Urology Services Inquiry

Oral Hearing

Day 92 – Monday, 8th April 2024

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

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THE INQUIRY RESUMED ON MONDAY, 8TH APRIL 2024, AS FOLLOWS:

CHAIR: Morning. Good morning everyone. Mr. O'Brien. Mr. Wolfe. 09:57

MR. WOLFE: Morning Chair and members of the panel. Your witness this morning is the familiar figure of Mr. O'Brien who, as you will recall, was last with us on the 21st of April last year when he gave his evidence as part of a three day session. This is a 09:58 further three day session during what we anticipate is the final week of public hearings. Mr. O'Brien proposes to be re-sworn.

CHAIR: Very well.

09:58

MR. AIDAN O'BRIEN, HAVING BEEN SWORN, WAS QUESTIONED BY MR. WOLFE AS FOLLOWS:

MR. WOLFE: As I say, Mr. O'Brien was last with us on the 21st of April last year. The transcript recording 09:58 his evidence on the three dates from last year is to be found at TRA-04619 through to 05014.

Since you were last with us Mr. O'Brien, you have provided us with an addendum statement. We can find 09:59 that at WIT-107564. And that was provided to the Inquiry just over a week ago. If we go to the last page of it at WIT-107623, that is your signature dated 28th March 2024. And subject to one typographical

error which I'm going to bring you to, would you wish to adopt this statement as part of your evidence to the Inquiry?

A. I do.

1 Q. I'm obliged. The one typographical error is to be found at paragraph 64(ii) at WIT-107586. And I think this error was just discovered overnight, so we can quickly tidy it up. It's to be found in the second sentence of that (ii) paragraph, where it says: 10:00

"The Trust has provided redacted copies of the operation note written by Mr. Hagen on 6th May 2010."

That should read 6th May 2000, isn't that correct?

A. That is correct, yes. 10:00

2 Q. So we'll change that, with your permission. And then the second reference continuing the sentence:

"...and the discharge summary dictated by me on 3rd August 2010." 10:01

Again, that should simply be changed to 2000?

A. That's correct.

3 Q. I'm obliged. So those corrections can be considered as having been made. 10:01

One further housekeeping matter before we proceed. Mr. O'Brien has sought permission to have an aide-memoire beside him to ease his ability to refer to

particular documents. I've considered that and you have considered that?

CHAIR: Yes, I've no difficulty with that, Mr. O'Brien.

A. Thank you.

4 Q. MR. WOLFE: Okay, let's begin. On the last occasion when you were with us the focus was primarily on the MHPS process, and you'll recall that at the commencement of your evidence we had brief opportunity to touch upon the -- some of the contextual factors that informed your practise, and in that regard you made a number of, I suppose remarks, which help us to better understand your perspective. So, for example, at TRA-04641, you explained to the Inquiry that you would like any of your alleged shortcomings to be viewed in the context of you doing your very best to provide the best care to patients when the resources weren't there to do so. Isn't that right? That's very much your philosophy or very much part of your thinking. 10:01 10:02 10:02

A. That's correct. 10:03

5 Q. And what I want to do this morning is, recognising that we really only touched lightly upon some of those contextual factors, I want to give you an opportunity, through my questioning, to better explain how the service developed -- that is the Urology Service, how it developed, and it's weaknesses as you saw them, and how those weaknesses impacted upon patients, the service itself and how it was managed, and your practice. And perhaps, where it's relevant to say so, 10:03

the practice of your colleagues. So that's, in large part, our agenda for today. And probably into tomorrow and Friday we will touch upon, perhaps in some detail, some of the alleged shortcomings of your practice and give you an opportunity to respond to those, recognising, of course, that the primary interest of the Inquiry is in respect of the governance arrangements touching upon the clinical aspects and, therefore, the opportunity to dilate into the fine detail of individual cases is not available to us. So, with those signposts in mind, let me recall that you commenced your role as a Consultant Urologist in Craigavon, I use that location to reflect the Trust and the arrangements as they were at that time, you came into that post in July 1992, isn't that right? 10:04 10:04 10:05

A. That's correct.

6 Q. And you were a single-handed consultant in what was, I suppose, the first appointment of a urologist in that location?

A. That's right. 10:05

7 Q. And you quickly saw a very significant demand for urological services?

A. I did.

8 Q. Yeah. And I think as we touched upon the last time, you, at quite an early stage, were led to the view that -- and this is from, this is taken from your witness statement at paragraph 28, the foundation, you have said, upon which the Department and service was initiated, was one of a lack of awareness of the 10:05

urological need which was not serviced. So I think I understand you as saying that at the outset the Trust or the organisation was blind or not sufficiently informed as to the requirements for a modern urological service and the demands that would come with that. Is that a fair way of summarising it? 10:06

A. Absolutely. And just to elaborate, you know, simply, I mean the distinction between urological need in any community and urological demand are two different things because, you know, demand only presents itself when there is some kind of service and people become aware of the service. So the urological need in any population is always much greater than the urological demand, which only manifests itself in the presence of some kind of service. And prior to my appointment, the perception of a urological service was very rudimentary almost. It entailed, you know, resection of the prostate, resection of a bladder tumour perhaps, dealing with ureteric stones as they were dealt with at that time and the occasional nephrectomy, but when a urologist who is trained in the speciality comes along, you bring with you a completely different perspective and range of abilities and awareness of need which rapidly manifests itself. 10:07 10:07 10:08 10:08

So I think I said in my witness statement, you know, that after about six months I came to appreciate that the perception of urology -- urology was spelt TURP I think I said at one stage, and I remember, I remember

the date for a particular reason, 15th December 1992, I did the first radical cystectomy and orthotopic bladder replacement in a lady with bladder cancer, and when I went to the consultant dining room -- there was such a thing in those days -- the following day, as soon as I opened the door there was silence because they were all talking about this enormous operation that was done that they hadn't heard tell off, which is not surprising, but that just gives you an example of the disparity between or the discrepancy between their perception of what was going to be provided, what their need was, and what the reality actually would be. And from that time it has been an uphill struggle, and we've never got there, it's still not got there and that's... 10:09 10:09

9 Q. We'll have an opportunity as we go on to look at, for example, the waiting lists, which have been the subject of scrutiny throughout our proceedings. And I just want to sort of check the baseline. Is it your understanding or belief that the problem of a lack of understanding of the need for a fully developed urological service, which seemed to be the position at the outset, according to your understanding, and you've set that out in your statement, is that something that this Trust, and the Trust has changed in its shape or its constitutional form, location, et cetera, over years, but you know what I'm saying, that general geographical location we now call the Southern Trust, is that problematic birth that this Urology Service 10:10 10:10

emerged from or suffered, has that not been reformed or remedied during its history?

A. To a degree. But, you know, that disparity is not just -- it wasn't and still remains not just restricted to the Southern Trust, it pertains to Northern Ireland as a whole. But certainly, you know, from my direct experience of the initiation of a urological service back in 1992, I mean it did take 10 months for the Trust at that time -- I don't think the Trust became -- the Craigavon Area Hospital Group Trust came into existence the following year -- but anyhow, the management at that time, it took them 10 months to persuade the consultant in public health for the Southern Health Board at that time, of the need for one urologist at that time with a population of about 260,000. And I remember whilst I was still in Bristol and after having been appointed, I got a call one day from one of the general surgeons, sadly no longer with us, to say that he had written out, they had written out to all the GPs to say I was arriving on 6th July 1992, just in case I didn't have enough to do, and I thought, my goodness, you know. So you had that coupling, you know. There was a lack of acknowledgment at Board level of the need. There was a lack of acknowledgment within the surgical establishment in the hospital of the need, and that pertained for quite a long time, and I would say it still is there, as is manifest by the waiting lists that still pertain to this day, which are now worse than ever.

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10 Q. And we can see from the materials that the Inquiry has assembled that from time to time you have sought to initiate improvement and reform and expansion, or better support for the service. Some of the headlines we'll briefly walk through now. You wrote a paper in 1997 called "The Future Development of Urological Services". Mr. Young came into -- I forget precisely the date he came in, so you can maybe help me on that -- but he joined forces with you in pushing for an improvement. We then had the intervention of the McClinton Review, and then a short number of years after that we were into 2009 Regional Review. Let's just walk through some of those developments. 10:13 10:13

Your paper in March 1997, AOB-00027. That's the cover page. If we move to, if we drop down two pages, sorry, yeah, to the background. Just scroll down. Sorry, I think I've lost my page. If we just scroll back, please, to the page before that. Back again. Yeah. So just here. 10:14 10:15

You summarise in that second paragraph there, "This document provides an outline" of the purpose of the document. So you're setting out within this document, I suppose your understanding five years into your post, where urological need is within the population you served and how the Trust needs to, if you like, be more ambitious to develop the service going forward if it's to meet the needs of its population. What was your 10:15

thinking in developing this paper?

A. I can't remember now what precipitated it, you know. It would have been one occasion when I would have put or would have had need to put my, or motivation to put my thoughts into print. But, you know, five years in, 10:16
and if this was 1997 you say, so at that time we did have a second consultant urologist in post who took up post on 1st January 1996 and then he left on 31st December 1997, and Michael Young was appointed on 1st May 1998. So during that period of time, I mean I had 10:16
just emerged from being the sole urologist for a period of three and a half years, during which time I provided a continuous emergency service, or an acute service, and we basically needed to expand. It was always trying to impress upon the authorities at that time of 10:17
the need, the demand, how inadequate the service was, what I considered were the priorities in moving forward, particularly with regard to the continued provision of an acute service. I mean there's no point in trying to see as many people electively as possible 10:17
if you cannot provide an acute service. I think I may have concentrated in that document on the need to provide a stone service, because even in some audits that we did away back then, the Southern Trust, for whatever reason, that geographical area, has a very, 10:18
very high preponderance of stone disease. So it was about trying to put into writing for those who needed to consider it, what it was that was required. What the deficiencies, what the most important deficiencies

were at that time in terms of patient need and in terms of addressing the major risks to patient safety at that time.

11 Q. And I think if we maybe just scroll through to page 35 in the sequence, 00035, you were making the case, I think, that this -- yeah, just at the top of the page. Maybe just scroll down so we can see it all in context. I think you talk there about the ambition should be for the appointment of four consultant urologists. At this point in time there was you and Mr. Young, sorry, Mr. Bush? 10:18 10:19

A. Mr. Baluch.

12 Q. Baluch. Thank you for that. Mr. Baluch. And Mr. Young to come the following year. But at that stage, I suppose it's you're making, or you're observing, based on your experience, that even two consultants isn't enough, we need to expand? 10:19

A. Well at that time I mean I was entirely aware, because one of my peer colleagues from my days in Dublin was the Chair of the Manpower Committee of the European Board of Urology, and at that stage I knew that the mean consultant urologist to population ratio in Western Europe was 1 to 53,000 population, and we're sitting with two for a population of over a quarter of a million, which obviously is inadequate. And, you know, when you're one, like myself, who in my training days and as a consultant, you know, went to European meetings and you talked and listened to people outside of their presentations, and you appreciate how 10:19 10:20

different the working practices are of consultant urologists on the European mainland, where basically a consultant urologist would be operating at least two days a week, if not three, and doing one ward round and one clinic. Whereas, you know, even years after this document, we're lucky to get two operating sessions per week, because when you have inadequacy of such a degree the pressure is always to see more people at the front door without having any backup service to provide for their need. So, yeah, I mean at that time certainly four consultant urologists -- and that's 1997. 10:21 10:21

13 Q. We have heard from Mr. Young, and I'm sure you heard his evidence or read his evidence, about the build up to pushing, I think it was Mr. Templeton at that time, in the direction of bringing in an independent expert who could consider the state of the service and make suggestions or recommendations for change, and Mr. Young portrayed that pressure, if you like, as coming from both himself and yourself so that the Trust could understand, so that Mr. Templeton and others could understand that this was really a patient safety issue. And, as I say, that led to the McClinton Review taking place and reporting in August 2004. So seven years after you've written the document we have in front of us, finally, I suppose, a report spelling out the changes that needed to be made. What's your recollection of that period and your state of mind seven years after writing this, without changes having been made? 10:21 10:22 10:22

A. You know, it's a very good question, because in terms of state of mind I can't recall what my state of mind was in that period of seven years, but basically you can imagine that if you write the document, and this is not the only document, you know, or it may be the only document, but you've had many conversations with the Chief Executive or Medical Directors about this need and what needs to be done, and when little progress is made over a long period of time, and seven years is quite a lengthy period of time, you just try day in day out, through long days, to try to mitigate as best one can, with your colleague, the risks of people coming to harm due to that service inadequacy. 10:23 10:23

And then when you come to the Sam McClinton Report, and I did have the opportunity subsequently of speaking with Mr. Templeton, then the Chief Executive -- and for whom, I would like to take this opportunity of just adding, I had the greatest regard and respect -- and he actually did say to me subsequently prior to his retirement that he had difficulty in actually believing the two of us that there was this degree of need and demand. And, you know, that was a mark of him as a person to have that degree of honesty. So there is no doubt that the Sam McClinton Report was a significant injection of reality into a situation where there was even a kind of disbelief in management of those who were trying to tell them of the need and what needed to be done. 10:24 10:24 10:25

14 Q. We can see the executive summary of Mr. McClinton's report. It's to be found at WIT-52123. We heard evidence already from Mr. Young summarising those, the recommendations that he made, but he sets out the key challenges adversely affecting the urology services in your area at that time, and he characterises these as: 10:25

"Insufficient manpower or capacity to deliver a full urological service, increased waiting times for outpatient, in-patient and day cases, and an increasing emergency workload." 10:26

Scrolling down, he talks about what has been done. But ultimately his recommendations come to the need to expand the service, isn't that right, including the addition of consultant capacity and the development of what was to become the Thorndale Centre, or the Thorndale Unit, which was to house the Southern Trust's equivalent of the ICATS arrangements. But do you share Mr. Young's belief that there was a period of inertia before the recommendations contained in the McClinton Report were put in to effect and, indeed, some of them weren't put into effect at all? 10:26 10:26

A. Yes, I do. And, you know, I mean I do know that there would have been pushback from other specialties within the hospital. I do know that complaints were made to John Templeton that he was actually showing a degree of favouritism by trying to be as supportive as he possibly could of the development of a urological 10:27

service. So was there inertia? Was there resistance to expansion? There was inertia, and in addition to that inertia, or possibly it was consequential and a result of a degree of pushback, because there was demand for increase in services all around, and still in 1997 and through to 2004, there was a degree to which urology, and the service that was required, and the service that it delivered, was still regarded very much as a Cinderella subspeciality of general surgery. But we had achieved quite a lot, you know. We had, particularly, the installment of Northern Ireland's only on-site lithotriptor in 1998. I visited a number of centres in 1997 in Berlin, Hamburg, Antwerp, looking at different models, and we came up with a very good lithotriptor in a very good site adjacent to theatre that would enable lithotripsy stone treatment to be done under general anaesthesia or as a walk-in outpatient service, and there was quite a bit of resistance to that development particularly from Belfast Urology because they reckoned it should be in Belfast.

So, we had -- we met quite a bit of resistance, and I take my hat off to John Templeton for having resisted the resistance, you know, and enabled us to have as much development as took place at that time. But, even after the McClinton Report...

15 Q. So the response -- sorry to cut across you. One of the responses, or at least it happened in the same

timeframe to McClinton, was the appointment of an Australian team?

A. That's right, yes.

16 Q. Who came...

A. That's right. 10:30

17 Q. Based themselves in South Tyrone Hospital and -- as a project, I suppose?

A. That's right.

18 Q. Sought to address waiting list problems in your location at that time. But as Mr. Young remarked in 10:30 his evidence, it wasn't until 2007, despite the recommendations of McClinton, that a third consultant was appointed, that was Mr. Akhtar you'll recall, and the proposal of a fourth consultant recommended by McClinton in due course, never actually materialised 10:30 until the expansion following the Regional Review. I mean, how would you characterise the response to McClinton? Was it slow but a case of "we got some improvements that represented a significant stride forward", or was it something more negative than that 10:31 in your view?

A. I think there were two sides to that coin at that time, because we were very pleased with the effort that was put in by the Australian team coming to South Tyrone Hospital, and it was led by a consultant urologist 10:31 called Mr. Batstone, and in fact we were very, very keen to appoint him as the third consultant, but then he decided at the last minute not to be interviewed for it and he went further afield. So that's one side of

the coin.

On the other side of the coin is that, you know, when you put in a particular time restricted effort, like the Australian effort was, or awaiting list initiative, 10:31
it's just a stopgap, you know, it isn't actually, you know, a mature strategic planned expansion of a service throughout all of the domains of practice that are required to provide such a service sustainably in the long-term. So that's the negative aspect of it. 10:32

So there was a positive element to it in that we got a lot of work done, a lot of backlog work done, particularly operatively -- that was the emphasis, it was to address the long waiting lists that were 10:32
considered long at that time. So it was very, very welcome. We thought that there would be a continuity with the appointment of Mr. Batstone as that third urologist and we would build from there, but that didn't materialize, and then there was a hiatus until 10:32
Mr. Akhtar came and, as you have just said, it took another five years after that before we managed to appoint a fourth consultant.

