Urology Services Inquiry

Oral Hearing

Day 37 – Wednesday, 19th April 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

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CHAIR: Good morning, everyone. Apologies for the delay. I think our technical Tuesdays and Thursdays are moving to Wednesdays, but hopefully not.

I think we're ready to start, Mr. Wolfe. 10:29

MR. WOLFE KC: Yes, good morning. Your witness today, Panel, is Mr. Aidan O'Brien who, I understand, wishes to take the oath.

CHAIR: Very well. 10:30

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

MR. WOLFE KC: Good morning, Mr. O'Brien.

A. Good morning. 10:30

1 Q. Thank you for coming along to give evidence to the urology Inquiry. The first thing we need to do is have you adopt the witness statement you have provided some months ago. We can find it at WIT-82399. You'll recognise that, it's your response to Notice 68. 10:30

A. I do.

2 Q. The last page thereof is 82657, WIT-82657. There you'll find your signature.

A. That's it.

3 Q. Discussing matters with your legal team, there's two small corrections that you have notified to me through your legal team. I can tell the Panel they are not relevant to this week's business, and I understand from Mr. Boyle that we will have an addendum statement 10:31

dealing with those in due course. I'm content with that and we don't need to go to those amendments at this stage.

You're happy to adopt that? 10:31

A. I am.

4 Q. Thank you.

You also provided to the MHPS investigation, Dr. Chada's investigation, which we're primarily here 10:32 to talk about today, you provided two statements to her and some corrections to those statements. I want to draw the Inquiry's attention to those. The first arises out of a meeting with her on 3rd August 2017. TRU-00821. You'll recognise that statement, 10:32 Mr. O'Brien.

A. I do.

5 Q. And the last page of that is 829 in that series. 00829. This version isn't signed. 10:32

Just so that the Inquiry sees the form of this, you made comments to amend that statement, which you handed or sent to Dr. Chada in April 2018. I think it was 2nd April. We can have those up on the screen, please. AOB-01792. As the title to the document clearly 10:33 explains, they're your comments relating to your statement, Respondent's statement, of 3rd August 2017. That statement is to be read with the statement document I've brought up already; is that right?

A. That is correct.

6 Q. Are you content to have the Inquiry regard those two documents in combination --

A. I am.

7 Q. -- as an accurate account of what you're saying? 10:34

A. Yes.

8 Q. I'm obliged. Thank you for that.

Then we know that you met with Dr. Chada for a second time. That was 6th November 2017. That led to the 10:34 production of a statement and, again, a commentary document correcting aspects of it followed. Let's have a look at that, TRU-00830. Again, a familiar pro forma preamble setting out the attendees at the meeting and the date of it. 10:35

The last page, please, is 834 in that series. Again, unsigned. The comments you add are to be found at AOB-01794. They run to some several pages.

10:35

Again, Mr. O'Brien, bringing those two documents together in the same form as the August interaction with Dr. Chada, are you satisfied they represent an accurate account?

A. I am. 10:35

9 Q. The Inquiry understands this already, but your first encounter with Dr. Chada dealt with the first three elements of the terms of reference. The fourth engagement primarily dealt with the fourth element,

which was the private patients issues.

A. That is correct.

10 Q. Thank you.

Now, I want to begin by asking you just about your qualifications and career background. We can see from your witness statement, WIT-82436, at paragraph 6 that you graduated in medicine 1978 from Queen's University, Belfast, and went on to do higher professional training in urology, which you completed in June 1991, taking up a locum consultant role in Craigavon in the summer of 1991; a spell in paediatric urology in Bristol between September 1991 and June 1992, and then back to Craigavon in what is now the Southern Trust; isn't that right? 10:36 10:36 10:37

A. That is correct.

11 Q. You took up a position as a consultant urologist in what was then the Craigavon Trust on 6th July 1992?

A. That is correct.

12 Q. And you remained in that post until July 2020? 10:37

A. That is correct.

13 Q. For the Inquiry's convenience, there is, I suppose, an old CV from 1992 to be found in the documents. The reference for that - we needn't bring it up - is AOB-82662. It conveniently contains much of interest in Mr. O'Brien's academic career history to that point. 10:38

We also have your appointment letter and your original job description, Mr. O'Brien. It's not relevant for

present purposes to bring that up but just to assure you that the Inquiry has all of that material.

In terms of your role in Craigavon in what was to become the Southern Trust, you set out within your statement a number of the roles that you took up. If we could just briefly run through some of those, because it wasn't a case of being consultant urologist and nothing else, there was quite a number of strings to your bow and quite a number of demands on your time. Apart from what most people might understand as a purely clinical role, it was broader than that; isn't that right? 10:39 10:39

A. That is correct.

14 Q. We can see some of that and I'll just outline it. If we go to WIT-82438, paragraph 102. You refer here to your role as a lead clinician for the Urological Cancer MDT in the Southern Trust from April 2012; isn't that right? 10:39

A. That is correct. 10:40

15 Q. And you continued in that role until December 2016?

A. That is true.

16 Q. You were also Chair of the weekly multi-disciplinary -- sorry, multi-disciplinary meeting from April 2012 until September 2014 when the Chairmanship entered into a rotational format. You continued to act as Chair, albeit the baton was passed to a colleague or colleagues between meetings so you weren't the constant Chair; is that right? 10:40

A. I wasn't the constant Chair. We had to introduce a rota in preparation for the introduction of urologist of the week, because you couldn't have someone being a urologist of the week and possibly operating on an emergency case and having to Chair a multi-disciplinary meeting. So as lead clinician of the team, I introduced a rota in September '14.

17 Q. Paragraph 104, just scrolling down on to the next page. You also were appointed in January 2013 to the role of Clinical Lead and Chair of the Northern Ireland Cancer Network, or NICaN, clinical reference group in urology, a post you held through until December 2015; isn't that correct?

A. That is correct.

18 Q. Another matter - we needn't go to it - paragraph 111, you were clinical supervisor from time to time for the intercollegiate surgical curriculum programme?

A. That is correct.

19 Q. You explained at paragraph 107 - just scroll up to that - that during the years that you held these additional roles, the roles set out there, they were not accounted for in terms of time commitment and your job plan. Whilst you took on the additional duties, you were not given additional time by the Trust to perform them; is that right?

A. That is correct, yes.

20 Q. So, the duties of a clinician are set out in the job plan but these were additional tasks over and above the job plan which, if urology is to function well, both

within your home place, if you like, within the Trust, and regionally with your NICaN work, somebody has to take these roles on?

A. That's true. So, I was the one who didn't step back when it came to the regional post. It was proposed by the incumbent, who was leaving to take up a new post in Liverpool, that I would be suitable for that role of Lead Clinician and Chair of NICaN clinical reference group, and the secretariat of that group also asked me if I would do it and I said yes, if no one else offers. So no one else offered so I took on that role. It's not that I did it completely reluctantly, because I was interested in making a contribution regionally, it's also important to point out that that was in itself not a Trust appointment, but the Trust were aware, of course, that I was fulfilling that role. 10:43 10:43 10:44

21 Q. Was it ever a consideration for you, given the demanding nature of your clinical role within the Trust, that some of these duties were creating an unnecessary pressure for you, that objectively, perhaps, you shouldn't be taking on if you're seen to be struggling with aspects of your clinical role? 10:44

A. You're right. I thought about that at the time and I thought about it a great deal. I thought that the regional role with regard to NICaN was relative to Chairing the Trust's MDM, and being its lead clinician in that regard was relevantly minor even though we had a significant task ahead of us in terms of national peer review, which came up for the first time in June 10:45

'15. But I had been approached and I didn't feel that I was in a position to say no. I was approached, I was asked, it was proposed that I would take on that role. I think, actually, that there was an appetite within the organisation at that time to have that role filled by someone not in a clinical post in the Belfast Trust, that it would be good to rotate it out of Belfast. So, for all of those reasons, I said yes.

With regard to being Lead Clinician of our Trust MDT and Chair of the MDM, I gave that a great deal more thought, and I discussed it with Michael Young, the Lead Clinician at that time, for the very reason for your question. The only other person who could take up that post at that time was Mr. Glackin, who had just been appointed in 2011, and we both thought perhaps that's a heavy ask in your first year or so in a post. In retrospect, Mr. Glackin would have been entirely fit for it but it was a very, very demanding role. But I did give all of that consideration to it. 10:46 10:46 10:47

22 Q. Thank you.

Now, within your statement - and I don't mean to gloss over it but in the interest of time I'll mention it and you can come back with any comments - but you mention at paragraph 98 how you were the only consultant in Craigavon until January 1996. At that point, a second consultant came in. 10:47

As an illustration of how demanding your role was for those initial several years, and no doubt you will say since that, but certainly for those initial several years setting up the service, the Inquiry has from you a letter which you sent to Human Resources in March 1996. Just maybe put that up on the screen to show what you are saying. It is AOB-00018.

In this letter to Human Resources, you were pointing to the scale of your role and your commitment, and you were seeking a retrospective award of, was it two sessions per week, to reflect the extra hours which perhaps nobody had foreseen in establishing the service?

A. Yes, I think that's correct. I mean, I was advised to do that by the Chief Executive at the time. It was, I think, for the organisation a rather unique situation to find themselves in, some one single-handed person providing a continuous service for a significant period of time really, three and a half years until 1996 when Mr. Wahid Baluch was appointed. So, apart from occasional short breaks from elective surgical provision, I provided a continual emergency service provision during that period of time. So, yes.

23 Q. And that was a strain?

A. Oh, it was continuous. I did get one break out of Northern Ireland for a week in 1995 when one of my more senior colleagues in Belfast provided cover to enable me to go to the American Urological Association

meeting. Apart from that, I would stay at home within Northern Ireland and take a break from elective work but I was on continuous emergency. It got increasingly busy from zero to a very busy place within a short period of time.

24 Q. One of the things that we should mention is your Clinical Excellence Award in 2009. We can see reference to that at AOB-00121. 12th April 2009. Just scrolling down, the Medical Director, Mr. Loughran, is telling you that the Local Clinical Excellence Awards Committee met on 23rd March 2009 to consider all consultants who submitted an application for an excellence award, and he was pleased to confirm that as a result, the committee have decided that you should receive an award effective from the previous year.

What, Mr. O'Brien, to elaborate on that, is that kind of award reflective of, in your view?

A. Well, I think actually it's the only time -- I think it's the second time I had been awarded such an award. They were previously called discretionary points or discretionary awards. I felt that was a more honest description of the award because it was at the discretion of others that you would receive such an award. Frankly, I didn't like the process of applying for a Clinical Excellence Award. I always thought excellence was something, you know, that one is always in pursuit of. I just didn't like that. It was the last time I applied for one. I think it is just

a general recognition of your clinical standing, your clinical ability and probably the contribution that you have made to the organisation to date.

25 Q. Thank you. Can I take you back to something you've said in your statements about the context in which you were appointed as a consultant urologist. You refer to your discussions with the Chief Executive, Mr. Templeton -- 10:52

A. Templeton, yes.

26 Q. -- at that time, and you reflect on what I take, what you interpreted anyway, as something of a struggle with the Board to try and get recognition that Craigavon required a urology service. I suppose, correct me if I'm wrong, it set something of the tone, at least in your mind, for how urology was to be regarded even up until this day. Is that a fair summary, before I go to the material? 10:52 10:53

A. That is a fair summary. We are where we started.

27 Q. If we just go to WIT-82406. At paragraph 25 you begin the process of setting out that view in your conversation with Mr. Templeton. He wanted assurance from you. This was in the context of you having done some locum work in the summer of '91, was it? 10:53

A. That is correct, yes.

28 Q. He thought it appropriate, is it fair to say, to have a full-time consultant urologist appointed. You're explaining there that he wanted a commitment from you that you would apply for the post if it ever came up. He explained that he would not be prepared to go out on 10:54

a limb to secure approval without having a guarantee of having one appointable person to apply, so you gave him that undertaking?

A. That is correct.

29 Q. Then if we scroll down, please, on to the next page. You explain that - the penultimate sentence in that paragraph - it took a further eight months, you say, it appears, for the hospital or Mr. Templeton to convince the Director for Public Health of the Southern Health and Social Services Board of the need for a consultant urologist. 10:54 10:55

You take up the theme at paragraphs 29 to 30. Maybe it is more particularly set out in 30. You're making the point that within your statement, you're going to explain that what has already been described in this Inquiry as a demand/capacity mismatch was there from the start. If I'm summarising this inaccurately, correct me, please. You're saying that that is, in many respects, because of all that did go wrong and all that could have gone wrong were it not for the commitment and efforts of those charged with the provision of the service? 10:55 10:56

A. That is absolutely correct.

30 Q. Is it within this paragraph you reflect the view that urology was seen as, I suppose -- well, urology issues were seen as predominantly a male pathology, and you, I think, reflect the view that there's - again, correct me if I'm wrong - almost a bias or built-in lack of 10:56

favourable treatment for the service which wouldn't be there if it was a female pathology?

A. That's my belief, but that's not just a local experience, that's a national and international experience. I've no doubt about that whatsoever. 10:57
I mean, 70 percent of adult urology patients are male. I'm not an historical authority but I think in terms of the United Kingdom, the only time that men did have an advantage in terms of healthcare provision was when British soldiers serving in World War II were awarded, 10:58
or provided with, access to free dental care. It lasted for a year until their wives very successfully succeeded in getting the same free dental care. So, yes, I do think that that has to be stated. I do believe it to be the case. But it's not just a local 10:58
issue.

But there are several factors, there's the emergence of a specialty, the belated emergence of a specialty from under the cloak of general surgery. I think that there 10:58
was not only, as you have already pointed out, the absence at the level of public health of an awareness of the need and how that compared with service provision throughout Europe, but there was a very, very limited, restricted view amongst the general surgical 10:59
establishment of what exactly urology meant, and I think I've made some reference to that as well. So, you had the combination of all of those things to have a situation where the Director of Public Health didn't

even think there was a need for such a service with a population at that time of 269,000 people, and with a consultant urologist to population ratio throughout Western Europe in the 1990s of roughly one to 53,000. If Northern Ireland had been a sovereign country or were a sovereign country, we would have been at the bottom of the European league with the Republic of Ireland just above that and Great Britain just above that. So, that's where we have been for 30 years. 10:59

Forgive me if I sound rather rhetorical, but at the end of Section 21 it asks you to reflect on what went wrong, but it's been wrong from the very start, it just got worse. 11:00

31 Q. Yes. We can see, certainly within the first substantial section of this Section 21 response, that you reflect in great detail, Mr. O'Brien, about the working environment in which the transformation of urological need into demand hasn't been met, in your view, because capacity of the service has been so inadequate. 11:00 11:01

You give a number of illustrations of that. For example, at paragraph 43. Just scrolling down. Yes, thank you. You talk about the inadequacy of operating capacity against a background of increasing elective referrals. 11:01

At paragraph 45 you reflect the disparity between an

increasing need for review facility or review appointments, and an incapacity or inability to meet that demand.

