Urology Services Inquiry

Oral Hearing

Day 74 – Tuesday, 5th 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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1 THE INQUIRY RESUMED, AS FOLLOWS, ON TUESDAY 5TH
2 DECEMBER 2023
3
4 CHAIR: Good morning, everyone.
5 MR. WOLFE KC: Good morning, Mr. Young. You are very 10:17
6 welcome back to the Inquiry and thanks for coming back.
7
8 You'll recall, just by way of recap, Chair, that
9 Mr. Young came to give evidence on the 8th November.
10 The transcript in association with that evidence 10:18
11 commences at TRA-08975 and continues through to 09090.
12 When he was last with us, and you'll recall, Mr. Young,
13 we covered a number of issues in your evidence to
14 enable us to better understand the environment in which
15 you worked, the challenges you faced and the role that 10:18
16 you performed. We took you through or you helped us to
17 understand how Urology Services in what is now the
18 Southern Trust has grown up and developed over the
19 years, the challenges which those services have faced
20 and still face in meeting the demand for urology care 10:18
21 against the backdrop of scarce resources in terms of
22 staffing and facilities.
23
24 You introduced us to some of the positive initiatives
25 which have been overseen in Urology Services and which 10:19
26 have led to beneficial outcomes for the population that
27 you serve. We discussed some of the tools of
28 governance, notably the Patient Safety meeting, and
29 aspects of audit and we looked at management

1 arrangements and your part in them and the approach
2 that you took and your understanding of the role of
3 clinical lead.
4
5 Just on the clinical lead point, we spent a little bit 10:19
6 of time in the afternoon of the last occasion. Whereas
7 your Section 21 statement tended to emphasise
8 a predominant service aspect associated with that role,
9 I think it's fair to say that when I questioned you
10 about that, you allowed for more of a management 10:20
11 involvement in terms of the management of people as
12 being part of that role, perhaps encapsulated by the
13 phrase that you were the "captain" of the team. You'll
14 recall that?
15 A. Yes. 10:20
16 1 Q. And as part of that you explained to me that in terms
17 of dealing with staff who were maybe not performing or
18 behaving as they should, you did have an involvement
19 with that, particularly with more junior staff, but
20 when it came to your peers, you found that difficult 10:20
21 and you considered it to be an unfair ask. Do you
22 remember saying that?
23 A. I do.
24 2 Q. Just I used these words and you agreed with them.
25 I said to you: 10:21
26
27 "When it comes to direct responsibility for what
28 consultants are doing in their day-to-day practice,
29 I will speak to them, I will offer advice, I will

1 convey messages from wider management, but it is not my
2 direct responsibility to manage them."
3
4 And you agreed with that as an apt description of your
5 role? 10:21
6 A. I did, yes.
7 3 Q. So this morning we're going to start by looking at that
8 distinction. We're going to look at some of your input
9 into dealing with a number of members of staff
10 mentioned in your statement as performing in a way that 10:21
11 was causing difficulty. Then we're going to look at
12 a number of the clinical approaches or clinical aspects
13 to a urologist's post and your post and that of your
14 peers, and we'll look at that through a number of
15 lenses and I'll explain more about that by way of 10:22
16 a signpost in just a minute.
17
18 If we could start with your witness statement. If we
19 could have up on the screen, please, WIT-51800. Here
20 you introduce us, just at the bottom of the page, to 10:22
21 the names of four doctors who you explain had
22 a responsibility or perhaps an opportunity to address,
23 in terms of difficulties with their practice, in
24 addition, as you say, to Mr. O'Brien. We'll go on to
25 look at Mr. O'Brien and the difficulties that he was 10:23
26 presenting as we go on this morning. But if we can
27 start with, if we scroll down a little, and the first
28 doctor you have referred to, we've named him publicly
29 when dealing with Mr. Simpson's evidence, it was

1 Dr. Aminu. Although it is blanked out on the screen in
2 front of you, it is important we know what we're
3 talking about.
4
5 You explain in your witness statement here that you had 10:23
6 to produce a competency report for the Clinical
7 Director in respect of that doctor.
8
9 Could I introduce what Mr. Simpson, Dr. Simpson, who
10 was Medical Director at that time, said about that 10:24
11 incident or that involvement. If I could take you,
12 please, to Dr. Simpson's statement at WIT-25696. Just
13 at the bottom of the page he refers to being copied
14 into an e-mail. We needn't bring this up in respect of
15 this doctor, Dr. Aminu. Over the page, please. 10:24
16
17 The long and short of it from his perspective, as he
18 explains here, is that there was a query from the
19 General Medical Council in respect of this doctor. The
20 Director of Acute, Dr. Gillian Rankin, had received an 10:25
21 Inquiry from the GMC in February 2012 and she had
22 brought that to his attention and the letter was then
23 copied to him.
24
25 Just scrolling down. 10:25
26
27 The point that he is making is that Mr. Brown
28 discovered that a senior nurse, Shirley Tedford had
29 raised concerns about the competency of this doctor to

1 you in your role as lead clinician, but this had not
2 been escalated to either of us, that is to the Medical
3 Director or to Mr. Brown, who was Clinical Director, or
4 indeed to the AMD for Medical Education and Training,
5 Mr. Colin Weir. He says: 10:26
6
7 "Although this was a matter of concern, the swift and
8 appropriate response by Mr. O'Brien compensated".
9
10 So that is his statement on the point. Just to pull 10:26
11 out of that what his concern was. If we turn to
12 a couple of e-mails that he sent around that time,
13 TRU-250599.
14
15 Here he is writing to the Director of Nursing, Francis 10:27
16 Rice, in March 2012, just in the middle of this issue.
17 He explains:
18
19 "This was kicked off by a letter I see got from GMC to
20 inform me this doctor is under investigation. Our 10:27
21 urology consultants thought he was just about okay, it
22 seems the nurses have a totally different view. My
23 guess is that there is something amiss in urology
24 regarding multi-disciplinary working, never mind
25 professional governance." 10:27
26
27 Then, if we just go to AOB- -- sorry, it is just over
28 the page. Yes. So he is writing to various people.
29 It is just the last piece I want to pick up on, Gillian

1 and Francis:

2

3 "It is a matter for concern that a senior nurse would
4 have significant concerns about the performance of
5 a doctor that don't seem to have been followed through. 10:28
6 I think there must be some learning here regarding
7 Clinical Governance."

8

9 Now, you wouldn't have, presumably, seen those e-mails
10 in real-time. But his point, as he explains in his 10:28
11 evidence, when he came here was that there appeared to
12 be a blockage and it was a blockage not confined to
13 urology in terms of bringing up for the attention of
14 more senior management concerns about the performance
15 of doctors. Here the concern was alive to the nurses, 10:29
16 made known to you, but the concern stopped
17 there, it didn't go up to where it needed to be in
18 order to be dealt with. Is that a fair criticism?
19 A. No, I don't think so. We work as a team on the ward.
20 If you're talking about the interaction between our 10:29
21 nursing staff and us on the floor, we do work very much
22 as a team. There's no impediment for the nurse not
23 being able to speak to us as seniors. I would
24 generally, when I'm doing a ward round or going up to
25 the ward, I speak to the sister asking is there any 10:30
26 problems going on. So there's very much an open arena
27 that even a staff nurse can speak to the consultant
28 without feeling aggrieved or hard done by or, you know,
29 it's not the environment to speak. That's not the

1 picture that we have on the urology ward. So there's
2 an open court that way.
3 4 Q. So how did this problem, which the nurses were drawing
4 to your attention, a concern about this doctor's
5 competency, not percolate up to where Dr. Simpson 10:31
6 thought it should arrive at?
7 A. Okay. The next step up then would be from our
8 intervention to take it higher to Colin Weir, who was
9 the educational lead, I understand that, or to our
10 Clinical Director, I think that was Robin Brown at the 10:31
11 time. So those are our initial steps. Also, we would
12 have discussed this with Martina Corrigan, for
13 instance, as a lead, she would be involved in the
14 process as well. For us to then speak directly to the
15 Medical Director was not really the pathway that we 10:31
16 would have taken initially. We take it from an
17 escalation point of view that that is what happens, but
18 I don't think we would skip all the intervening people.
19 5 Q. I suppose what he was pointing to and I suppose what we
20 are aware of broadening this out, this is 2012, 10:32
21 broadening this out and taking into account how, as
22 we'll see this morning, concerns in association with
23 Mr. O'Brien were dealt with. Do you see a similar
24 problem there in terms of a blockage? It may not all
25 rest with you, don't get me wrong, there's obviously 10:32
26 steps above you, but issues don't seem to get to the
27 top, to the Medical Director's office.
28 A. Right, okay. I accept -- I see where you're coming
29 from there.

1 Yes, there does appear to be a block in getting
2 information to the top table. I'm not sure where that
3 complete sort of blockage is. It may be a series of
4 blockages.
5 6 Q. We'll bear that thought in mind as we proceed this 10:33
6 morning.
7
8 I suppose, moving to some of the other cases you
9 mentioned in your statement, I was struck on the last
10 occasion by, I suppose, the distinction which you were 10:33
11 drawing about, I suppose, the levels of comfort or ease
12 with which you might deal with doctors less senior than
13 your peers. There's an example given of Dr. Fernando
14 set out in your witness statement, if we go to
15 WIT-51801. You explain at 57.4 if I can summarise, 10:34
16 that this was a locum specialty doctor. There was
17 a concern expressed about his temperament. It seemed
18 to come to a head somewhat when he was expected to
19 attend and work at a clinic in the afternoon of
20 a particular day. That was, I suppose, a late 10:34
21 arrangement. Something had happened to make it an
22 arrangement that maybe came to him as something of
23 a surprise, but he failed to show up. You arranged to
24 speak with him and when you arrived, I suppose, you
25 found him sitting in your seat and he behaved, 10:35
26 I suppose, rather impertinently on your description, in
27 your statement set out here. You dealt with that by,
28 I suppose, ending his contract. Is that fair?
29 A. That's fair. I found his behaviour -- I found him

1 a competent doctor. He knew a lot of the subject of
2 urology. His interaction with patients, I was told,
3 was good, having observed it myself and also via the
4 nursing staff. But I found that he could be a bit of
5 a hothead, if you want to put it that way. And the 10:36
6 actual incident arose from in the Thorndale Unit there
7 was two rooms, one needed decontamination and therefore
8 the clinic was swapped to the other room. It seemed
9 a very simple thing to do. But he didn't accept this,
10 for some reason. The nurse, the senior nurse, phoned 10:36
11 me saying, 'I think there's going to be a problem
12 here.' She was thinking he's not going to turn up for
13 the afternoon clinics so I said 'well, I'll ring him at
14 ten past two, and see how you are getting on.' He
15 hadn't arrived. I rang him on his phone finding he was 10:37
16 already at home, so there's a big flag being raised.
17 7 Q. I'm not so much, to be frank with you, interested I
18 suppose in the fine detail, although I don't wish to be
19 unfair with you. I suppose what I'm interested in
20 primarily is are you exercising these responsibilities 10:37
21 of management of this doctor behaving badly wearing
22 your clinical lead hat?
23 A. As part of the team, I am doing that, yes. Just to
24 finish this bit, when I rang this doctor, the HR
25 person, Malcolm Clegg, was in the room with me when 10:38
26 I phoned him; we were talking about something else. So
27 we did discuss what the best way to play this was and
28 instead of having a reaction, I thought a face-to-face
29 meeting with him was the right idea, which Mr. Clegg

1 agreed with so there was a joint decision there. Then,
2 when the event happened, I phoned Martina Corrigan
3 about it saying, 'look, here's what's happened, here's
4 what I've done'. So there was a joined up writing on
5 the event. But, yes, I was making a decision for us as 10:38
6 a group.
7 8 Q. I appreciate that. What I'm anxious to understand then
8 is here is, I suppose, a junior doctor behaving in
9 a manner which is not what is expected. He is failing
10 to comply with the standard. You approach that, you 10:39
11 manage it, and you deal with it, and we see the outcome
12 in this case. If you are working alongside a peer,
13 a consultant who is not complying with any particular
14 standard, why do you not approach the consultant in the
15 same way? Or perhaps you do. Help us with that. 10:40
16 A. Well, that's a different interaction. You're dealing
17 with a locum doctor from an agency here, a junior. You
18 are obviously trying to sort of train them and teach
19 them as they go along, and there's a way of doing it.
20 When you're dealing with your peer, it's a different 10:40
21 conversation, you are talking to an equal, if you want
22 to put it that way, and trying to put across your
23 points and see if they engage. But it's a different
24 conversation.
25 9 Q. Okay, but what you're telling us is that it's 10:40
26 a different conversation but you do have those
27 conversations with peers from time to time?
28 A. Yes.
29 10 Q. Okay. Maybe we'll look now at an example of that.

1 Mr. Suresh, you explain -- of we just scroll down. The
2 concern with Mr. Suresh is explained in your witness
3 statement as being a problem that arose in terms of his
4 competence in association with the performance of open
5 urological procedures unsupervised, perhaps when on 10:41
6 call and the worries around that. Is that a fair
7 summary of it?
8 A. That's a fair summary. Maybe to go into it in slightly
9 more detail, a standard operation on the kidney, which
10 is tucked at the back of the tummy, is -- you have to 10:42
11 be well trained to do renal surgery. And in the
12 elective situation that can be a challenge on its own,
13 but in the emergency situation of an organ that is well
14 supplied by blood vessels and it's bleeding, it's
15 a challenge. If you were a urology registrar at your 10:42
16 exams and asked how you deal with renal trauma, the
17 first thing you do is to find a friend and ring
18 a buddy. It's not for the faint hearted. So that's to
19 put this into a wee bit of context.
20 10:43
21 The other thing about renal trauma, it's not
22 necessarily that common, so your exposure to it is
23 going to be on a limited basis. I think that's a fair
24 assessment.
25 10:43
26 Now, there is an element of saying that you're not
27 experienced in this field or could be better and, as
28 time goes by, you do lose your -- if you haven't been
29 exposed to it enough, your actual competency in that

1 arena becomes less. So that's to put this particular
2 case into context and this came to light over a case of
3 renal trauma that had to be dealt with.
4 11 Q. Yes. And the way of dealing with it was that you with
5 the Clinical Director and I think with Mr. Mackle's 10:44
6 oversight brought the body of consultants in the team
7 together and you worked up a solution. Maybe I can
8 assist you by bringing up on the screen the record of
9 a meeting, WIT-53310.
10 10:44
11 "A meeting to discuss the issue took place on 17th
12 December at 2015 at the AMD's office."
13
14 You're obviously in attendance. Mr. Mackle in the
15 chair, Messrs. O'Brien, Glackin, Haynes and 10:44
16 Mrs. Corrigan in attendance. If we just scroll down
17 here we can see what was discussed. Scrolling down
18 further. I think just at the -- so the proposition
19 here was that there would be a body of support built
20 around Mr. Suresh involving some supervision, 10:45
21 consideration of training needs, and ability to contact
22 a colleague when on call if such a situation arose,
23 that kind of thing?
24 A. This was a package that we felt was appropriate and
25 agreed. Mr. Suresh felt that this was good for him as 10:46
26 well. We did this as a body and went up the line, as
27 you've seen it went to Mr. Mackle.
28
29

1 There was conversations before this particular date.
2 This is a formal meeting that we're having here but
3 we had already tried to put in place these activities.
4 Probably the first thing that we wanted to put in place
5 was from a patient safety point of view was there was 10:46
6 associated cover of the unit, that if this happened
7 again, there was somebody to ring. So that was the
8 first thing we put into action. But as far as the
9 persons concerned, there was a package here of feeling
10 that there was support, there was education being 10:47
11 planned and for it to be kept an eye on and followed
12 through.
13 12 Q. Yes. We can see that there was another meeting to
14 discuss this issue or developments in it around
15 April 2016. I don't think you were in attendance at 10:47
16 that meeting but you were obviously keeping abreast of
17 the situation and receiving information in terms of
18 whether there were improvements visited on the issue in
19 terms of Mr. Suresh's progress.
20 10:47
21 You wrote to the Medical Director. If we could pull up
22 WIT-55345. You wrote to the Medical Director
23 in June 2016. You were highlighting the background to
24 the issue and, just to get to the end of the letter,
25 I think what you were communicating was broad 10:48
26 confidence that things had improved significantly.
27 Mr. Suresh was fully engaged with the process...
28
29 "...recognising the areas that require attention and he

1 has recognised the patients under his wing of on call
2 are his responsibility, yet other consultants are
3 available for consultation and he has availed of this
4 facility."
5 10:48
6 Over the page you explain that the matter will be kept
7 under review. Again, you are becoming involved and you
8 became involved in that issue as clinical lead. It is
9 one of the aspects of your responsibilities as clinical
10 lead that you would get involved with? 10:49
11 A. Yes, and as a consultant, yes.
12 13 Q. But you're taking the lead on it, you're writing the
13 letter to the Medical Director's office, it is not any
14 other consultant that's doing it, you're doing it
15 wearing your clinical lead hat? 10:49
16 A. I am.
17 14 Q. And, Mr. O'Brien, he in his statement draws a contrast
18 between how Mr. Suresh was approached and treated with
19 his particular problem or issue and he says, if you can
20 maybe just bring it up on the screen, WIT-82544, 10:50
21 paragraph 405. He describes concisely how he was
22 available to support Mr. Suresh without receiving any
23 remuneration for doing so. And he says:
24
25 "I've since had reason to contrast the support offered 10:50
26 to him in 2016 to that offered by the same persons to
27 me in 2016."
28
29 I suppose we can unpack that with him but 2016, he

1 received, I suppose, something of an ultimatum in terms
2 of a letter to get his practice back in order, produce
3 a plan, and he's saying here, well, I didn't get the
4 arms round the shoulder support that Mr. Suresh
5 received. 10:51
6
7 Obviously different issues, different practice issues.
8 Is there a point in that, a good, valid point in what
9 Mr. O'Brien is saying or do you think, by contrast,
10 that he was offered support with the issues he was 10:51
11 facing?
12 A. You're commenting on the word "ultimatum" there in
13 2016. I wasn't party to that --
14 15 Q. Of course?
15 A. -- but there's an element of help, I think this is what 10:52
16 you're asking. I think Mr. Suresh's help was of
17 a slightly -- it was of a different type and nature,
18 and Mr. O'Brien was looking for -- he was looking for
19 something else. So I can't comment on the help
20 required from March, of this letter that we're talking 10:52
21 about in March '16. But, you know, was Mr. O'Brien
22 offered help for some other aspect of his practice, the
23 answer to that is yes, it will be of a different
24 nature.
25 16 Q. We'll come to that later this morning, a little later, 10:53
26 about your input by way of assistance around the triage
27 issue and taking on the aspects of that, but -- sorry,
28 go on.
29 A. But there was more help. I mean it dates back before

1 my triage help. I mean, part of this issue is to do
2 with outpatients, for instance. Going back to the 2009
3 urology review, as you know there was some sort of
4 tensions that we did have with the Trust trying to work
5 out what was going to be happening for the 10:54
6 Southern Trust, one of which was outpatients and it was
7 the design of the outpatients. We were concerned that
8 the review had taken the premise of the BAUS 2000
9 document, which set out how many patients that you were
10 meant to see at a clinic. Whereas, you know, we had 10:54
11 already set up an ICAP service so the consultants were
12 seeing more of the complex cases that were taking
13 longer to discuss and, therefore, we couldn't see as
14 many patients as were expected. But part of the
15 setting up of the clinic design was that there was time 10:55
16 at the end of the clinic for admin and we were keen
17 that it was, you know, a clinic was the start and
18 finish that you managed to get -- so there were
19 discussions set up beforehand to actually put that into
20 action. 10:55
21
22 We can fast forward to -- we did clinics in the
23 Southwest Acute Hospital. It takes a fair bit of
24 driving time to get there, as far as I'm concerned.
25 For the day that I went it was 150 miles round journey. 10:55
26 So we accommodated that we had part of the travel time
27 within the clinic and part of the travel time in our
28 own time, if you want to put it that way. And the
29 clinic was set at a certain volume. That was a Monday.

