



Urology Services Inquiry

Oral Hearing

Day 94 – Wednesday, 10th 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

I N D E X

W I T N E S S

P A G E

MR. A I D A N O' B R I E N

QUESTIONED BY MR. WOLFE 3

1 THE INQUIRY RESUMED ON WEDNESDAY, 10TH APRIL 2024 AS
2 FOLLOWS:

3
4 CHAIR: Morning everyone.

5
6 MR. O'BRIEN, PREVIOUSLY SWORN, WAS QUESTIONED BY
7 MR. WOLFE AS FOLLOWS:

8
9 MR. WOLFE: Good morning, Chair. Morning members of
10 the panel. Good morning, Mr. O'Brien. We concluded on 09:56
11 Monday by taking a step into the area of appraisals,
12 and you offered a general reflection to open that area
13 for us, and I got the sense from what you were saying
14 that you found it to be a generally positive
15 experience, albeit you offered the view that it was 09:57
16 rather rudimentary, I suppose, in terms of its scope
17 and ambition, that is the scope and ambition of
18 appraisal towards the early days. I want to offer a
19 couple of perspectives to you and seek your response.

20
21 We can see from studying the appraisal documents how 09:57
22 some aspects of your professional practice, some issues
23 associated with your professional practice were drawn
24 out or at least mentioned as part of the appraisal.
25 Let me give you some examples. In 2011, if we could 09:58
26 have up on the screen, please, TRU-251256? So we can
27 see there under "Probity", the recent issue at that
28 time which had come up where you were found to have
29 disposed of some paper records from a patient's file

1 into a bin, or into a place where they shouldn't have
2 gone, was the subject of informal disciplinary action.
3 So that's drawn to your attention, or you draw it to
4 the appraiser's attention, who at that time was
5 Mr. Young, isn't that right? 09:59

6 A. I think it might have been Mr. Sterling at that time,
7 who was the Clinical Director at that time. I stand to
8 be corrected. I think if I were to see perhaps any of
9 his handwriting I would be able to clarify that.

10 1 Q. Yes. It doesn't much matter. 09:59

11 A. It doesn't much matter.

12 2 Q. For the majority of the time Mr. Young...

13 A. Yes.

14 3 Q. Did your appraisals. In mentioning that kind of thing
15 during the appraisal process, was it merely that, or 09:59
16 was there discussion, to take this example, around what
17 was to be learnt from that, why you did it, why you
18 shouldn't have done it? That kind of discussion.

19 A. Oh, there would have been, because it was well known, I
20 made it well known why I did it, and I regretted that I 10:00
21 did do it, and I would have considered that there was
22 fulsome discussion of the context, the reasons for my
23 doing it, and the consequences. There wouldn't have
24 been anything held back in the course of that
25 whatsoever. 10:00

26 4 Q. We can see additionally in 2017, to take another
27 example, that you drew attention, or at least the
28 appraisal process drew attention to the MHPS
29 investigation that was midstream. Let's take a look at

1 that. AOB-22954. And at the bottom of the page, I
2 think last section, it says:

3
4 "Mr. O'Brien will continue to participate in and Chair
5 Urology MDMs on a weekly basis." 10:01

6
7 It says:

8
9 "The ongoing investigation is having a detrimental
10 effect on his health and well-being. It remains a 10:01
11 difficult concern for Mr. O'Brien."

12
13 And then appended to the appraisal documents, if we
14 scroll forward to 22956, two pages further on. Oh,
15 sorry, that's it there. Just scroll back. So you put 10:01
16 in a paper setting out the background to your
17 employment, et cetera, and then over the page you talk
18 about the formal investigation and exclusion, and you
19 set out your perspective in relation to that. You talk
20 about the meeting in March of 2016, which we dealt with 10:02
21 during your evidence last year:

22
23 "I left that brief meeting wholly despondent knowing
24 that I would receive no support or assistance in
25 addressing the concerns." 10:02
26

27 And scrolling on down you go on to say -- just scroll
28 on further down I think. Maybe over the page. Yeah,
29 that's the point I wish to draw your attention to. You

1 comment, having been excluded, you say:

2
3 "Since then any recision of confidence which I had in
4 the integrity of a number of senior personnel in the
5 Trust has been completely..." 10:03

6
7 -- I think it should say "demolished". And who was
8 that a reference to?

9 A. I can't recall right now. I think most in a sense. I
10 think I was, I think I was particularly disappointed 10:03
11 with that interregnum between March '16 and the
12 decision that had been taken at the end of December '16
13 that I would be subjected to a formal investigation,
14 and then the manner in which that got off the ground,
15 particularly it was my -- it was through my initiative 10:04
16 and exerting some pressure that actually got some
17 meetings held during that four week period during
18 which, or by the end of which a determination should be
19 made as to whether I continued to be formally excluded,
20 and thereafter. And I think that what I was doing 10:04
21 here, rather -- more importantly, perhaps, than venting
22 in the way that you have drawn attention to me having
23 done so -- was, I had decided that appraisal and being
24 as open as I could about all of that that had happened,
25 the fact that there were issues of concern, the fact 10:05
26 that I was submitted to formal investigation and so
27 forth, and that was ongoing at that time, was drawn to
28 the attention of Dr. Scullion, and I had asked
29 Dr. Scullion to be my appraiser hence forth because he

1 was de facto or precariously the head of the appraisal
2 system on behalf of the Medical Director. And, you
3 know, he anaesthetised for me on alternate weeks for 20
4 years probably by that stage, that's another factor I
5 thought that he knew me well, but I choose him. But 10:05
6 lastly, you know, he, like everybody else, or most
7 other people, had not been au fait with what had gone
8 on. So I wanted to inform him, and I thought it was
9 best to do it in a manner like this, which the format
10 didn't particularly lend itself to doing. 10:06

11 5 Q. Mmm. And in drawing issues such as this significant
12 issue out during the appraisal process, did you find it
13 supportive and helpful?

14 A. Well it had to be reported. I didn't regard the
15 appraisal process at that time as the mechanism by 10:06
16 which these issues were being concerned, or would
17 continue to be concerned -- or to be addressed, sorry.
18 So it was more a matter of reporting it, being open
19 about it, making sure my appraiser knew of the issues,
20 how things were being addressed, in addition to my 10:06
21 discontent with aspects of it. That was certainly
22 included in making my appraiser aware of it. So I
23 would have considered that he was fully aware of it.
24 And you will see in the recommendations or the advices
25 that he gave during that appraisal process about 10:07
26 addressing the issue of job planning and that it was
27 onerous and so forth, so.

28 6 Q. One of the issues which obviously preoccupied
29 management, and then the MHPS process, and indeed

1 yourself, was dealing with triage.

2 A. Mmm.

3 7 Q. And I think you mentioned it yesterday, or on Monday I
4 should say, but we'll bring it out again. During this
5 2017 appraisal process, if we go back to AOB-22961 or, 10:07
6 sorry, forward to 22961? Sorry, the next page, I beg
7 your pardon, 962. So one of the things that is brought
8 out as part of your personal development plan here is
9 that an action agreed is the need, I suppose, for a
10 Memorandum of Understanding of what is expected from 10:08
11 the Trust, that's your perspective on what was required
12 so that you could have definition and certainty, as I
13 think you put it on Monday, about what was expected of
14 you when Urologist of the week for the purposes of
15 trriage? 10:08

16 A. Well just to clarify, it wasn't just my expectation of
17 the meetings that we thought were going to happen, it
18 was a collective -- in fact it was Mr. Glackin's words
19 of Memorandum of Understanding that we came to agree is
20 what we wanted at a departmental meeting in August '18, 10:09
21 and that's when we arranged the Monday away days, or
22 development days as they have been called.

23 8 Q. And I suppose when we think about the appraisal
24 process, which is supposed to have, I suppose, several
25 attributes. It's supposed to be developmental, it's 10:09
26 supposed to offer some form of nudge or challenge in
27 the context of perhaps difficulties or shortcomings in
28 a practice, and it's supposed to offer goals and
29 objectives via personal development. Scrutinising the

1 appraisal forms up to this point, and I could stand
2 corrected on this, and will stand corrected if I've got
3 this wrong, but I don't see much mention, if any
4 mention of triage, until this point in 2017 when you're
5 being challenged by management through the MHPS process 10:10
6 in terms of your perceived shortcomings in dealing with
7 it. Is that your memory, that you didn't bring triage
8 to the table, or your appraisers didn't bring triage to
9 the appraisal table before this?

10 A. That's true. And I think there, you know apart, you 10:11
11 know, acknowledging that there were times when there
12 were delays in triage, triage wasn't such a big issue,
13 there weren't so many delays in triage up until that
14 period when I took on those leadership roles in
15 2012/2013 and leading into Urologist of the week, and 10:11
16 even since Monday, you know, when I reflect on all of
17 this, you know, to my mind there was no doubt that I
18 had made it, what I considered to be explicitly clear
19 to my colleagues and all of the people involved in the
20 referral centre when we met in March '15, that I had 10:11
21 found it impossible to complete triage whilst Urologist
22 of the week. That's the word I used. I thought that
23 that was synonymous with telling them that I couldn't
24 complete it.

25 9 Q. I get that. 10:12

26 A. You do get that. But...

27 10 Q. But let me refocus if I can? I'm focussing here on
28 appraisal and whether appraisal would have been an
29 appropriate place in which to talk through your

1 difficulties with triage, and it doesn't get mentioned
2 until you get into trouble over it, if I can put it in
3 those terms?

4 A. Well, that doesn't necessarily mean that it wasn't
5 mentioned in passing. It may not have been recorded. 10:12
6 It was a well known fact, that was my understanding of
7 it. And, you know, it's -- even though others managed
8 to do it, it was one of the challenges that all of us
9 faced. So I think we would, there would have been an
10 awareness of the difficulties during any appraisal in 10:13
11 those years, certainly. It may not just have been
12 highlighted as well as perhaps it should have been in
13 the recordings.

14 11 Q. Yes. Let me make a more general point. Triage is one
15 example of a, let me put it as neutrally as possible, a 10:13
16 problem within your practice that wasn't, it appears to
17 me, certainly recorded in the appraisals, whether or
18 not it was briefly discussed.

19 A. Mmm. Mmm.

20 12 Q. If we think of the various other issues that maybe drew 10:13
21 attention to your practice over that period of seven
22 years or so between 2010 and 2017, so, for example, the
23 never event, the retained swab, and then the outworking
24 of that in terms of controversy around whether you were
25 reading your results at an appropriate time, whether 10:14
26 you were reading them promptly enough, that wasn't
27 something that appears to have been discussed through
28 the appraisal process. There are other examples I
29 could point to, but in the interests of brevity let me

1 just ask the general question: was appraisal, when you
2 think back on it, sufficiently helpful in challenging
3 you in relation to areas of your practice that required
4 improvement?

5 A. In retrospect possibly not. And in addition, possibly 10:15
6 not with a view to seeking support or having any
7 difficulties addressed in a constructive manner. So
8 when you look back on it, and I know that you have
9 addressed this issue of appraisals with others giving
10 evidence, that perhaps it could have been more 10:15
11 wide-ranging than it appeared to be. I think it did
12 improve as the years went on, and I think that those
13 who conducted appraisals were making every effort for
14 it to be as comprehensive and as constructive, or as
15 scrutinous or as challenging as was possible. I 10:15
16 certainly had never any intention to, you know, conceal
17 or glide over any aspects in the appraisal process. So
18 if you, in retrospect, feel that it has, it fell short,
19 it had it's own shortcoming, that's probably the case,
20 and such shortcomings could be addressed in the future 10:16
21 with appraisals.

22 13 Q. Take the year 2015.

23 A. Mmm.

24 14 Q. It was the year when Mr. Haynes drew Mr. Young's
25 attention to concerns about private patients in your 10:16
26 practice.

27 A. Mmm.

28 15 Q. It was the year when apparently your colleagues were
29 talking about the absence of dictation and the

1 difficulties that that was causing then when doing
2 reviews.

3 A. Mmm.

4 16 Q. Triage was a feature. Concerns around triage was a
5 feature of that year. We have seen also that your
6 retention of patient files at home was also a feature
7 of correspondence and communication that year.

10:17

8 A. Mmm.

9 17 Q. But if we look to the appraisal for that year, we'll
10 see no mention of those issues, Mr. Young being your
11 appraiser.

10:17

12 A. Mmm.

13 18 Q. Mr. Young also being the clinical lead, and perhaps one
14 of the people in the Trust who knew your practice best.
15 Your reflections on that. If those issues weren't
16 being raised, perhaps the answer is that's not --
17 appraisal isn't the appropriate place to raise them.
18 But do you think that they, when you think about it,
19 ought to have been raised, and ought you to have been,
20 I suppose, pushed or nudged into a discussion about how
21 you could improve in that setting?

10:17

22 A. Well in that period of 2015, you know, my understanding
23 of it was that it had been clarified quite clearly that
24 with regard to triage, as I have stated, that I found
25 it impossible to complete it, and that a default
26 process had been put in place, not necessarily solely
27 because of me, but it was a major contributor to that
28 being put in place. To my mind, I mean I didn't raise
29 it during appraisal because that was the situation at

10:18

10:18

1 that time. The issue of dictation was never raised
2 with me until I received the letter of March '16. I
3 was completely unaware that that was an issue for
4 anyone. Certainly I could have raised myself the issue
5 of the backlog in processing and dictating on patients 10:19
6 who had attended my clinic at Southwest Acute Hospital,
7 I could have done that during the appraisal process.
8 There's no reason why the appraisal vehicle is not the
9 vehicle for discussion and addressing all of these
10 issues. But those are the reasons why -- and private 10:19
11 patients wasn't, in spite of the email from Mr. Haynes
12 to Mr. Young in 2015, I mean that wasn't raised with me
13 at all in 2015.

14 19 Q. We have Mr. Young's evidence in relation to that last
15 point? 10:20

16 A. Yeah.

17 20 Q. And, you know, he differs in his recollection, although
18 his recollection, some might say, isn't entirely clear
19 as to time and place when he raised the issue with you,
20 and we have your perspective. 10:20

21
22 what we do see from the appraisals is frequently, I
23 think almost year on year, you are raising as a
24 reflection, I suppose, the heavy demands that are being
25 placed upon you, and the impact of resourcing 10:20
26 difficulties for your patients. So those issues of job
27 related pressures are being raised in that general
28 sense, and if I may say so, on my analysis, with very
29 little specific attention to the individual aspects of

1 your job that are not up to scratch, as some might see
2 it.

3
4 So let me just touch upon some of that. If we go, for
5 example, to your 2012/2013 appraisal, which was an 10:21
6 appraisal for those two years, and we can look at
7 TRU-251265, and under "Current Job Plan", and you'll
8 recall that that was the subject of some difficulty at
9 that time, and you appealed it and you were unhappy
10 with the outcome of that. But under "Additional 10:21
11 Information" you say:

12
13 "The main issues compromising the care of my patients
14 are my personal workload and priority given to new
15 patients at the expense of previous patients. With 10:22
16 regard to workload, I provide at least nine clinical
17 sessions per week, Monday to Friday. Almost all
18 in-patient care and administrative work arising from
19 those sessions has to be conducted outside of those
20 sessions. Secondly, the increasing backlog of patients 10:22
21 awaiting review, particularly those with cancer, is an
22 ongoing cause for concern."

23
24 So in that way you're drawing attention both to your
25 workload, and the impossibility, as you see it, of 10:22
26 getting it done within standard hours, if I can put it
27 in those terms, and the knock-on effects for your
28 patients in that environment. As I say, there's a
29 number of examples of this through the years of your

1 various appraisals, and the picture I think you present
2 is of it getting worse. I think you say that. You're
3 asked in one of the boxes to comment on how things are
4 now, and you say "the same only worse", if I can put it
5 in those terms. 10:23

6 A. Mmm.

7 21 Q. What was your objective in raising the issues in that
8 way, and what was your expectation, if any, in raising
9 those issues?

10 A. Well, I'd be reiterating what I said last day, do you 10:23
11 know. For me, throughout all of my 28 years as a
12 consultant urologist, my overriding concern has always
13 been the safety, and the risks to the safety of
14 patients due to the inadequacy of the service, and as I
15 have stated last day, the inadequacy of the service was 10:24
16 such that that inadequacy presented the greatest risk
17 of harm coming to patients, harm that we saw
18 repeatedly, and harm that sadly occasionally at times
19 led to mortality. And if you are a clinician and
20 you're working in such an environment, I found it 10:24
21 ethically difficult, if not impossible, to always dot
22 the I and cross the T on every aspect of my individual
23 professional practice at the expense of ignoring what I
24 could possibly do in the same finite period of time for
25 those people who I knew were at risk of coming to harm 10:25
26 because of long waiting lists. So I felt a duty during
27 appraisal, I mean, to draw attention to that. I wasn't
28 expecting the appraisal process to be the vehicle for
29 addressing the long waiting lists, but it was my

1 explanation as to what concerned me as a clinician, and
2 whilst I didn't quite see it at the time, but in
3 retrospect it would be my explanation for any alleged
4 shortcomings which, as I explained last day, I felt
5 carried lesser risk to the patients affected by such 10:25
6 shortcomings than the mitigations that I could deliver
7 to people by taking on additional operating sessions,
8 for example.

9 22 Q. As you know, it is the Trust's perspective that the
10 shortcomings in your practice go much beyond the mere 10:26
11 dotting I and crossing T. They say that plainly it's
12 much more significant than that. And we'll look at
13 some of those issues as we go on today and tomorrow.
14 You've reflected in your witness statement that
15 although you're highlighting these kinds of significant 10:26
16 issues, no one ever came back to discuss them with you,
17 or nor was there any process for how they would be
18 addressed. Assumedly you weren't articulating these
19 difficult issues simply to put ink on paper. Was it
20 your expectation that in some shape or form the Trust 10:27
21 would interrogate what you're putting on paper and at
22 least try to engage with you and your colleagues to try
23 to improve matters?

24 A. I would have had much greater expectation that they
25 would have done so as a consequence of making such 10:27
26 representations along other avenues rather than
27 appraisal. As you know, you know, we were frustrated
28 by the tardiness or the non-existence of any addressing
29 of those issues in a sustainable substantive manner

1 over the years. But to answer your question directly,
2 I don't think that I would have a great expectation
3 that by documenting them in the appraisal process that
4 that would have resulted in a rushed comeback to
5 address concerns, because they knew what the situation 10:28
6 was, they knew it was getting worse, either they could
7 not do it, because of their own financial situation or
8 whatever. But I think actually that -- I mean
9 appraisal, if appraisal is not a moment for the
10 clinician to document their concerns about their 10:28
11 practice and the patients that they are to look after,
12 I don't know what is. So that's the reason why it's
13 documented.

14 23 Q. Yes. Your exclusion from work, your return to work in
15 early '17, and then the publication of the MHPS 10:29
16 Investigation Report and its determination in late
17 2018, are obviously significant moments in your long
18 professional life. During the MHPS process you were at
19 least candid in acknowledging that triage, notes at
20 home, dictation, were issues for you, but you put 10:30
21 obviously the mitigations around them. I wonder upon
22 reflection whether, when you returned to work in early
23 2017 or at some point after the publication of the MHPS
24 Report, whether there was an opportunity for you to be
25 transparent or at least clear about any other issues in 10:30
26 your practice that were causing difficulty that you
27 perhaps struggled to maintain? Take, for example, your
28 approach to dealing with results, which we'll look at
29 in some detail this afternoon. Say, for example,

1 issues around pre-op assessment, which again we'll look
2 at. The Trust, as you know will say, has said, that
3 those were issues in your practice that they placed
4 patients at risk. Should you have been clearer and
5 more open, particularly in light of the MHPS 10:31
6 investigation, that there were other areas that you
7 perhaps struggled to cope with and to have sought
8 assistance or at least advice?

9 A. With regard to pre-operative assessment. I mean
10 pre-operative assessment, and I know that that is a 10:31
11 particular issue in the one case -- I'll not look for
12 the number right now.

13 24 Q. Patient 90 I think?

14 A. Yeah. Ehm, do you know, pre-operative assessment was a
15 big issue that not only pertained to my practice, 10:32
16 because one of the problems that you have when you have
17 such long waiting lists is, coupled with frankly an
18 inadequately resourced pre-operative assessment
19 service, which wasn't able to cope with the totality,
20 and then you have -- if you have somebody waiting six 10:32
21 years for an operation, the pre-operative assessment
22 that was conducted six months after they were entered
23 on the waiting list is of no relevance.

24

25 But perhaps more importantly, and I think it came out 10:32
26 on Monday, is, if you have a situation whereby you're
27 expecting to get this stented patient back within one
28 month preferably, and you have a compressed
29 pre-operative assessment service which is not able to

1 cope, as indeed in the case of Patient 90, I mean they
2 did make an appointment, he was in the Emergency
3 Department, they gave him another time to come back, he
4 didn't go back, all of that compression, and you might
5 say "well, if actually he had been scheduled six weeks 10:33
6 in advance?" But as Mr. Haynes and I discussed many a
7 time, if you organise your theatre six weeks in
8 advance, you're leaving absolutely no scope whatsoever
9 to deal with the stented, the patient who is going to
10 be stented tomorrow to have their stent attended to in 10:33
11 a reasonable timeframe. So I didn't think that
12 pre-operative assessment -- I do appreciate...

13 25 Q. Let me keep the issue general, because we're going to
14 come to that.

15 A. Yes. 10:34

16 26 Q. I suppose the question is, the specific question is:
17 At that time, say 2018, you're emerging from a very
18 difficult process.

19 A. Mmm.

20 27 Q. I know there's further battles from your perspective to 10:34
21 be fought around that.