Is it purely financial, Mr. O'Brien, or is there a series of systemic issues, or is it alternatively a bias, a blind spot in failing to realise the importance of this, or is it a combination of all of that? 11:02

A. I think it's a combination of all of that. If there is a complete absence of a service, then it's very easy by definition not to see the service. There is no need for a service that doesn't exist. It's only when a service, even grossly inadequate, as it was with me for the first three or four years, and even when there were two of us for a lot more years, does need transform into demand and demand grossly overwhelms the capacity. Then you end up with all of these distortions that you may go on to point out, such as there being no increase in operating theatre capacity in conjunction with an increase in staffing. So whereas I had four, five, and at a time six operating sessions per week if I was lucky, but I certainly had four, that was my allocation when I was a single-handed urologist. When a second one was appointed in 1996 and subsequently replaced by Mr. Michael Young in 1998, there was no commensurate increase in operating theatre capacity. 11:02 11:03 11:03 11:04

So, you have the back end of the shop where very little is happening, and the emphasis politically is to get more people in, and it's called integrated elective access protocol. It doesn't look good at the front, so you get them in in equal measure, in a nondiscriminatory measure, then you tell them you're not going to get it at the end of the day, we're just going to put you on a list, which gets longer and longer and longer. Whereas if you look at the likes of myself or, if I may say so, Mr. Hanbury in mainland Europe, the emphasis was on operating and being there at the back of the shop actually providing the service that people ultimately needed. 11:04 11:04

But that wasn't the case when you have such an inadequate service. But it's a big political issue. It's about taxation, it's about funding, it's about social priorities and all of that kind of thing. 11:05

32 Q. You will no doubt appreciate that the scope of today's proceedings into tomorrow doesn't allow us the time to ruminate to any significant degree on these issues. You will again appreciate that the Inquiry has your statement in that respect, and the Panel may later have some further questions about the environment in which you had to work. 11:05 11:05

Just continuing further along for a little bit longer in this. You say at paragraph 75, if we go down to WIT-82428:

"While it would indeed appear to be 'bizarre" to the uninitiated or those without longer experience, I find it entirely familiar and consistent with the success with which Trusts have been able to transfer all responsibility for the consequences of inadequacy to clinicians".

What do you mean by that phrasing?

A. Well, I think this paragraph is preceded by some other paragraphs. 11:06

33 Q. Yes, it does?

A. I see the italics above that refers to the contents of an email sent by Mark Haynes in 2019, I think. It's about, you know, I've tried to portray as comprehensively as is possible the consequences for everybody that arises due to inadequacy. I have talked about the DARO System, for example. If you see 100 people as new patients and you might not want to see 20 of them after that date but you want to review 80 but there's not the capacity to do that, you have to find some kind of safety measure or safety net that has been referred to at great length. So, who is responsible for the safety net? It's the same small number of consultants who are running to standstill providing the safety net. 11:07

Progressively you will find that measures are taken, sometimes without intent. Sometimes there are

unforeseen circumstances and consequences whereby the responsibility and the accountability for everything that arises due to inadequacy is progressively transferred to those few people who are providing it.

34 Q. Whereas you say in your second point there, I think paragraph 75, that really the responsibility should lie with the commissioners and the Trusts to put in place a proper service as opposed to devising, if I understand you correctly - I'm putting these words into your mouth as opposed to mine - is sticking plasters and putting them in the hands of clinicians to operate and police when you have many other demands to meet. 11:08 11:08

A. Absolutely. I mean, in a sense the Trust is the provider and the Trust will provide what it has had commissioned of it, and there's very, very little autonomy and independence of the provider from the Commissioner. The Commissioner will do what is regarded as the Department's policy and agenda, often expressed as ministerial targets and so forth. It is a circular argument because Trust commissioners and department and ministers, they're part of our society and, you know, different societies have different socio-political priorities. You see that throughout Europe. 11:09 11:09 11:10

Sometimes I think actually if the UK and Ireland weren't islands and were attached physically and geographically to mainland Europe, it would be an awful

lot more difficult to have such inadequacy compared to mainland Europe because it wouldn't be tenable if you can drive across borders. So, we have a major problem and there's a major problem, as we're all aware of - but we're not here to talk about the wider picture -- 11:10
but I'm a urologist, I have been for a long time and that's always been my interest, and I haven't really been particularly interested in any other speciality as such, but we have a major issue with regard to urological service and trying to meet the need, and it 11:10
is grossly inadequate. I mean, it is exceptional by national standards. It doesn't pertain in Great Britain. I have many friends who are urologists in Great Britain. This is a foreign country when it comes to urological service provision, and we're not even 11:11
comparing the UK with our international comparators in that regard.

You know, this is not the place to be, you know, subjective about it, but it really is little short of 11:11
being scandalous, the kind of service that has been provided and is being provided.

35 Q. Obviously you've put the time into explaining this in your statement and we're dwelling on it for some time this morning because this is the environment in which 11:11
you had to work and in which your perceived shortcomings - at least perceived by the Trust and we'll look at those shortly - in which those shortcomings arose.

You say at paragraph 95, WIT-82435. This rounds off that particular section. If you just go to the bottom of the page, please. Thank you. This paragraph rounds off this section of your statement that has set out 11:12
those contextual factors that we've spent probably too little time talking about this morning. You say:

"Since my appointment in 1992, I have endeavoured to the very best of my ability to provide the best care 11:13
that I could possibly give to the maximum number of patients whom I considered were in most need of it at any particular time. I regarded it as a vocation and a privilege to do so. However, I have endeavoured in this general narrative to describe the inadequacy of 11:13
the urology service provided by the Trust, and the relentless burden carried by me and my too few colleagues to maximally mitigate the risks of patients coming to harm due to that inadequacy. I have worked far beyond any contractual obligations, as has been 11:13
acknowledged. I have worked when on leave and even when on sick leave. I have tried to do the impossible, but the impossible proved not to be possible. I hope that any failings on my part may be viewed in this light". 11:14

As we look at issues such as triage and dictation and that kind of thing, that's how you wish your actions or inactions to be viewed; is that fair?

A. That's very fair, yes.

36 Q. We can see, just finally on this broad area, that, I suppose, the service of urology and these resource and organisational shortcomings which you've described not only affected consultant urologists but also affected nursing staff, for example. If I could just bring up on the screen, please, AOB-75761. Catherine Hunter was the ward manager for Ward 3 South, which, and forgive the expression, housed urological patients, but also ENT patients and -- 11:15

A. And some medical patients, yes.

37 Q. -- some medical patients.

She is writing on 12th November '15 to Esther Gishkori, who was the Director of Acute Services at that time, 11:15 copying in a range of people, including yourself, the other consultants and some others about her concerns as ward manager. I suppose it might be described in summary. Maybe if we just scroll down the page and on to the next page, she sets out in a lengthy document - 11:16 it runs to five or six pages - a concern, forgive the summary, but an unsafe ward where there's a significant shortfall in nursing capacity and she's looking to see what management would do about it.

A. That's right. 11:16

38 Q. In your view, was that a snapshot in time that was, if you like, temporary and passing, or is the narrative that she presents typical of a service that was in difficulty in terms of its resourcing for a number of

years?

A. For a number of years. It was not temporary. Without dwelling longer than you might want me to do, we did have a very healthy situation with regard to inpatient care with our own ward, Ward 2 South, from 1992 when I started, until 2009, when we lost it effectively and our patients were scattered throughout three other general surgical wards. That resulted in a lot of our experienced staff, whose experience and skill we had spent all of those years building up and developing, they left. Thereafter, we had a progressive slide and deterioration in the quality of inpatient care, which concerned not just me but all of my colleagues. It is not insignificant to point out that this was written in November '15 -- 11:17 11:18 11:18

39 Q. Yes.

A. -- which rather coincides the period when you will want to discuss triage or the lack of it. And, indeed --

40 Q. Sorry to cut across you. This was, just to put it in the chronology, this was a year into the introduction of urologist of the week approach? 11:19

A. That's right, yes.

41 Q. If we just scroll down, it may just be useful to illustrate a little point -- I didn't mean to say a little point, one of the main points in the lengthy document which she wishes to illustrate. She is showing the current deficit in nursing availability. Obviously there's an effort to redress the gap by using bank or agency staff. They appear to be substantial 11:19

numbers?

A. Yes.

42 Q. How does that problem on the ward impact the urologist of the week? The urologist of the week, as I understand it, was intended to provide a facility whereby resource would be directed to optimising patient management. 11:20

A. That is correct.

43 Q. Inpatient management?

A. Inpatient management. So, in fact actually from 2009, since we lost our own ward at Ward 2 South, which really was the first negative deleterious knock that we got in the service. Everything up until then, though inadequate, was moving belatedly in a dilatory manner in the right direction. But the loss of the ward was a significant blow. As I said, our patients were scattered over three wards. But then, after that approved to be disastrous for our patients, then they were concentrated in Ward 3 South. But we never recovered from that. 11:20 11:21

With increasing concern about the quality of inpatient care, that played no small part in our increasing need for urologist of the week. I was very, very keen to have urologist of the week introduced. We really felt that calling in to see your patient or being on-call parallel with this kind of situation, with nursing care, was dangerous. So, eventually urologist of the week. This is one year later and she is pleading with 11:21

us and she is pleading with her line management to have this situation addressed.

44 Q. Yes. It is fair to say that management do respond, at least in writing. Whether the response is satisfactory is for others to judge. But we can see that 11:22
Mrs. Trouton writes, I think it is the next day, 13th November. AOB-75791. I won't bring the Inquiry to this but below this email are all the various representations that Mrs. Trouton has been sent from other nursing staff, and indeed from Mr. Haynes if we 11:23
were to scroll down. But Catherine Hunter, the ward manager, had taken the lead on this and this is Mrs. Trouton's response. Obviously Mrs. Trouton has to work within certain parameters which aren't of her making but she indicates that: 11:23

"Please be assured that various staff members are working to address the concerns. But there is a very real shortage of qualified staff nurses regionally and nationally and it is currently a real challenge to 11:23
recruit qualified nurses permanently to this or any ward. There are, however, further recruitment strategies planned and we would hope that this will yield successful recruitment soon. That said, we do have some options for improvements to the current 11:24
situation in the intervening period."

It was, and possibly remains, Mr. O'Brien, a complex problem that has yet to be resolved fully.

A. Well, I don't know what the situation is like now because I haven't been there for three years, but it didn't really improve significantly. You know, sometimes this kind of situation can be portrayed inappropriately as a conflict between the agitators, whether it is a nurse or doctor, and managers, but if you can't recruit people, you can't recruit people and you depend on locum agencies. It is a very, very worrying situation but this is what happens. It doesn't happen overnight. You know, the big issue there -- I don't think we would have been in that position if we had not had our ward taken from us in 2009 because we gave great priority to inpatient management. My colleague Michael Young, and Mehmood Akhtar at the time, and myself, a former boss of mine in Dublin when I was training, he is long deceased he was president of the Royal College of Surgeons, he said the inpatient ward is the cockpit of your service. If you don't have everything right there, it doesn't matter what you do in your operating theatre or in the outpatient clinic because, in due course, people will not want to come to you if you can't care for them.

11:24 11:25 11:25 11:25

This was a priority item. It had been allowed to slide. It was a disaster losing the ward. In general terms, with the loss of that ward, it was one of four surgical wards so we had a 25 percent reduction in inpatient beds. But that's the kind of global

11:26

circumstance that...

45 Q. It's within that context, Mr. O'Brien, that we will turn to look at the MHPS issue, which we're primarily here to address over the next coming days. You will appreciate that this module is focused on the MHPS investigation and we anticipate that we will have you back, perhaps in the autumn, to look at some other issues. For our remaining time together, we'll be looking at your engagement with the MHPS process and your response to it. We'll be looking at how your practice was perceived and whether the perception of shortcomings in your practice was, in your view, a fair judgment. We will take the opportunity, I suppose in passing, to hoover up some other issues such as your job planning, your relationship with Mr. Mackle, your relationship with Mrs. Brownlee, and various other issues. 11:26 11:27 11:27

I think, Chair, if it's convenient, we could take a short break now and start into that after that? 11:27

CHAIR: Very well. If we rise now and start again at a quarter to twelve.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 11:28

CHAIR: Mr. Wolfe, ready to continue?

MR. WOLFE KC: Yes. Thank you, Chair.

46 Q. Now, Dr. Chada, Mr. O'Brien, completed her report by 21st June 2018, and on 10th July you supplied

a response to that report having had an opportunity to consider it, and that response was delivered to Dr. Khan; isn't that right?

A. No, I think it was delivered to Human Resources because Dr. Khan was on extended leave at that time. 11:45

47 Q. I understand. It was for --

A. For Dr. Khan.

48 Q. -- for his attention --

A. Indeed.

49 Q. -- as case manager, I should have said. 11:45

If we can take some time to look at that document, AOB-01879. That's the document. It may appear a little unusual, Mr. O'Brien, to be starting at the end of the process with you but we will turn and go back to 11:46 the start of the process. The point here is to see what you made of the allegations by the time of the report's delivery. On the issue of the report's terms of reference, can we go to AOB-01893. Obviously a lengthy document. It takes some time to set out some 11:46 historical context, a little like we've been doing this morning. In terms of the terms of reference, you worked through the five aspects of those terms.

Let's start with triage, as you have. You said: 11:47

"I do accept that I was not undertaking triage of non-red-flag referrals". You say: "I have been clear since the outset of this investigation that I was not

doing so because I found it impossible to do so".

The background to that is explained above. You say that:

"Triage is a vitally important process to ensure the patient's management is initiated effectively and to ensure that patients are correctly categorised. It is my belief that sometimes triage is necessary if the consultant urologist is to bring the value of his or her specialist expertise to the process, and that means triage becomes time-consuming. I believe that it would be beneficial to the department to allocate sufficient time for the consultants to complete triage effectively. I've raised this issue as part of my response to the SAI and I hope that the Trust will address that issue as soon as possible".

That was the response to the Patient 10 SAI; isn't that right?

A. That is correct.

50 Q. In those two paragraphs, and obviously you say much more about it, we see reflected your view that you found triage of non-red-flag referrals to be impossible to perform during your period as urologist of the week. You do not underestimate the importance of triage, it being important for it to be done for reasons that we'll look at, but you need sufficient time to be able to perform that task?

