



# Urology Services Inquiry

## Oral Hearing

**Day 75 – Wednesday, 6<sup>th</sup> 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.

---

**Gwen Malone Stenography Services**

INDEX

	<u>PAGE</u>
Mr. Michael Young	
Examined by Mr. Wolfe KC (cont'd)	3
Lunch adjournment	70
Questioned by the Inquiry Panel	115

1 THE INQUIRY CONTINUED, AS FOLLOWS, ON WEDNESDAY, 6TH  
2 DECEMBER 2023

3  
4 CHAIR: Good morning, everyone.

5 10:01

6 CONTINUED EXAMINATION OF MR. YOUNG BY MR. WOLFE KC:

7  
8 1 Q. MR. WOLFE KC: Good morning, Mr. Young. I had  
9 a nightmare last night that I was about to question  
10 Boris Johnson this morning. That must be some other  
11 Inquiry.

12  
13  
14  
15 10:02

16 Just to recap, yesterday we spent some time focusing on  
17 the four issues that went to make up the MHPS  
18 investigation and I suppose focusing on three of those  
19 at least, leaving aside the private patients issue.  
20 I think you would accept that the three other issues,  
21 charts at home, triage, dictation, together might  
22 indicate that Mr. O'Brien appeared to be a doctor in  
23 difficulty, a doctor who wasn't meeting the standards  
24 that were expected of him and I think you accepted  
25 towards the end of our discussion that more could have  
26 been done by you, by other people, to address this, to  
27 challenge this, and you, I think, indicated that  
28 Mr. O'Brien was not necessarily an easy person to  
29 challenge.

10:03

10:03

10:03

I want, in the course of this morning, to pose  
a question in terms of why the issues in relation to

1 Mr. O'Brien were not detected or addressed at an  
2 earlier stage. We'll come on and look at whether  
3 appraisal was a useful tool.  
4

5 You took over appraisal duties with regards to 10:04  
6 Mr. O'Brien from 2010, with the introduction of the  
7 appraisal system. But before we get to that, there's  
8 a couple of other issues I wish to explore with you  
9 under this broad heading of why the issues surrounding  
10 Mr. O'Brien didn't get addressed sooner. I wonder 10:04  
11 whether you would agree with me that some early  
12 warnings were ignored.

13  
14 In that respect I want to raise with you the evidence  
15 given to the Inquiry by Mr. Christopher Hagan, who you 10:04  
16 will be aware has given a statement to the Inquiry and  
17 given evidence. I want to take up his witness  
18 statement with you at WIT-98844 and at paragraph 26,  
19 just to recap, he recalls that he was a Urology  
20 Specialist Registrar in the Craigavon Hospital as part 10:05  
21 of his rotation. He was there in the year 2000 and he  
22 goes on, at paragraph 27, to explain that there was  
23 a Thursday morning ward round, that you and Mr. O'Brien  
24 had your own sets of patients. He attended this ward  
25 round. It meant that you and Mr. O'Brien were involved 10:05  
26 with each other's patients, that you would have had  
27 a knowledge of each other's patients and would have  
28 covered for each other at various times.  
29

1 He goes on at paragraph 29 to set out the fact that he  
2 had nine areas of concern in respect of Mr. O'Brien's  
3 practice, which he sets out in his witness statement.  
4 If I could just list those so that you are oriented.

5  
6 He had concerns about IV antibiotic use. He had  
7 concerns about a benign cystectomy performed on  
8 a patient, apparently simply because she had recurrent  
9 UTIs, that's his recollection. He had concerns about

10 the performance of long TURPs, one case going up to 10:06  
11 nearly two hours in the procedure. Concerns about  
12 ureteric stone management and a particular incident  
13 where he perforated a ureter. He had concerns about  
14 paediatric urology, a radical prostatectomy, concerns  
15 about a penile disassembly process, and concerns about 10:07  
16 outpatient practice administrative delay. So a host of  
17 issues set out in his statement.

18  
19 Then, if we just scroll down to paragraph 32, so these  
20 are the list of issues I've just read out. Just 10:07  
21 WIT-98852. He says:

22  
23 "I did raise issues with Mr. O'Brien about his practice  
24 during my time as a surgical trainee. Mr. O'Brien did  
25 not agree with me and was essentially dismissive. 10:08  
26 I did also raise issues with Mr. O'Brien with his  
27 consultant colleague, Mr. Young, during my rotation.  
28 This would have been in an informal manner, and I would  
29 not have recorded them in written form. It would not

1 have occurred to me at the time to do that. It means  
2 that I cannot now say precisely what I raised with  
3 Mr. Young, or how precisely I said it. My recollection  
4 of Mr. Young's response to what I said was 'that's just  
5 Aidan'. Mr. Young did not give me the impression that 10:08  
6 he had any major concerns about the matters I was  
7 raising. I don't know if Mr. Young spoke to  
8 Mr. O'Brien about anything or if Mr. Young spoke to  
9 anyone else about them. I certainly thought at the  
10 time that I was brave in speaking to both the 10:09  
11 consultant himself and to the consultant colleague. "

12  
13 If I can leave that there. So your position, as  
14 I understand it from your addendum statement,  
15 Mr. Young, is while you recall Mr. Hagan's presence at 10:09  
16 Craigavon as part of his rotation, you don't recall him  
17 raising any serious concerns with you?

18 A. This goes back 23 years.

19 2 Q. Of course, yes?

20 A. And it's a bit hard to get a full recollection of 10:09  
21 a precise conversation. I don't recall Mr. Hagan  
22 raising any of these sort of major concerns. I know  
23 that on ward rounds he would be talking about certain  
24 patients and I certainly do remember Mr. Hagan and  
25 Mr. O'Brien having -- well, both had an interest in 10:10  
26 prostate cancer and they would have had conversations  
27 about treatment plans and the way that it is looked  
28 after, but I don't recollect specific points raised by  
29 Mr. Hagan here on these points.

1 3 Q. I just want to show you how you put it in your  
2 statement. If we go to WIT-103605. Conscious that  
3 Mr. Hagan introduces the important caveat that he  
4 cannot specifically recall what he specifically raised  
5 with you, but it's the sense of his evidence that he 10:11  
6 believes that he raised some of these significant  
7 issues with you. You have said there at 1.01:  
8  
9 "There is always the expectation that a registrar, as  
10 part of their training, will inquire about care 10:11  
11 pathways for patients. For instance, I recall  
12 Mr. Hagan would have discussed prostate cancer  
13 management with Mr. O'Brien on ward rounds."  
14  
15 what you have just said a moment or two ago. 10:12  
16  
17 "However, I did not ever interpret this as a concern  
18 and I do not recall Mr. Hagan during his six-month  
19 attachment ever raising any serious issues because  
20 I would have acted upon them." 10:12  
21  
22 We saw yesterday that in terms of the issues that you  
23 were aware of, your actions upon them were, I think you  
24 would agree, fairly minimal and certainly lacking in  
25 any great aggression and they weren't resolved. When 10:12  
26 you say here you would have acted upon them, on what  
27 basis would you have acted upon them? How would you  
28 have acted upon them if, for example, you were aware of  
29 the operation performed on the patient for recurrent

1 UTIs, the removal of her bladder, benign cystectomy.  
2 How would you have acted upon that if you had been  
3 aware of it?

4 A. I would have inquired about why the procedure was  
5 performed in the first place from Mr. O'Brien. I am 10:13  
6 aware of the antibiotics and fluids being used to treat  
7 urinary tract infections, that's a detailed discussion,  
8 but to do a cystectomy purely for an infective reason  
9 is very unusual. I must say, I have had one case  
10 myself that I've undertaken a cystectomy for, but that 10:14  
11 was very detailed. That's one case in 30 years.

12  
13 Now, at this stage I was just a consultant 18 months or  
14 a year, I think, so I was taking on board what was  
15 being undertaken in the unit, but I am unaware of the 10:14  
16 precise nature of the case that you are referring to.  
17 There are patients who have had a cystectomy who do get  
18 urinary tract infections, it is relatively common. So  
19 I was maybe taking it that if this case was in front of  
20 me that this was an ileal conduit patient who was 10:15  
21 having a recurrent urinary tract infection as part of  
22 that history, but I'm not aware of the case that you're  
23 referring to of why she had a cystectomy, I'm afraid.

24  
25 But if you are telling me that it was done for an 10:15  
26 infective perspective, yes, I would have been more  
27 interested in finding out the past history to the case.

28 4 Q. Well, let me put it in these terms. Mr. Hagan at that  
29 time was a trainee. It would have been unusual, would



1 it not, for trainees to be as vocal as he claims to be  
2 in his statement? In other words, he claims to have  
3 raised, both with you and with Mr. O'Brien, a range of  
4 issues of concern. That would be unusual for a junior?

5 A. It would be unusual for a junior. I haven't had any 10:16  
6 other juniors raising such a list of questions.

7 5 Q. Yes. While you don't recall precisely, it being  
8 23 years ago, do you recall Mr. Hagan as being  
9 a particularly interested and perhaps vocal trainee in  
10 terms of raising issues? 10:16

11 A. Mr. Hagan's demeanour of putting a question across,  
12 sometimes you didn't realise if he was asking  
13 a question or making a statement. That's maybe just  
14 a personality thing at the time. I do agree that, as  
15 a registrar, as I was a year or two before that, 10:17  
16 sometimes it is hard to raise things and it takes a bit  
17 of courage to actually challenge something, so I do  
18 agree with that statement.

19 6 Q. Do you also agree that in terms of the descriptions  
20 that he provides, conscious that you don't have access 10:17  
21 to the particulars, you now don't have access to the  
22 particulars of these individual cases, but going on his  
23 descriptions, a TURP taking nearly two hours to perform  
24 before the case is closed, a penile disassembly, an  
25 injury to a ureter in circumstances where the 10:18  
26 protections that you would usually use for stone  
27 fragmentation are not in place, as I say, a benign  
28 cystectomy, are those the kinds of cases that would  
29 qualify as serious concerns, at least on the face of

1           it?

2           A.    Yes, absolutely on the face of it is the question that  
3           you're asking. I was just not aware of him having  
4           those raised. If he has raised them, certainly they  
5           are very concerning. 10:18

6        7    Q.    would you agree with me that, as a matter of  
7           governance, they each require, if they were raised with  
8           you or if you were aware of them, they each require  
9           some form of response, in the first instance, perhaps  
10          drawing Mr. O'Brien's attention to your concern or the 10:19  
11          trainee's concern, and then escalating appropriately if  
12          you are not satisfied with the response you receive?

13          A.    Yes. That's true. A TUR going on for two hours is  
14          a long period of time. A perforated ureter, and  
15          I understand that this needed an open operative 10:19  
16          procedure to correct, is something that you rarely  
17          would want to see.

18        8    Q.    Just thinking about the long TURP issue, because  
19           I think you reflect in your statement that while you  
20           have no specific memory of Mr. Hagan raising that with 10:20  
21           you, if we go to your statement at WIT-98847 -- sorry,  
22           just pause that a moment, I think it's the wrong  
23           reference. Yes, WIT-103608. Here you are talking  
24           about the TUR being a well-recognised entity in  
25           urology. You say that several features are relevant, 10:21  
26           one of which is the duration of resection. But you  
27           say:

28

29           "The critical point, however, is the fluid balance as

1           opposed to the precise time scales."

2  
3           You go on to say it is the aim to finish within the  
4           hour. Just scrolling down. It was in association with  
5           incident, or this matter, that Mr. Hagan believes that 10:21  
6           your response might have been something along the lines  
7           of 'that's just Aidan'.

8  
9           If we scroll down just a little further, you say that  
10          that is a phrase that would have been used by yourself 10:22  
11          and others, in general terms, but it wouldn't have been  
12          a phrase that you would have used when responding to  
13          something like this, a TURP of this duration. So  
14          you're suggesting that if the matter had been raised  
15          with you, you would have taken a more serious tone or 10:22  
16          a more earnest response than that?

17         A.    Yes, as I say, a TUR prostrate for up to two hours is  
18               going to put people at added risk, even with taking all  
19               of the monitoring events of height of fluid and  
20               measuring the ins and outs and risk of bleeding. It's 10:23  
21               not just one feature, it's there are several features  
22               that contribute to hyponatremia and glycemias, one is  
23               the duration of time. Our teaching in urology is that  
24               a TURP is usually done within the hour. There is a  
25               little bit of science behind the hour, but it's not 10:23  
26               a dogma that you have to finish before the hour.  
27               Certainly there's occasions that the patient will have  
28               absorbed fluid well in advance of the hour. So it is  
29               the monitoring of it throughout the whole procedure

1 that is very important. But there is increased risk  
2 observed if it goes on beyond the hour. Now, if  
3 you are going to put an exact clock on it, that's not  
4 wise, because it may take an extra 5 or 10 minutes to  
5 complete the operation, and completing the operation  
6 meaning to stop any bleeding. 10:24

7  
8 Another issue is maybe a surgical technique but it's  
9 all about surface area, so if you can reduce the  
10 surface area that's likely to bleed a little bit extra, 10:24  
11 resection is going to complete the procedure. But  
12 I would use the words "a little extra time", and that's  
13 where we're coming into what you are talking about. So  
14 I do find it unusual. I would say it is not acceptable  
15 to go on for two hours. And I'm not aware -- and 10:24  
16 that's exactly why I said in my statement here, if  
17 somebody came to me and said this operation went on far  
18 too long, I asked, well, was there a complication of  
19 hyponatremia, so that would be a question I would have  
20 asked the registrar. 10:25

21 9 Q. If you are unlikely to have dismissed such a concern as  
22 that's just Aidan', where does that phrase come from?  
23 It is a phrase that, clearly, Mr. Hagan has heard on  
24 his evidence. It is a phrase that you have accepted  
25 that you and others have used. What does the phrase -- 10:25  
26 where does it derive from or what does it convey?

27 A. Well I don't know where it derived from. I know I'm  
28 quoted here as saying it, but I think it has come from  
29 the ward in some capacity. It is not me making that

1 up. But it is conveying that Mr. O'Brien has certain  
2 ways of doing things and that's his plan, that's his  
3 policy, that's the way he looks after certain things  
4 and I think everybody has their own wee sort of foibles  
5 of how they do things. 10:26

6 10 Q. Maybe we shouldn't read too much into that kind of  
7 phrasing, but is it suggestive that in certain  
8 circumstances Mr. O'Brien is acting in an  
9 unconventional manner outwith what would be expected?

10 A. Unconventional, I wouldn't accept that. I think 10:26  
11 there's certain ways people go about doing things.  
12 I think if I had seen something that was  
13 unconventional, then that would be challenged; if  
14 that's fair enough.

15 11 Q. Well, not doing triage is unconventional, would you say 10:27  
16 'that's just Aidan' or would you say that's...

17 A. Well, it's proving to be that way.

18 12 Q. You go on, at 3.6, just that as you say:  
19  
20 "I have no recollection of having discussions around 10:27  
21 this issue with others."  
22

23 But you do recall being generally aware that  
24 Mr. O'Brien had on occasions taken more than one hour  
25 for a TURP. You believe you're aware of this 10:27  
26 informally through theatre tearoom chat?

27 A. Yes.

28 13 Q. Does that suggest that those participating in theatre  
29 with Mr. O'Brien, because you would hardly be in

1 theatre with Mr. O'Brien, are bringing this out as an  
2 unusual feature of his approach? In other words, it  
3 was so significant that it warranted discussion as an  
4 unusual feature in the tea room, is that what you are  
5 putting across there?

10:28

6 A. I'm putting across that if the nurses are talking in  
7 theatre that a procedure has taken a long length of  
8 time or longer than usual, or if a theatre list has run  
9 over because of an excess time attached to a particular  
10 procedure. Yes, so it is a topic that maybe somebody  
11 has brought up and it may be observed that Mr. O'Brien  
12 is performing TURPs for longer than an hour, maybe more  
13 than the other team members.

10:28

14 Q. I would venture to suggest that the Panel are not  
15 particularly interested in the minutiae of these  
16 individual incidents, I would say. What they are  
17 interested in, and no doubt you'll hear from them this  
18 afternoon with some questions, what they are probably  
19 interested in is where you have clinical issues raised  
20 such as this, so that they become part of your  
21 awareness, whether they come through Mr. Hagan or  
22 whether they come through tearoom chat, they're all  
23 pointing in the direction of a problem or a potential  
24 problem, one that needs investigated and potentially  
25 addressed. Did you ever raise excessive time  
26 performing TURPs with Mr. O'Brien?

10:29

10:29

10:30

27 A. No, I don't believe that I have. I mean, if a TURP is  
28 going to go on between 15 minutes and 10 or 15 minutes  
29 over the hour, that's to complete the operative

1 procedure. There is an element of how long is a piece  
2 of string, okay? So the whole issue is, is there  
3 a complication occurring at the end of the day. The  
4 major point about TURP is hyponatremia due to glycine  
5 absorption. That is the crux of the matter. A very 10:31  
6 important part of TURPs surgery is to stop bleeding at  
7 the end of the operation. So some people may operate  
8 more slowly than others and, therefore, it may take  
9 them longer to complete the task. So the issue is  
10 about complication rather than a precise time. But, 10:31  
11 coming full circle to the question that you're asking,  
12 if I had known that a procedure had gone on for two  
13 hours, that is excessive and it needs a conversation to  
14 be had of why. Why, for instance, well a TURP going on  
15 for two hours, obviously the prostate is large. Why do 10:31  
16 you not do a hemiprostatectomy, just do the one lobe,  
17 and come back a second time and do the second. That's  
18 maybe a point of techniques, but it's the risk of  
19 complication I might get back to.

20  
21 But, I mean, I must say, I haven't done a TURP for two  
22 hours. I have done TURPs that go over the hour, but  
23 you're always very wary of the nurse in your ear saying  
24 the time, it is now half an hour, it is now 45 minutes,  
25 it is now an hour, do you not -- it is a live 10:32  
26 interaction with the theatre staff, who are the nurses,  
27 and the anaesthetist at the top end. So it is not just  
28 you working on, there's a live environment to the whole  
29 thing.

1 15 Q. So I think you have helped us as much as you can with  
2 that particular issue and Mr. Hagan's input. The point  
3 remains that -- just to use the TURP as the vehicle for  
4 this governance issue -- the point remains is that you  
5 have become aware, tearoom gossip maybe, but the issue 10:33  
6 has been discussed, assumedly, because people think it  
7 is unusual, and it gets to your ears at an early point,  
8 perhaps an early point in your working relationship  
9 with Mr. O'Brien. You haven't specified the date, but  
10 when you think about it now were there issues coming to 10:33  
11 your attention, even at the level of suspicion, that  
12 you should have been addressing with Mr. O'Brien in  
13 association with his clinical practice?

14 A. Certainly not at this stage. This is the year 2000.  
15 I had just joined the unit. I was building my own 10:34  
16 practice. I was getting to know the arena. I trained  
17 in Belfast, Mr. O'Brien trained in Dublin. It's  
18 a different set-up, people might treat things in  
19 a slightly different way. You have to take it on  
20 board. But, as I say, bringing this to the table about 10:34  
21 the duration of the operation, as much as the focus, is  
22 Mr. O'Brien has a bit of a slow nature. He does  
23 everything slowly, so it is going to take him slightly  
24 longer. But, coming full circle is was I observing  
25 a higher incidence of hyponatremia due to glycine 10:35  
26 absorption, at this stage no. We, the same as any  
27 unit, it has cases of this, but we weren't having  
28 excessive numbers of cases with hyponatremia being  
29 focused on one particular surgeon. And that continues



1 for the next ten years that we're talking about.

2 16 Q. I think you would accept that the longer the TURP  
3 procedure goes on, the greater the risk of  
4 hyponatremia? It is one factor that should be  
5 controlled in order to reduce the risk. Sometimes, as 10:35  
6 you say, it is not possible to conclude within the  
7 hour, shouldn't be dogmatic about that, but it is  
8 a risk factor and in Mr. O'Brien's practice it appears  
9 to have been a factor that people were talking about?

10 A. Yes, I agree with that. Beyond the hour increases risk 10:36  
11 of complication and, yes, here we have this. But the  
12 question is did the complication occur? It increases  
13 the risk of it but the important point is did it happen  
14 and was the length of the operation due to a safety  
15 issue of, for instance, was the patient bleeding. But, 10:36  
16 yes, I agree, it is a wee bit of an alarm bell to say  
17 here is somebody that keeps on operating beyond the  
18 hour.

19 17 Q. If it's an alarm bell, I suppose the question arises  
20 from a governance perspective, what is the clinical 10:36  
21 lead doing about it?

22 A. Well, it's observing if there was a complication.  
23 Again, it comes back to how long is a piece of string?  
24 An operation starts and finishes. You know, you have  
25 to get all the joined up writing in the middle of that. 10:37  
26 I'm not entirely sure my responsibility of what you're  
27 saying here. I mean, this is a team approach. There's  
28 the recovery staff, there's the admissions to intensive  
29 care, there's the anaesthetic service. It is all very

1 live and observing. Are cases like this brought to the  
2 Patient Safety Meeting, you know, if there was  
3 a complication as such. So I understand what you're  
4 saying. There could be a conversation held: Yes,  
5 Mr. O'Brien, why are you being observed to be operating 10:38  
6 for more than an hour? An answer could be: I was  
7 completing the operation, you know, and I haven't had  
8 any problems. So I'm not certain if, you know, this  
9 was one point and, as you're saying, you're adding up  
10 all the points together and trying to put the jigsaw 10:38  
11 together, I understand that.

12 18 Q. Mr. Hagan drew the Inquiry's attention to the use of IV  
13 antibiotics and fluids with particular patients. If  
14 we just pull up his statement in that respect,  
15 WIT-98845. Just scroll down to 31. This is the first 10:39  
16 of the concerns he set out:

17  
18 "There was a group of patients that seemed to me to be  
19 being regularly admitted to the ward for antibiotics  
20 and IV fluids by Mr. O'Brien. My recollection is that 10:39  
21 these patients would make contact with Mr. O'Brien in  
22 some way and be admitted directly to the ward as an  
23 in-patient for treatment. When I asked about this  
24 practice, the ward nurses referred to this treatment as  
25 "Mr. O'Brien's regime". I would do an unaccompanied 10:39  
26 ward round every morning during my six months rotation  
27 when I would come across these patients. It was often  
28 not clear to me the reason for this approach or the  
29 evidence base for the treatment. I considered patients

1 who fell into this category could have been managed as  
2 outpatients as they could eat and drink. I did not  
3 encounter this approach in any other urological unit  
4 I worked in before or since."

