Urology Services Inquiry

Oral Hearing

Day 73 – Monday, 4th December 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 MONDAY, 4TH DECEMBER 2023

CHAIR: Good morning, everyone.

MS. MCMAHON: The witness this morning is Mr. David Connolly, who's a consultant urologist and he wishes to take the oath.

MR. DAVID CONNOLLY, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MS. McMAHON AS FOLLOWS:

1 Q. MS. MCMAHON: Good morning, Mr. Connolly. My name is Laura McMahon and I am junior counsel to the Inquiry. I'll be taking you through your evidence this morning.

The context of your evidence is that you worked as a registrar and a urology consultant in Craigavon at various times. And you've provided us with a reply to the Section 21 notice we served on you. And we can Find That At WIT-41966. You'll just see your name at the top of that. It's dated 7th June 2022. Notice Number 60. And if we go to your signature at the end at WIT-41997, we'll see a signature there. Do you recognise that as your signature?

A. It is.

2 Q. It's dated 1 August 2022. And do you wish to adopt this statement as your evidence today?

A. I do.

3 Q. Now, I'll ask you some questions about your statement.

I'm going to work through it and just identify some of the issues that you have addressed that the Panel may be interested in. But I wonder, just before we do that, could you summarise your education and your career path to date?

A. So, I studied medicine at Queens. I graduated in 1999. I did my GHO year in the same hospital. I then went straight into basic surgical training, which was for three years. When I finished that, I did a year as a staff grade in general surgery in Causeway Hospital. And then I went into research in 2004. That was in the City Hospital and in the Cancer Registry in Queen's. So that was in 2004 to 2007.

During that period of 2004 to 2007 I also did locum nights in Craigavon and in the City Hospital as a registrar. I then interviewed and was appointed to higher surgical training in urology in Northern Ireland, which started as ST3 in August 2007. And that was in Craigavon, for a year. And then I rotated round through the City Hospital, Altnagelvin Hospital and the City Hospital, and then I did a fellowship year in the Monash University Hospital in Melbourne for a year. That was a fellowship in endourology, primarily stone surgery, and laparoscopy.

Then I was appointed to Craigavon as a consultant in September 2012. And I left Craigavon in March of 2013 to join as a specialist endourologist in the City

Hospital, and that's my current post.

4 Q. Thank you for that. And just if I can summarise, for our purposes, the relative time periods and you can confirm if that's correct. You were a locum registrar in Craigavon from 2004 to 2007?

A. Yeah.

5 Q. Then you started your higher training in urology, August 2007 to August 2008?

A. Yeah.

6 Q. And then you were a consultant in urology in Craigavon from September 2012 until March 2013?

A. Correct.

7 Q. Thank you. I just want to look at your statement now and set out the lines of management and your role while you were at Craigavon. If we go to WIT-41966, paragraph 1.1 and 1.2. So you say:

"I started in Southern Health and Social Care Trust as a consultant urologist in September 2012 and left to join the Belfast Health and Social Care Trust in March 2013. This was my first consultant job and was always going to be a short term appointment for me, as I planned to move to Belfast Health and Social Care Trust. As a new consultant, I only had a basic knowledge of the processes behind running a consultant practice, managing a rapidly expanding service and the governance structure of a health trust."

At paragraph 1.2 you say:

"I was a standard core urologist with responsibilities as outlined at paragraphs 5 to 8. I did not take on any other management roles, nor did I get involved in the long-term planning for the unit, as within a few month my consulting colleagues knew that I was leaving."

Just in relation to your plan to move to Belfast, when you took up the post, did you know you were going to move on relatively quickly?

A. Yeah.

8 Q. And what was the reason behind that?

A. So, when I was in Australia, I was in communication with the team in Belfast City Hospital, I was aware that a new job was going to be starting, which I'd hoped would've started in August 2012, that I would've been able to come back to. But the post wasn't ready to be advertised at that stage, so I applied for jobs both in the Ulster, Altnagelvin and Craigavon. But no matter where I was appointed to, it was only going to be for six months, because my plan was always to work in Belfast Trust in a specialist endourology role.

9 Q. And what was attractive about that specialist unit for you? Was it your area of expertise or planned expertise?

A. Yeah. So in all the other Trusts, that you were a core urologist, which meant that you dealt with all of

urology and then you had a limited role in your subspeciality. In Belfast, because it was a larger unit with more consultants, then I would primarily be doing my subspecialty near enough all of the time. It was also much closer to home, so it would save me driving.

10 Q. Now, you mention as well in that paragraph this was your first consultant post.

A. Mm-hmm.

11 Q. And you say:

"I only had a basic knowledge of the processes behind running a consultant practice."

In 2012 was there any training for new consultants in how to run a consulting practice, or was it very much on the job training, that you learned as you went along from your peers?

A. I think certainly as you're training in urology - and I'm sure this is the same in other specialties - that you do reading about the practical theoretical part of the job and then you have your apprenticeship part of the surgery, which is doing the operations. So the main focus of my training was knowledge and practical experience and to become competent in the operations that I would need to do.

The actual running of a consultant practice was something that was hardly talked about, to be honest.

Now, it may well have been that when I got to my final year in ST7 that that would've been part of my sort of training to finish off so that I would be -- sort of that would be part of it. But I was in Australia, so therefore I may have missed out on that. But I certainly felt that whenever I started my first consultant job, I knew how to treat urology problems, I knew how do the operations, but in terms of actually being a consultant, there was major gaps in terms of running a practice that I had.

So, for example, I can remember starting in Southern Trust and being contacted by the outpatient manager to say what my outpatient template was going to be, and I had never heard of an outpatient template, I didn't know what that meant, so I had to ask the other consultants, what do you do?

12 Q. So, from the administrative side of your role, it really was learning on the job as best you could?

A. Yeah, you knew that you had triage to do, you knew that you had discharge letters to do, you knew that you had outpatient clinics and letters to do, you knew that you had to have the whole results and background behind that and that you had to be able to run that efficiently. But it was very much left to you and your allocated secretary to work out the practicalities of how that would run.

13 Q. And in relation to governance - we'll talk about the specifics of governance at the time in a little while -

but in relation to governance and structures and your understanding of governance around 2012, was there any specific training around that, or were you informed in any way that these are the processes that you follow should anything happen?

A. Well, you know during your training that there are governance structures that are within a unit and within a Trust; you know, so there's audit, M&M, IR1, critical incidents. But in terms of the practicalities of how that all works in the background, I had no idea, to be honest.

14 Q. If we fast forward to now, you're a consultant at the City now; what's the situation like for new consultants coming into posts? Do you know anything about that? Is there much of a difference? Can you inform us about whether processes are perhaps more comprehensive at this stage?

A. Well, I think that we, as a group of consultants, as part of the training, do try and involve our ST7 senior registrars as part of that. And I'm a clinical supervisor and education supervisor for the higher trainees, so that would be part of what I would see as my role, is to train them in terms of how to run a practice, not just the knowledge and the operations. So it would be part of that. And, you know, for example, the ST7s in Belfast, we would bring them to our business meetings so they would see what happens with the management and what happens to how the unit is run outside of just audit and M&M that they would be

involved with through their training.

15 Q. And is that something you've undertaken with the other consultants on a local basis or is that something formalised by the Trust, where's there's an expectation that there is a gradual easing of a registrar into a consultant's post so that they know all of their roles and responsibilities?

A. There's no formal guidance that I'm aware of that you do as a consultant for your higher trainees to get them involved with that side of thing. It's something that, probably because we have experience of starting, not really knowing how it works, to try and not have them in the same position.

16 Q. The Inquiry has heard evidence in relation to administrative practices that perhaps have impacted on patient care and perhaps risk; do you think, given what you've said, that it would be beneficial for new consultants to have some sort of formalised, structured training around what's expected of them and from them in relation to their role?

A. I think that, you know, even within my current practice, that the registrars that I supervise, that they have their own aspects of admin that they have to do. And I keep a very close eye on that and I make sure that they develop good practices in terms of signing off their letters in terms of doing the results and actioning things that need to be actioned within a reasonable timeframe.

17 Q. I suppose my question's perhaps a little bit broader

than being specific to your assistance that you provide. Do you see any merit in the Trust having a formal or a structured approach to new consultants to allow them to understand exactly what's expected from them in their role, as regards, for example, administration, discharge, the processes by which they engage with wider ancillary staff within the Trust?

A. So, again, when I started in Belfast Trust, that there was a programme of training as a junior consultant. But that only happened after I was appointed and then it was, I think it was like one day of training per month for the first six months - I think it was called the CLIME sort of training, C-L-I-M-E. I can't remember what that stands for. But that was sort of part of being a new consultant, how you were introduced to the governance structures and how the Trust expected you to run your practice. But certainly, bringing that into higher training so that when they start that they have a better idea of what's expected I think would be beneficial.

18 Q. Now, your line manager, when you worked in Craigavon, was Michael Young?

A. Yes.

19 Q. And that was during your time both as a registrar and as a consultant - because he was clinical lead at the time?

A. He was always the clinician lead, as far as I remember.

20 Q. And you worked with Martina Corrigan as well?

A. Yes.

21 Q. And during your time you were responsible, together with the other consultants, for the training of two of the urology registrars, Derek Hennessy and Matthew Tyson?

A. Yeah.

22 Q. Now, if you go to paragraph 7.2 at WIT-41972, you speak to the way in which you would've dealt with any issues. You say:

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

Was that during your time both as a registrar, the early days of your training as a registrar, as a locum registrar, and as a consultant, you never had cause to raise any concerns with Mr. Young, or indeed anyone else at Craigavon?

A. No.

23 Q. And again, at WIT-41966, paragraph 1.5, you say formally in your statement:

"I was not aware of any issues or concerns with any staff members or the urology unit management during my time in Southern Health and Social Care Trust. I was aware of my line managers and who to report concerns to, if they had been identified. I first became aware

of issues with Mr. O'Brien and with the SHSCT Urology Service in a telephone conversation with Mr. O'Brien."

Which you have outlined. And if we perhaps go to paragraph 53. I'll give you the reference for that. WIT-41990. And just before I read this paragraph in, have you had the opportunity to listen in or read any of the press reports about the Inquiry, the issues that have arisen that we've been discussing over the last while?

A. Just what I've read in the evidence and what I've seen in the news, nothing more.

24 Q. So that's how you found out about the issues that we're discussing?

A. Yeah.

25 Q. You say at 53.1:

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

And at 53.2 you say:

"I first became aware of potential issues when I was speaking to Mr. O'Brien after he retired. I believe this was in late July or early August 2020. He informed me of his perceived poor treatment by SHSCT after his retirement at the end of a telephone conversation about one of his SHSCT patients who he had planned to refer to BHSCT for a metallic stent.

Mr. O'Brien was aware that this patient was a family friend of mine and he did not want his care being delayed with his retirement. He was also aware that I had already been helping the patient understand his illness and make decisions regarding his treatment with Mr. O'Brien. He advised that he had a verbal agreement with SHSCT that he would return to work on a part-time basis after his formal retirement. When he contacted SHSCT to arrange his return, he was advised that SHSCT did not want him to return to work, as he had an outstanding grievance against Trust management. He felt this was unlawful and he advised that he planned to sue the SHSCT. Mr. O'Brien informed me that he believed that SHSCT began an investigation into his clinical practice after he brought an unfair dismissal against SHSCT."

So that provides the context for your contact with Mr. O'Brien. Did he mention anything in the call about the issues that are subject to this Inquiry, about the specific complaints in relation to him and the general governance within the trust?