19 Q. I suppose the next significant chapter in the development of Urology Services, both locally with your 10:33
own Trust, and regionally, was the 2009 Review which was endorsed by the then Health Minister in March 2010. We can see that, looking at the recommendations if we can just bring that up on the screen, please? There

were 26 recommendations that emerged from the Regional Review, WIT-11877, and I think it's a document that the Inquiry is familiar with. But a broad ranging set of recommendations, everything from requiring providers to conduct an ICATS review, an emphasis on trying to develop single visit outpatient and diagnostic services for prostate cancers in particular. Consideration of the need to reform elective surgery, including the need to develop action plans for day surgery. A whole emphasis on consideration of the need to work differently, including, as we'll look at perhaps tomorrow -- not tomorrow, Wednesday -- the requirement to transfer the care of radical pelvic procedures to Belfast. 10:34 10:34

So far as the configuration of regional services was concerned, a three team model was developed. Team south, based in Craigavon, was of direct concern for you. And coming with that reconfiguration was provision for two consultants, full-time consultants to be appointed, in addition to the three who were already in place, as well as support staff, including an expansion of nursing staff. That's a bit of a whistle-stop tour through the recommendations. 10:35 10:35

It led to a Team South Implementation Plan. Did you regard the review of Urology Services as a good idea in principle?

A. Yes.

20 Q. And in terms of its outworking in relation to the Southern Trust, how would you characterise that or reflect upon that?

A. In terms of how long it took to implement it or...

21 Q. Well in terms of what emerged from it. 10:36

A. Ehm, well basically, you know, it was a good idea, of course, to see expansion in the service. You very often can translate in any of these documents and plans expansion equals increase in consultant numbers. It's not as simple as that. Obviously you do need increased 10:37 manpower, but you need an awful lot more to enable the increased manpower to provide the service. You need increased beds, you need increased theatre sessions. So the frustration for me and for my colleagues at that time was that all of that backup infrastructure didn't 10:37 necessarily accompany the increased manpower that was the headline.

22 Q. I wonder was that frustration that you talk about reflected in terms of how you related to management who were trying to develop an implementation plan with you 10:38 and your colleagues? We've heard evidence from Gillian Rankin, Mr. Mackle, Mr. Young in relation to that. I just want to get your perspective, in all fairness, in relation to what they've said.

10:38

If I could first of all bring you to what Dr. Rankin has said. TRA-06341. And she, in her evidence, referred to the Monday evening meetings, which I think you've touched upon already in your evidence, but if we

go to line 10 she talks about -- I was asking, or my colleague, Ms. McMahon, was asking her about the process and whether there was a resistance or an inability to change because the reform recommendations that came with the Regional Review called for change, 10:39
called for change in working practices, called for change in terms of the services that were to be provided and how they were to be provided, and she says in her evidence that certainly that was a theme, that was -- the theme of resistance or inability, was a 10:39
theme throughout, and particularly in the Monday evening meetings, that an issue for change might be agreed, and perhaps that was then retrenched or rescinded the following meeting. In terms of making changes in clinical behaviour, and this is directly a 10:40
reference to you:

"Whilst help was offered, there was a resistance to making that change. I think the only thing that was requested was additional secretarial time. There was 10:40
no other help sought in thinking about how he could change his administrative processes to free up time for clinical work, which is primarily what his job was around."

10:40

Mr. Mackle's comments, and I'll try to summarise these as a package and maybe -- what he said is that in terms of the Monday meetings in the context of the 2009 Review, he was met, and Dr. Rankin was met by three

urologists with a lot of suspicion, obfuscation and obstruction to the process. Mr. Young, his perspective is that he thinks maybe "Some of us" he said:

"...were a little bit more vocal than others. I know it's saying here..." 10:41

- that is in response to what Mr. Mackle has said:

"...that it's the three of us, but certainly I think it's reasonable to say that Mr. O'Brien wasn't so keen on all the changes that were coming. I did agree with him because we had to agree as a unit of where we were wanting to go, but I think some were more against it than others." 10:41

So hopefully that encapsulates something of the theme that has been presented to the Inquiry, that you, perhaps more softly through some of your colleagues, but certainly you were leading the charge in opposing or challenging some of the changes that were being proposed to you? 10:42

A. Well, the one change that comes to mind that I think you might be most referring to, or perhaps the witnesses were most referring to, was, you know, the impression or the directive that we were being given at that time that we had to see a certain number of patients in an outpatient clinic in an accordance with the BAUS recommendations of 2000, and having moved on 10:42

in the nine or 10 years since those recommendations were drawn up by the British Association of Urological Surgeons, and even though all three of us said, you know, they're out of date, practice has moved on, if you're doing a one stop clinic or if you're reviewing patients post MDM, for example, it takes a longer period of time. So, there is no doubt, frankly, that the review recommendations, you know, at the end of the day they were very, very much top down, and you were being told at Monday evening meetings "This is what you must do in order to have this whole package implemented and signed off", and even though you, all three of us, tell Dr. Rankin and Mr. Mackle, it's just not possible to do it with following those guidelines or recommendations. That's what gives rise to this impression of Dr. Rankin that we come back to the next meeting having reflected upon it and we're more, even more resistant, because all we're doing actually is reiterating what had been said in the previous meeting and which has not really been taken on Board. If there are any other specific recommendations that you can think of.

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23 Q. No. I think we wish to have your, I suppose, general reflections on, I suppose, the sense that this was a period of great rancour and instability within Urology Service because of the position adopted by you and your colleagues vis-à-vis the -- as opposed to the position adopted by management, and your sense of it that, your sense of it in terms of how it impacted the service

going forward?

A. Well it was a very unpleasant period of time, quite frankly, and I think I have said, and I think I did say in giving evidence a year ago, that the conduct of some of those meetings should really not have been tolerated by us at all. You know, it's fine for people coming along 10 or 15 years later and putting a less negative spin on those meetings, but they were most unpleasant. I didn't enjoy them at all. My colleagues didn't enjoy them either. And they were very, very difficult, because, frankly, you weren't being listened to, and it's very demoralising when you have been, in my case, a consultant for almost 20 years at that time after years of training, you sometimes wonder was it all necessary or what's the point in having all of that experience in everyday practice and to be in a position to advise people? And it doesn't matter because it's top down and there's no meeting of the waters, as it were. 10:45 10:45 10:46

24 Q. The objective of the review, if we can just have a look at that and have your comments. It's set out at AOB-00142. And this is the -- just scrolling back so we can see the front page. This is the document that sets out the Team South Implementation Plan, and just scrolling back to 142, it sets out that: 10:46 10:47

"The purpose of the Regional Review was to develop a modern, fit for purpose in the 21st Century, reformed service model for Adult Urology Services which takes

into account relevant guidelines. The future model should ensure quality services are provided in the right place at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care." 10:47

So that's the, I suppose in grandiose terms some might say, the objective for the Regional Review, and we'll come on to look at how, over the period of the next decade, services weren't able to cope with the demand. 10:48 So we'll look at that in some depth. But can I initially have your perspective on how well that objective has been met, looking back from, I suppose, the date of your -- I know you don't wish to call it retirement, but when you left the service of the Trust 10:48 in 2020, had that objective been met?

A. Well, not at all. You're descriptive adjective of the paragraph in italics as grandiose is exactly appropriate. It's entirely apt. Like "develop a modern" - well that didn't happen. "Fit for purpose in 10:49 the 21st Century", what does that mean? "Reformed service model for Adult Urology Service taking account of the relevant guidelines", and so forth, "making sure that people get quality services", and quality at least should include safe, "provided in the right place at 10:49 the right time by the most appropriate clinician", and so forth. In effect, actually, at the Monday meetings we were telling them that this would not work if you don't listen to us and take on board what we -- and

they did to a degree, but it was a very, very unpleasant, difficult period for all of us. So, did it succeed? No, it didn't. No more than it did in 1997.

25 Q. Well if you're looking at what was put in place, what changes were made, from that knowledge that you now have about it and how the service ended up, what were the problems? What were the traps at the start of this process that led to the poor outcomes, as you see it? 10:50

A. Well it's a difficult circle to square in a sense, because if I were the urological director I would -- you'd have to be honest with the population and say to them, the most important thing is not to have people seen within two weeks, or one month, or two months, or three months. I mean the emphasis should be at the back of the shop. I mean I think it is scandalous really that you have a situation then, and we have it even more now, where people are waiting years for urgent admission for surgery or treatment, during which time their conditions are getting worse. I mean you've seen it throughout the course of this Inquiry, I have read it in all of the evidence that has been given, I just in the last number of days was reading an email from Mr. Matthew Tyson two years ago where he predicted it would take him 6.25 years to clear the complex stone cases that were on the waiting list at that time. You know, I don't have a magic solution to the current situation, which is dire, but surely it is entirely unacceptable that you have a situation where people are losing their renal function due to stone disease. They 10:50 10:50 10:51 10:51

could end up in dialysis, they have premature deaths, urosepsis and death. And instead we have had an emphasis this past 20 years and more on ensuring that people are not queueing up outside the concert hall in long queues because it doesn't look good, so that we get them in as best we can, irrespective of where they come from geographically, and when they get in we'll tell them actually there's no concert on today, but we'll take your name and address and we'll contact you in a few years time when you can come and see the concert that you have queued up for. There's something fundamental and asymmetric and unacceptable about that situation. And if you compare it to the practice in mainland Europe, it's entirely different. Or even indeed in Britain, you know, my colleagues in Britain in 2020 had a maximum time for a first outpatient consultation, irrespective of the urgency, of 18 weeks. And in 2020 we had routine patients waiting three and a half years. So in every aspect from every perspective it has been grossly inadequate. 10:52 10:52 10:53 10:53

26 Q. The summary position I suppose set out in your statement is, throughout your time at the Trust there was inadequate staffing and insufficient logistics, such as availability of theatre time. Does that, I suppose in a nutshell, explain the waiting lists as you see it? 10:54

A. Yes, of course. The whole service in every respect has been inadequate, and when I use that word I'm very, very mindful of the situation that we found ourselves

in in those years around 2013 to 2016, when the in-patient ward became increasingly unsafe. I mean, the first major setback for our service was the loss of the ward that we had spent 18 years, or whatever, building up with experienced Staff Nurses and so forth, and the loss of that in 2009. Thereafter we didn't have, we couldn't provide an adequately staffed in-patient facility to ensure safe care of patients peri-operatively. So inadequate and unsafe, I don't know how I can describe it additionally. It is sad that we found ourselves in this position, and how it can be rectified, in my view it's going to take a generation to do so. 10:54 10:55

27 Q. Of course one of the outworkings of the Regional Review was the appointment of more consultant staff. The ambition of the implementation plan was to have those two additional consultants in place by February 2011, but they didn't -- they weren't appointed until the end of 2012 in the case of Messrs. Glackin, Connolly, and I think a third was appointed, Pahuja, but that was to cover the fact that Mr. Akhtar had left. And then two of those consultants didn't stay around in the Trust very long, they moved on to pastures new, leading to the appointments of Mr. Suresh in 2013 as well as Mr. Haynes and Mr. O'Donoghue. Nevertheless, after a period of stability in the waiting lists, perhaps as a result of the Australian initiative, as we called it, and the appointment of Mr. Akhtar, the waiting lists got considerably worse in the period following the 10:55 10:56 10:56

Regional Review. Is that your understanding?

A. It is, and I think I am correct in saying that the date of the last waiting list initiative target was December 2013. I think that all of us did work additionally doing waiting list initiatives to take the target time down to 36 weeks, and I think actually perhaps even a shorter period. I think the last time that we had a target to be met was at the end of 2013. But, you know, waiting list initiatives they are a stop gap, you know, as I have referred to previously and, thereafter, things just progressively got worse. 10:57 10:58

28 Q. We can see, and I'll invite your comments on this, we can see the waiting lists and how they I suppose got worse over the period of time, let's take the period 2015 to 2019. If we go to WIT-27319. And this is the review backlog position as of the 30th April. And just scrolling down. You have a total of 916 patients at that time, if these figures are correct, and Mr. Young 150 or so better off than you, but still significant numbers. It also being significant that some of these backlogs go back a number of years. They're primarily routine patients, but also some urgent categories of patients. The review backlog in your case, if we go to 19th February 2019, and that's at WIT-27573. And in your case we can see that review outpatient backlog figure, I think we're comparing like with like, has been reduced by 300 or so in that four-year period. 10:58 10:59 11:00

A. Mmm.

29 Q. But longest waits going back four years. So some

improvement, you might say significant improvement, but how do you explain the fact that in terms of review backlog you have the most reviews comparatively speaking? What brings that about? Is that because you're slower at attending to reviews or is it some other factor?

A. If you compare myself to Michael Young, who has a large stone review waiting list at that time, and a lesser general review waiting list at that time, it's reasonably comparable. It's interesting that if you compare mine at 675 to John O'Donoghue at 549, even though he was only appointed whenever, going back to September 2015, and to Mr. Jacob at 634, there's not an awful lot of difference. And the interesting thing is, is that when you compare all of those to Mr. Glackin and Mr. Haynes, and I think actually if you would have flipped back to 2015, it's only in the last years that I appreciate, you know, the extent to which I think...

30 Q. I can come back to it, sorry. Do you want to go back to WIT?

A. Yeah. Yeah. It...

31 Q. WIT-27319.

A. Yes. Yes. So just if you'd scroll down. So I think Mr. Haynes, yes, none! Zero. I think that's right. Yeah. And Mr. Glackin is something like 256 at that time. And I thought that that was just an error at that time, but if it is the case that there were none for review, I mean there is a reality there that is that he didn't review patients to the same extent that

others did, and you know my views on that because, you know, you could regard it as a criticism of mine of his practice, but on the other hand, it's not what I would like to do, because I do believe that this is one of the consequences of inadequacy of service, and to my mind it's a negative consequence in that patients are no longer reviewed at all. Instead, they are monitored, and they're not monitored, but some feature of their pathology is monitored, whether it's a PSA or a CT scan or whatever. I think Mr. Young in his evidence referred to it very, very simply and nicely and eloquently as "it's a one way conversation", which of course is not a conversation at all, and... 11:03 11:04

32 Q. So just to be clear. If your premise is right, and you say that might reflect that Mr. Haynes isn't carrying out as many reviews as -- I think to finish the sentence -- as you would in similar circumstances, and to translate that into what I think you're saying, are you saying that the pressures on the service are forcing clinicians into, I suppose choices, difficult choices in terms of how they practise, in order to get on to see the next urgent or red flagged patient? 11:04 11:04

A. Yeah, I do, very, very much so. And I think that one of the -- I hope you don't mind me saying it, but one of the sad features of this, of what has given rise to the Inquiry and so forth, is, do you know, this comparative study of O'Brien versus others. I think actually there is a gross underestimation of the impact of inadequacy. When you have such severe inadequacy, 11:05

as is self-evident from all of the data that you can look at and which you may go on to look at further, it does result in people responding to that in very, very many varied ways, do you know. Do you no longer review patients but just monitor their PSA? Do you stop doing ward rounds, which is one of the saddest things I had to listen to in listening to evidence being given in recent months, when a phone call can do instead? All of these things, you know, we are diminishing patient care and patient experiences being diminished. And I can tell you that even though I am four years gone, I mean I'm still being approached by people on the street, in shops and so forth, to tell me about their experience. And it's getting worse instead of getting better, even though you listened to -- I didn't listen to her -- but like Dr. O'Kane telling the Inquiry about how wonderful everything is getting better. But they're detached from the reality on the ground.

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33 Q. Well I'm not sure in all fairness that that entirely captures her evidence. But let me take it back to another aspect of the waiting list, and that is in-patients without a date. If we scroll down to the next page, please, and, again, this is the position in 2015. In-patient and day case waiting lists. A total of 924 on the waiting list. Again, I don't intend to turn this into a beauty contest. You have 112 patients, which is more than anyone else. But -- and with the longest wait of 81 weeks. Mr. Young has a longest wait of 84 weeks. Again, help us to understand

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how that comes about that you would have more patients on your in-patient and day case waiting list than any of your colleagues?

A. I don't know, is the simple answer. This is 2015. It doesn't surprise me at all. In fact I think actually in more recent times, as we have just seen in the 2019 figures, it was about 280. So 112 is quite respectable in that whole timeframe going on from 1992. 11:08

But it's interesting that Mr O'Donoghue, down at the bottom of the screen, even though he has only 30 patients waiting is -- nonetheless the longest wait is 91 weeks. So there are disparities there. It's also perhaps related to the nature of the cases, the nature of the surgery that is provided, what different consultants are concentrating on. So you can have 112 patients waiting 81 weeks, and those 112 patients may not require as much operating time as half that number requiring more complex surgery, so there's all of those factors that would contribute to that disparity. 11:08 11:09

34 Q. Yes. And if we just scroll up so that I can see the top of the page. Yes. Thank you. If we go -- just to compare with 2019 so that we can see the picture. If we go back to WIT-27574. And here we have, I suppose, in-patient day case waiting lists. We can see that, I suppose, there's an expansion in the numbers waiting to be seen compared to 2015, perhaps not surprisingly given the contraction in resources that has been reflected upon in the evidence before this Inquiry. 11:09

Again, you've a significant number on your urgent 216 patients, and on the routine side of it you have 57 patients. In terms of -- we'll look after the break at the impacts that you were seeing and were aware of in terms of the patients themselves and morbidity, and we'll look also at the impact on practitioners, including yourself. But these figures are stark. They clearly reflect a service under strain, is that fair?