1 Now, on a Tuesday morning it is usually day surgery
2 unit work in Craigavon which was either between
3 Mr. O'Brien or myself. So we set it -- at that point,
4 we did our scheduling programme once a month that,
5 specifically for Mr. O'Brien, that if he was at the 10:56
6 Southwest on the Monday, he didn't do the Tuesday
7 morning day surgery list because that's when he wanted
8 to catch up with the clinic on the day before.
9 17 Q. Do you mean catch up on administration?
10 A. Well, administration of the clinic associated with the 10:57
11 clinic the day before. Now, I mean, I was able to
12 complete by administration and dictation at the clinic
13 or when I went home at night. Mr. O'Brien was a bit
14 slower, maybe took a little bit longer, but
15 we accommodated that by time out on the Tuesday morning 10:57
16 to do that admin. So that's maybe a slightly different
17 type of support, it's more sort of targeted. Again, it
18 is a bit like Mr. Suresh, it was an educational
19 programme he needed to go on to get taught. As far as
20 Mr. O'Brien is concerned, he does not need to be taught 10:58
21 surgery. Mr. O'Brien is a very competent surgeon,
22 there's no doubt about that, so that's not what he
23 needed. But he needed support from the admin and that
24 admin was in time. That is just an example.
25 18 Q. Just to summarise from what we have so far looked at 10:58
26 this morning, in terms of your role as clinical lead,
27 you did have a responsibility to intervene and show
28 some element of managerial output when it came to
29 dealing with doctors who were in difficulty, for

1 whatever reason? In the one case, clearly poor
2 behaviour on your account. In another case it was an
3 issue of experience, in Mr. Suresh's case an issue of
4 experience around a particular competency. But you
5 recognise in those examples an obvious role for you, as 10:59
6 the captain of the team, to take appropriate action or
7 to ensure that appropriate action was taken?
8 A. Yes, but still as part of the team, yes.
9 19 Q. You have touched on administration. We have touched on
10 triage. I want to go now and look at some of those 10:59
11 specific clinical aspects of urology practice. We'll
12 look at them through a number of lenses or for a number
13 of reasons. We need to understand why the clinical
14 aspect or the clinical task is important. We need to
15 understand how you and others would have performed that 11:00
16 task, and there will be an opportunity for you to
17 identify or highlight any difficulties in performing
18 the task. And we particularly, with reference to
19 Mr. O'Brien, but others if there were others who were
20 not performing the task adequately, we want to hear 11:00
21 from you about that, your knowledge of that, and
22 whether the issue was effectively or appropriately
23 managed or challenged and maybe with some hindsight you
24 will be able to offer some insight into what might have
25 been done better, if you think that was the case. 11:01
26
27 Clearly, within your statement, your first statement,
28 you reflect that over the years of your career the
29 volume of administrative work has increased

1 exponentially, you say without a corresponding increase
2 in time allocated to address it. You give some
3 examples, no doubt by way of example rather than
4 comprehensively, of the type of administrative work
5 that you had to undertake: Triage of referral letters, 11:01
6 correspondence with GPs, discharge letters, results
7 sign-off, attendance at and preparation for audit, to
8 name no doubt but a few. Administration work was
9 a challenging feature of your role, is that the point
10 that you are wishing to get across? 11:02
11 A. Yes, it seems to -- it doesn't get detracted, it always
12 seems to get more in volume and in content and in time
13 to have it done.
14 20 Q. And triage specifically, it's obviously a clinical task
15 with an administrative element to it. Let's try and 11:02
16 put triage, as you have helpfully done in your
17 statement, into some kind of historical perspective.
18 If we pull up your statement at WIT-51716, you say at
19 13.1, just at the top, to pick up on a few points here.
20 You are saying that triage was, well, it's evolved over 11:03
21 your tenure. It was initially done as part of general
22 administration, and you explain that your understanding
23 was that until the introduction of the IEAP, the
24 Integrated, Elective, I forget what the A stands for,
25 Protocol, there was no specific time limit associated 11:03
26 with it.
27
28 You go on at 13.2 to explain that there was a degree of
29 impingement of triage on your other clinical duties and

1 it was rather -- I think you make the point it was
2 sometimes a bit of a juggling exercise knowing what to
3 prioritise so that if you're in theatre all day, for
4 example, it was impossible to reach the triage.
5 A. Yes. They were keen to have the red flags done within 11:04
6 24 -- the regular flag referrals done within 24 hours.
7 So if you were either at an outreach clinic and went
8 back to pick up the data or all day theatre, long
9 cases, you weren't going to be doing that in between
10 cases. So there was reasons for the trouble with the 11:04
11 exact timelines.
12
13 We generally had a week on call. The routine and
14 urgent cases to be seen in outpatients were weeks and
15 months ahead. To have that letter precisely triaged 11:05
16 within 72 hours didn't seem an exact priority. The red
17 flags were slightly different in that those patients
18 obviously were given priority. So the Trust were keen
19 to have them back as soon as possible but within
20 a 24-hour period did seem a little bit tight, when 11:05
21 you are trying to do all of the rest. In fact, this
22 was one of the reasons why we moved to the urologist of
23 the week.
24 21 Q. I want to try to put some loose chronological framework
25 around this and we will move to urologist of the week 11:06
26 presently and the challenges associated with that move
27 and the opportunities that it may have delivered. But,
28 just in terms of the importance of triage, you made the
29 point that with a significant backlog in terms of

1 urgent and routine patients, it didn't always seem
2 terribly important to get those back, those referrals
3 back as quickly, maybe, as the authorities might have
4 liked. But, nevertheless, in terms of the importance
5 of triage, it's significance or its importance didn't 11:07
6 change over time, did it? The reason why you were
7 doing triage remained the same?
8 A. Exactly. All letters, indeed, need to be triaged on
9 a reasonable period of time. Coming back to before the
10 urologist of the week, I believe that we had our on 11:07
11 call week and there was an arrangement with The Trust
12 that the week that you were on call, by the end of the
13 week you had the letters triaged, red flags, urgent,
14 and routine, in that order. But the principle has
15 always been that all letters -- all letters -- are 11:08
16 triaged.
17 22 Q. Just spell it out for the record why that is important.
18 There's obviously an importance in terms of directing
19 the next steps for the patient, but there's
20 a significance in the performance of triage, is there 11:08
21 not, for the purposes of interrogating the
22 classification which the referrer has placed on the
23 patient?
24 A. Absolutely. On a personal note, I do look at what the
25 GP has categorised the patient as but, you know, I read 11:08
26 the content of the letter and put my angle on it.
27 Okay, I have more experience than the GP, but the
28 information and the significance of what is being
29 written down, maybe the GP has written the information

1 down but hasn't actually twigged to the significance of
2 the content and to try to get the joined up writing on
3 the whole thing. So, yes, it is very important. And
4 we have, in our unit there has been discussion about
5 offloading triage to other people, but we have always 11:09
6 felt that the consultant is the best person to triage
7 a letter. And in fact, probably the most important
8 letters to read are the routines, and then the urgents
9 and then the red flags because the red flag letters are
10 always going to be red flag. It's very rare that we're 11:10
11 going to change that. So, actually, the red flag
12 letters should actually just go through on the red flag
13 system, to be honest. But it is reading between the
14 lines of the content of the letter in the routine and
15 the urgent. That's where I felt that the consultant 11:10
16 comes into the role.
17 23 Q. We'll come later to ask for your views, if you can
18 offer any views on why Mr. O'Brien might have left so
19 many urgent and routines untriaged. But, from your own
20 perspective, would you ever feel comfortable leaving 11:10
21 a large quantity of such referrals untriaged?
22 A. Absolutely not. I wouldn't agree with leaving any --
23 I would get upset if there was 20 letters in my drawer.
24 In fact, if you go slightly further into that, I have
25 remembered occasions that the booking office would have 11:11
26 contacted my secretary saying we haven't received the
27 letter back on X, Y and Z person, and all my referrals
28 were put into a special A4 box, so that's where all my
29 communication was. And so if Patient X, Y and Z's

1 letter wasn't in that, it has been lost, and I asked
2 them to reprint the letter and I would triage that. So
3 that's to the level I do triage, the word is "all".
4 24 Q. Yes and I think you have agreed with me that this
5 patient safety issue, which is at the heart of why you 11:12
6 clinicians perform triage and, if I'm interpreting you
7 accurately, it's why you are so punctilious in
8 performing it, ensuring that it's done. Do
9 you understand that across your team of colleagues over
10 the years, that this appreciation of this patient 11:12
11 safety principle was well understood?
12 A. It should have been. I mean, I think we all do sort of
13 realise that there is information in a GP's letter that
14 has to be assessed. I do believe that we all knew
15 that. But maybe coming back to the original comments 11:13
16 of administration, it is the volume of it is the
17 challenge.
18 25 Q. We can see that from 2008 some witnesses, such as
19 Mr. Mackle, have pointed to earlier concerns about
20 triage. But, certainly, if I can draw your attention 11:13
21 to an e-mail or series of e-mails in 2008, you are
22 being pulled into the issue of Mr. O'Brien's delay in
23 dealing with triage as far back as then. I just want
24 to put that up on the screen and we can take that as
25 our starting point: WIT-23742. Just at the bottom of 11:14
26 the page Teresa Cunningham is writing to Eamon Mackle
27 and Simon Gibson. She's explaining that, as regards
28 referrals, I am just trying to pick up on an
29 appropriate line there. Essentially they are working

1 to a six week target and Mr. O'Brien's delays in
2 relation to triage is causing that target to become
3 unmanageable and she is asking for assistance to
4 resolve the problem.
5 11:15
6 Just going up the page, Simon Gibson is writing to you,
7 copying you into that, presumably, again, wearing your
8 clinical lead hat.
9
10 "What solutions could you propose to this continuing 11:15
11 problem."
12
13 And there's a bit of back and forward. Mr. Mackle to
14 you suggesting that:
15 11:16
16 "If you don't think urology can cope I think we have no
17 choice but to ask Philip Rodgers ..."
18
19 Was he a general practitioner with a specialist
20 interest in urology? 11:16
21 A. He was our GP with specialist interest. He worked
22 certain sessions of the week.
23 26 Q. Just scrolling up, you are explaining:
24
25 "Mr. O'Brien is on leave. I have triaged all the 11:16
26 letters in my box. If mine are outstanding, someone
27 else has them. I do note that my triage box letters
28 have not been taken from last week's session to triage,
29 therefore several factors involved. Will speak in

1 person."
2
3 So I think you are scouting around there for an
4 explanation as to what has gone on. It is one moment
5 in time, one episode in time. But is it fair for me, 11:17
6 do you think it's fair for me to pick that as I suppose
7 a starting point by way of illustration that this
8 triage issue remained unresolved, as we'll see various
9 communications over the years, but it has a long
10 history? 11:17
11 A. It has a long history.
12 27 Q. One can see as well, and I ask for your comments on
13 this, that the Trust's response to the problem of delay
14 on getting referrals back, ultimately it becomes more
15 than delay but there seems to be a number of responses. 11:18
16 Mr. Mackle has described circumstances in which
17 Mr. O'Brien was given some time off, a month off to
18 catch up on his administration work. There also seems
19 to have been an element of a stick approach, you
20 reflect in your statement an awareness of the fact that 11:18
21 Mr. O'Brien was told he couldn't travel to a BAUS
22 conference in Barcelona if he didn't bring himself up
23 to date. A third element of the response would appear
24 to have been for colleagues to volunteer or for the
25 Trust to ask colleagues to intervene and assist. Then 11:19
26 the fourth element may reflect a degree of giving up on
27 Mr. O'Brien by the introduction of the default system
28 some time in 2014 and formalised in 2015.
29

1 I just want to ask you about elements of those four
2 approaches.
3
4 In terms of assistance from The Trust, as I say,
5 Mr. Mackle said in his evidence that in or about 2007 11:19
6 or so Mr. O'Brien was given a month off -- or, sorry,
7 clinical work, I should be precise, clinical work was
8 cancelled for a month to enable him to catch up. Do
9 you have any memories of that or other initiatives from
10 The Trust to assist him with his triage? 11:20
11 A. There was this period of time, I couldn't tell if it
12 was 2007, but I'm aware that there was time put aside
13 for him to catch up. It was put across as extra admin
14 time. I don't know if that was specifically to do with
15 trying to clear triage, but it was the general 11:20
16 principle of being behind on admin and this was time
17 allocated.
18
19 I'm not aware of anything else that the Trust had put
20 in place to help him beyond time, but that's what was 11:21
21 needed was obviously time for him to actually do that
22 work. Do you have extra admin time from a secretarial
23 point of view or an audio typist? I don't know if
24 there's any dictation but, I mean, that would have been
25 his dictation, but that time allocated to that would 11:21
26 have been, obviously, dealt with by somebody else. So
27 it was time was what he needed, I would have thought,
28 apart from somebody else actually doing the work
29 themselves.

1 28 Q. You say, as regards what I've described as the "stick
2 approach", this is at paragraph 63.4 of your statement.
3 I needn't bring it up, you'll recognise it when I say
4 it. You interpreted the "you're not going to Barcelona
5 unless you catch up approach" as evidence that they 11:22
6 regarded this as a more chronic issue, however you were
7 not very appreciative of that fact at the time.
8 A. Yes.
9 29 Q. There's elements, and we'll come to different examples
10 of this, there's elements of your evidence which 11:22
11 suggest over the course of many years that you didn't
12 seem to fully appreciate the nature and extent of the
13 problem. In other words, you didn't recognise it was
14 a chronic issue?
15 A. I recognised it was a chronic issue, but the point of 11:23
16 the example of the event of trying to get to a meeting
17 is that there was outstanding triage to be done and it
18 could be done and was done so that he could have gone.
19 So there's an element there that Mr. O'Brien was able
20 to do it when necessary. 11:23
21 30 Q. Yes. Let me ask you about that. Mr. O'Brien put
22 forward explanations for why he couldn't do it and they
23 revolve around time and when we get to the urologist of
24 the week part, there's a kind of added element to it in
25 terms of his interpretation of how triage should be 11:24
26 performed.
27 A. Yes.
28 31 Q. Which, again, comes back to whether there's sufficient
29 time to do it. What's your response to that over any

1 of the period of the chronology?
2 A. Yes --
3 32 Q. You had demands on your practice, fellow clinicians had
4 other demands. I suppose across the team there are
5 different responsibilities. Mr. O'Brien was heavily 11:25
6 involved in NICaN. He ran the MDT for a number of
7 years. But time management is something all clinicians
8 have to grapple with?
9 A. Yes. You have used the example that I was going to
10 raise there. Mr. O'Brien was heavily involved in the 11:25
11 administration and documentation of the NICaN work.
12 That, undoubtedly, took extra time to do. I would
13 suspect strongly that that was in his own time because
14 I doubt the Trust would add that to your job contract.
15 That would have ate into the time allocated to do 11:26
16 everything else and that was one of the reasons why
17 I stepped in to help out for a period, a short period
18 of time. So, yes, there were other constraints.
19
20 Mr. O'Brien also, in setting up the Trust's MDT 11:26
21 Invested a lot of time doing that, and that did take
22 a lot of time. He spent time preparing for it and,
23 okay, he's maybe switching one role for another, but,
24 again, the triage issue is still one of those top-level
25 things that you still do, it may be at the expense of 11:26
26 something else. But I agree there was a lot of other
27 things that he was doing that could have impinged on
28 the ability to do it. But, again, it's getting your
29 time arrangements and management at a level that can

1 cover the post.
2 33 Q. One can see that -- this is fast forwarding somewhat to
3 2013 -- that management of various hues, whether that's
4 Mrs. Corrigan or, in the example I'm going to give you,
5 Mrs. Trouton, were frequently in touch with you to try 11:27
6 to get you, I suppose, to prevail upon Mr. O'Brien to
7 operate in accordance with their tune or with their
8 understanding of the applicable standard. I just draw
9 your attention to this particular example. If we go to
10 TRU-276904 and it's November 2013 and she's writing to 11:28
11 you as well as Mr. Brown. She's explaining that this
12 letter, I think, this e-mail is to cover two issues,
13 one is retaining charts at home, which we'll look at a
14 little later, as well as triage. What she's staying is
15 that she's dealing in terms of triage, she's saying: 11:29
16
17 "Despite the fact that patients not triaged from your
18 office mean that we have breached the access standard
19 before we even start to look for appointments, I am
20 more concerned about the clinical implications who need 11:29
21 seeing urgently and possibly even needing upgraded to
22 a red flag status."
23
24 So there she gets the cardinal importance of triage and
25 she says: 11:29
26
27 "We really need you to speak with Mr. O'Brien both in
28 the capacity of a colleague but also in your capacity
29 as clinical lead and Clinical Director for Urology as

1 well of course as patient advocates."
2
3 She says:
4
5 "If it is not addressed I will be forced to escalate to 11:30
6 Debbie and Mr. Mackle as director and AMD for the
7 service. It has already been suggested that
8 Dr. Simpson become involved."
9
10 So a number of issues arising out of that. You 11:30
11 e-mailed back, I needn't put it on the screen. You
12 said "I will speak", short and succinct.
13
14 In terms of directing this trouble over to you to sort
15 out as clinical lead, did you think that that was 11:31
16 appropriate in the first instance?
17 A. It's appropriate to have myself and Robin Brown, as was
18 on the e-mail list, to have a conversation with the
19 person involved with what you're trying to put across,
20 rather than making it very formal. Sometimes something 11:31
21 formal is good, sometimes something informal can do the
22 job as well. So here is the management trying to get
23 Mr. O'Brien to do triage. They're trying to have a
24 look to see if there's a different angle can be taken
25 on that, which they had done before in the years 11:31
26 before, you know, and --
27 34 Q. I agree with you, it is not the first time that your
28 door has been rapped?
29 A. Absolutely not.