10:40

6 It's fair to say that some of the issues that Mr. Hagan  
7 has highlighted have been described by him as not  
8 necessarily crystallising when he was at the Craigavon  
9 Area Hospital, they may have occurred to him later,  
10 perhaps with experience and reflection. This is one  
11 issue that he took away with him. He's not suggesting  
12 that he raised it with you. Were you aware that this  
13 was Mr. O'Brien's regime, as he has described it?

10:40

14 A. Yes, I recognise that. Mr. O'Brien would have admitted  
15 patients who had had a history of urinary tract  
16 infection and this was a method of trying to control  
17 the situation. This was Mr. O'Brien's regime of  
18 looking after the condition.

10:41

19 Q. Yes. This is a trainee who, as I say, it might have  
20 been a later crystallisation of a concern, leave the  
21 timing to one side, he is describing it as a concern.  
22 Was it a concern that you as a more experienced,  
23 obviously qualified consultant, had?

10:41

24 A. I also later partook in the principle of IV fluids and  
25 antibiotics. This was further down the line in my  
26 career. The treatment pathway of people with urinary  
27 tract infections is very common from a urology  
28 perspective, predominantly looked after by the GPs.  
29 There are a small percentage will come our way for more

10:42

1 complex discussion with the patient in how to treat  
2 them and then there will be those patients that our  
3 outpatient consultations and advice aren't working  
4 fully. Then you are getting people coming in with  
5 sepsis, people coming to our clinics that aren't 10:43  
6 sensitive to the oral antibiotics and only sensitive to  
7 the intravenous ones. Then there's a group that will  
8 be responding to the oral antibiotics, will have been  
9 on prophylactic antibiotics, and when the treatment  
10 stops, the infections come back fairly promptly. 10:43

11 20 Q. Forgive me, Mr. Young, I asked you whether you had  
12 a concern about the approach in the way that Mr. Hagan  
13 did?

14 A. Okay. Right, Mr. O'Brien has obviously been in post  
15 considerably longer than I had and I think would have 10:44  
16 collected more patients than I had; I had only been  
17 there a short period of time. So he was entering into  
18 a plan of action for admitting people for fluids and  
19 antibiotics. Now, you would have to ask Mr. O'Brien  
20 his approach to why he did that but there's a small 10:44  
21 select set of patients that are needing a special  
22 approach to. But, again, it is very much on an  
23 individual basis and you would have to ask Mr. O'Brien  
24 about his approach to those individual ones. But I can  
25 comment that I've also had patients that I've admitted 10:44  
26 for antibiotics, but this was further down in my  
27 career.

28 21 Q. Forgive me again, Mr. Young. A very straightforward  
29 question: In the year 2000 Mr. Hagan observed this.

1 His concern about it may have crystallised somewhat  
2 later, we don't know. In 2000, did you have a concern,  
3 did you have any concern about the practice at in point  
4 before The Trust raised it in 2009?

5 A. In 2000 I wouldn't have, myself, partaken in that 10:45  
6 approach to treating patients, so I would agree with  
7 Mr. Hagan that it was maybe not standard practice in  
8 the way of treating a patient with such a condition.

9 22 Q. And it not being a standard practice, you being aware 10:46  
10 that it's happening on the ward, you do a joint ward  
11 round with Mr. O'Brien on a Thursday, you're aware of  
12 each other's patients. Is it something you raised with  
13 him, discussed with him, got to understand?

14 A. We would have discussed it on the ward round, about 10:46  
15 patients having the treatment but it's a two-way  
16 conversation. He had felt this was a way of looking  
17 after patients with such infections. I agree, I hadn't  
18 used that policy in my training in Belfast, it was  
19 different. But he was trying to approach a clinical  
20 situation. I don't know if Mr. O'Brien had used this 10:47  
21 in his training in Dublin, for instance. But it was  
22 a clinical approach to looking after a condition and  
23 I was observing if it was working or not. But,  
24 I agree, it's not the standard practice, and I agree  
25 with Mr. Hagan making comments on that. So, yes, I do 10:47  
26 agree with what I was trying to explain earlier, but --

27 23 Q. But you didn't so it was a different, unconventional  
28 might be an appropriate word. You didn't challenge it?

29 A. I would have challenged it on the ward rounds about

1 asking about why you're taking this approach. But  
2 there's a conversation coming back and whether you  
3 accept that or not, that's a clinical decision.

4 24 Q. You've gone on to say in your answer a moment or two  
5 that you went on to develop a practice of bringing 10:48  
6 patients in for IV antibiotic management. I'm  
7 interested to know whether there's a distinction  
8 between your approach and that of Mr. O'Brien. Before  
9 I come to that question, let me just bring up on the  
10 screen your statement in this respect. WIT-51814, and 10:48  
11 at paragraph 63.1 you're saying:

12  
13 "My first awareness that The Trust had issues of  
14 concern regarding Mr. O'Brien was in 2009."

15 10:49  
16 I just park that for a moment. We saw yesterday that  
17 you were aware of concerns around triage in 2008,  
18 I think Mrs. Cunningham's email was fed up to you. But  
19 this you are describing was your first awareness that  
20 The Trust had concerns with Mr. O'Brien. 2009, he is 10:49  
21 admitting patients who had a chronic history of urinary  
22 tract infections on an elective basis for IV  
23 antibiotics and fluids. You say:

24  
25 "It should be noted that I also admitted patients for 10:49  
26 intravenous antibiotics but they either had infections  
27 present or were symptomatic. The Medical Director at  
28 the time, Dr. Loughran, commissioned an external review  
29 of this practice. This resulted in the elective

1 admission of these patients stopping, with a new Trust  
2 pathway being put in place."

3  
4 You're differentiating your practice from Mr. O'Brien's  
5 practice in this respect. What is the distinction that 10:50  
6 you're highlighting here?

7 A. Mr. O'Brien would have electively admitted patients for  
8 the fluids and antibiotics. My approach was for  
9 patients that weren't -- that had an infection, that  
10 had been through the use of prophylactic antibiotics 10:50  
11 where they had been stopped and the patient had  
12 developed a urinary tract infection again and again and  
13 again, and the use of oral antibiotics weren't working  
14 properly to treat their infection, I would have  
15 admitted them for intravenous gentamicin. Now, the 10:51  
16 other aspect of that is patients may -- there are  
17 several patients have commented on 'I've been on oral  
18 antibiotics for a long time here but when I get the  
19 intravenous antibiotics, it lasts six months'; they are  
20 getting a good amount of time out of the use of the 10:51  
21 intravenous approach to it.

22  
23 The other -- although I did have a planned admission  
24 for some people, I did try to target their time of  
25 admission to be similar to when they were recording 10:51  
26 that their infections were coming back. So if somebody  
27 noted that they had been on a course of antibiotics for  
28 three months -- sorry, and got three months out of it,  
29 then I would be trying to pinpoint their admission to

1 actually be at the three-month spell. So I was using  
2 it to try to target patients when they were having  
3 their recurrent infections, and to give them a proper  
4 dose of an antibiotic.

5 25 Q. So is it your suggestion that Mr. O'Brien was admitting 10:52  
6 patients who did not have evidence of urinary infection  
7 and symptoms, whereas your approach was focused on  
8 patients who either had infection present, who were  
9 symptomatic or, taking your three-month approach who  
10 were likely to be symptomatic around that point in 10:53  
11 time?

12 A. Yes. I was trying to target the therapy to be of the  
13 right antibiotic to treat it for the right length of  
14 time, and I was very focused on the patients who were  
15 symptomatic. 10:53  
16

17 There are some patients actually, although there was  
18 two patients I know of that, although I was planning  
19 a date to come in, they had attended casualty and one  
20 lady had come in on that planned three months, for 10:53  
21 instance, and she was well when she came in but got  
22 septic on the award, for instance, so I did have it  
23 timed right. But it's getting the right antibiotic.

24 26 Q. Just to be clear, are you saying Mr. O'Brien's 10:54  
25 patients, in your experience did not have evidence of  
26 the presence of infection or had not developed symptoms  
27 of emerging infection whereas, by contrast, yours did?

28 A. Sorry, I was answering for myself there. Certainly my  
29 observation of Mr. O'Brien's patients is that they were



1 more often admitted electively without a proven  
2 infection. Some may still have had a urine culture  
3 done that had been positive but it's the symptomatic  
4 nature. So that was my observation, that his set of  
5 patients were more likely to be elective.

10:54

6 27 Q. So you were, for a period of some years, aware of  
7 Mr. O'Brien admitting patients electively without --  
8 and commencing the treatment without proof of  
9 infection?

10 A. Yes, our unit did a paper on this and it did show that  
11 this plan of action did reduce the number of acute  
12 admissions to the ward. So there was some science  
13 behind it but it probably could have been at a higher  
14 level.

10:55

15 CHAIR: Sorry to interrupt, Mr. Wolfe. Forgive me,  
16 Mr. Young, I'm trying to get this clear in my head.  
17 I'm not entirely clear what you mean by Mr. O'Brien  
18 admitting patients electively and how that differed  
19 from what you were doing by scheduling an admission in  
20 three months' time. So can you please explain, just  
21 for my understanding, the difference?

10:56

22 A. I was observing that patients had a time frame between  
23 having a treatment and then coming --

24 CHAIR: Needing it again?

25 A. -- and then when they would have had an infection again  
26 and I was trying to plan that. And sometimes that  
27 planning, the patient was ahead of me and would be  
28 admitted via casualty. So I was trying to focus more  
29 on the patients that were going to get an infection, a

10:56

1 symptomatic infection.  
2 CHAIR: Forgive me, is that not what Mr. O'Brien was  
3 doing too? These were people with recurrent infections  
4 who -- I'm just trying to see where the difference is.

5 A. Okay. So I was trying to focus on patients who had 10:57  
6 symptoms at a certain period of time and try to get in  
7 ahead of the game. I think the approach that  
8 Mr. O'Brien was he was electively admitting people to  
9 have IV fluids and antibiotics to then reduce their  
10 risk of subsequently having an infection. It was an 10:57  
11 elective admission every three or four months that  
12 he would have brought them in, whether they had  
13 symptoms or a urine culture that was positive.

14 CHAIR: But surely you were doing the same thing in  
15 that you were saying come back in three months and 10:57  
16 we'll give you another dose of this antibiotic.  
17 Assuming you -- I mean, you're saying that you had  
18 focused on what you thought was the right time period,  
19 but I'm just -- you got lucky, if you like, that they  
20 were symptomatic when they came in. They may not have 10:58  
21 been, would you have still given them the antibiotic  
22 when they came in?

23 A. No, if they weren't symptomatic. I did have a few  
24 patients that I had seen a pattern and I brought them  
25 back for their fluids, I mean it's only two or three 10:58  
26 out of the whole group. My approach to this was that  
27 it was the intravenous antibiotics, it's the strength  
28 of the antibiotic that is the crux to the matter.  
29 I say that, I have three or four of the ladies who said

1 that they had been on oral antibiotics and, yes, it  
2 worked, but it didn't work for long enough and whenever  
3 they stopped the antibiotic, their urinary tract  
4 infection was coming back at a much earlier, quick  
5 stage. whereas if they had had -- when they had the 10:59  
6 intravenous antibiotics of gentamicin, they said I've  
7 had a good six months here. That is quite good.  
8 CHAIR: I get that. I get what you were trying to do  
9 and why you were trying to do it. But I'm just still  
10 confused as to what Mr. O'Brien was doing that was 10:59  
11 different from what you were doing?  
12 A. I was maybe waiting for the patient to be sort of  
13 phoning up to say 'I'm getting into trouble here'.  
14 whereas the elective admission is you're well and you  
15 just come back in three months' time to have 10:59  
16 a treatment, to try to stave off the potential.  
17 28 Q. So Mr. O'Brien was scheduling them to come back in  
18 three months' time but you were waiting until you got  
19 a phone call to say, 'yes, it's back again, and I have  
20 to come in'? 11:00  
21 A. In the vast majority of cases. I do accept I've had  
22 cases where I have brought them back. There's  
23 a specific lady that I have in mind. In fact we had  
24 a case conference on her with the microbiologist and  
25 the nephrologist and she was actually put on permanent 11:00  
26 prophylactic antibiotics on a cyclical basis. So it  
27 was a very targeted treatment plan for an individual  
28 lady with a urinary tract infection.  
29 CHAIR: I'm sure we'll hear from Mr. O'Brien in due

1 course.

2 A. Yes.

3 CHAIR: There may be less of a distinction than I'm  
4 seeing, I think. But we'll move on, perhaps,  
5 Mr. Wolfe. 11:01

6 29 Q. MR. WOLFE KC: Let's bear in mind that the reason we're  
7 even looking at this issue is through the lens of  
8 trying to work out, you wearing your clinical lead hat  
9 and others who might or should have been aware of an  
10 issue such as this, whether you might be said to be 11:01  
11 guilty of ignoring an early warning that Mr. O'Brien  
12 was practising in a way that was unconventional, that  
13 should have been challenged, just like a collection of  
14 other issues that we have looked at and are to look at.  
15 That's why we're in this field. 11:01

16  
17 You have explained to us that the first time you were  
18 aware of The Trust being concerned about Mr. O'Brien's  
19 practice was this issue, 2009.

20 A. Yes. 11:02

21 30 Q. You were aware of this issue for some time and, while  
22 you had discussions about it, didn't challenge it. As  
23 you've explained to the Chair just now, you would argue  
24 that there was a distinction, perhaps a fine  
25 distinction between your approach and Mr. O'Brien's 11:02  
26 approach.

27  
28 Can you help us to understand before we move forward  
29 why you didn't, in essence, challenge and perhaps

1 escalate what was an unconventional medicine on  
2 Mr. O'Brien's part?

3 A. I can't answer that question fully. I do know that our  
4 Medical Director, Dr. Loughran, got involved in this  
5 and had taken advice outside of The Trust. 11:03

6 Dr. Loughran and I had a meeting about all of this. He  
7 told me what the plan of action was going to be and it  
8 was to involve the microbiologist, and I was in full  
9 agreement with that because I said to him: If we're  
10 going to stop this practice, can you at least allow me 11:03  
11 to speak to the microbiologist to plan a care pathway.  
12 Actually, out of this we got our ambulatory ward unit  
13 which had -- part and parcel of it was the provision of  
14 the IV antibiotics with a care pathway that involved  
15 the microbiologist being involved. I was in full 11:04  
16 agreement with that and followed that pathway.

17 31 Q. Let's just look at some of the contemporaneous  
18 documents to tease this through.

19  
20 The issue arose in 2009. You've explained that 11:04  
21 a protocol or a care pathway was developed. The Trust  
22 sought some external advice which Mr. Mark Fordham  
23 provided. But we will look at all of that, and  
24 thinking about two questions, first of all whether the  
25 Trust differentiated between your practice and that of 11:04  
26 Mr. O'Brien's. And, secondly, perhaps more  
27 importantly, in terms of the Inquiry's enterprise is  
28 whether Mr. O'Brien or indeed yourself complied  
29 initially or at all with the new protocol and the new

1 pathway that was introduced. So with those thoughts in  
2 mind let us start with WIT-11850.

3  
4 1st December 2009, the issue has already been discussed  
5 with you and Mr. O'Brien. Here you have a meeting of 11:05  
6 senior managers, including Acting Chief Executive and  
7 Medical Director. If we scroll down, we can see this  
8 issue is the subject under "quality and safety". It is  
9 described as a key issue:

10 11:05  
11 "The Evidence base for the current practice of IV  
12 antibiotics for up to seven days repeated regularly  
13 requires urgent validation. There's a current cohort  
14 of 38 patients even though this clinical practice  
15 appeared to change after commitment given to 11:06  
16 Dr. Loughran at the end of July 2009."

17  
18 That's alluding to the fact that both yourself and  
19 Mr. O'Brien had met with Dr. Loughran in the summer and  
20 apparently a commitment had been given to stop the 11:06  
21 practice of bringing patients in. Do you recall giving  
22 that commitment?

23 A. I do, yes.

24 32 Q. The point being that there's still a cohort of 38  
25 patients, some of which, the majority of which were 11:06  
26 Mr. O'Brien's, some of which were yours, is that right?

27 A. Yes. I've seen the list that you have provided. There  
28 was maybe six or seven cases of mine and I can account  
29 for their pathway. They were the patients that were

1 having continued urinary tract infections and had been  
2 admitted, for instance, via A&E. So, yes, and I did  
3 have a consultation face to face with Dr. Loughran  
4 about this. My approach, as I've said there, was as  
5 long as I can get speaking to the microbiologist for  
6 firm advice, I'm perfectly willing to comply as you  
7 point out.

11:07

8 33 Q. I am anxious to move through these issues fairly  
9 quickly. Dr. Loughran was going to have a discussion  
10 with Mr. Fordham to get urgent professional opinion on  
11 the appropriateness and safety of the current practice.

11:07

12  
13 Then if we go down to TRU-251041. This is a short  
14 note. I suppose a couple of key aspects in it, that:

15  
16 "The current regimes do not have a scientific  
17 evidence-base and, number six, there is no need to  
18 treat patients who are able to drink normally with IV  
19 fluids."

11:08

20  
21 I suppose from The Trust perspective this is viewed as  
22 supportive of their view that before you would engage  
23 in intravenous antibiotics with this cadre of patients,  
24 you would have to or you should run it through  
25 microbiological opinion before commencement.

11:08

11:09

26  
27 I want to take you to then apparent deviation from what  
28 had been agreed. Maybe I have your answer to that  
29 already but I just want to check it. If we go to

1 TRU-259410. This is Martina Corrigan writing to  
2 Dr. Rankin. It's the summer of the following year.  
3 It's a year since this issue was raised with you. And  
4 she is saying:

5  
6 "See attached the update on IV fluids and antibiotic  
7 recent admissions. I checked with Shirley if any of  
8 these had involvement from bacteriology and she has  
9 advised that these are the routine elective patients  
10 who are admitted and treated prophylactically,  
11 irrespective of positive or negative culture results.  
12 To my knowledge the consultants have not discussed any  
13 of them with Dr. Damani's team."

14  
15 And that's the microbiologist. Just scrolling down,  
16 we can see that there's a list of patients behind this.  
17 The first list is Mr. O'Brien's. Scrolling on down,  
18 the second list, a shorter list, is yours.

19  
20 Is it the case that, notwithstanding the imposition of  
21 a protocol which was to involve microbiology advice,  
22 that there was still a residual reluctance to comply?

23 A. As I say, here's my list. If it wasn't myself phoning  
24 the microbiologist, it was one of the juniors under my  
25 instruction. The first patient, it is the second on  
26 the list there, was a frequent admission with  
27 infection. He had tried his antibiotics at home, would  
28 come to casualty and would be admitted to the ward for  
29 treatment. On these occasions he came to the



1 ambulatory centre with a positive urine. I remember  
2 very well phoning the microbiologist myself about him.

3  
4 The second lady -- sorry, third down, is a lady that  
5 I referred to that ended up with case conference and 11:12  
6 being on the antibiotics for prophylaxis for a year as  
7 a treatment plan and she would still be admitted with  
8 infection from a symptomatic point of view.

9  
10 Five down is a lady, very complex history. Yes, has 11:12  
11 had IV fluids and antibiotics. This lady was admitted  
12 with sepsis. This is the lady that I referred to that  
13 I've done a cystectomy on for infection. Very complex.

14 34 Q. Is it the case -- I'm not sure we need -- I think your  
15 broad answer is the continuation of antibiotics, 11:13  
16 recommencement of antibiotics in these cases is  
17 justifiable. 2nd September of that year, TRU-281845,  
18 this is Dr. Rankin writing to Dr. Loughran. If we just  
19 scroll down to the bottom of this page, she says it is  
20 of concern to her that the agreement -- basically the 11:13  
21 pathway or the protocol as set out above --

22  
23 "...has not been followed by Mr. Young and Mr. O'Brien,  
24 in particular I understand that there are seven  
25 patients remaining on the IV treatment and two or 11:14  
26 possibly three have permanent intravenous access."

27  
28 So the Trust has taken the view that the agreement  
29 wasn't being followed in one shape or form. That's not

1 something you agree with?

2 A. I've gone through my list there. I can account for why  
3 these patients were sick. They were symptomatic  
4 patients.

5 35 Q. And -- 11:14

6 A. And to take the approach -- sorry for cutting across  
7 you -- taking the approach that all urinary tract  
8 infections can be treated by taking an oral antibiotic,  
9 I mean it's the vast majority but there are some  
10 selected cases that do need some strong antibiotics. 11:14  
11 So it's a targeted individual treatment but I can  
12 account for my patients.

13 36 Q. But were you following the process is the question?

14 A. Yes. Yes, they had positive cultures and the  
15 microbiology team were involved. A lot of them would 11:15  
16 have gone through Shirley Tedford in the ambulatory  
17 centre, and part of the process was to have urine  
18 cultures done and the microbiologist spoken to. I'm  
19 accounting for my patients.

20 37 Q. Just to be clear, it would appear that The Trust hasn't 11:16  
21 differentiated between your practice and Mr. O'Brien's  
22 in terms of their approach to you through this  
23 correspondence?

24 A. It would appear to be that way. Well, I'm reading this  
25 here as well. 11:16

26 38 Q. Yes and subsequently, you, with Mr. -- you put your  
27 name to an article published in the Journal  
28 of Infection signed by yourself, Mr. O'Brien and  
29 Mr. Koo, which I suppose was the same hymn sheet

1 endorsing antibiotic approaches in the field of  
2 recurrent IBTs?

3 A. Yes, we had written the paper on this. It was mainly  
4 led by Mr. O'Brien and Mr. Koo, but they had been using  
5 my patients as well. 11:17

6 39 Q. Yes. I am just conscious of the distinction you drew  
7 earlier. Do you agree that's a fine line distinction  
8 in terms of your approach compared with Mr. O'Brien's?

9 A. I wouldn't say a fine line. I would say I focused on  
10 the more symptomatic patients at the time and getting 11:17  
11 a better response with intravenous antibiotics than  
12 ploughing on with oral antibiotics.

