Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Ms. Esther Gishkori
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

14 April 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference.

The Inquiry is of the view that in your roles you will have an in-depth knowledge of matters that fall within our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now, or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you may be aware the Trust has responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or your legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make an application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Issued by Urology Services Inquiry on 14 April 2022. Annotated by the Urology Services Inquiry.

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 7 of 2022]

pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Ms. Esther Gishkori**
C/O
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon **on 26th May 2022.**

APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon **on 19th May 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 14th April 2022

Signed: Personal information redacted by USI

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 7 of 2022]

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

The Inquiry understands that you are no longer employed by the SHSCT. Inquiry has named certain personnel in this Notice, which it understands as holding certain posts during your tenure. Please either confirm those are the correct post holders when answering those questions or, if not, please identify who held the posts referred to and name any additional personnel not referenced by the Inquiry but which you are aware of.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly reported and those departments, services, systems, roles and individuals whom you managed or had responsibility for.

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your roles and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, or any subsequent protocol (please specify) provided to or disseminated in any way to you or by you, or anyone else, to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of that protocol or any subsequent protocol? What action, if any, was taken (and by whom) if time limits were not met?

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

    I. What is your knowledge of and what was your involvement, if any, with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role, if any, in that process?

IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

14. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

16. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

17. Were you aware of any staffing problems within the unit during your tenure? If so, please set out the times when you were made aware of such problems, how and by whom.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

21. Did your role change in terms of governance during your tenure? If so, explain how and why it changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. Are you aware of any concerns having been raised about the adequacy of support staff availability? If so, please explain and provide any documentation. If you do not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were concerns from administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

26. What, if any role did you have in staff performance reviews?

27. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

31. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Governance – generally

32. What was your role in relation to the Directors of Human Resources and Organisational Development, the Heads of Service for Urology, the Clinical Directors, Medical Directors, consultants and other clinicians in the unit, including in matters of clinical governance? You should explain all lines of management and accountability for matters of patient risk and safety and governance in your answer. Please name the post-holders you refer to in your answer.

33. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

34. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

35. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for overseeing performance metrics?

36. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

37. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

38. Did those systems or processes change over time? If so, how, by whom and why?

39. How did you ensure that you were appraised of any concerns generally within the unit?

40. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

41. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.

42. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

43. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

44. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

45. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

46. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

47. Did you feel supported in your role by general management and medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

Concerns regarding the urology unit

48. The Inquiry is keen to understand how, if at all, during your tenure you liaised with and had both formal and informal meetings with:

(i) The Chief Executive(s) - the Inquiry understand these post holders to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin;

(ii) the Medical Director(s) - the Inquiry understand these to have been John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane;

(iii) the Directors of Acute Services and HROD - the Inquiry understand these to have Anita Carroll, Vivienne Toal and Siobhan Hynds;

(iv) the Director of Pharmacy/Governance Lead for Acute - the Inquiry understands this to be Tracey Boyce;

(v) the Assistant Directors - Heather Trouton and Ronan Carroll;

(vi) the Associate Medical Director - the Inquiry understand these to have been Mark Haynes and Damian Scullion;

(vii) the Clinical Director(s) - the Inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe;

(viii) the Head of Service, namely Martina Corrigan, and

(ix) the consultant urologists in post.

The Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to urology services concerns. Were not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc. Your answer should also include any individuals not named in (i) – (ix) above but with whom you interacted on matters falling with the Inquiry's Terms of Reference.

49. During your tenure, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not?

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements and how was this done? Please provide all relevant documents.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, please name those individuals and set out the assurances they provided to you. How did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

50. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

    (a) properly identified,
    (b) their extent and impact assessed,
    (c) and the potential risk to patients properly considered?

51. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q65 will ask about any support provided to Mr O'Brien).

52. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

53. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

54. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

55. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention?

56. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

57. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

58. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

59. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

60. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

61. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

62. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

63. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

64. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

65. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

66. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

67. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

68. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

69. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

70. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

71. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

72. Do you think, overall, the governance arrangements were fit for purpose? Did you have concerns about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

73. Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

The end of your tenure

74. Please explain the reasons why you no longer work at the Trust? Did those reasons involve anything touching upon the Terms of Reference of the Inquiry? If so, please explain.

75. Were there any concerns identified to you about your performance as Director of Acute Services as relevant to the Inquiry's Terms of Reference? If yes, please set out all details in full.

76. At the time your tenure at the Trust ended, were you involved in any pending, withdrawn or completed grievance or disciplinary process touching upon the Terms of Reference of the Inquiry? If so, please explain.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 7 of 2022

Date of Notice: 14/04/2022

Witness Statement of: Esther Ann Gishkori

I, Esther Ann Gishkori, will say as follows:-

Paragraph 1.

My name is Esther Gishkori and I was the Director of Acute Services in the Southern Health and Social Care Trust (SHSCT) from August 2015 until June 2020. I graduated from the University of Ulster Jordanstown in 2009 with a masters degree in public administration. I am from a nursing background, and I am also qualified to teach post graduate community nursing students.

This was my first job in the SHSCT. I had previously worked in the South Eastern Health and Social Care Trust (SEHSCT), working there since 1989 when it was Down Lisburn Trust. This was across several operational, governance roles and management roles, the last of which was the Assistant Director of Prison Health Care. A large part of this role was measuring practice in Northern Ireland Prisons against a given set of standards (audit) used elsewhere in the UK. Managing change and conflict as well as education in relation to safe and evidence-based practice was also part of this role. Before this I worked in a governance role (8B) in the "Safe and Effective Care" department of SEHSCT. This involved leading, designing, and completing clinical audit, monitoring trends and patterns in relation to incidents and accidents and leading reparative change. I managed the standards and guidelines team, helping junior doctors design audits and assisted consultants who needed to write or amend policies procedures or guidelines.

