Urology Services Inquiry

Oral Hearing

Day 65 – Wednesday, 11th October 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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

CHAIR: Good morning, everyone.

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

MR. JOHN O'DONOGHUE, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE, AS FOLLOWS: 10:14

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

A. Good morning, Mr. Wolfe.

MR. WOLFE KC: Welcome to the Urology Services Inquiry. Thank you for coming to give your evidence. 10:14

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

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

A. Yes.

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

A. Yes.

2 Q. So subject to the revisions contained in your addendum, are you content to adopt this statement as an accurate account of your evidence to the Inquiry?
A. Yes.
3 Q. Thank you. 10:15

Then, to that addendum, as I said, received and signed on 3 October of this year, WIT-103266, that's the first page, and then to the last page at 103269. Again, are you content to adopt that as part of your evidence? 10:16
A. Yes.
4 Q. Thank you.

I understand from your counsel that there's one additional correction you would wish to make to your 10:16 primary statement. Let me bring you to it. If we go to WIT-50528. In the middle of the page, 13.1, you list a number of locum consultants. Was Dr. Fel or Mr. Fel a locum consultant?
A. He was, yes. 10:16
5 Q. Should he be added to that list?
A. He should be. I think I inadvertently forgot to put him in.
6 Q. I understand that he came in in July 2020?
A. Yes, I think so. 10:16
7 Q. And he served until August or September of that year; is that right?
A. That's right, yes.
8 Q. Thank you.

If we can go then to WIT-50521. Just to get your career background and academic history on the record. You are currently a Consultant Urologist working at the Southern Trust?

A. That's right.

9 Q. You have been in that position from 4 August 2014?

A. That's right.

10 Q. And helpfully, if we just scroll back up the page, we have your occupational -- if just go above that again, please. Yes. So you qualified with a Medical Degree out of University College Cork -- 10:17

A. That's right.

11 Q. In 1993?

A. Yes. 10:18

12 Q. Then qualified as a surgeon in Ireland 1997?

A. Yeah.

13 Q. And completed your urological training in 2013, 4 October 2013?

A. Yes, in Oxford. 10:18

14 Q. We can see then the next stage, I think you took up your first consultant role at Watford?

A. Watford General Hospital, yes, I was there for a year.

15 Q. We can see that. If we just scroll down to August 2013. We can see it all in order. Yes. So August 13th at Watford, served there for a year, and then straight over to us at Craigavon? 10:18

A. Craigavon, yes.

16 Q. And you have been there --

A. Ever since.
17 Q. Uninterrupted ever since. So ten years, give or take?
A. Yes.
18 Q. We have your job description. We'll just put it up on the screen. I don't intend to interrogate it to any degree. WIT-50648. It is more for illustration purposes. 10:19

You were appointed on the same day as Mr. Haynes, is that correct? 10:19
A. That's right. We interviewed together but I delayed coming because my children were in school and we had to give notice to come.
19 Q. Yes, was there a third consultant appointed that day?
A. Not that I'm aware. I understood there was two but I'm not too sure. 10:19
20 Q. Yes. It's described here, just in the introduction, as a "replacement post". You see in the introduction section. Do you have a sense of who you were replacing? 10:20
A. I think that was just generic. I think in the end, because two suitable candidates applied, they created an extra post, so I'm not entirely sure it was a replacement post that I took.
21 Q. Did you inherit, coming into post, did you take on a backlog of patients from the waiting list or how was that -- how was your practice, if you like, in terms of people or patients. How was that assembled for you? 10:20
A. Well the first two weeks, or first few weeks when

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

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

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

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

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

A. That's right.

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

beginning in the Trust in 2014?

A. That's right.

25 Q. Just working through some of that. Your you're one in seven on-call for urological emergencies, is that something other than performing your role as Urologist of the week, or is that another way of saying -- 10:22

A. That's another way of saying it, so we initially did -- we were doing one day a week on-call but I think within a few months of me starting Craigavon in 2014 we changed to urologist of the week, so it's roughly one in seven. 10:23

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

A. Yes. 10:23

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

A. Yes.

28 Q. We'll come on and look at aspects of urologist of the week in just a moment or two. 10:23

Let me ask you this. The Inquiry wants to get to know, I suppose, the context in which you came to work in Craigavon and the environment you found when you came there in 2014 and the particular challenges that you faced. So an easy question, what kind of department did you find when you arrived in 2014? Can you offer maybe, a sense, given your experience in Great Britain, of whether things were done as well here, as compared 10:24

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

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

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

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

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

30 Q. Any oncology work?

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

it hasn't changed.

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

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

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

A. Yes.

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

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

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

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

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

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

A. Well, I do --

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

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

37 Q. Of course.

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

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

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

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

39 Q. Yes, briefly. 10:31

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

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

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

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

by the capacity demand problem?

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

42 Q. But is it a stressful environment?

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

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

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

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

A. Yes.

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

A. Yes. 10:35

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

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

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

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

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

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

A. Yes, I saw those emails.

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

10:37

He sets out in this third paragraph a concern that:

"We, as a team, in agreeing to the urologist of the week model, agree to include triage in the duties."

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

10:38

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

If we go on to just the next page, we'll come back to this again. 10:38

Scrolling down. Thank you, on further. He has said -- just going down to "triage". He has found it impossible to complete triage while being urologist of the week, and he still does. We'll look at triage from 10:38 different angles as we go on today, but you attended this meeting?

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

50 Q. So he's spelling out a sense of regret that triage 10:39 was --

A. I was aware, yes.

51 Q. -- included within the duties. He reflects that, there seems to be a range of ideas on how it should be done and taking into account his approach, he finds it 10:39 impossible to complete triage when serving as urologist of the week and it spills into his Friday and his weekends.

Just from your own perspective, did you find it

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

expect via the consultant?

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

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

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

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

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

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

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

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

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

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

A. On a Thursday morning. 10:48

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

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

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

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

A. Well, certainly earlier on in the urologist week we were certainly doing ward rounds and we met on the ward rounds. 10:49

61 Q. Okay, so --

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

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

A. Yes.

63 Q. -- on the Thursday?

A. Yes. 10:50

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

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

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

10:50

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

round being conducted by the urologist of the week."

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

10:50

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

10:50

So I suppose that latter bit might be you?

