Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Mr. David Connolly
Consultant Urologist
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

7 June 2022

Dear Sir,

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.

The Inquiry is aware that you have held posts relevant to the Inquiry's 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 details 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 are aware the Trust has already 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/or 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 the Trust's 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 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

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 60 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:

David Connolly
Consultant Urologist
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 18th July 2022.**

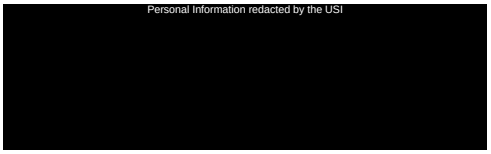
APPLICATION TO VARY OR REVOKE THE NOTICE

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 11th July 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 6th June 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 60 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. If you are uncertain about what documents have been provided to the Inquiry please liaise with the Trust's legal representatives. 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.

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. 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.

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 report/ed and those departments, Services, systems, roles and individuals whom you manage/d 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, including your lines of management in respect of matters of clinical care, patient safety, administration and governance.

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

Urology services

9. For the purposes of your tenure, in April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices *(sic)* and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick

response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

During your time working in Urology services, was the *'Integrated Elective Access Protocol'* provided to you or its contents made known to you in any way by the SHSCT? If yes, how and by whom was this done? If not, how, if at all, were you made aware of your *role and responsibilities* as a Consultant urologist as *to how data should be collected, recorded and reported … to establish good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists for the successful management of patients waiting for hospital treatment*?

10. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits and guidelines, etc., within it) impact or inform your role generally as a Consultant urologist? How, if at all, were the time limits for Urology Services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

11. What, if any, performance indicators were used within the Urology unit during your tenure? If there were changes in performance indicators throughout your time there, please explain.

12. Do you think the Urology services generally were adequately staffed and properly resourced throughout your tenure? If not, can you please expand noting the deficiencies as you saw them? Did you ever complain about inadequate staffing? If so, to whom, what did you say and what, if anything, was done?

13. Were there periods of time when any staffing 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 such staffing challenges and vacancies within the unit managed and remedied?

14. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of Urology services? In your view, did staffing problems present a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples.

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

16. Did your role changed during your tenure? If so, did changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

17. Explain your understanding as to how the Urology unit and Urology Services were and are supported by administrative staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to you as a Consultant so that you may properly carry out your duties. Accordingly, please set out in full all assistance and support which you receive from administrative staff to help you to fulfil your role.

18. Did 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?

19. Did all Consultants have access to the same administrative support? If not, why not?

20. Have you ever sought further administrative assistance? If so, what was the reason, whom did you ask and what was the response?

21. Did administrative support staff ever raise any concerns 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 or anyone else did in response.

22. Did you feel supported by the nursing and ancillary staff in the Unit? Please describe how and when you utilised nursing staff in the provision of clinical care

for Urology patients. Did you consider that the nursing and ancillary staff complement available was sufficient to reduce risk and ensure patient safety?

23. Please set out your understanding of the role of the (a) specialist cancer nurse(s) and (b) Urology nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. How often and in what way did you engage with those nurses in your role as Consultant? Did you consider that the specialist cancer nurse, and all nurses within Urology, worked well with (Consultants? Did they communicate effectively and efficiently? If not, why not.

24. What was your view of the working relationships between nursing and medical staff generally? If you had any concerns, did you speak to anyone and, if so, what was done?

25. What was your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient? If not, why not? Did you consider you had sufficient administrative support to fulfil your role? If no, please explain why, and whether you raised this issue with anyone (please name and provide full details).

26. As Consultant urologist, how did you assure yourself regarding patient risk and safety and clinical care in Urology Services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

27. Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer? 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. Identify the person/role to whom you were answerable.

28. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

29. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and refer to (or provide, if not provided by the Trust already) 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.

30. Were you involved in the review or appraisal of others? If yes, please provide details. Did you have any issues with your appraisals or any you were involved in for others? If so, please explain.

Engagement with Urology staff

31. 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.

Governance

32. During your tenure, who did you understand as overseeing 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?

33. Who oversaw the clinical governance arrangements of the unit and how was this done? As Consultant urologist, how did you assure yourself that this was being done properly? How, if at all, were you as Consultant urologist provided with assurances regarding the quality of urology services?

34. How, if at all, did you inform or engage with performance metrics overseen in Urology? Who was responsible for overseeing performance metrics?

35. 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?

36. How did you ensure that governance systems, including clinical governance, within Urology Services were adequate? Did you have any concerns that

governance issues were not being identified, addressed and escalated as necessary?

37. How could issues of concern relating to Urology Services be brought to your attention or be brought to the attention of others? 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 during your tenure? If so, how, by whom and why?

39. How did you ensure that you were appraised of any concerns generally within or relating to Urology Services?

40. 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 (unless provided already by the Trust).

41. What systems were in place for collecting patient data in Urology Services? How did those systems help identify concerns, if at all?

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

43. During your tenure, how well do you think performance objectives were set for Consultant medical staff and for specialty teams within Urology Services? Please explain your answer by reference to any performance objectives relevant to Urology during your time (and identify the origin of those objectives), providing documentation (where it has not been provided already) or sign-posting the Inquiry to any relevant documentation.

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

45. 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 within Urology Services. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) 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.

46. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

Concerns regarding the Urology unit

47. The Inquiry is keen to understand how, if at all, you engaged with the following post-holders:-

    (i) The Chief Executive(s);
    (ii) the Medical Director(s);
    (iii) the Director(s) of Acute Services;
    (iv) the Assistant Director(s);
    (v) the Associate Medical Director;
    (vi) the Clinical Director;
    (vii) the Clinical Lead;
    (viii) the Head of Service;
    (ix) other Consultant Urologists.

    When answering this question please name the individual(s) who held each role during your tenure. When addressing this question you should appreciate that the Inquiry is interested to understand how you liaised with these post-holders 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 the concerns raised regarding Urology services which are the subject of this Inquiry. You should refer to all relevant documentation (and provide that documentation if not previously provided), dates of meetings, actions taken, etc.