A. No. It was that the Trust had started looking at his practice in very great detail because he was bringing -- because he was going to sue them for unlawful dismissal. That's the only thing he said to me.

26 Q. And you time this call to late July or early August 2020.

A. Yeah.

27 Q. Did you have any contact with Mr. O'Brien subsequent to this call?

A. No.

28 Q. If we go to WIT-41973, paragraph 9.1. And this is a paragraph in relation to the Integrated Elective Access Protocol. We've heard a lot of evidence around this. At paragraph '9.1 you say:

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

Now, the Integrated Elective Access Protocol sets down timeframes for treatment. And as a new consultant, was it the case, as you didn't have a list, or a patient

list, did the longest waiters go to you, or what was the process at that time when you started in Craigavon?

A. Yeah, so most of my outpatient clinics would've been seeing new patients. So they would've been whoever were the longest wait patients waiting to be seen, sort of urgent or routine. Because at that stage I didn't have a operating waiting list, my operating theatres would've been with other patients, or other consultants' patients, and they would've been given to me by Martina through Mr. Young and Mr. O'Brien.

29 Q. And they were allocated to you, you took those on. And did they stay as your patients or did they go back to the original consultant? Were they transferred to you?

A. I can't remember. I think they were probably transferred to me because I operated on them, then I would've followed them on thereafter.

30 Q. Do you have any recollection around the target time set out in the IEAP and whether patients that you dealt with had exceeded those target times at that point?

A. There was numerous patients that were waiting longer than the targets. And that was the main focus of Martina and the Trust management, which was to try and sort of meet those targets as best they could. Like, it was unrealistic at the time, based on the patients had exceeded the target and the capacity within the unit, but they would've just taken the longest waiters and then give them to me and the other two new consultants to see whether or not we were able to get close to or meet the targets.

31 Q. And when you joined as a consultant in 2012, you were aware of these target times at that point - you've mentioned that Mr. Young and Martina Corrigan probably made you aware of that. But prior to that, when you were there as a locum registrar during 2007/2008, did you have any awareness around waiting times or long lists or anything like that at that time, was that on your radar?

A. Well, you always would've known that waiting times were excessive. But in terms of actual targets and the practicalities of how the Trust were meeting them targets, I wouldn't have been involved.

32 Q. I suppose I'm trying to get to the sense of, given you were there for three different time periods over a period of time, every time you went back - 2004 to 2007, then back as your training 2007 to 2008, then you came back as a consultant in 2012 - did you have any sense that things were seemingly worse?

A. No.

33 Q. So the target times in 2012 that you were experiencing as a consultant, they weren't a surprise to you?

A. I wouldn't have been that aware of the waiting times when I was a registrar, because the lists would've been booked by the individual consultants. You know, whenever I started as a consultant, the waiting times were above target - well above target - but compared to now, they're not bad. So, at that stage I didn't think it was excessive. And my expectation, given the fact that they had went from two consultants to five

consultants, that we would actually, by working together, be able to meet those targets.

34 Q. And did you have a sense that management had an expectation that it would be urology consultants who would work together to meet the targets or try and bring some of those patients in to reduce waiting times?

A. Yeah, so --

35 Q. Was the onus on you as the urology consultants?

A. So we would've had a meeting once a month where we would've went through the whole theatre lists for the following month in terms of who was doing the lists, if someone was on holiday or someone was on leave or doing something else, that someone then would've been allocated to backfill that list so all available lists were covered all of the time. So that's the way the unit would've ran. And then -- so, for example, if I had taken on one of Mr. Young or Mr. O'Brien's lists, that they then would've said 'Right, I need three prostate operations done, these are my ten longest waiters, can you choose three of them?' And I would've then looked at the cases and then chosen the cases that I was happy to operate on.

36 Q. So there was that flexibility among the consultants to try to get people off the list who'd been waiting excessive times?

A. Yeah. So, I don't know how Mr. Young and Mr. O'Brien did t, but they would have sent me a list of patients to say 'Can you operate on these patients?' And then

I would've looked at them and I would've said 'Yes'.

37 Q. Do you have any recollection or any view on whether you felt, at the time, Urology was adequately resourced to meet the targets?

A. I think there was, and I mention in the statement that there was, an expectation amongst the team that our capacity was going to increase, because they had moved from two consultants - well, previously three consultants - up to five consultants and, therefore, the operating time, the theatres that we had available to us, the clinics we'd available to us, the diagnostics we had available to us would be increasing in line with the number of consultants that had been appointed and, therefore, the waiting times were going to come down. And the expectation was it may take a period of time, a year or two years, but that we would be able to get the unit running on a self-sustaining basis so we would be able to meet the targets the majority of the time.

38 Q. And was that still the expectation when it came around to March 2013 and you'd moved to Belfast, was it still going that direction?

A. Well, I know the extra lists hadn't materialised at that point, so Urology were not being given the resources that we felt we needed to be able to meet the targets from the Trust. But, again, getting a theatre list and making that active takes a long time. You know, obviously you need a theatre available. Most Trusts do not have free theatre space - you know,

basically because the theatres are already used by other specialties. So, in order for Urology to be able to access additional theatre capacity, then that required a lot of work from the Trust to be able to get that theatre up and running and us to be able to utilise it. So it was always an expectation that this would take a long time, and that I wouldn't be involved with it, because as I said, I was always going to be moving on.

39 Q. Now, was there any sense from your perspective during that time that general surgery or other surgeries were prioritised over urology?

A. It certainly would've been Mr. O'Brien's belief that urology was treated badly compared to general surgery and other subspecialties of general surgery and that that had been a longstanding problem within Southern Trust.

40 Q. And was that your perception for the short period of time you were there? Did you share that at all?

A. I didn't have enough info -- you know, like, I don't know, I didn't know how it was between 2008/2012 and how it changed after I left, so it's hard for me to say yes or no.

41 Q. You've mentioned it in your statement - perhaps we'll just go to that paragraph. WIT-41992. That's paragraph 62.1. You say:

"I cannot recall the specific details, however I do remember that Mr. O'Brien had longstanding concerns

regarding the perception or support of Urology by the general surgical management in SHSCT. This would have been discussed informally during conversations at break times and during meetings with the whole consultant team about the restructuring of Urology services. There was no specific patient safety concerns raised, it was more about the perception of, and resource given to, Urology compared to other services. Specifically, I recall that he did not have a good relationship with Mr. Eamon Mackle, Associate Medical Director. I recall that Mr. O'Brien felt that Mr. Mackle did not take Urology seriously and would always make decisions that prioritised general surgery over Urology."

Do you have any recollection of any specific examples that you may have heard or were aware of where Mr. O'Brien indicated that he thought general surgery was given a priority over Urology?

A. As I said, this was just conversations at break time over coffee. But, you know, for an example, Mr. O'Brien told a story of when he first was appointed to Southern Trust in '92 or whenever that was, that on the interview panel was the Chief Executive and a number of the consultant surgeons and after he'd been appointed, he was brought back into the room to congratulate him and go through how it happen and he was asked how many urologists he thought Southern Trust needed and I think he said five or six and they laughed at him.

So, even from when he started, he knew that he was in a very minority position at that stage, a single consultant running the whole of the Urology service, and that he obviously didn't feel that urology was an important part of the surgical management of Southern Trust. Now, obviously that was back in the early '90s, when urology was, right throughout Northern Ireland, a very sort of fledgling specialty. But even as we expanded from two consultants to five consultants, that there was still that perception that we were a lesser specialty and that, you know, even though there were massive waiting time problems and that urology continues to be one of the worst waiting list problems in Northern Ireland, that we do not get the resources that other specialities get.

42 Q. Do you think the impact of the urology restructuring around that time, just before then and leading into the time that you joined, do you think that seemed to make things better or worse for at least the perception of the urologists in Craigavon?

A. It improved things. Because as I say, they went from a team of two to a team of five. We also then were restructuring ourselves to take over the urology catchment of Fermanagh, so we were taking over going to Erne Hospital at that stage, or SWAH. And that would've been part of then the Southern Trust's urology, so it covered a massive geographical area from Fermanagh across to South Down, so it covered a very

large population. And it was then a more sustainable unit, because obviously, if you're dealing with a unit of two people, if one person gets sick, it's almost unsustainable.

So it certainly improved the belief that this was a proper urology team that would be sustainable going forward. And it was a very exciting time in the unit - you know, that they were opening up the Thorndale unit, which was a one-stop clinic for doing sort of diagnostics all at one time and there was a lot of planning went into it. And, like, even amongst the managerial staff, the consultant staff and the nursing staff, it was an exciting time, that you sort of thought 'We're actually going to make this work', you know? And I'm sure Aidan probably felt at that time that he was getting the service that he envisaged was needed back in 1992.

43 Q. You did have cause to send an email yourself about the general surgical list, the emergency list. If we just go to that. Just as an example of, perhaps you can explain if there is tension, but just an example for the Panel. AOB-06264. And if we just move down to the bottom e-mail, first of all, from you, sent on 25th November 2012. And you've copied in the other consultants. The subject is "emergency lists". And you say:

"Hi, was anyone aware of the way that emergency lists

are now running? What I was told is the surgeon of the week reviews the list and prioritises it, giving time limits that the cases need to be performed in (1 hour, 4 hours, 12 hours, 24 hours etc.). I did not receive any communication about this as far as I know, but it appears to have been implemented from last week.

I have just had a case bumped down the list without any communication from the surgical team (bilateral ureteric stones with hydro). Luckily she is not septic and renal function is okay. But when I went down I was told that their case had to be done within four hours, so got prioritised.

Just slightly annoyed that this seems to have happened without any input from the other specialties which also use the emergency list.
David."

11:31

11:31

11:31

Mr. Young then replies to you the next day, 26th November 2012, and he says:

"What exactly is this? Completely unaware of this.
Will investigate.
MY"

11:31

So that seems to be an example when your case was bumped for another case that had been assessed as of greater urgency; would that be fair from what you've

written?

A. Yeah.

44 Q. But the issue is that youse weren't informed or consulted on this process for allocation of emergency list? 11:31

A. So, there's a general etiquette in terms of how an emergency list works in every hospital that I've worked in, which is that the most urgent life-threatening cases go first and then when they're finished, then everything else is done in chronological order 11:31 depending on who booked first. But it may well be cases that aren't immediately life-threatening but are still urgent, which I presume this case from the general surgical team was, because they felt it needed to be operated within four hours. So the etiquette 11:31 would be that the general surgical team would phone me and say, you know, 'We have to go ahead of you because of this case'. And I would've said 'That is no problem at all'. But what happened - and obviously this happened without any discussion with Mr. Young or with 11:31 any of the urology team - is that the general surgical team in Craigavon implemented a system whereby the surgeon of the week, who is a general surgeon, would look at the list and they would then prioritise the cases, not knowing any of the clinical history of the 11:31 individual cases, and then they would say which gets most priority. And, you know, whilst everybody tries to be fair, you will tend to prioritise your own case.

45 Q. And would that have been a system introduced that

would've affected other specialties as well as urology?

A. It would've been every speciality that would've used the emergency list. But the surgeon of the week is a general surgeon, so no matter who the speciality was, the general surgeon was making the decision in terms of which cases went first in the emergency lists. And again, this was obviously introduced by the general surgical team and Urology and I presume no other specialty were actually told about it until it was already implemented. 11:31

46 Q. Mr. Young has said "I will investigate". Did you ever get any feedback from him about what the outcome of his queries on this issue were, or did anything change after that, or did it happen again?