A. Yes. I would also qualify that by saying that we needed to sit down around a table and agree exactly, clearly, in writing, what it was that was expected of those doing triage. What was expected. It may not necessarily have been consultant urologists that were doing triage at all, it could have been others. So, yes.

51 Q. The impossibility of doing triage, as you've described there, that impossibility, if we unpack that a little, that derives from your view of how triage is to be performed; isn't that right? 11:49 11:50

A. Yes. And before dwelling upon that, I should clarify, which I haven't done really entirely when I read that, and that is it's not that I didn't do any non-red-flag triage whilst urologist of the week; I did some, I did as much as I could find time to do. But I certainly found it impossible to complete it, and I made that very clear. 11:50

To expand in response to your question. Yes, I found it very, very difficult as a clinician to read a referral letter about a 60-year-old woman with recurrent urinary tract infections who had no features or signs that would indicate upgrading to red-flag status; had no imaging done; had, if you look on ECR, had been on four antibiotics in the previous six months, one week each, she's no further on. Even if I label that as urgent, it may not be seen for a year and a half. How do you read that? Do you take 11:50 11:51

responsibility for it? I felt that we should, as clinicians, or that we should have a department that takes some kind of clinical responsibility and ownership of that lady's situation.

11:51

I felt, actually, that -- I always felt and found that if you put that effort in at the start, it pays off. Because if you organise that ultrasound scan and it's fine, and if you prescribed a prophylactic antibiotic for six weeks or two months or whatever it may be, and 11:52 by the time you see her the first time, (A) she has no other pathology on the scan and, secondly, she's cured and you give advice and she's discharged. Or, alternatively, you may find she has a bladder tumour or a kidney stone and you're finding it out a year and a 11:52 half before it would be found.

52 Q. So that's the problem, pathology in perhaps many cases coming in to you as urgent or routine referrals.

A. Yes.

53 Q. Your decision in very many cases is not to triage them 11:52 at all?

A. Well, I mean, I found it impossible -- I couldn't spend that 10 or 15 minutes on I would say 50 to 70 percent of the non-red-flag referrals, ordering investigations and prescribing or speaking to the patient. If you 11:53 have, let's say 150 referrals per week and let's say 100 of them require 10 minutes each - please work that out for me in terms of hours - if you do that, you're going to compromise inpatient care. I think I have

expressed that clearly. I have observed it; it does happen. You cannot spin two plates at the same time, it just doesn't work.

54 Q. Could I put to you this perspective. It is contained within the SAI report concerning Patients 11 to 15. 11:54

If we have up on the screen, please, PAT-000417. You are consultant 1 for the purposes of this report. The report says:

11:54

"Consultant 1's chosen method of triage was beyond what was required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the review team realised this was a detailed triage process, they 11:55 concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment of other patients. Consultant 11:55 1 is aware of this.

"The review team concluded that consultant 1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while 11:56 others ran the real risk of having a cancer diagnosis delay until it was dangerously late".

If you just scroll down the page, please. Further

down.

The review team note that the consultant of the week workload, including ward rounds, clinics, emergency theatre sessions, was a contributory factor. 11:56
"Consultant 1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the consultant of the week. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other consultant 11:56
urologists were able to manage this workload and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to 11:57
outcomes achieved from consultant 1's 'advanced triage'".

There's two perspectives, it appears, Mr. O'Brien. You are doing it in a way that you think appropriate, or 11:57
you want to do triage in a way you think appropriate, but for many, many urgent and routine referrals you find that if I can't do it by way of that methodology, I'm not going to be able to do it at all. Is that a fair summary of your approach? 11:58

A. Yes, but it's not just as black and white as that, you know. I've listened to very many witnesses placing great emphasis on the fact that I lift the phone and speak to a person. But if you want to arrange an MRI

scan, you have to speak to the person actually to assess their compatibility for MRI scanning.

I have listened to various narratives with regard to the ability or the practice of my colleagues in the conduct of triage whilst being urologist of the week, from it being, you know, we don't do that, or they do do that and they do varying things at varying times and so forth. I mean, I think it is somewhat of an irony. I think, you see, the problem is that in the introduction of urologist of the week, there was undoubtedly a belief that this urologist of the week is going to be the least occupied person of the team because the others are going to be doing all the work and we'll going to be twiddling our thumbs and we'll have piles of time to do this. Within a short period of time, months, there was a general acceptance, in fact, that this person is the busiest person. You know, I just found that I couldn't do what I felt was required. I felt that there's something fundamentally wrong, if I just use that simple example, of not dealing with the lady with the recurrent urinary tract infections.

11:58
11:59
11:59
11:59

If you look at - and forgive me, I'll give you the - yes, Patient 2. Patient 2 is referred in November '18 as a routine referral with left epididymal testicular pain. He was triaged by the urologist of the week; kept as routine. If that had remained the case,

12:00

he would have received a first appointment about August/September 2021. Fortunately, he also suffered from ankylosing spondylitis, so a second referral was sent, which I picked up in April/May '19. What did I do? Did I respond just by making it urgent and instead of waiting two-and-a-half years, he'll just wait one-and-a-half years. No, I got an ultrascan done. That is a person with a testicular tumour which has been considered as a Serious Adverse Incident. That is the situation I found myself in, and there are many more of them. 12:00 12:01

There are many 60-year-old ladies who have had their bladder tumours resected and have had their chemotherapy before they would otherwise have been seen. 12:01

55 Q. But the other side of the coin, Mr. O'Brien, is that with Patients 11, 12, 13, 14, and 15, you put those referrals in a drawer and didn't take any steps by way of triage, any variety of triage, and they went on, each of them, to develop cancer in circumstances where the information on the referral, had it been looked at, would have led to an escalation from routine in one case, urgent in four of the cases, to red-flag. Do you accept that? 12:01 12:02

A. I do accept that, yes.

56 Q. Do you accept that failing to triage routine and urgent referrals creates a risk of harm and in some cases may lead to actual harm?

A. Of course.

57 Q. Do you accept that in those five cases, a risk of harm and a delay in treatment was the common factor across four of the cases, and actual harm in the case of one of them, Patient 13, was the upshot of a failure to triage? 12:03

A. I mean, I'm not dismissing for one moment the risks of patients coming to potential harm or to actual harm. Actual harm has had various definitions as well. I didn't appreciate that Patient - forgive me - 13 was considered ultimately to have come to actual harm as a consequence of the delay in his triage. 12:03

58 Q. Certainly within the context of the report. I'll pull up the reference, maybe later. I'll come back, maybe, and use the phrasing that they use in the report, in all fairness. But there was a deeper concern about the delay in his case -- 12:04

A. Absolutely.

59 Q. -- compared to the other, perhaps to put it somewhat more fairly. 12:04

It's your perspective that you recognise that in not doing triage and in failing to pick up on the need to upgrade the referral from, say, urgent to red-flag, creates in some cases a risk of harm. But your response to it, at least in part, is, well, I don't have the time to do meaningful triage, triage that might make a meaningful difference in many cases, so I won't bring any level of triage or expertise to bear 12:04

on the subject?

A. Once again, I think that -- I mean, I'm not dismissing the significance of triage. I contributed greatly to, at a regional level, emphasising at that point in time back then, let's say 10 to 13 years ago, that perhaps 12:05
consultant urologists were those people best able to undertake triage rather than considering others like junior staff, staff grades or clinical nurse specialists. I do appreciate everything that you are saying in that regard, but what I'm also saying is 12:06
I found the situation whereby, as urologist of the week, if you started a ward round at nine o'clock, if you had 32 patients in a ward, if you actually had to go and see 10 outliers during the course of which you had to deal with referrals of an acute nature from two 12:06
other hospitals in your geographical area, and take five cases to theatre and leave at two o'clock in the morning in order to get some sleep. Now, the alternative is that you defer the surgeries in order to do that meaningful triage. I appreciate everything 12:07
you're saying. Or you don't do the ward round, or you don't go to theatre. And that's how it was done and I didn't believe to be right. I wasn't the only one who felt that was not the raison d'être, the whole purpose of being urologist of the week. The whole 12:07
purpose of being urologist was to try to ameliorate, to try to mitigate the risks that Catherine Hunter described. It was not -- it was unfortunate. I agreed to it actively to include triage as urologist of the

week in order to get urologist of the week across the line, because at least it was a better option than doing a clinic because the clinic is at a fixed time whereas, whereas at least you could triage at two o'clock in the morning. 12:08

So, I do appreciate the perspective that has been formed. As an individual I have worked very, very hard and I have always had patient care at the centre, but the most important patients that you have as urologist 12:08 of the week are the inpatients. They are the critically ill. You should not be sending a junior registrar to deal with those people whilst you triage. There's something fundamentally wrong about that. 12:08

So by, I think it was March, I don't have a record of the meeting when we all met and when we were informed of the informal default process, and I made it very, very clear that I had found it impossible.

60 Q. I want to come to that aspect of the narrative later. 12:09 Could I ask you this just in terms of the impossibility, as you put it. There is always an opportunity, is there not, to work in a different way to bring different methods, different levels of intensity to the task at hand. Your colleagues, and 12:09 you may look unfavourably at their approach to triage, but whatever standard they brought to it, they were getting it done, they were processing the cases. As the SAI suggests, they were in many cases organising

investigations, moving the thing along. It wasn't just a traffic light system, as I referred to it yesterday, for some; perhaps all of your colleagues. Why could you not evaluate what you were doing in order to fit within the demands on your time and the resources available to you?

A. You know, I think that for years I had been doing that. I think you indicate that there's always a possibility. I think it had come to a stage that it was no longer sustainable. I think language is very, very important. I thought that Mr. Haynes, when he was writing to Esther Gishkori in October '18 when he was considering resigning from the post as AMD, he talked about the Trust's "institutional blindness to unmeetable expectation". There comes a time when you have to say this situation I have found, all I was dealing with was I have found it to be unsafe, I cannot do it to the extent that I believed it should have been done. That's what I stated.

61 Q. If we go to the page 000401, PAT-000401. It's just a little earlier in that document. You will see the description here of each case. I won't read out the initial. We have the cipher for each patient. The first patient referred to here is Patient 13. If we just scroll down, please, he was referred with an episode of haematuria. The referral was marked routine by the general practitioner. The letter was not triaged. He was placed on a routine waiting list. It was recognised that this was an incorrect referral.

The conclusions reached are that the resultant six-month delay in obtaining a diagnosis - and there's a correction to the record in terms of how I described it earlier - what the SAI review team found is that it is probable that the delay is clinically significant, time will tell.

Just taking that as an example and building it into your duties as urologist of the week, you've got red flag referrals to progress during that period of your working week and you're doing them. There may be issues about delay sometimes with them but they are being done. You've said this morning - and I wasn't aware of it until you said it - that sometimes you find yourself able to do routine or urgent referrals. 12:13 12:13 12:14

A. Oh, yes. Yes.

62 Q. Very well.

This one is in the pile in front of you during September 2016. The letter from the GP tells you about an episode of haematuria. The SAI reviewers think this is red-flag territory. I don't have the notes in front of me. I don't think you're disagreeing with that? 12:14

A. Not at all.

63 Q. This was -- 12:14

A. Visible haematuria.

64 Q. Yes. You'll tell me if it's an unfair question but if you look at that letter from the general practitioner, the word "haematuria" would be with the other details

in the letter jumping out at you almost immediately as a matter of concern. You'll be thinking potential malignancy.

A. Yes.

65 Q. That doesn't take a lot of time to spot the danger for that patient? 12:15

A. That's right.

66 Q. Viewed from that perspective, these referrals, upon reflection, you should have found a way of doing them even if it meant reducing the time commitment to other aspects of your job description. 12:16

A. Whilst urologist of the week?

67 Q. Yes.

A. Well, this is the difficulty because we're just into a few months into the urologist of the week, finding it much more demanding than we had anticipated. I think it was in the first week of April 2015 that, as Lead Clinician of the Cancer MDT, I had tried to persuade my colleagues to do advanced triage on the red-flag referrals that came in. At that time there would have been 30, roughly 30 red-flag referrals per week. They couldn't commit to undertaking that in order to expedite the processing of the red flags. Which, this patient, if he had been upgraded or if he had been referred as a red flag, was going to wait 60-odd days at that time to be seen at the haematuria clinic. If I had seen this and haematuria would have jumped out at me, you know, I would have been in touch with this person, I would have been checking to see what his 12:16 12:16 12:17

renal function was like, to see if he could have CT urography done, and expediting it. You may feel, and others may agree with you, that what I found in this situation to be inappropriate, it is what I found. I tried my best. I found it sat uncomfortably with the situation that pertained in that ward at that time. That was our primary duty, to offer the best possible care to those people who were acutely admitted. 12:18

One thing that we discovered after the introduction of urologist of the week was that the urologist of the week would also be responsible for all of the other consultants' elective admissions whilst inpatients so that they could be in other places operating and doing clinics without worrying about their other patients. 12:18

68 Q. I hear you, I hear the background and the demands that you're explaining. But what do you say that the five patients, the subject of this SAI, a total of 30 patients according to the SAI report, who are found to have cancer? What do you say to them? These patients are patients to whom you offered no care or found yourself unable to offer any care to. 12:19

A. Well, it's 24 patients who were upgraded out of 783 referrals, and four of those patients were found to have a malignancy. Another one was added at a later date. So, four of those patients were found to have relatively early prostate cancer. Two of those have since been managed by active surveillance, that's my understanding, and two proceeded to radical 12:19

radiotherapy. It was concluded or considered by the SAI Panel that the delay in those patients' diagnoses did not impact upon either their management or their prognosis. I think after this period of time, I think that is agreed. 12:20

With regard to Patient 13, I read the SAI and I was here when he appeared before the Inquiry last June. And not to detract, because this is the risk when you raise another issue, but not to detract from the 12:20 significance of the delay in his diagnosis in 2017, but I cannot overstate how gravely concerned I was to find that he had been taken off my waiting list for cystoscopy and bladder mucosal biopsies on 26th January 2001 - he had been waiting for 2 years at that 12:21 time - not just because he had had dermatomyositis treated with cyclophosphamide, which by then has a 16 percent probability of causing bladder cancer after 10 to 20 years, but he was on that list because he had already been found to have urothelial atypia. 12:21

So without detracting for one moment about some months' delay in his diagnosis, it grieves me that this man may actually have had a diagnosis made one or two years before then if that action hadn't been taken in 2001. 12:21

69 Q. My question, Mr. O'Brien, was rather more prosaic than your answer allowed for.

A. Oh, sorry.

70 Q. What I take from your answer is that with regard to

these five patients, your omission to triage, in your view, was a product of the environment in which you had to work in but was inconsequential in their ultimate outcome, and in that context you have no regrets to offer? 12:22

A. That is not the case at all. Those are not related in any sort of causal or consequential manner whatsoever. These five patients, they are, and I am, lucky in that the delay in their diagnoses didn't impact upon their management or their outcomes. With regard to the four 12:23 patients who had been found to have prostate cancer, if they had had the same diagnosis six months previously, it would not have altered their management.