Finally, before joining the Southern Trust I had the opportunity to do some consultancy work in The Bahrain Prison System.

Paragraph 2.

My predecessor in the SHSCT was Mrs Debbie Burns. Whilst I had the opportunity to shadow her on occasions throughout the summer of 2015, I didn't receive a handover, neither formal nor informal.

Mine was an operational role, looking after the day-to-day operations of all the acute sites in the Trust. These were Craigavon Area Hospital (CAH) Daisy Hill Hospital (DHH) and South Tyrone Hospital (STH) which did not have an Emergency Department (ED) but had a minor injuries unit, elective surgery sessions and Out-Patient clinics. There were 4 broad areas I needed to consider as part of my role: Finance, Performance, Governance and Human Resources. In terms of "lines of reporting", I reported to the Chief Executive (who changed 7 times during my tenure) and of course Trust Board who were nonexecutive members and who held the Chief Executive and Directors to account by way of a monthly Trust Board Meeting.

In terms of training, I received a large folder which contained my responsibilities in relation to Trust Board. I no longer retain this folder and expect it is still in the possession of the Trust. I was taken through this folder by the Chair's personal secretary. I also received training on how to deal with the press and how to give an interview to the media. This was delivered by the organisation called "Red Box".

There was no other training of any kind.

My initial objectives were to find out about the Trust and its systems and processes, and what the organisational culture was like.

In terms of guidelines, there was no recognised Trust policy on writing guidelines or policies. A consultant physician decided to write a policy within his field of practice and put it on the Trust website with no problem. This posed many risks at many levels.

I immediately told the CE who agreed that this particular policy should be taken off the website.

I then told the Medical Director and offered to borrow a copy of the policy on the writing of guidelines and policies from the South Eastern Trust. This was an all-inclusive process to the writing, maintaining and monitoring of guidelines and allowed disciplines from all areas to comment and add to the guideline. By means of a systematic process, the author of the policy included /excluded all comments, and this process continued until everyone was satisfied. There were then a strict set of rules as to who can put this guideline onto the intranet.

When Dr Maria O'Kane became Medical Director, I explained the same thing to her and shared the policy from the other Trust. This was not implemented during my tenure.

The Chair of the organisation during my time there was Mrs Roberta Brownlee.

My peers were:

The Director of Human Resources and Organisational Development – Vivienne Toal

The Director of Finance – Stephen McNally / Helen O'Neill

The Medical Director – Richard Wright / Maria O'Kane

The Director of Children and Young People's Services – Paul Morgan

The Director of Older People and Primary Care – Melanie McClements

The Director of Mental Health and Disability Services – Francis Rice

The Director of Performance and Reform – Aldrina Magwood

At this time, governance was an add-on to the responsibility of the Medical Director. Nursing and Allied Health Professionals were the responsibility of the Director of Mental Health (because he was a registered nurse and therefore able to hold this executive role) and Estates was managed by the Director of Finance.

As the Director of Acute Services, I was also responsible for Maternity provision across the sites of CAH and DHH. Together they made up the biggest Maternity service in Northern Ireland.

Paragraph 3.

I had six Assistant Directors (AD) who were a band 8C and who reported directly to me. They were:

AD for medicine – Anne McVey

AD for Surgery, Elective care and Anaesthetics – Ronan Carroll

AD for Radiology – Barry Conway

AD for Pharmacy – Tracey Boyce

AD Maternity and Women's health – Heather Trouton (Barry Conway when Heather moved to Director of Nursing).

AD Patient Experience (Including medical records) – Anita Carroll

AD HR – Helen Walker (This post was from the HR directorate but worked in conjunction with my other ADs in Acute Services).

In turn, my ADs had heads of service (HOS) who were normally grade 8B reporting to them. There were between 5 and 2 HOS per AD, depending on the size of the division. The teams cascaded down to 8As who were lead nurses, specialist nurses and some Allied Health Professionals (AHP) and then band 7s who were normally ward or department managers or other AHPs, right to band 5, 4 and 2 who worked right at operational level. Everyone had a vertical line of reporting.

I was insistent on very clear vertical lines of reporting with sound horizontal lines of communication. This was necessary in such a big team. Everyone was required to know what each other's roles and responsibilities were as well as their own.. In a multidisciplinary arena failure to follow this caused chaos and ill feeling between staff members. I had an open-door policy and unless the person was discussing sensitive issues, I always asked if they had discussed things with their manager and if not, why not.

Within the acute directorate and as far as medical staff were concerned, all professional issues including job plans and revalidation were the responsibility of the Medical Director. All operational issues were the responsibility of the Acute Director. Clearly there was a big overlap in the roles with not every issue fitting neatly into either box. It was arranged therefore that the Medical Director and the Director of Acute would meet fortnightly but this was difficult to arrange with ongoing time pressures and the meeting did not always take place.

I agreed to give one of my Assistant Directors to the Medical Director. I was informed by the Director of Finance that this post would still be included in my budget as the medical Director no longer had the money for it.. This was Simon Gibson. He is an 8C but was not a qualified Doctor. His was a senior clerical post and even though he was 8C I understood he was to work to the old 8B Job description with a few other duties added. I never saw this job description.

Paragraph 4.