1 35 Q. And it wouldn't be the last.
2 A. Yes it's not -- absolutely. And I think they're
3 looking at a different angle to try to target the
4 problem. But, you know, I had tried this before by
5 doing the triage. Mr. Brown was involved and knew all 11:32
6 about this as well and had spoken to Mr. O'Brien on it.
7 There would have been sort of temporary times of when
8 it went well, and then it would slip. I think that's
9 a reasonable thing to say. And at this period of time
10 I was looking at this, you know, can you help out 11:32
11 again? And my thoughts on this was it really needs
12 something at a higher level to have this sorted out.
13 And I see at the very bottom here, you know, involving
14 Mr. Mackle and have suggested that Dr. Simpson be
15 involved. So I don't know how far up the channels this 11:33
16 went. I'm talking about this on a firefighting
17 perspective, can you help out here again, would you
18 speak to Mr. O'Brien to try to sort it out, can you
19 come to terms and find a process of making it happen?
20 Now, sometimes it did for a period of months, and then 11:33
21 it would tend to slip back again.
22 36 Q. We'll bring up your response back to Mrs. Trouton,
23 WIT-11955. Robin Brown, he's making the point that
24 Aidan is an excellent surgeon, so the approach should
25 be how can we help. Your approach, just going further 11:34
26 up the page, you have spoken and offered help with the
27 triage issue, "and will reinforce again this week". So
28 that suggests you have spoken to Mr. O'Brien?
29 A. Yes.

1 37 Q. I don't wish to use the word pejoratively, but you seem
2 to have been forced into a position of offering to help
3 again, in other words offering to take some of the
4 triage off of him?
5 A. You use the word "forced" there. I helped out. I'm 11:35
6 part of the team. This is about making the system
7 work.
8 38 Q. Okay.
9 A. But the system to work is a team approach. If it needs
10 a little bit of help here and there, that's fine. But 11:35
11 behind all this I really did feel that the higher
12 echelons of the administration needed to find
13 a solution to this problem.
14 39 Q. Let's look at aspects of that triangle. You are taking
15 a constructive approach, it is how can I help. You've 11:36
16 spoken to Mr. O'Brien. So this is 2013. Do you seek
17 to convince him that he must do what is expected of
18 him?
19 A. Well, yes. I mean it's fairly obvious. I take it as
20 fairly obvious that, you know, everybody is harping on 11:36
21 about triage having to be done. There's a certain
22 element of reflection to say, right, there's something
23 needs to be done about this, what help do I need to do
24 it? What can I do myself? What do I ask for?
25 40 Q. Yes? 11:37
26 A. And also what other people are coming back to say, how
27 can we help you on this.
28 41 Q. That seems to be an acceptance on your part that
29 Mr. O'Brien either can't or won't do all that's

1 expected of him and, no doubt, that is what is
2 communicated to senior management and, indeed,
3 Mrs. Burns meets with Mr. O'Brien in February of the
4 next year, 2014. And the upshot of that is that is
5 that there is an agreement that, save for, if you like, 11:37
6 specific or personal referrals to Mr. O'Brien, the
7 urology team would take the rest of the triage. But
8 ultimately that falls on your shoulders?
9 A. Yes. So my understanding of that conversation was that
10 the Trust had spoken to -- sorry, I know you said this, 11:38
11 it is just to get in my own head here -- that the Trust
12 had spoken to Mr. O'Brien, how can we help with the
13 triage? I think he said that he would do the red flag
14 and the arrangement was named referrals, which leaves
15 all the rest. So there's a help. 11:38
16
17 I think the issue is relating to the volume of
18 referrals. I think if there was only X amount to do,
19 then you could cope with this, but its just the endless
20 volume of referrals is the big issue. 11:38
21
22 Now, so there was help there and Debbie, Mrs. Burns,
23 said that she would ask the team. I happened to be in
24 the corridor at the time, I think, with -- or in
25 Martina Corrigan's office when Debbie came up to talk 11:39
26 in the corridor or in the room about this, asking the
27 team. I said, well, look, I've dealt with this before.
28 Let's see what sort of volume this is. I'll do it to
29 start with before you start asking the rest of the

1 team, which I didn't know if they would -- I haven't
2 asked that question, I don't know if they would have
3 agreed to do it or not. I'm sure they would have.
4 I didn't ask the question, but I did offer to do the
5 triage at that time to help out with what Mrs. Burns 11:40
6 had arranged, and I would see what volume that was and,
7 if acceptable, I continued. But if it was excessive,
8 I was going to then speak to the rest of the team. But
9 that is the reason I ended up doing it.
10 42 Q. Mr. O'Brien, he has reflected -- if I just bring this 11:40
11 up on this screen at WIT-82498. So he reflects, just
12 on the last line there, that you generously undertook
13 this triage for a period of about six months or -- six
14 months or more, sorry, during 2014. I think just over
15 the page, yes. If we go to WIT-82562. But he makes 11:41
16 the point at 469, paragraph 469 that this was
17 a temporary fix but failed to address the underlying
18 cause which he says was progressively exacerbated by
19 the additional burden of his roles with NICaN and with
20 the Trust's MDT and MDM at the time. So that's right, 11:41
21 isn't it, it was a very helpful solution to get over
22 that impasse at that time. But it seems that the Trust
23 really ought to have arrived at a permanent fix, which
24 was either, assumedly, to take the responsibility from
25 Mr. O'Brien or, in the alternative, to require him to 11:42
26 do it, whether that came with additional time or not,
27 isn't that right?
28 A. That's right. That's what I was saying earlier. This
29 was a temporary fix that I was offering help in 2012

1 and then again here. There was the expectation that
2 the Trust was going to sort it out rather than me.
3 43 Q. Yes. We saw in the e-mail from Mrs. Trouton, which
4 started the series of conversations, that she was
5 hinting at the possibility that this would be 11:43
6 escalated. Going back to what Mr. Simpson said at the
7 start of our piece this morning, this issue doesn't
8 reach the Medical Director's door until, on the
9 evidence that this Inquiry has received, until probably
10 December 2015 or January 2016 and then there's a delay 11:43
11 of a year or so before the MHPS process is instigated.
12
13 Can you help us with this, in terms of reflecting back
14 in terms of how this issue was dealt with over that
15 time, did management address the issues as well as the 11:44
16 public ought to expect from them?
17 A. The fact that this had been a chronic issue, it should
18 have gone up the line more so and quicker, I would have
19 thought. Do I reflect myself, should I have gone to
20 the Medical Director? As I said earlier, usually you 11:44
21 speak to the next person up the line. Most of us would
22 have spoken to the AMD at the time. But --
23 44 Q. I don't get a sense from your evidence, Mr. Young, and
24 obviously we've looked at your statement, your approach
25 seems to have been let me see if I can help Mr. O'Brien 11:45
26 out here, if you like, to keep the service ticking
27 along. It also, if you like, forgive my expression,
28 keeps the wolves from the door. In other words, it
29 doesn't get escalated because you came in with this

1 temporary fix. I don't get the impression that you had
2 any hard conversation with the clinical director, for
3 example, your next step up. Perhaps you ought to have
4 had a conversation along the lines of: This is
5 impossible, it's putting a burden on me and others, 11:45
6 it's endangering patients, you need to sort this out.
7 Was that the kind of conversation had by you with, for
8 example, Mr. Brown?
9 A. Yes. And it was evident that from the administration
10 perspective that at the AMD level, I would have thought 11:46
11 that there had been conversations. Certainly I knew
12 that Mrs. Trouton had been speaking to Mr. Brown, so
13 I already knew that level was occurring. It's whether
14 the Acute Services team had escalated that higher to
15 the Medical Director, I would have thought it would 11:46
16 have been prudent. But my role here, as I'm saying,
17 I'm trying to help out with the expectation that the
18 administration was taking it further and I sort of knew
19 that they knew about it, so that's...
20 45 Q. It's perhaps an unfair question, but do you have 11:47
21 a sense, thinking back on these matters, as so why more
22 effective action to challenge Mr. O'Brien wasn't taken,
23 perhaps, by way of escalation? As I say, that didn't
24 happen until the very end of 2015.
25 A. I think the conversations that the administration had 11:47
26 with Mr. O'Brien had been taken on Board, as we can see
27 here. I have had Mrs. Trouton and Mrs. Burns having
28 spoken to Mr. O'Brien saying, and he coming back
29 saying, yes, I will sort it out myself, I'm doing the

1 extra triage, but then it tends to slip. So there was
2 a period of time where the word was getting through to
3 him, it was being done, and then it appeared to slip.
4 Now, that's the impression given. Now, whether they
5 thought it was done or not, I don't fully know. 11:48
6 46 Q. Let's, subject to the Chair, take a short break?
7 CHAIR: Yes, it is time for a break, ladies and
8 gentlemen, five past 12.
9
10 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:05
11
12 CHAIR: Thank you, everyone. Mr. Wolfe.
13 47 Q. MR. WOLFE KC: So Mr. Young, just before the break we
14 were looking at that point in the timeline when you had
15 taken over, from about February 2014, elements of 12:07
16 Mr. O'Brien's triage. Could I draw your attention to
17 something Mrs. Corrigan has said about that, WIT-26283.
18 And at paragraph 58.1(a).
19
20 "On at least two indications, 2012 and 2014..." 12:08
21
22 I'm not sure if 2012 was right, it might have been
23 2011, but it was two indications.
24
25 "Mr. Young did his triage for him to allow him to get 12:08
26 caught up on his admin. Whilst he agreed to this for
27 a short period of time, on both occasions I was led to
28 believe by Mr. Young that Mr. O'Brien asked to have
29 triage given back to him. In addition, on 19th

1 September 2014, I received an e-mail from the booking
2 centre advising that Mr. Young was no longer doing
3 Mr. O'Brien's triage. On both occasions this had been
4 done without mine or any of the senior managers'
5 knowledge." 12:08
6
7 So I think she is making the point that triage went
8 back to Mr. O'Brien after a period of time and you
9 hadn't notified and Mr. O'Brien hadn't notified
10 management that the arrangement had come to an end. Is 12:09
11 that fair?
12 A. The first occasion Mr. O'Brien asked to take it back,
13 so it was a temporary fix. The second occasion,
14 September '14, was really meant to be October '14 when
15 the urologist of the week commenced. It was meant to 12:09
16 have been in September and, for some reason, it got
17 moved on a month.
18 48 Q. Yes?
19 A. So the point being here was the understanding that it
20 was moving to the -- and triage was part of the 12:09
21 urologist of the week -- was going to be incorporated
22 into that.
23 49 Q. Yes?
24 A. And it was my understanding that that was fairly clear.
25 50 Q. And there were discussions, let's just move to 12:10
26 urologist of the week, there were discussions in the
27 build-up to launch date, if you like, about what would
28 be the responsibilities of the urologist of the week
29 for that week, the Thursday to the following Thursday,

1 when that duty was held. A system of advanced triage
2 was the agreed approach, isn't that right?
3 A. That was part of the urologist of the week. There were
4 several components to urologist of the week, but
5 specifically you're asking about the advanced triage, 12:10
6 is that this was the opportunity to look at the
7 referral in slightly more detail and if thought a good
8 idea or would have been of advanced information for
9 a clinic appointment, that the investigation would have
10 been done to the advantage. The main one comes out as 12:11
11 the red flags, so if somebody was attending
12 a haematuria clinic, they would have had a CT urogram
13 at least booked ahead of the game. Now, whether the
14 scan was done in time for the haematuria clinic is fair
15 enough, but at least it had been booked. The length of 12:11
16 time between the referral and getting a flexible
17 cystoscopy, there's a very good chance that that CT
18 urogram would have been done.
19
20 Now, at the clinics that were set up in the Thorndale 12:12
21 at that time, we already had an ultrasonographer at the
22 clinic, so the patient would have been having
23 ultrasounds. We were planning a one-stop clinic but
24 this was even before that, I believe that we had an
25 ultrasonographer at the clinic to help out. So not all 12:12
26 investigations needed to be done but if you were
27 reading between the lines of the referral letter, if
28 you felt there was something additional that could
29 help, that was the idea.

1 51 Q. Yes. And if one looks at your statement, if we bring
2 it up, WIT-51717, and just scroll down, please. You're
3 explaining -- this is I think looking at IEAP, but you
4 go on to say half way down this paragraph:
5 12:13
6 "The original plan for the consultant urologist of the
7 week was to cover the emergency workload, such as ward
8 round, theatre cases and in the afternoon to undertake
9 other activities such as clinics or day surgery. This
10 was the initial plan, but it became obvious that the 12:13
11 afternoon activities were not practical due to the
12 volume of emergency work and our departmental thoughts
13 that a system of advanced triage would be beneficial.
14 This new system at least provided more of an
15 opportunity to perform triage on..." 12:14
16
17 I have lost my place. You go on to say:
18
19 "The general compression was that the number of
20 referrals were increasing again contributing to the 12:14
21 overall time required to triage. The time frame to
22 return all letters did not seem as important..."
23
24 A point you made earlier.
25 12:14
26 "...as the time from triage to when the patient would
27 be seen was still going to be long. However the point
28 of a timely triage was to spot the particularly urgent
29 case that special arrangements could be made such as to

1 be seen in a Hot Clinic."
2
3 Just scrolling down to the next page. You make the
4 point that:
5 12:15
6 "Advanced triage involved the assessment category the
7 patient was to be allocated, namely red flag, urgent
8 and routine and, in addition, via a rubber stamp box
9 tick a care pathway to a specific clinic and
10 investigation was defined." 12:15
11
12 Did you get consensus across the team that that was
13 what was understood by "advanced triage", a limited
14 number of investigations might be indicated were
15 appropriate for a patient as opposed to, I think, 12:15
16 what's been described as a remote clinic?
17 A. Yes. This was not designed as a virtual clinic --
18 52 Q. Virtual clinic, I beg your pardon?
19 A. A virtual clinic was where we would ring the patient at
20 home and consult over the phone, as we did during 12:16
21 COVID. But it wasn't defined to be at that level at
22 all. I use the example here of the stamp box, okay?
23 Do we understand what that is?
24 53 Q. The box on the form, yes?
25 A. When a letter comes in, our booking office, I had 12:16
26 designed a stamper which gave -- on one side was red
27 flag, upgrade to red flag, urgent and routine, so the
28 doctor would tick that. On the other side was an
29 investigation like ultrasound, flow rate, trus biopsy,

1 flexible cystoscopy. So this was the code that allowed
2 the booking office to put the appropriate person on to
3 the outpatients. So you weren't going to have ten trus
4 biopsies or ten flexibles. It allowed the booking
5 office to make the clinic for a particular session fit. 12:17
6 And then the bottom third of the box allowed the doctor
7 to write in it some ad hoc statement, "booked a CT
8 urogram" or "I have contacted..." so and so and "we're
9 going to do this" or "put directly on to the waiting
10 list". So that's what that extra was. It wasn't just 12:18
11 to put somebody into red flag, urgent or routine, there
12 was a little bit more processing.
13 54 Q. Just to be clear, this was agreed across all of the
14 consultant team?
15 A. Our stamper had been in -- 12:18
16 55 Q. But I mean more broadly, this approach to advance
17 triage was agreed across the team?
18 A. That was my understanding. Everybody else seemed to
19 understand it.
20 56 Q. Yes. The view expressed by Mr. O'Brien was that, as 12:18
21 I think became clear to you, that you actually needed
22 to do more by way of advanced triage, certainly for red
23 flag patients and, where possible, and if time allowed,
24 with urgent and routine referrals. When did you begin
25 to understand that his approach to advanced triage was 12:19
26 not one which you understood was appropriate or
27 practical in the time allowed?
28 A. Well, it would have come up, obviously, after
29 we introduced the advanced triage and at departmental

1 meetings there's a couple of occasions that this had
2 been brought up and we would have informed Mr. O'Brien
3 that he is going into it in far too much -- far too
4 much detail. It is very hard to do the advanced triage
5 on all patients in the time allowed but, certainly, you 12:20
6 had to try to spot the person that it would have been
7 an advantage to have some information ahead of the
8 game. It was generally a CT scan we were looking at in
9 the knowledge that we had an ultrasonographer at the
10 clinic. But it was the time taken to actually do all 12:20
11 of this was important and we sort of learnt as we went
12 along what could be done. I think that's a reasonable
13 phrase.
14
15 Can I maybe just step back slightly to maybe explain 12:20
16 that in a bit more detail.
17 57 Q. Of course?
18 A. Is that we were learning as we were going along. With
19 the introduction and our conversations about setting up
20 the urologist of the week, if we go back one step 12:21
21 further than that, our clinical input when on call was
22 you had a day's work, you were on call, and you
23 triaged. Now, hence moving to the urologist of the
24 week, this was all getting far too much of a volume to
25 do a day's work and to be on call at the same time, 12:21
26 hence going to the urologist of the week. Trying to
27 put that across to The Trust of saying there's going to
28 be no clinical output, in other words you are not doing
29 a clinic and you are just going to be on call didn't