A. I believe the system continued, but I don't know the outcome of the thing. So I think this system was in place in Craigavon for a period of time, but I think the outcome of the investigation with Mr. Young was that this is how it's working now. 11:31

47 Q. And is there anything in this example - I know it's one email 11 years ago - but is there anything in this example that would support any perception that urology perhaps was the poor relation within the surgical structure in Craigavon? 11:31

A. Well, I think if you look at what happened, inferring from what I've written in the email, is that general surgery implemented a system without discussing it with Urology that clearly was going to impact on how the Urology service was going to run. So, to me, that's 11:31

disrespectful.

48 Q. Now, when you were the consultant at Craigavon, your secretary was Noleen Elliott?

A. Correct.

49 Q. And she was appointed to you when you started off. And she was already working with Mr. O'Brien at that point, is that your recollection? 11:31

A. No, I think Noleen started and she was my secretary. I don't believe she worked with anybody else at that stage. 11:31

50 Q. And had she started long at that point in 2012, do you recall?

A. No, she was new as a medical secretary as well.

51 Q. And given you were both relatively new to the post, how did you go about developing your working relationship as regards your admin duties? 11:31

A. I can't honestly remember it being an issue. It was just basically we sort of said 'Right, this is what we need to do. This is how we will run it'. Again, Noleen would've been in an office with other secretaries, so we probably asked, you know, how do other consultants do it and what way do they run it and then we kind of just followed suit. 11:31

52 Q. In relation to notes, the Inquiry has heard evidence in relation to notes being kept away or located where they may not expect to be; did you have any recollection that there was an issue among other consultants around keeping notes or taking notes away or having access to notes? Did you yourself experience a problem with 11:31

that?

A. So, this was pre-electronic care records, so therefore, everything was in the paper notes. So if you had to do a discharge letter or if you had to do a result letter, that would require you getting the paper notes to be able to do that. So, everybody had, like, a filing cabinet that notes were kept in and I was aware of a section that I had that were notes that needed discharge letters, I had a section that were notes that needed results letters and then I would've just taken my time to go through each of those and to do a letter and when I finished with the letter, the notes would've went back to Noleen to go back to file. 11:31 11:31

53 Q. So when you finished that, it was Ms. Elliott who sent it back then to -- 11:31

A. Yeah.

54 Q. -- where the notes were kept at that time?

A. Yeah.

55 Q. In relation to your dictation after clinics, what was your process at that time starting out for you to get those tapes back and for letter to be dictated, what was your system? 11:31

A. So, again, during training there were two different ways that I seen it being done. The first and the most common way was that when you saw a patient in Outpatients, you dictated the letter immediately onto a tape. And then you did that for each patient and then at the end of the clinic you would have put the tape into an envelope and written on it "Mr. Connolly's 11:31

outpatient clinic, 1st January". And that would've went to the outpatient team or the clerk at the front of Outpatients and they would've sent that with all of the notes back to my secretary to get the letters typed.

The other way which was done, primarily in Vascular, from what I remember, was that because the clinics were very busy, with a very high turnover, that they asked you to do your dictation all at the end. So you would've held onto all of the notes in the room and then when all of the patients were seen, you would've went through and then dictated all of the letters at the end of the clinic. I personally disliked that, because, you know, many vascular or many urology patients have similar problems and, therefore, you know, I wouldn't have been able to remember the intricacies of each of the notes. So I always dictate the letter after I see the patient.

56 Q. And did you ever find yourself falling behind with dictation?

A. So, that would've happened at the time. So I would've sign the patient, dictated the later, put the notes to one side and moved on the see the next patient. So the outpatient dictation always would've happened at the time and always would've finished by the end of the clinic.

57 Q. So, based on your workload, it was manageable for you to be able to do that, either at the time or at the end

of the clinic, without falling behind?

A. Oh, it was just part of your clinic time is that you had time built into that so that you would be able to do your dictation as part of seeing the patient. It was considered part of your allocated four hours, is that you had that time to see the patient and dictate on them and book whatever investigations or procedures they needed. 11:31

58 Q. And at the time that you were there in 2012, was triage part of your role? 11:31

A. It was.

59 Q. And what way was it carried out when you started your post at Craigavon?

A. So you would've got paper triage letters from GPs or from A&E or from other consultants and that would've went to a central appointments and they would've then date stamped it and sent it to individual consultants for triage. Because there were five of us, it would've been split between the five of us. I don't remember how that they chose, I assumed it was just, you know, evenly sort of given to all of the consultants. Like, I don't honestly know how it happened, but I knew that every day I would get a folder that had a number of triage letters in it and then it was my job to triage those. 11:31 11:31

60 Q. And again, was that something that you ever weren't able to do because of your other commitments, or was it something, a bit like your dictation, you just factored into your working day?

A. You generally would've done it around what else you had done. So, you know, you can't do it at clinic, because clinics are busy and there's patients there all the time, but, for example, in theatre it would've been fairly common that you bring your triage down to theatre and, therefore, when you were waiting for a patient to be put to sleep, that you would have 10/15 minutes and you would be able to triage some of the letters. And then if you didn't have time to do that, then you may have done it at the end of your working day. And it would've been not uncommon that I would've stayed on late to finish off admin tasks that I didn't want to leave behind. 11:31 11:31

61 Q. Do you have any recollection of Ms. Elliott or anyone else having to chase you up for dictation or triage or for the location of notes? Did any of those things happen when you were there? 11:31

A. As I said, I was just started. I was trying to make an impression.

62 Q. Best behaviour, you were on your best behaviour? 11:31

A. You know, I didn't want to sort of, like, fall behind. So it was never an issue. But as I said, like, you never had enough time for admin. And I still don't have enough time for admin and I regularly stay on at the end of a working day in order to make sure that it's all done. But, you know, the admin roles you have are very important, so I would make sure that I did what was allocated to me. 11:31

63 Q. I just want to read into the record your comments on

what you considered was the organisation's efficiency of the unit at WIT-41994, paragraph 67.2 of your Section 21 reply. It starts at 67.1. They both cover the same issue, but I'll read both of them in. WIT-41994. The system's just having a Monday moment. Perhaps if I just can read this while we're waiting for the system to heat up.

CHAIR: Sure.

64 Q. MS. McMAHON: At paragraph 67.1 you say: 11:31

"When I started at the Urology unit SHSCT, I felt it was a good unit with good working relationships between staff members, including consultants, trainees, nursing staff, both ward and their specialists, secretaries and unit managers. The unit had significant backlogs and 11:31 waiting times and this would have taken time and effort from all staff to organise and resolve. With the expansion of consultant numbers and the upcoming rebuilding of a dedicated urology one-stop clinic, there was a lot of goodwill and excitement about the 11:31 future of the unit. In the intervening years, I and a number of other staff members have moved on and I understand there has been difficulties with recruiting and retaining full-time staff. The SHSCT have advertised on a number of occasions for 11:31 substantive consultant urologists and have not successfully appointed anyone. I suspect that this has led to increased pressure on the remaining staff and the services have become stretched and pressurised.

I expect that this has likely led to worsening interpersonal relationships between individual consultants, admin staff and management. It also leaves less time for the usual governance structures to work robustly. With COVID, these problems have exacerbated the underlying issues, so that the service now has difficulty managing even its core work."

At paragraph 67.2 you say:

11:31

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

I just want to pick up a couple of issues in those paragraphs. Obviously, you've already reflected in your evidence that you felt things were improving, there was a greater capacity of staff at that point, but you've also highlighted information that we've heard previously about the staff recruitment and retention, and that seems to have been a problem within Urology generally, I think. Is that still your experience or is there a greater capacity now for being able to attract the right staff and to keep them in post? 11:31 11:31

A. No, it's still a problem in the majority of Trusts that -- like, Northern Ireland is a small place, urology is a small specialty; there are only a limited number of people who want to come and work here. And the vast majority of those are trainees that come through. At present, there are vacancies in all of the Trusts bar one. And therefore, for every trainee that comes off the top of training, they have three or four job opportunities that they can choose between. So we're all fighting for the same trainees and we all have the same issues in terms of being able to attract people. 11:31 11:31

Obviously, with Craigavon, they had specific issues - you know, primarily that they were a small team and that people like myself and Mr. Pahuja, who were appointed - and as I say, at the time there was an expectation that the unit would become self-sustaining 11:31

within a period of a few years - but I left, Mr. Pahuja left. And, therefore, whenever that happens, you have a prioritisation of work. So, emergencies always are priority, followed by red flag cases, followed by urgent cases, followed by routine cases. When you have two or three vacancies, it means more of the emergency work falls onto the in-house consultants, more of the red flag work falls onto the in-house consultants, so even the urgent stuff waits and the routine stuff just doesn't get done. So, therefore, it's just a self-fulfilling prophesy, that it just keeps going on and on. And that makes the life more difficult for the current consultants. And, therefore, if they see an opportunity of a job elsewhere when there are vacancies elsewhere, then they may well choose to leave it. And there was a period of time where I and other consultant urologists in Northern Ireland had concerns about the viability of Craigavon as a unit going forward because of its inability to attract new consultants. 11:31 11:31 11:31

65 Q. And as you say, the knock-on effect of that is that the system gets squeezed more and more. And you've hinted at the potential for interpersonal relationships then to degrade? 11:31

A. Yeah. As I say, your focus always goes onto emergencies and red flags. And the red flags were a massive thing - so, obviously that's for possible cancer cases - so, so much of your time and energy is put into that, that a lot of the standard work -- and, you know, if you don't specialise in cancer, as I 11:31

don't, then that puts a lot of pressure, because, you know, Mr. O'Donoghue, for example, in Craigavon, his subspecialty interest is in female urology and reconstructive urology, which is a benign problem; whenever he is doing emergencies and red flags, he doesn't get to do any of his subspecialist interest. So, I can understand why - like, I appreciate he's still a consultant there - but I understand why he may not be happy with that situation. And that's reflected in other Trusts as well. 11:31

66 Q. Now, you've mentioned that the issues tended to be managed informally around governance and almost on an ad hoc basis. Now, I appreciate it was 2012, but what do you mean by that? Have you any examples you could give us in relation to that, how you know that to be the case? 11:31

A. Well, I suppose I can't remember any occasions where these things were formally discussed at any of the meetings where there were any issues raised with individual consultants. Now, I appreciate from evidence that other people have given that there were issues in the background that I wasn't aware of, you know, and from a governance perspective, that this tended to happen as, you know, a corridor conversation or a coffee break at theatre where, you know, someone may mention something to the Clinical Director or the Associate Medical Director but wouldn't make a formal complaint or raise a formal issue, it's sort of more, you know, 'This might be something you want to know 11:31

about'. You know, that's kind of what I mean, is that it was -- you know, there was very little in terms of formal structure to it, it tended to be more 'Well, you better let the CD know that this might be an issue so that they can go and talk to the individual consultant so they can stop that practice', as opposed to it being raised through a formal channel, you know, such as poor performance. 11:31

67 Q. And now that you know some of the issues, because of the Inquiry, do you think they were issues you shouldn't have been made aware of or it would've been beneficial to know about at that time? 11:31

A. Well, I think that there was a perception that there were ways that Aidan was dealing with cases that would've been different to other consultants and that would have been accepted, you know, as a 'Well, that's how he's always run it and, therefore, that's how he's continued to run it', as opposed to that formally being challenged through the clinical lead with Mr. Young or Mr. Mackle or Mr. Brown. 11:31

But again, I don't know whether any of those issues were ever raised directly with Aidan in sort of 2007 or before. But there is the potential that, had they been -- if some of the issues that -- probably the way to say it is that if that was happening now in Belfast Trust, that that would be dealt with in a more formal way. 11:31

68 Q. So that's the difference between then and now, is there

would be a form formalised structure?

