Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
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Mr. Andrew Anthony obo Mr. Aidan O'Brien
Tughans Solicitors
Marlborough House
30 Victoria Street
Belfast
BT1 3GG

23 August 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').

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 been sending Section 21 Notices, requiring the provision of evidence in the form of a written response, to individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference. I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

This Notice is issued to you in your capacity as legal representative to Mr. Aidan O'Brien, pursuant to the Inquiry's 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.

You will also find attached 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. The Schedule to the enclosed Section 21 Notice provides full detail as to the matters which should be covered in the written evidence which is required from Mr. O'Brien. As the text of the Section 21 Notice explains, Mr. O'Brien is 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, you have already responded to our earlier Section 21 Notice requesting documentation. However if Mr. O'Brien holds any additional documentation which you consider is of relevance to our work and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you to discuss what documents you have and whether they are covered by the Section 21 Notice.

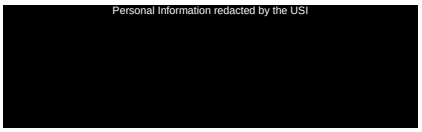
Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if Mr. O'Brien would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

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

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

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

Yours faithfully



Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 68 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: **Mr. Aidan O'Brien**
C/O Mr. Andrew Anthony
Tughans Solicitors
Marlborough House
30 Victoria Street
Belfast
BT1 3GG

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 **12 noon on 4th October 2022**.

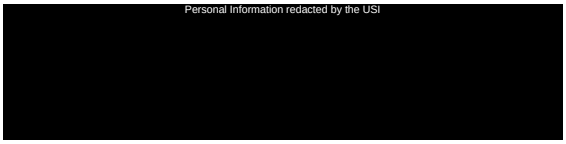
APPLICATION TO VARY OR REVOKE THE NOTICE

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 **12.00 noon on 27th September 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 23rd August 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 68 of 2022]

SECTION 1 – GENERAL NARRATIVE

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 your legal team. If documents you refer to have been provided, please state the relevant BATES number of the documents you reference, as applicable. If you are uncertain about what documents have been provided to the Inquiry please liaise with your 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. 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 and, as far as possible, to address your answers in a chronological format. 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.

SECTION 2 – YOUR ROLE

Your position(s) within the SHSCT

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

4. 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. If, for example, you were appointed to chair any standing committee or meeting or led on any project during your time in any post, it will be helpful to refer to this also.

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

6. With specific reference to the operation and governance of Urology Services, please set out your roles and responsibility and lines of management, both operational and clinical.

7. 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 Director, Medical Director, Associate Medical Director, and Head of Urology Service or with any other role which had governance responsibility.

SECTION 3 – BACKGROUND TO ESTABLISHMENT OF UROLOGY SERVICES WITHIN THE SOUTHERN TRUST AREA

Establishment of Urology Services within the Southern Trust Area.

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

Regional Review of Urology Services, Team South Implementation Plan

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

   I. What is your knowledge of and what was your involvement with this plan?
   II. How was it implemented, reviewed and its effectiveness assessed?
   III. What was your role, if any, in that process?
   IV. Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved. If not, please explain why not?

10. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems with, for example, a backlog of patients, persist following the setting up of the Urology unit? Please explain your answer.

SECTION 4 – UROLOGY SERVICES

Integrated Elective Access Protocol

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to you or disseminated in any way by you or anyone else to Urology Consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on your role as a Consultant urologist, and in the management, oversight and governance of Urology Services?

13. How, if at all, were the time limits for the provision of Urology Services to patients monitored as against the requirements of the Protocol? What action, if any, was taken (and by whom) if time limits were not met?

14. Were breaches of the *Protocol* by (i) you and/or (ii) others brought to your attention, or the attention of any other senior staff member, within Urology Services? If so, what, if anything was done to address this and by whom?

Performance indicators/Patient data

15. What systems were in place for collecting patient data in Urology Services?

16. What, if any, performance indicators were used within the Urology Department at the start of, and throughout, your employment? If there were changes in performance indicators throughout your time there, please explain.

17. In what way did you contribute to the performance metrics in Urology? Who was responsible for overseeing performance metrics and the quality of the service provided?

18. What is your view of the efficacy of those systems? How did those systems help identify concerns, if at all? Did those systems change over time and, if so, what were the changes?

Management

19. Who was in overall charge of the day to day running of the Urology unit? To whom did that person(s) answer? Give the names and job titles for each of the persons in charge of the overall day to day running of the Department and to whom that person answered throughout your tenure. Identify the person/role to whom you were answerable.

20. 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.

Staffing

21. Do you think the Urology Department and Urology Services generally were adequately staffed and properly resourced from the inception of the Urology Department and 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?

22. Were there periods of time when any staffing posts within the Department 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 Department managed and remedied?

23. 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.

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

25. 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?

Administrative support

26. Explain your understanding as to how the Urology Department 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 could properly carry out your duties. Accordingly, please set out in full all assistance and support which you received from administrative staff to help you to fulfil your role.

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

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

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

30. What is your view of the relationships between Urology Consultants and administrative staff, including secretaries? Were communication pathways effective and efficient in your experience? If not, why not? Did you consider

you had sufficient administrative support to fulfil your role? If no, please explain why, how this impacted on your practice, and whether you raised this issue with anyone (please name and provide full details).

31. 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.

32. Explain the nature of your working relationship with your Medical Secretary. What duties of an administrative or secretarial nature did she perform for you? Did you retain to yourself any duties which are typically performed by a Medical Secretary, and if so, please explain why?

Nursing and ancillary staff

33. 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 retain to yourself any duties which are typically performed by nursing staff or specialist nursing staff, and if so, please explain why?

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

35. Please set out your understanding of the role of the clinical nurse specialists, and explain how, if at all, they worked with you in the provision of clinical care. If you did not rely on their services, for example in consulting and engaging with patients, and in particular cancer patients, please explain why not.

36. Did you consider that the specialist cancer nurse, and all nurses within Urology, worked well with you and other Consultants? Did they communicate effectively and efficiently? If not, why not.

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

Engagement with Urology staff

38. Describe how you engaged with all staff within the unit, including the details of any daily, weekly, or monthly scheduled meetings with any Urology unit/Services staff, including fellow clinicians, and how long those meetings typically lasted. Please provide any minutes of such meetings.

39. 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 Head of Service;
(viii) the 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.

Multi-disciplinary meetings (MDMs)

40. Please explain how MDMs functioned and your view of their effectiveness.

41. How were decisions reached within MDMs? Was there a collective agreement that decisions made would be acted upon? Did these decisions dictate outcomes and next steps? Was there an opportunity within MDMs for differing views regarding patient next steps to be discussed and debated?

42. How are final decisions regarding patient next steps taken forward following MDMs and who, if anyone, actions and monitors those next steps? Who informs the patients of MDMs outcomes?

43. If a decision collectively agreed at MDM in relation to the next steps for a patient has to be altered following the MDM, was there a process to govern this? If yes, please explain the process, including how decisions to change agreed pathways may come to be altered post-meetings, and how, if at all, other MDT members are informed of this deviation.

44. Have you ever failed to implement a decision reached at MDM in relation to the treatment or care pathway of a patient? If so, provide full particulars of the case(s) concerned, explain the circumstances in which you failed to implement the decision, your reasons for so doing and explain the process which you followed.

Patient risk/safety

45. As a 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?

Performance review and objectives /Appraisal/Job planning

46. Was your role subject to a performance review or appraisal? If so, please explain how and by whom you were appraised and refer to (or provide, if not provided already) any relevant documentation including details of the agreed objectives for your role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

47. 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.

48. 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.

49. Did your job plan accurately reflect your role? If not, please set out why not. What, if any, impact do you consider discrepancies between your job plan and your role had, or may have had, on patient safety, risk management, or on governance generally?

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

Practice standards and continued development

51. Please identify all relevant professional standards and guidance, including domestic, national and international standards and guidance which were applicable to urology and within which you were required to operate and comply.

52. How did these standards and guidance inform your practice?

53. How, if at all, did you maintain your standards of professional practice on an ongoing basis? Please explain your answers, and include an explanation as to how you kept up to date with any new guidance, protocols, standards, etc relevant to your clinical practice and general practice management.

Quality improvement initiatives

54. Were you, or Urology Services generally offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

Other roles

55. Please detail any other positions relevant to your role as a Consultant urologist which you held during your tenure and how they informed or impacted upon your clinical and general practice management.

SECTION 5 – GOVERNANCE

Governance

56. Who oversaw the clinical governance arrangements of the Urology Department and how was this done? What is your view of the overall effectiveness of those arrangements? Please explain and refer to documents relating to any procedures, processes or systems in place on which you rely in your answer, and provide any documents referred to (unless provided already to the Inquiry).

57. How did you ensure yourself 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?

58. How could issues of concern relating to Urology Services be brought to your attention as Consultant 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?

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

60. Was it your understanding that governance concerns would be recorded, acted upon and monitored? If so, identify by name/post the person(s) who you would have expected to act upon and monitor governance concerns.

61. What is your understanding as to how, if at all, any concerns raised or identified by you or others were reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? As applicable, please provide any documents referred to (unless provided already). If there is correspondence reflecting any governance concerns which you or others may have held, please refer to it. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why you think they were not.

SECTION 6 – CONCERNS

Process for addressing concerns - generally

62. 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 your understanding 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.

Concerns about the practice of others

63. 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 or others had and if these concerns were raised with you by others, 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 relevant personnel, 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 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.

64. Having regard to any issues of concern regarding others within Urology Services which were raised by you or which you were aware of, including patient safety and clinical governance issues, explain (giving reasons for your answer) whether in your view these issues of concern -

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

65. 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.

Concerns regarding your practice

66. Please set out any concerns raised regarding your practice during your tenure as Consultant urologist. In relation to each concern describe the main communications, meetings and attendees, actions taken by you and others in response, any monitoring and support provided by the Trust or others and the outcome to the concern raised. The information you provide

in this section should include, but need not necessarily be limited to, detail of when and in what context you first become aware there were any concerns regarding your practice, what the issues of concern were, when were they first raised with you, and who raised them? Your answer should include your views on the response by the Trust, the support, guidance and monitoring you received and your view on the effectiveness of those actions. From documentation currently available to the Inquiry, concerns raised regarding your practice appear to have focused on the following areas. While you are free to raise any issue, please ensure your answer provides all relevant details in respect of the following specific areas:

(i) The admission of patients for administration of IV antibiotics and IV fluids in association with the management of UTIs (in and around 2009 or at any other time)
(ii) The performance of benign cystectomies
(iii) Disposal of hospital notes in a bin
(iv) Patient records kept at your home, office and car
(v) GP referral letters kept in your office filing cabinet
(vi) Non-triage of patients
(vii) Non-dictation after clinics and day procedures
(viii) Not adding patients to the Patient Administrative System (PAS)
(ix) Carrying out your own booking and scheduling of patients
(x) Booking private patients for procedures ahead of NHS patients
(xi) Failure to provide oncology patients access to Clinical Nurse Specialists
(xii) Not following up on results
(xiii) Prescribing bicalutamide outside of licensed usage/dosage/recommended guidance
(xiv) Actions not being followed through/Actions being changed following multi-disciplinary meetings, contrary to decisions reached at those meetings

67. Did you or do you now consider that any of the concerns raised regarding your practice may have or did impact on patient care and safety?

68. If your answer to Q67 is no, please explain why.

69. If your answer to Q67 is yes:

(i) In what way could or did those concerns impact on patient care and safety?
(ii) What risk assessment, if any, did you undertake, to assess potential impact on patient safety and risk? and
(iii) 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?

Processes to address concerns during your tenure

70. Did you participate in any agreements or processes designed to address concerns raised against you? If yes, describe those processes or agreements, how they worked, whether your practice changed as a result, and with what effect? What, in your view, could have been done differently?

71. Did you deviate from any agreed action plans or agreed arrangements to improve your practice in response to concerns, and, if so, when and why?

Reoccurrence

72. To the extent that any of the issues at Q66 (i) - (xiv) reoccurred during your tenure, please explain why in your view this occurred and what, if anything, could have been done to prevent this reoccurrence?

Support

73. In broad terms, did you feel generally supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

74. What support was provided to you by the Trust given the concerns identified by you and others? Were you offered and did you utilise support options, for example, Human Resources assistance, administrative assistance, Occupational Health and CareCall? If yes, please explain in full. If not, please explain why not and whether you now consider that those support mechanisms may have assisted you in addressing concerns and reducing the possibility for reoccurrences and relapses in agreed plans?

SECTION 7 – SUBSEQUENT PROCESSES

MHPS

75. The Inquiry is aware from documentation provided by you of your engagement with the Trust's MHPS investigation in respect of aspects of your practice, and the information provided by you to that investigation [**AOB-10585-10689**]. It is also aware from your grievance documentation of the views expressed by you in response to that MHPS investigation and its findings. Without repeating the contents of those documents, provide any additional comment which you would wish to make about the MHPS process and its findings.

Serious Adverse Incidents (x3) – 2017

76. The Inquiry is aware from documentation provided by you of the submissions you provided to the Trust in response to the Serious Adverse Incident investigations, namely SAI Personal information redacted by USI SAI Personal information redacted by and SAI Personal information redacted by [Found at: **AOB-03494**, **AOB-01386-01394** and **AOB-02284-02289**].

Without repeating the contents of those documents provide any additional comment you would wish to make in relation to those investigations and their findings.

77. Do you consider that any processes undertaken by the Trust did or could assist in identifying core issues for learning to prevent or limit the reoccurrence of the concerns identified? If not, what, in your view, would be the most effective way of responding to the concerns raised about you so as to minimise patient risk and maximise patient safety?

Early Alert Notice 2020

78. Please comment on the issues underpinning the Trust's decision to send the 'Early Alert' notification to the Department in August 2020 [**DOH-00666**].

Serious Adverse Incidents (x9) - 2020

79. The Inquiry has been provided with details of the 9 *Serious Adverse Incidents* investigations carried out in 2020, provided to you in May 2021 [**AOB-61133**]. Please comment on the findings contained in the SAI investigation reports where they concern your acts/omissions and practice.

Recent *Lookback Review*

80. The Inquiry is aware that a further Lookback Review has been undertaken since your retirement, and a subsequent SCRR process is being carried out. Can you confirm whether or not you have been asked to contribute to that process and, as far as you are able, provide your views on it?

SECTION 8 – THE TRUST BOARD

Trust Board

81. Please detail all interactions you had with any Trust Board member, including the Chair, Roberta Brownlee, relating to or touching upon any of the concerns raised about your practice. This should include full details of all contact between you and any Board members at any time, and under any circumstances, in which the concerns regarding your practice or engagement with any Trust personnel touching upon those concerns, was referenced at all or discussed. What was the purpose of any such engagement?

82. Did you at any time, whether personally or through others, seek the involvement or help of any Board member, including Roberta Brownlee, in relation to the concerns raised about your practice and/or how you were being treated by other personnel in the Trust? Whether you or others sought involvement or help, are you aware of any involvement or help being provided on your behalf by any Board member?

SECTION 9 – LEARNING

Learning

83. Having had the opportunity to reflect, do you have an explanation as to what went wrong within your practice that enabled concerns to arise? Do you consider you made mistakes in your practice and clinical management? If yes, please explain. If not, why not?

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

85. 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?

86. What do you consider the learning to have been from a governance perspective regarding those concerns?

87. 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?

88. 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

Note: Addendum No.1 amending this statement was received by the Inquiry on 31 July 2023 and can be found at WIT-98807 to WIT-98808. Addendum No.2 was received by the Inquiry on 28 March 2024 and can be found at WIT-107564 to WIT-107623. Annotated by the Urology Services Inquiry.

USI Ref: Notice 68 of 2022

Date of Notice: 23 August 2022

Witness Statement of: MR AIDAN O'BRIEN

I, Aidan O'Brien, will say as follows:-

Section 1 – General Narrative (Q 1-2)

1. I am providing this response to the Section 21 Notice (hereinafter "the Notice") doing my best at this time to provide information that will assist the Inquiry to investigate the matters referred to in its Terms of Reference. As the Section 21 Notice is divided into various subject areas, I shall provide my response in relation to each of those areas, insofar as I can. If there are any areas which the Inquiry considers I can provide greater clarity in relation to, I shall be happy to provide such further information that I can on request.

2. The Inquiry will be aware that I have received approximately 217,000 pages of disclosure between late May and mid-August. Neither I, nor my legal team, have been able to consider all the documentation disclosed. Apart from the volume of information to collate, I was also served with Patient Hearing Bundles for hearings taking place in September which related to patients that I had treated, and which included patient records, accounts from patients and/or relatives of the treatment provided and, in addition, correspondence from the Southern Health and Social Care Trust (the "Trust") management and in one case records relating to a Structured Clinical Record Review (SCRR). I obviously needed to consider all of that material, prepare for and attend the patient hearings themselves as well as try and continue to consider the vast amount of material disclosed. Therefore, there

will undoubtedly be relevant documents which have been disclosed that I have not considered as yet. This has two inevitable consequences. First, I have not been able to cross reference such documents, where relevant, to the various paragraphs set out in the response below. Second, I have not had the opportunity to refresh my memory from all of the documentation. As such, it may be necessary for me to clarify, expand upon, or correct, material below following consideration of all the relevant documentation and/or to cross reference to further documents at a later stage. I have nevertheless endeavoured to provide as fulsome a response as I have been able to.

3. Due to the wide range of areas the Notice covers I have referred, in response to certain Questions to chronologies which my legal team and I have developed in order to assist the Inquiry in cross referencing relevant documents. The chronologies are not comprehensive as my team and I have been unable to consider all documentation disclosed to date. The chronologies were initially developed for the purpose of assisting me in providing instructions, rather than with a view to being provided to the Inquiry and were generally developed prior to receipt of the Section 21 Notice. Due to the pressure of time in responding to the Section 21 Notice it has not been possible to re-read and check for accuracy the various documents the chronologies refer to. Therefore, I would ask that where the chronology refers to a particular document (such as an email, or a minute of a meeting) the Inquiry reads in full the relevant entry in the corresponding document (email / minute of meeting etc) rather than relying entirely on partial quotes or summaries of documents as set out in the chronologies. These were tools to assist myself and the legal team working with me to navigate through the documentation, are very much a work in progress, and were not intended to be served upon the Inquiry. However, to assist me in providing as comprehensive a response as possible I have provided the below mentioned chronologies, which in turn it is hoped will assist in drawing the Inquiry's attention to relevant matters referred to in the Notice.

4. As a general observation there are a substantial number of Questions where other postholders / individuals will be better placed to answer than me, and I will indicate

on a question-by-question basis where that arises. Otherwise, I respond to Question 1 as set out below.

5. Given the sheer breadth of Question 1 it is almost impossible to provide a comprehensive narrative addressing all issues identified. The issues are therefore addressed in response to the subject-by-subject requests which follow in the Notice in Sections 2-9. However, I thought it would be helpful to set some context in these opening comments. From the material which is already in the possession of the Inquiry, some of which is referred to below, it will hopefully be apparent that a central issue which the Inquiry should consider is the resourcing and management of the working environment at the Trust, throughout my tenure.

6. However, before I set out that general background, I do wish to refer to an overarching matter which is fundamental to the chain of events that culminated in this Inquiry. I have significant concerns in relation to information that was provided to the Minister and/or Department of Health prior to the announcement of the Inquiry on 24 November 2020, and which appears in a number of witness statements, including that of Dr Maria O'Kane at WIT-04474. On 24 November 2020 Mr Robin Swann MLA the Minister of Health, made a statement to the Northern Ireland Assembly, which included the following:

   "On 31st July 2020 the Southern Trust contacted my Department to report an Early Alert concerning the clinical practice of this consultant. The Trust informed my Department that on the 7th June 2020 it became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of the consultant urologist employed by the Trust. The Trust became aware that 2 out of 10 patients listed for surgery under the care of this consultant were not on the hospital's Patient Administration System at that time".

7. That statement appears to arise from a letter sent by Mr Mark Haynes to me on 11 July 2020 [AOB-02534 - AOB-02536] where he wrote the following:

   "On 7th June 2020 at 22.25, you sent an email which was copied to me, in

which you explained that you had added 10 patients to the Trust's list for urgent admission. On my initial review of the list of patients in my capacity as AMD [Associate Medical Director], I noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring Removal / Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy.

It appeared to me that these patients had been assessed on the dates given by you, but the outcomes of these assessments did not appear to have been actioned by you as required with the patients being added to the inpatient waiting list on the Trust's Patient Administration System. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risk attendant on that.

Since this has come to light, the Trust has been seeking as a matter of urgency to establish the position in relation to these 2 specific patients and also to clarify whether any other patients are similarly affected. A review of records back to January 2019 has been undertaken."

8. It has been stated that I sent an email to Mr Mark Haynes on 7 June 2020 regarding placing 10 patients on an operative list which alerted Mr Haynes to the "*awareness that 2 of the patients named had not been contained as should have been on the patient information system…"* [WIT-04474]. I have been able to identify the two patients that Mr Haynes referred to as Mr Patient 105 and Mr Patient 104. I have disclosed relevant records in respect of each of these patients at AOB-37001 to AOB-37035 for Patient 105, and AOB-37036 to AOB-37067 for Patient 104.

9. As is clear from the documentation provided by me in respect of these patients, they were both added to the waiting list on the Patient Administration System for readmission as inpatients under my care at the appropriate times: 11 September 2019 in respect of Patient 105, and 11 February 2020 in respect of Patient 104.

10. In respect of Mr Patient 105, I emailed my secretary Noleen Elliot on 11 September 2019 [AOB-37001] and the subject of the email is stated as "Patient 105 Personal Information redacted by the USI". In that email, I wrote:

> *"This man had incomplete fragmentation of a right ureteric stone and right ureteric stenting yesterday evening.*
> *He may be going home today.*
> *Please place him on CURWL for:*
> *Removal / Replacement of Stent and Right Ureteroscopic Laser Lithotripsy*
> *Urgency 2*
> *Date of entry: 11 September 2019"*

11. The abbreviation 'CURWL' is the code for my inpatient waiting list. This patient was then placed on my waiting list on the Patient Administration System on that date. A copy of the inpatient waiting list from 27 September 2019 is included at AOB-37002 which confirms that he was entered on the waiting list on 11 September 2019.

12. In relation to Mr Patient 104, I initially arranged for his admission to Craigavon Area Hospital on 8 January 2020 for endoscopic management. This did not take place due to industrial action. The admission was ultimately rescheduled for 11 February 2020. It was not possible to gain ureteroscopic access to the large stone located at the right renal outlet due to relative stenosis of the lower right ureter. For that reason, the right ureter was stented. The patient had an uncomplicated recovery following the procedure, which was performed under general anaesthesia, and was discharged later that day. Nevertheless, he attended the Emergency Department at South West Acute Hospital ("SWAH") on 14 February 2020 due to increased right loin and flank pain. Further CT scanning confirmed that the right ureteric stent was in a satisfactory position, and that stenting has caused the large stone to migrate to the lower pole of the right kidney.

13. The ward clerk of the Elective Admissions Ward, Veronica Baird, sent an email to

my secretary on 12 February 2020 at 13:32 [AOB-37041] to request that the patient be placed on my inpatient waiting list for readmission in 4 – 6 weeks for "*URS/Furs/Laszer lithotripsy"*. The terminology used has been the vernacular for "*Rigid / Flexible Ureteroscopic Laser Lithotripsy*". The patient was placed on the waiting list that day, with effect from 11 February 2020. This is shown by the copy of my inpatient waiting list for the week commencing 6 May 2020, which is found at AOB-37045.

14. In addition to the above, which clearly shows that the patients were appropriately added to the waiting lists well in advance of June 2020, I wrote by email to Mark Haynes on 11 April 2020 and requested that Mr Patient 104 be electively admitted during the week commencing Monday 20 April 2020 for Removal / Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy [AOB-37043]. I further emailed Mr Anthony Glackin on 2 June 2020 to advise of 5 patients who would be suitable for admission on the week commencing 8 June 2020. Mr Patient 104 was among the patients on that list. That email specified his "*Date on W/L*" as 11 February 2020. Mark Haynes was copied into that email.

15. Mr. Haynes replied to me by email on 3 June 2020 [AOB-37049], advising that he had highlighted the names of three of the five patients whom I had nominated, and whom he believed were suitable for admission to the Ulster Independent Clinic. Mr Patient 104. was one of the three patients whom he had highlighted. Details pertaining to Mr Patient 104., including the date of his entry on my waiting list (11 February 2020) are included in the highlighted spreadsheet.

16. On 4 June 2020, I submitted a list of 10 patients whose admissions were to be arranged. This was done by email to Anthony Glackin and copied to Mark Haynes [AOB-37053]. This list included Mr Patient 104 and Mr Patient 105.

17. As is clearly established by the above, both of the patients to whom Mr. Haynes referred in his letter of 11 July 2020 were definitely placed on my inpatient waiting list at the appropriate times: on 11 September 2019 in the case of Mr Patient 105,

and on 11 February 2020 in the case of Mr Patient 104. Not only is it indisputably so, but there is also much documentation arising from and in further support of both patients being on my waiting list from the appropriate time. Moreover, Mr Haynes was aware of both patients being on the waiting list for admission at various times prior to my email of 7 June 2020.

18. I therefore fail to understand how it could have appeared to Mr. Haynes that these two patients had not been added to the inpatient waiting list when it was plainly evident that both had been. I further find it concerning that it appears that Mr Haynes' misplaced, claimed concern in respect of these patients was the basis in his 11 July 2020 letter for "*a review of records back to January 2019*".

19. It appears that the very trigger for a look back exercise of all of my patients to January 2019 was the totally untrue assertions in this letter about two patients who had been placed on the inpatient waiting list on the Patient Administration System in the ordinary way and which any competent and impartial consideration of the medical records and correspondence held by the Trust would have revealed.

20. It is of further concern that this untrue assertion should have led the Minister of Health to misinform the Northern Ireland Assembly in his Ministerial Statement on 24 November 2020.

21. Throughout my tenure the greatest threat to patient safety in providing safe care to urological patients was due to the inadequacy of the service provided by the Trust.

22. I first became aware of the comparative inadequacy of urological consultant staffing in Northern Ireland when co-opted onto the Council of the Irish Society of Urology for the years 1990-9. I learned that the Republic of Ireland, with a consultant / population ratio of 1:240,000, having 15 consultant urologists, had an inadequate staffing complement compared to the UK which had a consultant /

population ratio of approximately 1:180,000. I was shocked to appreciate that Northern Ireland, having 5 consultants, had a consultant urologist / population ratio of 1:300,000, the worst in these islands.

23. In April 1991, I received a telephone call from Mr Ivan Stirling, then a consultant general surgeon at Craigavon Area Hospital, to advise me that his general surgical colleague, Mr Graham, was due to retire on 30 June 1992, that he had provided a urological service for a number of years, and that he and his colleagues had been giving consideration as to whether he should be replaced by a general surgeon or by a urologist. He asked for my view. With the above insight into the inadequacy of specialist urological services in Northern Ireland, I proffered my view that his colleague should be replaced by both a consultant general surgeon *and* a consultant urologist.

24. I was scheduled to complete Higher Professional Training in Urology on 30 June 1991, and I had been successful in being appointed a Clinical Fellow in Paediatric Urology at the Bristol Royal Hospital for Children, commencing 1 September 1991. As Mr Graham was retiring, leaving 77 patients on a list awaiting admission for TURP, I was asked whether it would be possible for me to undertake some of these patients' operations. I agreed and completed all 77 TURPs in seven weeks.

25. I was then offered the possibility of remaining at Craigavon Area Hospital as a Locum consultant urologist, with the prospect of being appointed a consultant urologist, if approval for such a post could be secured. I declined as I was keen to go to Bristol and had given an undertaking that I would do so. I was asked by Mr John Templeton, then the Chief Executive, if I would assure him that I would apply for the post of consultant urologist if approval were secured. He explained that he would not be prepared to go out on a limb to secure approval without a guarantee of having one appointable person apply if successful. I gave him that undertaking, though I could not understand how or why it could be so difficult to secure approval for the post.

26. I did suspect, indeed anticipated, that there would be opposition from the

Department of Urology at Belfast City Hospital as its monopoly over specialist urological services would be dented. However, I did not anticipate that the dominant opposition to the approval of a post would come from the Director of Public Health of the Southern Health & Social Services Board, who did not believe that there was a need for even one consultant urologist, even though it had a resident population of approximately 269,000 at that time. It took a further eight months to convince her otherwise. I duly applied for the post, was competitively interviewed on 11 June 1992 and took up the post as a consultant urologist at the Trust on 6 July 1992.

27. I have related the above experience to identify at least one of the several putative reasons for the inadequacy of staffing and of resources that persisted throughout my tenure as a consultant urologist during the subsequent 28 years. I believe that there are others. I believe that there was a reluctance by others to acknowledge that there was an endemic need which would be best served by a specialty separate from and independent of the generalists who previously provided that service, coupled with their resentment of and resistance to the diversion of resources previously allocated to them. Secondly, I have remained convinced throughout my career that the inadequate commissioning, staffing and resourcing cannot be dissociated from the fact that approximately 70% of adult urological patients are male.

28. Nevertheless, the foundation upon which the Department and Service was initiated was one of a lack of awareness of the urological need which was not serviced, and particularly by those who should have known otherwise. I was immediately concerned that the provision of a service, no matter how inadequate, would result in the transformation of urological need into demand, and that the demand would always exceed the capacity of the service to provide effectively and safely for it. I believe that has been the destiny which has plagued the urological services provided by the Trust since 1992.

29. My concerns were reinforced by the accumulation of data from the 22-member, associate member and affiliated member countries of the European Board of

Urology in 1998 which found that the mean urologist / population ratio was 1:36,654, ranging from 1:15,150 to 1:184,210, as reported in 2000 (The European Board of Urology Survey of Current Urological Manpower, Training and Practice in Europe. E.A.Kiely. BJU International (2000) 85, 8-13) [see supplemental October bundle pages 35 - 41].

30. In providing this response to Questions 21 to 25 of the Notice, comprising the section entitled 'Staffing', I wish to avail of the opportunity to address the issue which, as I have already indicated, I believe has been, overwhelmingly, the fundamental, underlying cause of all that was wrong with the Urology Service, of all that did go wrong and of all that could have gone wrong, were it not for the commitment and efforts of those charged with the provision of it. That issue has been its inadequacy since 1992. I will endeavour in this and subsequent sections of the Notice to outline to the best of my ability and recall, within the time allotted to me, how the inadequate capacity of the service has impacted its various aspects and components, its consequences, how the latter have affected those providing the service, and most importantly, those dependent upon it for their well-being. In doing so I will endeavour to make reference to data and documentation which I consider the Inquiry may find to be of relevance. However, as the Inquiry may appreciate, I have not had adequate time to review more than a small proportion of the documentation disclosed by the Inquiry.

31. I have related in other documentation provided to the Inquiry and to which I have referred in my response to Question 8 of this Notice the difficulties and challenges I experienced in establishing the Department and the Service it provided. The deficiencies were to be seen and experienced in every respect. The Service was provided by one consultant from July 1992 until January 1996. I was assisted by a share of one of the surgical registrars until August 1993. I was then allocated that registrar until July 1994. I was then successful in having his work visa extended for a further year by having him appointed as a clinical research fellow until July 1995. This post was designed to enable him to provide a clinical service limited to two to three days per week, while having a minimum of two days of protected time for research. The clinical service provided justified the Trust

providing him with a salary. While his research was of a clinical nature, the need to fund the research of Fellows who followed him gave rise to the founding of Craigavon Urological Research Education (CURE) in 1996. I was fortunate to have him replaced in August 1995 by another registrar. Prior to a second consultant urologist taking up his post in January 1996, I additionally had the shared support of a senior house officer as well as Junior House Officers. Following the appointment of a second consultant urologist, Mr Wahid Baluch, we continued to have the support of the same complement of junior medical staff. Mr Baluch left in December 1997, leaving a hiatus for a period of four months until his replacement by Mr Michael Young in May 1998, who remained in post until termination of my employment in July 2020. As a consequence of an increase in the number of specialist registrars in urology in Northern Ireland, the Department was accredited for specialist registrar training, resulting in the Department having a specialist registrar from 1998/9, in addition to a registrar.

32. Until the appointment of a second consultant, I provided a continuous, acute urological service while taking infrequent breaks from elective care. The major constraints during that time, which persisted following the appointment of a second consultant, were the inadequacy of operating sessions and of inpatient beds allocated to the Service. While I was initially allocated four inpatient beds, those occupied by urological patients unavoidably increased in number, not least as a consequence of acute admissions. The greater constraint was the initial allocation of two operating sessions per week, incrementally increasing to four per week, with the additional availability of one or two more sessions vacated on occasion by other users when on leave. At that time, Craigavon Area Hospital had a total of only four operating theatres available to all users, and emergency surgery was undertaken out of hours, unless critically urgent, in which case it displaced elective surgery. Therefore, the appointment of a second consultant could not be accompanied by a commensurate increase in urological operating capacity.

33. The establishment of the Department and Urological Service in the 1990s could not have been achieved to the extent that it was, irrespective of its inadequacy,

without the support of a number of persons, particularly the Ward Manager, Ms Eileen O'Hagan, and the Chief Executive of Craigavon Area Hospital Group Trust, Mr John Templeton. Eileen O'Hagan's dynamic enthusiasm for the development of safe, structured management of inpatients by nursing staff, and her concurrent support of nurse education and of development of specialist training of nursing staff, were critical. Her status in this regard was reflected in her being the first person from Northern Ireland to be appointed to the Council of the British Association of Urological Nurses (BAUN). She tragically died prematurely in 2001, but her contribution to urological nursing was such that she remains memorialised by BAUN's highest honour, to be invited to deliver the Eileen O'Hagan Memorial Lecture at its Annual Conference ever since.

34. I have no doubt that there would not have been a consultant urologist appointed in 1992 had it not been for John Templeton. He was generously supportive of the development of the Department and Service during subsequent years. Though out of service provision necessity, he was persuaded to fund the appointments of clinical research fellows, provided the research was funded by CURE, the founding of which he also supported. It was no mean achievement, with his undented support, to have a Dornier MPL Lithotripter purchased in 1998 and to have the Stone Treatment Centre opened later that year, since when it has remained the only fixed, on-site, such facility in Northern Ireland. With the capability of providing Extracorporeal Shock Wave Lithotripsy (ESWL) under general anaesthesia, if required, it additionally provides the Paediatric ESWL service for Northern Ireland.

35. Mr Templeton was equally supportive of the joint appointment of Mr Jerome Marley to the post of Lecturer Practitioner in Urological Nursing at the University of Ulster. That appointment led to academically accredited modules in urological nursing at undergraduate and postgraduate levels, being gained by international students by remote e-learning which was pioneered by his appointment. Jerome replaced Eileen O'Hagan on the Council of BAUN and was President of BAUN from 2004 to 2006. He was a founding member of the European Association of Urology in 2000 and launched the International Journal of Urological Nursing in

2006, becoming its editor in chief. One of my proudest moments was to present John on his retirement with the first edition of the International Journal of Urological Nursing.

36. Nevertheless, alongside those early successes, the provision of the service was predictably accompanied by an annual increase in demand which could not be met with adequacy and safety. As Mr Templeton was the Chief Executive of Craigavon Area Hospital Group Trust, which was significantly smaller than the much larger Southern Health & Social Care Trust into which it would later be consumed, he was much more accessible then. I met with him regularly, once or twice each year, to share my concerns regarding patient safety and the risks of their coming to harm. However, over the years, the concerns remained unchanged, having not been addressed and resolved. It proved to be a frustrating process. It gave rise to a sense of fatigue and disillusionment with regard to raising concerns. I did often wonder whether repeatedly raising the same concerns which were not resolved made it even more difficult for them to be resolved. Upon subsequent reflection and with the benefit of insight from others, I came to appreciate that the support given had certainly been met with resentment and resistance from other specialties and had probably already exceeded the support considered appropriate by the commissioning authorities. Irrespective of the reasons, I was certainly left with the belief by the end of the 1990s that raising concerns was no longer productive.

37. Lack of access to adequate operating theatre sessions remained the dominant constraint in the delivery of an adequate, safe service to those in most need of it. In the late 1990s, I had more than twenty patients waiting longer than their intended readmission times for endoscopic resection of recurrent bladder tumours, or for cystoscopy and resection of recurrence or bladder mucosal biopsies. At a monthly meeting of the Surgical Directorate, I requested all theatre users to each give me one of their operating sessions, once only, to facilitate my being able to clear that backlog about which I shared my concerns, but my request was not positively received. I then wrote to the Clinical Director requesting that he address the issue, but I did not receive a reply or response of any kind. I then

wrote to the Medical Director expressing my concerns but did not receive a reply. I then wrote to the Chief Executive, but again did not receive a reply or response of any kind. My concerns regarding these patients were not addressed and resolved.

38. One of these patients was a man of approximately fifty years of age who had been referred with haematuria. He was found to have a single, small bladder tumour which was completely resected. It was found to be a muscle-invasive, transitional cell carcinoma. There was no evidence of metastatic disease. It was recommended that he have a cystectomy, but he could not bring himself to agree to have such life-changing surgery and even though it offered a greater prospect of cure than radical radiotherapy. However, he did agree to being readmitted three months later and to proceeding with cystectomy if there was any evidence of malignancy on endoscopic reassessment. Some months after the intended time of readmission, he presented with haematuria and back pain. He was found to have recurrence of bladder carcinoma and skeletal metastases. He died some months later.

39. I recall being asked by the Trust to provide a report in relation to this patient. I believe this was as a result of the patient's family making a complaint. I met with the then Medical Director and the Trust's solicitor to discuss the report I had produced. I have been advised by counsel that the Trust may be entitled, and wish, to claim legal advice privilege for what took place at this meeting. I therefore will not comment in relation to that interaction.

40. This experience left me with the belief that the inadequacy of the service, evidently so unsafe, was an issue which would not, or could not, be resolved by the Trust, and that the most that my colleagues and I could do was to attempt to mitigate the risks to patients as much as we possibly could.

41. I had the benefit of having an operating session in the Day Surgical Unit every Tuesday morning prior to the appointment of a second consultant. I recall another weekly operating session becoming available. I requested that this vacant session

be allocated to my consultant colleague so that we each would have one session each week. However, my request was declined on the grounds that it was being reserved for the intended appointment of another consultant gynaecologist who would need it.

42. Thereafter, my colleague, Michael Young and I shared the Tuesday morning session in Day Surgery on alternate weeks. This arrangement particularly affected Michael Young as this session ran in a physically separate Day Surgical Unit concurrently with his inpatient operating sessions every Tuesday. This arrangement did not lend itself to patient safety.

43. Alongside the inadequacy of operative capacity and increasing acute urological admissions, the number of elective referrals continued to increase. By the second complete year following my appointment, there had been over 1,000 referrals. In his witness statement to the Formal Investigation, dated 23 October 2017 [see AOB-10123 – AOB-10126], Mr Mackle related that I had a ring binder containing over 200 referrals which may or may not have been triaged. In fact, when I was the single urologist, I had four ring binders for referrals received, each for a separate category of urgency. A small folder contained those referred patients who required to be provided appointments as soon as possible, at the next available clinic, if not directly admitted. As a consequence, this folder contained few referrals at any time. The other three folders were for referrals of patients triaged as ‘urgent’, ‘soon’ and ‘routine’. I continued to have outpatient appointments allocated to my clinics in addition to Mr Baluch’s clinics following his appointment in 1996, and I also continued to have patients allocated to my clinics in addition to Mr Young’s clinic following his appointment in 1998. However, Mr. Young soon appreciated that he had inherited a significant cohort of patients from Mr. Baluch requiring review, and so I then no longer had referred, triaged patients appointed to his clinics. I think that Mr. Mackle subsequently referred to the single ring binder containing the ‘routine’ referrals yet to have been appointed, all the other more urgent referrals having been so. It was an effective and safe method of triage and appointment in the pre-digital era.

44. Of greater concern was the expectation that all referrals would be allocated appointments. I was told by the Clinical Director that they all had to be *'seen',* irrespective of their clinical priority and even though there was insufficient capacity to review those who had greater clinical priorities than those newly referred. Having only one outpatient clinic each week initially, having to accommodate 20 new referrals at each clinic would have resulted in minimal capacity to review patients. Even with the later addition of a second outreach clinic each week in either Armagh Community Hospital or Banbridge Polyclinic, an outpatient review backlog soon accumulated, and with all of the accompanying concerns of patients coming to harm as a consequence.

45. Even though Mr Young and I each had an outpatient clinic at Craigavon Area Hospital and an outreach clinic each week at one of the above locations, there evolved an ever increasing disparity between the numbers of patients requiring review and the capacity to do so. There evolved an increasing expectation that the results and reports of requested investigations would be reviewed by the two consultants in order to determine the urgency with which reviews should be arranged. Whether the consultants actually had the time to do so, and irrespective of whether any notional time had been allocated in job plans to do so, and even more importantly, whether there was actual review capacity available, the consultant urologists were progressively held responsible for all of the clinical implications and consequences of inadequate capacity until that responsibility was effectively considered to be completely and solely theirs. As related in my response to Question 9, this expectation was formalised by Dr Rankin by the introduction of Discharge Awaiting Result Of (DARO) in or after 2010. I shared my concerns regarding DARO with the Head of Service and my colleagues by email on 6 February 2019 [AOB-07571 – AOB-07577]. My main concern regarding DARO was the reality that all such patients did not exist on a list awaiting outpatient review and would not until and unless the inadequate numbers of consultants with inadequate time reviewed their result or report, if it was made available to them.

46. Inadequacy of service capacity of such severity had unintended consequences.

It was fortuitously discovered in July 2019 that the administrative practice of DARO had been inadvertently applied to newly referred patients. If newly referred patients had investigations, such as scans, requested on triaging the referrals, these patients had not been added to lists awaiting first outpatient appointments at clinics requested by the triaging consultants, but only when the investigations had been undertaken and the reports were available. Instead, it was expected that the reports would have been provided to the consultants who triaged the referrals, with appointments at clinics predicated upon the reports. This posed an additional risk of harm to patients.

47. I documented the early consequences of the inadequacy of the Urological Service in the document 'The Future of Urological Services' in March 1997 [AOB-00027 – AOB-00035]. By January 1997, with two consultant urologists providing the service, there were 451 patients waiting up to 43 months (over 3½ years) for inpatient admission. There were 370 patients waiting up to 13 months for flexible cystoscopy and 75 patients were waiting up to 9 months for urodynamic studies. These were all massive percentage increases since March of 1996 [AOB-00031]. I had anticipated at that time that the Trust would seek to appoint a third consultant urologist during 1998, as it was evident that the service was inadequate.

48. However, six years after advising in the above document that "*Undoubtedly, by currently accepted standards, the population of the Southern Area requires a urological service provided by 4 Consultant Urologists"* [AOB-00032], a third consultant urologist had still not been appointed. Mr Templeton invited an external review of the service by Professor Sam McClinton of Aberdeen. I believe he advised that the Service was severely inadequately resourced and that steps should be taken as soon as was possible to alleviate the situation. I believe that he recommended that the Service required the appointment of two more consultant urologists as the urological demand required a service provided by four consultant urologists, as I had advised in 1997. Even though the waiting lists and waiting times were not as long then as they were to become years later, they were then alleviated by the commissioning of a major waiting list initiative provided by an Australian team, under the leadership of Mr Richard Batstone, and undertaken

at South Tyrone Hospital, Dungannon. Following its completion, Mr Batstone remained at Craigavon Area Hospital as a locum consultant urologist until his departure in early 2007. In my appraisal in July 2007 [AOB-22189], my appraiser has recorded the fact that the "*External Service review recommended a 4th consultant to take up post in 2007",* however, at that time, we were only about to appoint a third consultant. I expressed my concern and frustration at the lack of consultant expansion. Mr Mehmood Akhtar was appointed as the third consultant urologist soon after.

49. Prior to the appointment of a third consultant urologist, I had sought recognition of the additional commitment and work provided by me since my appointment in 1992. Following the appointment of a second consultant in January 1996, Mr. Templeton advised me to write to Ms Helen Walker of the Directorate of Human Resources, requesting that she address the issue of remuneration for the work that I had undertaken in excess of contractual obligations and expectations until then [AOB 00018 – AOB-00022]. This was eventually satisfactorily addressed by the offer in July 2006 of an ex-gratia payment of Personal Information redacted by the, in addition to 5.5 additional Programmed Activities (PAs) over and above the standard contractual duties under the New Consultant Contract [AOB-00039 – AOB-00049]. My colleague, Michael Young was also offered and received 5.5 additional PAs thereafter in recognition of the additional work undertaken by him since his appointment in 1998.

50. The waiting list initiative undertaken by the Australian team did significantly reduce the length of the inpatient waiting lists, though there were 551 patients awaiting admission on 30 June 2007, but no patient waiting longer than 26 weeks. Having a service provided by three consultants did stabilise the waiting lists and waiting times over the next three years. There were 580 patients awaiting inpatient admission by 30 June 2010, with only 53 patients waiting longer than 26 weeks. There was then a dramatic increase within one year. There were 1141 patients awaiting admission on 30 June 2011, with 302 patients waiting longer than 26 weeks. The total had more than doubled in four years, while the number waiting longer than 26 weeks had increased almost six-fold (see

https://www.health-ni.gov.uk/ for statistics). My colleagues and I had increasing concerns regarding the risks associated with increasing numbers of patients waiting ever longer for admission for surgery.

51. The greatest concern we had was the clinical consequences of the continuous expectation to meet cancer timeline targets on one hand and the frequent expectation to meet waiting list targets with no genuine clinical prioritisation on the other hand. Clinical priority was not an officially permitted consideration, other than the distinction between urgent and routine. If the reason for admission was related to a diagnosed or suspected cancer, or if the patient remained on a waiting list longer than the current target (whether 26 weeks or 52 weeks), these patients were targeted for admission. The increasingly large numbers of patients with no suspicion or diagnosis of malignancy, but whose health and lives were at risk while awaiting shorter periods of time on waiting lists, were not considered priorities for admission. The risks to their health and lives then increased.

52. In order to mitigate these risks, my colleagues and I committed to undertake additional sessions. I availed of every opportunity to use available and extra operating sessions. I continued to use my usual operating sessions when on periods of annual leave, and to use the operating sessions vacated by other surgeons when on their annual leave. I used administrative time and Supporting Professional Activity (SPA) time to operate. I availed of additional operating sessions at weekends. In 2013, I agreed to embark upon extended operating days, initially from 09.00 am to 07.00 pm, and later to 08.00 pm.

53. During the years 2013 to 2016, I had undertaken 122 additional operating sessions, equivalent to an additional 488 hours [see AOB-15274 – AOB-15291/Appendix 43 of Formal Grievance] In fact, I conservatively estimated that it would have required one additional hour of administrative time to arrange the admissions for each session, and one hour of perioperative care for each session, giving rise to a conservative total of an additional 732 hours during that four year period. As a consequence, I was able to reduce the total number of patients on my waiting list from 275 in April 2016 to 232 by October 2016. However, I still had

more patients awaiting urgent admission than all awaiting urgent admission under the care of my four colleagues.

54. There were 1,076 patients awaiting admission on 30 June 2016, but 256 patients were waiting longer than one year, and increasing numbers of these patients were waiting longer than two years. The total increased by 50% to 1,572 patients by 30 June 2017 when 382 patients were waiting longer than one year, and a number of these waited longer than three years. The total number awaiting admission had increased to 1,698 by March 2018, when 557 of these patients were waiting up to 205 weeks for urgent inpatient admission and 321 patients were waiting up to 162 weeks for urgent day case admission.

55. All of the additional operating undertaken continuously and repeatedly by those providing the urological service had evidently failed to match the demand. Most importantly, we were increasingly concerned by the increasing risks of worsening morbidity and mortality suffered by increasing numbers of patients. Our greatest concerns related to the risk of chronic and recurring urinary infection, the risk of urosepsis with its associated risk of mortality, the risk of increasing stone burden, the risk of loss of renal function, the risk of obstructive stone disease, the risk of worsening lower urinary tract function and the risk of delayed diagnosis of malignancy.

56. These risks were exemplified by the death of a 70 year old man due to urosepsis complicating ureteroscopic management of an obstructive ureteric stone for which he had his ureter stented 10 weeks previously. In the intervening 10 weeks, he had been acutely readmitted to a hospital due to urosepsis resulting in acute renal injury. The risk of urosepsis complicating ureteroscopy in previously stented patients has been quantified at approximately 5% when surgery is performed between two and three months following stenting. That risk increases to 9.2% for patients undergoing ureteroscopy after three months following previous ureteric stenting. The risk of urosepsis culminating in death has been reported to be approximately 10%.

57. The postoperative death of this patient caused Mr Haynes to communicate by email his concerns to Esther Gishkori [see AOB-01811-AOB-01812 and TL6 pages 666-667 and AOB-80959-AOB-80960] copying in myself, my colleague and others at that time in relation to the urology waiting lists. Many of the points and concerns I have referred to above were also made by Mr Haynes as follows:

"*Dear Esther*

I write to express serious patient safety concerns of the urology department regarding the current status of our inpatient theatre waiting lists and the significant risk that is posed to these patients.

As you are aware over the past 6 months inpatient elective activity has been downturned by 30% as part of the winter planning. This has meant that for our speciality demand has outstripped our capacity for all categories of surgery. In reality this has meant that Red Flag cases have been accommodated, with growing times for referral to treatment and increasing numbers of escalations / breaches. However, only limited numbers of clinically urgent non-cancer cases have been undertaken with waiting times for these patients increasing significantly. These clinically urgent cases have also been subject to cancellation on occasion due to bed pressures. Routine surgery has effectively ceased. As you are aware there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity. This is likely to disproportionately impact on Urology as we have, as a specialty three 4 hour theatre sessions which take place as part of extended days and it is these sessions that will not be running.

The clinically urgent cases are a significant risk as a result of this. Included in this group are patients with urinary stone disease and indwelling urethral catheters. The progressive waiting times for these patients are putting them at risk of serous sepsis both while waiting for surgery and at the time of their eventual surgery. In addition for the stone disease patients, their surgery can be rendered more complicated by development of further stones and/or encrustation of ureteric

stents. The clinically urgent category also includes patients who are at risk of loss of kidney function as a result of their underlying urological condition (eg benign PUJ obstruction). Many of these patients are recurrently attending A&E and having unscheduled inpatient admissions with urinary sepsis while awaiting their inpatient surgery. Catheter related sepsis is a significant risk and all catheterised patients on our waiting lists are at risk of this, the recognised mortality risk for Catheter associated sepsis is 10%. Patients with stone disease and other benign urological conditions which affect upper urinary tract normal functioning are at risk of losing kidney function and consequently renal failure. The current duration of our waiting lists means significant numbers of patients are at risk of loss of renal function and consequently these patients are at a risk of requiring future renal replacement therapy. Duration of ureteric stenting in stone patients is associated with progressively increasing risk of urosepsis, and its associated risk of death, as a post-operative complication. This risk has been quantified at 1% after 1 month, .9% after 2 months, 5.5% after 3 months and 9.2% after greater than 3 months. Currently our waiting lists have significant numbers of patients who have had stents in for in excess of 3 months and therefore our risk of post-operative sepsis is significant and is continuing to grow.

*Tragically, a 70 year old male patient died this weekend following an elective ureteroscopy. He had a stent inserted in early March as part of his management of ureteric stones and was planned for an urgent repeat ureteroscopy. This took place 10 weeks after initial stent placement. He subsequently developed sepsis and died on ICU 2 days after the procedure. While this may have happened if his surgery took place within 1 month of insertion of the stent, and there will be other factors involved (co-morbidities etc), his risk of urosepsis was increased 5 fold by his waiting time for the procedure.**

Unless immediate action is taken by the Trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur.

The private sector does not have a role to play in the management of this problem

(previous experience) and the Trust needs to therefore find a solution from within. We are aware that while our waiting times are far longer than is clinically appropriate or safe, other specialities have far shorter waiting times with waits for routine surgery being far shorter that our clinically urgent waiting times. Given the risk attached to these patients and the disproportionately short waiting times in other specialities one immediate solution is to have specialities with shorter waiting times 'give up' theatre lists to be used by the urology team until such a point as these waiting times come back to a reasonable length (less than 1 month for all clinically urgent cases).

Looking at our current waiting list there are currently approximately 550 patients in the clinically urgent category, waiting up to 208 weeks at present. In order to treat these patients we would require a minimum of 200 half day theatre lists. We would suggest the target should be 4 additional lists per week in order to treat this substantial volume of patients and this would therefore need to run for at least a year in order to bring the backlog down to an acceptable level (waiting time less than 1 month). It may require a longer period / more sessions as patients continue to be added to the waiting lists and demand outstrips our normal capacity. This requirement is on top of our full complement of weekly inpatient theatre sessions (11). With regards staffing of these lists we currently have 2 locum consultants providing sessions in the department and these individuals could be used in order to deliver the surgery or back fill other activity so the 5 permanent consultants can undertake the additional lists. In addition the department need a longer term increase in available inpatient operating in order to match demand. Clearly the above would not tackle the routine waiting list.

Once again, we would stress that without immediate action to start treating these patients there will be a further adverse patient outcome / death from sepsis which would potentially not have occurred if surgery had happened within acceptable timescale.

I am happy to meet to discuss timescales to implement the changes required."

58. The SAI report in relation to this matter can be found at AOB-09632- AOB-09646.

59. Mr Haynes clearly continued to have concerns similar to mine in relation to the delays in urology patients being treated, particularly in comparison with other specialties. In his email of 8 June 2018 [see AOB-01814] he provided the following table which again demonstrated the disparity:

Specialty	Urgent Inpatients	Weeks Waiting	Routine Inpatients	Weeks waiting	Urgent Daycases	Weeks waiting	Routine Daycases	Weeks waitin
Urology	596	208	237	225	378	173	541	212
ENT	29	1x38 19	142	64	64	23	923	80
General Surgery	113	147	75	139	437	131	901	121
Breast	16	1 x 41 27	15	82	10	1 x 19 4	9	38
Orthopaedics	200	1 x 160 85	1155	171	130	1 x 101 80	805	128
Gynae	28	11	168	50	26	1 x 26 6	106	44

60. In the context of the investigation against me, in a meeting with Mr Weir on 21 September 2018 concerning job planning, [see AOB-56386] I raised the overwork in urology and also provided a comparator to gynaecology in the following terms:

"Mr O'BRIEN: I think it is a pretty overworked specialty.

MR WEIR: Yeah, yeah

MR O'BRIEN: And the other big issue that needs to have a response from the Trust, which is appalling at present, is having 597 patients awaiting urgent in-patient admission.

MR WEIR: Yes.

MR O'BRIEN: With a waiting time of 210 weeks and gynaecology have 28 patients waiting 11 weeks."

61. In response to the increasing concerns, I and my colleagues had regarding the increasingly long waiting lists and the attendant risks of patients coming to harm, my colleagues and I agreed in July 2018 to seek a meeting with the senior management of the Trust. I have referred to this meeting in greater detail in my comments under the heading “Staffing” at Question 21 -25 [see paragraph 201]. Despite our concerns a meeting to address same was not attended by senior management.

62. One of the concerns we raised in late 2018 related to the inadequate theatre time allocated to urology, which had not been adequately adjusted to facilitate surgery by the increased number of urologists at that time. Our concerns in relation to that issue were not met. I have referred to this in greater detail in my response to Questions 21-25 on “Staffing” [see paragraphs 206 - 212].

63. I found it remarkable that the increase in the total number of operating theatre sessions allocated to urology could be increased by only 0.5 sessions per week, in order to facilitate specialties which had minimal numbers of patients waiting relatively short periods of time for urgent admission. As was the case twenty years previously, this was a demonstration of the Trust’s inadequate response when legitimate concerns were raised.

64. By December 2018, the total number of patients waiting over one year for urgent inpatient and day case urological admission had increased to 785. That number then increased to 823 patients by June 2019, with patients waiting up to 286 weeks for inpatient admission, while patients waited up to 273 weeks for day case admission by July 2019. Such increasing numbers of patients were suffering increasing morbidity due to waiting ever longer for admission for surgical management, in addition to increasing risk of suffering harm due to poorer outcomes arising from delayed management.

65. Our concerns were further exacerbated by the discovery in September 2019 that patients had again been removed from waiting lists as a consequence of

administrative validation exercises funded by the Health and Social Care Board's (HSCB) Directorate of Performance Management and Service Improvement, even though we had previously been reassured that these exercises would be discontinued and would not recur. [see AOB-09344–AOB-09350 & AOB-09353–AOB-09355 & AOB-09357–AOB-09385 & AOB-09426-AOB-09432 & AOB-09435]. Patients had again been removed from waiting lists, without their clinically informed consent. For years, it required additional administrative time to review updated waiting lists to identify patients who had been removed from waiting lists since previous review, to contact them, to learn that they may have been unaware that they had been removed and to find that their condition may have worsened in the interim, with increased risk of significant morbidity and possible mortality as a consequence.

66. On reviewing my inpatient waiting list in August 2019, I noted that a patient, [redacted] (Personal Information redacted by the USI), had been removed from the waiting list for prostatic resection. This diabetic man had been found to have a grossly enlarged prostate gland when he underwent endoscopic management of an obstructive right ureteric stone in October 2015. He was advised at that time that he would be best served by having his prostate resected. He was placed on the waiting list in October 2015. When I contacted him by telephone in August 2019, he advised me that he had received a letter from the Trust asking whether he still needed or wished to have the operation performed. As his only symptom was nocturia, he replied that he did not wish to have the procedure performed. Upon my advice, he agreed to have an ultrasound scan of his urinary tract which indicated that he had recurrence of stone in his right kidney, that he probably had chronic urinary retention and that he probably had a stone in his bladder. He agreed to have a CT scan performed to further assess his stone status and to be returned to the waiting list for bladder lithotripsy in addition to prostatic resection. I requested his GP to have his diabetic control optimised in preparation for his admission. He remained on the list awaiting admission in June 2020.