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

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

A. Or in until he retired, because he would always follow me, so I would always have met him and discussed the patients. 10:51

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

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

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

A. Yes. 10:51

69 Q. Is that about five years?

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

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

A. Yes.

71 Q. For five years?
A. And if there was some reason that I couldn't get to it on a Thursday, we would certainly have a phone call and discuss the patients.
72 Q. Did you consider whether it was a phone call or participating in the, if you like, a joint ward round, the incoming and the outgoing, that was an important patient continuity of care and/or safety mechanism? 10:52
A. But a phone call you can equally talk about the patient equally as well, than spending four hours walking around a ward. If it's commoner to do the ward round, but if for some reason one couldn't, it was a phone call. 10:52
73 Q. Has it now moved to a phone call completely or comprehensively? 10:52
A. Certainly, I think that it is, that it's a phone call, yes, and it's equally as effective.
74 Q. Leaving aside the working of the UOW model and thinking back across the 10 years of your career so far at Craigavon or the Southern Trust, what has been I suppose the biggest professional challenge for you as a urologist? 10:53

We spoke earlier about whether it was a pressurised or stressful environment and you helpfully said, well, you know, it's a busy environment but you don't feel the stress. What is the -- is there a constant professional challenge that has been in place or a regular professional challenge that has been in 10:53

place?

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

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

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

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

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

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

10:56

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

A. With regards to waiting lists, et cetera, I was certainly aware. In other words, I was aware that we were finding it difficult to keep up with our waiting lists, or the numbers of patients we had far exceeded our capacity. I wasn't aware of a lot of the issues in the background that were happening. 10:56 10:57

Certainly at our weekly Departmental meetings, and Martina Corrigan was the Head of Service at that time, as far as I remember, I think we were certainly informed of the state of our waiting lists, planning for the future issues, if we were getting a vacant post and who was being interviewed. So I think we were being kept up-to-date reasonably well, yes. 10:57

77 Q. Just touching on the Martina Corrigan input. If we go back up through your statement of WIT-50518 at paragraph 1.5. I'm conscious that you said within your statement that you had not been made aware specifically of the IEAP Protocol, the Integrated Elective Care Protocol. Nevertheless, attending at these meetings -- 10:57

is this the weekly Departmental meeting?

A. Yes.

78 Q. She would have furnished the attendees with key performance indicators including, as you say --

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

A. Thank you.

79 Q. MR. WOLFE KC: As you say here at the bottom of the page, the KPI included cancer waiting times, the red flag urgent routine waiting times for in-patient, out-patients and day surgery. I suppose you make the point that being made aware of those indicators presented every month and it allowed you and others, supposedly, to engage with efforts to reduce waiting lists and improve performance. 10:59

Help us understand that. You're getting the message, one might assume, that there's more coming on to our lists, the position isn't getting any better, in fact the Inquiry observes from evidence received before you came to us that waiting lists of all varieties were getting worse exponentially over the period. What, in a real sense, were you able to do in terms of engagement with efforts to reduce waiting lists and improve performance? 11:00

A. Well, we ran extra lists to try and get the numbers down. We ran extra clinics to try and clear the waiting lists. Certainly in the last few months, the patients -- or last year and a half patients were sent

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

80 Q. Mr. Glackin has offered some reflections upon the, I suppose, effectiveness of the team in terms of participation at these meetings. 11:01

A. Yes.

81 Q. He said, and if I could just bring his particular witness response up on to the screen, WIT-42307. And he says at 31.2 that: 11:01

"Mr. Young tried his best to lead the Urology team. However, despite his best efforts Mr. O'Brien, Mr. Haynes and Mr. O'Donoghue frequently failed to attend Departmental meetings or arrived late. All too often I sat across the table from Mr. Young wondering 11:02 why my colleagues had not shown up. Due to the number of fronts on which the service was failing to deliver (growing waiting lists for appointments and surgery)...".

11:02

He cites:

"...it was difficult to achieve a consensus as to how to move forward without engagement from our colleagues." 11:02

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

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

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

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

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

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

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

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

He said that in Craigavon, while we have had elements of that at times, it was only within, literally, the last week as he stood giving evidence -- or sat giving evidence in the seat that you're in, but now within the last month, I suppose, he said: 11:05

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

And he congratulated the person who did it: 11:05

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

11:05

So I suppose what we're getting from him, and I'm interested in your perspective, rarely before, at least until relative recently, has there been a concerted and thought-through effort to put all of the relevant data on the table and to have a serious conversation about 11:05 how you, as a team, might better manage the waiting list challenge.

A. Yeah, I'm thinking back to my time in England first. My experience certainly wasn't Mr. Glackin's. I was in Oxford and certainly when I was in Oxford it didn't 11:06 seem to be -- it seemed to be again extremely busy, long waiting lists, and registrars there weren't party to the workings of Department like Mr. Glackin was exposed to. That's the first point.

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

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

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

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

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

A. Yes.

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

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

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

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

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

89 Q. Yes. Incorporated within the preparation, is it reviewing letters, results and reports on the NICER?
A. Yes. Because the narrative always doesn't give sufficient information. So one has to go back to the original letters to get further information. 11:11
90 Q. So there's a patient narrative, that's a background piece. I suppose it tends to be quite immediate in terms of where the case is at?
A. Although some -- it does give historical information as well. It depends how -- 11:11
91 Q. Is that prepared by the clinician with responsibility for the patient?
A. Things have changed. So I think in the last year we now have a pro-forma, so when we submit a patient to the MDM we write a narrative. But there's also 11:11 a narrative which I think cancer tracker sort of cut and paste from previous MDMs.
92 Q. Do you review imagining as well?
A. Yes. If necessary, yes.
93 Q. Do you have specific time allocated within your job 11:12 plan for preparation?
A. I have time but it's not specific time as in it is not a certain time of the day or week, but I have time allocated, yes.
94 Q. But does it -- does it adequately reflect the 11:12 preparation activity in terms of time that you commit to the task?
A. Well it doesn't adequately for me because I spend longer on it. I spend at least four hours trying to

get it ready, probably longer.

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

A. Yes.

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

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

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

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

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

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

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

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

radiologist.

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

A. Yes.

101 Q. Has that worked well? 11:14

A. I think it works better, yes.

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

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

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

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

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

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

With regard to the actual running of the meeting, I think -- well, certainly now it is much better because there's quoracy. We always now have an oncologist, a clinical and medical oncologist and a radiologist, most of the time although not always. So it certainly runs better than it did in the past.