22 A. Mmm.

23 28 Q. But did you take a moment to think "Here were those
24 issues, they've all been unpacked in a kind of
25 confrontational way and I've had to face up to my 10:34
26 shortcomings, albeit I think there is mitigations
27 around it".

28 A. Mmm.

29 29 Q. "Is there anything else in my practice that I should,

1 if you like, reveal or let go off, and let management
2 know that I'm struggling here?", or did you not, I
3 suppose recognise or apprehend that you had any other
4 particular shortcomings in your practice that would
5 need address or assisted? 10:34

6 A. I think the latter is probably the case, that I didn't,
7 I didn't recognise that there were any other
8 shortcomings. Like, for example, reading all results.
9 From some people you'd get the impression that I didn't
10 read any results. But being able to read all results, 10:35
11 because, essentially, at the end of the day, you know,
12 there just wasn't enough time to do everything, and I
13 know that other people have contended that if I had
14 delegated certain aspects of scheduling to my secretary
15 -- because we didn't have schedulers at that time -- 10:35
16 then, and my secretary wouldn't have been able to do
17 it, you know, if a query comes back from the patient
18 who, do you know, I felt actually I was doing it in the
19 shortest period of time by contacting them myself. So
20 I didn't think actually that the reading of all results 10:35
21 was something that was particular to me. I didn't
22 think that pre-operative assessment was anything that
23 was of particular to me. I do know that a consultant
24 anaesthetist, you know, did raise with me that patients
25 weren't having pre-operative assessment who were 10:36
26 attending the day surgical unit. I can't remember when
27 that occurred.

28
29 So if I may go back to, you know, like when you have

1 Mr. Haynes spending 15 to 16 hours a week in
2 administration to try to cover everything, it's just,
3 it's just unreasonable to expect that one would
4 eliminate all perceived shortcomings in their practice
5 by spending another 16 hours on top of what you're 10:36
6 scheduled to do in order to achieve that objective, and
7 if in my case, you know, I am less able to perhaps --
8 I'm struggling to get the right word, which is not in
9 any way offensive to anybody, or critical, and that is
10 to compartmentalise other aspects of my concerns about 10:37
11 patients, then it's impossible. So I hope I have
12 described adequately any -- my reasons, or the reasons
13 for my not introducing other aspects of my practice at
14 that time, because it was just so intense.

15 30 Q. One of the, one of the themes that has emerged in the 10:37
16 evidence concerns insight and reflection. Maria
17 O'Kane, in referring you to the General Medical Council
18 in March 2019, has reflected that when she looked at
19 the MHPS papers she was concerned that your behaviour
20 had impacted on patient safety and that you had limited 10:38
21 insight into that impact and your responsibilities,
22 whereas your tendency, as she saw it, was to point the
23 finger at the system, and that seemed to be the
24 mainstay of her decision to refer, picking up perhaps
25 on Dr. Chada's conclusions in her report, that you 10:38
26 lacked insight and reflection and an awareness of the
27 potential seriousness of the flaws in your practice.
28 Is that a fair analysis, in your view, of your state of
29 mind at least at that time?

1 A. No, I don't think it is at all. And I simply do not
2 know how, you know, anybody can come to such a
3 conclusion on the papers, as it were, particularly on
4 papers that only a few months previously had stated
5 quite categorically in the report of the investigation 10:39
6 by Dr. Chada -- the determination, sorry -- that he
7 didn't see any reason at that time to refer me to the
8 GMC. I have to, if I'm being honest with you, I am
9 very sceptical of her consideration that I lacked
10 insight. I have, I have no reason to believe that I 10:39
11 have not been fully acknowledging of alleged
12 shortcomings. I have described at all times, including
13 to the Inquiry, what I regarded as the mitigations
14 surrounding those, as you have referred to it, and the
15 context. I do not know how anybody can make a decision 10:40
16 to refer a colleague to the GMC without at least
17 meeting them, speaking to them. I didn't even know
18 what she looked like. We have never met.

19 31 Q. Of course I should say, just to emphasise, there was
20 strong advice from Ms. Donnelly, the Employer Liaison 10:40
21 Adviser of the GMC, in a series of emails, of which I'm
22 sure you're familiar, strongly advising the Trust that
23 this was a case that had crossed the threshold for
24 referral?

25 A. I am aware of that too, and I've never met her either. 10:40
26 There are two further comments I'd like to make just on
27 that issue. The latter one -- we've often heard the
28 term "triangulation", and I'd like to introduce a new
29 term and that is "quadrangulation". I do wish that

1 people would actually make contact with the person
2 involved, do you know. If you're considering making an
3 important step like referral to the GMC, I would have
4 thought that before I would -- if I were a responsible
5 officer I wouldn't do that without actually making 10:41
6 direct contact and touching base with and establishing
7 whether the perspective that you have arrived at -- in
8 this case lack of insight -- is wholly justified and
9 reliable.

10
11 The second point I would make, and that is, I find it
12 difficult to believe that the decision to refer me to
13 the GMC had absolutely nothing to do with the fact that
14 I had submitted a grievance. 10:41

15 32 Q. very well. Thank you for that perspective. Let me 10:42
16 move on. I want now to examine the clinical aspect of
17 a number of issues, including but not limited to some
18 of the important themes that emerged from the 2020/2021
19 SAIs, in order, through your evidence, to assist the
20 Inquiry in its responsibility to make findings related 10:42
21 to the governance of patient care and safety.

22
23 Now, as you know, we've heard from some of your
24 colleagues in relation to a number of clinical practice
25 issues, and clearly interested to hear from you in 10:43
26 relation to how you practised and why you considered it
27 to have been a valid or an appropriate way of
28 practising. And where you feel that you have been
29 inappropriately criticised by the Trust, or by

1 colleagues, you'll have an opportunity to provide an
2 explanation, no doubt.

3
4 If you consider that the systems of governance relating
5 to patient care and safety could have been better, 10:43
6 better deployed and better used by, for example,
7 providing you with clearer instruction about what was
8 expected of you, you will no doubt explain that.

9 Furthermore, if you consider that the resources
10 available to you, or the pressures created by the 10:44
11 demands on the service caused you to practice as you
12 did, again you'll have an opportunity to address that.
13 So that's, I suppose, a clear signpost as to where
14 we're going for the next -- perhaps the remainder of
15 your evidence into Friday. 10:44

16
17 We have heard that at an early stage, or a reasonably
18 early stage of your career at Southern Trust, aspects
19 of your practice raised the concerns of a trainee at
20 that time, Mr. Chris Hagan, who was carrying out a six 10:44
21 month rotation in the Craigavon Hospital, or I think
22 Daisy Hill as well, during the year 2000, and we can
23 see that you have used your addendum witness statement
24 to respond to many of the issues that he has raised.
25 Let me summarise his evidence, if I can? 10:45

26
27 He says that he raised issues that concerned himself
28 with you and with Mr. Young. Those issues, I suppose,
29 broke down into nine, eight or nine areas. Mr. Young,

1 from his perspective, doesn't recall Mr. Hagan raising
2 any of these sort of major concerns, as he put it. But
3 he does reflect that he could remember Mr. Hagan
4 working in Craigavon. He had a particular interest in
5 prostate cancer at the time. He can remember fairly 10:46
6 close engagement between you and Mr. Hagan during ward
7 rounds for, example, where you both had an interest in
8 prostate cancer and would have had conversations about
9 treatment plans and that kind of thing. From your
10 perspective you've said at paragraph 48 of your most 10:46
11 recent addendum statement, that you had very minimal
12 recollection of Mr. Hagan's presence as a specialist
13 reg during that period. Does that, when you say "very
14 minimal", no recollection of any fine, of the fine
15 detail of any interactions, is that what you're seeking 10:47
16 to convey?

17 A. Oh, in that sentence what I was seeking to convey is,
18 you know, when you've been a consultant for 20 or 30
19 years and many specialist registrars have passed
20 through your department, there will be those who stand 10:47
21 out in your memory for various reasons, and they're
22 usually positive, do you know. They are particularly
23 intellectually bright. Their clinical acumen is
24 superior to others. Do you know, the contribution that
25 they made to research or audit or whatever, you 10:47
26 remember it. So because of the kind of absence of any
27 of those I had not a particular memory of any -- I just
28 don't remember actually -- I had forgotten that he was
29 even with us for six months until I received, that it

1 came to prominence during the course of the public
2 inquiry. So that, it's just a statement, a general
3 statement along those lines.

4 33 Q. Yes. Do you remember Chris Hagan, or for that matter
5 Mr. Young after speaking with Mr. Hagan, raising or 10:48
6 discussing any issues of concern with you?

7 A. No. No. Unless I have said to the contrary about
8 something specific, but I have no recollection
9 whatsoever of any concerns being raised. And you would
10 have imagined actually with the multitude of concerns 10:48
11 that he did have that, you know, there would be some
12 discussion, but I have no recollection.

13 34 Q. That you would have some memory of the discussion?

14 A. That I'd have some memory of the discussion, yeah. I
15 don't think there was discussion, quite frankly. 10:49

16 35 Q. In terms of trainees. By this stage Mr. Hagan had had
17 other rotations before he came to, or other placements,
18 if that's the appropriate jargon, before he came to
19 Craigavon. And viewed from his perspective he saw much
20 in your practice, I think it's fair to say, that he 10:49
21 regarded it as unconventional and of concern. In
22 general terms, would you agree that there should be a
23 procedure by which trainees should be in a position to
24 articulate concerns in real-time in confidence, without
25 being dismissed or without having their opinion 10:50
26 diminished?

27 A. Absolutely. Not only should there be, but I would have
28 thought at that time there was. So, absolutely. I
29 mean that's unequivocal, yeah.

1 36 Q. And you think there was a process at that time?
2 A. Well, I mean there is -- I mean I don't know of the
3 absence of any process that would have prevented any
4 registrar or junior doctor raising concerns to, for
5 example, a medical director. They can always go to the 10:50
6 medical director if they have concerns about the
7 practice of a consultant. I have had contact in the
8 past from registrars who were working in our department
9 who went to work in England who had concerns about one
10 or more of their consultants and who sought my advice 10:51
11 as to how to deal with it. So, yeah, I mean if he had
12 had any significant concerns with my practice at that
13 time I would be very, very surprised that he did not
14 consider them of such significance and of such an
15 abundance that they didn't require to be raised in some 10:51
16 manner. And certainly I've no recollection of any
17 concerns ever having been raised with me. And I think
18 actually he says himself that in some of them he didn't
19 discuss them with me, and he couldn't recall whether he
20 had discussed them with Mr. Young either. So. 10:51
21 37 Q. Yes. I sense from your evidence that you are sceptical
22 of Mr. Hagan's evidence, as is your prerogative. You
23 either doubt that he had the concerns at the time, is
24 that it, or is it certainly that he didn't raise them?
25 Is it a degree of both? 10:52
26 A. I have a degree of scepticism as to whether he had the
27 concerns at the time. And, as you know, on two of the
28 concerns, with regard to two of the concerns they have
29 since been considered. Well, in the case of the

1 perforated ureter, and in the case of him raising
2 concerns about my operating for up to two hours, or
3 whatever the words used were, and having a phone call
4 from Dr. McAllister and so forth, do you know, there's
5 major doubt, let's say, cast upon whether those issues 10:52
6 did actually occur. I have a degree of scepticism.

7 38 Q. would you be sensitive to the view that a trainee,
8 inexperienced, towards the bottom of the, if you like
9 the professional ladder, looking to learn, looking to
10 get on, looking not to fall out with people perhaps in 10:53
11 the interests of career preservation, might find it
12 difficult to use formal mechanisms to raise concerns or
13 make complaints?

14 A. well, there's always that issue. That's a well
15 acknowledged issue. But, you know, I have worked with 10:53
16 many registrars and junior doctors over 28 years, and I
17 have always gone out of my way to be as supportive to
18 them in their careers. I don't think that I would have
19 been the kind of person with whom anybody would have
20 had a difficulty in discussing a concern. 10:53

21 39 Q. Is that the appropriate mechanism, as you would recall
22 it, or were there other mechanisms? In other words,
23 should he have brought his concerns to you directly
24 face to face, and you say he didn't, or were there
25 other avenues? 10:54

26 A. well, there are always other avenues. In every
27 workplace, even though it's 24 years ago, I mean it's
28 not in, do you know, Neanderthal times, you know,
29 antediluvian, you know, it's recent, and there were

1 mechanisms by which one could raise concerns. So. But
2 Mr. Hagan, you know, wouldn't necessarily have been a
3 personality who would have, at that time, and since in
4 the years that I have had minimal contact with him
5 since, he's not the most conversant of persons, and 10:54
6 perhaps he harboured concerns, or perhaps he made
7 observations, but certainly I wouldn't -- I've never
8 been dismissive of anybody raising concerns, and it's
9 not just junior doctors, I mean the most common
10 concerns are raised by nursing staff who are looking 10:55
11 after patients at the time. So I refute the notion,
12 you know, that I was a person who was difficult or who
13 was dismissive. I have never had a dismissive
14 tendency. I don't dismiss people raising their
15 concerns. It's not my personality to do so. If I 10:55
16 thought that their concern was unfounded, I would
17 explain to them the reason why I considered that to be
18 the case. So.

19 40 Q. And cognisant of the view expressed in your addendum
20 statement that many of the issues that Mr. Hagan has 10:56
21 raised critically, would require you to have some
22 exposure to or re-exposure to patient notes and
23 records.

24 A. Mmm.

25 41 Q. And you've said in respect of some of the issues raised 10:56
26 "I simply can't remember this, I would need the notes
27 and records."

28 A. Mmm.

29 42 Q. "If the Inquiry wishes to hear from me in greater

1 detail on those issues", you would be happy to assist.

2 A. Mmm. Yes.

3 43 Q. So that's on the record, and thank you for that. Many
4 of the issues that are raised are purely clinical, and
5 I think the Panel would take the view that they 10:56
6 probably stray beyond the Terms of Reference. What I
7 want to do, in short form, is perhaps ask you for your
8 observations on some of the governance aspects that
9 might be said to arise from what Mr. Hagan has said.
10 Now, take, for example, the issue that he raised in 10:57
11 relation to what he recalled was a procedure performed
12 by you in relation to a young female patient. I think
13 it's described as a benign cystectomy with neobladder
14 to treat, as he understood it and as he remembered it,
15 recurrent urinary tract infections. That being, as he 10:57
16 understood it, the sole, or perhaps the primary reason
17 for the intervention. And your response to that, and I
18 think Mr. Young's response to it as well, was that if
19 the operation was performed solely for the recurrent
20 UTIs, you would agree with him, that in the absence of 10:58
21 other pathology it would be difficult to justify the
22 intervention. In terms of the performance of a
23 procedure.

24 A. Mmm.

25 44 Q. Say hypothetically you decided, as per what Mr. Hagan 10:58
26 has said, to operate in such circumstances.

27 A. Mmm.

28 45 Q. What, from a governance perspective, or a supervisory
29 perspective, would prevent you from doing so?

1 A. Well, very often prior to undertaking something of
2 significance, such as a cystectomy and orthotopic
3 bladder replacement, some major complex surgery like
4 that, I mean I would have discussed it with Michael
5 Young in the earlier days. We frequently did that. In 10:59
6 fact, in my early days at Craigavon Hospital I brought
7 cases for discussion to Dublin because we had once a
8 term sort of clinical meeting that took place in a
9 particular drug company house -- I've forgotten the
10 name of it now -- it went on for years. In fact 10:59
11 actually before I did my first cystectomy and
12 orthotopic bladder, it was a radical cystectomy for
13 bladder cancer, I discussed that case at that time. So
14 in terms of scrutiny, in terms of -- in fact, actually,
15 I did likewise for Michael Young in relation to a 11:00
16 patient as well. So we would have had that kind of
17 mechanism in place which provided some oversight.

18 46 Q. But that, if I may say so, is you opening up to a
19 colleague that "I'm going to perform this operation"?
20 A. Or asking "What do you think?", and "Should we?", and 11:00
21 "Does it justify it?", and so forth.

22 47 Q. So is there anything -- was there anything and is there
23 anything other than that voluntary exposing of your
24 practice to a colleague, that would have prevented you
25 from operating in the way that Mr. Hagan said that you 11:00
26 did?

27 A. At that time there wasn't. The only thing that emerged
28 subsequently was the termination of simple cystectomies
29 for a benign pathology back in 2010, or whenever it

1 happened, do you know, following the Regional Review
2 and the centralisation and all that went into that
3 period of benign cystectomies, as they were called.

4 48 Q. Yes. He went on to give evidence in relation to his
5 exposure to a procedure, a TURP that you were 11:01
6 performing, which he said approached two hours in
7 duration. He said that nursing staff who were present,
8 and the anaesthetist, he recalled as having expressed
9 concerns. He raised his concerns with you and you were
10 dismissive. He spoke to Mr. Young about it and he 11:01
11 recalls vaguely, he can't be precise about this, but
12 words to the effect that "that's just Aidan". Again,
13 we have your perspective on it in your witness
14 statement. But can I ask you this from a governance
15 perspective, if a procedure doesn't go as planned, so 11:02
16 hypothetically you're running towards one and a half
17 hours/two hours, which would be unusual for a TURP,
18 we've seen a paper you've presented where I think it's
19 9% of TURPs go beyond I think it was an hour or maybe
20 it was an hour and a half? 11:02

21 A. I've never known one to go beyond an hour and 20
22 minutes or an hour and a half at the very maximum.

23 49 Q. Yes. So if he is right in his recollection, and the
24 anaesthetist and the nursing staff are expressing
25 concern, what would you expect would be done about 11:02
26 that? what were the processes in place by which an
27 anaesthetist or nursing staff could raise concerns?

28 A. They just did it, you know. If there was a concern,
29 you know -- when you're working in an environment like

1 that where, you know, you're so familiar with the
2 people that you're working with, and they with you, and
3 you can understand their body language, never mind what
4 they have to say, it's completely free. There is no
5 inhibition whatsoever, because the most important 11:03
6 person in the room is the person on the table. So, you
7 know, the notion that I would dismiss a concern about
8 any procedure coming from an anaesthetist or a member
9 of experienced nursing staff is -- I find it absurd
10 really, quite frankly. And I just don't believe it, 11:04
11 quite frankly.

12 50 Q. Mr. Young gave evidence that it would have been his
13 awareness that there was, if you like, theatre tearoom
14 chat that Mr. O'Brien's TURPs would, I think he used
15 the word, "regularly" go beyond the hour mark. Were 11:04
16 you aware that there was perhaps a sense of disquiet
17 around the length of time you had the patient on the
18 table in performing that procedure?

19 A. Not at all. Not at all.

20 51 Q. Did Mr. Young ever discuss it with you? 11:04

21 A. Not at all.

22 52 Q. If he had a concern, should he have discussed it with
23 you?

24 A. He should have.

25 53 Q. Do you think that it would have been an easy matter for 11:04
26 nursing staff, or an anaesthetist, or indeed Mr. Young,
27 to discuss such concerns with you?

28 A. It would have been an easy matter. And particularly
29 someone of the calibre, for example, talking of

1 anaesthetists, of Damien Scullion, and Dr. Bennett, and
2 before that Dr. Des Orr who anaesthetised for me for
3 many, many years. And, you know, with respect, it's
4 very, very -- it's a very easy matter for the Inquiry
5 to ask those people, to have asked those people did 11:05
6 they have concerns about my operating? Did they have
7 difficulty in raising concerns if they did have such
8 concerns? Rather than me sitting here refuting the
9 notion that they had concerns which they would have had
10 difficulty in raising with me, or that I would have 11:05
11 been dismissive of them, and weighing that against the
12 report of tearoom chat and so forth.

13 54 Q. Of course another way to do it would be to objectively
14 get hold of the operation charts?

15 A. Absolutely. 11:06

16 55 Q. Or notes.

17 A. Yes, that's true.

18 56 Q. And subject TURP procedures to some form of regular
19 audit?

20 A. Yes. 11:06

21 57 Q. Was that done, in your experience?

22 A. There was one study done at the time which I've
23 included in disclosure to you of the duration of...

24 58 Q. That was 2014?

25 A. '14, yes. Where it was shown in fact that there was no 11:06
26 correlation between the duration of prosthetic
27 resection.

28 59 Q. But what I mean is a local audit. A local, if you
29 like, monitoring of the practices of the surgeons

1 within the urology speciality in relation to patient
2 safety issues such as this?

3 A. Was there one conducted?

4 60 Q. Yes?

5 A. No. Other than the one that I have included in the 11:07
6 disclosure.

7 61 Q. Could I -- another example of a concern he had was in
8 relation to the ureteric stone fragmentation process,
9 which in one case I think you accept, having seen the
10 notes, he was the operator using EHL as the 11:07
11 instrumentation or energy source, which he, in his
12 evidence, explained he had an apprehension about. His
13 experience to that date had been the use of the Swiss
14 Lithoclast, and he found the EHL, his words, "powerful
15 and unpredictable", particularly in the setting of a 11:08
16 ureteric procedure. Do you remember having an
17 awareness of his apprehension in using that tool?

18 A. I don't.

19 62 Q. It appears from the notes that I suppose contrary to
20 what he said in his evidence, or recalled in his 11:08
21 evidence, that you took over the procedure from him
22 when he ran into trouble, that in fact you were simply
23 informed about it later. And as I understand the
24 discharge note, you took over the care of the patient
25 in subsequent days to try to impose a stent to address 11:08
26 the effects of the injury.

27 A. Mmm.

28 63 Q. But leaving that bit aside. If, as one of his
29 supervisors, you were aware that he had an apprehension

1 or a wariness of using the tool, should you have
2 arranged for either yourself or a suitable alternative
3 to be there to supervise him through the process and to
4 be at hand to guide him?