But Patient 13 is a very different patient and it could 12:23 have been very, very different in his case. I'm just drawing attention to the fact that as a urologist, I found there was a much greater issue going on in the years previously. That's not dismissing or trivialising for one moment the significance of delay. 12:23

71 Q. Let me move on from triage then and get back to the document with which we started, which was your response to Dr. Chada's report. If we go to AOB-01894. This is the second tab of reference "Patient Notes Stored At Home". You accept that you had a significant number of 12:24 charts at home. So again, by reference to the terms of reference, this is an admission, as such, as you've always accepted, that you had notes at home.

You say:

"This was well known to The Trust. At the time of my meeting on 30 December 2016, I had 288 sets of patients' notes at home dating back to April 2015. Ninety-nine of these charts were for private patients. I accept that this could be considered not to be best practice. I have assured the Trust that I have discontinued this practice and that I will not do this in the future". 12:25

I think there's a bit of inconsistency between your figures, your precise figures and the Trust's precise figures. It's not my interest at this point to poke at that, I'm highlighting it. 12:25

Your acceptance around issues is the word "could", "it could be considered not to be best practice".

A. It is not best practice. It was unfortunately. Basically, I was overwhelmed, for the reasons that we have already touched upon, the time on my demands as a consequence of those other roles that I played and the fact that home was on the way from Southwest Acute Hospital to Craigavon, and taking them home -- 12:26

72 Q. Just to be clear. Sorry to cut across you. There is a correlation, is there, between your inability or your failure to do dictation at the clinic or in the days after the clinic and the retention of the notes at home? 12:26

A. Yes. Yes.

73 Q. They were retained at home so that, in the fullness of time, you would have them at your desk without having to recall them --

A. Yes.

74 Q. -- in order to do the dictation? 12:26

A. Yes. Yes.

75 Q. I'm obliged.

It is the case that, again, you didn't have to work in that way when you were the subject of the monitoring 12:27 plan from March/April 2017. You didn't bring notes home with you?

A. Well --

76 Q. Or you didn't store them at home?

A. I didn't store them at home, so -- 12:27

77 Q. You did your dictation generally promptly, albeit there were one or two exceptions to that for reasons we may look at later.

A. Yes. The logistics of taking patient charts to and from Enniskillen proved difficult. So, for a period of 12:27 time Martina Corrigan brought them to Enniskillen and then collected them the following morning. Then we had a transition period where she delivered them and I brought them back, for the reasons that we have just stated, to enable me to dictate on them in reasonable 12:28 time. Then eventually I just brought them to Enniskillen and back again. So they would have stayed in my home overnight, but it's secure and so forth.

78 Q. The third element of the terms of reference,

"Undictated Clinics" and obviously its connection to that we have just discussed, again an admission or acknowledgment on your part that it was suboptimal practice to not have dictated letters on outpatient consultations in a timely manner. You realised in particular that it is important so that the GP will be aware of the management plan. You say: 12:28

"I had endeavoured to ensure that the clinically urgent patients were dictated upon, and had succeeded in doing so in the majority of cases. As stated above, the number of undictated outcomes was 189, markedly less than the 688 which [has] been informed to the case investigator. I had provided the documentation that sets this out. I am unaware of harm or risk of harm of any of the 189 patients who had not had letters dictated". 12:29 12:29

I just want to look at aspect of that with you, Mr. O'Brien. I suppose first of all let's put to bed at this early point the numbers game here. You say it is 189, the Trust puts 688 on the record. As we'll see maybe later, Dr. Chada says you acknowledge that and we'll look at that. 12:29

In terms of your figure of 189, if we go to AOB-10671. This is the appendix 12 which we've heard something about already which you gave to Dr. Chada, I think it was at your August interview with her. 12:30

A. Yes.

79 Q. If we go over the page then, please. Scroll down.

I don't need to bring the Panel to this but I'll ask them to take the note of TRU-255969. That's a document that the Panel will have seen yesterday, and I drew attention to the fact that Mr. O'Brien's secretary, Mrs. Elliott, had supplied a list of the clinics where the outcomes hadn't been closed, and I made the point that it amounted to 61 clinics. So, what Mr O'Brien appears to have done - and you can confirm this - he has gone through each of these clinics -- 12:31 12:31

A. That's right.

80 Q. -- and he has put his count on the cases that were dictated and those that were not. Is that right, Mr. O'Brien? 12:31

A. That is correct.

Do you mind if I say, there's a very simple explanation for the confusion. When my secretary was requested in December '16 to provide a list of the clinics for which outcomes had not been completed, this word "outcome" encapsulates and can be confusing, because you can have a dictated outcome. But really what she actually provided was a list of 61 clinics for which none of the outcome sheets had been provided at that time. That is the simple, straightforward explanation for this significant disparity. 12:32 12:32

So, they equated the lack of complete outcome sheet for each of the 61 clinics; they came to the premature conclusion that there were 668 patients who attended these clinics, none of whom had any outcome determined by having correspondence dictated. That was not the case, as you can see.

81 Q. Well, we can see here, as we look down through it, we know that Mrs. Elliott sent her document on 15th December. You're saying here that, by reference to the words "return by 30th December", we know that - or we suspect and you can confirm it for us - from your email correspondence around that time, you were continuing to dictate on outcomes during your sick leave and perhaps right up to late December. So, it is the case, to look at it in its fullest context, that you were significantly behind on dictation? 12:33 12:33 12:34

A. That's right.

82 Q. And you were busy trying to improve the situation rights up to, if we draw the line at 30th December when you had your meeting leading to your exclusion? 12:34

A. Yes.

83 Q. So the figures are to be viewed in that context as well.

If you just scroll down and on to the next page, we can see the figure of 189 is the figure of unprocessed cases. Just so that we're clear what the word "unprocessed" means in terms of what you felt you still had to do, you still had to put a letter on a tape, to 12:34

use old-fashioned technology, and get it to your typist, and then that letter would be sent to the GP, perhaps the patient in some cases, and on to the chart so that colleagues within the hospital knew what was going on. 12:35

A. Hmm-mm.

84 Q. Are there any other elements of processing?

A. Yes, there would have been an outcome. If all of them had been done, they would have all had an outcome. Sometimes that tabulated outcome can also give rise to confusion because the outcome doesn't really include that they had a CT scan requested. It is, as in these columns, either they're discharged, they're going to be put on a list for outpatient review, or they're going to be put on another list such as for inpatient day surgery or diagnostics, or they may not have attended. 12:35 12:36

85 Q. You would recognise, I think, the force of the point made by Mr. Carroll yesterday, and I don't again need to bring this up on the screen, but it is at TRU-258863 and 864. Mr. Carroll's point was, even if you look at this bottom line, when you fail to dictate, then the Trust is unaware as to what is to happen to the patient. Waiting lists are not filled out for clinics, for theatre, and of course the general practitioner doesn't get to know what's going on in respect of his or her patient. That's the mischief that a failure to complete outcomes creates. 12:36 12:37

A. Well, the communication one is -- certainly that is the case. Not only the communication, the recipient of the

correspondence to whom its directed, but anyone else who wants to view it, that is undoubtedly the case.

It is important, nonetheless, that Mr. Carroll pointed out that these people weren't disadvantaged in terms of timing, whether it is review or on a waiting list, because they were all routine. That's an entirely separate issue all together. You know, I have listened to, you know, the fact that the Trust are not able to manage their waiting lists, and that would be a novelty. 12:37 12:38

86 Q. One of the things picked up upon by the SAI review team for Patient 10 led by Mr. Glackin was, I suppose, the length of time before dictation arrives, before the outcome is processed. I was to take your view on that. 12:38

If we go to AOB-01246. This is the "Dear Tracey" letter we saw something of yesterday. He sets out three concerns which were, I suppose, of general application or of more general application beyond the instant case of Patient 10. If we scroll down the page, please. It says: 12:39

"During the manual look-back exercise, a particular patient's chart could not be found on Trust premises. The chart did appear in the Acute Governance office week commencing 28th November. After informal queries, it is understood that patient notes are not transported Via Trust vehicles to or from Mr. O'Brien's outlying 12:39

clinics. This could compound efforts to establish any chart location or outstanding dictation".

That's the issue about records not making their way back to the Trust. 12:40

But scrolling down to his third point then. He says:

"There is clear evidence that this patient's letter was not triaged in October 2014", which was the same week 12:40 which was relevant to Patient 10's case. That's why they're looking at these cases.

"The patient seen by Mr. O'Brien in January 15 in the SWAH. The outpatient letter was dictated 11th November 12:40 2016 and typed 15th November 2016. The Review Panel have grave concerns that there are other urology patients' letters not being dictated in a timely manner".

12:41

It is fair to say, is it not, that some of these delays in completing outcomes for patients were very great?

A. Yes.

87 Q. Many, many months.

A. Yes. 12:41

88 Q. Again, I think I've seen you say in places you had made efforts to try and deal with the more urgent cases first. Did you have a method to that and, in that context, how does a patient such as this wait almost

two years before his outcome is complete by way of dictation?

A. Well, you know, you hope that you're able to identify the clinical priority patients by virtue of their pathology, their symptoms, their diagnoses, their management, their need for onboard referral and so forth; and then those that are less urgent or not urgent at all, it appears to be -- that's how I distinguish between the two. That's not an excuse, of course, for having anybody who has attended a clinic in January '15 not having an outpatient letter dictated until November '16. I don't have a detailed knowledge of who that patient turned out to be but I gather there was no consequence to that. But that's apart from the lack of communication. 12:42

89 Q. You obviously had a private practice from home. Did it suffer from a similar tardiness or difficulty in processing communication --

A. Yes.

90 Q. -- or was that prioritised? 12:43

A. No, not prioritised over NHS. The same kind of principle was applied to it as I applied to my NHS practice. Something that was urgent was dealt with and something that was less urgent suffered tardiness.

91 Q. You've said, very plainly, in your response to the investigation report that you're unaware of harm coming to any patient as a result of delay in dictation. Would you agree with the proposition that communicating promptly with the general practitioner, giving him or 12:43

her a clear readout on what is to be expected in terms of next steps for his or her patient is, as it were, something of a safety net in the system to ensure that if anything does slip, say the need for radiotherapy for whatever reason falls through the net at the City Hospital, that at least the general practitioner would have your letter, if it was done in time, to know what was going on? 12:44

A. Well, I agree with you entirely in general but in relation to, I think, the patient that you may be referring to, of course the GP did have the letter because the letter was generated by the MDM, and generated to the Cancer Centre. I believe in addition to that, the outcomes of the MDM were emailed to the Cancer Centre. 12:44 12:45

92 Q. This is Patient 102?

A. 102, I believe. Yes.

93 Q. That was. That's the patient I have in mind. Just if we outline something of the history of that. The recommendation of a multi-disciplinary meeting in late 2014 was that Patient 102 should be referred for radiotherapy directly; isn't that right? 12:45

A. That's right.

94 Q. What does that mean in terms, "directly"? Were you the Chair of the MDM? 12:45

A. I don't know because I don't have a record.

95 Q. What is the process of direct referral?

A. So direct referral means a direct inter-Trust Transfer, or ITT we refer to it in Northern Ireland. When

I previously reviewed this particular patient -- I've been able to do some detective work and find from my email file this patient. I reevaluated him by getting an MRI scan done again, and that he would be discussed at our local MDM with a view to direct inter-Trust transfer. I'll explain that in a moment because it is important to say that the patient was advised that this was the plan.

When we discussed him at our local MDM, it was agreed with our regional MDM that he would be transferred from us to the Cancer Centre for treatment. The automatic thing is that the clinical summary and the update and the findings in the agreement is produced in the letter format which goes both to the GP and the person to whom you're referring. 12:46 12:47

96 Q. The GP had, by dint of that process, a clear indication of what is to be expected for the patient?

A. Absolutely. I reviewed that patient out of courtesy to him, just to confirm that the referral had been made. In addition, which was my routine practice at that time, I e-mailed an update pertaining to my review of him, saying that patient has been advised that the referral has been made, and that goes on to the CAPPS system. That is the next update that appears on the system so the next time that that person is discussed at the MDM, if they ever are, that will be included in the letter to the GP. 12:47 12:48

97 Q. Just to be clear, does the general practitioner have

access to CAPPS?

A. They don't have access to CAPPS. They get the letter generated by CAPPS.

98 Q. You saw the patient at an outpatient clinic on 28th November 2014, so that's after the direct referral? 12:48

A. That's right.

99 Q. The point made in the incident report that Mr. Haynes raised in respect of that incident, just to put the conclusion on it, the patient doesn't actually make its way to radiotherapy until late 2015, 12 months later. So, Mr. Haynes raises an incident report which focuses on the failure to get patient into the system for radiotherapy, for reasons which were no doubt investigated, but he highlights a failure of dictation arising out of your outpatient encounter with the patient in November 2014. 12:48 12:49

Can I ask you this: Should that patient have had the benefit of a dictated outcome sent to his general practitioner? 12:49

A. He did have.

100 Q. Arising out of your 28th November?

A. I don't believe so. I mean, I reviewed that man that day just to confirm that he had been referred. I would never have considered that I additionally had to then do another letter of referral. So, not only has it been generated but apparently it wasn't received by the Cancer Centre, and the outcome also actually e-mailed 12:49

to the Cancer Centre. I mean, how many times in one week do you have to write to the Cancer Centre.

101 Q. I understand that's one part of the process and the Inquiry will know that there was some failure in that process with the Cancer Centre. What I am focused on is whether, following the MDM, you should be sitting down with the patient explaining that a referral has been made and the implications of that, and no doubt there's an element of a consenting process around that or at least an explanation to allow the patient to go away and think. The GP, as you say, has had the benefit of being copied into the direct referral. Should there additionally be a letter generated by that encounter to explain to all that need to know, particularly the general practitioner, that I've seen your patient, he or she is content with radiotherapy and these are to be the next steps? 12:50 12:51 12:51

A. Well, I accept your point to a degree. The patient had consented to it before the direct referral was made. The direct referral had definitely been made. The patient was -- the GP was advised that the direct referral had been made. In fact, the GP direct referral letter generated from the MDM will have said "for review by Mr. O'Brien". So, the only thing that the GP didn't know about was that I had reviewed him and that I intended to review him in February '16, is it, I think? The following year. 12:51 12:52

102 Q. Very well. But, broadly, you accept the observation I've made at the start of this, that a dictation to the

general practitioner is there, at least in part, as a communication tool which provides a safety net?