But in saying that, you know, there's only three core, well, four I suppose, four urologists, but we're not always there if somebody is on-call or away. 11:16 11:17

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

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

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

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

particular thing you're talking about.
107 Q. No, it's just what you have just said?
A. I personally haven't experienced -- I've been reading in some of the folders that pathology didn't always -- it was probably patients who weren't followed up, it wasn't passed on to the trackers. And that's something I was reading in the evidence bundles in the last three weeks, but it was not something that I was aware of when I was chairing. 11:19
108 Q. We'll maybe look at that particular case. I think it is one of Mr. Glackin's cases where the case was closed down before pathology was discussed. That's not a general concern that was -- 11:19
A. No.
109 Q. -- being discussed or was known to the MDT in real-time? 11:19
A. I think it certainly wasn't common. I think it might have been a one-off. I think it is not something I was aware of.
110 Q. Let me ask you about the patient safety meeting. If we go to WIT-50523. At 7.2 you explain that this was a monthly meeting. 11:19
A. Yes.
111 Q. You say it was either urology specific or combined surgical directorate, and it was held to discuss clinical cases of concern and deaths: 11:20

"Learning points were noted. Audits and studies were presented and directives from various NHS sources were

noted."

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

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

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

A. Well, you are expected to attend both.

113 Q. Okay.

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

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

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

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

But how does what is discussed at the Patient Safety meeting translate into real practical effective action, what is the join between the PSM meeting and what's discussed there and what needs to happen? 11:23

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

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

that it is delivered?

A. Well, if it requires equipment we aim to get the equipment. I mean if we need equipment or if we need training, we access the training. I mean I'm speaking generally rather than a specific case. But if the outcome was that Doctor So-and-so should get further training, he or she would go and find that training. 11:25

116 Q. Who superintends the action that is required, whose responsibility does that become?

A. I would have thought if a directive came from the Patient Safety meeting that once the doctor got the training he ought to report back to the Patient Safety meeting. I think that's how I would see that it would happen. 11:25

117 Q. Because one could get the impression at looking at some of the incidents that arise, whether it's -- I don't know, the need for sign-off of diagnostic investigations, perhaps preoperative assessment, perhaps the stenting issue. 11:25

11:26

You see these on the agenda of PSM across different incidents over an expanse of years. The same issue or a similar issue is arising and it is discussed and, as you say, learning noted. But, in fact, conscious that accidents can happen, or shortcomings can occur with the best will in the world, but you don't perhaps get the impression that the learning is translated into effective curative action at the earliest opportunity. Is that a fair comment? 11:27

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

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

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

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

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

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

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

practice that comes there. Are there listening ears in terms of those on the governance and/or management side? Are they present at the meeting so that they can hear this alarm, worry, if that's how it is to be characterised in terms of any particular clinical issue? 11:32

A. Yeah, and very often a Head of Service comes to the Patient Safety meeting. We now have audit people at it as well. You know, we have a good turnout of medical professionals, nurses, doctors, at the meeting. So it is a good forum for discussion, discussing concerns. I think it is effective, albeit slowly effective. But it is, things do change ultimately. Maybe not as fast as we would like, but they do change. 11:32

121 Q. You took over the role of Chair from -- 11:32

A. Mr. Glackin, yes.

122 Q. -- Mr. Glackin in 2021. Can I just offer you a reflection or a series of reflections that have come through him. I'll read them out. It's not word for word but it's reflective of his sentiments. He said, this is WIT-42299 at paragraph 17.3, that Clinical Governance has been neglected. At wIT-42289, paragraph 7.5, that support for clinical audit has been insufficient. He has said that: 11:33

11:33

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

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

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

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

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

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

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

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

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

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

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

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

change?

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

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

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

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

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

133 Q. Who polices that?
A. I take all the names and I submit it to the Clinical Governance Department so they're aware of everybody who attended. So that goes into their appraisal, obviously their attendances. 11:42

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

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

11:42

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

CHAIR: Thank you, everyone. Mr. Wolfe.

MR. WOLFE KC: Before we look at some of the further tools or instruments of good governance, I just want to 12:01 ask you some questions about, if you like, management responsibility for governance.

You've said, if we can have up on the screen please, WIT-50536 at paragraph 32.1. You've said overseeing 12:01 the quality of services in Urology was within the remit of the Consultant Urologists and the Head of Service.

Then, scrolling down, I suppose by difference or by contrast, in relation to the Clinical Governance of the 12:01 profession of those services, you said that overseeing Clinical Governance was the responsibility of the Clinical Director, the Associate Medical Directors and the clinical Lead. They're obviously all on the

medical side or the professional side. Was there a role in overseeing clinical governance for the professional managers, as such, I'm thinking in particular the Director of Acute and the Assistant Directors? 12:02

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

134 Q. When you use the phrase -- maybe you are using our phrase back to us -- about the oversight of Clinical Governance and the responsibilities that fell to the people you have identified, and I take it those to be the current, whereas when you wrote the statement, the then current -- 12:03

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

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

A. I think Patient Safety, certainly, is important. I think if patients suffer any untoward events, it's certainly something they will take up and pursue, that it is identified what the problem is, or at least it is reported to them what the issues are. So I think Patient Safety. Also Patient Safety in its audits aspects and that would include, obviously, waiting lists and patients waiting in a timely manner for surgery. I mean other issues would come into Clinical Governance. Obviously paperwork and summing-up 12:03 12:04

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

136 Q. Yes. I suppose if you put a distinction between the role of the consultant providing the service and the people you've identified as having oversight responsibility for Clinical Governance, the practitioners deliver the service, so it's for the people that you have identified here in Clinical Governance terms to ensure that the service is being delivered safely? 12:04 12:05

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

137 Q. If things weren't being done correctly, would you expect these people, these post-holders would be active then in pursuing the shortcomings in practice, whether it was a particular practitioner's approach to the delivery of a service, or any particular aspect of his or her practice, as well as, I suppose, bigger issues or macro issues in association with the infrastructure, perhaps, or the ability to deliver? 12:05 12:05

A. Yes. They should have used all the tools at their disposal to do whatever they needed to correct the problem or stop issues happening. 12:06

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

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

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

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

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

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

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

A. Yes, I think he said --

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

regarding Patient Safety.

Then, if we go to -- and I suppose the emphasis here is he doesn't see his role as being management in nature. If we go then back in his statement, WIT-51696. If we go to 6.3, please. He reported, he said, to the Clinical Director of Surgery and Director of Acute Services. This role, again, he uses the phrase "was a service post". He was not responsible for individual team members but was a coordinator of activities for the Urology team members. He may have coordinated activities, such as Departmental meetings. The role did not manage or have responsibility for the overall running of the Urology Unit per se. It did aid the Trust management structure if asked for clinical direction. 12:09 12:09 12:10

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

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

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

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

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

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

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

A. At that time, yes. Yes.

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

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

You set the types of MDMs out there.