13 40 Q. Was Mr. Akhtar also a participant in the approach that  
14 you and Mr. O'Brien were adopting, allowing you the  
15 distinction you draw? 11:18

16 A. Mr. Akhtar joined the unit in 2007. Again, it may take  
17 a period of time to build up a practice of such, but  
18 I wasn't aware of Mr. Akhtar being a major contributor  
19 to the numbers. He may have used the ambulatory unit,  
20 but I'm not aware of his major activity in that arena. 11:18

21 41 Q. In terms of your compliance you've said,  
22 notwithstanding what The Trust may be pointing out  
23 here, that you considered that any patient moving  
24 forward from 2009/2010 was treated in accordance with  
25 the protocol that was adopted so you were in compliance 11:19  
26 and you had no difficulty complying, Mr. O'Brien,  
27 I just want to ask you about his approach. If we go to  
28 TRU-281944. This is Mr. Mackle writing in June 2011  
29 and he is saying:

1 "I am seriously concerned that you don't seem to recall  
2 our conversation at a meeting last Thursday. At that  
3 meeting I informed you that if you wanted to admit  
4 a patient for pre-op antibiotics or for IV fluids and  
5 antibiotics, that a meeting had to be held with 11:19  
6 Sam Sloan and a microbiologist and that this was  
7 a pre-requisite, non-negotiable. You have also been  
8 given this in writing following a previous meeting with  
9 Dr. Rankin and myself. I now find that you initially  
10 planned to admit a patient this week without having 11:20  
11 discussion with anyone and then, when challenged, you  
12 spoke to Dr. Rajesh Ranjudran."

13  
14 2012, TRU-259904. Mr. Mackle, 30th January 2012  
15 writing to Sam Hall copying Mr. O'Brien in: 11:20  
16

17 "I have been advised that a patient may have been  
18 admitted last week to urology by Mr. O'Brien and under  
19 his instruction was given IV antibiotics, the latter  
20 necessitating a central line to be inserted. I have 11:20  
21 checked with Dr. Ranjudran and he advises me that no  
22 discussion took place prior to the administration of  
23 antibiotics."

24  
25 2013, if we could bring up TRU-276833. Just scrolling 11:21  
26 down, Dr. Tracey Boyce is writing to Heather Trouton:

27  
28 "Mr. O'Brien seems to have another patient on  
29 gentamicin this month with no evidence of infection.

1 I am sure Anne has the patient's details if you want to  
2 look at their reason for admission further."

3  
4 Then in, I think it's 2016, if we go to Mr. Suresh's  
5 statement at WIT-50361, and at 47.12 he says:

11:21

6  
7 "On the clinical aspects there were some discrepancies  
8 in the practice of individuals in terms of choice and  
9 usage of antibiotics. For example, Mr. Aidan O'Brien  
10 admitted a patient for administration of intravenous  
11 antibiotic just based on the symptoms. I do not recall  
12 the exact date or month. I directly discussed with him  
13 during the joint ward rounds about seeking the advice  
14 of microbiologist. He paid attention to my suggestion  
15 and acted accordingly."

11:22

11:22

16  
17 A number of contributors suggesting that,  
18 notwithstanding the discussions held in 2009, 2010, the  
19 introduction of a protocol and pathway, Mr. O'Brien  
20 continued to be noncompliant. I'm not terribly  
21 interested in whether there were vast numbers of these  
22 or whether these were isolated cases, but what I want  
23 to understand from you is, given that both of you were  
24 being brought into, if you like, the room to have these  
25 matters discussed and worked through with senior  
26 managers, that must have necessitated conversations  
27 between you and him about the approach of management?

11:22

11:23

28 A. The meeting with Dr. Loughran was fairly clear-cut. It  
29 was understood by me, I thought it was understood by

1 Mr. O'Brien what he was saying. It was a very  
2 appropriate way of helping us deal with a problem,  
3 offering us a unit, a protocol, to actually follow,  
4 which I did, as I pointed out. And my practice of this  
5 had fallen off. I had very selected patients brought 11:24  
6 in. Further treatments that we have is the  
7 intravesical treatments that were now available. That  
8 has made a big difference to our care pathway of  
9 urinary tract infections. But, as I say, when needed  
10 we had to phone Sam Sloan and a microbiologist to do 11:24  
11 the same. It was fairly clear-cut. It wasn't  
12 high-powered to know that that's what you had to do.  
13 I remember doing that on a few occasions and getting it  
14 sanctioned for my patients. I can't account for these  
15 other ongoing ones for some years. 11:25

16 42 Q. Again, you're the clinical lead, this is happening,  
17 more than once Mr. O'Brien is, on the face of this  
18 evidence, not compliant with the protocol. Has he  
19 discussed that with you at all? Has he discussed his  
20 preparedness to comply? 11:25

21 A. Yes. You are pointing at me knowing that this was  
22 going on. No, Mr. O'Brien wasn't telling me that he  
23 was continuing to admit people and not speaking to the  
24 microbiologist and not speaking to -- so that  
25 conversation has not been had with me. I don't know if 11:25  
26 I was meant to be going and trying to source out that  
27 information. I mean I -- I mean that's -- to try to  
28 keep a check on all that's going on in the department  
29 is very hard for me to do.

1 43 Q. Yes?  
2 A. Number one, I myself have a busy practice from  
3 a general perspective. I ran the stone treatment  
4 centre, I was the lead clinician. Am I meant to know  
5 all the finer points going on unless told? I am busy. 11:26  
6 It is hard to know about all the things going on. So  
7 it does take people to come and tell me, and  
8 Mr. O'Brien didn't come to tell me that he was  
9 continuing to admit people, if that's what you're  
10 asking. 11:26  
11 44 Q. So for you to know you would either have to be told,  
12 and clearly there's a team on the ward, there's access  
13 to patient notes and a network through which people  
14 could report to you, or indeed report to others. And  
15 I suppose there might be an argument for saying that, 11:27  
16 given the views that might have been expressed to  
17 management about the benefits, as Mr. O'Brien perceived  
18 them, of this form of treatment, that his compliance  
19 with the protocol should have been the subject of some  
20 checking or audit by others. Is that a reasonable 11:27  
21 point to make in governance terms?  
22 A. That's a very reasonable point to make on terms, yes.  
23 MR. WOLFE KC: It is 11.30.  
24 CHAIR: I think we'll come back at quarter to 12.  
25 11:44  
26 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:  
27  
28 45 Q. MR. WOLFE KC: I want for the next hour or so to look  
29 at the whole area of appraisal. You'll recall from

1 what I said this morning, we are considering these  
2 issues under the broad theme of why the issues, of  
3 which we're now so familiar, concerning Mr. O'Brien's  
4 practice didn't get addressed much before 2017. This  
5 morning we've looked at some early warnings, 11:45  
6 Mr. Hagan's evidence, the IV issue. Now we are going  
7 to look at appraisal, and I suppose the focus of my  
8 questioning is whether appraisal was an effective tool  
9 or an ineffective tool. Was it a sufficiently focused  
10 tool at identifying concerns around doctors? 11:45  
11

12 You told us in your statement, Mr. Young, that you  
13 undertook various appraisals for Mr. Akhtar,  
14 Mr. Glackin, Mr. Brown, Mr. Suresh, Mr. O'Donoghue, and  
15 for the years 2010 through to 2015 you conducted four 11:46  
16 appraisals for Mr. O'Brien; isn't that right?

17 A. Correct.

18 46 Q. We've had various perspectives, notably from  
19 Dr. Simpson, who came into the Medical Director's role  
20 and drove appraisal in its early years. He was 11:46  
21 explaining to us that appraisal wasn't designed,  
22 although he had his views about it, it wasn't designed  
23 as a performance management tool. It was, to use his  
24 words, a formative tool. It was designed to help  
25 doctors put their best foot forward, it was about 11:46  
26 personal development. Still and all, if there were  
27 issues of concern about a doctor's practice, they could  
28 be discussed during appraisal; isn't that right?

29 A. It is a forum for discussion, yes.



1 47 Q. You said on the last occasion that the quality of  
2 appraisal is only as good as the information that is  
3 supplied to you?

4 A. Yes, I said that, yes.

5 48 Q. When you think back over the five years during which 11:47  
6 you appraised Mr. O'Brien and you consider the issues  
7 that developed, that were investigated, and led  
8 ultimately to this Inquiry, do you think appraisal as  
9 a tool could have been used by you in any other way,  
10 any better way, to have targeted, addressed, sought to 11:48  
11 remedy some of the issues with which we're concerned?

12 A. Indeed. On reflection, obviously, yes, the issue of  
13 triage could have been brought up at the consultation  
14 more than is enclosed in the document. But, as I say,  
15 it is as good as the information that is being 11:48  
16 supplied. I do appreciate that appraisal has moved on  
17 in its arena and the way it is conducted now. Back  
18 when I did my original appraisal training in 2009,  
19 2010, it was all about engaging with the appraisee,  
20 trying to encourage an open forum and for the appraisee 11:49  
21 to showcase what they had to do and offer from  
22 a performance perspective. I know you used the word  
23 "performance" there, but it was for them to show that  
24 they were up to date with their plan of action, their  
25 education, that they were meeting standards, being part 11:49  
26 of the team, these sorts of things. But not --  
27 I understand that appraisal has moved on and is more  
28 interrogating, if you want to use that word, now than  
29 when I was involved in it originally.

1 49 Q. We'll see as we move through some of the years that,  
2 I think it's fair to say, and maybe you would agree  
3 with me, that the issues around triage, around keeping  
4 notes at home, around the delays in dictating and  
5 issuing correspondence, are nowhere addressed with  
6 Mr. O'Brien, at least in writing. Unless I missed  
7 something. Is that something you would agree with?

11:50

8 A. I would agree with that.

9 50 Q. Yes. I'm going, in a moment, just to take you through  
10 some of the years. I'm going to use this exercise in  
11 order to bring in other issues with which the Inquiry  
12 is familiar which occurred during some of those years  
13 which, again, don't feature in discussions. I'm going  
14 to be asking you, just to give you a heads up, whether,  
15 if you were aware of these issues, should they have  
16 been discussed. It will also be an opportunity to ask  
17 your views, for example, on the issue of actioning  
18 results, say, from investigations and that kind of  
19 thing.

11:50

11:51

20  
21 Just in terms of what you said there, that there's been  
22 changes in how appraisal is done, it's perhaps more  
23 interrogating, to use your word, which I take to mean  
24 is the style of appraisal now can allow for, or maybe  
25 requires greater focus on shortcomings and teasing  
26 those out, maybe, with questioning, appraiser to  
27 appraisee, and working up solutions perhaps. Is that  
28 your understanding of how it now works?

11:51

11:51

29 A. That is my understanding of how it now works.

1 I haven't done appraisal for, appraiser for  
2 a considerable number of years.

3 51 Q. Looking, just to pick one example from 2015 I think it  
4 was. If we go to TRU-251319. At the heart of the  
5 appraisal process, when you did it was the development 11:52  
6 of a personal development plan. That allowed doctors  
7 to set targets, and you've described these as generally  
8 educational or to address a specific project as opposed  
9 to target clinical driven output. So there's an  
10 example of a personal development plan for 2015. This 11:53  
11 has been signed off in December 2016, a few days before  
12 the MHPS investigation is launched.

13  
14 I'm conscious that the appraisal process worked, at  
15 least at that time, worked in arrears. You're signing 11:53  
16 off in 2016 but looking back at what happened during  
17 the calendar year 2015; is that right?

18 A. Mr. O'Brien's appraisals were always slow in coming  
19 through. They were very delayed in comparison to  
20 everybody else's. I think if you look at the dates of 11:53  
21 all the previous ones signed off, in fact one appraisal  
22 may have been involving two years in the one go.

23 52 Q. 2012-2013, I think.

24 A. Yes. And then '13 would have been done because I think  
25 he was revalidating in '14, so that was done early. So 11:54  
26 they were always a year behind.

27 53 Q. Yes. So the personal development plan here is  
28 I suppose in this respect is somewhat wide ranging.  
29

1 "To address in a durable and effective manner my long  
2 inpatient waiting list and in so doing to reduce  
3 inequity in the waiting lists."  
4

5 He's saying. That is his language is it?

11:54

6 A. Yes.

7 54 Q. "To address long waiting list for urological cancer  
8 reviews, to reduce the numbers of new patient  
9 consultations. To attend course..."

10

11:55

11 Is this your handwriting?

12 A. The bottom line is my handwriting.

13 55 Q. "To attend a course in urology."

14

15 So there are some thoughts here around practice issues  
16 about I suppose the clinical challenges he's facing.  
17 I suppose it does show the possibility through the  
18 appraisal process of directing the appraisee's mind  
19 towards gaps in the practice, shortcomings in the  
20 practice or challenges in the practice?

11:55

11:55

21 A. Yes.

22 56 Q. Let me bring you to 2010. This one was signed  
23 off November 2011. It is TRU-251244. There it is,  
24 just to show you the shape of it. Can we have that on  
25 the screen. The form of it is, for a bit of

11:56

26 a background, a pen pic of the person being appraised  
27 and setting out some of the information. So no formal  
28 complains nor critical incidents are logged by The  
29 Trust. Is that you observing that on the basis of what

1 The Trust has told you as the appraiser?

2 A. It would be, yes.

3 57 Q. There's action agreed for the next appraisal set out.  
4 And, just going over the page -- so that is under the  
5 heading of good medical care, maintaining good medical 11:57  
6 practice. I assume there's definitions attaching to  
7 each of these headings and you know what ground to  
8 cover.

9 CHAIR: Could we make it a little bit bigger? I'm  
10 struggling to read it. Thank you. 11:57

11 58 Q. MR. WOLFE KC: This is telling us, telling the reader  
12 what Mr. O'Brien has done in terms of maintaining his  
13 practice, the kinds of educational-type visits he's  
14 made, safety courses he has undertaken, and there  
15 regionally being involved in discussions about bladder 11:58  
16 dysfunction and an MDT. So just scrolling through  
17 again so we can see the shape of the form, I'm not  
18 terribly concerned with the detail at this point.  
19 Setting out working relationships with colleagues which  
20 is described as a good relationship with colleagues, 11:58  
21 nurses and ancillary staff. A reference to a current  
22 issue at that time. There was concern around the ward  
23 reconfiguration, you dealt with that, the challenges of  
24 that in your statement.

25  
26 Scrolling down again, just so we see the full shape of  
27 this. 11:58  
28  
29

1 Relations with patients are described in positive terms  
2 generally, albeit two complaints have been raised which  
3 have been resolved, one a waiting list issue,  
4 assumedly, a non-Trust issue as described here, with no  
5 action required.

11:59

6  
7 Scrolling down. Teaching and training, self-evident.  
8 Further on: Probity, no issues arising. Health,  
9 nothing of note there. Keep going, please. "Any other  
10 points". It is referring to the IV fluid antibiotic  
11 issue is simply referred to. Would that have been  
12 something that would have been the subject of  
13 a discussion? Both of you, unusually perhaps in this  
14 scenario, are in something of the same boat for the  
15 reasons we discussed earlier. It doesn't appear  
16 there's been any, at least on the note here, there's  
17 been any reflection. "We must comply", the appraisee  
18 must comply with the protocol or the pathway.

11:59

12:00

19 A. I think there's further comments in writing,  
20 potentially. It may not have been in that year but it  
21 may have been in a subsequent year that it was  
22 commented upon. I say these are bullet point, so they  
23 will have been discussed. Appraisal can last up to an  
24 hour so trying to write down every word written -- it's  
25 more of a summary of what was discussed.

12:00

12:01

26 59 Q. Yes. One of the issues that is picked up is, just  
27 there, is the centralisation of radical pelvic cancer  
28 surgery imposed by the Department of Health. You can  
29 see the detail:

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

"Aidan has concerns that this will have significant knock-on effects for services in the future."

Did you know that this issue and Mr. O'Brien's handling of it with regard to three patients, three bladder cancer patients in particular, was the subject of complaint by the Belfast Trust? 12:01

A. Yes.

60 Q. We can see, just to remind you and remind everyone here, AOB-00191. I think it is Mrs. Rankin, Dr. Rankin writing to Mr. O'Brien, September 2010 drawing the Belfast Trust's concern or some of their concerns to Mr. O'Brien's attention. Perhaps the third paragraph picks up the crux of it. 12:02

"It is of great concern that you indicated to a patient in advance of a care pathway being agreed your preferred management of the case. I believe that this puts inappropriate pressure on the receiving team and is regrettable. I understand that the transfer of these patients, with whom you may have already formed a good therapeutic relationship, was somewhat unexpected." 12:03

Just scrolling down. 12:03

"... a warning that since we have an internal agreement that the future care pathway of these patients will be

1 the subject of a multi-disciplinary decision I do not  
2 want you to write to any of these patients  
3 individually, it is a matter for the MDT."  
4

5 That issue of writing to patients, one patient in 12:03  
6 particular highlighted here, was clearly the subject of  
7 concern. Was that the subject of discussion between  
8 you and Mr. O'Brien at appraisal?

9 A. No, I wasn't aware that Mr. O'Brien had written to the  
10 patients ahead of their transfer, so that's the 12:04  
11 question answered there. But the reason for, I think,  
12 Mr. O'Brien writing to the patients, he can confirm  
13 this, was that the decision to transfer -- the actual  
14 date of transfer of such surgery to Belfast hadn't been  
15 defined precisely and we hadn't heard when that 12:05  
16 transfer was to be by the City Hospital until  
17 Dr. Corrigan, I believe, got involved, and said that  
18 the transfer was going to start on a certain date.  
19

20 I must say, on a personal note, it's not good to twist 12:05  
21 a surgeon's arm to do, what to do. So he really should  
22 have just transferred the patients without any arm  
23 twisting, frankly. So I wouldn't have agreed to any  
24 letter being written in such terms. So I wasn't aware  
25 of Mr. O'Brien writing to the patients at that time. 12:05  
26 So I wasn't aware of this letter.

27 61 Q. There's a broader issue which we perhaps don't need to  
28 get into this morning, that was Mr. Hagan's concern  
29 that the patients were being offered a treatment or



1 Mr. O'Brien was describing a treatment which was at  
2 variance with the MDT's decision, and that's perhaps  
3 hidden from the complaints that eventually passed  
4 between the Medical Director at Belfast and the Medical  
5 Director in the Southern Trust. But you're saying not 12:06  
6 aware of this, but you would agree that it was  
7 inappropriate for Mr. O'Brien to write in the way that  
8 he appears to have done, notwithstanding his  
9 frustrations with the process?

10 A. I can understand the frustration but you do not write 12:07  
11 a letter. I wouldn't have done that.

12 62 Q. In terms of, just thinking here about appraisal as  
13 a process, a complaint like that, do you think it  
14 should have come to your attention as the appraiser so  
15 that it could be properly discussed in the appraisal 12:07  
16 system as it was designed in those days? Would that  
17 have been an appropriate matter to discuss?

18 A. It would always be an appropriate thing to discuss.  
19 But it's being informed about the information in the  
20 first place. 12:07

21 63 Q. Of course. It is only as good as the information you  
22 receive, as you've said.

23 A. I think as an appraiser, as I say, you do get certain  
24 information from The Trust, but it would be good to  
25 have had that in the folder supplied by somebody. 12:08

26 64 Q. Because, presumably -- let me see if you accept this as  
27 part of the appraiser's job description -- is it part  
28 of the appraiser's job description at that time where  
29 you are aware, and in this case you are not aware, but

1 where you are aware of, let's call them faults, in the  
2 approach of the clinician in front of you. If you're  
3 aware of those faults, is it part of the appraiser's  
4 role to try to shape the thinking of the practitioner,  
5 try and tilt the practitioner into a more appropriate 12:08  
6 way of responding or dealing with matters going  
7 forward, or at least to have that conversation?

8 A. It is up to the appraisee to be fairly open and clear  
9 about what they are aware of and to bring to the table.  
10 Is that what you're asking? 12:09

11 65 Q. Yes. You're suggesting that, at least in terms of how  
12 the system was arranged at that time, you were really  
13 beholden to the information that you received. But if  
14 the information was available to you, I think you're  
15 agreeing with me that there was a role to -- a role 12:09  
16 residing with you to try to tilt or shape the appraisee  
17 into a better way of dealing with things?

18 A. Yes, if this had been declared it would have been  
19 a topic of conversation that you would be putting into  
20 one of the four -- 12:10

21 66 Q. You are aware, you've made mention of it in your  
22 statement, that during this appraisal year Mr. O'Brien  
23 had received the, if you like, the stick; you can't  
24 travel to Barcelona if you don't have your admin,  
25 including your triage, up to date. Indeed I think as 12:10  
26 we scanned through the form there, we could see that  
27 his visit to Barcelona was cancelled due to the dust  
28 cloud. But we don't see your knowledge and awareness  
29 of his administrative issues being a feature of the

1 appraisal discussion. The form may not contain  
2 everything that was discussed, but what's your response  
3 to that?

4 A. It's clear an issue about triage hasn't been enclosed  
5 in this documentation, either by Mr. O'Brien or me 12:11  
6 investigating it further. I do accept that.

7 67 Q. It's convenient to deal with it now, as I think  
8 I heralded earlier, across the five years these issues  
9 of triage, notes at home and dictation, or the want of  
10 dictation, are within your awareness, albeit at 12:11  
11 different times and ebbing and flowing and improving  
12 and disimproving. But at no point do you appear to  
13 have recorded any discussion around them. Explain that  
14 to us, is it not appropriate to discuss these matters  
15 at appraisal? 12:12

16 A. Yes, I didn't interrogate that enough. Observing the  
17 other appraisals, a lot of this is written by  
18 Mr. O'Brien in the first person. Again, the principle  
19 being here that Mr. O'Brien was very slow in his  
20 appraisals so I was trying to get him to engage in the 12:12  
21 procedure and getting him to do the writing of the  
22 things that he wanted to discuss that he felt was maybe  
23 aggrieved about, this was a good opportunity to do so.  
24 In the latter years we did discuss capacity demand.  
25 We did talk about triage component. I don't think 12:13  
26 we discussed the notes at home. I wasn't fully aware  
27 of the depth of that when actually doing appraisals at  
28 that time. So when it came out afterwards that  
29 I appreciated the depth of the problem rather than

1 interrogating every fine point. But we had discussed  
2 the triage issue as part of the capacity demand, but  
3 not written, not written down, but it should have been.  
4 68 Q. You've explained that Mr. O'Brien was typically slow at  
5 turning around his part of the appraisal exercise and 12:14  
6 that resulted in delayed sign-off. As we explained  
7 earlier, 2012/2013 was a combined appraisal exercise.  
8 As we can see at TRU-251278, this appraisal was signed  
9 off on 22nd April 2014.