48. Were any concerns ever raised regarding your clinical practice? If so, please provide details.

49. Did you ever have cause for concern, or were concerns ever reported to you regarding:

(a) The clinical practice of any medical practitioner in Urology Services?

(b) Patient safety in Urology Services?

(c) Clinical governance in Urology Services?

If the answer is yes to any of (a) – (c), please set out:

(i) What concerns you had or if concerns were 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 action (if any) was planned in response to these concerns.

(ii) What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

(iii) Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.

(iv) Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?

(v) How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?

(vi) How, if you were given assurances by others, you tested those assurances?

(vii) Whether, in your view, the systems and agreements put in place to address concerns were successful?

(viii) If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.

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

(a) Properly identified,
(b) Their extent and impact assessed properly, and
(c) The potential risk to patients properly considered?

51. What, if any, support was provided to you and Urology staff by 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. (Q64 will ask about any support provided to Mr. O'Brien).

52. Was the Urology Services offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

Mr. O'Brien

53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. Do you now know how long these issues were in existence before coming to either your own or anyone else's attention? Please provide full details in your answer.

54. 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 they were 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 which were known to you, please explain why you did not?

55. As relevant, 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.

56. If applicable, 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.

57. As Consultant urologist, did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

    (i) In what way may concerns have impacted on patient care and safety?
    (ii) When did any concern in that regard first arise?
    (iii) What risk assessment, if any, did you undertake, to assess potential impact? and
    (iv) What, if any, 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?

58. 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.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of any agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? Who was responsible for overseeing any agreed way forward, how was this done, where was record of the oversight recorded, and how long did this oversight last? Please include any documentation (unless already provided) and/or indicate where the Inquiry may find a record of any oversight.

60. As relevant, 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? Are there records of you having assured yourself that systems and agreements put in place, to address concerns, were effective?

61. 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?

62. Did Mr O'Brien raise any concerns with you 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 if not with you, with whom), and when and in what context did he raise them?

63. 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? How far would you expect those concerns to escalate through the chain of management?

64. 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 options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

65. 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, unless already provided. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

66. 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.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within Urology Services and why?

68. 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?

69. 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.

70. 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?

71. 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?

72. 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?

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: S21 No.60 of 2022
Date of Notice: 7th June 2022

Witness Statement of: David Connolly

I, David Connolly, will say as follows:-

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.**

   1.1 I started in Southern Health and Social Care Trust (hereafter 'SHSCT') as a Consultant Urologist in September 2012 and left to join Belfast Health and Social Care Trust in March 2013. This was my first consultant job and was always going to be a short-term appointment for me as I planned to move to Belfast Health and Social Care Trust. As a new consultant, I only had a basic knowledge of the processes behind running a Consultant practice, managing a rapidly expanding service and the Governance structure of a Health Trust.

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

   1.3 I thought it was a very good unit and there was excellent collaboration and working relationships between Consultants, junior medical staff, ward nurses and nurse specialists, managers and administrative staff as outlined in Paragraphs 22 to 28.

   1.4 I thought the Governance structures at SHSCT were satisfactory at the time. As stated above, this was my first Consultant post and the processes and Governance Structure of a Health Trust were all very new to me. There

did not appear to me to be any deficiency in Governance at SHSCT compared to other Trusts I had worked in during my training. I have noted with my experience in recent years in Belfast Trust, that Governance structures have greatly improved, becoming more formalised, with better documentation and independent oversight. As outlined in Paragraph 67, 68 and 71, in hindsight, I believe that the Governance structures in SHSCT were not fit for purpose.

1.5 I was not aware of any issues or concerns with any staff members or the urology unit management during my time in SHSCT. I was aware of my line managers and who to report concerns to if they had been identified. I first became aware of issues with Mr. O'Brien and with the SHSCT urology service in a telephone conversation with Mr. O'Brien as outlined in Paragraph 53.

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. If you are uncertain about what documents have been provided to the Inquiry please liaise with the Trust's legal representatives. 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.**

2.1. I do not have any documents in my possession relating to my employment in SHSCT. I was a urology consultant in SHSCT from Sept 2012 until March 2013 only and even at the time of appointment, I knew it was just going to be a short term position so I did not get significantly involved in the development / management of the unit.

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. 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.**

3.1. As per responses below.

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Your position(s) within the SHSCT

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

4.1. Qualifications

(a) St. Michael's College, [redacted] (1987 – 1994)

- GCSE 1992: 9 A, 1 B.
- A-level 1994: 2 A, 2 B.

(b) Queen's University of Belfast, University Road, Belfast, BT7 1NN (1994 – 1999)

- MB BCh with distinction in Pathology; Obstetrics, Gynaecology and Child Health.

(c) Queen's University of Belfast, University Road, Belfast, BT7 1NN (2004 – 2007)

- Doctor of Medicine

(d) The Royal College of Surgeons, England (February 2004)

- MRCS qualification

(e) The Intercollegiate Speciality Board (November, 2010)

- FRCS (Urol) qualification

4.2. Occupational History

Employer	Post held	Dates		Outline of duties
		From	To	
(a) Belfast City Hospital	Consultant urologist	April 2013	Present	Consultant urologist (Endourology)

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(b)	Craigavon Area Hospital, Craigavon	Consultant urologist	Sept 2012	Mar 2013	Consultant urologist with special interest in endourology. Moved to regional centre into endourology post
(c)	Southern Health, Monash Medical Centre, Melbourne, Victoria.	Urology Fellow	Aug 2011	Aug 2012	International Fellowship in Laparoscopy and Endourology. Consolidate core training and extend training in endourology. Train in novel procedures and revise patient pathways.
(d)	Belfast City Hospital	ST6 Urology	Aug 2010	Aug 2011	Higher surgical training in urology: 6 month uro-oncology and 6 month endourology attachment
(e)	Altnagelvin Hospital, Derry	ST5 Urology	Aug 2009	Aug 2010	Higher surgical training in urology: 12 month core urology attachments
(f)	Belfast City Hospital	ST4 Urology	Aug 2008	Aug 2009	Higher surgical training in urology: Two 6 month uro-oncology attachments
(g)	Craigavon Area Hospital, Craigavon	ST3 Urology	Aug 2007	Aug 2008	Higher surgical training in urology: 12 month core urology attachments
(h)	Belfast City Hospital / CCPS, QUB	Urology research fellow	Aug 2004	Aug 2007	Full-time research (MD) on PSA. Development of PSA database, prostate data. MD thesis on long-term significance of moderately raised PSA.
(i)	Causeway Hospital, Coleraine.	Trust grade registrar	Aug 2003	Aug 2004	General surgical registrar duties – acute admissions, in-patients, DPU/main theatre sessions, outpatient clinics. Entered into full time research