A. I believe so. But as I said in the statement, I don't believe Southern Trust in any way was different to Belfast Trust/Western Trust at that time, I think that's just how things were done, is that it tended to be done on an informal way where, if you had concerns about a colleague, you would go to your CD and you would say 'I don't like the way that he's doing this' and then the CD would go 'Oh, you're probably right' and they would talk to the consultant and say, you know, 'Somebody has raised a concern about this. You probably shouldn't be doing that'. 11:31 11:31

69 Q. You said in that paragraph as well that any Patient Safety issues, complaints and incidents tended to be managed by the individual consultants involved. And I know you've said a moment ago that you don't think the Southern Trust was any different from other Trusts in relation to the way ad hoc governance was applied. Would that be the same for that sentence, would most trusts have operated in the same way at that time? 11:31

A. Yeah. So, as I said, if there was an issue with an individual consultant's performance, that that would've been dealt with just with that individual consultant by either CD usually. So it wasn't have been -- you wouldn't have had other consultants really being involved with the process, you know. And therefore, you lose some independent oversight, because -- and, like, you know, if you look at the structure where you had us as standard consultants and then Mr. Young as 11:31

the clinical lead and then Mr. Brown as the clinical director, Mr. O'Brien, Mr. Young and Mr. Brown worked together for 20 years, you know, so therefore, they knew each other personally. And it's more difficult to then formally discipline someone if you know them personally. It just, it can create a lot of ill feeling within the unit.

70 Q. And perhaps it's more difficult to even challenge someone, rather than discipline them, if those relationships exist? 11:31

A. Absolutely. And, you know, obviously when you have Mr. Young and Mr. O'Brien were the only two consultants for a long period of time, that they needed to have a good working relationship, because they were completely depend on each other. Because if Mr. O'Brien wasn't in the Hospital, Mr. Young was the only urologist and, therefore, everything that happened fell onto him. So you needed to have good working relationships. And, therefore, having Mr. Young and then Mr. Brown as the clinical lead and Clinical Director when there was a dependence on each other probably isn't -- has potential for things to be dealt with in an informal way because you know them personally and you want to keep everything smooth. 11:31

71 Q. Now, you've mentioned in your statement some of the structures in place for governance at that time and I just want to read out those particular references. At WIT-41979 at paragraph 26.1 you say: 11:31

"As this was my first consultant post (and I had not planned to stay in the unit on a long-term basis), I did not have a good grasp of the clinical governance struck and processes at the time. On appointment, I believed that the Trust governance structures were already in place and I was happy to fully engage with them. I was aware of the unit's M&M meetings, grand ward rounds, audit meetings, complaints management, critical incident reporting (IR1) risk management and MDT (and appraisal had I stayed longer). This provided me with reassurance that patient safety and minimising risk were an important part of the unit's standard work." 11:31 11:31

Then if we go to WIT-41981 at 32.1, you say: 11:31

"I believe that I had individual responsibility for ensuring that I was providing good quality care for my patients. This would have been assured through the Trust's governance structure, such as IR1s, complaints, audit or M&M meetings and the risk remember, for example. This would have been overseen by my clinical lead, Mr. Young, and my Service Manager, Martina Corrigan. I do not recall any issues regarding the quality of care that I provided being raised during my time in SHSCT. I was never aware of any issue with any of the wider Urology service." 11:31 11:31

You say later on at 37.1 that you cannot comment on the

efficacy of any of those systems, as you weren't personally involved with them.

Then at WIT-41983, at paragraph 39.1 you say:

11:31

"Had any issues been raised, I would have expected these to be discussed during the dedicated governance day (Thursday), either around the discussions during the grand ward round, during the lunchtime meetings or during the cancer MDT. There were also ad hoc meetings 11:31
between the consultant team to discuss the proposed service changes which would have provided a further opportunity for concerns to be raised. I never asked for, nor was I provided with, any assurances regarding the quality of urological care under any consultant." 11:31

Now, just in relation to that, the Thursday, you've described it as governance day, was that the opportunity then, you feel, for both you to raise any governance concerns, but also for any governance 11:31
concerns arising within the unit, for you to be informed of those?

A. Well, I'll say that it was a day where standard clinical work was stopped, so there were no operating lists, there were no outpatient clinics, so it was 11:31
expected that all of the consultants, all of the trainees, the senior nurses, would do a grand round of all of the patients. And that was an opportunity where you could discuss patients' care and it was an

opportunity to ask questions of the treating consultant team what was happening and what options, maybe, they had for treating patients differently. The meeting at lunchtime, again it was a scheduling meeting or it was a meeting about -- it was like a business-type meeting where you were then talking about the running of the unit. And in the afternoon it was the cancer MDT. And each of those, you had the opportunity of raising any issues that you felt you weren't happy with how the unit was being run. 11:31

72 Q. If we go to WIT-41987. At paragraph 47.9(ix) you say:

"I trained with Mr. Glackin and Mr. Pahuja and I consider them to be my contemporaries. I would have been comfortable raising clinical concerns directly with them. Mr. O'Brien was my supervising consultant both when I was a locum registrar in Craigavon in 04 to 2007 and when I started my higher training in urology (Urology ST3) 2007 to 2008. I would not have felt comfortable going directly to Mr. O'Brien if I had concerns, as he only knew me when I was very junior and inexperienced and we did not have time to build a stronger relationship before I left. In any event, I did not have any concerns to raise." 11:31 11:31

Now, you worked then with Mr. O'Brien; as you say, you were a registrar at the time.

A. So when I was a locum between 2004 to 2007, so I would've done nights on call and weekends. So

Mr. O'Brien would've been the consultant on call for a third of those. And then my first role as an ST3 when I started proper urology training, that it would've been him, Mr. Young and Mr. Akhtar were the three consultants that were supervising me at that stage.

73 Q. And did you work in surgery with Mr. O'Brien during any of those periods. Were you in theatre with him?

A. Yeah, yeah.

74 Q. And did you have any view of his ability as a surgeon or sense of the culture in theatre when he was there? 11:31

A. Mr. O'Brien was technically a very good surgeon. I learned an awful lot from him. I still believe how I do a TURP, a prostate operation, a lot of what I do is how Mr. O'Brien did it. And he was a very careful, slow, meticulous surgeon who done things in a very stepwise way. So I learned the steps from him and I probably still do the operation very similar to how he did it. The same thing with open surgery; he was a very careful, meticulous surgeon who took his time and did everything, in my view, by the book, how it should've been done. 11:31 11:31

75 Q. Did you have cause to call Mr. O'Brien in when he was on call during those periods, weekends and --

A. On numerous occasions. As I said, 2004 to 2007, I hadn't even started urology training, so I was very much a junior who could do very little on my own, so any time a patient would've had do go to theatre, I would've expected, certainly in the first few years, 11:31

that the consultant would've been there with me.

76 Q. And the urology consultants, there was never any difficulty, they came in from home and --

A. None at all.

77 Q. -- when you contacted them, they responded to that appropriately, in your view? 11:31

A. Absolutely. They were very supportive.

78 Q. We'll go to WIT-41996. And at paragraph 71.1 you say:

"In hindsight, I do not think the governance arrangements were fit for purpose. I did not appreciate this at the time, as this was my first consultant job and the processes in SHSCT appeared to be similar to other units I had worked in during my urology training. As a result, I did not raise this as 11:31 a concern. As outlined in my answer to question 67, this was my experience of all the units I worked in during my urology training and as a consultant until the last five years or so. I have noted within Belfast Trust in the past five years that governance procedures 11:31 have become far more formalised, the recording and documentation of issues and the independent oversight of these has greatly improved. I suspect this relates to lessons learned from the Dr. Michael Watt case." 11:31

Just before we look at what has improved, when you say "In hindsight, I do not think the governance arrangements were fit for purpose", is that based on what you know from the Inquiry or is it on reflection

now as a more experienced consultant looking back?

A. I think it's both. That, as I said, that in Every Trust I worked with, the structures were there, you know, sort of -- so, M&M, audits, complaints, IR1s, that was there. But it was dealt with in a very informal way between the individuals and, you know, it was probably done in a way to not raise issues, you know, so that things would sort of return back to normal as long as no patient harm was done. And, therefore, it would've been dealt with informally between the individual consultant and their CD and it's not something that probably would've involved the rest of the of the team and a lot of the learning then may not have been shared. 11:31 11:31

As I say, the individual issues with Aidan's practice, I was completely unaware of as a registrar and then even as a consultant, that there were issues going on in the background that were never discussed at any of the formal meetings that I was at. And I presume, therefore, that that was being dealt with in-house between Mr. Young, Mr. Brown as the CD and then Mr. Mackle as the MD. But me, as a another consultant in the unit, would not have been aware that those issues were happening. 11:31 11:31

79 Q. Now, you've mentioned in that paragraph recording, documentation and oversight, independent oversight, has improved within the governance procedures in the Belfast Trust and you mention the Dr. Michael Watt

case. Can you tell the Panel in what way they've improved, or what's your experience of what has been enhanced, perhaps, as a result of that?

A. Yeah, so probably from around 2015/2016 there's been a massive change in the culture, where everything is far more open and far more transparent in terms of what's going on with individual consultants and with the processes. There's now, each specialty have a dedicated governance lead who's paid to do that job. So it isn't just that you have the CD and it's part of their role; that you have a person who's individually responsible for the governance issues; in our unit that there's a weekly meeting between the management team and the governance lead so that all issues are dealt with very rapidly, so that these types of things aren't able to just go on for months and years without ever being addressed. 11:31 11:31 11:31

As part of my appraisal, I get a document sent to me that tells me, as well as my activity and morbidity/mortality, it tells me how many complaints I've had, what the individual complaints are, it tells me any IR1 that either I've completed or another person has completed that involves me and any litigation that the Trust has about me, that I get advised of all of this. And the expectation is, as part of my appraisal, that I will reflect on each and every one of those incidents and then record that and that will be part of the appraisal discussion with my appraiser. My 11:31 11:31

appraiser is also completely independent from urology, so therefore, they are not a friend of mine or someone who is able to kind of just go 'Ah, don't do it again, David', that they're someone who's independent and part of the appraisal team, not someone who'd be directly affected by my performance. 11:31

80 Q. In relation to learning from incidents that have happened or complaints, is there a way in which you receive feedback even if you're not directly involved in the incident, that there's some learning fed back formally to either the individual clinicians, the general consultants within the unit or more broadly? Is there structure for that feedback? 11:31

A. Yeah. So, currently, as part of our monthly M&M meeting, that we discuss all of the IR1s or potential SAIs that are currently live within the unit. So our service manager comes to the end of that meeting and we go through with the governance lead the outstanding IR1s or SAIs and what we need to do then as a team in order to meet the recommendations of any SAIs. 11:31

There's then also sort of specialty-specific local and -- or trust-wide and regional learning letters that go out. So, you know, if there's a specific issue to urology then that will go to the urology teams in all of the different Trusts, or if it's a more general thing, you'll get an email that'll have a learning letter on it. 11:31

81 Q. And the governance improvements that you've outlined

there, do you know if they're specific to the Belfast Trust, or is there any feedback from the Department that there's an expectation that certain procedures will come into play given issues that have arisen from past cases? 11:31

A. I'm not involved with other Trusts, so I don't know. But as I say, I would've thought that the learning from the Urology Inquiry will have been regional and will not be just specific to one individual specialty, it would be expected that everybody will then form 11:31 a similar process.