10  
11 We can see, just going back to the top of it, 12:15  
12 TRU-251265, that he provides additional information.  
13 This is characteristic, I think, of his approach in the  
14 next appraisal year as well, it may even have been part  
15 of his previous appraisal year. But he's pointing out 12:15  
16 the difficulties or the challenges of workload within  
17 his practice. He says, I'll read it out in full:

18  
19 "The main issues compromising the care of my patients  
20 are my personal workload and priority given to new 12:16  
21 patients at the expense of previous patients. With  
22 regard to workload, I provide at least nine clinical  
23 sessions per week, Monday to Friday. Almost all  
24 in-patient care and administrative work arising from  
25 those sessions has to be conducted outside of those 12:16  
26 sessions. Secondly, the increasing backlog of patients  
27 awaiting review, particularly those with cancer, is an  
28 ongoing cause for concern."  
29

1           There is something that might be described as a cry for  
2           help or a need for support indicated within that; is  
3           that fair? Is that what you understood it as?

4           A.    That's fair. He's commenting on a heavy workload.

5   69   Q.    And you have seen the manifestations of his workload in 12:17  
6           terms of him describing an inability to complete  
7           triage, for example, during this year and other years.  
8

9           In terms of his workload at that time, he's taken on  
10          the NICaN role, no doubt a prestigious role, but 12:17  
11          outside of his Trust work. He, the evidence before  
12          this Inquiry tends to suggest he works in ways, or  
13          others have described as idiosyncratic, not delegating,  
14          not using the administrative support that he has in  
15          necessarily the most optimal fashion. Looking at that 12:18  
16          package of issues, any suggestion if he can't cope with  
17          the pressures of his workload that he should be giving  
18          up extra curricular activities, prestigious though they  
19          are, such as NICaN?

20          A.    Yes. He would not have been job planned for nine 12:18  
21          clinical sessions. I think he took on extra clinics.  
22          He may have swapped clinics for theatre lists due to  
23          what he is seeing as the volume of work to get through.  
24          But he would have taken on those sessions himself.  
25          I don't think he would be scheduled for nine sessions. 12:19  
26          And, yes, he was trying to maybe juggle far too much at  
27          the time, but that would have been his choice. I mean,  
28          he took on the NICaN role. You can always not do that  
29          job, you know, but he chose to take that on. But if

1 you're going to choose to take it on you have to take  
2 the responsibility with that. And if something else  
3 has to give, then it's maybe up to the individual to  
4 take charge of his or her own practice to accommodate  
5 that.

12:19

6 70 Q. You have told us the last time that in your role as  
7 clinical lead you have to be aware of whether  
8 a clinician should be offered additional sessions?

9 A. Yes.

10 71 Q. You found yourself from time to time saying -- I think  
11 this was a general comment, not necessarily directed to  
12 Mr. O'Brien -- saying to people, no, I'll not offer you  
13 that extra session because you are already  
14 oversubscribed.

12:20

15 A. Yes.

12:20

16 72 Q. But was that part of -- just to be clear, was that ever  
17 part of a conversation that you had about Mr. O'Brien,  
18 whether at appraisal or more generally?

19 A. Specifically that would have been brought up at the  
20 rota meeting.

12:20

21 73 Q. Of course.

22 A. That I alluded to maybe before. Certainly our unit was  
23 trying to use our clinical sessions and theatre lits to  
24 its maximum, I appreciate that. We often moved the  
25 clinical sessions around to accommodate this. And if  
26 extra theatre sessions came up because of other  
27 departments being on holiday, for instance, we would  
28 pick those up. And then, as I say, most importantly  
29 there was the best attended departmental meeting, the

12:21

1 whole team were there, and we tried to hand out those  
2 extra sessions as necessary, and certainly Mr. O'Brien  
3 would have been one to try to pick up on them.  
4 Certainly on several occasions I said 'this isn't  
5 appropriate, Aidan, you have got a heavy enough week  
6 there'.

12:21

7  
8 We all do have varying weeks. Looking at myself, some  
9 weeks I may have two or three outpatients a month for  
10 my clinics, one week I would have four and one week in  
11 four I will have had five clinics myself and I was  
12 aware that that's very much a limit. So I said to  
13 Mr. O'Brien 'I think this is not appropriate that you  
14 take on extra sessions', and would have given it to  
15 somebody else.

12:22

12:22

16 74 Q. It may, and help us with this, it may be a limitation  
17 of the appraisal process as it stood at that time that  
18 this kind of thing, this kind of fairly important thing  
19 can be said by a clinician: My workload is  
20 compromising, I suppose he is saying, my ability to  
21 care for patients as well as I would like. That can be  
22 said but it doesn't go anywhere. There's no practical  
23 engagement with that, I'm not saying necessarily by  
24 you, but by the higher ups who receive this  
25 information?

12:23

12:23

26 A. It's information that is received. It's what you use  
27 with the information. My understanding is that part of  
28 appraisal is to take to your job plan. I know the job  
29 plan is part of appraisal, it's a documentation, but

1 part of this is also that you can take it to your job  
2 planner and use appropriately.

3 75 Q. Yes?

4 A. So if in part of your personal development plan that  
5 you see that there is a deficiency in something that is 12:24  
6 hindering you from accomplishing something, at least it  
7 is already documented here and can transcribe on to  
8 a job plan. But this would have been something to take  
9 to his job plan with.

10 76 Q. In terms of your role, hearing this from Mr. O'Brien, 12:24  
11 perhaps appreciating it already because you are the  
12 appraiser but also a clinical lead and colleague with  
13 Mr. O'Brien, is this not an opportunity to get lots of  
14 these issues out on the table; 'well, I can see how you  
15 are compromised, you are not getting your triage back, 12:25  
16 you're not doing your dictation on time, how can I help  
17 you make that better?' would appear to be an  
18 appropriate question or was that outwith the appraisal  
19 process, as you understood it?

20 A. Well, as part of that departmental meeting about 12:25  
21 assigning a clinic to somebody, this would have been a  
22 discussion here, do you not think that you're taking on  
23 too much in other arenas to allow you to catch up.

24 77 Q. The pro forma goes on to look at relationships. Can  
25 I just pick up an aspect of that. If you go down to 12:25  
26 TRU-251270, I think it's five pages on. Just scroll  
27 down. So this is discussion of relationships:

28

29 "I believe that my relationships with many colleagues



1 of many disciplines is at least satisfactory. Even  
2 though I have on occasion been outspoken in my views,  
3 particularly in relation to patient care, I have  
4 endeavoured to do so in a non-confrontational manner  
5 and hopefully with minimal offence to others." 12:26

6  
7 And it continues. In or around 2012 Mr. Mackle has  
8 described for the Inquiry a breakdown in his  
9 relationship with Mr. O'Brien. On Mr. Mackle's account  
10 he had been told that Mr. O'Brien had a complaint to 12:26  
11 make about him allegedly harassing or bullying  
12 Mr. O'Brien and, on Mr. Mackle's account again, he  
13 stepped back from any direct engagement with  
14 Mr. O'Brien and Mr. Brown was pushed more slightly  
15 forward and became more involved in issues that 12:27  
16 Mr. Mackle would otherwise have tackled. On  
17 Mr. O'Brien's account, while he disputes any suggestion  
18 that he was making a complaint through Mrs. Brownlee or  
19 through anybody else, he understood that he had an  
20 agreement, I think, with Dr. Rankin that Mr. Mackle 12:27  
21 would have no further involvement with him in the  
22 round.

23  
24 I ask this in the context of relationships which are  
25 otherwise described in positive or fairly positive 12:27  
26 terms; were you aware of this breakdown in the  
27 relationship between Messrs Mackle and O'Brien?

28 A. I was aware that Mr. O'Brien didn't see eye to eye with  
29 Mr. Mackle. I didn't take it to the level of the words

1 used by you just now about sort of bullying, I wasn't  
2 aware of that. But I knew that their interrelationship  
3 wasn't healthy.

4 78 Q. Were you aware of the practical manifestation of that  
5 in terms of a senior manager in this context, Associate 12:28  
6 Medical Director, Mr. Mackle, stepping back and not  
7 having, on the face of it, direct contact with  
8 Mr. O'Brien?

9 A. No, I wasn't aware of that.

10 79 Q. That wasn't discussed with you? 12:29

11 A. I wasn't aware to the degree that we're talking about  
12 here about stepping back.

13 80 Q. Also within that year there was an issue raised arising  
14 out of an SAI or a Serious Adverse Incident that had  
15 taken place in 2009. There was a so-called "never 12:29  
16 event". A swab had been retained in the cavity of  
17 a female patient. That led to a review, an SAI review,  
18 and that was written up in 2010. But the issue came  
19 back again in 2011, and it came back in this way:

20 A concern was expressed that the clinician who 12:30  
21 performed the surgery in relation to the never event,  
22 Mr. O'Brien, might have been better able to discover  
23 the problem if he had looked at the post surgery scans.  
24 There was a scan performed I think four months post  
25 surgery. He didn't read it because the patient hadn't 12:30  
26 come back for review. A waiting list issue prevented  
27 her coming back for review in a timely fashion. And  
28 the issue was, I suppose, in the round, should you read  
29 your reports, the investigation reports coming back, in

1 this case from X-ray, from radiography, should you read  
2 them as soon as they are available to be read or  
3 within, a period of promptitude.  
4

5 Could I ask you, just before I ask you for your 12:31  
6 thoughts on that, let me just introduce you to the  
7 e-mail correspondence around that. If we go to  
8 TRU-276805. So under the heading of "results".  
9 Managers have been told:

10 12:32  
11 "I know I addressed this verbally with you a few months  
12 ago, but just to be sure can you please check with your  
13 consultants that investigations which have requested  
14 that the results are reviewed as soon as the results  
15 are available and that one does not wait until the 12:32  
16 review appointment to look at them."  
17

18 If you scroll on back to what Mr. O'Brien has said  
19 about it. I'm conscious that this is directed to  
20 Mrs. Corrigan. You're not copied in. He writes to 12:32  
21 express his concern that this would be the expectation  
22 and he sets out a series of reasons for that in the  
23 form of questions. So he appears, and I don't think  
24 I've asked Mr. O'Brien about this, I will in due  
25 course, but he appears to be suggesting that there are 12:33  
26 impediments or obstacles in the way of practising in  
27 the manner which The Trust's management would expect  
28 and that any attempt to change his practice in this  
29 regard would need to be -- would first need to address

1           these kinds of questions.

2  
3           First of all, were you aware of his practice, that he  
4           would read results only, it appears, and I hope this  
5           isn't a gross generalisation, but we've seen it in 12:34  
6           other situations where he will not read the results  
7           until the patient appears at review. Were you aware of  
8           that?

9           A. I wasn't aware of it this far back. He did bring up  
10          this topic at some departmental meetings, I don't have 12:34  
11          precise dates, I'm sure they're available, that he had  
12          an issue with reviewing the results. He had this  
13          approach of saying, you know, he would wait until the  
14          clinic appointment. But these results would have been,  
15          back in this time, was all done on paper. So the x-ray 12:34  
16          department would have sent a report to him via the  
17          secretary or directly to him. So there would have been  
18          a printed version to have been reviewed. As you say,  
19          whether he looked at it or not, they would have been  
20          supplied to him. This would have come under the view 12:35  
21          of administration, time. This is what admin was for,  
22          to follow-up on outpatient X-rays. And the reason why  
23          it was set up this way indeed was, if there was such  
24          a long delay in the review, at least you had the X-ray  
25          results available or blood tests available to you that 12:35  
26          if you wanted to make a change in your action plan.  
27          Although he said he had difficulty with this, it was  
28          assumed that he did -- assumed -- that he had looked at  
29          the results because, as I say, they were all done on

1 paper, they would all end up in your office and, you  
2 know, if it wasn't looked at there would be a very big  
3 bundle. So this practice here, at that time I wasn't  
4 fully aware that -- well, I was not aware that  
5 he didn't -- is he saying here that he did not look at 12:36  
6 the results?

7 81 Q. Well, the SAI report on I think it was Patient 95, yes,  
8 the SAI report on Patient 95 indicated that this was  
9 a part of his practice, that was his way of doing it.  
10 You said in that year, 2011, you didn't know and, 12:37  
11 therefore you didn't, presumably, engage with him on it  
12 on appraisal?

13 A. No, I didn't engage with him during appraisal.

14 82 Q. Back to the system generating information. Is that the 12:37  
15 kind of thing, if it comes to a dispute between the  
16 Trust's preferred way of doing it and the clinician's  
17 preferred way of doing it. No doubt that should be  
18 refereed and resolved in a number of places, but if it  
19 is a problem should it be discussed as part of  
20 appraisal, if it is drawn to your attention? Is that 12:38  
21 an appropriate forum?

22 A. It is an appropriate forum for an appraisee to bring  
23 forward to say this is an area I have some difficulty  
24 with. But, as I say, appraisal is to showcase your  
25 engagement and commitment to the job. Whether the 12:38  
26 appraisee should be bringing that to discuss or not,  
27 I think this topic is more at The Trust level to try to  
28 sort out. That is going against a bit of governance to  
29 the whole thing, which is part of appraisal. There's

1 a bit of it in both camps. I don't think that's solely  
2 an appraisal point but should be enclosed.

3 83 Q. We also know, Mr. Young, that, scrolling on to 2019,  
4 that in the context of a conversation about DARO, which 12:39  
5 is closely related to the issue we're talking about for  
6 obvious reasons, that Mr. O'Brien is at that point  
7 engaging with Mr. Haynes about his concerns around the  
8 use of DARO. I just want to seek your views on that  
9 and then we'll pull these related issues together.  
10 WIT-55862, if you go to 864, please, 55864. 12:40

11  
12 Colette McCall is, in January 2019, writing to a group  
13 of medical secretaries, I assume yours is amongst the  
14 list here. She is explaining what should be done in  
15 order to comply with the DARO process. Could you just 12:40  
16 help us in terms of, while the Panel are reading that,  
17 could you help us in terms of somehow you practice,  
18 Mr. Young, taking into account both the DARO process  
19 and the message which I read from 2011 which was that  
20 management expected clinicians to read the results and, 12:41  
21 if necessary, action them as promptly as possible. How  
22 did you deal with that?

23 A. My approach to this is that a patient may have been  
24 seen in the clinic and given an appointment for X  
25 period of time at a later date, it could have been 12:41  
26 a year, and if there was a blood test or an X-ray  
27 requested from the first occasion, is that that needed  
28 to be reviewed to see if it was appropriate for the  
29 next date. So if something unusual had cropped up in

1 the blood test or in the X-ray, that needed to be --  
2 should be expedited, then that action is taken. So you  
3 had to review the test result and that seemed  
4 appropriate.

5 84 Q. Did you have a system in place, perhaps using your 12:42  
6 secretary, in terms of when you would read the result  
7 and how would that be draw your attention?

8 A. Okay. Going back before the ECR system kicked in well  
9 that it was all done on the computer, it was all done  
10 by paper. I mentioned before about my black box. That 12:42  
11 was an A4 box in my office that my secretary would put  
12 all the printed X-ray results and bloods into. She  
13 would put the important ones to the top. The black box  
14 also took at the time any referral letters from other  
15 consultants or admin that didn't go via the booking 12:43  
16 office all went into this box. And those test results  
17 that she screened that were exceptionally important she  
18 put on my chair so, you know, those were done first.

19  
20 The administration of that, again might have been a wee 12:43  
21 bit like the triage we talked about before, are they  
22 done on a daily basis, are they done at 72 hours or is  
23 it done on a weekly basis? But certainly I like to  
24 clear my box at least once a week.

25 85 Q. I just want to take your views on DARO. If we just 12:43  
26 scroll up, please. You'll see Mr. O'Brien coming back  
27 on this 6th February. He is greatly concerned,  
28 alarmed, "to learn of the directive which has been  
29 shared with me", presumably by his secretary, about a

1 similar concern. I suppose, in a nutshell, he's  
2 objecting to the use of DARO. He has the view that  
3 DARO is standing in the way of the clinician's decision  
4 that there should be a review, because a review is in  
5 the clinician's view needed. And if you're not listing 12:44  
6 the patient for review but, instead, putting them on  
7 DARO pending receipt of results, that's diminishing the  
8 clinician's role and avoiding or preventing the patient  
9 coming in for review as per the clinician's decision.  
10 Did you use DARO? 12:45

11 A. We all used DARO. But if you wanted to make sure you  
12 saw somebody on a certain date you would instruct your  
13 secretary to actually offer that date. I mean some  
14 people I would have brought back within a fortnight  
15 just to see how they were doing, knowing fine rightly 12:45  
16 that some other investigation might have been after  
17 that. So there was a way of making sure that your  
18 patients were seen. So my understanding of this is  
19 that patients are still to be seen in the outpatients  
20 department, but the whole idea is that the secretary 12:46  
21 knows to expect a test result by a certain time.

22 86 Q. Yes. Mr. Haynes, I think, comes in on this debate. If  
23 we just scroll up, please. He explains that the DARO  
24 process is a Trust wide process.

25  
26 "It is, in light of the reality that patients in many  
27 specialties do not get an outpatient's review at the  
28 time intended, to ensure that scans are reviewed and,  
29 in particular, anticipated findings actioned."



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

He goes on to say:

"I have no issue as a clinician or as an AMD with the process described as it does not risk a patient not being seen and acts as a safety net."

12:46

Is that sentiments with which you agree?

A. Yes. It's a safety net that the secretary is expecting a result back and for the secretary to look out for that.

12:47

87 Q. We've seen various cases. I take you to one example where Mr. O'Brien was the clinician. It concerns Patient 92 on the list. If I bring up TRU-162180. Just before I refer to that, just in fairness to put Mr. O'Brien's Perspective once again and clearly as I can, I don't need to bring the witness statement up on the screen, it's WIT-82540, paragraph 39.7, for the Panel's note.

12:47

12:48

He, Mr. Young, sorry to bring you away from reading that, just Mr. O'Brien's perspective on DARO. He concerns the practice to be concerning as he believed that it presented a very real risk that patients would not be reviewed at all. Is that something you understand? Is that the real risk of DARO or does your previous answer hold, that you can instruct your secretary?

12:48

A. Yes, my previous -- yes, my understanding is that the

1 patients were going to be given a review appointment  
2 but the point about a DARO report was the expectation  
3 of the result.

4 88 Q. This is a case, Patient 92, who was referred to  
5 Craigavon 2nd November 2017. Discharged home the 12:49  
6 following day, plan for outpatient renal tract  
7 ultrasound, which she had 16th November, reported for  
8 further investigation to exclude malignancy. I think  
9 fast forwarding really to March where it is recorded  
10 that she received a follow-up urology appointment, had 12:49  
11 a repeat CT scan on 13th March which reported a solid  
12 nodule suspicious of renal cell carcinoma, and there  
13 was no follow-up following the CT report. She attended  
14 her GP in July of that year complaining of right side  
15 abdominal pain. The GP noted that the CT report was 12:50  
16 overlooked and immediately forwarded a red flag  
17 referral to Craigavon Area Hospital.

18  
19 Just in terms of the clinician, Mr. O'Brien's role in  
20 this, if we go to the findings at TRU-162813 of this 12:50  
21 review. Just at the bottom of the page, I think.  
22 Sorry, I think I'll come back to that one, a rogue  
23 reference. Thank you, my apologies. Just at the  
24 bottom of the page, please.

25 12:52  
26 It's recorded that the referred to the scan took place  
27 in March and the review team have confirmed  
28 communication was e-mailed to the referring consultant  
29 urologist and his secretary and an additional secretary

1 because Mr. O'Brien's secretary was off on leave. The  
2 e-mail advised in all correspondence an urgent report  
3 was available, and the review team have identified that  
4 the patient's report was completed in a timely manner  
5 and escalated to the referring consultant immediately. 12:52  
6 The review team, on the other hand, cannot confirm that  
7 the consultant read the report.

8  
9 "Secretary two has advised the review team that in an  
10 instance like this one whereby an urgent report is 12:52  
11 e-mailed, she would print off the report and leave it  
12 in the consultant's office for follow-up."

13  
14 That is I suppose an object lesson where, if it isn't  
15 read, it falls through the cracks, and the patient, 12:53  
16 fortuitously in this case, shows up because her  
17 symptoms arise and her general practitioner is alert to  
18 the failure to action on the CT report.

19  
20 You mentioned earlier that you weren't alive to the 12:53  
21 problem of Mr. O'Brien not reading results promptly  
22 when the issue was raised in 2011, but it was  
23 subsequently to become an issue that was discussed at  
24 departmental meetings. Take us through that, was there  
25 a challenge to Mr. O'Brien in terms of his approach? 12:54

26 A. We all would have contributed to that conversation,  
27 noting that the results should still be -- should be  
28 read. So it was challenged on a verbal basis at the  
29 departmental meeting, saying that these results are

1 very important to be reviewed in the knowledge that we  
2 have such a long waiting list to be reviewed.

3  
4 It is absolutely fine that if you book an X-ray and the  
5 patient is known to be coming back in the month, 12:54  
6 there's your face to face and can put it across to the  
7 patient. If there's the expectation that the patient  
8 comes back in the month, but doesn't get back for  
9 a year, then we know there's a distinct problem there.  
10 So we are already aware, with our very long outpatient 12:55  
11 backlog, even with our request for the patient to come  
12 back at a certain date, it doesn't happen, so this is  
13 very important that the results are looked at. This  
14 has been brought up at the departmental meetings and  
15 said how important it is to do. But, you know, it's 12:55  
16 following through on that and making sure that the  
17 person does it, obviously, is the issue. But it was  
18 discussed and the importance of it mentioned.