A. It's minimalistic to say it's fair, it's absolutely correct, and these figures just bear out what the likes of myself and my colleagues have been saying for decades. We are providing a grossly inadequate service. And the only other thing I would say to that is to reinforce what I've said earlier, and that is if you look at those figures of those people waiting like 230-odd weeks, do you know, four and a half years for urgent surgery, even if you look at the best, which is Mr. Jacob at that time, waiting three years for admission for urgent surgery, it is appalling really. And this is not -- I'm not speaking here with an agenda to be finger pointing and blaming and so forth, it's just a statement of my view of the reality of the situation, and it's going to be difficult to identify the priorities. These figures would be the priorities to my mind. It is terrible if you have any one of these, there's 677 patients awaiting urgent admission for four and a half years, and it wouldn't be at all surprising if you had 10 of those patients who died prematurely because of complications of their

condition, and that is unacceptable. It's sad.

35 Q. Yes. Well, we'll come back and touch upon that in a little more detail after the break.

A. Thank you very much.

CHAIR: Okay. Thank you. Come back then at 11:30 everyone. 11:13

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS:

11:14

CHAIR: Thank you everyone.

MR. WOLFE: So just before the break we were looking at the waiting list figures, which the evidence has been, and is again reflected through your statements, those waiting lists have been, I suppose, an outworking or a 11:30 reflection of the demand, capacity mismatch as it has been neatly called. I suppose to put more humane context to this, you've explained in your witness statement that behind these waiting lists are unsafe services which result in increasing risk of serious 11:30 harm to multiple patients. Mr. Haynes has, I suppose particularised that by saying in a similar vain, this is in his witness statement at paragraph 393:

"We see patients come to harm, example emergency 11:31 attendance, when on a lengthy waiting list for surgery necessitating emergency treatment. We see recurrent catheter blockages, changes in catheter related infection in men awaiting bladder outflow surgery..."

- and so on. "We're seeing it so regularly", he has said, "that it is almost normalised." Again, your reflections on that. Do you share that view?

A. Absolutely, and I think it's a very, it's a very apt term to use, "it has become normalised" and, as you know, this Inquiry has inquired into how the Trust went about assessing that kind of risk to patient safety due to long waiting lists. And, you know, increasingly I think we all shared that probably central concern with regard to -- this is the greatest risk to patient safety. It is the length of time that they're waiting to have their definitive remedy to their condition. And if I may say so, in general parlance, in the public domain, you will often hear it being referred to as people in pain, and I'm not diminishing pain. If you have a painful right hip whilst awaiting a hip replacement, it's pain that you're suffering every day, and that impacts negatively upon your quality of life, but ask most orthopaedic surgeons, and I would say if you have to wait five years, it's a different operation that is required, and by that time your left hip has gone as well. So this is what had become our -- it has always been my concern since day one since 1992, quite frankly, the harm that people were coming to. I have seen people become dialysis dependent because of waiting too long to have their stones dealt with. I have seen, as the Inquiry has heard, of patients dying of urosepsis following stone management. So it's a reality and, you know, I'm just going on just to

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confirm what you have said, but my emphasis is that this is the greatest source of patient harm, in my view.

36 Q. I want to go on just a little bit later to delve into some of the responses to this malaise that were initiated by you and your colleagues to try to, I suppose, arrest management's attention to the need for solutions. I also want to look at whether it would have been feasible to work in a different way as a clinician, or as part of a clinical team, to arrest some of the worst effects of this shortfall in resources. But can I have your general observation, without descending perhaps into the detail, in terms of whether you think, as a general observation, more could have been done within the Trust, including amongst the Urology team, to better get to grips with these spiralling waiting lists and the pain, as you say, that lies behind it? 11:34 11:35 11:35

A. I don't really think that we could have done anything differently that would have impacted positively upon the totality of the operative waiting lists. I think it would be quite reasonable to state that perhaps we could have done things differently that would have targeted those people, or cohorts of patients on the waiting lists that were at most risk of coming to harm, and one thinks of the stented patients, and it may not be the appropriate time now, but my aide-memoire brings me back to an email that I wrote in June '16 where I had 276 patients I think on my waiting lists at that 11:35 11:36

time, and I had placed the red flagged patients, cancer patients who had not been given a red flag status, patients with stents in and patients with catheters in, all in the same category of urgency.

37 Q. So if you could just give me that reference and we'll... 11:37

A. Yes, it's AOB-77568.

38 Q. And what we'll do is we're going to look at stents as a capacity as well as a clinical management issue in the course of the early afternoon I think. So we'll touch upon that now. One of the things I think you've hinted at, perhaps more than hinted at, is that the situation in which the Trust found itself with Urology waiting lists being, I think by any standard -- out of control might be too strong language to put on it, but certainly spiralling and causing difficulties for patients. You've hinted at, I suppose, what you might regard as a somewhat desperate measure on the part of the Trust, and you refer here to a waiting list validation exercise which you became aware of in 2019, and you discovered that a patient had been removed from the waiting list through an administration, administrative validation exercise, and you were concerned about that. And we can see, if we bring up the emails in this respect, AOB-09499. And this is an email from you on 22nd September. Just scroll down. Yeah. So you're writing regarding this particular male patient who had a stone obstructing his right, upper right ureter in 2015, and you explain his management

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and how he was placed on the waiting list on 8th October 2015. You discovered in August of 2019 that he had been removed, or in July of 2019 he had been removed from the waiting list. You contacted him by phone and he explained the correspondence that he received. Can you just elaborate then, Mr. O'Brien, on why you were concerned about what you had discovered and what you think it was pointing towards? 11:39

A. Well if you could scroll on down it might help?

39 Q. Sure. 11:39

A. So basically this is a topic or an example that touches upon several aspects of practice, one is waiting list management, and I mean I paid a great deal of attention to waiting list management out of necessity, because every day one would receive queries about where I am, get messages about deteriorating conditions and so forth. So I always, when I got a new print-out of my waiting list, I compared it to the previous one to see if someone was missing, why were they missing that I didn't know about? So I explored it from that point of view. 11:40 11:40

So four years in this man has been removed from the waiting list. So he indicated that he felt that he didn't require his operation anymore because his only problem was getting up at night to pass urine and that was relatively tolerable and mild for him. But then I got an ultrasound scan performed finding that he had inadequate unsatisfactory bladder voiding, that he had 11:40

also a stone in his bladder, and I subsequently found on that CT scan that he also had a stone in his kidney I think, and when I reported back to him the findings of all of that, I dictated a letter to the GP asking that he be prescribed some medication whilst awaiting admission for the TURP that I recommended that he still did have, and after he would have his diabetic control optimised.

So basically my concern at that time was that a waiting list, an administrative waiting list validation exercise was being undertaken without any clinical advice being requested or inputted. Basically, this comes down to informed consent, do you know. It's perfectly reasonable for any patient to say "I do not wish to proceed with the surgery", provided that they are optimally informed of the consequences of their decision, because it's very easy to be taken off a list, but if he had changed his mind a month later and wanted to be put back on the list, he wouldn't necessarily have been put back on his previous date. And you will have heard I think from Mr. Cavanagh when this was addressed when he gave evidence, because it appeared to me that Mr. Cavanagh wasn't aware that there was no clinical input into the validation exercise. So I drew attention to this, and you may wish to draw attention to the fact that I copied Mr. Haynes into this and then he...

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40 Q. Yes. We can see, if we scroll back up, that Mr. Haynes

was also concerned. There was no awareness that this processed started, and he explains that if the process is limited to checking whether a patient is deceased and hasn't gone elsewhere, then that would be fine, but he's articulating the view that there was information to suggest that the process went beyond that, and that was unsatisfactory and perhaps dangerous from a clinical perspective. 11:43

If we look at -- and it appears that because of your interventions the process ceased to be carried on. If we look at what Mrs. Corrigan, Martina Corrigan has said about that. If we go up -- just let me see the page numbers at the top of the page? If we go back four pages to 495 in the sequence, please, and she's explaining, if we just go to the third main paragraph, this process, as she explains: 11:43 11:44

"...had been discussed originally with me as being an admin validation, that is to determine if they are not deceased, living at the same address, check that they have not had their procedure done elsewhere. However, on discovering through increased MLA and patient inquiries that this was a letter sent to patients to ask if they still wanted their surgery, I immediately put a stop to urology and ENT..." 11:44 11:45

- although she says she believes other specialties are continuing. So it would appear from a service

perspective, including Mrs. Corrigan's view on it, that this was certainly an unanticipated validation exercise and one that she was not supporting. But it perhaps illustrates your view on this, that sometimes desperate measures are taken to try to address waiting list issues? 11:45

A. Yeah. Well, I mean I'm somewhat sceptical, not particularly of Martina's view, that she wasn't aware of the clinical consequences of that, because they had been going on for years previously, and if I am correct, and I stand to be corrected if I am incorrect, as far as I could see from more recent disclosure they're still continuing. I do not know whether they're continuing with clinical input or otherwise. And really, you know, it's the kind -- I think actually apart from my criticism in relation to that particular patient and, indeed, Mr. Haynes' criticism, because he found one of his patients who had been taken off the list with even more dire consequences, is that, you know, it's unnecessary. If the patient is on the waiting list, and if I were considering his admission, of course I would be contacting him and I would be having that discussion with him as to whether or not he wished to have it and whether he was clinically informed and so forth. So I just considered it to be, you know, a waste of money, because it's easy to take the patient off the waiting list when the clinician is in contact with them, which is one of the reasons why I always felt that the clinician is the most appropriate 11:46 11:46 11:46 11:47

person to be conducting waiting list management rather than a validation exercise like this, for which £20,000-something was paid to undertake at that time.

41 Q. Yes. Just continuing our look at the impacts on this demand capacity mismatch and the pressures it created. 11:47
Clearly patients come first, and we've explored how delays in treating patients lead to the risk of greater morbidity and presentation through the emergency channels in extremist, that's one very significant impact. Mr. Haynes in his evidence also reflected upon 11:48
the impact on management and their ability to do their job in the way that, I suppose, the whole service would like. And let me just bring you to his witness statement in this respect and ask for your views. It's to be found at WIT-53884, and he says at 19.3 at the 11:48
bottom of the page that:

"The mismatch between demand and capacity and the strains of delivering care within current capacity, also means the directorate management team, that is the 11:48
operational managers and the assistant directors, spend a large proportion of time managing day-to-day pressures and responding to complaints with consequent negative impact on their ability to function in a strategic service planning and development role." 11:49

Your reflections on that. Is that also part of the -- is that impact also part of the vicious circle or the consequence of resource pressures?

A. I would concur with that entirely, and whilst in view of the fact that I mentioned Martina Corrigan earlier, I often wondered how she managed to work the long days and parts of nights that she did. She spent a lot of time reacting to the consequences of the inadequacy of the service, just as we as clinicians did, as the nursing staff did, and if there is one message that I would wish to convey by the end of this week is exactly that, that the most important finding on review of the urological service is that it had become so inadequate that it became so unsafe and, you know, it's like complaints, and people making inquiries and so forth, and sometimes historically you will read and hear people referring to those people as the creaking gates and so forth, but they became less and less the creaking gate and the silent sufferer was ignored. These were people in desperation through their representatives, their GPs, their MLAs or whatever, due to the inadequacy of the service. So it impacts, it ripples everywhere. So I would concur entirely. 11:49 11:50 11:50 11:51

42 Q. Did you understand that ripple or that effect, as, in essence, creating a service where management were reactive as opposed to finding the time and the resources to be, if you like, in planning mode, in a strategic mode? 11:51

A. Yes. Insofar as ultimately a strategic mode was going to bring you forward in view of the inadequate resources that were being allocated to you and budgetary terms. You have listened to the difficulties

that the service has had over the years in recruiting additional staff and so forth. So even if the money is there you don't always -- are able to expand and to make progress. It's an extremely difficult situation to address and resolve. It's very easy for me sitting here looking back and saying, you know, we should have had twice as many operating sessions, but then you don't see anybody at a new clinic if all of the inadequate numbers of consultants are operating. So it's a difficult one to address, but I agree, yes. I mean we experience the consequences of that inadequacy every day. I think in my witness statement I've referred to -- my secretary used to actually come up with the top five major complaints of the 20-odd she would get each day, and there's just only so much that any one person, or indeed a collection of clinicians, can attend to day in/day out in a sustainable manner.

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43 Q. Let me move to look at the impact, as you describe it on yourself, and perhaps you would say other of your colleagues, of the inadequate system. Your witness statement -- and we may have had this before and I may have summarised it at the start of the piece this morning, but it's helpful just to put it on the screen again. It's WIT-82597. And at paragraph 584 you say:

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"Issues which arose in relation to my practice were inextricably linked to the inadequate system I was working in. That led to recurring issues, for example, in relation to triage. These issues could have been

prevented had the Trust ensured that Urology Service had adequate staffing and capacity so that a practicable system could have been put in place to deal appropriately with triage."

11:54

You link the inadequate system to the choices that you say you had to make in relation to triage, and that was ground we covered in great depth on the last occasion, so you'll excuse me if we don't trespass upon that area in any great detail. 11:54

A. Mmm.

44 Q. But your answer linking the inadequate system to how you practise, and the way you practised, you've given the example of triage, we have seen other allegations of shortcomings in your practice, or inadequate 11:55 practice, on the last day, and we'll look at others as we go on over the course of the next several days. Do you say that in terms of the impact of the inadequate system, do you say that it forced you into practise that was less than optimal in any other area apart from 11:55 triage?

A. Yes, I would. And without trespassing into triage, but just permit me this one reference, and that is, if you have a situation where you know that someone who has been urgently referred is going to wait 85 weeks, or 11:56 routinely referred to as going to wait three and a half years, as a clinician I felt an ethical issue: Do you regard the information that you're provided with, and even if you investigate it just as nevertheless it's

urgent or routine, but you do not take any further measures to rule out a greater issue, I always considered that to be an ethical problem. It's like driving past the road traffic accident, or stopping and having a look and seeing injured people, and then getting back into your car and not doing anything about it. 11:56

So with regard to dictation, yes, similarly so. One has to make choices with regard to actually reading or being able to deal with all of the emails that you receive each day, which is the more important things to do as you walk into the hospital each morning? Is it go to deal with the in-patients? Is it to sit down and read your emails? You know, I think that when you look at the differing practices that evolved, whether it's Mark Haynes getting up at 5:00 o'clock in the morning to do all of his administration, and spending some 15 hours a week in doing so, or whether it's me doing it until 3:00 o'clock in the morning, or whether actually increasingly it's people saying "actually I'm not prepared do either and I walk away from it". In fact I have been reading recently some interesting literature talking about the impact of what's called discrepant services on individual clinicians when issues like compassion and empathy and support that they're able to give to patients during their caring for them is squeezed out because of the priorities that the employer or management would have. So there are 11:56 11:57 11:57 11:58

serious issues indeed. So, yep, there is no doubt about it, I agree entirely with Mark Haynes. This is the -- he described it very appropriately as the unmeetable expectation arising from that mismatch between demand and capacity.

45 Q. So in terms of the impact of the system, it's making you, you would say, or it's forcing you and compelling you to make choices in terms of how you practised?

A. And trade offs, yeah.

46 Q. Yes. You mentioned triage, you mentioned dictation, what about results? 11:59

A. Everything.

47 Q. Everything?

A. Yep.

48 Q. Mr. Young was asked about additionality, the extra work in theatre predominantly that was from time to time offered to members of the team in order to assist with the clearance of backlogs, and I note that you have said, for example, in your grievance to the Trust -- and I don't need to bring it up on the screen, it can be found at AOB-02029 -- that you were explaining in your grievance that the pressures you were under for many years with waiting lists for both in-patient treatment and review, and the time that you were using to ease the backlog, caused you to fall behind in your administrative work. "There had been times", you said. 11:59 11:59 12:00

"...when I fell behind in administrative work in the past and would have worked additionally to ease that

backlog."