5 A. Yes. Yes. And I mean I spent, you know, years of 11:09
6 being in theatre with specialist registrars whilst they
7 operated. Not always, because when a specialist
8 registrar gains a degree of competence built upon
9 experience, they often don't need you to be there, but
10 I would have been in my office working and always 11:09
11 available to come. So, yes, I mean, no difficulty
12 whatsoever. I mean I think if you actually ask any
13 personnel from theatres, that's the kind of person that
14 they would describe, because I have lived in theatres.

15 64 Q. He appears to have been without immediate supervision 11:10
16 or assistance that night, just scrutinising the notes
17 that the Trust made available after Mr. Hagan gave
18 evidence.

19 A. Mmm.

20 65 Q. Looking at that in light of the injury caused to the 11:10
21 patient and the inexperience of the operator in terms
22 of his use of that energy source and that tool, is that
23 something you reflect upon as from a governance
24 perspective, left something to be desired?

25 A. Well it left something to be desired that he was 11:10
26 relatively inexperienced and he was taking on a case
27 about which he had reservations about the energy
28 source. You mention in passing there something that I
29 hadn't thought of before, like what time of the day did

1 this take place and was I even the person on-call? I
2 don't know. I don't know the date of it and so forth.

3 66 Q. Yeah.

4 A. So, yeah, I mean, I agree with everything you say. If
5 he had reservations and -- if anybody rang me to say 11:11
6 that "I have reservations about taking this patient to
7 theatre to use EHL", I'd have been there.

8 67 Q. One final point just before the break to take another
9 example. He referred to your administrative practices
10 as being disorganised and chaotic. He recalled that 11:11
11 your office was full of charts awaiting dictation,
12 which took a considerable time to process. Those
13 criticisms chime, do they not, with what might be
14 observed later in your practice, struggling with
15 dictation, struggling with triage and that kind of 11:12
16 thing. Is his observation, at least in that respect,
17 likely to be correct?

18 A. Yeah. I mean I had always a lot of charts in my office
19 awaiting dictation. They were always in chronological
20 order. They may have appeared to be chaotic or 11:12
21 disorganised, but I felt that they were very organised.
22 I knew where everyone was, and I had pigeonholes for
23 them and dealt with them in chronological order when I
24 would get time do so.

25 68 Q. But were you already struggling at that time, for 11:13
26 reason that you've rehearsed?

27 A. It was a struggle -- it was a struggle from 1992
28 because of the demands upon one person for the first
29 four years. I mean that's the reality. Do you know, I

1 remember actually in the second full financial year, I
2 think '94 to '95, when I was a single-handed urologist,
3 and there were approximately, somewhere between 1050
4 and 1100 referrals in that year, which is like over 20
5 per week. I didn't take holidays during those years 11:13
6 anyhow, or minimally so. And if you're, do you know --
7 I remember being told by Mr. Sterling, who sadly is
8 deceased, he was a Clinical Director, that, you know I
9 had to see them all. So you have to see them all, 20
10 per week. When do you review them? If you take the 11:14
11 proportion of those who translate into people needing
12 operative intervention and so forth. So, yes, it was
13 -- and looking after them in the ward.

14
15 I had a great mentor in Dublin who used to say "The 11:14
16 ward is the cockpit of the service." There's no point
17 in deluding yourself into thinking that if you actually
18 don't have charts in your office, or you do, as
19 Mr. Hagan says, do you know, a succinct letter of two
20 or three sentences long and you ignore the in-patient 11:14
21 management. The in-patient management was always my
22 top priority, and particularly to deliver it to the
23 best of my ability in conjunction with all of the team
24 of people that we had trained up, and to deliver a
25 service to those who most acutely needed it at any 11:15
26 particular point in time.

27 69 Q. Okay. That brings us to a break I think?

28 CHAIR: Yeah. I think we'll take 20 minutes and come
29 back at twenty-five to twelve.

1
2 THE HEARING RESUMED AFTER A SHORT BREAK AS FOLLOWS:

3
4 CHAIR: Thank you everyone.

5 MR. WOLFE: Just to conclude with Mr. Hagan's evidence. 11:33

6 Another issue that came to his attention in 2000, when
7 he was on rotation, was your management of certain
8 patients with IV fluids and antibiotic therapy. In his

9 evidence he said here were patients who could eat and
10 drink who were being managed on this therapy, an 11:33

11 approach that he hadn't witnessed in any previous
12 setting or subsequently, and he wasn't clear of the

13 reason for the approach or the evidence base for the
14 therapy, and that was his recollection. I think

15 Mr. Young in dealing with that himself said he would 11:34

16 agree with Mr. Hagan in the sense that it was maybe not
17 standard practice, indeed. I'm going to come on to ask

18 you about Mr. Young's role in the therapy, but as he
19 explained it he was not at that point a convert to it.

20 You've no recollection of speaking to Mr. Hagan about 11:34
21 this matter?

22 A. I don't, no. The one thing I would comment on his
23 description of the case is, it's an interesting aspect
24 of it, and that is, you know, patients who could eat
25 and drink normally was an expression also echoed by one 11:34
26 of the expert subject experts.

27 70 Q. Mr. Fordham?

28 A. Well, no, I think one of the people whom he may have
29 commissioned. I think they remained anonymous in their

1 giving of their expert opinion. And that person said,
2 you know, the notion that patients need to have
3 intravenous hydration and antibiotic therapy when they
4 can drink normally is nonsense, and that's one of my
5 criticisms that I have submitted in my recent addendum, 11:35
6 and that is that that expert, and indeed going back to
7 Mr. Hagan, they weren't patients who could drink
8 normally or adequately because they were continuously
9 nauseated. And in my original witness statement I
10 think Mr. Young and I would agree that we had been so 11:36
11 successful in dealing with this cohort of patients over
12 a long period of time that we probably actually could
13 have, and did, then shed a significant number of them,
14 because they no longer needed to be treated in this
15 manner. But still leaving a cohort of severe cases 11:36
16 who, as I have articulated quite clearly in the recent
17 addendum, are people who were admitted electively when
18 they had the prodromal symptoms of emerging infection,
19 including nausea, including vomiting, including not
20 being able to drink normally, and we admitted them in 11:36
21 the knowledge, with certainty, that one week or two
22 weeks later they would be admitted acutely, more
23 severely ill, more severely dehydrated, septic, and
24 needing the same treatment for a longer period of time.

25 71 Q. Did you recognise in 2000, when you were engaging in 11:37
26 this therapy with this group of patients, that your
27 approach was novel, unconventional perhaps, not
28 practised elsewhere?

29 A. Yes, I did. Oh, sorry.

1 72 Q. And did you think it was an efficacious thing,
2 something that should be, if you like, used more
3 widely?
4 A. I did, and for which reason we reported it in the
5 manner in which we did. 11:37
6 73 Q. But that was to be 11/12 years later that you reported
7 it?
8 A. Yes. Yes, yes.
9 74 Q. I suppose Mr. Hagan, young trainee, you don't have any
10 recollection of explaining to him the rationale for your 11:37
11 treatment?
12 A. I don't have any recollection of explaining to him the
13 rationale for the treatment.
14 75 Q. Yes. Yes. When did the therapy commence? When did
15 you commence using it? 11:38
16 A. Well, if we were doing it in 2000, I presume it may
17 have been -- I don't think actually I started doing
18 that prior to Mr. Young's appointment. So it probably
19 would have been maybe just a year or two prior to then.
20 76 Q. Yes. And your rationale, as I think you've expressed 11:38
21 it, you've expressed it variously, but in a nutshell it
22 was, from your perspective, to prevent the acute
23 admission of this group of patients in a worse clinical
24 condition?
25 A. That's right. 11:38
26 77 Q. Having, I suppose, tried using pre-emptive oral
27 antibiotics in the community to address their needs,
28 and recognising that that was ineffective or less
29 effective than admission electively at predicted times

1 for IV therapy?

2 A. That is correct.

3 78 Q. Yes. And it wasn't until 2009, and then into 2010,
4 that this issue -- your manner of practicing around
5 this issue, and indeed Mr. Young's manner of practicing 11:39
6 in relation to this issue, was to become a matter of
7 controversy, isn't that right?

8 A. That's correct.

9 79 Q. And nevertheless were you practicing openly in this
10 respect? In other words, patients were openly coming 11:39
11 on to the Urology ward for three, four or perhaps five
12 days at a time, and not being subject to microbiology
13 assessment or input?

14 A. Well not by a consultant clinical microbiologist at
15 that time. 11:40

16 80 Q. Yes.

17 A. Because I don't think that we did have clinical
18 microbiologists doing ward rounds at that time. But we
19 never excluded them. We never excluded their advice or
20 anything of that nature. We directed our antibiotic 11:40
21 therapy in accordance with the findings of urinary
22 microscopy and culture. So we did it openly, yes.

23 81 Q. Yes.

24 A. Yes.

25 82 Q. So help me understand this. This becomes a 11:40
26 controversial matter in 2009.

27 A. Mmm.

28 83 Q. It was discovered by, as I understand the paperwork,
29 Ms. Youart was looking through materials, seeing

1 throughput through wards, and discovered this cohort of
2 patients and the conversations ensued from that. What
3 was it about the governance arrangements within the
4 Trust that this issue hadn't been triggered long before
5 2009, if you were practicing openly in this respect for 11:41
6 about nine years or so?

7 A. I think that's a question that needs to be addressed to
8 those responsible for governance. I mean for me it
9 wasn't an issue. We were endeavouring to do our best
10 to prevent people becoming seriously ill, and I think 11:41
11 others have given testimony to the fact that others did
12 become seriously ill, and in fact I am quite -- it's
13 amazing in fact that we managed to avert mortality in
14 one or two patients, so severely ill did they become
15 acutely. 11:42

16 84 Q. Yes.

17 A. And we prevented them, to a large extent, doing so by
18 the regimen that we, we came to as a last resort
19 because we had tried everything else.

20 85 Q. Yes. I suppose you're right in one sense that the 11:42
21 question I've just asked is one better directed to
22 governance managers and what have you. But I suppose
23 if I could ask the question in a slightly different
24 way? You were using the Trust resources, nursing, bed
25 space and what have you, repeatedly with these patients 11:42
26 for a long period of time, and it didn't come to any
27 untoward attention for nine or 10 years?

28 A. Well, I would rhetorically ask the question, like why
29 should it have done when the same patient would have

1 come in 10 days later and spent 7 to 10 days achieving
2 the same outcome as we managed to achieve two weeks
3 previously? Because that's a reality of what was going
4 on.

5 86 Q. Well that's -- I suppose that's a restatement for your 11:43
6 justification for the treatment?

7 A. Yes.

8 87 Q. We'll come on to look at aspects of that. But just
9 briefly if you can help the Inquiry with this.
10 Mr. Young, in his evidence, drew a distinction between 11:43
11 his approach to it and yours. He explained that, in
12 his witness statement:

13
14 "It should be noted that I also admitted patients for
15 intravenous antibiotics but they either had infections 11:43
16 present or were symptomatic."

17
18 He said of you in his oral evidence:

19
20 "Certainly my observation of Mr. O'Brien's patients is 11:44
21 that they were more often admitted electively without a
22 proven infection."

23
24 whereas by contradistinction he was saying:

25
26 "I would say I focused on the more symptomatic patients
27 at the time and getting a better response within
28 intravenous antibiotics." 11:44
29

1 So do you follow his distinction and do you think it's
2 a valid distinction?

3 A. I don't think actually -- I mean I listened to it
4 carefully and I think that his, do you know, this is
5 like semantics, but his were still elective admissions. 11:44
6 The reality is, is that if you had put this patient on
7 a waiting list to be electively re-admitted in let's
8 say eight weeks time, based upon the intervals between
9 previous infections, and you rang them up on week, at
10 the end of week 7 and say "How are you?", and they say 11:45
11 "I'm wonderful", there's not one of them wanted to come
12 in one week later. I think that mine would have been
13 symptomatic. And the symptoms were not typically those
14 pertaining or arising from the urinary tract.
15 Remarkably they were more general than that. I recall 11:45
16 after this controversy, as you put it, arose, getting
17 an email from Mr. Mackle sort of being critical that I
18 hadn't taken on board that I wasn't allowed to admit
19 someone electively without consulting with the Clinical
20 Director and the Clinical Microbiologist at that time, 11:45
21 and I had -- I got this about maybe two or three hours
22 after I had received a phone call from a general
23 practitioner, who has long since retired, about one of
24 our patients in this cohort, he was ringing from her
25 home because she was so dehydrated because she had been 11:46
26 nauseous and vomiting for two days, and asked me if he
27 could admit her, and I said "Of course you can admit
28 her." So.

29 88 Q. Well, I want to come to this in the proper order. I

1 take your point, but let me start at the beginning.

2 A. Okay.

3 89 Q. -- of the chronology, if I may? I want to use this
4 controversy, if I can call it that, to look at whether
5 you should have started this form of therapy at all. 11:46

6 whether it was not obvious that you should have been
7 stopping sooner because of the interventions of the
8 Medical Director, and Dr. Rankin, and whether you
9 actually stopped when told to stop. So those are the
10 kinds of issues I want to explore. 11:47

11
12 So the starting point for this would appear, at least
13 in terms of the Trust's engagement with you on it, was
14 a meeting with Mr. Loughran, or Dr. Loughran, who was
15 the Medical Director at that time. 28th April 2009 he 11:47
16 met with you in the presence of Dr. McAllister, and I
17 think you'll have seen the record of that? It's at
18 PHA-0439 or 00439. And this meeting raised --

19 Dr. Damani MD is present as well, and he was the
20 Consultant Microbiologist in the Trust. And a number 11:48
21 of issues are raised, and the first issue was
22 compliance with the Trust Antibiotic Guidance. At that

23 time the Trust was consulting, as I understand it, on
24 the guidance, and it was being remarked upon that the
25 urology team had not joined the consultation. That 11:48
26 would appear to be relevant in the context of the
27 therapy that you were promoting with this cohort of
28 patients, which the meeting goes on to discuss at Item
29 2:

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"The Trust has identified a cohort of about 30 patients who are admitted as elective cases for IV antibiotics for recurrent UTIs. The evidence base for this was described by Mr. O'Brien and he described a study of outcome which was being prepared for publication."

11:49

So those are the issues. And then a third issue, Mrs. Hanna, MP, or MLA, had engaged with the Health Minister at that time about the use of this therapy, and a preference that the patient might be able to undertake the therapy in the community is the sense of it.

11:49

So that was the first interaction between you and the senior management around this issue. Were you surprised that it was being taken up in this way?

11:49

A. I was surprised. In fact I didn't really appreciate, to the extent that I now appreciate the genesis of the issue, because I think there may indeed be some -- the genesis may have had a number of sources, including that of Dr. Diane Corrigan at the time, looking at operative codes for patient admissions and so forth. So irrespective of its genesis, it seemed to be that it arose because patients were occupying beds without having an operative procedure, and it seemed that there was an issue arising from that, you know, that if patients are occupying beds without an operative procedure there's something fundamentally wrong with

11:50

11:50

1 that and, in fact, actually, it touches upon a wider
2 issue that I struggled with for 28 years at the
3 Southern Trust in relation to the treatment of patients
4 with urinary tract infections, because typically
5 patients with urinary tract infections are admitted to 11:51
6 anywhere in the Southern Trust but the Urology Ward.
7 They'll be admitted to orthopaedics, cardiology,
8 respiratory or where ever. A typical example is the
9 one that I alluded to, the patient who died after stent
10 manipulation who had been admitted to another hospital 11:51
11 rather than being readmitted to the Urology ward.
12 Leaving that aside, yes, it was top heavy, it was
13 unidirectional, and we had the best interests of our
14 patients at heart. We knew them well. And during the
15 course of discussion of this topic, it's very useful to 11:51
16 look at two of the cases that have been referred to in
17 emails, one of mine and one of Mr. Young's, where...
18 90 Q. We'll come to that. But let me just -- the cases you
19 want to refer to come in 2010?
20 A. Yes. 11:52
21 91 Q. After there have been many discussions and an agreed,
22 and apparently an agreed process in how to overcome
23 this controversy.
24
25 If I could move to Mr. Young's meeting with 11:52
26 Dr. Loughran on the next page, if we scroll down.
27 Mr. Young -- or it's a note between a telephone meeting
28 between Loughran and Young, and he explains the
29 approach, but he confides in Mr. Loughran that he

1 expects that the evidence base is not there to support
2 the therapy, although clinical experience, that is your
3 experience and his experience, would support it's use.
4 And he says he expects that an independent inspection,
5 which was being mooted at that time, would not support 11:53
6 the therapy. And, of course, the patients will be
7 unhappy.

8
9 Just scrolling down. Dr. O'Driscoll, who was a
10 microbiologist based in the Stoke Mandeville Hospital 11:53
11 in England, has been consulted by Mr. Loughran, or
12 Dr. Loughran, about the issue, and Mr. Loughran or,
13 sorry, Dr. Loughran explains to her that Dr. Damani
14 believes the IV therapy is inappropriate. So -- and
15 then Dr. O'Driscoll, the microbiologist, says she has 11:54
16 never heard the IV therapy used for prophylaxis, but is
17 familiar with the oral regime, and she says she would
18 check out the literature in that respect.

19
20 So the problem building up for you and Mr. Young, and 11:54
21 you might say your patients in this respect, is that
22 first of all resources are being used within the Trust
23 without a recognised or established pathway. No code
24 for this. Secondly, across the wider urological
25 community there is no evidence base to support this. 11:54
26 You have your local experience. And, thirdly, locally
27 the microbiologist is antagonistic to this in the sense
28 that you are bringing patients in electively providing
29 IV antibiotics. That particular route for the

1 antibiotic is regarded as placing patients at risk.
2 And it, from his perspective, might be regarded as
3 unnecessary if the infection isn't established. In
4 other words, you're using the drug prophylactically.
5 Was that your understanding of what you were facing
6 into at that time? 11:55

7 A. Yes. And I think, you know, the common theme in all of
8 that is that, you know, respectfully, these people were
9 not fully informed of the nature of the patients that
10 we were dealing with, and what had been tried, what had 11:55
11 been unsuccessful, their clinical status when they're
12 electively admitted, and the fact that, you know, we
13 were admitting patients electively at the 11th hour,
14 and one hour later -- I'm speaking metaphorically --
15 you know, they were going to be in the hospital 11:56
16 somewhere much more severely unwell and septic. We
17 have had patients admitted to Intensive Care as a
18 consequence. So we were dealing with, by the time it
19 was reduced to about 10 patients from 30 patients, we
20 were dealing with a cohort of patients who were at risk 11:56
21 of serious illness and, indeed, of death. So I also
22 think, as someone said particular about language, I
23 think actually the acronym of UTI doesn't help this
24 situation because it tends to trivialise the issue that
25 we're talking about, and it's an issue that I have a 11:56
26 great interest in, not least to bring us all up to
27 date, because it would appear from the presentation to
28 the European Association of Urology, a meeting of the
29 past weekend, that all of this will have been resolved

1 by the development of a vaccine against the three most
2 common infecting organisms which have left people like
3 this, and this is work that has been done in England,
4 and which was started off licence in private practice.
5 So sometimes, you know, developments do occur when
6 they're not mainstream and when you're forced into a
7 particular situation.

11:57

8 92 Q. But can I just bring you back to 2009?

9 A. Yes.

10 93 Q. Can I ask you from, I suppose, your understanding of
11 the limits of a professional practice such as yours.
12 You are no doubt conscious that there is nothing in the
13 literature at that time to support this practice.
14 There is the use of Trust resources in bringing these
15 patients into the hospital. How can you do that
16 without resort to permission from the management side
17 of urology, whose resources, whose need to control the
18 resources is important from the perspective of other
19 patients and their needs?

11:57

11:58

20 A. Well we didn't -- Michael Young and I didn't do so,
21 because there would have been no difficulty in the same
22 organisation, the same urology management accommodating
23 these people for a longer period of time. You asked
24 the question from the perspective: How could you
25 justify admitting these people when there was no
26 evidence base for it, even though we had accumulated
27 our own experiential evidence base, that by doing so we
28 prevented them coming in and using the same resources
29 for a longer period of time.

11:58

11:59

1 94 Q. But the symptomatology of these patients wasn't unique
2 to Portadown, or Lurgan, or those hinterlands, your
3 demographic. This symptomatology is, no doubt,
4 worldwide, or Europe wide, or whatever. The point I'm
5 making is, you're pursuing a treatment for these 11:59
6 patients whose symptoms are perhaps universal, and
7 you're doing it without seeking permission or
8 authority?

9 A. Yes. Well we were, you know, we were forced into it,
10 you know, through caring for our patients. And I mean 11:59
11 in later years I came to appreciate that, once again
12 without an evidence base for it, that there may be an
13 immune deficiency that is contributing to this, and now
14 for the first time, what is in 2020, it has been
15 acknowledged from research done in London that 12:00
16 patients, particularly women, who have more than three
17 or more urinary tract infections per year are deficient
18 in IgG2, which is -- it's an immunoglobulin, and we in
19 fact actually got some of our most at risk patients
20 referred to the Department of Immunology, it was an 12:00
21 initiative of mine, with some scepticism actually in
22 immunology that such patients couldn't possibly have an
23 immune deficiency because it hasn't really been
24 reported. Urinary tract infection was not really a
25 feature of immune deficiency, but they were found to be 12:00
26 immune deficient and are now having immune replacement
27 therapy, and up until four years ago when I left, it
28 had made a significant difference to their
29 readmissions. But even that may not be needed anymore

1 with the vaccine that seems to be the -- probably a
2 significant panacea.