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

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

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

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

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

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

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

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

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

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

148 Q. I quite take the point that if your actions, or actions of a colleague led to disaster, or led to injury, you would expect to be held to account, because that's a very visible evidence of something that has perhaps gone wrong. But you make the point that at that time I was aware that there wasn't any great scrutiny of results sign-off. You probably, if you had thought about it, would you have recognised that while systems were in place to spot that, triage wasn't being done, it wasn't always being done in a timely fashion. Ultimately enforcement action around that was less than optimal. 12:17 12:18

You would, as we'll see when we look at some of the other incidents that arose, you would have seen that a failure to dictate, following a clinical encounter, wasn't particularly well-monitored and due, and Mr. Haynes, for example, I suppose stumbled upon it isn't the right word, but you became aware of it as opposed to some system of superintendence or governance becoming aware of it. Just some examples to set against your view that you felt reassured. 12:18 12:18

Do you now, upon reflection, see holes in either the system of governance and/or the appetite for enforcing good governance when problems were identifiable? 12:19

A. Absolutely. I mean sitting here now, I can't say I was happy with -- I could be happy with how things were done then. I suppose, with regard to results, because

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

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

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

A. Yeah.

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

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

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

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

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

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

You go on and expand to say that: 12:22

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

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

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

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

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

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

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

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

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

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

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

got a complication" or something like that?
A. Yes.
156 Q. So the communication from the secretary is: Here's the problem. I need to communicate back to the patient.
A. She would ring, if there was a phone call, she would ring the GP or ring the patient with my answer. 12:24
157 Q. So it's a task you feel comfortable delegating to her.
A. Well yes, because she's been doing it -- unless it was something I needed to do myself. But if somebody rings up to say "can I stay on my certain tablet", fine, she would ring and say "Mr. O'Donoghue said you can stay on your tablet", so that kind of stuff. But if I needed to speak to the patient I would do, or if she wasn't comfortable to do it. 12:25
158 Q. Working through, what else might be... 12:25
A. And so it's changed now, but she would have had patients -- we would do our theatre lists and we would -- there would be always patients that I would feel that she would keep an extra -- patients that needed to be done soon, TRBT, et cetera, and then patients with stents. We would try and do that, take those off chronologically or on clinical need. So we would organise our list for the next month. 12:25
159 Q. Just on that, would it be your approach to delegate to your secretary, if you like, the contact with the patient to say: You're coming in or you're likely to come in in the next three weeks, the letter will be coming your way soon, that kind of thing? 12:26
A. Yes. I never rang the patient saying come in for

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

160 Q. Again, what else might typically arise during these face-to-face? 12:26

A. If a result, a paper result had come into her again, they're on ECR now, but if a paper result came in she would -- she got lots of results, but if it had come from X-ray that I needed to act on it, although I would have got an email from X-ray anyway, she would bring my attention to that, that it was something I needed to act on it. 12:27

161 Q. So she would be in, in a sense, highlighting that this one is pressing. It may not be pressing because you have it under control, but it is an extra safety net? 12:27

A. I always dictate letters on all results and still do. So if a result didn't -- wasn't dictated on, she would make sure that I was dictating on it, that I had acted on it. So she was another mechanism to try and make sure that everything was dealt with and she was very good at it, or she is very good at it. 12:27

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

A. At the time she was finding it difficult and she needed more time. I mean that was -- I acted on that, when she spoke to me about it. You know, if I needed MDM -- MDM patients, we get a list of MDM patients who need to be seen in clinic and she will book them into the clinic. If she feels she hasn't enough space we will 12:27

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

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

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

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

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

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

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

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

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

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

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

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

168 Q. Yes. We'll come later to look at an Incident Report that you raised in respect of an MDM decision which you understood, I think, had not been implemented by Mr. O'Brien or there had been a delay in relation to it. 12:32

A. Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

there's quite detailed discussion on the events that occurred. There's good support from the manager who sort of coordinates all these SAIs.

177 Q. Just to be clear, have you served as a Chair or a lead clinician on an SAI? 12:40

A. Yes, in the last year.

178 Q. We have heard about, I suppose, the difficulties of combining a busy clinical practice with trying to move forward with what might be a complex SAI review, you know, in terms of finding the practical things, about 12:41 finding the time to marry several diaries and get that work done. Is that something you have experienced?

A. It can be and lots of emails go back and forth. If you're trying to get 5 or 6 people together, it can take quite a while to get everybody, to coordinate 12:41 everybody to get them to meet.

179 Q. Because presumably there's an understanding that if an SAI is to be, I suppose, worth anything, it's got to do its work relatively efficiently so that learning emerges at a time relatively proximate to the incident. 12:41

A. Yes, although it can take quite a while, ultimately, for these SAIs to end. Probably because of, one, getting everybody together for a several meetings over a few months and, two, is to gather evidence and information on the events. 12:42

180 Q. Presumably you regard delay, even unavoidable delay in the context of how they are currently run, as being regrettable?

A. Absolutely. I mean in an ideal world I would like it

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

Has that become your experience, that there has been a change in the character of the process, or do you still remain relatively content that it is a positive experience?

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

188 Q. Have your appraisers been external to Urology?

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

189 Q. Is there something, if you like, to be preferred from using a person from another discipline to conduct the other?

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

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

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

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

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

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

A. I don't think I ever had a battle about my job plan. I mean it hasn't been a difficult situation for me. You know, I've job planned in the last few months and it's a discussion, it is a two-way discussion, and there's a mutual agreement. So I personally haven't had difficult conversations on job planning. 12:56 12:57

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

A. It's a great concept. I'm not too sure how it would work because we all work different PAs, we work different days. You have infrastructure requirements so you can't necessarily -- I think there's so many variables feeding into it, I think it would be very difficult, but it sounds good in theory. 12:57 12:58

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

"haphazard until recently".

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

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

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

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

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

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

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

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

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

ladies and gentlemen.

LUNCHEON ADJOURNMENT

13:00

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Mr. O'Donoghue. 14:00

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

14:01

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

14:01

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

14:01

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

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

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

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

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

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

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

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

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

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

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

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

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

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

199 Q. What does that mean? Can you spell it out for us -- 14:06

A. Well it means that you take all the calls --

200 Q. When you should be in bed, you're in hospital?

A. No, no, it means that during the day all the calls that a registrar would take, you take. So you're rang every few seconds by GPs. You're covering theatre. You're covering the wards. You're covering. You're supervising F1s. So everything is under your control, so it's quite difficult. There's a lot of territory to cover. It happened only a few occasions but too much even just being a few. 14:06 14:06

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

A. Yes. 14:07

202 Q. You go on in the last sentence to say:

"In conjunction with the Head of Service and other Urologists, if patients were not reaching their

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Just scroll back 3 or 4 lines. You say:

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

So no risk to them.