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(j)	Causeway Hospital, Coleraine.	General surgery SHO	Feb 2003	Aug 2003	General surgical SHO duties in busy DGH First on-call for all surgical problems. Obtained trust grade post to increase responsibility and operative experience.
(k)	Ulster Hospital Dundonald	Surgery / urology SHO	Aug 2002	Feb 2003	Working directly under consultant urologist looking after acute surgical/urology patients. In-patient/DPU theatres, urology outpatient clinics.
(l)	Royal Victoria Hospital, Belfast.	Fractures / orthopaedics SHO	Feb 2002	Aug 2002	Acute management of trauma patients, pre- and post-operative care of orthopaedic patients.
(m)	Belfast City Hospital, Belfast.	Urology SHO	Aug 2001	Feb 2002	In-patient/DPU theatres, outpatient sessions. On-call for regional/in-patient/A+E referrals.
(n)	Royal Victoria Hospital, Belfast	Vascular SHO	Feb 2001	Aug 2001	Responsibility for management of vascular surgery patients and dealing with acute vascular emergencies.
(o)	Belfast City Hospital, Belfast.	General surgery SHO	Aug 2000	Feb 2001	Dealing with acute surgical patients in a busy surgical unit specialising in upper GI and breast surgery. Continued on BST rotation until August 2003.
(p)	Belfast City Hospital, Belfast.	JHO	Aug 1999	Aug 2000	General JHO duties rotating through general surgery, urology, cardiology and general medicine.

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

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relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1. I was employed as a Consultant Urologist in SHSCT from 1st September 2012 until 31st March 2013. I do not have access to my job description from this time. I was employed as a Core Urologist but I had a special interest in endourology and laparoscopic surgery having just completed a Fellowship in this in Monash Hospital, Melbourne. From the best of my recollection, it was a standard job description for a core Urology Consultant. At the time, I did feel like it accurately represented my duties and responsibilities as a Urology consultant. I did not have any other formal management roles in SHSCT. I left the SHSCT and I returned to Belfast Trust on 1st April 2013 to take up a specialist Endourology Consultant role.

6. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, Services, systems, roles and individuals whom you manage/d or had responsibility for.**

6.1. My only role in SHSCT was as a Core Urology Consultant. My line manager was Mr. Michael Young who was the Clinical Lead for Urology at that time. My Service manager was Mrs. Martina Corrigan. I was responsible, together with the other Consultants in the Urology team, for the training of 2 Urology registrars namely Mr. Derek Hennessey and Mr. Matthew Tyson.

7. **With specific reference to the operation and governance of Urology Services, please set out your roles and responsibility and lines of management, including your lines of management in respect of matters of clinical care, patient safety, administration and governance.**

7.1. As a Consultant Urologist, I was responsible for the care of elective and emergency patients admitted under me. I took part in the Unit's clinical governance structures including Morbidity & Mortality (M&M) meetings, grand ward rounds, audit, complaints management, Critical incident reporting (IR1) and appraisal (as I was only employed in SHSCT for 7 months, this time was included in my first annual appraisal in Belfast Trust).

7.2. Any issues relating to clinical care, patient safety, administration and governance would have been raised with my Clinical Lead, Mr. Young. I do not recall ever having any such issues that I had to discuss with him.

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

8.1. I was a standard Consultant Urologist and did not feel that I had any higher level of governance responsibility which would have overlapped with my Clinical Lead, Clinical Director, Medical Director, Associate Medical Director, or the Head of Urology Service. I did feel that I could have raised any issues or concerns with my Clinical Lead or Service manager however this never occurred during my employment within SHSCT.

Urology services

9. **For the purposes of your tenure, in April 2008, the SHSCT published the *'Integrated Elective Access Protocol'*, the introduction of which set out the background purpose of the Protocol as follows:**

1.1 INTRODUCTION
1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients

and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices *(sic)* and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

During your time working in Urology services, was the *'Integrated Elective Access Protocol'* provided to you or its contents made known to you in any way by the SHSCT? If yes, how and by whom was this done? If not, how, if at all, were you made aware of your *role and responsibilities* as a Consultant urologist as *to how data should be collected, recorded and reported ... to establish good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists for the successful management of patients waiting for hospital treatment*?

9.1. I was aware of the Integrated Elective Access Protocol (hereafter 'IEAP'), most probably from Mr. Young and Martina Corrigan. I do not recall if I was ever given the full document or signposted to it on the Trust intranet. I was informed from an early part of my employment (Sept or Oct 2012) that the main focus of the IEAP in the urology unit was trying to decrease the waiting times for all patients so that the target times were met. As a new Consultant in a new post, on a practical basis this meant taking the longest waiters from other consultant's waiting lists and operating on them. I was aware of the importance of reducing waiting times and of ensuring no patients were waiting longer than the agreed target times for their planned out-patient review or surgical intervention.

Urology Services Inquiry

10. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits and guidelines, etc., within it) impact or inform your role generally as a Consultant urologist? How, if at all, were the time limits for Urology Services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

10.1. I believe the time limits of IEAP were closely monitored by the Unit's management team. There were regular email updates on the Urology unit's performance against the IEAP, usually from Martina Corrigan. Every month, there was a scheduling meeting to ensure all available theatre and/or diagnostic sessions were fully utilised. The IEAP progress would have been discussed as part of this meeting. As a new Consultant in a new post I did not have long wait patients. As a result, I regularly transferred long wait patients from Mr. Young, Mr O'Brien and Mr Akhtars' waiting lists to mine so that the targets could be reached. I, together with the other Urology Consultants, also worked Waiting List Initiative lists every Saturday to help decrease waiting times. If time limits were not met for individual patients, the Consultants would have received emails from Martina Corrigan asking if we were able to operate on them as soon as possible, even in circumstances where this was not by their original Consultant. I never considered my role or responsibility relating to how data was collected, recorded or reported as this all happened within the standard Trust pathways so it did not differ from my standard practice for all patients.