82 Q. I want to look at WIT-41995 at paragraph 70.2, where you speak about Mr. O'Brien. And you say:

"In my time working with Mr. O'Brien, I found him to be 11:31 very similar to other older consultants that I had worked with during my training. He had a wealth of experience and was technically a very good surgeon. He was a good teacher and was very patient with trainees. His patients were very fond of him, even to the point 11:31 where they preferred to see Mr. O'Brien personally instead of other consultants or trainees and they respected his opinion above all others. He did, however, have idiosyncrasies to his practice that I did not understand. As a new consultant and having 11:31 recently passed the FRCS urology exit exam, I was very guideline and evidence-focused and I practised as closely to what I had learned during my training as possible. Mr. O'Brien had changed his practice based

on his experience and anecdotal cases."

Then you go on to give us some examples at 70.3. And there are two examples in this paragraph. The first one relates to IV fluids and the second one to BCG therapy. So I'm just going to split the paragraph slightly and read the first part. You say:

"For example, Mr. O'Brien (and Mr. Young and Mr. Akhtar) used to regularly admit patients with recurrent urinary tract infections to the urology ward for 5-7 days to be treated with intravenous antibiotics and fluids. I never saw this in any guideline, but accepted that this was the standard practice in the unit which predated my time. I felt that I was never going to change this practice in the short time that I was planning to stay in SHSCT, but I was not going to practise in the same way."

11:31

Now, just stopping there for a moment. That issue in relation to intravenous antibiotics and fluids seems to suggest that that was an issue that came to your attention when you went back as a consultant in 2012, or were you aware of it --

11:31

A. Oh, no, when I was a registrar.

11:31

83 Q. When you were a registrar.

A. It was far more apparent then, because I would've been doing the ward round and seeing these patients. Obviously, as a consultant, they would've been admitted

under the other consultants, so I wouldn't have been involved with their care. So it was mainly I note this as a registrar between August 2007/2008.

84 Q. I took that to be the case, given you'd said you were only going to -- 11:31

"I was never going to change this practice in the short time that I was planning to stay."

I took that to mean as your consultancy post -- 11:31

A. Oh, sorry, yes.

85 Q. -- but in fact you had noticed it in the years prior to that?

A. Yeah. And I can remember conversations with other registrars and the research registrars at that stage, 11:31 who would've been in Craigavon before me, about this practice. And I believe there had been previous audits or discussions about this and that even though there was no evidence behind it, it was ingrained practice in the unit and that it was not going to change. 11:31

MS. McMAHON: I wonder if I could just stop there, Chair. I believe there's a problem with the case note, it hasn't been working for a while, so perhaps it would be a convenient time?

CHAIR: Well, yes, I think it's an appropriate time 11:31 then to take a break. We'll come back at 25 to 12.

SHORT ADJOURNMENT

CHAIR: I believe the technical difficulties have been

resolved, so hopefully they'll stay that way.

86 Q. MS. McMAHON BL: Yes, smooth sailing, hopefully.

Just before the break, Mr. Connolly, we'd spoken about the IV, intravenous antibiotics and fluids issue and we'd looked at paragraph 70.3 of your statement. Now, you'd said something you'd noticed, I think you said, both when you were there as a registrar and later on as a consultant, is that right, for the purposes of the transcript? 11:34 11:35

A. So, it would've been -- I first identified that when I started as a registrar, as an ST3 in August 2007, that this was common practice that once or twice a month a patient would've been admitted for a five to seven-day course of IV fluids, IV antibiotics. 11:35

87 Q. And why did you consider that to be unusual, if you did consider it to be unusual at that time?

A. Because the patients tended not to be acutely unwell. This was a planned admission, so this isn't someone who has come through A&E, is septic, with high temperatures and high inflammatory markers, that these were patients who were clinically well and were a planned admission to the ward on a timetable, so that they would have it three times a year - I don't remember exactly what way it worked. But again, it was the same people that you would've seen every three or four months that would've come in to have this course of fluids and antibiotics. 11:35 11:36

88 Q. You've mentioned clinical markers that would've perhaps indicated the need for IV antibiotics and fluids and

these patients weren't exhibiting those markers; was that something you ever discussed with either Mr. O'Brien, Mr. Young or Mr. Akhtar, who you said used this practice of regular admission?

A. No, again, the administration would've been arranged by the consultant and there would've been a plan in place for them and I would've followed the plan. 11:36

89 Q. Was it something that other registrars noticed or was discussed at all? Were you aware of anyone else --

A. No, as I said, that whenever I started and this practice was ongoing, it was discussed by registrars and by the clinical fellows and I was advised that this practice had been looked at previously and there was an audit done, I don't remember which registrar did the audit, but there was a audit done sometime between 2004/2007 which showed there was no clinical benefit to this. But the practice was ingrained and that audit, despite having negative findings, was never -- it didn't change practice. 11:36 11:37

90 Q. Just for our understanding of the reasons behind why a registrar might undertake an audit, could you set that out, why that might happen in practice? 11:37

A. Yeah, so it was part of your training, was that you were expected to perform an audit or a quality improvement project at least once a year. And that usually would be under the supervision of one of the consultant team. And the way it would tend to be is that you would -- something that you were interested in, or a practice that you saw within the unit that you 11:37

felt could do with improvement, that you would then see what the practice was, how it was being measured, you would then look at it, see if there was any national or international guidelines in terms of what we consider the gold standard, you would then collect the data to see how the unit's practice compared to the international standard and then you would recommend changes based on that. And then once the changes were implemented, you would then re-audit it, you know, six or 12 months later to see whether or not the changes made any clinical impact. 11:38 11:38

91 Q. And are those audits usually published or are they internal documents? What's the status of that sort of work?

A. So, again it would be normal for that to be presented to the whole team as part of your monthly M&M audit meeting. And that would be just like a PowerPoint slide and a team discussion about it and then any changes that were needed. But again, the M&M meetings were not minuted, so no one would've kept a record of what was discussed or what the outcome of that was. If the audit was a good quality audit and could potentially change clinical practice, then that's something that you could've put forward as an abstract for a meeting, such as the Irish Society of Urology, that audits would be presented at that, or then if it was very good, then you may be able to get that published in a journal. 11:38 11:39

92 Q. And you say there was an audit carried out at some

point between 2004 and 2007 by another registrar?

A. Yeah. Again this is going on memory, but I believe that whenever I sort of talked about this, to say 'Why is this happening' and 'Has no ever one ever looked at this', I was advised 'It has been looked at before, it's been shown it doesn't make any difference, but it sometime happens'. 11:39

93 Q. And for a registrar to do an audit like that, would they need buy-in from the consultants? Would they need their engagement? Or is it autonomous work which is done at that stage? 11:39

A. So you would have a supervising consultant, but generally the whole team would be aware that the audit was happening. Because it's a lot of work, there's a lot of data collection on lots of different patients, and particularly at that stage, because it was paper notes, it would've been a matter of getting all of the notes put together to be able to get all the information to put an audit together. So it was a lot of work. And, like, it would be very unusual that somebody would object to an audit. Like, it was just standard that if someone decided they were going to do an audit, that it would just go ahead. 11:39 11:40

94 Q. And would it be usual for an audit's outcome or findings to perhaps be disregarded or not taken on board? 11:40

A. It depends on the audit and what the findings were. As I say, I wasn't involved in the audit or the findings, I was just advised, when I sort of was in Craigavon as

a registrar, that 'There's no point in trying to audit this or to look at it, because it's not going to change the practice of admitting these patients'.

95 Q. If an audit was done, as you say you were informed it was, and the finding was that the practice as you witnessed it wasn't clinically beneficial to patients, would that be, in your view now, a significant enough finding for the practice to be reviewed? 11:40

A. Well, you would hope that if you were doing something as a practice and then an audit showed that it didn't help, that you would then personally review your practice to decide whether that's something that you should continue to do. 11:41

96 Q. Was there any indication that it was harmful to the patients or carried any element of risk? 11:41

A. No. Like, the patients would've received intravenous fluids that they didn't need, because they could eat and drink and, therefore, there's no benefit to them getting intravenous fluids. They would've had bloods done to check for fluid overload or low sodium levels. 11:41 But that was never an issue, basically because the amount of fluid they`re getting was not excessive, that their body wouldn't be able to just pass out. They would've been getting regular doses of antibiotics, usually Gentamicin. Gentamicin does have side effects, 11:41 but again, the doses, I can't remember exactly, but they were low dose that they were being given, it wouldn't have been a full therapeutic dose. So the antibiotics that they were getting, at the level they

were getting, the risk to an individual patient was very low, but there would've been a community risk to resistance, because you were giving antibiotics in a person who doesn't clinically have an infection that needs them. 11:42

97 Q. Now, you'd mentioned in your statement earlier, we talked about, that you didn't have any difficulty speaking to, for example, Mr. Young as your clinical lead and you felt well supported. Would that have been an example of an issue that you may have gone and 11:42 spoken to him about, just to get some clarity from a clinical standpoint?

A. I believe Mr. Young also admitted patients for IV fluids and antibiotics, so I didn't see any point in talking to him about it. 11:42

98 Q. Now, the other issue that you mention at paragraph 70.3 is the BCG issue. And if I could just back to that paragraph. It's on the screen. In the second part of that you say:

11:43

"Similarly, he did not like using intravesical..."

Is that, am I saying --

A. Into the bladder. Intravesical.

99 Q. "... intravesical BCG therapy for high risk, non-muscle 11:43 invasive bladder cancer and preferred mitomycin therapy. I was informed (I do not recall if this was by Mr. O'Brien himself or someone else) that Mr. O'Brien had a patient soon after BCG was first

introduced that developed a small capacity, poorly function bladder as a side effect of the BCG treatment and since that time he did not likely using BCG. I did not have this experience and continued to advise BCG for my patients. Over time, there may have been the opportunity for me to challenge some of the differences between our practices, but I never felt this was a realistic prospect during my short tenure at Craigavon Area Hospital." 11:43

11:44

"BCG" stands for...

A. Oh...

100 Q. ... Bacillus - if I can say this correctly - Bacillus Calmette-Guérin therapy. And it's the same BCG we get at school? 11:44

A. Yeah, for TB vaccination, correct.

101 Q. And what's the benefit of that, or the use of that in your practice, just for our understanding?

A. So if the patient, after the initial treatment where the bladder tumour is removed, if they then have a six-week course - so, once a week they will attend, they'll have a catheter put in their bladder, the BCG will be instilled into their bladder, that will stay within their bladder for one to two hours, they will then pass it out and the will go home. And they will do that once a week for six weeks. And then they will go on to a maintenance programme of between one to three years, during which time that they will come up, usually sort of on a three-monthly basis, to have 11:44 11:44

further courses of the intravesical BCG. And the principle behind it is that by having the induction course and the maintenance course, that you decrease the likelihood that the cancer will recur and the cancer will then progress to muscle invasive decease, which is far more serious and more life-threatening.