A. I agree with that entirely, but I just don't accept in this case that it was a failure to do that letter. It's not that letter at all, actually. The proposition that a failure to write another referral letter to the Cancer Centre was the reason that this person didn't get -- 12:52

103 Q. No, I haven't suggested that.

A. Yes, okay. 12:53

104 Q. Could I give you another example and take your view on this, if you're able to help us. It is Patient 103. If I could put up on the screen, please, WIT-54883. If we go to the bottom of that page, please. 12:53

Regarding this patient, as we will see from to these emails I'm going to take you through, Mr. O'Brien, this was a patient seen by you in 2015, September and December. It appears that she required surgery for the removal of a nonfunctioning kidney. She presented in Accident & Emergency in April 2016. When Mr. Haynes saw her for the first time, he found that there was no correspondence on the ECR arising out of your encounters with her and there were no notes available to him on the ward. I take that to be what we'll find from these emails. 12:53 12:54

Peter Beckett, do you know who that is?

A. I do, yes.

105 Q. He's in Daisy Hill?
A. No. He's a general practitioner in Armagh.
106 Q. The general practitioner for this patient. He is writing in to Mrs. Corrigan. I'm looking at the address here and I'm wondering how it got to Mrs. Corrigan. But in any event, he is in receipt of a letter stating that she is to have a nonfunctioning kidney removed. He's unsure as to the care provider, whether it is you or Mr. Haynes, and the ECR doesn't help so he is asking Martina to assist him with that. 12:54 12:55

If we scroll up, please. Just go beyond that one, please. Thank you. On up.

So, Martina engages with Mr. Haynes and is able to write back to Mr. Beckett to say that Mr. Haynes had seen her in A&E. Mr. Haynes is copied into this email. Then if we scroll up, please, Mr. Haynes explains the problems he has encountered. By this stage the lady is obviously on the ward. He had not been involved in her care to date; he had not received a referral; there are no letters on ECR, and "her notes detailing previous consultations were not available to me on the ward". He has discussed a plan going forward, that will depend on how her current plan settles, but he is considering an urgent laparoscopy nephrectomy. 12:55 12:56 12:56

Do you know or recall that case, Mr. O'Brien? I want to be as fair as I can with you.

A. Yes, vaguely. I remember this was a relatively young person and she had a nonfunctioning, I think, cystic kidney or polycystic kidney. I don't... it's a long time ago. I remember her being in the ward then under the care of Mr. Haynes subsequently, having had her surgery. 12:57

107 Q. Is it clear that he's pointing out omissions by you --

A. Yes, absolutely.

108 Q. -- on the part of -- sorry, in the context of your encounters with her at the tail end of the previous year? 12:57

A. Yes.

109 Q. Should there have been information on ECR?

A. Should have been, and there should have been a referral to him. Because that was the plan because she was a young woman in her 20s, I think, if I remember correctly. Obviously laparoscopic nephrectomy would have more much appropriate for her than open nephrectomy, and I didn't do any laparoscopic surgery. I accept that entirely. 12:57 12:58

110 Q. Is that a situation where a failure of referral, a failure of dictation, a failure to complete the clinical encounter does place a patient at risk of harm?

A. Yes. This case is most regrettable. I remember this case very well, because she could have had infection in that kidney or -- if I remember correctly, it wasn't a stone-bearing kidney, if I remember it correctly, attention was drawn to it by her pain or discomfort 12:58

related to a polycystic kidney. But that's as good as my memory is at present.

111 Q. Thank you for helping us with that.

Just two points before the imminent break. Private patients, you deal with that issue in your response to Dr. Khan. If we just have that on the screen, please. AOB-01894. Bottom of the page, please. 12:59

So, whereas you have admitted or acknowledged shortcomings, albeit within particular contexts and particular circumstances which we have spent some time looking at, with regard to private patients it's a flat rejection of Dr. Chada's finding and any culpability on your part for the alleged preferential treatment of private patients; isn't that right? 12:59 13:00

A. That is largely right. It's almost 100, but you have dealt with this issue at length with other witnesses.

112 Q. Yes. Don't fear, we will deal with it at length at some point. But what I'm putting out on the table here is by the end of the process, and it was a lengthy process, and again we'll look at some of the reasons for that, this was your position? 13:00

A. Yes.

113 Q. Three acknowledgments or admissions, this one solidly rejecting? 13:00

A. Yes.

114 Q. And, indeed, as appears, I think, from what you say here, a critique and a robust critique of the process

adopted to investigate this issue?

A. Yes.

115 Q. You thought there should have been a comparative analysis?

A. Yes. 13:01

116 Q. When you looked at Mr. Young's workings, you couldn't see that?

A. Yes.

117 Q. We'll look at some of that as we go on. 13:01

The final issue to deal with, and I'm going to leave it hanging and come back to it in some detail after lunch is the role of management. That was the fifth aspect of the terms of reference. It is your belief, as you say here, that management knew of the problems that you 13:01 were having with administrative practices; "management did not take the opportunities to assist me. It is apparent from the written statement gathered by Dr. Chada, that when some members of management indicated that they would like to address these issues 13:01 with me informally, they were instructed not to do so".

That's, I think, a reference to something Mr. Weir said to Dr. Chada. We'll have an opportunity, as we go on, to look at aspects of what management knew and your 13:02 concern that over a lengthy period of time, you were deprived of the necessary support and assistance to deal with the issues that were described at shortcomings.

At this stage, I'm going to come back to that issue directly after lunch.

CHAIR: Okay. 2.05, ladies and gentlemen.

13:02

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Chair. Good afternoon, Mr. O'Brien. 14:06

118 Q. Just before lunch we'd reached the last parts or last entry in your piece to Dr. Khan in response to the investigation. It's up on the screen in front of us. Just going down the page to the next page, you pick up on the fact, or you make the assertion, I should say, 14:06 that when the issues were raised with you in the meeting March 2016, you asked for some guidance on what I could do and you received no assistance. That's the meeting with Martina Corrigan and Eamonn Mackle?

A. That right. 14:07

119 Q. We'll come to that later this afternoon, hopefully.

But just on this issue of management support. As I understand it, Mr. O'Brien, we'll pull up a theme that is recurrent through much of your statement 14:07 AOB-02 --

CHAIR: Mr. Wolfe, can we just stop a minute? I think there might be a technical problem. We're just checking monitors.

That's everything sorted, I believe, Mr. Wolfe. Sorry for interrupting.

120 Q. MR. WOLFE KC: In the context of the points you make to Dr. Khan about the lack of management support, I just want to draw out a theme from your Section 21 statement. AOB-02029. This is your grievance that you put in towards the end of 2018. If we just scroll down to the fourth paragraph. You say you have provided to Dr. Chada details of the pressures that you were under for many years with waiting lists for both inpatient treatment and review, and "how I was using available time to ease that backlog". You say: 14:09 14:10

"There had been times when I fell behind in administrative work in the past and would have worked additionally to ease that backlog. This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming". 14:10

Just to draw that out a little, Mr. O'Brien. Is that, in more specific terms, you saying that, to use your description earlier this morning, you were spending a lot of the time at the back of the operation doing theatre work to help ease these backlogs and these pressures, and there is a correlation between doing that work, given that there's only so many hours in the day, and the falling behind aspect, which is described here and was to be the subject, at least in part, of 14:11 14:11

the MHPS investigation?

A. That's accurate and fair. It's a trade-off, really. It's making judgment calls. The beneficiary of any particular week or day can be different from the next week or day. 14:12

121 Q. I just want to show the Inquiry, as you say the Trust knew this and maybe this is one illustration of it. AOB-00686. Just scroll down to the page so we can see Mrs. Corrigan's... Thank you. 14:12

Martina is writing to you in relation to triage:

"Can you advise please when these will be triaged".

Up the page, Heather Trouton to Martina Corrigan: 14:13

"If you don't get a response by Wednesday can you please advise or escalate". Then Martina Corrigan to Heater Trouton: "Aidan and Monica are on annual leave this week but he normally does this sort of admin when 14:13 he is off so I will advise next week if this has not been sorted".

Was that part of your pattern, playing catch-up at convenient times because you spent a lot of time at the 14:13 back of the house doing the theatre work?

A. That's definitely the case. That was the case and had been for all of my working life at the Trust.

122 Q. In your engagement with Dr. Chada, you presented her

with Appendix 11, which was an outline of your various commitments beyond the administration requirements of your role. Let's just take a look at that. It's at AOB-10653. Appendix 11, then scroll down.

14:14

Here you are seeking to illustrate, I think by reference to your job plan, what you were doing by way of inpatient operating over and above the commitment expected from you in your job plan. Is that the proper way to put it?

14:15

A. That's the proper way to put it, yes.

123 Q. You say for 2016, which is obviously an important year in our chronology, that the job plan required 61. Is that 61 sessions; PAs?

A. 61 sessions, yes.

14:15

124 Q. And you performed 83.25. Do you multiply each session by four to get the hours?

A. You do.

125 Q. Is that the way to do it? Yes.

14:15

You record at the bottom:

"All of this additional operating was directed to those patients in most need".

14:16

Another document which is on this point which we find that you've disclosed, AOB-23225. Is this you drilling down and illustrating in greater detail the 2016 figure that we've just looked at?

A. That is correct.
126 Q. Are these your own records or are these hospital Trust records?
A. No, these are mine. I have constructed this record.
127 Q. Yes. The session figure, is that something that the Trust would have a record? 14:16
A. Oh, they would have. Absolutely.
128 Q. Just scrolling down through it. Over the next page, please, takes us all the way through the year, and obviously then you yourself go into - without dwelling on the detail - you yourself go off work for medical reasons in November 2016? 14:17
A. Yes.
129 Q. So it brings us up to then. Just working up from the bottom here, here we have your job plan, 58. A matter of fine detail perhaps, the last document we looked at had your job plan at 61 sessions. Maybe you can have a think about that. If you feel you can clarify that, please do. 14:17

14:17

The 83.25 sessions is the same figure as we saw in the previous document but then you add to that, I suppose, follow-up on each of these patients, whether it is perioperative care; is that after the theatre?
A. So, normally we would be allowed for one hour prior to the commencement of theatre, you know, with the patients, and half an hour afterwards. I found it necessary and reasonable to allocate an hour of administrative time per session as well, making up that 14:18

total.

130 Q. These are estimates made by you --

A. Yes, yes.

131 Q. -- of the commitment to get a patient pre-theatre, through theatre and out the other end? 14:18

A. Yes, yes. The 1.5 of perioperative patient care would be quite standard surrounding to bookend an operating day.

132 Q. This document, you'll have to forgive me, I'm not quite sure of the circumstances in which this particular 14:19 document was developed. I know that the one I first showed you was for Dr. Chada's investigation. This is a follow-up on that, is it?

A. It is. The previous one was almost the cover summary document, and I did this here for all of those years of 14:19 2013 up to '16. The same as this.

133 Q. Is it in broad terms? There may be other purposes for it but is this to attempt to demonstrate or illustrate how many hours in the working year were devoted to X?

A. Yes. 14:19

134 Q. And when you look at the number of hours over and above your job plan, I assume you are suggesting to the Inquiry through me that there weren't enough hours available to do all the administrative tasks that the Trust required of you? 14:20

A. That is exactly right. Yes.

135 Q. Okay. How does it come about, Mr. O'Brien, that in circumstances where you know that the basic requirements of your role - the triage, the

administration after clinics, those kind of things - you know that all of those ducks aren't in a row, those tasks are not being completed by you in the way that the Trust would want. So, those basic tasks aren't being performed. But are you putting your hand up and volunteering to do over and above tasks in theatre, obviously for the good reason of tending to people in pain and distress and difficulty, but with the full knowledge that you're doing that and the basic stuff isn't being done? 14:20 14:21

A. Well, it's a combination of both. For example, in 2013 - I've have made reference to it in my witness statement - where there was a ministerial target, I think, to meet 35 weeks maximum waiting time by 30th September. Having achieved that, then for 31st December, we had to meet a 26-week target. It is a combination of expectation on the part of the Trust to do additionality, to meet ministerial targets, and it is me volunteering for those reasons at other times as well. It's a mixture in there. 14:21 14:22

136 Q. Is there a financial incentive to doing these sessions?

A. No. If you were to scroll back upwards, most of the -- in the early years, I did all of that extended operating on typically a Wednesday, the extended bit, unpaid. If there's work done on a Saturday, it would typically be paid in this later year. For example, 27th August may have been paid, I can't recall. Friday, not at all. So, once again, there may have been an additional payment when finance was available 14:22

to do that. I can tell you if would only have been done on a Saturday if there were finance because you have to fund other staff as well. But mid-week, no, that wouldn't be the case, you wouldn't have been paid.

14:23

I think by the time -- I can't recall whether by 2016, I can't recall whether 12:00 noon to 8:00 p.m. had become part of my job plan, but we can check on that at a later time.

137 Q. So why are you doing this work if the basic elements of your work can't be performed in time? You partly answered it by saying it's sometimes political ministerial requirement. You could refuse to do that, couldn't you and say, listen, I have catching up to do with my basic job requirements, or is that not the real world? 14:23 14:24

A. Well, it's not the real world when it comes to the Trust having an imperative to meet a particular target that is set for a particular date. That was anything but optional. Once again, it's a trade-off. I can't find the designation of the patient that we heard from, I think it was in June, who waited a long time to have a stent removed, a young man. So, there you have it. You are trying to get stents removed, stents replaced. 14:24 14:24

138 Q. Allow me a moment. I think I can find it for you. Maybe not.

A. You know, if you take, for example, Patient 16 is a case in point. There are many cases in point. You

know, it's not like as if the patients whom we are taking in are necessarily in a static state since when they were entered on the waiting list. Like, you have a painful right knee and it just remains painful and the persistence of pain isn't accompanied by some deterioration in the knee joint requiring more extensive or riskier surgery. We're talking here about people who, because of the longevity of their duration on the waiting list, are suffering incrementally increasing risk of coming to harm. So it's a difficult situation to be in. And I wish it -- I love dictating; I love doing administration. I couldn't do everything at the same time, it's like spinning plates. There are too few plate spinners, basically. 14:25 14:26

139 Q. Can I ask you about something you committed to upon your return to work in 2017. If we go to TRU-00720. 14:26

You are speaking to Colin Weir on the 24th January and you're discussing alternatives to exclusion. If we just scroll down, please, you talk about the impact exclusion had had on you. Just scrolling down a little further so I can see more text. Thank you. 14:28

You say that you are entirely happy to return to work within a defined framework. You say you would be accepting of working within normal time constraints, both for operating lists and clinics, and agreed that any clinics would have outcomes recorded and dictation done by the end of that clinic. Entirely open to 14:28

regular review and monitoring. You say if you had been advised in March that these concerns would lead to this, then you would have taken the time out to clear your backlog. Just scroll down.