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

207 Q. It's maybe not entirely clear in how it is expressed, but you do come back and say there was a risk for benign patients, and in particular, you are using the example of ureteric stents?

A. But there were other benign, patients with long-term catheters, although they probably -- urinary catheters, although they probably didn't have the same risk as patients with stents. 14:10

208 Q. I think we'll probably stumble across it in one of the SAIs that I'm going to refer you to, but would you just articulate for us the risk associated with leaving stents in beyond the optimal date for removal or replacement? 14:11

A. Well, if a stent is removed after one month, the risk of sepsis is about one percent. The longer it goes on, the higher the risk. So it is a risk of sepsis and encrustation of a stent as well which means the stent ends up with stones at either end of the stent and that makes it a much more complicated and difficult operation to remove the stent. 14:11

209 Q. Yes. I can't remember off the top of my head, we heard from a patient directly, and indeed, the daughter of a patient who had come through that process of, on the one part encrustation with a patient who also had cancerous comorbidity, and another patient who had a delay and then was admitted with sepsis and became very ill, he had repeated admissions? 14:12

A. It also impacts -- even if it doesn't affect their lives, it affects their quality of life. Stents cause

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

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

A. Yes.

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

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

212 Q. Has that been resolved, the coding issue? 14:14

A. It has.

213 Q. Has the resourcing issue been improved?

A. Well, in -- well, there are lots -- I mean one is, we've sorted in lots of ways, we try and avoid putting

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

We do primary ureteroscopy which is an operation to remove the stone on acute presentation, that tries to obviate the risk of having a stent in place as well. So lots of little ways of trying to -- then we also try and privatise patients with stents as well. 14:15

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

"I have seen a couple of patients recently with 'forgotten stents', with no mention about the stents in 14:16 the discharge letter. I have filled in Incident Forms. We can discuss about this issue in the next governance meeting, please, particularly about the need for stent registry."

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

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

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

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

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

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

"Patient was wait-listed for removal of ureteric stent

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

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

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

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

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

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

14:19 14:19 14:19 14:19 14:20

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

216 Q. Yes, it is fairly fundamental.

A. Yes.

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

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

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

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

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

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

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

A. I was using, not now.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

226 Q. Perhaps the point is, as highlighted here, is that there was no protocol when, in fact, given the problems that there were around stents, there ought to have been a protocol? 14:28 14:29

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

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

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

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

228 Q. Perhaps that explains why no protocol was developed?
A. Because it is easy to say "we'll give a date", but that's meaningless because you won't be able to reach that date. 14:30

229 Q. But there is a recognisable standard, isn't there?
A. There is, but again, it is pious aspirations. If you have more coming in than capacity, it soon gets out of control. You know, there is more water running into the bucket than going out of the bucket. 14:31

230 Q. Is this area of stent replacement an area where you, as a clinician, would candidly recognise that the service within which you were employed was failing to comply with the standard or stent management?
A. It was failing, yes. That's why I tried to deal with different ways of getting BAUS stent register and try and get ways myself to try and keep track of it. 14:31

231 Q. And it was placing patients at risk?
A. Absolutely, patients at risk.

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

in association with Patient 91. We can see if we just go forward just to confirm for myself that my note is right. If we go through to WIT-33321. Yes, we can see that the report was approved on 11 October 2019, which is about a year and a half after this patient came in to difficulty and died during the replacement, or as a result of complications arising out of a stent process. 14:33

If we go then to WIT-33315, under "What happened". Just park it there for a moment. We can see that this is a case where a stent was placed in or about 4 March 2018, but he was not admitted - scrolling down - he wasn't admitted until 18 May for urethroscopy and laser. He was a patient with comorbidities, but he did not emerge well from the operation. Part of the difficulty here was the preoperative assessment. There was a failure to conduct, I think, a midstream urine analysis prior to surgery. 14:34 14:34

If we scroll down, please, we can see that the stent was placed. His condition deteriorated post-operatively and despite efforts he sadly passed away. 14:35

If we could go to the recommendations at WIT-33320. Particularly scrolling down the page and looking at recommendations 3 to 6. Recommendation 2 deals with the preoperation assessment issue. But 3 to 6, I think, in particular deal with the need to improve 14:35

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

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

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

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

233 Q. I think he did.

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

234 Q. Yes?

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

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

235 Q. The case itself gives rise to --

A. So there's lots of issues there. 14:38

236 Q. -- many concerns and issues --

A. I think there's more than one.

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

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

238 Q. Generally?

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

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

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

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

240 Q. Yes. The broader point is, and it comes to you in a Patient Safety meeting context, remember this report, it's produced a year and a half after the incident in October 2019. 14:39

If we go to WIT-33309 we can see that Mrs. Clayton is writing to you on 21 September 2021. So it's two years after the SAI report is issued: 14:40

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

14:40

It has Item 5 and 6 of the document that I have just shown you. We go, just to close the circle, if we go to TRU-387892. You're chairing this meeting. The second page, if we just scroll down. This is the meeting of 13 October 2021 and we can see there; sorry, 14:41 I wasn't looking at the screen. If we scroll down a little further to Section 10.

I think we understand that one of those items under "shared learning" relates to Patient 91 and it's the 14:41 one 19.08.21 on the left-hand side. It says obviously the seven recommendations in the SAI were discussed. Then there is, amongst the attachments, a copy of the action plan for Patient 91. What's less obvious is the

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

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

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

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

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

whether a stent with a string can be used?

A. So if it's appropriate, yes.

243 Q. But there will be cases where it is not, and I suppose what the Inquiry wishes to understand, because we've seen quite a number of stent cases, and that is why I am spending so much time on it, what can you say about today, October 2023, that could re-assure the public that they're not going to get into difficulty with indwelling stents staying in too long and being forgotten about by clinicians who don't have it on a management plan? 14:45 14:45

A. Well, as I said, we're probably putting in less stents because if we're putting in stents with strings, the cohort of patients that are waiting for stent removal is less. We are doing, as I said, primary ureteroscopy. So if it's feasible we're treating the stone when the patient comes in acutely, rather than putting a stent in and bringing them back at a later date for treatment of that ureteric stone. 14:46

Three is, a recording is better in that we now have two codes, a code whether there's a stent in or whether there's a stent not. So we are aware on the database that a patient has a stent in situ. We have a Scheduler appointed in the last few weeks who now takes pools lists and so -- or pools the patients. So the next person with availability will get that patient. 14:46

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

14:47

14:47

244 Q. Thank you for that.

14:47

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

14:48

14:48

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

plagued urologists for a long time.