The Acute Directorate has always been by far, the biggest division in the organisation and spends annually circa 99% of the money. To that end, the following support was part of the Acute structure:

- From Finance - 2 divisional accountants who met all the assistant directors and their teams individually on a monthly basis. Further, the same accountants met the Director separately, also on a monthly basis. At these meetings, any drift from the agreed budget was discussed and reparative measures initiated. I found these meetings extremely useful, especially since such an emphasis was put on the financial health of the Trust. There was often unmet need in terms of finance which I then reported to the corporate Senior Management weekly team meetings which consisted of the Chief executive, all Directors and the Head of Communications. Towards the end of my tenure, the two divisional accountants were removed without explanation or notice.
- From Performance and Reform – 2 members of the performance team (normally the assistant director and an 8B) visited the acute teams separately and discussed all issues of performance. They also visited the Acute Senior Management meeting on a monthly basis. These were long and complex meetings that reflected the harsh reality that there simply wasn't enough staff or space to see patients or for the surgeons to operate. Interestingly, money

was not usually the issue here. Getting it spent was a recurrent difficulty. Often the Health and Social Care Board (HSCB) allocated money that had to be spent before the end of the financial year in March. This was non recurrent money so staff could not be recruited in time. Every Trust was in the same position so the private sector was saturated and could not facilitate the demand. 3-5 yearly budgets were requested but this was not agreed by the department during my tenure. Another problem was a hospital full of medical patients taking up beds that should have been reserved for surgical patients. Surgery was postponed on a regular basis.

- Human Resources It had always been the case that a senior member of HR was based in and worked solely for the Acute Directorate. Having so many staff in the division, this was an invaluable resource. They dealt with secondments, recruitment, disciplinary issues, job descriptions and anything else that fell within the HR remit

Paragraph 5.

As previously stated, I was responsible for the operational element of delivering the service. To communicate in a meaningful and organised way with my medical colleagues, I met with the Associate Medical Directors (AMD)s monthly. They were appointed by the Medical Director and answered directly to me in terms of operational delivery. They were responsible for the following areas:

Dr Philip Murphy – AMD for medicine and ED

DR Charlie McAllister /Dr Damien Scullian – AMD for anaesthetics (consecutively)

Mr Eamon Mackle / DR Charlie McAllister /Mr Mark Haynes – AMD for surgery (consecutively)

Dr Stephen Hall (now deceased) Dr David Gracey/ Dr Shahid Tariq - AMD for radiology (consecutively)

Dr Martina Hogan – AMD for maternity and women's health.

At the monthly meeting with the AMDs the Assistant Director from that area also attended. It meant that any actions from the meeting would be disseminated to the whole team and go to the appropriate personnel for action. Often the representative from HR or Finance attended depending on what was going to be discussed.

In turn, the AMD had a Clinical Director (CD) reporting to him/her. They were responsible for clinically managing their team. This included training and development, housekeeping issues, collating information to present to the AMD, answering their part in complaints in a timely way and any other business in relation to the smooth running of their section. This was a busy role and they often deputised for the AMD at meetings and as appropriate.

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Paragraph 6.

Below is a table of the regular meetings that required clear lines of reporting within the Acute Directorate.

MEETING	CHAIR	FREQUENCY	ATTENDEES	AGENDA
Acute SMT	Director of Acute	Weekly – on same day, after Corporate SMT	All ADs and any colleagues with specialist input e.g. performance team or divisional accountants.	Corporate agenda items from earlier passed on for info or action. Governance, Finance, HR and Performance rotated each week. On extra weeks in the month, training items are added, eg, visiting presentations from a range of specialties.
Corporate SMT	Chief Executive	weekly	All executive directors	Finance,Governance,Human Resources,Performance always on the agenda. Was mostly applying for funding for a project. Chair shared a corporate overview of all Trusts and HSCB over the week.
Friday Morning Governance	Director of Acute	Every 4th Friday Morning at 8am.	Governance team, all ADs, All AMDs and all CDs. Video linked to DHH.	A wide range of governance agenda items. **See note below.
AMD meetings	Director of Acute	Monthly wherever diaries could correlate	AMD,Director and AD from the AMD'S area.	Normally led by the AMD or AD, this informal style meeting discussed any topic or issue they felt appropriate

*Governance meetings;

When I joined the SHSCT, there was no governance team in the Acute Directorate. There were a few admin band 2s in the corporate office and one band 8A in acute.

Having looked at my budget, I found that there was funding for an 8C, an 8B, two band 7s and some 5s, 4s and 3s. One of my first priorities was to fill these posts. Once appointed, the 8C and 8B led the Friday morning governance meeting.

Unfortunately, due to a backlog in the processing of Serious Adverse Incidents (SAI)s, this meeting was largely taken up with those but the eventual aim was to cover a wide range of governance topics.

Dr Gillian Rankin was the Acute Services Director before Debbie Burns. She told me she had set up the Friday governance meeting as governance did not feature anywhere when she joined. The meeting was virtually non-existent when I joined but it was not difficult to revive as the Terms of reference and list of attendees were already there. I included the Clinical Directors in the list of attendees as they often brought a different perspective to the topics discussed.

Paragraph 7.

Mr O'Brien

An e mail to me from the Medical Director, Dr Richard Wright on 9th February 2016, suggested that in replying late to an e mail from a member of the legal team, Mr O'Brien (who from the time line of his e mails suggested that he was working almost 24/7) was crying out for help. This was the first time Mr O'Brien had been mentioned to me as possibly having an issue.