19 89 Q. Was it discussed in a general sense: Listen up, all of  
20 you in the team, or was it recognised that Mr. O'Brien 12:56  
21 was an outrider and it was discussed for his benefit,  
22 if you like?

23 A. It was discussed for his benefit. Everybody else looks  
24 at -- well, as far as I know -- I do, I know that  
25 Mr. Haynes does, and I know that the other two, 12:56  
26 Mr. Glackin and Mr. O'Donoghue do so and comment on the  
27 amount of results that we're expected to sign off in  
28 our admin time, but it's done.

29 90 Q. Just the current arrangement, I know that you work now

1 on a part-time basis having formally retired. In terms  
2 of the safety net in place to ensure that unactioned or  
3 unread results is known to the wider system,  
4 I understand that there's an electronic facility that  
5 draws to the attention of both the referring consultant 12:57  
6 and the Associate Medical Director and perhaps others  
7 if there's a problem?

8 A. Yes.

9 91 Q. Can you just briefly describe that for us?

10 A. So the results are, now, produced from the NICR, it's 12:57  
11 not a paper version, it is the results given a date to  
12 come back from -- they're produced, and then there is a  
13 time line, and it does x-rays, bloods, microscopy, and  
14 it does it on a two-week basis. I think it's yellow,  
15 orange, red. 12:58

16 92 Q. I'm not sure if we have that precise example.

17 A. Is that what you are referring to?

18 93 Q. I hope so. TRU-301800. I want to see if this  
19 illustrates your point?

20 A. I think that might illustrate it better. Yes, that's 12:58  
21 exactly --

22 94 Q. This is directed to you last year?

23 A. This is directed at me. My take on this is that this  
24 was relatively recent. This is a fabulous way of  
25 ensuring that the results are up to date and it lets 12:58  
26 everybody see that. It's all on the one page, as you  
27 can see here. So this will record, as I say, x-rays,  
28 bloods and microscopy. It's done on a fortnightly  
29 basis, that if you haven't signed it off, it goes into

1 the next box. If you're behind in a month it goes into  
2 the red. And the important point with that, I'm led to  
3 believe from Mr. Haynes, is that if it gets to the 7th  
4 week, then it does get lost in the system. It doesn't  
5 do a "+36". So that's why it's red, to actually let  
6 you know. So it's very clear what's going on.

12:59

7  
8 I understand that this might have been done for some  
9 time, but I retired in June 2022. I think this might  
10 have started before that but I wasn't aware of that  
11 process, but it certainly has become more published to  
12 us all over the summer of '22. And this is produced on  
13 a weekly basis. I'm taking it it is sent to us.

12:59

14 I appreciate that this has been specifically sent to me  
15 but there is a general report of this sent to all of  
16 the consultants on a weekly basis.

13:00

17 MR. WOLFE KC: very well. It is 1:00 o'clock, we'll  
18 leave it at that for lunchtime.

19 CHAIR: It is just after 1:00. We'll come back at  
20 2.05, ladies and gentlemen.

13:00

21  
22 THE INQUIRY THEN ADJOURNED FOR LUNCH.

23  
24 CHAIR: Thank you, everyone.

25 MR. WOLFE KC: Hopefully the final lap, Mr. Young.

14:03

26  
27 Just briefly before lunch we touched on, in your  
28 evidence, a discussion you said took place at  
29 a departmental meeting, focused on Mr. O'Brien's issues

1 in relation to actioning results, reading results and  
2 actioning them. Can you remember approximately when  
3 that was discussed? Was it triggered by any particular  
4 event or incident?

5 A. Triggered by an event or incident, apologies, it might 14:04  
6 have come up as part of a general discussion about the  
7 likes of triage and how you handle data. But it wasn't  
8 brought up as a specific topic, from what I can  
9 remember. It wasn't on our list of tonics. I don't  
10 know what dates, but it wasn't just brought up once. 14:04  
11 We have -- it was part of a general discussion about  
12 how a practice is run, shall we say. Is that fair  
13 enough? I can't be more specific.

14 95 Q. Is that back in the mist of time or more recent times? 14:05  
15 In other words, there's a couple of pillars there, the  
16 was the 2011 intervention, which I mentioned, the  
17 patients case I mentioned to you, which is a 2018 case  
18 but the SAI wasn't reported until 2020.

19 A. Okay. Our departmental meetings had been more active 14:05  
20 with the arrival of Mr. Haynes and Mr. O'Donoghue. We  
21 would have had some meetings before that, when  
22 Mr. Suresh and Mr. Connolly were here. But it's been,  
23 you know, between '14 and now.

24 96 Q. Okay, thank you. Let me bring you to the last of the 14:06  
25 appraisals, 2015. We can see that it wasn't signed off  
26 until 23rd December 2016, which was, as I think  
27 I remarked earlier, on the eve of the MHPS process  
28 which a decision had been made to pursue that process  
29 a day or two so before, Mr. O'Brien wouldn't have been

1 aware of it, I don't think. But, certainly, in the  
2 course of that year, 2016, he had been brought to  
3 a meeting, as we'll recall, a March 2016 meeting.  
4 You'd had a conversation with Mr. Weir. There was  
5 a sense that things were coming to a head. You wanted 14:06  
6 to speak to him. You wanted to have an office meeting  
7 before Mr. Weir got to them, and we got all of that.

8  
9 In that context, is it not remarkable that the  
10 appraisal didn't deal with any of the issues that were, 14:07  
11 at least on the face of the paperwork, didn't deal with  
12 any of the issues that were to be part of the MHPS and  
13 which you were aware of?

14 A. This appraisal was his 2015, so it was meant to be the  
15 activity during that year. As I said, his appraisal 14:07  
16 was always rather delayed in it being done. So it is  
17 all out of sync, so to speak. It should have been --  
18 I mean his 2015 appraisal should have been done,  
19 certainly, in the first few months of the year.

20 97 Q. Sorry to cut across you, it must be a difficult 14:08  
21 exercise involving some mental gymnastics. If you're  
22 aware of issues that have come to a head in 2016,  
23 you're having the conversation in 2016, do you keep it  
24 rigidly to what has happened the year before?

25 A. I was trying to deal with the year in question. It may 14:08  
26 have been the wrong thing to do, I accept that, but it  
27 is meant to be the appraisal for that particular year  
28 and dealing with the information that is supplied to  
29 you that is actually covering that year.



1 98 Q. That was the year, 2015, where Mr. Haynes had raised  
2 the private patients issue with you on two occasions.  
3 I don't know whether you consider it would be  
4 appropriate, but no mention of it in the appraisal  
5 correspondence? 14:09

6 A. That's correct. As I mentioned to you earlier, I'm  
7 afraid that those emails had -- I had forgotten about  
8 the importance of.

9 99 Q. Yes. One issue that was certainly live but maybe  
10 developed after 2015 was the issue around the safety 14:09  
11 alert that came via the coroner into the deputy medical  
12 officer --  
13 CHAIR: Chief Medical Officer?

14 100 Q. MR. WOLFE KC: His or her deputy at the time, I think,  
15 took the lead on the issue with the correspondence. So 14:09  
16 that was an issue that came in to The Trust, I think it  
17 was 2015. But what I want to ask you about is  
18 Mr. O'Brien's response to it, indeed, the response of  
19 you and your colleagues to the policy that was handed  
20 down by the Deputy CMO in August 2015. You'll recall 14:10  
21 that there was a need for The Trust to develop an  
22 action plan?

23 A. Yes.

24 101 Q. We can just look briefly at -- well, I'm not sure -- in  
25 the interests of time, the Inquiry is familiar with 14:10  
26 that background.  
27  
28 Once the policy was written, the Urology Service  
29 obtained the use of a number of bipolar instruments to

1 trial. I just want to bring up Mr. O'Brien's response  
2 to that. It's TRU-395975. He sets out his experience  
3 of using it and he finishes by saying:

4  
5 "The audit asks the question whether the trialists 14:11  
6 would be happy to use it. His answer was a definite  
7 no. I will do if I have to. I just do hope that the  
8 operating procedure will allow me to continue to use  
9 monopolar, as it is very much superior."

10  
11 That was his view at that point. If we go to 14:12  
12 TRU-395978, a month or so later. He's explaining  
13 he last used the bipolar two weeks ago to resect a  
14 moderately enlarged prostate gland. He had to abandon  
15 after ten minutes because of bleeding and poor 14:12  
16 irrigation, and moved presumably to monopolar and  
17 glycine. He explains his experience that bipolar had  
18 placed the patient in interoperative danger and he  
19 salvaged the situation by switching to monopolar.

20  
21 "I have therefore pledged not to do so again. I will 14:13  
22 not use or try bipolar resection again."

23  
24 It was to be I think a full two years from that point  
25 before The Trust acquired the equipment. In fact, at 14:13  
26 one point you wrote to the powers that be to say this  
27 is a safety requirement handed down to us by the Chief  
28 Medical Officer's office. We're going to stop TURP --  
29 this is towards the end of 2017 -- we're going to stop

1 TURP until you get the equipment in place. That  
2 quickly led to the situation whereby in I think  
3 March 2018 the equipment was in place?

4 A. Yes.

5 102 Q. You said in, I think it's, I'm not sure if it is your 14:14  
6 statement or -- let's bring it up, WIT-54057. This is  
7 a record of a discussion in a departmental meeting,  
8 essentially about which equipment to buy. There's  
9 a number of options. I think if we go to the bottom of  
10 it, just over the page. So there was a vote on which 14:14  
11 to buy and all the urologists, it's recorded, have  
12 backed this decision with a unanimous vote.

13 Mr. O'Brien being an attendee at that meeting, and  
14 yourself and others, Mr. Haynes was the only absentee.  
15 Does that suggest that Mr. O'Brien was in favour of the 14:15  
16 purchase of the equipment, not necessarily committing  
17 to use it, or was he committing -- was it your  
18 understanding that he was committing to use it?

19 A. This study was to look at four bits of equipment by  
20 these suppliers logged here and we were assessing which 14:15  
21 we felt suited Craigavon Area Hospital and all of the  
22 surgeons involved in the system. So we were trying to  
23 accommodate everybody's wish. This was an assessment  
24 of the kit and the kit was obviously one that we knew  
25 could be interchanged fairly easily between the use of 14:16  
26 saline and the use of glycine. This was, as I say, to  
27 accommodate the team's approach to the introduction,  
28 gradual change over to the system. The operative  
29 technique is fairly similar between the use of

1 monopolar and bipolar. It's not a new technique, it's  
2 just a slight change in how you do the resection.

3 103 Q. why, just very briefly, if you can, why was it  
4 considered to be a safer method to resection, the use  
5 of sodium and the bipolar particular instrumentation, 14:17  
6 why was that regarded as a less risk environment for  
7 the patient?

8 A. Okay. This morning we talked about hyponatremia and  
9 glycine and changing to saline changes that dynamic in  
10 that you are cutting out the hyponatremia component of 14:17  
11 it. The use of saline is not without its risk factors  
12 either. If you get an excessive amount of saline on  
13 board you can get cardiac issues, but in general it is  
14 noted to be a safer option. And it comes back to the  
15 original coroner's case. This was a resection of the 14:18  
16 uterus in a female. If you don't mind me passing  
17 comment, hyponatremia in a female is much more risky,  
18 and that's what happened in that particular case. So  
19 trying to transpose all of that information over into  
20 the use in a gynaecological setting in the hospital as 14:18  
21 well as from a urology perspective, it was the way to  
22 go.

23 104 Q. Yes.

24 A. Hence --

25 105 Q. You've recalled in your statement, this is 14:18  
26 paragraph 6.6 for the Panel's note:  
27  
28 "There was an adaptation required to our surgical  
29 technique but overall the majority observed that it

1           wasn't a major issue."

2

3           A.    Yes.  So it's the same instrumentation, it's the same  
4           use of the mechanisms within the scopes, it just --  
5           when you're resecting with a monopolar, it's quicker       14:19  
6           with the loop, it's like using an ice cream scooper, if  
7           you want to use it that way, as an analogy.  You just  
8           had to use the loop or the scoop a little slower to get  
9           the cut right.  So it's a little adaption.

10

14:19

11           The second point to it is that I observed that the  
12           haemostasis used during the surgery isn't maybe quite  
13           as good as the instruments used in glycine, but it  
14           still works, and it's a fair swap from a safety  
15           perspective.

14:20

16 106 Q.    Now, you observe in your statement -- maybe just bring  
17           it up, WIT-103617, paragraph 6.  So you personally  
18           discontinued the use of glycine when the new resective  
19           scope system was on site.  And you understood, next  
20           paragraph, the other urologists had also changed to the   14:20  
21           saline system.  Why did you change?  Did you feel it  
22           was an obligation to change given the direction  
23           signaled by the Chief Medical Officer's office and the  
24           adoption of a policy by the Trust?

25           A.    Yes.  It was a directive.  But, in saying that, having   14:21  
26           used the use of glycine for 25 years and well used to  
27           it, I observed that this was coming through as a safer  
28           option.  It was easy to learn and, as a comment, that  
29           the use of the cut and the diathermy were not quite as

1 good as the glycine, but was a fair swap because of the  
2 safety issue.

3 107 Q. You go on to reflect there, paragraph 6.9, that you  
4 were aware, and we've seen the emails, that Mr. O'Brien  
5 did not like the saline system, he regarded it as an 14:21  
6 inferior system. You personally thought he needed  
7 a further period of time to get used to the saline  
8 system. It has only come to your knowledge recently  
9 that he never did convert to using saline and continued  
10 to use glycine. How was it not obvious that he had 14:22  
11 failed to make the transition?

12 A. We all operate independently. I don't go to  
13 Mr. O'Brien's theatre list. I don't think any of the  
14 rest of us go. We all have our theatre days, and  
15 there's very little overlap. I had thought that, and 14:22  
16 again hadn't heard until I directly asked the question  
17 from theatre, had he actually moved over. So I thought  
18 that we were --

19 108 Q. When did you ask that question?

20 A. Very, very recently. 14:23

21 109 Q. Yes. Of course, upon the purchase of the equipment it  
22 might be suggested that clinical lead or perhaps the  
23 clinical director would assemble the team and say,  
24 right, we have the equipment, you know the policy, you  
25 know our expectation, I expect each member of the team 14:23  
26 to enter into a commitment to use it, because it is  
27 safer, it has been directed upon us by the CMO. Was  
28 there no such conversation or communication with Mr.  
29 O'Brien?

1 A. I think there was the expectation that he would move  
2 like the rest of us too. I don't remember him  
3 informing us that he had not moved over. I agree, it's  
4 a question maybe I should have asked. This is  
5 a theatre directive as well. It's not just me in the 14:24  
6 department --

7 110 Q. Of course?

8 A. -- it's not just me in the department asking the  
9 question. There's CDs and AMDs. I'm not entirely sure  
10 if they knew Mr. O'Brien hadn't moved over either. 14:24

11 111 Q. We can see, if we bring it up briefly, it's the policy  
12 or the directive coming down from the CMO at WIT-54052.  
13 Under the heading of "monitoring", it is said that the  
14 Trust's audit department will need to monitor that the  
15 recommendations are implemented. An audit would have 14:25  
16 revealed outliers in terms of the expected practice,  
17 enquiries aware of no contemporaneous audit. Was this  
18 matter audited?

19 A. Not to my knowledge.

20 112 Q. You, as I noted, reflected in your statement that you 14:25  
21 have recently become aware that he never did covert.  
22 The Trust has recently supplied the Inquiry with the  
23 findings of an audit which Mrs. Corrigan has overseen.  
24 I just want to bring that to your attention and have  
25 your comments, please. It is at TRU-396059. Take it 14:25  
26 from the top of the page. Thank you.

27

28 So the question posed by the Inquiry is:

29

1 "Do we know whether Mr. O'Brien did, in fact, use the  
2 bipolar equipment or did he continue to use monopolar  
3 in glycine, as his emails suggest was his intention?"  
4

5 The methodology is briefly explained:

14:26

6  
7 "As part of this audit it was felt that the best period  
8 to look at and determine did Mr. O'Brien use this  
9 equipment was January to December 2019, which was  
10 a year after its purchase, and to ensure equity of the  
11 process the audit was conducted across all of the  
12 consultant urologists."  
13

14:27

14 If we scroll down we can see more detail in this  
15 document and the Panel can look at it. If we scroll  
16 down to the next page, please. Just there. This is  
17 the number of charts requested for the purposes of  
18 analysis. So they didn't, for the purposes of this  
19 audit, look at every case but they took a pro rata  
20 sample, making sure that there was similar equity or  
21 a similar pro rata applied to each consultant. The  
22 results are just down the page and we can see each of  
23 the consultants. Maybe jump immediately to  
24 Mr. O'Brien's. On the left-hand column is the  
25 instrumentation. He performed nine cases with  
26 monopolar. One other patient of his was operated upon  
27 by Mr. O'Donoghue, who used bipolar. Seven of these  
28 cases were conducted in glycine. Two other of the  
29 monopolar cases had no indication of the fluid used in

14:27

14:27

14:28



1 the fluid balance notes. When Mr. O'Donoghue was the  
2 operator on that one case it was sodium chloride used.

3  
4 You can observe, yours is at the bottom of the list,  
5 towards the bottom of the list. So three bipolar and 14:29  
6 two for which the product was awaiting notes. I assume  
7 that might be updated for us in due course. So of the  
8 three that they looked at in yours, sodium chloride was  
9 the irrigation fluid used. We can see across the other  
10 consultants that bipolar is the instrumentation of 14:29  
11 choice in sodium chloride as the irrigation fluid.

12  
13 So your sense of it now is that maybe making real your  
14 suspicions that Mr. O'Brien didn't comply and was an  
15 outlier here? 14:30

16 A. Yes, correct. This is the proof.

17 113 Q. If I could just bring up something Mr. Haynes has said.  
18 It is WIT-53949. It is 69. So he's discussing his own  
19 knowledge of the approach adopted around this issue and  
20 he's referring to Mr. O'Brien at the top of the page 14:31  
21 here as:

22  
23 "Subsequently expressing the view that he would  
24 continue to use monopolar resection glycine and  
25 therefore not conforming with the policy." 14:31

26  
27 On reflection he says:

28  
29 "This unwillingness to conform with recommendations

1 from others should have provoked concern regarding  
2 wider aspects of his practice, especially with regard  
3 to delivering treatment in line with NICE guidance and  
4 MDM recommendations. "

14:31

5  
6 I suppose the broader point, and I'll ask for your  
7 comments on whether you agree with that, is that  
8 you have a number of practice issues which, I suppose,  
9 any one of them in isolation may not be regarded as too  
10 bad or terribly worrisome. But when you join them all  
11 together, and take this example, a very clear  
12 recommendation or direction coming down from on high  
13 for good reason, and Mr. O'Brien, on the face of it,  
14 and we can ask him about his reasons, says, no, I don't  
15 propose to do that and it's not properly overseen by  
16 The Trust. The Trust, through people like yourself,  
17 Mr. Haynes, have an appreciation or a suspicion,  
18 perhaps, that he's not going to comply, but it's not  
19 properly supervised; would you agree with that?

14:31

14:32

20 A. I would agree with that. It's not -- we had a plan of  
21 action to put this in. There was a training scheme to  
22 do it, and it wasn't conformed. And there's an  
23 element, also, that he didn't continue to say that he  
24 wasn't using it. There was a learning curve and there  
25 was the expectation that somebody would come back and  
26 say, look, I still can't use this. So there's a bit of  
27 an onus there as well. But it is two-sided. The other  
28 option would have been to take glycine out of the  
29 hospital completely. I had that with the use of water.

14:32

14:33

1 There was water used for irrigation at one stage on the  
2 ward and in A&E. And that was found that they had  
3 three litres of water used for irrigation, which is not  
4 good. So there was an action plan, again, I can't  
5 remember dates exactly, but myself and the Chief 14:34  
6 Pharmacist went around all the wards and to A&E to take  
7 out water as an irrigating system, and it wasn't  
8 purchased anymore, from what I gather. So there was an  
9 action plan for water which was used for a bit of  
10 irrigation and that has been taken out of The Trust, 14:34  
11 actioned by myself and the pharmacist. But, yes, you  
12 are correct here, it wasn't followed through as part of  
13 The Trust.

14 114 Q. I introduced this issue in the context of appraisal,  
15 the point being that within the timeline, the Medical 14:34  
16 Director's directive came in in 2015. I fully accept  
17 that it wasn't until 2018, perhaps, that anyone would  
18 have realised that Mr. O'Brien wasn't compliant.

19  
20 Having said all of that, and thinking about appraisal 14:35  
21 overall in light of your evidence, do you consider that  
22 appraisal in your hands with Mr. O'Brien was poorly  
23 focused and ought to, but failed to, get to grips with  
24 some of the issues that we've discussed? Or, in the  
25 alternative, do you consider that appraisal at that 14:35  
26 time it in its development wasn't a particularly  
27 effective tool anyway to address these issues?

28 A. I think it's the latter. I could have challenged him  
29 more but I don't think appraisal was set at that level.

1 It was the information supplied. At that time you  
2 chose your appraiser, whereas the more recent method,  
3 which is good, is that you are actually given an  
4 appraiser, and I think that's meant to change every  
5 three years. So if you have a five-year cycle, you're 14:36  
6 going to get two appraisers.

7  
8 Now, would the new system pick up on what I didn't ask  
9 or what wasn't asked? would the new appraiser know to  
10 ask about the untriaged letters unless the appraiser 14:36  
11 was told about that in the first place? So, again,  
12 there's an element of the information that you're  
13 supplied at the time and it is a retrospective  
14 collection rather than a forward-thinking one. So  
15 there is advantages to the new appraisal system. It is 14:37  
16 more robust, I understand that, and inquisitive, and  
17 the appraiser is from a different specialty and,  
18 therefore, might not be as closely attached to the  
19 clinician. Again, maybe I found it a little bit too  
20 close a situation within the same department to sort of 14:37  
21 challenge things. There's an element of being told if  
22 there's an answer for everything, that Mr. O'Brien  
23 seems to have, he always seems to have an answer to  
24 explain something, then it seems to cover the situation  
25 a little bit. So I think there's a balancing act and, 14:38  
26 again, it is going back ten years to when I did the  
27 appraisal. But, yes, I agree with your latter comment.