67. I also requested a list of my patients who had been written to as a consequence of this validation exercise. By then, 123 of my patients awaiting admission had

been so contacted, in addition to some 30 patients awaiting admission under the care of my colleagues. One colleague discovered that a 52 year old patient, Personal Information redacted by the USI, with a staghorn calculus in a non-functioning, xanthogranulomatous kidney had been removed from his waiting list in a similar fashion and without clinically informed consent. This patient would have been at significant risk of urosepsis with its associated risk of mortality.

68. I subsequently noted that one of my patients, Patient 111 Personal Information redacted by the USI, who had received a validation letter, was then a 79 year old man who similarly had been found to have a grossly enlarged prostate gland, with a volume of 164 ml, causing bladder outlet obstruction with inadequate bladder voiding on assessment in July 2017 when he was placed on the waiting list for admission for prostatic resection. His serum PSA level was 8.7ng/ml in March 2017. He was prescribed Finasteride when placed on the waiting list. On receipt of the validation letter, he advised that he remained well on the medication which I had prescribed for him in July 2017. Three years later, he was referred for assessment of malaise, weight loss and with a grossly elevated, serum PSA level of 370.6ng/ml. He was found to have advanced, metastatic prostate cancer.

69. If this man had been offered admission for prostatic resection earlier, he may have declined or deferred admission as he was satisfied by his symptomatic status. However, a clinical review would probably have included an assessment of renal function, a serum PSA level and a further ultrasound scan of his urinary tract, particularly as patients often remain symptomatically stable even though lower urinary tract function has deteriorated. He may have been found to have an elevated serum PSA level, leading to an earlier diagnosis of prostate cancer, and possibly before it had become metastatic. If he had proceeded with prostatic resection, he may have had a histopathological diagnosis of prostatic carcinoma, and again possibly prior to it having become metastatic.

70. These three patients are examples of patients having been exposed to the risk of serious harm due to long waiting lists. However, the risks have been further compounded by the HSCB funding validation exercises resulting in patients being

removed from waiting lists without fully informed consent. It has required significant time over the years to review waiting lists to prevent or minimise the additional risks of patients coming to even greater harm due to these 'validation' exercises which have not been valid due to the lack of clinically informed consent.

71. We requested that all patients be returned to the appropriate waiting lists so that they could be clinically reassessed and advised prior to arranging their admissions. We requested that our concerns be shared with the HSCB [see AOB-09482-AOB-09500]. Most importantly, we were once again assured that the practice had ceased and would not recur.

72. A particular feature of our ongoing concerns regarding urosepsis was the increasing incidence of patients being acutely admitted to hospital due to severe, often life-threatening infection. In October 2019, we were informed of the Department of Health's targeted reduction in the incidence of health care associated infections (HCAI). The three infecting organisms (E.coli, Klebsiella and Pseudomonas) causing most urinary tract infections were reported to be the cause of 57% of HCAI in Northern Ireland. The Department set a target of a 25% reduction in bacteraemia due to these three organisms and acquired by Southern Trust patients. It was then proposed by the Associate Medical Director, Mr Haynes, in his email of 11 October 2019, [AOB-09632 – AOB-09635], that Datix Incident Report (IR1) forms should be completed for patients waiting longer than *"reasonable*" for elective treatment and who were subsequently admitted as emergencies. What was 'reasonable' was 'up for debate' but Mr Haynes suggested IR1 be completed for all patients:

"As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery.

Amongst the key trust targets set by the DoH is a reduction in healthcare associated gram negative bloodstream infections.

Going forwards, can we each submit an IR1 form for any patient who has waited longer than a time we consider 'reasonable' for elective treatment and is subsequently admitted as emergencies, in particular those with positive gram negative blood cultures, but including any patient whose emergency admission would have been avoided if they had received timely elective surgery? This will clearly document to the trust and HSC the patient risk and harm.

What constitutes 'reasonable' is up for debate and has to be left to each of our clinical judgement. As an initial thought I suggest;

- *1 month delay for planned change of long term stent or beyond planned timescale for ureteroscopy for stone in stented patient*
- *3 month wait for treatment for catheterised man awaiting TURP/incomplete bladder emptying awaiting TURP, stone disease for ureteroscopy, PCNL or nephrectomy (in non-functioning kidney), pyeloplasty.*
- *1 year wait for routine elective treatment*

As onerous as it may be completing these forms, the documentation will heighten the recognition of our patients needs and suffering due to the lack of capacity. It will also protect us to some degree, I am aware that a specialty (not urology) in an NI trust has come in for criticism because it did not flag/document delays in cancer treatments which are felt to have resulted in patients coming to harm."

73. The Assistant Director of Acute Services supported the above proposal as it was compliant with the recommendations of the report of the SAI investigation into the patient who had died of urosepsis in Personal information redacted by USI. Moreover, the above categories met the criteria and thresholds for Serious Adverse Incidents which have been defined as "*any event or circumstance that led or could have led to serious unintended or unexpected harm, loss or damage to patients".*

74. In December 2019, Mr Haynes reiterated his concerns regarding the inadequacy of operating theatre sessions available to him in January 2020 [WIT-34357] when

he required 65 hours of operating time to attend to those patients at most risk of coming to serious harm, but had been provided with only 28 hours of operating time. He did so again in January 2020, similarly identifying that he required 59 hours of operating time during February 2020, but had only been allocated 24 hours of operating time for that month [WIT-34356]. I make reference to these communications as Mr. Haynes reported that:

"Another surgical specialty in another NI Trust has come under significant criticism for treatment delays and subsequent adverse outcomes for not highlighting the waiting times to the Trust (genuinely bizarre given that the waiting times were known to the Trust) and in order to protect ourselves, we have been advised to highlight treatment delays!"

75. While it would indeed appear to be "*bizarre*" to the uninitiated or those without longer experience, I find it entirely familiar and consistent with the success with which Trusts have been able to transfer all responsibility for the consequences of inadequacy to clinicians. Secondly, I have so often listened to the refrain that *"it is well known that urology waiting lists are very long".* It has appeared to me that Commissioners and Trusts have been so aware of long waiting lists for such a long time that they have become complacent to the extent that they become absolved of any responsibility or accountability for them.

76. By December 2019, there were 883 patients waiting longer than one year for inpatient and day case urological admission, the exact same number as the total number of patients awaiting urological admission in June 2013. The number waiting longer than one year for admission surpassed 1,000 for the first time, at 1,066 patients in June 2020, and some patients had been waiting since August 2014, almost six years, for urgent admission. By June 2021, there were 2,078 patients awaiting admission. Sixty five per cent of these, 1,356 patients, were waiting more than one year. It was then reported in mainstream media that the Southern Trust's patients were waiting up to 365 weeks (7 years) for admission for urological treatment, including urgent urological treatment. The Southern Trust's urology waiting list was then the longest urology waiting list in the United

Kingdom. I trust the Inquiry will note that I had been raising issues in relation to the adequacy of Trust's provision for decades by this point.

77. The largest cohort of patients at risk of harm is the large number of men at risk of delayed diagnoses of prostate cancer while awaiting elective admission for TURP. A second patient, [redacted], was found to have high risk, metastatic, prostatic carcinoma while still awaiting elective admission for TURP. In addition, prostate cancer was found in seven (15%) of 46 men who had been electively admitted in 2019 for TURP. The incidence of prostatic carcinoma has been reported to vary greatly, up to 28.7% of cases, depending upon age and racial ethnicity. Most recent reports cite incidence of the order of 5 to 12%. A most recent report from St Vincent's University Hospital, Dublin, found 50 of 497 patients (10%) undergoing elective TURP to have prostatic carcinoma, and 24 patients (4.8%) had Gleason 8-10 carcinoma. There were 110 patients waiting longer than one year by 30 June 2020 (up to 70 months) for elective admission under my care for TURP. A further 28 patients were then waiting less than one year at that time. It would therefore be reasonable to expect some 14 to 21 (10 – 15%) of these patients to have a delayed diagnosis of prostate cancer. As I do not have access to the relevant data, I am unable to report the total number of patients awaiting elective admission for TURP under the care of my colleagues and I by the 30 June 2020. However, pro rata, it would be reasonable to anticipate there having been some 500 patients awaiting elective TURP. Therefore, some 50 – 75 patients may have a delayed diagnosis of prostate cancer, and a proportion of those will have clinically significant disease. It is my view that all patients waiting longer than one year for elective TURP meet the SAI criteria.

78. Eighteen of the patients awaiting elective admission for TURP under my care had the additional risk of infective complications due to indwelling urethral catheters while awaiting their admission. With respect to infective risk, there were 15 patients with stented ureters waiting up to 11 months for elective readmission by 30 June 2020 for removal or replacement of their stents. In addition, there were 18 unstented patients waiting up to 58 months for elective admission for endoscopic stone surgery. All of these patients have been at risk of harm,

including potentially life-threatening harm, primarily as a consequence of the Trust's Urology Service being inadequately staffed and resourced.

79. It is ironic that the significant numbers of patients under the care of the Trust and who may suffer the consequences of delayed diagnoses of prostate cancer due to the inadequacy of the Service, are not included in the priority accorded by the Trust to its urology cancer service. The Trust's Urology Multidisciplinary Team (MDT) was established, with weekly multidisciplinary meetings (MDMs), in April 2010. Mr Akhtar, Consultant Urologist, was the Lead Clinician of the MDT, and Chair of the weekly MDM. Mr Akhtar left the Trust in March 2012. I was appointed to succeed him in both roles. I continued as Chair of the weekly MDMs until it was necessary to introduce a rota of chairs in September 2014 in preparation for the implementation of Urologist of the Week (UOW). I remained Lead Clinician of the MDT until 31 December 2016. Until then, I chaired 137 MDMs. Each one required at least three hours of preparation time, and at least thirty minutes following MDMs to check and sign off their outcomes prior to sending to GPs. This conservatively equated to some 480 hours of additional administrative time, all undertaken in my own time. Moreover, the role of Lead Clinician required further administrative time to prepare the Trust's MDT for National Peer review in June 2015.

80. The provision of a urological cancer service by the Southern Trust was an increasingly significant undertaking since 2010. Data included in the Cancer Performance Dashboard Reports demonstrated that there were 1,602 patients with Day 62 referrals with suspect urological cancers during the year April 2015 to March 2016. This represented a mean of 136 referrals per month or a mean of 31 referrals per week. By the year ending August 2019, there were 2,082 Day 62 referrals, with a mean of 40 referrals per week. This represented a 30% increase in demand without a concomitant increase in capacity to provide for it.

81. The operational priority afforded to urological cancer services by the Southern Trust had resulted in only three of its patients breaching urological cancer timeline targets at the time of National Peer Review in June 2015. However, the best efforts of an inadequate service could not prevent increasing breaches of timeline

targets for long. The Cancer Performance Dashboard Report of December 2017 [see AOB-80387 – AOB-80391] detailed the numbers of patients breaching timeline targets in 2016 and 2017, and the service inadequacies causative of those breaches. The Cancer Performance Dashboard Report of January 2018 [see AOB-80491 – AOB-80506] demonstrated that urological breaches accounted for 52% of all Southern Trust breaches of the 62 day targets during 2017 and 37% of all Southern Trust breaches of the Inter Trust Transfer targets. These reports confirmed the disproportionate and disparate inadequacy in the Trust's urological cancer service, even though it continued to be the priority of the urological service. The disparity continued to worsen during 2018 and 2019. Some 60% of the Trust's breaches of the 62 day timeline targets were urological in 2018, and 41% of its breaches of Inter Trust Transfer targets were urological in 2018. By mid-2019 onwards, patients referred with a suspicion of prostate cancer waited over 100 days for a first outpatient appointment, never mind having their definitive treatment initiated within 62 days. [see TRU-83024 – TRU-83038 (Dec 2017), AOB-80480 – AOB-80506 (Jan 2018), TRU-83039 – TRU-83334 (Mar 2018 – Dec 2019]

82. Cancer services apart, it had been evident for years that the urological service was inadequate, as the numbers of acute admissions and of referrals continued to increase. Among conflicting concerns was an increasing appreciation of the need to be able to provide, at the very least, as optimal a service as possible to those acutely admitted. It was increasingly acknowledged that this was not possible without having a 'Urologist of the Week' (UOW) freed of all elective care to ensure optimal inpatient care, and particularly to those acutely admitted. This was all the more evident due to patients acutely presenting to three acute hospitals within our catchment area. The UOW model was fully introduced in November 2014 and did ensure improved management of those patients. In particular, every effort was increasingly made to avail of staffed theatre sessions for the surgical management of patients who had been acutely admitted.

83. Concurrently, the number of referrals to the Urology Service was steadily increasing. By June 2012, there were only 533 patients awaiting a first outpatient

consultation, and only 5 of those patients were waiting longer than 18 weeks. Even though the total number of patients awaiting a first appointment had increased to 639 by June 2013, there were still only 8 patients waiting longer than 18 weeks. However, those numbers had increased significantly by June 2014 when there were 1,488 patients awaiting a first appointment, and 415 of these patients were waiting longer than 18 weeks. This marked increase may have been a consequence of the additional provision of urological services to the additional 70,000 population of County Fermanagh since January 2013.

84. In addition to the introduction of one stop clinics in an attempt to deliver a more productive, first outpatient consultation service, we had considered that the obligations of the UOW would still leave adequate time to additionally triage all referrals in the hope that so doing would also contribute to shortening the pathway for referred patients. However, it soon became evident that it was not possible to undertake a clinically safe triaging process in the context of increasingly long waiting times for a first outpatient consultation, as there was inadequate time for the UOW to do so, without compromising the management of inpatients.

85. The total awaiting a first outpatient appointment had increased to 1,737 patients by December 2014 and 797 of those were already waiting longer than 18 weeks. If a patient had been referred by an Emergency Department following initial relief of ureteric colic due to an obstructive ureteric stone, or following urethral catheterisation for acute urinary retention, it was not clinically tenable to have either waiting months for a first outpatient consultation. Clinically safe triage of the first patient would have necessitated contacting the patient to enquire whether a stone had been passed, whether they have had recurrence of colic, whether they required admission which needed arranging or whether further imaging was required and which also needed arranging. Similarly, the catheterised patient probably required a trial removal of the indwelling urethral catheter to be arranged followed by appropriate assessment. Such interventions upon triage may have required 30 minutes each. Not all referrals would have required such intervention. However, a significant proportion did. There were approximately 120 referrals per week in 2014/15. If the mean time spent per patient on triaging had been 10

minutes, a total of 20 hours would have been required to triage while the UOW, and 30 hours if the mean had been 15 minutes.

86. There were 1,782 patients awaiting first outpatient consultations, with 853 of these waiting more than 18 weeks, by March 2015 when consideration was given to arranging, upon triage, appropriate imaging for those patients referred with a suspect urological malignancy, in order to enhance the diagnostic prospects by the time patients attended their first outpatient consultation, and in order to render their pathway more productive and efficient. Even though such patients accounted for approximately 20% of the total, it was collectively concluded that there was inadequate time when UOW to commit to do so.

87. The numbers of referrals continued to increase during subsequent years. By 2016, there were approximately 7000 referrals, resulting in a mean of 135 per week. By June 2016, there were 2907 patients awaiting a first outpatient consultation, and 506 of these were already waiting longer than one year. The number of referrals had risen above 8,000 per year in 2017 with a mean of 175 referrals for triage each week. Concurrent with increasing referrals for triage, by March 2018 patients were waiting up to 110 weeks for a routine first outpatient consultation. By June 2018, there were 3,137 patients awaiting first outpatient consultations, with 1,364 of these patients waiting more than one year, and an increasing number of these were already waiting more than two years.

88. In the context of such increasing numbers of patients waiting increasingly longer periods of time for first outpatient consultations, I found that undertaking clinically safe triage was impossible without spending significant and unavailable time in doing so. Spending that time while UOW could only be done by compromising the time dedicated to inpatient management for which reason the UOW model was introduced. Conversely, undertaking triage without reference to the long waiting periods for first outpatient consultations was accompanied by risk of triaged patients coming to harm.

89. While there have been Ministerial targets for first outpatient consultations and for

patients awaiting admission, I am unaware of any such targets for patients awaiting review as outpatients. Comparative data for both new and review urological outpatient appointments in March 2018 indicated that there were 2,988 patients awaiting first urological outpatient appointments, with 1,079 (36%) waiting longer than one year, with the longest waiting period being 110 weeks. At that time, there were 2,386 patients awaiting urological review appointments, the longest waiting for review since February 2015 (160 weeks).

90. Outpatient review of patients has suffered throughout the last twenty years and increasingly so during more recent years. Since 1992, there has always been an emphasis placed upon *"seeing"* all newly referred, newly presented and newly admitted patients. This has been entirely proper for the newly admitted patients and those who have acutely presented to Emergency Departments, as well as those ill patients referred from other specialties. It is also entirely proper for those outpatient referrals at most risk of having significant pathology. Nevertheless, everyone had to be *"seen".* Once *"seen",* and if not discharged, they will have been placed on lists awaiting review or lists awaiting admission for treatment. Even though the latter have been waiting up to seven years for admission for that treatment, targets have been set, even if not met for years. For outpatient review of patients, I am unaware of any such targets.

91. Quarterly data relating to clinical services are published by the Department of Health. As of 31 March 2022, the Trust had 4,615 patients awaiting first outpatient consultations, with 2,709 (59%) waiting longer than two years. There is no published data regarding the numbers of patients awaiting urological outpatient review or the periods of time waiting. The Trust also had 2,086 patients awaiting inpatient and day case admissions, with 1,263 (61%) waiting longer than one year. Maximum waiting times have not been published.

92. The fate of patients awaiting outpatient review has been one of the many consequences of the ever-increasing inadequacy of the urological service provided by the Southern Trust and its predecessors since 1992. That inadequacy has resulted in an unsafe service which resulted in increasing risks of serious

harm to multiples of those patients and I would ask that the Inquiry investigates the extent to which actual harm has been caused. The Trust has failed to provide a urological service equitable to other specialist services which it has provided. It has not only failed to address and resolve the concerns that its consultant urologists have had for years, but it has also avoided and evaded sharing the responsibility for the clinical consequences, transferring that responsibility to the inadequate numbers of clinicians who have overworked, beyond their contractual obligations, to mitigate the risks of patients coming to harm.

93. I do not know of the extent of autonomy, if any, that the Trust has had in relation to the commissioners, or the extent to which the Trust has been able to diverge from a Service & Budget Agreement. If none, then the HSCB and / or the Department of Health have not only failed to commission an adequately funded service to prevent such harm, but it has also funded measures that additionally enhanced the risks of harm. In September 2019, the Trust continued to implement 'validation' of outpatient waiting lists, again without clinically informed consent.

94. I have attempted in this narrative to describe the inadequacy of the urology service provided by the Trust during my tenure as a consultant urologist since 1992. The extent and severity of that inadequacy barely requires description as the data defines it perfectly. I could never have anticipated thirty years ago that the resourcing of the service would persist to the extent that patients could ever possibly wait seven years for elective surgery for conditions which may have since progressed to the extent that they have become life threatening. The inadequacy in staffing has been so chronically severe that periods of posts remaining vacant had little further negative impact on those remaining in post. Most importantly, the demonstrable futility of raising concerns regarding patients certainly left me permanently carrying the burden of worry for their well-being.

95. Since my appointment in 1992, I have endeavoured to the very best of my ability to provide the best care that I could possibly give to the maximum number of patients whom I considered were in most need of it at any particular time. I regarded it as a vocation and a privilege to do so. However, I have endeavoured

in this general narrative to describe the inadequacy of the urology service provided by the Trust, and the relentless burden carried by me and my too few colleagues to maximally mitigate the risks of patients coming to harm due to that inadequacy. I have worked far beyond any contractual obligations, as has been acknowledged. I have worked when on leave, and even when on sick leave. I have tried to do the impossible, but the impossible proved not to be possible. I hope that any failings on my part may be viewed in this light.

Section 2 – Your Role (Q 3-7)

96. I graduated in medicine from Queen's University Belfast in 1978. Following completion of basic surgical training in Northern Ireland in 1985, including one year as a Demonstrator of Anatomy at Queen's University, Belfast, I was appointed a Registrar in Urology at the Meath and St. James's Hospital in Dublin. Following two years as a Registrar and one year as a research fellow, I was appointed a Senior Registrar in Urology in Dublin in 1988. I completed Higher Professional Training in Urology in Dublin in June 1991. I took up a locum consultant post at Craigavon Area Hospital in July 1991 for two months, prior to taking up the post of Clinical Fellow in Paediatric Urology in Bristol Royal Hospital for Children from September 1991 until 30 June 1992 and returned to Craigavon Area Hospital in July 1992 as a consultant urologist. Details of my early career are contained in the CV which I have recently provided to the Inquiry and is awaiting a Bates number [see supplemental October bundle pages 1 - 34] Following my appointment to Craigavon Area Hospital I worked there and at a number of other hospitals (given the changing requirements of the various Trusts I worked for). I was a consultant urologist from 6 July 1992 through until 17 July 2020. When my employment ended on 17 July 2020, my employer was, and had been for some time the Southern Health and Social Care Trust (SHSCT). Throughout this statement when I refer to "the Trust" that shall refer to the SHSCT and its predecessors.

97. Throughout my time at the Trust, I worked as a urologist, with special interests in the fields of oncology, lower urinary tract dysfunction and paediatric urology. I shall refer further below to my job plan which may assist the Inquiry in understanding the

activities I undertook in that role (insofar as I have been able to identify relevant documents in relation to same to date).

98. I was the only consultant urologist at the Trust until January 1996 when a second consultant, Mr Wahid Baluch, took up post. He remained in place until December 1997 and thereafter I was the sole consultant urologist again until May 1998. At that stage Mr Young was appointed.

99. During the initial years, I fulfilled the role of Lead Clinician in Urology. I cannot recall having a specific job description or contract in relation to that and I have not, as yet, been able to identify one in the Inquiry papers. Mr Young took over that role from me in or about 1999 and remained in post as Lead Clinician until my employment with the Trust ended in July 2020. (Consultant Urologist Job Description, 1992 [AOB-00001 – AOB-00006], Consultant Urologist Job Contract, 1992 [AOB-00007 – AOB-00010])

100. During the period from taking up the post of consultant urologist in July 1992 until the appointment of a second consultant in 1996, I provided a continuous acute urological service and an almost continuous elective urological service, as related in my letter to the Directorate of Human Resources in March 1996 [AOB-00018 – AOB-00022]. That letter gives a clear picture of the scale of the role I was appointed to. At the time of my appointment the ratio of urologists to patient population was the worst in Western Europe. I was the only urologist providing a service for a population of approximately 290,000 in the Southern Health Area. The service was rudimentary, and I committed myself wholeheartedly to the task of enhancing and improving it. With the administration entailed in coping with increasing demand, superimposed upon the underlying clinical commitments, I was regularly working 80 hour weeks. In four years I had only four weeks of holiday with my family. The extent to which I was working beyond contractual obligations during these and subsequent years was recognised in 2006 when both Mr Michael Young and I were awarded an extra 5.5 PAs in recognition of the additional workload "*over and above the 10 programmed activities that constitute your standard contractual duties".* An ex-gratia payment of Personal Information redacted by the was made in respect of my extra contribution from

the period 1998 until the new contract [AOB-00039- AOB-00040]. The 2006 contract is at AOB-00048 – AOB-00058.

101. The Inquiry may be further assisted by considering document AOB-03504 which was prepared in the process of an Awards Round Application. It provides information in relation to the duties and roles I was undertaking at that time and how I assisted in the establishment of the Urology Service between 1992 and 2007. I was awarded a local clinical excellence award in 2009 [see AOB-00121].

102. In April 2012 I was appointed Lead Clinician of the Southern Trust Urological Cancer Multidisciplinary Team (MDT) and Chair of the weekly Urological Cancer Multidisciplinary Meetings (MDM). I remained as Lead Clinician until December 2016. I did not receive a job plan for the post of Lead Clinician, nor was any provision made for it in any proposed job plan during the period of tenure, even though the responsibilities of the MDT Lead Clinician were such as those outlined in the Urology MDT Operational Policy Brief for the AGM in 2014 [see AOB-00734-AOB-00757, page 12]. In doing so, I also identified each week those patients at greatest risk of breaching cancer timeline targets, ensuring that their management was progressed, thereby succeeding in having had only three patients breaching targets prior to peer review in June 2015.

103. I remained as Chair of the MDM which took place each Thursday afternoon from April 2012 until September 2014 when it became necessary to introduce a rotating Chair in advance of the introduction of Urologist of the Week (UOW), as it would not have been possible to prepare for or chair the MDM if also UOW. Two of my colleagues agreed to rotate as Chair with me from then. I remained one of the rotating Chairs from September 2014 until December 2019. Chairing MDMs required the Chair to preview all of the cases to be discussed before each MDM. As the number of patients to be discussed at each MDM ranged from 25 to 40 cases, previewing the cases required some 2.5 to 4 hours. I previewed all cases each Wednesday evening, after an operating list, prior to MDM the following day. I regularly worked into the early hours of a Thursday morning to enable me to do so. Following each MDM chaired by me, I reviewed the accuracy of the outcome for

each patient prior to sign off. While the actual chairing of the MDM was included in proposed job plans, there was inadequate provision in proposed job plans for previewing cases in preparation for MDM and none for reviewing and signing off the MDM outcomes.

104. In January 2013 I was appointed as Clinical Lead and Chair of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology and continued to hold that post until December 2015. I was not given a specific job plan/description in relation to that, however, it would be in keeping with the Clinical Lead's responsibilities outlined in the Constitution of the Northern Ireland Cancer Regional Network Groups, February 2009 [see AOB-00119- AOB-00120].

105. The role with NICaN was not a Trust post, but a Northern Ireland wide post. The Trust however was well aware that I was undertaking this role. NICaN comprised consultants from throughout Northern Ireland. NICaN is split into nine different cancer areas, urology being one of them. It is a forum for specialists to provide advice to the Department of Health (DoH) by way of the HSCB, which commissioned urological cancer services throughout Northern Ireland. The usual, ongoing function of a Clinical Reference Group is to provide updated advice regarding the factors and features giving rise to a suspicion of, or increased risk of, cancer, referral pathways for such persons, investigative and diagnostic procedures, in addition to multidisciplinary, clinical management guidelines, all with reference to national and international guidelines and evidence. In doing so, such advice enables the HSCB to be informed of current service capacity, its deficiencies and investment requirements. On my appointment in January 2013, the Group was additionally aware that the Urology MDTs throughout Northern Ireland would be subject to National Peer Review for the first time, and which occurred in June 2015. It was therefore my additional responsibility to have the Group's Clinical Management Guidelines for all urological cancers drafted for peer review, as those were the guidelines which would be used by all MDTs.

106. In fulfilling the above role, I had to chair meetings which included clinicians from other specialities such as oncology, pathology, radiology and clinical nurse

specialist etc. NICaN meetings were held once every two or three months and a full afternoon was devoted to them. As Chair there was a substantial amount of preparation for the meetings and also work which I carried out closely with Mary Jo Thompson (who herself previously had been a Urology Staff Nurse but was by that time seconded to work for NICaN). I regularly liaised and met with her throughout my tenure as Lead Clinician and Chair of the Group in relation to actions which had been decided at the NICaN meetings and in preparation for follow up meetings. In retrospect, I would have spent a mean of one hour per week doing so, in addition to the actual chairing of meetings.

107. During the years I held these additional roles of Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology and Lead Clinician of the Trust's Urology MDT, they were not accounted for in terms of time commitment in my job plan. Whilst I took on additional duties, I was not given additional time by the Trust to perform them.

108. Mr Akhtar had been Chair of the Trust Urology MDM from April 2010 to March 2012. With his departure I volunteered to take over the role. Mr Young had other commitments and the only other available consultant at that time was newly appointed, Mr Glackin. Mr Young and I considered that it was unfair to expect a recently appointed consultant to assume such an additional burden

109. I also undertook the role of Lead Clinician of the MDT from April 2012 to December 2016. Please see letter dated 10 April 2012 from Rory Convery, Clinical Director of Cancer Services, to me in relation to my appointment as the Lead Clinician for Urology Cancer Services. It notes that the role and responsibilities of Lead Clinician "*are detailed in the Operational Policy for the Service*". Please see document AOB-22874. The Operational Policy is at AOB-231126 noted in the following terms:-

3.1 Responsibilities of MDT Lead Clinician

- Consolidation of the MDT and its activities within the wider urological service.
- Development of the concept and responsibilities of the MDT in its delivery of cancer services.
- Oversight of systems to ensure that all cases of cancer or suspected cancer referred to the service are referred in an informative and timely manner to the MDT for their discussion at MDM.
- Chairing or delegating the chairing of MDM.
- Arrangement and oversight of systems to ensure that patients are reviewed following MDM in a timely manner.
- Organising and chairing Business Meetings to advance the development of MDT and its activities.
- Development of an Operational Policy for MDT.
- Compiling Annual Reports and Work Plans.
- Chairing an Annual General Meeting to agree Reports and Plans
- Attending the Urology NSSG meetings (as the Lead Clinician is considered an integral member of the NSSG).
- Ensuring a high quality integrated service, which meets local, regional and national standards.
- Participation in the regular review of the regional guidelines.
- Ensuring collection of appropriate cancer minimum dataset, working with the cancer management team.
- Developing an audit programme and review of outcomes.
- Ensuring governance arrangements are in place.

110. At the time I undertook the role of Lead Clinician for the MDT, the Trust was preparing for National Peer Review which included presenting the service and its operation to a review panel when they attended to assess same at the Trust in June 2015. The role included formulating reports for peer review. As Chair of the MDM, I concentrated on the clinical aspects of patients' care whereas as Lead Clinician of the MDT, I dealt with administrative and operational requirements, and this carried with it additional time commitments. I estimate that I spent approximately one hour per week on this role and also had regular business meetings. The role included ensuring that there were adequate operational policies and annual reports

available for the Peer Review. Again, this role was not reflected in my job plan.

111. A further function which I carried out was as an Intercollegiate Surgical Curriculum Progamme (ISCP) Clinical Supervisor. As trainees came towards their six-monthly appraisal, one would receive requests for reports. The time spent on those reports is an example of a further commitment I had during my time as a consultant, again it was not reflected in my job plan nor was time made available to carry out this function.

112. I shall refer in greater detail below to the inadequacy of resources for the Urology Department at the Trust. During the period I held these posts there were ongoing resourcing issues. It was also a period of significantly increased demand for urology services. Performing these extra roles, without time being provided to do so, put me under additional strain during this period.

113. In terms of medical line management, when my employment ended with the Trust it was as follows:-

(i) Medical Director
(ii) Associate Medical Director
(iii) Clinical Director
(iv) Lead Clinician
(v) Consultant

114. I would request that the Inquiry liaise with the Medical Director's Office and/or Human Resources in relation to individuals who occupied those posts throughout my tenure as they should be able to give more accurate dates than me. That structure was in place for many years, although I cannot now recall exactly when the role of Associate Medical Director was introduced, as I do not recall the post having existed in the early years of my consultancy.

115. Of the various roles I have referred to above, the medical management post I had most interface with was the Lead Clinician for Urology. As I have mentioned

above, Mr Young occupied that role for most of the time I was employed at the Trust and will be better placed than I am to relate the exact functions and requirements of the role. From my perspective, Mr Young took an active interest in day-to-day operational activities within the Department such as organising rotas, departmental meetings, and such like. I was never clear whether the role of Lead Clinician was one whereby the post-holder was an advocate on behalf of colleagues to management or was to be the conduit between management and clinicians in relation to managerial responsibilities, or a mixture of both.

116. The Clinical Director covered the Surgical Directorate which later became the Surgical & Elective Care Directorate and covered urology, general surgery, breast surgery, orthopaedic surgery and ENT surgery. The role therefore was not specific to urology. We did not have a Clinical Director who was a urologist. I did not have regular interaction with the Clinical Director, probably due to the fact the post holder was not a urologist.

117. I had little contact with Medical and/or Associate Medical Directors. For example, one of the recent Medical Directors, Dr Wright, I first met, to the best of my recollection, in April 2016 when we discussed the inadequate availability of a radiologist to attend MDMs. I did subsequently meet with him in December 2016 when he initiated the formal investigation of my administrative practices. I have not met him since. Dr O'Kane was the Medical Director when my employment ended in July 2020. I have never met or spoken to her.

118. With regard to the operational and administrative management of the Urological Service, that function was carried out by the Head of Service. Ms Martina Corrigan occupied that role for a substantial number of years prior to the end of my employment by the Trust. I am sure that Ms Corrigan and others at the Trust will be better able than I am to explain the full extent of that role. I regularly had interface with Ms Corrigan in relation to operational issues such as targets, waiting lists etc. This was a major issue at the hospital due to under-resourcing. I shall comment further on that under the heading "Staffing". My interactions with Ms Corrigan often related to those issues.

119. I have outlined above the role I had in the MDT and NICaN. Other than those roles, my job as a consultant urologist included a leadership role and taking responsibility within the urology team on matters that related to the day-to-day delivery of care to patients. As such, I had responsibility for supervising junior doctors, including staff grade, registrars and foundation trainees (previously JHO/SHOs). All of those doctors would have reported to me in the normal consultant/junior doctor relationship. I also liaised with nursing staff and the Ward Manager. I had a clinical leadership role in theatre during my operative sessions. I did not however generally have the role of overseeing other consultants, as that would have been a matter for the Lead Clinician and Clinical Director respectively. I did however liaise regularly with other consultant urologists at departmental meetings, MDMs and such like along with day-to-day informal interactions.

120. As Lead Clinician for the Trust Urology MDT, I was accountable to the Lead Clinician for the Trust's cancer services, Dr Rory Convery, who can comment more fully on his role and responsibilities in relation to oversight of the MDT. Within NICaN, I was accountable to the Medical Director, Dr Martin Eatock, who was preceded by Dr Dermot Hughes.

121. I do not know the exact extent of the role and responsibilities of the Clinical Director, Medical Director, Associate Medical Director or Head of Urology Service. As such it is difficult for me to comment on the overlap of their roles with mine. However, my impression is that they generally were in positions of management (although some also continued as clinicians) whereas my role was primarily one of delivering clinical care.

Section 3 – Background to Establishment of Urology Services within the Southern Trust Area

(Q 8)

122. In the formal investigation against me which the Trust referred to as taking

place under Maintaining High Professional Standards, I submitted a document dated 10 July 2018 entitled "Response to Report of Formal Investigation". On pages 1-8 under the heading "Historical Context", I provided a background history in the context of that investigation which set out my involvement in the establishment of the Urology Department [see AOB-01879 – AOB-01886]. I also provided comments in relation to the development of the Service in a letter provided to Catherine Nichol at the time of the Regional Review of Urology Services dated 20 December 2008 [see AOB-03498 – AOB-03503]. Both of those documents set out my involvement in the development of the urology services at the Trust.

123. While not repeating the contents of these documents, I believe that it would be appropriate to summarise the main concerns I had and contribution I made to the further development of the Urological Department in the Southern Trust at or around the time of the Regional Review. I had already attended a number of meetings within the Southern Trust and regionally to discuss how best to improve services with the limited and inadequate resources made available.

124. My dominant concern for the Southern Trust's urological patient cohort was the centralisation of radical cystectomy for bladder cancer to Belfast. Mindful that centralisation of both radical prostatectomy and of radical cystectomy was to the Department of Urology at Belfast City Hospital, which had its own service capacity inadequacies, my dominant concern was that older or comorbid patients would not be offered potentially curative radical cystectomy. Regrettably, my concern proved prescient.

125. Otherwise, I was supportive of the changes proposed by the Regional Review of Adult Urological Services, even though the proposals included our department being additionally responsible for urological service provision for the resident population of County Fermanagh, and even though some of my consultant colleagues had legitimate concerns concerning our ability to provide that additional service, even with the prospect of additional appointments of consultant urologists. My colleague, Mr Michael Young and I volunteered to undertake

outpatient clinics at South West Acute Hospital i from January 2013. It has been one of the most satisfying experiences of my career as a consultant urologist to have brought an outpatient service to the people of County Fermanagh, in County Fermanagh for the first time. We continued to do so until the Covid 19 lockdown in 2020, and since when it has been terminated.

(Q 9 - 10)

126. I was aware of the Regional Review of Urology Services, however, to the best of my recollection Mr Young was the person with most involvement on behalf of the Trust Urology Team. As urologists, we were consulted during the Review. I attended a meeting at the Park Avenue Hotel on 9 October 2008 when the Review was in progress and discussed with us. I had concerns in relation to the direction of the Review and accordingly corresponded with Ms McNichol on 20 December 2008. [see AOB-03498 -AOB-03503].

127. I have been able to identify the Regional Review of Urology Services, Team South Implementation Plan [AOB-00140 – AOB-00172]. I cannot recall being involved in the creation of that document or the plan that is outlined in it. I note the Trust was to provide a further plan (see pages 15-16 of the Plan), however, I have to date been unable to identify any follow up document referencing this. I would hope that Mr Young will be able to provide information to the Inquiry in relation to who at the Trust devised the plan and who was responsible for its implementation

128. Upon reviewing the Implementation Plan, I have been reminded that I was aware of this plan to address the outpatient review backlog, which amounted to 4037 patients by 31 May 2010. I had minimal involvement, if any, in the organisation or implementation of the Plan. I certainly have had the experience over the years of being asked whether patients could be discharged from review, or reviewed by a Trust Doctor or Clinical Nurse Specialist, or similarly for review by myself. I believe such practice predated and post-dated the Implementation Plan. I cannot recall being requested by a Lead Nurse to consider management plans for cohorts of patients in an organised fashion consequent upon the Implementation Plan. I therefore am

unaware how it was implemented, reviewed or its effectiveness assessed, if at all.

129. Human Resources should be able to provide the Inquiry with a details of the number of consultants employed following the Implementation Plan. Recruitment and retention were significant problems in the following years.

130. I refer to the chronology I have attached to this statement in relation to under-resourcing. That has numerous references to waiting lists after 2010, which remained largely unaddressed right through until the end of my employment by the Trust in July 2020. That, as I have indicated elsewhere in this statement, was a significant risk to ongoing safe delivery of service to patients. Thus, I do not believe that the Plan, if implemented, fully achieved its aims as our department continued to have an outpatient review backlog during the following decade.

131. Whilst it may not directly relate to the Implementation Plan, I wish to draw to the Inquiry's attention an issue which concerned me in relation to the completeness of the statistics in relation to the waiting list. If the figures were indeed worse than those recorded it may reflect further on the failure of the Implementation Plan to address the backlog of patients.

132. In 2019, I was informed that Dr Rankin, Director of Acute Services, had introduced a system known by the acronym DARO (Discharge Awaiting Result Of) around 2010. Essentially, administrative and secretarial staff had been instructed not to place any patient on a waiting list for outpatient review if the patient had any investigative test requested, whether it be a blood test or a scan. The patient was instead placed on a DARO list awaiting the result or report of the investigation. The report would then be provided to the appropriate consultant who would then determine the urgency with which a patient would be reviewed, if at all. I had occasion to find a patient remaining very well, their previous problem having been resolved, and planned to discharge the patient provided that a requested test confirmed their well-being by its normality. However, I had been unaware that any and all patients having any test requested, such as a further scan in six months' time, followed by review, was actually not to be placed on a waiting list for review with the report of the test at all.

133. In my view, DARO was introduced due to service inadequacy. It was presented as a patient safety measure, in that patients whose test results were abnormal would be prioritised for review. However, the outpatient review capacity was so inadequate that patients whose test results were normal, and patients who did not have any tests requested, would wait ever longer periods of time for review. Its implementation resulted in a practice whereby review of patients was replaced by communication of the test results to them. In fact, it was discovered in 2019 that one unintended consequence of DARO was that patients who had tests requested at the time of triage of their referral, were not placed on a waiting list for a first outpatient appointment until the test result or report was reviewed by a consultant.

134. I cannot recall having been consulted concerning the introduction of DARO and have been unable to find any evidence of having been consulted. I would not have agreed to it if I had been, particularly as the Patient Administration System (PAS) prevented administrative staff from placing patients on both a DARO and outpatient review waiting list. It would appear that no consideration was given to the time required to undertake the task of reviewing results and reports, and whether the exercise was at all possible. There certainly was no time allocated to this additional workload in any proposed job plans.

135. Apart from the obvious risk to patients failing to be reviewed, and to those with abnormal results and reports due to lack of time provided for their review, the addition of DARO to the Implementation Plan (if that is what was occurring) did not succeed in fully addressing the outpatient review backlog, as there were 2386 patients still awaiting review appointments in March 2018, the longest awaiting review since February 2015 (160 weeks). I did express concerns in relation to DARO in an email exchange in January/February 2009 primarily between Colette McCaul and me. [see AOB-07566-AOB-07567]

136. As with the failure of the Implementation Plan to resolve the outpatient review backlog, it similarly failed with regard to every other domain. The fundamental reason for that failure was that the Plan took no account of the urological need of the resident

population it proposed to serve. This is a failure which has plagued the Service since 1992 when it proved almost impossible to convince the Director of Public Health for the Southern Health and Social Services Board that its resident population of 269,000 required the appointment of even one consultant urologist.

137. Instead, the Implementation Plan took account of the Service's current performance or output, added a further 18% of performance or output due to the addition of the resident population of County Fermanagh, as well as additional output if breaches of targeted services (such as cancer services) were to be avoided, and calculated how much additional resource would be required to provide that increased service. The future service was essentially determined by the currently restricted service capacity.

138. This is very well reflected in increasing waiting lists for admission for elective inpatient surgery. Inadequate elective urological surgical capacity results in increasing numbers of patients waiting for longer periods of time for admission. Elective surgical capacity is determined by several factors, including elective bed capacity, elective operating theatre capacity and the multidisciplinary staffing to facilitate it. When I was providing a service as a single consultant in the early 1990s, I had four to six operating sessions available to me each week. The elective operating sessions available to three consultant urologists in 2010 remained unchanged at a total of six per week. The Implementation Plan proposed an increase in that total to nine per week. By December 2018, five permanent consultant urologists and two locum consultant urologists had a total of eleven elective operating sessions available to them each week. That total was reduced to 10.5 sessions per week by January 2019.

139. At the time of the Implementation Plan, on 30 June 2010, there were 580 patients awaiting elective admission, with only 53 of those patients waiting longer than 26 weeks, which was the target at the time. Provision would have been made for those additional 53 patients in calculating future service provision. Not surprisingly, as a consequence of calculating future service provision from the base of current service provision which was inadequate for all of the above capacity constraints, there were

1141 patients awaiting admission one year later, on 30 June 2011, and 302 of those patients were waiting longer than 26 weeks. The numbers increased during the following decade. By 30 June 2020, there were 1066 patients waiting longer than one year for elective admission, with some patients awaiting admission since August 2014, almost six years. To place that number in context, on that same date, there were 1647 patients in all of England waiting longer than one year for admission to hospital for any procedure in all specialties (this figure I gathered from a report on BBC News).

140. The statistics I have quoted above are taken from the Northern Ireland Hospital Statistics website which is freely accessible but can be a little difficult to navigate.

141. Further reference will be made to such issues in the later sections of this response.

Section 4 – Urology Services (Q 11 – 14)

142. I have been aware of the Protocol and have read it at some point in time following its publication. I cannot recall by whom or by which means I was made aware of it, or by whom or by which means it was provided to me, if indeed it was provided to me. I did not disseminate it in any way to other urology consultants in the Trust, and I am unaware of it having been disseminated to those other consultants by anyone else. If it was not provided to me, or to other consultants, I do not know why that was the case.

143. The Inquiry will be aware that I was subjected to a formal investigation which endured from 30 December 2016 until receipt of its determination on 1 October 2018. During the course of that investigation, I requested on a number of occasions a copy of the Trust's policy regarding triage of referrals, and to which reference had been made. I was eventually advised that the Trust did not have such a policy, and that the Protocol was its policy. [see AOB-01690 Request via email dated 31 July 2017, see AOB-81602 – AOB-81603 Request via email dated 01 October 2018, see AOB-81601 Response via email dated 23 October 2018, see AOB-01774 – AOB-01777 Request via FOI (undated) & see AOB-02102 –

144. It has been, and remains, my understanding that the Protocol is essentially a directive to Trusts to have its objectives implemented. It is my understanding that it was the responsibility of Trusts to ensure that services were adequately resourced and structured to render implementation of the Protocol feasible and sustainable. However, as detailed in this response, the Urological Service commissioned by the HSCB and hence provided by the Trust was so inadequate as to render implementation of all its objectives impossible in a sustainable fashion.

145. The greatest awareness of time limits during the years following publication of the Protocol related to the provision of cancer services. These time limits derived from Ministerial targets which were apart from the Protocol, and not specifically contained within it.

146. Some of the underpinning principles in the Protocol are apparently laudable but clinically indefensible in practice. For example, while it is right and proper that patients should be treated on the basis of clinical priority, the Protocol also asserts that patients with the same clinical priority should be treated in turn. There are only two categories of clinical priority of patients on lists awaiting admission as inpatients and day cases: urgent and routine. There is no separate red flag category. Such patients awaiting cancer surgery are placed on the urgent waiting list. If the urgent waiting list is five years long, it is inconceivable that all of the patients in that category actually have the same clinical priority. As a consequence, I spent a number of hours each month sub-categorising the urgency of patients on the urgent waiting list, in addition to upgrading patients on similarly long routine waiting lists to urgent waiting lists as their conditions worsened due to the length of time they were waiting.

147. A similar underlying principle of the Protocol was that inpatient care should be the exception. The Trust did nominally have a Day Surgical Unit. However, patients being admitted electively for a surgical procedure performed under

general anaesthesia had to be admitted by 08.00 am and discharged by 01.30 pm to vacate beds for the afternoon list in another specialty. Such inadequate day surgical provision rendered the objective impossible.

148. As for the triage of referrals, apart from the lack of provision of adequate time for triage, the time limits were set in the context of patients suspected of prostate cancer waiting up to 107 days for a first outpatient appointment, urgent referrals waiting up to 85 weeks for a first outpatient appointment and routine referrals waiting over three years for a first outpatient appointment in 2019.

149. I am not aware if time limits specific to the Protocol were monitored or by whom, apart from those relating to the prioritisation or triage of referrals. I was repeatedly aware of requests by the Head of Service to me and my colleagues to address issues of timeliness across all domains arising from the inadequacy of the Urology Service, even though it was often impossible to resolve them. I do not recall any specific reference being made to the Protocol when issues of the timeliness of service provision by me or by others were raised or discussed.

(Q 15 – 18)

150. Collection of data in general terms did not fall within my remit as a consultant urologist. The Inquiry should be able to obtain a better understanding of systems in place for collecting patient data from those employed in operational/administrative functions. Ms Corrigan, as Head of Service, may well be able to assist.

151. In my role as a consultant, however, I was well aware that the Trust, on a regular basis, collected patient data for example in relation to waiting times, waiting lists, new to review ratios, length of stay, day case rates etc. There were many systems in place for collecting data to monitor performance. As a consultant I was made aware of certain of that data (for example waiting lists) on a regular basis.

152. Others will be better able to comment on performance indicators, however, as

I will highlight below under the heading "Staffing", those indicators that I was made aware of confirmed what we knew on the ground, namely that the Urology Department was failing its patients in terms of new appointments, review appointments and times to investigation/treatment/surgery. I would have inputted information as appropriate, which led to the compilation of the statistics, although in later years this was carried out by other Trust staff known as "coders".

153. I am unsure who was responsible for overseeing the performance matrix and the quality of the service provided. Ms Martina Corrigan had a role in that, as she would have been my main point of contact in relation to matters that needed addressed such as waiting times. It seems to me, however, that the matrix demonstrated that unfortunately the Department was unable to deliver the quality of service which patients deserved.

154. In terms of endeavouring to provide a quality service, within the constraints of the system, there were a number of processes I participated in as a consultant which should have assisted in patient safety including departmental meetings, MDMs, patient safety meetings, audit and appraisal. Those procedures would not as easily have been measured in terms of statistics. As is apparent from my comments under the heading "Staffing" at Questions 21 - 25, I consistently raised issues in terms of the statistics I was aware of in relation to waiting lists etc and the potential impact these issues had on the quality of care that could be delivered.

155. The Trust analysed consultants' statistics through a system known as CHKS/CLIP. I cannot recall when this was first implemented, however, I have made reference to it in a number of my appraisals. I had doubts about the effectiveness of the system as it appeared to analyse blunt statistics rather than what underlay the statistics. For example, in relation to the numbers of cases completed in the operation theatre, no allowance appears to be made in relation to the nature of the procedure. Some operations can be performed much more quickly than others, dependent on the nature of the surgery and the patient

concerned. I also had reservations about the accuracy of the data contained in the reports. I expressed some of my doubts in relation to the reliability and utility of the CHKS/CLIP process in my 2016 appraisal [see AOB-22866].

156. In terms of statistical analysis, the system certainly identified what we all knew was a significant problem – the volume of patients requiring treatment and the length of time it took to treat them. Whilst the system may have been effective in identifying issues, the difficulty was that these issues could not be adequately addressed and resolved.

157. There also appeared to be a disconnect between the statistics which demonstrated a problem and management input in relation to the workloads of consultants. I would take the period of 2012-2016 as a particular example when my waiting lists were substantial and at the same time, I took on additional responsibilities of Lead Clinician of the Trust's Urological Cancer MDT, Chair of its MDM as well as Lead Clinician and Chair of the NICaN Clinical Reference Group for Urology, including the particular pressures of preparation of both bodies for National Peer Review in 2015.

(Q 19 – 20)

158. I refer to my comments above under Section 2 "Your Role".

(Q 21 – 25)

159. Throughout my time at the Trust there was inadequate staffing and insufficient logistics (such as availability of theatre time). I refer the Inquiry to the narrative account I have provided at the beginning of this statement, and I adopt the same where relevant to the issues raised here about the inadequacy of staffing levels giving rise to an inability to see and treat patients in a timely manner.

160. The lack of adequate resources had real tangible results. The Trust, as time progressed, became increasingly sophisticated in collection of data in terms of

waiting times, review times and such like, however unfortunately the collection of data did not result in an adequate response to the needs that data demonstrated. Statistics constantly showed unacceptably long waiting times, which were frequently disproportionate to other specialities within the Trust. Behind every statistic is a person with the worry of awaiting a diagnosis and/or treatment. During that time their condition is unaddressed, leading to needless suffering and/or deterioration in their condition making treatment more difficult and ineffective. Being unable to provide treatment in a timely manner can also lead to acute admissions, which in themselves can be very time demanding to deal with and thus exacerbate the waiting lists further, given that acutely ill patients need to be dealt with as a priority. If dealt with in a timely manner many such admissions could have been avoided. Increased waiting lists in themselves created additional administrative burdens as patients and their GPs contacted the Service for information, to complain etc in relation to the length of waiting times. That in itself took time and effort to respond to.

161. There were long term problems with under-resourcing at consultant level. Even when it was accepted that there was a need for increased numbers of consultants, there tended to be a delay in implementing a plan to employ extra consultants, or to successfully recruit appropriate individuals. When posts were created, many were not filled for significant periods of time. Human Resources and/or the Medical Director's Office should be in a position to provide the Inquiry with a table of exactly who was employed when within the Urology Department and when posts were unfilled. That however will not necessarily show the full picture as I do not accept that the Service could have been satisfactorily run at any time even with the posts which the Trust created and identified as needing to be filled.

162. The lack of consultants also directly impacts on the number of junior grade doctors who can work. Those staff need supervised and accordingly lack of consultant numbers means a lower number of junior posts, which in turn feeds into capacity (or lack thereof) to deliver the service.

163. From early days I raised concerns in relation to the capacity of the service to meet the growing demand. Throughout my time with the Trust there was a significantly increasing demand for urological services, as indeed there was throughout Northern Ireland. That was not, in my view, met by an adequate response from the Trust. Whilst I am sure there was increasing demand in other areas, their statistics suggested they were better resourced than the Urology Department. I raised my concerns in relation to the likely impact that would have on patient care, for example through the appraisal process. Other colleagues also raised concerns of a similar nature.

164. My response was also to work as hard as I could both in accordance with my contracted hours, which were never sufficient, and way beyond that to try to deliver a service to patients who desperately needed it. Each patient contact creates additional work such as administration in terms of recording information, corresponding with others, arranging investigations and acting on the outcome thereof. Therefore, working harder and seeing more patients in itself creates additional work to be carried out in respect of those patients. With ever-growing waiting lists, that also led to the need to prioritise patients. Urgent patients were displaced by those with even more urgent needs. When you are operating and consulting with patients, you cannot do administration at the same time. This often leads to prioritising what can be done. I often therefore completed administration as and when I had time to do so, often within my own personal time. As is apparent from the below this is an area that I struggled with.

165. The constant pressure did impact on the Department as a whole, including my ability to provide safe clinical care. If I could not see patients in a timely manner by its nature you cannot provide safe and appropriate care. Working under constant pressure, including outside of hours contracted, contributes to fatigue and low staff morale.

166. Staffing issues were also complicated by the lack of the Trust providing a fair allocation of time for additional work, such as the work I have referred to above when I took on the role of Chair of the MDT and Lead Clinician with NICaN. In

short, if one takes on those additional responsibilities, other matters will be displaced, leading to additional pressures on the patient backlog.

167. On occasions the Trust made efforts through various measures to try to address the under-resourcing issues. That included use of the independent sector, however, that was not without its shortcomings. The Trust also appointed locums, however, on occasions also failed to consult with clinicians in relation to the appropriateness of their proposed appointees.

168. As staffing issues persisted throughout my time at the Trust it would be unwieldy to try to commit to this statement each and every staffing issue which I encountered.

169. I attach a chronology entitled “Under Resourcing” which cross references a number of the documents my legal team and I have been able to review to date which are relevant to resourcing and staffing issues. Some contain summaries and extracts from various documents. The documents have been cross referenced and should be read in full as the summaries may not fully reflect all matters relevant to staffing issues, having been prepared prior to receipt of the Section 21 Notice. Time has not permitted a full review of all documents referred to therein. Within time constraints it is impossible for me to add a commentary in relation to each and every entry, however, I will endeavour to point towards a number of entries which may assist in illustrating the points I have made above in the introductory paragraphs to this section.

170. From early days in my employment, I raised issues in relation to adequacy of the resourcing in urology. An example of this is in my letter of 7 March 1996 to Helen Walker, then Human Resources Manager at Craigavon Area Hospital [see AOB-00018 – AOB-00022]. At that time, I was the sole consultant urologist at the hospital. To try to maintain the service I was working 70-80 hours per week and often sacrificing holidays. I gave a comparator to HR in terms of the ratio of population numbers to Urologists elsewhere. I noted how in Western Europe statistics were 1 Urologist to every 50,000 people approximately; in Northern

Ireland there was 1 Urologist to every 200,000 people; and in Craigavon I was the sole urologist for a population of around 300,000. In fact, a survey of urological manpower by the European Board of Urology found the mean urologist / population ratio in 1998 was one for every 36,654 people. (E. A. Kiely. BJU International (2000), 85, 6 – 13) [see supplemental October bundle pages 35-41].

171. Throughout the early years I continued to work excessive hours. This was reflected in the ex-gratia payment I have already referred to above. I was also offered additional PAs in recognition of the additional workload I had been undertaking. Please see letter of 10 July 2006 from Dr Orr to me [AOB-000039 - AOB-00040].

172. In my appraisal in July 2007 [see AOB-22189], I noted that an external services review had recommended a fourth consultant, however, at that time we were only about to appoint a third consultant. I expressed my frustration at the lack of consultant expansion.

173. As the Inquiry is already aware, there was a review of urology services in Northern Ireland reporting in March 2009. I shall not comment on that in detail as no doubt the Inquiry will read it in full. In passing however the Inquiry will note that at that stage (page 12) the Trust had three consultants for a population of 305,000. Themes and challenges were identified at paragraph 6.2 including the increasing demand in workload, capacity pressures both in terms of staffing and infrastructure and the challenges presented to small teams of 2-3 consultants in terms of on-call and cross cover arrangements. It also noted the impact of the European Working Time Directive on Junior Doctors hours and how there had been a shift from consultant led services to consultant delivered services. It also noted at paragraph 8.1 the consultant population ratio that the British Association of Urological Surgeons (BAUS) recommended of 1 to 80,000 by 2007. In 1999 the Northern Irish ratio was 1 to 167,000 reducing to 1 to 103,000 at the time of the review in 2009. These factors affected the delivery of urology services generally in Northern Ireland however, they were particularly acute in the Trust.

174. At a Morbidity Mortality Meeting on 17 July 2009 [see TL1 pages 306-313 and AOB-82345 – AOB-82352] a discussion noted the main issue from a urology perspective was that clinicians recommended timescale for patients review at OPD were not being adhered to, with the waiting time for review within urology at that stage being 18 months.

175. There was discussion on 16 October 2009 in relation to a five consultant model and the workability of it. However, it is clear that consultant urologists at that stage considered there were going to be challenges with that model due to the lack of junior medical staff in the team [see AOB-82422 – AOB-82423].