1 appear very attractive to The Trust's figures to start
2 with. But, at the same time, the Trust was wanting
3 a higher turnover of our beds so they saw that if
4 a consultant was on the ward all the time, that there
5 was a decision to discharge, and turnover was a good 12:22
6 carrot, shall we say.
7 58 Q. Yes?
8 A. So it sold itself well. Also, there was an endless
9 amounts of patients in the casualty department that
10 were sitting there and waiting for a decision to be 12:22
11 made so here was the opportunity of the urology team
12 going to A&E and trying to sort it out at base camp,
13 shall we say. So there was a few good sell points.
14
15 And the other point, as I say, we had the idea of a hot 12:23
16 clinic. Those patients that really did need to be seen
17 could be seen in the outpatient department rather than
18 necessarily being admitted to the ward and being
19 processed that way.
20 12:23
21 Now, I had observed that where this, the urologist of
22 the week, had been in other units or I had heard that
23 they would do emergencies in the morning and they would
24 do a clinical session in the afternoon -- I'm going to
25 smile at this point here -- I sort of knew that that 12:23
26 wasn't going to really be a frontrunner but it was part
27 of the sell to The Trust that here's something that
28 we might be able to do. But, as I say, we all realised
29 very, very quickly that having a clinical session in

1 the afternoon wasn't going to work.
2
3 So then coming back to not just doing triage of red
4 flag, urgent and routine, we were trying to add in
5 something further that could help the overall process. 12:24
6 I don't think we all had fully worked our way through
7 it precisely what was to be done, but the point again,
8 which I brought up earlier, is that you complete the
9 triage and some weeks are going to be more free to
10 arrange more scans and if you had a busy week, you 12:24
11 weren't going to be able to do as much. So we were
12 learning on the job, so to speak.
13 59 Q. Sorry to cut across you, but in terms of your approach
14 to triage, taking into account each of the three
15 possible categories of referral, how did you approach 12:24
16 that ultimately after this period of learning in terms
17 of the depth of the triage?
18 A. Yes. Where it was appropriate in the red flags,
19 I would have booked the appropriate scan. For the
20 routine and urgents I would look at the letter in more 12:25
21 detail and if there was a hint that there was something
22 of advantage to know ahead of that, I would book it.
23 For instance, somebody who had a prostate problem and
24 the GP said their renal function was off, I would book
25 an ultrasound. There's a wee flag there sort of 12:25
26 letting you know that something else would be more
27 appropriate to do. A lot of the GPs would have sent
28 referrals in without any blood tests or it needed a
29 second blood test done. You might write back and ask

1 them to do that.
2 60 Q. I want to move down and draw a contrast between your
3 approach and the approach of your colleagues and that
4 of Mr. O'Brien. I think you said, well, in a couple of
5 places in your statement, if I could bring up 12:26
6 WIT-51822. You explain at this top paragraph that:
7
8 "Mr. O'Brien was a great advocate for the principle of
9 advanced triage, however his concern was the depth of
10 the added work involved rather than an emphasis on the 12:26
11 number of referrals, which we all knew. The level of
12 triage he was aspiring to achieve was difficult to
13 attain, possibly, and some may comment that he was
14 almost trying to do it in too much detail, and as such
15 the totality took too long. He complained that others 12:27
16 may not have done it properly. It was appreciated that
17 triage was taxing but the other consultants felt that
18 if they were able to complete the task, then they could
19 not understand why Mr. O'Brien could not also do so.
20 The nature of these discussions would note the detail 12:27
21 of depth of triage as arranging of first line
22 investigations which were mainly to book a radiological
23 test. The triage was not set to the level of a virtual
24 clinic."
25 12:27
26 So the latter you judged as being Mr. O'Brien's
27 preferred approach. The more appropriate and given the
28 resource of time that was available was, in appropriate
29 cases you booked the first line investigation?

1 A. Yes. The triage would not necessarily involve -- well,
2 it wouldn't involve having to phone the patient and
3 have a consult about it and discuss it further. Yes,
4 we will all have a slightly different level of tests
5 performed but, again, it is trying to read between the 12:28
6 lines. It wasn't about having advanced tests done on
7 all patients before they came.
8 61 Q. In terms of Mr. O'Brien's approach, it appears to be
9 part of his thinking that, in order to do it properly,
10 particularly where the waiting lists, the pressures 12:29
11 faced by the Trust for the treatment of routine and
12 urgents, that there's almost at the level of an ethical
13 responsibility to look more deeply into those cases and
14 triage at a depth commensurate with discovering whether
15 they had any morbidity that needed immediate or more 12:29
16 immediate investigation than your approach would
17 necessarily allow. Do you recognise that distinction
18 and that thinking in what Mr. O'Brien was putting
19 across?
20 A. I can understand that but it is -- it's the information 12:30
21 that you are given on the original letter from the GP
22 that you have to interpret. The understanding that you
23 book a scan for everybody that has been referred into
24 the system is not a practical -- it's not practical to
25 actually do all of that. But, I mean, you can 12:30
26 understand it's nice to know that information ahead of
27 the game. I think there's two edges to what you've
28 said is, yes, it's nice to have a detailed test on
29 a patient but you have to offer the same to all the

1 referrals coming through, so there is a balancing act
2 here to be done. If that's the level that you want to
3 do, you have to do it for everybody. So we've been
4 sailing close to the wind for a long time. We have to
5 make up a decision pathway for all patients rather than 12:31
6 just a selected amount. If it is going to take you
7 a whole week of just doing triage, you have to fit it
8 all into the week.
9 62 Q. The piece we've just read from, or I've just read from,
10 appears to recognise that Mr. O'Brien wasn't doing what 12:31
11 was expected of him in terms of the completion of
12 triage in that you are reflecting that colleagues were
13 saying back to him at a meeting, well, we can all get
14 it done in time. It is the case, as you reflect in
15 your statement, that Mr. O'Brien was vocal, as you say 12:32
16 at paragraph 64.4 about saying that he had difficulty
17 completing triage. You seem to be saying that
18 you didn't understand that he was failing to do triage?
19 A. I'm just saying that he couldn't -- he was having
20 difficulty completing it and it was taking him longer 12:32
21 to get through it than the rest of us because he was
22 doing it in more detail than the rest of us. So, okay,
23 the rest of us were maybe doing it in less detail but
24 at least we were able to get it completed. Is that
25 what you're asking? 12:33
26 63 Q. Am I to understand -- let me approach it in these
27 terms, come January 2017 at the commencement of the
28 MHPS investigation, a significant number, let's call it
29 in round terms 700 referrals emerged from his office

1 apparently untriaged. Mr. O'Brien adds a caveat to
2 that, that he kept an eye on cases to make sure that
3 they were coming into the system and action was being
4 taken. But the cases were largely untriaged. We can
5 argue about the precise number. You knew, indeed, 12:33
6 wasn't there a meeting at the start of 2015 which
7 examined and had a discussion about the default system
8 that was in place to cope with delayed triage? You
9 knew that there was a significant problem here?
10 A. Yes. There was a delay in the triage letters coming 12:34
11 back. So the term "default" was used. We were not --
12 I was going to use the word "happy". We did not agree
13 with the whole principle of the default. The point
14 about triage is that the letter is triaged. Coming
15 back to the original point earlier is that if there is 12:35
16 a letter sent in as routine and we re-triage it as
17 a red flag, that's the point about doing triage.
18 64 Q. Yes?
19 A. Now, I can understand the principle of the default. If
20 you take the exact sort of figures that you are talking 12:35
21 about here of a letter comes into the system, it's put
22 in the drawer, it's then forgotten about and, unless
23 that letter goes back to the booking office, it's not
24 going to get -- it's going to be lost completely.
25 Whereas the principle of the default was at least if 12:35
26 the clock was started and the bell rang, then that's
27 when the booking office went by the GP.
28
29

1 So I can understand why it was brought in. At least it
2 was a process that a patient's letter wasn't lost and
3 they would still get an appointment based on the GP.
4 65 Q. Let me come back to the advantages and dangers of the
5 default in a moment. I just want to be sure. You seem 12:36
6 to be saying it was your appreciation that Mr. O'Brien
7 was merely delayed and perhaps substantially delayed in
8 doing triage. But was it not more than that? Did
9 you not appreciate that, in fact, in terms of routine
10 and urgent referrals, he had, for very many cases, and 12:37
11 I'm not sure what he will say about how many he
12 actually did perform, but the impression, perhaps
13 formed by the Trust, is that he had stopped, largely
14 stopped doing urgent and routine referrals. Did
15 you fail to appreciate that? 12:37
16 A. Failed to appreciate he had stopped. We weren't told
17 by -- no, we thought they were still being triaged but
18 being dreadfully slow on it. So the whole idea of
19 having stopped doing triage, that wasn't being put
20 across. I do think if somebody -- if I said I was 12:37
21 stopping triage, I would have let everybody know quite
22 precisely.
23 66 Q. I'm going to later look at the appraisals that you
24 overseen. Could I bring you to TRU-25132. My mistake.
25 Let me check. If we go to AOB-25132. No. I'll come 12:38
26 back to that reference.
27
28 Mr. O'Brien, in his evidence to the Inquiry, rather
29 than phrasing it in terms of him having a difficulty

1 with completing triage, he says that during these
2 meetings he used the word "impossible", he found it
3 impossible to complete triage. Maybe, for some,
4 a matter of semantics, but was that not the impression
5 that he was giving to you? 12:40
6 A. He used the word "impossible". I do understand that
7 from the transcripts. I don't think he put that --
8 I think he was using that word as it was he was having
9 significant difficulty with it. But I don't think the
10 rest of us picked up on the word "impossible" meaning 12:40
11 that he wasn't doing. We took it that he was having
12 difficulty with it and it was part -- it was one word
13 used in the conversation we would have had with him to
14 say, look, there is an alternative way of doing triage,
15 you're putting too much effort in here, here's our idea 12:41
16 and it is part of a conversation. I certainly didn't
17 take it as "no, I'm not doing triage".
18 67 Q. Perhaps an illustration of him not doing it is to be
19 reflected in an e-mail that Martina Corrigan sends you
20 in November 2015, about a year into the introduction of 12:41
21 urologist of the week. If we can have up TRU-258498.
22 Just scrolling down. As I say, 30th November 2015:
23
24 "Please see attached. I have got eight more of these
25 similar e-mails this morning asking for my action. 12:42
26 I am only forwarding this to you as an example and
27 I will really need help at getting this resolved as
28 there are currently 277 not triaged letters from when
29 AOB has been on call dating back to October 2014."

1
2 So she's saying the earliest of these is a year stale,
3 a year unactioned. Is that not very clear evidence to
4 you that he had stopped?
5 A. He was certainly -- well, he certainly had slowed up 12:43
6 quite, quite considerably. It's not the 277, it's
7 actually, it's the October '14 is the key to that
8 sentence. Again, this was at the end November '15.
9 This was already -- I observed this was already
10 building up to an issue and I understand that this is 12:43
11 an e-mail but a lot of my conversations with Martina
12 weren't necessarily on the e-mail, it would have been
13 in the office to discuss this issue.
14 68 Q. But obviously the default arrangement had been
15 implemented. Did you appreciate that, at least in 12:44
16 substantial part, that this was a response to the
17 problem which was Mr. O'Brien's failure to complete
18 triage?
19 A. The default process was meant to be brought in for all
20 triage not coming in, but it was obviously purposefully 12:44
21 targeted at Mr. O'Brien's practice because the rest of
22 us were, wouldn't have fallen into this sort of
23 category. So, yes, it is appreciated that there was
24 a problem, it was becoming an increasing problem.
25 We had tried to help out, something more needed to be 12:44
26 done.
27 CHAIR: I hesitate to interrupt but if you look at the
28 line beginning "I have no doubt":
29

1 "I have no doubt that Aidan does look at these while he
2 is on call, but it would just appear that he doesn't
3 return them with instructions to the booking centre."
4
5 Which seems to suggest that Mrs. Corrigan at least felt 12:45
6 that he may have been looking at the matters but not
7 returning the forms. Would that be fair?
8 69 Q. MR. WOLFE KC: Yes. I was about to say that.
9 A. Yes, we had the assumption that the letters were at
10 least screened or sort of flicked through. That was 12:45
11 a miss -- I don't know if they were or not, that was an
12 assumption that we had.
13 70 Q. I think you've reflected in your statement that so far
14 as the default arrangement is concerned, that had been
15 put in place as, if you like, an immediate stopgap, 12:46
16 pending amendment to the consultant's assessment later,
17 if necessary. In other words, it wouldn't be -- the
18 use of this system wouldn't absolve the clinician from
19 completing the triage process?
20 A. Yes. So as Chair has mentioned, the red flags at this 12:46
21 time seem to have been all sorted. The understanding
22 is that the rest would be then screened. If the
23 letters didn't come back to the booking office on time,
24 then if they had been screened and looked at and
25 triaged, then the appropriate changes could be made by 12:46
26 the booking office. So if somebody was, in fact, late
27 in getting back on their routine letter and they were
28 looked at, then, and they were upgraded to urgent or to
29 red flag, then that obviously takes the default out of

1 the system.
2 71 Q. As you will have by now appreciated, Mr. O'Brien
3 wasn't, despite what might be suggested by
4 Mrs. Corrigan here, Mr. O'Brien wasn't going back to
5 these referrals and looking at them to see if they 12:47
6 needed upgraded. That much is obvious from the series
7 of SAIs that arose out of his failure to triage.
8
9 You've said, if you bring up on the screen WIT-51842.
10 Just scroll down, please, 79.2: 12:48
11
12 "I would have expected Mr. O'Brien to have come to me
13 and alerted me about the referrals not being triaged.
14 I hadn't spotted that it had been such an issue. I'm
15 not in charge of his practice but I thought he would 12:48
16 have afforded me the opportunity to speak to him on
17 a personal level. There was no reason why he couldn't
18 approach me, I had helped him in the past."
19
20 Et cetera. Plainly, when you're in discussion around 12:48
21 the default triage and you're realising that that is
22 put in as a device because there's a problem here, when
23 you get e-mails such as what we have seen from
24 Mrs. Corrigan, backlog of 12 months, it really
25 shouldn't have needed Mr. O'Brien to come to you. It 12:49
26 should have been obvious to you, wearing your clinical
27 lead hat, that there was a dangerous patient risk issue
28 that needed firmly grappled with?
29 A. So it was my expectation to go and speak with him.

1 That could be said. But it's -- I was not aware of the
2 volume. When it came to our January '17 meeting, we
3 were all rather aghast by the number and we really
4 weren't aware of the volume of what was going on. So,
5 yes, there would have been an opportunity in November 12:50
6 to have had that conversation, but it is also fair
7 enough to say that if I had that number of letters in
8 the top drawer, I would have been the one to go and
9 mention to somebody, rather than the other way around.
10 72 Q. Maybe it comes back to something you said on the last 12:50
11 occasion, about, I suppose, a sense of awkwardness or
12 reluctance to be able to challenge a peer about an
13 obvious shortcoming in his practice. We've seen how in
14 the past you've helped out, I suppose, rather than have
15 a confrontation. 12:51
16 A. Yes.
17 73 Q. This was clearly a time for a confrontation, was it
18 not, whether you to him or by escalating it to
19 a clinical director, so that this could be finally
20 resolved? 12:51
21 A. Yes, that's a fair comment, as a peer-to-peer that
22 I could have, I should have. On reflection that's
23 a very valid comment. But, having done this before and
24 offered help and received, you know, it may have been
25 more appropriate that somebody much higher than myself 12:52
26 was actually doing that. And, potentially as a friend
27 and a colleague, yes, I potentially could have.
28 74 Q. I lost the reference earlier and I just want to seek
29 your view on this. It is Mr. O'Brien's appraisal form

1 from 2015, which wasn't signed off until 2016.
2 Hopefully this is the reference, TRU-25132?
3 CHAIR: That was the reference you gave last time.
4 MR. MURPHY: 253210? TRU-253210.
5 MR. WOLFE KC: Try that? Best laid plans. 251320. So 12:53
6 he is setting out in this form -- you'll recognise the
7 format -- he's giving, in these boxes, details of his
8 work. In terms of details of any other clinical work
9 at 2.5 he tells you how triage red flag referrals when
10 urologist of the week. It doesn't appear that that's 12:55
11 interrogated in any way. Indeed it's a feature of the
12 appraisals, and we'll look at these this afternoon,
13 that his problems with triage are not addressed through
14 this process. It is perhaps not obvious now, maybe
15 with some hindsight, that he is telling you that he 12:55
16 doesn't triage anything else apart from red flags?
17 A. I have gone over these appraisals and what's written in
18 this first section is often a copy from the year before
19 and it's only in recent times, when I have reviewed the
20 whole document, that I saw that one line. 12:56
21 75 Q. It stood out for you as well?
22 A. Well, I have had to read the document several times.
23 It's only in recent times that I've -- I saw that one
24 sentence. Having done appraisals before, I accept
25 that. 12:56
26 76 Q. Now, in terms of your management role, and you
27 helpfully tried to describe it for us on the last
28 occasion, and, indeed, when we were asking Dr. Simpson
29 about the role of clinical lead, he had it might be

1 described as a degree of sympathy for the role. It
2 wasn't particularly well defined, there being no job
3 description, et cetera. When it came to March of 2016,
4 Mr. O'Brien is handed a letter in a meeting which he
5 was asked to attend with Mrs. Corrigan and Mr. Mackle. 12:57
6 You knew nothing about that meeting, is that right?
7 A. Correct. I didn't know about that meeting or a letter
8 or anything had been undertaken. I wasn't part of that
9 process and didn't hear about that until afterwards.
10 77 Q. Perhaps that is a reflection of how others perceived 12:57
11 the role of clinical lead, that you were kept out of
12 that loop. Would it have been helpful, given what was
13 being asked of you in terms of trying to manage the
14 triage issue, for you to have been appraised of the
15 fact that this process was starting? 12:58
16 A. It may have been advantageous. I had been involved
17 before, helped out, it hadn't worked, it was needing
18 a higher level of input to make it get sorted out.
19 Whether I should have been appraised of it or not or at
20 least know about it is a question, but I wasn't. 12:58
21 78 Q. Clearly you weren't. But the Inquiry will have to
22 reflect upon how management works, how it did work in
23 this situation, or how it failed to work and whether
24 any lessons are to be drawn from it. So you're cast in
25 the role of clinical lead. We can see not infrequently 12:59
26 people are rapping your door to ask you to help out to
27 try to resolve, to take this example, triage. They
28 meet with Mr. O'Brien to discuss triage, amongst other
29 issues, and you are not advised that this process is

