24 the GP categorised the patients' level of urgency.

25 328 Q. Again, briefly and finally for the purposes of this
 26 afternoon, I think we touched upon it in short order
 27 this morning. In terms of your own approach to triage
 28 when you Urologist of the Week, I think you have said,
 29 when we touched upon this morning, listen, I don't

16:28

1 leave the hospital until it's done.

2 A. No.

3 329 Q. The technique or the approach to triage, again, I think
4 you touched upon it briefly this morning, but do you
5 have anything further to add in terms of your own
6 approach to triage?

16:29

7 A. So as you quite rightly said, and even when we were
8 doing the hard copy triage, I never took the triage out
9 of the outpatients, I always did it in the Department
10 to avoid the referrals going missing. I always did
11 them -- never left, as you quite rightly said, until
12 I triaged. Now on ECR, I still deal with them in the
13 hospital, triage and will stay until they're all done,
14 so I can start a new day with a blank sheet.

16:29

15 16:29

16 with regard to the red flags, I booked the scans, I'm
17 selective with regard to the urgent/routine depending
18 on what the nature of the referral is.

19 330 Q. Could I take you to the vision document. I think it
20 was a document perhaps authored by Mr. Haynes and maybe
21 with the input of the team of Urologists from September
22 2014. WIT-50676. This is the first page of the
23 document in it. It covers a wide variety of issues but
24 it was written in the context of, I suppose
25 a stock-take exercise being conducted by The Trust in
26 terms of Urology Services and the future. This is the
27 contribution on behalf of the Consultants as to how
28 things might be done better having regard to the
29 context in which you were working in, including the

16:30

16:30

1 demand on services.

2
3 If I could take you just through to the latter section
4 of it. It's WIT-50687. At the bottom of the page,
5 please. The point is made that as part of what is 16:31
6 being proposed it is anticipated that patients will
7 attend Outpatients where only absolutely necessary. It
8 said:

9
10 "This will be achieved by the triage ensuring that all 16:31
11 necessary investigations have been performed prior to
12 the first outpatients attendance. Where investigations
13 are arranged, writing with results, and if required
14 telephone follow-up."

15 16:32
16 It's clearly talking about urgent and routine patients
17 in that context. I suppose the bright idea contained
18 within it is, that in order to make ourselves more
19 efficient and in order to support Patient Safety as
20 part of the triage exercise, it will be necessary to 16:32
21 arrange investigations and that they're performed prior
22 to first OP attendance.

23
24 Now, as I understand it your approach and the approach
25 of your colleagues to routine and urgent triage does 16:32
26 not routinely involve arranging for investigations?

27 A. No. It's selective because just the sheer numbers of
28 patients being referred-in precludes some of these
29 booking all those -- I mean the number of referrals

every day, I don't know the exact figure, there must be 50, 60. I mean you would just spend your day booking scans. But I think it is on a case-by-case basis. So if you're concerned enough to think that this patient needs a scan in the relatively near future, one would book it.

16:33

331 Q. So it's a time factor that would prevent you taking the step of arranging investigations for all such patients?

A. Yes. Because I mean to do it on the computer it probably would take 6 or 7 minutes. But if you have 6 to 7 minutes, 60 to 80 times, well that's a lot of time just booking scans, particularly when a lot of them don't immediately need scans.

16:33

332 Q. How do you apply the test, you talk about selectively?

A. Well I use my clinical knowledge to decide whether a patient needs a scan or not.

16:34

333 Q. We know from the waiting lists that large numbers of patients who fall into these categories of routine or urgent are not going to be seen for significant periods of time with the morbidity that is often associated with that delay.

16:34

How do we square the circle, assuming the circle hasn't yet been squared. Because isn't it the case that really there's no mechanism to routinely check on those patients that are on these waiting lists. They come in as emergencies quite often if Mr. Haynes and Mr. Glackin's evidence is to be accepted. But is there not a better way of doing it?

16:35

1 A. Well they're generally stones. So they would have
 2 scans organised. If a patient has voiding dysfunction,
 3 one would routinely get a scan of those, although you
 4 will have a small cohort that will go into retention.

16:35

6 You are dependent on the GP's assessment as well,
 7 whether somebody has chronic retention of urine or not.
 8 If the GP has assessed a patient poorly, your triage is
 9 going to be based on that poor assessment. But in
 10 saying that, by getting scans on patients who are
 11 referred in with renal colic or stones, one would hope
 12 that you avoid sepsis and most of the sepsis are
 13 patients with stents anyway.

16:36

14 334 Q. Just to finish on the point, looking at Mr. O'Brien's
 15 perspective that it was impossible, he says, to do the
 16 routines and urgents, and still provide a service of
 17 excellence across the other jobs requirements during
 18 the on-call week. What is your response to that?

16:36

19 A. Well, I think you need to use your time sensibly and
 20 I suspect he didn't use his time sensibly. I mean, you
 21 need to spread the time that you have over all the
 22 patients that you have, inpatients and triage and those
 23 for theatre. So at least your triaging patients.
 24 You're getting scans on red flag patients and
 25 selectively on the urgents and routines.

16:36

16:37

26
 27 You're seeing the patient on the ward and supervising
 28 and treating patients in theatre. So I think you can
 29 do them all, although, you know, one would always love

1 to have scans on everybody and do everything, but, you
2 know, I think it's impossible. But I think if you
3 spread yourself, use your time sensibly and safely,
4 you're not going to run into problems.

5 MR. WOLFE KC: Thanks for your evidence today. We'll
6 pick up again at 10:00 a.m. in the morning.

16:37

7 A. Okay, thank you.

8 CHAIR: Thank you Mr. Wolfe. Thank you,
9 Mr. O'Donoghue. We'll see you again at 10 o'clock in
10 the morning.

16:38

11 A. Thank you.

12
13 THE HEARING WAS THEN ADJOURNED TO THURSDAY, 12TH
14 OCTOBER 2022, AT 10:00 A.M.