176. The Annual Report for year ending 30 April 2010 noted the "*considerable challenge to the provision of urological services in Craigavon*" [see AOB-05727 – AOB-05735].

177. An example of concerns about appointment of clinicians without adequate consultation with existing consultants, to ensure that appropriate CVs were considered, was expressed by me to Dr Rankin on 18 January 2010 [see AOB-000138 – AOB-000139]. I also raised my concerns in that document about the impact ward re-configurations would have (essentially meaning that patients would be admitted to a number of wards rather than a urology ward with the attendant difficulties that would cause) and the impact of loss of radical pelvic surgery from the Department and impact that may have on recruitment, which already was a known challenge.

178. The Regional Review of Urology Services Team South Implementation Plan of 14 June 2010 [see AOB-82479 – AOB-82510] proposed that Team South would be based at the Southern Trust and treat patients from the southern area and the lower third of the western area (Fermanagh). The total catchment population would be 410,000 and it was suggested that there should be an increase of two consultant urologists, giving a total of five and two specialist nurses. At that time

(see page 4) the urology team was noted to have three consultants, two registrars, two Trust grade doctors (one post currently vacant), one GP with special interest (seven sessions per week), one lecturer practitioner in Urological Nursing (two sessions per week) and two urology specialist nurses. The review noted the substantial backlog of patients awaiting review at consultant led clinics which at that time numbered 4,037, and the Trust's plan to address that backlog was outlined.

179. On 19 July 2011 Ms Rankin emailed the consultants [see AOB-05791] noting that at that stage the Trust had received approval to proceed with the development of the urology service in line with the Regional Review. It is worth noting this was two years after the review and one year since the proposed implementation plan. During that period, despite an increased population to cover, we had to continue with three consultants until 2011 when Mr Glackin was appointed.

180. On 20 July 2011 Ms Corrigan emailed to indicate there was further funding for additional review backlog clinics [see AOB-05792 – AOB-05793]. The review backlogs in outpatients in the various specialities were quoted as follows:

> "General Surgery – 1972
>
> Breast Surgery – 3
>
> Oral Surgery – 56
>
> Urology – 3329
>
> ENT – 2126
>
> Ophthalmology – 1837
>
> Orthopaedics – 455
>
> Thoracic surgery – 0

181. Throughout my time I was always concerned that urology was so poorly resourced compared with other specialities receiving preferential treatment, given their significantly lower backlogs and waiting lists. This was an ongoing pattern.

182. On 7 March 2012 I expressed my frustration to Ms Corrigan in an email referring to the difficulties in how patients were categorised as "*urgent*" and when patients who were categorised as urgent required treatment how that displaced others in the following terms:-

> *"With regard to the numbers of patients on urgent waiting list for long periods, I believe that there is a rational explanation. The only category available for all patients who are not routine is "urgent". This is entirely due to the fact that there are only 2 categories of clinical priority available. When there were 4, we had available a much wider and more appropriate, 4 lane carriageway, along which to streamline patients. I believe that it was unwise to have dispensed with that years ago. I voiced my opinion at that time, but found myself in the wilderness, as usual. However, the department should be reassured that those urgent patients waiting a long time are so because patients much more urgent have since been attended to, but still have a greater clinical priority than those labelled as routine. Mind you, it would help greatly if one recurrently did not have to consume operating time to the routine and in chronological order, at the whim of the same department."* [see AOB-03663 – AOB-03666].

183. An example of the type of issue we faced in recruiting qualified urologists can be found in an email from Mr [redacted] to Mr Young dated 5 October 2012. He quoted issues in relation to inadequate theatre time, providing inadequate operative training, how the job would personally develop him and his wage expectations, all of which militated against him taking the job as a Speciality Doctor in Urology. In short, we continued to have difficulties in recruiting both at consultant and more junior levels [see AOB-06179].

184. In my 2012/13 appraisal I drew attention to the extra demands Chairing the MDT were putting on me in terms of timescale in the following terms [see AOB-22323]:

"Since assuming the Chair of Southern Trust Urology MDT in April 2012, the supervision and overview of the provision of urological cancer services has added significantly to my work. Each week, 35 cancer cases are discussed at MDM. All aspects of each case are previewed by me before each MDM, presented by me at MDM, and the plan for each case signed off by me after each MDM so that each GP, and other specialists to whom a case may be referred, receives that communication one day later."

185. I also noted the lack of time we had for administrative work when carrying out so much clinical work in the following terms [see AOB-22325]:

"The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is on ongoing cause for concern."

186. Waiting lists continued to be a problem in 2013. There had been an initiative at that time to try to address the waiting lists operating on Saturdays. However, when a new locum was appointed, there was no longer the availability to carry out Saturday work due to lack of funding. I would refer to Ms Corrigan's email of 20 May 2013 in that regard which reads in the following terms:-

"You may be aware that I had been using the funding from the vacant consultant's post to fund the additional lists during April and May. Since we have now employed a locum from today, there is currently no more funding for these additional lists during April and May. I have put in a bid for more funding but for now please do not send for any patients for Saturday's 8th, 15th, 22nd and 29th June. It is ok to go ahead with 1 June list and with the additional clinics that I have

agreed for June, however I cannot agree to any more additionality for June." [see AOB-06665].

187. In my 2014 appraisal I reiterated my concerns in relation to the delays in seeing patients and increasing waiting lists. I also noted how that had a negative impact on me in the following terms:-

"The factors impacting upon the delivery of patient care have been the same for years. They have not changed from year to year, or perhaps more precisely, the only change has been that they impact more and more negatively. Even though I, like all of my colleagues, have increasingly long waiting lists for surgery and increasing numbers of patients waiting longer periods of time for review, the relentless expectation is to take us increasing numbers of new patients and do so in within stipulated time periods, and only to join the lengthening queues for surgery and review, and to the extent that the wait impacts negatively upon their care and outcomes. I work long hours every day, contracted or otherwise, paid and unpaid, in an attempt to mitigate the worst outcomes." [see AOB-22550]

188. I also made the following comments in relation to the non-clinical demands I had in relation to Lead Clinician of the MDT and Chair of NICaN and preparation for Peer Review in the following terms:-

"Discussion

My main roles in this domain have been those of Lead Clinician of the Urological Cancer MDT for the Southern Health and Social Care Trust, and as Lead Clinician and Chair of the Northern Ireland Cancer Network (NICaN) Urology Clinical Reference Group.

As evidenced by the documentation above, the Southern Trust has had a progressive increase in the numbers of referrals of patients suspected of having cancer, the numbers confirmed of having cancer and the numbers managed. This increase has been the case across all urological malignancies, but was

most pronounced in relation to renal tumours. In spite of this increase, we made very significant progress during 2014 in assessing and managing increasing proportions of all cases within the 62 day pathway, until we reached 100% compliance by January 2015.

During 2014, much of my effort was in constructing all of the organizational infrastructure and documentation in preparation for Peer Review in 2015.

Similarly, as Lead Clinician and Chair of NICaN Urology, I led the development of agreed Referral Guidelines, Clinical Management Guidelines and Patient Pathways in preparation for Regional Peer Review in 2015." [see AOB-22596]

189. I was not alone in my concerns in relation to the waiting lists and capacity being unable to meet demand in terms of appointments per month and operating time, not to mention administration and follow-up investigations. On 18 July 2014 Mr Haynes enclosed Minutes of Urology Meeting re "vision". The notes can be summarised as follows:-

"Meeting dated 10 July 2014

Main challenge is that patients are waiting too long for their care. Receive an average of 416 new outpatient referrals per month while we are only currently delivering 366 new OP appointments per months. For inpatients/day case surgery we list approx. 160 hours of operating per month while capacity to deliver is 140 hours per month. The demand vs capacity is therefore 50 new referrals per month and 20 hours operating. This does not account for follow up outpatient reviews or the ESWL, flexible cystoscopy or urodynamics waiting lists. The current total backlog stands at:
1390 new outpatients without appointments
802 patients listed for IP or day case procedure
3600 FU appointments pending

Tasked by the board to do the following:

1. *Deliver a sustainable service*
2. *Is based on efficient models of care*
3. *Maximises available capacity*
4. *Maintains acceptable, equitable waiting times*
5. *Incoorporates planning for delivery of increasing demand*
6. *Identifies what additional resource is required to deliver this service*
7. *Identifies risk which pose a threat to delivery of the vision*

Notes that previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation.

We agreed that the board want us to look to re-examine the entire urology service and redesign but that the board expects us to fail to deliver its requests and anticipates us to return with one or two ideas that ultimately fail to deliver real change" [see AOB-71178 – AOB-71184].

190. Mr Haynes summarised the position in an email of 27 June 2014 [AOB-71077-AOB-71079] in the following terms:

"Re: Follow up from meeting with Dean Sullivan

It is clear that we cannot work to meet demand as it is at present without <u>huge</u> capacity expansion." (my emphasis)

191. In my email of 18 July 2014 [see AOB-71188-AOB-71189] I noted the principal challenge facing the Trust Urology Department which was patients were waiting too long for their care.

192. In the context of the formal investigation against me, in a meeting of 30 December 2016 with Dr Wright I commented as follows:

"I don't know what is your view about that because the – I mean, some the context of this though is the enormous pressure to operate. The complaints and the enquiries that I deal with every day are, when am I having my operation done? People's clinical outcomes are being compromised all of the time, day in day out, because of not only the lack of capacity as a whole but, in addition, the inequity within departments. For example, in performance data – I think it's ironic that it's called performance data because it is not the performance, it is not what you do, it is what has to be done. In October I had 288 people on my waiting list for in-patient admission and one of my colleagues 29. And I have implored that situation would be addressed…" [see AOB-56005-AOB-56006]

193. In a further formal investigation meeting, on 24 January 2017, with Mr Weir and Ms Hynds, the following exchange took place:

"Mr O'Brien: The letter was just telling that others shared my concerns. And the biggest concern that I had then and had for years and had since then was the big elephant in the room, which is not on any of these things, and that is the sheer numbers of patients awaiting admission and re-admission for procedures and operations and suffering poor clinical outcomes as a consequence.

Siobhan Hynds: Can I ask who you were raising that with at a point?

Mr O'Brien: At a point.

Siobhan Hynds: No, I mean at the various points, who was it you were raising that with?

Mr O'Brien: I have raised that with everybody that I can think of over 20 years. This is – I have raised this with – the titles have changed it's that long. Clinical directors, Ivan Sterling, Liam McCaughey John Templeton, Michael Young. And they, sort of, cliched response that these are Trust issues. Except for the fact, regrettably, the Trust doesn't make than an issue. It is – I mean, I do have already prepared, I have gone through all of my operating over recent years, and in fact

whilst I would like to have the opportunity at a subsequent time when meeting both to share these with you, but like, for example in 2013, as far as the job plan would go, I would have been expected to do 84 sessions. I did 113 elective sessions that year.

Colin Weir: Is that operating?

Mr O'Brien: Operating. I would have been expected to do 79 session in 2014 as the urologist of the week was introduced that year and I did 101. 2015, 70 sessions according to my job plan, I actually did 95.5 four hour sessions. You multiply that by four for every hour. In 2016, up until I left, I would have been pro rata expected to do 61 sessions. I did 83.25." [see AOB-56040-AOB-56043]

194. In the context of my meeting with Dr Khan on 9 February 2017 (within the context of the formal investigation) I noted the time pressures that I was under in the following exchange:

Page 35 (section A-H)

"MR O'BRIEN: That is a concern, It is also a concern of mine from the point of view of the patients because there is another reality here and that is that, you know, if I – if I am not – If I am quarantined from a whole load of patients and as a consequence they are not going to be reviewed by anybody else, because there's a limited capacity, you know, they're suffering. Like as I was saying, I had certainly booked up until the first three monthly clinics of 2017 in South West Acute Hospital. To my knowledge only two of those patients have been reviewed and there's a lot of people needing to be reviewed. I mean, I think a lot of these 668 patients with no outcomes formally dictated would have been cancer review patients that I would have done updates on CAPS, which my colleagues didn't do, instead of dictating letter, but these people all need to be reviewed."

Page 37 (Section D – H)

"MR O'BRIEN: I will just give you a snippet. I quantified all of my additional elective in-patient operating. Right. My additional. Over what I was job planned or expected to do. From 2012 through to the end of 2016. And that has required 3.78 additional hours per week.

DR KHAN: Nearly a PA.

MR O'BRIEN: A PA. probably my administration time. And that's only one activity. I can tell you MDM and what I was previewing, four hours. Another one. Gone. Non-existent in the scam job plan. But I can tell you something, If I hadn't done any of that we wouldn't be sitting having this meeting with me and I feel very angry when it comes to that." [AOB-56139 and AOB-56141].

195. I also provided a document in the context of the formal investigation on 3 August 2017 summarising additional work hours as follows:

"In the context of the MHPS investigation, AOB relates to additional work 2012 to 2016 in detail in document. He emphasises these are underestimates and take no account of holidays etc.

The mean time allocated to NICaN per week during 2012 to 2015 – 1 hour.

Time as mean time, additional time, allocated to MDT and MDM work from 2012 to 2016 – 3.9 hours per week.

Additional time allocated to Clinics 2012 to 2016 – average 2.65 hours per week." [see AOB-01700 – AOB-01703].

196. In May 2018 the post-operative death of a patient caused Mr Haynes to communicate by email his concerns with Esther Gishkori (see AOB-01811-AOB-01812 AOB-80959-80960] copying in myself and others at that time in relation to the urology waiting lists. Many of the points and concerns I have referred to above were also made by Mr Haynes [see paragraph 57].

197. The report of the SAI in relation to this patient (who was not under my care) is at AOB-09636 and specifically refers to the review team noting "*that there are demand and capacity issues within the urology service*" with "*758 patients waiting over 52 weeks on 7 December 2018*" with an associated recommendation that the Trust "*should review waiting times and put systems and processes in place to minimise waiting times across specialties and continue escalation to the Health and Social Care Board as required."*

198. This is just one example in a case not involving one of my patients where there was delay and an SAI which may assist the Inquiry's understanding that this was not limited to my practice.

199. Mr Haynes clearly continued to have concerns similar to mine in relation to the delays in urology patients being treated, particularly in comparison with other specialties. In his email of 8 June 2018 [see AOB-01814] he provided a table which again demonstrated the disparity (this table has been reproduced in my responses to Questions 1 and 2 of the Notice [see paragraph 58] above.

200. In the context of the investigation against me in a meeting with Mr Weir on 21 September 2018 concerning job planning [see AOB-56386]. I raised the overwork in urology and also provided a comparator to gynaecology. Please see the comments reproduced in my responses to Questions 1 and 2 of the Notice [see paragraph 60].

201. In response to the increasing concerns I and my colleagues had regarding the increasingly long waiting lists and the attendant risks of patients coming to harm, my colleagues and I agreed in July 2018 to seek a meeting with the senior management of the Trust as soon as was possible to discuss this issue, in addition to arriving at an agreed memorandum of understanding regarding the Trust's expectations concerning the duties and priorities of consultant urologists when Urologist of the Week (UOW), and the feasibility of including triage of referrals by consultant urologists when UOW. A meeting was arranged for Monday 24

September 2018. On scheduling for September 2018, it was agreed with the Head of Service that there would be no elective clinical activity that day in order to have a comprehensive, multidisciplinary preparation for the meeting so that the above issues, and any others, could be discussed. I submitted my thoughts regarding the three primary issues [see AOB-01904 – AOB-01907]:

1. Urologist of the week
2. Triage
3. Waiting times for elective inpatient surgery

202. The meeting with senior management was indeed cancelled as the Head of Service had since undergone surgery from which she was recovering. As elective clinical activity had been cancelled, we used the day to discuss the above and other issues with senior nursing staff, in preparation for a future meeting with senior management. It was agreed that meeting would take place on Monday 3 December 2018, and again no elective clinical activity was arranged as it was our intention that adequate time would be available for discussion leading to consensus.

203. Mr Glackin circulated the minutes of the meeting of 24 September 2018 to those who had attended by email on 27 November 2018 in preparation for the meeting of Monday 3 December 2018. However, we were informed by the Head of Service by email on Friday 30 November 2018 [AOB-04250] that it had been agreed that the meeting was cancelled, but that she would meet with the consultant urologists at 10.00 am for two hours to discuss some of the issues raised previously on 24 September 2018. She did not specify with whom it had been agreed to cancel the meeting or for which reasons.

204. I note the GMC raised queries with Dr O'Kane in relation to the meeting which was due to occur between urology consultants and management in September 2018 but which was cancelled [Document File 5 pages 67-70 and AOB0-2639-AOB-02642]:

Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management.	*The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress.* *The meeting schedule for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.*

205. Dr O'Kane advised the GMC that the reason the meeting scheduled for December 2018 did not progress was because three of the six consultant urologists were unable to attend. This was not correct as the audio recording, and the transcription, of the early part of the meeting confirmed that all five of the permanent consultant urologists were in attendance. The sixth consultant was not invited to attend as he was a locum. [see AOB-56478 – AOB-56493 for this transcript of audio recording of 3 December 2018].

206. Nevertheless, having had our concerns raised, there was an expectation in late 2018 that additional operating capacity would be allocated to urology. The maximum number of fixed operating sessions allocated to urology up to this time had been eleven per week, to be shared between five permanent consultant urologists as well as one or two locum consultant urologists. Even though there had been a sixfold increase in the number of consultant urologists since 1995, it had not been accompanied by a commensurate increase in operating capacity. It

is also worthy of note that the Regional Review of Adult Urology Services had asserted in 2010 that Urology Teams must ensure that current capacity is optimised to deliver the number of Finished Consultant Episodes (FCEs) by consultant as per BAUS Guidelines and that this may require access to additional operating sessions up to at least 4 per week and an amendment to job plans.

207. However, the total allocation of inpatient operating theatre sessions to urology had been decreased to 10.5 sessions per week earlier in 2018 in order to provide additional operating capacity to another specialty.

208. The Head of Service then informed my colleagues and I by email on 12 November 2018 [AOB-04004 – 04005] that:

"Urology will be getting their 11 inpatient operating lists reinstated from 03 December 2018".

209. The outcome of our collectively expressed concerns in 2018 was to have the current compliment of 10.5 theatre sessions per week increased by 0.5 sessions by having our previous, inadequate allocation reinstated. Nevertheless, I was relieved that the inadequacy had been acknowledged when I wrote in response by email to Ms Martina Corrigan and my colleagues [see AOB-04006] in the following terms:

"I welcome the belated acknowledgement that the allocation of theatre sessions to our speciality has been disproportionately inadequate.

I hope that this reversal of fortunes may also be an indication of an acceptance of the suffering and risk of mortality endured by hundreds of our patients awaiting admission for surgery.

I wish to take this opportunity to acknowledge Mark's contribution to this recent increased allocation of theatre sessions."

210. One month later, on 17 December 2018, the Head of Service informed us by email [AOB-04251] that:

"After discussion with Esther and Ronan, we have had to reduce the Urology lists for January from 11 to 10.5 lists…This is outside our control as we need to give an alternative list to Gynae / ENT specialties".

211. I found it remarkable that the increase in the total number of operating theatre sessions allocated to urology could be decreased by 0.5 sessions per week, in order to facilitate specialties which had minimal numbers of patients waiting relatively short periods of time for urgent admission. As was the case twenty years previously, this seemed such an inadequate and short-lived response to having raised our concerns.

212. On 22 January 2019 in an email from Ms Martina Corrigan it again confirmed that the longest waits for first outpatient appointments for patients suspected of having malignancies (red flag referral) remained disproportionately with urology [see AOB-07451-AOB-07452]. The following figures were given:

"Breast – 11

Gynae – 5

E-Gynae -6

ENT – 10

Surgical (GPC) – 11

Surgical (OC) – 10

E-Gastro – 10

Urology Prostate – 67

Urology Haematuria – 60

Urology other – 31

Lung – 10

Skin – 6

Oral Surgery – 20"

213. By late 2019 the inability of patients to be operated on promptly led to an administration driven 'validation exercise' where patients who had been waiting for a long time on the waiting lists were contacted and effectively asked whether they still wanted their surgery or not, without any medical input at all. The emails at AOB-09489 – AOB-09484 reflect the incredulity of myself and Mr Haynes that such an exercise could be undertaken. Having considered the patients on his waiting list, Mr Haynes noted "*none of the decisions are free of clinical consequence"*. I observed that it would be "*courteous if not prudent to advise Michael, Tony and John of our exchanges"*. I was referring to our remaining colleagues Michael Young, Tony Glackin and John O'Donoghue respectively. This validation exercise is dealt with in greater detail in my response to Questions 1 and 2 of the Notice.

214. I do hope the above will assist the Inquiry in appreciating the chronic staffing issues we had since 1992, the risks of harm that caused to patients and the fact it was well known to the Trust during all of that time. No matter how often concerns were raised, or by whom or to whom, inadequate medical staffing persisted as a feature of an insufficient, unsafe service.

(Q 26 – 32)

215. Mr Young as Lead Clinician, and / or Ms Corrigan as Head of Service and / or Human Resources should be in a better position than me to explain to the Inquiry the extent of administrative support staff provided to the Department as a whole during my tenure.

216. In this part of my statement, I shall concentrate on the administrative support

which was immediately available to me. That primarily was via a personal secretary. Initially, I did not have a personal secretary allocated to me, which from memory was for 1 to 2 years. Then I did have a personal secretary allocated to me for a few years until she moved to live and work in England. She was replaced by Fiona Lee who was similarly my personal secretary for a number of years until she relocated to a similar post at South Tyrone Hospital, Dungannon. During the last 15 to 20 years of my tenure, I had two personal secretaries for longer periods of time, Monica McCorry and Noleen Elliott. Monica replaced Fiona Lee and initially worked five days per week for me but subsequently went to a four-day week. In or around 2012, following an episode of ill-health, Monica retired and was replaced by Noleen. Noleen always worked a four-day week and worked with me until the end of my tenure. Both secretaries worked solely for me but would have taken calls for other secretaries when on leave. Outside of them, I also had access to a typing pool where audio-typists were available, and they would have provided administrative support, particularly on days when my secretary was not working. Their support however was limited to audio typing and / or taking calls. The audio typists pool was not allocated to one specific consultant but rather was available to all.

217. Matters which my secretary assisted me with included the following:

1) On the last Thursday of every month my secretary attended at a Departmental Meeting to agree the elective clinical sessions and the Urologist of the Week rota for all consultants and registrars for the calendar month following the next. The meeting was organised and run by Mr Young who organised the schedule. It was attended by all consultants, registrars and secretaries. Mr Young brought a spreadsheet with a suggested rota for the calendar month, with sessions to be agreed by everyone. It also took into account matters such as annual leave. My secretary would have had an input in relation to organising my diary following that meeting and on an ongoing basis, particularly when interim changes occurred.

2) Apart from the above, the bulk of my secretary's work consisted of performing

the administrative functions which I requested of her, answering and addressing communications received by email, in addition to the typing and sending letters dictated by me and by the registrars.

3) My secretary's first priority each morning was to review email correspondence received since the end of her previous working day. Many of these emails would have been sent to her by me. When Urologist of the Week, I communicated to her by email the details of patients to be placed on waiting lists on the Patient Administrative System (PAS) for elective readmission or review etc., as only the secretary could undertake that administrative function. Similarly, when undertaking triage of referrals, my secretary would conduct all similar administrative functions. My secretary undertook all the administrative functions associated with PAS as I did not have access to it or the ability to undertake those functions. These included adding patients to waiting lists and removing patients from waiting lists when requested to do so.

4) Having attended to those priorities and while continuing to do so as the day progressed, the greater part of her secretarial time would be spent typing and sending letters dictated by me, by locum consultant staff and registrars concerning patients under my care. This was an onerous task at times requiring my secretary to work later in the evenings to keep on top of typing, and probably exacerbated by having a four-day week. My secretary preferred to avoid having letters dictated by me being typed by audio typists as they may not have been able to undertake associated administrative tasks.

5) A lot of my secretary's time would have been involved in making and receiving phone calls relevant to my day-to-day work. Calls were fielded by my secretary on a daily basis and at the end of each day I tended to check in with my secretary about what contact she had had during the day and if there was any matter which required my personal input. If I was unable to do so, my secretary would bring to my attention either verbally or by email any matters which she was concerned about. Most of the calls related to patients seeking

advice from her on when they could expect to be admitted for surgery as a consequence of long waiting lists. I believe that secretaries had been advised by their line managers to enquire of patients or those calling on their behalf whether there had been any change in their circumstances, such as deteriorations in symptoms. If not, they were to be advised of their location on the relevant waiting list. If there were such changes, or if during taking those calls anything arose which my secretary considered needed my personal input, she would bring that to my attention. She would typically do so by email. The fact that the waiting lists were so long caused a great deal of further work for my secretary as she constantly had to field ongoing queries from patients in relation to same. While she was not required to keep a log of such calls, she estimated that she would have received approximately 20 such calls per day.

6) Correspondence and test results were provided to my secretary. Historically, my secretary would obtain the relevant charts and leave them with the test results / correspondence on my desk. As matters developed towards the end of my tenure, with greater information available and reliance upon the electronic care record, there was less need for charts to be left with me for review. There was a period of change over from around 2014/5 onwards when sometimes a hard copy chart would have been available but also information was available on ECR. During more recent years, attempts were made not to have reports accompanied by charts, as results and reports were so numerous, and as ECR progressively replaced charts.

7) My secretary kept on a shelf in her office charts for patients awaiting a the dictation of discharge letters, and on a separate shelf charts awaiting results and reports, which when received were left on my desk (as above), or returned to Medical Records if no actions were required. We both found it frustrating that registrars did not have adequate time to keep the dictation of discharge letters up to date, and I did not have adequate time to review all results and reports, particularly as the numbers of reports had been further increased as a consequence of triage.

8) When it was determined which patients should be admitted, my secretary corresponded with patients and liaised with them in relation to the inpatient booking. At one point the Trust appointed "schedulers" who would consider the relevant consultants' waiting lists and schedule who was to come in to be operated on. That is not a system I was in favour of as I considered the decision as to who should have priority, on the basis of clinical need, was better decided by the consultant than a scheduler.

9) Arranging elective admission for surgery requires consideration of a significant number of factors. The first group of factors relate to the available operating sessions and associated conditions. Is it a single session during the morning or in the afternoon or are there consecutive sessions on the day in question? Is there a need for equipment which may not be available if needed concurrently in another theatre? Has a registrar been rostered to assist? The second group of factors relate to potential patients for admission. This group includes clinical priority, change of clinical priority, comorbid status, current medication, distance from the hospital, transport availability, pre-operative assessment etc. I always phoned patients myself in advance of their possible admission to discuss their current condition and also to continue discussing with them the treatment options. I found that to be a vital part of the ongoing consent process. Moreover, as a consequence, I had few patients cancelling their admission, or being cancelled on the day of admission.

10) When a decision had been made that a patient was to be admitted for surgery, my secretary notified the relevant departments, including Preoperative Assessment (POA) and theatre. Having obtained the consent of patients for admission, I decided upon their time of admission, any pre-operative tests that were required and arranged the order of the operating session. I would have communicated all of that information to my secretary by email. She then formalised all of the administrative aspects of that, such as distributing lists of patients being admitted to the relevant wards, notifying POA, entering operative lists on the Theatre Management System (TMS), sending out formal letters of confirmation of admission to patients, and removing them from

waiting lists on PAS.

11) The day surgical list was organised by me and in conjunction with my secretary who would have formalised this in a manner similar to above.

12) In a similar manner, my secretary undertook all of the administrative functions in relation to arranging admissions of patients for flexible cystoscopies, for urodynamic studies and for interventional radiological procedures. The latter required additional coordination with the Department of Radiology.

13) In relation to outpatient appointments for general review clinics, they were not organised by my secretary but rather by the Appointments Office, though she did have protected review slots which were occupied by patients with clinical priority. My secretary however would have had a role in appointing new patients to the Outpatient Clinic when I specifically asked her to do so. Otherwise, patients were arranged by the Appointments Office. The oncology review clinic was also arranged by my secretary with priority given occasionally to new patients, to review of patients following MDM discussion and then to review of patients in order of clinical priority.

14) Similar systems related to the Armagh and SWAH Clinics. In the SWAH I normally saw 18 patients at the clinic, some of whom were new red flag patients, and some of whom were review patients. The red flags and cancer review patients would have been selected by me or by my secretary to occupy protected review slots and the remaining appointments were filled by the Appointments Office. Many of the appointments were self-selecting as the review was necessary following an MDM discussion.

218. As I understand it, secretaries were designated to specific consultants and other secretaries were personal secretaries to other consultants on the team. As with me, other consultants had access to the audio typists. However, when a

secretary was off on leave, secretaries to other consultants tended to cross cover them in relation to taking calls, but not other work. It is my understanding that the individual and collective workload of secretaries was monitored by their line managers, but I have no knowledge of how that was done.

219. I liaised with my secretary on a daily basis in person, on the telephone and/or electronic communications.

220. I do not know whether all consultants had the same access to administrative support. In particular, I do not know whether other secretaries worked four or five day weeks. Individual consultants will need to be asked that in order that a comparison can be made.

221. I cannot recall making a request at any time for further administrative assistance.

222. I cannot speak for the relationships between other urology consultants and administrative staff. However, from my own perspective, my communication pathways I always found effective and I always felt that I had a good support from very loyal, hardworking dedicated secretaries.

223. I do recall occasions when my secretaries raised concerns with me. I was always aware that both of my secretaries were under pressure and overwhelmed by their workload. It must have been a tremendous frustration to them having to constantly field calls from patients, who I am sure on many occasions were exasperated by the delays in being seen. It became something of a vicious circle as dealing with such calls in turn caused an additional administrative load, but at the same time often not being able to substantively move the patients' treatment on.

224. In addition, secretaries were being instructed by their line managers to undertake tasks which they did not feel qualified to undertake. For example, secretaries received an email from Ms. Andrea Cunningham, Service

Administrator, on 12 May 2016, to remind them of an earlier instruction in November 2015 to add comments regarding patients on waiting lists:

"to provide updates of what is happening with the patient and an explanation of why they have not been seen so far...to evidence chronological and appropriate management of patients / waiting lists" [AOB-77304 – AOB-77305].

225. My secretary shared her exasperation with me by email that day in these terms:

"This is yet another task that management are expecting secretaries to do. I do not think it is the responsibility of the secretary to ensure patients are operated on in chronological order rather than on clinical need." [AOB-77304]

226. I would confidently state that my secretaries and I shared much in common in that we were both expected to do that which was impossible in the time provided to do it. As with me, my secretary often related to me that she did not have any such concerns adequately addressed and resolved when raised with her line managers.

227. For a short time, I had some administrative work carried out at the South West Acute Hospital when we initially started seeing patients at the clinic there in January 2013. For the initial year approximately the patients' urology records remained as Western Trust records with the typing being carried out by a secretary based at the SWAH with a copy of the letter being sent to Craigavon Area Hospital. This however became administratively unmanageable and at or around the end of 2013 SWAH patients were provided with Southern Trust charts. The system developed whereby the notes were physically transferred by me as the records were located at Craigavon Area Hospital whereas the patient was being seen at the South West Acute Hospital. On a Friday afternoon records were delivered to me ahead of the Monday clinic at SWAH. I transferred the records with me and as I was returning home on the Monday (other than back to Craigavon Area Hospital) I brought the records from SWAH home with me so that I could complete any administration arising from them at a subsequent available

time, and in order of clinical priority. I appreciate that the issue of having patients' clinical records at home for longer periods was raised and is dealt with elsewhere in this response.

228. I am unaware of having retained to myself any duties which are typically performed by a medical secretary.

(Q 33 – 37)

229. I worked alongside many nurses and ancillary nurses in virtually all areas of my practice during my tenure at the Trust, in the management of inpatients in wards, in theatre and in outpatient clinics in various hospitals. Indeed, I have been privileged to have known, to have worked with and to have been supported by so many nurses and ancillary colleagues in caring for patients.

230. As I have already related, I was initially welcomed to Ward 2 South at Craigavon Area Hospital in 1992 when I was granted a total of four inpatient beds. I have recounted how the numbers of beds occupied by urology patients increased over the following years, and I have described how many nurses embarked upon journeys of discovery and learning of new pathologies, new managements and new skills required for the optimal care of patients. The founding of CURE played a crucial role in the development of urological nursing skills as it enabled us to

fund nurses attending conferences and training courses, such as those in urodynamic studies provided by Professor Abrams in Bristol.

231. The first ten years were replete with enthusiasm and ambition, hard work and commitment to caring for patients to the highest standard that we could provide. I have described the successes of Eileen O'Hagan and of Jerome Marley [see paragraph 35], both of whom were nurses on a ward which had no experience of urology prior to 1992. Their successes alone are reflections of the progress that was made in those early years. It was indeed a privilege and pleasure to be a part of it.

232. However, I do recall representations being made during the first 10 to 15 years by nursing staff, ward sisters and managers to their nursing managers with their concerns regarding inpatient care arising from insufficient numbers of nurses on the ward at varying times, and particularly during the night. I recall being advised that their concerns were rebuffed as they were advised that the ward did have the appropriate nurse / patient ratio.

233. Due to the expanding need for increased outpatient capacity throughout the hospital, the Urology Department had a modular building constructed to enable us to provide outpatient clinics in one location with dedicated nursing, ancillary and clerical staff. This building was named the Thorndale Unit and was opened in 2007. Its opening attracted a number of more senior nurses to move from Ward 2 South, diminishing the experience and leadership of nurses involved in inpatient care.

234. Nevertheless, all urological inpatient care was concentrated in one ward, and it was as a consequence of that concentration that we were able to maintain high standards of inpatient care. That all changed irrevocably with the reconfiguration of ward occupancy announced in 2009 when the number of inpatient beds occupied by surgical patients was reduced by 25%, This was achieved by a reduction in the number of surgical wards from four to three. Ward 2 South was lost to urology and became a medical ward.

235. The reduction in the numbers of inpatient beds occupied by urological patients, and their dislocation to another ward, would have had a significant impact upon the nursing staff whose commitment and skills I have described. However, it was devastating for all nursing staff to learn that reconfiguration also involved urological patients being dispersed throughout the remaining three wards, and with no undertaking that urological patients would be cared for by urology nurses. Many of our most experienced urology nurses were either deployed elsewhere or were lost to the Service. I have no doubt that the reconfiguration had an

irrevocable negative impact upon the standard of care of urological inpatients, from which it never recovered.

236. It was both ironic and contradictory that the reconfiguration was the outcome of the Acute Quality Care Project in March 2009. The overall aim of the Project was stated to be "*to improve the quality of surgical services delivered by the SHSCT across the acute hospital system"*. I do not know whether the reconfiguration was considered to have resulted in improvements in the quality of general surgical or breast surgical services, and others may be better placed to inform the Inquiry in that regard, including the Project Lead, Mr Simon Gibson, and the Clinical Lead, Mr Eamon Mackle.

237. One memorable feature of the reconfiguration was that it was announced as a *fait accompli.* I was not involved or included in any consultations or discussions prior to its announcement. The most I could do was to contribute to an attempt to minimise the predictable risks of harm to patients. I contributed to the Response to Trust's Proposals for Ward Reconfiguration, submitted 26 May 2009 [see AOB-03510 – AOB-03514]. The most that could be achieved was to have patients acutely admitted and those remaining for a longer period of time accommodated on Ward 4 North, while patients admitted as day cases or for short stays were to be accommodated in Ward 3 South. The result was the decimation of the inpatient urology nursing establishment, and more importantly, a fractured care of patients. Even though the compromise was abandoned by 2010 with the concentration of all urological inpatients in Ward 3 South, I believe that the care of urological inpatients never recovered to its former standard.

238. I also believe that the collective concerns of my colleagues and I regarding this diminished standard of inpatient care was a factor in the introduction of Urologist of the Week (UOW). In retrospect, I believe that there had been a growing concern regarding postoperative care of electively admitted patients which led us to conclude that we could not compensate for that while continuing with busy elective schedules. A UOW would provide some measure of assurance that

electively admitted patients would be adequately cared for, in addition to acutely admitted patients.

239. I am sure the Inquiry will be assisted by obtaining information from nursing staff in relation to particular stresses and strains they may have been under whilst running the Urology Service. However, a difficulty the Inquiry may have is identifying urology nurses who were in post for significant periods of time before and after ward reconfiguration in 2009, and able to provide comparative views.

240. The introduction of UOW was not enough to compensate for the effects of the ward reconfiguration, as concerns regarding patient care and safety persisted. The experience of the Ward Manager, Sister Catherine Hunter, sent an email to Ms Gishkori dated 12 November 2015 which was in the following terms:

"While I appreciate the need to keep 36 beds open on the ward, I am gravely concerned with the lack of staff and skills mix at present. While I am very grateful for the help given to me in recent days by Heather and Trudy Reid in getting us staff to cover unfilled shifts, I feel this is only a short-term measure and a medium to longer term solution needs to be developed and I would be keen to discuss this with you and my clinical sisters.

Currently, the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times. I am also responsible for the welfare of my staff and feedback from them indicates an environment of

desperation with many of them coming to see me in tears and unsure how long they can continue to work in such conditions.

In such circumstances, I am obliged by my NMC Code of Conduct to escalate my concerns to senior management and I would request an urgent meeting with you to discuss a plan of action to address the situation." [see TL5 pages 3566-3570 and AOB-75761-AOB-75765].

241. The document Sister Hunter attached to her email is an indictment of the conditions in which nurses were attempting to provide patient care. No doubt the Inquiry will note her own frustration at the

"lack of time I have to put plans in place given the need to take allocations of patients … it is impossible to do 2 jobs at once." [AOB-75762 – AOB-75765]

242. In this communication, the Ward Manager related her grave concerns regarding the inability to provide adequate inpatient care while concurrently failing to undertake all of the managerial and administrative duties expected of her. She was concerned that the risk of the requirement to record the care given by her nurses could compromise or replace the care given. The lack of time to complete all administrative expectations in addition to attending to the care of patients in conditions of such inadequacy has been an experience shared by nursing staff.

243. Mr. Haynes was concerned by this and commented in the following terms:

"This is extremely concerning and in particular if patients incidents have occurred due to staffing issues already we need to act now and not wait for a more significant incident to occur.

My experience of Bank / agency staffing is that while they may fill a vacant gap, they often do not perform the full role as we would see performed by a regular member of staff. The result is that the regular members of staff come under increased pressure during their shift. In addition to the Bank and agency staff you also highlighted to me that some members of our nursing team are very newly qualified and this has meant that at times the ward staffing (at staff nurse level) has been made up of bank / agency staff, a newly qualified nurse and one more experienced nurse, increasing the pressure on the regular members of staff significantly. I recently operated on the relative of a colleague and the informal feedback from this family regarding the ward was that the staff are excellent but under significant pressure and not able to attend to patients as would be expected.

Where the ward is understaffed for the 31 beds continuing with 36 beds open and relying on Bank/agency staff is not safe as you highlight. In prioritising care, emergency admissions come first and so we should not be admitting elective patients while the current situation exists." [see AOB-75766 – AOB-75767]

244. Sister Hunter's concerns remained unaddressed and resolved during the subsequent months leading to her resigning from her post in July 2016. She related the reasons for her resignation by email on 2 July 2016 as follows:

"I have enjoyed my short time in post and have tried my best to keep patient safety and quality of care to a maximum at all times. This however has been one of the main reasons that I felt I needed to move on, as I'm sure you our aware we have quite a few vacancies on the ward and with the posts not being filled and being expected to keep beds open to maximum I have felt at times that patient quality of care was not present. This is through not fault of the nurses at ward level as they all try very hard but it's extremely difficult to deliver good quality care when the staff feel so exhausted and morale is in their boots.

I WILL BE SENDING Mark Haynes an email explaining in more depth how I think management could take the ward forward, but I fear that management just don't want to know." [see AOB-77594].

245. The conditions found by the Ward Manager in 2016 were those which persisted following the ward reconfiguration of 2009, and which had progressively deteriorated since then, despite the introduction of Urologist of the Week (UOW) in 2014. It was sad to have such an able and committed ward manager leave her post in 2016 because of such conditions which we feared in 2009, and because the management did not want to know then anymore then, than they did in 2009.

246. On the other hand, my experience of working with and supported by nurses and ancillary staff in the Day Surgical Unit at Craigavon Area Hospital was very different in that the staffing compliment appeared to be adequate, committed and competent at all times, and I felt entirely supported when working there.

247. It has been my greatest pleasure to work with very many, committed and caring nurses in the operating theatre suite, the theatre recovery ward and the intensive care unit during my tenure. I was always fully supported by them.

248. Following my appointment in 1992, I was fortunate in having the hospital fund the purchase of equipment to undertake urodynamic studies, and which was located in a room off Ward 2 South. A number of staff nurses keen to develop specialist skills became trained and accredited, experienced and skilled in the total, holistic assessment and management of lower urinary tract dysfunction in both male and female adults. One of these nurses, Ms Jenny McMahon, was appointed a Clinical Nurse Specialist (CNS) when the Thorndale Unit was opened in 2007. She has been an outstandingly competent CNS. She is one of the most experienced urodynamicists in Northern Ireland. She has augmented her competence by performing flexible cystoscopies and is an accredited prescriber. She conducts her own Lower Urinary Tract Symptom (LUTS) review clinics. I have always been supported by her. She has been a pleasure to work with.

249. The Department had the additional benefit of having a Urology Cancer CNS since 2007 with the appointment of Ms Kate O'Neill to that post, though she was a loss to inpatient management as she had been the Ward Manager until then. Kate was joined by a second Urology Cancer CNS, Ms Leanne McCourt, in or around 2016/17. Both were based in the Thorndale Unit.

250. Kate O'Neill has contributed significantly to the development of urological cancer services since her appointment in 2007. Since the establishment of the Urology MDT in 2010, she has attended most MDMs as the MDT Core Nurse Member. If unable to do so, she ensured that she was deputised. She was the author of the section regarding Urology Cancer CNS involvement in cancer services in the Clinical Management Guidelines which I commissioned in preparation for National Peer Review in 2015. She became competent in performing trans-rectal, ultrasound guided, prostatic biopsies, contributing significantly to diagnostic capacity. She ensured that all patients were reviewed

by consultants following MDM discussion and, as the MDT Core Nurse Member, she was responsible for ensuring that all newly diagnosed cancer patients had access to a Urology Cancer CNS for Holistic Needs Assessment, support and signposting, etc. She was assisted by Leanne McCourt. It is regrettable that there was no Urology Cancer CNS available to patients when attending for review at clinics at SWAH. Nevertheless, I found both Kate and Leanne to be supportive of me in my practice.

251. I had always felt that the urological medical and nursing staff had worked well together, enjoyed good relations with each other and were supportive of each other in endeavouring to provide the best care that they could provide to those in most need of it, even though a severely inadequate service had been commissioned and resourced, as described throughout this statement. However, I found it disappointing to learn that a colleague could initiate a SAI investigation concerning Patient 10 in 2016 without ever being informed of it, and having it chaired by another colleague with ever having been consulted about it. Since then, I increasingly listened to criticisms of colleagues without those colleagues being aware of the criticisms. Since then, I found the absence of candour, honesty and integrity to be disappointing and most concerning.

(Q 38 – 39)

252. Even when providing the service as a single consultant from 1992 to 1996, Thursday morning was the only session free of any other elective commitment. Thursday mornings therefore lent themselves to being the time for a Grand Ward Round (GWR) of sorts, even though it did not merit the label with only one consultant, as the essential purpose of a GWR is for the management of inpatients by one consultant to be exposed to the scrutiny of another. Nevertheless, Thursday mornings were to become our multidisciplinary mornings and, with the eventual addition of Urology Cancer MDM every Thursday afternoon, Thursday became our department's multidisciplinary day.

253. I introduced Grand Ward Rounds proper on the appointment of a second consultant urologist in 1996. The GWRs were attended by both consultants, junior medical staff, ward managers, nursing staff and medical students. During the GWR, we presented the clinical histories, assessments and managements of all patients, reviewing each inpatient with team members contributing as appropriate. The GWR round was focused on patient care. The GWR was a form of multidisciplinary care of inpatients. I do believe that it contributed significantly to their care, and that patients appreciated the transparent, collective attention being afforded to their care. I believe that it also contributed to the multidisciplinary cohesion of the department. Notes were entered in the patients' clinical charts as they would have been on any ward round. However, there were no separate records maintained due to their GWR status, such as records of those in attendance.

254. Prior to the GWR on Thursday, we had a Radiology Meeting which commenced at 8.30 am and ran for about 45 minutes. That meeting was attended by urologists and radiologists when issues arising from radiological investigations could be discussed. Advice and recommendations offered by the radiologists were typically recorded in the patients' clinical records and acted upon. Even though this was another form of multidisciplinary meeting, there were no additional records maintained, such as a record of those in attendance. Following the Radiology Meetings, all urology attendees retired to the dining room for breakfast together prior to commencing the GWR at 10.00 am.

255. Following the replacement of Mr Baluch by Mr Young as the second consultant in 1998, we had increasing need to meet to discuss anything that needed discussing. This need was met by sitting down following completion of the GWR and evolved with increasing consultant staff into the weekly departmental meeting. As Lead Clinician, Mr Young chaired the meetings. They usually began between 12.30 and 1.00 pm and lasted approximately 45 minutes to one hour. There was no set agenda for the meetings, though Mr Young would often maintain a list of topics or issues that we wished to address over a cycle of meetings. Though usually confined to the consultant staff, we would often invite other

personnel, such as the registrars, or the Head of Service to attend. The departmental meeting of the last Thursday of each calendar month was dedicated to future scheduling. Those meetings were attended by all consultants, registrars, staff doctors, clinical nurse specialists, all personal secretaries and the Head of Service. Irrespective of the purpose of the meetings, no minutes were taken or recorded, nor was a record of attendees maintained.

256. The GWR became unwieldy with the appointment of additional consultants in or around 2011/12, due to the number of people involved in the round and their crowded nature was exacerbated by the lack of concentration of our patients in one location following ward reconfiguration in 2009.

257. Following the introduction of Urologist of the Week (UOW) in 2014, the GWR was no longer feasible or, to the same extent, necessary, as the UOW was to be the first point of contact for in-patient care. The GWR was replaced by what was known as a Handover Round which occurred between the urologist who had just completed being UOW with the incoming UOW. It was usually the case that the remaining consultants would be engaged in elective activity elsewhere, in theatre or in clinics. If not, they would join the Handover Round, particularly if they had inpatients who had previously been admitted under their care. Otherwise, the Handover Rounds were similar to the Grand Ward Rounds in that junior medical and nursing staff attended. It was particularly important for the Ward Manager or Nursing Sister to attend as it enabled them to hear an overview of patients under their care, as was the case with GWRs.

258. Then, from April 2010, we had Urology Cancer Multidisciplinary Meetings (MDMs) every Thursday afternoon from 2.15 pm to 5 pm, and which I have referred to elsewhere in this statement. The combination of the Urology Cancer MDMs each Thursday afternoon, when much of the radiology previously discussed at Radiology Meetings each Thursday morning was discussed again, and the need to commence the Handover Rounds at 9.00 am, saw progressively less need for the Radiology Meetings, until they were eventually discontinued.

259. We also had a monthly Morbidity and Mortality Meeting, which subsequently became known as the Patient Safety Meeting. Any patient who died in hospital that month would be considered at that meeting. In more recent years the Patient Safety Meetings were chaired by Dr Aidan Cullen, who would select patients for discussion and so that learning points could be addressed. In addition to any morbidity in the previous month, clinicians could suggest patients to be considered at the meeting when learning points or points of interest were considered. These meetings were attended by the Surgical Directorate as a whole which encompassed Urology, General, Breast and Orthopaedics. They were also attended by other specialists, including anaesthetists, radiologists, pathologists, and anyone who had a particular interest in what was being discussed that afternoon. For example, if a medication issue was to be discussed a pharmacist would attend, or if a peculiar infection was to be discussed a microbiologist would attend. Junior surgical staff also attended. As such, it was a large meeting of in around 150 people.

260. As the number of persons attending Patient Safety Meetings increased, there was an increasing appreciation that each specialty would benefit from having similar meetings dedicated specifically to the specialty. Therefore, a three-monthly cycle of meetings developed. In the first month morbidity and mortality within the Urology Department was discussed. The second month was the plenary session described above, and the third month we attended a regional urology meeting. Anyone could select patients to be presented at the regional meetings. The regional meeting however tended to be audit focused with the presentation of audits which had been carried out in any of the Trusts. An agenda for the regional meetings would be circulated, but I am unaware if those meetings were minuted.

261. The first Chief Executive that I worked with was Mr John Templeton. He was there from the time I joined the Trust, through until approximately 2006. On a personal level, I got on very well with him and developed a friendship with him outside of the workplace. I therefore knew him both personally and professionally. Professionally he was supportive of the development of the Urology Department.

For example, we succeeded in having Northern Ireland's only lithotripter under his tenure. I arranged meetings approximately bi-annually with Mr Templeton to address any urology issues that I wished to discuss with him. He was always accommodating in that regard. Whilst I made requests on behalf of the Urology Department, Mr Templeton was not always in a position to facilitate those requests. I do however recall him being of great help in very practical issues from time to time, such as assisting with visa related problems with a particular registrar to enable that doctor to continue working in the Department at a time we were under pressure due to staff shortages. Whilst I raised issues in relation to resourcing with Mr Templeton on a number of occasions, after a while I did not continue to raise the same concerns as there seemed to be a limit to what he could do by way of providing additional resources.

262. I hope that I am correct in stating that the next Chief Executive was Mr Colm Donaghy; the Trust will be able to confirm that. I cannot recall ever having a meeting with him for any reason.

263. The next Chief Executive was Ms Mairead McAlinden, who was in post until approximately 2015. I had similar interactions with her to those with Mr Templeton. Again, whilst she listened to my concerns in relation to resourcing, there didn't appear to be anything within her power that she was able to do to address the on-going resourcing issues. I always found Ms McAlinden approachable, and she had a clear understanding of the Health Service, having spent her career working through it. Ms McAlinden would have been well aware of the resourcing issues within Urology.

264. I do not know the extent to which the Trust had discretion, or the extent to which any such discretion rested with the Chief Executive or Board, in relation to how funds received from the Commissioners were divided between the various departments. As I have mentioned elsewhere in this statement, I had on-going concerns, based on my analysis of waiting list statistics, that other departments were better resourced than Urology and therefore throughout my tenure I was concerned that resources were not diverted to Urology to assist with the ever-

growing demand and backlog. I do not know whether decisions were made at a Trust level or by the Commissioners, or to what extent the Trust attempted, or was able, to influence the decisions of the Commissioners. The majority of patients in Urology are male and, until recent years, there has not been the same degree of lobbying on male health issues, in particular prostate cancer, whereas other cancers had long-standing lobbying such as breast and cervical cancer. I do not know whether that consciously or otherwise had an impact on resourcing as those specialties did not suffer from the same pressures urology did in terms of waiting times.

265. Following Ms McAlinden's departure, there were a number of Chief Executives in relatively short succession: Mrs Clark, Mr Rice, and more recently Mr Devlin. As I understand it, the current Chief Executive is Dr O'Kane. During my tenure, I did not have any professional interaction with these post-holders.

266. Human Resources will be better able to provide details of the exact tenure of the various Medical Directors during my time at the Trust. The first I recall was Mr Paul Singh, however I cannot recall any interactions with him. I believe that he was succeeded by Mr John O'Neill who was succeeded by Dr Liam McCaughey.

267. I believe Dr McCaughey was followed by Dr Patrick Loughran. The only occasion I can recall meeting with Dr Loughran was at a meeting also attended by Mr Young, when we discussed the use of IV fluids and antibiotics. Dr Loughran was followed by Dr John Simpson. I cannot recall meeting him personally in relation to any matters, although I would have sat on interview panels with him.

268. Dr Simpson was followed by Dr Richard Wright. I had relatively limited interaction with him, although in 2016 I did meet with him to discuss issues in relation to radiology input at MDM. I also recall meeting him informally at a birthday party and finally I met him again on 30 December 2016, the date on which I was excluded by the Trust.

269. Dr Wright was succeeded by Dr O'Kane. I did not have any interactions with her. I have never met her.

270. The Directorate of Human Resources will be able to assist the Inquiry in determining the tenures of Directors of Acute Services. The first whom I recall was Ms Joy Youart who held that post at the time of the ward reconfiguration which was a consequence of the Acute Quality Care Project: Surgery & Elective Care in March 2009 [see supplemental October bundle pages 44 – 66] I contributed to our department's response of 26 May 2009 to the Trust's proposals for ward reconfiguration in which the medical and nursing staff expressed their concerns regarding the reconfiguration [see AOB-03510 – AOB-03514]. Ms Youart wrote to me on 1 June 2009 to express her gratitude for my input into attempts to mitigate the risks which we feared would accompany the reconfiguration [see AOB-82230 – AOB-82233]. I wrote to her on 3 June 2009 [see supplemental October bundle page 78] to express the persistent concerns of the nursing staff, and to invite her to address these concerns directly with the nursing staff at a meeting which I arranged for 4 June 2009. The nursing staff was not adequately reassured by Ms Youart when she attended on 4 June 2009. As related elsewhere in this statement, their concerns were justified. Regrettably, the reconfiguration proved to be a regressive step in terms of retention of nursing staff and of quality of inpatient care.

271. I believe that Ms Youart was succeeded by Dr Gillian Rankin who remained as the Director of Acute Services for a considerable period of time during my tenure until she was replaced by Ms Debbie Burns. I recall that in 2011, Dr Rankin and Mr Mackle had a number of meetings with the consultant urologists on an individual basis. I found a number of meetings with Dr Rankin and Mr Mackle to be distressing and traumatic and believe that my two colleagues, Mr Young and Mr Akhtar, were also distressed by the meetings, which may have contributed to Mr Akhtar's subsequent decision to leave the Trust in March 2012.

272. I recall a meeting with Dr Rankin and Mr Mackle 9 June 2011. Mrs Heather Trouton, Assistant Director of Acute Services – Surgery & Elective Care, was also in attendance and provided a note of the meeting on 1 July 2011 [see AOB-00255 – AOB-00256]. The meeting commenced with Mr Mackle reporting to me that I

had recently reviewed at an outpatient clinic the parent of a person who worked in administration or management in the Trust. Mr Mackle told me that this person had alleged that I had explained to the patient at review that the reason for the delay in their review was that there was a backlog due to inadequate review capacity. Mr Mackle was unable to advise me of the name of the patient or of the relative. Based upon anonymous, anecdotal innuendo, Mr Mackle insisted that it was inappropriate to share such concerns with patients and that I should instead apologise to patients on behalf of the Trust. I was not prepared to apologise on behalf of the Trust as that was the reason for the patient's delay.

273. In that same meeting, Dr Rankin then insisted that I should be able to have consultations with sixteen patients at each outpatient clinic, which would equate to four patients per hour. I indicated that a clinic was more suitable for review of twelve patients and that I was not prepared to increase my clinic numbers to sixteen. I considered this to be a decision which I was better able to form an opinion on in relation to the nature of the conditions I was having to deal with and the appropriate number of patients that I could safely see. The outcome was that Mrs Trouton was to set up a meeting to discuss "*a way forward in managing review backlog in a timely manner"* and "*to ensure that responsibility is taken to manage all outpatient appointments in such a way as to only review those who clinically require review and thereby reduce the formation of a review backlog unnecessarily"* [see AOB-00255]. Apart from the presumed impossibility to retroactively manage a review backlog in a timely manner, this was a rather explicit transference of responsibility for the review backlog to the clinician as it implied that the backlog was due to the clinician reviewing patients with no clinical need for their review. I believe that Dr Rankin then introduced DARO which I have referred to elsewhere in this statement. Essentially DARO entailed secretarial and administrative staff being directed not to place patients on the waiting list for review at all, if they had an investigation requested by the clinician who would be provided with the report of the investigation when it became available.

274. The clinician was expected to 'action' the report, determining if or when a review would be required. This later evolved to clinicians being expected to 'follow up' on

the requested investigations, and all without any assessment of the time required to do so, whether such time was available, or whether there still remained capacity to review the patient. DARO transferred ever greater responsibility from the Trust to clinicians for clinical outcomes.

275. I also recall two other meetings which I had with Mr Mackle and Dr Rankin.

276. One such meeting occurred soon after the commencement of centralisation of radical pelvic surgery to Belfast. While my colleagues and I had concerns regarding the centralisation of radical cystectomy in particular, we did request that we would be notified of when the transfer would begin, so that we would have an interval, such as one month, to arrange the transfer in an orderly fashion. Instead, we were informed in late 2010 that the transfer of patients would begin two days later. My colleague, Mr Akhtar, had to cancel a radical prostatectomy which he had scheduled. I had an inpatient whose bladder was painfully distended by a non-metastatic carcinoma. His bladder was so fully distended that it could not accommodate an indwelling urethral catheter. He remained as an inpatient due to his discomfort and distress. I had scheduled to perform a radical cystectomy early the following week. I requested that I be allowed to proceed with performing a radical cystectomy and ileal conduit urinary diversion as planned, but my request was resolutely declined. I was able to contact a colleague at Belfast City Hospital who kindly cancelled the admission of one or more patients early the following week so as to accommodate my patient. In formalising the transfer as an inpatient, I shared my criticism of the disregard for the welfare of my patient. I was then summoned to a meeting with Dr Rankin and Mr Mackle who advised me that my criticism had been widely distributed, without my consent or that of the patient, and that consideration had been given to referring me to the GMC due to my criticisms. I was also instructed by Mr Mackle that I "*had to obey my political masters".*

277. On another occasion, I was again scheduled to meet both Dr Rankin and Mr Mackle as they had been informed that there remained a patient on my waiting list for elective admission for a simple cystectomy and ileal conduit urinary

diversion. Though I cannot recall the patient's name, she was an elderly lady who had had two or more unsuccessful attempts by gynaecologists to manage her severe urinary incontinence by surgery. She had then been referred to me for consideration of a urinary diversion as she remained totally incontinent of urine. I agreed and considered that it would be reasonable to remove her bladder at the time of urinary diversion. I was instructed by Dr Rankin and Mr Mackle that I would not be permitted to undertake her surgery, as simple cystectomies had been centralised to Belfast. I asked whether I would be permitted to perform an ileal conduit urinary diversion for her, without cystectomy. Both were happy for me to do so. I found it remarkable that I was not permitted to perform a simple cystectomy, but that there was no concern whatsoever in performing an ileal conduit urinary diversion, without simple cystectomy, the reconstructive component of the operation accompanied by greater risk than simple cystectomy.