1 happening. How can the management of that kind of
2 scenario be improved for the future?
3 A. It would be improved by involving the full team in the
4 situation, yes. I think I probably should have been at
5 least informed of what was going on. 12:59
6 MR. WOLFE KC: Thank you. Is it just gone past
7 1 o'clock.
8 CHAIR: We'll come back, ladies and gentlemen, at 2.05
9
10 THE INQUIRY THEN ADJOURNED FOR LUNCH 13:00
11
12 CHAIR: Good afternoon, everyone.
13 MR. WOLFE KC: Good afternoon, Mr. Young. Just before
14 lunch I was asking you about the meeting that took
15 place in March with Mr. O'Brien, Mrs. Corrigan and 14:05
16 Mr. Mackle. I was asking you about both the
17 implications, in a management sense, that you weren't
18 involved in that and not informed about it.
19 I suggested to you that that might appear unusual if
20 you were the man they were coming to regularly to try 14:06
21 to sort things out. I just want to illustrate that
22 point again, perhaps, by reference to an e-mail that
23 you received from Mrs. Corrigan in February 2016, just
24 a month before this meeting, TRU-258510. And so
25 Mrs. Muldrew in the booking centre is telling 14:06
26 Mrs. Corrigan, February 2016:
27
28 "There are referrals, see below, that we are awaiting
29 come back from triage. Could you please chase these up

1 for us."
2
3 Then, up the page, Mrs. Corrigan:
4
5 "See blow. In light of previous conversations I am 14:07
6 just escalating to you. I have already forwarded to
7 Aidan, but I'm under pressure to get this sorted out."
8
9 I don't think there's a reply from you on this page.
10 Maybe that was the subject of, no doubt, frequent 14:07
11 conversations, she alludes to conversations. She has
12 it in mind that she's escalating to you, that you're
13 the appropriate rung on the ladder to deal with it.
14 That's the regular flavour of it. I haven't taken you
15 to the whole catalogue of emails that Mrs. Corrigan 14:08
16 sends to you on triage and other issues, but you're
17 uncomfortable that you were cast in that role?
18 A. I'm frustrated that the issue wasn't getting resolved.
19 I felt there was a fair bit of pressure on me to try to
20 do so. I had spoken to Mr. O'Brien on several 14:08
21 occasions over the previous few years and it seemed to
22 get sorted out for a while and then it goes backwards.
23 So I'm not entirely sure what more I was going to be
24 able to offer fully.
25 79 Q. Did you, in any sense, take that stand with her and 14:08
26 say, listen, this isn't for me to resolve, it's for the
27 Clinical Director or higher?
28 A. I would have had that conversation. I thought it
29 should have at least been sorted out at the

1 Acute Services level and to take further afield.
2 I felt I had done my bit and had said so.
3 80 Q. But maybe March was the -- the March meeting was the
4 final coming to terms with it, perhaps at last is the
5 caveat that might be added to it. 14:09
6
7 Come the summer of that year, plainly the wagons were
8 being circled to some extent behind the scenes.
9 Mr. Weir, if I can bring up his witness statement at
10 WIT-19904. He writes that, this is paragraph 10: 14:10
11
12 "I recorded in my handwritten notebook a meeting with
13 Mr. Young on 9th August 2016. I noted: 'Aidan MY will
14 discuss with him'."
15 14:10
16 That's referring to you --
17
18 "Meaning that, as lead consultant, Mr. Young would
19 discuss with Mr. O'Brien issues in relation to some or
20 all of the four concerns raised above." 14:11
21
22 Those are the concerns that had been raised in the
23 March meeting. Do you recall that kind of conversation
24 with Mr. Weir who, at that time, was Clinical Director?
25 A. Mr. Weir -- yes, is the answer. Mr. Weir had come into 14:11
26 the post that April or June, I think, might have
27 been June. He was freshly into the post as CD.
28 I remember Mr. Weir coming to speak to me and it was --
29 he was trying to find out how urology ticked over. He

1 was a general surgeon and had a vascular interest.
2 He wanted to know how we worked. He was interested in
3 our ward. We talked about the equipment that we used
4 in urology, we were relatively high-tech. And, as part
5 of that conversation, he had mentioned about 14:12
6 Mr. O'Brien and some of the issues.
7
8 It says here "all four concerns". I'm afraid I don't
9 fully recollect all the topics that we had discussed.
10 It was discussed at the end of finding out about 14:12
11 urology and, from my recollection, we talked about
12 triage. But I'm not entirely sure about the other
13 topics that are referred to. I don't know what the
14 other topics were in the March letter.
15 81 Q. But they were triaged? 14:13
16 A. Triaged.
17 82 Q. They were a failure of dictation of clinical episodes?
18 A. All right.
19 83 Q. They were the issue to do with review backlogs and the
20 fourth issue was retaining charts at home? 14:13
21 A. Okay. I can't recollect a discussion about them all.
22 That's not saying that we didn't, but I can't remember.
23 But I do know that we had talked about --
24 84 Q. Yes, the upshot would appear to be that he's recording
25 that you're going to speak with Aidan? 14:14
26 A. Yes.
27 85 Q. Just before you address that, if I could add into the
28 mix, e-mails between you and Martina Corrigan two or
29 three weeks after that, 24th August. If we can bring

1 up TRU-258526. If you go to 258528. This is an issue
2 we'll come on to look at in a little bit in a bit more
3 detail. It concerns on the failure of Mr. O'Brien to
4 follow-up on a clinic with dictation and an indication
5 of how the patient is to be treated in next steps. So 14:15
6 that's the question being posed.
7
8 "Please advise if we need to review this patient or
9 expedite the procedure."
10 14:15
11 It comes to you, Martina Corrigan asking you how to
12 advise. So you obviously go and have a look at what
13 is, in essence, Mr. O'Brien's patient and provide the
14 advice that presumably he should have advised or
15 provided following the clinical episode, the meeting 14:15
16 with the patient.
17
18 Just going on up, please. So Martina Corrigan is
19 explaining that this is one example of a developing
20 problem. Just going on up to the top of the page 14:16
21 because some of this isn't -- you say, ultimately
22 I think an office conversation is about to happen
23 before CW, Colin Weir, gets to him. So, as
24 I understand it, putting these pieces together,
25 Mr. Weir, from his statement, is telling us he's met 14:16
26 with you. You recall that?
27 A. Yes.
28 86 Q. It is a discussion mainly about how urology ticks?
29 A. Yes.

1 87 Q. But you get into on your recollection a discussion
2 about triage, and then this additional problem is
3 raised with you by Mrs. Corrigan about dictation,
4 essentially. Is that you indicating that you would
5 speak to Mr. O'Brien before Colin Weir gets to him? 14:17
6 A. Yes. That's what I'm saying there. I think it is
7 prudent for me to go and a have a chat, a conversation.
8 88 Q. You say in your statement that there was a meeting in
9 December or a discussion with Mr. O'Brien in December,
10 probably around the time of the appraisal. Did 14:17
11 you immediately -- was there any other meeting with
12 Mr. O'Brien to work through these issues?
13 A. Yes. I'm looking at the dates of this. After Mr. Weir
14 came to see me at the beginning of the month, I had
15 a meeting with Mr. O'Brien to discuss what Mr. Weir had 14:18
16 been speaking to me about. Now, I don't have the
17 precise date of this but we did discuss the triage
18 issue. But, this will be a sensitive comment to pass
19 now, the conversation I had with Mr. O'Brien was of
20 a clinical nature here but it also switched to 14:18
21 a personal discussion with Mr. O'Brien. If you want me
22 to go into that in more detail, I can. He was due to
23 go off on sick leave.
24 89 Q. Okay. So you're putting the date of the conversation
25 before he went off on sick leave, I think that is 14:19
26 towards the end of October, start of November 2016.
27 The dates may be perhaps not terribly important. What
28 was the upshot of that conversation in terms of
29 Mr. O'Brien's professional life and the shortcomings

1 that were well known to you but which were also being
2 discussed with you by Mr. Weir?
3 A. Yes, I was -- Mr. Weir is logging four things
4 discussed. I can't fully remember all of those four,
5 but when I went back to speak to Mr. O'Brien it would 14:19
6 have been about the triage issue. I can't remember --
7 I know Mr. Weir has logged the date of when we met
8 because he had written in a diary. I'm afraid I don't
9 keep such a diary so I can't remember the precise date
10 when I spoke to Mr. O'Brien, but the actual gist of it 14:20
11 was there was two things discussed, one of which was
12 the personal issue, which I think maybe sort of
13 sidelined what the rest of the conversation was about.
14 90 Q. Okay.
15 A. And maybe I missed the opportunity of being more 14:20
16 forthright with the issue but, as I say, the personal
17 issue then became the topic of the conversation.
18 91 Q. Yes. There was, as you reflect in your statement,
19 paragraph 64.9, I don't need it on the screen, I'll
20 just summarise it. You say in the latter part of 2016 14:20
21 you had a conversation with Mr. O'Brien and he spoke
22 about not being keen to take new patients on as
23 he wanted to deal only with his waiting list. At this
24 point Mr. O'Brien said something to you about
25 a communication from The Trust about several issues but 14:21
26 he didn't elaborate. That rather suggests you weren't
27 fully in the loop?
28 A. Yes.
29 92 Q. But do you regret that all of these bubbled up and

1 reached a fairly dramatic conclusion at the end of 2016
2 leading into the MHPS investigation when, taking the
3 triage issue as a key example, it was on the agenda for
4 the better part of ten years and hadn't been addressed.
5 Is that something, upon reflection, you think you could 14:22
6 have done better with?
7 A. Yes, I could have been more forthright with the whole
8 thing, I suppose. As I say, it's maybe hard to
9 challenge Mr. O'Brien on occasions and, yes, instead of
10 being as polite, maybe I should have been a bit more 14:22
11 forthright in the whole situation. I do agree. It's
12 getting the joined up writing with all the different
13 aspects. One person would know about one thing,
14 somebody might know about something else. But it would
15 have been -- I think if I was involved in the situation 14:22
16 in the March issue a little bit more, I would have been
17 able to stand up to the occasion a little bit better.
18 93 Q. I wonder in all of this was the Patient Safety factor
19 or the risk factor neglected and perhaps even ignored,
20 because as we now know there was this pile up of triage 14:23
21 that wasn't performed. You, I think, insist that
22 whether or not you should have recognised that it
23 wasn't being performed, you merely thought it was
24 a delay issue?
25 A. Yes. 14:23
26 94 Q. You were written to in the summer of 2016 in connection
27 with Patient 93?
28 A. Yes.
29 95 Q. You have the designation list in front of you. And as

1 we can see, if we pull up the e-mail chain starting at
2 TRU-274751, at the bottom of the page, please. So
3 Mr. Haynes summarises the clinical background. He's
4 saying that the patient's case wasn't returned from
5 triage so the patient was entered on the waiting list 14:25
6 as routine. If the patient had been triaged, given the
7 PSA findings on repeat, it would have been a case of
8 red flag upgrade. Fortunately, the patient came back
9 in to the system and his metastatic disease was
10 diagnosed. He says: 14:26
11
12 "As a result of no triage, the delay in treatment was
13 of the order of three and a half months."
14
15 I suppose that case to some extent, mirrored the 14:26
16 situation in association with Patient 10, Patient 10's
17 case being what has been described as the index case or
18 the index case for the purposes of the triage SAIs.
19 A. Yes.
20 96 Q. Just scrolling up back from whence we came, and we can 14:26
21 observe your response. This e-mail from Mr. Haynes has
22 been put into the system so that, and thank you for
23 that, to express a view as to whether an SAI review
24 should be undertaken. I think the Trust has told us
25 candidly that no SAI review was performed. We have 14:27
26 your answer there in front of us in terms of the
27 various issues that you say in the case.
28
29

1 You're not pushing -- and maybe you didn't think you
2 were being asked this question -- you weren't pushing
3 for an SAI review in this one?
4 A. Patients coming to me from Martina are asking is there
5 something urgently needed to be done? So I might have 14:27
6 misinterpreted the e-mail on that front but, also,
7 there was an opportunity for me to expand on that a
8 little bit more to say, look, should a Datix be put
9 into the situation. But I was aware that there were
10 other people involved in this loop, not just myself. 14:28
11 As you say, Mr. Haynes had already seen a patient,
12 I think, isn't that right? So I'm looking at the
13 letter, I think I'm looking at the letter of referral
14 here. I think the first line says it all, that the GP
15 should have referred it in as a red flag. The blood 14:28
16 tests for the prostate was high enough to be recognised
17 as that.
18 97 Q. That's the whole point of triage, isn't it?
19 A. It comes back to what we were talking about earlier,
20 it's the point of the GP referring it in as routine and 14:28
21 why the letter is looked at and looked at and to an
22 element of what I was saying, how I do it is I don't
23 regard the GP's triage code, I look at the content of
24 the letter.
25 98 Q. I suppose just to get back to the thrust of the point 14:29
26 I'm bringing to you, urologist of the week was
27 instituted tail end of 2014. Into 2015, in the early
28 part of it, you realise that there's a default
29 procedure in place for late triaging. Late '15 you're

1 told by Martina Corrigan, I've got this pile of triage,
2 some dating back a year, and it hasn't been completed
3 by Mr. O'Brien. And into 2016 we have Mr. Haynes
4 picking up on Patient 10's case, starting a Datix which
5 eventually becomes an SAI. Here's another one, and no 14:30
6 doubt, and we know there to have been many others which
7 were only looked at in 2017 and 30 or so cases were
8 triaged by the group of consultants in Mr. O'Brien's
9 absence and 30 cases were upgraded to red flag.
10 14:30
11 Do you accept that this was a period of time where the
12 information was there, people knew what was going on
13 and there was a failure to grapple with the patient
14 risk issue that was at the heart of this?
15 A. 2016 was very important. I agree fully with what 14:31
16 you're saying. There was a missed opportunity there.
17 I don't think we realised the volume of what we were
18 talking about but, certainly, here's a further example
19 that should have been escalated. It's only been picked
20 up whenever the patient is coming through the system 14:31
21 again. So it's knowing -- it's getting ahold of those
22 untriaged letters was the crux of the point.
23 99 Q. But it was perfectly obvious to some, wasn't it?
24 A. Yes.
25 100 Q. You might say it wasn't perfectly obvious to you, but 14:31
26 if the letter has not come back, there's a way of
27 tracking that isn't there?
28 A. Yes, it is via the booking office, not knowing it's
29 coming back.

1 101 Q. Mr. O'Brien was, obviously, excluded from work and he
2 returned and was the subject of a monitoring
3 arrangement, and we'll come to your knowledge of that
4 maybe later this afternoon. But I think you've said in
5 your statement that there was a rostering of the Friday 14:32
6 clinical sessions upon his return and these were left
7 free or taken as leave. I think Mr. O'Brien would
8 insist that all of those Fridays were taken as leave to
9 enable him to perform triage in the way that he wished
10 to. It was obvious to you, was it, that he was 14:33
11 continuing to triage -- well, I'll remove the word
12 "continuing". He was now being required, or at least
13 being monitored, to ensure that all of the triage was
14 carried out, Mrs. Corrigan had a primary role in that.
15 But he triaged using that, a deeper method of triage 14:33
16 which wasn't required of him, is that fair?
17 A. I think he was performing his triage to the same depth
18 that he wanted to do beforehand.
19 102 Q. And that was the subject of a discussion, I'll just
20 briefly deal with this, at a urological departmental 14:34
21 meeting in September 2018. And arising out of that
22 meeting is the following minute, if we turn to
23 WIT-52833. You'll recall that in advance of this
24 meeting Mr. O'Brien provided a paper and, dealing with
25 the triage of new referrals, the following observations 14:35
26 are made. Just scrolling down:
27
28 "The Trust needs to provide a plan detailing what
29 exactly it expects the consultants to do in terms of

1 triage. This must include recognition of time
2 constraints and time commitment required to complete
3 triage including time spent speaking to patients,
4 booking scans, reviewing results and mitigating risks
5 for patients on the current long outpatient waiting 14:35
6 list. Consideration was given to decoupling the triage
7 activity from that of the urologist of the week."
8
9 Is it wide of the mark to suggest that this has been
10 the message that Mr. O'Brien had been preaching for 14:35
11 some time from the institution of the urologist of the
12 week mode of working?
13 A. Yes, this is what he wanted to be included.
14 103 Q. Does that reflect -- does what was written there
15 reflect solely his views or is it the view of the 14:36
16 urology department that this is what is required?
17 A. No. It's not necessarily to speak to the patient. It
18 is scans are booked appropriately. It says "current
19 long outpatient waiting list", that's not triage. And
20 the bottom line is -- there was discussions in general 14:37
21 terms about decoupling the activity of triage, to do it
22 at some other occasion by somebody else or whatever,
23 but it wasn't linked. That was a topic that was up for
24 discussion but it never really got that far. It may be
25 fair to say it is an active thing that the trust may be 14:37
26 looking at at the moment. But certainly throughout all
27 of this we never got as far as talking about decoupling
28 of the two situations. And it would be -- it would
29 have been advantageous for us to have been formally

1 told what was expected of us during triage. We had
2 made up our own rules to a certain degree, what we are
3 talking about, but there is the document, the IEAP that
4 tells us that they want triage done within the
5 72 hours. So there is information out there that had 14:38
6 been available and had been worked to for the previous
7 eight years. So there is an element of documentation
8 there but the documentation to go with the advance
9 triage, I agree, was a bit on the cloudy side, it was
10 our interpretation. But the very important point is it 14:39
11 is all the triage and what you can do on top of that.
12 And we were learning as we were going along. And
13 I think, okay, some people can triage faster than some
14 other people, but the principle is it's completed.
15 I don't think triage involves having to speak to 14:39
16 a patient.
17 104 Q. Yes, but from Mr. O'Brien's perspective it might, and
18 that's why I'm posing the question in this way. Is
19 this minute reflective of each of your views which
20 tends to be the purpose of a minute, or it might 14:39
21 require -- sometimes minutes record dissenting views.
22 This looks as if there's a consensus that as a group of
23 clinicians you require recognition from the Trust that
24 appropriate triage might involve each of those things,
25 including speaking to patients. But I think you're 14:40
26 telling me that is not the consensus?
27 A. Correct, yes. This paragraph is trying to put
28 everybody in the room's view on to the page.
29 105 Q. I see. But the bottom line is -- well, it's not the