At their AMD meeting around the end of February / beginning of March, Heather Trouton (Assistant Director for surgery) and Eamonn Mackle (AMD for surgery) told me that they were going to write to Mr O'Brien telling him he needed to complete his triage referrals quicker, complete timely dictations and that he needed to be quicker in general. I did not see all of the contents of the letter. I asked what prompted them to initiate this letter and they told me this was an ongoing problem that had dated back to Dr Rankin's time. It was just that it was getting harder and harder to manage his "slow style of working" and that others were now complaining as they were having to help with his unfinished work.

I did not know Mr O'Brien at all nor did I know his history in the ST. However, Mr Mackle and Heather Trouton did know him well. In fact, Mr Mackle stated he had been having issues with Mr O'Brien "dating back a number of years". I understand that Mr O'Brien accused Mr Mackle of bullying (p32 para 4 and 5 Investigation report; Dr Neta Chada) Mr Mackle left his post soon after the sending of said letter.

Mr O'Brien was always described to me as an excellent clinician who was trusted with patient safety issues by his colleagues. They never doubted his clinical ability. This was a surgeon who had been instrumental in setting the service up. He agreed as to how referrals would be triaged and never, to the best of my knowledge, said he was not going to do these referrals.

Paragraph 8.

After there was no response to the AMD and AD's letter of March 2016 and after Mr O'Brien protested profusely to a member of the legal team, blaming unnecessary administration on his late response, Mr O'Brien became an item on an already existing Oversight committee. I was first aware of this when I looked at the agenda on my way to the meeting and his name was included on that.

Sensing real and meaningful remedial action was necessary, I spoke with both Mr O'Brien's CD, Mr Colin Weir and AMD (now Dr Charlie McAllister) and asked if they could suggest an efficient solution to address Mr O'Brien's issues with administration in particular. Being an Anaesthetist and having worked in theatre for a long time with Mr O'Brien, Dr McAllister said he was almost certain that if Mr O'Brien was "relieved of his theatre lists" until his administration was up to date, he would soon catch up. Mr O'Brien loved the operating theatre. I understand that he would be prepared to spend all day and into the evening there if he could. If someone else did his lists, he would consider this intolerable. Both clinicians thought that it would take 3 calendar months to rectify.

Mr Weir was to meet Mr O'Brien and discuss the plan. It was to be supportive, constructive, and low key but very clear with no room for deviation. This plan was set out in an e mail from Colin Weir to Charlie McAllister on 16th September 2016. I was hopeful about it, but when I told him, the Medical Director was reticent. The Medical Director and Vivienne Toal (Director of HR) preferred to continue with the oversight Committee deciding on what action was to be taken next. I was invited to this committee and was a member, completing actions and reporting back to the committee as appropriate.

Mr O'Brien went off [Personal Information redacted by the USI] in November 2016. He was due to return to work in January 2017. However,it had latterly come to light that there had been further issues of concern with a possibility of actual patient harm, again in relation to the referral process. It was therefore decided at an oversight committee meeting in December (at which I was represented by one of my assistant directors, Ronan Carroll) that Mr O'Brien be excluded from work for the duration of what was now a formal investigation.

Paragraph 8.

On 13th January 2017, in my capacity as the Director of Acute Services, I wrote to Mr O'Brien, giving him the opportunity to review and return comments on the SAI review into patient [Patient 10] He replied on 25th January with 11 pages of comments.

Mr O'Brien's 11 pages of comments and questions sent people in all directions answering and gathering comments. For me, he simply didn't follow a system which had been religiously and ably followed by ALL the other team members.

Paragraph 9.

Some time between August 15 and September 16, I read a letter of complaint. Not about Mr O'Brien but about the fact that the ward staff were not expecting the complainant to appear for surgery and therefore there was no bed for the patient. It transpired that Mr O'Brien himself had phoned the patient the night before and told him to come in the following day. Unfortunately, the ward staff nor consequently theatre staff had been informed.

[Personal Information redacted by the USI]

[Personal Information redacted by the USI]. I was off work for circa 2 months. The case of Mr O'Brien was managed by the oversight group during that time and thereafter. I know that Ms Corrigan, the HOS for Urology, monitored Mr

O'Brien's weekly activity in relation to his admin duties. I checked on a weekly basis with the AD and any time I met the HOS. When I went off Personal Information redacted by the USI at the end of May 2019 I never returned to the Southern Trust.

SCHEDULE

(No 7 of 2022)

1. Please see paragraphs (para) 1, 7 and 8.

2. I do not hold any further documents in relation to the Terms of Reference of the Urology Services Inquiry (USI).
3.
4. Please see para 1.

5. Please see para 1.

6. Please see para 2 and 3.

7. Please see para 5. I directly reported to the CE for all issues falling within my remit.

8. Please see para 2 and 3. The HOS replied directly to the AD for surgery who reported to me. The medical director was responsible for the professional aspect including job plans and revalidation whereas I was responsible for the operational side of matters; this included *inter alia* the provision of theatre services, staff provision, provision of cleaners and porters etc. There was an overlap in the roles with not every issue fitting neatly into a box. It was scheduled that I would meet with the medical director every fortnight. There was a clinical director for each for each division. The clinical director did not ordinarily communicate with me and only would have done so if the AMD was off. The associate medical director reported directly to the Medical Director for professional issues and reported to me for operational issues. The Head of the Urology Service was Martina Corrigan who managed everyone in the urology team. The Chair of the organisation was Roberta Brownlee.