278. I hope that I am correct in relating that Dr Rankin was succeeded by Ms Debbie Burns whom I found to be as supportive of me as she could be during the years when I was Lead Clinician of the NICaN Clinical Reference Group in Urology and when I was additionally Lead Clinician of the Trust's Urology MDT and Chair of its MDM, particularly in the lead up to National Peer Review in June 2015. As I have related elsewhere, Ms Burns appreciated the additional workload that emanated from these roles, particularly in the advent of National Peer Review of the Trust's urological cancer service and of regional urological cancer services in 2015. She relieved me of having to conduct triage in early 2014 and my colleague, Mr Young, generously undertook this for a period of six months or more during 2014.

279. Ms Burns was succeeded by Ms Giskhori whom I never met. Ms Giskhori was succeeded by Ms McClements whom I have never met.

280. The Assistant Directors that I recall were Ms Heather Trouton and more recently Mr Ronan Carroll. I certainly did have a number of meetings with Heather Trouton during the years prior to 2016 concerning a number of issues relating to the

service, including that of triage. I had occasional meetings with Ronan Carroll since 2016. I was advised by Mr Haynes on 8 June 2020, when he called me by telephone to inform me that I would not be accommodated with continuing in part-time employment in August 2020, that he was accompanied by Mr Carroll, but Mr Carroll did not speak during the call.

281. For a substantial period of my time, the Associate Medical Director responsible for Urology was Mr Eamon Mackle. Mr Mackle was a general surgeon, rather than a urologist and therefore I did not have day to day interaction with him. However, in terms of governance, I did have a number of significant dealings with him.

282. Mr Mackle was for a time responsible for job planning. I refer to my comments under "Performance review and objectives/Appraisal/Job Planning" (Questions 46 to 50 of the Notice) which provide more detailed comments in relation to same. One of the matters I raised in that context concerned the inadequacy of time allocated for administration related to direct clinical care of patients. That had an impact in relation to administration issues which are dealt with further in my response to Questions 66 and 67 below.

283. Mr Mackle was also present at the meeting with me in March 2016, when administration issues were raised with me. Whilst he was in a governance role, he gave me no assistance or support in relation to how I could go about addressing the issues identified.

284. In January 2012, I had cause to lodge a formal grievance against Mr Mackle following the discovery that he had unilaterally altered agreed payments owed to me for undertaking additional work sessions [see AOB-00342 – AOB-00343]. He did so without consultation or authorisation. The grievance was upheld. I was asked by Ms Zoe Parks of Human Resources whether I wished to have the matter pursued further. As Mr Mackle had a personal issue to deal with at that time, I agreed to suspend any further action while retaining the right to reactivate proceedings at any time in the future should the need arise.

285. Mr Haynes succeeded Mr Mackle as Associate Medical Director and I had a great deal more interaction with him on a regular basis, as he is a urologist. Mr Haynes was well aware of my concerns in relation to the inadequate resourcing of the Urology Service, which I had expressed for a number of years. Indeed, from correspondence identified (for example, that included in my response to Questions 73 and 74 of the Notice), it is clear that he shared similar concerns in relation to the adequacy of the Service. The information available to me suggests that he expressed his concerns in writing in more recent years. Mr Haynes will be able to indicate whether he had those concerns on a long-standing basis and, if so, whether he escalated his concerns, before and/or after he became the Associate Medical Director. Whilst he had the role of Associate Medical Director during my tenure, I did not perceive that he was able to substantively influence the resourcing issues in Urology, as many of the same issues persisted until termination of my employment with the Trust and, I suspect, are still issues.

286. There were a number of Clinical Directors during my tenure. Again, I would defer to HR to give exact details of who occupied the post and when. During the earlier years of my tenure, when the compliment of consultants within the directorate was significantly smaller, the directorate held monthly meetings which were chaired by a succession of Clinical Directors, including Mr John O'Neill, Mr Ivan Stirling and Mr Osmond Mulligan. Even though there were competing interests between the small number of surgical specialties during those years, the monthly meetings did bring a sense of cohesion to the directorate.

287. When Craigavon Area Hospital Group Trust was consumed into the larger legacy Trust, clinical directorate meetings became logistically impractical. Clinical Directors then appeared to assume a less significant role. My interaction with Clinical Directors would primarily have been in relation to job planning. During more recent years, Mr Robin Brown, Mr Sam Hall, Mr Colin Weir and Mr Ted McNaboe have been Clinical Directors.

288. The Head of Service during the last ten to twelve years of my tenure was Ms Martina Corrigan, with whom I would have had numerous communications, virtually on a daily basis, by email, by telephone and face to face. I have referred to some of my interactions with her elsewhere in this statement.

289. I have referred to my interaction with other urologists in the Department throughout this statement. In my view, each of the urologists I worked with to a greater or lesser extent had concerns in relation to the governance issues, particularly in relation to the threat to patient care and safety posed by the inadequacy of the urology service commissioned of and provided by the Trust. Each of them will be better placed than me to comment on the extent of their concerns, the steps they took to escalate same and the responses they received to their escalations.

(Q 40)

290. The Southern Trust's Urology Multidisciplinary Team (MDTs) was established in April 2010. Mr Mehmood Akhtar was its first Lead Clinician and remained so until his departure in March 2012. I was then the Lead Clinician and remained in that role until December 2016.

291. Multidisciplinary Meetings (MDMs) were also initiated in April 2010, Mr Akhtar being the sole Chair of MDMs until March 2012. I then became the sole Chair until the introduction of rotating chairmanship in September 2014 in preparation for the introduction of Urologist of the Week (UOW) at the end of October 2014 I continued to chair MDMs on a rotational basis until December 2019.

292. The Urology MDMs were required to include and have in attendance individuals of the following disciplines in order to comply with the National Cancer Peer Review Measures:

- Two urologists - This was the only discipline that required two consultant practitioners. The reason for this was to avoid a singular, uncontested

approach from a urological perspective

- Radiologist
- Pathologist
- Oncologist (preferably a clinical oncologist with expertise in radiotherapy)
- Clinical nurse specialist / key worker
- Cancer tracker (secretarial support)

293. The above was the minimum required to meet a quoracy for each MDM, and they were known as core members of the MDT. There were also some extended members, including Mr Michael Young Consultant Urologist, a Palliative Care Cancer Nurse Specialist ("CNS"), a Social Worker and a Psychologist. These extended members were not required to attend MDMs but were welcome to do so and did so on request for discussion of relevant cases.

294. The model we adopted from the outset was that the Chair would present each case for discussion at MDM. In some hospitals, each individual consultant urologist brought the records for their own patients they wished to discuss and presented this to the MDM. The rationale behind our approach was that the Chair was independent, and it was more objective (although of course some of the patients being discussed would be patients under the care of the Chair). With the introduction of digital technology, the MDMs became more efficient as it was easier to display patients' records on screen. Prior to that, when the first MDMs started, there were trolleys of patient records brought to MDMs to facilitate presentation and discussion.

295. The effectiveness of MDMs has been reasonably extensively studied and reported upon. The factors which contribute to the most appropriate recommendations being agreed are well known. Conversely, the factors which compromise the probability of MDMs reaching inclusive consensus regarding recommendations to be shared with the patient are also well known.

296. Even when all the other factors which contribute to the most appropriate recommendations being agreed are present, the single factor which most compromises the appropriateness of agreed recommendations is the absence of relevant and holistic information concerning the patient. When information is presented regarding the patient's demographic details, performance status, comorbid status, previous clinical history, medications, personal priorities and expectations, then it is known that agreed recommendations are most likely to be appropriate. The absence of such detail, or of some of it, renders it more probable that agreed recommendations are pathology centred rather than patient centred.

297. As the number of newly diagnosed cancer cases increased, resulting in increasing numbers of patients being discussed for a second or more times following staging, or postoperatively or following recurrence, the number of case discussions increased. MDMs were held each Thursday afternoon from 2.15 pm until 5.00 pm, except for public holidays, which was a further reason for increased numbers of patients to be discussed during subsequent weeks. By 2013, I came to appreciate that the maximum number of patients that could be optimally discussed in that period of time was 40. Otherwise, fatigue set in. Therefore, I capped the number of cases to be discussed at 40 at each MDM.

298. When I was Chair of the MDM, I previewed the cases each Wednesday evening, following my return home from work and facilitated by remote access. Subsequent rotating Chairs found it easier and better to split the previewing exercise over the preceding two evenings. I did aim to be able to preview ten cases per hour. Previewing was made easier if a comprehensive but relevant clinical summary had been submitted to the Cancer Tracker and was available to the Chair for previewing, which also included a preview of test results, imaging and histopathology.

299. Clinicians were expected to submit clinical summaries to the Cancer Tracker. Regrettably, as Lead Clinician, I was unable to obtain the agreement of my colleagues to do so, as submission of clinical summaries was consuming of time which was not provided. As a consequence, the Cancer Trackers found it

necessary to create a clinical summary from any letters of referral or letters dictated following earlier consultation with the patient. In that regard, patients were occasionally listed for MDM discussion prior to any meeting or consultation with the patient.

300. Within the above constraints, the Cancer Trackers performed their function with excellence, circulating all MDT members by email each Wednesday with the clinical summaries, however constructed, of all cases to be discussed the following day.

301. While the MDM room was adequate, it did not lend itself to optimally inclusive discussion as everyone sat facing in the same direction. On the other hand, facing in the same direction was practically necessary to enable everyone to view the video screens on which could be displayed clinical details, histopathological and radiological imaging, in addition to video conferencing.

302. MDMs, when quorate, were in my view effective. When I was Chair of the MDM, I put a lot of effort into previewing each patient and ensuring that each patient was adequately discussed. There was a discussion around what was the best way forward for each patient. I was certainly never aware of anyone feeling inhibited in terms of expressing any views that they had in respect of the management of patients at MDMs. Such discussion was welcome and indeed expected.

303. However, from their inception in 2010, there were persistent problems in ensuring the quoracy of MDMs. There was a clear and persistent problem in ensuring that a radiologist, particularly one with a specialist expertise in urological imaging, and an oncologist were present at the MDMs. Of course, that reduced the overall effectiveness of the process, as by definition it was a multi-disciplinary review meeting, and the fewer disciplines that were represented, the less multi-disciplinary the review became. Quoracy was a particular problem with regard to the attendance of oncologists.

304. I met with Dr Richard Wright, then Medical Director, in April 2016 when we discussed the issue of the inability of the Department of Radiology to ensure the attendance of a uroradiologist at all MDMs. While this did result in some improvement for a period of time, it was inadequate. As with the failure of attendance of clinical oncologists, the essential constraint was the regional shortage of radiologists and oncologists.

305. This issue is highlighted in the SAI reports which are dealt with at Question 79. For example, in the SAI Report regarding Patient [redacted] see AOB-61216 – AOB-61226], it was noted at page 7 that the MDM was quorate 11% in 2017, 22% in 2018, 0% in 2019, and 5% in 2020. There was evidently a failure on the part of the Trust to ensure that the MDMs were quorate, and that undoubtedly reduced their effectiveness, and arguably their legitimacy. The poor MDM quoracy is but another feature of an inadequate urological service provided by the Trust over many years. It should also be noted that the Trust's Urology Cancer MDT's Operational Policy, agreed in September 2017 [AOB-03859] expressly states that the MDT should be quorate for at least 95% of MDMs. That policy was evidently not complied with by the Trust.

306. The quality of chairmanship of MDMs is critical to the outcomes of MDM discussions and to the recommendations agreed. It is essential that the Chair, or indeed whoever presents the case, has adequately previewed the cases so that the members will be optimally informed. The inclusiveness of discussion is dependent upon the Chair. The Chair should not have a predetermined view as to the next step or be resistant to a change in his or her view. Of greater concern over recent years has been the increasing tendency of the MDT members at MDM finding themselves agreeing to management recommendations which had not only already been recommended to the patient by the consultant urologist and core member but had already been implemented. In most cases, the MDM would have agreed in retrospect with the recommendations already shared with the patient, if not already implemented. As I recall, this applied particularly to patients being recommended with regard to the management of upper urinary tract pathology, and even of patients having undergone renal surgery without previous

discussion at MDM, as occurred in the case of Patient 10 [PAT 000001 – 000055].

307. It has been reported that it is of critical importance that the agreed recommendation should be audibly dictated by the Chair to and recorded by the Cancer Tracker. It has been my experience that the language used in expressing the agreed recommendation is of critical importance, particularly when there are management options to be considered with the patient at review, as is often the case. Sometimes, the recommendations more importantly specified management options which were not to be recommended, rather than those which could be recommended. While not all of these features were characteristic of all rotating Chairs at all times, overall, I would have considered the MDMs to have been effective within the constraints placed upon them

308. Please see the Trust's Urology Cancer MDT's Operational Policy, agreed in September 2017 [AOB-03859]

(Q 41)

309. Decisions were generally unanimous because most cases discussed were straightforward in terms of the recommended next steps. There was certainly an opportunity within MDMs for differing views regarding patient next steps to be discussed and debated. My view was that the focus at the MDMs was always on recommending the right approach for each patient, and as stated above I never felt that anyone felt inhibited from expressing their views at the MDMs.

310. The decisions made at MDM with regard to any patient were the agreed recommendations which would be considered and discussed with the patient at review. The agreed recommendations have been variously referred to as MDM outcomes and MDM plans. Irrespective of those labels, the agreed next steps are recommendations to be considered, shared and discussed with patients, and, with the patients' consent, with those accompanying them, when reviewed

following MDM discussion. Therefore, the agreed recommendations could not dictate the next steps in all cases, as not all patients were agreeable to comply with the recommendations, or the latter may not have been considered appropriate or advisable following a more holistic review of the patient.

311. In that regard, I note that Dr Hughes at PAT-001323 describes the MDT pathway as "*a contract between the medical team and the patient. It is based on international best practice guidelines. Individuals do not have the right to deviate from that."* I was surprised and concerned to read this and even more concerned that the family of SUA had been so advised. Certainly, I am unaware of any contractual relationship arising between the medical team and the patient based on an MDM discussion. Moreover, I have been unaware of any patient having appreciated or having been informed that he/she had entered into such a contractual relationship. Crucially, this statement fails to reflect a fundamental tenet of modern medical care that the patient has autonomy for their treatment decisions. The patient is not present at the MDM. If the patient is advised of a MDM recommendation and, following discussion with their treating consultant, decides not to proceed with the course of treatment recommended by the MDM, there is no question that the patient is entitled to do so. To suggest that the MDM recommendations are in some way mandatory or contractual is to fail to respect the principle of patient autonomy. The patient has the right to deviate from a MDM recommendation and that right must be respected by the consultant treating the patient.

(Q 42)

312. The final decisions regarding next steps are taken forward by the treating consultant when reviewing the patient. The MDT Core Nurse Member, Kate O'Neill, made sure that every patient was reviewed following a MDM. Each consultant would have been responsible for considering, discussing and informing the patients of the recommendations agreed following MDM discussion.

(Q 43)

313. No, there was no process to govern this. As indicated above, if an agreed pathway is recommended to a patient at review following MDM discussion, the patient may decline to comply with the recommendation, or wish to defer further consideration of doing so until a later date, or some variation of that nature. It may also be the case that the clinician and the patient may conclude at review that the recommended pathway is inappropriate for one or more of a multitude of reasons, as has been acknowledged in Guidelines and publications concerning MDTs and MDMs (such as Multi-disciplinary Team (MDT) Guidance for Managing Prostate Cancer, published by the British Uro-oncology Group and the British Association of Urological Surgeons' Section of Oncology in September 2013) [see supplemental October bundle pages 324 – 401].

314. Other members were not subsequently informed of a deviation from an agreed recommendation, as there was an understanding that the clinician and patient had the right, and indeed responsibility, to deviate from the agreed recommendation if the latter was declined by the patient, or if the recommendation was concluded by the clinician and patient to be inappropriate.

(Q 44)

315. I am unable to recall each specific instance where I did not implement a decision reached concerning recommended treatments or care pathways at MDM over a 10-year period, although I am sure there are examples of occasions when, following a decision made at MDM, and after reviewing the patient, a different approach was taken to that recommended by MDM. If the Inquiry is able to identify any such specific cases, I am happy to provide further details if required.

316. I can, however, refer to one example which has been provided in the disclosure by the Trust [see TRU-09828]. While I do not have the benefit of this patient's full clinical records, the details included in the emails exchanged

between myself and Ms McVeigh, Cancer Tracker, on 23 June 2019 [see supplemental October bundle pages 703 - 704], between myself and Dr Drake, Consultant Oncologist, on 15 August 2019 [see supplemental October bundle pages 705 - 706], between myself and Mr Haynes on 04 October 2019 [see supplemental October bundle pages 709 - 710] provide sufficient clinical detail for the purpose of addressing this particular issue. The patient presented to haematologists in March 2019 with lymph node enlargement and a biopsy in April 2019 confirmed follicular lymphoma. Staging of the lymphoma revealed the presence of a right renal lesion. While it was considered that this lesion was probably a primary renal cell carcinoma, it remained a differential possibility that the lesion may have represented lymphomatous infiltration of the kidney. If that was confirmed by percutaneous biopsy, that alone would have been an indication for treatment of the lymphoma. Percutaneous renal biopsy with prophylactic Factor VIII was recommended at Urology MDM on 27 June 2019.

317. When I subsequently reviewed the patient, I did not follow that recommendation as the patient had already begun chemotherapy for his lymphoma. Not only would a renal biopsy have been accompanied by risk of renal haemorrhage, it would have additional been accompanied by the risk of infective complication which would have exacerbated the risk of secondary renal haemorrhage. In any case, a provisional plan was for him to continue with chemotherapeutic management of his lymphoma followed by reappraisal prior to initiation of maintenance therapy. Accordingly, I made the decision to defer consideration of a kidney biopsy and I note that Mr Gilbert in his email of 13 December 2020 [TRU-09829] stated that this was a "*reasonable change of plan".*

318. It is of crucial importance to state that the MDM, while unquestionably useful, often did not have the full patient history when making recommendations. Situations did arise whereby a recommendation was made at MDM, and on review of the patient by the consultant it became clear that the MDM recommendation was not appropriate. Indeed, to slavishly follow the recommendations of the MDM in such circumstances would be to put patient

safety at risk. MDM recommendations must be subject to the clinical judgment of the treating consultant when reviewing the patient.

319. I did not follow any particular process when departing from the MDM recommendation in respect of this particular patient. I note that in the email from Patricia Kingsnorth to Mr Gilbert at TRU-09830 she indicates that, in reference to departing from MDM recommendations:

"[t]here does not appear to be a proper process for feeding back to MDM and this will be one learning from SAI."

320. I am unaware of any such process being implemented.

(Q 45)

321. At all times that I was employed as a consultant urologist within the Trust, I endeavoured to provide a high level of care to patients and aimed to reduce any risk to patient safety as far as practicable within a system that was so fundamentally inadequate as to be unsafe.

322. Throughout this statement, I have related the many occasions on which I and others raised concerns regarding the risks of patients coming to harm as a consequence of such an insufficient service. I have also related how I and others encountered the limitations of our capacity to assure patient safety and the pursuit of optimal clinical outcomes.

323. In terms of my own clinical care, I was regulated by the General Medical Council and aimed at all times to provide care in accordance with the standards devised by my regulatory body. In that context I was subject to appraisal and revalidation.

324. I also sought to take optimal care of my patients by keeping abreast of the body of literature and guidelines relevant to urological clinical practice and was mindful

of the professional responsibilities arising therefrom. NICE [NH131 page 2] describes the clinician's responsibility thus:

"The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions."

325. Therefore, the individual clinician carries a considerable responsibility to arrive at the appropriate decisions at all times in pursuit of optimal outcomes for his / her patients. I have endeavoured to do that throughout my career, and I have never shied away from scrutiny of my care of patients. I have exposed the care of my patients by participation in grand ward rounds, multidisciplinary meetings and patient safety meetings, in addition to engagement with Trust management.

326. Other individuals involved in clinical governance within the Trust would be better placed to comment on what systems were in place to ensure appropriate standards were being met and maintained.

(Q 46)

327. My role was subject to annual appraisal which would have taken place towards the end of the following year; for example, my 2012 appraisal would have taken place at the end of 2013. I attach a chronology entitled "Appraisals" which cross references a number of the documents which would have been held within my appraisal folders as well as any documents which are relevant to my appraisals in general terms.

328. Appraisals were introduced into the Southern Health and Social Care Trust on 12 March 2001 by HJ Vance, Deputy Director [see AOB-22002 – AOB-

22008]. Mr HJ Vance set out in his correspondence the criteria and documentation which must be met and considered to ensure consistency and a successful appraisal throughout the appraisal process. [see AOB-22002 –AOB-22008]. All appraisal documentation would have been sent to the Medical Director and was also closely linked with my revalidation.

329. Appraisals were organised and prepared for by the individual consultant and they consisted of a discussion around my work activities and commitments, such as emergency work, practice, sub-specialist skills and so on. I provided commentary on any non-clinical work that I undertook such as teaching/academic work as well as providing documentation on my current job plan schedule. I also included in my appraisals, documentation of my development over the year to show continuance of professional development and my working relationships with colleagues and patients, including any patient complaints or claims.

330. Following a discussion with my appraiser, we set personal development goals and objectives which were dependent on my personal performance as well as to the Trust's overall Urology service. The goals and objectives set would also take into consideration any concerns around my practice or concerns that I may have in relation to the Urology Service. Generally, the personal objectives during the appraisal process were objectives which I considered to be relevant to the needs of the Service, and which I considered to be attainable. They were then agreed with my appraiser.

331. Whilst I do not have an individual appraisal folder for documentation pre-dating 2010, appraisals were carried out by Mr Ivan Stirling, then Clinical Director, in the early 2000's, when consultants within the Surgical Directorate were expected to organise a 1-hour slot with him to have their appraisals completed [see AOB-82210]. My appraisal documentation, which was completed and signed off by Mr Stirling is contained in my 2010 appraisal folder. [see AOB-22009 – AOB-22030 & AOB-22175-AOB-22183].

332. During my appraisals with Mr Stirling, I raised my concerns about the inadequacy of the Service and the lack of progress in its development, concerns that were reflected in Mr Stirling's comment that it was the development of the Service which was my priority, rather than my personal professional development at that time. Mr Stirling documented that urological care was being provided to a population which *probably* exceeded the capacity of the service to provide. He made particular reference to the difficulties in providing an acute / emergency service to a large volume of patients, often without the assistance of a registrar [see AOB 22175 – AOB 22188].

333. In 2007/08, Mr Eamon Mackle completed and signed off my appraisal documentation, which is also contained in my 2010 appraisal folder [see AOB 22189– AOB-22195]. During my appraisal with Mr Mackle, concerns were expressed that a third consultant was just about to take up post even though the external review (conducted by Professor Mc Clinton) had recommended that there would have been four consultants appointed by that time. Mr Mackle documented our shared concerns regarding the meeting and maintaining of access targets.

334. From 2011 until around 2016, Mr Michael Young carried out my appraisals [see AOB-22310– AOB-22829]. During my appraisals with Mr Young, I raised various concerns such as the ward reconfiguration, workloads and the increasing backlogs. I set my personal development needs such as to improve the urodynamic service, to address the long waiting lists for urological cancer reviews, to develop an Operational Policy for Urological Cancer MDM, ensuring all urological cancer services in Northern Ireland are IOG and National Cancer Programme compliant by Peer Review, to attend conferences and so on. All of this is detailed in my appraisal folders as referenced above.

335. From 2017 onwards, Dr Damien Scullion carried out my appraisals [see AOB-22830 – AOB-23283]. During my appraisals with Dr Scullion, I raised various concerns such as; the lack of beds and emergency operating capacity,

long waiting lists, inadequate job plans and so on. I set my personal development needs to include addressing the long waiting lists, attending urology courses, to continue triaging and dictations, resolving the concerns raised in March 2016, to attend conferences, all of which are detailed in my appraisal folders as referenced above.

336. Mr Robin Brown was scheduled to carry out an assessment of my appraisal documents to ensure that they complied with and satisfied the requirements of revalidation in 2019. Mr Brown did so, finding my documentation to be entirely satisfactory and complimenting me on its quality. I was scheduled to meet with Dr Scullion on Friday 5 April 2019 for revalidation. However, it was requested that I attend a meeting on 4 April 2019 with Dr Khan [see AOB-08172], who had been the Case Manager of the formal investigation conducted during 2017 and 2018. At this meeting, I was advised that Dr O'Kane, the Medical Director, was referring me to the General Medical Council (GMC) [see AOB-56494 – AOB-56496]. On Friday 5 April 2019, Dr Scullion informed me that Dr O'Kane had contacted him earlier that day to advise him that she was referring me to the GMC, as I allegedly lacked insight, and that I was to be advised by him that my revalidation was to be deferred. Dr Scullion had the unenviable task of doing this when I met him for revalidation as scheduled.

337. My role was also subject to a "GMC Colleague Feedback Report", which surveyed the feedback received by my colleagues in relation to me, a "Patient Feedback Questionnaire Report", which surveyed feedback received by my patients, and CHKS Consultant Level Indicator Programme reports, which surveyed data in relation to the number of patients seen, workloads and so on. All these reports are included in my appraisal folders.

(Q 47)

338. I did not carry out reviews or appraisals of others. The only issue which I had with appraisals was to find the time to prepare the documentation for them

as I used much of the time allocated to Supporting Professional Activities (SPA) to carry out direct clinical care (DCC) due to the inadequacy of the service.

(Q 48)

339. Performance objectives were set for me and my colleagues, both medical and nursing, in a number of forms during my tenure as a consultant urologist, and these have been described in their several forms elsewhere in this statement. They included targets set for patients awaiting admission for inpatient and day case management, for those awaiting outpatient appointments following referral, for those specifically related to patients having or suspected of having cancer, for those who required treatment for cancer, triaging of referrals etc. These were addressed by participating in waiting list initiatives, additional operating sessions and clinics etc.

340. Performance objectives relating to personal professional development were discussed and supported during appraisal, through attendance at conferences and courses, involvement in audit and in research activities.

(Q 49)

341. During the period from January 1992 until August 2006, the Trust did not have a job planning process. Job plans were first introduced in August 2006 as evidenced in the letter received from Ms Richardson dated 10 August 2006 [AOB-00045 – AOB-00046]. In my opinion, from their introduction, my job plans were always inadequate and were an inaccurate reflection of my role as a consultant urologist.

342. As I have explained above, during my time as a consultant urologist with the Trust, the Urology Department was always inadequately resourced and this in turn had consequences for the already overwhelming workload that the consultant urologists carried. For example, the increasing waiting lists created additional administrative burdens for the consultant urologists on a daily basis,

which the consultants were regularly having to deal with. I also took on additional roles such as Chair of the Trust's Urology MDM. I was allocated an inadequate provision in proposed job plans for previewing cases and no allocation for reviewing and signing off MDM outcomes. I also took on the roles of Lead Clinician and Chair of NICaN's Clinical Reference Group for Urology as well as Lead Clinician of the Trust's Urology MDT, none of which was ever adequately reflected in my job plan, if at all.

343. Prior to job planning and as a single-handed consultant urologist, I was contracted to undertake four to six operating sessions, two outpatient department (OPD) sessions, one/two cystoscopy sessions and two urodynamic sessions. None of these contractual obligations took into consideration the administration time that I was spending time or the time I was spending on developing academic urology. For example, the weekly average number of hours I spent at work in February 1995 was 89 hours. I raised my concerns with Ms Helen Walker in March 1996 [see AOB-00018 – AOB-00022] in relation to extra remuneration for this period of extra-contractual work and was given an extra 5.5 PA in recognition of the additional workload that I had taken on over and above my "*10 programmed activities that constitute your standard contractual duties*" [see AOB-00039-AOB-00040].

344. From the introduction of job planning, I frequently raised concerns and rejected the proposed job plans due to the inadequacy of the job plans to reflect my role. I raised these concerns through, for example, the appraisal process, the job planning process and via email correspondences with my colleagues. I felt that my continuous concerns were met with a lack of resolution and therefore I did not sign the majority, if any, of my job plans, but begrudgingly accepted them whilst continuing to overwork in order to meet the demands of my role. In fact, had I adhered to the job plans that were allocated to me, the impacts on patient care, patient safety and risk management would have been significantly magnified.

345. I attach a chronology entitled "Contracts and Job Plans" which cross references a number of the documents my legal team and I have been able to review to date which are relevant to my raising concerns about the inadequacy of my job plans. Some contain summaries and extracts from the various documents. The documents have been cross referenced and should be read in full as summaries may not fully reflect all matters relating to the job plan issues, having been prepared prior to receipt of the Section 21 Notice. Time has not permitted a full review of all documents referred to therein. Within the time constraints, it is impossible for me to add a commentary in relation to every entry. However, below I will endeavour to point the Inquiry towards a number of entries which may assist in illustrating the points I have made above.

346. Job planning was formally introduced in August 2006. At this initial stage, I was allowed to have a 10 Programmed Activities (PA) allowance for all "*Contracted Programmed Activities",* and a 5.5 PA allowance for any "*Additional Programmed Activities"* and was on-call on a 1 in 2 frequency basis [see AOB-00045 – AOB-00046]. However, by October 2006, my job plan had been reduced to 11.07 total PAs. This job plan included administration time within direct clinical care time. This job plan was inadequate and my diary entries for October 2006 [see AOB-00063 – AOB-00082] evidence the inaccurate reflection that this job plan had on my role.

347. In April 2007, my job plan was again changed but had increased to 11.57 total PAs. This job plan provided 8.38 PAs for direct clinical care which was to include a 0.5 PA of patient administration, 1.38 PAs of SPA and 1.57 PAs for on-call allocation [see AOB-00083 – AOB-00087]. As with many of my job plans, I did not sign this job plan off due to my reluctance to accept an inadequate and inaccurate job plan. This job plan remained unsigned until December 2007 when I received a letter from Dr Hall asking me to confirm whether I accepted or did not accept the proposed job plan. In response to Dr Hall, I put my concerns in writing and requested facilitation, noting the following [see AOB-00100 – AOB-00101]: -

"The Job Plan that was then constructed, and which forms the basis upon which the Trust has made its offer, is both minimalist and incomplete. It is neither a complete or true portrayal of my workload.

...

Also, since 2006, the meeting of ever-increasing targets has impacted significantly upon our regular workload, particularly by increasing the time spent in administration (in the organisation and meeting of PTL's, triaging of referrals etc). This administrative burden will assuredly increase in the coming year with the advent of cancer targets. Currently, I am participating in additional urodynamic service provision (without additional remuneration)

…

As you have requested, I have indeed considered the Trust's current offer carefully. The Job Plan upon which it is offered is detached from the reality of the work required to provide the urological service which the trust is obliged to provide. I have carefully constructed a Job Plan which I have no doubt is the minimum required to meet those obligations. There is no exaggeration in any part of it."

348. I do not recall receiving a response from Dr Hall to the above. Instead, I received a letter from Dr Loughran dated 16 April 2008 advising me that my on-call PA would be reduced following the appointment of Mr Akhtar [see AOB-00117 – AOB-00118].

349. I was not the only consultant who had concerns and issues with the job plans, although many of their concerns were never put into writing. In October 2010, Mr Akhtar raised concerns with Martina Corrigan which he requested were to be discussed at a meeting. The concerns which Mr Akhtar raised were as follows [see AOB-82594]:

1. Monday OPD
2. SPA

3. MDT
4. Friday OT times

350. By 2011, the 5-consultant model had been established. I raised further concerns in July 2011 when my job plan was changed to 11.25 total PAs with 8.18 PAs allocated to direct clinical care [see AOB-00257]. I raised my concerns over the allocation of 8.18 PAs to direct clinical care with Mrs Corrigan and Mr Mackle [see AOB-00266 – AOB-00273]. I explained that I felt the allocation was *"inappropriate, inadequate and unsafe".* I explained that the reason I moved to the new consultant contract was to avail of the 2.5 PA allocation to SPA to enable me to conduct audits and audit generated research. It was and still remains my understanding that an allocation of 2.5 SPA is a contractual right. I further raised the following issues of inadequacy of the job plan [see AOB-00262 – AOB-00265]:

"*I presume that it has been an oversight, the almost complete lack of any time allocated to inpatient management from one Thursday to the next when Grand Rounds take place. I presume that it does not need to be said that such would be entirely untenable and unacceptable, and that a daily agreed period be allocated to inpatient management.*

…

The allocation of 2.5 hours per week for all of the administration involved in the effective execution of my job, is wholly inadequate, and reflects how detached the proposed plans are from the realities of our jobs…

There would appear to be a tendency to have unremunerated periods during the course of some days in the proposed plans. This would be a departure from the practice to date, and, in my view, will be counterproductive."

351. In relation to the July 2011 job plan as above, I wrote to Mr Mackle on 22 July 2011 to set out what amendments the job plan needed [see AOB-03570 –

AOB-03571] as well as raising some of my concerns in relation to what was the most substantive issue throughout the job planning process, namely the allocation of administration time, stating:

"I believe all of the above can be readily addressed and resolved, leaving one more substantive issue, which is the totality of Administrative time, which currently stands at 4.25 hours. As I have related previously, and in discussion with my colleagues, there is absolutely no doubt that such an allocation is inadequate. It is just simply impossible to do the proposed work with one PA allocated to Admin. Upon your request, I have given consideration to the amount of time required. I am entirely cognisant of the presumed requirement to be perceived to be as productive and as efficient as is possible. Taking that into consideration, I believe that 2 PAs are required to be allocated to Administration. If allocated a total of 2 PAs, I would be committed to continuing to provide to the best of my ability, all of the administration arising from the proposed Job Plan, knowing that I would be doing unremunerated work. I would propose that one additional hour be allocated to Administration at the end of each of the four days, Monday to Thursday."

352. Following the above communication with Mr Mackle, I received a revised job plan, of which I do not have a copy. Again, the job plan was inadequate and did not reflect my role. I advised Mr Mackle that I would not be accepting the revised job plan on the following basis [see AOB-03577 – AOB-03581]:

"I find it unacceptable the proposal to travel to Banbridge on the morning of the fifth Monday of the month, to conduct a clinic, lasting four hours, without credit in a Job Plan

…

I believe that it was both important and reasonable to have time allocated to addressing patient management issues arising in Thorndale Unit. Last Friday, I spent one hour doing so. That included contacting the GP of a patient whose serum PSA had increased from 8ng/ml to 803ng/ml in less than one year. I had proposed the inclusion of a nominal time allocation of 30 minutes per week (on

Tuesdays 1.00 to 1.30pm). I believe that Urology ICATS cannot function safely without Consultant Urologists providing advisory input and I believe time allocated to that function should be included in the Job Plans.

…

I believe that it remains a necessity to allocate time to conduct a ward round on Tuesday evening

…

The time allocated to administration remains inadequate. I note a recent expectation that the results of all investigations (presumably of outpatients) be read by consultants as soon as the results are available. How much administration time will this consume? How much time will be allocated in the Job Plan?

…

Lastly, I would propose to increase SPA time by one PA per month to conduct audit in urological oncology."

353. Following my raising of concerns, Mr Mackle responded with little resolution to my concerns and advised that I should request facilitation. Facilitation was requested on 2 September 2011 on the basis that I could not accept the proposed job plan of 26 August 2011. Ahead of the facilitation meeting I further raised the following issues of concern [see AOB-00308 – AOB-00313 for further detail]:

- *Inadequate time for administration relation to direct patient care*
  - *Arrangement of Admissions and attendances*
  - *Review of waiting lists*
  - *Enquiries from GPs and Patients*
  - *Referrals*
  - *Correspondence*
  - *Reports and Results*

- *Dictation arising from Outpatient Clinics*
- *Administration arising from Urological Cancer MDT*
- *Administrative Time arising from Thorndale Unit*
- *Administrative Time required to review Outpatient Backlog*

354. In order to evidence how inadequate the job plans were, I advised the following at the facilitation meeting in relation to administration time:

"Since proposed Job Plans were first submitted in July, and particularly since Facilitation was requested on 02/09/2011, I have made note of the actual amounts of time consumed weekly by the above activities. As a result, I am able to submit bare minimum amounts of time consumed by these activities each week:

- *Admissions and waiting lists* *2.0 hours (usually approx.. 3 hours)*
- *Enquires from GPs and Patients* *1.0 hour*
- *Referrals and Correspondence* *1.0 hour (2 hours)*
- *Dictation* *2.0 hours (usually 3-4 hours)*
- *MDT* *0.5 hours*
- *Thorndale* *0.5 hours*
- *Results and Reports* *to be determined*

The inadequacy of the time allocated to administration in the Job plan is most reflected in its complete absence on several days. In fact, if I do an outreach clinic on a Monday morning, day surgery on Tuesday morning, followed by a 30 minute lunch break (instead of administration), and similarly doing so on Thursday, a whole week will have passed before having one hour of administrative time on Friday. If the total amount of time were in accordance with the minimums listed above, then there would be administrative time each day.

In listing these minimum times, I am honestly conscious that I will spend considerably more time in carrying out the above administrative components of the job. It would seem the prevalent experience of my colleagues in Northern Ireland, and in Great

Britain, that they feel pressurised, obliged into agreeing to Job Plans which allocate grossly inadequate times to administration. In fact, I have had my request for an increased allocation of administrative time answered by a reduction, solely on the criterion that the new allocation was commensurate with those allocated to my colleagues, irrespective of whether their allocations are adequate. I believe that it is wrong and unjust to be expected to do so."

355. I further raised concerns in relation to the following issues [see AOB-00308 – AOB-00313 for further details]:

- Lack of Rest/Lunch Breaks
- Specialist Clinics
- Availability whilst On Call.

356. During the facilitation meeting, I discussed the above concerns and issues but highlighted specifically that the administration time of 4.25 hours was "*ridiculously inadequate" and* noted that my colleagues were equally unhappy about the administration time. In response following the facilitation meeting [see AOB-22331], I received a letter from Dr Murphy noting that my administration time was appropriate but that I would be allowed a transitional period to adjust my working practices. I was therefore allocated an additional 0.75 PA per week administration time until February 2012 when it was reduced. I raised further concerns that it was not only my administrative time that caused issue in the job plans. I noted that my job plan was "*physically impossible"* and that no further issues had been addressed [see AOB-03620 – AOB-03621]. I received my updated job plan on 31 October 2011 which allocated a total of 12.75 PAs, 9.56 PAs for direct patient care, 1.5 PAs for SPA and 1.57 PAs for on-call. Whilst I did not agree with the amended job plan, I felt compelled to accept it on 10 November 2011 noting the following [see AOB-03624 – AOB-03627]:

"I am by now disappointed, disillusioned and cynical of Job Planning and Facilitation. Even though I had brought attention, in writing and verbally, and over

a period of two months, to the physical impossibility of earlier job plans offered, a possible (whether acceptable) job plan was submitted for the first time on 31 October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1 September 2011. Upon query, now it is to be effective from 1 October 2011, a month before it was offered, and on the grounds that another consultant's job plan, presumably both possible and acceptable, had become effective from that date. Surreal relativism comes to mind!

By now, I feel compelled to accept the Amended Job Plan effective rom 01/10/2011, even though I neither agree with it or find it acceptable. I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the job plan, to completion and with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate".

357. I received a new job plan on 1 April 2012 which was in discussion [see AOB-00361 – AOB-00371] with an allocation of 11.28 total PAs, 9.80 PAs for direct clinical care and 0.80 PA for administration time. I did not accept this job plan as I felt it wholly inadequate. I received a further proposed job plan in February 2013 that proposed an 11PA job which, again, was never agreed [see AOB-06516]. By April 2013, there was a further proposed job plan which allocated 11.275 total PA, 9.80 PAs for direct clinical care and 0.80PA administration time [see AOB-00431 – AOB-00436];s this job plan was also never agreed. It was noted during this time that Dr Rankin and Mr Brown were keen on having 11 PA job plans [see AOB-06516]. It is my belief that the idea of having an 11PA job plan is directly related to the salaries of the consultant urologists as opposed to making an allowance for patient safety and care.

358. During my 2012/2013 appraisal [see AOB-22325] following the above number of proposed job plans, I raised the issue that the job plans were not being

reviewed based on the changes being made within the Urology Department; they did not allow for any change in work patterns. I highlighted the following:

"I have attached the proposed Job Plan which was to come into effect on 01 July 2011, and for a period of one year. This Job Plan provided a total of 11.25 programmed activity sessions. Following facilitation in September 2011, the total number of programmed activity sessions was increased to 12.75 until 28 February 2012, reducing to 12 thereafter (letter attached). The current Job Plan (attached) proposed to come into effort on 01 April 2013, providing for a total of 11.275 programmed activity sessions. However, that Job Plan was predicated on 5 Consultant Urologists in post, and which has only variously been the case since 01 April 2013. As a consequence, the initial job plan of 2011/12 remains in effect. However, that job plan has not been reviewed or amended to take account of changes in work patterns which have since developed, such as all day clinic sessions at South West Acute Hospital (Rather than a half day) once monthly, extended inpatient operating sessions once weekly and the additional work required in chairing Urology Multidisciplinary Team meetings."

359. I received another job plan, dated January 2015 which was not agreed. This job plan allocated a total of 12.042 PA, 10.458PA for direct clinical care and 0.667PA for administration [see AOB-00795 - AOB-00799]. However, in December 2015, an updated version of this job plan was sent to me for agreement. It allocated a total of 12.229PA, 10.875PA for direct clinical care and 1.083PA for administration [see AOB-75949 – AOB-75955].

360. A further example of my job plan failing to accurately reflect my role can be seen in the analysis of my elective inpatient operating for the year 2016 [see AOB-23225 – AOB-23226]. When calculated, I had completed a total of 118.6875 sessions whilst my job plan contracted me to carry out only 58 sessions. This in itself evidences how inadequate and inaccurate the job plans were throughout my time as a consultant urologist in the Trust. Regardless of whether the job plan has been accepted or not, the consultants were mainly working outside of their job

planned contract. I raised this issue with my job plan further during my January - December 2017 appraisal, stating that [see AOB-22887]:

"My Job Plan does not adequately reflect the amount of work that I undertake each week, and the work which I do each week is inadequate relative to the need. The more patients one attends to, the more work it generates, and the inadequacy increases."

361. On my return to work following sick leave and the formal investigation, my job plan was again reduced to a total of 10.951 PA, 9.328PA for direct clinical care and 0.577PA for administration [see AOB-01408 – AOB-01413]. I raised with the Case Investigator, that I would have completed additional clinics during my SPA allocated time in order to deal with the priority of direct clinical care [see AOB-56279 – AOB-56282]. As stated previously, had I stuck to my job plan, the impact on patient care would have been significant. I stated the following during a meeting with Dr Chada on 30 August 2017:

"Dr Chada: Is it part of your job plan to work until 8 o'clock in the evening?

Mr O'Brien: It is part of my job plan to do two sessions per week but I do more than that. So they were done Wednesdays, there was Saturday, Tuesday. Like 8.00am to 12 noon …

Dr Chada: So are these additional clinics – sorry, additional surgeries on top of normal surgeries?

Mr O'Brien:… These are all of the additionalities that have been done … So I have calculated through the years 2012, 13, 14, 15 and 16 the additional hours per week spent in in-patient operating for example. 4.47 hour per week additional… to the job planned activity"

362. During the course of the formal investigation of 2017/18, it was reported that I had been allocated more time for administration in proposed job plans than

my colleagues. I requested an anonymised report of the times allocated to my colleagues for their administration, but was informed by Ms Vivienne Toal, Director of Human Resources & Development, that this information could not be provided. A comparative analysis of job plans which have been provided by the Inquiry, has revealed that I was in fact, allocated less time for administration than my colleagues during most of these recent years, see below:

2011

AOB: 12.544 total PA, 11.094PA DCC, 2.077PA admin [see TRU-102227 – TRU-102234]

2012

Mr Glackin: 10.5 total PA, 7PA DCC (no breakdown of admin) [see TRU-101612 – TRU-101617]

AOB: 11.275 total PA, 9.80PA DCC & 0.80PA admin [see TRU-102235 – TRU-102243]

2013

Mr Young: 11.20PA total, 9.755PA DCC & 1.075PA admin [see TRU-102261 – TRU-102270]

AOB: 11.275 total PA, 9.80PA DCC & 0.80PA admin [see TRU-102244 – TRU-102252]

Mr Haynes: 10.60 total PA, 8.68 DCC, 0.66 admin [see TRU-101627 – TRU-101634]

Mr O'Donoghue: 10.60 total PA, 8.68DCC, 0.66 admin [see TRU-101643 – TRU-101650]

2014

Mr Haynes: 12.712 total PA, 11.172 DCC, 1.042 Admin [see TRU-102304 – TRU-102311]

2015

Mr Glackin: 11.458 total PA, 9.979 DCC, 1.0 admin [see TRU-102354 – TRU-102361]

Mr Glackin: 11.437 total PA, 9.958 DCC, 0.979 admin [see TRU-102362 – TRU-102369]

AOB: 12.042 total, 10.548 DCC, 0.667 admin [see AOB-00795 – AOB-00799]

2016

Mr Suresh: 11.229 total PA, 9.771 DCC, 1.0 Admin [see TRU-102509 – TRU-102514]

Mr O'Donoghue: 11.545 total PA, 9.982 DCC, 1.142 admin [see TRU-102404 – TRU-102411]

Mr Glackin: 11.429 total PA, 10.020 DCC, 0.932 admin [see TRU-102370 – TRU-102377]

Mr Young: 11.993 total PA, 10.334 DCC, 0.991 admin [see TRU-102271 – TRU-102278]

AOB: 12.143 total PA, 10.635 DCC, 0.476 admin [see AOB-01072 – AOB-01076]

Mr Haynes: 11.987 total PA, 9.487 DCC, 0.992 admin [see TRU-102312 – TRU-102319]

2017

Mr Haynes: 12.434 total PA, 9.824 DCC, 1.166 admin [see TRU-102338 – TRU-102335]

AOB: 10.951 total PA, 9.328 DCC, 0.577 admin [see AOB-01408 – AOB-01413]

2018

Mr Haynes: 12.434 total PA, 9.824 DCC, 1.166 admin [see TRU-102328 – TRU-102335]

Mr O'Donoghue: 11.560 total PA, 8.997 DCC, 1.145 admin, 0.286 triage new referrals [see TRU-102412 – TRU-102420]

Mr Tyson: 10.964 total PA, 9.240 DCC, 0.952 admin [see TRU-101655 – TRU-101665]

AOB: 11.733 total PA, 10.271 DCC, 0.77 admin, 0.381 triage new referrals [see TRU-102253 – TRU-102260]

Mr Young: 12.44 total PA, 10.354 DCC, 0.991 admin [see TRU-102279 – TRU-102287]

363. Not only was I not allocated times commensurate with scheduled commitments to Directorate Clinical Care (DCC) as recommended by The British Association of Urological Surgeons (BAUS), I was allocated less time for patient related administration than were my colleagues, and even then the scheduled DCC sessions in the job plans proposed for me were less than those for colleagues also receiving greater allocations of time for administration.

364. By April 2018, my job plan was allocating a total of 11.733 PAs, 10.271 PAs direct clinical care and 0.72PAs administration [see AOB-01804 – AOB-01809]. I met with Mr Colin Weir in September 2018 [see AOB-56366 – AOB-56385] and corresponded with him frequently throughout September and October 2018 with a view to agreeing an adequate job plan. In December 2019,

I wrote to Mr Ted McNaboe to advise that I wished to withdraw from clinical commitments on Thursdays [see AOB-70038 - AOB-70039], however, when I received my job plan following my discussion with Mr McNaboe, I raised the following issues [see AOB-70084 – AOB-70085]:

"Regarding Mondays:

… I increased the number of attending during the past year, so that the clinic is scheduled to commence at 09.30am and is supposed to end at 5.00pm, but usually does not end until 5.30pm. You have not included travelling time which has been included previously, one hour each morning and one hour to return each evening. So, I would be grateful if you would increase the number of SWAH clinics to 11, or indeed 12 per year as in the current Job Plan, as that number is vitally needed. I would also be grateful if you would have the clinic start at 09.30 am and end at 5.30pm, and add in one hour travelling time, each way, as at present.

Regarding operating sessions:

… Greatest concern with the proposed Job Plan is the sparsity of inpatient operating sessions included. At 1.18 sessions per week, the Job Plan is more akin to that of a physician, with a little operating added in.

During 2019,

- *On one Wednesday, I had an operating session in the morning only, as there was a PSM in the afternoon*
- *On ten Wednesdays, I had an operating session in the afternoon only*
- *On 26 Wednesdays, I had all day operating, morning and afternoon*
- *On 12 Thursdays, I had an operating session in the mornings only*
- *In addition, I have had another 12 operating sessions while being urologist of the week, though perhaps this activity should be regarded as predictable emergency activity while urologist of the week, as it is done in addition to the unpredictable.*

The proposed job plan implies that I would have only 40.33 operating session per year.

In 2019, I had 75 sessions, plus another 12 when UOW, plus 3 paediatric urological sessions in DHH, a total of 90 sessions! I think the number included in the proposed Job Plan is clinically untenable…

Regarding Urologist of the week:

The proposed Job Plan implies that one would do seven per year, presumably one in every six weeks during a 42-week year. But I will have done eight in 2019. Six urologists still do have to be urologists of the week for a 52 week year. If annual leave coincides with a scheduled week of UOW, your turn is brought forward or later. It is not cancelled.

It would appear that you may not have included the session for handover on each Thursday morning on completion of UOW.

Increasingly, we have been undertaking operating sessions when UOW. These are undertaken in addition to all the other duties of UOW, including emergency surgery. I will have undertaken 12 such sessions, a mean of 1.5 for each UOW. Should these not be regarded as predictable emergency work?

In our last round of Job Plans, it was also agreed that each of us would be allocated one session for a weekend ward round. That would appear not to have been included in the proposed job plan.

Lastly, it was agreed during the last round that we would be allocated six additional hours of predicted time for triage while UOW. It would appear that this may not have been included in the proposed job plan.

Regarding Administration time:

The proposed job plan provides for a total of 18 hours every six weeks. It has been my understanding that we should have one session per week provided for administration…"

365. Following the above discussions, my job plan was proposed at an allocation of 9.668 total PA with 8.201PA for direct clinical care, 1.466PA for SPA and administration was allocated only 0.897PA. From recollection, this job plan was also not finalised or signed off. Following this, the Covid 19 pandemic descended and Dr McNaboe was indisposed for other reasons and thus, I had no further job plan meetings or correspondence with any of my colleagues regarding job planning.

366. As the above demonstrates, throughout my tenure, I endeavoured to ensure that management were fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the job plan to completion and with patient safety as the paramount priority of my role as a consultant urologist. Moreover, BAUS published guidance in relation to job planning in a document titled "*A Guide to Job Planning for Consultant Urologists, 2016* [see supplemental October bundle pages 520 - 559]. Which states, in relation to patient administration, that:

"This work is directly related to patient care and would normally attract an allowance of 1PA, although an extra allowance should be allocated when the administrative burden is high."

367. Based on an 11PA contract with 1 extra PA of direct clinical care, BAUS recommends an administration allocation of 1PA. However, based on my commentary above, in the years 2012, 2013, 2015, 2016 and 2018, I was contracted to a minimum of 11PA total contract with an allocation of less than 1PA administration time in each job plan.

368. It is my belief that had I complied with the proposed job plans throughout my tenure (in other words limited my work to only that which was provided for by the Trust's inadequate job plans), patient safety, clinical care and the backlogs of patient waiting lists would have been considerably adversely impacted. I worked many many hours over a number of decades well in excess of my proposed job plans to lessen any such impact as best I could in the circumstances.

(Q 50)

369. See my response to Questions 46, 48 and 49.

(Q 51 – 53)

370. The standards and guidance applicable to urology and within which I was required to operate and comply include those issued by the Northern Ireland Cancer Network ("NICaN"), the British Association of Urological Surgeons ("BAUS"), the National Institute of Health and Care Excellence (NICE), the GMC's Good Medical Practice and the European Association of Urology (EAU).

371. These standards and guidelines informed my practice every day.

372. The dominant guidelines in the UK for the assessment and management of urological patients and their conditions are those issued and regularly updated by NICE. I found these Guidelines particularly useful for both me and my patients as they adopt a holistic approach to the assessment and management of conditions, setting out the merits and risks associated with every form of investigation and management. This has been particularly useful in providing documentary evidence to patients of those merits and risks, The Guidelines are readily accessible for the patient and written with the patient in mind.

373. They are compiled following careful consideration of the published literature and updated as new evidence emerges. They are largely reflective of

similar guidance issued by the EAU and by BAUS, though there can be variations which urologists should be aware of, as well as the reasons for them.

374. The guidelines issued by NICaN have been more reflective of those issued by the EAU than those issued by NICE and have had to take account of various capacity constraints in their compilation. The EAU and BAUS are also professional organisations, while the GMC has issued guidance as a regulatory body.

375. I am a product of training in an era which largely preceded the formation of bodies issuing guidance in clinical management. In that era, there was a greater emphasis on reading and knowing the literature and of being able to critique it. I think the emergence of the guidance industry has had one downside; I have found that younger urologists have outsourced their knowledge of the literature, and the value of the evidence contained within it, to the guidelines. I also think that younger urologists often equate the lack of a recommendation or guidance in the guidelines to it having been investigated or tested and found not to be recommended.

376. As a consequence of my training, I have continued to read the literature (and still do every day) as I have continued to be fascinated by the relentless layering of knowledge upon knowledge. I have also found it most helpful to attend national and international conferences, such as the EAU and that of the American Urological Association (AUA). By doing so, you are reminded that not all is settled, that some things remain controversial, and it has been fun to watch those great authors of the literature debate with one another at the podium. I have enjoyed operative workshops, from female incontinence surgery in Barcelona to radical cystectomy in Karachi.

377. I have appended references to my continued professional development [see AOB-22105 – AOB-22106 for CPD certificates received in 2006, see AOB-22118 – AOB-22123 for CPD certificates received in 2007-2009, see AOB-

22140 & AOB-22163 for CPD certificates received in 2010, see AOB-22253 – AOB-22259 for CPD certificates received in 2011, see AOB-22351 – AOB-22365 & AOB-22563 for CPD certificates received in 2012 – 2014, see AOB-22686 for CPD certificates received in 2015]

378. All of the above assisted me in maintaining my standards of professional practice.

(Q 54)

379. Each consultant was allocated a certain level of funding on a 3-year cycle to attend conferences etc. However, to the best of my recollection I only applied for this once, as when I attended conferences I was generally invited to the conference and my costs and expenses were funded by whoever invited me.

380. I do recall obtaining excellent support for certain quality improvement initiatives. In and around 1998, the Urology Service obtained excellent support in obtaining the only on-site lithotripter in Northern Ireland, used for extracorporeal shock wave lithotripsy (ESWL), in the management of kidney stones. Also, at this time the Chief Executive of the Trust, Mr John Templeton, was very supportive of research activities. I persuaded him to appoint clinical research fellows. The Trust paid their salary and they usually worked 2 - 3 days, providing a clinical service and 2 – 3 days of research, which was funded by CURE (Craigavon Urological Research & Education). Overall, there were 5 clinical research fellows from our department who took higher degrees from research.

381. I was also supported in founding CURE, which is a company still in existence, to fund research. The company was set up by Roberta Brownlee.

382. I recall that John Templeton was supportive in enabling the appointment of a Lecturer Practitioner in Urological Nursing with the University of Ulster, and

introducing academically accredited modules in urological nursing, and which were accessible on site or remotely by international students by e-learning.

383. The launching of the International Journal of Urological Nursing was a major international achievement gestated within our department.

(Q 55)

384. Other positions relevant to my role as a consultant urologist have been referred to elsewhere in this statement and were as follows:

- Director of CURE – 1998-present
- Lead Clinician and Chair of NICaN – January 2013-December 2015
- Lead Clinician MDT - April 2012-December 2016
- Chair MDM – April 2012-December 2019

385. All of the above informed my clinical and general practice by helping me maintain my knowledge of urological practice.

(Section 5 – Governance)

(Q 56 – 61)

386. My responses elsewhere have addressed these issues. If clarification of any aspect of governance is required, I shall be happy to assist the Inquiry further in any way that I can.

(Section 6 – Concerns)

(Q 62)

387. My responses elsewhere have addressed these issues. If clarification of any aspect of processes for addressing concerns is required, I shall be happy to assist the Inquiry further in any way that I can.