245 Q. Yes?

A. Perhaps it has plagued us more than other Departments, but it is a problem that has been around for a long time. 14:49

246 Q. Yes. Returning to the theme of capacity issues more generally, you spoke this morning briefly about initiatives to try to improve the capacity problem or to address the capacity problem. From time to time there were waiting list initiatives. It was the use of 14:49 the private sector.

You talk in your statement about specialist nursing and what specifically trained or specialist trained nurses can bring onboard to help address problems by, 14:49 I suppose it would be wrong to say "by filling gaps", but by providing services that maybe historically consultants and senior medical staff would provide. Can you help us on that and what you have seen over the course of your career at Southern Trust? 14:50

A. Well I think we are quite lucky in Craigavon. We have got five Clinical Nurse Specialists and two more who are in-training now. They have a lot of extended roles. So we have one of the nurses, two of the nurses actually do prostate biopsies. We have two nurses who 14:50 can do flexible cystoscopies, we're training them up. We have a nurse who does urodynamics. One of the Nurse Specialist is taking prostate cancer for surveillance, and another one has an interest in kidney cancers,

small renal masses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRU-98238. Thank you.

A. These are obviously reviews.

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

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

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

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

254 Q. I suppose the point I'm making, I haven't got the reference for you to bring it up on the screen, but what I'm saying is that by 2021, for the same cadre of patients, in other words those waiting on a consultant-led first appointment in Outpatients, the number of those waiting more than a year has gone up massively to more than three and a half thousand? 15:02

A. I think during COVID I didn't see any urgents, I saw just red flags. So between MDM patients coming back to be seen at review, because they were the only review patients, MDM patients, and new red flags, they were the only patients we were managing to see. So I think that's probably the reason why the numbers have gone a way up with regard to urgents, and routine, and new patients. 15:03

255 Q. We can see, perhaps, similar increases across other indices, number of patients waiting on a Day Case waiting list. If we go to TRU-98245. These are figures for 2016. Those waiting more than 52-weeks is 241. 15:04

If we go to 98251, TRU-98251. So that figure of 241 waiting more than 52 weeks for in-patient or day case has now grown exponentially up to 1321. Is that all related to COVID, the bounce in these figures? 15:04

A. Putting it simplistically, because that's what I'm doing, I think it certainly is. I can't see what other variables, there probably are other variables, but certainly I would have thought COVID, because

we weren't doing any day surgery, any routine day surgery at all, so I can see why those numbers went up. TRPs suffered, TRPs are outlet surgeries for benign prostate, I think they suffered. So anything that wasn't cancer, I think, suffered because of COVID. 15:05

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

A. No. They weren't healthy before, but they were even worse afterwards. 15:05

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

A. No, not in the slightest. But again, a lot of these are now going to the independent sector for patients 15:06 needing bladder outlet surgery. We have new technology and if they are suitable we do that with something called "Rezum" which is a treatment for prostates. It wasn't there when these patients were listed for prostate surgery. If they are suitable, we certainly 15:06 put them to Lagan Valley to have that procedure done there. You can do a lot more with that patient with Rezum than you can for a TRP because it is a day procedure.

258 Q. Just before we move on to see what the view of the 15:06 staff was and your colleagues was in relation to waiting list problems, just going back to the reference I needed to give you for 2021 for those waiting for a first outpatient appointment. The reference is

TRU-98244.

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

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

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

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

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

So whilst I have a specialist interest in benign urology, I obviously also do some oncology. And that's why these patients have suffered, because they have gone on the long finger.

260 Q. So the side effect of you being necessarily brought into oncological practice is that nononcology patients suffer these waits. 15:10

A. Yes.

261 Q. Again that is a resourcing issue, is it?

A. Things have got slightly better since August because the registrars have come back into clinic, whereas they weren't before. When a registrar is with me in clinic, they are now seeing benign patients, benign review patients. So hopefully -- but I'm still seeing a lot of MDMs. 15:10

262 Q. Mr. O'Brien's name appears on that list, somewhat unusually, perhaps. He departed practice in July 2020. Do you understand why his name is set against?

A. Yes, my understanding is that they were Mr. O'Brien's patients, but as they are picked up by Mr. Haynes or one of the rest of us, they then change over. So they're on his name but they'll slowly drift over to one of us. 15:11

263 Q. Do they stay under his name, do they, until their review date occurs? 15:11

A. Either Mr. Haynes or one of us, one of the other consultants will take them over.

264 Q. I appreciate that.

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

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

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

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

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

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

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

CHAIR: Thank you, everyone.

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

you explain that you strived to provide, along with Mr. Young, and no doubt other of your colleagues, to provide an excellent and efficient service for patients. How was that possible in terms of the excellence and efficiency of delivery. How was that possible when you see the state of the waiting lists and what lay behind the waiting lists? 15:33

A. I think on reflection, "efficient" is probably a bad choice of word. Excellent, in my eyes, I provide the best service I could, so I think it was excellent in that sense, but "efficient" perhaps shouldn't be in there. 15:33

266 Q. I suppose there's two ways of reading that. As you suggest, you did your level best to provide an efficient and excellent service but the Service itself, in terms of its efficiency and excellence was okay for those who got in the door, but it wasn't by any other definition an efficient or excellent service if you're waiting for more than a reasonable period? 15:33

A. Absolutely. I did my best with what I had, but I think if you were looking at it objectively, it certainly wasn't efficient. But I worked hard or I do work hard. 15:34

267 Q. Yes. You have explained to us that there were these recruitment issues and the Trust worked, as best it could, to try and fill the void with locums on the consultant end. Ultimately, you know, there are insoluble problems or at least problems that are difficult to get around on the recruitment side. 15:34

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

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

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

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

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

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

15:37

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

15:37

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

"The private sector has a role to play in managing the problem, but the Trust needs to find a solution from within." 15:38

He concludes by saying he would stress that:

"Without immediate action to start treating these patients there will be further adverse patient outcome, death from sepsis, which would potentially not have occurred if surgery had happened within an acceptable timescale." 15:38

15:38

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

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

268 Q. Is that a recent initiative?

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

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

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

there:

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

15:41

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

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

A. I would have thought so, yes.

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

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

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

He asks for a meeting at some point and says:

15:43

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

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

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

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

But in saying that there is quite a disparity, but I can't remember whether we got theatre space or not from another specialty. I think we did.