14:28

Essentially, the last bullet probably captures it. You were happy to work within a defined framework set by the Trust to comply with hospital policies and procedures, to work to predetermined time scales, and you gave an assurance that no patient files would be 14:29 removed from the Trust.

Can I interpose that into your description of this additionality and being unable to cope or manage, and having to play catch-up regularly with your 14:29 administration, and compare that with the commitment you were able to give in 2018 in order to return to work from exclusion. How were you able to give that commitment to manage all the plates that were spinning within your practice and to deliver on the Trust's 14:30 expectations thereon?

A. I could only consider making that commitment by undertaking not doing any additionality, basically. At that point in time, you know, my first and top priority was to get back to work. To answer your question, 14:30 I don't think -- I had to reduce the number of plates to be spun.

140 Q. And how was that achieved?

A. It was achieved over the next period with difficulty in

that I had to reduce the time spent in an Oncology Review Clinic in order to spend the time on a Friday on annual leave to do triage, which I still couldn't complete entirely within each urologist of the week week. So, I had to spend an awful lot of my own free time doing these things, whether it's triage -- 14:31

141 Q. Just to be clear, was there any additionality after returning to work in 2016?

A. Ever, until I left?

142 Q. Yes? 14:31

A. Oh, there was. Yes.

143 Q. Your example of taking yourself out of certain clinics on a Friday, the Oncology Review Clinic, does that demonstrate that there was, with the Trust's blessing, options available to you to move the furniture around a little to enable you to better comply with the expectations? 14:31

A. Yes. When these expectations were made, yes, there was, but with a cost to patients. Patients don't get reviewed at a clinic that doesn't take place. 14:32

144 Q. Yes.

Just going back to your Section 21 statement at WIT-82547, paragraph 415. The page reference is obviously 546, just for the record. 14:32

You say:

"Overall, I did not feel that I received much support

from the Trust in respect of concerns raised. Over the years, the concerns that I had remained largely unchanged, having not been adequately addressed and resolved. It proved to be a frustrating and concerning experience. It gave rise to a sense of fatigue and disillusionment with regard to raising concerns. I did often wonder whether repeatedly raising the same concerns which were not resolved made it even more difficult for them to be resolved. I was certainly left with the belief that raising concerns was no longer productive". 14:33 14:33

I want to ask you about this sense of despondency you're reflecting here. How deep-rooted was that and when did it begin to affect you? 14:33

A. I would say by the late '90s. If we can just briefly recall, starting from scratch in 1992, there had been a lot of progress. It might have been inadequate in its totality but a lot of progress, and with a lot of support from the most senior people in the Trust, as it was at that time, particularly from the Chief Executive, John Templeton. I think I have related that in that response. Such as, for example, for a department, a single-handed department in its infancy, to secure Northern Ireland's only onsite lithotripter was a huge achievement. To have research fellows. To have set up with Roberta Brownlee a cure to fund all that. There was a lot of dynamism. I had a very good relationship with the Chief Executive in 14:34 14:34

particular in that I would go to him every -- say twice a year at least, anyhow, and try to not make it any more than that, with the same shopping list. Then after a few years with the same items on your shopping list and you're still asking for the same. Sometimes I did come to the conclusion that repeatedly asking for the same was only not productive, but I felt it was counterproductive. I felt, actually, if the person whom you were asking eventually gave in, why did they not give in three years ago? So I felt it created a kind of obstinacy, and I'm not the only one. 14:35 14:35

As you can see from Katherine Hunter, looking at her this morning, her testimony, it goes back to the '90s. You are left with disillusionment and fatigue; don't waste time raising concerns and asking for things because it is a waste of time. 14:36

145 Q. To bring this back to a specific thing, you'll recall in 2011 you engaged in a facilitation process with Dr. Murphy -- 14:36

A. That's right.

146 Q. -- in respect of your job plan?

A. Yes.

147 Q. If we can take a look at that. If we start with AOB-00308. This is your comments and concerns regarding your proposed job plan. It's a note in preparation for facilitation. The Inquiry can obviously look at the totality of the note. One of the issues which I think becomes significant during the 14:36

process is the time allowed for administration relating to direct patient care, and that's ultimately a matter that led to disagreement; is that fair?

A. Yes.

148 Q. No doubt there's other issues within this which we could focus on but just trying to follow that through. Six pages further down at 14 in the sequence, AOB-00314, we have the record of your facilitation meeting. Admin time is discussed at the top; you say that was a substantive issue for you. There was inadequate time allocation within the proposed job plan. You describe it - I take these to be your words - as being grossly detached from reality. You had been allocated 4.25 hours for admin and you explain why that is inadequate. 14:37 14:38 14:38

The upshot of this meeting, to your disappointment, I think, is set out at TRU-265964. This is Dr. Murphy writing to you. He says:

14:39

"I have compared your proposed job plan with those of your colleagues in urology and am content that the time you have been allowed for administration seems appropriate. One of your colleagues has been allowed slightly more time; however, he has agreed to undertake an additional clinic which will generate more administration". 14:39

He goes on to look at the historical aspects. He says

he will allow you a transitional period at a slightly higher allowance of 0.75 of a PA until February 2012, and he says this will result in a total of 2.75 PAs over and above the 10 programmed activities, but from 1 March 2012 the transitional period will end and you will be left with 12 PAs.

He says, and I'm interested in your views on this:

"This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this". 14:40

You, as it appears from correspondence, were disappointed with this outcome? 14:41

A. Yes, I was disappointed because you ask for -- I think actually this is accompanied by my request for seven hours of administration time, but that seven hours didn't include the time that was going to be required to action results and reports because that directive had just recently come in. So seven hours. Essentially what happens then is that you, having gone to facilitate -- if you ask, my experience is you end up with less than what you ask for, and it gets worse. Over the years the amount of time allocated to administration that was proposed in job plans certainly never increased and it just got progressively less. 14:41 14:41

149 Q. He makes two points of significance, perhaps. One,

your allocation for administration is at least as generous as your colleagues, with one exception, which he explains. Secondly, he's urging you to give appropriate consideration to changing the way you work, your working methods, to enable you to better manage within the time allowed.

The first point is is he right, that you had been generously compensated and it is now an appropriate time for the Trust to claw back on that and reduce your admin time? 14:42

A. You see, it's a complex answer possibly to that. I've heard it being said by Mr. Mackle that, you know, I wouldn't have looked forward to or wouldn't have welcomed this outcome because it results in reduced remuneration. The reality for me, at that time and since, for me and for many other people, is that we work grossly in excess of job planned activity. Whether it's 12 or 12.75 is, frankly, irrelevant. The motivation for getting you from 12.75 to 12 is not to encourage you necessarily to change your administrative practices, it is just to pay you less. 14:43

Ultimately, if you fast forward to 2022 and 2023, you end up with a situation whereby you have people proffering different views as to whether Mr. O'Brien or Mr. Haynes or Mr. Glackin uses their free time as efficiently as possible in the service of the Trust or in providing care for their patients, whether it is at 14:44

two o'clock in the morning and then going to bed or, as Mark Haynes has done, getting up at five o'clock to work for two hours. That's the reality.

It's almost esoteric at this stage whether you are dictating a letter to your patient at six o'clock in the morning, in the case of one consultant, or whether actually you are phoning the patient at nine o'clock in the evening in the case of the other, because neither of them are being paid in any case. That's the reality. Being honest about it, that is the reality for a lot of hard-working consultants. 14:44 14:44

150 Q. Let me just further develop that with you. If we look at what Mr. Mackle says to you. WIT-90291. He emails you on 5th December -- or was it 12th May? I think it is 5th December. He's building on this point about changing your working practices and administrative methods. He said he organised a meeting to discuss this with you. 14:45

"I note however you cancelled the meeting. I am therefore concerned we haven't met to agree any support that you may need. I would appreciate if you would contact me directly this week to organise a meeting. If however you are happy that you can change your working practice without the need for Trust support, then you obviously do not need to contact me to organise a meeting". 14:45 14:46

You say in your Section 21 response, it is paragraph

603 - we don't need to have it up on the screen - you cannot now recall why you had had to cancel the meeting; you don't recall rearranging it; you don't recall Mr. Mackle recontacting you. But, in any event, you do not consider his engagement in such meetings helpful in addressing the issues you faced.

First of all, in terms of your working methods, was there anything that you could have done/changed in order to bring you within the time allowed within your job plan so that you weren't working unpaid hours? 14:46 14:47

A. I'm not so sure that there was. I know that very many people have been critical of me for being in contact with patients by telephone and why didn't I have my secretary or some other person such as a scheduler - which we didn't have - to organise your admissions or theatre list or whatever, which seemed to me just like putting the cart before the horse. You have a clerical person actually who picks four people and then comes along to you and asks do you think this is appropriate, and I say well, I don't know because they've been on the list for four years, I better ring up to see if they are dead or alive or what has changed. 14:47 14:47

I don't think there was much change I could do. My secretary couldn't do that kind of work. She did the administrative aspect of it when I organised it. 14:48

151 Q. Is there not a serious point there to be made about your ability to delegate to either more junior

clinicians or to the administrative team that surrounded you and other clinicians to free up more time so that you could more readily achieve the administrative targets that had been set for you?

A. No. You couldn't possibly delegate to a registrar, certainly not in our department, I've never known of it, to choose and organise an operating list. I don't know what Mr. Hanbury's experience has been but my experience has been that most trainees actually complete their training and they have never set eyes on a waiting list. They wouldn't know one if it shook hands with them. We didn't have any clerical staff to do that. 14:48 14:49

Around about that time, I think the general surgeons did try schedulers and found that it didn't work. We certainly didn't use them at all. We didn't have any clerical staff or junior medical staff to whom to delegate these tasks at all, never mind in some kind of more efficient manner. 14:49 14:49

152 Q. Did you think there was an air of unreality about Mr. Mackle even suggesting that there might be a way of assisting you?

A. Yes. And...

153 Q. Was it more than that? Did you distrust him? 14:49

A. Well, it's not that I -- I wouldn't have gone to him seeking help.

154 Q. I mean, you've said in your witness statement 'I can't recall the reasons why I didn't' --

A. I think actually I did have to cancel it first time around for some reason. I can't remember what it was. He organised the time; it didn't suit. But I wouldn't have gone back to Mr. Mackle, you know, asking for support from him or the Trust by way of him. I just wouldn't have done that.

155 Q. He was the Associate Medical Director --

A. Yes.

156 Q. -- with responsibility for the service?

A. Yes. 14:50

157 Q. I suppose a medical line manager within the hierarchy to you?

A. Yes.

158 Q. He's reaching out on the face of this email correspondence offering to explore with you ways around this difficulty. And you wouldn't have gone to him? 14:50

A. No.

159 Q. Why not?

A. Well, Mr. Mackle was Clinical Lead with Simon Gibson as Project Lead in the reconfiguration of the wards two years previously, which was undertaken without any consultation with us consultant urologists at all. It was a fait accompli announced one day. 14:51

160 Q. That's why I was asking was there no longer any trust in your relationship with him -- 14:51

A. No.

161 Q. -- in terms of getting things done?

A. No. None.

162 Q. How do we get out of this trap or vicious circle, if

you like? You are running to standstill. You're hitting out in your evidence that the Trust knows all about your problems but isn't providing assistance. Here you have, on the face of it, a good faith offer to discuss assistance with you and you don't go; and you didn't deliberately, it seems, go?

A. I regarded this as just a procedural ticking of the box. How do we get out of it? We don't get out of it. Because you're working for a Trust that, by this stage - I think I've tabulated it in my witness statement - I think there was something like a 50 percent increase in the inpatient waiting list between June '10 and June '11. Things had remained pretty static because we had a waiting list initiative undertaken by an Australian team in the mid noughties which stabilised the situation for a period of time, up until June '10. Then thereafter you had significant annual increases in all of the metrics that demonstrate the progressive inadequacy of the service. So, you continue -- I continued to run to standstill.

I accept that others may consider that some part of my running was not as efficient as some others, but that's what I did.

163 Q. I want to ask you something more about your relationship with Mr. Mackle. You raised on 30th January 2012 a written grievance relating to what you perceived as a breach of contract, an unlawful deduction, an unauthorised deduction from your pay. And

we don't need, perhaps, to worry about the fine detail of it but you had a clear understanding that monies were due to you for some additionality, some additional work, and you saw documentation which showed that Mr. Mackle had intervened without reference to you and deducted it, and that gave rise to a complaint. You've explained that your complaint was upheld, you received the money but because of Mr. Mackle's difficult personal circumstances at that time, you parked the grievance and reserved the right to reactivate it if you saw fit. Is that a fair summary of the background from your perspective? 14:54 14:55

A. That's a fair summary, yes.

164 Q. I suppose the further chronological or historic background to this involved a number of interactions which didn't go your way. We've seen your unhappiness with the modernisation, so-called, that Mr. Mackle and Mr. Gibson had overseen. We've seen his involvement in the job plan issue and the facilitation. He also had dealings with you in respect of the IV antibiotic issue, and I think the cystectomy issue that we'll maybe take a look at at another time. 14:55 14:56

The build-up to your complaints about the deduction from your pay was not a happy build-up in terms of your relationship with Mr. Mackle; is that fair? 14:56

A. That's very fair, yes.

165 Q. It was reported to Mr. Mackle, on his evidence, that Roberta Brownlee had reported to senior management that

you had made a complaint to her that Mr. Mackle had been bullying and harassing you. Did you make that complaint to her?

A. Absolutely not and, you know, I can give you some reasons why I wouldn't. Because we're neighbours, we're good friends. She had been my patient away back years ago. It would have been totally inappropriate to put someone who has done so much for urology by way of CURE in such a position. I would never have done it. So, the short answer is no. 14:57 14:58

166 Q. Thank you.

Would she, nevertheless, have known your unhappiness with how you felt you were being treated by Mr. Mackle?