11. What, if any, performance indicators were used within the Urology unit during your tenure? If there were changes in performance indicators throughout your time there, please explain.

11.1. Waiting times were the only performance indicator that were regularly monitored that I am able recall. Complications would have been discussed during our monthly M&M meeting. All cancer cases would have been discussed at the weekly Cancer Multidisciplinary meeting (hereafter 'MDT'). There were no changes in performance indicators during my time.

12. Do you think the Urology services generally were adequately staffed and properly resourced throughout your tenure? If not, can you please expand noting the deficiencies as you saw them? Did you ever complain about inadequate staffing? If so, to whom, what did you say and what, if anything, was done?

12.1 The Urology Unit had just begun a period of expansion in 2012, having increased from 2 to 5 Consultants. It had also taken on responsibility for the Fermanagh catchment from the Western Trust. It was planning the rebuilding of the Thorndale Unit as a 'one-stop' Urology outpatient service. Given that this was a new role for me and that there were so many changes that were happening at that time, I did not have a full understanding of the staffing needs and/or resources which would be required to have a fully functioning independent Unit. In that regard, I would have been guided by the staff members who had been in the unit longer, primarily Mr. Michael Young and Mr. Aidan O'Brien.

12.2 There was good support to the Urology Consultants by the specialist nurses and general nursing team. I also felt that the administrative team (primarily Martina Corrigan) were very proactive in ensuring all theatre, scope lists and outpatient resources were utilised as much as possible. The theatre sessions dedicated to Urology did not increase in line with the consultants available. I believe there was an expectation that over time that more theatre lists would be offered to urology. I do not know if this happened.

12.3. I cannot recall raising any staffing or resource concerns during my time in SHSCT.

13. Were there periods of time when any staffing 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 such staffing challenges and vacancies within the unit managed and remedied?

13.1. I cannot specifically recall any staff vacancies during my employment within SHSCT.

14. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of Urology services? In your view, did staffing problems present a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples.

14.1. Not applicable. There were no staffing issues that I recall.

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

15.1. No.

16. Did your role change during your tenure? If so, did changes in your role impact on your ability to provide safe clinical care, minimise patient risk and practice good governance?

16.1. No, my role did not change during my employment tenure. I always felt that I was a safe Consultant Urologist who provided high quality care for my patients.

17. Explain your understanding as to how the Urology unit and Urology Services were and are supported by administrative staff during your tenure. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to you as a Consultant so that you may properly carry out your duties. Accordingly, please set out in full all assistance and support which you receive from administrative staff to help you to fulfil your role.

17.1. As a new Consultant, having just finished urology training, the administration of a service behind patient clinical care was a very new experience. A secretary, Noleen Elliott, was appointed to me and we quickly developed a good working relationship. The vast majority of my practice was administered between my secretary and me. I felt very well supported by Mr. Young (my clinical lead), the other consultants and by Martina Corrigan as my service manager. The monthly scheduling meeting made it very clear as to the expectation of my duties in the following month. I never had any concerns regarding my ability to fully fulfil my responsibilities as a Consultant or the support that I had in place via my secretary, Mr. Young and Martina Corrigan**.**

18. Did 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?

18.1. Each Consultant had their own secretary who administered the majority of their practice. There would have been arrangements for ‘cross cover’ when my secretary was on leave from the other secretaries in the unit. I do not know how the administration workload was monitored. I do not recall this ever being raised as an issue.

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19. Did all Consultants have access to the same administrative support? If not, why not?

19.1. Yes. As far as I am aware each Consultant had an allocated secretary.

20. Have you ever sought further administrative assistance? If so, what was the reason, whom did you ask and what was the response?

20.1. No. My secretary and I were always able to manage the administrative workload and no issues were ever raised.

21. Did administrative support staff ever raise any concerns 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 or anyone else did in response.

21.1. No**.**

22. Did you feel supported by the nursing and ancillary staff in the Unit? Please describe how and when you utilised nursing staff in the provision of clinical care for Urology patients. Did you consider that the nursing and ancillary staff complement available was sufficient to reduce risk and ensure patient safety?

22.1. Absolutely. The specialist nurses in the Thorndale Unit were very advanced in their practice and were also forward thinking and progressive with their ideas on how to improve things. The ward and theatre staff also worked very well together. It was a very exciting period of time for the unit. Even though there were a lot of changes, there was a very real expectation that the Unit would progress and modernise and, in my opinion, the nursing staff were invested in doing so. The nursing staff were happy to assist whenever needed. They also were keen to learn to develop their own skills. I recall that the Unit was trying to recruit new specialist nurses and to progress the nursing role into performing cystoscopies and prostate biopsies in 2012.

22.2. I do not recall that nursing staff vacancies were ever an issue regarding patient safety.

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23. Please set out your understanding of the role of the (a) specialist cancer nurse(s) and (b) Urology nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. How often and in what way did you engage with those nurses in your role as Consultant? Did you consider that the specialist cancer nurse, and all nurses within Urology, worked well with (Consultants? Did they communicate effectively and efficiently? If not, why not.

23.1. The Urology cancer nurses and Urology nurse specialists were very good and very helpful to me as a new Consultant. The Urology cancer nurses provided a support role to newly diagnosed and known cancer patients. They sat in with Consultant clinics and provided information and a point of contact for future concerns. They also planned much of the follow up and ensured that matters, such as scans, were performed and/or actioned. They were involved in the Unit and attended Cancer MDT. The nurse specialists provided a similar role for non-cancer patients. They participated in Male Lower Urinary Tract Symptom clinics doing flow rates and bladder scans. They arranged the Trial Removal of Catheters and taught Clean Intermittent Self-Catheterisation. They performed urodynamics alongside a Consultant. The specialist nurses were always available to assist in Thorndale Unit when I did clinics and prostate biopsies. I thought the whole nursing team communicated very well with the Consultant team.