(Q 63 - 65)

388. I believe that it is important to appreciate that all individual health care professionals are different. We all do have our individual strengths and weaknesses. Some have regarded the strengths of others to be unnecessary. We are different in our subspecialty interests. Our differing personalities, skills and experiences lend some to suitably apply themselves to particular areas of clinical practice that are less appealing to and suited to others. Indeed, some will have strengths which are particularly applicable to organisational aspects of a service than the clinical aspects of the service. I experienced many examples of this reality in several renowned urological departments during my years of training.

389. Prior to the appointment of Mr Michael Young as a consultant urologist in 1998, I had visited a number of urological departments in Belgium and Germany to decide which kind of lithotripter the Trust should consider procuring. Having decided upon the Dornier MPL lithotripter, the Trust then decided to locate it in the former CSSD area which had been vacated and which was adjacent to the theatre suite, a location which I considered to be optimal. Following his appointment, I asked Mr Young whether he would agree to drafting plans for the new Stone Treatment Centre (STC) in that location. Within a relatively short time, he had done so, and to a remarkable degree of detail which has served the STC very well ever since. I appreciated that he had done what I could not have done.

390. Mr Young became the Lead Clinician soon after his appointment and remained in that role until my employment with the Trust ended in July 2020. Throughout those years, he arranged the monthly schedule of clinical activities for all consultant and junior medical staff in the department. He designed the Thorndale Unit in 2007 and redesigned it when it was later relocated into the main hospital building.

391. I relate the above to emphasise the positive contribution made by the differing strengths, weaknesses and interests of colleagues. I have no doubt that the totality of the complimentary differences in strengths, weaknesses and interests of my colleagues and I down the years has been above all, the strength of the Department and optimised the service which we could provide within the severe constraints in which it was provided.

392. One significant frustration which I did have with Mr Young was in relation to the introduction of Urologist of the Week (UOW). It was my view that Mr Young did not foresee there being any substantive difference between being the consultant urologist on call and being UOW. It was for this reason that he considered for some time that the UOW would need to be free of any elective commitments each morning only, and could probably and safely undertake an elective commitment, such as a clinic, during the afternoon. My colleagues and I succeeded in dissuading him from this belief, not least as patients appointed to such clinics may have to be cancelled at short notice, and even on attending.

393. In his defence, I do think that we did not foresee the extent to which UOW would free all the other consultants so completely to commit to elective work, including at other locations, and to the extent that they could not be expected to care for those patients who had been electively admitted under their care. It was for that reason that we relatively quickly came to appreciate, following its implementation, that the UOW would be required to care for all inpatients, whether acutely or electively admitted.

394. However, we did agree to commit to undertaking the triage of all referrals received by the Department while UOW in order to get UOW over the line. Within a few months, I appreciated that the time consumed in providing optimal care to increasing numbers of inpatients who were often elderly and comorbid with complex needs, in addition to the assessment and management of patients attending the Emergency Departments or already admitted to any of the three acute hospitals for which we were responsible, was all consuming throughout the course of the week. It was for that reason that I found it impossible

to complete the triage of non-red flag referrals, and particularly in the context of these patients having to wait increasingly long periods of time for ~~a~~ first outpatient consultation, without investigation and / or treatment having been initiated. I advised my colleagues and personnel from the Appointments Office that I had found it impossible to do so when we met in early 2015 to discuss the Informal Default Procedure whereby patients would be appointed in accordance with the category of urgency attributed by the referrer.

395. While I believe that it was regrettable that triage was included among the commitments of the UOW, it also became progressively apparent to my colleagues and I that UOW was very different from being on call, and that it increasingly contributed to improved care of all inpatients under our care and all those acutely referred to us from elsewhere. Much of the operative commitment arose from the acute admission of patients with obstructive uropathy, most commonly due to obstructive stone disease. Many of these patients were ill due to infection complicating obstruction, a condition that can deteriorate quickly without intervention.

396. Against this background, I observed and was concerned that the management of such patients could be left by the UOW to the registrar rostered with the UOW. I am aware that it was known that Mr Mark Haynes was less likely to commit to spending time conducting ward rounds with junior medical staff when he was UOW. I also experienced patients having obstructive stone disease managed endoscopically by a registrar, unsupervised by Mr Haynes while he was UOW. On discussing this with him on one occasion, he asserted that it was by "*letting them get on with it*" that they learn. Ironically, on that occasion, he was conducting triage of referrals while the patient was having a difficult ureteroscopy and ureteric stenting performed by a relatively inexperienced registrar.

397. However, the aspect of Mr Hayne's practice which gave rise to most concern from my perspective was his endorsement of the practice of DARO in 2019 [see AOB-07525, AOB-07566 – AOB-07570 & AOB-07571 – AOB-07639].

I considered the practice to be concerning as I believed that it presented a very real risk that patients would not be reviewed at all. Since then, I had been contacted informally by a number of patients requesting that I review their management as they had not been reviewed for some time. It was as a consequence that I came to appreciate that Mr Haynes had effectively completely replaced holistic urological, clinical review of the patient with an ongoing monitoring of their pathology, based solely upon the results and reports of investigations. I became aware prior to the end of my employment that other colleagues were aware of this practice.

398. I believe that this is an important issue which requires consideration and discussion. I believe that it probably developed as a consequence of the service inadequacy. If that inadequacy contributed to the introduction of DARO, then DARO becomes self-perpetuating to the extent that review of the patient is completely replaced by the unidirectional communication of monitored results and reports, and can become the next, new standard of care. I believe that there is a place for both monitoring and communication of results and reports by staff provided with the time to do so, and review of the patient as well as their pathology. Regrettably, my employment was terminated prior to my having the opportunity of discussing this probably contentious issue with my colleagues.

399. Lastly, with regard to Mr Haynes, I have been most disappointed to learn since 2016 the extent to which he criticised me to others, formally and informally, without ever speaking to me regarding any concerns or criticisms which he did have. Needless to say, this disappointment reached its zenith when I realised that he was prepared to make an untrue allegation against me with regard to two out of ten patients not being on the Patient Administration System when they should have been (and were) in order to justify a Look Back review of my practice.

400. The only reason for my having any concern regarding the practice of my former colleague, Mr John O'Donoghue, was in his previewing of cases in

preparation for Urology MDMs which he chaired, and in the chairing of them. I had no doubt that he did not adequately preview cases for MDM. On enquiring why he had not adequately previewed a case while that case was being discussed, he explained that he did not have adequate time to do so. In that regard, he could hardly be faulted as we did not have adequate time to prepare for MDM as Chairs, if at all. The lack of adequate preview probably also contributed to the quality of his chairing, as his dictation of the outcomes of MDM discussions was often truncated, or incorrect, as in the case of Service User A (SUA) [see AOB-40064 – AOB-40074].

401. I did not have any reason for concern regarding the clinical practices of Mr Anthony Glackin or of Mr Mathew Tyson, Consultant Urologists, or of Mr Derek Hennessey or of Mr Thomas Jacob, Locum Consultant Urologists. However, the assessment and management of an inpatient by Mr Ram Suresh, Consultant Urologist, following the transfer of the patient from South West Acute Hospital in late 2015 with evidence of a significant intra-abdominal, secondary haemorrhage following an earlier partial nephrectomy did give rise to concern regarding his clinical acumen and ability to undertake emergency surgery in a life-threatening situation when UOW. This case was discussed with me and his remaining colleagues by Mr Mackle, then Associate Medical Director and Mrs Corrigan, Head of Service, in early 2016 when we were requested by them to provide back-up support for Mr Suresh when UOW. As can be seen from the email from Martina Corrigan dated 4 March 2016 [AOB-76726] a meeting took place on 17 December 2015 following the above incident and then a follow up meeting took place on 4 March 2016. I was not present at that meeting, but the email indicates that Mr Mackle, Mr Young, Mr Glackin, Mr O'Donoghue, and Ms Corrigan were present. The following support measures were agreed to be put in place to assist Mr Suresh:

Actions agreed:

1. Mr Young to meet with Mr Suresh this week/early next week and explain what processes are being put in place for cover/support/mentorship for him and also to explain to him why the Team are doing this for him. (Mr Young to update when this happens)
2. Mr Mackle to meet with Mr Suresh on Wednesday 16 March 2016 at 2:30pm in AMD office, M Corrigan to organise
3. Mr Mackle and Mr Young to advise him that he should be seeking appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
4. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – M Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh
5. Formalise evening cover and the purpose of this will be explained to Mr Suresh in his meeting with Mr Mackle and Mr Young.
   Mr Young to formalise after discussions with the rest of the Team and that this should be shared with all the Team, Mr Mackle and M Corrigan. Mr Suresh is going back oncall on Thursday 17 March (Bank Holiday), Mr Young has agreed that he will do the handover Ward Round and cover Mr Suresh on this day.
6. Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and M Corrigan.
7. The Consultants involved in the 'second on call' and Ward Rounds will be renumerated by ½ PA – M Corrigan to organise.

402. On 23 March 2016, Mr Suresh met with Mr Mackle and Ms Corrigan, and the following note of that meeting is available at AOB-77453:

To formalise, please see the notes/actions arising from your meeting with Eamon and I on 23 March 2016.

Present: Mr Mackle, Mr Suresh, Mrs Corrigan.
Venue: Associate Medical Directors Office, Admin Floor, Craigavon Area Hospital

Mr Mackle advised that the purpose of the meeting was to follow up from the meetings that Mr Young and Mr O'Brien had with Mr Suresh.

Actions agreed:

1. Mr Mackle asked Mr Suresh to source appropriate courses that will assist him in building up his surgical and decision making skills and that Mr Mackle will approve if these are appropriate.
   Mr Suresh to Source and provide details of courses to Mr Mackle/Mrs Corrigan by Friday 22 April 2016 so that arrangements can be made to approve/attend if deemed appropriate.
2. A Multi-disciplinary feedback questionnaire should be completed and collated within the Team (not linked to the 360 feedback) – Mrs Corrigan to organise and will collate responses. This will be used as constructive feedback for Mr Suresh and will be strictly confidential.
3. Formalise evening cover for all oncall weeks for Mr Suresh.
   Mr Young has agreed to formalise after discussions with the rest of the Team and that this will be shared with all the Team, Mr Mackle and Mrs Corrigan.

   Formalise the Ward rounds with one of the Consultant Team accompanying Mr Suresh each day (except Thursday) Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr Mackle and Mr Suresh and Mrs Corrigan.
4. Mr Suresh to arrange to attend theatres with the other consultants in order to train in his surgical skills. The details of when and what cases he is involved in should be logged and shared with Mr Mackle/Mrs Corrigan – this should be provided on a monthly basis.

A further meeting in 3 months to be organised in order to update on progress – Mrs Corrigan to confirm date.

403. On 18 April 2016, Mr Suresh wrote to Mr Mackle by email [AOB-77447 - AOB-77449] confirming that he had met Mr Mackle on 23 March 2016 and presented an action plan, which was as follows:

Action Plan

Type of Action	Details of Action	Outcome	Comments
Formal and Informal Discussions	Engaged in discussions with my consultant colleagues – Mr Young, Mr O'Brien, Mr Glackin, Mr Haynes and Mr O'Donoghue. Requested my colleagues to inform me of any major urological emergency, even if out of hours, so that I can avail the opportunity to observe and assist.	Finalised days/time to attend extra theatres for observation of major open cases	I am liaising with the secretaries to keep me up to date on current theatre schedules for major cases
Theatre Observations	Attended various theatre sessions to observe and to assist major cases	Improved my confidence and skills in open cases	All such theatre sessions attended are recorded on a separate log book
Research / Booking of Suitable courses	Engaged in independent research about suitable courses. Contacted BAUS Office of Education and the organisers to obtain course details	Identified three courses* which will enable me to gain hands on skills	To book the courses, soon after the announcement.

*Courses Identified

1. Advanced Cadaveric Trauma Emergency Surgery Course (ACTs)
   Date: September 26, 2016 Emailed Newcastle surgical training centre and is awaiting registration

2. Cadaveric Course Module 3- Male and female urinary incontinence – Probably in Oct 2016. Date yet to be announced.

3. Cadaveric Course Module 4- Emergency and Trauma Urology cadaveric course- Probably in Oct 2016, Date yet to be announced.

404. I wrote to Ms Corrigan on 12 June 2016 by email [AOB-774921]. I was responding to her email to me dated 7 June 2016 [AOB-77492] where she had raised concerns in respect of Mr Suresh's cover for working on call on Thursday 9 June 2016. I noted in my email that Mr Suresh had made every effort to improve his management of inpatients while on call and that he had succeeded. I noted that I was impressed by his diligence. I felt at that point that he was up to speed. I indicated that I felt his ability to undertake major open surgical intervention, particularly in a very acute setting, was distinct from his general clinical management of inpatients. I observed that I felt that at that point only a proportion

of urologists completing their training would be able, or expected, to do so. Overall, I felt that Mr Suresh had made excellent progress and was keen to improve his surgical competence. I felt that he deserved and had earned the ongoing support of the Urology Service and his colleagues.

405. I continued to provide support to Mr Suresh until he returned to take up another post in England in October 2016. I did not receive any remuneration for having done so. I have since had reason to contrast the support offered to him in 2016 to that offered by the same persons to me in 2016.

406. I attach a chronology entitled "*Trust Concerns / Consultant Concerns*" which cross references documents my legal team and I have been able to review to date which are relevant to issues related to the questions above in terms of complaints about the practice of others. Some contain summaries and extracts from various documents. The documents have been cross referenced and should be read in full as the summaries may not fully reflect all relevant matters. If the Inquiry has any further queries in respect of any concerns raised in respect of any medical practitioner referred to within the attached chronology, I would be happy to provide further details as required.

407. My response at Questions 1, 9, 10, and 21-25 sets out in detail my concerns in relation to patient safety in urology services and clinical governance in urology services, as well as concerns being raised and not being adequately addressed by the Trust.

408. I have no doubt that the concerns identified and raised by me, and others, impacted on patient safety, and indeed I have provided various examples above of individual patients coming to harm as a result of the issues underlying these concerns. While I believe that concerns were identified, both by me and by others, I do not believe that their nature and impact were adequately appreciated by the Trust, nor do I believe that their potential risk to patient safety was adequately considered by the Trust, and steps were not taken to adequately address and mitigate the risks posed to patients.

409. Certain examples can be provided in respect of how inadequate the Trust's response was to issues affecting the Urology Service. In September 2019, I became aware of a patient validation exercise that was being undertaken by the Trust. I wrote by email to Martina Corrigan [AOB-09426] in respect of a patient who was under my care. I wrote that this patient was a 69 year old diabetic man who had a stone obstructing his upper right ureter in 2015. He was managed by ureteroscopic laser lithotripsy. He was noted to have a grossly enlarged prostate gland on endoscopic assessment. I advised him he would be better served by having his prostate resected and he was placed on the waiting list for that procedure on October 2015. I wrote that on reviewing my waiting list in August 2019 (almost 4 years after the patient had been placed on the waiting list) I noted that he had been removed from the waiting list in July 2019. On speaking with the patient by telephone, it transpired that he had been contacted by the Trust by letter to enquire whether he wished to remain on the list. As his only symptom at that time was nocturia, he replied that he did not wish to proceed with surgery. I wrote in that email that it was entirely inappropriate that non-clinical staff should correspond with a patient to enquire whether they wished to remain on a waiting list. I noted that that process was entirely for the purpose of reducing the numbers on the waiting list. I noted that patients, who have the right to decline proposed management, should only make decisions when informed by clinical advice. The above practice was clearly unsafe and exposed patients to considerable risks of harm.

410. Mr Haynes wrote by email dated 24 September 2019, having been provided with a list of patients under his care who had been written to as part of the patient validation exercise, that "*none of the decisions are free of clinical consequences, all carrying at minimum a risk of emergency admission, most a risk of gram negative sepsis, and in the case of one...the clinical consequence is a risk of life threatening sepsis / death.*" The above reflects the incredulity of myself and colleagues in respect of this exercise from the Trust to aim to deal with the increasing waiting lists. The action taken by the Trust was entirely

inappropriate and, more importantly, was unsafe, exposing patients to significant risks of harm.

411. The concerns I had in respect of DARO, and the steps I took to raise such concerns, are detailed above in my response to Question 9. Again, this was presented as a patient safety measure to address service inadequacy by the Trust. However, it was clearly an unsafe and inappropriate response and posed an obvious risk to patient safety.

412. I have provided my comments in respect of the quoracy of urology MDMs above (see paragraphs 292 – 293, paragraph 303 & paragraph 305). The Trust failed to take adequate action to ensure the quoracy of MDMs, which potentially exposed patients to risk where their care was being discussed at such non-quorate MDMs.

413. While my concerns in respect of staffing are dealt with in detail in my response to Questions 21-25, a further example of the inadequacy of staffing is that which I have highlighted in my comments on Nursing and Ancillary Staff relating to the email sent by Sr Catherine Nurse Hunter on 12 November 2015 [see paragraph 240]. Suffice it to note that, over many years, the approach taken by the Trust to address staffing issues was inadequate and that, along with a lack of resources, certainly impacted patient safety within the Urology Service.

414. I raised various concerns over many years during my appraisals, and that is detailed in my response to Question 46.

415. Overall, I did not feel that I received much support from the Trust in respect of concerns raised. Over the years, the concerns that I had remained largely unchanged, having not been adequately addressed and resolved. It proved to be a frustrating and concerning experience. It gave rise to a sense of fatigue and disillusionment with regard to raising concerns. I did often wonder whether repeatedly raising the same concerns which were not resolved made it

even more difficult for them to be resolved. I was certainly left with the belief that raising concerns was no longer productive. I have no doubt that my experience has been the experience of many others, and which has resulted in experienced, skilful staff of differing disciplines leaving their posts, their commitment to caring exhausted.

(Q 66 (i) – (xiv))

416. Please see attached a chronology relating to concerns regarding my practice. The chronology includes relevant documents that my legal team and I have been able to identify to date. I have tried to identify as broad a range of documents as possible which may be relevant to the matters referred to under this Question of the Notice. If there is any item arising from the chronology in respect of which the Inquiry would be assisted with further input from me, please let me know and I shall provide further comment if I can. For the purposes of this statement, however, I shall concentrate on the sub-paragraphs identified in Question 66.

(i)

417. When patients are acutely admitted under the Urology Department, they initially attend the A&E Department and it is the A&E Department that makes a decision on whether or not the patient should be admitted. Urinary tract infection is one of the most common infections in society, most frequently diagnosed in women. Such infections may occur only once or occasionally during the course of a lifetime, but they may recur more frequently or become chronic. Irrespective of their frequency, they may have a wide range of severity, from minimally symptomatic to the life-threatening. They may be all the more severe due to other urinary tract pathology which may not have been diagnosed.

418. Over a period of years, my colleague, Mr Michael Young, and I had patients being repeatedly admitted to our department with severe urinary tract infections. If they had been acutely admitted to our department once or twice previously, they

would usually have been acutely readmitted to our department once again, at the request of their GP, or on presenting to the Emergency Department at Craigavon Area or Daisy Hill Hospitals. A common feature of these patients was that they would have been dehydrated to varying degrees due to nausea or vomiting persisting for days prior to admission. In addition, they may have been painful, febrile and hypotensive. Their immediate management included intravenous rehydration as they were unable to tolerate an adequate oral fluid intake. It also would have included intravenous antibiotic therapy, either pre-emptively or following identification of the antibiotic sensitivities of the infecting organism. We typically found that 5 days of intravenous hydration and antibiotic therapy was required to achieve optimal clinical outcomes, with patients rendered asymptomatic and with negative urinary cultures.

419. However, we saw these patients being repeatedly acutely readmitted after varying periods of time, usually of the order of 2 to 3 months. One might have expected that they would not have been as severely symptomatic as previously, having derived benefit from their previous infection. However, a common feature was that they tended to be as severely symptomatic as previously, if not worse. One would have anticipated that they may have had a lower threshold for readmission due to having been made well from previous admissions. However, we found this cohort of stoical patients to have made every effort to avoid or defer having to spend another 5 days in hospital. By the time of their acute readmission, they were more unwell than previously.

420. We wondered whether we could prevent these patients becoming repeatedly so acutely unwell, requiring acute re-admission, by having them electively readmitted prior to acute readmission. By analysing the periods of time that had elapsed between acute readmissions, we were able to determine a planned date for elective re-admission for intravenous hydration and antibiotic therapy. Prior to doing so, we had already found that pre-emptive oral antibiotic therapy in the community had been ineffective and had only delayed their acute re-admission. So, we electively re-admitted patients, usually 2 weeks prior to their otherwise, anticipated acute re-admission. We also hoped that by doing so,

we would be able to lengthen the periods of time between elective re-admissions, while hopefully preventing acute re-admission.

421. Overall, over a period of time, we found this to be effective. Most patients reported that they considered that the most important component of their elective management was the intravenous hydration. We certainly found that intravenous antibiotic therapy without intravenous hydration was either not effective at all or took longer to be so. We also frequently found that patients had positive urinary cultures on elective readmission, though they had not yet become symptomatic. We were able to increase the periods of time between elective readmissions. We were able to do so without finding evidence of emerging antibiotic resistance. However, we were unable to prevent acute readmission in a minority of patients.

422. The practice of elective readmission of these patients came under scrutiny in 2010 when Mr Young and I were directed that the practice had to end, and that the further management of these patients had to be undertaken by a multidisciplinary team (MDT), including a consultant microbiologist. Dr Rankin, the then Director of Acute Services, prohibited us individually from communicating directly with these patients, with any communication having to come from the MDT instead [see AOB-00191]. By this time, the majority of patients had been managed so successfully by elective readmission that they continued to be managed successfully in the community by having urinary cultures repeated regularly and by having therapeutic courses of oral antibiotic therapy, or by antibiotic prophylaxis, or by a combination of both. However, a minority of patients were left to be acutely readmitted when they became unwell enough to warrant admission. This minority proved to be increasingly difficult to manage due to progressive deterioration in peripheral venous access, occasionally requiring central venous lines. One or more of these patients required acute admission to intensive care because of the severity of their bacteraemia / septicaemia, and these patients were still being acutely readmitted prior to the end of my employment with the Trust.

423. In 2011, we communicated our experience of the practice of elective readmission in a letter to the Editor of the Journal of Infection (2011: xx, 1-3).

424. A different cohort of patients electively admitted for intravenous hydration and antibiotic therapy were those patients who were admitted one or more days prior to elective surgical management of urinary tract stone disease. This practice was restricted to a relatively small cohort of comorbid patients with a large stone burden, either in the kidney or in the bladder. It was focussed on diabetic patients, particularly insulin-dependent diabetic patients, who had previously suffered acute infection and / or were known to be repeatedly or chronically infected. We had found that elective admission, one or two days pre-operatively for intravenous hydration and antibiotic therapy, had significantly reduced the risk of urosepsis that accompanied stone surgery. We were directed that we could only admit such patients with the permission of a consultant microbiologist and the Clinical Director. As Mr Young cared for more patients with large stone burdens, particularly renal staghorn calculi undergoing percutaneous surgery, he may be better able to advise the Inquiry of the impact of the direction to restrict this practice on the accompanying infective risks to such patients since 2010.

(ii)

425. A cystectomy is known as a simple cystectomy if it is performed for any reason other than malignancy. In discourse concerning the issue at the Southern Trust, the term ‘benign cystectomy’ has been used.

426. My colleague, Mr Michael Young, and I had performed benign cystectomies at Craigavon Area Hospital for a number of years. As I recall, I think that the first benign cystectomy I performed was on a woman who was paraplegic, having been born with spina bifida. She had an ileal conduit urinary diversion performed in infancy. She had developed a pyocystis, her bladder was full of pus, resulting in a continuous, purulent vaginal discharge which proved refractory to intermittent bladder irrigations.

427. In my practice, the most common indication for benign cystectomy has been in the management of painful, chronic interstitial cystitis, which has been refractory to all other pharmacological and endoscopic treatments. The pain may be resolved by performing a urinary diversion without cystectomy. However, ileal conduit urinary diversion requires a urinary stoma which can have significant negative consequences for the patient to the extent of it being life-changing. Removal of the painful bladder is preferable, followed by either a continent urinary diversion or, as was my preference, an othotopic bladder replacement. This entailed replacement of the inflamed bladder by a neo-bladder constructed from bowel. I have also performed benign cystectomies for haemorrhagic radiation cystitis in a few patients and as a last resort in their management.

428. I was aware that the Trust had arranged for a urologist from Southmead Hospital in Bristol, Professor Marcus Drake, to review the practice of carrying out benign cystectomies. I was not advised of the review in advance. I believe he was commissioned to visit the hospital to conduct a review of patients' clinical records. I understand that he did not meet any patients who had had benign cystectomies performed. I was not invited to meet him, and I do not recall being provided with a copy of Professor Drake's report which is at WIT-17341. However, Mr Mackle, then Associate Medical Director, wrote to Dr Diane Corrigan, Consultant in Public Health, by email on 5 August 2011, summarising Professor Drake's conclusions in the following terms [see AOB-05813]:

"Diane

Following the concerns regarding the number of benign cystectomies being performed in the Southern Trust I met with Mr Marcus Drake, Senior Lecturer in Urology, University of Bristol and discussed the concerns raised….

Conclusions:

…

He essentially did not have any major concerns regarding the overall practice. He felt that this group of patients can be very complex and difficult to manage. He stated that often the problem can be getting a surgeon to take them on as patients because they can become one's albatross. He did feel that for a couple of patients he would have preferred more comprehensive notes but didn't feel that this was sufficient grounds to warrant serious concerns. He also expressed concerns the in-patient management of infection in one of the cases and I pointed out that this has already been addressed and that the Urologists are involving the Microbiologists and the CD as part of a treatment plan when the use of antibiotics is being considered"

429. In overall terms, therefore, Professor Drake appeared supportive of the benign cystectomies that he reviewed, albeit he expressed some reservations on the standard of notes and management of infection. I am unaware whether his reservations related to my patients and would be happy to review the clinical records for the patients in question to comment further if requested.

(iii)

430. This relates to a patient who had long-term complex urological issues which required multiple admissions, long in-patient stays and surgery. As a result, the patient's records were voluminous and occupied two or three hospital patient folders which were bulging as a consequence. From each admission she had charts such as fluid balance sheets, NEWS sheets, TPN prescription forms, Aminoglycosides prescription forms and a prescription card-ex along with relevant hand-written medical notes, nursing notes, test results and such like.

431. Each time I was due to see the patient I found it impossible to secure newly hand-written clinical notes in the correct location in the most recent, current folder. I asked the ward clerks to get a new folder, only to be advised, to

the best of my recollection, that it was difficult to get folders due to budgetary constraints.

432. One Saturday, I was working and opened the current folder. The filing was in a mess. The plastic straps securing pages in place had become undone due to the volume of pages within the folder. The pages of hand-written notes were lying loosely both within and some outside the folder. The latter were folded and creased. I therefore removed some of the oldest sheets from the rear of the oldest folder, moving records back into chronological order to make room for the pages of hand-written clinical notes at the front of the patient's current chart. It took me some time to do it. In my frustration, I wrongly and unwisely placed the old sheets which I had removed in the bin in the nurses' station. I accept, and accepted at the time, that it was wrong for me to do this. I was issued with an informal 6-month warning [see AOB-00277].

(iv)

433. I fully accept that, in an ideal world, records should not be kept at home, other than perhaps for a very short period if it is not possible to carry out work required by reference to the records while at the Trust's premises. However, I worked in a service that was far from ideal, which led to me often working from home. In more recent years, with the increasing reliance on electronic care records (ECR), it became easier to work remotely without having paper records to hand.

434. This issue needs to be considered in the context of the overall excessive workload I was labouring under, and lack of support from the Trust to deal with it. I have commented on those issues throughout this statement, in the context of the formal investigation and my grievance and will not repeat the detail here. However, I will set out a summary below.

435. First, in relation to records held at home, I was primarily based at Craigavon Area Hospital (CAH). I also conducted outreach clinics at South West Acute Hospital (SWAH), in the Western Trust. SWAH was exactly 50 miles distant from my home and travelling from home to there through several towns in the early morning and returning each evening took 70 minutes each way. Travelling to an outlying hospital, with the additional time demands that involved, added significantly to the length of my day.

436. I was unaware of any definite system employed by the Trust in relation to the transfer of records between hospitals, and perhaps particularly to a hospital in another Trust. There was no written direction to me in relation to how, or when, they should be returned.

437. The clinic at SWAH took place once each month on a Monday. The Medical Records personnel at CAH would deliver the charts for the patients attending the clinic to my office in CAH on the preceding Friday for me to take to SWAH three days later. I was provided with a container on wheels in which to transport the charts.

438. As a result of the significant pressures I was under, I did not have time to complete all work required on records (in particular correspondence) while at SWAH, as insufficient time was allocated to allow me to adequately review patients, including new and cancer patients, and complete administration work within clinic time. Initially, the clinic commenced at 10.00 am with 16 patients attending until 05.00 pm. More recently, in an attempt to review as many patients as possible, I had 18 patients attending, with the clinic starting earlier at 9.30 am.

439. As nursing staff were understandably keen to leave as soon as possible following the clinic, I developed a practice of bringing the records home to complete administration when I had the opportunity do so, mostly in my own time. I would usually arrive home by 7.00 pm, have dinner, and then attend to administration concerning the most urgent cases. There can be no doubt (as the

formal investigation accepts) that Trust managers were aware of this practice. As such, the Trust condoned the practice.

440. I also conducted an outreach clinic at Armagh Community Hospital in Armagh. This clinic also occurred once monthly, on a Monday morning. It was a general urology review clinic with 12 patients attending between 9.00 am and 1.00 pm. This clinic was different from the one at South West Acute Hospital as the patients' clinical records were delivered by Trust transport, though occasionally none were delivered at all, due to oversight. The problem I had with completing administration relating to the patients attending this clinic was that the room had to be vacated at 1.00 pm to prepare for a dermatology clinic which began at 1.30 pm. As I did not have any elective session during the afternoon of that Monday, I brought the patients' records home to complete administration, which I was able to do remotely.

441. I had a busy outpatient clinic at CAH each Friday when I would have patients attending for flexible cystoscopies and urodynamic studies concurrently with patients attending for oncology reviews. Having remained at the hospital to undertake as much administration as possible, I found it tempting to bring home some records, usually of those patients who had attended for flexible cystoscopies and urodynamic studies, so that I could join my family for the 'end of the week' dinner at 8.00 pm, and with a view to being able to complete the administration from home remotely, so as not to have to return to the hospital over the weekend.

442. Lastly, the only other patient records that I had at my home were those relating to patients who had attended me privately and those awaiting some kind of report.

443. It was accepted, in the context of the formal investigation report, that if notes were requested from me I would return them promptly.

444. It is clear that by March 2016, the Trust was aware of the practice and indeed appeared to have concerns, hence it being one of the issues identified in the letter

of 23 March 2016 [AOB-00979]. At that time, no plan, support, guidance or assistance was offered or put in place to address the issue. As the report of the formal investigation notes on page 43, when the issue was identified in March 2016, "*there appears to have been no management plan put in place at the time and Mr O'Brien seems to have been expected to sort this out himself….*" [AOB-10044].

445. The Trust was aware that I continued to have records at home after March 2016. For example, I liaised with Ms Corrigan of the Trust in relation to catching up on administration in late 2016 when I was on sick leave (see pages 13 and 14 of Grievance [AOB-02038] – [AOB-02039]). I was not required to return records then, but rather was encouraged to work on them at home during my sick leave.

446. I accept it was not best practice to have kept NHS patient records at home. There is no suggestion there was any security breach in relation to these records. The records were stored in my private office at my home, which is totally secure.

447. Secondly, in relation to records kept in my office, these originated from two sources. I brought patients' charts from my clinics in CAH upstairs to my office to complete related administration there, as I preferred the ambience of my office to that of the clinic. My secretary also left patients' charts in my office when I requested those records or for review with the reports of investigations.

448. I wish to avail of this opportunity to relate that I found it disturbing to learn from my secretary that she was being repeatedly requested by managers to enter my office to count the numbers of charts and to report back, informing them of the reasons for the charts being there. On other occasions, she would receive a call from a manager enquiring whether I was in my office as they intended to come to my office themselves to count charts. I found this activity to be both intrusive and concerning. I found it all the more concerning when, on one date in October 2018, my secretary was able to advise me that there were 52 charts in my office. On that same day, three of my colleagues had 14, 22 and 23 charts respectively in their office, while two consultant general surgeons had 53 and 266 charts

respectively. I wonder whether they were subjected to the same level of scrutiny as I was. It has been all the more distressing to learn that the Head of Service saw fit to come to my office early each Friday morning to count patients' charts.

449. Thirdly, in relation to patient records in my car, it was necessary for me to carry records with me when travelling to and from outlying clinics, as well as between my home and Craigavon Area Hospital. I wish to emphasise that patients' records were never left in my car at any location; they were placed in the container provided in the boot of my car on departure and removed on arrival at the destination.

450. The practice of having records at home or in my office was not for a malign purpose, quite the opposite. I struggled with the overwhelming administrative burden, with insufficient time allocated by the Trust for me to complete same. That led to me having to complete administration during my own time and hence I kept records at home so that, when I could find time, I would complete any administration work as required.

451. The Trust was aware that records were kept at home by March 2016 when the matter was first formally raised with me. Individuals within the Trust were aware that I had records at home well before that time. At no stage did the Trust implement a system to assist me in coping with the huge administrative burden I was under, which led to me having to do so much work in my own time at home.

(v)

452. As I have related elsewhere in this statement, and summarise again in my response to Question 66 (vi) below, I found it impossible to complete the triage of non-red flag referrals while being Urologist of the Week (UOW) and confirmed that this was the case when my colleagues and I met with personnel from the Appointments Office in early 2015 when we were advised of the Informal Default Process that was being used. We were advised that copies of all referrals were

being maintained by the Appointments Office so that referred patients would be placed on lists awaiting appointments in accordance with the category of urgency indicated by their referrers, in the event that referrals were not triaged and returned.

453. All referral letters were delivered on a daily basis to the Thorndale Unit for collection for triage. I collected all referrals from the Thorndale Unit regularly, usually daily. If working all day on the wards or in theatre as UOW, I would have deferred collection of referrals until the following day. I then brought all the referrals to my office.

454. I continued to triage all red flag referrals, returning them to the Thorndale Unit for collection or, alternatively, delivering them myself to the red flag appointments office. If I had the time to do so, having completed the duties of UOW or while awaiting access to the Emergency Theatre, I would have reviewed non-red flag referrals, particularly to identify any which should evidently have been categorised as red flag on referral. If time was available, I would have triaged whatever number of non-red flag referrals I collected.

455. However, I was unable to undertake triage of all non-red flag referrals which I collected as I did not have the time to do so, as priority was given to the duties of UOW. I do believe that it is important to appreciate that those duties may have had one fully engaged from 9.00 am until midnight or after, if having to operate on a number of acutely ill patients. I found it important to get rest and sleep at that hour as the duties as UOW were unpredictable and resumed at 9.00 am the following morning, at the latest.

456. In any case, I then stored the non-red flag referrals which I had not been able to triage in chronological order in a drawer in the filing cabinet in my office for the following reason. When I did have time when in my office, I checked on my computer the referrals in chronological order to ensure that each had been offered an appointment, or had already attended as an outpatient, or had been admitted

to our department, in order to ensure that none had been overlooked, as rarely occurred. If I found that to be the case, I arranged an appointment for the patient.

457. Having been excluded from the workplace in January 2017, I informed Ms Corrigan of the location of the duplicate letters of referral which I had not yet checked. I advised her of their location in a drawer in the filing cabinet in my office. They were not discovered or uncovered or found as was later reported. I also gave her a few letters of referral of patients who had not been appointed for reasons I cannot now recall.

(vi)

458. I have commented in detail elsewhere in relation to the issue of triage. I have done so in my comments on the draft reports of the Root Cause Analyses (RCA) of SAI Personal Information redacted by the USI and of SAI Personal Information redacted by the USI, during the course of the formal investigation in 2017 and 2018, and in the formal grievance submitted in 2018. However, I shall try to summarise my position on triage here.

459. I do believe that it is critically important to appreciate the relationship between service capacity and triage. I have related how the inadequacy of the service was so severe as to render it impossible for the too few urologists to undertake all of the tasks expected of them while endeavouring to provide as safe a service as possible to those in most need of it. However, that relationship was brought home to me recently when discussing the issue with a consultant urologist working in England. I asked him which triage category he would attribute to a woman referred with urinary tract infections which recurred despite repeated courses of antibiotic therapy. He advised that he would categorise her referral as routine. I enquired whether he would request, or advise the referrer to request, any imaging of her urinary tract to ensure that she did not have any significant urinary tract pathology. He advised that he would not as the likelihood of significant pathology would be minimal. I then listened in disbelief as he confirmed that such a patient would be assessed as an outpatient within 18 weeks, prior to the Covid-19 pandemic.

460. I would contend that if a service is so adequate as to be able to facilitate such a routine referral having an outpatient appointment within 18 weeks, there would actually be little, if any, need for any triage of referrals. All urgent referrals would have had outpatient appointments even earlier. In fact, my colleague confirmed that the only reason for their triaging is to ensure that all red flag referrals, or referrals upgraded to red flag status, are offered appointments to attend within 2 weeks.

461. By contrast, the service provided by the Trust has been so inadequate as to present very significant and conflicting ethical challenges on a daily basis for the too few clinicians (and nurses) employed to provide the service. Frankly, the service has been so inadequate and unsafe over the years that I have questioned how it could be considered morally acceptable to receive ever more patients into it. The hypothetical patient referred to above would have waited over 3 years for a first outpatient appointment prior to any exacerbation due to the Covid-19 pandemic.

462. It is deeply regrettable that any patient was delayed in their diagnosis of cancer, or of any other urinary tract pathology of similar, or even greater, implications as a result of inadequate service capacity impacting upon this one aspect of that service. Throughout my career, I endeavoured to provide a high standard of care to my patients and regret greatly that the care of any patient may have been compromised. Of the five patients reviewed in the RCA report of SA[Personal Information redacted by the USI], four had a delayed diagnosis of non-metastatic prostate cancer. All four patients were subsequently managed with curative intent, two by initial active surveillance and two by androgen deprivation and radical radiotherapy. It was considered by the Review Panel that the delays in their diagnoses had not adversely affected their management and prognoses. The fifth patient was found to have bladder cancer invasive of his prostate gland and obstructing his left upper urinary tract resulting in loss of left renal function. He required major surgical management which would appear to have been curative at the cost of a major negative impact upon his quality of life.

463. I implored in my comments relating to the RCA Report of SAI [redacted] that the management of the Trust meet with consultant urologists to agree who, where and when triage of referrals should be conducted. When such meetings were arranged in 2018, the attendance of Trust management was cancelled. In the RCA Report of SAI [redacted], one of the lessons learned, according to the Trust, was that there was "no regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters". A definition of what was expected of whom when conducting triage remained outstanding at the time my employment with the Trust ended in July 2020.

464. The issues that arose in dealing with triage were inextricably linked with the pressures I was working under. There were not enough hours in the day to satisfactorily complete all clinical and administrative duties. The Trust was well aware of the difficulty I had in completing triage over a period of years but failed to put adequate systems in place so that triage could be carried out in a safe manner.

465. From 2011, there are multiple references all of which demonstrate that I was struggling with the administrative burden of completing triage [see, for example, AOB-03547 - AOB-03548, AOB-00279, AOB-00348 - AOB-00349, AOB-00440 - AOB-00445]. On occasions the Trust acknowledged that this was due to the pressures I was under. For example, please see the email to Mr Young and I from Ms Troughton of 25 March 2010 when the triage backlog was noted in the context of both Mr Young and I being "*extremely busy*" [AOB-82440].

466. In an email of 1 September 2011 to Mr Mackle I wrote "*I believe that urology ICATS cannot function safely without consultant urologists providing advisory input, and I believe time allocated to that function should be included in Job Plans."* [AOB-00295 - AOB-00296]. Unfortunately, this was never adequately reflected in my job plan, leaving me to have to find time by sacrificing other activities to carry out administration, including triage, or carrying out such tasks in my own time.

467. At a consultant's meeting on 18 July 2013, it was recorded that "*The current triage process was discussed with its dangers of patients being delayed in triage due to current workloads. Tony has suggested we develop a similar system to that used in Wolverhampton and Guys hospital which we will take forward with our IT and booking centre colleagues"* [AOB-06748]. This demonstrates that others had concerns in relation to the triage system at that time, yet the Trust failed to address and change the system.

468. On 8 October 2013 Ms Trouton noted the serious delay in triage at that stage, whilst understanding the pressures within urology [AOB-06960 – AOB-06962]. I made the Trust aware in an email of 26 November 2013 that I was sorry I was behind in triage and had arranged to catch up on it during leave [TRU-01666-TRU-01672]. Surely the response to that should have been to provide adequate time to carry out the tasks within my job plan, rather than simply raise the issue, know the cause was overwork, yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave.

469. In early 2014 temporary measures to relieve me of triage commenced [AOB-00611] as Mr Young had agreed to help out at that time [AOB-00646]. That, however, was not only temporary but failed to address the underlying cause, which was progressively exacerbated by the additional burden of my roles with NICaN and with the Trust's Urology MDT and MDM at that time.

470. I was not the only consultant who struggled with the demands of triage whilst on call [see email 13 March 2014 AOB-70484 - AOB-70485].

471. I highlighted a number of issues in relation to red flag triage to colleagues on 16 March 2014 [see AOB-70487 - AOB-70488].

472. In March 2014 I again referred to pressure of work in the context of the referring to the triage backlog [see AOB-70605 - AOB-70606].

473. In March/April 2014 triage continued to be a significant issue for me, a matter the Trust was well aware of [see, for example, AOB-00671 - AOB-00674 and AOB-70701 - AOB-70704].

474. Ms Corrigan made Ms Trouton aware that I normally tried to catch up on matters during my leave [TRU-01649 – TRU-01651]: "*Aidan and Monica are on Annual Leave this week but he normally does this sort of admin when he is off…"*. Surely the response to that should have been to address why I had inadequate time to carry out the tasks within my job plan rather than wait on my next period of leave to catch up again. This of course also demonstrates that the Trust knew this was happening and knew I was 'normally' having to do admin when on leave.

475. Triage was raised with me in June and July 2014. The temporary arrangements whereby Mr Young agreed to help were still not assisting me in addressing my triage backlog [see AOB-00698 - AOB-00702].

476. I was made aware that issues in relation to triage were being escalated in an email from Ms Corrigan on 11 September 2014, wherein she acknowledged the pressures I was under with administrative work [AOB-71589], yet still nothing substantive was done to help me to manage this issue going forward.

477. I expressed concerns to colleagues about the format of triage. I had advocated an enhanced triage system, whereby consultants would direct investigations prior to patients being seen at a first appointment so that certain basic information was available to the consultant when reviewing the patient. I considered that particularly important set against the background of significant delays in patients being offered first outpatient appointments, and would have facilitated, where required, expediting patient care. For example, please see my email of 17 August 2014 [AOB 71484-71486] which stated as follows:

"*I believe that advance triage will be the essential bridge between successful demand management and the successful, effective, safe and efficient delivery of*

outpatient consultation and procedural assessment/investigation such as flexible cystoscopy, biopsies and urodynamic studies.

I also believe that if we are capable of determining pathways for assessment and management in primary care, we should be equally capable of designing pathways for effective, safe and efficient triage, so that the bulk? all of triage could be conducted by Nurse Specialists, rather than consultants, one of the latter always available whilst urologist of the week to advise."

"….. I hope I have made myself clear; demand management and advanced triage will have ensured that all that can be done as an outpatient prior to arrival at our Department will already have been done……."

"I am passionately of the view that we have not yet grasped the potential impact of demand management, advanced triage and then single visit assessment could have on our Department.
I do believe that it could certainly stall and hopefully reverse the migration of consultant time being increasingly consumed in outpatient services, rather than operating, and which has occurred progressively over the past twenty years…

The first and overriding priority of every clinician of the week is the provision of round the clock emergency care. It is therefore impossible to provide emergency care if you have a fixed commitment elsewhere in the hospital or in any other place."

478. Unfortunately, I was unsuccessful in reaching agreement with colleagues that such measures should be introduced.

479. Triage continued as a problem during 2014 with both Mr Young and I falling behind [see AOB-71992 - AOB-72007].

480. In October 2014 Urologist of the Week (UOW) was commenced, which added to, rather than alleviated, triage delays. In my comments concerning the RCA

Report of SAI [redacted], I set out the development of the role of Urologist of the Week, and how it had evolved over time. The role, however, remained undefined and variously understood by consultants. There was no written policy introduced to define the scope of the duties encompassed within that role then, and indeed that situation persisted at the time my employment with the Trust ended in July 2020.

481. As I have related elsewhere, UOW was introduced primarily to enhance inpatient management as well as to free the remaining consultants to commit to elective activities without having to be concerned about the ongoing management of their patients previously admitted. We had every reason to introduce UOW due to increasing unease concerning the reliability and quality of inpatient care. The reasons for those increasing concerns dated back to the Ward Reconfiguration of 2009 resulting in the loss of experienced nursing staff. Those concerns were to be described in detail by the Ward Manager, Catherine Hunter, one year later, in November 2015 [AOB75761]. Therefore, the UOW was introduced and we continued to make every effort to improve the management and outcome of inpatients in conditions which were giving rise to increasing concern.

482. I agreed to the inclusion of triage as a duty of the UOW in order to have UOW introduced in late 2014. I soon concluded that it was a mistake to have it included. I believe that it was entirely inappropriate to have the UOW additionally undertaking the triage of approximately 120 referrals during that week, and particularly in the context of increasingly long periods of time for first outpatient appointments. I found it untenable as a clinician to read a letter of referral of a patient who would not receive an outpatient appointment for over one year later but who was referred with symptoms or a problem which justifiably required some investigation and / or treatment in the interim. That required time, which was not available. I found it impossible to fulfil the purpose of UOW and also to do justice to the referred patient. I believed that the management of one should not have been compromised by the other.

483. Regrettably, they were compromised, for as with me, other consultants were having to make judgement calls and to decide how best to prioritise what was essentially a set of tasks for which there was insufficient time to adequately and satisfactorily complete.

484. I have no doubt that there was inadequate time available to complete triage of all referrals while UOW without compromising the quality of inpatient management or the quality of triage, particularly in the context of increasingly long periods of time awaiting first outpatient appointments, or both. I have no doubt that the chronic, concerning conditions within Ward 3 South demanded more time-consuming vigilance on the part of the UOW. I also do believe that the chronological documentation detailed above reveals a dissonance or disconnect between managerial directorates to an extent that is concerning. Lastly, I also found it consistently the case that the clinician is expected to do it even if he/she has advised that it is impossible.

485. Following my return to work following exclusion in 2017, I continued to conduct triage of red flag referrals as I had always done. However, I had to take one day of annual leave following my UOW week to facilitate complete triage of all referrals. Regrettably, this was at the cost of fewer oncology review clinics each year.

486. As Lead Clinician of the Trust Urology Cancer MDT, I had proposed to my colleagues at an MDT Business Meeting on 12 March 2015 that advanced triage of red flag referrals be undertaken in order to expedite patients along their care pathway. In numerical terms, this represented approximately 20 to 25 red flag referrals, about 20% of the total number of patients referred each week. The cohort of patients being particularly considered were those who probably had prostate cancer, and who could have had prostatic MRI scanning performed prior to their first outpatient consultation when prostatic biopsies could be performed, or soon thereafter. However, my colleagues were unable to commit to doing so, because "*the other duties when urologist on call did not leave adequate time to undertake it"* [see AOB-00839]. As early as four months following the introduction

of UOW, my colleagues had established the relationship between the lack of time available while UOW and the inability to undertake optimal triage for a relatively small number of patients. That relationship only worsened as time progressed due to increasing demands upon the time of the UOW due to increased admissions, competing with increasing referrals.

487. Issues in relation to late triage followed through into 2015 [see AOB-73298 - AOB-73302 and AOB-74600 - AOB-74612].

488. It was apparent that there were inconsistencies in the approach to triage between the various consultants raised at that time [see AOB-74600 - AOB-74612, AOB-75200 - AOB-75204, AOB-75205 - AOB-75208 and AOB-75209 - AOB-75212].

489. The Trust failed to address the underlying issue but rather in an email from Anita Carroll of 17 November 2015 introduced the following system:

"…*It has been brought to my attention that triage of referral letters can still be delayed in being returned to the RBC. Some areas in particular are very poor at doing this. To this end I would be grateful if you would agree with your clinicians that where referral letters are not returned within a week, or thereabouts (IEAP states 72 hours) that the RBC will add patients to the waiting list* ***with the priority type dictated by the GP.*** *Given that waiting lists are now much longer than they were previously this could cause problems so it is in everyone's interest to try and encourage quicker turnaround triage."* [AOB-00886 - AOB-00888]

490. In an email to Mr Haynes, Assistant Medical Director, on 31 August 2018, Ms Coleman noted in the context of an exchange in relation to a possible SAI (regarding patient Patient 93):

"We have been advised that if we get no response after chasing missing triage that we are to follow instruction per referral - the GP originally referred Patient 93 *as Routine."*

491. Mr Young confirmed this in an email of 9 September 2016 when he commented:

"If booking centre has not received a triage back then I agree that they follow the GP advice…" [AOB-01036 - AOB-01037].

492. If referrers had reliably and correctly categorised the category of all referrals, there would have been no need for triage. In the RCA Report of SAI Personal Information redacted by the USI the review panel found referral letters did not have a clinical priority accurately assigned by the GP. Recommendations were made for the Health & Social Care Board, the Trust and GP's to address that situation. The Report specifically noted that *"the triage system works best when the initial GP referral is usually correct and the secondary care safety net is only required in a minority of cases. The system should be designed to make that particular sequence the norm"*. The question of course arises why that situation was not the norm at the time in question and what if anything the Trust, Board and/or GP's have done to change the system so that it complies with this recommendation. I have not to date been able to identify any documentation in this regard in the disclosure made to the Inquiry by the Trust or the Department of Health.

493. Even if referrers could not be relied upon to correctly categorise the urgency of referrals, there would have been little need, if any, for triage if there was an adequate service. However, too few clinicians providing a grossly inadequate service are challenged by so many competing clinical priorities that not all of the expectations placed upon them can be met satisfactorily, if at all. While I for one certainly did have such challenging difficulty in completing the triage of increasing numbers of referrals prior to the introduction of UOW, the challenge was condensed to an impossibility while UOW. The RCA Report of SAI Personal Information redacted by the USI also recommended that the Trust reassure that it was feasible to complete triage of all referrals while UOW. It certainly had not done so by the end of my employment by the Trust in July 2020. In summary, I believe that the inadequacy of the urology service provided by the Trust since 1992 resulted in consequences which impacted upon the care that could be given to patients and their outcomes by the

too few personnel employed to provide the service. The challenges I faced in triaging increasing numbers of referrals, initially as a single urologist and subsequently with my too few colleagues, were but a consequence of the inadequacy of the service.

(vii)

494. In responding to this part of the question, I would like to state clearly the importance and value that I attach to dictation in the care of the patient. However, I cannot do so in isolation from what happened during the course of the formal investigation that was initiated by the Trust in December 2016 and which resulted in the Investigation Report of June 2018. I commented on this issue during the course of that investigation and I wish to refer generally to the comments that I made at that time.

495. In summary, the report concluded that I did not dictate letters concerning patients who had attended a number of my clinics, including the clinic at the South West Acute Hospital, and did not complete clinic outcome sheets. The Report stated that *"In total, it was found that dictation had not been completed for patients who had attended 66 clinics dating back to November 2014, affecting 668 patients".* This finding is incorrect.

496. I returned the Outcomes Sheets of all affected clinics to Ms Martina Corrigan, Head of Service, on 9 January 2017 when I distinguished between all of the patients for whom letters had been dictated, with their outcomes implemented, and those for whom letters had not been dictated.

497. The Investigation Report included, at Appendix 6, a "Preliminary Report from Case Investigator for Consideration by Case Manager / Case Conference to be held on Thursday 26 January 2017". The Preliminary Report provided an updated position as at 24 January 2017. It stated '*that 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months'.* Again, this is incorrect.

498. Ms Corrigan wrote to Ms Siobhan Hynds, Assistant to the Case investigator, by email on 7 June 2017 [AOB-01617 – AOB-01618] to inform her of the findings of the 'undictated clinics' as follows:

"There are 110 patients who are being added to a Review OP waiting lists – a number of these should have had an appointment as per Mr O'Brien's handwritten clinical notes before now, however I would add that Mr O'Brien has a Review Backlog issue already so these patients even if they had of been added timely may still not have been seen.

There are 35 patients who need to be added to a theatre waiting lists, all of these patients he has classed as category 4 which is routine and again due to the backlog.

I have attached Mr O'Brien's sheets that he had given me in January after he returned the charts.

I have now gone through all of the charts that were in the AMD office and will be back in Health Records tomorrow…."

499. The Case Investigator, Dr Chada, was evidently aware of this emailed communication when she interviewed me on 3 August 2017 as she referred to some of its content. However, as I was unaware of its existence, I provided a spreadsheet of the 41 clinics that a total of 450 patients had attended and of whom 189 patients had not had letters dictated. I provided this spreadsheet to Dr Chada when she interviewed me for the second time on 6 November 2017, as related in the "Response to Report of Formal Investigation of July 2018" [AOB-10596]. The data correlated with that provided by Ms Corrigan in June 2017, in that 110 were to be placed on waiting lists for review, 35 patients had been discharged from review, 10 patients had not attended, 13 had been placed on waiting lists for urodynamic studies and the remainder had been placed on waiting lists for routine admissions for inpatient and day case surgery. As indicated by Ms Corrigan, in

none of these cases had the management of the patient been negatively impacted.

500. Yet, in her Report of June 2018, the Case Investigator stated that "*Mr O'Brien acknowledged there were 66 undictated clinics and no dictated outcomes for these".* This is simply not correct. I found it profoundly concerning that Dr Chada could write such a statement having been provided with the data that demonstrated it to be incorrect.

501. Having demonstrated that this assertion was incorrect, I expected the Case Manager to acknowledge and correct that in his Determination that was presented to me on 1 October 2018. It was with disbelief that, instead, Dr Khan reiterated that "*It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016"* and that *Mr O'Brien accepts this".*

502. The Determination also stated that it is a requirement of the GMC that *"all notes / dictation are contemporaneous".* I expressed my view that I was unaware of any explicit requirement of the GMC concerning dictation being contemporaneous. Dr Khan declined to show me the evidence for this requirement.

503. The Determination then stated that it was "*unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment".* This was incorrect as the Case Investigator had been informed by Ms Corrigan in June 2017 that the delay had had no impact.

504. While being interviewed by the Case Investigator on 3 August 2017, I related how important I regarded the dictation of letters concerning patients to their GPs following their attendance at an outpatient clinic. However, I asserted my view that, important as this was, it was not as important as using the available time at consultation to ensure in so far as is possible that the patient had a full understanding of their condition, the rationale for proposed investigations and management options, medications and operative procedures, prognoses etc. If

all of the consultation time is required to achieve that, it was my view that it should be used for that purpose. Indeed, if it proves to be inadequate, the clinician should take longer. If that is not possible or practicable, arrange another review consultation, or indeed speak to the patient by telephone at a later date or time, when the patient is available.

505. It has been my view throughout my career that the most important communication is with the patient. Communication is a two-way process, and the most important component can be the listening component, which can also be the most time consuming. This process is vital to the relationship between doctor and patient and to the consent of the patient based upon the patient's trust in the doctor.

506. The use of the consultation for this purpose should not be compromised, or displaced, by the dictation of a letter to the GP. Important as that letter is to the GP, and to others, it is of secondary importance at that time. Indeed, the irony is that displacement of consultation time by dictating the letter to the GP has rendered the letter to the GP all the more important, as there is an increased likelihood that the patient may then have to consult with their GP to obtain more information, which might have been given to the patient by the hospital doctor if the consultation time had been fully used to do that. This is an example of process or protocol displacing the purpose.

507. It has not been my experience that my patients have had to consult their GP to gain further information or insight following consultation with me, though I do appreciate that I may have been the last to know. My experience has been to the contrary, but it has taken time, and that time has usually been my own, as sufficient time was never allocated to me.

508. It was in the context of my view of the relative importance of dictation that I found the investigation of this issue to be duplicitous, not only in the persistent reportage of statements proven to be untrue, but also in the significance that was

attributed to it. I had dictated letters concerning all patients whose clinical priorities required it. I requested of Dr Wright, Medical Director, on 30 December 2016 that I be allowed to dictate letters concerning the remaining patients, estimating that it could be done in 2 weeks. I was not permitted to do so, as it was considered more important that Dr Wright should see their returned records, though I have no evidence to indicate that he ever did so. He did assure me that the records of these patients would be returned to my office for dictation of letters concerning them but they never were.

509. Dr Khan in his Determination asserted that *"the look back exercise to ensure all patients had a clear management plan in place was done at significant additional time and cost to the Trust".* If so, this could have been avoided if I had been permitted to dictate the outstanding letters. If the Trust incurred *"significant additional time and cost"*, it was not due to the dictation of letters, as no letters were dictated concerning these patients during that costly review, so far as I am aware.

510. Over two years later, Dr Khan attended a meeting in January 2020 convened at the request of Dr O'Kane, then Medical Director, to describe in detail the management plan around the dictation backlog report of October 2019, the expectations re compliance and the escalation of the backlog report. The meeting was also attended by Mr Ronan Carroll, Ms Martina Corrigan and Mr Mark Haynes. The meeting was chaired Mr Simon Gibson, Assistant Director, who reported its conclusions to the Medical Director on 24 January 2020 [WIT-14209]. It concluded that:

"None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standard set externally by Royal Colleges or other organisations. Therefore, on the occasions when this data was considered, there was no agreed standard to use as a guage against reported performance."