A. I genuinely and honestly do not believe she would have any reason - certainly not from me or from any party in my family - to have known that. I can't think of -- no, I don't believe. 14:58

167 Q. So you're clear that to the best of your knowledge, no member of your family and certainly not yourself ever discussed your unhappiness regarding Mr. Mackle's management of you with Mrs. Brownlee? 14:58

A. That's right. I mean, my children wouldn't have been in a position to be doing that anyhow, so it's just my wife and I. No, certainly not. That has never arisen. Absolutely not. I'm saying it, I want to emphasise the no, because it's not just because to the best of our ability or memory or knowledge that it didn't happen. When you value someone like I value Roberta Brownlee, 14:59

and what she has done and what we have done together, like we have funded half a dozen research fellows and higher degrees, and all things that I may have made some reference to, I certainly would not have. I know what's proper and improper. So the answer is no. 14:59

168 Q. Very well. That's very clear. Thank you for that.

It's certainly the case that we can see from a number of pieces of evidence that the word around the place with certain people was such a complaint had been made. 15:00 If you think you're into the realms of speculation, then simply say so, but I give you the opportunity to explain or provide a hypothesis, if you wish, as to how that kind of belief or understanding came to be part of the currency with certain members of the staff? 15:00

A. Well, there are two beliefs that could easily be confused. One is I certainly didn't make any complaint about Mr. Mackle harassing or bullying me. I have no reason, for the reasons I have just stated, that Roberta Brownlee did on my behalf. But the second 15:01 reason I believe is not a complaint about harassment, but was there harassment, was there an observation on the part of others, including myself, that I was harassed, because I do believe that I was harassed repeatedly during those years. I believe I attended 15:01 meetings with both Mr. Mackle and Dr. Rankin, that, looking back on them, they should not have been conducted in the manner in which they were conducted, and they should not have been tolerated by me and by my

colleagues who attended similar meetings because of the manner in which they were conducted.

So, did I feel harassed? Certainly. Did I make a complaint? No. I don't think that Roberta Brownlee had any reason from me or my family to do so. Did someone else speak to him because of what's on the grapevine and what was maybe general knowledge? That's a possibility, but I can't speculate as to who that may have been. 15:01 15:02

169 Q. Why did you not make a complaint of harassment, if that's how you felt?

A. Why? Things were bad enough without making them worse for myself. That's why.

170 Q. On the face of it, your complaint was one of financial deduction. Mr. Mackle provided an explanation as to his fault in relation to that. He should not have made that deduction; certainly not without consulting with you and taking soundings. That was, I suppose, the extent of his concession around that. That issue was in your favour. 15:02 15:03

Can you help us understand how an issue like that resolved, apparently with a degree of goodwill or ease, it didn't need to go to a hearing or anything like that, how does that lead to a situation -- what's your understanding of how that leads to a situation where you are being told, and it seems to be Mr. Mackle's understanding as well, that he would no longer place 15:03

himself in a position of a direct managerial relationship with you. So, for example, he would not attend the March meeting accepted. He would not attend meetings with you, generally, to work through any issues. How does that happen on the back of a financial dispute? 15:04

A. I don't think it happened on the back of a financial dispute at all.

171 Q. Okay.

A. I think the financial dispute was so black and white that, to me, I think it was right and proper that it should have been addressed in the form of a formal grievance and resolved in that matter. My response on its being resolved is suspend it. I wouldn't have had any desire to progress things along a disciplinary matter, irrespective who had done that to me. So I don't think there's any connection at all between that particular grievance and this complaint. 15:04 15:04

I didn't know at all that there was a standoff or he wasn't -- or these other arrangements were made for other people to intersect with me until I read all of this documentation more recently. I wasn't aware of that. 15:05

172 Q. You weren't aware of? 15:05

A. That he wasn't to meet with me. Wasn't it Mr. Brown had been appointed instead to interact with me? Or he was not to meet with me on his own.

173 Q. I think that's what Mr. Mackle said. The pieces were,

I suppose, choreographed so that Mr. Brown took a more...

A. Yes.

174 Q. You didn't know that until when?

A. I don't think I was aware of that until '21/22 when I saw all that documentation being disclosed to me as part of this Inquiry. I was entirely aware that Mr. Brown would meet with me about the records in the bin, for example, but I had no idea that it was by arrangement. I didn't pass any remarks on the fact Robert Brown was meeting with me because I've known him as long as I've known Eamonn Mackle so it wasn't an issue.

175 Q. Just so I'm clear, you weren't given any understanding that Mr. Mackle - whether formally or informally, however it came about - but you didn't know he had been removed from, stepped aside, whatever the description is, from managing you directly?

A. No. No.

176 Q. I just want to ask you about that. If we look at AOB-56083. Just at the bottom of the page, please.

This is a meeting with Mr. Wilkinson, who was the nonexecutive director, who was, as you know, engaged in the MHPS process. You attend a meeting with him. I think this meeting is March 2017 but I'll have that checked. You attend with your son, Mr. Michael O'Brien. Michael says -- and the dictation maybe doesn't give the best sense of this:

"But it had also been agreed at that time, around that time that the grievances were being issued that he would have no dealings with him again". You interject and say:

"Yes, I sought and obtained an assurance from Dr. Rankin and from Eamonn Mackle himself, particularly from Dr. Rankin, that I would have had no more dealings or meeting with him because I was on the point of breakdown as a result of his treatment over a period of years".

Does that account more accord with the reality of it? You had taken steps, according to this, to produce a situation where he wouldn't be managing you?

A. I had a number of -- I was invited, to put it politely, or summoned, to a number of meetings with Dr. Rankin and Eamonn Mackle over a period of time from 2010 up until -- I can't remember when this relates to. They were anything but -- they were not pleasant; they were brutal. Being told that I had to obey my political masters, having allegations fired at you. I had come to a stage where my previous secretary one day said to me, "Can you meet with Dr. Rankin and Mr. Mackle tomorrow or the next day?", and I asked her, "What's it about", and she said "It's about cystoscopies". I was wondering what's the next item on the agenda, you know, it's cystoscopies.

So I went to this meeting. The typical form was Dr. Rankin thanks you for coming and then thereafter she generally wouldn't speak. And after Eamonn, Mr. Mackle assaults you with "I thought you knew that", 15:10
"I thought you were told that". I just actually had to put my hands up and I said "Please stop". I was on the point of breakdown at this stage. I do not know actually how I managed to turn it around. And he went on to continue speaking. I said, "Please, stop". 15:11

So what this was about - this is typical - is that there was an elderly lady on my inpatient waiting list for quite some time since she had been referred to me by a gynaecologist after she had had unsuccessful 15:11
surgery for stress incontinence performed; the gynaecologist being of the very recent review that this lady would be suitable for an ileal conduit urinary diversion. I had seen her two years previously; we have long waiting lists. I thought at the time -- 15:11
she also had vaginal discharge. I thought what I'll do is I'll put her on the list for cystectomy and ileal conduit urinary diversion. So, this is why I was being summoned - "You still have a patient -- you have a patient on your waiting list for cystectomy after you 15:11
have been told that you are not allowed to do a cystectomy any more. There was no inquiry, no questioning. This was a pattern going on for two years.

177 Q. So, this is an example of kind of bullying or harassment behaviour that --

A. I just couldn't take it any more, Mr. Wolfe.

178 Q. Thank you for that background. The question I was probing with you was your suggestion that it wasn't until 2021 that you received information that established for you that Mr. Mackle had been moved out of the managerial picture. But what you're telling Mr. Wilkinson is something contrary to that. You had made an intervention and you had spoken to Dr. Rankin and, as a result of that, you were fully aware that Mr. Mackle would no more have dealings or meetings with you. Is that a more accurate way of putting it? 15:12 15:12

A. It's possibly more accurate but it's not entirely accurate, because that day was difficult. If you would just allow me to expand a little bit on it. Because I was allowed -- I asked "Can I do the ileal conduit urinary diversion without a cystectomy"? No problem. So, I was allowed to do the more difficult, the riskier reconstructive surgery without doing the relatively simple cystectomy. It worked out very, very well for the lady. 15:13 15:13

I just said, please, I can't take any more. The following day Dr. Rankin contacted me. The following day, it was a Friday. I was in theatre doing extra operating and she said she would wait around for me and I was concerned about that. But I went to her office and she was -- I was very appreciative of it because 15:14

she said she was very worried about my state the day previous, and I just said I can't take any more of this kind of behaviour, as I said earlier. She undertook that there would be no more such behaviour either, I have to say implicitly, at least from herself or, indeed, from Mr. Mackle.

So, I mean, months later I met with Dr. Rankin and it was a very, very different kind of meeting. I had no idea, as I said to you just now, that definite arrangements were put in place for other people to replace Mr. Mackle in his stead thereafter. Is that reasonable?

179 Q. Well, your answer here seems fairly clear that at some point long before 2021, you knew through Dr. Rankin that you'd have no more dealings -- or Mr. Mackle would have no more dealings with you. Is that fair?

A. I tried to explain. You know, I didn't mind meeting with Mr. Mackle at any time provided that they were conducted in a manner entirely different from previously. Dr. Rankin give me that undertaking. She honoured it herself and, as far as I was concerned, so did Mr. Mackle thereafter, including in the manner in which he approached me in the March 2016 meeting. So, if that answers you.

180 Q. I think the transcript speaks for itself.

MR. WOLFE KC: Chair, perhaps a short break now.

CHAIR: We'll come back at 3.35, Mr. Wolfe.

MR. WOLFE KC: Very well.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Everyone.

Last session of the afternoon, Mr. Wolfe.

MR. WOLFE KC: Yes.

181 Q. Mr. O'Brien, I want to use the remainder of our time this afternoon to chart the pathway, if you like, into what happened in March 2016 by going over in not too much detail, hopefully, but sufficient detail to allow you to get your position across and for me to reflect some of the position we've heard from witnesses already in respect of the issues which were then to emerge and form part of the investigation. 15:36

Starting with triage. I suppose when we think about it, the earliest indication that the Inquiry appears to have received of you facing a difficulty in processing triage and management wishing to speak to you about it was from 1996, when, in the statement of Mr. Mackle, he, as Lead Clinician For Outpatients said he spoke to you about a folder of triage that you were maintaining at that time. Does that accord with your memory? 15:37

A. Not entirely because, as I have stated in my witness statement, I had four folders because I had four categories at that time, which was, you know, as soon as possible, urgent, soon, and routine. And I was single-handed, and I really had to keep a control over 15:37

how I would manage things. And this is pre-digital era. So the as soon as possible was generally a thin one and emptied, and urgent was generally well emptied, and soon and routine was the most.

15:38

That system worked very, very well for me because if I got another referral from somebody previously referred and I had them in chronological order and all of that kind of thing, it worked for me. It worked after Mr. Baluch was appointed because I was able to 15:38 siphon off some of these on to his clinics. For a relatively brief period after Mr. Young was appointed, by which time he had inherited a backlog from Mr. Baluch and was building up his own and wanted to have somewhat of a clean slate. I believe it was 15:38 somewhere around that time, it doesn't matter if it was '96 or '97 or '98, and I no longer held these folders, or ring binders as they were, really, and they were given over to the central booking office or referring booking centre. 15:39

182 Q. Thank you. I suppose the clean point I want to make to you and take your response on is this: From early times in your career at Craigavon, let's call it the Southern Trust for present purposes, all the way through to, and we'll take it through to December 2016, 15:39 were you facing challenges in being able to deliver on triage in the way that the Trust expected you to do, and that in turn led to the Trust putting pressure on you, engaging with you, asking you to get things back,

that kind of thing? Do you recognise that as a general pattern?

A. Yes. Entirely, yes.

183 Q. Let me put up on the screen Mrs. Trouton's take on it. She was Assistant Director within Acute Directorate from in or about 2009 through to March 2016. WIT-120004. Sorry, I'll rephrase that, WIT-12004. I haven't written down the paragraph numbers so I'll have to just peer into this. Scroll down, please. 15:40 15:41

At paragraph 57, she describes the following.

"An escalation process was put in place with initial action through normal administrative processes had not proven effective. The issue was escalated both through the administrative admin, management lines and directly to the Head of Urology and ENT. The Head of Urology" -- I think that's Mrs. Corrigan in those terms? 15:41

A. That's right.

184 Q. 15:41

"And ENT would have contacted Mr. O'Brien directly and requested urgent return of triage. This was usually effective but, on occasion, it was escalated to myself and the Director of Acute Services for action. On intervention at senior level, Mr. O'Brien would then have completed and returned his triage. He would then have managed it appropriately for a time and then the cycle of delayed triage would start again". 15:42

Is that again a pattern that you would accept as being a reasonable synopsis?

A. It is.

185 Q. From your perspective I should say that the Inquiry is aware that when looking at monthly reports on triage, there are occasions when the amount of outstanding triage is very small; one case in some months during early, I think, 2013. 15:42

A. That's right. Yes.

186 Q. What is this sort of peak and trough pattern, if I can put it like that, reflective of? 15:43

A. Me having too much to do and not enough hours to do it. Just that's it. It's not like, you know, you would tend to one thing and then when you have that done, then you turn your attention to another priority, as you perceive it to be. 15:43

187 Q. The issue would appear to have been on the agenda for a meeting involving the Chief Executive in 2009. I just want to look at that with you. WIT-16552. Let's just go to the first page so I can better orientate you to what is happening here. It is the 1st December 2009. The persons in attendance include Mairead McAlinden, then Acting Chief Executive. Then you can see the remainder of the cast list including Eamonn Mackle and Heather Trouton. If we scroll to the next page, you can see what's being said about the triage of referrals. It says it is undertaken by one of three consultants within the required time scale. One consultant is triage is three weeks and he appears 15:44 15:44

to refuse to change to meet current standard of 72 hours. I asked Mr. Mackle and I think Mrs. Trouton about that, and I think it was their evidence that this related to you, you being the outlier here.

15:45

Whether or not you accept that suggestion, do you recall any particular follow-up after this 2009 meeting, any particular initiative to engage with you?

A. I don't have any recall. I do know that subsequent to 2009, I would have met With Heather Trouton and with Martina, and I can certainly recall meeting with Debbie Burns. But I don't know if any of those meetings emanated from this action plan.

15:45

188 Q. Okay. This perhaps saves me a little bit of time. You can recall that senior operational managers such as Debbie Burns and the Assistant Director, Mrs. Trouton, did meet with you from time to time to try to address issues around triage?

15:45

A. I Think Heather Trouton did more frequently than Debbie. My engagement with Debbie Burns was very much based upon and centred around the priorities regarding cancer timelines, my role as lead of MDT, and even the regional lead role as well. That led to she requesting Mr. Young to help out for a period of some six months. It was the intent, anyhow.