3 95 Q. Yes. It would appear that Dr. Loughran, listening to
4 the views of yourself, Mr. Young, but also the views of
5 Mr. Fordham, Dr. O'Driscoll, and Dr. Damani, decided 12:01
6 that he needed to build a new process for dealing with
7 such patients, and he sets it out in a retrospective
8 note. If we could open page TRU-281845? And I say a
9 retrospective note. This is a memo from the 2nd
10 September 2010, and in it you will see that -- so there 12:02
11 you have it. 2nd September 2010, he's writing to
12 Dr. Rankin and he, if we scroll down, setting out the
13 history of the thing, and he says:
14

15 "As a result of the expert external opinions and 12:02
16 following several meetings, I met with the two
17 urologists on 4th August 2009..."
18

19 so he's looking back at the previous year.
20 12:02

21 "...and during this meeting the surgeons agreed to
22 compile an accurate list of patients who were on the IV
23 regime. That each surgeon would review the treatment
24 regime for each patient and that a multi-disciplinary
25 group would be convened to look at a treatment plan for 12:02
26 each patient. The core of this treatment plan would be
27 to convert the patient from IV to oral therapy or
28 another non-intravenous treatment."
29

1 And Dr. Damani agreed that he would provide
2 microbiological support for Items B and C.

3
4 Now, is that your understanding of the step that was
5 taken... 12:03

6 A. Yes.

7 96 Q. In meeting with the two of you?

8 A. Yes. Yes.

9 97 Q. Did that microbiology group or that multi-disciplinary
10 group meet? 12:03

11 A. No.

12 98 Q. Between 2009 and 2010?

13 A. No. I don't think we ever met. I think that what we
14 had to do as clinicians was to consult with the
15 Clinical Director and to consult with a microbiologist, 12:03
16 not necessarily Dr. Damani, but his colleague as well,
17 if we wanted to electively admit. I think actually the
18 need for a multi-disciplinary team meeting was very
19 much obviated by the establishment of Shirley Tedford,
20 who was our ward manager, as a person who would manage 12:04
21 these patients on all our behalves, as it were, insofar
22 as it was possible for her to do.

23 99 Q. So that was to be the arrangement that these, this
24 current cohort of patients were to be the subject of
25 scrutiny with microbiology. 12:04

26 A. Mmm.

27 100 Q. When you think about it now, Mr. O'Brien, should this
28 intervention, this form of therapy, have been pursued
29 by you without seeking the approval of your employer?

1 A. I think actually we saved lives by it, quite frankly.
2 If we had sought approval we may not have had it
3 approved and people would have died, I've no doubt. I
4 can name those who would have died. So it wasn't the
5 intent at the time, but the old adage sometimes, it's 12:05
6 better to seek forgiveness than to seek permission.

7 101 Q. Is that the long way around of saying that you would
8 have understood the process at the time should have
9 been to seek approval for a form of treatment that
10 wasn't commissioned and wasn't recognised, before doing 12:05
11 it, but the benefit of not seeking permission was the
12 outcomes that you refer to?

13 A. No, prospectively it never crossed my mind to seek
14 permission.

15 102 Q. Yes. Looking back on it now, I think you're 12:06
16 recognising that you should have?

17 A. Not necessarily.

18 103 Q. Well, I think the Panel would appreciate a straight
19 answer to a straight question. Given your
20 understanding of the norms of the time, before engaging 12:06
21 in therapy for patients that wasn't commissioned and
22 didn't belong on any recognised patient care pathway,
23 should you have sought permission before engaging on
24 it?

25 A. Ehm, well, when you frame it in that way, yes. I think 12:06
26 that patients would have suffered and patients would
27 have died as a consequence, and I've no doubt about
28 that.

29 104 Q. July 2010, Mrs. Corrigan provides Mrs. Rankin,

1 Dr. Rankin, with an update on the position. How has
2 the cohort of patients that were receiving this
3 therapy, how has that developed? Is this therapy at an
4 end? Has it diminished or is it still ongoing? And if
5 we could look at TRU-259410. Mrs. Corrigan is writing 12:07
6 on the 6th July, and she is showing Dr. Rankin an
7 update on IV fluids and antibiotic recent admissions.
8 She says:

9
10 "I checked with Shirley. . . " 12:08

11
12 - Shirley is the nurse, the senior nurse:

13
14 "...if any of these had involvement from bacteriology,
15 and she has advised these are the routine elective 12:08
16 patients who are admitted and treated prophylactically
17 irrespective of positive or negative culture results.
18 To my knowledge the consultants have not discussed any
19 of them with Dr. Damani's team."

20 12:08
21 Is her conclusion right that these remaining patients
22 had not been discussed?

23 A. Not necessarily. Yeah, it was, as she says, to her
24 knowledge. I can certainly recall discussing patients
25 with microbiology. Whether they all were discussed 12:09
26 with microbiology, I cannot say. It's a long time ago.

27 105 Q. Mmm. But certainly your understanding of the process
28 was that for the patients who fell within this group,
29 and you had been asked to provide a list of names, and

1 I think if we scroll down you can see that the names
2 are provided. For many of them there's no recent
3 admission, but the information across some of them is
4 that there had been planned admissions. Take the first
5 patient, that planned admission, we're looking back the 12:09
6 way, had been for a month earlier. But your
7 understanding of the process handed down by
8 Dr. Loughran after speaking to you was that there was
9 to be a microbiology input?

10 A. Mm-hmm. 12:10

11 106 Q. And approval process?

12 A. Mm-hmm.

13 107 Q. In order to determine whether the intravenous fluid and
14 antibiotic management should continue?

15 A. Mm-hmm. 12:10

16 108 Q. And if I could bring you to TRU-281845. And this is
17 the memo we were looking at retrospectively a moment
18 ago. He set out the process, as you can see, if we
19 scroll down slowly. Just scroll down further. He says
20 that since the August 2009 meeting or agreement, he 12:10
21 understands, and we could see it if we studied that
22 list provided by Mrs. Corrigan a moment ago, that there
23 has been a significant reduction in the number of
24 patients within the cohort. But he says he had
25 expected that the number of patients would be extremely 12:11
26 small by now and that the patients with central venous
27 lines or long peripheral lines would have had the lines
28 removed. He goes on to say:
29

1 "It is of concern to me that the agreement as set out
2 above has not been followed by Mr. Young and
3 Mr. O'Brien."

4
5 And he says:

12:11

6
7 "In particular I understand there are at least seven
8 patients remaining on the IV treatment and that two and
9 possibly three have permanent intravenous access."

10 12:11

11 And it's recorded that:

12
13 "It was agreed that Mr. Young and Mr. O'Brien should be
14 informed of a meeting on Tuesday and should be informed
15 that any patient..."

12:11

16
17 Sorry, that he is concerned that any patient is
18 receiving this treatment. So there you have it.
19 Certainly Dr. Loughran's understanding is that although
20 the numbers are reducing, the agreement with you and
21 Mr. Young has not been honoured in full. You say it's
22 a long time ago, and it certainly is, but I don't see
23 any record of you challenging that proposition that you
24 were in breach of your agreement with him?

12:12

25 A. Well, we tried to implement the agreement. My memory
26 of it is, is that insofar as we possibly could, and you
27 know, when you have two or three patients who either
28 have permanent intravenous access, because if you
29 actually remove that intravenous access you do not have

12:12

1 intravenous access at all, that's the severity of the
2 problem that we were having at that time. So, you
3 know, we had reduced it to a small number of people who
4 were -- we were attempting -- we made every attempt to
5 implement this, because we appreciated the concerns 12:13
6 that other people did have. Far more importantly than
7 patients being electively admitted to use a bed for
8 five days where the concerns surrounding antibiotic
9 resistance and the concerns surrounding central veinous
10 access, and as a clinician I was appreciative of all of 12:13
11 those concerns, and we had tried our very best to
12 reduce this as far as was at all possible. And in the
13 busyness of everyday clinical life, there were times
14 actually when the reality of the clinical situation
15 with regard to a small number of patients met this 12:14
16 policy drive, and they clashed, and I think there are a
17 couple of examples of that in the disclosure.

18 109 Q. Yes. Certainly you were drawn into a meeting with
19 Dr. Rankin and Mr. Mackle on 9th September of that
20 year, 2010. Just briefly look at that. It's 12:14
21 TRU-281856. And at that meeting one can see that a
22 case review process which, correct me if I'm wrong, had
23 been heralded at the 2009 meeting, but was now being
24 put in writing before you. In other words, the process
25 whereby you were to engage with Dr. Damani had now been 12:15
26 committed to writing, and your response to that was -
27 this is paragraph 2:

28
29 "Patients may become less well as a result of the

1 withdrawal of IV antibiotics."

2
3 Is that suggestive, is that remark suggestive of your
4 view that you were still resistant to what management
5 were expecting you to do? 12:15

6 A. I was pointing out to management the consequences of
7 implementing fully their expectations. These are
8 people actually who, after their elective admission for
9 their intravenous hydration and antibiotic therapy that
10 lasted typically for a period of five days, they went 12:16
11 home well, rehydrated, infection free, and without any
12 antibiotic therapy for the next 8 or 10 weeks or
13 whatever the interval would be until they started to
14 symptomatically become unwell again.

15 110 Q. But from a microbiology perspective and a general 12:16
16 medical perspective, some of them were receiving
17 antibiotics which they may not have needed?

18 A. In...

19 111 Q. And some of them were at risk of venous deficiency?

20 A. Mm-hmm. 12:16

21 112 Q. And some of them had, dangerously from the perspective
22 of some, had PICC lines, central lines in place.
23 That's the other side of the argument against the
24 background where there was no, if you like, recognised
25 industry or peer support for you're initiative. 12:17

26 A. Yes. But I mean I was very, very much involved. I
27 mean the patient who will remain unnamed, it was
28 actually not my patient, one of Mr. Young's patients.
29 You know, we had a huge multi-disciplinary meeting

1 about her on a number of occasions, because we had
2 arrived at a stage...

3 113 Q. This is -- just to assist you, this is the patient --
4 we can find it at TRU-259512. Is that who you refer
5 to?

12:17

6 A. No, actually, that's another of Mr. Young's patients,
7 but you can leave that on the screen, because that's
8 where -- that's an example of where policy and reality
9 does collide.

10 114 Q. Well, is it? Because what we can see in this example,
11 and I'm going to bring up on the screen in a moment the
12 two processes that were tabled on 9th September.

12:17

13 A. Mmm.

14 115 Q. And one of the processes was in terms of these patients
15 you must seek the input of the microbiologist before
16 you admit the patient for IV antibiotic. In other
17 words, it wasn't closing down IV antibiotic therapy
18 where it could be demonstrably shown to be needed, and
19 that's an example of this, isn't it, this is the
20 process working, this is Dr. Damani approving, if we
21 scroll down:

12:18

12:18

22
23 "The following instructions were issued by Dr. Damani
24 as he feels the patient may have that infection."

25
26 And the instructions beneath -- I think we're running
27 into a technical difficulty here -- but the
28 instructions below allowed for -- there we go --
29 admission to the Urology ward and the commencement of

12:18

1 an IV regime.

2 A. Mm-hmm.

3 116 Q. Let me bring you to the processes that you were
4 required now to comply with. The first one is a review
5 process for existing patients. So this is September 12:19
6 2010. TRU-251143. So it's a process to review all
7 cases of people currently and intermittently receiving
8 the fluids. So you were expected to bring all of your
9 patients within a process whereby with microbiology
10 input, and involving the Clinical Director Ms. Sloan, 12:20
11 advice and direction would be provided on the future
12 management of that existing cohort of patients. Is
13 that right?

14 A. Yes. I don't think actually we ever met in the one
15 room to discuss not even one patient, never mind -- it 12:21
16 was all done by telephone. The first item on that, the
17 first paragraph:

18
19 "In order to agree a management plan which may require
20 oral antibiotics..." 12:21

21
22 And I know it's reiterating the fact that oral
23 antibiotics in this cohort had been found by us to be
24 unsuccessful and, in fact, actually posed a greater
25 risk to the emergence of antibiotic resistance than did 12:21
26 ours, and as we reported, there was no evidence of the
27 emergence of any antibiotic resistance by our regimen.

28 117 Q. But isn't the important point, Mr. O'Brien, is that
29 albeit, for good reason, you had launched off on this

1 initiative 10 years earlier, without bringing your
2 wider colleagues with you, so that the intravenous
3 management of these patients was directed by you and
4 Mr. Young without microbiological oversight and without
5 the knowledge of the Medical Director, who ultimately 12:22
6 is responsible for the expenditure of medical
7 resources. So isn't that the problem, which I want to
8 ask you, do you recognise that that was the problem and
9 that this was bringing proper process and proper
10 governance around it? 12:22

11 A. Well, I mean that's the problem viewed from governance,
12 viewed from management perspective. I'm looking back
13 in retrospect at this point in time. You know, did we
14 actually manage these patients without any clinical
15 microbiological oversight? I would refute the notion 12:22
16 that we did. It may not have been organised for a
17 cohort of patients, but individually we consulted with
18 microbiology frequently and we had every good reason to
19 do so. Did we get -- did we go along to the Medical
20 Director, whoever it may have been, at any particular 12:23
21 time to gain permission to embark upon this? We
22 didn't. I cannot speak for Mr. Young, but it really
23 didn't cross my mind that we needed to do so. Perhaps
24 you would argue that we -- it should have crossed my
25 mind. But we were dealing with a situation, without 12:23
26 checking on whether it affected Belfast, or Derry
27 similarly, or Birmingham or whatever, where we had a
28 cohort of patients that I have described and which we
29 had run out of options for their successful management,

1 and this form of management turned out to be
2 successful, whilst acknowledging the complications that
3 can arise as a consequence, and the only one that
4 really materially was a concern was the venous access,
5 and particularly in the one patient that I was earlier 12:24
6 referring to, who essentially we had to have a
7 multi-disciplinary meeting concerning her as to the
8 reality that we may not be able to resuscitate her at
9 all next time round in Intensive Care, and if we
10 couldn't do that, whether admission to Intensive Care 12:24
11 would actually take place because of the difficulties
12 with venous access and the complications that could
13 arise with attempting to get further venous access.

14 118 Q. Can I just put up on the screen for illustration
15 purposes the pathway which was introduced then for 12:24
16 recurrent UTIs going forward for any new patient.
17 TRU-251144. Actually, sorry, it's the very next page.
18 Let's not risk a delay with the Trust documents. So
19 there you go. That's the pathway that you were
20 expected to follow going forward with any new 12:25
21 admission. And I think we saw maybe earlier when we
22 looked at your appraisal documents, maybe I'll just
23 bring it up on the screen again? Sorry, just scroll
24 down so the Panel can see this. So it's again
25 essentially bringing in a need for a discussion across 12:25
26 a multi-disciplinary group before determining the
27 proper management of the patient. would you agree that
28 that was ultimately the sensible way to do it and the
29 more, let me add this, the more -- with this kind of

1 treatment there is a need, there is always a risk to
2 the patient, particularly where central venous lines
3 are involved, but there's also other risks. Obviously
4 the expenditure of scarce resources. So this is not
5 only an appropriate, but a necessary way to govern this 12:26
6 form of treatment?

7 A. You know, as it was seen by the Medical Director at the
8 time, if you just scroll back up again just a little
9 bit, and you'll see that the nurse led oral antibiotic
10 regime prescribed and altered by consultant urologist 12:26
11 as per culture with input when necessary from
12 bacteriology. And I just harp back to the fact that we
13 often found that this was the worst kind of management
14 of these patients because all you had six weeks down
15 the line was antibiotic resistance and a patient 12:27
16 getting unwell. And if you scroll up again to the last
17 line, you know, it is a concern that any pathway should
18 have that last sentence:

19
20 "Under no circumstances is central venous access to be 12:27
21 used for treatment of recurrent UTIs."
22

23 119 Q. You did, however, complete an appraisal in the year
24 after this in respect of the Year 2010. And if we
25 could look at that? TRU-251244. And just at the 12:28
26 bottom of the page it says:

27
28 "No formal complaints nor critical incidents are logged
29 by the Trust. The Trust, however, has had discussions

1 with reference to patients being treated with IV fluids
2 and antibiotics and this has been satisfactorily
3 concluded. "

4
5 Is that a sentiment that you would have agreed with at 12:28
6 that time?

7 A. No. I don't know who wrote that, whether it was me or
8 my appraiser. I think it might have been my appraiser,
9 I'm not quite sure. I don't think it was
10 satisfactorily concluded. And, in fact actually, you 12:29
11 know, there were maybe three or four patients continued
12 to be admitted, not necessarily electively, but so
13 frequently acutely, severely septic, up until 2020 when
14 my employment ended.

15 120 Q. Could I just bring you to another entry in that 12:29
16 appraisal. It's four pages on down at sequence, 248 of
17 the sequence. And it records at the bottom of the
18 page, yeah:

19
20 "The IV fluids antibiotic issue has been improved by a 12:29
21 new care pathway defined by the Trust."

22
23 Again are they sentiments...

24 A. I think "improved" is a much more appropriate
25 sentiment, yep. 12:29

26 121 Q. Nevertheless, you saw fit to publish a letter to a
27 journal in 2011, and I needn't bring it up on the
28 screen, the Panel is familiar with it. It's to be
29 found at WIT-82743. That letter to the Journal of

1 Infection to which you, Mr. Young, and Vincent Koo put
2 your names, essentially presented an argument based on
3 your experience in favour of the IV fluid and
4 antibiotic treatment of this cohort of patients with
5 chronic or recurrent UTI, and that was published in 12:31
6 circumstances where, ringing in your ears was the
7 Trust's view that it could not endorse this treatment
8 in the way that it was performed by you and Mr. Young.
9 The Commissioner was not lending its support to it, and
10 internally you knew of the opposition of the 12:31
11 microbiologists. You're familiar with the expression
12 "two fingers", was this you and Mr. Young giving two
13 fingers to the organisation by publishing this article?
14 A. That's amazing! Absolutely not. What we were doing,
15 in fact... 12:31
16 122 Q. Sorry, what's amazing about it?
17 A. Because it never occurred to me that that was even --
18 that never crossed my mind that we were putting two
19 fingers up to everybody who had their concerns. Not at
20 all. I'm just -- my apologies for the reaction, it's 12:32
21 just that didn't occur to me. Vincent Coe was a very
22 talented specialist registrar who published a number of
23 papers whilst he was with us, and is a consultant in
24 England, and all we did actually was -- I'm quite a
25 disciplinarian when it comes to publication, because 12:32
26 what we were doing was reporting our experience. It
27 wasn't actually promoting anything. It wasn't
28 expecting the rest of the world to agree with us. We
29 reported our experience, and we reported the efficacy

1 of it, and we particularly reported on the fact that it
2 had not been associated with the emergence of any
3 antibiotic resistance. So it wasn't done in any shape
4 or form to -- I mean we do have academic freedom to
5 report in good faith, accepted by a reputable journal, 12:33
6 our experience, and that's what we did.

7 123 Q. But you didn't report within your article the
8 opposition to your approach?

9 A. No.

10 124 Q. The well, some might argue, the well-founded arguments 12:33
11 against it or the dangers of the approach?

12 A. I can't -- it's some time since I have read it, but we
13 simply reported our experience. And the only, the only
14 word I would change is that in the title again "UTI",
15 because I think it has minimised in the perception of 12:33
16 the person who may read the title and not bother to
17 read the actual article or the letter, that we were
18 doing something that was rather extreme for simple
19 recurrent urinary tract infections.

20 125 Q. Could I just bring together three further strands of 12:34
21 evidence and seek your view on them collectively in the
22 interests of time. Mr. Mackle wrote to you on 15th
23 June 2011. If we could have on the screen, please,
24 TRU-281944, and he is explaining that he has found that
25 you initially plan to admit a patient this week without 12:34
26 having discussion with anyone, and then when challenged
27 you only spoke to a Dr. Rajadran, who I assume is part
28 of the microbiology team. Could I invite your answer
29 to that as well as a number of other examples of

1 apparent departure from the management arrangements
2 which Dr. Rankin had handed to you in 2010? So another
3 example is to be found at -- let me just find the
4 reference. TRU-259904. Sorry, is that the one I just
5 -- yep. So it's - this is now 2012, and Dr. Mackle is 12:36
6 informing the Clinical Director, Dr. Hall, that:

7
8 "He has been advised that another patient has been
9 admitted last week by Mr. O'Brien. Under his
10 instruction given IV antibiotics. Central line 12:36
11 involved. There's been no discussion with
12 microbiology."

13
14 Just finally in this sequence if we could go to
15 TRU-276833, and just while we're waiting on this, if 12:37
16 you bring that up when you can? We also have the
17 evidence of Dr. Suresh who said that he recalled
18 encountering a patient admitted for IV antibiotics on a
19 ward round, raising this issue with you, and you said
20 you would check with the microbiologist, and when you 12:37
21 did there was no need for antibiotics.

22
23 And this final example which I want to draw to your
24 attention is the Director of Pharmacy, Tracey Boyce,
25 writing to Heather Trouton three years after the 12:38
26 management regime had been handed down by Dr. Rankin,
27 and saying to you, or saying to her:

28
29 "Mr. O'Brien seems to have another patient on

1 gentamycin this month with no evidence of infection."

2
3 It's not entirely clear whether that was an IV?

4 A. I don't think it was.

5 126 Q. Or whether it was some other departure from the 12:38
6 antibiotic policy. Did you continue to disregard, even
7 on an isolated basis, the requirements of the
8 management policy for this cohort of patients by
9 failing to bring them through the microbiology stage of
10 the process before prescribing IV antibiotics? 12:39

11 A. I don't think so. And I think I have already given the
12 explanatory, the explanation for the first email,
13 because that was the patient that I was referring to -
14 the GP at the patient's home asking for her acute
15 admission, and you say yes, and she arrives in the 12:39
16 ward, and with other things on your plate you haven't
17 yet had time to consult with the microbiologist.