So Mr. Young's point is this: that in taking on extra slots in theatre he says it's clearly done on the basis that you can cope with doing the extra, it's in addition to what you do, it shouldn't displace what you are assigned to do in your job plan. Did you take on additional slots, as he put it, whilst recognising that this would impact on other aspects of your work? 12:00

A. Yes. And I'm glad you picked up this topic because you will -- I've made reference to it in my aide-memoire, but it's also referred to by Michael Young when he was my appraiser. You know, Michael did have the ability to compartmentalise, you know, so that the waiting list of any kind, any kind of waiting list was a Trust issue, and I think somewhere in -- I wasn't able to put a Bates reference number to it, but somewhere, whether in giving evidence or in his witness statement, he said, you know, the waiting list is a Trust issue or a Trust problem, it's not the clinician's problem. And once again ethically I felt, actually, do you know, that's a sterile argument, because it's the third leg of that stool is the most important, and it's the patient's problem. 12:01

49 Q. I think we can just -- I think it is in your aide-memoire? It's written into one of the... 12:02

A. Yes, but I don't have a Bates reference number for it. I couldn't find it.

50 Q. Yes.

A. But, anyhow. I mean I read so much of people saying "Well, that's just Aidan", whatever. I didn't hear of it until the Inquiry. But the number of times, you know, that Michael would be able to say "Well, that's a Trust issue. That's not our issue", and I just found that ethically and compassionately, if you are reading and trying to respond to cries of desperation every day, I couldn't pass up the opportunity to operate on two or three more patients. I think I'm correct in saying -- I was reading some of my own notes in recent days where I think I did something like 26 additional operating sessions during 2019, and yet my urgent in-patient waiting list is longer than ever. 12:02 12:03

So to answer your question more directly, did it impact upon my ability to do the administrative work that then manifests itself as shortcomings? Yes, it did. Do I think in retrospect that that was worth it in order to reduce the risk of other people coming to serious harm by taking on additionality? Yes, I do. 12:03 12:03

51 Q. But in taking on the additionality were you not creating risks elsewhere in your practice?

A. Lesser. That's the point I'm making.

52 Q. And who judges that?

A. Well it was my judgment. 12:04

53 Q. And is that not something that should be, if you like, talked through transparently with management so that they can make the decision whether you can safely leave behind that which is expected of you in the job plan in

order to cope with what, I think you've described in your statement as the invidious position of leaving patients suffering?

A. Well, you will have noted the success that we achieved or had in engaging with management and discussing exactly that kind of issue with relation to Urologist of the Week and how that related to triage and the feasibility and what it was possible and what the Trust expected of us to do, and it never materialised. So, ehm... 12:04

54 Q. But Mr. Young, accepting his evidence if you do, he is saying that "I made it perfectly clear when holding out the opportunity for extra slots that this has to be done, it can only be done if you're able to cope with it, if you're able to cope with all of the other demands in your practice", and he said explicitly in his evidence that he reflects that you were trying to maybe juggle far too much at the time, but that would have been your choice. He sets, for example, the NICaN role, the other roles that you took on. There was an element of choosing to take on work that impacted on the basics of your practice and created risk as a result? 12:05

A. Yeah, it's -- in retrospect it's a major regret of mine, and I think I've said that in my witness statement in the final sentences of my original witness statement. But, you know, it's not like as if I raced anywhere to take on these roles. I was approached by NICaN if I would consider doing it. It was suggested 12:06

by the previous incumbent that I should consider doing it. I then made the cardinal mistake "Well, I will consider it if no one else steps forward", and of course no one else did step forward, and then I felt that it was incumbent on me to take up the role because no one else was going do it and I felt it was an important role. That was at the start of 2013, and we knew that we were going to be peer reviewed in 2015. 12:07

With regard to lead clinicianship and chairing of our own MDT and MDM respectively, this was on the departure of Mr. Akhtar in March 2012, and at that time the only other possible candidate would have been Tony Glackin, who would, in retrospect, have been entirely fit and capable of being a good lead clinician and a good Chair. But Michael Young and I discussed it and we felt that he wasn't long in position at that time and it was perhaps not quite fair to load that kind of responsibility on a recently appointed consultant. I think he came in in 2011 or thereabouts. 12:07 12:07

So, once again, if I may say so, maybe the reason why I took on that role in the Southern Trust is maybe another ripple of consequence of inadequacy of manpower. You know, there's very little choice. But there is no doubt whatsoever that taking on both of those roles from April '12 right through to the end of 2016 had a major impact, and I think in the addendum statement that I have put in where now, do you know, 12:08

the lead clinician gets a PA, and the lead clinician and Chair of the NICaN gets half a PA, do you know, which was actually -- that's twice what I was getting or offered for my total administration time during that period of time.

55 Q. You do use the word "invidious position", maybe we'll just bring it up and have your comments upon it and you can fully explain what you mean by it? WIT-82599. This comes towards the end, I think, of your primary witness statement at sub-paragraph (2) there, and you say: 12:08 12:09

"The Trust's knowledge that I was grossly overworked on a chronic basis and its failure to provide realistic job plans and/or support so that I only worked in accordance with those job plans. Had I only worked in accordance with the time allowed in my job plan, more and more patients would be waiting longer and longer to see a consultant and/or have treatment. That placed me in an invidious position, meaning that I tended to sacrifice my own time to try to address the issue." 12:09 12:09

I think if I can add a caveat to that, I think one you've already accepted, you also sacrificed duties that you recognised that you should have performed in order to address these issues. Is that entirely fair? 12:10

A. Not necessarily entirely fair. It depends on which duties you are referring to, because it's easy just to pass over. I'm just thinking of dictation, for

example, do you know, where, you know, there was no policy, or guidance, or expectation, for example, that every patient you encounter in an outpatient clinic would have dictation done afterwards. So...

56 Q. You'll forgive me if I don't cross swords with you on that. I think we have dealt on the last occasion... 12:10

A. No, but it's just to make -- I'm just using the point.

57 Q. Well I'm not sure that all of your colleagues would accept there was no expectation. It may well be that the expectation, some might say, wasn't sufficiently defined or wasn't put into a policy. But leaving that behind, the invidious nature of it is really what I want to get to. Did you feel that in essence if you didn't work in the way that you worked greater suffering would be the lot of a large number of patients? 12:11 12:11

A. Absolutely. I was between a rock and a hard place basically.

58 Q. The addendum statement that you've put together has taken the opportunity to address in forthright terms some of the criticisms that were made by witnesses in relation to the way that you worked. So, for example, where Ms. Gishkori said that you created havoc in theatres, albeit her explanation around that didn't appear to relate to the theatre itself, more to the process of establishing -- and for example, she referred to Patient 84 -- the process of making arrangements for theatre. That was the patient who gave evidence before this Inquiry about arriving in the 12:11 12:12

ward over Easter 2015, I think off the top of my head, and finding nobody there, nobody was there who knew why he was there. But leaving all of that aside, and you've dealt with that in detail, I do want to ask you whether upon reflection you consider that you could have worked in a more efficient way or in a more productive way during your practice?

A. Well if I may deal with havoc in theatre? Because I don't want these opportunities to be...

59 Q. Well I think, with all due respect, I think those issues are well covered in your addendum, both your response to Mrs. Gishkori and your response, lengthy response to Mrs. Corrigan, who set out a number of criticisms. 12:13

A. Okay. 12:13

60 Q. And that evidence has been received now by the Inquiry through your addendum statement.

A. Yes. Yes.

61 Q. Let me take triage, for example. Mr. Haynes's evidence was that you made a choice to telephone a significant number of patients, and in doing that you were unable to meet the bare minimum triage for other patients. Michael Young reflected in his evidence that triage would certainly not involve, in his view, having to phone the patient and having a consultation about the issues. 12:13 12:14

Anita Carroll, just to bring it to a different issue, reflected that by 2017 you were the only consultant, I

think she meant in urology service, not using digital dictation. You've heard evidence -- we've heard evidence about excessively long dictations when you did them. That kind of practice. Can you help us better understand that? Could you have improved your administrative efficiency working in different ways, perhaps delegating to your secretary more often, so as to free up time for what was more important?

A. Well, I say this respectfully, Mr. Wolfe. I think what you have listened to is a lot of almost gossip. It's rumour. I know that you have not wanted me to do it, but just one statement. I didn't even arrange the admission of Patient 84. It wasn't me at all. Mrs. Gishkori, I'll just say, she formed a view on hearing of this one experience, of which I wasn't even involved. I've never created administrative havoc in theatre or in the scheduling of patients, because I paid attention to it. There has been no inquiry of theatre staff and so forth from the Inquiry as to whether or not I ever did create any administrative havoc.

With regard to triage. It's all so grossly exaggerated. You know, if you actually are referred someone with an elevated PSA and you reckon it would be a good idea to have an MRI scan done prior to the patient attending, you cannot request it without speaking to the patient to ensure their compatibility to have an MRI scan to make sure about stents in, or

other -- have you ever had shrapnel injuries? You can't do it. And actually I was able to, whilst filling it in, I could speak to the patient, if they answered the phone, otherwise an MRI scan, I didn't do it at all because you can't request it without checking that for the patient. So I could have what's been described -- not every patient had a consultation. In fact actually the only patients who had a kind of a consultation would have been patients like, for example, a 60-year-old woman with recurrent urinary tract infections who otherwise may not be seen for three years and whom I had noted hadn't had any antibiotic prophylaxis, that maybe that would be a good idea. So in a sense, actually, that involved a discussion, but the discussion didn't go on for half -- it has been exaggerated, grossly in my mind. 12:17 12:17 12:17

And I think actually that those who haven't practised in that way, they think that there is something particularly efficient about allowing a scheduler or the secretary to do it, who will then come back to you and say "Well, this patient doesn't know. Could they speak to you?", and I just actually bypassed that and did it myself. So I think in triage -- and what was the third example you gave? 12:17 12:18

62 Q. Well I was referring to trying to, perhaps unfairly, group the -- the general concern is: Could Mr. O'Brien have worked in a more efficient, modern manner?

A. (Laughs). Yes.

63 Q. And the examples that have been given relate to, in the triage context, contacting patients directly. In the scheduling context, we have the evidence of Mrs. Corrigan that unlike other practitioners you would have rang the patient detailing what they needed to do, she said. That's a good service for that individual patient, but no other consultant did it, and whilst you were doing that triaging and dictating, or looking at results, there were matters that suffered. Do you reflect at all, Mr. O'Brien, that there were significant improvements to have been made in terms of your approach to tasks that would have freed up for you the time that you complain was lacking? 12:18 12:19

A. Well it would have been my own time, for a start off, you know. All of this -- most of us were doing this outside of our job planned time, as has been detailed very well by Mark Haynes. And if you were to ask the same, the others to do likewise, it would be a similar issue. 12:19

64 Q. It doesn't quite answer the point, Mr. O'Brien. Significant parts of your practice were falling into disrepair, 12:19

A. Mmm.

65 Q. Some would say, and let me take you to Mr. Glackin's evidence. He was a Research Fellow in 2002, and he got to know your practice quite well, he was explaining. And he came back in to Craigavon as a fully fledged consultant in 2013, and to his eyes, his evidence to this Inquiry, nothing had changed around your 12:20

administrative approach. He said:

"Part of it is due to how he chose to practice. He would have explained on occasion..."

12:21

-- giving his example:

"...that he wanted all the results back before he would write a letter."

12:21

That's in the context of dictation. So is there something in that, upon reflection, that all of these observers, you may call it gossip or secondhand, but a lot of these observers are working very closely with you and they can see room for greater efficiency and 12:21
see tasks that you shouldn't be performing that no other clinicians would perform, opportunities for delegation that you just weren't taking?

A. Yeah, I mean if it is the case that no other consultant ever contacted a patient prior to scheduling their 12:21
admission for surgery, which I find almost impossible to believe, but there you are, if it is the case that, you know, if you have reviewed a patient today and the only thing that you are awaiting is to have a urine culture result back, that nevertheless is more 12:22
efficient do two letters rather than one, you know, three days after the event, if that is a greater degree of efficiency, fine.

I think delegation is the singular most important aspect of that. And, you know, I mean people can have their criticisms of my way of working and, you know, I'm not so sure, and I go back to the inadequacy of the service once again, I'm not so sure that all of the modern more efficient ways are necessarily an improvement to the patient experience. There is too much one way conversations prevalent now. 12:22

I have listened to the Inquiry, and I gather from Dr. Swart and others that it has been mandatory for some years to send a copy of the letter addressed to the GP to the patient. Now, I mean, you know, patients are approaching me asking me if I could explain what this letter means. But it's very efficient and patients are really, they're hardly service users, they're passive service recipients, because the modern efficient service has them less well-informed, less well-understanding than ever. So, that's my cautionary note about, and comments that I would make about any criticisms of me with regard to adopting more modern efficient services. 12:23 12:23

I've even actually had one or two patients approach me receiving copies of letters addressed to the GP telling the GP about findings of investigations and the intent to have the patients admitted for something, even invasively, under general anaesthesia, without the patient understanding what has been found or what 12:24

they're going in for. Efficient? That's the way it is right now. Is that good? I don't think so.

66 Q. Part of your explanation for being unable to meet the standard expected of you by the Trust, for example, in triage, not dealing with all or a significant number of the urgent referrals and the routine referrals, part of your explanation for that is "My focus had to be on the patient during Urologist of the Week and on the red flags that were coming in, and that was just the simple reality", you would argue, "of the environment in which I worked, with all of the pressures that came with that." But in that environment, no doubt you were reckoning all of the time: What can I do with the resources and time available to me? Is that fair? 12:24 12:25

A. That's fair, yeah. 12:25

67 Q. And part of that reckoning should have involved: How can I work most efficiently with the cards that I have at my disposal? So, part of that reckoning was "Well, I can't do urgent and routine", and you asked the Inquiry to understand the context for that. But equally on the other side you are delivering what some might regard as an excessively high standard of service to patients by, for example, contacting them directly when a scheduler could have assisted you with that, or a secretary could have assisted you with that. Was the balance -- I suppose the question that comes to this is: Was the balance tilted too far on occasions? 12:26 12:26

A. It is possibly the case. I mean I am not opaque or resistant to criticism, and constructive criticism, but

you know, as urologist of the week, Urologist of the Week was a very different model. Now I wouldn't have been scheduling patients during Urologist of the Week and, you know, when all of triage was included in Urologist of the Week, and to which I agreed and which I found impossible to complete, you know, I did, I did observe, Mr. Wolfe, I have no doubt that whether it was a major contributor to other people having to allocate their time to triage as opposed to other, I mean I did see, and it's well known, it's well established in other specialities as well, you know, where, do you know, the urgent operation will be put off until tomorrow, or put off until the next surgeon of the week comes on-call, and I witnessed all of that. You've heard it being given in evidence to the Inquiry where the ward rounds will not be done anymore. I mean, the priority -- in fact actually, in referring me to the GMC, Dr. Maria O'Kane said that Urologist of the Week was introduced to facilitate triage. It wasn't. It was introduced in order to improve the in-patient care, care of in-patients which we were so worried about. Triage was an add-on. It should never have jeopardised in-patient care. And there were days when I think the maximum number of emergency operations I did in one day was seven or eight in one day. If you actually are operating on eight patients in one day, you don't have time for red flags, never mind urgent and review.

12:27 12:28 12:28 12:28 12:29

I also would just like to take this opportunity of

correcting one impression that I think I'm guilty of giving myself, and that is, is that I never triaged an urgent or routine. I did. I just couldn't complete them all, but I certainly did all the red flags.

12:29

So -- and as you know, when I responded in detail to the Patient 10 SAI in January '17, I asked earnestly that this very conundrum be addressed by the Director of Acute Services to determine who should triage, when it should be done, how it should be done, and to what degree it should be done, and as you know, two years later when we made a second attempt to meet with senior management to address these fundamental issues, they didn't attend.

12:30

68 Q. I want to actually move on to the kinds of engagements that were -- that took place and were available to you and your clinical colleagues, and part of that will be, as we move through it, engagement with management. I want to start, however, with whether there was adequate engagement across this urological team in the Southern Trust, and I want to look at it, I suppose, for a number of reasons. I want to have your observations on whether could matters, looking at it from our standpoint today, could matters have been handled better if the team had worked better together? Could difficulties have been mitigated with better engagement across the team? I want to have your views on whether communication was adequate within the team, or whether perhaps each of you, perhaps because of the pressures

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12:31

that you were facing, whether you perhaps functioned independently? Was there a silo culture in place? So those are the issues we're going to spend the next period looking at.

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It appears from your witness statement that there were no shortage of opportunities to meet with your colleagues. There were departmental meetings, there was the multi-disciplinary team meeting, there was a scheduling meeting, patient safety meeting. Ward rounds, we've received evidence about that how they fell into some difficulty around the introduction of Urologist of the Week and we don't need to go back over the reasons for that, but the short point is that there were lots of opportunities for communication between colleagues. Is that fair?

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12:33

A. That's fair.

69 Q. Mr. Young, who was obviously the clinical lead, he explained to the Inquiry that he said as many as possible of the decisions within the service are led by committee. In other words, he said:

12:33

"I, as lead clinician, bring the topics to discuss at departmental meetings. We all discuss any changes and agree them with the team of consultants. All of the consultants in the unit are involved in decision-making about how the unit was run."

12:33

And he said that in his input into Dr. Chada's

investigation. Is that an accurate sense of how things were done within the service?