102 Q. So you've recounted anecdotal evidence of Mr. O'Brien's dislike for that, or perhaps caution around it and as a result of that reference to that issue, the Trust, as part of their Lookback Review undertook an audit of patients in relation to this particular issue and have replied to the Inquiry. And I just want to detail that response. It's at TRU-320011. Just for the Panel's note, this was an audit by Mr. Mark Haynes, the outcome of which is dated 24th November 2023. And I just want to read out, given this issue has been raised, this paragraph. It says:

"With reference to the concern raised with regard to Mr. O'Brien's use of intravesical BCG treatment for patients with high risk non-muscle invasive urothelial cancers of the bladder, the existing Lookback Review cases have been interrogated. A single case of high risk non-muscle invasive bladder cancer was identified where BCG treatment was not offered. For this patient there was clinical justification for the decision to not offer BCG. Therefore, to date the Lookback Review has not identified any concerns regarding the offer of BCG treatment to patients with high risk non-muscle

invasive bladder cancer.

As BCG treatment for high risk non-muscle invasive bladder cancer is given after initial diagnosis and resection TURBT and that, following retirement, Mr. O'Brien's patients' case has been continued by the remaining members of the Southern Trust urology team, we do not have any concern that there is an ongoing patient concern regarding this group of patients not currently receiving appropriate management. 11:46 11:47

Mr. Connolly references the risk of functional side effects of BCG therapy, in particular in the long term bladder function/symptoms factor into decision making for patients and may be a clinical reason why BCG treatment is not offered. In order to receive BCG treatment, patients need to retain the BCG in their bladder for up to two hours. Patients who are unable to do this, either because of incontinence or severe urgency symptoms, would not be suitable for the treatment. In addition, patients' bladder symptoms can become worse during the course of BCG treatment. Approximately one-third of patients do not complete three-year maintenance BCG programmes, with the majority of these being because of worsened bladder symptoms. 11:47 11:47 11:48

Risk of persistent bladder pain, sometimes leading to bladder removal, is quoted as 1:50/1:250 in the patient

information leaflet produced by BAUS for patients receiving BCG treatment. Patients are counselled regarding these risks when their treatment options are discussed with them. Unfortunately, some patients do develop intractable bladder symptoms, as described by Mr. Connolly, as a result of BCG treatment and they subsequently require surgery to remove their bladders to manage these symptoms. 11:48

We have considered the guidance for bladder cancer management which was available during the time which Mr. Connolly was a consultant in the Southern Trust in order to ascertain if the assertion by Mr. Connolly can be evidenced in the treatments received. At this time, NICE guidelines had not been published. They were first published in 2015. The available guidance for multi-disciplinary teams at this time has been produced by BAUS in January 2013, which recommends intravesical BCG and maintenance 1 - 3 years and references the European Association of Urology guidelines for bladder cancer. 11:48 11:49

A significant factor which has occurred on a number of occasions over the past decade is disruption on availability of BCG supplies. This was an issue during the time period 2012 to 2013. There has been a worldwide problem and has meant that at times of unavailability of BCG, patients were not able to be offered this treatment and delivery of maintenance BCG 11:49

for patients has been interrupted and, therefore, suboptimal. Supplies of BCG during periods of disruption have been intermittent and variable, meaning we have not be able to clearly identify dates between which BCG was unavailable." 11:49

Then at TRU-320013, the second paragraph, beginning:

"Despite the NICE guidelines not being published until 2015, in order to assess the care of patients with 11:50
non-muscle invasive bladder cancer treated in Southern Trust during the time period when Mr. Connolly worked as a consultant in Southern Trust, we utilised the audit tool published alongside these guidelines. Unfortunately, the data output from this audit did not 11:50
provide sufficient insight into the care provided to patients with high risk non-muscle invasive bladder cancer to be able to assess Mr. O'Brien's utilisation of BCG for patients with high risk non-muscle invasive bladder cancer and the concerns raised in 11:50
Mr. Connolly's statement.

This audit did enable us to identify those patients who were first diagnosed with high risk non-muscle invasive bladder cancer in the 2012 - 2013 and 2013 - 2014 11:51
financial years and a subsequent review of all of these cases was undertaken with regard to the offer of intravesical treatment and the MDM recommendations given at the time.

A total of 38 patients were identified with a diagnosis of high risk non-muscle invasive bladder cancer on their initial TURBT. Of these, seven patients were upstaged to muscle invasive decease on resection TURBT and one patient was found to have metastatic disease on staging. A further three patients had severe significant comorbidities and were managed with palliative intent. The remaining 27 patients were potentially eligible for BCG treatment. A total of nine consultants who worked in the Southern Trust Urology Department during this time period managed these patients. Mr. O'Brien was recorded as managing five of these patients." 11:51 11:51

11:52

Then the report, for the panel, provides details of the treatment offered to each of those patients.

Then if we move down below the table, and the summary of that: 11:52

"From the data collected over this time period, there is therefore no evidence that patients under the care of Mr. O'Brien during this time period were less likely to be offered BCG management in the management of their high risk non-muscle invasive bladder cancer than patients under care of the rest of the urology team." 11:52

It goes on just at the last page, at TRU-320015, and

the audit includes:

"Of note, during the process of this review, concern has been identified regarding the management of one patient (who is now deceased) with metastatic/muscle invasive decease and this has been flagged to The Trust Lookback Team for further assessment. This concern is not in relation to intravesical treatment." 11:52

And it's signed by Mr. Haynes, consultant urologist, 24th November 2023. 11:53

So that was a piece of work undertaken by the Trust simply to have a look back to see if that issue was prevalent and the information that they have and those are the conclusions of that. 11:53

I just want to ask you a couple of other issues that have been raised through the Inquiry to see if you have anything you can assist us with. 11:53

You've mentioned about the clinical nurse specialists in the unit --

A. Mm-hmm.

103 Q. -- in Urology and you work very well with them. For the Panel's note, that is at WIT-41877 and the relevant paragraphs are 22.1, 22.2, 23.1 and 24.1. 11:53

In summary, you have said that they were excellent and they had very advanced practice at that time. And also we've heard since then, obviously they have -- the developments and the work that they have undertaken has seemed to be quite progressive within urology, more roles falling to the cancer nurse or the clinical nurse specialist.

A. Yeah.

104 Q. Is that the experience in the Belfast Trust? Is there a parallel in expertise? 11:54

A. We are years behind the specialist nurses in Craigavon. When I was in Craigavon - so that was ten years ago - the specialist nurses were training to do diagnostic flexible sigmoidoscopies and training to do prostate biopsies. That process is currently happening within Belfast Trust, where the clinical nurse specialists are just being trained now. So the CNSs in Southern Trust were being trained ten years ago and I presume have been working independently doing those two diagnostic procedures which in the past would have been done by consultants for many years. 11:54 11:55

105 Q. And did you have experience of working with the cancer nurse specialists in clinics for new diagnosed patients or review patients?

A. Yeah, so there would've been, both for prostate cancer and bladder cancer there would've been a results clinic where you would've seen patients, usually in the Thorndale unit, because it's sort of quieter and you were able to take time with the patients there. And as 11:55

part of that results exercise, the Clinical Nurse Specialist would've sat in with you, would've been there when you gave the patient the news about their cancer diagnosis and would've been the first port of call for any questions that they would've had. So the 11:55
nurses would've come in with a little, like a booklet that would have information on prostate cancer or bladder cancer and they would've given that to the patient at the end of the consultation and they would've give them their contact details so that if 11:56
they'd any more questions, that -- like, when you give patients a diagnosis of cancer, a lot of the time they do not remember a lot of the details you gave them thereafter. So the nurses had a very important role to be able to be a first point of contact if they had any 11:56
further questions coming back. And the nurses in Southern Trust were excellent.

106 Q. And did you have any problems accessing the Cancer nurse specialists when you needed them to come into the clinics or you needed them to provide information to 11:56
patients?

A. No, these were all planned clinics, so I would've known in advance that the CNS would be there.

107 Q. Do you remember if there was ever an issue with any of the other consultants having access to, or utilising, 11:56
the cancer nurse specialists?

A. Not that I was aware of. As I say, there may well have been times where, because of leave or other issues, that there may not have been a CNS at every single

results clinic, but it would've been normal practice that they would've been there had they been available.

108 Q. You've stated that the nurses were also there for the MDTs, they attended the MDT, the general meetings.

A. The cancer CNSs did. 11:57

109 Q. In relation to MDT and the way in which it worked at the time you were in Craigavon, if you were to -- if the MDT were to agree, or recommend a course of treatment for a patient and you then felt that that treatment should perhaps be changed or wouldn't follow, 11:57 you didn't think the recommendation was suitable for the patient, was there a process by which you revisited that with the MDT or was that something, as a clinician, you could independently take a decision on and move forward with your course of action? 11:57

A. So, in the Southern Trust, I was at MDT every week that I was there, so therefore, my patients would've only been discussed at MDT when I was actually at the meeting. So I would've been part of that consensus discussion and writing the decision of the MDT. So it 11:57 would've been very rare that the MDT decision would not have been what I, as an individual, felt was the right course of action. Because had it have been different, I would've challenged it at the time. So it would be very rare that the MDT outcome would differ to what 11:58 I would want to do as an individual.

110 Q. Were you aware that there had been any variations in MDT recommendations from other consultants?

A. I wasn't at the time, but obviously I am now.

111 Q. And what would be the procedure if you were to want to change a course of treatment that had been recommended by the MDT as a clinician? What would you do?

A. Well, as I say, when I moved to Belfast Trust in end of March 2013, I no longer was involved with cancer treatment or MDT, so I'm not at MDT. So, some of my patients will go to MDT and the MDT discussion happens without me being there and then the results of the MDT will come back. Most, the vast majority of the time I would follow the recommendations from MDT, because it's usually the right thing to do. There have been a small number of occasions where I have disagreed with the outcome of the MDT and my belief is usually because I know the patient very well, I've been caring for them, I know all of their history and all of the results. The MDT might see 50 or 60 patients in three hours, so they have five minutes to discuss a case, so they may not have picked up all of the information that I know. So had that been the case, then it would be my normal practice to then refer them back to the MDT, giving them the additional information to state why I felt that the original recommendation was not, in my view, the best treatment course for that patient. 11:58 11:58 11:59 11:59

112 Q. So you would be referring it back with justification for why the recommendation is perhaps not the best route and what you consider to be the best route? 11:59

A. Yeah. So, you know, at the MDT there are numerous different consultants from numerous different specialties, but in simple terms, I do an operation to

burn kidney cancer or upper tract TCCs - transitional cell carcinomas - that nobody at the MDT does, so I will occasionally get recommendations from the MDT for me to laser a cancer, which I know is wrong. So, therefore, I will write back to the MDT and I will say 12:00
'I appreciate that you've recommended this, but because this does not fall into the criteria for this operation, I do not believe this is the right treatment'.

113 Q. So there can be a two-way conversation with that based 12:00
on your particular expertise, your knowledge of the patient and it's just a matter of letting the MDT know about that and the reason for alteration of the recommendation and then the treatment plan moves forward? 12:00

A. Yeah.

114 Q. The issue around Bicalutamide 50 has also come up for the Panel, we've heard evidence in relation to that. Is that something that you would prescribe, Bicalutamide in any format? 12:00

A. So, as I say, I don't treat prostate cancer any more, but I would still diagnose prostate cancer when patients attend my clinic. So, Bicalutamide 50 can be given for two reasons. The most common reason is when you're about to start formal androgen deprivation 12:01
therapy. So you would treat them with LHRH analogue. When you give someone an LHRH analogue, that increases their level of testosterone, which could, for a short period of time, allow the prostate cancer to progress.

So what you do is that you give them Bicalutamide 50mg for 14 days before you give them the dose of the LHRH analogue.