18
19 The second one, the one preceding this, I have no
20 recollection of that at all. And this I don't think 12:39
21 actually is necessarily one of those cohort at all. I
22 wouldn't be at all surprised that that may have been
23 someone who has remained on gentamycin after prostatic
24 resection or something of that nature. But obviously I
25 can't -- I don't have a recall of a particular case. 12:39
26 But I do recall the case of the patient dehydrated in
27 bed at home. I can name her, I can name the GP, him
28 ringing me up "Can I admit her? Yes", and then within
29 a short period of time you get an email, I'm pretty

1 certain it was the first email, you haven't actually,
2 "you have planned or you have arranged to take this
3 patient." I'm just responding to a GP can I admit the
4 patient. So that's where I would describe that
5 collision once again between the protocol and the
6 reality.

12:40

7 127 Q. Yes. Very well. I wonder, Chair, should we take an
8 early lunch?

9 CHAIR: Lunch. Yeah. we'll do that and we'll come
10 back at 1:50.

12:40

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1 THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS
2 FOLLOWS: .

3
4 CHAIR: Thank you everyone. Mr. wolfe.

5 MR. WOLFE: Good afternoon, Chair. Good afternoon,
6 Mr. O'Brien. 13:47

7 A. Good afternoon.

8 128 Q. Just before lunch I was asking you by reference to
9 several examples whether you complied with the

10 management decision in terms of how patients would be
11 managed if you thought that they required intravenous
12 antibiotics. And I think I've brought you to several

13 examples. Can I bring you back to one of them very
14 briefly. TRU-276833. And that is the example raised

15 with Heather Trouton by, just scrolling down, raised
16 with Heather Trouton by Tracey Boyce three years after
17 the management process had been introduced. And you

18 wondered whether that was a different kind of a case,
19 one not involving IV antibiotics. Could I just scroll
20 through to three pages down to 836 in the sequence. 13:48

21 Just on down one more. And Dr. Boyce has, in respect
22 of her consideration of the auditing of your
23 antibiotics use in that period, she has recorded:

24
25 "One patient on IV gentamycin, once daily." 13:49

26
27 Sorry:

28
29 "240mg once daily. No documentation of antibiotics in

1 the notes. No documented evidence of infection."

2
3 So it does appear that what she was pointing to was the
4 use of IV in association with the particular issue she
5 was raising. And on the face of it, non-compliance 13:49
6 with the management arrangements that had been handed
7 down in 2010. And for that matter that seemed to be
8 the significance of the issue raised by Mr. Suresh in
9 2016, who had to go to the microbiologist after he had
10 spotted the problem. 13:50

11
12 Just to go back to the point. Did you, whether
13 frequently or infrequently, not always comply with the
14 arrangements?

15 A. I would have thought at most infrequently. Excuse me. 13:50
16 (Coughing). And I would have thought that this
17 antibiotic, you know the antibiotic stewardship ward
18 round, this could very, very well have pertained to a
19 peri-operative period in a particular patient, I do not
20 know, obviously, but I wouldn't be at all surprised 13:50
21 that it could very well have done. If, for example,
22 you have felt during the course of an operative
23 procedure that a person is particularly disposed to
24 having that operative procedure complicated by
25 infection or urosepsis, particularly if you were 13:50
26 resecting a prostate or whatever, and particularly in a
27 comorbid patient whom you would have considered to be
28 vulnerable, we may very well have continued antibiotic
29 therapy for a period of time, without evidence,

1 documented evidence of infection. I'm just
2 speculating.

3 129 Q. Yes.

4 A. But that could very well be the scenario here.

5 130 Q. Yes. But was there a requirement, was there not, to 13:51
6 comply with the Trust's antibiotic policy, and she
7 seems to be highlighting, albeit in a very brief
8 comment, that the absence of documentation of infection
9 at least raises a concern about your management of
10 antibiotics in this case? 13:51

11 A. I do appreciate that that's from her perspective,
12 having seen the documentation or the lack of
13 documentation, I do appreciate that. But it's also
14 important to point out that on occasion, if it is
15 surrounding an operative procedure where you think that 13:51
16 there is a real risk of infection. For example, in
17 resecting prostate, sometimes you can get an endoscopic
18 impression of increased risk of infection, and we would
19 have employed antibiotic therapy like that to prevent
20 an operative procedure becoming complicated by 13:52
21 urosepsis.

22 131 Q. Okay. Let me move on to the issue of cystectomies that
23 come up in a number of ways. Starting, I think, with
24 the recommendation that came through the Regional
25 Review in 2009, that by March 2010 at latest, all 13:52
26 radical pelvic surgery, as it was described, should be
27 undertaken on a single site, the Belfast City Hospital.
28 I wanted to look at that issue, and in particular the
29 clarity which attended that issue and the

1 responsiveness of urologists, including yourself, to
2 that recommendation. I also want to go on to look at
3 your response to the transfer of three patients in
4 particular during September 2010. And, thirdly, I want
5 to look at and have your response to the comments that 13:53
6 came out of the Drake Review when the issue of
7 cystectomies was raised by the Commissioner. And,
8 finally, I want to take your view on an issue raised by
9 Mr. Hagan in 2016 when he was concerned that there had
10 been unacceptable delay in the transfer of what I 13:54
11 understand to have been one of Mr. O'Donoghue's
12 patients who had been diagnosed with a muscle invasive
13 bladder cancer, and who would appear to have been
14 subjected to an unnecessary bone scan before the
15 transfer took place, leading to some delay. 13:54

16
17 So going back to the start of that then. The first
18 issue is the transfer of complex pelvic surgery. And
19 if we could have on the screen, please, WIT-11878, and
20 we can see at the bottom of the page under the heading 13:55
21 "Section 7: Urological Cancers", the recommendation
22 that I just alluded to that:

23
24 "By March 2010 all radical pelvic surgery should be
25 undertaken at the Belfast City Hospital. The transfer 13:55
26 of this work should be phased to enable the City
27 Hospital to appoint appropriate staff."

28
29 And:

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"A phased implementation plan should be agreed with all parties."

Now you were, it would appear from some of the material which the Inquiry has considered, was dissatisfied with that recommendation. For example, within your appraisal signed off in November 2011. If we go to TRU-251248. I always regret pulling up TRU-references. There we go. And you say, I take it you can correct me if I'm wrong, that they are essentially your words, your sentiments, that: 13:55

"A further change in practice has been the centralisation of radical pelvic cancer surgery imposed by the Department of Health. This has resulted in the loss of this provision at Craigavon and negative consequences for patients. There is general discontentment in the decision-making process conducted by the recent Regional Review of Urology. Aidan has concerns that this will have significant knock-on effects for services in the area in the future." 13:56

If you can summarise for us, what was your concern in respect of the radical pelvic surgery? 13:57

- A. My concern at that time was, excuse me, my apologies. (Coughing). My concern, and I think I wrote, and I'm sure that the Inquiry does have it, I had considered that a very reasonable arrangement to arrive at would

1 have been for radical prostatectomy to continue to be
2 conducted at two centres, one being in Derry,
3 Altnagelvin Hospital in Derry, and the other being
4 Belfast City Hospital, and that radical cystectomy
5 could have been done at Craigavon Area Hospital and 13:58
6 Belfast City Hospital, and we could have had a robust
7 audit supervisory scrutiny process to ensure that they
8 were being conducted to proper standards with good
9 outcomes and so forth with that arrangement. I think
10 that that was -- I have no doubt that that was based 13:58
11 upon a concern that we were aware of that Belfast City
12 Hospital wasn't necessarily optimally prepared to
13 accommodate both of those operations from a particular
14 date, and I also had a concern that more co-morbid
15 patients, or patients perhaps with increased risk of 13:59
16 poor outcome, would not necessarily be offered that
17 surgery and have that surgery performed, particularly
18 once again if there is an inadequacy of service
19 provision in Belfast for a period of time. Those were
20 my dominant concerns. 13:59

21 132 Q. And of course the Commissioner took a different view,
22 and moreover although it's expressed in the
23 recommendation under the heading "Cancer Services" and
24 the use of the word "radical pelvic surgery", in time
25 it was clarified, was it not, that this decision, this 13:59
26 recommendation leading to a final decision was also to
27 apply to non-malignant cases?

28 A. That's right.

29 133 Q. Yes. And as I say, this was intended to have been done

1 by March 2010. There's reference to it being phased.
2 I'm not sure if it's intended to mean phased up to
3 March and then March being the final date, or started
4 in March and phased thereafter, but maybe that's a
5 semantic we don't need to worry about today. What I'm 14:00
6 interested in charting is your's and Mr. Young's
7 response to this, and if we look at TRU-259467. And
8 Heather Trouton writes, and this is August 2010:
9
10 "We discussed with Mr. Young the issues around three 14:00
11 radical prostatectomies being scheduled for surgery
12 here."
13
14 That is Craigavon, or it should say "here":
15 14:01
16 "...over the next few weeks. We advised that this was
17 contrary to the new agreement and that these patients
18 must be referred to Belfast for their surgery.
19 Mr. Young emphatically denied having seen any letter
20 saying that they were to stop performing such surgery 14:01
21 and advised that they, as a consultant body, would
22 continue to perform such surgery until the Department
23 sent a clear letter."
24
25 Gillian Rankin -- sorry, Heather Trouton says she is 14:01
26 looking to contact Beth. That is -- I forget her
27 surname?
28 A. Molloy.
29 134 Q. Molloy. And she was employed in the Commissioner's

1 office of the HSCB. So what was that opposition about,
2 can you help us with that? The recommendation is clear
3 that the movement, the transfer of patients should
4 commence, and here we have it in August, Mr. Young
5 saying "well I want, and my consultant, the consultant 14:02
6 body, wants to see a letter", even though it's set out
7 plainly in the recommendation, and it's a sense of
8 "we're not doing it until we see the letter".

9 A. I don't think the letter was, I am sorry, seeking to...
10 CHAIR: Mr. O'Brien, there is some water there in front 14:02
11 of you.

12 A. Yes. Thank you very much. A reaffirmation of the
13 recommendation. I think actually that this was purely
14 and solely nothing other than our understanding at the
15 time that Belfast was not yet able to accommodate our 14:03
16 referrals to it for the two radical pelvic operations.
17 We were aware that Altnagelvin had transferred to
18 Belfast, and it was our understanding that they were
19 not able to cope with ours yet, and my understanding
20 from this email, that Mr. Young was just stating 14:03
21 nothing other than some kind of confirmation that from
22 next month we are now, we are able to accommodate you.
23 Nothing more than that.

24 135 Q. MR. WOLFE: So it would be wrong to suggest, would it,
25 that there was any dragging of feet on the part of you 14:03
26 and Mr. Young perhaps because you disagreed in
27 principle with the decision?

28 A. I think that that would be a wrong interpretation.

29 136 Q. Okay. Were you not reluctant? Sorry, I'll put it more

1 positively. Were you reluctant to transfer patients?
2 A. No, not at all. What we were -- what we didn't want to
3 have happen, and which subsequently did happen, we
4 asked for notification, let's say it were on the 19th
5 or the following day, if we had been told that from the 14:04
6 1st October Belfast City Hospital is now prepared and
7 is able to accommodate the transfer of radical pelvic
8 operations to it, that's what we requested so that we
9 would have a transition period to prepare patients for
10 transfer. 14:04

11 137 Q. Then if we could look at TRU-259513, and just at the
12 bottom of the page, please? So it's 17th September,
13 about a month after Mrs. Trouton has sat down with
14 Mr. Young, and she is writing to Beth Molloy explaining
15 that there are two patients who require a cystectomy 14:05
16 due to malignancy and she's asking what's to be done
17 about this in terms. And if we scroll up to Beth
18 Molloy's response. There we are. And she is -- just
19 scroll down. I thought we had Beth Molloy's response?
20 Maybe not. Just go on up then, please. So Heather is 14:06
21 being told by Diane Corrigan, a colleague of Beth
22 Molloy, Dr. Corrigan, in the Commissioner's Office:
23

24 "The patients need to be referred as soon as possible
25 to the Belfast City Hospital Service. I would 14:06
26 suggest..."
27

28 - and then she provides contact arrangements for that.
29 And then up the page, please? On up the page. Okay.

1 we can move beyond that I think. So it was clear, was
2 it not by this stage, that the Commissioner needed
3 these radical pelvic cancer patients to be transferred,
4 and it was setting out a pathway for Craigavon to make
5 the relevant transfer contacts in Belfast? 14:07

6 A. Well it wasn't made clear to us. I mean this was a
7 communication between Diane Corrigan, whom I believe
8 may have been working with the Public Health Agency,
9 but I'm not -- and Beth Molloy and Heather, but that
10 communication wasn't shared with us in mid September 14:07
11 2010.

12 138 Q. Well eventually it must have been shared with you?
13 A. It was. On a Wednesday.

14 139 Q. And you were unhappy with the circumstances in which
15 your patients had to be transferred. Is that fair? 14:08
16 A. That is fair. As was Mr. Akhtar, because the radical
17 prostatectomies was his patients.

18 140 Q. Yes.
19 A. Which we had arranged to do on that Friday morning, you
20 know, two days later. 14:08

21 141 Q. Yes.
22 A. But they were transferred. And then there was actually
23 by that time three radical cystectomies to be offered
24 or done.

25 142 Q. Yes. 14:08
26 A. And they were transferred.

27 143 Q. And it's those bladder cases that attracted the --
28 those three bladder cases, in particular, that
29 attracted the particular concern of Mr. Hagan. And if

1 I could ask for your observations in response to what
2 he said in his witness statement. If we go to
3 WIT-98857, and his initial responses here are to set
4 out the terms on which you expressed yourself to both
5 himself and to general practitioners in relation to
6 these patients. So if we just scroll down? So he's
7 setting out there the history in relation to Patient 1,
8 and then at the bottom, towards the bottom of the page,
9 he's saying in your letter to the general practitioner
10 you wrote in the following terms:

14:09

14:09

11
12 "As you are now aware a decision was made by officials
13 in the Department in conjunction with the Commissioner
14 to cancel Patient 1's admission and to have his further
15 management transferred to Mr. Hagan at the City
16 Hospital."

14:10

17
18 And you say:

19
20 "The patient and their family has been gravely
21 distressed by the cancellation of their admission. The
22 patient is suffering gravely from severe lower urinary
23 tract symptoms. I do hope that their further
24 management can be expedited as soon as possible."

14:10

14:10

25
26 And then you wrote to the patient in order to express
27 your regret that it had not been permitted to continue
28 with the treatment in Craigavon, and you say that you
29 hope that the management under the care of Mr. Hagan

1 will take place as soon as possible.

2
3 And then if we go down to WIT-988 -- sorry, 98862. He
4 sets out how you had written to him. Just up the page
5 a little bit. Sorry, on up to the bottom of the 14:11
6 previous page. Thank you. And particularly with
7 regard to Patient 3, as he names that patient, not the
8 Patient 3 that we have used, setting out that patient's
9 circumstances. And then down onto the top of the next
10 page he writes, or you write: 14:12

11
12 "Even more importantly, their present dread is that you
13 would not agree to proceed with cystectomy. I do hope
14 that you will agree to do so. I dread to think of the
15 distress if you were not to agree." 14:12

16
17 That's a snapshot of some of the correspondence that
18 you issued in respect of the three patients at that
19 time. He thought your intervention, and the tone and
20 indeed the content of the correspondence was 14:12
21 inappropriate, almost I think unethical in some
22 respects. Is that how you view it?

23 A. Well, there are two sides to that story, because
24 basically if you go back to Patient 1, it's interesting
25 the perspective I've just gained from that, because by 14:13
26 the Friday, if I had -- I had been in contact with
27 Mr. Hagan about Patient 1, because Patient 1 was now in
28 our ward with a bladder so painfully distended, full of
29 tumour, with little room for urine to enter it, never

1 mind to have a catheter draining it, and he -- we had
2 decided to keep him over the weekend so that I would
3 operate on him the following week, and he was
4 particularly distressed by the prospect that relief of
5 his painfully distended bladder could be delayed. And 14:13
6 I was very, very grateful to Mr. Hagan for actually
7 taking him with first priority and, in fact, he
8 cancelled cases that he had arranged to do the
9 following week in order to facilitate that patient. So
10 I recall clearly that day leaving a patient that 14:14
11 evening, a patient in tearful distress at the prospect
12 of having his surgery deferred. So even though
13 Mr. Hagan subsequently expressed some concern about the
14 unnecessary readmission of that patient in the months
15 since his first diagnosis in July, and now it's 14:14
16 September, two months later, thankfully he proceeded to
17 have his surgery done the following week and I
18 continued to review him for the next 10 years, because
19 his surgery was curative, and the only reason I was
20 reviewing him was because he was affected by recurrent 14:15
21 urinary tract infection for which we did not need to
22 use elective admission for IV fluids and antibiotics.

23 144 Q. But getting back to...

24 A. And getting back to the....

25 145 Q. The premise of my question was these were inappropriate 14:15
26 correspondence on the part of you.

27 A. Well -- yes.

28 146 Q. You should not have been, as Mr. Hagan would have it,
29 writing to the patients in the way that you were,

1 suggesting management decisions, or the appropriateness
2 of management decisions that he may not be able to
3 deliver, and putting him under pressure using words
4 like "dread" to make a decision consonant with your own
5 management decision for the patient? 14:15

6 A. Yes.

7 147 Q. Inappropriate he thought.

8 A. Yeah, I understand how he came to that conclusion and
9 felt in that way. And when you look at it
10 retrospectively in the cold light of day, it would -- I 14:16
11 can understand how anybody would agree with that.
12 However, the context is equally important. Because if
13 we had had that one month notice period in order to
14 transfer people in an orderly fashion, such
15 communications would not have been made to GP, to Chris 14:16
16 Hagan, or to any patient, and I cannot emphasise that
17 adequately. Whether that excuses, in your view, the
18 language that was used. But patients were dreading the
19 prospect that they would have their surgery or
20 management deferred by this precipitous decision that 14:16
21 took place on a Wednesday.

22 148 Q. Yes. We know from the materials that have been made
23 available to the Inquiry, and I'm sure you've seen it
24 and indeed remember it, your actions in writing these
25 letters in that way was the subject of criticism from 14:17
26 Dr. Rankin.

27 A. Mm-hmm.

28 149 Q. The correspondence AOB-00191 was sent to you on the
29 27th September 2010, and it is expressed in terms of

1 being great concern that you've indicated to a patient
2 in advance of a care pathway being agreed your
3 preferred management of the case.
4

5 "I believe this puts inappropriate pressure on the 14:17
6 receiving team and is regrettable."
7

8 That's something, looking back on it now you see the
9 sense of, that being a fair comment, albeit that you
10 were working in, you would call, extreme circumstances? 14:18

11 A. Yeah. It is most regrettable that this transfer at
12 that time took place in the manner in which it did.

13 150 Q. Yes?

14 A. And I appreciate that the Inquiry is also familiar with
15 the other aspects of the communications between 14:18
16 Mr. Hagan and Dr. Diane Corrigan subsequently about
17 their lack of preparedness for such a precipitous
18 decision. So I think actually that there was a lot of
19 exasperation, and frustration, and concern for patients
20 at that time that led to that kind of language being 14:18
21 used.

22 151 Q. Could I bring you to internal correspondence between
23 Mr. Hagan and his colleague Dr. Stephens, the then
24 Medical Director at the Belfast Trust. And if we start
25 at WIT-99146, and this is correspondence written the 14:19
26 day after, this is 28th September, the day after you
27 received your letter which we've just looked at from
28 Dr. Rankin. He says at the top of the page:
29

1 "Whilst the letters sent..."

2

3

That is the letters sent by you:

4

5

"...about these patients were unhelpful, I think it misses the point with these patients and the governance issues that have been raised." 14:19

6

7

8

9 And he then proceeds to set out in a little bit of
10 detail how he considers the care of the patients has
11 been mismanaged, and he -- I don't propose to go into
12 the detail of it. Just scrolling down onto the next
13 page, please. He deals with the five patients who were
14 lined up for treatment at the City Hospital following
15 transfer, but his focus was on the three cystectomies, 14:20
16 and he says with regard to those three:

17

18

"The main issues are with the bladder cancer patients. All three have had inappropriate management plans that may well have shortened life expectancy." 14:20

19

20

21

22

And he goes on to say:

23

24

"The lack of insight displayed by this surgeon, who then wrote letters suggesting that there was a callous disregard for patient welfare, is frankly unbelievable given the circumstances and the poor management decisions." 14:20

25

26

27

28

29

1 So the point I want to make to you is this - quite
2 apart from the inappropriateness, as he saw it, of you
3 writing letters, and the content of the letters, he
4 thought that the patients were poorly managed and
5 placed at risk because of that management. Were those 14:21
6 issues drawn to your attention?

7 A. No.

8 152 Q. So what I'm asking you here, just to be clear is, here
9 is a concern being expressed by a clinician in the
10 Belfast Trust to his Medical Director about the safety 14:21
11 and the adequacy of treatment in a hospital that's
12 referring, and you're saying those issues weren't
13 raised with you?

14 A. Mmm. They -- well, I don't recall them being raised
15 with me, because if they had been raised with me I 14:21
16 would have, it would have been obligatory for me to
17 respond to them, and I don't have any recall of having
18 been asked to or having made such a response.

19 153 Q. We know, and we'll look at this on Friday, perhaps,
20 that Dr. Mitchell... 14:22

21 A. Mmm

22 154 Q. Wrote to you in 2014 in respect of prostate cancer
23 management in a particular case.