A. Yeah, I think, yeah, to the extent that we collectively could address and resolve issues, yeah, that is fairly accurate. 12:34

You will recall that Mr. Young in his evidence giving, however, stating that if the issue was to be dealt with was one that was coming from senior management or from the executive that we had to address, it was 12:34 productive, or whatever. But if it was something that we were trying to have addressed by management and having to deal with it on our own, those discussions were less productive because you just continue repeatedly to discuss the same issues over and over 12:35 again. And, you know, if you take six consultant urologists in one room, you know, you may get five or six different views or priorities and so forth, and I really did feel that we needed to have a dialogue with senior management in order to make all of that 12:35 worthwhile, and we were just talking to ourselves in the room, and at one stage I think Mr. Haynes said, you know, that we are the Trust. Well, frankly, no, we're not the Trust, you know. We were a significant part of the Trust, but we needed to engage with the senior 12:35 management to make -- to at least have a truthful understanding of where we stood on certain issues.

70 Q. Would you have regarded the Departmental meeting, that opportunity to sit down with your consultant

colleagues, as being the, I suppose, the best opportunity to put matters on the table and discuss them colleague to colleague? I take your point about it not giving you access to the corridors of power and the need to advance things with management, but so far as it went, and perhaps limited as it may have been, was that, in your experience, a useful forum, the Departmental meeting? 12:36

A. Yes, it was a good forum, because when you, when you are pressurised, when you're aggrieved, when you face a problem, at least to have the opportunity of speaking about it and sharing that with your colleagues and collectively trying to find a resolution to it, it's very worthwhile. And there is no doubt that in the earlier years I found them to be more productive than when we became, not just a larger group, but half the group wouldn't have been present anyhow because they were doing things in other places, and I know that Michael Young was very, very frustrated by the poor attendance at times. But it was just -- it's not like that we found them to be pointless and didn't attend, even though were doing nothing else at the same time, most people were actually busy doing other things at the same time. Perhaps another consequence -- I'm sorry to blame everything on the inadequacy of the service, or appear do so, but that was a reality. You know, if you -- there were so many times actually that I would do an in-patient ward round as Urologist of the Week, and after dealing with, you know, maybe 30 12:36 12:37 12:37

in-patients on the ward with complex needs, with a registrar and so forth, and at 12:30 or 1:00 o'clock have the opportunity of getting a bite to eat before you would start to see the outliers in the afternoon, it wasn't always possible to fit in a departmental meeting as well. So...

71 Q. Yes. I mean your reflections of the meeting falling into disrepair as the years went on are perhaps consistent with what Mr. Young has reflected. At one point, I think it was 2019, he wrote out to colleagues -- yes, 29th November 2019, expressing concern about the lack of departmental meetings saying, "We've not met properly in about a year." Mr. Glackin, for his part, suggesting that he was a regular attender, but yourself, Mr. Haynes, Mr. O'Donoghue, frequently failed to attend, and he expressed the view that: 12:38 12:38 12:39

"Due to the number of fronts on which the service was failing to deliver, it was difficult to achieve a consensus as to how to move forward without engagement from colleagues." 12:39

So you put in mitigation "I wasn't away at a fancy restaurant, I was actually attending to work, and the pressure of work meant often times I couldn't attend." 12:39

A. Mmm. Mmm.

72 Q. But reflecting back on this period, could those departmental meetings have been better used?

A. They could have been, yes. That's a fair criticism.

And insofar as I contributed to that, it's a fair criticism, yes.

73 Q. Obviously it is convenient to try to analyse matters by reference to the line in the sand, I suppose, which was the MHPS investigation that was visited upon you. So there was the period before that where you would say you were struggling to keep your practice in order with regards to triage, with regards to dictation, and the things that form part of MHPS. Then your exclusion from work and your return to work, subject to the monitoring arrangement of the Action Plan. I mean, looking at both sides of that temporal line, do you reflect that you should have, could have sought better assistance or support from your colleagues? 12:40 12:40

A. Prior to MHPS? 12:41

74 Q. Prior to MHPS.

A. Hmmm. I -- that's a good multi-stranded question. I mean my initial reaction is, you know, all of them are working hard enough without my asking for additional support. I think that I have documented in my, was it the response to the investigation in due course, you know, the additionality that I had undertaken during those years. Could I have sought support? Possibly. Would it have been the right and proper thing to do and fair of me do so? I'm not so sure about that. I would have to think about it in more detail. 12:41 12:42

75 Q. Well, we know that before MHPS, on at least two occasions you reached out in relation to triage and Mr. Young stepped in for periods of time. It didn't

take the requirement to triage off you permanently, but was a short-term fix, one might call it. But assistance comes in a variety of ways. When you reflect upon it now, your approach to triage, and dictation, and those kinds of things, should you have talked it out with your colleagues in a manner which might have led to them better understanding your position and being in a position to offer you advice and guidance? 12:43

A. Well I think there's evidence that we did have those discussions. 12:43

76 Q. Well I know you had those discussions, but what I'm asking you is, could you have approached it in a better manner?

A. Possibly. I would still go back to for me what was the fundamental issue. The fundamental issue with regard to triage was for myself, with my colleagues sitting down with, for example, the Medical Director and the Director of Acute Services, to work out exactly what it was that was required of us. That's what I wanted. That's what I asked for. That's what did not happen. I don't know if it even has yet happened? So, ehm... 12:43 12:44

77 Q. But is that not, with all due respect, something of an elaboration, in the sense that I hear you repeatedly, and I see it in writing from you, and you've brought it to the meeting with your fellow consultants, "Give us direction on how do triage", was the request to management. But everybody else was doing triage in accordance with -- and I hope I'm not oversimplifying 12:44

no doubt some distinctions between colleagues, but broadly you had a way of doing triage which was not the understanding of others and, therefore, I wonder whether you are not asking for something that was unnecessary in seeking guidance from management on that issue? 12:45

A. I don't think I was seeking guidance from management at all. I was expecting that, as Mr. Glackin agreed, or it was he who came up with the notion that we would have a Memorandum of Understanding from the Trust. We wanted actually a shared responsibility that if, for example, I didn't have -- I would never be expected actually to contact the lady with recurrent urinary tract infections and have her started on an antibiotic if the Trust and ourselves were to agree "no, we don't have the time to do that. That's unrealistic. And if you spend time doing that, you're going to neglect other important things", that's exactly what I wanted. It was an agreement, a shared agreement as to what was expected of us. It wasn't guidance per se. And would I have adhered to that. And in fact, actually, that is referred to in my appraisals when Dr. Damon Scullion was my appraiser, that I was hoping to meet with senior management in December '18 with my colleagues and that we would have a Memorandum of Understanding and to adhere to that policy. 12:45 12:46 12:46 12:46

It wasn't, it wasn't -- I wasn't expecting a one way traffic. I was expecting, you know, to be able to sit

down in an adult fashion, and I've expressed those sentiments in the Issues of Concern document that I submitted in September '18, and its regrettable that to my mind that it didn't happen, because I think it would have been of benefit all round if it had done. 12:47

78 Q. Just coming back, I had sort of departed onto the interface with management, I want to bring it back to your interfacing with your colleagues. You remark in your witness statement that by contrast with how Mr. Suresh was assisted and supported when he ran into 12:47 practice difficulties in I think 2016, and you were I suppose in the vanguard in assisting him during that difficult year from your -- I think you explained how you put your own health needs to one side to assist Mr. Suresh. So, you've said: 12:48

"I've since had reason to contrast..."

- and this is in your original witness statement at paragraph 405: 12:48

"I've since had reason to contrast the support offered to Mr. Suresh in 2016 to that offered by the same persons to me."

12:48

A. Mmm.

79 Q. What do you mean by that? What assistance should your colleagues have granted you that was available to Mr. Suresh, albeit in a different context?

A. I think probably -- it's probably not fair or appropriate for me to actually refer to my colleagues so much. I think I was making reference to the fact that the person who was leading that assistance, or the formulation of that assistance to Mr. Suresh in 2016, or at the end of 2015 after the particular event in I think November '15, was Mr. Mackle at the behest of the Medical Director, and I think I was contrasting that, and in which I participated at his request, with the lack of assistance that was offered to me following March '16. 12:49 12:49

80 Q. But what is it, when you reflect upon it now, what is it in terms of assistance that should have been brought to bear in your case that would have been practicable and realisable, which you didn't receive by contrast with Mr. Suresh? 12:49

A. Well, the formulation and the discussions that went into providing support to Mr. Suresh is a perfect template of what could have been done in my case. You know, sit down, discuss the issues. If, for example, you know, I was being expected to come up with a plan to deal with a review backlog, I mean how am I going to deal with a review backlog on my own? So, that's what I'm referring to. So there were a number of meetings, I think one of which I didn't attend but others that I did, and you may have read -- I think you have in my witness bundle some email correspondence between myself and Michael Young talking about the support that we were giving to Mr. Suresh and so forth. So -- and he 12:50 12:50

benefitted greatly from it, and he participated greatly in it, and we have made reference to this previously I think in the words of Dr. Swart about a commonsensical approach to the matters that arose in 2016, and that's the contrast I'm making in that regard. 12:51

81 Q. Yes. Mr. Young was asked about this very issue, and he wondered, I suppose out loud, about the aptness of the comparison that you were seeking to draw. I suppose in his view the things that you were being pulled up upon as being shortcomings at that time, they were all 12:51 matters that you were capable of fulfilling, of performing. It was just a case of not doing it. It didn't need remedial action in the way that Mr. Suresh needed remedial action. He went on to explain that to the extent that you required assistance it was made 12:52 available to you. So, for example, the Tuesday following your clinic in the Southwest Acute was, the Tuesday morning was given over to you for the administrative obligations that followed from the clinic. I suppose by way of example we could also 12:52 point to the assistance provided to you around triage. So, in that sense, your engagement with colleagues, with Mr. Young, and perhaps then on to management, did bear fruit in terms of providing some assistance to you. Is your point it wasn't adequate or it wasn't 12:53 sufficiently broad?

A. It comes back, I suppose, you know, in the constituent parts of the issues that were raised in March '16. Triage, we've kind of referred to that. I mean I don't

think that for me it was going to be adequately dealt with until we had a clear view as to what it was that we were meant do in the context of increasingly long waiting lists and with regard to dictation. In terms of the Tuesday morning, I mean it was just that I wouldn't have any one of my two days surgical lists per month on that Tuesday morning, it wasn't a particular additional support, there was no additionality to it, it was just that I didn't do one of those on that Tuesday morning. 12:53

I take the point nonetheless with regard to dictation. Could I have dictated after every outpatient encounter, after every clinic? I mean, do you know, personally I always found it very, very difficult to dictate a quick letter after each outpatient had gone out the door and before the next one came in because I had a very full outpatient clinic at Southwest Acute Hospital, which was the main source of the lack of dictation, and not often reflected in the template, because I would see additional patients in conjunction with clinical nurse specialists and go to the wards to see patients and so forth, so it was a busy day, and I left the dictation to after the clinic and then I dealt with those that were most pressing. So. 12:53 12:54 12:54

82 Q. Just on dictation, and we'll close on this point before lunch. As you've said a moment or two ago, these issues were discussed amongst colleagues. The problem faced by you, say in relation to dictation, was the

subject of discussion. And let me just turn up what Mr. Glackin said in relation to that. TRA-08775. And if we go down to line 21, please. So he is saying -- this is in the context of dictation:

12:55

"It was raised with Mr. O'Brien in the departmental meetings and when I think Mr. Haynes raised the particular issue on the particular day, the necessity to have a clinical letter dictated and available in the chart for every patient, and Mr. O'Brien perversely 12:56
expressed the view, perversely from my perspective, the view that it wasn't necessary to dictate on every patient, that he knew what was going on and he didn't have to write to the GP."

12:56

Just scrolling down:

"I just couldn't get my head around that."

And then if we just go down to line 5, I'm asking him: 12:56

"Mr. O'Brien's simply wasn't changing his practice, was that your understanding?"

And Mr. Glackin bluntly says: 12:56

"Yes. Yeah, I think he would be digging his heels in."

So is the Inquiry to get the sense from this that your

colleagues on certain issues were trying to encourage you towards a different way of practising, but you couldn't, for whatever reason, or were reluctant, for whatever reason, to change?

A. Well, just departing from the issue of triage. There is no doubt whatsoever that we had discussions about triage. I have, and I'm saying this with complete honesty under oath, I have absolutely no recollection of there ever having been a discussion around the issue of dictating after every clinical episode, or encounter as it is referred to. It came to me as a complete surprise at the time of MHPS that people were frustrated because there was no dictation in the chart, often referred to actually as no record, because there was a handwritten record, and I would argue a legibly handwritten record. Some maybe regarded that it may have been minimalist, but there was a record nonetheless as to what the plan was. So I have absolutely no recollection of us sitting in a room at a departmental meeting discussing the issue of dictation. With one exception, and that is as lead clinician of the Urology MDT in those years from 2012 to 2016, I had to deal with the issue of dictation in that regard, because when listing a patient for MDM discussion, the clinician who is requesting the discussion to be made at a particular date, was to provide the Cancer Tracker with a clinical summary, or a clinical update if a summary had previously been done for discussion at an earlier time, and I couldn't get them to agree to that.

12:57 12:57 12:58 12:58 12:58

They insisted, you know, they only had time to do the dictation like as if it was absolutely mandatory to do the dictation, and then they would expect the Cancer Tracker to cannibalise the letter or go back to earlier information to see if she could construct a clinical summary, which she should not have been placed in that position, and I came across email correspondence of mine to Mr. Suresh in that regard. In fact the only other consultant who did provide a clinical summary was Mr. Jacob. So that's the only time when I had to deal with the issue of dictation. 12:59 13:00

I also observed the more recently appointed consultants dictating a letter after each operation, and they would dictate a letter to say "Your patient has had his prostate resected today", or "will hopefully be going home tomorrow", and as you have seen from the patient who sadly died, the patient of Mr. Glackin's, you know, the letter was dictated and then typed the day after he had died, and I always thought, you know, that the sort of predictive prognostic pronouncements dictated in such letters at the end of an operative procedure were not always appropriate. 13:00 13:00

So apart from those particular -- the particular instance of having a discussion around dictation was from me to my colleagues as lead clinicians of the MDT, but I have no recollection of it in any other context. 13:00

83 Q. Okay. That was the point that I wanted to get to. I

think it is time...

CHAIR: Yeah. I think we'll come back, ladies and gentlemen, at 2:10. An extra five minutes.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Thank you everyone. Mr. O'Brien. Mr. Wolfe.
MR. WOLFE: Good afternoon Mr. O'Brien. We spent part of this morning looking at the idea that inadequacies in the system or the environment within which you worked caused you to have to make what you described as choices, whether to do things in a particular way or at a particular time, or sometimes not to do them at all because other activities were regarded as more important. We moved into, just before the lunch, exploring the idea that engagement with colleagues might have been profitable in terms of providing support, or providing assistance, maybe even in the form of advice, when it came to professional practice issues and the kind of dilemmas that you were facing, and I'm rather left with the impression that you formed the view that that would not be productive in the sense that it would be putting a burden on your colleagues, who were already heavily pressed, and really it was to management that you would look to to provide solutions, and you perhaps majored in some of your answers, or focused in some of your answers on the triage issue and the absence of a Statement of Policy or a Memorandum of Understanding. Have I picked you up correctly? 14:08 14:09 14:09 14:10 14:10

A. Well the last remark is absolutely correctly, but we did have engagement, you know. Could we have had more engagement? Could we have had more discussion amongst ourselves about any number of issues? Yes, we could

have had. Would it have been any more productive? It could very well have been. I mean it's not a black and white, you know, there was no engagement/we should have had engagement, you know. We had many discussions about a number of issues. 14:11

84 Q. But I'm focusing -- I'm aware of that.

A. Yes.

85 Q. In the nature of departmental meetings you would have had lots of things to discuss.

A. Yes. 14:11

86 Q. And I know, or at least I know from the evidence, I'm not sure whether you would necessarily agree, that there were discussions about your practice issues, or at least if not discussions, communications of views. So, for example, when we come to it, there was a 14:11 suggestion on some of the evidence that Bicalutamide was an issue that was raised with you, not necessarily in discussion, although there is some evidence of discussion, but, for example, Dr. Mitchell writing to you, if I was to expand the notion of the team beyond. 14:11 We have evidence that the bipolar saline instrumentation issue was discussed. Triage was obviously discussed. Issues around the actioning of results and the use of DARO were raised with you in communication, you might tell me that they weren't 14:12 necessarily discussed. But I suppose the picture that emerges from some of the evidence that we've received is that practice issues were raised with you, if I can put that in the round. Issues -- or they were raised

with you in the sense that colleagues were maybe dissatisfied or unhappy with aspects of how you practised, or were offering you direction in terms of how you might practice in a different way. Does that resonate with you? 14:12

A. I don't think they were necessarily dissatisfied with me, or at least they didn't tell me that they were dissatisfied. The only time I ever heard or realised, came to realise that there was a dissatisfaction was the frustration that they reported to others like 14:13 Martina Corrigan and so forth that there were no letters in following the clinic appointments of some people when they came to do long waiting follow up reviews. But it was a two-way discussion. It's not just like, you know, so I sat there and others had a 14:13 different view, and they were all different to mine, and they were advising me that they should move towards them. It could have been that I equally well had a view that maybe we should move towards the centre somewhere. And the picture that I'm trying to get 14:13 across to you is that all of these issues are trade-offs, and it's a complex situation trying to collectively figure out which of the trade-offs is going to have the less negative effects on the larger number of patients or whatever? So, it was an 14:14 invidious position to be in. I'm not impervious to criticism. I'm not impervious to receiving advice. Perhaps, actually, we didn't have those discussions often enough and long enough and with greater, you

know, frankness and candour, without causing offence or being confrontational and so forth. They could have been perhaps more productive. But that doesn't necessarily mean that that means that we were all practising in silos and we were not communicating with one another. That would be an inappropriate picture to portray.