1 bottom line, it's the top line in that minute that what
2 you were looking for as a group was a detailed plan or
3 description of what was expected of you guys as
4 triaging consultants?
5 A. I think that's fair. 14:40
6 106 Q. Did that ever materialise during your time with
7 The Trust?
8 A. No. Just the first document of the IEAP.
9 107 Q. That was issued in 2008. I'm conscious I don't need to
10 bring it up but something of the flavour of that first 14:41
11 line in 1.2 the need for a plan detailing what The
12 Trust expects was also part of the conclusion written
13 into the SAI report dealing with the five patients.
14 You know the one I'm referring to? The five patients
15 that weren't triaged in or about 2014 that report being 14:41
16 finalised in 2020. So what you're saying is although
17 the SAI called for a detailed plan and you, as a body
18 of consultants were, through this minute, asking the
19 Trust for a detailed plan, that has never materialised,
20 to the best of your understanding? 14:42
21 A. To the best of my understanding, no.
22 108 Q. Where would this minute have been directed to? Just
23 scrolling up, I think Mrs. Corrigan was in attendance,
24 wasn't she? No.
25 A. I'm not entirely sure if this was forwarded. I didn't 14:42
26 take these minutes and I think Mrs. Corrigan might have
27 been off at that stage.
28 109 Q. I suppose, whether these minutes were forwarded or not,
29 was it made known to those holding the levers of power

1 that, as a group of urologists, you were unhappy with
2 the current arrangements for triage and they needed
3 clarified?
4 A. I'm not sure if the higher echelons ever received that.
5 I don't know. You would have to ask. I'm not aware of 14:43
6 the higher echelons being aware of this.
7 110 Q. As clinical lead, you didn't take this forward?
8 A. Well, these are the minutes of the meeting and I had
9 thought that they had gone higher. It wasn't me taking
10 the minutes. I had thought that they had moved on but 14:43
11 I have been told that they weren't.
12 111 Q. I suppose if you, as clinical lead, are not going to
13 bring this issue forward, whose responsibility should
14 it be?
15 A. I thought these sorts of minutes go to -- if we're 14:44
16 taking a minute from the departmental meeting, it goes
17 to Martina Corrigan and I would have thought that, you
18 know, it would go up the chain from there. I didn't
19 take it to the AMD or any level like that. These were
20 discussions that we had on that day and taking them 14:44
21 further, I'm not aware. Apologies.
22 112 Q. Just to reconcile that from a position where a failure
23 to triage had caused considerable difficulty, of which
24 you were aware, for a large number of patients and here
25 you have a meeting which is getting close to looking at 14:45
26 those kinds of issues through the lens of you
27 clinicians, some of you are struggling with the whole
28 concept. Surely, recognising the problem, there was an
29 onus on the clinical lead to take these matters forward

1 and make sure they were addressed?
2 A. I accept that.
3 113 Q. Can I bring you to another clinical aspect or
4 clinical-type activity, that is the area of handling
5 patient charts. Handling patient charts is part and 14:46
6 parcel of your daily experience as a clinician and
7 you would have understood that there are management
8 arrangements around the handling of charts, no doubt to
9 protect the sensitivity of the information contained
10 within them. But, broader than that, to ensure that 14:46
11 the chart is in the right place at the right time so
12 that colleagues who need access to them can get to them
13 when the patient is in front of them.
14
15 We know from Dr. Chada's report that a large number of 14:47
16 charts were brought from Mr. O'Brien's home, others
17 contained within his office in January 2017. Part of
18 the explanation for that revolved around the fact that
19 he had a clinic remotely in the Southwestern, but
20 another part of the explanation for it is interlinked 14:47
21 with his slowness at producing dictation. He needed
22 the charts by his side at home so that he could dictate
23 when he had the time to do so.
24
25 Tell me about your practice. Did you retain charts at 14:47
26 home?
27 A. I also covered the Southwest Acute Hospital outpatient
28 clinic. The clinic was on a Monday. Either
29 Martina Corrigan would have taken the notes down or the

1 notes were provided to me in a sealed box to take down.
2 As I said earlier, it was 150 mile round trip, I wasn't
3 going to drop off at the hospital to pick them up and
4 then go on to the clinic. So I would have had a sealed
5 box of charts which I took to the clinic. At the 14:48
6 clinic I used the charts and dictated on them there.
7 They went back into the box and on a Tuesday morning
8 I would have phoned my secretary and she would have met
9 me at the front door and she would have taken the box
10 off to her office to type with the outcome sheet. 14:49
11
12 So, yes, I did have charts. They were at home for as
13 minimal a period of time as possible, purely because of
14 the location of the clinic. I also did outreach
15 clinics in Banbridge Hospital at the poly clinic and, 14:49
16 well, I used to do a clinic in Armagh but when the
17 Southwest started, I dropped that one. But I would
18 never have taken charts home from Banbridge or Armagh,
19 it wasn't appropriate, there was a hospital system for
20 it. 14:50
21
22 Yes, the hospital system -- yes, the Banbridge in
23 Armagh is still within our Southern Trust area so it
24 had the transport system to make that work, whereas the
25 Southwest is in the Western Trust, different board, 14:50
26 different transport arrangements, it wasn't the usual
27 traffic, so there wasn't a way of getting the charts
28 down there other than in a taxi. A taxi there, taxi
29 home would have been an option but I don't think the

1 Trust was, potentially felt that was as safe, don't
2 know. So, yes, I did have charts at home but only from
3 that clinic.
4 114 Q. Yes, and one can understand that the practical features
5 of that narrative that required them to be at your home 14:51
6 for a short period of time. Mr. O'Brien's approach
7 seemed to be, for reasons that I explained, to be
8 different. You would have been told from time to time
9 that this was causing a problem for colleagues?
10 A. Yes. I heard that charts weren't available at a 14:51
11 clinic. Where those charts were, I don't know. The
12 hospital does have a tracking system for charts so they
13 should know if -- it should be as defined as is it in
14 your office or is it in your secretary's office, it's
15 that well tracked. But also sometimes charts do get 14:51
16 misplaced and you're given a temporary chart but, you
17 know, that's infrequent.
18
19
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1 115 Q. Can I bring you to just a couple of e-mails which help
2 to highlight the problem. TRU-278656. Pamela Lawson,
3 just scrolling down, is highlighting that a number,
4 I count more than 50, incident reports submitted
5 regarding charts that Mr. O'Brien has had to bring in 14:53
6 from his home for clinics and admissions. Just
7 scrolling up the page, I can see you're not copied into
8 these particular e-mails. We know from the e-mail
9 we looked at this morning, which Mrs. Trouton wrote to
10 you concerning both triage as well as the charts issue, 14:53
11 that you are by this stage, by 2014, well aware of the
12 problem. Were you aware of the fact that it was at
13 this scale that colleagues were having to file incident
14 reports to document the problem in significant numbers?
15 A. I wasn't aware of the significant numbers. I was aware 14:53
16 that there were charts. I had thought that they solely
17 related to the Southwest clinic. That was
18 a supposition, I think. I couldn't have seen any other
19 reason for having a chart at home from a clinic so
20 I was assuming that. 14:54
21
22 Yes, I was aware that there were charts at home and
23 they were delivered back and it was for clinicians that
24 were in our unit and were seeing some of Mr. O'Brien's
25 patients. Mr. O'Brien and my patients are -- well, you 14:54
26 know, we didn't really overlap so I wouldn't
27 necessarily have seen a lot of Mr. O'Brien's patients
28 when I had enough to do with my own.
29 116 Q. I think there was one patient, at least one patient who

1 through, I think, a political representative perhaps
2 complained that his chart could not be found. You had
3 took over that patient's care I think from Mr. O'Brien
4 and a temporary chart, unsatisfactorily, had to be
5 completed in order to corral the new material. But the 14:55
6 chart containing the history was absent and was causing
7 you difficulty as a clinician?
8 A. Yes. I said a wee while ago, sometimes a temporary
9 chart has to be and a chart can't be found. I have
10 that off my patients. The chart has been tracked to 14:55
11 another clinic and I may get a temporary chart. They
12 may be diabetic and they've gone to the endocrine
13 clinic for instance. So to have the odd temporary
14 chart is fair enough, but to have a large volume is
15 different. So, yes, there are temporary charts but it 14:56
16 should really be very small and it often relates that
17 the patient's chart is tracked to a different clinic.
18 117 Q. One can see this e-mail is 2014. A year later,
19 TRU-258477, just down at the bottom of the page,
20 I think, Pamela Lawson to Helen Ford and Marina 14:56
21 Corrigan, 23rd January '15.
22
23 "The situation is getting worse. Mr. O'Brien is taking
24 more charts home with him and we are spending more and
25 more time looking for charts that end up at his home. 14:57
26 We are wasting a lot of time that we do not have and
27 I'm having to give out overtime to get all the charts
28 for the clinics. The two charts we are currently
29 requiring..."

1
2 And those are set out. This is forwarded for your
3 attention, I think, if we scroll up the page.
4 Martina Corrigan escalates to you:
5 14:57
6 "See below another two charts. These will be escalated
7 through to Anita Carroll, and then on to Heather and
8 I am concerned that it will go to Debbie."
9
10 A bit of a pattern here, a concern that we might have 14:57
11 to escalate this to somebody who we might be afraid of,
12 who might take more aggressive action than we're
13 prepared to do. Is that a flavour of this?
14 A. It should be passed up. Yes, it should be passed up
15 the channels and it indicates that this was the 14:58
16 indication that they were going to do that.
17 118 Q. But it doesn't, as I say, get there until well into
18 2016, this being a pattern of behaviour that's gone on
19 for 4 or 5 years, perhaps longer. As I say, it is
20 being escalated to you so that we might avoid it going 14:58
21 any higher. Did you ever speak to Mr. O'Brien about
22 it?
23 A. The charts at home, it was the return of the south-west
24 acute charts I thought that this was about. I can't
25 remember a precise conversation, a dated thing, but 14:59
26 charts would have come up in a verbal conversation that
27 they should be returned. Again, an undated commentary.
28 And, you know, I'm interpreting -- you're saying that
29 it's an escalation to me to go and sort out but, you

1 know, charts are a trust point to try to track back.
2 This is already at quite a high level of Heather and
3 Debbie, that is Heather Trouton and Debbie Burns.
4 These are the administrators making charts work.
5 15:00
6 I will have had conversations with Mr. O'Brien, whether
7 I should been more forthright in the conversation, I do
8 accept that but there is an element of taking a horse
9 to water.
10 119 Q. If Dr. Chada is right that, I think there's no real 15:00
11 disagreement, maybe a bit of disagreement over the
12 final figures, but 300 charts sitting at home, plainly
13 you can see the problem with that. Is your evidence
14 really that it is not for me to change his behaviour,
15 that this should have been brought to a higher level? 15:01
16 A. I was unaware of the volume of charts at home. There's
17 no need to have 300 charts at home. I was not aware of
18 that volume until the January 17th meeting. I wasn't
19 aware of the degree. Just before this e-mail you
20 showed us a list of one or two charts here and there. 15:01
21 That's one or two charts, that's slightly different
22 from 300 charts.
23 120 Q. I also showed you 50 incident reports.
24 A. Yes, on different -- yes, but they were one chart for
25 each of the dates. I know they add up to the 50, 15:02
26 I agree. So I thought it was small volume, not coming
27 back, completely unaware that it was 300 charts.
28 121 Q. That, I suppose, tells its own tale in terms of
29 communication within urology. It's clearly more than

1 a couple of charts at a time.
2 A. Absolutely.
3 122 Q. That information was there to be extracted. If it's
4 right that it's not being communicated to you, it
5 perhaps reveals a gap in the governance of this 15:02
6 important issue.
7 A. Yes, now I am aware of the triage letter volumes, as
8 documented earlier, but the actual volumes of the
9 charts here was not passed to me until such time --
10 I knew there was an issue with it but not the volume. 15:03
11 123 Q. As I say, a companion piece to the charts at home is
12 the absence of --
13 A. Dictation.
14 124 Q. -- dictation on these clinical episodes. I think you
15 made the point earlier that at least as regards the 15:03
16 Southwestern clinic which Mr. O'Brien took fortnightly
17 or once a month, was it, on a Monday?
18 A. We had a monthly, yes there was a fortnightly clinic,
19 one by Mr. O'Brien, one by me.
20 125 Q. He had been facilitated, you explain, by being granted 15:04
21 Tuesday free of clinical duties in order to perform
22 whatever administrative catchup he required following
23 the Monday clinic?
24 A. Yes. We worked with that. It wasn't available at the
25 beginning. I think we started going to the Southwest 15:04
26 in 2013, January, I believe, but I'm not entirely sure
27 if that facility was available to Mr. O'Brien right
28 from the word go. But it is something that as time
29 went on he was asking for and we felt that that was

1 a good idea. But it was within a fairly short period
2 of time, I think, that we then -- I mean it was fine to
3 have Tuesday morning free because it was either day
4 surgery or admin and, as I said, I did the rota so it
5 was easy enough to switch somebody around from doing 15:05
6 a Tuesday day list. So it was easy for us to
7 accommodate that request. So, yes, it was fairly soon
8 after going to the southwest that there was the
9 facility of the Tuesday to be free for him to do.
10 126 Q. In terms of your own practice and your understanding of 15:05
11 other practitioners in your own group, when you conduct
12 a clinic, say at the Southwestern, what are the, if you
13 like, the documentation obligations that flow from
14 that? I suppose it can vary from patient to patient,
15 but assuming you make an entry in the chart and if 15:06
16 further steps are required you dictate what those steps
17 should be to an audience that might be variable as
18 well. Can you just take us through that?
19 A. The cycle of a clinic would be an engagement with the
20 patient. You would write a note in the chart. You 15:06
21 would dictate a letter to the GP. It would have been
22 common practice, certainly for everybody I would think,
23 would be to fill in an outcome sheet. And we had
24 discussed outcome sheets and the importance of them
25 over a good number because if the dictation tape didn't 15:07
26 come out you have to redo the clinic, and therefore
27 there is a document to know what you were trying to do.
28
29

1 Secondly when the dictation tape went back to the
2 secretary, there may be important things to do first.
3 So, in other words, the last patient on the clinic
4 might be the most important person of the day but would
5 have been the last dictated on the tape. So if you put 15:07
6 the outcome sheet down with the name at the bottom
7 "please sort this patient out urgently, it's a red
8 flag", or whatever, then that's what the secretary
9 would go to first. That's my practice and I assume
10 it's others'. So the whole idea of the outcome sheet 15:08
11 was to keep separate the chart, keep separate from the
12 dictation so if one got lost there was a way of trying
13 to track things.
14
15 So, you know, if you were behind on dictation, you 15:08
16 know, at least there was the outcome sheet for the
17 secretary to work from.
18 127 Q. How promptly would you normally expect to make each of
19 those documents?
20 A. The outcome sheet is -- you're talking about my 15:09
21 practice?
22 128 Q. Yes?
23 A. I do it, I see a patient, I take a sticky from the
24 chart, it goes on to the outcome sheet, I write beside
25 it what it is so it's live. The outcome sheet for me 15:09
26 is produced at the end of the clinic. If I don't do it
27 then, it gets displaced and I lose track of time. It
28 has to be done at the time, for me. Dictation for me
29 is either done immediately after seeing the patient.

1 If I run over slightly into the next patient's time,
2 I will dictate at the end of the clinic.
3
4 I mentioned earlier that our outpatient design was
5 meant to have had some time at the end of the clinic to 15:10
6 incorporate admin. That was fine, I think, at the
7 beginning when we were setting up after the 2010
8 regional review. That's the way we had set it then.
9 I think that's more than likely slipped and there's not
10 precise time at the end. But in theory the clinic slot 15:10
11 time should incorporate both a consult, the writing,
12 and the dictation. Now, again, if you are a bit slow
13 most -- well, most of my clinics are on in the
14 afternoon, I stay until that dictation is done, whether
15 that is 7 o'clock at night or 5:30, but for me it's 15:11
16 there and then. To take the chart off to an office to
17 do is up to the -- it is up to the clinician, but most
18 of the charts are bundled up and put into a box and
19 sent to the secretary from the outpatients' department.
20 129 Q. You talked about dictating a letter to the general 15:11
21 practitioner, a copy of that would go on the chart,
22 would it?
23 A. When that's dictated it goes into the chart and in
24 modern times now it goes on to the NIECR.
25 130 Q. Just a point of fine detail. Do you ever see fit to 15:11
26 dictate a letter to the patient directly arising out of
27 such a clinical episode?
28 A. There has been a move now to copy the patients more
29 into the correspondence. For me that's relatively new.