24 A. Mmm.

25 155 Q. And you didn't reply to that, so far as we're aware. 14:22

26 A. Mm-hmm.

27 156 Q. What we'll look at in a moment is 2016 correspondence
28 with you in respect of the muscle invasive bladder
29 case, and we see no reference or response to that.

1 A. Mmm.

2 157 Q. So it's in this context of the importance, perhaps, of
3 the governance of the relationship between the
4 referring hospital and the hospital that is receiving
5 the patient. You would agree with me, would you, that 14:23
6 if the receiving hospital has concerns about treatment,
7 it is good governance to ensure that they are properly
8 articulated to the referring hospital and an adequate
9 explanation or response is sought?

10 A. I would agree with that entirely. And I would add to 14:23
11 that, that it works vice versa as well, that if we --
12 if the referring hospital has a concern about the
13 receiving hospital that it should work both ways.
14 Absolutely.

15 158 Q. And to summarise, arising out of this transfer of 14:23
16 three, five patients, the only expression of concern
17 that you can remember receiving was in respect of the
18 content of your letters?

19 A. That's all.

20 159 Q. Yes. Thank you. Could I briefly ask you about the 14:24
21 Drake Review?

22 A. Yes.

23 160 Q. As we can see from TRU-25118 -- sorry, 58, that's
24 right. 251158. My apologies. 1st September 2010,
25 Dr. Loughran is writing -- sorry, Dr. Corrigan at the 14:24
26 PHA is writing to your Medical Director, your then
27 Medical Director Dr. Loughran, and if we just scroll
28 through, she is commenting upon what she, from reading
29 some materials, is concerned, is concerned that there

1 might be an excessive number or a high proportion of
2 procedures being conducted by way of cystectomy in the
3 Craigavon Area Hospital, and she is essentially
4 inviting the Trust to carry out some work around that
5 to see if there is any particular problem. Now we know 14:25
6 from Mr. Hagan's evidence in 2000 that he believes he
7 came across a case where cystectomy wasn't
8 appropriately carried out. You say you've no
9 recollection of that and haven't been assisted with
10 notes or records to be able to appropriately comment. 14:26
11 In terms of this need to examine the work that you were
12 doing in respect of cystectomies, did that come as a
13 surprise to you?

14 A. Yes, and I mean I can't remember clearly now my
15 reaction to it. 14:26

16 161 Q. One of your reactions, just to assist you with it.

17 A. Okay.

18 162 Q. If we could bring it up? It's at TRU-281856. It was
19 being proposed, if we just scroll down the page, this
20 is a meeting of 9th September 2010. It's recorded at 14:27
21 No.4:

22
23 "The Commissioner is concerned about a disproportionate
24 rate of cystectomy undertaken in Craigavon."
25 14:27

26 And Dr. Mackle was going to look at this. And if we
27 scroll up over the next page, you responded by saying
28 that you would not wish to meet with Mr. -- I take that
29 to be Mr. Fordham, who was being suggested as a

1 possible independent reviewer of this issue -- you
2 wouldn't wish to meet him under any circumstances and
3 would be glad if another expert was found, another
4 urologist was found, if an independent was necessary.
5 why did you respond in that way? 14:28

6 A. I think because of Mr. Fordham's involvement as what
7 was labelled a critical friend during the whole
8 Regional Review process, and particularly with regard
9 to centralisation of services to Belfast.

10 163 Q. So in that respect it blotted his copybook? 14:28

11 A. He blotted his copybook, yes.

12 164 Q. In your view.

13 A. Yes. Yes.

14 165 Q. The upshot of this process was a desktop report
15 prepared by, I think it's Professor Drake, if I'm 14:28
16 excessively elevating him?

17 A. No, no, he's Professor since then.

18 166 Q. And we can see that at TRU-281930. And a short report.
19 And if we go just to the conclusions three pages
20 further on at 281943. He makes his way through a 14:29
21 number of cases and offers the following conclusions.
22 Just before we look at those. Is this an intervention,
23 Professor Drake's intervention, that you were aware of?

24 A. I can't remember whether I was aware of it at the time.
25 I must say I was disappointed, and I think I've written 14:29
26 about that in the more recent addendum that, you know,
27 it was just a desktop review of patient records and
28 that he didn't have the opportunity of meeting either
29 Michael Young or myself, as the sample of patients

1 includes patients of both of us, and even more
2 importantly with the patients. Some of the patients on
3 that list also have some commonality with the IV fluids
4 and antibiotics. For example, the first one, who shall
5 remain unnamed, though it's named in that document I 14:30
6 think, so in preserving her anonymity, was the person
7 who the GP rang me about from her home.

8 167 Q. Yes.
9 A. So...

10 168 Q. So you were disappointed that you weren't directly 14:30
11 engaged by his work?
12 A. Yeah, very much so, yes.

13 169 Q. Yes. It calls to mind a point I was addressing with
14 you this morning. In terms of the, if you like, giving
15 you the green light to perform cystectomies or, indeed, 14:30
16 superintending the reasons for a cystectomy in any
17 particular case, that was something that was, if you
18 like, not the subject of scrutiny, save where you
19 wished to discuss it or were prepared to discuss it
20 with colleagues such as Mr. Young. 14:31
21 A. Mmm.

22 170 Q. So this was the first scrutiny being brought to bear,
23 if you like, as a matter of retrospective governance?
24 A. Mmm.

25 171 Q. In 10 years. 14:31
26 A. That's correct, yes.

27 172 Q. And he offers some positive conclusions, clearly.
28
29 "The majority of cases have been managed with

1 compassion and consideration."

2
3 And he goes on to say importantly:

4
5 "The cases in general appear to have supportable
6 clinical grounds." 14:31

7
8 However, he draws out a concern after considering the
9 documentation that it is insufficiently comprehensive,
10 and he says that: 14:32

11
12 "In order to warrant proceeding to cystectomy clear
13 description of the following is needed..."

14
15 And he sets out some of the indices that should govern 14:32
16 intervention by way cystectomy, including severe
17 pathology, substantial functional impairment and impact
18 on quality of life, attempting to using conservative
19 measures in the first instance, I suppose, and
20 discussions of the risks involved. So would those 14:32
21 indices have been familiar to you?

22 A. Very much so. And if you were to look at each of his
23 comments on the patients that are listed, you know,
24 there is pretty good evidence, you know, that there was
25 a clear indication or a supportable indication. You 14:32
26 know there was significant pathology and -- but, yes, I
27 take his point. You know, the documentation may be
28 insufficiently comprehensive, but all of those issues
29 that he refers to would have been very much -- you

1 don't embark upon major surgery like this without
2 having -- this is last resort kind of measure to
3 relieve people of their pain and their lower urinary
4 tract functional impairment, and I think, as I made
5 reference in my first witness statement, I mean I have 14:33
6 had occasion to do simple cystectomy as an emergency
7 when you have haemorrhagic radiation cystitis, when you
8 have pyocystis. So, you know, there were very definite
9 indications. In fact just a few days back, one of the
10 patients contacted me, he is now 93 years of age, it's 14:34
11 18 years since I did his simple cystectomy and an
12 orthotopic bladder replacement for painful interstitial
13 cystitis, which caused him at the time to be really
14 significantly parasuicidal because of the pain that he
15 had been suffering for years. So I have no doubt that 14:34
16 the vast majority of people who had such surgery
17 performed, they benefitted significantly from it. One
18 of the things I learnt in the process of doing so is
19 that it doesn't actually relieve patients of their
20 predisposition to have recurrent infection, and that 14:34
21 sort of harks back to the concern that Mr. Hagan claims
22 to have had back in the year 2000, because you don't do
23 this operation for recurrent urinary tract infection,
24 you do it for other functional impairments, and so
25 forth, and pathology that is documented, and for which 14:35
26 you have sought evidence, and sometimes actually the
27 evidence is not always there to correlate with the
28 severity of symptoms that patients are suffering,
29 particularly the painful bladder. And, of course, we

1 have a duty at all times to be -- to take every
2 diagnostic measure to ensure that we're dealing with a
3 painful bladder and not what is referred to as chronic
4 pelvic pain syndrome, which the patient may still be
5 left with if it's not confined to and arising from the 14:35
6 bladder.

7 173 Q. The point that's perhaps of most interest to the Panel
8 arising out of a scenario such as this, is that
9 cystectomy is obviously a very significant procedure, a
10 life changing procedure for many people, it carries 14:36
11 risk. Interested in your views as a clinician who
12 practised in the Southern Trust for 28 years as a
13 surgeon, operating every week, coming across other
14 colleagues operating every week, how would you measure,
15 if you like, the state of governance attending surgery 14:36
16 and surgical procedures and how things were managed in
17 theatre? To what extent was that area of the Trust's
18 output the subject of auditing, monitoring,
19 supervision, in a way which would have made meaningful
20 for observers, issues such as risk and patient safety? 14:37

21 A. Well I think actually apart from the clinicians like
22 ourselves doing it individually and placing our
23 management, or our intended management, or our thoughts
24 about management, subject to their collective
25 assessment and scrutiny, whether on ward rounds, or 14:37
26 patient safety meetings, or mortality and morbidity and
27 so forth, and we did indulge a great deal in that
28 process. We were very, very open and transparent and
29 welcoming of constructive criticism. From a management

1 perspective, I don't think that there was any
2 particular auditing going on in that regard, and I
3 don't think actually even as clinicians we had a
4 structure for doing audit, in terms of measuring
5 quality of life afterwards, in terms of, you know, 14:38
6 theatre utilisation. Now theatre utilisation audit did
7 take place previously during years, particularly during
8 that period around the Regional Review and, of course,
9 it led to a lot of controversy as to what's included in
10 an operative time, whether it's just the surgery, or 14:38
11 the anaesthesia, or the world Health Organisation
12 timeout and all of those kind of issues. So it's
13 easier said than done. I think actually what is far
14 more important in theatre utilisation, and getting lost
15 in the weeds of that, important as it may be, are to 14:39
16 look at the impacts, on clinical outcome and patient
17 reported outcomes, which can be measured, we're all
18 familiar with those. You refer to it as "life
19 changing", and in most of these cases I'm glad to say,
20 you know, it was life changing for the better. 14:39

21 174 Q. Mm-hmm.

22 A. Because these people were profoundly miserable. I
23 remember one lady who had an en suite adjacent to her
24 bedroom of course, and she hadn't slept in her bed for
25 years, she actually had slept on the toilet with a 14:39
26 cushion against the wall sleeping like that because she
27 couldn't -- and to relieve that person of that kind of
28 disorder was liberation for them. So it was life
29 changing usually for their benefit?

1 175 Q. We've seen one prominent example. Dr. Suresh, who had
2 a difficulty in terms of a specific aspect of his
3 operating practice.

4 A. Mmm. Mmm.

5 176 Q. And we've observed the steps that were taken to provide 14:40
6 support and to remediate that difficulty.

7 A. Mmm.

8 177 Q. But to take that kind of scenario. A practitioner,
9 Dr. Suresh happily raised his hands and asked for help,
10 but there could be practitioners who are less careful 14:40
11 and less insightful about their weaknesses and could be
12 causing harm to patients?

13 A. Yes, of course. Yeah.

14 178 Q. How would that have come to the surface in the Trust
15 that you worked in for 28 years in the absence of a 14:41
16 Serious Adverse Incident, for example? Was there any
17 standalone system that monitored on a periodic regular
18 basis outcomes from theatre?

19 A. Other than -- not other than serious adverse incidents,
20 the filling in of IR1 Forms. The case of Mr. Suresh is 14:41
21 a very, very good one, because obviously there was an
22 issue there, and it wasn't just an issue with regard to
23 his operative competence in dealing with a life saving
24 acute open major operation that required to be done in
25 the early hours of the morning, but there was also an 14:42
26 issue with regard to awareness of the patient's
27 deterioration during the day previously. So, I mean,
28 that is something that, I mean, I became aware of at
29 1:00 or 2:00 o'clock in the morning when he called me

1 and I went in and was able to rectify the situation.
2 And, do you know, in a relatively small hospital like
3 Craigavon was, and remains, I mean, that was, you know
4 -- there was a wide awareness of that particular
5 incident, so it had to be addressed.

14:42

6
7 With regard to simple cystectomy for benign pathologies
8 over the period of years that we were allowed to do it
9 from 1992 until 2010, whatever, I mean I didn't have
10 any issues, or I didn't have any awareness of -- I can
11 think of one patient whom I, looking back, regret doing
12 an ileal conduit urinary diversion on, because she
13 really had much more significant mental health issues
14 than we all appreciated, and this was a case that I
15 discussed with my colleagues at the time, because she
16 went on to self-harm her stoma and so forth. But apart
17 from that, I don't think that there is a parallel
18 situation -- I don't think it applies to benign
19 cystectomies.

14:42

14:43

20 179 Q. Thank you for that. Could I move to the fourth issue
21 under the heading of "Cystectomy", and it involved the
22 bladder, the muscle invasive bladder cancer which was
23 referred into the Belfast Trust by Mr. O'Donoghue, or
24 through the multi-disciplinary team and on to Mr. Hagan
25 in 2016, and I want to deal with this fairly succinctly
26 if I can. If we go to WIT-98871. Sorry, false alarm!
27 If we go to WIT-98874 first of all. And just scroll
28 down to the bottom. Thank you, just there. And
29 Mr. Hagan is writing to a colleague in the Belfast

14:43

14:44

1 Trust, Davina Lee, and he is saying:

2

3 "I am very concerned about delays in intra-Trust
4 transfer from Craigavon and how we raise this. Is it
5 possibly an interface Serious Adverse Incident?"

14:44

6

7 And he cites the patient and he draws attention to the
8 following:

9

10 "The original resection was 16th February..."

14:45

11

12 - that should say 2016:

13

14 "...with multiple local MDT discussions before a
15 regional discussion on 9th June 2016 and I see her
16 today."

14:45

17

18 So four and a half months have passed by:

19

20 "In my view there are multiple avoidable delays which
21 potentially lead to an adverse outcome. She is not fit
22 for cystectomy today."

14:45

23

24 And then he contrasts this with what he describes as an
25 exemplar where a muscle invasive cancer was turned
26 around from the TURBT, T-U-R-B-T, in May 2016, to be
27 seen for radical surgery by the middle of June 2016.
28 So he considers this issue with colleagues. It goes to
29 Dr. Hagan. Sorry not Dr. Hagan, Dr. Mitchell, at

14:45

1 WIT-98869, just a couple of pages back. And he writes
2 to you. And the issue here, or one of the issues, it
3 appears, when you look along the patient care pathway
4 for a muscle invasive cancer, there's no, according to
5 Mr. Hagan and his colleagues, no reference to the use 14:46
6 of an isotope bone scan, that the suggestion is, had
7 added four to six, possibly up to eight weeks by the
8 time that the scan was arranged, reported and
9 considered, and back into the MDT, only for it to be
10 realised that that wasn't getting to the heart of the 14:47
11 matter, and then there was a recommendation for a plain
12 x-ray, I think, of the shoulder and the scapula. And
13 so there were various layers to the investigation of
14 this patient, which in Mr. Hagan's view and
15 Dr. Mitchell's view, appeared to be, if not unnecessary 14:47
16 in some respects, the bone scan, but delayed in other
17 respects. So he's writing to you, and one might argue
18 good governance, the Trust receiving the patient has a
19 concern, it's writing to you to alert you to that
20 concern, you were at that time the lead clinician for 14:48
21 the multi-disciplinary team. He's copying in Shauna
22 McVeigh, who was the Co-ordinator of the
23 multi-disciplinary team at the Southern Trust, and he's
24 saying that he suspects that you'll want to do a
25 casenote review at the Southern Trust, and if there's 14:48
26 any shared learning from it either regionally or
27 locally. Would you agree that that is an appropriate
28 way to conduct business, if there is a concern?

29 A. I do, yes.

1 180 Q. whether or not you share the concern, or whether you
2 think it's overstated, it's good practice to draw it to
3 your team's attention through you as the lead?

4 A. Yes. Could I just add one, just one caveat to that? I
5 think actually in relation to the letter that he wrote 14:49
6 to me in November '14 with regard to the management of
7 a prostate cancer patient, I think, actually, I would
8 even suggest that there needs to be even a more robust
9 communication or inter-Trust interface when it comes to
10 dealing with such issues, rather than just by email, 14:49
11 and I think I'm not the only person during the course
12 of this Inquiry that has expressed concern about the
13 abundance of emails that one receives and how one can
14 miss out on it, like I did, with regard to the one from
15 November '14. But this one, I have responded to that 14:49
16 in the recent addendum.

17 181 Q. Yes. And I just want to take you to that. Could I
18 first of all ask your reflections on Shauna McVeigh's
19 evidence. I think you've read her statement?

20 A. Mmm. 14:49

21 182 Q. As I say, she was the MDT Coordinator at that time.
22 She'd copied into this email, she thinks appropriately.
23 And if we go to WIT-105875? She sets out that she
24 fully understands the reason for being copied into the
25 email. 14:50
26
27 "When a matter arises regionally I would expect to be
28 copied in."
29

1 But scrolling down to paragraph 1.04, she says that
2 having been alerted to this issue through the inquiry,
3 in essence, on checking through her emails she couldn't
4 find anything. She:

5
6 "...checked the patient's pathway on CaaPS and couldn't
7 see any diary comments added in relation to this email,
8 which is what I would normally do in this case and I
9 would have highlighted the matter to the MDT team."

14:50

10
11 She goes on in the next paragraph to say:

14:51

12
13 "This matter should have been brought up for noting at
14 the MDT meeting to highlight the delay and the issue
15 and see what could be done differently."

14:51

16
17 And at paragraph 1.08, if we scroll down, she says:

18
19 "I agree with Dr. Mitchell's observations and
20 understand why I was included in the email. This email
21 should have triggered a response and a feedback from
22 ourselves."

14:51

23
24 She inaccurately ascribes the ownership of the patient
25 to you, but we know that you were sent the email in
26 your -- wearing your MDT lead hat. So is it the case,
27 Mr. O'Brien, that you haven't found any record,
28 documentary record of having discussed this issue, it
29 having been referred back to you by Dr. Mitchell?

14:51

1 A. No, there's no record of it that I could find in the
2 MDM minutes, as that's where it would have appeared.
3 And...

4 183 Q. And there's no record of any correspondence back to
5 Dr. Mitchell?

14:52

6 A. No.

7 184 Q. As Shauna McVeigh anticipated there would be if it was
8 discussed?

9 A. I apologise for that, because if you want to look at
10 the elements of our discussion, which I clearly
11 remember, but we should have actually out of -- it
12 would have been polite, at least, and courteous, to
13 confirm that we had discussed this matter even though
14 we concluded that there was nothing regional to be
15 learnt from it, that we were the only ones to have
16 finally taken on board that we did not need to
17 routinely do bone scans and staging muscle invasive
18 bladder cancer. Even though it was somewhat ironic.
19 We had a very, very good consultant radiologist, who
20 has given evidence here, in Marc Williams, and Marc was
21 never a great fan of radioisotope bone scans and the
22 staging of anything, because they're very insensitive.
23 So he was delighted that we had taken that on board.
24 Even though ironically it is my understanding that we
25 actually did have two discussions at regional MDM, and
26 when there was some concern about the appearance of the
27 left scapula, it was recommended by regional MDM that
28 we would get a CT scan done, which further delayed
29 matters.

14:52

14:53

14:53

14:53

1 185 Q. But with respect, all those issues are in the rearview
2 mirror.

3 A. Sorry.

4 186 Q. And I have your addendum statement where you say you
5 can recall, following Dr. Mitchell's intervention, 14:54
6 discussing this with your MDM colleagues.
7

8 "We recognised that in light of Dr. Mitchell's
9 intervention the bone scan was unnecessary."
10 14:54

11 A. Mmm.

12 187 Q. And you say, if I can say so, somewhat strangely:
13

14 "We considered that there was no learning for the
15 region arising out of this so we didn't commit to 14:54
16 writing."
17

18 A. Yes.

19 188 Q. I mean, how would you know that there's no learning to
20 be derived from it? And is it more than professional 14:54
21 courtesy that merits a response back to the centre?
22

23 189 Q. It's an important governance issue to show to the
24 centre that you've understood the problem?
25

26 190 Q. And how you're going to repair it going forward?
27 A. Yes. I accept that criticism. As lead clinician, and
28 even if I wasn't Chairing that day, because I may not
29 have, it was addressed to me and I should have

1 confirmed that we had taken on board the learning that
2 we shouldn't routinely do radioscope bone scans, and I
3 think that's the only learning that we had derived from
4 it.

5 191 Q. Is it fair to say, and we've seen no document in 14:55
6 relation to this, so is it fair to say that the Belfast
7 Trust didn't come looking for confirmation that you
8 had, as an MDT in the Southern Trust, looked at this
9 issue and repaired your processes?

10 A. They did not, no. 14:55

11 192 Q. Thank you for that. It's 3:00 o'clock. Shall we take
12 a short break?

13 CHAIR: Until 3.15, ladies and gentlemen.

14
15 THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS 14:56
16 FOLLOWS:

17
18 CHAIR: Thank you everyone. Again, not too long after
19 4:00 o'clock, Mr. Wolfe.