511. Conversely, I am unaware of any patients admitted to the Day Surgical Unit not having had discharge letters dictated. I will be happy to consider any cases where this has not been so.

(viii)

512. At the outset, I wish to make it clear that I have never had any direct access to the PAS. This system was accessed by administrative staff, not by me directly. Therefore, it was not possible for me to add or remove patients on the PAS, or alter their status on the PAS in any way. The issue here, therefore, should be "not having patients added to the PAS".

513. I first became aware of this issue by way of a letter from Mr Mark Haynes dated 11 July 2020 [AOB-02534 - AOB-02536]. I have referred to this in my response to Question 1 above where I highlighted that the supposed basis for Mr Haynes' concerns was untrue in that both of the patients he referred to (whom I subsequently identified as Patient 105 and Patient 104) had indeed been appropriately added to the PAS at the times when they should have been. I have also indicated above that it is highly concerning that this purported concern on the part of Mr Haynes was the basis for undertaking a further review of patients under my care dating back to January 2019.

514. I note further that Dr Maria O'Kane wrote to the GMC on 27 November 2020 [AOB-02987 - AOB-02995] repeating Mr Haynes' purported concerns. She wrote as follows:

Record Keeping - Patient Administration System

In an email dated 7th June 2020, Mr O'Brien put forward a list of 10 patients for inclusion on a surgical waiting list. On the booking paperwork some of these patients appeared to have been diagnosed with stents requiring treatment There was concern that the patients had appeared not to have been added to the Trust waiting list for revision of indwelling ureteric stents in a timely fashion. This raised concerns that other patients might not also have been added to the Trust waiting list for revision of their stents in a timely fashion. Delay in this procedure increases the risk of patient morbidity. It appeared that months had gone by since they were recognised as requiring further procedures or investigations and they had not been processed in the interim.

The specific concern was that there had been a failure to adhere to standard administrative processes following stenting and as result these patients would be unduly delayed, not dealt with chronologically or potentially lost to followup until they presented as emergencies.

There were concerns about the attendant risks of delayed treatment; 2 of these patients required urgent attention. This concern triggered a further review of 41 other patients who had stents inserted in the previous 18 months. Of the total of 147 patients who had emergency procedures, 46 patients with stents were reviewed, 5 patients in total were identified as delayed due to failure to adhere to standard administrative processes.

Details about any local actions and outcomes (e.g. local restrictions, investigations, audits, practice reviews, or HR/disciplinary processes)

As a result of these potential patient safety concerns, an initial scoping exercise in relation to the consultant's work was conducted to quickly ascertain if there were other related areas of immediate concern. This initial scoping exercise, which considered cases over a 18 month period of the consultant's work in the Southern Trust (from 1st January 2019 - 30 June 2020), concentrated on whether patients had a stent inserted during a particular procedure and if this stent had been removed within the clinically recommended time frame, during this exercise there were a total of 5 patients who had a delay in the removal of their stent.

515. There are a number of issues in respect of the above section written by Dr O'Kane. First, as I have already explained above with reference to the relevant documentation, the 2 patients identified as allegedly not having been added to the PAS were in fact appropriately added to the PAS, namely Mr Patient 104 and Mr Patient 105. Secondly, Dr O'Kane indicates her concern that patients had not been added to the waiting list for revision of indwelling ureteric stents in a timely fashion. She refers to the risk that delays in this procedure increase the risk of patient morbidity. That is correct. However, in respect of the 2 out of 10 patients that were referred to by Mr Haynes in his letter of 11 July 2020, every effort was made by me to ensure that these patients were admitted for removal of stents within an appropriate timeframe.

516. In respect of Mr Patient 104, his right ureter was stented on 11 February 2020. He was added to the waiting list on 12 February 2020 with effect from 11 February 2020 for 'Rigid / Flexible Ureteroscopic Laser Lithotripsy' following a request sent to my secretary by email on 12 February 2020 at 13:32 from the Ward Clerk of 1 West Elective Admissions [AOB-37045]. His readmission was

complicated by the onset of the Covid-19 pandemic. Ultimately, I wrote by email to Mr Anthony Glackin on 7 April 2020 [AOB-37042] requesting that two patients be admitted to Daisy Hill Hospital during the week commencing Monday 13 April 2020. Mr Patient 104 was one of those patients. It was not possible to have him admitted on that occasion due to restricted operating capacity. I then wrote on 11 April 2020 to Mr Mark Haynes [AOB-37043] requesting that Mr Patient 104 be admitted during the week commencing 20 April 2020. I specified on that email that he was in fact due to undergo "*Removal / Replacement of Stent & Right Flexible Ureteroscopic Laser Lithotripsy*". In doing so, I iterated that Mr Patient 104 was entirely happy to be admitted to Daisy Hill Hospital, or to either the Ulster Independent Clinic or Kingsbridge Hospital, the latter being private hospitals which had been commissioned for NHS patients during the pandemic. However, that too proved not to be possible due to the excessive demand for inadequate capacity.

517. His elective admission was eventually scheduled on 1 May 2020. However, the patient cancelled his admission, and I emailed my secretary on 30 April 2020 [AOB-37044] to confirm that he had cancelled his admission on 1 May 2020 due to work commitments. I asked my secretary to make sure he remained on the CURWL. As stated above, CURWL is an abbreviation for my inpatient waiting list.

518. I spoke to this patient on 2 June 2020 at which point he was experiencing increasing discomfort related to the indwelling stent. I emailed Mr Glackin again on that date [AOB-37046] and requested that Mr Patient 104 be added to the list for admission on the week commencing 8 June 2020. Mr Haynes replied by email dated 2 June 2020 [AOB-37047] and advised that the lists for admission at Daisy Hill Hospital and Craigavon Area Hospital were full for the week of 8 June 2020. I replied that day [AOB-37053] to enquire whether it would be possible to have any of the five patients admitted to the Ulster Independent Clinic or Kingsbridge Hospital, in the hope that their admissions could be expedited. While

that was not possible, this patient was admitted eventually to Daisy Hill Hospital during the week commencing 15 June 2020.

519. The position is similar in respect of Mr Patient 105, as is entirely clear from the documents provided within my disclosure [AOB-37001 to AOB-37035]. Mr Patient 105, a 74-year-old man, was acutely admitted to South West Acute Hospital in September 2019 due to being generally unwell, vomiting and having urinary symptoms indicative of urinary infection. On CT scanning, he was found to have a stone obstructing his right ureter. He was transferred to Craigavon Area Hospital on 8 September 2019. On the evening of 10 September 2019, he underwent right ureteroscopic laser lithotripsy and ureteric stenting. As the obstructing right ureteric stone had been incompletely fragmented by laser lithotripsy, the right ureter was stented to prevent any persistence of ureteric obstruction by remaining stone fragments. In addition, as he had another stone located in his right kidney, stenting his ureter additionally prevented further ureteric obstruction if that renal stone had migrated to the right ureter.

520. On 11 September 2019, at 12:38:49, I sent an email to my secretary [AOB-37001], as follows:

> *"This man had incomplete fragmentation of a right ureteric stone and right ureteric stenting yesterday evening.*
> *He may be going home today.*
> *Please place him on CURWL for:*
> *Removal / Replacement of Stent and Right Ureteroscopic Laser Lithotripsy*
> *Urgency 2*
> *Date of entry: 11 September 2019"*

521. CURWL is the code for my inpatient waiting list, and urgency category 2 means 'urgent'. The patient was placed on my waiting list on 11 September 2019, and with effect from 11 September 2019. A copy of the inpatient waiting list

of 27 September 2019 confirms that he was entered on the waiting list on 11th September 2019 [AOB-37002].

522. The patient was unfit for discharge until 18 September 2019, due to his comorbid status. On his Discharge Notification of 18 September 2019, it was stated that the patient was "*On waiting list for urgent ureteroscopy and lithotripsy for remaining stone*".

523. In consultation with the patient's wife on 5 December 2019, I arranged his elective readmission to Craigavon Area Hospital on 11 December 2019. However, in the intervening days, he had become acutely unwell due to a respiratory infection due to Influenza A. He was acutely admitted to South West Acute Hospital on 9 December 2019 and was subsequently transferred to Omagh Hospital on 23 December 2019 for a period of rehabilitation, prior to his discharge to his home on 7 January 2020. [AOB-37003 – AOB-37004].

524. On further consultation with his wife on 15 March 2020, I arranged a further date for his elective admission to Craigavon Area Hospital on Wednesday 25 March 2020 [AOB-37006]. In doing so, I again advised that he not take Dabigatran, an anticoagulant, after Sunday 22 March 2020. This was documented in my letter of 15 March 2020, addressed to his GP [AOB-37007]. However, the patient was subsequently advised by Trust management that his arranged admission on 25 March 2020 was cancelled by the Trust due to the Covid-19 lockdown. As I remained concerned by any further delay to his readmission, Mr. Haynes communicated with me by WhatsApp on Monday 23 March 2020 that the patient could be admitted on Tuesday 24 March 2020. Regrettably, this admission could not proceed as the patient had already resumed taking the anticoagulant, on having been advised earlier that his admission had been cancelled.

525. As indicated previously, by this time, arrangements were being made to have patients who were presumed to be free of Covid-19 infection, electively admitted to Daisy Hill Hospital. On learning that it may have been possible to have him admitted to Daisy Hill Hospital on Friday 27 March 2020, I contacted the

patient's wife, requesting that he discontinue taking the anticoagulant once again, however, the admission could not proceed as the nursing staff in theatre in Daisy Hill Hospital had not been trained in the utilisation of laser.

526. During the first days of April 2020, I had the experience of caring for a number of urological patients who had presented with urological emergencies and had been admitted to Daisy Hill Hospital as they had no symptoms of Covid-19, but who became symptomatic and tested positive for Covid-19. I considered that Mr Patient 105 's comorbid status would have rendered him particularly vulnerable if he were to become infected. In discussion with him and with his wife, we agreed to defer his admission until the risk of infection could be minimised. I wrote to his GP on 23 April 2020 [AOB-37014] to advise him of this decision, requesting that the patient have a number of blood tests performed in early June 2020 to assess his fitness for admission then. I wrote to the GP once again on 4 June 2020 [AOB-37016] to advise that the results of the blood tests on 3 June 2020 were satisfactory, and that the patient was agreeable to proceed with elective admission to Daisy Hill Hospital when that could be arranged, and he was admitted on week commencing 7 June 2020.

527. As can be seen from the chronology above regarding Mr Patient 104 and Mr Patient 105 , and the associated documentation provided in my disclosure, I made every effort to ensure that both were readmitted for removal of their right ureteric stent and further inpatient care. Any delay in their admissions was entirely out of my control, and as a result of the Covid-19 pandemic and the consequent reduction in surgical capacity within the Trust, and the patients' comorbidities.

528. Also, I note that Dr O'Kane states in the extract above that "*2 of these patients required urgent attention*." This appears to be taken from the letter from Mr Haynes dated 11 July 2020 in which he states that "*the Trust has been seeking as a matter of urgency to establish the position in relation to 2 specific patients…*" I believe that it was dishonest or disingenuous of the Trust to claim that it should have been so concerned on 11 July 2020, given that Mr Patient 104 and Mr Patient 105 had both been electively admitted prior to that date. It is further concerning that

Dr O'Kane, in the above extract dated 27 November 2020, reiterates that 2 patients required urgent attention, without clarifying that both patients had in fact been electively admitted prior to 11 July 2020 when concerns were first raised by Mr Haynes.

529. I should also add that it is entirely consistent with its long-standing practice that the Trust should seek to place some responsibility on me personally in respect of the perceived delay in having the above two patients admitted for removal of stents when there are significant numbers of patients who have suffered harm arising from delayed admission for stent removal or replacement, among other issues, as a result of the Trust's inability to operate an effective and safe urological service over many years. An example of such a patient is Mr Patient 84 [PAT-000200 to 000238] who gave evidence to the Inquiry in June, as well as others.

530. Moreover, the Urology Assurance Group, established by the Department of Health, tasked Dr O'Kane and Ms Mc Clements with checking for factual accuracy the contents of the Minister's draft statement which he intended to present to the Northern Ireland Assembly in November 2020. In his statement, the Minister informed the Assembly that 2 out of 10 of patients under my care had not been placed on the Trust's Patient Administration System (PAS), and not necessarily just these two of these ten patients. Either these two members of the Group did not make the checks they were tasked to undertake, or they did so but still permitted the Minister to misinform the Assembly on 24 November 2020.

531. If the Inquiry identifies any other patients who I have allegedly not added to the PAS, I am happy to consider this issue further and provide further comment if required.

(ix)

532. Please see my response to Questions 26-32 dealing with Administrative Support for a full explanation of the process that was used to book and schedule patients.

(x)

533. I set out my position in relation to private patients in my response to the formal investigation (page 16, paragraph 4 - see [AOB-10600]) and in the Grievance (pages 21 and 22 – see [AOB-15022 – AOB-15023]) and pages 24 to 26 with the attachments referred to therein [AOB-15025- AOB-15027] and shall not repeat the detail here.

534. In summary, however, my position is as follows:

(1) I did not provide preferential treatment to private patients.

(2) I had, and continue to have, deep concerns in relation to how the cases were identified and raised in the context of the formal investigation. The concerns raised initially related to a specific urological procedure – transurethral resection of the prostate (TURP) and related to 9 patients. Due to the very specific nature of this procedure, I was in a position to carry out an audit comparing my private patients to NHS patients. This demonstrated private and NHS patients were treated within broadly similar time periods. The focus of the Trust's investigation then shifted to a wider set of patients, with a more diverse range of urological conditions. The Trust thereafter based its concerns within the formal investigation on this new expanded group (retaining only 3 of the original 9 TURP patients). For there to be any fair analysis of my treatment of patients, there needed to be a comparison between patients I saw privately prior to their definitive treatment and those seen on the NHS prior to their definitive treatment with similar conditions. When I carried out this exercise in relation to the 9 TURP patients I demonstrated there was no preferential treatment. Despite raising those concerns both in the context of the investigation and my Grievance, no comparative analysis has been undertaken by the Trust. An analysis should have been done.

(3) The Trust's case is, apparently, based upon a review by Mr Young, and was based on his consideration of acceptable timelines. To date I have been

unable to identify a report by Mr Young outlining his rationale or methodology. There is no suggestion he carried out a comparative analysis. His statement in the formal investigation is not suggestive of any concern he had in relation to treatment of private patients, other than by hearsay. He contended therein he had no evidence of preferential treatment.

(4) Any analysis by Mr Young of my cases, in the absence of a comparative review, will by its nature be by reference to Mr Young's own waiting list and waiting times. Any view which he may have expressed in relation to same is likely to be from his own experience, and thus subjective. To fairly comment on my lists a comparative analysis is required. I would have no confidence in a comparative analysis being carried out by or under the direction of the Trust.

535. If the Inquiry requires any further detail on this issue, please see my Grievance and the appendices provided therewith.

(xi)

536. The Trust Urology Cancer MDT's Operational Policy of 1 September 2017 [AOB-03859] is explicit in stating that it is the joint responsibility of the MDT Lead Clinician (a role which I occupied from April 2012 to December 2016) and of the MDT Core Nurse Member to ensure that all newly diagnosed cancer patients have a Key Worker allocated. The above policy, at Section 3.1, states as follows:

3.1 Key Worker **(14-2G-113)**

The identification of the Key Worker(s) will be the responsibility of the designated MDT Core Nurse member.

It is the joint responsibility of the MDT Clinical Lead and of the MDT Core Nurse Member to ensure that each Urology cancer patient has an identified Key Worker and that this is documented in the agreed Record of Patient Management. In the majority of cases, the Key Worker will be a Urology Clinical Nurse Specialist (Band 7) or Practitioner (Band 6). It is the intent that all Key Workers will have attended the Advanced Communications Skills Course.

537. The first time I became aware of concerns in respect of an alleged failure to provide oncology patients access to CNSs was when I had sight of the SAI reports referred to in Question 79. In that regard, to use one example, as stated in my response to Question 79 in respect of SUA, at the time of his diagnosis I was not the MDT Lead Clinician / Clinical Lead and was not responsible for ensuring he had access to a CNS. I further note that it is stated in that SAI report that I excluded all CNSs from the care of patients at clinics. That is untrue. I have requested the involvement of CNSs many times in the care of my patients, and that care has been gladly given and gladly received.

(xii)

538. I am unaware of having failed to request that any patient be placed on a list for planned review at the appropriate time following a requested investigation. For example, if I had just reviewed a patient on Friday 28 October 2022, and requested the Department of Radiology to arrange an appointment for the patient to attend for a CT scan during December 2022, I would request my secretary to have the patient placed on the list for planned review in January 2023 with the report of the scan. If an adequate service had ever been commissioned of and provided by the Trust, then all such reports would have been followed up in this manner and conveyed to the patient in the setting optimal for ensuring the patient's appreciation and understanding of the report, as well as any further investigative or management plans arising from it.

539. No such adequate service was commissioned or provided by the Trust. Instead, the Trust introduced alternative arrangements to compensate for its inadequacy. The greatest of these measures was the introduction of DARO apparently by Dr Gillian Rankin when she was the Director of Acute Services. The Inquiry will be aware of the directive issued by email to all secretaries by Ms Collette Mc Caul, Acting Service Administrator, on 30 January 2019 [AOB-02116], to remind them that:

"If a consultant states in letter "I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are not missed…

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward."

540. I do not recall having had any consultation regarding the earlier introduction of DARO, and I shared my concerns regarding its usage from a clinical perspective by email on 6 February 2019 [AOB-02130]. In addition, this had resulted in an expectation that clinicians would review and follow up on these results and reports without any assessment of the time required to do so, and without any time being provided for it. Nevertheless, the consequence was increased numbers of results and reports for which the clinician was being held responsible.

541. Irrespective of whether the consultant or registrar availed of DARO, there was a similar expectation that the clinician would follow up on the results of investigations requested at review, without allocation of time to do so.

542. Secondly, a similar expectation arose if the consultant triaging new referrals had requested any investigations. While it would appear not to have been intended, we luckily discovered later in 2019 that these patients were also being placed on a DARO list rather than being placed on a list awaiting appointments at a New Patient Clinic. Even if that had not occurred, there would appear to have been an expectation that consultants would follow up on results while patients

were waiting on a first outpatient appointment. I would have requested 50 – 100 investigations during the course of triaging during and after being UOW. Moreover, I believe that the expectation to follow up on the reports of these investigations proved to be a disincentive for others to similarly request investigations on triaging.

543. Urological practice generates investigations in the majority of patients who attend outpatient clinics. To have expected consultants to follow up on the reports of all of these investigations without provision of any or sufficient time to do so was unfair. I believe that to additionally jeopardise the patients' review was irresponsible. To transfer all responsibility to the clinician in the process was consistent with the approach of the Trust to its failure to provide a sufficiently safe service.

(xiii)

544. At no point during my years of clinical practice as a consultant urologist within the Trust, from 1992 until 2020, was any concern raised with me in respect of the manner in which I prescribed Bicalutamide. Indeed, it was well known within both the urology service and the oncology service that Bicalutamide was being prescribed, and how it was being prescribed. No issues were ever raised with me in that regard. The first time concerns were made known to me in respect of my prescribing Bicalutamide was when the Directorate of Legal Services wrote to my solicitors by letter dated 25 October 2020 [AOB-02772].

545. I note that the SAI report in respect of SUF states that the use of Bicalutamide was known to the MDM, was challenged, was not minuted, and was not escalated. I entirely refute that. The reason it was never minuted at an MDM as having been challenged, or escalated, is that it was never challenged or escalated. Indeed, in MDMs such as that regarding SUF, the fact that the patient had been prescribed Bicalutamide 50mg was specifically noted on the patient's MDM clinical history and when this was reviewed by Mr Haynes in August 2019

(for the purposes of an online 'MDM' conducted solely by Mr Haynes) no issue was raised in respect of that treatment.

546. The effect of prescribing Bicalutamide in terms of patient safety is best considered with reference to specific patients and this is addressed in my response to Question 79.

(xiv)

547. Please see my response to Questions 41 - 44 in respect of MDMs for an explanation of the circumstances, and reasons, why an MDM recommendation may not be implemented.

(Q 67 – 69 (i) – (iii)

548. With regard to the admission of patients for administration of intravenous hydration and antibiotic therapy in association with the management of recurrent urinary infection, I have related how those patients benefited from our management of them. I have related how the management had been so successful for the majority of the cohort of patients that they were subsequently able to be managed effectively in the community without elective or acute admission following termination of the practice. I have also related how the termination of the practice left a minority to become recurrently so ill as to require acute readmission. In order to further mitigate the risks posed to this minority, I had some patients subsequently referred to the Department of Immunology at the Royal Victoria Hospital in Belfast for assessment. Without access to their clinical records, I recall that, in general terms, these patients were found to have borderline or mild immune deficiencies and have since gained some significant benefit from having regular immune replacement therapy which has reduced to some degree the frequency and severity of recurrence of infection requiring acute readmissions.

549. With regard to the elective admission of patients for intravenous hydration and antibiotic therapy one or more days prior to elective urological surgery, and particularly for elective surgical management of infected stone disease, I believe that the prohibition of the above practice did pose a risk to the safety of those patients. I believe that my colleague, Mr Michael Young, would be better equipped than me to describe such risk.

550. In relation to the performance of 'benign' cystectomies, I have no doubt that patients derived very significant benefit from that practice. Some days ago, one such patient, who had been having suicidal ideation some 18 or 19 years ago as he could no longer tolerate the constant pain of his chronically inflamed bladder, contacted me to thank me once again for the simple cystectomy and orthotopic bladder replacement which I had performed for him at that time. He had recently celebrated his 90th birthday. The one thing which I did learn from my experience is that simple cystectomy may indeed relieve the patient of the painful bladder, but it does not relieve the patient of recurrence of infection, as the neo-bladder is no more immunologically competent than the native bladder.

551. With regard to the disposal of hospital notes in a bin, I have related the circumstances giving rise to my wrongful action at that time. I fully accept that it was wrong of me to have acted in such a way, irrespective of the circumstances. It did not have any impact upon the safety of the patient, or risk harming the patient, as the notes were retrieved from the bin and again filed in the patient's clinical records, a new chart having been provided for the purpose.

552. With regard to the storage of patient records kept at my home, I have related the circumstances giving rise to my doing so. I do accept that it was wrong to have retained clinical records at my home for such long periods of time. I do acknowledge that there could have been a risk to patient safety if their records were unavailable to other staff in the event that the patient was acutely admitted or was scheduled to attend an outpatient clinic. I always returned such records to the hospital immediately upon request. However, the majority of the records

retained at my home were brought back from my clinics at South West Acute Hospital. As a consequence, the likelihood of such patients requiring acute admission to Craigavon Area Hospital was remote. Their clinical records retained by me at my home would not have been required for any acute admission or clinic attendance at SWAH as that hospital had its own clinical records. Charts retained at my home were securely maintained. No records were lost or 'missed' as a consequence. I am unaware of any harm coming to any patient as a consequence of this practice.

553. With regard to patient records being kept in my office, the majority of these would have been brought to my office following clinics for dictation of letters following clinics. Others would have been delivered to my office by my secretary with the reports of investigations, or on my request. These charts were retained for as short a period of time as possible. They were probably less secure than those retained at my home, as other staff had access to my office, and this could have posed a risk to patient care and safety, as it would appear that clinical records have been lost by the Trust.

554. There was no risk due to retention of patients' records in my car as I have never retained or left such records in my car.

555. With regard to GP referral letters kept in my office filing cabinet, I believe that it is important to emphasise that these letters were either the original letters of referral with copies retained by the Appointments Office, or vice versa. The retention of the letters in the filing cabinet in my office did not hinder or interfere with referred patients being offered appointments in accordance with the category of urgency attributed by the referrer, in compliance with the agreed Informal Default Process. I kept the letters of referral to ensure nevertheless that no referral had been overlooked. In doing so, one patient referred by a consultant gynaecologist for urodynamic studies had not had the referral copied by the Appointments Office. Otherwise, I am unaware of any patient having been placed at risk by my keeping the letters of referral in the filing cabinet in my office.

556. The retention of GP referral letters in the filing cabinet in my office was closely related to and was a consequence of the non-triage of referrals. I always accepted, and still accept, that triage of referrals is an important task. The failure of referrers to reliably categorise the urgency of referrals and the Trust's failure to ensure that there was an adequate system in place whereby triage could be performed, did impact on patient safety [as did the difficulties that I experienced in carrying out triage]. It was not my role to conduct risk assessments in terms of the extent of this risk. However, as stated above, I made the Trust aware on countless occasions over many years that I was struggling with triage, and not completing it for non-red flag cases, as I had found it impossible due to the conflicting pressures of work. It was the responsibility of the Trust to assess and address the risk arising from this. The Trust failed to do so even though I and others had repeatedly brought the issue to its attention.

557. In terms of non-dictation after clinics and day procedures, I have previously accepted and continue to accept that this was sub-optimal. It could have impacted on patient safety. However, it was determined in 2017, during the course of the formal investigation, that no patient had been exposed to the risk of harm, as I had taken every measure to mitigate this risk by identifying and prioritising urgent cases requiring a prompt transfer of information. It was the responsibility of the Trust to assess this risk and to devise a system whereby I had sufficient time to cope with the excessive administrative demands placed upon me. I am unaware of any failure to dictate letters following discharge of patients from the Day Surgical Unit.

558. With regard to not adding patients to the Patient Administration System, I have related that I did not have access to the Patient Administration System for any such function. Therefore, patients could not have been impacted or at risk by my failing to carry out a function which I did not have. As the Inquiry will be aware from my response to Question 1 above, I have been able to demonstrate that the allegation that 2 out of 10 patients had not been added to the Patient Administration System by my secretary is simply untrue.

559. With regard carrying out my own booking and scheduling of patients, I cannot think of how this could have had or risked having a negative impact upon the care and safety of patients. On the contrary, I would contend that it enhanced patient care and safety

560. During the course of the formal investigation, I refuted the allegation that I had arranged the admission of patients who had previously attended privately and ahead of NHS patients with similar clinical priorities. I believe that there is a lack of appreciation of the inadequacy of having only two categories of urgency that can be attributed to patients awaiting admission: 'urgent' and 'routine'. If such waiting lists are up to seven years long, the proposition or policy that all patients in these two categories be admitted in chronological order posed a significant risk to patient care and safety. I am unaware of any negative impact on patient care and safety by my arranging the admission of patients who had attended privately.

561. The failure to provide oncology patients with access to a CNS could have impacted patient care. However, as stated above, it was the responsibility of the MDT Lead Clinician and the MDT Core Nurse Member to ensure that patients had access to a CNS.

562. With regard to following up on results, I am unaware of having failed to request that patients be placed on the list for review at the appropriate time with the results or reports of investigations which had been requested. It was the responsibility of the Trust to ensure that a service was provided which was sufficient to ensure that this was facilitated. Instead, the Trust introduced DARO, which resulted in patients not being placed on lists for such planned outpatient review of patients at all, with all of the attendant risks to their care and safety. In addition, the Trust transferred all responsibility for the care and safety of those patients endangered by DARO to the too few clinicians providing the service, and without the provision of adequate time to do so. Against this background, I endeavoured to review as

many reports as possible, for the sake of the safety of patients so endangered by the Trust.

563. No concerns were ever raised during my tenure in respect of the use of Bicalutamide. The appropriateness or otherwise of this medication cannot be considered in isolation without reference to specific patients and their individual clinical situations.

564. In respect of MDMs, I do not believe that any failure on my part to follow MDM recommendations would have or did impact on patient care and safety. In any case where there may have been a departure from a MDM recommendation, a detailed review of the individual case would be required in order to comment on the rationale for departing as there can be many appropriate reasons to do so. For example, it would not be appropriate to follow such recommendation if, following discussion with the patient, the patient did not wish to follow the treatment recommended at MDM. That would be a more serious patient care and safety issue in that it would amount to providing medical treatment without the patient's consent.

(Q70 – 71)

565. I have provided comments under the heading "Concerns regarding your practice" (Questions 66 - 67) which refer to concerns that were raised and will not repeat the detail of same here.

566. As the Inquiry is aware, I had concerns regarding my practice addressed by the formal investigation initiated on 30 December 2016. I have commented on that process extensively elsewhere in this statement (see response to Questions 66 - 69) and in the grievance submitted in November 2018. I can only recall one occasion on which it was suggested that I deviated from an action plan that was put in place during that process and I will refer to that below.

567. I was excluded from work on 30 December 2016. Following representations by me, a return to work was agreed on 9 February 2017. The terms of that return to work were noted at as follows:

"Mr O'Brien's return to work is based on his:

Strict compliance with Trust policies and procedures in relation to:

- *triaging of referrals*
- *contemporaneous note keeping*
- *storage of medical records*
- *private practice*

Agreement to comply with monitoring mechanisms put in place to assess his administrative processes" [see AOB-01426 - AOB-01428].

568. The note of the meeting also specifically recorded the following:

"This action plan for Mr O'Brien's return to work will be in place pending conclusion of formal investigation processes under Maintaining High Professional Standards framework." (my emphasis)

569. The formal investigation process was concluded with production of the Case Investigator's report [see AOB-10001 – AOB-10584] on 21 June 2018. The investigation was thereafter referred to the Case Manager for a determination.

570. The Case Manager's determination dated 1 October 2018 can be found at Appendix 44 of my grievance [see AOB-15293 – AOB-15303]. On pages 7 and 8 of that determination under the heading "Restriction on Practice," the Case Manager recorded as follows:

"At the outset of the formal investigation process Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'Brien worked successfully to the action plan during this period.

It is my view, in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practices and management of his workload, an action plan should be put in place with the input of the Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties." (my emphasis).

571. Thus, the return-to-work plan came to an end at the conclusion of the investigation process.

572. A recommendation was made by the Case Manager for a further action plan to be agreed (with the input of NCAS). I was not approached by the Trust to agree any such plan.

573. The return-to-work plan required the triaging of red flag referrals on a daily basis, and completion of all referrals by 4 pm on the Friday afternoon following my being Urologist of the Week (UOW). I did try to triage all red flag referrals on a daily basis, but it was not always possible, depending upon the demands of UOW. I still found it impossible to complete all triage by 4 pm on the day after completion of UOW, and particularly in the context of ever increasingly longer periods awaiting first outpatient consultations (a point acknowledged by Dr O'Kane in her undated letter to the GMC referring to the 67 day wait for a first appointment [AOB-2271], which rendered the Friday 4 pm deadline all the more unnecessary. In endeavouring to comply, I took off each Friday following UOW as an annual leave day in order to complete as much of the week's triage as possible. However, doing so was at the cost of losing an oncology review clinic as well as a clinic for patients attending for urodynamic studies and flexible cystoscopies.

574. The return-to-work plan required that dictation was required to be completed after completion of each clinic. This remained a problem because of the limited time actually available to remain on location at outreach clinics for reasons related in response to Question 66.

575. The return-to-work plan required that my secretary would actually choose who would be admitted for surgery. As my secretary was unable to do this, I continued to select patients for admission while my secretary continued to conduct all the administrative tasks which arose as a consequence.

576. The one aspect of the return-to-work plan which could have been done differently was in relation to triage. I believe that it was an opportunity to review the conduct of triage in relation to UOW and in the context of increasingly longer periods for patients awaiting first consultation appointments. I believed then that it was a missed opportunity to appreciate that triage did not need to be conducted by consultants at all and could well have been undertaken by clinical nurse specialists, empowered to request investigations, if not limited prescribing. Instead, the return-to-work plan was a triumph of process over purpose.

577. No issue was raised by the Trust with me in relation to any potential breach of any plan until November 2019 when I received emails from Ms Corrigan, Head of Service, as follows [see AOB-02259 – AOB-02261]:

Email of 5 November:

"Dear Aidan
[Unclear] and I have been asked to meet with you to discuss a deviation from your return to work action plan when you were on call in September…

Email of 6 November:

"*The deviations are listed below and attached and Ted would also like to take the opportunity to organise a another meeting with more time for you and him to sit down and discuss your job plan:*

CONCERN 1 (Triage) – after your week of oncall on Monday 16 September, there were still 26 paper referrals outstanding, and on Etriage 19 Routine and 8 Urgent referrals outstanding triage, escalation emails were sent to you during your week oncall.

CONCERN 3 (dictation) – As per Marie Evan's email dated 4/11/19 attached there are undictated clinics going back to 23 September and I have attached the detail for these.

I have also received a datix for Patient 112 *, H&C* Patient 112 *the datix advises that the patient was discussed at MDM on 27 June 2019 and at the MDM on 3 October it was stated that 'it would appear outcomes from previous Uro-Oncology MDM (27/06/2019) have not been actioned), as part of my investigations to close off this datix I noted that you had seen the patient at clinic on 16 August 2019 and only dictated the letter on 4 October 2019 a day after the MDM, therefore this has also been a deviation from your return to work plan."*

578. In that 5 November 2019 email I was requested to attend a meeting with Ms Corrigan and Mr McNaboe, Clinical Director, on 8 November 2019. I emailed on 5 November 2019 [see AOB-02260] asking for the nature of the deviation and further wrote a letter addressed to Ms Corrigan dated 7 November 2019 [AOB-02262] indicating my willingness to attend (despite the stress of having to do so in the midst of a cancer review clinic and at under 24 hours' notice) but indicating that, whatever the issues they wished to discuss, there could have been no deviation from the return to work plan, given that it had expired one year previously.

579. I duly attended Mr McNaboe's office at the allotted time (which I cannot recall) on 8 November 2019 but found it locked. I did not receive a follow up invitation

to meet with them in order to discuss issues which, from their perspective, appeared to have arisen.

580. I accept that during the autumn of 2019 I may have been somewhat slower in administration than otherwise had been the case, due to personal circumstances. [redacted] Personal Information redacted by the USI .

581. It would appear that the Trust notified the Employer Liaison Advisor (ELA) of a potential deviation at a meeting on 7 October 2019 (see email from Miss Donnelly to Dr O'Kane dated 12 November 2019 [AOB-02269 – AOB-02273]). Dr O'Kane asked Mr Simon Gibson by email on 17 November 2019 to coordinate a meeting to describe in detail the management plan around this, the expectation concerning compliance and the escalation [WIT-14210]. On 24 January 2020, Mr Gibson reported the proceedings and conclusions of the meeting which had convened on 17 January 2020 [WIT-14210 – WIT-14211]. The meeting concluded that backlog reports could not necessarily be relied upon for their accuracy. The meeting, attended by Dr Khan, the Case Manager of the formal investigation, concluded that there were no standards, guidelines or policies of the Trust or of any external body concerning the dictation of letters after clinics or of results, even though Dr Khan had insisted that there were such in delivering his determination in October 2018.

582. Dr O'Kane provided a detailed report to the GMC (undated) which appears at page 59 of the first attachment of the GMC's email to Tughans on 13 March 2020 [see AOB-02270 – AOB-02273]. In that email Dr O'Kane reported that monitoring continued and noted that in overall terms I was compliant.

583. Thus, there was no ongoing action plan following conclusion of the formal investigation, as recommended in the determination presented on 1 October 2018. Nevertheless, the Trust continued to monitor me, and no significant issues

arose in relation to the various concerns that were raised within the context of the formal investigation.

(Q 72)

584. Issues which arose in relation to my practice were inextricably linked to the inadequate system I was working within. That led to recurring issues, for example, in relation to triage as detailed above in my response to Questions 66-67. These issues could have been prevented had the Trust ensured that the Urology Service had adequate staffing and capacity so that a practicable system could have been put in place to deal appropriately with triage.

585. During my tenure, there was a recurring issue with records being kept at my home and office as well as non-dictation of clinics. Again, that could have been prevented had the system within which I was working been adequately staffed and properly run by the Trust.

586. If there was any recurrence in the failure to ensure oncology patients had access to a Clinical Nurse Specialist (CNS), that could have been prevented by those responsible, namely the MDT Lead Clinician and the MDT Core Nurse Member, complying with their responsibilities as stated in the MDT Operational Policy to ensure that such patients had access to a CNS.

587. It could not be said that any issue in respect of my prescribing Bicalutamide recurred during my tenure, as no issue was ever raised with me in respect of my prescribing that medication during my tenure as a consultant urologist with the Trust. As stated elsewhere in this statement, the use of Bicalutamide was known to both the Urology and Oncology Service and no issue was ever raised in respect of Bicalutamide until after the termination of my contract with the Trust.

588. While I cannot be sure how many times it would have occurred, it is likely that there was some recurrence in respect of MDM recommendations not being followed through. That is dealt with in detail at Questions 40-44 in terms of the reasons why an MDM recommendation may not, on occasion, have been followed through.

(Q 73 – 74)

589. I believe that it is important to emphasise that the context in which support was given or not given was the gross inadequacy of the Trust's Urology Service which was also the factor which limited the support that could be given and was given. There was a universal knowledge of the inadequacy of the Service, and both our Lead Clinician and Head of Service tried to be as supportive as they could be to me and my colleagues in our attempts to provide a service which required more personnel and more resources for it to be safe and effective**.**

590. Ultimately, neither my colleagues who worked in the Urology Department, nor I, were provided with appropriate support in order to satisfactorily discharge our roles. The lack of support was not unique to me, or indeed consultant urologists, but applied to the Department as a whole. The lack of support is closely related to the issues I have identified above under the heading "Staffing". I believe the lack of support was not only at Trust level but also at regional level. Urology services in Northern Ireland, from information available, were generally under-resourced, with a particularly acute problem at the Southern Trust.

591. Human Resources would have been well aware of the issues within urology regarding staffing levels, yet that was never satisfactorily addressed. The administrative management at the hospital was also aware of the resourcing issues. Thankfully, I did not have the need to attend occupational health as a result of ill health, albeit that I was under a considerable degree of stress throughout my tenure. Had I attended occupational health and had occupational health considered me unfit to work that would have exacerbated the position on

the ground for patients, meaning one less consultant to tackle the long, unsatisfactory, waiting lists.

592. Below I will refer to a number of examples of failure to provide support to both colleagues and me. The examples relate to the following broad areas:

(1) Overwork of consultants, including me. This has already been dealt with in my comments above under "Staffing". It was, however, the single most concerning lack of support throughout my time at the Trust.

(2) The Trust's knowledge that I was grossly overworked on a chronic basis and its failure to provide realistic job plans and/or support so that I only worked in accordance with those plans. Had I only worked in accordance with the time allowed in my job plan, more and more patients would be waiting longer and longer to see a consultant and/or have treatment. That placed me in an invidious position meaning that I tended to sacrifice my own time to try to address the issue.

(3) Failure to have adequate regard to the views of the team in relation to service delivery.

(4) When it was apparent that I was struggling, in particular with my administrative load, failure to implement systems which would assist me in dealing with that aspect of my practice.

593. In or around 2008/2009 the wards were reconfigured. I have referred to this in the general narrative in my response to Questions 1 and 2 of the Notice. However, I also consider this is relevant here. Previously there was a dedicated urology ward. Having a dedicated inpatient ward for urology patients was important and something that, as a department, we really valued and had been keen to develop. There were obvious benefits to urological patients being in one area. Apart from anything else, that made it logistically easier to see and

manage them. A particular point of importance was that when we had a dedicated ward, we had dedicated staff on that ward who developed their own expertise within urology. We had a stable nursing staff, many of whom knew and were able to react to the peculiar demands of urology patients. With reconfiguration of the wards, patients were split between three different wards. That meant patients were being seen by nursing staff who did not have the expertise in urology that nurses working on a dedicated ward had. I was not alone in my concerns in relation to reconfigurations of the wards. For example, I refer to an email from Colin Weir dated 24 March 2009 which included the following comments:

"There is widespread concern regarding ward reconfiguration. This is another example of how things are not negotiated anymore. We all have concerns how this will work. When did we have a detailed discussion about it? When did we talk through the implications of it? How are we going to do a ward round when everyone including urology are in attendance? Tell me what the benefits are to quality of care and how you see this working in the real world? Maybe I have missed those discussion too and I am sorry I have." [AOB-82229]

594. This was an example of management taking decisions without due regard to the opinion of those working on the ground.

595. In 2009, Mr Mackle expressed concerns in relation to the possibility (as he understood it) that I should cancel clinical work to allow me to catch up on paperwork. He noted the following in his email of 2 June 2009 [see AOB-00131]:

"If, as you state, Aidan feels there is now a clinical risk because he has allowed the backlog to develop, then there is a serious governance issue regarding his practice. I am copying this email to him so as to get an urgent response to the clinical risk issues he has raised and I may need to consult with the Medical Director regarding the performance issues raised."

596. I clarified in my letter of 12 June 2009 that I was not seeking to cancel all clinical work. I did however highlight the stress which the ward reconfiguration was causing and that the fragmentation of inpatient urological services posed an existential threat to care [AOB-00133].

597. To date I have not been able to trace a response from Mr Mackle to that correspondence.

598. Although I was keen to try to address waiting lists by making extra efforts, for example working on Saturdays, it was not possible for the Trust to provide the support to facilitate this. An example of that is referred to in an email from Ms Trouton of 11 January 2011 when she referred to that in the following terms:

"I appreciate that you have offered to do additional Saturday lists which is great, however as you know this is proving difficult to secure with theatre nursing staff and we really do need to use the core lists we have to treat these long waiters at least until we see what additionality, if any, we can secure." [AOB-05687]

599. The content of this email was largely directed at the proposed use of theatre sessions the following day, Wednesday 12 January 2011, to operate on patients who were not waiting longer than the target time of 36 weeks, and irrespective of their clinical priority. It did not take account of whether I was operating alone without the assistance of a registrar, and whether I was additionally on call for emergencies that day. It was then, prior to UOW, of reassurance to be able to schedule patients for procedures that could be competently undertaken by a registrar while I attended to an emergency if one arose, or vice versa. So, the purpose of the email was to convey the expectation that I would use theatre sessions available to me on a weekday for those waiting longer than the target time, irrespective of clinical priorities, other conflicting considerations, and because of the lack of availability of theatre nursing staff to facilitate additional operating at weekends, and which I had offered to undertake.

600. On 19 September 2011 I expressed concerns in relation to the administrative tasks I was having to undertake as part of the job planning process. I provided a summary of the administrative tasks at that stage and noting the lack of time allocated to them by way of PAs. [AOB-00308-AOB-00313].

601. Following facilitation in relation to this job plan, Mr Clegg emailed Mr Mackle on 16 November 2011 in the following terms:

"I do feel however that we cannot ignore Mr O'Brien's comments. Mr O'Brien was informed in his notification letter following Facilitation that the new job plan will require him to change his working practices and administration methods and that the Trust will provide any advice and support it can to assist him with this. It is important therefore in view of the comments made by Mr O'Brien that we follow through with this." [AOB-00326]

602. Mr Mackle wrote to me on 5 December 2011 in the following terms:

"*Dear Aidan*

As you are aware in the letter post your job plan facilitation it was stated 'This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this.

I as a result, organised a meeting to discuss same. I note however, that you cancelled said meeting. I am therefore concerned that we haven't met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without the need for Trust support then you obviously do not need to contact me to organise a meeting." [AOB-00337]

603. I cannot now recall why I had to cancel the meeting with Mr Mackle and do not recall rearranging a meeting with him, as I did not consider his engagement in such meetings helpful in endeavouring to address the issues I faced. This can be illustrated by his lack of any offer of help or assistance to me when he subsequently formally raised administration issues with me in March 2016. To the best of my recall, Mr Mackle did not seek a further meeting with me in or around December 2011.

604. An example of management not liaising with clinicians in relation to important matters such as the job specification for new appointees can be found in Mr Young's letter to Dr Rankin of 4 March 2012 which included the following comments:

"Re: The proposed imminent advertisement for three consultant urological surgeons.

"In principle, it is found to be very unusual practice to advertise potential jobs within a department, without involving or even showing the job specification to the Lead Clinician of the Unit. I understand this would have been sent to press on Tuesday 6th March, unseen by myself, even though my name would have been used as the reference point. Would this have been tolerated in any other department? …

Suggestions provided to make the job descriptions more accurate.

In conclusion, there are several other erroneous points within most of the job descriptions, not least for instance, the "one-stop clinic approach" to the prostate diagnostic service, which is currently available. This appears to have been abandoned" [AOB-06027-AOB-06039].

605. Within my appraisals, I consistently raised my concerns in relation to the level of care being provided to patients due to the long waiting times to be admitted and reviewed. I included the following comments in my 2012 appraisal:

"*The main issues compromising the care of my patients are my personal workload and priority given to new patients at the expense of previous patients. With regard to workload, I provide at least 9 clinical sessions per week, Monday to Friday. Almost all inpatient care and administrative work, arising from those sessions, has to be conducted outside of those sessions. Secondly, the increasing backlog of patients awaiting review, particularly those with cancer, is on ongoing cause for concern." [see AOB-22325]*

606. Whilst I highlighted matters in my appraisal, no-one ever came back to discuss with me how those issues would be addressed.

607. We often met as a team to agree strategies to address the ongoing difficulty the Urology Department had in providing an adequate, safe service. Following those meetings, it was often difficult or impossible to follow through with plans. Surely management should have been providing support and structure? This appears to be acknowledged in an email from Ms Trouton of 18 July 2013 when she referred to that issue in the following terms:

"I thought it might be good to take a moment to summarise the few actions that were agreed and discussed this afternoon as, as Aidan quite rightly states we often agree actions but often never get to implement due to many competing demands on our time." [AOB-06748]

608. As is apparent from elsewhere in this statement there was an ongoing issue in relation to triage. I had a particular view of how triage was best carried out for patients (advanced triage), against a background of increasing numbers of referred patients waiting increasingly long periods of time for first outpatient appointments without any diagnostic or therapeutic measures being taken while waiting. In the context of triage and issues in relation to health records not being found, there was an email exchange in late November / early December 2013 when Mr Brown made the following comments:

"…… I had a lengthy one-off meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.

I agree that we are not making a lot of headway but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.

Perhaps some of us – maybe Michael, Aidan and I could meet and agree a way forward.

Aidan is an excellent surgeon and I'd be more than happy to be his patient (that can be sooner than I hope!) so I would prefer the approach to be 'how can we help" [AOB-00487].

609. This is an example of the Trust being aware of the administrative issues I was having by that time. I had of course raised them in the context of the job planning process and within my appraisal. Yet systems were not put in place to free up adequate time for me to address all of the various demands I had to deal with as a urologist. At that time, I was allocated 0.8 PAs for administration in a job plan with 9.8 PAs of Direct Clinical Care, which was not commensurate with the BAUS recommendation of 1.0 PA for administration for 7.5 PAs of Direct Clinical Care.

610. However, by then, Ms Debbie Burns had replaced Dr Rankin as the Director of Acute Services. I had a number of informal meetings with her during this period of time, and particularly since assuming the roles of Lead Clinician of the Trust Urology MDT and Chair of its MDM in April 2012, in addition to Lead Clinician and Chair of NICaN's Clinical Reference Group for Urology in January 2013. She was appreciative that these roles alone consumed more time than the total allocated for administration in proposed job plans. Ms Burns was keen that I would be successful in having the Trust MDT and MDM meet approval at National Peer Review in June 2015. She was also keen to ensure that we could implement the Trust's plans arising from the Regional Review of Adult Urology Services. She was appreciative of the additional contribution that my colleague, Mr Young, and

I had made since providing outpatient clinics at South West Acute Hospital since January 2013.

611. It was in this context that she appreciated that it was not possible for me to additionally complete the triage of all referrals directed to me. She arranged for Mr Young to undertake the triage of those referrals. Mr Young generously agreed. So far as I can recall, he continued to do so from early 2014 and for a period of six months or more.

612. In a stock take of the Regional Review of Adult Urological Services in Northern Ireland, I emailed Mr Mark Fordham, External Adviser to the Regional Review, on 26 May 2014 [SUP 312-314 and AOB-03808-AOB-03810] and again raised the inadequacy of our job plans in relation to administration. In the subsequent Report of Stock Take of Regional Review of Adult Urological Services in Northern Ireland of May 2014, the following issues were identified as persistent issues for the Southern Trust [see supplemental October bundle pages 454 – 479]:

"Southern Trust

1. *The waiting times particularly outpatient services have very long waiting times.*
2. *Access to operating theatre sessions is limited resulting in waiting lists for operative procedures in particular core urology cases.*
3. *The commissioned service and budget agreement aims are based on the workforce capacity rather than the demand.*
4. *Recruitment of clinical staff [consultants, juniors and specialist nurses] has until very recently been a problem. Recent consultant appointments are hoped will improve clinical services in time. The 3 funded specialty doctors remain vacant.*
5. *Numerous outreach day surgery and clinics involve significant travel times and absence from Craigavon Hospital site*
6. *Engagement between primary and secondary care has been limited. The development of regionally agreed care pathways has not been fully instituted or adopted by referring services in primary care and A&E.*

7. *Administration time for consultants is significant and is not reflected in their job plans. There is a particular worry in delays in consultant to consultant referrals, MDT referrals and triage."*

613. This would suggest the issues were known at a regional level. The Trust's Urology Service had been struggling for years by this point. I do not know what steps were taken in relation to this at a regional level; all I can say is that the issues persisted on the ground.

614. On 18 July 2014 I highlighted in an email to Mr Haynes [AOB-71188-AOB-71189] that the principal challenge was that patients were waiting too long for their care. Whilst management and the Trust did endeavour to review the urological services at this stage (see email exchange of the 17 August 2014 [AOB-00779-AOB-00784]) and issues were identified as is apparent from elsewhere, no effective steps were taken to ensure that the Trust was able to provide an adequate service to its patients. In failing to do so the Trust failed to support urologists, including me.

615. In a letter dated 6 September 2012 in a response to a complaint [AOB-06126 - AOB-06128] the patient was advised in the following terms in relation to his wait:

"I apologise that you have had to wait longer than you had expected for your procedure and for the pain and discomfort you experienced during this wait. There has been an increase in the demand for urology within the Southern Health and Social Care Trust. The Commissioners are working with the Trust and Consultant Urologists to address this increase."

616. It will be a matter for the Trust and the Commissioners to provide evidence to the Inquiry in relation to why, by that stage, it being very well known that urology in Northern Ireland generally was inadequate and particularly so in the Southern Trust, adequate steps were not being taken at the Trust or regional level to address same.

617. In my appraisal of 2015 I once again raised issues in the following terms:

"Additional Information

The issues which have impacted upon the delivery of optimal patient care have remained unchanged from those recorded in previous appraisals. I have a waiting list of over 280 patients waiting up to almost three years for admission for surgery. More patients are added to that waiting list each week than can be removed from it. Within the totality, there are patients with clinical urgencies waiting so long that their clinical conditions are worsened by doing so. My waiting list has been up to ten times greater than those of some of my colleagues. A similar situation pertains to outpatient reviews, and particularly those of cancer patients. Yet the situation has not been addressed in a durable and effective manner, whilst there persists an expectation that I will continue to accommodate new referrals." [AOB-22655]

618. Again, I received no response to that.

619. I discussed statistics from the Consultant Led Indicator Programme (CLIP) Report with my appraiser who made the following note [AOB-22675]:

Urology Services Inquiry

Southern Health and Social Care Trust
Quality Care - for you, with you

CLIP (Consultant Led Indicator Programme) Report structured reflective template
Requirement: One annually

Name of doctor: Aidan O'Brien GMC No: 1394911

Date of report:

January 2015 to December 2015

What issues can I identify from the report?

There was an apparent decrease in the total number of finished consultant episodes from 1003 in 2014 to 830 in 2015.
There was an increase in the total number of outpatient attendances from 899 in 2014 to 1109 in 2015. Most of this increase was due to an increased number of new patient attendances from 285 in 2014 to 462 in 2015.
The number of patients attending as outpatients and having a procedure as doubled, from 39 in 2014 to 81 in 2015.
The new / review ratio has decreased from 2.2 in 2014 to 1.4 in 2015

What actions will I undertake?

I would like to significantly reduce the numbers of new patients attending as outpatients as a proportion are added to waiting lists for admission as inpatients, only to languish there for periods so long as would be considered untenable in other parts of the UK. The situation is so bad that many patients have diminishing prospects of ever being admitted.
I also believe that it is inappropriate for me to spend time seeing new patients when urological cancer patients are waiting years beyond their review dates for review.

Final outcome after discussion at appraisal:
(Complete at appraisal)

. Notes the changes in 'Numbers' and sets out the Trusts objectives.
Concerned that Trust is not providing facilities to deal with issue. This is outside his Control
Regards the balance of provision as wrong.
issues to be discussed at Trust level.

620. I note that matters were to be discussed at Trust level. I am unaware of the outcome of those discussions. It certainly did not result in support being given to me.

621. I have referred above, in my comments under the heading "Nursing and ancillary support" (see Question 33 – 37), to the significant concerns of the manager of the urology ward, Ward 3 South, Sr Catherine Hunter, dated 12 November 2015 [AOB-75761-AOB-75765]. Sr Hunter expressed how she was "*gravely concerned with the lack of staff and skills mix at present"* and how she considered the "*ward to be clinically unsafe at times".* Mr Haynes in an email of 13 November 2015 noted the concerns raised by Ms Hunter as "*extremely concerning"* [AOB-75766-AOB-75767] and noted how the Trust needed to act now and not wait for a significant incident to occur. Clearly Sr Hunter was

dissatisfied with the support she was provided with by the Trust and sent an email dated 2 July 2016 citing her reasons for leaving [AOB-77594]. It seems clear that despite raising significant concerns she did not feel supported by the Trust and her response was to leave.

622. It is clear that FY1s (the most junior hospital doctors) were raising significant issues (see email from Mr Haynes of 1 October 2015 [AOB-75461-AOB-75463] and further email of 26 February 2016 [AOB76687-AOB76688]). Notably one of the issues was FY1s inability to do discharge letters and their concern "that they are under pressure and unable to complete all their duties". Mr Haynes will be better placed to say how the Trust addressed the concerns raised by the FY1s, and whether the response was adequate.

623. In March 2016 I had a meeting with Mr Mackle (Associate Medical Director) and Mrs Corrigan (Head of Service) who deputised for Mrs Heather Trouton (Assistant Director) who was unable to attend. This meeting has been commented on extensively within the formal investigation. It was the first occasion on which the administrative backlog was formally put to me in a meeting of this nature. Issues were identified but the Trust took no practical, supportive steps to assist me with my administration backlog [AOB-02031 – AOB-02033]. I recall asking Mr Mackle what should be done to address the situation and he simply shrugged his shoulders. I felt thoroughly unsupported as a hard-working employee who had consistently raised concerns in relation to workload including in relation to administration and when formally confronted with it, no action plan was put in place to assist me in managing my workload.

624. On 28 June 2016 [AOB-77568 – AOB-77570] I emailed Ms Corrigan with my concerns in relation to how the Trust was managing non red flag patients whose treatment was continuing to be delayed. I reminded her that they were clinically important.

625. Needless to say, when I was advised in December 2016 of the formal investigation, I was devastated.

626. I found out subsequent to the events in question, that other senior clinicians had suggested that a support plan be put in place for me to assist in dealing with the urology backlog. Please see email of 15 September 2016 from Ms Gishkori in the following terms:

"*Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.*
Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

I appreciate you highlighting the fact that this long running issue has not been resolved. However given the trust and respect that Mr O'Brien has won over the years, not to mention the life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good." [AOB-01053-AOB-01054].

627. There was a lack of support in failing to put such a plan in place but instead opting to undertake a disciplinary investigation.

628. The formal investigation is dealt with elsewhere. However, in broad terms, I found a real lack of support throughout the investigation. I was particularly devastated to have been excluded from work for a period of time. The Case Investigator's report was available in June 2018, however, steps were not taken by the Trust to bring the matter to a final resolution by way of a disciplinary hearing prior to termination of my employment with the Trust on 17 July 2020. It was deeply unfair for the process to be hanging over me for such an extended period. During that time, I made a Freedom of Information request to obtain relevant documentation to assist me in defending myself. Those requests were never fully

responded to and, when they were responded to, this was done so in a dilatory manner.

629. On 26 January 2017 I note there was a case conference that I was considered at. The case conference noted as follows:

"It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties – there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.

It was agreed by the case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers." [see TRU-00037 – TRU-00040]

630. I continued to raise my concerns about the "elephant in the room", namely that patients awaiting admission and re-admission for procedures were suffering poor clinical outcomes as a result of delays (see transcripts of meetings on 30 December 2016 [AOB-56005 – AOB-56006], 24 January 2017 [AOB-56040 – AOB-56043] and 24 January 2017 [AOB-56052 and AOB-56053 by way of example). As is apparent from elsewhere in this statement, that issue was never addressed.

631. I did endeavour to get the Trust to amend my working pattern to allow me the opportunity to deal with my backlog, by having a period when I was not seeing new outpatients. The Trust was unwilling to support me in relation to that. See note of meeting dated 9 March [AOB-01469-AOB-01474] which noted the following:

"Mr O'Brien advised Mr Weir and Mrs Corrigan that he no longer felt it was fair that he would continue to see New Outpatients. Mrs Corrigan advised that this was not feasible as all Consultants needed to see New Outpatients. Mr O'Brien clarified that the reason he felt this was because he had the most patients waiting

to be operated on with the longest waiting times and that it wasn't fair for him to continue to see new patients and adding to his waiting list as he couldn't deal with them.