1 Some clinics have been doing that for years, that what
2 written to the GP goes to the patient as well. I have
3 a little bit of concern about that because sometimes
4 there can be -- there can be big words used that you
5 have to interpret for the patient and, yet, you want to 15:12
6 give the right information to the GP. But certainly
7 having a letter written to the patient is becoming more
8 common practice. But I would specifically write to the
9 patient if there was something that the patient needed
10 to know and to take away from the consultation, shall 15:12
11 we say.
12 131 Q. Yes. Just in terms of Mr. O'Brien's practice, I want
13 to just dwell for a few moments on how Mr. O'Brien's
14 practice appeared to impact on his colleagues.
15 15:13
16 If I can bring you to something that Mr. Haynes said in
17 evidence. It is at TRA-00867. So he's explaining the
18 context where this is that when both Mr. Haynes and
19 Mr. O'Donaghue commenced in The Trust in 2013, to some
20 extent they took on some of Mr. O'Brien's cases. It 15:14
21 was a review of his backlog, as I understand it, and
22 that was part and parcel of it. Mr. Haynes recounts
23 that:
24
25 "Progressively as I recognised that that was the way he 15:14
26 worked, I would have raised -- so during them times
27 when we moved up to six when Mr. O'Donaghue started, we
28 would have tried to work as a team and as individuals
29 and as new starters. Myself and Mr. O'Donaghue seeing

1 some patients who Mr. O'Brien had seen previously and
2 both of us raised a concern, along with Mr. Glackin and
3 Mr. Young when they were doing it that you didn't have
4 any documentation about the decision making that had
5 gone on before. There wasn't a letter available and so 15:15
6 it made reviewing these patients very difficult."
7
8 Mr. O'Donoghue in his evidence last month recalled that
9 when he was taking patients to theatre and going to the
10 chart he was sometimes left wondering what the purpose 15:15
11 of the visit to the theatre was. Is that something
12 that was recounted to you, perhaps, as a complaint and
13 was it something you experienced yourself?
14 A. Mr. O'Brien's patients and myself didn't really
15 interlink because we had our own lists to look after. 15:15
16 Mr. O'Donaghue and Mr. Haynes were coming as new and
17 they were taking, as you say, the backlog of
18 Mr. O'Brien's list here. Now, this had been brought up
19 at some of our departmental meetings, you know, and
20 I did ask Mr. O'Brien why, you know, there wasn't 15:16
21 something in the chart. Mr. O'Brien usually liked to
22 have maybe one letter to cover the whole episode of the
23 patient, not the episode of the date, but the whole
24 arena of what that patient's journey was.
25 15:16
26 That is a fine approach if everything is all very sort
27 of concerted and quick but in our arena to get somebody
28 back for a review was taking a long time. Now, I'm not
29 so sure about the writing in the chart, I'm not aware

1 of that. But I know that he would have written in the
2 charts. I don't know if it was as infrequent as is
3 commenting here but, certainly, there didn't appear to
4 be a dictated letter. I mean, I do remember one
5 occasion at a departmental meeting, I was getting 15:17
6 rather frustrated with the situation. Even if somebody
7 comes to your outpatients and you consultant with them
8 and there's no change in the plan, you know, let's just
9 run with what was going, you know, that's what you
10 write down "no change in plan". But at least that lets 15:17
11 the next person coming along know that that's what your
12 train of thought was. But if there's no letter or
13 nothing written in the chart, as you pointed out there.
14 But undoubtedly a dictated letter is the best, in my
15 view. And the reason for that is that that now goes on 15:18
16 to the NIECR system, so it's on the computer. Written
17 notes on the chart, I must confess the chart issue in
18 Craigavon, you know, they're a bit higgledy-piggledy
19 and sometimes you might miss somebody's writing.
20 That's maybe a finer point. If you look through 15:18
21 a chart you probably will find it but sometimes it can
22 be a little bit on the difficult side. But certainly
23 a dictated letter is the way to go and even, as I say,
24 if there's no change in plan, at least write that.
25 132 Q. As we've observed from Mr. Haynes' remarks, there's an 15:19
26 importance residing in the principle of continuity of
27 communication that was, it appears, somewhat frequently
28 missing from Mr. O'Brien's clinical practice. I think
29 there is a dispute on the final numbers as found by

1 Dr. Chada. Dr. Chada talked about dictation not
2 completed for 66 clinics affecting 668 patients.
3 Mr. O'Brien says it was 189 patients across 41 clinics.
4 Whatever be the precise number on that, do I draw from
5 your evidence that you regard it as a shortcoming that 15:20
6 dictation was not done promptly by way of letter so
7 that everybody concerned would know what was going on
8 by way of next step?
9 A. It's a distinct shortage, yes, shortfall.
10 133 Q. Are you at all sympathetic to the view of Mr. O'Brien, 15:20
11 there's a number of layers to this, that, first of all,
12 clinical encounters with patients are important and
13 it's important to speak to the patient and use the time
14 to communicate well so that they understand face to
15 face what's going on and that that inevitably eats into 15:20
16 the time available for note making or dictation?
17 A. Yes, it's the complete clinic slot. So it needs to
18 have adequate time for that slot to complete all of
19 those points that you just made. Obviously, the most
20 important person is the patient sitting in front of 15:21
21 you. That's who you are communicating to with advice,
22 but that advice also needs to be transcribed so that
23 the next in line knows who's carrying the baton. You
24 need to pass the baton down the line. So the GP needs
25 to know what you talked to the patient about. But, 15:21
26 yes, most of the time -- I mean most of the
27 consultation time is the talking and the examination of
28 the patient. You know, you can make -- you could spend
29 half an hour talking to somebody and yet you could

1 summarise the consult within a couple of minutes by
2 a dictation. But, as you say, there are other features
3 that go on in the consultation if you're going to book
4 an X-ray you have to fill in a green form. If you want
5 to log somebody for theatre -- you know, there's admin 15:22
6 to go with the whole situation. It's actually that wee
7 bit that often takes a little bit longer. Yes, it's
8 the complete clinic slot time that is the complete
9 journey.
10 134 Q. His other point, the other layer to this is, as I think 15:22
11 you highlighted, he would have a "some time" approach
12 to dictation, that he would do it at the end-of-the
13 patient's journey or after a number of clinical
14 interactions.
15 A. Yes. 15:23
16 135 Q. Is that a wise approach?
17 A. In my view, if you can -- well, the answer is no in
18 short form, but to explain it, you know, if the
19 consultations are all very short in time between and
20 you can complete the journey -- if the whole thing is 15:23
21 a month or two, you can do it. But if there's
22 a lot-of-time between clinics, it's going to be hard to
23 fully remember what you discussed with the patient.
24 You are going to miss, well, speaking for myself here,
25 you would miss the finer nuances of what you discussed 15:24
26 with the patient I think. Well, I would.
27 MR. WOLFE KC: 3:25 should we take a short break?
28 CHAIR: Yes.
29

1 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
2
3 CHAIR: Thank you, everyone. Hopefully it will be a
4 little bit cooler.
5 136 Q. MR. WOLFE KC: Mr. Young, I'm going to rewind slightly 15:43
6 before moving forward again. If I just take you back
7 to patient charts issue and bring up on the screen
8 please, if you would, AOB-01225. This is
9 14th November, 2016. Mr. O'Brien has gone off work to
10 have surgery and he's asking Mrs. Corrigan for 15:44
11 permission to work on dictation from home. He says:
12
13 "I expect that I will be well enough to dictate
14 correspondence concerning patients and have the charts
15 delivered to Noleen's office for typing. I would 15:45
16 greatly appreciate if I could be afforded this
17 opportunity to have all charts returned in this
18 manner."
19
20 Were you aware of that plan on the part of Mr. O'Brien? 15:45
21 I should just say, for completeness, scrolling up, that
22 Mrs. Corrigan was content with that:
23
24 "I am more than happy with this plan. Please let me
25 know if there is anything I can do to assist." 15:45
26
27 Were you aware of that plan?
28 A. This is when he was meant to be off sick.
29 137 Q. Yes?

1 A. I'm not too sure I was. I can't say one way or the
2 other, but I really don't recollect that.
3 138 Q. Plainly, come January, 300 or so charts are coming back
4 from his house. This e-mail from Mrs. Corrigan would
5 certainly appear to acknowledge that she was aware the 15:46
6 charts were at home because work was going to be done
7 on them and she was giving her blessing for that,
8 rather than raise any noise about the fact that the
9 charts were at home. But you have no recollection of
10 engaging with that? 15:46
11 A. No.
12 139 Q. Thank you. Could we turn to the issue of private
13 patients. This is the fourth of the issues that we've
14 gone through. Triage, dictation, charts at home,
15 private patients being the fourth of the issues that 15:46
16 Dr. Chada grappled with during her investigation.
17
18 Could I open with you your statement to Dr. Chada. If
19 we go to TRU-00756 and you are speaking to Dr. Chada on
20 3rd April 2017. At paragraph 34, if you just focus on 15:47
21 that. So you're saying:
22
23 "I can't comment on the placement of private patients
24 in the NHS queue. I don't track Mr. O'Brien's
25 patients. Any concerns I heard about private patients 15:47
26 were just hearsay. I had no idea when patients were
27 seen by Mr. O'Brien at his home. I would have thought
28 patients go on to the NHS waiting list as per clinical
29 priority. I have subsequently heard that some private

1 patients might have been given dates sooner on the list
2 but I was not aware if this was down to clinical
3 priority. While I have recently heard this,
4 I personally had no evidence of it."
5 15:48
6 When you say this was just hearsay, was that an apt
7 description of what you were told or were aware of at
8 the time?
9 A. No. That's not the right word to use. This was
10 a consultation with Dr. Chada and Siobhán Hynds. So 15:48
11 this was a transcript of what I had said that day. I
12 probably hadn't had enough time to reconsider or
13 inwardly digest what I was trying to put across. So
14 the word "hearsay" isn't quite true, but I am aware
15 that there had been some e-mail conversations and I do 15:49
16 specifically remember -- I think what I'm really
17 referring to here is what I do clearly remember is
18 having a conversation with Mr. Haynes at the sisters'
19 nursing station at the front of the ward one Wednesday
20 probably because I would have generally done a post 15:50
21 surgical ward round. My day was Tuesday, so I would
22 have seen my patients afterwards. No matter who was on
23 call, I would generally go and see my patients. But on
24 a Wednesday morning after that I would, I had a stone
25 clinic. So I remember Mr. Haynes mentioning to me or 15:50
26 having a conversation about a private patient being in
27 the ward and he was concerned about the issue. And
28 although I was in a hurry, I asked was there a clinical
29 reason, did he think, for that happening. So that's my

1 main point. I really hadn't heard anything along this
2 line about private patients before him actually raising
3 that point on the ward. So that was a quick remark
4 said and the word "hearsay" is taken in the context of
5 just what I've said. 15:51
6 140 Q. I suppose the further and you might agree the more
7 accurately way of portraying this to Dr. Chada would be
8 to say I received two e-mails six months apart from one
9 of my senior colleagues, Mr. Haynes, who is very
10 concerned about the morality and the probity of what he 15:51
11 thinks is going on?
12 A. Yes.
13 141 Q. Just turning to Mr. Haynes' intervention on this
14 subject matter. He wrote to you and Mrs. Corrigan in
15 May 2015, TRU-274504. Just scrolling down. I'll let 15:52
16 you digest that and the Panel digest it. To summarise,
17 he's draw your attention to two patients who have come
18 in for treatment on the NHS and it's his belief that
19 those patients had been relatively recently seen by
20 Mr. O'Brien in a private capacity and he's comparing 15:53
21 the lot of those patients with others of whom he's
22 aware who have, in similar need, have been waiting up
23 to 92 weeks. He rounds off by saying: "This behaviour
24 needs challenged, a stop put to it." He is unwilling
25 to take the long waiting urgent patients while a member 15:53
26 of the team offers preferential NHS treatment to
27 patients he sees privately. He suggests that an audit
28 be conducted for us all to have an honest discussion
29 about what is happening. He says the alternative is to

1 remove waiting list management from individual
2 consultants and give it up to an admin team which would
3 manage the waiting list in a strict chronological
4 order. Your response to that, just up the page, is the
5 point is taken and you agree, play a straight, honest 15:54
6 game.
7
8 "We are best placed defining our lists but at risk if
9 the above comments are not taken on Board."
10 15:54
11 You say management are not playing it straight either
12 by resetting the patient's clock. What does that mean?
13 A. Patients may be put on to the waiting list at
14 a specific date but due to reasons like pre-op
15 assessment, patient unfit for surgery, patient doesn't 15:55
16 attend, patient changes their mind, then their date of
17 going back on to the waiting list can change.
18 142 Q. But it's not a repost to the merits of Mr. Haynes'
19 point?
20 A. No. No, it's not. 15:55
21 143 Q. You say there are a few issues that you're not prepared
22 to put on paper about the process so you'll discuss
23 later. Can you help us in terms of what they are?
24 A. I can't remember.
25 144 Q. Is it what process do you think you're referring to? 15:55
26 A. I honestly don't know. It may not be actually that
27 that I was referring to. It might have been a list of
28 other things. I can't remember, honestly.
29 145 Q. You go on to finish with:

1
2 "Mark's points are valid. I fully appreciate the
3 questions raised".
4
5 Certainly it would appear from the next e-mail sent by 15:56
6 Mr. Haynes that maybe he didn't get any response beyond
7 that from you. Let's just look at his e-mail, and you
8 can comment. So we're now in November '15, six months
9 along, it is TRU-270115. So he is saying to you,
10 26th November: "I e-mailed you on 2nd June" -- I'm 15:57
11 never quite sure where that 2nd June date comes from.
12 It would appear he e-mailed you on 27th May, but that
13 fine detail aside, it's about the ongoing issue of
14 patients on waiting lists not being managed
15 chronologically, in particular private patients. 15:57
16 That, in essence, is the issue. The rest of the detail
17 is not terribly significant. I suppose it is your
18 response I'm more interested in. He's raising the same
19 point and you say by way of response:
20 15:58
21 "I have spoken before to the person in question
22 regarding this issue in general and the justification
23 of urgency, and since the waiting list for some things
24 are so long, example urodynamics, I will have to speak
25 to him again." 15:58
26
27 The person concerned here is Mr. O'Brien; isn't that
28 right?
29 A. Yes.

1 146 Q. Are you being deliberately careful about committing
2 names to writing?
3 A. No, that's not meant.
4 147 Q. Sorry?
5 A. That's not meant to be deliberate. 15:58
6 148 Q. Okay.
7 A. I could have put in there: I have spoken before to
8 Mr. O'Brien.
9 149 Q. Had you spoken to Mr. O'Brien about it and did
10 you speak to him again? 15:59
11 A. If I put this in an e-mail then I have spoken to him
12 but, again, a precise date of which I haven't got in
13 a diary, I'm afraid. It's not something that I would
14 keep in a diary. But from the e-mail here, I obviously
15 have spoken to him. 15:59
16 150 Q. Yes. I suppose this is a serious concern on the part
17 of Mr. Haynes, he's suggesting an audit of the cases.
18 That wasn't done?
19 A. No. No, it wasn't done.
20 151 Q. Just in case anything pops out of it, the e-mail from 15:59
21 Mr. Haynes, WIT-54106. I'm not sure if anything more
22 turns on it, but that's the reference. While that's
23 coming up -- yes, there it is. So it's a patient
24 apparently referred September 2015, seen on a Saturday,
25 10th October, and then in for treatment on 6th 16:00
26 November. It's one of the cases that you go on to look
27 at as part of Dr. Chada's investigation, Dr. Chada's
28 MHPS process.
29

1 Then another patient seen by Mr. O'Brien, again
2 privately, it would appear, Saturday 7th November and
3 then cystoscopy on the 25th November 2015. On the face
4 of it, those bald dates would cause you concern that
5 patients are being seen a lot quicker than the NHS 16:01
6 average, given the state of your lists?
7 A. Yes, these dates are short.
8 152 Q. Why was an audit -- fancy word for an investigation in
9 one form or another, not performed at that time?
10 A. Apologies, I'm afraid the ball was dropped on this one. 16:01
11 It was a word used in the middle of a long e-mail.
12 I probably should have had a look at it in more detail
13 at that time. I do accept that we didn't follow
14 through on it and, certainly after this second e-mail,
15 this was at the end of November into December, which is 16:02
16 usually a fairly active time in the Trust looking after
17 patients and I didn't follow through.
18 153 Q. Mrs. Corrigan has said that to the best of her
19 knowledge this concern about Mr. O'Brien's private
20 practice and the mingling with NHS work was not 16:02
21 addressed until into 2017 and the commencement of the
22 MHPS investigation. You said you had a word with
23 Mr. O'Brien. What did that amount to can you remember?
24 A. I can't remember the precise wording but, as per my
25 e-mail there, I've obviously had a general conversation 16:03
26 with him. I use that "in general". I think used the
27 words urodynamics there, so I know there was a long
28 urodynamics list. So I have obviously had
29 a conversation, I can't remember the precise detail of

1 it but I am logging that I've had one. Again, the
2 forcefulness of the conversation may not have got fully
3 through, but...
4 154 Q. He certainly, when he gave evidence before the Inquiry
5 in the spring of this year, I'll just bring it up at 16:04
6 TRA-04742, the last line. I am asking him the
7 questions. "Do you recall Mr. Young?" He clearly
8 pre-empts what I'm about to say. He says:
9
10 "I have no recall of, if you're asking specifically, 16:04
11 whether there was ever a discussion between Mr. Young
12 and myself about any allegation that any private
13 patients of mine were ever given preferential treatment
14 in the view of anybody else in the form of jumping the
15 queue, the answer to that is no. I have my own view on 16:05
16 queue jumpers."
17
18 He's emphatic or adamant that there was no such
19 discussion with you. You caveat your memory or your
20 recollection that there was a discussion by saying it 16:05
21 may not have been terribly forceful.
22 A. Yes. I can't remember the content of it and it may not
23 have come across as strong as it should do.
24 155 Q. In terms of the approach which clinicians should adopt
25 when carrying a private list as well as an NHS list, it 16:05
26 should have been well known to you and Mr. O'Brien and
27 other colleagues by that time, isn't that right?
28 A. Correct.
29 156 Q. You worked privately. Could I draw your attention to

1 the following and ask for your views. At AOB-77753,
2 this is August 2016 and Mr. Williams, the radiologist,
3 who is part of the urology MDT in the Southern Trust
4 invites Mr. O'Brien to discuss the issue of private
5 patients being discussed at the urology MDT. He says: 16:06
6
7 "I understand that the trust does not indemnify us for
8 discussing these cases so if an error is made, we are
9 personally liable".
10 16:07
11 He ultimately says:
12
13 "I will not be providing any radiology input into these
14 cases until I receive clarification".
15 16:07
16 It would appear that that issue may have been prompted
17 by a need to discuss or a desire on your part that one
18 of your patients might be discussed at this MDT. Let
19 me bring you to this, if we go to AOB-77844.
20 Mr. O'Brien is writing to you and he's explaining that: 16:08
21
22 "Today on reviewing and amending the outcome of the MDM
23 of 4th August I realised I had not been in contact with
24 regard to the above case."
25 16:08
26 He says:
27
28 "I regret that it was not possible to have the case
29 discussed at MDM for the sake of the patient. Mark

1 declined to make any comment upon the CT images
2 imported from UIC."
3
4 That's the Ulster Independent Clinic, which is
5 a private facility. 16:08
6
7 "... as he is not indemnified to do so."
8
9 We can see the rest of it. You respond to that and you
10 say that: 16:09
11
12 "As far as I am aware there is no MDM facility for
13 private patients. Frankly, this is a poor show. It
14 does sound as if certain members of the team are not
15 interested. The CT scans have all been reported by 16:09
16 Dr. Rice and I do not get a chance to present when my
17 patients are being discussed."
18
19 Is this a case of you using an NHS facility or wanting
20 to use an NHS facility for the purposes of 16:09
21 consideration of one of your private patients?
22 A. Yes is the answer to the question. The full history is
23 that this lady had had a radical nephrectomy a good
24 number of years beforehand and, very unusually, had
25 developed pain in a rib. She was having annual CT 16:10
26 scans and this had shown up a very small lesion in her
27 left second rib, very small, reported on by Dr. Rice
28 who works within The Trust but working privately
29 outside. So this was a very unusual case. I didn't