So that is the only time I ever prescribe Bicalutamide 50mg. It is also used further down the line when the patient becomes resistant to LHRH analogues. Then you would add in Bicalutamide to give them maximum androgen blockade. But I don't do that any more, because I don`t be seeing them at that stage. 12:01 12:02

115 Q. So you wouldn't, and you've never prescribed Bicalutamide 50 as a monotherapy?

A. No. As a monotherapy with the expectation they will get an LHRH analogue 14 days later.

116 Q. So as a dual therapy then with the expectation of something else? 12:02

A. Yeah, correct.

117 Q. I've covered all the areas from your Section 21 and your evidence generally that I wanted to cover. Is there anything else that you would like to say or want to draw attention to that might assist the Panel? 12:02

A. No, I'm grand.

MS. McMAHON BL: Well, I'll hand you over to the Panel then, who have their own questions, but thank you.

CHAIR: Thank you, Mr. Connolly. I'm going to ask Mr. Hanbury, first of all, if he has any questions for you. 12:02

MR. CONNOLLY WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS:

118 Q. MR. HANBURY: Thank you very much for your evidence. I've just got a few clinical things. You mentioned about the lack of main theatres, particularly for urology, and the need to do additions, especially on Saturday mornings and the waiting list initiatives. I wasn't quite sure, were you expected to do that? Were you asked to do that? Did everyone do extras? What was the -- 12:03 12:03

A. So it was above your job plan, so there was no compulsion to do it. But because the waiting times were so bad and we were given -- well, we were offered every Saturday in theatres, that we basically had a rolling rota, so everybody took their turn. 12:03

119 Q. Okay. And that was all day on the Saturday?

A. It was all day Saturday, yeah.

120 Q. And what would you do, typically the long waiters or would there be red flags and -- 12:03

A. No, all long waiters.

121 Q. All long waiters?

A. Yeah.

122 Q. And did you think that was a good use of time or...

A. We had no other way of treating the long waiters. And therefore, if we did not have elective sessions during the normal working week, to me, again, it's probably not a cost effective way of treating the patients, because obviously it's additional sort of payment to 12:03

the consultants, to the anaesthetists and to the nursing staff, but it freed up theatre capacity that you were able to treat six or eight patients that otherwise wouldn't have been treated.

123 Q. On the same subject of sort of inadequate theatre capacity, if you like, you mentioned that you had a discussion with Mr. Brown about restructuring theatre rotas. What was that about? 12:04

A. So, as part of -- it wasn't just to do with theatre rotas, it was to do with the whole way that the unit was working. Because having went from two consultants up to five consultants, we were starting to do theatre sessions in Daisy Hill, I believe, and because we were taking over Fermanagh, that we were doing clinics and diagnostic sessions down in Enniskillen, so there was an expansion in the availability of what we were getting, but not in Craigavon, which obviously, if you need to do in-patient operating, then it has to be at that stage on the Craigavon site, because we didn't do that elsewhere. 12:04 12:05

124 Q. So did you do any day surgery in other places or --

A. There was a day surgery unit in Craigavon, but it was, I believe there was one list a week of circumcisions type thing, just very straightforward day cases. But -- 12:05

125 Q. So that was one a week for the whole unit, or for yourself?

A. I believe it was one list a week for the whole unit, but honestly I can't remember.

126 Q. Okay.
A. I just remember doing it as a registrar. But I don't remember, as a consultant, doing it.
127 Q. And did you do anything more technical in day surgery?
A. No. 12:05
128 Q. I mean, obviously, as an endourologist now, you'd presumably do quite a lot of your stone surgery, ureteroscopy there. Was there a move to do that more as a day facility?
A. The day unit in Craigavon was a very small building off the main hospital, it was not well equipped and it was not very useful, to be honest. Like, it was inguinoscrotal surgery and that's pretty much it. 12:05
129 Q. Okay. So there wasn't a move to do more technical things there in your short time there? 12:06
A. No.
130 Q. Okay, thank you. I suppose on the subject of theatre capacity, you make some mention about trying to get people in to have their stents removed on flexible cystoscopy lists. Was there a problem with that? Did you have a regular weekly cystoscopy list? How did that work? 12:06
A. You would have had a weekly list of flexible cystoscopies but that would have been mainly for red flag haematuria patients. The stent removals would have been fitted in on an ad hoc basis so. It wasn't anything that was formalised in terms of: This is when you will get your stent out. This is your two slots at the start of a list to remove stents. I can't remember 12:06

that ever being a formalised way; it was more it was just put onto a waiting list.

131 Q. So who did the scheduling for what was going to go on that list? Did your secretary do that or that was the done by endoscopy? 12:07

A. I honestly don't know. I presume it was done by the waiting list office.

132 Q. You mentioned outreach services. I`m just interested, you did regular clinics at South Tyrone; is that right?

A. So when I was there as a registrar, there would have been an outreach clinic in Banbridge in South Tyrone and in Armagh. Then, whenever I started as a consultant, we were also then going to Enniskillen and to Daisy Hill. 12:07

133 Q. How did you think they worked, in general terms? In terms of efficiency and support? 12:07

A. It was a standard clinic. You turned up, the notes would have been there. You would have seen 12 new patients. You would have then dictated your letters, stick the tape on to the front of it, and then went home. 12:08

134 Q. Sure, I accept that. I was more getting at other things that we do in clinics, usually flow rates, this kind of thing. Did you have simple diagnostics there?

A. No. It was a room that you went and talked to a patient and examined a patient. There was no flow rates, there was no availability of bladder scanners, there was no cystoscopies. It was just a room that you discussed a patient, which is why there was a move to 12:08

seeing all the new patients through the Thorndale unit, which was going to be a one-stop with all of that additional equipment so that that you were able to -- you know, if you needed a cystoscopy, if you needed a bladder scan or a rectal scan, you could do it there and then. But that was only in the Thorndale unit, it wasn't in any of the outreach clinics.

135 Q. If you wanted to follow up someone with lower track symptoms, you actually couldn't do a flow rate in an outreach clinic? 12:08

A. No.

136 Q. Thank you.

List planning. One characteristic at Craigavon seems to be you organised the lists with your secretary 12:09 rather than the waiting list facility or offices, and in your evidence there was a huge Excel spreadsheet full of a few hundred people and "please choose so many". That included quite a lot of radiological things like cystogram and embolisation. Were you 12:09 expected to negotiate that with radiology?

A. I don't remember that at all.

137 Q. You don't remember.

Also on that were numerous vasectomies. You've gone 12:09 through the waiting list. Did you query why ultra routine things were even being considered to be done in that time when people were waiting years and years?

A. Well, I presume it is because from a Commissioner and

Board perspective, that a patient waiting a vasectomy is the same as a patient waiting a TURP. You know, therefore, it is one person who has been waiting for years, therefore they were interested in having no patients waiting past a prolonged period of time. 12:10
Therefore, if the person who is waiting beyond the target was a vasectomy, then you would have been asked to do a vasectomy.

138 Q. But was there any challenge at managerial level? Why are we doing these when our symptomatic patients need 12:10 doing, yet patients...

A. The booking of the lists would always have been ultimately the consultant`s responsibility and decision. So you wouldn't have chosen a vasectomy even though it may have been on the list of potential people 12:10 to do.

139 Q. Thank you.

Also, I was interested that there was one of your attachments which said you suddenly had, I think it was 12:10 a cancellation, so you said, Listen, I have an hour's space, and that e-mail went out to about 18 different people. Was it an efficient way? Could you not say to just your secretary, I'll choose one or two people and get them in. I didn't understand why so many people 12:11 had to know that you had an unexpected slot.

A. As I say, I wouldn't have had a personal waiting list, you know, so I wouldn't have anybody there, so, therefore, it is very much we have a day to get

a patient in. If anybody has a patient who's ready to go, just let me know. That's why I would have involved the other consultants and their secretaries, because they may well have had patients that they were going to book in three or four weeks that were suitable to come in at short notice and, therefore, as opposed to that slot being wasted, you would have treated somebody. But I wouldn't have my own waiting list, I just started, and that's why it would have been like anybody at all. 12:11

140 Q. So is that a good way to run a waiting list, do you think? In the other places you've worked, has that method between a consultant and a secretary been the default position or not?

A. At present I have my personal list of patients I know are suitable to come in as cancellations. Therefore, if that same situation happened, I would say to our scheduler, any of these three people have said they can come in, can you get them in. You know, there have been times in our unit where the same thing happens, you get a cancellation 24 hours in advance and you say, I will literally operate on anybody, just get me somebody who will come into the slot. 12:12

141 Q. Just one more question about -- we look at BCG in a lot of detail, but that obviously struck you as -- did that come from an MDT meeting, MDM meeting, that you were there and you witnessed this debate or was it challenged or how... 12:12

A. Again, this preceded me becoming a consultant. So when

I was a registrar this was still -- I was aware that Mr. O'Brien did not like using BCG. Again, as I said, I'm not sure if Mr. O'Brien said that himself or this was just said to me by one of the other registrars, that he doesn't like using BCG and, therefore, the likelihood is that he will offer Mitomycin instead of BCG.

142 Q. Just one other thing. One of your emails about being bounced down on the emergency list. That is something that would irritate a lot of surgeons, that we see. Did you feel that part of the problem there was that there was no CD who was a urologist and you had a lead clinician, so the person you went to didn't perhaps have enough clout in the system to make changes?

A. Well, the CD was a general surgeon with a special interest in urology. Although he was based in Daisy Hill Hospital as opposed to Craigavon, so he wouldn't have been directly involved with that but, again, reading by email, this was a decision that was made by the general surgical team as to how they wished to run the emergency lists in Craigavon. And that did not involve other specialities, including urology. Although, obviously, Mr. Young as the clinical lead hadn't been advised that this change was happening, so until I booked the case on and this happened, I wasn't aware this change had been made. I don't know where the discussions happened, from a general surgical level why they made that change and who agreed it, but it obviously did not involved other specialties.

12:13 12:13 12:13 12:14 12:14

143 Q. Yes. And it obviously irritated you, and you heard nothing back, and that is not good?
A. Yes. You know -- but when you have been bumped and you haven't been advised you have been bumped and no one explains why you have been bumped... 12:14

Everyone knows that when you get that phone call, you invariably say yes. Because, you know, if a vascular surgeon rings you up and says, "I have an aneurism coming", absolutely no bother at all. 12:15
144 Q. I totally agree with that. But, actually, you raised it through the formal channels, got nothing back, despite the fact that your CD was a general surgeon and a urologist and you should have had an answer, would you not agree? 12:15
A. Yes. Again, it wasn't part of the email, but I believe we did get an answer and the answer was: This is what we are now doing. You know, it wasn't as it --
145 Q. But that's not a discussion, that's an instruction.
A. That was that the general surgical team decided this was the way the emergency list was running and we can just accept that because the decision is already made. 12:15
146 Q. Does that happen in Belfast?
A. You know, the emergency -- urology, unfortunately, has very few true emergencies bar a torsion and a trauma. You know, that we frequently, in the Royal, which is where I now do my emergencies, we get bumped by other specialities for numerous reasons. So it is a very frustrating specialty to treat emergencies in because 12:15

we regularly get bumped. But in the Royal I would always get phoned by the other specialty to tell me that they have an emergency and, as I said, it's just protocol and good manners.

MR. HANBURY: Thank you. That's what I wanted you to say. Thank you very much, Chair. 12:16

CHAIR: Thank you. Dr. Swart.