20 MR. WOLFE: Yes, that's my plan. With the little time 15:12
21 we have available to us this afternoon, Mr. O'Brien, I
22 want to seek your views on that area of practice
23 connected with the actioning of investigation results,
24 whether that's pathology or radiology. We will use one
25 of the cases that we're going to look at to diverge 15:12
26 into pre-operative assessment as well, and we'll also
27 take your views on the issue of DARO and its attachment
28 to your practice. So could I have up on the screen,
29 please, WIT-17475? And this is the Root Cause Analysis

1 Report in connection with Patient 95, and within this
2 document there is a summary of the chronology. Just
3 scrolling down a little. Let me see the whole page.
4 Yeah. Yeah, just scroll down to Episode 2. Thank you.
5 Just stop there. So this female patient was the 15:14
6 subject of surgery in July 2009, and discharged from
7 hospital 25th July 2009 with arrangements for a CT scan
8 to be performed. This CT scan as we can see.
9 A. October.
10 193 Q. It was, yeah. The important one was October 2010. It 15:14
11 might be over the page on the chronology. Scroll down.
12 Well, I think it's in there somewhere. It was
13 performed on 1st October 2009. An outpatient's review
14 planned for four months didn't happen, isn't that
15 correct, and that was a product of untold pressure on 15:15
16 slots for review. Into the following year, into 2010,
17 she attended Accident & Emergency in July with a two
18 week history of abdominal pain. Abdominal x-rays were
19 performed and she was discharged. Coming back in to
20 the hospital four days later, when a re-review of those 15:15
21 x-rays showed the possibility of a retained swab, and
22 she underwent a laparotomy on 21st July 2010, roughly
23 12 months after her initial surgery, for the removal of
24 that retained swab. You would have had access, would
25 you not, to the surveillance scan that was performed 15:16
26 four months after her surgery in October 2009?
27 A. Well if I had read it I would have acted upon it. I am
28 aware that the Inquiry does have my statement in
29 relation to the report that I did for the root cause

1 analysis at that time.

2 194 Q. Yeah.

3 A. And certainly if I had read that report I would have
4 acted upon it.

5 195 Q. Could I take you to one of the key findings of this 15:17
6 report on the facts? It's three pages down at
7 WIT-17478, and it says, just scrolling down:
8
9 "Although a diagnosis of a retained swab was not made
10 on the CT scan..." 15:17
11
12 - that's the CT scan of October 2009, four months after
13 the surgery:
14
15 "... a pathological abnormality was described. However, 15:17
16 this report was not seen by the consultant urologist as
17 it is his routine practice to review radiological and
18 laboratory reports when the patient returns for
19 post-operative follow-up. The planned four month
20 follow-up never took place due to the waiting times for 15:18
21 review."
22
23 So that's something you don't disagree with, is it? In
24 the round you tended to wait for the review to take
25 place before you would consult the investigation 15:18
26 report?
27 A. I don't think it's necessarily entirely accurate, if I
28 may put it that way? I think it's interesting to note
29 my comments on that in the statement that I've made in

1 this particular case in the investigation. I think,
2 actually, I see no reason why reports would not have
3 been coming back to the person who requested them. I
4 did say in that statement that, you know, it wasn't
5 until relatively recently that there would have been 15:19
6 such a delay between the scan being done and the
7 planned review. So somewhere in between there is the
8 truth. I think I have said, you know, in that
9 statement, it could be said the report returned to me.
10 In any case, I didn't see the report or otherwise I 15:19
11 would have acted upon it. So I think up until
12 relatively recent -- in recent times there would not
13 have been this inordinate delay between the timing of
14 the intended review, and it never actually took place
15 because her acute readmission effectively, as you say, 15:19
16 one year after her major surgery, had taken place
17 before that review had itself taken place. So does
18 that answer the question?

19 196 Q. Well, it does in part. But the essence of the problem
20 here is that this was an extreme case, clearly, but an 15:20
21 investigation report is undertaken for a reason.

22 A. Mmm.

23 197 Q. It's clearly to check that all went well in this case
24 with the surgery.

25 A. Mmm. 15:20

26 198 Q. There's no reason why you shouldn't have seen it. You
27 were the referring clinician and this patient was under
28 your care, so you should have been on the lookout for
29 this report coming back. And that would be the same

1 across all of your colleagues?

2 A. Yeah.

3 199 Q. You own the report and there's an obligation to action,
4 to study it and carry out follow-up action. Is it
5 perhaps more so, it's more urgent or more important to 15:21
6 ensure that you see the report in circumstances where
7 you were aware, acutely aware, of the environment in
8 which you work where patients were frequently missed
9 for review because of the waiting list pressures?

10 A. Well, I mean I think at that time, I think my 15:21
11 contemporary, more contemporaneous remarks that I made
12 in that statement with regard to there not being such a
13 delay until relatively recently, and I cannot add
14 anything more specifically to that because I don't have
15 the data to look back on at that time, but I... 15:22

16 200 Q. The issue identified in this report came to the
17 attention of the Commissioner?

18 A. Mm-hmm.

19 201 Q. And this was to prompt email correspondence with the
20 consultants, including yourself. And if we could look 15:22
21 at that? TRU-276805. And just scrolling down to the
22 bottom of the page. So Martina Corrigan is writing to
23 a range of consultants, including yourself. Just
24 scroll down to see what she says. She's referring to
25 Mrs. Trouton's message below, and it is that -- sorry: 15:23
26
27 "Dear All,
28 I know it has been addressed verbally with you a few
29 months ago but just to be sure can you please check

1 with your consultants that investigations that are
2 requested that the results are reviewed as soon as the
3 result is available and that one does not wait until
4 the review appointment to look at them."

15:23

5
6 So that's a straightforward principle or a
7 straightforward instruction. Was it something that you
8 agreed with in principle but couldn't put into
9 practice, or was it something that you thought needed
10 to be the subject of some flexibility?

15:24

11 A. No, I agreed with it entirely in principle, because it
12 is the responsibility of the requesting
13 doctor/clinician, these days it doesn't have to be a
14 doctor, to review results when they are made available
15 to them, but the practicality of everything that we had
16 to do, with inadequate time to do it, you know, you
17 couldn't guarantee that you would be able to review all
18 results, and I appreciate that that leads into the
19 whole issue of DARO and what I have written about that
20 in times past, so I don't want to lead you rather than
21 you...

15:24

15:24

22 202 Q. We'll come to DARO in due course.

23 A. Okay.

24 203 Q. But whether it carries with it some element of myth, or
25 whether it's factually correct, you can help us with.
26 Is it the case, as described in that report, that you
27 did not look to read the investigation report until the
28 review of the patient was upon you?

15:25

29 A. No, I don't think that that is accurate. I think

1 actually that I would have attempted to do both. I
2 think that that's not an accurate reflection. In other
3 words, what I'm saying to you quite categorically, I
4 did not have a practice that I did not look at any
5 result of any investigation until the patient turned up 15:25
6 for review, that would be inaccurate, because they
7 would have been returned to me. But as we may discuss
8 later, I always had a concern as to the robustness of
9 that system. Can you be sure that all reports come
10 back to you? Like honestly I didn't... 15:26

11 204 Q. Well what kind of system, obviously you had a secretary
12 to administer your practice, and no doubt you worked
13 very closely with each of them over your career.

14 A. Mmm.

15 205 Q. But what was your system to ensure that where a report 15:26
16 is commissioned, such as this with this particular
17 patient, that it would come to your attention that
18 there was some unusual pathology that needed to be
19 looked at urgently?

20 A. I don't think actually that we had a system at that 15:26
21 time to account for every requested investigation to
22 expect, as they do have now, a report to come back
23 within an indicative timeframe. Like, for example, if
24 I -- that was requested to be done in October. So at
25 least by the end of October a secretary or some other 15:27
26 person would have been looking for that result to make
27 sure that I had seen it. We didn't have that system at
28 that time.

29 206 Q. But that's something that you surely should have a

1 personal responsibility with your secretary to develop.
2 So "I've asked for a report on Mr. Smith today. I know
3 I've arranged for him to come in in three months. I
4 know that that may not happen", but I should know to go
5 looking for that report. 15:27

6 A. Mm-hmm.

7 207 Q. At some point in time. And if it doesn't -- worse case
8 scenario, if it isn't produced, for some reason, I need
9 to ask questions about that.

10 A. Mmm. 15:27

11 208 Q. But if it is produced and there's some concerning
12 pathology in it, I need to take action. So did you
13 have anything resembling that in terms of a procedure
14 to cover that?

15 A. We didn't have -- I didn't have that system or a system 15:28
16 like that with my secretary to go searching for and
17 taking account of investigations requested, and I
18 appreciate that it could be argued that I should have
19 had, but we didn't have.

20 209 Q. What would your patient expect of you? 15:28

21 A. I'm sure that the patient would have expected that when
22 the investigation was done that the report would be
23 sent to me, and that if there was anything untoward
24 about it that I would have arranged an appointment for
25 that patient. But, I, I obviously did not read that 15:28
26 report, or did not receive that report, because
27 otherwise I would have acted upon it.

28 210 Q. If we scroll back up the page we can see that you asked
29 a range of questions in response to Mrs. Corrigan's

1 email, and here they are. So you're writing in
2 response, you say, to:

3
4 "...an email informing us that there is an expectation
5 that investigative results and reports be reviewed as 15:29
6 soon as they become available and that one does not
7 wait until patient's review appointments. I presume
8 this relates to outpatients and arise as a consequence
9 of patients not being reviewed when intended."

10 15:29
11 And you're concerned for several reasons. I suppose
12 those questions, to summarise, are relating to the
13 practical aspects and the responsibilities which flow
14 from that statement of principle which Mrs. Corrigan
15 and her fellow managers had sent your way. Does it not 15:29
16 portray -- does your response not portray, at least
17 implicitly, the view that "I'm simply not in a position
18 to review results in all cases when they're available"?

19 A. In addition to everything else that, you know, we had
20 to do, that was my concern. And I know that it's been 15:30
21 described, this email, as "pushback". I didn't regard
22 it as pushback because I agreed with the principle. I
23 just was concerned about the practicalities of it. How
24 robust would it be? What time would it take to
25 undertake all of this? And, indeed, nowadays, in 15:30
26 addition to actually reviewing, we have heard that in
27 addition to that you action it. Do you phone the
28 patient with a quick telephone call to tell them that
29 the x-ray is okay, or do you write to the GP and to the

1 patient to tell them? So I mean there was an enormous
2 time implication involved in this, and that was my
3 concern. I felt that all, each and all of these
4 questions that I had raised at that time were quite
5 legitimate and, do you know, I still have that concern. 15:31
6 It goes back to the amount of time that is required for
7 administrative processes and how you trade that off
8 with all of the attempts that one might feel obliged to
9 make to prevent patients coming to harm, even though
10 there's the risk that such a patient as this comes to 15:31
11 harm.

12 211 Q. When this case developed and you saw what had happened
13 to the patient whose life was endangered by the
14 retention of the swab in surgery, did you regard that
15 as some kind of wake up call, or did it sound on you in 15:32
16 any kind of pronounced way that "perhaps maybe I need
17 to change my working practices"?

18 A. Yeah, it did. I mean I assisted the general surgeon in
19 doing this operation, because this operation wasn't
20 just a simple matter of a swab being retained in the 15:32
21 location that it had been retained, which was in the
22 right renal bed, it had actually migrated through the
23 wall of the duodenum and had travelled all the way down
24 to the terminal ileum before it caused the obstruction
25 that caused the lady to be re-admitted, and that's 15:32
26 where it was found, and I subsequently presented the
27 case at a patient safety meeting.

28 212 Q. I suppose the point is that the pathology would have
29 been a whole lot less complicated and less endangering

1 if it had been spotted in October 2009, as opposed to
2 June or July 2010. So the question that I just asked
3 you was, in terms of changes to your practice, or
4 reflection leading to changes to your practice, here
5 was a situation where, for whatever reason, you hadn't 15:33
6 seen the report?

7 A. Mm-hmm.

8 213 Q. For whatever reason the patient hadn't been reviewed at
9 the time you expected her to be reviewed?

10 A. Mm-hmm. 15:33

11 214 Q. But nobody picked up on those two items until she was
12 wheeled into Emergency Department in extremis.

13 A. Mmm.

14 215 Q. So what, if anything, did you do with your practice by
15 way of adjustment? 15:34

16 A. To try do more of all of it, basically. You've heard
17 Mr. Brown saying that he remembers me saying that
18 there's not enough hours in the day. So basically it's
19 to try to do more of it during a 12 to 16 hour day. I
20 mean I've worked six days a week, probably doing we'll 15:34
21 say 70 hours, and I worked every Sunday afternoon from
22 2:00 until 6 o'clock, after church going on a Sunday
23 morning. That was my week for 28 years, during which
24 time I carried with me the burden of concern for so
25 many patients and, you know, I'm not being critical, 15:34
26 but it is relatively easy to look at one particular
27 domain of clinical practice and say, you know, "how did
28 this change your practice?", or pre-operative
29 assessment, "How did that change your practice?", or

1 digital dictation, "How did that change your
2 practice?", and so forth. And I think actually that
3 this boils down to one core issue, and that is; are you
4 able to draw a demarcation line between what is
5 regarded as one's professional practice on one side, 15:35
6 whilst not having a concern about the harm that is
7 coming to patients because of the lack of service
8 provision on the other side of that line, and
9 unfortunately for me, if I had retained my focus on
10 this side of the line I probably wouldn't be sitting at 15:35
11 a public inquiry.

12 216 Q. Your colleagues have given evidence around the issue of
13 results, actioning of results, when they should be
14 looked at, and as a team you all faced pressures. Did
15 you have any discussion with them about this particular 15:36
16 pressure, this particular aspect of your work?

17 A. Not with regard to this particular aspect of my work,
18 but with regard to what I have just said previously.

19 217 Q. Of course, in general.

20 A. Yep. 15:36

21 218 Q. I mean in the answer that you gave, "I work six days,
22 I'm run from pillar to post, I have many patients to
23 give consideration to", do we simply have to regard
24 incidents like this, including the failure, for
25 whatever reason, to review the results in a timely 15:36
26 manner, is that just an inevitable accident, do you
27 think, that has to be tolerated by the patient, or do
28 you think upon reflection there are other approaches
29 that you could have brought to your practice to make it

1 less likely to happen?

2 A. That's a possibility. But I think at the end of the
3 day it is a consequence of the totality of concern that
4 I did have, and I have alluded to it previously that,
5 you know, others were able to compartmentalise issues, 15:37
6 which I struggled to do, and always remain conflicted
7 in terms of, do you know, do I confine my attention to
8 those issues, one of which we're now just discussing,
9 or do I do, as in 2016, I did an additional 24, 26
10 operating sessions? As a consequence of which many 15:38
11 more stented patients will have avoided their morbidity
12 and potentially even mortality, and more patients are
13 diagnosed with prostate cancer as a consequence, and so
14 forth. So in a sense actually that summarises my ethos
15 to my work. 15:38

16
17 I think actually also perhaps it's genesis comes when
18 you're the only consultant, because when you're the
19 only consultant for a period of years, when you're the
20 first one, I think you carry a burden for all of those 15:38
21 aspects of concerns that the later arrivals, even the
22 second one appointed, or the third one appointed,
23 doesn't have the same kind of experience that forms
24 their future practice and their future concerns and
25 ethos towards their work. 15:39

26 219 Q. But would it not have been a straightforward matter to
27 work with your secretary to devise some kind of
28 mechanism. So, for example, here's the report landing
29 on your desk. She could -- you could ask her to direct

1 your attention to its arrival, and if it hasn't arrived
2 to follow it up. And if the review is cancelled, to
3 absolutely make sure that you read the report because
4 you don't know when the review is going to be
5 accommodated. Simple practical measures. 15:39

6 A. Yeah, we did that, but we didn't have a comprehensive
7 system of where that secretary actually also went
8 looking for the report that didn't come back. That's
9 what I was trying to explain earlier.

10 220 Q. Yes. Are you able to put a number on the cases that 15:40
11 were missed by you in terms of a failure to consider
12 the investigation results in a timely fashion?

13 A. I have never done an audit or an analysis of that.
14 What I do know is this is one case. If you think of
15 the case of Patient 5, who had the CT scan reported in 15:40
16 January '20, and if you think of the patient who had
17 the infected kidney and who turned out to have a small
18 renal tumour, I think that was in 2018.

19 221 Q. Patient 92?

20 A. 92. Let me see. So I am aware as a consequence of 15:41
21 individual -- that's right -- individual cases arising.
22 So, you know, it's unfortunate that that is the case.

23 222 Q. The next case that we are aware of after the retained
24 swab incident.

25 A. Mm-hmm. 15:41

26 223 Q. Concerned Patient 128.

27 A. Mm-hmm.

28 224 Q. You had an early involvement in that case and then it
29 was handed over to Dr. Connolly, or Mr Connolly, to

1 manage.

2 A. Mmm.

3 225 Q. You performed a nephrectomy in relation to that
4 patient. The criticism of you in the Serious Adverse
5 Incident Report that followed from it, the first 15:42
6 Serious Adverse Incident Review that Mr. Glackin
7 undertook, was that there was a delay of eight months
8 in your dictation. But leaving that aspect aside, it
9 wouldn't have escaped your notice, would it, that
10 Mr. Connolly, having departed for pastures new shortly 15:42
11 after he asked for a report for that patient who needed
12 to be reviewed on a regular basis because of her
13 history, that that report was missed in the somewhat
14 unusual circumstances where he had left and there
15 hadn't been any handover. But that again was a 15:42
16 significant case, because the review pointed out that
17 the scan should have been read in or about May or June
18 2013, but the patient wasn't summoned back to the
19 hospital, and it was only through the intervention of
20 her general practitioner in August 2014, recognising 15:43
21 the symptoms of deterioration in her condition, and the
22 risk of metastatic disease, that she came back into the
23 hospital. So, again, another, I suppose warning, that
24 these reports need to be considered.

25
26 And then we have the case of Patient 90. That was the
27 patient who died following surgery on 9th May 2018, and
28 you'll recall that case. That was a case where -- and
29 the Serious Adverse Incident, or Serious Events Audit

1 is set out at TRU-161137. That was a case where the
2 patient had an identified need to have his coronary
3 condition investigated by way of echocardiogram, and
4 you -- that was known from December 2016, when a CT of
5 his chest and abdomen revealed this potential 15:44
6 difficulty which would be a risk factor for future
7 surgery. He came into your care in June 2017, when you
8 listed him for surgery, and then he was operated upon a
9 year later in May 2018. Now, two points arising out of
10 that. In listing him for surgery, should you have been 15:45
11 asking questions or raising enquiries as to the
12 completion of the coronary investigations that were
13 indicated at the end of 2016?
14 A. Yes, I should have. I've stated that in my statement.
15 I mean it's important to point out that the patient 15:45
16 wasn't under my care in December '16.
17 226 Q. No. That's correct, of course.
18 A. Yes. And, you know, it wasn't requested by my team.
19 In fact I was on sick leave at that time. So
20 irrespective of whether it was requested by me, or even 15:46
21 by our own department, I still felt, you know, that it
22 was something that I should have been cognisant of.
23 227 Q. You say in your response to the incident that you had
24 no regrets in terms of the surgery itself, but you do
25 regret not sending him for a cardiac workup? 15:46
26 A. Yes.
27 228 Q. I mean just thinking, thinking through that, is that
28 distinction simply logically incoherent in the sense
29 that the obligation as a surgeon is to ensure that your

1 patient is optimally prepared for surgery, and this
2 patient wasn't, and if he wasn't optimally prepared for
3 surgery because he didn't have that investigation and
4 there was no pre-operative assessment in this case, he
5 simply shouldn't have been anywhere near theatre?

15:47

6 A. Mmm. Well I take your point, but one thing that I
7 didn't include in that report is that I parked my car
8 in a street in Portadown to go to a shop, I think the
9 Saturday week before, and I met him on the footpath and
10 he literally was in such severe pain because of his
11 indwelling stents, and he begged me to do his
12 operation. Now that doesn't excuse, as you said at an
13 earlier time, like we didn't plough ahead with his
14 operation. I did take -- I arranged for him to be --
15 attend the clinical day centre, I think it's called,
16 day clinical centre, to have a transfusion of blood
17 preoperatively. I did arrange for him to attend for
18 pre-operative assessment the Friday before, and I have
19 discussed this with the consultant anaesthetists on a
20 number of occasions since then, and in view of the
21 distress that the man did have with pain -- and the
22 consultant anaesthetist was happy to proceed. But,
23 looking back, I think actually that even more
24 importantly than his cardiac status was to establish
25 whether or not he had a bleeding tendency, because it
26 was the bleeding tendency that resulted in his cardiac
27 vulnerability coming to the fore and resulting in his
28 demise.

15:47

15:48

15:48

15:48

29 229 Q. And that was viewed by the reviewers in the SEA as a

1 major contributory factor in his demise.

2 A. Mm-hmm. Mmm.

3 230 Q. I suppose the general observation is that you had the
4 wherewithal to -- even though he wasn't initially your
5 patient, but you had the wherewithal, and indeed the 15:49
6 responsibility as the surgeon, to ensure that the
7 cardiac workup took place.

8 A. Mmm.

9 231 Q. There was a year between you putting him on the list
10 and the surgery taking place. 15:49

11 A. Mmm.

12 232 Q. In terms of the pre-operative assessment. We saw -- we
13 can see in the report the practical difficulties that
14 emerged around that. He presented himself at a certain
15 time that wasn't convenient for those who do the 15:50
16 assessment to complete it, and he went away and didn't
17 come back.

18 A. Mmm.

19 233 Q. But, again, that's something you would have, and your
20 anaesthetist would have been aware of as you brought 15:50
21 him to theatre?

22 A. Mm-hmm. Mmm.

23 234 Q. I wonder, Mr. O'Brien, because the issue of
24 pre-operative assessment emerged as an issue in respect
25 of your practice a number of years before that. If I 15:50
26 can refer you to WIT -- sorry, TRU-277928. And just
27 while we're waiting for that. Was it the policy of the
28 Trust that all patients coming in for elective surgery
29 should have some form of pre-operative assessment?