9. This was established prior to the commencement of my employment.

10. I was not employed prior to the inception of the urology unit.

11. The "Integrated Elective Access Protocol" 2008 was not disseminated in any way to me. The protocol was implemented in 2008 which was prior to the commencement of my employment. I was aware of the protocol upon commencement of my employment. I am unaware if someone else disseminated this protocol to urology consultants in the SHSCT.

12. The protocol was introduced in 2008 which was prior to the commencement of my employment. The time limits were monitored by way of monthly meetings

wherein Service Level Agreements would be compared with actual delivery and each team, including urology, were required to give account of their performance, any deviance from the agreement and the reasons for same. In circumstances where time limits were not met, attempts were made to correct same. This included extended days and weekend working; elective sessions at Daisyhill hospital (although this was limited to day surgeries). I am aware that the urology department had implemented a procedure whereby they could replace major surgery with lithotripsy (resulting in reduced hospital stays for the patient.)
Performance was measured every step of the way and gathered for Service Level Agreements and this was then reported on a quarterly basis to HSCB. Attempts were also made to streamline and centralise certain services however this came with its own problems as patients were unwilling to travel for example to a less convenient location. One of the urology consultations was also sent to Belfast one day a week to perform specialist surgery. Specialised nurses and Advanced Nurse Practitioner were also appointed and Allied Health Professionals as part of a multi-disciplinary approach. The person responsible for this was Martina Corrigan, in conjunction with the Assistant Director and Assistant Medical Director.

13. The Regional Review of Urology Services, Team South Implementation plan was published 5 years prior to the commencement of my employment.
Upon commencement of my employment I understand that the implementation plans involved initiatives that were designed to manage patients timely and appropriately.

I. My main involvement in this initiative was working with teams to find additional operating space and appropriately trained staff. I also had monthly reports in terms of SLA performance and what the barriers were to delivering on target. Urology is a service whose increase in demand is correlated with the ageing population of the area. In the Southern Trust the elderly population has increased recently by circa 11% more than in the next biggest Trust. I was not involved in the original writing or implementation of the plan as it was introduced prior to the commencement of my employment.

II. The plan was implemented prior to the commencement of my employment and I do not have further information as to how it was implemented. There was a formal monthly audit performed by the performance team which was brought by the assistant director.

III. I attended regional meetings as required and I also reviewed the monthly audit performed by the performance team. At this meeting steps were agreed and a template was prepared by the performance team. The Head of Service and Assistant Director were responsible for same.

IV. Throughout my time at the Trust it was rare that plans ever totally achieve their aims. That's why the urologists tried to triage the GP referrals as an extra step to make sure actual red flags were identified and seen as appropriate. Some referrals should really have been dealt with by Primary Care, Specialist Nurses

or Allied Health Professionals. I also believe that the budgets provided were not fit for purpose and the department would have benefitted from 3-5 year budgets rather than annual budgets. This would have assisted with more efficient allocation and use of funds.

14. There was a risk register which was utilised by the urology department and was reviewed monthly at Corporate SMT after an update by the director concerned. It was either left, updated or removed. The urology department were on every agenda due to the number of patients and long waiting times. The Trust Board had continual access to the Risk Register. This meeting occurred weekly and I understand that meetings were collated. I do not have access to the minutes of said meetings.

15. The main issues raised in the urology department were in relation to demand outstripping capacity. Capacity was in the form of staff or theatre space. There were never enough theatre slots in relation to the demand for surgery. (This was the case across all departments.) Extended days and weekend work were tried but theatre staff were at a premium and it was the same pool of staff working at weekends and evenings, meaning that in keeping with working time directives staff were required (and needed) to have their days off. It takes a while to get used to new systems and processes and I understand that referrals were not always in keeping with the regional review.

16. No, I do not believe the urology unit was adequately staffed and properly resourced. Please see paragraph 15 above.

17. Yes, I was aware that it was very difficult to recruit and retain staff in the Southern Board. This was partially due to the rotas in bigger sites such as Belfast being more appealing and staff opting to work in Belfast. I was made aware by the Assistant Director, Ronan Carroll, who regularly complained that he did not have enough staff. Ongoing staffing problems were also discussed by the assistant medical director on occasions, in addition to Mark Haynes and other directorate meetings.

18. I am unaware what specific posts may have been vacant for a period of time. The usual steps were taken such as securing bank or agency staff or recruiting locum doctors. There were always recruitment drives and the Director of nursing and Director of HR had a few open days in an attempt to recruit nurses. There was also a drive to encourage student nurses to become Health Care Assistants (HCA)s in the hope that when they qualified, they applied to the Trust to work. Attempts were also made to outsource the load in line with the protocol.

19. Management posts were never vacant throughout my employment. Where there is a deficit in staffing, there is always a chance that quality is

compromised. Staff are encouraged to report unmet need and raise a "Datix" for a near miss or unsafe practice. This was an incident report which noted any incidents which occurred and was to be reported. These are in turn processed by the Head of Service and team and reparative steps are taken as far as possible. Waiting times were becoming increasingly lengthier as a result of ongoing staffing issues.

20. There was a retriage system of referrals introduced and a surgeon of the week process. All referrals were dealt with by the surgeon of the week. A fail safe system was introduced also so that any referrals not triaged by the Consultant of the week were then entered on the system as the original category of the referral indicated by the GP. During my time as Director, Mr Mark Haynes was also required to do a "complex" list at Belfast City Hospital (BCH) every Friday morning. This was so that patients needing radical surgery didn't have to go to England.