1 know -- she had come to see me privately because of the
2 pain but having been followed up otherwise. So I got
3 a CT scan done, read the report, it just wasn't
4 straightforward, something more to this and wanted to
5 know what my colleagues would do in this case. And the 16:10
6 private basis there, there is no MDT, or at least there
7 wasn't at this stage, and I was just asking my
8 colleagues what their view on a care pathway would be.
9 I thought that was a simple enough question.
10 16:11
11 Now, as it transpires, she had come to see me and then
12 I transferred her on to the NHS system for her
13 subsequent care, which she had. I followed
14 Mr. O'Brien's advice, that was his thought process, so
15 we did get a second CT scan which showed the lesion to 16:11
16 have increased in size, so I was right in my suspicion.
17 Subsequent to this she was discussed at MDT and I was
18 referring her to the thoracic surgeons for their
19 opinion, which subsequently followed, and she had her
20 second rib resected, which is rather sore. But in 16:12
21 saying that, I did transfer her over to the NHS. I was
22 asking, and if the answer was no, the answer was no,
23 they weren't prepared to do it, that's fine, I'm just
24 expressing a bit of frustration.
25 157 Q. The point being, and I think you recognise it, is there 16:12
26 was a procedure in place for the treatment of patients
27 who were private if they wished to receive treatment,
28 including radiographic, in the NHS, then they should
29 pay for it or else, in the alternative, a transfer form

1 should be completed and sent to the Medical Director's
2 office for approval. It would appear that you're
3 describing a process here that was eventually done but
4 wasn't done at the time that this request was visited
5 upon this MDT? 16:13
6 A. Yes, I accept I was asking for an opinion on an X-ray.
7 I probably could have just taken the X-ray to another
8 radiologist to pass comment on but it wasn't
9 a radiological opinion I was looking for, I was looking
10 for a urological opinion. 16:13
11 158 Q. I wonder, Mr. Young, was there a cosiness between you
12 and Mr. O'Brien which might explain why you didn't
13 effectively challenge him on the complaint that
14 Mr. Haynes had raised about the use of NHS facilities
15 for what were private patients? 16:14
16 A. It's not a cosiness. No, I don't --
17 159 Q. Are you not doing something not dissimilar, albeit in
18 a different context to what Mr. O'Brien is said to have
19 been doing?
20 A. Right, okay, but I was transferring this lady over to 16:14
21 the NHS to have it done. There was a certain element
22 of oncology based here that was time dependent. And it
23 does take time to get the process of transfer over.
24 Now, whether that time frame didn't just fall into the
25 exact timelines or in the right order, should I say, in 16:15
26 the right order, but...
27 160 Q. The principles governing the transfer of private
28 patients into the NHS sector is set out in "A Guide to
29 Paying Patients". There was an iteration of that in

1 2016, there's probably a subsequent version and there's
2 certainly previous versions. Let me just bring that
3 up. We'll take a quick look at it, TRU-267673. This
4 is described as a change of status between private and
5 NHS and you can see the description set out there. An 16:16
6 important one in terms of the work that you were to
7 perform for the MHPS investigation -- I am just going
8 to move on to that -- is perhaps 7.4.1:
9
10 "A patient seen privately in consulting rooms who then 16:16
11 becomes an NHS patient joins the waiting list at the
12 same point as if his/her consultation had taken place
13 as an NHS patient."
14
15 In other words, there is to be no advantage gained from 16:16
16 having seen a clinician privately. You go to that
17 point in the queue which is appropriate for an NHS
18 patient. Is that a principle that was well understood,
19 do you think, amongst your colleagues?
20 A. The sentence is maybe not fully understood. When 16:17
21 somebody is seen on a certain date and, say, is to be
22 reviewed or to have surgery as a routine patient, they
23 then transfer into the system as a routine patient.
24 161 Q. Was that understood?
25 A. Yes. Well, that's what I work on. I think it is 16:17
26 understood that, you know, when the patient transfers
27 over, their date is X and they go on to the list at
28 whatever -- I mean if they are a red flag, they will be
29 processed as a red flag. If it is routine they should

1 go on to the list as per that date.
2 162 Q. Yes, but the operative date is the completion of
3 a patient transfer form, isn't that right? So the
4 completion of the patient transfer form is, according
5 to the rule book, a condition precedent to you being 16:18
6 accepted.
7 A. Yes. It would probably be the date of the
8 consultation. Whether the transfer form is completed
9 exactly the same day, but it's -- well, I take it as
10 the date of the consultation. 16:18
11 163 Q. Is that right? Should it not be the approval of the
12 application to become an NHS patient?
13 A. Approval --
14 164 Q. You're supposed to completed a form and send it to the
15 Medical Director's office? 16:19
16 A. Yes.
17 165 Q. Was that routinely done?
18 A. The forms are filled in but who puts them on to the
19 list at that date would be, you know, if the letter
20 goes into the system, your secretary will put the 16:19
21 patient on to the list as per the date.
22 166 Q. You, as I said, became involved in the MHPS process not
23 only as a statement giver, and we've looked briefly at
24 your statement, but you also took a look at 11 patients
25 who Mr. O'Brien had consulted with in a private 16:20
26 capacity and were asked to assess, it would appear,
27 whether the time frame within which they were seen for
28 a procedure within the NHS was reasonable. I just want
29 to ask you some aspects of the process or the

1 methodology that you followed.
2
3 Let me start with what Mrs. Corrigan says about the
4 work that you did. TRU-283681. She is explaining to
5 Siobhán Hynds and Dr. Chada what work had been 16:21
6 performed by you. So the process undertaken was that
7 Ronan Carroll had requested Wendy Clayton to request
8 a report to be run on all Mr. O'Brien's surgery during
9 2016.
10 16:21
11 "Any patients that had a short wait time between being
12 added to the waiting list and been operated on had
13 their record checked on NIECR to see if they had
14 a private patient letter. Out of this list there were
15 11 patients for which all the letters were printed off. 16:22
16 I then asked Mr. Young if he could look at these
17 letters and gauge, from his clinical opinion, should
18 they have been seen as soon as they had been or should
19 they have been added to the NHS waiting list to wait
20 and to be picked chronologically." 16:22
21
22 Just that paragraph there that I have just read, does
23 that match with your understanding of your
24 instructions?
25 A. I was asked to review the letters to see if it was 16:22
26 a reasonable time frame.
27 167 Q. Yes. So you don't disagree with that?
28 A. No.
29 168 Q. She goes on to say that you agreed:

1
2 "... took away the letters and using NIECR, i.e. checking lab results, imaging and any other diagnostics available, made his decision on whether in his opinion they were seen sooner than they should have been." 16:23
6
7 And she attaches letters with your comments which you went through and advised whether you felt it was reasonable or not.
10 16:23
11 I understand that you would say that you didn't use the records viable on NIECR when completing your work.
13 A. I just looked at the letter. I didn't go into it in any more depth.
15 169 Q. Would it have been feasible or possible for you to look at other records when conducting this work? 16:23
17 A. Most letters will have a health and care number on it. But I was asked to look at time frames so I looked at the start date and I looked at the finish date.
20 170 Q. And you would have seen the history that the patient presented with, the patient's interactions with Mr. O'Brien or the health service generally and what ultimately was offered and took place by way of procedure? 16:24
25 A. Yes. I passed comment earlier that Mr. O'Brien generally does one letter to cover the whole thing. So I sort of knew that that existed. 16:24
28 171 Q. We can see what was produced. I understand that this is Mrs. Corrigan's work, populating a table with your

1 comments which were written on to the letters. So the
2 table which the Inquiry is familiar with, this table,
3 but we'll bring it up on the screen just to assist you.
4 TRU-01069. So the question at the top of the -- the
5 issue at the top is described as: 16:25
6
7 "Patients seen privately by Mr. O'Brien and added to
8 the waiting list and came in for a procedure within
9 a short time frame".
10 16:25
11 One can see the details of the patients on the
12 left-hand side. They're there before redaction,
13 obviously. The number of days is recorded between
14 added to the waiting list to the operation date, and
15 then the question is is there a clinical reason why 16:25
16 they should have waited such a short time? And you, it
17 would appear, have advised that in two out of the
18 11 cases it was a reasonable time frame but the rest
19 were unreasonable. Now, I understand from your amended
20 statement that you have reflected upon this and that 16:26
21 your view has changed in respect of a number of cases.
22 Starting with this -- just do this gently --
23 A. Could I make a point, please?
24 172 Q. Of course.
25 A. Third down, it says four. On my original assessment of 16:26
26 this I believe I was unable to make an assessment of
27 the time frame. It was either 200 or four or something
28 similar. And I think I put that down as uncertain, and
29 therefore accept.

1 173 Q. Let me help you with that and illustrate it for the
2 Inquiry. What you are pointing to is the third entry
3 on the table, where it is four days?
4 A. That's right.
5 174 Q. And it's recorded as, no, this isn't reasonable. You 16:27
6 say that that has been misinterpreted. You've given
7 Mr. O'Brien the benefit of the doubt. Let me just slow
8 the Inquiry what you mean by that. If we go to
9 TRU-01082. This is a typical private letter that you
10 would have received. Just scroll up to the top. So it 16:27
11 has got Mr. O'Brien's private notepaper and what you
12 did by way of report back to Mrs. Corrigan across these
13 11 cases is to add a Post-It, which we can see here on
14 the right-hand side. And what you've said in respect
15 of this patient, this is the third one on the table, 16:28
16 "not sure of timelines, accept". So you are saying not
17 sure of the timelines, accept this was a reasonable
18 approach. Is that, in essence, it?
19 A. That's, in essence, what I'm trying to put across.
20 175 Q. Additionally, if we can bring up your addendum 16:28
21 statement at WIT-104219, this is paragraph D3. You
22 say:
23
24
25
26
27
28
29

1
2 "I have revised my opinion in respect of four of the 11
3 patients, three in light of Mr. O'Brien's responses and
4 one in response to my own..."
5 16:29
6 So this revision is summarised below in ease of the
7 Inquiry. So the first patient that you highlight here
8 is Patient 118. And we can, if we were to go back to
9 the original table we would see that you had, as it
10 said, expressed the view that it was not reasonable 16:29
11 that he was seen in the time frame. You have now taken
12 the view that it is reasonable. Can you help us
13 understand why you have come to that view?
14 A. It relates to the added information that Mr. O'Brien
15 produced after his original letter. The original 16:30
16 letter didn't contain that information. If you want to
17 refer to that, that's fine. But it wasn't included in
18 the original letter and I felt that the original letter
19 content didn't sort of justify such a short period of
20 time. 16:30
21 176 Q. So on the face of the private letter --
22 A. On the first letter, yes.
23 177 Q. You looked at that and decided that's not reasonable,
24 this man has been seen too quickly compared to the
25 other NHS patients, but then you picked up on what 16:31
26 Mr. O'Brien said outside of that letter and you reached
27 a different view.
28
29

1 What he has said is set out in the following document,
2 I think. If we go to TRU-01094. Actually, if you just
3 go back. I think it is contained in what is written on
4 that statement. Maybe if we go back to that for ease
5 of reference. That's WIT-104218. 16:31
6
7 What you're picking up on is that this man's symptoms
8 were so severe that they were leading to him and his
9 wife sleeping in separate beds with resulting marital
10 strife, and this provided you with additional 16:32
11 information, and that was good reason to permit him to
12 be seen as quickly as he was?
13 A. Yes. Well, it -- whether you accept it as good or not,
14 it was additional information and there's a bit of
15 sympathy involved here. So... 16:32
16 178 Q. Yes. Did you wrestle with whether an NHS patient, as
17 opposed to a private patient would attract the same
18 sympathy and be seen as quickly as this patient?
19 A. If somebody had come in to an NHS arena and had said
20 this, I think you might also take a bit of sympathy. 16:33
21 This man was for urodynamics I believe. Most
22 urodynamics are done on a routine, sort of
23 chronological order. There will be some that are off
24 an urgent basis. I do urodynamic, I have a urodynamic
25 practice, and I've been asked to do urodynamics, maybe 16:33
26 slightly out of order. An example would have been --
27 the one that comes to mind is a man who was waiting for
28 a renal transplant and it depended on the function of
29 his bladder. That is a time dependent thing so there

1 may be certain features that you might want to take
2 into account. I'm erring on the side of --
3 179 Q. Generosity?
4 A. Generosity.
5 180 Q. Very well. The next patient that you have gone back 16:34
6 and looked at is 119. You are saying that you have
7 presumably listened to Mr. O'Brien's evidence and he
8 was making the case that this was a 14 month wait for
9 this patient rather than two months.
10 A. This might have been the one that I changed. I think 16:34
11 I misinterpreted my writing on my Post-It note.
12 I thought it was two months but in fact it was a year
13 and two months. Maybe you want to have a look at that.
14 I'm going by my Post-It note rather than...
15 181 Q. Yes. Well, the description for this patient is to be 16:35
16 found at TRU-01078. So just scrolling down so we can
17 see, this is a patient that is being seen privately but
18 he has had some involvement with the NHS. Just
19 scrolling down, Mr. O'Brien says that:
20 16:36
21 I advised the patient in July 2015 that he would be
22 better served by having his prostate gland resected.
23 As you may be aware from recent correspondence from
24 Kathy Travers..."
25 16:36
26 That's the nurse is it?
27 A. Yes.
28 182 Q. "She has found his flow rate to be very poor".
29

1 Just scrolling up. July '15, the patient is being
2 advised, this letter is being written, I think the 5th
3 September 2016. That's where you get your 14 months
4 from, is it?
5 A. Yes. I was interpreting advised to have a TURP as, you 16:36
6 know, taking that, again the benefit of the doubt
7 possibly, sorry. But there was a mention of July '15
8 of having a TURP.
9 183 Q. Mr. O'Brien was asked about this case when he came
10 along to give evidence and let me just draw your 16:37
11 attention to what he says and what is perhaps a problem
12 in many of these cases, and its TRA-04948. He was
13 being asked by me about when this patient would have
14 gone on to the waiting list. So if he went on to the
15 NHS waiting list in July 2015, then your maths is 16:37
16 correct, he has waited 14 months. But I'm asking him,
17 as you can see at line 9:
18
19 "Does that mean that this patient was placed on the NHS
20 waiting list on 20th July 2015?" 16:38
21
22 And his answer is "no". And I say "help me with that."
23 His evidence seems to be accepting of the view that one
24 can only calculate 14 months if you take it from the
25 date when the patient went on the NHS list and it would 16:38
26 appear that he didn't go on the NHS list
27 until July 2016, which would have been two months from
28 the procedure.
29 A. So my first assessment was correct.

1 184 Q. Yes. The upshot of this, I don't intend to go through
2 all four of the patients that you have changed your
3 view on, but I suppose, taking into account what
4 you have said in your addendum statement, that you have
5 been prepared to take a generous approach with one of 16:39
6 the patients, a bit of a question mark now over what
7 you are saying about this last one, but it remains, in
8 light of your further analysis, that there are at least
9 four of the patients that you looked at that you remain
10 convinced, and perhaps this is a fifth one -- 16:39
11 A. Yes.
12 185 Q. -- you remain convinced that they were seen and treated
13 in the NHS unreasonably quickly.
14 A. Yes.
15 186 Q. Could I just draw your attention to Dr. Chada's 16:39
16 conclusions. If we go to TRU-00702 at the top of the
17 page she's reflecting on Mr. O'Brien's justifications
18 in respect of the nine patients that you had said were
19 seen unreasonably quickly. She has concluded that:
20 16:40
21 "These patients seen privately by Mr. O'Brien were
22 scheduled for surgeries earlier than their clinical
23 need dictated. These patients were advantaged over NHS
24 patients with the same clinical priority."
25 16:41
26 And she plainly relies upon your analysis to reach that
27 view. Is that what your analysis was saying, that
28 comparing the wait that these nine patients
29 experienced, it was a shorter wait and they were seen

1 more quickly than HSC patients with the same
2 conditions?
3 A. It appeared to be an assessment that they were shorter.
4 I don't have any comparators, I just felt that this was
5 a shorter period of time than you would expect. 16:41
6 I mean, our waiting lists for prostate surgery is
7 months and months and months, even with a catheter in.
8 I appreciate there may be an analysis made of the time
9 frames between both, but I'm given X number of patients
10 here and they seem to have been admitted sooner. 16:42
11 I mean some were within the month.
12 187 Q. Yes?
13 A. It's very hard to treat most people within the month.
14 188 Q. Yes. Mr. O'Brien would quarrel with the conclusion on
15 the basis that you haven't engaged in a comparative 16:42
16 exercise using his typical approach to his own patient
17 list where the inference from what he's saying is
18 he would treat all patients with these conditions in
19 a similar way, within a similar time frame, give or
20 take. Is that a valid point in your view, given what 16:43
21 you know of the lists in Craigavon or the lists in the
22 Southern Trust?
23 A. Our lists are very long, even for the more urgent.
24 Patients with a catheter in are given preference over
25 a non-catheterised patient for all sorts of reasons, 16:43
26 mainly sepsis. But to be able to offer somebody
27 surgery within a month seems to be a bit short.
28 I didn't compare Mr. O'Brien's patients. I didn't do
29 an analysis of that. I was asked to do: Does this

1 seem to be reasonable or not? And that's the answer
2 that I gave. As you saw, I did this on a Post-It.
3 Post-Its aren't Mr. Young's usual way of completing his
4 reports, and there were certain reasons for that.
5 189 Q. Did your findings, if I can call them findings, and you 16:44
6 modestly explain that really it was a post-it note kind
7 of exercise, but did your findings cause you concern
8 and did they cause you to reflect that maybe I should
9 have more thoroughly and forensically investigated this
10 or brought other people in to forensically investigate 16:44
11 it when Mr. Haynes raised the issue two years earlier?
12 A. Forensically look at this, these cases?
13 190 Q. He raised the issue, suggested an audit, that wasn't
14 done.
15 A. So you're looking at the complete picture. Yes, I do 16:45
16 agree fully with you, it should have been looked at in
17 more detail before and after.
18 191 Q. Okay. I think that completes business for today?
19 CHAIR: Unfortunately you are going to have to come
20 back tomorrow, Mr. Young, as are all of us. I'll see 16:45
21 everyone at 10 o'clock in the morning, then.
22
23 THE INQUIRY ADJOURNED TO WEDNESDAY 6TH DECEMBER 2023
24
25
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29