28 115 Q. Moving full circle, perhaps, to the early months of  
29 2017, the consultant team is told that Mr. O'Brien has

1           been excluded from the workplace, that a process is to  
2           commence and your assistance and the assistance of the  
3           team is sought in order to engage with the work that  
4           Mr. O'Brien has not performed with regard, in  
5           particular, to triage. Those clinical episodes which      14:39  
6           he has participated in but hasn't written up or hasn't  
7           taken the next steps in terms of correspondence, you've  
8           described in your witness statement as this having come  
9           out of the blue. I just want to be sure I understand  
10          what you mean. The issues hadn't come out of the blue,      14:39  
11          certainly, for you; is that fair? You were aware of  
12          the issues, it was the volume of the issues; is that  
13          right?

14          A.    It's the volume of -- it is the volume of all three  
15                components and certainly the undictated outpatient      14:40  
16                letters in clinics was something I hadn't been fully  
17                aware of the degree of volume.

18   116   Q.    When you came to do the triage work, just pull up your  
19                statement to highlight what you found, WIT-51823, and  
20                at paragraph 65, just at the top. So you explain that      14:40  
21                you're asked to participate in an exercise to triage  
22                these outstanding referrals. You say those:

23  
24                "Of those referrals I triaged several were upgraded to  
25                red flag and I asked a colleague if he agreed with my      14:40  
26                decisions. Some were clearly red flag referrals. I am  
27                also aware my colleagues upgraded some referrals. All  
28                untriaged referrals had the potential for patients to  
29                come to harm."

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

And you go on to add that it seems that the red flag letters that Mr. O'Brien had received had been triaged.

Just in terms of categorising, I suppose, the significance of what you discovered on the triage front, you had historically been aware of delayed triage. You have given evidence that you didn't quite come to the realisation that he wasn't doing it. But here you have in front of you a collection of cases and you are finding maybe months, a significant period of months, perhaps, after the referral had gone in, that you're having to upgrade. How significant was that in your view? 14:41

A. It's very significant. It's not spotting the red flag patient in all of the correspondence that you get. So yesterday or before I commented on, it is very important to look at all the letters to spot the issue. I personally feel, as I think I maybe said before, is that the routine and the urgent referral letters are probably the most important ones to be looking at because the red flag ones are going to automatically be seen anyway. So it is the screening of these routine and urgents are the most important. 14:42

I had conversations with Mr. O'Brien to say that these are the most important ones to look at and he had agreed that that was the case. 14:43

117 Q. When is this --

1 A. I was about to add that. This would have been --  
2 I certainly do remember one of these occasions, it  
3 would have been after this event, but certainly  
4 conversations had been had before to note that a review  
5 of these letters were important. Well, I understand 14:43  
6 from some of the MHPS conversations that he also noted  
7 that that was important.

8 118 Q. Yes?

9 A. But my observations and conversations were that these  
10 were the important ones and he had agreed. So my 14:44  
11 assumption had been that he had at least viewed these  
12 letters, maybe not processed them, but at least had,  
13 shall we say, flicked through them, if you want to use  
14 that sort of terminology, to at least have them  
15 screened. Now, that was an assumption, a missed 14:44  
16 assumption, unfortunately.

17 119 Q. Because, plainly, you are looking at cases which  
18 appeared obvious to you to be deserving of upgrading,  
19 and Mr. O'Brien, had he looked at them in the manner  
20 that you had, would have seen that? 14:45

21 A. Yes. I put in this document here that I screened the  
22 letters. I would have upgraded them, and that would  
23 have been the end of it. But due to what was going on,  
24 I passed them to my colleague saying would you do the  
25 same thing? So -- 14:45

26 120 Q. Could I bring you, briefly, to the second element of  
27 the work, the cases where Mr. O'Brien hadn't dictated  
28 or indicated the next steps for the patient following  
29 a clinical meeting or clinical review. How did you go

1 about that work? I understand from what Mrs. Corrigan  
2 told the Inquiry and contained in her evidence that the  
3 consultants, when doing this work, preferred to go with  
4 Mr. O'Brien's outcome as set out in an outcome sheet.  
5 Was that the approach, to go with that and then write 14:46  
6 up the next steps for the patient?

7 A. The outcome sheet was a separate piece of paper.

8 121 Q. Yes?

9 A. Okay, rather than what was in the notes. I say the  
10 outcome sheet was a safety net to make sure that all 14:46  
11 the information was connected. So it would have been  
12 a combination so there was a review of the chart from  
13 what I remember. I don't remember it all quite  
14 precisely, it is a wee while ago, but the charts were  
15 reviewed and if an outcome sheet was supplied, then at 14:46  
16 least you knew what was planned.

17 122 Q. Just maybe to assist you and your memory in this  
18 respect. If you go to TRU-268814. Mrs. Corrigan is --  
19 at this point this is June 2017. She is, I suppose,  
20 summarising the findings of the exercise. So there's 14:47  
21 110 patients needed added to the review outpatient  
22 list, 35 to be added to the theatre waiting list. You  
23 can see there are three patients the consultants have  
24 particular concerns about. Then some comments at the  
25 bottom giving an indication of the delays in 14:48  
26 Mr. O'Brien's dictation work. It maybe gives you  
27 a refresher from your memory.

28

29



1 Can I ask you this. When she gave evidence earlier  
2 this year, Mrs. Toal, who you may know from The Trust,  
3 she reflected that given the wider concerns that came  
4 to the fore in 2020 with regards to Mr. O'Brien's  
5 practice, is it not worrisome that the exercise that 14:48  
6 the consultants performed in 2007 didn't pick up on  
7 some of the themes that were to emerge later? I'm  
8 thinking, perhaps, about the Bicalutamide issue, about  
9 delays in referral, that kind of thing. How carefully  
10 and how intensively was the process that you and your 14:49  
11 fellow consultants were asked to participate in, how  
12 was that conducted?

13 A. There was a list of exercises to complete, one of which  
14 we've covered as the untriaged. This is a further  
15 example. We were processing the information supplied 14:49  
16 to us to give back to The Trust to put it into some  
17 form of an action plan. Now, we as consultants weren't  
18 asked our opinion on what we thought should be done, if  
19 that's what you're asking. But, I mean, we were aware  
20 of the joined up writing here to a degree with the 14:50  
21 untriaged letters, we were doing it. We were doing  
22 these outpatients that weren't being actioned with the  
23 admin. So we were aware of this but, by the time all  
24 of this was going on, Mr. O'Brien I think was back at  
25 work and had been a decision by the Trust to -- that 14:50  
26 that's what was happening.

27 123 Q. You'd obviously worked with Mr. O'Brien by this stage,  
28 this is 2017, for the better part of two decades, just  
29 a little shy of that, perhaps. You, presumably, had

1 a high degree of trust and confidence in his abilities  
2 as a clinician. Did what you see here through this  
3 exercise cause you a crisis of confidence in him?

4 A. Yes, it certainly did. I was surprised that the Trust  
5 hadn't asked our opinion at this time of whether his 14:51  
6 return was as prompt as it had been. I personally  
7 thought that added time should have been set aside to  
8 let the dust settle, find out what was coming out of  
9 all of this. I thought that was an alarm bell to me  
10 but, again, we weren't asked. I may have commented 14:52  
11 that I thought this was a little strange, that he was  
12 coming back so early, but, again this decision  
13 I understand was taken at the top level. There may be  
14 a process involved in all of this about exclusion for  
15 a month and beyond. But taking it as it stands, I was 14:52  
16 rather amazed that he was allowed back to work,  
17 frankly.

18 124 Q. As part of that answer does it suggest that, if he was  
19 coming back to work, there ought to have been -- I use  
20 the phrase deeper dive, some people use 360 degree 14:53  
21 consideration. In other words, a comprehensive  
22 exploration of his practice to see what else there  
23 might be of concern. Do you reflect back and think,  
24 well, that would have been appropriate?

25 A. Yes, reflecting back that certainly would have 14:53  
26 appropriate. Again, should we have been suggesting  
27 that to The Trust? But, again, I think the Trust's  
28 higher echelons of administration and management and at  
29 the Medical Director level, you know, probably should

1           have been making that decision along with us,  
2           obviously.

3 125 Q.    For the avoidance of doubt, in case it might be  
4           suggested that the problems of 2020 were there to be  
5           found in the 2017 notes or exercise, what I'm  
6           suggesting to you is broader than that. 14:54

7           A.    Yes.

8 126 Q.    while there might have been other issues to be found in  
9           the 2017 notes, the question which I'm asking embraces  
10          looking at Mr. O'Brien's practices within the MDM, for 14:54  
11          example; his prescribing practices, for example; the  
12          timing of his referrals to oncology. That would all be  
13          capable of being scrutinised, would you agree?

14          A.    It would have been. Sorry, I thought you were  
15          referring to these letters of us screening them. 14:54  
16          That's not what you're asking. A deeper dive is not  
17          what our role was doing here.

18 127 Q.    Of course.

19          A.    But, yes, I agree, there was lots of pointers here that  
20          was giving the trust an opportunity to say, look, 14:55  
21          I think there might something more to this. So you are  
22          correct.

23 128 Q.    You said a few moments ago that you had spoken to  
24          Mr. O'Brien, you think, both before this and after this  
25          about his approach to triage, that the routines are 14:55  
26          almost the most important, they should be the ones you  
27          start with. You explained yesterday that is because  
28          a red flag is a red flag, it's not likely to change in  
29          all likelihood. Now you haven't mentioned such

1 conversations in your statement. Did you follow that  
2 up with him at any point?

3 A. The last conversation I had with Mr. O'Brien on this  
4 very topic was in a corridor with a very direct  
5 question, you know, a one-liner, and he agreed fully 14:56  
6 that this was the way to do it. So I was taking it  
7 that he agreed with what I was saying. It wasn't just  
8 a conversation, it was a little bit more pointed.

9 129 Q. Just to orientate us in time, is that after this all  
10 came out in the wash? 14:56

11 A. That particular one was after 2017.

12 130 Q. Yes. Could I bring you to the outcome of the MHPS  
13 process. I want to draw your attention to Dr. Khan's  
14 conclusions. He was the then-acting Medical Director  
15 and he was also the, I think his title was Case Manager 14:57  
16 for the MHPS, the investigation having been conducted  
17 by Dr. Chada. If we go to AOB-01923, just the final  
18 conclusions at the bottom. And he describes that the  
19 investigation focused on the administrative practices  
20 of Mr. O'Brien. 14:57

21  
22 "The investigation report presented to him focused  
23 centrally on the specific terms of reference set for  
24 the investigation. While the report is outlined above,  
25 there have been failings identified on the part of 14:58  
26 Mr. O'Brien which require to be addressed by The Trust  
27 through A Trust conduct Panel and a formal action  
28 plan."  
29

1 The next bit is the bit directed to management.

2

3 "The report highlights issues regarding systemic  
4 failures by managers at all levels, both clinical and  
5 operational, within the Acute Services Directorate. 14:58

6 The report identifies there were missed opportunities  
7 by managers to fully assess and address the  
8 deficiencies in practice of Mr. O'Brien. No one  
9 formally assessed the extent of the issues or properly  
10 identified the potential risks to patients." 14:58

11

12 Scrolling just down a little bit, the last paragraph:

13

14 "In order for the Trust to understand fully the  
15 failings in this case, I recommended The Trust to carry 14:59  
16 out an independent review of the relevant  
17 administrative processes with clarity on roles and  
18 responsibilities at all levels within the acute  
19 Directorate and appropriate escalation processes."

20

21 MHPS is an employee/employer process, there's no doubt  
22 confidentiality and sensitivity issues around findings.  
23 But here you have a specific conclusions directed  
24 towards management of all hues. were those conclusions  
25 ever drawn to your attention? 15:00

26 A. I've only been drawn to the conclusion of this,  
27 I believe it was October '18; is that right?

28 131 Q. Yes, that's when this was published or thereabouts?

29 A. I was unaware of the publication, that hadn't been

1           supplied.

2   132   Q.   Regardless of whether you saw the document, it's the  
3           sentiment, it is the message?

4           A.   The message, okay, I thought you were asking me if I  
5           knew about this. I agree with the sentiment here.           15:00  
6           This was the conclusion that an external review should  
7           have been undertaken. And, from what I said earlier,  
8           I would have agreed with that. It obviously needed  
9           somebody else to have a look at it, from a supportive  
10          point of view and correction.   15:00

11   133   Q.   And my question is those being, I suppose, the damning  
12          findings of the performance of management at all levels  
13          with operational and medical, you being in the  
14          management framework, albeit at a first-step level,  
15          I suppose, did anybody sit down with you at any point           15:01  
16          and say this is what we have found about the  
17          performance of management, we need to talk about this?

18          A.   No. I don't recognise that.

19   134   Q.   Did anybody come to you and say, listen, you were the  
20          clinical lead for all of these years, you appraised           15:01  
21          Mr. O'Brien for all of these years, you never once  
22          raised an incident report in respect of his conduct and  
23          these things went on and on and on and were never  
24          resolved, this is what you need to think about going  
25          forward. Any conversation like that?                                   15:02

26          A.   I don't remember anybody going into that depth.

27   135   Q.   It is right to say that at no point did you ever raise  
28          an incident report in respect of Mr. O'Brien's  
29          behaviours?

1 A. I preferred to talk about it. I would have gone to the  
2 likes of Martina to discuss it. I do have one incident  
3 that the Trust wouldn't have been aware of, and that  
4 related to the prescription of the tablet called  
5 desmopressin. It's rarely used. It's used for 15:02  
6 nocturnal polyuria. It's a specific drug used in the  
7 elderly. It has to be used with a bit of care. Its  
8 very infrequently used. I prescribed it maybe two or  
9 three times. It's of a low incidence.

10 136 Q. Just to assist the Panel with this, we can draw your 15:03  
11 remarks on this to the Panel's attention through your  
12 statement. If we go to WIT-104217. This is one of  
13 your addendum statements and you're explaining, just  
14 scrolling down to paragraph 7. You say when you were  
15 triaging this particular patient you observed in 15:03  
16 correspondence that Mr. O'Brien had commenced on  
17 200 micrograms of the preparation whereas the  
18 appropriate dose, I think you say somewhere, yes, was  
19 25 micrograms. The patient, presumably because of  
20 a correlation with the excessively high dose came back 15:04  
21 into the system with hyponatremia which happily  
22 resolved.

23 A. Yes.

24 137 Q. This is July 2018. The MHPS investigation had just 15:04  
25 reported, Dr. Khan was about to write his  
26 determination, which I've read to you. You've  
27 indicated just at the bottom here that you wrote to  
28 Mr. O'Brien about this issue but, having reflected on  
29 it, you acknowledged that an option open to you in 2018

1 would have been to complete an IR1 form?

2 A. Yes, I agree with that. I did this correspondence  
3 having triaged the letter on that date. I thought it  
4 was important to try to correct early. I thought  
5 a correspondence with Mr. O'Brien on the issue would  
6 have been the appropriate thing to do to correct the  
7 issue fairly promptly. 15:05

8 138 Q. While you are speaking I'll pull up the e-mail, it is  
9 WIT-104223. That's you writing to him explaining  
10 concisely the problem. Did you, in writing that, give 15:06  
11 any consideration to, I suppose, the many years of  
12 dealing informally with Mr. O'Brien and the problems  
13 that were being drawn to your attention? Was this not  
14 a situation where as well, perhaps, as writing to him,  
15 the issue should have been placed on a formal footing 15:06  
16 through the governance professors. It was a medication  
17 error, potentially a serious one giving rise to harm to  
18 the patient. On any analysis that is something that  
19 needs closely scrutinised?

20 A. Yes, I agree. I was obviously doing triage at the 15:07  
21 time. That's a large volume of information to try to  
22 get through in a sitting. I saw this, I wrote an  
23 e-mail to have it corrected. I should indeed have  
24 filled in an IR1 form, I do accept that. But having  
25 observed myself sometimes the length of time to get the 15:07  
26 full circle of an IR1 back, in my own case that took  
27 18 months of a report on me. I thought this was  
28 appropriate to address at that precise time rather than  
29 to wait for the cycle of the IR1. I should have done



1 both, I did this option.

2 139 Q. Can I move briefly to discuss some MDT or MDM issues  
3 with you. I'm conscious that your role in the urology  
4 multidisciplinary team certainly wasn't a regular one  
5 from 2016 or thereabouts, but on occasions your  
6 patients would be discussed at MDT.

15:08

7  
8 If your patients are discussed, does that necessarily  
9 require your attendance?

10 A. When the MDT was set up originally, we were informed  
11 there was -- two of the urologists were meant to attend  
12 to it and not the full team. As time went on  
13 I understand that the team was meant to be there. In  
14 saying that, with us in Craigavon, they realised that  
15 I didn't have enough clinic space for my new patients  
16 and on a Thursday was the MDT, was meant to be my new  
17 patient clinic and for the last hour of the MDT they  
18 were meant to wait until I had finished my client to go  
19 to it. But either MDT finished early or my clinic went  
20 on beyond the time, and my colleagues discussed my  
21 cases with an MDM outcome, having supplied them with  
22 a clinical report to start with.

15:08

15:09

15:09

23 140 Q. Yes. One of the themes that the Serious Adverse  
24 Incident reviews explored in 2020 was the whole area of  
25 whether the MDT was appropriately resourced, was it  
26 sensitive to the need to ensure appropriate patient  
27 care pathway for the purposes of tracking to ensure  
28 that MDT decisions were implemented and that kind of  
29 thing. It observed that, in its conclusions that there

15:10

1 was a repeated failure to appropriately refer patients  
2 and it suggested, by way of recommendation, that one of  
3 the ways to catch that or identify it and remedy it is  
4 to have better tracking and better, I suppose, use of  
5 governance resources to get to grips with any problem. 15:11

6  
7 You refer in your witness statement to two cases or two  
8 patients for whose care you were responsible where  
9 a problem arose in terms of the referral. And, no  
10 doubt, in any system these things can happen but the 15:11  
11 problem being, perhaps, that it wasn't immediately  
12 picked up upon by The Trust's system because the safety  
13 net -- and maybe you'll help us understand if there was  
14 a safety net -- the safety net, if there was  
15 one, didn't work or there wasn't an effective safety 15:12  
16 net.

17  
18 So the two issues that you describe concerned patients  
19 166 and 137. I just want to deal with these very  
20 briefly, if you would. 15:12

21  
22 Patient 166, an incident report was raised in relation  
23 to that patient. We can see this at TRU-165621. So  
24 this is August 2017. The description is what I wanted  
25 to bring you to. It says that the patient's wife 15:14  
26 contacted the reporter, that's Nurse Campbell...

27  
28 "As they were expecting an appointment with oncology or  
29 surgery to discuss curative treatment for prostate

1 cancer. Upon checking with Belfast they had no record  
2 of a referral having been received."

3  
4 The action taken was to bring this matter back to an  
5 MDT meeting and, as I understand it, correspondence 15:15  
6 with the Belfast Trust to get the patient seen quickly,  
7 given that the problem had been identified after,  
8 I think, the passage of three or four months. What had  
9 happened in this case to the best of your  
10 understanding? What has caused the problem? 15:15

11 A. This man and his wife had attended post an MDT for  
12 a record of their treatment options, which was either  
13 oncology or surgery. I had written a letter to the GP  
14 and, unusual for me, I sent a copy of the letter to the  
15 cancer tracker, asking if she would forward it on to 15:16  
16 the oncology and surgical team. So there was the  
17 expectation that that was sent on. Now that, I must  
18 confess, is not my normal approach. I usually would  
19 have written directly to the oncologist and the  
20 surgeon. I'm not entirely clear why I didn't copy them 15:16  
21 in. So there was the expectation -- it was  
22 a triangulation of the communication, but maybe  
23 that didn't get through properly. Then, when the  
24 patient's wife rang through to Thorndale to inform us  
25 of this, this information was passed from Dolores to 15:16  
26 Kate O'Neill who was then to investigate it, came to  
27 speak to me and I then dictated a fresh letter to the  
28 oncologists who then processed it through their MDT.  
29 141 Q. So the safety net here, if it can be called that, is

1 the GP becoming aware of the situation and, I think it  
2 was the GP, wasn't it? The patient themselves.

3 A. It was the patient ringing back into Thorndale and  
4 speaking to the nursing team, who was the sister at the  
5 time, and then passing it to the CNS. 15:17

6 142 Q. In the 2020 SAIs that we've looked at, the safety net  
7 is of the described as the key worker, the specialist  
8 nurse, in a triangle with the secretary for the  
9 consultant, with the consultant in there, as well as  
10 the tracker, perhaps. What happened that the safety 15:18  
11 net, in this instance, appears to have failed?

12 A. The communication, obviously, didn't get to the city.  
13 If you go back one step, maybe either -- well, either  
14 there wasn't a copy of the letter available to the  
15 tracker, or the tracker didn't send it on or there was 15:18  
16 a paper chase issue of not being passed on  
17 appropriately. Is that answering --

18 143 Q. How could that be avoided today?

19 A. Undoubtedly --

20 144 Q. Or how would it be avoided today? 15:18

21 A. Well, on my opinion the new process of what's coming  
22 through is of the audit. I mean, I think a letter  
23 should be -- I think the letter to the oncology service  
24 or the ongoing service should be copied into the cancer  
25 tracker system and there's a physical letter to prove 15:19  
26 you have done what you said you were going to do and,  
27 you know, there's a good audit trail. You know, each  
28 month there's the opportunity of tracking to make sure  
29 that all the MDT outcomes have been processed as they

1 were meant to be, one, in their content and, two, that  
2 they have gone to the right place, and I think that  
3 possibly would have picked that up.

4 145 Q. Could I bring you to the case of patient 137, the  
5 second patient that you mentioned in your statement. 15:20  
6 The IR form is to be found at WIT-100386. Just  
7 scrolling down to get the description from Mr. Haynes.  
8 So the patient was discussed at an MDM on 12th  
9 January 2017. The outcome was that he was to be  
10 referred to the endocrine MDM. Unfortunately 15:20  
11 this didn't happen. A further GP referring on 12th  
12 May 2017 brought this to my attention -- that's  
13 Mr. Haynes' attention -- and a referral has now been  
14 done. So there has been a four-month delay in this  
15 process. 15:21

16  
17 I think if we scroll down four pages to 100390. It  
18 describes the action taken is that the consultant has  
19 been spoken to, that's you, and the importance of  
20 follow-up stressed. 15:21

21  
22 "it was an oversight on his behalf as he was not at the  
23 meeting."