21. My role in terms of governance changed in that I appointed an acute governance team when I joined. I also resurrected the "Friday morning governance" meeting. The urology team were represented at this meeting. SAI were presented at this meeting by the relevant consultant; they provided outcomes and asked questions. Please also see the information contained at paragraph 6.

22. I am aware that before I was appointed there was a regional review of clerical and admin services, dealt with by Anita Carrol I understand that there was a reduction in secretarial support per team. This was a regional initiative that the Trust was required to follow. I do not know further details however Anita would know more.

23. I do not know what arrangements there were for admin staff in the unit nor how their workload was allocated. (Mrs Martina Corrigan (Head of Service) would know this).

24. Concerns from administrative staff were never raised directly to me.

25. The overall charge of the day to day running of the urology unit was the responsibility of the HOS, Mrs Martina Corrigan. She was answerable to the AD for surgery Mr Ronan Carroll who answered directly to me. See para 3.

26. I did PDPs with my ADs and my personal assistant.

27. My role was subject to a performance review by the CE. This followed the usual template and gave me a chance to identify training needs and for the CE to approve or reject. It was also an opportunity for the CE to make suggestions for my continued development, and objectives were agreed. I do not hold copies of any of the records of PDP's however same would be held by the trust.

28. Please see para 3. Urology was represented at my weekly SMT acute meeting, my AMD monthly meeting and the Friday morning governance meeting. These meeting lasted 1 – 3 hours depending on the agenda.

29. See no. 28.

30. No.

31. At the time, I was unaware of and nor did I see or sense any conflict between the team members. I was aware that Mr O'Brien could be slow with the administrative side of things but I did not know that there were any difficulties between him and his colleagues. I was aware that he had previously made an allegation of bullying against Mr. Eamonn Mackle however I did not know the details of same.

32. Please see para 2, 3 and 4. Also point 25. My HR colleague who was based in acute services was Helen Walker.

33. Clinical governance was the responsibility of the HOS as were matters of finance, HR and performance. I managed everything through the lines of accountability as outlined in para 2,3 and 5.

34. My role was to ensure safe and effective care across units, systems and processes. There were various protocols and processes in place and we would have carried out audits and reviews. The performance team would have raised any issues at monthly meeting (they were responsible under the performance directorate.)

35. Through the lines of management and with the help of the clerical teams, the metrics were presented to me and I in turn presented these to the HSCB personnel as appropriate. As outlined in para 4, the performance teams were involved also.

36. As outlined in the lines of accountability, governance and risk were discussed in the various fora. I was always keen to examine and discuss trends and patterns in relation to incidents, complaints, compliments, comments, accidents and near misses. We would have looked at trends and rates of complaints, compliance with protocols, infection rates and rates of ventilator acquired pneumonia. On occasion the Head of Service would have also attended these meetings, on an ad hoc basis.

37. There was a formal procedure of answering a complaint from both inside and outside the organisation. I read and signed off every complaint. I often sent the complaint back to the author of the response with my comments if I felt more information was required. The whole file was available so I could track back and see if perhaps there was a miscommunication along the way and obtain an oversight of the matter. This was often the case. Sometimes There were occasions where I also phoned the patient and this worked well most of the time. There was a corporate governance meeting, chaired by a non-executive

board member. They also looked at trends and patterns in the form of pie/bar charts. Waiting times and patient safety issues were also discussed there. Complaints process required that complaints were reported through the line manager. These processes were only effective as those who used them. There was a culture of skipping the hierarchy and moving to the next person up the chain to make complaints. Please see paragraph 3 for more information. There was also a doctor's mortality and morbidity meeting to discuss matters for the purposes of learning from previous patients, and any mistakes made. I have no knowledge of these meetings as I did not attend them.

38. I appointed a governance team upon commencing my post (There was no governance team when I joined but the budge was still there.) They mostly dealt with the SAI backlog at the outset of their implementation. They also implemented audits; the governance team performed audits against SLAs. There was a corporate governance team also set up, chaired by a Non Executive Director. He presented at that meeting and service users attended. Feedback was provided by users and we were be able to act on some of this feedback.
Complaint handling was audited against the regional standards set.

39. There were clear lines of accountability and reporting as set out in paragraph 3 and 5 above.
This procedure was to be followed: Datix was then raised on system and everything recorded. This system was set up that had to be dealt with and all steps were recorded.

40. There was a system in the Southern Trust which received and disseminated standards and guidelines from Department of Health or HSCB. The person who managed this was Caroline Beattie and was one of the most thorough, pleasant, and reliable members of staff I had. She not only ensured that all changes to standards, guidelines or standard operating procedures were sent out to the correct team and made sure they acknowledged receipt and had indicated their compliance with the latest guidelines. There were hundreds of these each week. Caroline attended my monthly governance SMT meeting and reported to me at this meeting. Solutions were sought from the group and Caroline took this forward.

41. Governance meeting minutes were circulated by the clerical team from Chief Executive Office. I do not retain copies of the meeting minutes but these would be held by the trust. I'm not sure where the CE recorded concerns raised by me. Depending on the concern, it may have been brought to SMT and put on the corporate risk register. I considered the directorate risk register or it may have been taken forward as an incident or near miss. It very much depended on the nature of the concern. Often things had to be actioned immediately. I was responsible for the Directorate Risk Register and the Chief Executive was responsible for the Corporate Risk Register. All matters were recorded and

reviewed on a monthly basis. I do not retain copies of the risk register but anticipate that the Trust would retain same.

42. There was a computerised system operated trust wide; the Patient Administrative System. The Trust was not yet entirely paperless and there were also paper charts.