87 Q. Certainly, I suppose in support of that analysis, we've heard from Mr. Glackin, who, if we cross the timeline into the, if you like the post MHPS period, or certainly the period after you returned from the four weeks or so of exclusion, he, in his evidence, I suppose, displays an appetite for receiving more information about the matters affecting you, for a variety of reasons. And what he says is, if I can just bring it up on the screen, or what is said in his evidence, TRA-08769. And at the top of the page he says:

"I think it would have been much better if these issues..."

- and here he's talking about the issues that Dr. Chada investigated as part of MHPS, and she says:

"I realise there are sensitivities around some of them, but certainly I think if the medical managers had discussed with us as a team of consultants the particular issues and allowed us to understand the

breadth of issues, but then also to formulate a support plan, a network, if you like, as to how Mr. O'Brien could return to the team and practice safely. It would also have given us greater oversight going forward as to when, if there were any dips in performance or non-adherence to agreed behaviours, then we would have been able to identify them at an earlier stage." 14:16

Is that something that you would have welcomed, or is it fair to say that there were sensitivities surrounding, if you like, the attack on your way of practicing that was at the heart, I suppose, of MHPS and it's investigation. It wasn't a pleasant exercise. It was in essence an exercise that led to criticism of you. Would you have -- would his suggestion of better inform the team as to what was going on have endeared itself to you? 14:16 14:17

A. Absolutely. In fact I think I dealt with this in giving evidence last time. I, I would agree entirely what was said in that paragraph, particularly if it had been done in March or April 2016 and not waiting until 2017, and that's exactly what I was referring to earlier this morning. And perhaps, you know, the medical managers were not necessarily best equipped to do that either. And you've heard evidence from Mr. Haynes and others about the time pressures on all of us and the lack of time that they had to dedicate to doing so, not that I was expecting Mr. Haynes to do so in that regard, but, yes, I would agree entirely with 14:17 14:17

that.

88 Q. I mean...

A. Would I have welcomed it? Absolutely.

89 Q. He is suggesting that medical managers could have led the discussion on this? 14:18

A. Yes.

90 Q. There was no reason, I suppose in principle, why you couldn't have led the discussion and been more open about it yourself in terms of your need for, as he puts it, a framework or a network of support? 14:18

A. Pre '16 or pre MHPS, possibly, yeah, I could accept that. That was -- it was difficult because I was trying my best to respond to the letter by addressing the issues raised within it, and which I succeeded in some degree by reducing the review backlog by 14:19 additionally operating on patients and so forth.

91 Q. Mmm.

A. After my return to work? I think there was, there was an awkwardness there, because when I came back to work for the first couple of weeks, you know, you have 14:19 phased return, as advised by Occupational Health and, you know, I sat in my office and no one came to me. You know, it was difficult, you know. I felt I would have been receptive, but really no one mentioned or offered any kind of assistance, or enquired about it or 14:19 anything of that nature, and I felt that if I had led on that, that that would have been maybe an invidious position to be in as well, that maybe I wasn't the most appropriate person to be leading on a support package

or the formulation of one.

I endeavoured, as best I could, to behave with dignity and in a professional manner towards my colleagues thereafter, and I think they have given evidence to that effect. But it was difficult for them and it was difficult for me, and I think that, you know, a different approach could have been taken to these matters all along from March '16 onwards. I actually did, after a period of recovery I suppose, you could think of that in terms of 2017. When we got into 2018 I was very, very keen to have these matters addressed, and I've made reference to that earlier this morning, and we had bonded sufficiently by that time to be able to sit there in departmental meetings and discuss the issues and how we would bring them forward, and credit to my colleagues for being receptive to that initiative on my part, but it didn't come to fruition.

14:20
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14:21

92 Q. Yes, and we'll look at those meetings and efforts to engage with management shortly. One of the issues you raise in your witness statement, your first witness statement, was a sense of disappointment. I think you direct it specifically at Mr. Haynes for, as you say, failing to raise a variety of concerns directly with you. A concern, you say, that reached its zenith in what you describe as a preparedness to make untrue allegations against you regarding what we've described as 2 out of the 10 patients, that scenario. And using that, as you suggest, to justify a lookback exercise.

We'll come to the 2 out of 10, if you don't mind, at a different point in time in your evidence over the next few days. But in terms of the other issues as you saw it, that should have been raised with you which you say were not by Mr. Haynes, what were you particularly thinking about?

A. Everything. Because when you -- I mean I had a very, very good working relationship, as I believed, and on the face of it, with Mr. Haynes. He never raised, to my memory, a criticism of me with me. As I read more and more disclosure, I was taken aback by the magnitude, almost like an avalanche of escalations from Mr. Haynes to whoever, and back again, and so forth, without ever raising these issues with me. If you take the issue, for example, of private practice and the allegation that I gave preference to people who had attended privately, did he ever discuss that with me? No. Did he ever discuss triage with me? No. In fact if you -- actually as I was doing this yesterday, I was reading some of the communications we had back and forth, and they were always professional, pleasant. We have dealt with one of them this morning in terms of the waiting list validation exercises and how we collaborated on that. Did I have any idea that in the background he was being critical of me, do you know, at the earliest opportunity with Dr. O'Kane or whoever it may be? I had no knowledge of that. I had no awareness of that. That's not how I would practice, and I know that I have been the recipient of some

14:22 14:23 14:23 14:23 14:24

criticism for being critical of people directly, but I have done it honestly to their face and I have never escalated things behind their back without speaking to them. So have I been -- I was shocked actually. Have I been surprised? Yes. Let down, disappointed? Absolutely. All of those things.

93 Q. There's perhaps two ways to respond to that and seek your reflections upon them. The first way is to suggest that when it comes to serious matters, such as the suggestion that private patients were receiving an advantage, they're so serious that they should be brought to the attention of the immediate rung of management, in this case Mr. Young, to investigate and address, rather than for the, if you like, the informant to address with you directly. 14:24 14:25 14:25

The second point is this: Mr. Haynes has reflected in his evidence that he has spoken to you about things, but to use his phrase, you were difficult to challenge, you were a challenge to challenge, and that made it difficult to deal with you directly. Your observations on that? 14:25

A. Okay. Well...

94 Q. And there's two points there of course.

A. There's two points there. The first one is that even if you were to accept the proposition that some matters are so serious that they need to be escalated to the next in command, in that case the lead clinician, my approach would be that that should also have included 14:26

notifying or discussing it with me directly as well, and not doing all of the escalations about other people without discussing them with the persons involved. And I mean, you know Mr. Haynes, I mean I have listened to Mr. Haynes criticising all of his colleagues to me without necessarily sharing his criticisms of them with them directly, I suspect. So in the first instance I think -- there are good practice guidelines, GMC Good Practice Guidelines as to how to deal with these matters, depending upon the gravity and the seriousness of the issue concerned, and virtually all of them actually include arranging to discuss it with the person about whom you have the concern directly in an appropriate setting, possibly accompanied if you think that is necessary, and so forth, and that was not practised in my case. 14:27 14:27 14:27

I don't, I don't buy into the challenge to challenge gossip at all. I think we have listened to chill factors, legal connections, knowing Roberta Brownlee, and frankly I find it confetti really. I don't accept it whatsoever. If you have a serious issue about anything, you know, you deal with it. I don't buy into that allegation at all. 14:28

95 Q. Let me give you a particular example. The issue of moving from the use of Glycine for transrectal prostate procedures and moving across to the use of bipolar instrumentation with saline. Mr. Haynes, in his evidence, said he couldn't remember challenging you in 14:28

relation to that. He said, when asked why not:

"I suspect that the same, if you like, fear element of challenging Mr. O'Brien existed for the likes of Martina Corrigan and others who were challenged with challenging his practice. As a result, the easier route of essentially allowing things to continue may have happened."

14:29

Now by contrast, Mr. Glackin could remember you being challenged in relation to the need to move to saline as he saw it. He said he could remember saying to you, and others saying to you at a meeting that:

14:29

"The next patient that we sent to the ITU with hyponatraemia or a TUR syndrome, you won't have a leg to stand on."

14:30

And yes, as we'll -- and we'll look at this issue in some detail maybe tomorrow -- and yet you continued to practice in the way that you had.

14:30

Now I don't want to get into the weeds of that particular issue, but what I'm asking you for is your observations that so many people have come before this Inquiry and suggested that the way you responded to issues of concern wasn't helpful, you dug your heels in, to use the phrase that I used this morning, and were not receptive to the view that you should change.

14:30

Is that mere confetti?

A. It would be extreme to say it is mere confetti but I think it's a post hoc characterisation that doesn't stand up to scrutiny and objective analysis. I think it's a very unfair characterisation. I'm not that kind of person, and we can get into the detail of glycine and other issues tomorrow, if that's what you prefer to do? 14:31

96 Q. Is your -- how would you reflect upon your outlook? I mean one perhaps stereotype that is often drawn upon in these situations is that you have a highly respected experienced practitioner who has been occupying the top chair, or is known or perceived to be the top practitioner, the most experienced practitioner in the area, and whether it's an experience thing, or whether it's as you grow older in the job you're less resistant to change, is that something that could have infected your practice as you went on so that you, although other people were standing back and saying "Really you do need to think about this in a different way", that that was something you were unable to do? 14:31 14:32 14:32

A. No, I don't think -- I mean I think that is a characterisation, I've read it and listened to it in other ways. For example, I was slow to accept digitalisation. I thought digitalisation was wonderful when I received it. I can recall the number of times that my secretary enquired about getting a computer in my office. You made reference to one earlier today, and that was that I was the last person to convert to 14:32

digital dictation, whereas in fact actually Mr. Young was still using tapes from his Southwest Acute Hospital after I had gone over to digitalisation. You know, in the context of Mr. Hagan's evidence, whilst I used electrohydraulic energy for Lithotripsy when we had nothing else, I found laser to be absolutely wonderful.

So it's -- I don't accept that I am impervious or resistant to change. Is there -- I think the -- as you become more experienced, and I don't know if Mr. Hanbury identifies this, with your build up of experience you come to actually value what is of value and you actually will adopt a change if you are impressed that that change actually brings significant additional value. If it is change for the sake of change without any significant value being added, you're not necessarily prepared to jump on the bandwagon for the sake of it. Does that answer the question perhaps? 14:33 14:33 14:34

97 Q. Perhaps one of the -- you point to Mr. Haynes not addressing you directly, going behind the scene speaking to operational and medical management about concerns that he had. You would say you would rather deal with things directly, and one of the, perhaps a small matter, was your approach to Mr. O'Donoghue at a meeting, and we've heard from Mrs. O'Neill, Mrs. McCourt, Mr. O'Donoghue himself, and Mrs. Corrigan, that that incident were you openly chastised Mr. O'Donoghue for commencing a 14:34 14:34

multi-disciplinary meeting before your arrival so that you weren't in the chair when two of your patients were being discussed, they found that episode to be very uncomfortable, perhaps at best. It reminded Mrs. McCourt of how you might speak to a naughty child, and in her impression the talking to lasted several minutes. That isn't the appropriate way to deal with colleagues, is it? 14:35

A. Well let me put this in context. First of all, there was no arrival. This happened in April 2020. I was joining remotely, as was Mr. Glackin and as was Mr. Haynes, and we joined the meeting at 2.15. Now I have Chaired that meeting myself alone for many years, and then shared the Chairing of that meeting from the introduction of Urologist of the Week, and we would have never started at 2.15, the starting time. We would have waited a few minutes, usually at the latest to twenty past two, to allow any latecomers to arrive. So important is it that everybody who intends to attend is in attendance, particularly in the context of deficient quoracy, which is another issue. So then when I linked in to find that three patients had already been discussed at 2.15, and one of them was mine, and I wanted to have the benefit of my two colleagues also being aware of the management and the discussion, I felt it was most appropriate at that time to ask why he had started four or five minutes earlier? It was an important matter to me. I didn't consider that I spoke to him as a teacher would speak to a 14:36 14:36 14:37

naughty child or whatever. I felt it was a very, very important issue, and I didn't consider that I had acted inappropriately. I insisted that we discuss the three patients. And then I remember this particularly, and I don't know if you want me to refer to it, because within ten minutes of that meeting having ended, I received a phone call from Mr. Haynes, he was in agreement with my criticism of Mr. O'Donoghue, and he was even more concerned about why Mr. O'Donoghue and two CNSs, and a tracker, were in the one room in the midst of a global pandemic. 14:37 14:38

98 Q. I don't think we need digress into that, that's an issue well covered in your addendum statement.

A. Yes. Mmm.

99 Q. I suppose the point is, and you appear to resist it, is that you dealt with Mr. O'Donoghue in an unreasonable way, albeit the issue may -- the issue itself, the criticism itself may have had merit. Can I deal perhaps with the more important issue? Mr. O'Donoghue is the subject of other criticism in your statement in terms of how he performed his MDM duties. You talk about inaccuracy, about truncated notes, and about the quality of his Chairing. None of those issues were ever brought to his attention by you on his evidence? 14:38 14:38

A. That is true. But not that we sat down and discussed those issues, but indeed, actually, discussed them case by case. So, you know, I think I made reference, or I alluded to it in my witness statements, so that, you know, if I asked for the background to a particular 14:39

case that we were discussing, and he -- obviously it wasn't his patient but he was Chairing, he said "Well I just didn't have time to look into the electronic care record or look at results in order to prepare", and I think I alluded to the fact that, you know, on the one hand that's reasonable because he may not have had the time to do so, trade-offs once again. But, yeah, I was -- I took the time, should it have been 2:00 and 3:00 o'clock in the morning to preview for such a meeting. And to be fair, my other colleagues did as well. And I have to tell you that Mr. Haynes also shared my concerns about Mr. O'Donoghue's preparation for MDM. I do -- I've heard him refute that contention, but that is true. 14:40 14:40

100 Q. Let me move on to your engagement with your colleagues around capacity or resourcing issues. So we've looked at whether your colleagues were in any sense supportive, or whether you expected them to be supportive with regard to practice issues. So this is a separate, different topic about whether as a team you could have done more to address issues to do with capacity and resourcing. 14:40 14:41

We have seen that the stenting of patients, and the management of patients requiring stents, is and was a capacity issue. And it might also be seen, and we'll look at a number of cases, that although there were capacity issues, there is also, notwithstanding those capacity issues, an obligation on the part of 14:41

clinicians to effectively manage their patients who require stenting, so far as those resources allow, and it is a feature of the evidence received by the Inquiry that management of those patients, notwithstanding the resourcing problems, has, over a period of time, left something to be desired, that at least is the evidence. Is that your impression that although there were resourcing issues, clinicians, including yourself, might have done better in terms of the management of patients? 14:42 14:43

A. Of the stented patients in particular?

101 Q. Yes, indeed.

A. Yes. I think so. You know, I think that -- you've read it where people have said that I didn't, I didn't agree with the red flag category and different circumstances or contexts. I believe that patients who were stented and were on a waiting list for readmission for definitive management of their stented ureter, for whatever reason it was stented, should have been treated with the utmost urgency, and equivalent to most red flags, and with greater urgency than some cancer patients. For example, if someone is just awaiting readmission for recurrence of a superficial bladder tumour that they have had several times before, I would have placed a patient who was waiting longer with a stent in to have that managed. 14:43 14:43 14:44

I think actually, and here I'm going to be somewhat self-critical, I think that we could have taken up

Mr. Young's suggestion of stents with strings, much more for those people who didn't require readmission for definitive obstructive ureteric management. I tended to, if I had such a patient, I put them on to my next available day surgical unit flexible cystoscopy list for flexible cystoscopy and removal of stent. So I think, yes, we could have done that.