24  
25 So this is the MDM meeting. 15:21

26 A. Yes.

27 146 Q. The action that came out of it was endocrine and MDM  
28 referral. You missed it, you weren't at the meeting,  
29 the letter of referral didn't issue?

1 A. Yes.

2 147 Q. Does that sum it up?

3 A. Not fully.

4 148 Q. Okay.

5 A. This man was discussed on 12th January. He had 15:22

6 a clinic appointment with me on 19th January, which is

7 the week later after MDT. This is my normal practice

8 is that patients who attended MDT came for a consult.

9 This man was from the Southwest Acute Hospital area, so

10 it is a fair journey up to Craigavon. My understanding 15:22

11 is that there was a phone consultant between the cancer

12 tracker and my secretary saying, look, it doesn't need

13 a consult as Mr. Young normally does, a letter will do.

14 So, now, I'm sure that correspondence was passed on to

15 me but I missed that then. When I went to the clinic 15:22

16 I would have observed that this man had DNA'd and when

17 that happens then there's a cycle of bringing the

18 patient back to the next clinic. But that got lost

19 because it was meant to be a phone call to the patient

20 and then a letter. 15:23

21

22 So, again, coming back to the exact comment we were

23 talking about just before, tracking of the outcome at

24 a month would have actually picked that up.

25 149 Q. Yes. You were the subject of correspondence in 15:23

26 relation to that incident. It is WIT-100383. It's

27 sent by 14th August 2018. So the processing of the

28 issues has taken a while to come through the system and

29 back to you for what they asked for here is for you to:

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29

"Provide reassurance that you now have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner."

15:24

I don't think we have any written response to this correspondence. Were you pressed in any way provide reassurance?

A. I had a face-to-face meeting with Mr. Haynes about this issue in my office. We had a long conversation.

150 Q. What kind of assurance did you give in that kind of situation? Was an important gap in this your absence from the MDT, is that considered to be a relevant factor?

15:24

A. No. I'm annoyed that I didn't action this particular case. It's a little -- this is very unusual for me to have skipped or even my secretary to have skipped the point. At the end of the MDT meeting there's -- originally the list came out as one big, long list alphabetically of the patients and you had to try to find your patient on the list. Then it moved to the cancer system, logging a list of patients per consultant, so you actually knew your list, and also -- so Kate O'Neill would come down after MDT and say, Mr. Young, here is your list, here is what we talked about and the outcome is going to be printed off and it's sort of cross-referenced, what you're meant to do. And especially trying to catch these odd cases. In

15:25

15:25

1 other words, the odd cases being the ones that maybe  
2 aren't coming back to the clinic which then would be  
3 caught. There was a process of catching, the phone  
4 call or the letter. But, as I say, the vast majority  
5 of my patients come back to actually see me in person. 15:26  
6 It's just the way I like to run my practice.

7 MR. WOLFE KC: Chair, I have three short issues to  
8 complete Mr. Young's evidence.

9 CHAIR: Shall we take a shorter break then, maybe ten  
10 minutes, and come back at twenty to. 15:26

11  
12 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

13  
14 CHAIR: Thank you, everyone.

15 151 Q. MR. WOLFE KC: Good afternoon again, Mr. Young. I want 15:39  
16 to deal briefly with the Bicalutamide issue as we know  
17 it. Concern has been expressed through the Serious  
18 Adverse Incident review and some of the cases that made  
19 up that review and, subsequently, the Trust's look back  
20 and audit that Bicalutamide was being prescribed 15:40  
21 inappropriately. Sometimes patients were getting  
22 a suboptimal dose of 50 mg, in other cases there seemed  
23 to be a tendency towards maintaining patients on 50 mg  
24 over a lengthy period of time when surveillance, for  
25 example, might have been the appropriate response and 15:40  
26 Bicalutamide unnecessary.

27  
28 Could I draw your attention to a patient's case that  
29 has your name on it. It's Patient 141. The case comes



1 out of a Multi-Disciplinary Meeting in September 2019,  
2 AOB-09572, Patient 141. You're the surgeon, and the  
3 description on this MDT read-out is that this gentleman  
4 with a clinical diagnose of prostate cancer, four  
5 years. He has been on Casodex 50 mg for some time. 15:41  
6 His PSA is now, could that be right, 105?  
7 A. Sorry.  
8 152 Q. His PSA is 105, is that right?  
9 A. I know the case.  
10 153 Q. Okay. Can you help us out in terms of the description 15:42  
11 here of the patient having been on Casodex, which is  
12 the generic name for Bicalutamide, for some time.  
13 A. I can clarify that more.  
14 154 Q. Please.  
15 A. I can clarify the case and why he was on this dose. So 15:42  
16 this patient is from Fermanagh. I'd seen him at the  
17 clinic there. He had prostate symptoms, poor flow, and  
18 then in 2014, when he was 80, examination of his  
19 prostate I felt just wasn't quite normal. It felt as  
20 if there was a tumour within the gland but his PSA was 15:43  
21 acceptable, it was below 10 at that stage, this is  
22 2014. I explained to him at that stage my concern but  
23 he was resistant to investigation and didn't want  
24 treatment unless it was necessary.  
25 15:43  
26 So I reviewed him on an annual basis. His PSA did  
27 climb. I think in 2016 it was up at 26. I again  
28 explained to him, you know, there is a treatment path  
29 for this if you wish to avail of it. He was keen just

1 to have therapy if necessary. So, to me, I twigged  
2 that, right, we would do a bone scan and see if it had  
3 spread anywhere, which would indicate a strong  
4 indication to move on, and the bone scan at that stage  
5 was clear.

15:44

6  
7 So he continued to be reviewed on an annual basis. His  
8 PSA then got to 62. He was still very resistant to  
9 having therapy or investigation unless it was  
10 necessary. Then it got to the stage that his PSA got  
11 to 112. Now at this stage my conversation with him  
12 changed from, you know, 'look, don't be sitting on  
13 this, you should be having a therapy', and he asked  
14 what was the most simple to look after the situation.  
15 At which I told him to start on the Casodex at 50 with  
16 the subsequent option of either converting to 150, the  
17 standard dose, or, my preference was to start the  
18 injection treatment.

15:45

15:45

19  
20 He then, instead of an annual review at that stage, he  
21 came back at three months and had his PSA checked.  
22 I found that it had dramatically dropped from 112 down  
23 to 16, which I thought was a good response.

15:45

24  
25 Now, going on from that he then had a review either 6  
26 or 9 months later, again with myself. On checking the  
27 notes I then realised that I thought I had changed him  
28 to the other treatments, although he had a good  
29 response to the 50. And I told him, right, our

15:46

1 standard practice now is not to accept this but to have  
2 the injection treatment, which I thought was a better  
3 treatment plan for him. So he was keen to have the  
4 lowest dose and if you're going to have injection  
5 treatment, you have 50 mg of Casodex before you have 15:46  
6 the injection so it was going to cover that approach.  
7 Although I had thought that I'd asked for -- I think  
8 I might have actually written to the GP to say, look,  
9 here's an option to add in the injections but, as  
10 I say, it was only when he came back to see me six 15:47  
11 months later that I appreciated that he was on the  
12 wrong dose. I don't think that 150 milligrams was the  
13 right thing to do, I thought the injection treatment  
14 was better, which I started.

15 155 Q. In starting him on the 50, I think your point is that 15:47  
16 it was with the intention, eventually, of moving on to  
17 the LHRHA agonist; is that right?

18 A. Here is a man that I was trying to persuade to have  
19 treatment and he was resistant to it. So he was asking  
20 what the lowest treatment was and, yes, this was it, 15:47  
21 but with the intention of either converting him to the  
22 one -- in my letter I said it's either the 150 mgs or  
23 the injections, but in my head I was really looking to  
24 start him on the injection treatment.

25 156 Q. You would appreciate, would you, that 50 mgs is, as per 15:48  
26 the regional guidelines, to be used as an anti-flare  
27 agent as you're describing, prior to the injections, it  
28 has no other licensed or indicated use; is that right?

29 A. I use a lot of Casodex 50 and it is always before the

1 injection treatment. It is not used on its own. If  
2 I use Casodex on its own, it's the 150.

3 157 Q. How long, if you can recall, did this patient run on 50  
4 without moving to the injections?

5 A. My understanding is I saw him in September of whatever 15:49  
6 year, and I reviewed him the following summer.

7 158 Q. He's coming to this meeting in 2019, having been on it  
8 for some time. Does that suggest that he's been on it  
9 for several years?

10 A. No. He was on -- no. He was on this for a short 15:49  
11 period of time until he started the injection  
12 treatment.

13 159 Q. Did he start the injection treatment at this point?

14 A. He had started -- no, I think he --

15 160 Q. He is coming to this meeting with metastatic disease of 15:49  
16 the prostate?

17 A. He had been on the 50 mgs and I had asked for the  
18 injection treatment to be started and he had agreed to  
19 that and then here's the September. So he must have  
20 come in at that stage. So I was asking the GP to start 15:50  
21 the injection treatment. But he has come in ill at  
22 this stage.

23 161 Q. This letter reads as if he is on 50 mgs as  
24 a monotherapy. There's no mention of the other element  
25 to the hormone regime? 15:50

26 A. No, I have read the letter. I asked for the GP to  
27 start him on the injection treatment. So there was the  
28 clear intention of starting him on the injection  
29 treatment.

1 162 Q. We have seen a range of cases where -- and this is  
2 particularly coming through The Trust's audit, where 50  
3 mgs as a monotherapy seems to have been the approach of  
4 Mr. O'Brien and, indeed, we received evidence from  
5 Belfast Trust clinicians that as far back as 2008, 15:51  
6 2009, perhaps into the next decade, they're observing  
7 50 mgs as a monotherapy preference on the part of  
8 Mr. O'Brien. Were you familiar with that, that that  
9 was an approach he favoured?

10 A. I wasn't aware of his approach to that. I hadn't seen 15:51  
11 it in scripts. Again, our patient load doesn't cross  
12 over on a clinic appointment. So I wasn't aware of him  
13 regularly using 50 mg, I'm afraid.

14 163 Q. An awareness might come from discussion of patients in  
15 multi-disciplinary meetings. Did you not pick up on 15:52  
16 his preference for this monotherapy at such meetings?

17 A. Well, again, I was outside of the MDT on a regular  
18 basis from 2015 and, prior to that, I hadn't twigged  
19 that he was using it on a long-term basis. My clear  
20 understanding is that 50 mgs is used before the 15:52  
21 introduction of the injection. So you may see on an  
22 MDT script that that 50 mgs had been prescribed, but  
23 there was the assumption that the injection treatment  
24 was going to be following.

25 164 Q. Could I bring you to a concern you expressed in your 15:53  
26 witness statement that I suppose post 2018's  
27 publication of the MHPS investigation you received what  
28 I think you describe as unwanted telephone calls from  
29 members of Mr. O'Brien's family. You say that, this is

1 paragraph 55 -- sorry, paragraph 81 of your statement.  
2 You say:

3  
4 "In mid November 2018 I received two phone calls from  
5 Mr. O'Brien's family. The first was from Mrs. O'Brien 15:53  
6 noting her anxiety that none of her husband's  
7 colleagues had rang to ask how he had been."

8  
9 And, paraphrasing here, you took that telephone call to  
10 be, really, the expression of some sense of being 15:54  
11 distraught on the part of his spouse.

12  
13 The second call, two days later, was from a Mr. Michael  
14 O'Brien, who I understand to be Mr. O'Brien's son, and  
15 he phoned asking more pointed questions about the 15:54  
16 process of triage and how the system works for putting  
17 patients on waiting lists and theatre lists. The  
18 conversation progressed but with what you felt was an  
19 air of intimidation. So it appears to be that both  
20 calls were somewhat unwelcome but the second of the 15:55  
21 calls from Mr. O'Brien, you're seeming to suggest, was  
22 particularly inappropriate?

23 A. Yes.

24 165 Q. What was it, in terms of its content, that you found to  
25 be intimidating? 15:55

26 A. Just a passing comment halfway through that this might  
27 create trouble for you and your colleagues.

28 166 Q. Was he alluding to any particular issue?

29 A. The fact that he commented on it at all I didn't

1 approve of, so I thought it was inappropriate to  
2 continue the conversation further.

3 167 Q. Did you tell him that?  
4 A. Politely I told him this was the end of the  
5 conversation. 15:55

6 168 Q. Yes. He was, that is Michael O'Brien, was somebody you  
7 had met. You had attended his wedding as a guest; is  
8 that right?  
9 A. Correct.

10 169 Q. Did you previously tell Mr. O'Brien that you would be 15:56  
11 prepared to take a call from Michael O'Brien to discuss  
12 matters?  
13 A. Both conversations were out of the blue.

14 170 Q. In other words, you hadn't solicited them and hadn't  
15 agreed to them taking place? 15:56  
16 A. No. They were both unexpected phone calls.

17 171 Q. You obviously spoke to Mr. Weir about this?  
18 A. I thought that was appropriate to inform Mr. Weir of  
19 it, just to express my concern in case a similar phone  
20 call was going to happen to anybody else. 15:57

21 172 Q. Did you speak to Mr. O'Brien about your disquiet?  
22 A. No, I just mentioned it to Mr. Weir who then,  
23 I understand, took action.

24 173 Q. Could I finally seek your views on the circumstances of  
25 Mr. O'Brien's retirement. He says in his witness 15:57  
26 statement, this is WIT-82628, paragraph 675, just down  
27 the page, please. He said it was never his intention  
28 to completely retire, whether on 30th June 2020 or  
29 17th July. It was his intention, after much

1 consideration, to retire from full-time employment with  
2 The Trust on 30th June 2020 and to return to part-time  
3 employment from Monday 3rd August 2020. He had  
4 discussed his intentions with Mr. Young, with  
5 Mr. Haynes, and with Mrs. Corrigan. He says if he had 15:58  
6 been advised of the possibility of any impediment to  
7 him returning to part-time working, he would not have  
8 retired from full-time employment.

9  
10 Do you recall discussing with Mr. O'Brien his 15:58  
11 preference to return part-time, having retired formally  
12 from a full-time position?

13 A. Yes. Mr. O'Brien discussed -- well, informed me that  
14 his intention was to retire in mid 2020. This  
15 conversation was, to my recollection, around Christmas 15:59  
16 time '19. And he said he was keen to return in some  
17 form to do work. My conversation with him at that time  
18 was that he needed to engage with The Trust to enquire  
19 about returning to work but I had mentioned to him that  
20 in view of his past history he may -- and difficulty 15:59  
21 with The Trust -- that he needed to resolve that issue  
22 before he was going to take that further. So I said to  
23 him that his return may not be as easy as he was hoping  
24 for. I also informed him that it was not within my  
25 gift to say yea or nay, it wasn't my decision. But I 16:00  
26 informed him he needed to engage and find out exactly  
27 where he stood.

28 174 Q. Did you express to him any support for his plan to  
29 return part time?



1 A. I suggested to Mr. O'Brien that he needed to be very  
2 careful about what he wanted to come back and do.  
3 I had said to him you're aged 67 at this stage, and  
4 I said you really should be considering what you want  
5 to do and, with that, what The Trust would agree to. 16:01  
6 But it was really asking him did he really think this  
7 was a good idea. But, yes, I -- and I said, you know,  
8 you need to be very careful. You don't want to do any  
9 on call, you want to just look after outpatients or  
10 something simple that is not going to be of a stressful 16:01  
11 nature. So I was -- I personally was happy enough for  
12 him to come back if he gave great thought to why he was  
13 actually really wanting to come back.

14 175 Q. It doesn't suggest that you were expressing support in  
15 any kind of enthusiastic way. It seems to be 16:01  
16 suggesting you need to be careful here and if you work  
17 out it is the best thing for you, I'll support it. Is  
18 it more that?

19 A. Yes. It was more that. I was trying to be protective  
20 of him in saying that he needed to give due concern to 16:02  
21 what he wanted to come back to do, but also telling him  
22 that what he wanted to do had to be agreed by The Trust  
23 and, indeed, the other way round.

24  
25 I think -- I've retired. I would have a difficulty 16:02  
26 just walking out the door and switching off. It is  
27 nice to ease into retirement slightly. I think that's  
28 what Mr. O'Brien was trying to do as well.

29 176 Q. Did colleagues within The Trust seek your views on



1 expectation of returning part-time would be -- was  
2 extinguished. He wasn't being permitted to return.  
3 Were you advised or consulted in advance of that  
4 decision, that the strings attached proposition had  
5 gone, it was now into he cannot return?

16:05

6 A. Further discussions on the strings attached, of what  
7 that involved, was never a conversation. And  
8 Mr. O'Brien not returning was not -- not returning to  
9 work, that information was not given to me before 8th  
10 June. It was away at the end of the month and, in  
11 fact, I was organising Mr. O'Brien's leaving do and had  
12 written to members of The Trust who he had worked with  
13 and had actually written a letter or an email to past  
14 colleagues. I think that's dated 22nd June. And I,  
15 you know, if I had known that at that stage I wouldn't  
16 have been writing that email. This was all in the  
17 middle of Covid as well, we have to remember. So there  
18 was a bit of planning that I was trying to do but, you  
19 know, it wasn't -- so it was the end of June before  
20 I was informed.

16:06

16:06

16:06

21 180 Q. Okay, Mr. Young. Thank you for answering my questions.  
22 I have nothing more for you. The Panel may have some  
23 questions to address to you.

24 CHAIR: we'll hopefully not keep you too much longer,  
25 Mr. Young. I'm going to hand you over, first of all,  
26 to Mr. Hanbury for some questions.

16:07

27  
28 MR. YOUNG EXAMINED BY THE PANEL:  
29

1 181 Q. MR. HANBURY: Mr. Young, thank you very much for your  
2 evidence. I have three short questions which hopefully  
3 shouldn't be too onerous.  
4  
5 First of all, one thing on triage, essentially this is 16:07  
6 a GP asking a specialist for an opinion. Do you agree  
7 with that?  
8 A. Yes.  
9 182 Q. When you were having your discussion as a department  
10 there was some opinions expressed that The Trust should 16:07  
11 tell you how to do it. Did that...  
12 A. There's an element of the information supplied by the  
13 GP could be better, more information that is of  
14 relevance to what we're trying to inform us about. For  
15 instance, if somebody comes in with haematuria, we 16:08  
16 would like to book a CT, urogram, we need to know what  
17 the renal function is. That sort of thing would have  
18 been good to include on the letter for instance, it  
19 might save us a little bit of time looking up.  
20 183 Q. It is just the concept of trust interfering or telling 16:08  
21 you how you should be doing it seems to go against the  
22 principles of, I would guess, most urologists.  
23 A. Sorry, I misinterpreted. Correct, no, it is nice for  
24 us to know how to triage.  
25 184 Q. And make the appropriate decision? 16:08  
26 A. And make a decision from that.  
27 185 Q. Thank you. Early on in your career there was a weekly  
28 uroradiology meeting, separate or rather before I think  
29 MDT started. This is, obviously, an opportunity to

1 discuss complicated cases, seek opinions from  
2 colleagues. As an endourologist or as someone with  
3 that interest you must have appreciated that meeting.  
4 I guess my question is it seemed to disappear.  
5 I suppose my question is was there a forum for you to 16:09  
6 ask colleagues difficult cases, to swap ideas and  
7 experience after the time the MDT started and the  
8 uroradiology meeting seemed to disappear?

9 A. On a personal note, our benign radiology meeting was  
10 the best of the week, frankly. It was a disappointment 16:09  
11 that it stopped. But there was plenty of opportunity  
12 to go down and speak to the radiologist team. It's  
13 good to go to the person who actually did the  
14 radiology, but there was a very open court there that  
15 you could go and discuss. It was a miss that 16:10  
16 we weren't all in the room at the same time, but there  
17 was free speech between us all that we could bounce  
18 cases back and forth off each other. But as a group  
19 together, unfortunately that meeting was run by the  
20 same radiologist that ran the MDT and it was going to 16:10  
21 be difficult to get engaged there as well.

22 186 Q. I think you've answered my next question. So the  
23 reason was there wasn't -- the radiologist couldn't do  
24 two meetings a week, is that correct?

25 A. Yes. We had a uroradiologist. In fact we had two 16:10  
26 you uroradiologists, but one left, and the other  
27 radiologist had their own meetings. So we were short  
28 a radiologist to actually cover our service. Our  
29 nephrostomy service insertion, you know, wasn't a 24/7,

1 it was only done on certain sessions. If we needed  
2 a nephrostomy, that patient had to go to Belfast to  
3 have it done. So we were short, undoubtedly for years,  
4 of urologists. Of the guys that are there, they  
5 are excellent but they have been pulled right, left and 16:11  
6 centre.

7 187 Q. Last question, hopefully right up your street, about  
8 urethroscopy and stone fragmentation. We have heard  
9 the early days of stone fragmentation using the  
10 electrohydraulic lithotripsy in many units, which we 16:12  
11 have all worked in, used that. You pick out one  
12 pertinent point is that if you have got a safety wire,  
13 you can rescue a situation if you have inadvertent  
14 ureteric damage. I guess my question here is did you  
15 discuss this case in a Patient Safety or departmental 16:12  
16 meeting and were you able to persuade other colleagues  
17 that the safety wire was a good idea and did it change  
18 their practice?

19 A. All of my colleagues use safety wires. Most of the  
20 colleagues who have joined the unit has been in the 16:12  
21 last ten years so they will all have been brought up in  
22 their teaching before they arrived on site. Maybe  
23 going back to the 2000s when I first joined the  
24 department, Mr. O'Brien wasn't observed, from speaking  
25 to the registrars, to be using a safety wire and 16:13  
26 fluoroscopy. But I changed that practice, from my  
27 understanding. Certainly, we've been inserting stents  
28 under fluoroscopy since I arrived basically.

29 188 Q. So he did change his practice after this case?