43. PAS did not change while I was there. The PAS (mentioned above) was a hospital system. There was also a NIECR system which GPs could also access.

44. The performance objectives were more or less dictated by the SLA with the HSCB. Doctors' job planning reflected the service need and was done with the medical line manager. Areas for training and development and SPA allocation were also identified in the job plan. The system was set up so that I was the eventual signatory. I had nothing to do with drafting the content of these.
Appraisals were facilitated by the line manager.) The Trust would retain copies of these.

45. This was not my responsibility but I believe the process worked effectively. There were time pressures with the nature of the workload experienced by the Consultants and it could have been more efficient. Doctors would occasionally have to give up SPA in order to attend clinics/ theatre etc depending on workload.

46. At first instance the concern would have been brought to the line manager (unless their line manager was involved.) If it was in relation to patient care which was dangerous they had to act immediately. An IR1 (DATIX) would have been raised. The line manager would make the decision to attempt to resolve at the lowest possible level. The IR1 in the meantime would go to the Head of Service, Martina Corrigan. I do not recall any specific incidents relating to urology. IR1 are recorded on an online system which is called Datix.

47. I, For the most part yes I did. Mark Haynes was the AMD for urology. We were supposed to meet monthly however he rarely attended scheduled meetings and he rarely attempted to make any informal contact with me. He was unable to provide time. Ronan Carroll was the AD and he regularly kept me informed, he attended the monthly meeting and directly reported to me. He was reliable and honest.
The Head of Service, Martina Corrigan did not report directly to me but she would have on occasion came with Ronan to meetings as required and I found her supportive.
Any dealings with Consultants would have been on an ad hoc basis and this would have been rare. Mr O'Brien did not come to my office at any time.

48. Please see paras 2,3 and 5. Question 48 (i) – (ix) should include the following individuals as follows.

i. CE: Mairead McAlinden, Paula Clark, Kieran Donaghy, Francis Rice, Stephen McNally, Shane Devlin. I dealt with the CE both formally and informally and they attended the weekly SMT meeting which we all attended. They were accessible via telephone had there been an issue. I did not have any contact with Mairead McAlinden as she was not in post at the commencement of my employment.

ii. Medical Directors: The medical director was my peer and he attended SMT meetings. We were to have scheduled catch ups however Richard was on a 4 day week and was harder to pin down due to time constraints for additional meetings.

iii. Directors of Acute Services: Dr Gillian Rankin, Debbie Burns, Esther Gishkori, Melanie McClements. I had contact with HROD and she was my peer. She dealt with all matters in relation to HR and organisational development. I was part of the oversight committee with her in relation to urology services.

iv. The Governance Lead met with my weekly and reported on any governance issues. She led SAI in acute for patient MH. She reported directly to me.

v. The AD reported directly to me, he was responsible for PDP. They were responsible for their division and attended the weekly divisional SMT meeting. Once a month the weekly divisional meeting was governance. They reported any issues directly to me.

vi. Associate Medical Directors: Charles McAllister, Mark Haynes I met AMD's on a monthly basis and they would have raised issues of concern or governance within their directorate. This was Mark Haynes in the urology department.

vii. The clinical directors would have occasionally stood in for their AMD at the monthly meeting. I invited them also to the Friday morning governance meeting and they would have attended monthly. I did not have much contact with the urology CD.

viii. The Head of Service would have attended my SMT, in place of their AD or when their area was being discussed. This would not have happened often in urology case as Ronan always attended.

ix. I did not have direct contact with the Consultants in relation to urology governance.

In essence, my direct report was the CE and all the AMDs and ADs reported to me for operational matters. Further information can be found at paragraph 2, 3, 5 and 6.

49. (a).

The main concern for urology was the increasing waiting lists and the backlog of patients. This was a regional issue and there were regional groups set up to deal with it. This would have been discussed at the performance meeting monthly; Lesley Leeman attended these meetings on behalf of the performance team. The ADs were also in attendance. She would have discussed all the issues once a month. I do not hold records of these meetings however minutes were kept and would be in the possession of the Trust. We would have discussed the type of procedures who were waiting, how long they had been waiting and whether these patients could be outsourced to the private sector as a method to alleviate pressures on the urology waiting lists.

(b). Cleansing of lists and reviews of waiting lists were carried out. When a person was seen they were re-evaluated and re assessed. Risk assessed and if cancer was diagnosed, they were placed according to the 14, 32, and 64-day cancer pathway. A 'one stop shop' clinic was also introduced to assist in alleviate lists where patients were provided with results on the same day as review.

(c). In relation to the long waiting lists and backlog attempts were made to resolve this; attempts were made to outsource procedures to other centres or private sector where practicable. A one stop clinic was also set up as discussed above. Mark Haynes also went to Belfast to deal with specialist lists also.

(d). The oversight committee was set up to deal with any ongoing issues. The reporting structures as set out n paragraph 6 also applied.

(e) There was a monthly performance meeting where Lesley would have reported figures to us at this meeting. A mini audit would have been carried out at those meetings. Minutes of same can be obtained via the Trust.

(f). Via the performance meetings and figures provided.

(g). This was partially successful however the growing waiting lists were a regional problem and required a regional solution. An ageing population meant that urology services were under particular strain.

50. This was discussed at the monthly performance meetings; we knew exactly who was on waiting list, who had been assessed and whether there were any outstanding red flags that had to be dealt with. It was always the cases that red flag surgeries were never cancelled.