Mrs Corrigan clarified that Mr O'Brien didn't have the most nor the longest waiting times for In and Day patients:

Mr Young - 228 patients (162 weeks)

Mr Suresh - 267 patients (93 weeks)

Mr O'Brien - 257 patients (152 weeks)

Mr Haynes - 191 patients (143 weeks)

Mr Glackin - 146 patients (62 weeks)

Mr O'Donoghue - 134 patients (101 weeks)

…

Mr O'Brien raised about the Urology Oncology MDT and advised Mr Weir and Mrs Corrigan that he was no longer prepared to operate on a Wednesday until 8pm then go home and preview for the next day's MDT as he had done in the past. He advised Mr Weir and Mrs Corrigan that he hadn't quite made up his mind if he was going to continue with chairing this MDT group but if he did continue then he wouldn't be coming into work on a Thursday morning but the time would be spent previewing for the MDT. Mr O'Brien advised that he spends considerable time preparing for the meeting if he is going to Chair and that he went through all patients in great detail including all their images. He also advised that in the past he had spent considerable time after the MDT correcting the outcomes i.e. grammar etc. He advised that he prided himself on having one of the best-prepared and well-run MDTs."

632. In my Personal Development Plan of 30 November 2017 (see 2016 appraisal, page 40 [AOB-22870]) I recorded as follows:

Name of doctor: Aidan O'Brien
Considering my comments under *Maintaining Good Medical Practice* (in my appraisal paperwork), the following strategies may help improve how I keep up to date in the next year: During 2016, I focussed on the areas which I believed were most clinically pressing, performing 25 additional, inpatient operating sessions, and 20 additional oncology review sessions, in the ten months available to me. I have no doubt that doing so significantly reduced the poor clinical outcomes and suffering of significant numbers of patients. I also have no doubt that doing so contributed to the issues since subject to formal investigation. My appraiser recorded that these were Trust issues to be discussed and agreed in 2017. They have yet to be so! Date of reflection: 30 November 2017

633. Thus, whilst I had been persistently raising concerns in my appraisal and again referred to those concerns as being a contributor to the investigation I was undergoing, I noted that whilst the concerns in relation to patient numbers had been raised and were to be discussed, that had yet to be done.

634. I have referred under the heading "Staffing" to Mr Haynes' email of 22 May 2018 [AOB-01811-AOB-01812 and AOB-80959 – AOB-80960] when he expressed his significant concerns in relation to the Urology Department at that time. Clearly, he too was concerned by the lack of support from the Trust in addressing the fundamental issues which affected urology. Of course, if the issues affected the Department as a whole, they also affected each of us individually. Mr Haynes can give evidence in relation to what, if any, response he had to that email, however, I assume that it was inadequate given that on 11 October 2019 he emailed further in the following terms:

"Re: Emergency admission of patients on waiting lists

As we are all aware, waiting times for our patients are considerable. For some patients this results in them being admitted as emergencies, with in particular urosepsis, and these admissions would likely have been avoided if the patient had received timely elective surgery."

635. Mr Haynes requested that an IR1 form was completed for any reasonable delay and expressed the view that the documentation:

"…*will heighten the recognition of our patients needs and suffering due to the lack of capacity. It will also protect us to some degree, I am aware that a specialty (not urology) in an NI trust has come in for criticism because it did not flag/document delays in cancer treatments...*" [AOB-09632-AOB-09633]

636. In December 2019 Mr Haynes raised further concerns in relation to his ability to treat patients noting that:

"In January I have an available 28hrs of operating with 65 hrs of surgery needing done to manage just red flags, bladder cancer surveillance, stented patient (planned changes and definitive stone management) and patients with obstructed kidneys secondary to stones".

He also noted *"I am aware you know the waiting lists in urology place patients at risk and there is no simple fix to the underlying issue of insufficient capacity…"* [WIT-34357]

637. Similar issues were raised again by Mr Haynes in two emails in January 2020. At that time, he calculated 24 hours operating time for red flag patients which required a total of 59 hours, meaning he could only manage red flag patients meaning risks to other patients such as stent patients [WIT-34356].

638. I do not know if Mr Haynes received any support for the issues he had been raising. I had been raising similar issues to those raised by Mr Haynes for years, yet no adequate solution was put in place to support the team and thus our patients.

639. On 12 November 2019 the Trust (Dr O'Kane) emailed the GMC in relation to support to assist me in addressing the deficiencies that had been identified. The email is in the following terms:

"*The Trust has offered a meeting with Mr O'Brien on 12th December for further discussions on his job plan, which will include measures to support him in his working practices. As this meeting has not yet taken place, we have not yet had the opportunity to discuss the issues raised in his letter to clarify expectations, agree an action plan and consequence of continued non-compliance. Once an action plan hasbeen agreed, it will be monitored and non-compliance will lead to the implementation of appropriate Trust disciplinary processes."* [AOB-02269-AOB-02273]

640. I certainly did meet Mr McNaboe once to discuss job planning. That was followed by correspondence by email concerning a job plan. However, that was all upended by the Covid-19 pandemic and by Mr McNaboe [redacted]. Correspondence with Mr McNaboe is referred to in my comments on job planning.

641. Whilst there were many excellent members of staff that I worked with and alongside, given the nature of the concerns that I (and others) raised throughout my tenure, I did not feel, overall, that I was adequately supported in my role. Nor did I feel that I was suitably supported to try and address the issues raised in March 2016.

(Section 7 – Subsequent Processes)

(Q75)

642. I wish to reiterate my concern and dissatisfaction in respect of the length of time the Trust took to conduct and complete the formal investigation, using the MHPS framework, and which was in breach of the Trust's own policy, namely the Southern Trust Guidelines for handling Concerns about Doctors and Dentists' Performance (September 2010). [see TRU-83685 – TRU-83702]. Under that Trust policy the investigation regarding my practice should have been undertaken and concluded within 4 weeks from the date of exclusion on 30 December 2016. The Trust did not comply with that policy, and indeed during the course of the investigation the Trust ignored it, preferring the MHPS Framework. On raising my concerns regarding this with the Trust, I was advised by Ms Hynds, Assistant to the Case Investigator, that the MHPS framework was "overarching" [see AOB-56443]. It remains my view that the Trust was entitled to use the MHPS framework in conducting such a formal investigation, and to which the Trust's Guidelines referred, but that it was the latter that which related to my contract of employment. I found it remarkable that the Trust could so readily fail to comply with its own Guidelines while alleging that I had failed to comply with the Trust's policy concerning triage of referrals, even though it did not have one.

643. In retrospect, I have also found it concerning that the Case Investigator's

investigation appears to have been limited to interviewing witnesses and reviewing information provided by others, while it appears that she did not request or review the evidence to support, or otherwise, the claims heard from witnesses at interview. If allegations were repeated by witnesses, they appear to have been treated as fact without evidence in support of them. One example was the allegation that I had been allocated more time for administration than had my consultant colleagues. It would have been reasonable to expect an Investigator to request the evidence for review. I subsequently did request the evidence but was denied it on the grounds that the information was personal to my colleagues. It was not until receiving documentation recently disclosed by the Inquiry, some 5 years later, that I found that there was no evidence that I had been allocated more time for administration than my colleagues. [see paragraph 362 - 363] In fact, the evidence indicated that I was often allocated less time than was allocated to my colleagues.

644. Not only would it appear that evidence of corroboration may not have been requested, it appears that the Investigator did not adequately consider evidence which disproved allegations. The Investigator's Report noted that, in December 2016, *'there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated'* [see AOB-01841]. Mrs Corrigan, Head of Service, wrote by email on 07 June 2017 to Ms Hynds, Assistant to the Case Investigator, to provide an update of the findings of her review of the undictated clinics [AOB-01617 – AOB-01618] and enclosing the analysis that I had undertaken of the undictated clinics prior to my returning the patients charts in January 2017 [AOB-15145 – AOB-15146]. Mrs Corrigan confirmed that my analysis had been correct in that there were 189 patients who had not had letters dictated following their outpatient attendances, and that their clinical outcomes had not been negatively affected as a consequence. This was because all of the clinically urgent cases had been processed by me with letters dictated in the course of so doing. Yet the Case Investigator reported one year later in June 2018 that "*Mr O'Brien had a significant volume of clinic outcomes and dictation outstanding. In total, it was found that dictation had not been completed for patients who had attended 66 clinics dating*

back to November 2014, affecting 668 patients" [AOB-01852].

645. Dr Wright, then the Medical Director, communicated the decision to proceed with a formal investigation and my immediate exclusion on 30 December 2016 [see AOB-01334 – AOB-01343]. He described his concern that large numbers of charts had been tracked out to me and that they were missing from the Trust's premises. He insisted that I return the charts which I had at home to the Trust by Tuesday 3 January 2017 as he needed to see them. I have no evidence that he ever did see them. Having prevented me from dictating letters concerning patients who had not had letters dictated, during the period of exclusion, he assured me that these charts would be returned to my office for dictation in due course. [see AOB-01354 – AOB-01356]. They never were. I was also concerned with regard to the patients of clinical priority whose admission for surgery or whose review I had arranged at clinics during the first three months of 2017, all of which were cancelled due to the formal investigation and exclusion. Dr Wright reassured me that he would put arrangements in place for these patients. [see AOB-56010]. Some reviews of these patients did not take place until late 2018, they having been exposed to risk of harm as a consequence of disease progression or deterioration in the interim. There was no reference in the Investigator's report to such risks for patients as a consequence of the investigation itself.

646. Most importantly, while completely acknowledging and agreeing with the right and obligation of the Trust to address concerns it may have had concerning patient safety, I believe that all of the concerns giving rise to the formal investigation could have been handled differently, from the perspective of minimizing the risks to the totality of patients. If the concerns identified in March 2016 had been approached in a collaborative and supportive manner, none of the 4 patients, who had delayed diagnoses of prostate cancer following upgrading to red flag status in 2017 of their routine referrals of 2016, would have had delayed diagnoses. If the advice sought from NCAS (since renamed NHS Resolution) [see AOB-01049 – AOB-01050] had been shared with the Oversight Committee / Group in September 2016, in October 2016 or in December 2016, the advice may have influenced their decision making. If the intended plans of Ms. Gishkori,

approved by the Medical Director and Chief Executive [see AOB-01053 – AOB-01054], had been implemented and communicated to me, there could have been a different outcome.

647. I found that one of the most remarkable aspects of the entire process was that decisions were made without any prior consultation with me, if only to validate the accuracy of information being considered by others in arriving at their decisions. As Dr Wright advised in September 2018, he had naively assumed that management had been working with me all along since March 2016 to resolve the concerns, without success. [see AOB-56364]

648. I find it concerning that an Oversight Group could decide to subject me to a formal investigation accompanied by immediate exclusion without assessing the validity of the information provided to it, and which included a SAI the investigation of which had not yet been completed or reported, and apparently without any consideration of the risks of an investigation and exclusion to patients, as indicated above.

(Q 76)

649. As is a recurring theme in respect of the Trust and the manner in which it conducted investigations regarding issues that touched on my practice, I wish to reiterate that no input was sought from me in respect of the drafting of the SAI reports referred to above. I do not believe that that is appropriate and deal with this issue further below. Moreover, you will see from the email at PAT-000122 from Carly Connolly to me that I received by email various SAI reports on 28 October 2019. I was requested to provide comments on these reports by 30 October 2019, a period of 2 days. I emailed Carly Connolly on 30 October 2019 [PAT-000121] and indicated that I was advised in early 2017 that the management of Patient 16 would be subject to an SAI investigation. Two and a half years later, I received the draft report, not having been consulted by the SAI review team during that period in terms of providing any input to the

investigation. Having been sent the draft report, I was provided with a period of 2 days to respond, a period which was entirely inadequate to provide a detailed and considered response. While this period was subsequently extended, it is indicative of the approach the Trust took to the various SAI reports involving me, none of which were prepared in a manner which attached any importance to any input from me.

650. I do unreservedly acknowledge that a concern giving rise to its investigation obviously has a starting point, or incident, of some nature, such as a failure or delay in the triage of a referral. However, I believe that it is flawed to restrict the investigation of the care of the patient to an examination of the impact of that precipitating factor. So doing carries the risk of the investigation being focused on the care given rather than on the care received, and the risk of being clinician centered rather than being patient centered. I believe that this disparity is inappropriate, can result in distorted conclusions and can fail to provide the patient or family with a complete appraisal of care. I have provided examples of this in the following comments.

SAI [redacted] **(** [redacted] **)**

651. In respect of SAI [redacted] [PAT-000001], the SAI Terms of Reference at page 3 of the report state that the SAI is to carry out a review into the care provided to [redacted] in Craigavon Area Hospital from 24 June 2014 until 6 January 2016. However, as noted in my comments [PAT-000012 – PAT- 000020], [redacted] had a complex right renal cystic lesion since December 2012. During the next two years, its significance had not been appreciated. The Terms of Reference of the SAI report beginning from 24 June 2014 ignored the relevant medical history of this patient, and consequently the report placed a disproportionate emphasis on the lack of triage of a routine referral as the main cause of the delay in the patient having a urological appointment. That reflects that the SAI terms of reference were not patient centered, as a patient centered approach would have considered the totality of care provided to and received by the patient as opposed to the specific timeframe chosen by the SAI review team.

652. Aside from the comments already submitted by me regarding triage [PAT-001125 - PAT-001130], having now been able to review some, but not all, of [redacted]'s relevant medical records, I wish to make further comment in respect of the SAI report which considered the care provided to this patient, who was designated as Patient 15 for the purposes of the September 2022 patient hearings.

653. At PAT-001165 in the patient hearing bundle there is a letter from Mr John P O'Donoghue, Consultant Urological Surgeon, to the patient's GP dated 8 February 2016. In that letter, Mr O'Donoghue notes that the patients' PSA was 7.75ng/ml in December 2013. The letter also makes reference to the patient taking Dutasteride, which he had been taking since 2012. On that basis, as indicated in the letter by Mr O'Donoghue, his real PSA may have been double what it is expressed as in December 2013. Accordingly, his PSA could have been 15.5ng/ml. Notwithstanding this elevated PSA level, he was not referred for further investigation until 20 months later, and even then, that referral was classed by the patient's GP as routine. Importantly, there was no reference in the SAI report to that delay.

654. In completing the Inquiry Questionnaire [PAT-001155] it is stated that the patient was upset when told that he had a raised PSA count. It is stated that the longer the silence lasted after the referral in 2015, the more worried he became. This would imply that the patient had not been made aware of the elevated PSA in December 2013, two years previously. In completing the Inquiry Questionnaire, the family was clearly concerned about the effect *any* delay might have had on the treatment obtained and the outcome. That was further reflected in the evidence provided to the Inquiry by [redacted]'s son on 27 September 2022.

655. I am concerned that the SAI report is silent on this issue. The SAI report evidently concentrates on the specific issue of triage in respect of the 2015 referral. However, by focusing on that issue solely, and seemingly ignoring

another lengthier delay in referral, this does not provide the patient or their family with an accurate and full report.

656. It has long been considered as a rule of thumb that the serum PSA level found in a patient who has been taking either Finasteride or Dutasteride for some time, will have been suppressed, and by at least 50% after taking either for six months. Therefore, it would be reasonable to assert that his serum PSA at that time would have been at least 15.5ng/ml, if he did have a large benign prostate, or even higher if he did have a malignant prostate. If he did have a malignant prostate in December 2013, and his 'true' PSA level was 15.5ng/ml, then he already had an intermediate risk, prostate cancer. Why was this not investigated by the SAI review team, which included Mr Haynes, Consultant Urologist, who would have been aware of the significance of this raised PSA level?

657. It is clear from the SAI report that the SAI team was prepared to consider issues relating to GP care and the role that might play in the management of urological referrals. At PAT-001102 it is noted as a causal factor in respect of the overall triage issues that referral letters did not have their clinical priority accurately assigned by the GP. Accordingly, why does the SAI process in respect of these patients make some comment in respect of the appropriateness of GP management in the context of referrals / triage but omit to raise as an issue the failure of the patient's GP to refer in December 2013 when the patient had an elevated PSA which warranted referral. I am concerned that no comment was made in the SAI report or in any subsequent correspondence or engagement with the patient's family regarding whether or not there was a delay in referring in December 2013. I am further concerned that, in the documentation submitted by the patient's family to the Inquiry, as well as in the evidence provided to the Inquiry by the patient's son, the family remains completely unaware of this much more significant delay in the treatment of Patient 15.

658. Similarly, Patient 13, whose care is also considered in SAI Personal Information redacted by the USI, was routinely referred by his GP on 30 September 2016 for investigation of visible haematuria. The referral was not triaged. He was subsequently found in

February 2017 to have transitional cell carcinoma of his bladder which had both obstructed his left upper urinary tract resulting in loss of left renal function and had extended to his prostatic urethra to infiltrate his prostatic parenchyma. He proceeded to have a left nephron-ureterectomy, radical cystoprostatectomy and ileal conduit urinary diversion in May 2017. While his surgical management has been curative, it has had a severely negative impact upon the quality of his life.

659. The SAI report [see AOB-02418 – AOB-02442] related that the Review Team had referred to an expert for advice. The expert advised that '*Delay in definitive surgical treatment beyond twelve weeks conferred an increased risk of disease specific and all-cause mortality among subjects with stage II bladder cancer'* and included reference to two publications in support of his / her advice. Apart from the fact that Patient 13 had Stage 4a disease, both publications relate to the interval between diagnosis of muscle-invasive bladder cancer (which Patient 13 did not have) and radical cystectomy. The publications did not review the effect of delay between referral and definitive surgery on survivals.

660. Much more importantly, and as a consequence of examining his care only from the date of his referral, his previous history of urothelial atypia related to treatment with Cyclophosphamide in the 1990s was overlooked. Patient 13 had been placed on my waiting list in 1998/9 for readmission for cystoscopy and bladder mucosal biopsies under general anaesthesia, in order to re-evaluate whether atypia persisted or had worsened. He was still awaiting admission due to long waiting lists when he was reviewed by a consultant external to the Trust in January 2001, [see PAT-000445 – PAT-000447] and removed from my waiting list on the ground that he remained symptomatically relatively well at that point. If he had remained on my list and, had been found to have persistent atypia I would have kept him under endoscopic review. It is possible that his emerging bladder cancer could have been diagnosed earlier and managed without the consequences he has suffered due to his later diagnosis. His discharge in 2001 had a much greater impact upon him that a delay in his later diagnosis in February 2017.

(Q 77)

661. As indicated in the comments I provided in respect of the SAI report Personal Information redacted by the USI [PAT-001135 - PAT- 001130], I generally agreed with the recommendations stated in that SAI report. I noted, however, that I felt it was of fundamental importance, supplementing Recommendation 6 in SAI Personal Information redacted by the USI, that the Trust develop a clear, written policy of the duties and performance expected of the Urologist of the Week (UOW), before considering whether it was feasible to undertake triage while being UOW. Moreover, I felt that it was vital that the Trust develop a clear written policy regarding the conduct of triage.

662. As the Inquiry is aware, I requested that the Trust address these issues in responding to SAI Personal Information redacted by the USI in January 2017 [see PAT-000012 – PAT-000020]. In 2018, my colleagues agreed with me that these issues required to be addressed with the Trust. Two dates were arranged, in September 2018 and in December 2018, to meet with the Trust's senior management, but those meetings were cancelled. The issues had still not been addressed when my employment with the Trust terminated in July 2020. [see supplemental October bundle pages 676 – 680, AOB-81402, AOB-81796-AOB-81798 & AOB-81805]

(Q 78)

663. I was not consulted or otherwise made aware of the Trust decision to send the early alert notification to the Department in August 2020.

664. I was first notified in a letter of 25 October 2020 [see AOB-02772 – AOB-02776] from the Department of Legal Services that the Chief Medical Officer ("the CMO") had deemed it appropriate to issue a professional alert in accordance with DHSSPS Circular HSS(TC8)6/98.

665. Prior to receipt of the letter from the CMO, I provided, via my solicitors, an undertaking to the Trust dated 16 July 2020 confirming that I would not see any private patients at my home or in any other setting [see AOB-02553 – AOB-02554]. My employment with the Trust ended on 17 July 2020. I was not asked by the Trust at or around that time to let the Trust know whether I was intending to work elsewhere within the NHS. Had the Trust requested such information, I could easily have told them that I had no intention of so doing.

666. The GMC invited me to confirm that I had no intention of applying for employment elsewhere and I did so on 31 July 2020 [AOB-02614].

667. Following receipt of the CMO's letter of 25 October 2020 I instructed my solicitors to write to the Department and they did so on 10 November 2020 raising my concerns in relation to the alert having been issued in circumstances where I had no intention whatsoever of working in any capacity requiring registration and had provided undertakings to both the Trust and GMC as outlined above [see AOB-02943 – AOB-02945]. Please see the letter for full details, however, the core points raised therein were that I could not be considered a potential danger to the safety of patients when I was not practising and further there was no basis for the Trust's belief that I would seek work elsewhere. It was a concern to me, though not a surprise, that the Trust corresponded with the Department without as much as asking me whether I had any intention of working elsewhere. I had provided an undertaking during my employment, as referred to above, that I was not intending to carry on private work.

668. I received correspondence from the Department of 24 November 2020 confirming that the Department had not been in receipt of my letter notifying the GMC of 31 July 2020 that I was not intending to work [see AOB-02972]. At that time the Department withdrew the alert letter.

669. The Trust's actions in relation to this are an illustration of the manner in which I have been dealt with in a number of respects by the Trust, namely reaching conclusions without seeking to substantiate information by reference to me. Had

they taken the time to approach me, I could easily have provided the assurance I provided to the GMC. Rather it seems that the Trust was more intent in damaging my name in any way that it could, than adopting fair process and allowing the opportunity to comment.

670. In the limited time available to me, I have had the opportunity of reviewing some of the documentation disclosed by the Department of Health to the Inquiry. I note the Early Alert Letter submitted by Dr O'Kane, then Medical Director of the Southern Health & Social Care Trust, to the Chief Medical Officer [DOH-00666]. She completed the 'Brief summary of event being communicated'. She commenced that summary by relating that:

"On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist".

671. I have already established in my response to Section 1 of the Notice that the potential concerns to which Dr O'Kane referred (namely the claim that 2 out of 10 patients had not been added to the inpatient waiting lists at the appropriate time) were without foundation, and that the allegations which arose from them were untrue. This narrative was repeated by Mr Ryan Wilson, Director of Secondary Care, in his communication with Mr Swann, Minister of Health on 6 August 2020 [DOH-00686 – DOH-00688]. The claim was repeated by Mrs Melanie McClements, Director of Acute Services, and by Dr Maria O'Kane, Medical Director of the Trust, in their 'Report to Department of Health on Consultant A' submitted on 14 October 2020 [DOH-00714 – DOH-00718]. Most concerning is that it remained unchanged even though the minutes of the meeting of the Urology Assurance Group on Friday 6 November 2020 recorded that Mrs McClements and Dr O'Kane were tasked with reviewing the excerpts of the draft oral statement due to be delivered to the Northern Ireland Assembly on 17 November 2020 [see DOH-00309 – DOH-00310], and which was deferred to 24 November 2020, in which the Minister repeated the claim that 2 out of 10 patients were not on the Trust's Patient Administration System.

672. Aside from the falsehood of the alleged potential concerns, it also has been repeatedly asserted that the Trust became aware of them, or that they were raised with the Trust, on Sunday 7 June 2020. The email which it was claimed gave rise to the potential concerns was sent by me at 10.25 pm. It was copied to Mr Haynes who subsequently raised the potential concerns, but he did not do so until his emailed letter to me of 11 July 2020. When I spoke with Mr Haynes by telephone on Monday 8 June 2020, he informed me that the Trust would not facilitate my return to part time employment from the 3 August 2020 as intended. He did not raise any concerns, potential or otherwise, regarding my practice during that call. In fact, he recommended that I could work in the independent sector instead. While it is possible that he had identified the potential concerns on 7 June 2020, he certainly did not raise any with me the following day.

673. Mr Haynes advised me that he was accompanied by Mr Ronan Carroll, Assistant Director of Acute Services during the telephone call. I greeted him but he did not reply. I remain uncertain whether Mr Carroll was present. If he was present, he did not raise any potential concerns with me.

674. In writing to the Minister of Health on 6 August 2020, Mr Wilson, Director of Secondary Care, referred to me as a "*retired Consultant Urologist"* and who had "*since retired from Trust employment at the end of June"* [see DOH-00686 – DOH00688]. Reference to my having retired was repeated in documentation until it was also included in the Minister's Statement on 24 November 2020 when he informed the Northern Ireland Assembly of serious concerns about *"the clinical practice of a urology consultant, Mr Aidan O'Brien, who retired from the Southern Trust earlier this year" [AOB-02973 – AOB-02979].*

675. I wish to take this opportunity to make it absolutely clear that it was never my intention to completely retire, whether on 30 June 2020 or 17 July 2020. It was my intention, after much consideration, to retire from full time employment with the Trust on 30 June 2020, and to return to part time employment from Monday 3 August 2020. I had discussed my intentions with Mr Young, Lead Clinician, with

Mr Haynes, Assistant Medical Director, and with Mrs Corrigan, Head of Service. If I had been advised of the possibility of any impediment to my returning to part time employment, I would not have retired from full time employment, or intended to do so. If I had been informed of, or known of, the Trust having a practice of not re-engaging people with ongoing HR processes, I most certainly would not have retired from full time employment.

676. It was for that reason that I revoked my intention to retire on 9 June 2020 by writing to Mrs Vivienne Toal, Director of Human Resources [AOB-02473 – AOB-02474], and similarly informing in writing Mr Devlin, Chief Executive [AOB-02480], and Mrs Brownlee, Chair of the Trust Board, on 10 June 2020 [AOB-02478 – AOB-02479]. Having been informed by Mrs Toal on 18 June 2020 that the Trust had been advised that I was not entitled to unilaterally revoke my intention to retire [AOB-02487 – AOB-02488], I had a pre-action communication issued on 23 June 2020 [AOB-02490 – AOB-02494]. It was the Trust which requested a period of time to respond and Friday 17 July 2020 was eventually agreed.

677. Mr Haynes sent me his letter of concerns on 11 July 2020. Mr Haynes' letter containing the misleading information about 2 out of 10 patients not being added to the lists triggering a look back thus followed after I revoked my intention to retire. I read the letter on 12 July 2020.

678. I had only ever wanted to continue to look after patients already under my care, but in a part time capacity with the Trust. I was not given any impression that that may not have been possible. I did not retire.

(Q79)

679. Before considering the specifics of the Serious Adverse Incident ("SAI") reports, I wish to comment on the process adopted by the Trust in respect of the production of these reports. My concerns were previously partially set out in correspondence from Tughans to the DLS dated 15 March 2021 [AOB-03356 – AOB-03360]. To summarise, the decision by the Trust to disclose the nine 'draft' SAI reports to the patients / families without any input from me in respect of the

content of the reports was grossly unfair, inappropriate, and prejudicial to the integrity of the SAI process. My input should have formed part of the process and should have been capable of influencing the conclusions. My input should not have been sought once those conclusions had already been reached. To conduct SAI investigations in such a manner is prejudicial to me and likely to lead to inaccurate and unreliable SAI reports, which is what has occurred.

680. The Overarching Report [AOB-03232 – AOB-03255] stated that the review would follow a review methodology as per the Regional Serious Adverse Incident Framework (2016) and that it would be cognisant of the rights of all involved to privacy and confidentiality and that it would follow fair procedures. It then stated that the review would commence in October 2020 and that it would be expected to last for a period of four months approximately, provided unforeseen circumstances did not arise. Following completion of the review, it stated that an anonymised draft report would be prepared by the review team outlining the chronology, findings and recommendations, and that all who participated in the review would have an opportunity to provide input to the extracts from the report relevant to them to ensure that they were factually accurate and fair from their perspective. As I was not provided with complete clinical records until February 2021, by which time reports had been drafted, I believe that it is evident that I was not provided with any real opportunity to contribute to the reviews at all, contrary to the Review Panel's claim to intend to follow fair procedure, and in contrast to the intent to be fair to those who did have the opportunity to provide input.

681. To date, the Inquiry has had the opportunity of hearing from only one of the patients or their families identified in the nine SAI reviews. This hearing from the family of SUA took place following the provision of a Patient Bundle which included documentation which I had not been provided with previously and which gave rise to additional concerns regarding the procedural propriety of the review of SUA. I found it concerning and alarming to read the record of the meeting that took place on 9 November 2020 between both Dr Dermot Hughes and Mrs. Patricia Kingsnorth of the Review Panel and the widow and daughter of the deceased SUA. Even though the Overarching Report of 1 March 2021 recorded

that the reviews would commence in October 2020 and would not be completed until February 2021, and irrespective of the correctness or otherwise of any of its content, I found it most alarming to find the family of one recently deceased patient being advised on 9 November 2020 that wrong had been done prior to a review of the case having been conducted and a report having even been drafted. I also find the breaches of claimed confidentiality to be equally concerning.

682. I have not been afforded the time to fully review all 9 SAIs and provide my detailed comments on each one, since receipt of this Section 21 Notice. However, I have been able to do so in respect of SUA and SUF, and can provide some comments in respect of the SAI report regarding SUB. I will ensure that detailed comments are provided on all of these SAI reports in due course, once time permits me to do so.

SUA

683. In terms of Patient SUA, I have appended to this statement the following documents to assist the Inquiry:

1. Clinical History of Patient SUA [see supplemental October bundle pages 759 - 767]
2. Comments on the SAI Report [see supplemental October bundle pages 768 - 783]

684. While my position and comments in respect of the SAI report for Patient SUA are dealt with in detail in the above documents, I can summarise the position as follows:

(1) The Executive Summary [PAT-001305] states that the patient was discussed at MDM on 31 October 2019 and that a "*recommendation to commence LHRH analogue and refer for an opinion from a clinical oncologist regarding external beam radiation therapy (EBRT) was agreed*". This statement is incorrect. The MDM Outcome stated that the patient had

'*intermediate risk prostate cancer to start ADT and refer for ERBT"* [PAT-001482].

(2) The Executive Summary then states that SUA was "*commenced on Bicalutamide 50 mg daily".* This is incorrect. SUA was commenced on Bicalutamide 150 mg daily, to which he appeared to be intolerant. Bicalutamide 150mg was discontinued and the patient was later prescribed a lower dose of Bicalutamide 50mg.

(3) Bicalutamide 150 mg daily was prescribed as it has non-inferior oncological efficacy to castration as neo-adjuvant and adjuvant, androgen deprivation therapy combined with radical radiotherapy in the management of high risk, locally advanced, prostatic carcinoma. Bicalutamide was chosen because of its lesser adverse toxicity profile, and particularly in view of the patient's history of ischaemic heart disease and comorbid risk factors for further cardiovascular events.

(4) It is stated in the seventh paragraph on page 4 that a *"planned review appointment for 27 April 2020 had been made"* [PAT-001307] but thereafter omitted to inform the reader why it had not taken place. It was cancelled by the Trust due to the Covid-19 pandemic lockdown.

(5) It is stated [PAT-001309] that the *"initial treatment should have been reversible ADT – most commonly a LHRH analogue – pending the results of the staging scans".* The initial treatment was a reversible ADT in the form of Bicalutamide 150 mg daily. Fortunately, the choice of Bicalutamide enabled its early discontinuation when it appeared that the patient had suffered intolerable, adverse effects of Bicalutamide or of Tamoxifen which had also been prescribed. If similar adverse toxicity had been experienced following the administration of a LHRH agonist, reversibility and relief from adverse effects would have been much more prolonged.

(6) It is stated [PAT-001309] that *"the prescribed hormone therapy did not conform to the Northern Ireland Cancer Network (NICAN) Urology Cancer Clinical Guidelines (2016), which was signed off by the Southern Health and Social Care Trust (SHSCT) urology multidisciplinary meeting, as their protocols for cancer care for Cancer Peer Review (2017)".* The initial treatment of Bicalutamide 150mg with Tamoxifen 10mg daily did conform to the Guidelines.

(7) It is then stated [PAT-001309] that the prescribed hormone therapy *"did not conform with the NICAN "Hormone Therapy Guidelines for Prostate Cancer 2016" which was signed off by Dr 1 as Chair of the Regional Urology Cancer Clinical Reference Group".* This statement is incorrect. There is no reference to, or preference for, any specific form of hormonal therapy in the Guidelines.

(8) It is then stated [PAT-001309] that the "*subsequent management with unlicensed anti-androgenic treatment (Bicalutamide) at best delayed definitive treatment".* This statement is incorrect as Bicalutamide 150 mg daily is licensed for the management of locally advanced prostate cancer at high risk of disease progression, either alone or as adjuvant treatment to prostatectomy or radiotherapy, and in locally advanced, non-metastatic prostate cancer when surgical castration or other medical intervention is inappropriate.

(9) The report correctly notes that the MDMs where SUA were discussed were not quorate. Despite approaches over a number of years, the Trust failed to provide an adequate oncological service sufficient to ensure that Urology MDMs have been quorate. This has been dealt with in my response to Questions 40-44.

(10) It is then stated [PAT-00130] that the specific MDM recommendations of 31 October 2019 "*to prescribe a LHRH analogue and to refer to clinical oncology for external beam radiotherapy were not actioned".* This is incorrect and misleading. The MDM did not recommend a LHRH analogue, but rather ADT. With regard to referral to clinical oncology, the patient experienced significant adverse effects after being prescribed Bicalutamide 150 mg daily and Tamoxifen 10 mg daily. Having been advised to discontinue taking both for two weeks, he resumed taking Bicalutamide 50 mg daily upon my advice. Even though he still had not fully recovered from the adverse effects, he was persuaded with reluctance to remain on Bicalutamide 50 mg daily until his review in January 2020 following his return from holiday. Indeed, it would have been his preference not to have hormonal treatment recommenced until after his return from holiday in Italy in December 2019. This important context could have been provided to the Review Team and could have informed the SAI report had my input been sought prior to the completion of the report.

(11) The patient did not have a Cancer Nurse Specialist ("CNS") assigned to him. This was primarily due to a failure of the MDT Core Nurse Member to ensure that SUA had an identified Key Worker, in accordance with the Urology Cancer MDT Operational Policy 2017. CNSs were certainly aware of the patient's diagnosis and proposed treatment as they attended MDMs where the patient was discussed.

(12) It is stated [PAT-001310] that I excluded all CNSs from the care of my patients at clinic. That is untrue, and offensive. I have never excluded any CNSs from the care of my patients at clinics. I have requested the involvement of CNSs in the care of my patients on many occasions, and it was generously provided and I have been grateful for their involvement.

(13) It is then stated [PAT-001310] that the patient was *"denied the opportunity of multidisciplinary professional referral and care, initially from a*

clinical oncologist when radical radiotherapy should have been considered". Again, as detailed in the clinical history and above, this statement is incorrect. Radical radiotherapy was considered at MDM on 31 October 2019, and again at review of the patient on 11 November 2019. However, at that time, the patient was just beginning to tolerate ADT and did not wish to consider any further hormonal treatment until his further review in January 2020. Thereafter, his disease progressed while he proceeded to tolerate optimal, safe androgen deprivation with neo-adjuvant and adjuvant intent.

(14) The allegation that he "*developed metastases while being inadequately treated for high risk prostate cancer"* [PAT-001310] risks the inference that he developed metastases *because* he was inadequately treated. It was as a consequence of the experience of adverse toxicity to his initial treatment that his subsequent treatment may have been considered by the Review Team to have been 'inadequate' for a period of time. However, that 'inadequate' treatment resulted in an impressive biochemical disease response initially. Biochemical evidence of rapid disease progression emerged while his treatment returned to 'adequacy' and persisted after it had done so. The "*opportunity to offer him radical treatment with curative intent was lost*" due to his experience of adverse effects of the adequate hormonal treatment initially prescribed in September 2019. Thereafter, I do not believe that radical treatment with curative intent would have been curative, even if available despite Covid-19.

685. It is clear that the SAI report contains numerous serious errors in respect of my management of SUA. I can only reiterate the prejudice that has been caused to me, as well as to the family of SUA, by the failure to allow me a reasonable opportunity to provide comment to inform the SAI report in respect of the treatment I provided to SUA. This represents a recurrent theme of a Trust which has followed processes which are manifestly unfair and unreasonable, and thus produced a report which is replete with errors both clinical and factual.

686. It should also be noted that, notwithstanding the comments I have provided in

respect of SUA, I am concerned by the contents of the Acute Governance Meeting with SUA's family on 9 November 2020 [PAT-001318]. This meeting was prior to the SAI report being prepared. It was prior to the Trust receiving any input whatsoever from me in respect of SUA. It is clear from the content of the notes of the meeting that a pre-determined view had been taken, which is not appropriate in the context of a review into a patient which had not at that point been completed.

SUB

687. I would make the following comments in respect of the SAI report regarding SUB:

(1) At page 3 of the SAI report it is stated that in my letter to the patient's GP following review on 2 July 2019 I deferred a prostatic biopsy until a planned review in September 2019. While I had indicated September 2019 in my clinical note, the letter in fact indicated that I hoped to review SUB in August 2019.

(2) In respect of this planned review, the report states that the "*appointment in September was not made and he was lost to follow up"*. The Executive Summary section of the report simply states that a "*routine review for September 2019 did not happen*". The report provides no analysis of why that occurred, which is surprising given how vitally important it is to the care that was provided to SUB. SUB should have been reviewed in August 2019, as I had hoped to do. If the Trust had ensured the provision of an adequate outpatient review service, SUB would have been reviewed, and he would have been found to have been as well as he subsequently claimed to be. He would have had prostatic biopsies, following by MDM discussion. If the Trust had ensured the provision of an adequate urology outpatient service, he would have been reviewed in August 2019, and would have proceeded to have prostate cancer safely diagnosed and appropriately managed. That is the single most significant issue in respect of the care provided to SUB and it is surprising that there is no reference to why that review appointment

did not take place in the SAI report. I further find the term "*lost to follow up*" to be at best misleading and at worse disingenuous. SUB was not lost to follow up. He was not followed up within a reasonable or adequate timeframe because the Trust failed to provide an outpatient service that was fit for purpose. The service provided by the Trust exposed patients to considerable risks and caused harm to innumerable patients over the course of many years, and SUB is but one of that cohort of individuals so affected.

(3) When SUB was reviewed by oncology at the Cancer Centre in Belfast City Hospital on 5 November 2020, he was prescribed Bicalutamide 50mg daily, contrary to the assertion by the Review Team that Bicalutamide 50mg daily is only indicated for the prevention of tumour flare associated with the first injection of a LHRH agonist.

(4) The Report found that there '*was no record in the medical notes of a digital rectal examination (DRE)*'. This is incorrect as '*DRE: T3 ?T4 CaP'* is recorded in my handwritten note of the consultation on 24 May 2019.

SUF

688. I have appended my detailed comments in respect of SUF's clinical history and the SAI report in respect of Patient SUF to this statement [see supplemental October bundle pages 784 - 799]. However, I wish to reiterate the following points:

(1) The Executive Summary makes two statements. The first asserts that SUF was commenced on a low (sub-therapeutic) dose of Bicalutamide for prostate cancer. This is incorrect as he was commenced on Bicalutamide 50 mg daily to relieve his concern regarding the risk of progression of any presumed prostate cancer while awaiting confirmation of its presence by biopsy. The second asserts that there was no documentary evidence of any discussion of the radical treatment options for prostate cancer recommended by the Multidisciplinary Meeting (8 August 2020 [sic]). This

too is incorrect as there was no Multidisciplinary Meeting on 8 August 2019 (or 2020).

(2) The 'MDM' on 8 August 2019 was in fact an online review by Mr Mark Haynes as it had not been possible to hold a MDM due to the lack of availability of other consultants. There was no discussion of SUF or agreement concerning his diagnosis. There was nothing multi-disciplinary about this MDM, which, as discussed in my response to Questions 40-44, was a recurring issue.

(3) The report finds at page 5 that the diagnostic pathway was rather prolonged. In fact, the diagnostic pathway was quite compressed in this case as the waiting time for a first outpatient appointment following referral of a patient with a suspect prostate cancer had already exceeded two months during 2019. If the referral had been triaged by a consultant urologist who had just requested that a red flag appointment be made for him at a New Patient Clinic, it could have been July 2019 before he would have attended as an outpatient for the first time. The diagnostic pathway was shortened by my requesting ultrasound scanning at triage, by the scan having been appointed and performed one day later, and by my requesting an outpatient appointment be arranged following the date of the scan. Taking the time to initiate assessment of his urinary tract by ultrasound scanning and requesting an outpatient appointment following the date of the scan, resulted in the patient having a staged diagnosis of presumed prostatic carcinoma established by the time he would have had a first outpatient consultation otherwise.

(4) The report finds that SUF was not referred to a Urology Cancer Nurse Specialist (CNS) to support and discuss treatment options, and that their phone number was not made available to him. The report does not specify by whom it was expected that the patient should have been referred to a CNS and why their phone number was not made available to him.

(5) The report finds that I provided uni-professional care despite multi-disciplinary input, and that this left the patient unsupported especially as their disease progressed. This is incorrect. There was no multi-disciplinary input as there had not been a multidisciplinary discussion of his diagnosis at a properly or adequately constituted MDM, as a CNS had failed to provide an input and as there was no evidence of disease progression while under my care.

(6) The report finds that there was no oncology referral. This is correct as I considered it inappropriate to refer SUF for radical radiotherapy until he had undergone assessment and management of his severe lower urinary tract symptoms, in compliance with NICE Guidelines [NG131 Paragraph 1.3.4].

(7) The report finds that the use of Bicalutamide was known to the MDM, was challenged, was not minuted, was not escalated and was known externally within Oncology. It is true that the use of Bicalutamide was known to the MDT and was certainly recorded in all cases at MDM when prescribed by me, such as would have been the case with SUF if he had been discussed at a MDM. I certainly have no recollection of it ever having been challenged, and I don't believe there is any record of it ever being challenged. In respect of this specific patient, Bicalutamide 50mg had already been prescribed in July 2019 prior to the 'MDM' in August 2019 (which was in fact simply an online review by Mr Haynes). The fact that Bicalutamide 50mg had been prescribed was noted on the MDM record under the section 'MDM Update'. No issue was raised by Mr Haynes in respect of the prescription of that medication.

(8) The report concludes that "*at that point, acceptable practice should have been to discuss the options available as recommended by the MDT".* Even though the options were not recommended by the MDT following discussion at a MDM, I would have discussed both options recommended by Mr Haynes, though advising SUF that all of the features of his confirmed

prostate cancer indicated that he would be best served by proceeding with management with curative intent. I would not have recommended active surveillance and did not recommend it. I recommended androgen deprivation prior to radical radiotherapy, as indicated in my letter to the patient's GP dated 27 October 2019.

(9) A letter from Mr Haynes to the Patient's GP dated 2 October 2020 refers to the patient indicating he did not recall any conversation about external beam radiotherapy as a radical treatment or discussion of surveillance as an option. I entirely refute that as both options were discussed with the patient by me.

(10) I initially prescribed Bicalutamide 50mg in July 2019 as the patient expressed some anxiety in respect of disease progression while awaiting prostatic biopsy. I then increased that to 150mg following review of the patient in December 2019. In view of the pronounced and bothersome urinary symptoms, especially the need for him to get out of bed 7 times each night, this therapeutic intervention and delay in referral to Oncology with a view to radiotherapy was perfectly justified and appropriate and in accordance with NICE guidelines.

(11) The patient was subsequently followed-up with regular PSA determinations and the possibility of radiation treatment was discussed with him by other clinicians, but he declined treatment on several occasions and so far as I can tell active surveillance has continued to date without adverse consequences. There is no conclusive evidence to suggest that active surveillance followed by delayed radiotherapy preceded by hormonal treatment with a LHRH analogue provides inferior outcomes to earlier radiation therapy. In many cases such as this, radiotherapy, preceded by LHRH analogue therapy, with all its attendant side-effects, especially in patients with pre-existing lower urinary tract symptoms, can be avoided and

this may be the case of SUF who might possibly be destined to die eventually *with* rather than *of* prostate cancer.

689. Again, it would have been preferable for the SAI review team to have sought my comments in respect of SUF prior to drafting their report. Had they done so, a more accurate and complete report could have been produced.

(Q 80)

690. I am aware that a Lookback Review has been undertaken since the end of my employment with the Trust. I have never been asked to contribute to that Review. Had I been asked, I would have been happy to provide my input into that process.

691. In respect of the SCRR process, my legal representatives received a letter (which was undated but was sent by the Directorate of Legal Services and received on 19 May 2022) [see supplemental October bundle page 748] which advised that, as a result of the Lookback Review, a further 53 patients whose care was felt to meet the threshold for Serious Adverse Incident Reviews were identified. That letter advised that these 53 patients would not be reviewed by way of the Serious Adverse Incident process but rather by using a Structured Clinical Record Review ("SCRR") process. The letter noted that at the conclusion of that process a "*summary themed report detailing the outcomes would be produced*." No such report has been shared with me as of 21 October 2022.

692. On considering this correspondence with my legal representatives, a letter of response was sent by Tughans to the DLS dated 13 June 2022 [see supplemental October bundle pages 749 - 750]. While I will not rehearse the entirety of the letter, I will reiterate the salient points insofar as this question is concerned:

(1) The letter reminded the DLS that, other than being advised that a Lookback Review was taking place, I had not been provided with any substantive information in relation to that Review nor had I been invited to contribute in any way to it.

(2) My concern in respect of the manner in which the SAI reviews took place was reiterated.

(3) This letter asked, on my behalf, whether I would be afforded the opportunity to contribute to the SCRR process. If I was not to be provided with any such opportunity, I sought an explanation why not.

(4) To date, no opportunity has been provided to me to contribute to any of the SCRRs and I have not been provided with any explanation why no input has been sought from me.

693. As explained above in the letter sent from Tughans to the DLS dated 15 March 2021 [see AOB-03356 – AOB-03360] in respect of the SAI process, similar issues arise in respect of the SCRR process. It is a matter of elementary professionalism and fairness that I should be permitted the opportunity to provide input in respect of the patients whose care was, is, or will be subject to an SCRR. This must be especially so where the Trust that instigated the process appears determined to (a) write to patients and/or families about treatment that I have provided but without giving me any opportunity to explain or comment; and (b) disclose SCRR reports to a public inquiry without fact checking the accuracy of the same with the clinician involved in their care.

694. My input should have been sought and should have been taken into consideration before any conclusions are made as part of the SCRR process. Again, similar to the SAI process, for the Trust to devise its procedures in this way is grossly unfair and is likely to produce outcomes as part of the SCRR process which are unreliable and inaccurate. Proceeding in this way has the

potential to result in patients and families being misinformed and a public inquiry being waylaid.

695. To highlight this point, I wish to provide comments in respect of one of only two SCRRs which I have seen as at the date of providing this response. I have been able to view it and cross-reference to some, but not all, of the clinical records and related documentation. This relates to Patient 35, whose son Patient 35's Son gave evidence to the Inquiry on 27 September 2022. The documentation related to this SCRR, and other documentation such as some patient medical records, is contained within the Patient Bundle for this witness.

696. My concerns regarding the SCRR process and its detail as far as this patient is concerned can be summarised as follows:

(1) In his letter of 31 December 2021 to Patient's Wife, Mr Shane Devlin, then Chief Executive of the Trust, advised her that he had commissioned urologists external and independent of the Trust, and that one such consultant had reported that Patient 35's treatment in 2009 was potentially not appropriate, and for which reason a SCRR would be conducted. The Patient Bundle provided by the Inquiry [PAT-00800 – PAT-00972] did not include the report to which Mr. Devlin referred.

(2) The report would appear not to have been provided by Professor Sethia as he reported no concerns regarding the management of the patient in his undated Urology Patient Review Form [PAT-000801 to PAT-000803]. Nevertheless, in completing the SCRR, its author reported that the case had been '*highlighted by Prof'.* It remains unclear whether the case was highlighted by another Professor, or whether Professor Sethia had provided another report highlighting the case, as the report highlighting the case was not included in the Patient Bundle.

(3) Mr. Devlin apologised to [redacted] in his letter of 31 December 2021 for expectations not being met, which was in fact prior to any SCRR being conducted to determine whether expectations had been met or otherwise.

(4) The Record of Screening [PAT-000800] records the date of the / an incident as 23 November 2021. The Patient Bundle did not include any information regarding the nature of the incident which occurred on 23 November 2021.

(5) The SCRR was not conducted for another 4 months *after* Mr Devlin's letter. When Mr Thomas, Consultant Urologist, undertook the SCRR on 22 April 2022 it took only 90 minutes to complete the SCRR [PAT-000819]. It contains factual errors.

(6) In Section 2.1 [PAT-000806], Mr Thomas wrote that the initial triage was correct following GP referral with an abnormal PSA of 3.47ng/ml and a small volume prostate. The patient was not and never was referred by his GP to Urology for any reason. He was referred by Mr Brown, Consultant Surgeon at Daisy Hill Hospital for assessment and management of left loin pain and a left renal lesion [page 68 PAT-000863].

(7) On receipt of the referral, I additionally noted that [redacted] had had two serum PSA levels of 3.47ng/ml and 4.26ng/ml (a mean of 3.865ng/ml) in 2008.

(8) Mr Thomas then reported that the patient's repeat PSA was 4.22ng/ml leading to prostatic biopsies at time of partial nephrectomy in November 2009. In fact, his repeat PSA level was 3.99ng/ml in January 2009, then 2.92ng/ml in March 2009, then 4.22ng/ml in April 2009 and 3.57ng/ml in October 2009 (a mean of 3.675ng/ml during 2009). The mean PSA level in 2009 was lower than in 2008. Mr Thomas' selective use of available data, whether intentional or otherwise, is of concern.

(9) The serum PSA level which Mr Thomas described as 'marginally' elevated is the PSA level of 4.22ng/ml. He may have considered that this level was

marginally elevated above the normal, age-related PSA range for the patient at that time. However, Mr Thomas may have failed to note that the patient had been found to have a prostatic volume of 30ml calculated on ultrasound scanning on 30 January 2009. The generally accepted upper limit of the PSA range associated with a prostatic volume of 30ml is, and was, 4.5ng/ml. Therefore, none of the patient's PSA levels prior to biopsy were elevated. In combination with the clinical impression of a benign prostate on rectal examination, there was in fact no indication for earlier prostatic biopsies.

(10) Even though Mr Thomas stated his view that there were no triage issues [PAT-00806], he nevertheless concluded this Triage Section as the patient having 'poor care' [Page 12 PAT-000807]. It is unclear why Mr. Thomas came to that conclusion at PAT-00807, as I would have considered that the issue of his elevated, age-related, serum PSA level of 4.26ng/ml in June 2008 was additionally noted on receipt of a referral for an unrelated urological issue.

(11) Mr Thomas wrote [PAT-00807] that I was chair of the MDT at a time which appears to be the MDM on 11 November 2010. That is incorrect. Mr Akhtar was the Lead Clinician of the Urology MDT, and Chair of MDMs from April 2010 until March 2012. I became Lead Clinician of MDT and Chair of MDM in April 2012. There is no such position as "*Chair of the MDT*."

(12) Mr Thomas concluded [PAT-00807] that there was "*no subsequent discussion of treatment options which would have included radical prostatectomy and radical radiotherapy*." That is incorrect. Following discussion of the oncological merits and the risks of adverse effects of radical prostatectomy, radical radiotherapy with or without androgen deprivation and active surveillance, the patient preferred and agreed to embark upon a period of active surveillance, particularly as he did not want to risk further exacerbation of his lower urinary tract symptomatic status or his compromised erectile function which he wished to maintain, and all in the context of a quality of life already significantly compromised by chronic left flank pain. I continued to have these discussions with the patient repeatedly

during subsequent years. Had I been afforded the opportunity to provide any input to this SCRR, I would have been happy to expand on the nature of the discussions that took place with Patient 35. These conversations took place between the patient and myself. It is concerning that no input was sought from me in respect of what was discussed. I have a very clear recollection of Patient 35. Rather than seeking input from me in terms of what was discussed between this patient and myself, Mr Thomas has simply concluded, based on the medical records, that no discussions in respect of any treatment options of any kind ever took place. That is not only unfair to both myself and Patient 35's family, it is also untrue.

(13) NICE Guidelines on Prostate Cancer [NG131] have defined active surveillance as "*part of a curative strategy and is aimed at people with localized prostate cancer for whom radical treatments are suitable, keeping them within a window of curability whereby only those whose tumours are showing signs of progressing, or those with a preference for intervention, are considered for radical treatment. Active surveillance may thus avoid or delay the need for radiotherapy or surgery".*

(14) Mr Thomas asserts that "*there was no subsequent discussion of treatment options which would have included radical prostatectomy and radical radiotherapy"* and that "*active surveillance would not have been recommended standard treatment for a fit 57 year old man"*. However, the patient's diagnosed and staged prostate cancer belonged to Cambridge Prognostic Group (CPG) 2. Review of the NICE Guidelines on Prostate Cancer [NG131] is explicit that the management options for men with CPG 2 prostate cancer are active surveillance, radical prostatectomy and radical radiotherapy. It is unclear why Mr Thomas concluded that active surveillance was not an option for this patient, and that finding is at odds with the current NICE Guidelines.

(15) Mr Thomas wrote that active surveillance was incorrect advice and that it was a serious failing not to provide active prostate cancer treatment options

with curative content. I would contend that his assertion is concerning as it implies that Patient 35 would have had radical prostatectomy or radical radiotherapy, with or without androgen deprivation, irrespective of the oncological merits or of the risks of harm.

(16) Even if Mr Thomas retained his disapproval of Patient 35's initial management by active surveillance, it is concerning that he failed to, or chose not to, acknowledge its vindication by the decreasing mean serum PSA levels of 3.59ng/ml in 2010 and of 3.05ng/ml in 2011.

(17) Following an increase in the patient's mean serum PSA level to 4.03ng/ml in 2012, he underwent reassessment by having prostatic biopsies completed in December 2012, staging and urodynamic studies in February 2013 when he was again found to have organ-confined, intermediate risk, CPG2 carcinoma in addition to detrusor overactivity. His dominant concerns then were the options of management of his prostate cancer with curative intent, his erectile dysfunction and to a lesser extent, his lower urinary tract symptomatic status. It was his preference to pursue the mode of management with curative intent that posed least risk to his erectile function in particular. It was for that reason that he agreed that he would be managed with neo-adjuvant androgen blockade prior to radical radiotherapy, but firstly he was prescribed Tadalafil for his erectile dysfunction for a period of three weeks prior to initiation of androgen blockade in March 2013. It is again concerning that Mr. Thomas took no account of his holistic assessment and management in the SCRR report.

(18) I also do believe that it was entirely rational to initiate androgen blockade in March 2013 by prescribing Bicalutamide 50 mg daily concurrent with management of his erectile dysfunction, and all the more so as his serum PSA level had decreased spontaneously to 3.17ng/ml prior to initiation of androgen blockade.

(19) I have found it concerning that Mr. Thomas failed to take account of the above considerations in Patient 35 's management, and the failure to include in his report that the reasons for his deferred referral for radical radiotherapy in 2014 was the subsequent deterioration in his urinary symptoms and in bladder voiding, requiring prostatic resection, as recommended by NICE Guidelines [NG131].

(20) Mr Thomas completed that Section [PAT-00809] by asserting that the patient was referred for radical radiotherapy in 2014 but could have had it in 2009, even though Patient 35 did not have a staged diagnosis until 2010, and apparently without any consideration of patient choice, oncological benefit or indeed of any risks of negative consequences.

(21) In Section 2.3, entitled 'Review of Diagnostics' [PAT-000809], Mr Thomas wrote that that there was no treatment outcome from MDM in 2009 at time of initial diagnosis. As explained above, we did not have MDMs in 2009.

(22) In Section 2.4 entitled 'Ongoing Outpatient Care' [PAT-000810], in addition to repeating that which he had previously repeated, Mr Thomas made reference to the MDM Outcome in 2019 being unsatisfactory. I presume that he intended to refer to 2009. Of course, as stated above, there was no MDM in 2009.

(23) I also find it a matter of grave concern that Mr. Thomas saw fit to write that in his report that I was the Chair of the Oncology MDM at the time and was making incorrect prostate cancer recommendations without challenge. In addition to my not being Chair of MDM in 2009 as there was no MDM in 2009, the MDM in December 2012 was chaired by Mr. Young when [redacted] Patient 35 's further management was discussed with the histopathological findings of repeated prostatic biopsies. I was not present. Moreover, when his further management was discussed at MDM in May 2014 following prostatic resection, that MDM was chaired by Mr. Glackin. There has been

no explanation provided of his assertion that I was making incorrect prostate cancer recommendations without challenge as Chair of MDM.

(24) At PAT-00817 Mr Thomas states "*No offer of radical treatment for a fit 59yo patient with localized T2 Gleason 7 prostate cancer*." That is not correct and had I been afforded the opportunity to provide input to this SCRR I would have been able to provide a full account of the discussions that took place in respect of treatment options.

(25) He also wrote that Patient 35 's *"localised prostate cancer treatment was not in accordance with standard treatment".* He did not relate which standard to which he referred.

(26) Mr. Thomas wrote that the use of Bicalutamide monotherapy was inappropriate, without providing an explanation for his assertion.

(27) He also reported that the patient was placed on "*active surveillance which would only be appropriate in the presence of extensive comorbidities limiting life expectancy".* I find this element of his report to be the most concerning as it is an entire contradiction of the purpose and applicability of active surveillance which is a component of a management strategy of patients with curative intent, based upon the assumption that they are curable and they will derive a survival benefit from that management, and which is not the case in patients with limited life expectancy.