24. What was your view of the working relationships between nursing and medical staff generally? If you had any concerns, did you speak to anyone and, if so, what was done?

24.1. As per my answers to Questions 22 and 23, I thought the nursing team in the Urology Unit of SHSCT were excellent. I thought there was an excellent relationship between the medical and nursing staff. I never identified any issues or concerns with the team nor were any ever raised with me about them.

25. What was your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient? If not, why not? Did you consider you had sufficient administrative support to fulfil your role? If no, please explain why, and whether you raised this issue with anyone (please name and provide full details).

25.1. As per my answers to Questions 17 and 22, I thought there were good relationships between individual Consultants and secretaries. I always felt I was able to communicate easily with my secretary and indeed, the whole

administrative team. I felt I had sufficient administrative support. I did not have any concerns**.**

26. As Consultant urologist, how did you assure yourself regarding patient risk and safety and clinical care in Urology Services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

26.1. As this was my first Consultant post (and I had not planned to stay in the Unit on a long term basis), I did not have a good grasp of the clinical governance structure and processes at the time. On appointment, I believed that the Trust governance structures were already in place and I was happy to fully engage with them. I was aware of the Unit's M&M meetings, grand ward rounds, audit meetings, complaints management, Critical incident reporting (IR1), risk register and MDT (and appraisal had I stayed longer). This provided me reassurance that patient safety and minimising risk were an important part of the unit's standard work.

27. Who was in overall charge of the day to day running of the Urology unit? To whom did that person answer? 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. Identify the person/role to whom you were answerable.

27.1. Mr. Young was my clinical lead. He was answerable to the Clinical Director, Mr Robin Brown the Associate Medical Director, Mr Eamon Mackle and the Medical Director, Dr John Simpson. Mrs. Martina Corrigan was the Head of Surgical Service. She was answerable to the the Assistant Directors, Mrs Heather Trouton, Assistant Director of Surgery and Elective Care, Mr Ronan Carroll Assistant Director of Cancer and Clinical Services and the Director of Acute Services, Dr Gillian Rankin.

28. During your tenure did medical managers and non-medical managers in Urology work well together? Whether your answer is yes or no, please explain with examples.

28.1**.** Yes, I thought they worked very well together. This was a time of great change in the Unit and there were regular meetings between the Consultants and Managers about restructuring and improving services which always appeared very productive to me. There was a monthly scheduling meeting chaired jointly with Mr. Young and Martina Corrigan and this was always very amicable and friendly.

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29. Was your role subject to a performance review or appraisal? If so, please explain how and by whom and refer to (or provide, if not provided by the Trust already) 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.

29.1. Yes. As a Consultant I was expected to take part in Annual Appraisal working towards revalidation (*the relevant document can be located at S21 60 of 2022 Attachments 1. DC.SHSCT.AppraisalData*) I successfully applied for another job in the Belfast Trust within a few months of starting in SHSCT and, as a result, was not subject to a formal appraisal during my tenure within SHSCT. However, Outpatient and admission data from my time in SHSCT was included in my first Annual Appraisal in Belfast Trust.

30. Were you involved in the review or appraisal of others? If yes, please provide details. Did you have any issues with your appraisals or any you were involved in for others? If so, please explain.

30.1. No.

Engagement with Urology staff

31. 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.

31.1. Thursday was a dedicated Governance day at the SHSCT's Urology Unit and other clinical duties were minimised on that day. This started with a Grand Ward round of all in-patients which was attended by all the Consultants, junior staff and ward nursing Sister. This involved each patient being presented by their Consultant and their clinical case, progress and future plan were discussed. This lasted approximately 2 to 3 hours. Afterwards, the whole team had a coffee break together. There was usually a lunchtime meeting, either to discuss service changes or scheduling, which lasted approximately 60 to 90 minutes. I do not believe minutes were taken for any of the above meetings. There was then Cancer MDT in the afternoon which lasted approximately 3 hours where a consensus plan was made and distributed to the consultant team but no formal minutes of discussions were taken.

31.2. There was also a weekly x-ray meeting (my recollection is that this occurred every Tuesday) which lasted one hour. Minutes were not taken however individual Consultants would have made a plan for their patients which were discussed. There was a monthly M&M audit meeting as part of the rolling audit calendar which lasted approximately 3 to 4 hours. I believe minutes were taken for the M&M meetings but I do not have access to any of these. SHSCT may have records from M&M meetings from that time.

Governance

32. During your tenure, who did you understand as overseeing 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?

32.1. I believe that I had individual responsibility for ensuring that I was providing good quality care for my patients. This would have been assured through the Trust governance structure such as IR1s, complaints, audit or M&M meetings and the risk register, for example. This would have been overseen by my clinical lead, Mr. Young, and my service manager Martina Corrigan. I do not recall any issues regarding the quality of care that I provided being raised during my time in SHSCT. I was never aware of any issue with any of the wider Urology service.

33. Who oversaw the clinical governance arrangements of the unit and how was this done? As Consultant urologist, how did you assure yourself that this was being done properly? How, if at all, were you as Consultant urologist provided with assurances regarding the quality of urology services?

33.1**.** As per my answer to Question 32, I believed that the clinical lead and service manager were responsible for overseeing the clinical governance arrangements of the unit. I am not aware of how this was undertaken, however, I assume that there were open lines of communication between Mr. Young and Martina Corrigan and that they had access to all of the governance data that the Trust obtained, such as IR1s, complaints, appraisal and the risk register.

33.2. I took personal responsibility for my practice and continued personal development. I ensured that I kept up to date and was aware of and followed current guidelines. I assumed other consultants did the same as this was expected as part of our annual appraisal. I never asked for, nor was I ever provided with, any assurances regarding the governance structure of the Urology Unit.