271 Q. You think you did? 15:45

A. I think it was Gynae.

272 Q. Was it short-term as opposed to a --

A. It's not a permanent, well it wouldn't be permanent. If we did get it, it was short-term, but I can't give you the time period. 15:45

273 Q. As opposed to a proper structural fix?

A. Yes.

274 Q. Perhaps my comparison is somewhat unfair and not precise enough, but was there any sense on the part of yourselves as a team of Urologists that 'we need more 15:45 access to theatre'?

A. No, we're always wanting more access.

275 Q. Yes?

A. You know, that's not just that time. We're constantly looking for more access. I mean we're always asking 15:46 for more access.

276 Q. Was there a sense as well as wanting more access that other disciplines were achieving more access or better access than urological patients?

A. I don't know whether they were getting more access. I 15:46 mean, their waits were less but I mean that's probably just a reflection of referrals that come into the specialty. Perhaps some of the specialities have a smaller operation so they can work through them a lot

faster.

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

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

"The waiting lists for patients are considerable. This results in them being admitted as emergencies within particular urosepsis and these could be avoided with 15:47 timely elective surgery. Going forwards we should 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 an emergency." 15:48

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

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

needing more theatre space. It's sheer numbers that need to be treated. There's certainly two that would come -- two reasons that would immediately come to mind. Sorry, I think a large number of patients, something would be -- and whilst we were working our way through them, they never made -- never seemed to make a huge impact on the waiting list. 15:49

You know, we're talking about benign cases there. So the red flag TRBTs would have always taken precedence on those. So there will always be, so we would have never had just fully benign lists because of the need to try and get the red flags done all the time. 15:49

278 Q. You speak in your statement about working together with line management to pursue common objectives as a team to ensure the best possible care is provided for patients. I think you say that you considered that: 15:50

"Medical and nonmedical managers work well in Urology and the Department ran effective." 15:50

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

A. Yes. 15:50

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

A. Well I think, you know, one could always do with more resources. But having the money to buy things doesn't necessarily, you know, you need people as well. You know, The Trust tried to recruit. So you can't do an operation without a surgeon. 15:51

I suppose subsequently they have, you know, employed the IS. There are Urologists coming from Manchester now. So they are thinking of ways to try and get the numbers through. They're also sending patients to the 15:51
IS for private surgery. So some patients have gone to Dublin for TRPs. Some patients have gone to Dublin for urethroscopy. Patients have had TRPs in Belfast.

So they are trying, spending lots of money now, but 15:52
perhaps that didn't happen back -- I mean that's going back to 2000-and -- certainly a few years ago. What we're doing now has only been going on for the last year or so.

280 Q. Mr. Glackin makes the point -- and this is at 15:52
paragraph 31.1 of his statement, WIT-42307, 31.1. He says that in his opinion:

"...senior managers did not work well with Urology. Engagement with the Department by Clinical Directors, 15:52
Medical Directors, Assistant Directors and Directors For Acute Medical Services was very limited and infrequent, in my experience. I do not know how much job planned time they had allocated to management

activity."

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

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

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

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

A. For me personally, no.

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

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

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

283 Q. I want to turn now and for the next half-hour to your understanding and awareness of what The Trust has identified as "practice shortcomings" in association with Mr. O'Brien. I suppose I want to start, and we can test it, test your view as we go along. But we'll start with a reflection you've shared within your statement at paragraph 67.1. So if we go to WIT-50550. At point 76.1 you're asked: 15:56 15:57

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

Your answer is: 15:57

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

Service are dealt with effectively and efficiently.

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

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

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

You say:

"No, I don't think mistakes were made by either me or others in handling the concerns identified. When concerns were identified, such as the failure to triage referrals or failure to follow through on MDM recommendations, systems were put in place to protect the patients." 15:58 15:59

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

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

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

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

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

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

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

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

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

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

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

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

287 Q. Yes?

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

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

A. Yes.

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

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

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

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

A. I was aware of that.

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

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

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

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

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

A. Yes.

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

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

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

A. Yeah, yeah.

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

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

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

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

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

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

298 Q. Yes. Just scrolling down, you said at 35.3, your understanding was the triage letters which had not been triaged were found in a filing cabinet in his office. You're not aware of the reasons why his office was searched and was not aware over what period this triage covered. 16:07 16:08

The use of the word "searched", is that your understanding of what you were told took place or could you have been informed that Mr. O'Brien himself directed Mrs. Corrigan to the location of the referral letters in his office? 16:08

A. Well, I think "searched" might be a poor choice of word. I know subsequently, again from reading the evidence in the last few weeks, that Mr. O'Brien directed Mrs. Corrigan to go to his office. But if I was aware, if I had been told about it at that time, it didn't stick in my memory. 16:08

299 Q. Just to push that a little further, have you been under the impression until relatively recently that perhaps implied by the use of the word "searched", have you been under the impression that Mr. O'Brien had hidden these letters away and hadn't informed anybody as to their presence? 16:09

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

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

300 Q. Yes. I think the impression, or the correct position in fairness to everybody, Mr. O'Brien and Mrs. Corrigan, is that she accepts that she was told that these letters would be found in a particular place, in perhaps a filing cabinet, I forget, but within his office? 16:09 16:10

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

301 Q. Yes. As I think you've acknowledged already, you did have a degree of knowledge prior to this January 2017 meeting, that triage and Mr. O'Brien were uncomfortable bedfellows. 16:10

A. Yes.

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

A. In that it landed on me, because I followed him. 16:10

303 Q. I think we touched upon this briefly this morning, how did you arrive at the view that he was having difficulty, or at least there was a difficulty in completing what was expected of him by the conclusion of his Urologist of the Week period? 16:11

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

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

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

A. Yes.

305 Q. Is that right? 16:11

A. Yes.

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

A. Yes.

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

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

308 Q. Yes. And was this a --

A. I can't remember. 16:12

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

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

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

A. Because it was --

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

317 Q. Is that your --

A. Probably definitely on the Wednesday. 16:16

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

A. Yes.

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

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

320 Q. I suppose, in addition to that, do you recall any attempts on behalf of the team, on the part of the team, I should say, or on part of the Team Leader, if I can call Mr. Young that, to try to interrogate the reasons for the difficulty, which I think was perceived on the part of Mr. Young as being a slowness in delivery of triage, whether or not he understood that there was a failure of triage. We can ask him? 16:17

A. You mean a slowness of Mr. O'Brien triaging or slowness of -- 16:18

321 Q. I mean there is different strings to the evidence this Inquiry has received. Some people have said and will say, I understand that we assume that Mr. O'Brien was just slow in getting it back, whereas the clear picture is that, in fact far from being slow, he was simply not doing it in terms of urgent and routine. 16:18

So my question to you is, I suppose, whatever the problem was being regarded as, whether slowness or not doing it, why was that not, and perhaps it was, was that a topic of conversation amongst you as a team with Mr. O'Brien? 16:18

A. I don't think it was. I think probably part of the problem with regard to me was I was doing them, so they weren't lying around. I think the issues came to a head and I sort of things came out. Those triage were found in his office and he was given the Friday afternoon afterwards, after on-call, to enable him to do that triage. I think part of the problem was the depth he 16:19

tried to do the triage.