(28) I recall Patient 35 very well as I observed him, listened to him and talked to him many times over a period of ten years. I have no doubt that the quality of his life had been seriously marred by the chronic left loin pain which he had suffered for years, and that the pain was exacerbated by pain associated with the incisional wound in his left flank. His lower urinary tract symptoms were variously described, but were not a significant issue initially, nor indeed was his mildly compromised erectile function. However, the risks of both being worsened by the management of his newly diagnosed prostate cancer

were significant issues for him indeed, as he was keen to avoid further compromise of his quality of life if it could be safely avoided. It was for that reason that active surveillance was initially agreed, and which appeared to have served him well with decreasing serum PSA levels until 2012. It was then for that reason that radical radiotherapy was chosen to be the mode of deferred treatment with curative intent. Bicalutamide was chosen as the form of androgen deprivation, and I believe that it was rational and reasonable to initially prescribe Bicalutamide 50 mg daily. The patient had Bicalutamide 50 mg daily prescribed initially with neo-adjuvant intent for the overriding reason that Patient 35 wanted to avail of any reasonable means of maintaining his erectile function which was important to him, while accepting that the time had come to proceed with a mode of management with curative intent which would hopefully not result in impotence.

(29) On foot of the SCRR, Dr O'Kane, Chief Executive, in her subsequent letter of 27 July 2022, advised Patient 35's Wife that her husband did not receive the correct treatment in 2009 [see PAT-000829 – PAT-000830] (without specifying which aspect of his treatment in 2009 was inappropriate), that he should have been discussed at MDM (which did not exist) that he should have been offered curative treatment (which he was), but that this did not happen (which it did); that he was placed on active surveillance which is "*treatment that would only have been appropriate if your husband had extensive past medical history impacting on his life expectancy*" (which is incorrect); that he did not receive treatment in accordance with '*standard*' practice (which standard?); that cancer guidelines were not followed (which?); and that he had been denied potentially curative treatment (which, by definition, he was not). She then apologised for a service well below the required standard.

697. On the basis of the above, I have fundamental concerns in respect of how the SCRR process is being and has been carried out. This is the only SCRR where I have had an opportunity to review some (but not all) of the medical

records and provide my considered input in respect of the conclusions reached by the SCRR. It is clear that the SCRR in respect of this patient is marred by inaccuracy. As stated above, I would have been happy to have provided my input to the SCRR but was not invited to do so. Notwithstanding my request for an explanation why I was not asked to provide any input, none has been provided by the Trust. The failure to permit me to provide any such input has resulted in an SCRR which is fundamentally flawed. I have serious concerns about this process whereby the SCRR review is undertaken, and the outcome advised to the family, without any input from me. That is not only grossly unfair to me, but also unfair to the patient and their family to be provided with such conclusions which have not been arrived at in a fair or reasonable manner. I would submit that the Inquiry should be reluctant to place much, if any, weight on the findings of a process which has been conducted in so prejudicial a manner as to produce report outcomes which simply cannot be relied on.

698. I reserve my position in respect of the other SCRRs, but I believe that the above provides sufficient indication at this stage of my concerns in respect of this process and I would be happy to expand further on the issues raised in this, and in any other, SCRR in due course.

(Section 8 – The Trust Board)

(Q81 – 82)

699. During my tenure as a consultant urologist, the only Board members I ever met or communicated directly with were Mrs Roberta Brownlee and Mr John Wilkinson. I never had any interactions with Roberta Brownlee relating to or touching upon any of the concerns raised about my practice. John Wilkinson was appointed Non-Executive Director ("NED") at the time of the MHPS investigation and all communication with John Wilkinson, which took place in meetings, was recorded ([AOB-56073 - AOB-56104] for meeting on 7 February 2017 and [AOB-56173 to AOB-56202] for meeting on 22 March 2017).

700. I never sought the involvement or help of any Board member in relation to the concerns raised about my practice.

(Section 9 – Learning)

(Q 83)

701. When I was eight years old, I accompanied my parents on a Sunday afternoon to visit my mother's uncle in hospital prior to his undergoing surgery the following day. I did not know what a hospital was prior to the visit. By the time I left, I had decided that this is what I would like to do with the rest of my life – looking after sick people, and in a hospital. Having studied medicine, having decided on a surgical career, having discovered urology, I trained in Dublin and Bristol to become a urologist.

702. I have endeavoured in this statement to describe the inadequacy of the Urology Service commissioned and provided by the Trust since my appointment as a consultant urologist in 1992. I have provided evidence in support of that inadequacy which continued to outstrip the best efforts of those employed to provide the service. The disparity between demand and capacity progressed until the Trust's waiting list for elective admission for inpatient and day case urological management was the longest waiting list in Northern Ireland by June 2020, and I believe the longest urological waiting list in the United Kingdom.

703. I made every effort that I possibly could to mitigate the risks of thousands of patients coming to harm due to the inadequacy of the service during the 28 years of my employment by the Trust. I ensured the provision of a continuous, acute service from 1992 to 1996. I availed of every opportunity during the subsequent years to operate on and review as many of the patients who most needed surgery and review as I could. I worked 70 – 90 hours each week to do so.

704. On reflecting upon what went wrong within my practice that enabled concerns to arise, I believe that the honest answer is that my practice could never have been wholly right in the first instance, working in the above circumstances, and which have been described in detail in this statement. The choice which I arguably did have was to resist the temptation to work beyond what was contractually expected of me, and ignore the consequences for patients by being able to compartmentalise the risks to patients arising from my practice and the risks to patients due to the inadequacy of the service. I have never been convinced that these risks are entirely separable for the clinician. In any case, it was not in my nature to do so, and I do not regret making the efforts that I did.

705. On the other hand, I do very much regret taking on the roles of Lead Clinician of the Trust's Urology MDT and Chair of its MDM in April 2012, and the role of Lead Clinician and Chair of NICaN's Clinical Reference Group for Urology in January 2013. I believe that I did make a contribution to the further development of urological cancer services in Northern Ireland in those roles, particularly in preparation for National Peer Review in 2015. However, the time required to fulfil these roles consumed considerable time that would otherwise have been spent in administration related to direct clinical care.

706. It is devastating both personally and professionally to have been, and continue to be, the focus of various investigations, including this Inquiry. Whilst I understand the Inquiry will have to investigate when and why concerns were raised, I do hope that it will also take into account the positive aspects of my practice, as hopefully that is also part of governance. Testimonials, thank you cards and a web-site support group all attest to the positive work performed during my career [see AOB-5001 – AOB-50018 & AOB-20001 – AOB-20365 & supplemental October bundle pages 751 - 758)

707. As the Inquiry will be aware concerns were raised with me in relation to my practice by Mr Mackle in March 2016 and subsequently the formal investigation, primarily in relation to my administration. I responded in full to those allegations within the context of that process. In summary, whilst I accepted shortcomings in

a number of administrative areas of my practise, I provided a full explanation in relation to why that had occurred. Essentially, it was due to working in an institution that provided grossly inadequate support to the Urology Service. It is unfair that the disciplinary process was not brought to a final conclusion during my tenure, hanging over me for a period in excess of 3 years and depriving me of arguing my case before a disciplinary panel and testing the Trusts allegations and evidence.

708. I intended to retire from full time employment in June 2020, having reached the age of 67, with the intention of returning to work for the Trust on a part time basis. I was not allowed to do so and that led to a legal dispute. Concurrent with that dispute for the first time significant concerns were raised in relation to my clinical practice, eventually leading to this Inquiry. I have addressed my concerns about the information underlying the Minister's announcement of the Inquiry above (please see the general narrative section at Questions 1-2). Prior to then I had been unaware of any significant concerns in relation to my practice.

709. I have set out my concerns in relation to the fairness of the SAI processes which occurred in late 2020/early 2021 in my Solicitors letter of [see AOB-03356 – AOB-03360). I have commented on a number of the SAI cases in detail herein (Question 79 "Serious Adverse Incidents (x9) – 2020). I have had relatively little information in relation to the SCRR processes which have been conducted entirely without my input. From what little I have seen in respect of the SCRR process, I have serious concerns about how that process has been conducted and the conclusions reached (see my comments on Question 80 "Recent Lookback Review"). Without having detailed information, including contemporaneous patient records, it is difficult to reflect on the extent to which I agree or disagree with the conclusions such processes may reach. Indeed, at this stage I have yet to see the conclusions, never mind the underlying information in relation to the vast majority of the SCRRs.

710. Therefore, in short whilst concerns have been raised they have never been fully or fairly investigated at a Trust level. Clinical concerns are being investigated by the GMC and I continue to liaise with them in relation to same.

(Q 84)

711. There was an abject failure by the Trust, throughout my tenure, to engage in a constructive manner and provide adequate support, management and resources to deal with the inadequate service clinicians could provide to patients. The statistics speak for themselves. The failure to engage left me stretched throughout my tenure, having to prioritise, as best I could, to deliver a service to patients. However, that inevitably led to issues occurring in my practice, as referred to in my response to Question 66. I have set out in detail, in my opening narrative to Question 1-2 and in my comments on Support (Question 73 and 74), the inadequacies of the Trust.

712. I cannot say the extent to which the Trust alone was at fault. On the basis of the respective waiting lists there was a disparity between the manner in which resources were allocated between urology patients and to other services – why was that allowed to be the case when it was clear to all we were failing to meet so many targets? I am quite sure this raises issues also at a regional level – what was the role of the Commissioners and Department of Health in failing to address this? I am quite sure in any other part of the UK a Urology Service, and its patients, would not have been left in the extremely vulnerable situation we were left in.

(Q 85)

713. I was very disappointed in the Trust's approach to the formal investigation. It is clear that both NCAS and colleagues considered there could have been an action plan put in place as opposed to recourse to disciplinary action. The Trust was well aware that I had been working excessively for years and had fallen

behind in administrative aspects of my practice. There was a failure before and after formal steps were taken to handle the concerns in a constructive manner. I was devastated when I was excluded and consider there were alternatives to the way in which that could have been handled. Issues did not arise acutely. Therefore, why could the Trust not have had the Return-to-Work Plan ready by the end of December, rather than exclude me, with the message that will have sent to colleagues? It was grossly unfair to hold disciplinary proceedings over me for a period of years and not to bring them to a conclusion.

(Q 86)

714. A central point of learning is that the Trust should have considered its own systems. I would ask the Inquiry to consider to what extent the Trust was and continues to deflect from the systemic issues by way of taking disciplinary action against me yet failing to investigate and remedy its systemic failings. A stark example of that is the failure by the Trust to promptly investigate the Case Manager's recommendation that there should be a review of the Trust's administrative systems. It is unclear to me if that ever occurred. Trust management should have had that as a central concern and followed that recommendation.

(Q 87)

715. I do not think the governance arrangements were fit for purpose. It was clear to all the central concern was the inadequacy of the service. A grossly inadequate service will inevitably give rise to service delivery issues. Yet the inadequate service was allowed to persist throughout the entirety of my tenure. I wonder if it has even been addressed now. Any concerns raised by me and others about the inadequacies were never satisfactorily actioned. I doubt whether they ever will. Instead, it would be my concern that the outcome will be more governance of an unsafe, inadequate service rather than less governance required for a safe, adequate service.

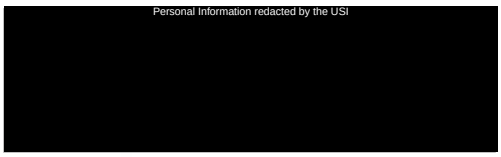
Urology Services Inquiry

(Q 88)

716. I do not believe that there is anything more that I wish to add at this time, but I will endeavour to provide any further clarifications that the Inquiry requires.

Statement of Truth

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



Signed:

Date: 2nd November 2022

SHSCT V MR AIDAN O'BRIEN

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CURRICULUM VITAE

AIDAN O'BRIEN

MAY 1992

PERSONAL

NAME	Aidan O'Brien.
PLACE OF BIRTH	Personal Information redacted by the USI
DATE OF BIRTH	Personal Information redacted by the USI
AGE	38 years.
SEX	Male.
MARITAL STATUS	Married.
WIFE	Personal Information redacted by the USI
CHILDREN	

FORMAL EDUCATION

PRIMARY

SECONDARY

UNIVERSITY

Queen's University,
Belfast.
1972 - 1978.

DEGREES / DIPLOMAS

M.B., B.Ch., B.A.O.

Queen's University, Belfast.
1978.

F.R.C.S.I.

Royal College of Surgeons in Ireland.
1983.

PRIZES

THE REGISTRAR PRIZE

The Irish Society of Urology.
1986.

EXTRACURRICULAR

PRESIDENT	Sinton Hall, The Queen's University of Belfast, 1974 - 1975.
MEMBER	The Senate Committee on Accommodation, The Queen's University of Belfast, 1974 - 1975.

SOCIETIES

FELLOW	The Royal College of Surgeons in Ireland.
FELLOW	The Royal Academy of Medicine in Ireland.
FELLOW	The Ulster Medical Society.
PRESIDENT	Urologists in Training in Ireland, 1990 - 1991.
MEMBER	Council of the Irish Society of Urology, 1990 -1991.
SECRETARY	Council Committee on Consultant Manpower, The Irish Society of Urology, 1990 - 1991.
FOUNDER	The Urological Research Society of Ireland.
CHAIRMAN	Executive Committee, The Urological Research Society of Ireland, 1991 - 1994.

CLINICAL EXPERIENCE

INTERNSHIP

CARDIOTHORACIC SURGERY

Royal Victoria Hospital, Belfast.
February 1979 to April 1979.
Head of Department: Mr. J. Cleland.

NEUROSURGERY

Royal Victoria Hospital, Belfast.
May 1979 to July 1979.
Head of Department: Mr. D. Gordon.

MEDICINE

Royal Victoria Hospital, Belfast.
August 1979 to October 1979.
Head of Department: Dr. T. Fulton.

CARDIOLOGY

Royal Victoria Hospital, Belfast.
November 1979 to January 1980.
Head of Department: Professor F. Pantridge.

SENIOR HOUSE OFFICER POSTS

THORACIC SURGERY

Royal Victoria Hospital, Belfast.
February 1980 to April 1980.
Head of Department: Mr. H. M. Stevenson.

PLASTIC SURGERY

Royal Victoria Hospital, Belfast.
May 1980 to July 1980.
Head of Department: Mr. R. Millar.

JOINT UNIVERSITY / NHS APPOINTMENT

DEMONSTRATOR OF ANATOMY

Department of Anatomy,
Queen's University, Belfast.
August 1980 to July 1981.
Head of Department: Professor T. Harrison.

CASUALTY OFFICER

Department of Accident and Emergency Medicine,
Belfast City Hospital, Belfast.
August 1980 to July 1981.
Head of Department: Dr. M. Turtle.

SENIOR HOUSE OFFICERS

ACCIDENT AND EMERGENCY SURGERY

Royal Victoria Hospital, Belfast.
August 1981 to October 1981.
Head of Department: Mr. W. Rutherford.

FRACTURES

Royal Victoria Hospital, Belfast.
November 1981 to January 1982.
Head of Department: Professor R. Wilson.

VASCULAR SURGERY

Belfast City Hospital, Belfast.
February 1982 to July 1982.
Head of Department: Mr. R. Curry.

REGISTRAR APPOINTMENTS

GENERAL SURGERY

Lagan Valley Hospital, Lisburn, County Antrim.
August 1982 to July 1983.
Consultants:

Mr. G. Young.
Mr. W. Mc Cullough.

Description:

My first appointment as a Registrar in General Surgery provided the first experience of working in a service - orientated department in a District General Hospital. Before then, I had worked in Surgical Specialties in Teaching Hospitals in Belfast. There was quite a marked distinction. It provided trials, challenges and satisfactions. Above all, it afforded me the invaluable experience of the provision of a truly general, surgical service, from gastro-intestinal to trauma surgery, from breast surgery and endoscopy to open urological surgery.

GENERAL SURGERY

Altnagelvin Area Hospital, Derry.
August 1983 to July 1984.
Consultants:

Mr. R. Mc Lean.
Mr. K. Panesar.
Mr. P. Bateson.
Mr. T. Day.

Description:

This second year as a Registrar in General Surgery afforded intensive post-Fellowship training. It was one of the busiest and most enjoyable appointments of my career. It was a natural progression from the previous year, it being a service provided by four consultant surgeons who had each developed specific areas of interests, based upon their own training. Therefore, I experienced the merits of a comprehensive service which included some degree of specialisation in the areas of oesophageal, biliary, vascular and urological surgery.

UROLOGICAL AND RENAL TRANSPLANT SURGERY

Belfast City Hospital, Belfast.
August 1984 to January 1985.
Consultants:

Mr. J. Kennedy.
Mr. G. Loughridge.
Mr. R. Donaldson.
Mr. R. Johnson.

Description:

During the previous year at Altnagelvin Area Hospital, I had become inreasingly aware that training or exposure to urology was the most neglected aspect or obvious deficiency in my general surgical training to date. I came to the Department of Urology and Renal Transplant Surgery in Belfast with the intention of rectifying that deficiency, still with intent to pursue a career in General Surgery. I was instead so impressed with the practice of Urology that my career intentions were seriously challenged. More specifically, by the end of six months there, it was obvious that Urology was such an expanding field in its own right, that only a full training in Urology would be adequate.

I was particularly impressed with the range and complexity of urological pathology which however was open to definitive assessment and diagnosis, quantitatively as well as qualitatively. In this regard, the Department had an established urodynamics unit. One of the strongest features of the Department was its well established practice of percutaneous nephrolithotomy, where percutaneous access was generally obtained by the urologists rather than by radiologists. The appointment also provided the opportunity, indeed privilege, of working in one of the premier departments of Renal Transplantation in Britain or Ireland. For two decades, Renal Transplantation in Belfast had enjoyed a standard envied throughout the world. This was in large part due to the integrated approach of urologists and nephrologists to all aspects of Transplantation, and to the attention to detail and high standard of operative technique by urologists. Exposure to and experience of such standards in cadaver donor renal harvesting and transplantation, and in addition, the surgery of arteriovenous fistula formation, at an early stage of my training in Urology, proved to be most valuable in later years.

ORTHOPAEDIC SURGERY

The Ulster Hospital, Dundonald, Belfast.
February 1985 to June 1985.
Consultants:

Mr. A. Macafee.
Mr. J. Halliday.
Mr. R. Dilworth.
Mr. A. Yeates.

Description:

This post was the last non-urological period of training in my career. I came to it by necessity as it was the only manner in which I could secure the previous appointment in Urology. By the time of my arrival, I had already decided to pursue a career in Urology. However, the experience was both enjoyable and worthwhile, as it reinforced my appreciation of the merits of specialisation. The experience in orthopaedic operative techniques were to be of value in their later application to open urological procedures, such as transpubic urethroplasty and pelvic osteotomies for closure of ectopia vesicae.

UROLOGY

Saint James's Hospital, Dublin.
July 1985 to June 1986.
Consultants:

Mr. M. R. Butler.
Mr. J. M. Fitzpatrick.

Description:

The Department of Urology at Saint James's Hospital provided a full urological service for Ireland's largest hospital. Consequently I obtained intensive experience in general urological experience, particularly in endoscopic surgery of the lower urinary tract. For example, I had performed over 100 transurethral resections of prostate by the end of year. The Department was also an integral part of the University Department of Surgery of the University of Dublin. As Registrar, I was a Tutor in Urology to medical students of Trinity College.

However, the most important aspect of this appointment was the experience gained through the Department's activities in the field of male subfertility. At that time, the Department of

Gynaecology ran a Department of Infertility, under the leadership of Professor R. Harrison. The Department was the National Centre for research and development of in vitro fertilisation. In such a milieu, the assessment and management of subfertility were vigourous. The subfertile couple were managed as a couple. The Department of Urology ran a weekly subfertility clinic to assess the male member of the couple. The clinic had an adjacent Semenology Unit where detailed assessment of seminal function was performed. During this year, I benefited greatly from the experience of the management of the subfertile male, particularly with regard to the endocrinology of subfertility, assessment by vasography, testicular exploration and biopsy, and research into the mechanism of infertility associated with varicocoele.

UROLOGICAL RESEARCH

The Meath Hospital, Dublin.
July 1986 to June 1987.
Consultants:

Mr. J. D. O'Flynn, V.P.R.C.S.I.
Mr. V. Lane, P.P.R.C.S.I.
Mr. M. R. Butler.

Description:

Since its foundation in 1946, the Department of Urology at the Meath Hospital has enjoyed a national and international reputation for its clinical practice and urological research. Both have resulted from the committment of its founder, Mr. T.J.D. Lane, the Department's autonomous dedication to Urology, a united departmental approach to research, and an unparalleled system of data storage and retrieval.

In July 1986, I was appointed to the Department with the task of directing urological research for a period of one year. I was responsible for the securing and selection of new funds for research. This included the integration of funded clinical research with laboratory research in related areas, enabling the otherwise unfunded laboratory research to proceed.

I developed upon the consensus attitude to research by organising and chairing monthly departmental research meetings, at which progress reports were mandatory, and proposals were submitted

for new projects. The agreement of consultants was secured to the extent of their foregoing clinical freedom with the individual patient, so that all patients with specific pathology would be recruited into prospective, randomised, controlled studies. Securing departmental agreement ensured that patient management was integrated into research, having the latter at the forefront of the Department's activities, to the benefit of clinicians and patients, rather than as a marginalised activity.

I introduced the notion of Research Clinics. These were clinics at which patients were screened for recruitment to studies, or were followed up, having already been recruited. I organised and ran these clinics, twice weekly, for 2 years. They were used particularly for studies of the use of the monthly subcutaneous depot preparation of leuprorelin acetate in advanced carcinoma of the prostate, and of the calcium - channel blocking drug, terodiline, in detrusor instability. They allowed time for patients to be screened or followed in the detail required by study protocols. Once again, the global management of the patients was entrusted to the individual responsible for the studies.

As is the case with any research experience, one becomes aware of the limitations imposed by time, funding, facilities and capabilities. However, this appointment at an early stage of my career, provided the much greater experience of coping successfully with the interchange between such limiting factors such as these, and the motivations and energies of many other people in a Department. I learned much of the logistics of organising collaborative research with other hospital, university and independent departments, like the Nuclear Energy Board of Ireland. More than 20 separate projects were completed, continued or embarked upon during the year, and I saw all work presented at national and international meetings.

The experience provided a valuable and lasting education. It has given me a clear view of the clinician's responsibilities to patients through research, and the expertise to organise it. It has encouraged me in founding the Urological Research Society of Ireland in 1991, a body committed to promoting and facilitating research that would be made feasible by, or best done by, collaboration between urological departments in Ireland. It will ensure an active committment to integrated clinical and laboratory research as a Consultant Urologist.

UROLOGY

Meath Hospital, Dublin.
July 1987 to June 1988.
Consultants:

Mr. V. Lane, P.P.R.C.S.I.
Mr. M. R. Butler.
Mr. T. E. D. Mc Dermott.

Description:

This appointment was the first of two clinical years at the Meath Hospital. During this two year period, my endoscopic operative experience and expertise increased considerably, as did exposure to and participation in the more major, open surgical procedures, such as nephrectomy and radical cystectomy.

However, the most significant event at this time was the arrival of the EDAP LT-01 piezolithotripter, and the Department's designation by Government as the National Stone Centre. There were learning curves in several respects for all clinicians in the Department: to develope expertise in ultrasound scanning of the kidney and localisation of calculi; to cope with the marked increase in ancillary endoscopic surgery (particularly ureteroscopy), necessitated by and pursuant upon the availability of ESWL; the determination of the optimal role of ESWL within the global management of stone disease. I was given the task of organisation of lithotripsy on a sessional basis, and of determining patient priorities for access to it. By the time of my leaving the Department in June 1989, we had treated over 1900 patients, of whom I had treated over 300.

In May 1988, I was upgraded to Senior Registrar status, with effect from 1 July 1988, and received from the SAC in Urology retrospective recognition of the current year as Registrar for the purpose of Higher Professional Training.

SENIOR REGISTRAR APPOINTMENTS

UROLOGY

Meath Hospital, Dublin.
July 1988 to June 1989.
Consultants:

Mr. V. Lane.
Mr. M.R. Butler.
Mr. T.E.D. Mc Dermott.
Mr. R. Grainger.

Description:

The first year since appointment as Senior Registrar was spent at the Meath Hospital. Even if this year had been purely a repetition of the previous year, it would have been worthwhile with regard to training, because of the volume of work handled, particularly since the introduction of lithotripsy, servicing a population of 3.5 million. However, the year differed for me in a number of respects.

The increase in the Department's workload necessitated by lithotripsy forced a rationalisation in two ways: prioritisation of a waiting list of over 600 patients, and the development of an outpatient flexible cystoscopy service. As Senior Registrar, I was given total responsibility for both. I developed a system of monthly review of the extensive waiting list, patients being admitted because of disease priority, irrespective of consultant allocation. This system is still operated. I organised and provided an outpatient flexible cystoscopy service, involving three sessions per week. The service was used for diagnostic purposes and for the removal of ureteric stents. The service remains in operation.

During this year, I also had the opportunity of working at the National Medical Rehabilitation Centre, the national hospital for the care of patients with spinal injuries and disease. The work there consisted of all aspects of the long-term management of the neuropathic bladder. As a result, I gained a lot of experience of the ultrasonic, radiographic, renographic and urodynamic assessment of the neuropathic urinary tract, and its management with intermittent catheterisation, augmentation cystoplasty and insertion of artificial urethral sphincters.

During the past two years, I also organised the Department's weekly clinical, radiological and pathological meetings.

UROLOGY AND RENAL TRANSPLANTATION

Beaumont Hospital, Dublin.
July 1989 to June 1990.
Consultants:

Mr. P. Mc Lean.
Mr. D. Murphy.
Ms. M.G. Donovan.

Description:

This appointment provided new opportunities, both in clinical experience and in research. As the Department had just procured two new Olympus flexible cystoscopes, and I had had the experience of some 1200 flexible cystoscopies, I set about developing a flexible cystoscopy service there. By the year's end, I had performed over 500 cases, with a dramatic impact on the utilisation of theatre time. The service remains in operation. It was also an opportunity to work in a Department with an established Video-Urodynamic unit, staffed by a trained technician, using the Aspen Gaeltec equipment. Before leaving, I formulated a system of audit, to determine the need for referral, and the impact of urodynamic assessment on patient management.

The National Renal Transplant Centre is located at Beaumont Hospital, and now has the largest transplant workload in Britain or Ireland, 119 transplants being performed during my year there, and 138 transplants being performed last year. Transplantation occupies therefore a major part of the Department's activities, and provided me the opportunity to perform 38 cadaver donor renal harvestings and 42 transplantations, as well as the experience of assessment of patients for inclusion in the transplant pool at weekly transplant clinics, the operative techniques of peritoneal dialysis and arteriovenous fistulae, and the patients postoperative management in the transplant unit.

While at Beaumont, I was asked to spend a short time working at the Ibn al Bitar Hospital, Baghdad, Iraq. This provided a wholly different experience due to the gross severity of pathology, particularly of urinary tract injuries resulting from the Iran/Iraq war, and of live donor renal harvesting.

During the year, I also made significant progress, in conjunction with the Nuclear Energy Board, of pursuing my interest in developing a primary, human urothelial, in vitro culture model, for the study of early neoplastic change, by controlled exposure to radiation in combination with other carcinogens.

Excluding transplantation, the most important experience I derived during the year at Beaumont Hospital was in the management of locally advanced, transitional cell carcinoma of the bladder with combination (MVAC) chemotherapy. The hospital does not have a Department of Oncology. With the assistance of Mr. D. Hickey, working with Mark Soloway in Memphis, we decided to embark upon a program of neo-adjuvant chemotherapy for patients prior to radical cystectomy. The experience left me aware that established chemotherapeutic regimens can be administered with excellent patient tolerance, with minimal, acceptable and easily manageable toxicity, and with marked downstaging of tumour in over 80% of our cases. As there is increasing evidence that such neo-adjuvant therapy does have an effect on prognosis, there is a strong argument for and encouragement for such therapy to be an integral component of patient management in a Urological Department.

UROLOGY

Mater Misericordiae Hospital, Dublin.
July 1990 to June 1991.
Consultants:

Mr. J. Smith.

Professor J.M. Fitzpatrick.

Description:

The third year of Higher Professional Training in Urology was spent at the Mater Misericordiae Hospital, which is one of the major teaching hospitals of University College, Dublin. On taking up the appointment, my first priority was to use my previous organisational experience to tackle a four-year waiting list to the Professorial Unit. Success was achieved through maximum utilisation of a five day ward. By the end of the year, I had reduced the waiting list by 80% to one of 10 months duration, involving only 42 patients. As a result, this was the busiest Senior Registrar appointment, and provided intensive experience in a wide spectrum of operative urology.

The Mater Misericordiae and Mater Private Hospitals each have a Video-Urodynamics unit, both with Dantec equipment, but without technicians. During the year, I provided a urodynamic service to both hospitals, doing 156 urodynamic investigations and reporting on them. The Department enjoys a close liaison with Our Lady's Hospital for Sick Children, and had begun to develope a urological service for adolescents, particularly for those with neuropathic bladders of varied aetiology. This led to a valuable experience of the operative techniques of continent diversion, particularly that of the Indiana and Hautmann pouches. Arising from the busy investigative unit, I also gained further experience of the surgical management of female stress incontinence, from the Stamey Raz to the Lapides retropubic urethropexy.

Perhaps most importantly, this appointment gave me the opportunity to have active experience of the use of the Siemens Lithostar lithotripter. This is a very different lithotripter from the EDAP LT-01, using XRay localisation and electrically - induced, membranous plate shock wave generation. It has the major advantage of the ability to accurately localise the majority of ureteric calculi, making this by far the optimal treatment modality for ureteric calculi, achieving clearance rates of 85 - 90% using this non-invasive technique. During the year, I treated over 150 patients, giving me an extensive and balanced experience and expertise in the use of Extracorporeal Shock Lithotripsy, over a period of three years.

PAEDIATRIC UROLOGY

Bristol Royal Hospital for Sick Children, Bristol,
and The Bristol Institute of Urology, Southmead, Bristol.
September 1991 to June 1992.
Consultant:

Mr. J.D. Frank.

Description:

Since I had long believed that the only significant deficiency in urological training in Ireland was the absence of a structured period in Paediatric Urology, I was delighted to secure and to extend my period of Higher Professional Training to include this appointment, which has been accredited by the SAC in Urology for that purpose. Any doubts I may have entertained regarding the necessity of Paediatric Urology to complete urological training, have long since been dispelled.

I approached this appointment with not a little trepidation, justifiably, as I had no previous paediatric or paediatric surgical experience. Covering general paediatric and neonatal surgery while on call on a 1:3 rota lends itself by necessity to a rapid learning process. I now have a working familiarity with once alien aspects of paediatric management, such as the prescribing of drugs and parenteral fluids by patient weight, venous access, ventilation, etc.

Though an established specialty, Paediatric Urology is certainly experiencing innovation. This is particularly seen in the area of prenatal diagnosis of urinary tract anomalies, and the role of prenatal and neonatal surgical intervention. The experience gained of the increasing understanding of the natural history of upper tract dilatation will be applicable to the management of upper tract dilatation presenting in adulthood.

The clinical and operative experience that I will have gained during this appointment will prove of immense value in the future. Without it, I could not have provided a full, comprehensive urological service to any general patient population. The experience has been on several fronts: laparoscopy and lower tract endoscopy, including resection of posterior urethral valves; all forms of inguinal and gonadal surgery; penile surgery, particularly the MAGPI, Mathieu and Duckett techniques of hypospadias repair; and upper tract surgery, particularly, heminephrectomy and ureteric reimplantation. The operative experience has included two unexpected bonuses: the value of magnification, not only for the obvious applications such as hypospadias repair, but for other procedures such as pyeloplasty; the intensity of lower tract reconstructive surgery,

particularly the techniques of bladder neck reconstruction and the Mitrofanoff continent urinary diversion.

The value of this appointment has been markedly enhanced by working at Southmead Hospital, which has one of the world's leading departments of investigative urodynamics, and management of incontinence. The experience of the application of urodynamic investigation to the management of the neuropathic or unstable bladder in children will be of immense value in my future practice.

Though not paediatric, the Department at Southmead is heavily committed in two areas of Urology, which I have taken every opportunity to observe: insertion of the artificial urethral sphincter by Mr. Paul Abrams, and insertion of the entire range of penile prosthesis for impotence by Mr. Clive Gingell. Both are leading national figures in these areas of prosthetic surgery, and the experience at Southmead will have helped to improve my expertise in both areas.

CONSULTANT UROLOGIST

CRAIGAVON AREA HOSPITAL, CRAIGAVON

During the two month hiatus, July and August 1991, between Senior Registrar posts in Dublin and Bristol, I was kindly invited by the management and surgeons of Craigavon Area Hospital to work there as a Locum Consultant Urologist. This served a number of purposes. It provided the opportunity of clearing a list of patients awaiting admission for urological treatment. During my time there, I performed 71 transurethral resections of prostate. It also provided an opportunity to advise the Management and Surgical Staff regarding their plans to develope a comprehensive urological service for the population of the Southern Health Board Area. Most useful was the opportunity to advise on costings on capital expenditure on facilities to provide that service. It lastly afforded me the best opportunity possible to appreciate the infrastructure, staffing and facilities already in place, and to realise both the need for and the determination and potential to provide such a full, comprehensive service.

I confidently believe that I now can offer myself for appointment to the post of Consultant Urologist at Craigavon Area Hospital, able to meet the challenge of leading the development of a Department of Urology which will provide a complete urological service required by the Southern Health Board, and the population it serves. I look forward to cooperating with the Surgeons at the South Tyrone Hospital, Dungannon, and of Daisy Hill Hospital, Newry, in order to achieve that objective. My extensive training in general urology, including the specialised areas of infertility, impotence, incontinence, lithotripsy, flexible endoscopy, spinal injuries, transplantation, urological oncology, paediatric urology, reconstructive and prosthetic surgery, has afforded me the expertise to ensure that that objective is achieved.

Appointment to Craigavon would also ensure that I would continue to play an active role in teaching and training in Urology. Moreover, I am well placed to ensure that in and from Craigavon, urological research in Ireland as a whole will increase in a collaborative, and well funded, manner. I would particularly look forward to cooperating and assisting in any and every way possible the future development of Urology in Northern Ireland as a whole. Lastly, appointment to Craigavon would mark my return to the place of my birth, and a returning home for my family. Though personal, these considerations will only serve to stimulate and motivate in achieving shared ambitions.

MAIN PERSONAL AND SUPERVISED OPERATIVE EXPERIENCE

(during H.P.T. only)

Flexible cystoscopy	1786
Rigid cystoscopy	227
Transurethral resection of prostate	331
Transurethral resection of bladder tumour	110
Insertion and removal of ureteric stents	257
Ureteric catheterisation	33
Internal urethrotomy	60
Hydrostatic bladder distension	55
Bladder mucosal biopsy	22
Bladder litholopaxy	18
Bladder neck incision	17

Extracorporeal shock wave lithotripsy	458
Ureteroscopic lithotripsy	134
Percutaneous nephrolithotomy	16
Pyelolithotomy	7
Ureterolithotomy	7

Orchidectomy	58
Orchidopexy	53
Inguinal herniotomy	30
Patent processus vaginalis	19
Testicular fixation	10
Hydrocoele repair	11
High ligation of varicocoele	9

Circumcision	50
Hemicircumcision	8
Hypospadias repair	26

Nephrectomy	43
Heminephrectomy	4
Nephroureterectomy	9
Pyeloplasty	19
Ureteric reimplantation	10

Renal transplantation	42
Renal harvesting	38
Tenchkoff catheter insertion / removal	31
Arteriovenous fistulae	8

Stamey Raz vesicourethropexy	10
Pubovaginal sling	5
Retropubic urethropexy	8

Radical cystectomy	17
Ileal conduit urinary diversion	21
Continent urinary diversion	6
Radical retropubic prostatectomy	5
Augmentation ileocystoplasty	13

THESIS FOR HIGHER DEGREE

Title: Neoplastic field change in the human urinary bladder: a histological, morphometric and DNA cytophotometric studu.

Description:

The existence of neoplastic field change in the bladder was first discovered in 1952, when Melicow identified the presence of 'carcinoma in situ' (CIS) in macroscopically normal urothelium in tumour bearing bladders. Since then, the natural history and prognostic significance of CIS has been realised. It has also been acknowledged that transitional cell carcinoma of the bladder is a panurothelial diathesis, and that there are less severe forms of such field change than CIS, variously termed atypia, dysplasia and more recently, intraepithelial neoplasia.

Conventional histopathological staging and grading of bladder tumours has been shown to be markedly subject to inter- and intra-observer variability. Many methods have been applied to the study of bladder cancer over the last 30 years, in an attempt to identify characteristics more reliably and consistently related to tumour biology and patient prognosis. Examples are the presence of marker chromosomes, surface blood group antigens, epithelial growth factor, tumour necrosis factor, nuclear size, etc. Of these, DNA cytophotometry has been that method most widely developed and applied in the form of flow cytometry, ploidy being related to tumour recurrence, progression and patient prognosis.

Similar methods have strangely not been applied in a structured manner to the study of neoplastic field change. The aim of this work was therefore to subject macroscopically and endoscopically normal urothelium from tumour bearing bladders, to conventional histological study, and to then compare the conventional histological diagnostic findings with multiple features of nuclear morplhology, determined by computerised image analysis, and with nuclear DNA contents, determined by DNA cytophotometry. In all cases, a comparison was also made with the tumour contained within the bladder. The morphometric features examined were those of nuclear area, nuclear orientation in relation to mucosal surface, the degree of nuclear pleomorphism, the nuclear / cytoplasmic ratio, and nuclear volume, on the assumption that the nucleus approximates to both

spheroidal and ellipsoidal shapes.

Progress in the work suffered a major setback when almost all of the morphometric data stored, was lost and / or 'contaminated' following a computer 'crash down'. This necessitated the repetition of a large amount of work. It did however provide an opportunity to modify and improve techniques.

The work is now complete and has produced interesting results: that even histologically normal urothelium from tumour bearing bladders have features previously found in malignant tissue; and most surprisingly, that such changes indicative of early neoplastic field change were more marked that those seen in the tumour of the same bladder.

As I am now completing the writing of the thesis, I plan to submit it for consideration for the degree of M.D., at the Queen's University at Belfast.

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REFEREES

1. Mr. Peter A. Mc Lean, MS(Urol)., FRCSI, FRCSEd., FRCSEng., FACS.,
Personal Information redacted by the USI

2. Mr. James Smith, FRCSI., FRCSEng.,
Personal Information redacted by the USI

3. Mr. J. David Frank, FRCSEng.,
Personal Information redacted by the USI

The European Board of Urology survey of current urological manpower, training and practice in Europe

E.A. KIELY
Cork University Hospital, Cork, Ireland

Objective To conduct a survey of urological manpower, training and current clinical practice throughout European Board of Urology (EBU) member, associate member and affiliated member countries.

Methods In 1998 a detailed questionnaire was forwarded to the secretary of each country's national association of urology, who then entered the data for their country in conjunction with that country's EBU delegates.

Results A response was obtained from all 22 countries and while some countries were unable to provide completed data, the result is the most detailed assessment to date of European urological manpower, training and practice. The mean ratio of urologist to population was 1:36 654 (range 1:15 150 to 1:184 210). Office-only urologists comprise 70% of practitioners in France and Germany and 30–40% in Austria and Greece. Although still few, the number of women urologists is increasing. While not uncommon, medical unemployment is currently not a problem for urologists. The duration of urological training among countries was similar (3–5 years), with 13 countries demanding a basic degree in surgery, and 13 also using a compulsory exit examination for trainees. Only 10 countries have a system for recording continuing medical education credits. Modern facilities for urological practice are freely available in all countries and the greatest differences were in treatment rather than diagnosis. Urologists play a dominant role in renal transplantation only in Croatia, Denmark, France, Ireland and Spain; about half of adrenal surgery and less than half of paediatric urology is performed by urologists. Cooperation with gynaecologists in managing female incontinence, and with paediatric surgeons in paediatric urology, was rare.

Conclusion There is a wide variation in urological manpower and while the duration of training was uniform, basic differences need to be resolved. It is vital that urologists maintain an interest in areas in which they can make a major contribution. Pan-European organizations should make it a priority to address these issues.

Keywords European urology, resources, training, employment

Introduction

The Union Europeene des Medecins Specialistes (UEMS) is a group of specialist doctors with the objective of advancing and harmonizing the quality of specialist medical practice in Europe, and the defence at an international level of the status of the medical specialist and of his/her professional role in society. The European Board of Urology (EBU) is a specialist section of the UEMS which in addition to these aims also has a primary role in the provision of a regulatory framework for urological practice and training.

In fulfilling its role in advancing and harmonizing urological practice throughout Europe, the EBU authorized a survey of manpower, training and current clinical practice. It was thought that there were substantial differences in these areas and in many cases these international differences could be explained by various internal circumstances. An example is the prevalence, particularly in France and Germany, of 'office-urologists', who function totally in the community, providing primary care and referring only patients requiring more major urological care to hospital-based colleagues.

An important factor in the provision of optimal medical (including urological) services is the achievement of the appropriate numerical balance between medical specialists and the population they serve. Too few specialists results in unacceptable delay in the provision of clinical care and inadequate time for satisfactory doctor–patient interaction, trainee teaching and supervision. Too many specialists is wasteful of postgraduate training, increases health service expenditure, and in surgical specialities the dilution of work-practice hinders the acquisition and maintenance of surgical expertise.

The standards achieved by urological trainees throughout Europe are not uniform; this results from

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potential factors such as candidate selection, organization and quality of structured training, and the absence of an agreed qualifying standard. One of the aims of this survey was to study and document these factors, and to encourage improvements.

This latest EBU survey provides an international comparison, aimed at helping the various national urological associations assess issues relating to urological practice in their countries, and thus provide comparative data for discussion with health-care management.

Methods

Included in the survey were all 17 EBU member countries, four associated members and one affiliated country (Table 1). A detailed questionnaire relating to urological manpower, training and clinical practice, compiled by the Manpower Committee in conjunction with the Residency Review Committee of the EBU, was circulated to all national urological association secretaries in May 1998. The deadline for the return of the data was 1 August 1998. The Chairman of the Manpower Committee collated the data and presented them to the EBU national delegates at their plenary session in November 1998. Amendments and additions to the data suggested by the delegates were noted, and a completed draft report was then returned to the national association secretaries for verification, completion or correction. The national population figures supplied were compared with those quoted by the European Statistical organization 'Eurostat', and where there was a difference of >0.5 million, the Eurostat figure was used.

Results

Completed questionnaires were received from all the countries surveyed. Table 1 documents the data relating to manpower and associated issues. The current mean ratio of urologist to population for all counties is 1 : 36 654 (range 1 : 15 150 for Greece to 1 : 184 210 for Ireland). This ratio is also shown in Table 1 for a similar survey in 1995 of the (then) 15 EBU countries [1].

Office-only urologists account for $>70\%$ of urologists in France and Germany, 40% in Austria and 33% in Greece, but there are none or very few in the other countries. There are hospitals with only one qualified urologist in most countries. There was a trend towards more women urologists; at present only $\sim 5\%$ of urologists are women but they comprise 10–15% of urological trainees and about half of current medical students. Medical unemployment in some countries is a major problem and this was closely related to responses from such countries indicating that medical school intake was not related to manpower needs. Retirement ages for urologists were consistently 60–70 years.

Table 1 also summarizes the responses relating to urological training, qualification and continuing education. There was a remarkable similarity in the duration of surgical (common trunk) and higher urological training internationally. In most countries 3–4 years of higher urological training was required before qualifying as a urologist, which on average was attained 12–15 years after entry to medical school. Only four countries (Belgium, Greece, Luxembourg and Malta) had no nationally organized training programme in urology. In 13 of the 22 countries a basic surgical degree is required for urologists, and 13 countries also use a compulsory 'exit' qualifying examination for urological trainees. Two further countries (Austria and the Netherlands) plan to use the EBU Fellowship examination (FEBU) for this purpose in the near future. In only 10 countries is there a system for recording and monitoring Continuing Medical Education (CME).

The survey of clinical urological practice (diagnostic and therapeutic; Table 2 and Table 3) showed only minor differences in the facilities available and in current standard diagnostic practice. There was a trend in countries well supplied with urologists for such urologists to adopt a more 'hands-on' approach to investigations such as ultrasonography and cysto-urethrography.

There was less uniformity in urological treatments and interaction with other specialists. Joint clinics with gynaecologists for couples with fertility problems are held in only 12 countries, while in 15 countries there was cooperation with gynaecologists in managing women with incontinence. However, in only one country (Denmark) was this practice common. It appears that most hospital urologists undertake major surgery for urological cancer, as the referral rate of this work to specialist urologists was very low. While in Belgium and Denmark $>75\%$ of major paediatric urological surgery is performed by urologists, in most countries it is considerably less than half. In only seven countries was cooperation with paediatric surgeons common.

The greatest difference was in the percentage of renal transplantations being performed totally by urologists, ranging from 100% in Croatia and Ireland, through $>80\%$ in Denmark, France, and Spain, to none in Belgium, Greece, Hungary, Malta, Norway and the Netherlands. Less variation was reported in adrenal surgery, with about half of such surgery being performed by urologists.

Discussion

The survey reported is the result of the efforts by the EBU to assess current manpower, practice and training issues

Table 1 Data relating to manpower and associated issues, and urological training

	Country																			
Data	*A*	*B*	*DK*	*SF*	*F*	*D*	*GR*	*IRL*	*I*	*L*	*N*	*P*	*E*	*S*	*CH*	*NL*	*GB*	*CR*	*H*	*M*	*PL*	*CZ*
Pop, millions	8	10	5	5	58.5	82	10.5	3.6	57.6	0.4	4.7	10	40	8.8	7	15.5	59	4.8	10.5	0.37	40	10
Urologists (*n*)	372	300	94	89	1000	3340	693	19	1865	18	70	240	1700	300	141	250	453	130	350	3	560	330
Ratio, 1: *N* (k)	21.5	33.3	55.3	57.3	58.5	24.6	15.1	184.2	30.5	22.2	67.1	41.6	23.5	29.3	49.6	62.0	130.2	36.8	30.0	123.3	71.4	30.3
1995*	37.5	40.0	76.3	82.5	75.0	50.0	–	232	17.5	–	–	40.0	36.3	–	52.5	71.3	132.5	–	–	–	–	
Women (%)	10	5	1	8.5	1	6.6	<1	6	3.5	0	7	2	5	3	0	1	5	3	1	0	11	11
Office only (%)	40	1	2	10	75	72	33	0	10	0	8.5	11	5	8	0	0	1	6	28.5	0	11	22
Unemployed																						
Urologists (%)	0	0	0	0	0	0	4	0	13.4	0	0	0	<1	0	0	1	0	<1	<1	0	0	<1
Doctors (*N* or %)	800	5%	0	1%	1000	11.0k	7-8%	0	59k	0	0	0	2%	117	~7%	<2%	~0%	587	?	0	6%	230
Single urologist hosp (*n*)	8	0	18	17	?	416	6	2	?	6	~12	10	0	20	18–20	17	42	4	All	0	12	18
Medical students																						
N (k)	16.2	10.0	5.0	0.4	3.58	82.3	12.0	0.44	50.0	0	2.5	2.5	?	4.5	2.9	11.6	1.5	?	6.4	0.09	12.0	8.36
Not native (%)	5	5	5	1	25	10	10	7	5		2	5		5	20	5	5		40	10	9	13
% women	50	50	55	67	50	33	25	55	58		50	60		50	60	55	50		47	50	66	60
Medical student number determined by†																						
	4	4	1	3	1	2	4	2	2	4	3	1+2	1+2	2+3	2	?	4	2	2	2	2	1+2
Urological trainees																						
Number	70	28	18	9	120	413	112	11	500	0	25	40	250	60	20	47	150	10	25	2	500	139
Women (%)	30	17	16	33	?	14	1.5	9	~3		20	5	15–20	20	10	14	20	10	0	0	20	11
Retirement age of urologist (years)																						
Hospital	–	65	70	65	65–68	65	65	65	65	65	67	70	70	65	65	65	65	65	65	61	65	62–65
Office	–	65	–	–	–	68	65–67	–	–	–	67	–	–	70	68	–	65	–	65	–	65	62–65
Urological training (years)																						
Common trunk	1.5	2	6	6	2	1	1	3–6	0	1–2	6	2	1	2	2	2	3	1.5	2	2	3	0.25
Higher	4	4	4	2	3	4–6	4	4–5	5	4–5	3	4	4	3–4	4	4	5	3.5	4	5	3	6.5
Entry med sch to end	14	13	17	14	13	14.5	12	15	11	12–13	13–15	14	>11	13	10	13–15	14	12	10	10	?	13
Structured training for specialities?																						
	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Training programme in urology																						
	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Training hospitals (*n*)																						
	28	14	8	5	50	430	42	4	10	–	20	35	?	30	16	20	?	5	5	–	81	65
Basic surgical degree essential?																						
	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes	No	No	Yes	No	Yes	No	Yes	Yes	Yes	No
Training‡	2	3	3	3	3	3	3	3	1		3	3	3	3	3	3	3	3	1	2	3	3
Selection¶	c	c	b+c	c	a	b+c	d	c	a+d		b+d	a	b+d	b+c	c	c+d	c	c	c	b+c	c	c
Applicants/post	2–3	1–2	3	2–3	1	170	?	5–15			0–2	3–5	2–3	2–4	3–4	2	30	5–8	5–6	2	2	2–3
Urological qualification by exam?																						
	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes
CME recording	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes

Countries: Full member countries of the EBU: A, Austria; B, Belgium; DK, Denmark; SF, Finland; F, France; D, Germany; GR, Greece; IRL, Ireland; I, Italy; L, Luxembourg; N, Norway; P, Portugal; E, Spain; S, Sweden; CH, Switzerland; NL, The Netherlands; GB, United Kingdom. Associated member countries of the EBU: CR, Croatia; H, Hungary; M, Malta; PL, Poland. Affiliated member countries of the EBU: CZ, Czech Republic.

* 1995 values from [1]. †, manpower needs; 2, medical school capacity; 3, other method; 4, no effective control. ‡1, academic; 2, clinical; 3, both. ¶ a, academic examination; b, academic examination + c or d; c, interview by representatives of hospital, university, lay people or urologists; d, other method.

as they relate to urology. The hope is that these data will provide national urological associations and healthcare administrators with a tool to enlighten discussions about advancing the quality of urological care delivered to that country.

Interestingly, the survey showed that little previous information was available in most countries surveyed and even the statistical organization of the European Union 'Eurostat' has only the most basic data about the numbers of specialists and healthcare facilities. The data

Table 2 Data relating to urological clinical practice (diagnostic)

	Country																			
Data	*A*	*B*	*DK*	*SF*	*F*	*D*	*GR*	*IRL*	*I*	*L*	*N*	*P*	*E*	*S*	*CH*	*NL*	*GB*	*CR*	*H*	*M*	*PL*	*CZ*
Urological investigation																				
IVU	A/P	A	A	A	A	A/P	A	A	A	P	A	A	A	A	A	A	A	A	A	A	A	A
Retrograde urography																				
	P	P	A/P	A	P	P	A	A	P	P	P	P	P	A	P	P	P	P	P	A	P	P
CUG	A/P	A	A	A	A	P	A	A/P	P	P	A	P	P	A	P	A	P	P	P	A	P	A/P
Interventional radiology																				
	A/P	A	S	S	P	P	A	P/S	P	P	A/P	P/S	S	A	P	A/P	A	S	P	A	S	S
Abdominal US	P	P	A	A	A/P	P	A	A	P	P	A	P	APS	A	A	A	A	A	P	A	A	A/P
TRUS	P	P	A/P	P	P	P	A	P/S	P	P	P	A	A/P	A	P	P	P	P	P	A	A	P
CT	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
MRI	A	A	S	A	A	A	A	A	S	A	A	S	A	A	A	A	A	A	A	A	A	S
Scintigraphy	A	A	S	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Laboratory investigations																				
Biochemistry	A	A	A	A	A	P	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
PSA	A	A	A	A	A	A/P	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Testicular	A	A	A	A	A	A/P	A	A	A	A	A	A	A	S	A	A	A	A	A	A	A	A
Hormones	A	A	A	A	A	A/P	A	A	A	A	A	A	A	S	A	A	A	A	A	A	A	A
Microbiology	A	A	A	A	A	A/P	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Urodynamics	S	P	A/P	P	P	P	P	P	P	P	P	P/S	P	A	S	P	A	S	P	A	S	A/P

CUG, cysto-urethrography; US, ultrasonography. A, easily available; P, performed personally by urologists; S, only in specialist units.

presented here are 'soft', in that they relate to the responses from a few personnel (national association secretaries and EBU delegates), but these individuals occupy pivotal roles and are best placed to provide the best possible data for their country.

There can be no ideal international manpower ratio for a medical speciality. Changes in clinical practice and population demography dictate that the situation is in constant flux. In addition, differences among European countries in relation to patient demands, healthcare organization, medical education and speciality training mean that unique factors operate in each.

The mean ratio of one urologist per 36 654 population in Europe is still less than the 1 : 26 326 in the USA quoted by McCullagh [2]. However, fewer urologists are currently being trained in the USA than previously, as it is recognized that the clinical demands can be met with fewer urologists. A survey there has also shown that, despite more surgical procedures, the expansion in urological manpower has kept the annual workload at 119 operations per urologist [3]. Under these circumstances, there is a risk that many urologists will be unable to maintain their existing surgical skills.

In some European countries the presence of office-only urologists means that surgical cases are concentrated amongst the hospital urologists, whose mean ratio to population is 1 : 54 062. This ratio, when compared with that previously quoted for the USA and applied to the USA workload, gives a more 'respectable' 240 surgical cases annually. It remains debatable if this is an optimal level for maintaining surgical competence, but limiting practice to specific interests (subspecialization) would help achieve this ideal.

While acknowledging that the unique clinical demands in certain countries dictate an increased allocation of clinicians, it is widely accepted that many countries have too many urologists. Decisions need to be made to begin to address this problem, as failure to do so will damage the status of the speciality. Conversely, there is patently a dearth of urologists elsewhere. In Great Britain, where there is currently one urologist per 130 000 of the population, the BAUS have a manpower target of one urologist to 80 000–100 000 population, and have succeeded in increasing consultant urological appointments to meet this target, with a plan to reduce trainee numbers when this target is met [4].

Ireland has the worst ratio of urologists to population (1 : 184 210) of all the countries surveyed. At present much urology, particularly in provincial areas, is dealt with by general surgeons. The need to appoint additional urologists is even more pressing as not only is the overall population increasing, but it is projected that those over 65 years old will increase from 11.4% to around 15% of the population over the next 20 years.

It is sensible that national urological associations should confront the national health systems to regulate the number and the quality of training offered to urologists. In addition, there should be only one route

In many countries the provision of office-only urologists would demand a major change in medical organization and patient behaviour, but even in these countries this change may be occurring covertly because of the overproduction of doctors and urologists, and through the practice of GPs developing an interest in specialist areas, e.g. erectile dysfunction or fertility problems.

There is a similar argument about urologists adopting a more active role in diagnostic methods. The survey results suggested that such is the case in countries where urologists are more plentiful. In favour of this trend is the increased awareness by the urologist of clinical factors and probable underlying pathology, making the urologist best placed to use studies such as ultrasonography and urography. The counter-argument refers to specialist radiologists providing the expertise to optimize diagnostic accuracy and to limit radiation exposure. In practice, technological advances have resulted in ultrasonography now being more widely and cheaply available to urologists; in general this has not resulted in conflict with radiology colleagues. However, it would be unwise for the urologist to attempt to monopolize urological imaging, as to do so may be at the expense of diagnostic accuracy and innovation.

The similarity in the duration of urological training in different countries was striking. Of course, a standard duration does not equate to a standard quality. Most countries conduct organized urological training programmes, and it is the hope and aim of the EBU that its process of assessment and recognition of training programmes will help to improve the overall training standards. Furthermore, the adoption of a standard recognized 'exit' examination should assist in achieving this goal. Again, the EBU, with its Fellowship examination, potentially meets this need. The acceptance of these measures has been, and will be, a slow process. There is a real fear in countries with well-regulated training and stringent qualification procedures that efforts at harmonization will mean a reduction in their standards. These countries must be convinced that this will not be the case.

Inevitably areas of urology such as infertility, female incontinence and paediatric urology lead to conflict and competition with other disciplines. Indeed, there are very few countries where cooperation with other specialities is common. It is vital that urologists maintain an interest in areas to which they can contribute; failing to do so will not only be at the expense of patient care but inevitably denies trainee urologists exposure to such experience. In the case of paediatric urology, if the paediatric surgeon monopolizes this area, the quality of care available to the former paediatric urology patient presenting to the urologist in adulthood will be diminished by the obvious gap in training and experience. The creation of obligatory shared-residency programmes in paediatric urology would help to overcome this dispute and possibly enhance this subspeciality. It is hoped that the resolution of other disputes will stem from the clear demonstration that patients are best managed by urologists. However, unless urological trainees are exposed to the relevant training opportunities it will not be possible for the urologists of the future to achieve this.

In summary, it is barely a century since urology became a separate speciality from surgery [5]. It has developed at a different pace but broadly in the same direction in the various European countries. This survey documents the shared similarities but also the glaring differences between nations, and is an informed basis for the advancement and harmonization of the speciality.

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