1 A. There was an element of having an image intensifier  
2 available. We've now got quite a few image  
3 intensifiers fires, but back at the beginning it was  
4 a combination of an image intensifier and  
5 a radiographer. Now, when I was in the City and 16:13  
6 training, you didn't have a radiographer, you were able  
7 to step on the pedal yourself. But when it came to us  
8 in Craigavon, any radiography work had to be supervised  
9 by a radiographer and getting that out of hours was  
10 a bit of a challenge at the beginnings, but, again, 16:14  
11 patient safety wise, I had spoken to the radiology team  
12 and they felt, yes, this is a good idea.

13 189 Q. So you changed that successfully.

14 A. Yes, we changed that very early in the whole -- well,  
15 I wasn't prepared to put in a stent without 16:14  
16 fluoroscopy.

17 190 Q. Thank you very much. That's all I have to ask.

18 CHAIR: Dr. Swart.

19 191 Q. DR. SWART: Going back to the dreaded triage for  
20 a moment. We saw yesterday some minutes of a meeting 16:14  
21 that you had and we heard quite a lot about triage.  
22 Generally it seems, and you can tell me if I've got  
23 this wrong, that in the main, as a consultant group you  
24 had a common understanding about the importance of it,  
25 the way you were going to do it, giving conversation to 16:15  
26 your time constraints and so on, but that Mr. O'Brien  
27 really didn't agree with you. That meeting didn't come  
28 to a proper conclusion other than to say The Trust  
29 should sort this out. One will ask oneself who is The

1 Trust and it is, of course, partly all of you. Was  
2 that the case, did you feel you couldn't agree and you  
3 needed some help with it? Was that the case? Because  
4 it wasn't really clear where that was going to go.

5 A. Yes. The vast majority of us knew what -- had 16:15  
6 interpreted what triage was involving. And Mr. O'Brien  
7 was making it too complex in that it was taking too  
8 long.

9 192 Q. So other than -- so that was the problem. Did you then  
10 go and talk to your Clinical Director or anyone else to 16:16  
11 say look, we can't sort this out. Clearly we're the  
12 urologists, we need to sort it out because we know  
13 about this, but we are having his difficulty, can you  
14 recommend how we deal with it. Did you do that  
15 conversation-wise or formally? 16:16

16 A. Well, our conversations were with the Acute Service  
17 Director level who was running the admin and the --

18 193 Q. But this is a clinical issue really, isn't it?  
19 A. Yes, I suppose it is. It had been going on so long  
20 we assumed that everybody knew about it, and that the 16:16  
21 likes of the CD and the AMD level -- we were aware  
22 that --

23 194 Q. You didn't have a a mediation meeting to sort it out or  
24 anything like that?

25 A. No. 16:17

26 195 Q. Okay. One of the things you said today was around as  
27 clinical lead you can't know everything, which is  
28 clearly true. You only know what people tell you or  
29 what data you are provided with. What is difficult to



1 see is what discussions did you have and did it lead to  
2 any data to help you with this in terms of complication  
3 rates for operations, blood loss, return to theatre,  
4 efficacy of pre-op assessment, these kinds of things.  
5 Did you sit down as a team to say we need to have some 16:17  
6 measures to know if our care is safe, we need to decide  
7 what those are and can someone collect that information  
8 for us. Did you do that?

9 A. We do have an audit department. It was --

10 196 Q. I know that but did you, as a group of clinicians, say 16:17  
11 this is what we think matters for urology?

12 A. Okay. I don't think so.

13 197 Q. And do you think that would be helpful?

14 A. Absolutely.

15 198 Q. why do you think you didn't feel you could ask for 16:18  
16 that? Do you think -- was it pressure of work? Was it  
17 a scant audit result? Because I'm sure every surgeon  
18 wants to know these things?

19 A. Yes, we do have our readmission rates --

20 199 Q. That comes from the Hospital episode statistics, 16:18  
21 doesn't it?

22 A. Exactly. So that's length of stay, readmission rates.

23 200 Q. But I'm thinking of -- we're talking about  
24 prostatectomy, and you said, really, it's not just the  
25 length of operation, it is is the patient all right, 16:18  
26 did they lose too much blood, was the sodium too low,  
27 all these kind of things. That kind of data can be  
28 collected in a department if somebody is minded to do  
29 it. Now, you can't just do it on top of everything

1 else, clearly. But were you aware of that, the need to  
2 do these things?

3 A. We were aware of these things that we should be doing.  
4 But, again, it's in the background of the overall  
5 volume of what we were trying to get through. A lead 16:19  
6 point is what's the waiting list. So those were --

7 201 Q. I can see that in the data. Did you have any direction  
8 from what you might have called, I think you referred  
9 to it as the higher echelons, in terms of what kind of  
10 things you should be looking at in terms of quality? 16:19

11 A. Yes. We certainly have this through our Patient Safety  
12 Meeting now, that's --

13 202 Q. Has that changed in recent years?

14 A. Our Patient Safety Meeting is fabulous now. If I may  
15 say, it was a breath of fresh air to have all the young 16:19  
16 consultants coming when Mr. Glackin arrived, he took  
17 charge of that and did a marvellous job.

18 203 Q. But you still don't have these measures?

19 A. No. But it is our audit and our audit department has  
20 improved considerably. There's now an audit 16:20  
21 coordinator and we have -- where we would have had  
22 maybe one or two audits a year, we now have a specified  
23 list that we go through. Some can be maybe more  
24 complex. Some are short-term snap audits. It's very  
25 audit driven now at the moment. For the last two 16:20  
26 moments I have been at, our audit tracker has been at  
27 them and we have discussed all of that. And, in fact,  
28 our Patient Safety Meeting used to always start off  
29 with deaths, morbidity, then audits and any other

1 comments. Now Mr. O'Donoghue has switched it round  
2 completely. The first things discussed on the meeting  
3 are the audits and the morbidity because our mortality  
4 patients are, well touch wood, are fairly predictable.

5 204 Q. We hadn't heard about that. It's good to hear that 16:21  
6 covered?

7 A. It's really good. I'm very impressed with what  
8 Mr. O'Donoghue is doing with the system.

9 205 Q. On the more mundane side, a basic patient safety issue 16:21  
10 is things like writing a letter to the GP, doing the  
11 triage, following your guidelines, looking at results,  
12 and I get the sense that it was too easy, in the past  
13 anyway, to do the wrong thing in some of this.

14 Therefore there wasn't really a track on whether  
15 everybody got a letter, whether everybody looked at 16:22  
16 results.

17  
18 Now, you showed us a little scorecard for results which  
19 is clearly an improvement and I would imagine some  
20 other metrics will come. But this business of the 16:22  
21 culture where it is too easy to do your own thing is  
22 key in patient safety, as I'm sure you're aware. Why  
23 do you think there was this tolerance of people just  
24 doing what they liked a bit?

25 A. It's the pressure of the volume of work to get through. 16:22

26 206 Q. Just that? Who should sort it out? We talked about  
27 the Trust, but where do you think the responsibility  
28 lies for ensuring these things are not tolerated.  
29 Because they are very basic patient safety things,

1 really?

2 A. These are within the department yourselves. And if  
3 it's not being done then maybe a stern conversation is  
4 maybe required, or a specific sort of focus on these  
5 things at a departmental meeting saying here's what we 16:23  
6 want to --

7 207 Q. Do you think there was enough emphasis from the top of  
8 the tree on these things as opposed to targets, money,  
9 waiting lists, whatever?

10 A. There could have been more support from above, 16:23  
11 probably, yes.

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

13 208 Q. CHAIR: A few things. I take it you're aware of the  
14 nine SAIs that fundamentally led to this Inquiry being  
15 set up in the first place. One of the things that is 16:24  
16 common to all of them is that there was no CNS, there  
17 was no key worker?

18 A. Yes.

19 209 Q. You, on 8th November when you were last here you talked  
20 about the value that the key worker brings to the 16:24  
21 cancer pathway. I just wondered, when you discovered  
22 that none of those nine patients had a key worker, how  
23 did you feel? Were you surprised? Were you shocked,  
24 or what was your view?

25 A. I was a bit surprised because in my practice I had 16:24  
26 somebody attached to it, which was a Friday afternoon  
27 staff nurse. So I had somebody. So I found it a  
28 little bit unusual.

29

1 It is the depth of involvement by the CNS. Are they  
2 physically in the room? Is that very important? The  
3 important -- you may think that may be important, but  
4 it's the importance of having the nurse talking to the  
5 patient after you've spoken to them. 16:25

6 210 Q. Isn't it even just the patient having the contact  
7 detail of who to contact?

8 A. Yes. So there's lots of stages. As I say, in the  
9 room, as I do, maybe the patient comes in, I then  
10 introduce the CNS and I go over a summary of the 16:25  
11 situation. That's another one.

12

13 Outside the room the nurse has the opportunity to go  
14 over that again and to have the holistic attachment to  
15 it that doctors maybe aren't the best at. Then, as you 16:25  
16 say, that --

17 211 Q. If a CNS isn't available --

18 A. That's what I'm saying, on a Friday I get a staff  
19 nurse, and we give them the pamphlet and say here's the  
20 CNS's phone number and it is open court for the patient 16:26  
21 to either ring in --

22 212 Q. If I have interpreted what you're saying, is really  
23 there's really no excuse for the patient not getting  
24 the information to allow them to have a key worker; is  
25 that fair? 16:26

26 A. Yes, yes. It might not be delivered on that exact day.

27 213 Q. But they should have the contact information given to  
28 them at the least?

29 A. Yes. Yes, that's right.

1 214 Q. Thank you. Just in terms of your role as clinical  
2 lead, am I right in thinking that you preferred to deal  
3 with things informally, you don't like confrontation,  
4 would that be fair?  
5 A. I think that's fair. 16:26

6 215 Q. I think it's clear from what the Inquiry has heard that  
7 Mr. O'Brien would be a dominant force within the  
8 department. would that be a fair comment?  
9 A. That's a fair comment. I know the words challenge to  
10 challenge. I would use the interpretation that when 16:27  
11 Mr. O'Brien has made up his mind he's hard to shift.  
12 Your idea has to be considerably better than his. So  
13 that's my interpretation. It's a slightly different  
14 twist to challenge to challenge. I would give my idea,  
15 he would give his idea, if mine wasn't better... 16:27

16 216 Q. You had no chance?  
17 A. Yes, well, that's coming -- in saying that, to be fair,  
18 on a clinical point of view, on the old sort of ward  
19 rounds, you know, Mr. O'Brien would ask my opinion on  
20 something and if he hadn't already made up his mind on 16:27  
21 it --

22 217 Q. He was open to be persuaded?  
23 A. He was open to talk on a clinical ground and  
24 we actually got on well that way. But I think if  
25 there's a pathway to follow, it is his way. 16:28

26 218 Q. That seems, perhaps, most obvious in the issue of  
27 triage?  
28 A. Yes.

29 219 Q. Just in terms of your -- you seem to have had a good

1 relationship. He was the first in the department, you  
2 were the second in the department. Did you feel that  
3 he was more senior to you, even though you were both  
4 consultants because he is the initiator of the  
5 department, if you like? 16:28

6 A. Yes, you will always have a senior and a junior, but  
7 I wouldn't let him know that.

8 220 Q. Did that mean you found it more difficult in your role  
9 as clinical lead?

10 A. Yes. I'm always -- I think you're always going to feel 16:28  
11 that way talking to a senior person.

12 221 Q. I take it, I mean you just mentioned earlier that you  
13 had been to his son's wedding so I take it you had  
14 a good social relationship with him. He described in  
15 his appraisals about, you know, having a good 16:29  
16 relationship with the staff even if he was somewhat  
17 direct at times?

18 A. Yes.

19 222 Q. What I'm trying to get at is if he never discussed  
20 receiving the March 2016 letter with you. He never 16:29  
21 came to you and said, look, I've got this letter, how  
22 am I supposed to deal with all of this? You never had  
23 that conversation with him?

24 A. No, I never had that conversation. He passed comments  
25 that he had received information from The Trust but 16:29  
26 wasn't allowed to discuss it with me. But I think that  
27 related to something later on.

28 223 Q. Yes. I mean he was given a letter at a meeting with  
29 Eamon Mackle and, I think, Martina Corrigan in

1 March 2016 and said -- he never told you that he had  
2 got that letter or that he was expected to do anything  
3 about it?

4 A. I would have appreciated that if he had done that  
5 I might have been able to help out. 16:30

6 224 Q. That was my next question.

7 A. But no, I never -- Aidan likes to sort everything out  
8 himself.

9 225 Q. Would that be to his detriment do you think?

10 A. Oh, absolutely. 16:30

11 226 Q. The other thing I just wanted to be clear about, you  
12 talked about a triage sheet. I'm not sure, and it may  
13 be some of the junior lawyers may have seen such  
14 a sheet, but you talked about when you had -- is there  
15 an example of that sheet? 16:30

16 A. Is this the actual stamper we're talking about?

17 227 Q. Yes.

18 A. I'm sure we can supply one.

19 228 Q. I mean we may well have one in the bundle somewhere but  
20 I know I haven't come across it yet. It's not to say 16:30  
21 it's not there. Was this something that you devised?

22 A. This is a stamper I devised.

23 229 Q. Was this to try to get over the issue about the  
24 difficulties with triage with Mr. O'Brien particularly  
25 or not? 16:31

26 A. No. It was for -- it was not designed for one person,  
27 it was designed for all of us. It was actually to help  
28 the booking office and it was to quicken up what you --  
29 instead of writing everything on the GP's referral, it



1 gave you the opportunity to put a tick in it.

2 230 Q. So a standard template, essentially?

3 A. It's a template. On the one side it was red flags and  
4 the opportunity to upgrade. Then there was urgent and  
5 routine. And then on the other side of the box it was 16:31  
6 the intention of the investigation to be done at the  
7 clinics. So you wanted an ultrasound, you wanted a  
8 flexible cystoscopy or you wanted a TRUS prostate  
9 biopsy. Now, that was the code for the booking  
10 office -- 16:32

11 231 Q. To organise?

12 A. No, not so much to organise but not to overbook one  
13 clinic with an excessive amount of one thing. In other  
14 words, you don't want ten TRUS prostate biopsies on  
15 your outpatient -- you will not get through the list 16:32  
16 adequately or -- well, one, in time and, two, there  
17 wouldn't be enough probes to actually make it happen.

18 232 Q. Am I right in thinking that this template document  
19 would have speeded up triage for all of the consultants  
20 if they just used that? 16:32

21 A. It was a mechanism -- yes, well it helped, in a way, to  
22 code what clinic you wanted it to go to. Then in the  
23 bottom half you could do a free text "I've booked a CT  
24 urogram". So it was more for the booking office to book  
25 to the appropriate clinic, so it wasn't overbooked or 16:33  
26 underbooked. And also whenever the patient came to the  
27 clinic and the chart was in front of the nurses with  
28 the referral letter on it, if they saw that there was  
29 an ultrasound to be done, that ultrasound --

1 233 Q. would be done then?  
2 A. -- which was done at the clinic, but could be done  
3 ahead of the consultation.  
4 234 Q. It speeded up the whole process?  
5 A. It was to speed up the process of booking. There was 16:33  
6 an element of helping the triager --  
7 235 Q. Focus?  
8 A. It was a focus in the clinic, it gave you a box to  
9 write in. It wasn't a replacement for the triage.  
10 236 Q. Very well. Talking about the TURP procedure and the 16:33  
11 length of time and you are saying that the issue was  
12 about complications rather than the precise amount of  
13 time that was taken, but surely there's an issue here  
14 as well about the theatre time that was being used up  
15 and the other staff commitments that were being used 16:34  
16 up, is there not? If someone is particularly slow,  
17 that is something that should feed down into the  
18 department for the department to address as a group?  
19 A. An operation will take as long as an operation takes.  
20 It may have a standard name to it but, you know, one 16:34  
21 TURP might be small, might take you half an hour --  
22 237 Q. I appreciate that. My point is that if there is one  
23 person in the department who is taking much longer than  
24 other people, what I'm saying is the department should  
25 be aware of that as a group so that they can find out 16:34  
26 why that might be. There may be good explanations in  
27 individual cases, but if it's a common problem and it  
28 seems to be if it was the subject of tea room  
29 conversation, it sounds as though it was more than just

1 a one-off.

2 A. Okay. As we said, Mr. O'Brien is maybe a bit slower  
3 than most things. He does everything slowly. But it's  
4 all about the safety of doing an operation. I remember  
5 very clearly when I was a registrar in the City 16:35  
6 Hospital that it was the charge nurse ran the theatre  
7 list. It's the old version of a scheduler. And she  
8 would schedule four TURPs for one consultant and two  
9 or three for another consultant. She knew how long it  
10 took him to do the procedure safely, and that's how the 16:36  
11 unit runs. So everybody runs at a different rate. And  
12 it's about scheduling your list appropriately, and not  
13 overrunning. Says me, smiling, when I overrun my  
14 theatre list, but....

15 238 Q. Two other matters. The DARO system was designed to 16:36  
16 ensure two things. To ensure that people weren't lost  
17 to the system, that the results would come through and  
18 that they would be put on to the waiting list  
19 appropriately when those results came through. But  
20 there is another, it was also designed, was it not, to 16:36  
21 reduce the waiting lists for people so that, for  
22 example, if the results come back and there's nothing  
23 to see here, you know, a short phone call to a patient  
24 might be don't need to see you for review, come back if  
25 there's any difficulty. That frees up a slot for 16:37  
26 somebody else to move up the list; isn't that true?

27 A. That's exactly right.

28 239 Q. So it served two purposes?

29 A. It served certainly more than one. We were maybe

1 concentrating on the writing of seeing the result but,  
2 yes, it had a knock-on effect that you could just say,  
3 'dear sir, your X-ray is fine'. As we do an awful lot  
4 now, I mean at our stone clinic it has turned around  
5 quite immensely. We tend to write a lot to patients. 16:37  
6 Going maybe to the dark ages when I ran the clinic, you  
7 know, I did a clinic, I saw the patient, I did an X-ray  
8 at the time, when the patient was in front of us, and  
9 I had a long waiting list. That's really why, in the  
10 mid of last decade, that I realised that we were 16:37  
11 getting behind on the situation and needed a change.  
12 So this is exactly an example. It is less personal but  
13 patients, I think, do appreciate having the earlier  
14 consultation with a letter saying you don't have  
15 a stone anymore or whatever the case might be. So it 16:38  
16 works both ways.

17  
18 A consultation, I'm a wee bit old school, I think  
19 consultation is good. A letter is a one-way  
20 conversation. 16:38

21 240 Q. I appreciate that. But it could be there is a short  
22 telephone conversation with the patient, for example,  
23 rather than bringing them all the way back from  
24 Fermanagh or somewhere?

25 A. Again, that's what our system at the moment is. 16:38  
26 Dr. McAuley, a big influence in our stone service with  
27 and Mr. Tyson and I'm sure you have heard what he has  
28 been going through.

29 241 Q. One final thing. We heard -- I think it is important

1 that all this Inquiry is hearing is put into the  
2 context of what you all had to deal with and it is  
3 clear that there were extraordinary pressures on this  
4 department. But I just wanted to be clear that the  
5 pressures that were on Mr. O'Brien were no different to 16:39  
6 those on yourself, for example, or on any of the other  
7 consultants; is that fair?

8 A. Yes. The pressures were not on one shoulder. It was  
9 very much the department. And even on our nursing  
10 staff. I mean, I think I said away back at the 16:39  
11 beginning when we were getting the original McClinten  
12 report, said we needed some CNS's and that the  
13 department says why, one will do, and I asked for two.  
14 I wished to heck I had asked for four because it took  
15 so long to get there. So it's the load on the nursing 16:40  
16 staff expected to have covered both the administration  
17 of nursing in Thorndale as well as producing a nursing  
18 output. Now that has been taken off them and with the  
19 expansion of the service in nursing staff, it has been  
20 remarkably fabulous. 16:40

21 242 Q. In that light what would you say, since all of this has  
22 come to light and this Inquiry has been set up, what  
23 would you see as the most beneficial change that there  
24 has been in the urology department, having retired and  
25 come back in on a part-time basis? 16:40

26 A. I see the input of the CNS service has been a major,  
27 major change. It's at that level of nursing has been  
28 very important. We've had staff nurses stepping up to  
29 the mark and helping out. It is the independence of

1 the nursing staff and giving them the support, knowing  
2 that there's a consultant there to ask. Maybe it is  
3 going back quite far. I talk about Thorndale 1 and  
4 Thorndale 2.

5 243 Q. We're aware of the change. 16:41

6 A. I know we had a lot of tensions with The Trust about  
7 trying to -- after the regional review and 9 and 10  
8 there was talk, but we knew which direction that we  
9 wanted our urology department to go, had to put that  
10 across. But I certainly knew that once we got the new 16:41  
11 floor space, the right size, the right number of rooms,  
12 all under one roof, and with our nursing staff there  
13 and auxiliaries, all there, knowing that there was the  
14 support of somebody coming in all the time that they  
15 could bounce questions off. That gave them more oomph 16:42  
16 to go on and do more things. As you'll have heard, our  
17 nurses do the transperineal prostate biopsies. That's  
18 pretty good going. It is not commonly see. Our benign  
19 service, the likes of Jenny does the Botox, you know,  
20 and that's great. And we now have a stone MDT as well. 16:42

21 244 Q. The corollary of that is that that takes pressure off  
22 you as a consultant body?

23 A. I've forgotten how to do it nearly -- not quite.  
24 We have a stone nurse as well who runs a clinic and has  
25 got well involved in that. So, you know, that's -- so 16:43  
26 that's probably the main thing. I haven't talked about  
27 a doctor there, so that's all about nursing. We could  
28 do with the full complement of consultants. Maybe also  
29 giving time to think, what you were saying as well, you

1 know, and having time to do the right audits and not  
2 just do the face to face. It needs the other joined up  
3 writing to make the service run very well and all the  
4 points that you're -- and having time to actually get  
5 it across.

16:43

6 CHAIR: Mr. Young, thank you very much. It has been  
7 a long three days I know for you. But we appreciate  
8 you coming, as we do all of the witnesses that we hear  
9 from. So thank you. You will be glad to know that's  
10 you finished with us. Thank you.

16:44

11  
12 Tank you everyone, back tomorrow morning, 10 o'clock.

13  
14 THE INQUIRY ADJOURNED TO THURSDAY 7TH DECEMBER AT 10:00

15 A. M.

16:44