As I said earlier today, I mean I've seen some of the letters he dictated whilst on-call and they were four-pages long of no paragraphs, just continuous narrative. I think if you tried to do that kind of long letters, I don't know how many hundred come in a week, it's impossible. I don't think of any benefit because nobody can read those letters. They're just too long, too unfocused. 16:19 16:20

322 Q. I'm keeping my finger on, if you like, the state of knowledge and what was done with that knowledge just for the moment. So you had a discrete piece of knowledge that he wasn't doing the Wednesday, if I can describe it in those terms, because you were left having to do them. 16:20

You are not giving us any indication of recollecting that Urology Consultants as a team at meetings attended by Mr. Young and Mrs. Corrigan were an opportunity used to address Mr. O'Brien's shortcomings, whether to provide support or challenge, but to at least address the issue? 16:20

A. Yes, because I'm not -- well I don't know, I may have said it casually rather than formally. So I don't think it was discussed at the meeting as an actual problem where there could be a solution to it. But I'm trying to remember back and it's not something I expected to have to reproduce, so I can't remember 16:21

exactly, but...

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

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

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

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

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

Sticking with the triage:

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

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

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

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

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

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

She agrees that:

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

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

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

As I said, you know, blood in the urine, categorised as urgent or PSA, elevated PSA, sent as routine. So I think -- personally I think it is a very unsafe. If I had known about it I probably wouldn't have agreed with it or certainly would have voiced my discontent. 16:27

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

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

326 Q. I'm not?

A. -- I actually became aware of it, again, reading the evidence in the last few weeks. So it's not something I was aware of. 16:28

327 Q. I suppose you would make the point it didn't apply to you because you dealt with your triage in a timely fashion. 16:28

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

328 Q. Again, briefly and finally for the purposes of this afternoon, I think we touched upon it in short order this morning. In terms of your own approach to triage when you Urologist of the Week, I think you have said, when we touched upon this morning, listen, I don't 16:28

leave the hospital until it's done.

A. No.

329 Q. The technique or the approach to triage, again, I think you touched upon it briefly this morning, but do you have anything further to add in terms of your own approach to triage? 16:29

A. So as you quite rightly said, and even when we were doing the hard copy triage, I never took the triage out of the outpatients, I always did it in the Department to avoid the referrals going missing. I always did them -- never left, as you quite rightly said, until I triaged. Now on ECR, I still deal with them in the hospital, triage and will stay until they're all done, so I can start a new day with a blank sheet. 16:29

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

330 Q. Could I take you to the vision document. I think it was a document perhaps authored by Mr. Haynes and maybe with the input of the team of Urologists from September 2014. WIT-50676. This is the first page of the document in it. It covers a wide variety of issues but it was written in the context of, I suppose a stock-take exercise being conducted by The Trust in terms of Urology Services and the future. This is the contribution on behalf of the Consultants as to how things might be done better having regard to the context in which you were working in, including the 16:30 16:30

demand on services.

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

16:31

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

16:31

16:32

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

16:32

Now, as I understand it your approach and the approach of your colleagues to routine and urgent triage does not routinely involve arranging for investigations?

16:32

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

every day, I don't know the exact figure, there must be 50, 60. I mean you would just spend your day booking scans. But I think it is on a case-by-case basis. So if you're concerned enough to think that this patient needs a scan in the relatively near future, one would book it. 16:33

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

A. Yes. Because I mean to do it on the computer it probably would take 6 or 7 minutes. But if you have 6 to 7 minutes, 60 to 80 times, well that's a lot of time just booking scans, particularly when a lot of them don't immediately need scans. 16:33

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

A. Well I use my clinical knowledge to decide whether a patient needs a scan or not. 16:34

333 Q. We know from the waiting lists that large numbers of patients who fall into these categories of routine or urgent are not going to be seen for significant periods of time with the morbidity that is often associated with that delay. 16:34

How do we square the circle, assuming the circle hasn't yet been squared. Because isn't it the case that really there's no mechanism to routinely check on those patients that are on these waiting lists. They come in as emergencies quite often if Mr. Haynes and Mr. Glackin's evidence is to be accepted. But is there not a better way of doing it? 16:35

A. Well they're generally stones. So they would have scans organised. If a patient has voiding dysfunction, one would routinely get a scan of those, although you will have a small cohort that will go into retention.

16:35

You are dependent on the GP's assessment as well, whether somebody has chronic retention of urine or not. If the GP has assessed a patient poorly, your triage is going to be based on that poor assessment. But in saying that, by getting scans on patients who are referred in with renal colic or stones, one would hope that you avoid sepsis and most of the sepsis are patients with stents anyway.

16:36

334 Q. Just to finish on the point, looking at Mr. O'Brien's perspective that it was impossible, he says, to do the routines and urgents, and still provide a service of excellence across the other jobs requirements during the on-call week. What is your response to that?

16:36

A. Well, I think you need to use your time sensibly and I suspect he didn't use his time sensibly. I mean, you need to spread the time that you have over all the patients that you have, inpatients and triage and those for theatre. So at least your triaging patients. You're getting scans on red flag patients and selectively on the urgents and routines.

16:36

16:37

You're seeing the patient on the ward and supervising and treating patients in theatre. So I think you can do them all, although, you know, one would always love

to have scans on everybody and do everything, but, you know, I think it's impossible. But I think if you spread yourself, use your time sensibly and safely, you're not going to run into problems.

MR. WOLFE KC: Thanks for your evidence today. We'll pick up again at 10:00 a.m. in the morning. 16:37

A. Okay, thank you.

CHAIR: Thank you Mr. Wolfe. Thank you, Mr. O'Donoghue. We'll see you again at 10 o'clock in the morning. 16:38

A. Thank you.

THE HEARING WAS THEN ADJOURNED TO THURSDAY, 12TH OCTOBER 2022, AT 10:00 A.M.