147 Q. DR. SWART: I'm quite interested in something that you've alluded to a few times, which is the changes in the Neurology Inquiry. I think you have, in my view, correctly stated that it's not just the structures of governance which are in place in most hospitals, it is the way they work together, the way governance is functioning, and you described improvements in the way that functions since this Inquiry. 12:16

Can you tell me, in terms of your specialty and your consultant discussions what the impact of that inquiry was on the way you talked about things in your department? Because, in addition to having a governance lead and so on, it's the way people talk to each other about things which may not be easy to measure. What impact did it have on you and your colleagues, just from a personal perspective? 12:17

A. It has been a process. It didn't just happen in 2016, like suddenly this is what we`re doing, and this came in and this came in and this came in and it has been, over the past two or three years. And I think that when you get that document as part of your appraisal 12:17

that has all of this information on it that, to be honest, in the past I wouldn't have been that aware of. You would have dealt with individual complaints, etcetera, but you wouldn't really have had it all sitting in front of you. And I think, with the development of the governance lead, that all of these things are now in the open. 12:17

148 Q. Do you have more conversations with your colleagues about some of them? I mean there's the formal appraisal, obviously, but there`s also -- what do you feel you can talk about or can't talk about? Is there any change in that in terms of actually telling people about the things you are worried about, for example, as opposed to assuming everything you do is right? 12:18

A. I think the big difference is openness and it being more formal and recorded. It is very much that you are in a room and you're talking about these things and everybody feels that you can talk about it and you can challenge it. 12:18

12:18

I remember an example that one of the consultant anaesthetists came to our M&M meeting because the ACU team were involved with the case and, at the end of it saying how impressed he was by how we spoke to each other. Because it is very much you just talk about it. There was very little sort of fear or, you know, like, "Oh, I don't want to upset him". The gateway is just you talked about it. And everybody accepted we all make mistakes. If you are a surgeon, you will have 12:18

complications. But to be able to talk about those complications and get advice from your colleagues and learn from them, that's...

149 Q. Do you think, for example, you would definitely be aware if one of your colleagues was doing things entirely differently, was, say, really not keeping up with things in terms of the admin, would you know about that on a day-to-day basis? Is it that open? 12:19

A. No. I think it's very difficult to know exactly what happens in a consultant practice. We've had recent experience in Belfast where consultants have left for various reasons and, as part of my role as one of the clinical leads, I will be overseeing the transfer of their cases to other consultants. And, as part of that, all of the results that were going to one consultant after he left then came to me. And you get a great insight into, then, how other consultants run their practice. You can get "I can't believe that they were doing that". 12:19 12:19

150 Q. So one of the things you can do to try to mitigate that is try to have objective measures of quality of outcomes, and so on. That isn't that easy always. Has there been any move towards asking each specialty to develop a kind of simple quality of outcome scorecard of some kind perhaps based on some National Audit metrics? So, for example, if it was a stroke service, you would have five or six things that are recognised as best practice. You could just monitor those; you don't have to be regulated. If you monitor these 12:20 12:20

things for consultants, they tend to want to try to make it better. Is there anything like that being developed at the Belfast Trust or any plans to do that, just so you've got a bit more of what I would call assurance rather than reassurance? 12:21

A. Not that I'm aware of. You get a lot of information as part of your appraisal in terms of admissions, discharges, length of stay, complications, but --

151 Q. Do you get complication rates information?

A. Not by specific -- 12:21

152 Q. Or compliance with guidelines information?

A. No.

153 Q. Do you think that would be helpful?

A. It would be very onerous to put together, but it would be helpful. 12:21

154 Q. So in terms of culture, you've talked about the open and transparentness which has been developing. As you say, it is not an overnight thing. When you moved from Craigavon to Belfast, did you find a difference in the cultural atmosphere or did you think it was much the same? 12:21

A. It was the same. Again, as during my training, you know these processes existed but it was very -- you know, at a different level. You weren't involved. Even when I became a consultant in Belfast, the processes existed, I knew you filled out your forms, you were involved with them, but it was still very much done on an informal ad hoc basis. If there were any issues it would have been dealt with in the background 12:21

by the CD and the individual consultants, as opposed to it being recorded anywhere.

155 Q. So, for example, audit, quite a number of people have told us that at the Southern Healthcare Trust there wasn't enough investment in audit. I don't get a sense that there was a regular discussion in departments as to which audit should be prioritised, when they should be reported, how they would be supported, what measures were particularly interesting. Was that the same at the Belfast Trust as it was in Craigavon? 12:22

A. So there would have been an audit department but the audit department would have been there to advise you in terms of how to run the audit. In terms of what you actually audited --

156 Q. No, I'm talking about the priority of what -- 12:22

A. Apparently not. It was -- a registrar would have chosen to do the audit, discussed with the consultant. That would be the audit, whether that was something needed in the unit or not.

157 Q. If I were to ask you how would a member of the board get assurance that consultants in the hospital generally were following best practice guidelines, do you think there's any mechanism currently or in the past that would say, yes, we've got the guideline, we've looked at it, and we use the audit tool once a year, or whatever? Is that anything that you've ever seen in practice? 12:23

A. Without taking a random sample of outpatients, then I can't see how --

158 Q. But there hasn't been a programme as far as you're aware?

A. No.

159 Q. Okay.

Huge recruitment problem, clearly. Huge waiting list problem. Lots of reports in the past. And you mention the look at urology in 2009. At this point in time, are you aware that there's any kind of strategic plan for urology for Northern Ireland that is revisiting all of this to bring it together? 12:23

A. Yes. So, again, during COVID there were a number of meetings between the senior leads within each of the Trusts in terms of how we were going to restructure ourselves. And it was a very useful thing. Because, in the past, each unit would have been competing with each other and very much would have been, you know "them and us". I think with COVID that there was a far more openness to work together and far more openness to be able to travel between Trusts by individual consultants. 12:24

So, again, probably around 2020, 2021, we had a meeting in Lagan Valley between all the different Trusts and we put on paper how we felt we should structure ourselves. Then, about a year or so ago, then we were advised there was going to be a GIRFT review. We were very happy with that because it was likely to formalise what we felt was the right way forward. And then the

GIRFT review happened and it was published last week and it basically --

160 Q. I've seen that.

A. It formalised what we discussed in a meeting two years ago, which was how we felt that the region should work. It didn't do everything that we thought was needed but it certainly gave a formality to it, that it wasn't just a group of consultants trying to sort stuff out for themselves, this actually was the right thing to do for the whole region. 12:25

161 Q. I've had a look at that report. Clearly GIRFT is a well-recognised programme in England and it has been adapted to look here. Is that, as far as you're aware, been given a formal status in terms of helping it to happen and taking it forward with ongoing discussions? I'm just trying to sense what you are aware of as a urologist working in a very pressurised system in Northern Ireland? 12:25

A. A lot of the changes are underway and were underway already. I am now back working in Southern Trust doing complex stones, having left 13 years ago to do complex stones. They are all now being centralised there. So that is happening. The ESWL service is happening. There are parts to the GIRFT review that will take a lot more changes and a lot more resource. 12:26

162 Q. That's kind of what I'm hinting at.

A. Ultimately that will come down to the politicians and to the --

163 Q. That is my question to you, really. Who do you feel is

leading that? You've described the consultants coming together, the Trusts coming together, do you feel there is a political mandate for this now to happen and do you have a clear sense of how that is being supported by, say, the Chief Medical Officer's Office and Public Health, and the Commissioners? Is that clear to you? 12:26

A. I think that everybody, both in urology and in general, know the direction of travel. We've had the Donaldson report, the Compton report, Bengoa report -- numerous reports that have said what needs to happen. I don't know that Stormont in itself will actually make that happen because they've had 15 years before it collapsed to make it happen, and it did. 12:27

164 Q. What do you think would make it happen? I`m just interested as a clinician in the service. 12:27

A. I would like Chris Heaton-Harris to close down numerous A&Es. That`s what I think would help. You know, because the political parties will not do that because of the outcome that would be in their own constituencies. Whereas someone who wouldn't have the same political back -- what's the word? -- blow-back from it then could make that decision. We've seen it happen in terms of other things, that the politicians can't agree to do it and therefore you need someone from Westminster to make that decision for them. 12:27

Personally, I believe that what needs to happen with the Northern Ireland Health Service is that there are far too many acute units, far too many A&Es, that some

of those need closed. And I don't believe, even if you have a health minister and Stormont up and running, that that decision will be made. In my view, the only way that will happen is if Westminster say, Right, you are spending far too much on health, you need to make your system more efficient, and the way to do this is to close down this, this, this, this and this. 12:28

165 Q. I think that`s an interesting perspective. I think, looking at this from the point of view of the Urology Inquiry, touches on all of these issues: what happened to the Donaldson report, the Bengoa report, what is going to happen next. However, I think what you've said to me is, partly as a result of pressures, partly as a result of learning to work differently during COVID, and certainly assisted by the GIRFT report, there is the backbones of a plan which, if properly implemented and taken forward in what I would call a delivery plan as opposed to an aspiration, would assist greatly, in your view, in taking urology and, by implication, other specialties at the same approach further? Is that what you`re saying? 12:28 12:29 12:29

A. It certainly will improve things. At the minute there are pressures in every urology unit and we have to work together in order to improve that. The progress that has been made in Craigavon with the complex stone service, it shows that if you have the right people involved and the right resource behind it, that you can actually create an exceptional service. I honestly believe that's what it will be. There's no reason why 12:29

the other aspects of urology and other specialities could not do the same thing if they had the same support and the same resource put into it.

DR. SWART: Thank you. That's all from me.

166 Q. CHAIR: Thanks, Dr. Swart. 12:30

Just a couple of things from me. When you worked in the SWAH clinic, were the notes brought to you or did you ever have to bring the clinic notes yourself to the hospital? 12:30

A. I never did the SWAH clinic. The SWAH clinic was Mr. O'Brien.

167 Q. You didn't have any involvement there and you wouldn't know whether a clinician had to bring the notes themselves and then bring them back themselves? Just 12:30 the other clinics, they were delivered to you?

A. The way it was sorted out was the people who lived on the east side of Craigavon tended to do the Banbridge. The people that lived on the west side of Craigavon tended to do South Tyrone. It was easier for them to 12:30 go there and get home.

168 Q. Clearly Dr. Swart was talking to you about the GIRFT report and what is likely to happen in future, but you talked also about the Neurology Inquiry and the recommendations that that made and that the processes 12:31 had changed in Belfast Trust as a result. I just wondered, if you had to pick one thing that has helped you in your practice generally as a whole, what do you think that would be?

A. The governance report that I get as part of my appraisal.

169 Q. Okay.

A. Because, basically, it tells me everything that has happened, you know, and it's all there on paper. 12:31
Therefore, you know, it`s -- in simple terms it means that the Trust knows all about this, and I know about it, and therefore we are able to reflect on it and change. Whereas, you know, I don't know what the Trust were aware of in terms of, you know, my complications, 12:31
my M&M, my complaints. Like they're obviously aware of them, but, you know...

170 Q. Was this not something that was provided to you previously for your appraisal?

A. No. It would have been something that I was expected 12:31
to gather myself and then provide that to my appraiser. But, you know, you try, obviously, to collect it all. You can't be sure that it is fully 100 percent there. And then if you looked at it, if you wanted to hide something, then you just wouldn't declare it. 12:32

CHAIR: Thank you. That's very helpful. Thank you very much Mr. Connolly. I think that concludes your evidence.

We're due back tomorrow at 10 o'clock. Thank you. 12:32

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 5TH DECEMBER 2023 AT 10:00