I think really if you were to ask me what is it that would have made all the difference in terms of shortening to some significant degree the length of time that people were waiting, I would have -- I would say to you it was to give them the same priority as red flag patients. 14:44 14:45

102 Q. And of course that wasn't always possible, given the resources available. But what appears to be a theme that has run through the evidence, and over a period of several years, was that there was sometimes an awareness, properly recorded, green form completed to indicate that the patient needed a stent removed or replaced, but that the management plan around that seemed to get lost, or there wasn't sufficient attention given to it so that the patient was delayed in coming back, leading to the risk of sepsis and what have you. I want to take your observations on a number of examples. 14:45 14:45 14:46

Patient 136, I don't understand him to be a patient of yours, but in April 2015, Mr. Suresh opened an incident

report, or a Datix, having become aware of the fact that a number of patients, including Patient 136, had been discharged with no mention about stents in their discharge letter. And if we pull up WIT-50465, we can see the Datix of the incident report opened by Mr. Suresh. He was discharged, as I understand, on 17th November 2014, at which point it says he was: 14:47

"Wait listed for ureteric stent on that date. Request: Registered in the book in the Stone Treatment Centre, a green booking form completed, but this was overlooked. The patient had to have the stent in unnecessarily long." 14:47

In fact it was March before the stent was removed. And if we scroll down through this document to WIT-50469, and we can see the analysis that flowed from the reporting of this incident. Just scrolling down the page. Back the way you went. Thank you. So it's recorded that interrogation of PAS confirmed that a green form had been actioned. "Therefore, this is not an admin issue", it said. 14:47 14:48

"The wait is related to capacity. The communication email sent to the Head of Service to comment and close." 14:48

And if we just scroll down further. Alongside that it's recorded that the lesson to be learned is that a

new process would be agreed that all patients that had a stent fitted need to be added to a waiting list with a planned date to come in.

So there seems to be two issues sitting side by side there. One, primarily perhaps, there's a resourcing issue. It's difficult to get these patients back in for replacement or removal of stents as quickly as clinicians would like, notwithstanding the risks. But equally it's felt that there's a need for a new process to be implemented so that the patients are not forgotten about. 14:49 14:49

I'm going to show you a number of further cases, but would you agree with me that this problem of trying to bring better management to a resourcing issue was one that dogged the service for too many years? 14:50

A. Yes. Well, I think it's important to appreciate, as Michael Young tried to describe the three, basically three different scenarios with regard to stents. The simplest being, the stented person, who on discharge, the only thing that is required is that they have the stent removed. The second one is where a stent is put in in conjunction with the management of usually obstructive stone disease, and they have to be readmitted for further management under general anaesthesia. And the third one is where patients are going to remain stented probably for the rest of their lives because of other kinds of pathology, and they're 14:50 14:50

going to have stents replaced on a yearly basis usually, or something of that order.

In this case that you have demonstrated, if it was purely the case that this patient required nothing other than removal of a stent, then I would doubt very much whether it was a capacity issue, because if this had been my patient, my own system, probably regarded as somewhat perverse, is, before I wrote an operation note I emailed to my secretary to put this patient on the list for whatever with whatever urgency, so that I wouldn't overlook it. That doesn't mean to say it was an absolutely perfect. 14:51 14:51

So this one, whether it was stent with strings, that would have been a solution, or put this patient on the next available flexible cystoscopy list that you have, I find it difficult to imagine that someone could wait three or four months to have a stent removed, if that's all they required. 14:52 14:52

103 Q. Yes. Patient 16 was one of your patients.

A. Mmm.

104 Q. And this was -- this case was a subject of a Serious Adverse Incident.

A. Mm-hmm. 14:52

105 Q. I bring it to your attention in this context to remark upon the fact that as we can see in front of us, Patient 136 on the screen, that investigation was closed on 7th September 2015, with the lesson learned

set out in front of us, need for better planning around stent replacement.

Patient 16, as we can see from the Serious Adverse Incident Review, was a case that was bedeviled by a range of communication failures. I don't wish to get into, if you like, the fine detail of it. The narrative set out in the review, and the Inquiry has your response to it, suggests that a number of efforts were made to contact you through your secretary and directly over a period of time. You'll recall perhaps that this patient was deemed ready for stent replacement in November 2015, and you called for his admission on 24th June 2016, and I think operated four or five days later. 14:53 14:53 14:54

So the outworking of that Serious Adverse Incident Review was a series of recommendations, and if I could bring you to those? PAT-00 -- sorry, PAT-000116, and Recommendation 6 in particular, if we scroll, down makes the point that: 14:54

"The Trust, with the Health and Social Care Board, must implement a waiting list management plan to reduce urology waiting times." 14:55

I suppose that, at a high level, is the problem here, that there wasn't sufficient resources to bring down waiting times. But in terms of stent management, this

seems to be a case, I'll take your views on it, that although it was appreciated that the patient needed his stent replaced, eight or nine months went by without that being done. Is that, notwithstanding the limited resources, another indication of stent management not being well attended to within the service? 14:56

A. Yes, I would agree, and if it's not inopportune to refer to that email that I mentioned earlier.

106 Q. Yes.

A. AOB-77568, if that's okay? Because I do think that the sentiments that I have referred to in that, and it makes reference to this particular... 14:56

107 Q. Would you like it up on the screen?

A. Yes, I would. Yes, please.

108 Q. Yes. So it's dealing with, yeah, AOB-77568, and it's an email from Mr. O'Brien to Mrs. Corrigan in June 2016. You're replying to an email from her, isn't that right, which urged priority would be given to red flag cases, and you're making the point that there are other kinds of case on the benign or non-malignant side that equally merit or co-equally merit urgent treatment. 14:56 14:57

A. Yes, as I referred to earlier. And if I may ask that you scroll down?

109 Q. Sure.

A. Because indeed without mentioning -- keep going I think. Oh, sorry, sorry, go back up again. Yes, so it has been redacted so I'm not going to mention the patient's name, but that is Patient 16: 14:57

"...had a stent in his left ureter for relief of left ureteric obstruction due to metastatic bowel carcinoma. Since 2nd April 2015 he has been waiting its removal, reassessment, and possible replacement since then. His oncologist has requested that his admission be expedited due to increasing back pain attributed to it, but he is not a red flag patient either."

And irrespective of whether he had his ureter stented because of malignancy that wasn't of the urinary tract, or some benign pathology, my contention was that he deserved to be treated with the same degree of urgency. I appreciate that doesn't absolve me of the communication failures, but it's just to make the point that I'm trying to make. 14:58

110 Q. Yes. And if we -- I just want to bring the various temporal pillars into play. So if we can fast forward a further two to three years until 2018. Patient 91, again I emphasise not your patient, came into the system. He required stent replacement. He was added to the waiting list in March 2018, and as Mr. Glackin suggested, but relatively speaking brought back into the system on 18th May 2018, ten weeks later, relatively quickly given the standards of the time. This was a patient who unfortunately died in the care of the service. He had a number of co-morbidities, so delay in the addressing of his stent needs need not necessarily have been the sole reason for his demise. But the point I wish to draw to your attention is set

out in the recommendations. WIT-33320. And Recommendations 3 to 6 at the bottom of the page I think encapsulate the point. Particularly Recommendations 4 and 5.

15:00

"The consultant urologist should ensure that they have a system in place which ensures that patients with ureteric stents inserted are recorded with planned removal or exchange dates in order to ensure patients do not have the stents in place for longer than intended."

15:00

And:

"All patients who have stents inserted should have plans for definitive management within one month unless there are clinical indications for a longer interval."

15:00

So these are recommendations being written some four years after Mr. Suresh had raised the Datix in connection with Patient 136.

15:01

And if we could just add one further ingredient to the mix before I seek your views? The issue of stent management was a frequent visitor to the patient safety meetings, which at that time I think were Chaired by Mr. Glackin, moved into the hands of Mr. O'Donoghue. And if we go to the meeting for 19th July 2019. We can find it at TRU-387331. So that's the first page of the

15:01

PSM for the 19th July. If we scroll just down onto the next page, please, and we can see that there's a new complaint for investigation. I emphasise it's not the case of Patient 91, which we have just looked at. In the same period of time another stent issue has arisen. 15:02
And the point that I suppose roars out from the page is that:

"All at the meeting agreed that the surgeon placing the stent is responsible for..." 15:03

- it should be "actioning":

"...the removal in a timely manner. There is no agreed Trust protocol in place for this scenario." 15:03

So your observations, please? You can see, because I've traced it since 2014/2015, along through a number of years, a number of similar cases where patients who are in need of stent management are being let down it 15:03
seems and, yet, in combination with the resources issue, the clinicians are not getting together to provide a protocol or an effective management plan. Is that fair comment?

A. Yeah, it is a fair comment. I mean I think -- I agree 15:03
entirely that the surgeon who places the stent is responsible for making arrangements for the stent to be removed in a timely manner, and I emphasise the word "removal" because that's Category 1 again. If you

think that any protocol is going to enable a patient in Category 2 to be re-admitted within one month in the context of the inadequacy of service that we did have to deal with, that's pie in the sky. That was never going to happen. That's an impossibility. And there you really are -- the only way that would happen, even a remote chance, is that if every stented patient had the same red flag category applied to them, and I think that there would have been resistance to that being the case. So I think that the person who places the stent has a responsibility. 15:04 15:05

I don't know if you would care to indulge me just for a moment, but going back to the case of Patient 91 that we have just looked at, because I have listened to all of the evidence in relation to that particular case, and the No. 1 clinical lesson that seems to have been learnt is that everybody should have a preoperative urinary culture done, and he didn't have one done long enough in advance for the result to be known, and so forth, and to me, crying out from that particular SAI, was the fact that this man was admitted to another hospital I think, or another ward in the same hospital, within three weeks of having his ureter stented with urosepsis. Now that man actually, in my view, should have been transferred to our department and had his intravenous hydration and antibiotic therapy continued until his inflammatory markers had all resolved, and then had his stented ureter dealt with, and he wouldn't 15:05 15:05 15:06

have been in the situation he found himself in in May. So thank you for your indulgence in that matter.

111 Q. But just to conclude on stent management. I raise it in this context because we have heard loud and clear before the Inquiry the evidence of resource problems, 15:06 that we don't have as a service the resources to deal with patients as we would like. But you would accept, and I think you have accepted, that notwithstanding those pressures, you have to find -- you have to try to find solutions to manage patients so that they don't 15:07 fall into risk, and I wonder when you think about how often these stent issues arose over a period of six years, and we hear the evidence from Mr. Young that resources are more readily available now, and the Lagan Valley initiative is available, the use of stents with 15:07 strings, that kind of thing. But before all of that arrived, was the service, were the clinicians doing all that they should have done to manage this problem and create solutions?

A. The answer is, probably not. Could we have done more? 15:07 Yes. Could we have had pooled lists? Yes. Personally, even if we had met frequently and discussed that frequently, I don't think that we would have been able to make an impact on this issue without giving stented patients the same priority as red flag 15:08 patients.

112 Q. Okay. I think we're going to take a short break now and come back in 10 minutes?

CHAIR: Yes. So 10 minutes then. I think that's 3:10.

So twenty past then.

THE INQUIRY RESUMED AFTER A SHORT PERIOD AS FOLLOWS:

CHAIR: Thank you everyone. I think in ease of everyone, Mr. Wolfe, we'll not sit beyond 4.15 today. 15:19

MR. WOLFE: We have spent some time, Mr. O'Brien, with other witnesses trying to get a sense of the, I suppose the effectiveness of both medical management and operational management as it impacted on the urology service. We've looked at that from a number of perspectives. We've looked at it, for example, in relation to the management of your clinical practice and how that worked. Was there a confusion or a sense of incongruity between operational and medical management in terms of how it handled things, for example. We've also looked at it in terms of the management of these resourcing capacity issues and how the service was supposed to respond to the environment in which it operated. 15:19 15:20 15:20

From your perspective, you've indicated within your witness statement, I suppose the frequency, the inevitable frequency of your engagement with Mr. Young. I suppose a sense on your part of not quite understanding or not quite knowing how to view him in terms of his management responsibilities. Was he there to support the service or support the clinicians within the service? Was he an advocate for the clinicians or 15:20

was he something else? You've also reflected that in terms of the Clinical Director, you didn't have regular interaction with him. A number of people wore that hat.

15:21

In terms of the Medical Director, again engagement with Dr. Loughran in relation to the intravenous fluid and IV therapy issue, but not much more than that, and very little, if any, engagement with his successor Dr. Simpson, and then you engaged with Dr. Wright and 15:22
Dr. Khan through the MHPS process. That's a bit of a summary of your engagement with medical management.

In terms of -- let me leave out of this your practice issues, or the issues that management had with you. In 15:22
terms of those tiers of management, and I've probably left the Associate Medical Director out, not deliberately, but in terms of your engagement, or your colleagues's engagement around the issues of the pressures faced by the service, had you much, if any, 15:22
interface with those management levels?

A. I would say 95% of any engagement that there was, was engagement that was necessitated from above rather than below and about which we have alluded earlier. In many ways, you know, my own personal view of this has been 15:23
for quite a number of years, there are far too many layers in that hierarchical management. I much preferred it when, in the days of John Templeton as Chief Executive, when literally those of us on the

ground, even though we were then even fewer in number, could draw up by consensus our priorities, our greatest concerns, and perhaps our shopping list, as it were, to address those in order of priority, and go once a year at least, preferably maybe twice a year, to the boss, 15:23
to bring our concerns, and at least you knew they got there and you discussed them frankly. I think the first document that you showed this morning in 1997 might have been very much a part of that kind of process, and if you didn't get what you asked for at 15:24
least you knew that you had addressed it and it hadn't been lost in the mists of layers of management. So...

113 Q. So in terms of - - one can see, and we'll turn to look at it in a moment, how concerns around practice issues, concerns around how you and your colleagues were able 15:24
to practice for the betterment of patients, those concerns tended to be directed at the Head of Service Mrs. Corrigan, or in extremist, to the Director of Acute -- and I'm thinking here in particular about correspondence with Mrs. Gishkori. But I don't get a 15:25
sense, correct me if I'm wrong, that you and your colleagues had the ear of the various levels, you say the unhelpful levels, of medical management to enable you to better address the needs of your patient body?

A. Well, I would agree with you, but I would add to that, 15:25
that even if we did have the ear, and I say this not in my defence but in defence of Mr. Haynes, I mean he has written graphically and extensively expressing his and our concerns about patient safety to the Medical

Director and to the Director of Acute Services, and yet there is very little comes out of that. And that may not be the fault of those personnel, you know, it just may be impossible and it doesn't happen.

15:26

I think one of the most -- the best example that demonstrates that is that, is it in 2018 or -- yeah, I think it is in 2018, or is it 2019, when we asked for more operating and we were given, we were increased from ten and a half sessions per week to eleven sessions per week and it lasted one month and it was back down again.

15:26

114 Q. Yes. Let me put the point precipitatively that I was pressing, I should say, I was maybe going to lead to.

A. Okay.

15:26

115 Q. As part of the leading to the point that you've just made, which was an attempt on the part of the clinicians within the service to, if you like, try to attract more operating time given the pressures of your waiting lists. The context for that is, it appears to me, the emphasis that was placed on the need to prioritise red flag cancer patients, and as we saw from your email just before the most recent break, the, I suppose, the attempts on the part of the Head of Service, Mrs. Corrigan, to -- I don't mean this pejoratively -- but to relegate in importance the needs of the non-red flag patients, the non-malignant cases.

15:27

15:27

A. Yes.

116 Q. Let me introduce that by reference to Mrs. Corrigan's

emails that you were responding to. We saw your response just before the break. We should maybe take a closer look at how she introduced the issues.

So if we go to AOB-77570, and just this is an email dated 21st June, I think. If we just go up? Up a little higher so we can see the date. Okay. So this is an email of 21st June 2016, and it is being issued to -- some of the names have been taken out, but it appears to be everybody of relevance within the Surgical and Elective Care Directorate. And she writes: 15:28 15:29

"As you will be aware, we are experiencing significant bed pressures which are impacting on the running of our elective lists. I've already been in touch with those of you operating tomorrow. However, a decision has also been taken for lists planned to take place in the Craigavon main theatres on Thursday, Friday, and Monday. Only red flag patients are to be operated on, and I would be grateful if you could review your lists and cancel anyone who is not a red flag." 15:29 15:29

And then -- so that was the 21st June. If we scroll up the page? Back up. Thank you. She writes again on the 27th June to repeat more or less the same message for the next period. So for those days in the middle of the email are to be red flag patients only. 15:29

So that reflects back on the point that you, your response, which is "Well, take for example, Patient 16, a patient who has been waiting six or seven months for a stent replacement. He's not red flag. Where does that leave us?" Your observations in your email are, I 15:30
suppose, echoed more -- a little more concisely by Mr. Glackin some several years later in 2019, and if I could just pull this up for illustrative purposes as well?

15:31

If we go to TRU-258588, and if we just go to the bottom of the page, please? Alana Coleman is writing and she is explaining to her colleagues:

"We have been receiving a few referrals back from 15:31
grading recently where the consultants have triaged patients to be booked within two to four weeks."

And an example is attached. She says:

15:32

"Red flags are booking at no less than six weeks at present."

And she is saying:

15:32

"Should these patients not wait longer than red flag patients or at least wait the same length of time, or should we just ask the consultants if they are willing for their clinics to be over-booked to accommodate?"