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34. How, if at all, did you inform or engage with performance metrics overseen in Urology? Who was responsible for overseeing performance metrics?

34.1. This was the immediate responsibility of Martina Corrigan as Head of Service. Bar waiting time data, and individual emails about long wait patients provided by Martina Corrigan, I do not recall ever seeing performance metrics for myself or the other members of the Urology team.

35. 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?

35.1. Patient risk and safety fell under the remit of the Trust clinical governance structures as outlined in my answer to Question 32.

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

36.1. As outlined within my answer to Question 32 I was not aware of any clinical governance issues nor did I have any concerns that any such issues would not have been dealt with or escalated appropriately.

37. How could issues of concern relating to Urology Services be brought to your attention or be brought to the attention of others? 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?

37.1. Issues of concern could be raised with me or others either by service users (for example patients, family members or carers) or by staff (either via IR1, complaints or whistleblowing policy). I was never aware of any issues during my time in SHSCT. I cannot comment on the efficacy of any of these systems as I was personally never involved with them.

38. Did those systems or processes change during your tenure? If so, how, by whom and why?

38.1. Not that I am aware of.

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39. How did you ensure that you were appraised of any concerns generally within or relating to Urology Services?

39.1. Had any issues been raised, I would have expected these to be discussed during the dedicated governance day (Thursday); either around the discussions during the Grand ward round, during the lunchtime meetings or during Cancer MDT. There were also ad-hoc meetings between the Consultant team to discuss the proposed service changes which would have provided a further opportunity for concerns to be raised. I never asked for, nor was I ever provided with, any assurances regarding the quality of Urological care under any consultant.

40. 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 (unless provided already by the Trust).

40.1. Not applicable. Any such concerns were not raised by me during my tenure, or by others, to the best of my knowledge and recollection.

41. What systems were in place for collecting patient data in Urology Services? How did those systems help identify concerns, if at all?

41.1 Data would have been automatically collected as part of each Consultants' Appraisal, for example, the number of elective or emergency admissions, the number of readmissions within 30 days, the number or rate of mortality, the number of patients seen at OPC with New Review ratio. I was never sent this data as I left the Trust before I did an Appraisal. I would have expected that this would also have included information on Complaints, IR1 and Serious Adverse Incidents (SAIs), as these data are routinely included in my Annual Appraisal in Belfast Trust. Data would also have been collected for M&M or audit meetings. These data should have been able to identify patterns of concern if these existed. Waiting time data was also regularly collected and presented to the Consultant team as part of IEAP.

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

42.1. I was unaware of these systems when I was in SHSCT. I only appreciated these data existed when I received information about my activity in Belfast Trust when I was working towards my first Annual Appraisal there. I never sought this level of information during my time in Southern Trust as I never had an Appraisal there. I cannot comment on any changes that may have happened.

43. During your tenure, how well do you think performance objectives were set for Consultant medical staff and for specialty teams within Urology Services? Please explain your answer by reference to any performance objectives relevant to Urology during your time (and identify the origin of those objectives), providing documentation (where it has not been provided already) or sign- posting the Inquiry to any relevant documentation.

43.1. I do not think that there were any clear performance objectives set out for each Consultant or for any team as a whole. There was an expectation that a Consultant would attend his/her planned sessions and that he/she would use his/her time to the best of their ability. There was also an expectation, via the scheduling meeting, that a Consultant would work flexibly to maximise the number of clinical or theatre sessions which were utilised by the unit as a whole. All of the Consultants engaged with this and worked in a similar way. I considered this as normal Consultant practice. There was an expectation that the unit as a whole would try to meet the IEAP waiting time targets, with the new consultants taking on long wait cases from the current consultants waiting lists.

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

44.1. I do not recall ever having a formal job planning meeting. There were a number of meetings and templates, regarding service changes, during my time in SHSCT which meant that the service did change frequently. I had an outline working week that I worked towards with flexibility built into cross-cover other Consultant sessions where necessary.

44.2. I was not subject to an Appraisal in SHSCT, as stated previously, and I am therefore unsure of how this would have impacted on my job planning or appraisal cycle.

45. 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 within Urology Services. Please

provide an explanation of that process during your tenure, including the name(s) and role of those involved, how issues were escalated (if at all) 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.

45.1. I did not raise any concerns. Had I had concerns, I would have raised them with Mr. Young initially. I would have expected that Martina Corrigan would also have been involved in the process of initially managing, investigating and resolving any issues. I do not have any examples or documentation regarding this.

46. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

46.1. Yes. I felt very supported by Mr. Young and Martina Corrigan. I always thought there was a good working relationship between them and that they would deal with any issues that I may have had effectively. They were both open to progressing the Unit and improving patient outcomes. For example, I introduced the operation of Supine Percutaneous Nephrolithotomy to Craigavon Area Hospital (having learned this technique in Australia). Mr. Young, Martina and the theatre staff were very helpful to me in starting and developing this new service.

Concerns regarding the Urology unit

47. The Inquiry is keen to understand how, if at all, you engaged with the following post-holders:-

(i) The Chief Executive(s);

I had no dealings with the Chief Executive at that time namely Mrs Mairead McAlinden.

(ii) the Medical Director(s);

I had no dealings with the Medical Director at that time namely Dr John Simpson.

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(iii) the Director(s) of Acute Services;

I had no dealings with the Director of Acute Services at that time namely Dr Gillian Rankin.

(iv) the Assistant Director(s);

I had no dealings with the Assistant Directors of Acute Services namely Mrs Heather Trouton (Assistant Director of Surgery and Elective Care) or Mr Ronan Carroll (Assistant Director of Cancer and Clinical Services).

(v) the Associate Medical Director;

I met the Associate Medical Director, Mr Eamon Mackle, before my Consultant interview. He advised me that if appointed I would have to move closer to Craigavon Area Hospital to cover on-call. This was not practical for me for family reasons and, as such, I knew even before accepting the job that I would not remain in Craigavon long term.

(vi) the Clinical Director;

I met with the Clinical Director, Mr. Robin Brown, on a few occasions and I corresponded with him via email around the restructuring of the Urology service and Consultant theatre rotas. I do not have any records or the times of these meetings. No concerns regarding other employees' performance (including Consultants' performance) were ever discussed.