1 A. Yes. Whether it was a review of records to see whether
2 they actually did need a pre-operative assessment and,
3 next, whether it was a telephone call to update whether
4 the patient's health status remained the same as
5 previously, right through to the likes of that case 15:51
6 that we have just discussed which would have required a
7 much more -- probably actually it would have resulted
8 in his presence on the waiting list being suspended for
9 a period of three months to undertake all of that.

10 235 Q. Because the pre-operative assessment is carried out, in 15:51
11 theory, several weeks before the surgery. In this case
12 it was only I think about a week?

13 A. Or, indeed, with someone on the waiting list for a year
14 awaiting significant interventional complex surgery,
15 you know, and I'm not distracting from any criticisms 15:52
16 of me in relation to his management, but if you did
17 have a more fulsome pre-operative assessment service
18 one could have reasonably expected that it would have
19 taken place some time during that one year period, but
20 I'm not distracting from any criticism of me. 15:52

21 236 Q. Yes. This is an email 2015, Mary McGeough, to a range
22 of people, including Martina Corrigan, and it's
23 referring to a number of patients listed below the
24 email who are listed for the next day's surgery under
25 your care, and it says: 15:52
26
27 "As you will see, three out of the five patients have
28 not been to pre-op."
29

1 And she's being asked to investigate this. And it's
2 said:

3
4 "We are now in a position where we are unable to get
5 these three patients preassessed due to the extremely
6 tight timeframe before their surgery." 15:53

7
8 Was that issue of being unable to get your patients
9 listed in good time for pre-op assessment in advance of
10 theatre, was that a frequent difficulty you faced? 15:53

11 A. Well, I remember this particular instance very well
12 because this related to our day surgical unit, and you
13 will have heard from myself and others that we were
14 very, very limited in what we could do in day surgery,
15 and we were usually, therefore as a consequence, 15:53
16 operating on people who were fit and well for
17 relatively minor procedures like circumcision or
18 something of that nature. So I think actually that by
19 2015 I think there was an increase in the input of
20 anaesthetists and others into pre-operative assessment, 15:54
21 to the extent that they wanted to have everyone
22 subjected to a pre-operative assessment, whether it was
23 a determination that no pre-operative assessment was
24 required. Whereas previously, and up until that kind
25 of time, not everybody attending that day surgical unit 15:54
26 for relatively minor procedures would have had a
27 pre-operative assessment done. So we came to an
28 inflexion point at that time, and then subsequently,
29 you know, I assured or made every attempt to ensure

1 that there was a time interval adequate for
2 pre-operative assessment. And most people didn't
3 require actually any kind of assessment or review or
4 whatever.

5 237 Q. Well is it not the case that every patient requires an 15:55
6 assessment? It's a question of maybe not every patient
7 requires any further follow-up from the assessment?

8 A. No, not everybody required an actual assessment,
9 particularly in the day case scenario. And, you know,
10 we had such a restrictive provision in that day 15:55
11 surgical unit that where there was any hint whatsoever
12 that someone who was older, less fit, on other
13 medications, co-morbidities and like, for example,
14 ureteroscopy or whatever, they would all have been done
15 in the main theatre where they would definitely have 15:55
16 had a pre-operative assessment.

17 238 Q. We can see here Mrs. McGeough taking the issue of
18 pre-operative assessment seriously. She's saying,
19 "Right, essentially, I'm going to call a halt to
20 tomorrow's surgery for those three patients". But 15:56
21 equally we've seen with Patient 90, you proceeded on,
22 and your anaesthetist proceeded on with surgery in the
23 absence of a pre-op assessment.

24 A. Mmm.

25 239 Q. We've seen in the case of Patient 91, we briefly 15:56
26 mentioned on Monday the stent patient who ought to have
27 had a midstream urine test. I remind the note that it
28 wasn't your patient. But, again, no pre-operative
29 assessment to check for infection. The operation

1 proceeded, and the gentlemen, who had co-morbidities,
2 and there may have been a range of factors, but
3 certainly the presence of infection in that case, it
4 was a relevant factor according to the Serious Adverse
5 Incident Review. But can I ask you this, was 15:57
6 pre-operative assessment taken sufficiently seriously
7 within the Trust during your time there and by
8 practitioners such as yourself?

9 A. I think progressively over a long period of time it
10 was. I mean we introduced -- our department -- I 15:57
11 introduced, actually, preadmission assessment back in
12 the late '90s, where people -- actually we had a
13 preadmission assessment clinic on a Friday afternoon
14 where every elective admission of the following week
15 attended, had urine cultures, had specimens of urine, 15:57
16 for example, taken. Blood tests done, chest x-rays,
17 ECGs and so forth. That was way back in the late '90s.
18 That wouldn't cut the mustard with regard to the
19 standard of pre-operative assessment today. So from
20 that point in time up until this juncture, and later, 15:58
21 it was -- it was very impressive. There was, there
22 were rostered consultant anaesthetists who spent a
23 considerable part of their practice in pre-operative
24 assessment.

25 240 Q. You would agree with the proposition, I hope, that 15:58
26 those patients with co-morbidities who might be
27 regarded as being most at risk in theatre, deserved
28 particular attention by way of pre-operative
29 assessment.

1 A. Mmm. Mmm. Mmm.

2 241 Q. But yet Patient 90, Patient 91, both gentlemen with
3 significant pre-existing disease, managed to come into
4 the theatre and unfortunately died in the setting of
5 not having a pre-operative assessment. How do you 15:58
6 rationalise that?

7 A. Well I think actually, you know, I've described the
8 circumstances in which Patient 90 came in, and I made
9 comments on Monday with regard to Patient 91, and I do
10 believe that the lessons learned, which are entirely 15:59
11 valid, were not the most important lessons learned with
12 regard to that patient. If I had to relive the

13 pre-operative arrangements for Patient 90, I would do
14 it very differently, and I would ignore his pleas and I
15 would have ensured that -- I do hope, actually, that I 15:59
16 would have noted the CT that he had done in December

17 '16 under the care of a general surgeon and made the
18 necessary arrangement, which I did many, many times
19 with a fantastic Echo Department at Craigavon Area
20 Hospital, who did echos for me at the drop of a hat, 16:00
21 would have done it within a day. So. And also more

22 importantly, and I do think it is the more important
23 thing, is that he would have been referred to a
24 haematologist in order to determine his coagulation
25 status, because he had -- he had a haemoglobin of 86, 16:00
26 in modern parlance, when he attended for transfusion of

27 two units of packed cells on the day prior to his
28 surgery, and the following morning pre-operatively his
29 haemoglobin was still 86. There was something going on

1 pre-operatively. And I've done bilateral ureterolysis
2 many times since I trained in Dublin in the 1980s, and
3 the operation that I did that day technically was
4 faultless. That's cold comfort to the patient who
5 deceased and his loved ones. So it was those 16:01
6 background issues that were really important, and it is
7 so regrettable. I mean I met that man frequently in
8 Portadown because I know where he lived, and I regret
9 very much that the outcome was as it was, and if I had
10 to do it over again it would be different. 16:01

11 242 Q. Speaking for yourself, and obviously you can't comment
12 directly on the thought processes that occupied the
13 surgeon in Patient 91's case, but did you detect in
14 your practice, and perhaps more broadly across the
15 team, any sense of pressure to operate and get patients 16:01
16 through operations, because if they weren't operated on
17 today, they might lose their slot for some period of
18 time because of the resource pressures that you worked
19 in? In other words, was there any appetite for greater
20 risk with patients because of that environment? 16:02

21 A. I can only speak for myself because, as you know, I
22 scheduled all my patients myself. So I think I would
23 have been -- I wouldn't have been -- that wouldn't have
24 been an issue for me at all. I could have deferred
25 that man for a month, or whatever, and if I had to do 16:02
26 it over again that's what I would have done, and it's
27 regrettable the outcome that he did have, and I have
28 thought of him numerous times since then and his
29 family.

1 243 Q. Yes. 16:03

2 CHAIR: Mr. wolfe, I'm very conscious of the time. I

3 know you're going to move on to a new issue, but it

4 might take some time.

5 MR. WOLFE: Yes, I've also got one eye on what we've

6 got to cover on Friday. 16:03

7 CHAIR: Friday.

8 MR. WOLFE: So if it's okay with you, we'll continue

9 for maybe ten minutes.

10 CHAIR: Very well. 16:03

11 244 Q. MR. WOLFE: You've mentioned already, or you looked at

12 the sheet in front of you and we came to the

13 understanding that Patient 92 was another patient of

14 yours whose result was missed.

15 A. Yes. 16:03

16 245 Q. And she was found to have an abscess resolved, but on

17 scan it was found that there was a solid nodule

18 suspicious of renal cell carcinoma. That report, it

19 appears from the SAI Review, was forwarded to you in

20 March 2018. The report shows the communications to you 16:04

21 and your secretary, but they can't say whether it was

22 read by you.

23 A. Mmm.

24 246 Q. Have you any recollection of reading it?

25 A. I don't have any recollection of reading it, and if I 16:04

26 had read it, you know, it would have been acted upon.

27 I think it's important to appreciate the enormity of

28 the results that you get. Not just of radiological

29 investigations, and not just pathology, because

1 pathology is relatively a small number. Most people
2 only have, you know, one pathology report surrounding
3 an operation. They may have numerous blood results and
4 radiological investigations. So it goes back to the
5 reservations that I did have about all of this in 2011, 16:04
6 and whether one just has enough time, and whether the
7 system is robust enough to ensure that it can be relied
8 upon, and its regrettable that there was a delay of
9 three months, four months in her management.

10 247 Q. Yes. The general practitioner saw the patient in July. 16:05
11 He or she was able to access the NICAR and draw down
12 the scan report and, thereafter, made a red flag
13 referral. So in that sense, a careful primary care
14 practitioner provided a safety net that should have
15 existed within the hospital setting. The 16:05
16 recommendations arising out of that SAI, or SEA, as I
17 think it was, Serious Event Audit. TRU-162185. And
18 the recommendations include the need to develop a
19 system or a process for communicating, or better
20 communicating with clinicians where there is a risk of 16:06
21 cancer, and it points up the need for the Trust to
22 consider a single system process in which results can
23 be communicated. And, secondly, a fail-safe mechanism
24 that can provide reassurance that reports issued to
25 referring clinicians identifying cancer have been 16:06
26 actioned. We see that kind of recommendation flowing
27 through a number of these SAIs and, nevertheless, in
28 the absence of that you would have recognised a
29 professional responsibility?

1 A. Of course, yes.

2 248 Q. To make it your business, if you could, to see the
3 reports and action them. One of the safety nets
4 commended to the Inquiry by some of the witnesses we
5 have heard from was the DARO arrangement. If you had 16:07
6 placed Patient 92 on DARO when her investigation report
7 was available from Radiology, it would have rung a bell
8 within your office that there was a report available to
9 be considered, but you didn't use that system, is that
10 right? 16:08

11 A. Yeah. I mean I did use -- you know my reservations
12 about DARO.

13 249 Q. Just let me try to summarise them. You see DARO as
14 being the outworking of an inadequate system whereby
15 patients who you would like to review for good clinical 16:08
16 reasons are, in your eyes, shunted out, at least until
17 the investigation report is available. Is that fair?

18 A. No.

19 250 Q. No. Okay?

20 A. No, it's not. My fundamental reservation about DARO is 16:08
21 that it's not that results wouldn't be returned to the
22 requesting or the responsible clinician and that they
23 would be returned in a robust manner and a reliable
24 manner, and that the clinician would have time to deal
25 with them all, and in addition the patient should be on 16:09
26 a review list. That has been my fundamental issue.
27 And with the added caveat that the review actually in
28 many cases is more important than the viewing of the
29 report, and as you know, you know...

1 251 Q. Well let me just pull you up on some of that before.
2 How can the review be more important than the reading
3 of the report?
4 A. Well...

5 252 Q. They surely ought to go hand in hand so that if there's 16:10
6 something sinister within the report, you can't detect
7 that without an image or without pathology. You need
8 the report. You then sit with your patient in review
9 and explain the report and the actions that you would
10 recommend. Is that not the proper sequence? 16:10
11 A. Of course it's the proper sequence. That's what's
12 always intended, that a patient will have a CT scan in
13 three months time and they will be reviewed during the
14 following month.

15 253 Q. Yes. 16:10
16 A. I've been doing that for 28 years. That has been the
17 intended plan. But if I may refer to that email that I
18 sent in response to the diktat at the end January '19,
19 I believe, I think I sent it on the....

20 254 Q. So Mrs. McCall wrote to your secretary. 16:11
21 A. Yes.

22 255 Q. And your secretary sent it on to you and you responded.
23 A. Yes.

24 256 Q. So let's just look at Mrs. McCall's email first. It's
25 to be found at WIT-27887. And she's telling the group 16:11
26 of secretaries that:
27
28 "If a consultant states in a letter "I am requesting CT
29 or bloods and will review with the result" these

1 patients all need to be DAROed first pending the
2 results, not put on the waiting list for an appointment
3 at this stage."

4
5 So the important words there is she's quoting a 16:11
6 scenario where you have decided, or a colleague has
7 decided, "I will review with the result". That's the
8 important point, I think, that maybe missing from your
9 understanding of what she has said in your critique of
10 it that we find in your addendum statement. Is that 16:12
11 fair?

12 A. Well, it's not -- perhaps to a degree. But far more
13 importantly, when DARO was first established as arising
14 from the retained swab case, it clearly stated that
15 when a clinician requested a CT scan, or any other kind 16:12
16 of investigation, and did so, and couldn't decide on
17 the follow-up or adding to a waiting list, or whatever,
18 until that report was available, that's what DARO was
19 supposed to be used for.

20 257 Q. Yes. 16:12

21 A. But fast forward to 2019, that's not the case at all,
22 because it is the case, as is stated here, that all
23 patients who have any investigation done. But,
24 Mr. Wolfe, with respect, you know, I could take you to
25 ... 16:13

26 258 Q. Well what she's saying, it's in front of us,
27 Mr. O'Brien, and she's saying that if the consultant in
28 the particular circumstances where he wishes to review
29 the patient with the result, it's appropriate to

1 discharge and await that result.

2 A. Mmm.

3 259 Q. So that's no different to the Terms of Reference or the
4 operating procedure that flowed from 2010. She's not
5 saying you could not arrange for a review of the 16:13
6 patient tomorrow, but it's in that situation where you
7 need a result to determine your management plan and you
8 plan to review, that's when you discharge and await the
9 result.

10

16:14

11 The important point in principle is this, that in a
12 system that many would say is inadequate because it's
13 not granting patients the review that you, the
14 clinician, want in a timely fashion, where patients are
15 being shunted down the road before they'll get the 16:14
16 review, we need some mechanism to ensure, as a safety
17 net, that nevertheless clinicians are going to read the
18 results. And there are many other elements of the
19 safety net that one could point to, depending on the
20 circumstances. But you didn't use it and, therefore, 16:14
21 you lost that element of the safety net?

22 A. Well, for a start off, I used DARO long before DARO was
23 ever mentioned, because when I discharged a patient or
24 felt that discharge was now appropriate because the
25 patient no longer had a problem, but it was predicated 16:15
26 upon the result of some last investigation that I
27 requested, I used DARO. Also I didn't dictate after
28 that final episode. I waited for that result to come
29 back and I finished the whole thing with one singular

1 letter of dictation. So I did use DARO. And, in fact,
2 I did have patients on my DARO list as a consequence.
3 But the point that I was making is, and the example
4 that I gave ...

5 260 Q. Let me bring you, sorry, to your emails, if you need to 16:15
6 speak to it as well. Just on up the page, please.
7 MR BOYLE: I'm sorry, if I may? Mr. O'Brien was in the
8 middle of giving answer to a question which he was
9 asked, and I wonder...

10 MR. WOLFE: I'm just trying to assist the witness, 16:15
11 Mr. Boyle, with something he wished to draw our
12 attention to earlier. I've got your point.

13 CHAIR: Yes. It has been a long day.

14 MR. WOLFE: Yes. we'll finish DARO surely.

15 A. Yes. 16:16

16 261 Q. MR. WOLFE: It'll not take very long. If we just move
17 up to the email you wanted to refer us to? There it is
18 there. Just scroll up to the very top of it.

19 A. Yes.

20 262 Q. I'm conscious that you asked me to bring you to that 16:16
21 five minutes ago. Sorry for cutting across you.

22 A. Yes. Not at all. If I may just go down, I think it's
23 best exemplified by the example that I have given. So
24 if you could just scroll...

25 263 Q. Yes. You refer to a situation that happened to you 16:16
26 today, that day.

27 A. Yes.

28 264 Q. On a 37-year-old lady.

29 A. So basically, being brief about it. For the second

1 time I had managed to hopefully completely fragment a
2 stone in -- and it's called a diverticulum, it's an
3 outpouching of the collecting system of a kidney that
4 had been in a lady who had been having pain and
5 recurrent infections, and it was the only source of 16:17
6 infection that I could find. So I had to use laser to
7 burrow a hole into that stone, fragment stone. This is
8 the second time I have done it. I requested a CT scan
9 to be done three months later and I'll review her in
10 June. The whole point of her review is to see have I 16:17
11 actually cured her of her problem, irrespective of
12 whether the CT scan demonstrates that I have achieved
13 complete clearance of stone or otherwise.

14
15 So here's a case where the report of the CT scan is 16:17
16 almost irrelevant, not totally, but what's far more
17 important is her review.

18
19 Now, I have absolutely no problem with her CT scan
20 being returned to me in May, and hopefully me being 16:18
21 able to review it, and hopefully irrespective --
22 hopefully there was nothing new to be seen on it,
23 provided I was still going to review her in June. The
24 point that I was making in all of this is that both
25 things needed to be done, but as was pointed out to me 16:18
26 by Mr. Haynes at that time, only one of them could be
27 done. That is why -- that is the precise fact that I
28 had complained about. And I still believe that it is a
29 safety risk not to have patients on a review list in

1 addition to having a system whereby reports can be
2 returned to the requesting clinician, hopefully with a
3 view to being able to action those on which there is
4 something significant. That remained my -- that was my
5 position then and it remains my position. 16:18

6 265 Q. Yes. And the point, and I showed you the email
7 earlier, that was being made to you was, it was in the
8 specific scenario where you wished to review with
9 results that you were being directed to use DARO, and
10 in not using DARO, we've seen through a number of cases 16:19
11 that that safety net which DARO was designed to
12 promote, recognising the inadequacies of the system
13 where reviews weren't granted on a timely basis, that
14 you were losing out on, but all of your colleagues were
15 using it? 16:19

16 A. They were using a system which I believe was risky. If
17 you indulge me, could you take me to TRU-274539?

18 266 Q. Just say it again for the record?

19 A. TRU-274539. I hope I've got it right. And in fact
20 it's in my witness bundle at page 629. So here is 16:20
21 where Mr. Young in September...

22 267 Q. Paragraph 6 I think, is it?

23 A. What's that?

24 268 Q. Paragraph?

25 A. 6. 16:20

26 269 Q. 6. Yeah.

27 A. Yeah. 6 and 7. So he has discovered in 2015 that
28 patients who are referred and who are being triaged and
29 investigations requested, are not being put on a list

1 for a first outpatient appointment until the
2 investigation has been viewed by the requesting
3 clinician. Now this is the kind of unintended
4 consequence that I was highlighting in 2019, and I
5 still maintain of the same view. That should never 16:21
6 have happened. That happened again in 2019, four years
7 later, where patients being triaged, investigations
8 requested, were being DARO'd and not being put on a
9 waiting list for a first outpatient appointment.

10 270 Q. And clearly a training issue, as Mr. Young suggests. 16:21
11 This is a complete mistake and shouldn't have happened
12 he's saying. So your view is these unintended
13 consequences can happen and nobody adequately controls
14 them. But just to finalise on this point. Given your
15 experience of missed results jeopardising the safety of 16:21
16 patients, is it not remarkable that when the Trust
17 constructs this kind of governance arrangement, that
18 you decide to isolate yourself from your colleagues and
19 not use it?

20 A. Well I always had results or, yeah, results and reports 16:22
21 coming back to me without using it. The DARO, I take
22 your point, is that kind of robust system that makes,
23 you know, that hopefully ensures that all investigated,
24 all requested investigations are reported on, and read,
25 and actioned and so forth. That was never my issue 16:22
26 with DARO. My issue, I have already explained it, and
27 I had grave reservations about it from the point of
28 view of this safety risk that I associated with it.

29 271 Q. But if a patient needed -- just to finalise on this --

1 if a patient needed a review?

2 A. Yes.

3 272 Q. An urgent review. There would be no difficulty posed
4 by DARO in you arranging that and identifying a slot
5 for that patient. DARO wouldn't stand in the way of 16:23
6 that?

7 A. To bring the review forward?

8 273 Q. If you saw -- say in the case of that patient you
9 mentioned?

10 A. Yes,. 16:23

11 274 Q. No, it's not up on the screen in front of us. Where
12 you obliterated a stone and you needed to check on her
13 progress within a fixed period of time.

14 A. Mmm.

15 275 Q. You could decide "I don't need to see a report", an 16:23
16 investigation report, "I can review her in the absence
17 of an investigation report", and you could fix a date
18 for that.

19 A. Yes.

20 276 Q. DARO isn't so inflexible, or the system isn't so 16:23
21 inflexible that it would stand in your way of
22 consulting with that patient?

23 A. Except for the long review waiting lists.

24 277 Q. Of course.

25 A. Of course. Yes. 16:24

26 MR. WOLFE: Thank you, Mr. O'Brien. That brings us to
27 a close this afternoon. I'm sorry and grateful to you
28 for staying on that little bit extra. And we'll see
29 you on Friday morning.

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CHAIR: Friday morning, Mr. O'Brien, and everyone else.
Thank you.

THE HEARING ADJOURNED UNTIL FRIDAY, 12TH APRIL 2024 AT
10:00 A.M.

16:24