51. My role was to support all of the surgical teams, not just urology. This was regularly discussed at performance and governance meetings. We discussed getting agency staff, locum doctors and arranging overtime in an effort to alleviate pressures.

Sometimes we could send day procedures to Daisy Hill, this also alleviated pressures on our limited resources.

Helen Walker always attended the HR meeting however I invited her to them all as I felt she had important input.

Urology also had their own divisional meeting and issues would have been fed up to me from that meeting by Ronan if they could not resolve them within their department. There were also performance team members at those meetings and they would have fed information to the urology team directly.

52. I do not recall any specific quality improvement initiative. There was also a planning and performance team who created plans which were then brought to me and then to the board for approval. This would have included quality improvement measures where appropriate.

53. I never had direct contact with Mr O'Brien He answered to AMD who then answered to me operationally. He wrote me a letter about overtime and sent me a bill which I then referred to Ronan and Martina before it was passed to the finance team to action as appropriate.

54. Job plans were the sole responsibility of the Medical Director. As previously stated, I had the eventual sign-off of these, even though I had nothing to do with them.

55. Please see paragraph 7 for further information. I hold no relevant documents. I am not sure how long these issued could have been ongoing.

56. Please see Para 7 and 8 above for further information.

The oversight committee was me, Richard Wright, Vivienne Toal. Simon Gibson, medical staffing team and Siobhan Hynds would have been in attendance. Minutes of these meetings would have been taken by Simon Gibson and retained by the Trust. I do not have copies of these meetings. I did not take part in discussions outside meeting.

57. These were as the result of the oversight committee meetings. At these meetings minutes were taken and actions were agreed. These were retained by the Trust and I do not hold copies.

58. At the initial meeting, the scale of the problem was not yet apparent. The oversight committee put in place actions to deal with the issues. Patients were assessed by the other Consultants and placed on the correct pathway. This was coordinated by the Head of Service, Martina Corrigian. Again, minutes were kept of all meetings and would be retained by the Trust.

59. After his return to work, the HOS and AD worked closely together to monitor all of Mr O'Brien's admin activities. The backlog was cleared.

60. They used protocol in urology to monitor Mr O'Brien; this essentially amounted to an audit to monitor Mr O'Brien's practice against the given standards. For example, incoming referrals were monitored to ensure they were dealt with and no backlog could accrue. This was a simple procedure however prior to this incident the Head of Service and the AD did not review and assess in this way. This was only performed against Mr. O'Brien.

61. Ronan would have reported at his AD & AMD meeting and Martina (Head of Service) would have been responsible for monitoring.

62. I know that whilst he was being monitored, Mr O'Brien did comply.

63. No risks were raised to me by Mr O'Brien.

64. I did not raise any concerns about the conduct of Mr O'Brien.

65. Not all issues were escalated to me so others may answer this question differently, however I was not aware that Mr. O'Brien had any issues. Trust support was provided by the HOS and AD and reviews were provided. I didn't deal with his support directly.

66. I do not have access to the Directorate or Trust risk register now and I am unable to recall whether he was on the Trust Risk Register. Upon Mr O'Brien's

return to work the Head of Service and AD would have reported to me and confirmed that Mr. O'Brien was complying with the action plan.

67. No.

68. Here, in my opinion are some of the reasons:

- Not many people wanted a nurse or AHP to deal with their urological problems which were very personal and important to them so referrals continued to be made to the consultant (The gold standard). This contributed to the growing waiting lists.
- GPs often referred everything as a red flag just to get their patients seen. That's one of the reasons why the urology consultants started to re triage the referrals.
- It took a long time for primary and secondary care to begin to work seamlessly. This still was not working as well as it should have as set out in the urology review of 2010.
- The elderly population is increasing steadily and therefore so is the demand for urology services.
- There was a general moving away from custom and practices which would have been how Aidan O'Brien operated at the beginning of his career and a reluctance to adopt to the modern demands of medical practice.

69. Governance is about quality and safety. It could be argued that it is difficult to deliver a quality service that is "free at the point of need" for a growing population with a very limited budget. The ack of resources and limited capacity of Doctors is difficult to rectify. I would suggest that a review of administrative processes at operational level was required in hindsight.

70. The problems as I knew them related to the backlogs and increasing waiting times. This was being engaged with across the board as It was a regional problem. I was unaware of any issues in respect of staffing. Aidan O'Brien engaged with the actions which were decided upon by the committee at that time and the issues were resolved going forward.

71. Prior to the issues regarding Mr. O'Brien coming to light ongoing concerns were identified and dealt with in the best way they could.

In relation to the specific concerns relating to Mr. O'Brien which came to light I believe the process was more prolonged that it should have been. The Health Service was on its knees and Mr O'Brien was a really good practical surgeon who had been excluded from work at a time when we really needed his skills. There were no concerns about the clinical side of his practice. The oversight committee resolved the backlog and he was essentially returned back to baseline but I think this could have been done faster had the suggestion by Charlie been implemented at first instance. The review was also carried out by his colleagues within the Urology department which left a negative feeling going forward. It is my view this could have been avoided by having the review carried out by other Urology Consultants from other Trusts.

Urology Services Inquiry

72. I think the Chief Executive and Medical Director should have a policy on policy writing. I suggested this on numerous occasions as set out in paragraph 2 and 6 above.

73. I have nothing further to add.

74. My employment with the Trust terminated on 30 April 2020 [redacted] Personal Information redacted by the USI [redacted]

75. No.

76. No.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: [redacted] Personal information redacted by USI

Date: 27:6:22