And Mr. Glackin comes in on this, if we scroll up, up above that, please. Keep going. And he is replying or copying you and others into his reply on this issue. He is saying:

15:32

"There are times when non-cancer cases are clinically urgent and should be seen within the stated timeframe. Based on the information provided in the referral I think I am making a reasonable clinical decision. If the Trust cannot deliver this then there is an issue of 15:33 demand outstripping supply. Simply relying on me or any other clinician to overbook a clinic will not solve this supply issue and I am not willing to do this work unpaid or to the detriment of my existing workload."

15:33

As I say Mr. O'Brien, broadly the same theme that you had addressed with Mrs. Corrigan three years earlier. There is from the management side a need to promote, it seems, the interests of red flag patients, and I suppose no understanding, or little understanding as 15:33 Mr. Glackin would portray it, that non-red flag patients, or to put it another way, patients not suffering from malignant disease do regularly have urgent needs, needs as urgent as the red flag patient.

A. And in many cases far greater. I mean, you can have an 15:34 urgent referral from the emergency department of a patient who has attended 24 hours previously with an obstructed ureter due to stone disease, and they do need to be, you know, attended to with some urgency.

Not every one such patient requires urgent attention. You look at all of the other details, and indicators of inflammatory markers and infection and so forth, and renal function, and co-morbidities, but you may have read email correspondence from me where I have arranged for people to be admitted directly from home whilst I was Urologist of the Week in such a situation, and there are very, very few malignant cases where you have to deal to respond with such urgency. 15:35

So not only would I back up what Mr. Glackin has written, but I would further state that at times they require a greater degree of urgency than red flag referrals.

117 Q. And to what extent, if we start with Mrs. Corrigan's intervention to the group of surgeons saying "it's red flag only for this week", and then the next week comes and it's red flag only for this week. How often was that intervention required of her, or how often did she make that kind of intervention? 15:35

A. Well increasingly frequently as the years went by. It used to be an annual occurrence, particularly in the winter months, but as everybody hears on mainstream media, you know, the winter has become June, July and August as well as November, December, January. So it became more frequent, and like Martina is the messenger in that regard. But I think the point that is being made here from a clinical perspective is that, do you know, patients who have malignancy and patients who are 15:36

suspected of malignancy are deserving of top priority, but so are some other cases as well, and even more so on occasion. But, it's very...

118 Q. And why -- if I can just intervene?

A. Yes. 15:36

119 Q. Why had that point, which has been made by you in 2016, and we'll come on to see how Ms. O'Kane has raised it with Mrs. Gishkori, and of course Mr. Glackin here in 2019, why had that point not landed? Why had it not apparently been understood by those in charge of 15:37 scheduling or managing throughput in the theatres?

A. Because you've got to understand, as I'm sure you do, that, you know, the Chief Executive, and the Medical Director and, you know, they are obeying their orders from above, you know. It's -- red flags are such a 15:37 politically potent issue, understandably, but we as clinicians found ourselves in that same situation time and time again as the years went by. Whether it's waiting list validation exercises, or whether it's this issue, and when you're at it for 28 years you get tired 15:37 of that, that's what gives rise to fatigue and burnout when you're dealing with the kind of discrepant service that I referred to this morning:

120 Q. We can pick up a trail of correspondence from May 2018, which would appear to have, at least in part, been 15:38 precipitated by the death of Patient 91, but I suspect knowing the contents of the letter, not only that. And Mr. Haynes, if we can bring it up on the screen, I think it's a letter which the Panel will be familiar

with, it's WIT-96842, and he's writing 22nd May 2018. You're copied in, along with your colleagues. He's writing to Esther Gishkori, who was the Director of Acute Services at that time. And he's setting out, if we take up the second paragraph, that routine surgery has ceased and clinically urgent surgery has been limited, and he's saying there are staffing difficulties in theatres which renders it likely that there will be ongoing reduction in elective capacity and this will cause a disproportionate impact on urology, because, as a speciality, you have such limited numbers of theatre sessions as a baseline. 15:39 15:39

He goes on in the next paragraph to talk about the risks for those patients generally regarded as falling within the urgent and sometimes the routine categories, the risks of, for example, sepsis. 15:40

And in the fourth paragraph he touches upon the death of Patient 91, the stent patient, if I can respectfully call him that? This operation he says: 15:40 15:40

"...took place 10 weeks after initial stent placement."

He says:

"While this may have happened because surgery took place within a month and there will be other factors involved including his co-morbidities, his risk of

urosepsis was increased five-fold by his waiting time for the procedure."

And then if we go over the page, I think, yes, he's making -- sorry, just at the bottom of that. Yes, he's 15:41
making a pitch, again if I can use that term, for, if we scroll down, the target, he says:

"...should be four additional lists per week in order to meet the substantial volumes which the urology 15:41
service faces."

Now, we don't have the time to go through all of the correspondence that flowed from that, but this was 2018, and there was intended to be a meeting with 15:41
management scheduled for September 2018, but it was cancelled as I understand it, because Mrs. Corrigan was off for surgery.

You contributed in advance of that meeting, if we just 15:42
bring it up on the screen, AOB-01904. You contributed your thoughts in writing covering the three issues of Urologist of the Week, the issue of triage I think, if we just scroll down, and a concern about the, if we go over the page, elective in-patient surgery. 15:42

The meeting having been postponed was rearranged for December and again didn't take place, isn't that correct?

A. Well, it's interesting that, because I attended -- if I may just take those two meetings in chronological order? Because even though the first meeting didn't include senior management because of the inability of Martina Corrigan to be present, it was a useful meeting. In fact it probably was a meeting that was necessary for the clinical team and the nursing team to discuss the issues that we wanted to deal with, and these three that I submitted were only three of those. I think the last time I gave evidence the Chair asked me -- there was a coffee break and whether we had gone on to discuss... 15:43 15:44

121 Q. The issue of triage?

A. Triage thereafter. I can't recall, because the only reason I was recording it -- and I'd like to take this opportunity -- was not to record actually discussions between me and my colleagues, but it was actually to record the discussions that we would have with senior management, and as they didn't turn up there was no point in continuing. 15:44 15:44

But then when it comes to the 3rd December, this might be entirely coincidental, but I submit my grievance on the morning of Friday, 30th December. I, like everybody else, turned up for the meeting to occur on Monday, 3rd December. I hadn't read the email that was sent by Martina Corrigan in the early afternoon of 30th December saying it had been... 15:44

122 Q. 30th November?

A. Of November, saying it had been agreed that the meeting was cancelled. I'm not quite sure of the exact words.

123 Q. Yes. I think that was the language she used. I think the email is at AOB-04250. Is it jumbled on your screen? Yes. 15:45

CHAIR: Yes, it's a jumble on ours.

MR. WOLFE: I think if I...

CHAIR: If you just want to read it out, Mr. Wolfe, that will do.

MR. WOLFE: Yes. So I'm reading from AOB-04250, which 15:45 is an email from Martina Corrigan to a range of personnel, including Mr. O'Brien:

"Apologies, as I had to send this email earlier. It has been agreed that the away day on Monday is 15:46 cancelled but the consultants and I would get together at 10.00am for a couple of hours to discuss some of the issues that had been raised on the 24th September..."

Which was the earlier meeting that had to be cancelled 15:46 due to her unwellness.

A. Mmm.

124 Q. So you were wishing to make a point about the cancellation of the December meeting?

A. Yeah. I mean, you know, I wondered who agreed it or 15:46 with whom was it agreed? I've never sought any clarification of that, nor have I ever received it. But for me, not necessarily particularly for me, but certainly for all of us it was a disappointment that

senior management couldn't meet with us to discuss and address and hopefully arrive at the kind of shared responsibility that I think I projected earlier this morning, rather than guidance.

125 Q. Yes. I draw attention to this correspondence in the context of the pressures being applied to the management of elective patients in the non-malignant area in order to allow you to illustrate that clinicians were not inactive in seeking to procure change and better support for their patients, who you well recognise were at risk, and we can see that through your response in 2016 to Mrs. Corrigan, and Mr. Haynes in his correspondence with Mrs. Gishkori. I wonder, however, whether upon reflection you consider that as a team of urologists, more might have been done, perhaps with the support of management, to better target your limited resources where they were most needed? I want to put the following perspective to you. In his evidence, Mr. Glackin, if we can bring it to the screen, please? WIT-42315. And at paragraph 46.1 he has stated that: 15:47 15:47 15:48 15:48

"Performance objectives are not utilised for consultant medical staff. A consultant job plan sets out sessions of direct clinical care and supporting professional activity. It records the frequency of clinics, theatre lists, on-call activity, et cetera." 15:49

But if I could just skip down to the important point:

"My job plan does not specify how many patients I am expected to see per clinic or theatre list. It does specify how many clinic and theatre procedural sessions I am expected to deliver over the course of a year." 15:49

And in expanding upon that in his evidence, the lack of performance objectives, he explained that it was his view that the consultant team should have been sitting down with management and with the relevant data 15:49 available to see what could be done to better deliver based on the resources available. In other words, using the data intelligently, where is our most urgent needs? How can we pool resources, perhaps? Divide our available time to more readily focus on what appears to 15:50 be most urgent? And he didn't diagnose or define what that might be. What he was reflecting, I suppose, was his experience in Great Britain as a younger professional, where the department met regularly to discuss workloads, numbers, available resources, and 15:50 arrived at strategies for dealing with it. He was reflecting that until relatively recently, and it was just a week or so before he had given evidence I think, that new age thinking hadn't arrived at the urology service in Craigavon, or perhaps within any of the 15:51 surgical services within Craigavon. Does that omission or that gap chime with you?

A. Yes, it does. It doesn't mean to say that it never occurred previously, because I remember a period of

time when there was an intensive look at operating theatre utilisation, do you know, arrival time, start time, anaesthesia time, WHO safety check time, and all of that. And very often actually there was, there were issues with regard to the reliability of data and what 15:51
exactly was being measured, and the heterogeneity that is intrinsic in patient operative cohorts and so forth. So it has been visited previously, but I certainly acknowledge that we stopped doing it, hadn't been doing it maybe for quite a period of time after we got the 15:52
one stop clinic model set up, which was a kind of issue like that.

So, yeah, I mean, I listened to his evidence with regard to performance measures, how performance perhaps 15:52
could be included in appraisals, so I've listened to all of that, and I'm just -- it's not either excuse or explanation or justification for such a gap, I just do remain somewhat sceptical of the extent to which you could achieve significant improvement in the context of 15:53
such inadequacy. I'm not, you know, knocking it on the head.

One of the things I did actually when I was lead clinician and Chair of MDT and MDM respectively, was 15:53
during 2014, I had the Cancer Tracker give to me the three patients who were waiting longest on their care pathway at the start of a meeting, and we started off with three patients only, and they might have been

about to breach in a week's time, and I took those three patients as Chair myself, and if the other clinician couldn't review them, I did it. And if you actually do things like that, if you start salami slicing off, you can make -- you can achieve change, but there are probably limitations to it as this ongoing inadequacy just spirals out of control, as you have said.

126 Q. Mmm. You've reflected already I think that process of engagement with Mrs. Gishkori, with Mr. Haynes taking the lead on behalf of the team. I'm not quite sure whether he was wearing his AMD hat or whether he was wearing the hat of a clinician within the team? It probably matters not. But it bore minimal fruit in that the number of operating or theatre sessions made available to the team increased marginally but were then reduced a short period of months, I think two months maybe? 15:54 15:54 15:54

A. One month.

127 Q. One month. One month later back to the level at which you were at. 15:54

A. Mmm.

128 Q. You spoke in your witness statement at paragraph 415 of your original statement, that having raised issues over time there is a sense of fatigue and disillusionment, as you put it, with regard to raising concerns, and it gives rise to -- the lack of responsiveness gives rise to a belief that raising concerns was no longer productive? 15:55

A. Or counter-productive even.

129 Q. In what sense?

A. I certainly remember Michael Young and I coming to the conclusion at times that if you kept repeatedly raising the same issues with the same people, it became increasingly difficult for them to respond positively to them because that kind of, you know, removed any justification for not having done so at an earlier time, and they kind of dug their heels in -- something I've been accused of earlier today. But, you know, it became difficult. 15:55 15:56

I also think actually that the term that sprung to my mind as you were introducing that question is one of additionality. I think actually from day one in 1992 the Urological Service was additional. You may have seen or read Mrs. Gishkori's response to the concerns that arose from the death of Patient 91 and, you know, that we need to respond to this. But, you know, we don't want to upset or diminish any other service, even though if you have finite resources you have got to actually share the cake out more equitably, even if the size of the cake does not increase. 15:56 15:56

130 Q. We can see from -- moving your engagement with management away from the bigger picture issues of the resources, we can see that in terms of your own specific practice that your engagement with management in terms of your requirements for support appears to be limited in a sense to finding or seeking to find more 15:57

time for your administrative obligations, whether that was facilitating you with a Friday on leave following your Urologist of the Week to enable you to complete triage. Were there any other types of support or forms of support that you sought from management to assist your own practice, particularly after returning to work in March 2017 or February 2017, or indeed after the publication of the MHPS Report in 2018? 15:58

A. I think the answer to that is on the one hand, no. I think on the other hand that really, I think in one of the meetings with Colin Weir and Martina Corrigan that I had recorded, I think that I refer to the job plan as a kind of scam, because I think actually what I would have liked to have done is for the management to acknowledge that if you're going to require, let's say six hours per week to do triage, or whatever administrative duty, or something like that, but management insist that you're not going to have more than 12 PAs, then management has to make some choices as well as to what kind of clinical activity is going to be dropped. So there is a distinction to be made between -- job planning really doesn't give you time, it acknowledges what you do in particular sessions, it is overruled by the amount of remuneration you're going to get for it, and that's expressed in PAs or whatever, but if you are, like as Mark Haynes has demonstrated, he took 15.25 hours per week to attend to his administrative duties, and that is the equivalent of two standard working days, which was in his own time. 15:59 15:59 15:59 16:00

I don't think that any consultant clinician should be expected, by their employer, to sacrifice so much of their time to meet the expectations of the employer.

Now, to answer your question more directly, what should have been the response in 2017, '18, '19? Could we have, as a group of clinicians, sat down in a room and somehow succeeded in getting management to engage with us to at least attempt to understand what those expectations meant for us, the amount of time that was required to undertake them, and what trade-offs that we could all agree to would be made? But, I mean, I did make a genuine and serious attempt to have those issues that I highlighted, from I would say actually early 2015, when I appreciated, and when I made it very clear that it was impossible for me to complete triage whilst Urologist of the Week, but then more formally in January '17, and again in 2018, to have that real substantive discussion with senior management to address these issues in a sustainable manner, but I didn't succeed. 16:01 16:01 16:01 16:02

131 Q. Yes. One of the supports on one view that is available to the clinician is the process of appraisal.

A. Mmm.

132 Q. And certainly we've heard evidence that when it was introduced in conjunction with the revalidation process, it was an instrument very much geared towards assisting the professional, the clinician, in their developmental needs, and I think we'll start with that 16:02

on the next occasion. But can I have your observations just before we close today. Appraisal, and we'll look at some of the particular appraisal documents on Wednesday, did appraisal provide any benefit or assistance to you, whether in the early years of it or as the process matured, in particular in relation to the challenges that you were facing in your practice? 16:03

A. Yeah. I think -- I mean appraisal in the early years from 2010 onwards was pretty bereft almost of detail and reflection and so forth. And even though it wasn't my favourite activity of the year, I found it to be increasingly useful as the years did go by, because you were -- it was obligatory, it was mandatory to reflect upon what had been identified by complaints, or SAIs or whatever. So I found it increasingly useful. 16:04 16:04

I, I mean I have my reservations about the whole issue of, not so much appraisal, but I have my own reservations about the issue of revalidation or validation in the first instance, because I've always believed from I first heard of it that the validation and revalidation of any clinician should not be at all the responsibility of that clinician's employer. I've always held the view that if the Royal Colleges, like in my case the Royal College of Surgeons in Ireland, had been regarded as trustworthy enough to determine whether I had completed satisfactory training and was eligible to become a consultant, that the colleges should be the repository of responsibility for 16:05 16:05

determining one's competence and fitness to practise and to be validated or to be revalidated, because it's obviously a conflict of interests, which is to me so glaringly evident, and which has been addressed as I think I believe you're aware, by Sir Anthony Hooper in his report to the GMC in 2015. It's open to abuse and it's open to exploitation. So that's a particular view I have about revalidation. But appraisal, yes. And could other things have been added into appraisal? Yes. But once again, do you know, what is appraisal and revalidation? It's about your competence in the speciality in which you have been employed to date, and it's a report that should go from an outside body to the employer rather than the employer doing it themselves. 16:06 16:06 16:06

133 Q. Well we will pick up on some of those strands on Wednesday, Chair. That concludes me for today.

CHAIR: Okay. Well ladies and gentlemen, we'll see you again on Wednesday, Mr. O'Brien, but we'll all be back here at 10:00 o'clock tomorrow morning for a different witness. Thank you. 16:07

THE INQUIRY ADJOURNED UNTIL TUESDAY, 9TH APRIL 2024 AT 10.00 A.M.