(vii) the Clinical Lead;

The Clinical Lead, Mr. Michael Young would have been my first point of contact for any governance issue which arose. I always felt supported by Mr. Young and would have had no worries about raising concerns with him. However, I never had any concerns during my time in SHSCT.

(viii) the Head of Service;

The Head of Service, Mrs Martina Corrigan, would have been my second point of contact for any governance issue which arose. Again, I always felt that I worked well with her and I therefore would not have had any worries about raising concerns with her. However, I never had any concerns to raise during my time in SHSCT.

(ix) other Consultant Urologists.

The other Consultant Urologists were Mr. Aidan O'Brien, Mr. Tony Glackin, and Mr. Ajay Pahuja.

I trained with Mr. Glackin and Mr. Pahuja and I considered them to be my contemporaries. I would have been comfortable raising clinical concerns directly with them. Mr. O'Brien was my supervising Consultant both when I was a locum registrar in Craigavon (2004 to 2007) and when I started my higher training in Urology (Urology ST3, 2007 to 2008). I would not have felt comfortable going directly to Mr. O'Brien if I had concerns as he only knew me when I was very junior and inexperienced, and we did not have time to build a stronger relationship before I left. In any event, I did not have any concerns to raise.

I have no relevant documentation.

When answering this question please name the individual(s) who held each role during your tenure. When addressing this question you should appreciate that the Inquiry is interested to understand how you liaised with these post- holders 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 the concerns raised regarding Urology services which are the subject of this Inquiry. You should refer to all relevant documentation (and provide that documentation if not previously provided), dates of meetings, actions taken, etc.

48. Were any concerns ever raised regarding your clinical practice? If so, please provide details.

48.1. No.

49. Did you ever have cause for concern, or were concerns ever reported to you regarding:

(a) The clinical practice of any medical practitioner in Urology Services?

No.

(b) Patient safety in Urology Services?

No.

(c) Clinical governance in Urology Services?

No.

If the answer is yes to any of (a) – (c), please set out:

(i) **What concerns you had or if concerns were 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 action (if any) was planned in response to these concerns.**

(ii) **What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?**

(iii) **Whether, in your view, any of the concerns raised did or might have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If no steps were taken, explain why not.**

(iv) **Any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements? What was your involvement, if any?**

(v) **How you assured yourself that any systems and agreements put in place to address concerns were working as anticipated?**

(vi) **How, if you were given assurances by others, you tested those assurances?**

(vii) **Whether, in your view, the systems and agreements put in place to address concerns were successful?**

(viii) **If yes, by what performance indicators/data/metrics did you measure that success? If no particular measurement was used, please explain.**

50. Having regard to the issues of concern within Urology Services which were raised by you, with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether in your view these issues of concern were –

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(a) Properly identified

Not applicable.

(b) Their extent and impact assessed properly, and (c) The potential risk to patients properly considered?

Not applicable.

51. What, if any, support was provided to you and Urology staff by 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. (Q64 will ask about any support provided to Mr. O'Brien).

51.1. Not applicable. No concerns were identified during my time in SHSCT and, as such, I did not require any support.

52. Was the Urology Services offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

52.1. There was an expectation that each Consultant (or trainee) would undertake an audit or quality improvement project each year as part of their Personal Development or Appraisal. I do not recall if I actually did these when I was employed at SHSCT (as it was known that I was moving on from an early part of my employment). From memory, I believe that the Trust audit Department registered any audits that were happening and provided support if required.

Mr. O'Brien

53. If you ever became aware of concerns regarding Mr. O'Brien, in what context did you first become aware? What were those concerns and when and by whom were they first raised with you? Please provide any relevant documents if not already provided to the Inquiry. Do you now know how long these issues were in existence before coming to either your own or anyone else's attention? Please provide full details in your answer.

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53.1. I was not aware of any concerns regarding Mr. O'Brien when I was employed by SHSCT.

53.2. I first became aware of potential issues when I was speaking to Mr. O'Brien after he retired. I believe this was late July or early August, 2020. He informed me of his perceived poor treatment by SHSCT after his retirement (at the end of a telephone conversation about one of his SHSCT patients who he had planned to refer to BHSCT for a metallic stent (Personal Information redacted by the USI , HCN Personal Information redacted by the USI). Mr. O'Brien Personal Information redacted by the USI didn't want his care being delayed with his retirement. He was also aware that I had already been helping the patient understand his illness and make decisions regarding his treatment with Mr. O'Brien). He advised that he had a verbal agreement with SHSCT that he would return to work on a part time basis after his formal retirement. When he contacted SHSCT to arrange his return, he was advised that SHSCT did not want him to return to work as he had an outstanding grievance against the Trust management. He felt this was unlawful Irrelevant information redacted by the USI . Mr. O'Brien informed me that he believed that SHSCT began an investigation into his clinical practice after he brought an unfair dismissal claim against SHSCT.

54. 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 they were 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 which were known to you, please explain why you did not?

54.1. I was not aware of, nor did I raise, any concerns regarding Mr. O'Brien when I was employed by SHSCT.

55. As relevant, 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.

55.1. I was not involved in any discussions or meetings regarding concerns about Mr. O'Brien.

56. If applicable, 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.

56.1. Not applicable.

57. As Consultant urologist, did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? If so:

- **(i) In what way may concerns have impacted on patient care and safety?**
- **(ii) When did any concern in that regard first arise?**
- **(iii) What risk assessment, if any, did you undertake, to assess potential impact? and**
- **(iv) What, if any, 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?**

57.1. No concerns were raised nor was I aware of any issues with Mr. O'Brien when I was employed as a Consultant Urologist in SHSCT.

58. 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.

58.1. Not applicable.

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59. What, if any, metrics were used in monitoring and assessing the effectiveness of any agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before? Who was responsible for overseeing any agreed way forward, how was this done, where was record of the oversight recorded, and how long did this oversight last? Please include any documentation (unless already provided) and/or indicate where the Inquiry may find a record of any oversight.

59.1. Not applicable.

60. As relevant, 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? Are there records of you having assured yourself that systems and agreements put in place, to address concerns, were effective?

60.1. Not applicable.

61. 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?

61.1. Not applicable.

62. Did Mr O'Brien raise any concerns with you 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 if not with you, with whom), and when and in what context did he raise them?

62.1. I cannot recall the specific details, however, I do remember that Mr. O'Brien had long standing concerns regarding the perception or support of Urology by the General Surgical management in SHSCT. This would have been discussed informally during conversations at break times and during meetings with the whole consultant team about the restructuring of urology services. There were no specific patient safety concerns raised, it was more about the perception of and resource given to urology compared to other services. Specifically, I recall that he did not have a good relationship with Mr. Eamon Mackle (Associate Medical Director). I recall that Mr O'Brien felt that

Mr. Mackle did not take Urology seriously and would always make decisions that prioritised general surgery over Urology.

63. 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? How far would you expect those concerns to escalate through the chain of management?

63.1. I was unsure if this was a real concern or just a clash of personalities. I was never aware if this was actually raised as a formal concern by Mr. O'Brien. In any case, Urology has just expanded to 5 consultants and would have a far greater input in SHSCT and I would have expected these concerns to improve over time.

64. 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 options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1. I did not provide support as I did not feel that Mr. O'Brien needed formal support at that time. I was unaware if the Trust were aware of any concerns of Mr. O'Brien nor if any support was given to him.

65. 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, unless already provided. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

65.1. I am not aware if a formal concern / compliant was raised by Mr. O'Brien nor how this was managed, if so.

Learning

66. 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.

66.1. No, the only formal information that I am aware of surrounding the concerns raised about Mr. O'Brien relates to that which I have seen or read on

the news. I have specifically not spoken to Mr. O'Brien given the potential that I may have to give evidence during the USI.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within Urology Services and why?

67.1. When I started in the urology unit in SHSCT I felt it was a good Unit, with good working relationships between staff members including Consultants, trainees, nursing staff (both ward and nurse specialists), secretaries and unit managers. The Unit had significant backlogs and waiting times and this would have taken time and effort from all staff to organise and resolve. With the expansion of Consultant numbers and the upcoming rebuilding of a dedicated Urology 'one-stop' clinic, there was a lot of good will and excitement about the future of the unit. In the intervening years, I, and a number of other staff members, have moved on and I understand that there has been difficulties with recruiting and retaining fulltime staff. The SHCST have advertised on a number of occasions for substantive Consultant urologists and have not successfully appointed anyone. I suspect that this has led to increased pressure on the remaining staff and the services have become stretched and pressurised. I expect that this has likely led to worsening interpersonal relationships between individual Consultants, admin staff and management. It also leaves less time for the usual governance structures to work robustly. With COVID, these problems have exacerbated the underlying issues so that the service now has difficulty managing even its core work.

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

68. 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?

68.1. I am not fully aware of the issues that have been identified in the Urology unit regarding governance procedures and concerns about Mr. O'Brien specifically. I think there has been significant change in Governance structures in Belfast Trust in the past few years and I would expect that the learning from the Dr. Michael Watt inquiry would be shared amongst all Healthcare providers in Northern Ireland to promote these recommendations being implemented regionally.

69. 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.

69.1. I do not feel that I have the knowledge of all the events to be able to comment on this. In my view, all the issues which were subsequently identified and managed in SHSCT occurred after I had moved to Belfast Trust.

70. 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?

70.1. No. I do not believe that I made any mistakes in handling concerns at the time. I did not identify any significant concerns during my time in SHSCT, nor were any concerns ever raised with me by any other staff members.

70.2. In my time working with Mr. O'Brien, I found him to be very similar to other older Consultants that I had worked with during my training. He had a wealth of experience and was technically a very good surgeon. He was a good teacher and was very patient with trainees. His patients were very fond of him, even to the point where they preferred to see Mr O'Brien personally instead of other Consultants or trainees and they respected his opinion above all others. He did, however, have idiosyncrasies to his practice that I did not understand. As a new Consultant and having recently passed the FRCS (Urol) exit exam, I was very guideline and evidence focused and I practised as closely to what I had learned during my training as possible. Mr. O'Brien had changed his practice based on his experience and anecdotal cases.

70.3. For example, Mr O'Brien (and Mr. Young and Mr. Akhtar) used to regularly admit patients with recurrent urinary tract infections to the Urology ward for 5 to 7 days to be treated with intravenous antibiotics and fluids. I never saw this in any guideline but accepted that this was the standard practice in the unit, which predated my time. I felt that I was never going to change this practice in the short time that I was planning to stay in SHSCT but I was not going to practice in the same way. Similarly, he did not like using intravesical BCG therapy for high-risk non-muscle invasive bladder cancer and preferred Mitomycin therapy. I was informed (I do not recall if this was by Mr. O'Brien himself or someone else), that Mr. O'Brien had a patient soon after BCG was first introduced that developed a small capacity, poorly functioning bladder as a side effect of the BCG treatment and since that time, he did not like using BCG. I did not have this experience and continued to advise BCG for my patients. Over time, there may have been the opportunity for me to challenge some of the differences between our practices but I never felt that was a realistic prospect during my short tenure at Craigavon Area Hospital.

71. 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?

71.1. In hindsight I do not think the Governance arrangements were fit for purpose. I did not appreciate this at the time as this was my first consultant job and the processes in SHSCT appeared to be similar to other units I had worked in during my urology training. As a result, I did not raise this as a concern. As outlined in my answer to Question 67, this was my experience of all the Units I worked in during my Urology training and as a Consultant until the last 5 years or so. I have noted within Belfast Trust in the past 5 years that governance procedures have become far more formalised. The recording and documentation of issues, and the independent oversight of these has greatly improved. I suspect this relates to lessons learned from the Dr. Michael Watt case.

72. 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?

72.1. No.

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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.

Statement of Truth

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

Signed: [redacted] Personal Information redacted by the USI

Date: 1st August, 2022.