15:46

15:46

189 Q. This is the meeting with Mrs. Burns?

A. Mrs. Burns, yes.

190 Q. We'll come to that just presently. That was in --

A. 2014.

191 Q. -- 2014; correct.

I just want to seek your sense of what was happening to address the issue of triage. I think if we can agree as a general proposition, because I'm sure you have seen the emails like me, that periodically you are receiving from, for example, 8th October 2013, Mrs. Trouton flags that a large number of untriaged referrals, this is serious delay and can't be ignored. March '14, 67 patients awaiting triage. 17th April, 59 patients. You don't disagree with me when I say you were receiving these communications asking you to get this done? 15:47 15:47

A. I'm not so sure all of them, actually, were triaged by me, by the way, but I agree with you that I was copied in to those. And I might have been the main culprit. 15:48

192 Q. But then in terms of the response, your response was, what, getting them done then as soon as you could?

A. Getting them done as soon as I could and then turning my attention to another priority. That's the way it was. 15:48

193 Q. In the pre-urologist of the week creation, you were receiving both red flag, urgent and routine?

A. Yes.

194 Q. While we can see that there was delay and you were chased, before urologist of the week were you, in fact, triaging almost universally or completely -- 15:48

A. Oh yes.

195 Q. -- all of the referrals regardless of the

classification?

A. Oh, yes.

196 Q. So the numbers that are investigated as part of MHPS, they are all after the creation of the urologist of the week? 15:49

A. Most definitely. Yes.

197 Q. We can see on 26th November 2013 that you wrote the following email to Martina Corrigan. TRU-267905. Sorry, let me just repeat that, it's TRU-276905. Just to the bottom of the page, please. So 24th November. 15:50 "Urgent. Needing response. Missing triage". You're asked by Mrs. Corrigan:

"Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and 15:50 I know that this will need to be escalated early this week if not resolved".

So that is the broad issue and I suppose it is typical of what we see in various emails. If we go then to 15:50 what you say in response. You say:

"I really am so sorry that I have fallen so behind in triaging. However, whilst on leave I have arranged all outstanding letters of referral in chronological order 15:51 so that I can pass them to CAO" --

A. Central Appointments Office.

198 Q. Thank you. "Via Monica". That was your secretary?

A. That was my previous secretary, yes.

199 Q.

"In that order, beginning tomorrow. I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me. I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion". 15:51

15:51

So, a conciliatory response from you. In your witness statement, you deal with that, you may recall. May we have on the screen WIT-82562. At paragraph 468, referring to that email, where you are saying you are sorry for falling behind, you reflect that: 15:52

"Surely the response to that should have been to provide adequate time to carry out the tasks within my job plan, rather than simply raise the issue, know that the cause was overwork, yet do nothing substantive to address it, leaving me to address and resolve the backlog while on leave". 15:52

So, during these catch-up engagements, these meetings, ad we will go on to look at what Mrs. Burns and you discussed in 2014, up to then did you get a sense that really there is nothing to be done for you other than to continually urge you to get with the Trust's message? 15:53

A. I think that's probably reasonably fair at that time, yes.

200 Q. Were you asking for -- I mean, you say here what should have been provided was adequate time. During any of these interactions up until 2014 when you met with Mrs. Burns, was there any specific facility or assistance requested by you? 15:53

A. No.

201 Q. What did you have in mind or what could have helped you to address this issue that you acknowledge had been with you for many years? 15:54

A. I think that, looking back, if it was considered to be of fundamental and primary importance by the Trust, that we should have, you know, looked at what else I was doing. We're looking here at on 8th October 2013. Earlier on today I was reminding you that I was then facing a ministerial target of 26 weeks by 31st December '13. I can tell you that we had at that time approximately 500 people waiting up to 59 weeks, and under a lot of pressure to achieve that. So it's rather unfortunate for me at this point in time that that is the dilemma that was current at that time. 15:54 15:55

So, you know, I can't run - and I wasn't the only one running - we can't run to standstill to meet the ministerial target and to meet every other unmeetable expectation, as Mr. Haynes described it. 15:55

This is about choices. It's about sitting down and

discussing how do we actually tackle this in a more sustainable way. And really was there a more sustainable way. Was the real world solution to this is we all continue what we're doing and trying to do the best we think and muddle on and try to minimise risk to as many people as possible? That's how I felt about it.

202 Q. Mr. Haynes suggests that in or about 2007 or 2008, you were permitted some time away to clear your administrative backlog, and that a request for that was then -- a request for further time away was made by you, or at least he understood that it had been made by you, in 2009, and there was some correspondence in relation to in 2009. Can I just seek your views on that. If we go to AOB-007131. 15:55 15:56 15:57

A. By the way, I think you're making reference to Mr. Mackle rather than to Mr. Haynes.

203 Q. Did I say Haynes? I beg your pardon. I should have said Mackle, of course. Thank you for the correction. 15:57

So Mr. Mackle is writing to Joy Youart. I had thought that that might have been written to Simon Gibson as well but I'm not sure why that name has been covered. But it's clear Simon is the person to whom it's addressed, so I'm not sure why that has been redacted. 15:58

Leaving that aside, the preamble is:

"Simon, thanks for discussing Aidan's request to cancel

clinical work during July" - this is obviously July 2009 - "to allow him to clear the backlog of paperwork and his several concerns in relation to that".

15:58

The first issue he raises:

"I think approximately two years ago the Trust funded a similar exercise to allow Aidan to catch up. It was agreed then that this was a one-off and it was his responsibility (as per consultant contract) to prevent such a backlog developing again".

15:58

Just on that Mr. O'Brien, is that factually correct? Do you remember that you had been granted a dispensation from clinical work to allow you to catch up on the other side of your practice?

15:59

A. I was neither aware of it then and I have remained unaware of it ever since. This is the kind of tone of correspondence I would have received from Mr. Mackle.

15:59

204 Q. You make it clear that this suggestion of a further request in 2009 is incorrect.

A. It is.

205 Q. Let me just pull up your letter in respect of that. Your letter of 12th June is AOB-00133. So 12th June, scrolling down. What you say is, second paragraph:

15:59

"I certainly did not make or submit to anyone any request to do so".

It doesn't appear, within that correspondence anyway, that you have challenged the suggestion that two years earlier you had been granted a dispensation to catch up with your administrative work. But your evidence today is that that's --

A. Well, I have no recall of it. That's right.

206 Q. If it had happened, that you had been granted the dispensation that Mr. Mackle recalls or recalled at that time, then there would be no issue, there would be no reason to challenge it, but you didn't challenge him? 16:01

A. About the previous one or this one?

207 Q. Yes.

A. Which? 16:01

208 Q. The previous one.

A. The previous one. No, to my mind it was fabrication, as this one was. And I insisted -- I mean this is -- this occurred after a period of a number of weeks following the revelation that we were losing our ward. 16:01 That's the background to that. You probably are aware of that in documentation. Trying to ameliorate the concerns of nursing staff; arranging meetings of the Acute Director with nursing staff having had no consultation; trying to work around this; facing an 16:02 existential threat to our service. That's why I had a backlog then. So I didn't request any respite to clear the backlog of paperwork. I did request a retraction and apology.

209 Q. Yes. You didn't receive it?
A. No, not at all.
210 Q. Why didn't you challenge his assertion relating to the previous time?
A. For the same reason, actually, that it was hardly worth my while challenging this one, except that I'm glad that there's a paper trail because I didn't get an apology. 16:02
211 Q. Is it the case that throughout this lengthy timeline, and we'll come to 2014 and your meeting with Mrs. Burns just now, that you weren't being offered any way out of the backlog; that these events didn't happen and nothing else was devised for you? 16:03
A. No.
212 Q. The events of late 2013, we've looked at Mrs. Corrigan's email to you and your response to it, that you would catch up in chronological order. 16:03
We know that Mrs. Trouton then wrote to Mr. Brown around that time saying that there was a need to speak about this issue. She wanted Mr. Brown in the capacity of both colleague and Clinical Lead, Clinical Director - Clinical Lead, sorry, being Mr. Young - to address these matters with you. Ultimately, the matter ended up on Mrs. Burns' desk; isn't that correct? 16:04
A. I'm not quite sure. I am not aware that was the origin of it but certainly I met with Mrs. Burns about that and other issues. 16:04
213 Q. If we look at TRU-282019. Mrs. Burns recalls a very helpful meeting with you on 20th February -

Mrs. Corrigan had also attended - and says you have agreed to not triage new referrals with the exception of those named to yourself. Also to think about if any additional admin support would assist him. Deborah Burns directing her remarks to Michael Young says: 16:05

"I know this may place an additional burden on the rest of the team but appreciate you accommodating".

So the measure that was being put in place, I think you would call it in your witness statement at paragraph 459, as a temporary measure to relieve you of triage through Mr. Young, but it was only temporary and it failed to address the underlying cause which was progressively exacerbated by the additional roles we looked at this morning - NICaN, Clinical Lead and Chair of the MDT, MDM. 16:06 16:06

This pragmatic approach on the part of Mrs. Burns and your colleague Mr. Young, that was helpful? 16:06

A. Very helpful, yes.

214 Q. In addition, you're being asked to consider whether additional administrative support would assist you. Is that something you gave consideration to?

A. Yes. With Martina, there was an offer can we make it easier in some way to print referrals off for you or that kind of thing. But it was just I didn't think it was going to make any difference and someone else doing it made an enormous difference. At this stage, I was 16:07

still spending three, four hours a week preparing for MDM, as well as Chairing it and some period afterwards. I was spending at least one hour per week as lead clinician of NICaN. Detaching that from how that relates to any hours allocated to administration and any job plan, I mean if that weren't there, I may not have needed that degree of help with triage at that time. So, I was spending quite a bit of time in those other roles, basically.

215 Q. That was the year then that you moved to urologist of the week? 16:08

A. Yes.

216 Q. Mrs. Trouton recalls in her statement that your new urology colleagues refused to let there be a situation where you wouldn't triage. Does she recall that correctly? 16:08

A. No. Sorry.

217 Q. We'll bring it up on the page. TRU-00806. Just go to the bottom of the previous page and we'll catch the full context. Thank you for that. I think just up a little bit further. I think she's catching Mr. Young's, at paragraph 10, intervention. The issues were improved for a period of time. He says: 16:09

"While I was concerned about his practice, I was content patients were being seen and red flags were being done. As most referrals come in as red flags, I was satisfied patients were being seen. I did have a concern about upgraded referrals but there was no 16:09

data to show how many were being upgraded so I felt relatively comfortable the patients coming in as red flags were being seen. The numbers being upgraded were not many and I felt that the risks was relevantly small for the one that may slip through". 16:10

I think she's talking about the introduction of the UOW, urologist of the week process or arrangement. She then says: 16:10

"New urology colleagues were not willing to let him not triage".

Your observations on that?

A. That's new to me. Anyhow, can you imagine how that would make -- I have never been told my colleagues would not allow me not to triage. 16:10

218 Q. Assuming for the sake of our discussion that that is an observation that she's been able to pick up from discussion or whatever, but certainly with the discussions around urologist of the week, you were content, indeed would it be fair to say that you were an instigator, of triage forming part of the job description for urologist of the week? 16:11

A. I wasn't an enthusiast for it but it was an awful lot better than agreeing, which I would never have done, to have urologist of the week each morning only and do an outpatient clinic in the afternoon, as was proposed and hung in the air for quite some time. I personally 16:11

refused to buy into that. So, in order to get urologist of the week over the line, I agreed that we would do triage as well.

219 Q. But it was with a lack of enthusiasm; is that correct?

A. I would have willingly participated in it and done it completely if there had been time. But triage was an add-on to urologist of the week. In fact, I have seen it reported that urologist of the week of the week was introduced to facilitate triage. Nothing could be further from the truth. 16:12

Just to correct one thing, she may not have intended to say it. The majority of referrals received are not red flags. They constitute about 20 percent of the total.

220 Q. Very well. But in a context where the UOW, if I can call it that, arrangement is being put in place, there was probably, would you agree, an understanding amongst your colleagues that everybody had to do it? 16:13

A. That was the understanding, that we would do it. Yes.

221 Q. Whether that was reflected to her more aggressively than that, as maybe that sentence suggests, is something I don't think we asked her. She has that evidence there and we have your views on it. You weren't aware of that? 16:13

A. No. I actually think what she may be reflecting is Mr. Young, he certainly agreed to help out with triage. I think that he may have had some sense that his colleagues or other colleagues may have been less willing to help out in a similar manner, and he did it 16:13

all himself. I think that's possibly what that short sentence reflects.

222 Q. We don't need to bring it up; hopefully it's a well-trodden path. We can recall from your witness statement to Dr. Chada that you have said that you considered that the Trust knew that you weren't triaging because you used words like "it's impossible to do", "I find it impossible to do", but you regret not saying explicitly to colleagues or to Trust management that you're not doing it? 16:14

A. When it came to the time of the investigation and looking back, at the time I felt it was entirely adequate to say that something is impossible, it is impossible. It's not "nearly impossible". This goes back to the working environment that not just clinicians, but even people in management that work very hard, there's an endless expectation that the impossible will somehow, by some means, prove to be possible after all. Impossibility is not a word often used. It's not used in common parlance when it comes to impossible situations in healthcare, they use words like "challenging" instead, whereas, in fact, actually the truth is it's impossible. 16:15

223 Q. Could I put Mr. Young's perspective around that to you. TRU-00754. If we scroll down, please to paragraph -- yes, just before that. 16:15

He reflects that he knew that you found triage arduous and would often say you had difficulty completing

triage on a timely basis. Issues would be raised at departmental meetings. He says:

"However, I was unaware that triage was not being done". 16:16

Then he goes on, if we look down to 20:

"My experience of Mr. O'Brien is that if he was not wanting to do something, he wouldn't be pushed into 16:16
doing it. Mr. O'Brien would be the first to politely say when he didn't agree with something. I am not aware of Mr. O'Brien saying he wasn't doing triage. I knew he may have been behind with triage but not that he wasn't doing it". 16:17

Then if we look at 22:

"I would have expected Mr. O'Brien to have come to me and alerted me about the referrals not being triaged. 16:17
I hadn't spotted that it was such an issue".

Would the proper thing to have done, Mr. O'Brien, upon reflection, would be to have gone to Mr. Young, your Clinical Lead, with the batch of duplicate referrals 16:17
and put them on his desk and say, "I can't do them and I'm not doing them. I think it's unsafe and unsatisfactory to require me to do them. Bring me a solution"?

A. That is my regret. So I find it difficult, if not impossible, to have told people I wasn't going to do the impossible. I regret not handing them back. I kept them because I felt at least if I get time -- I mean, there was a default process in. I know that the default process is considered to have been a weakness in this system. In fact, I was quite surprised at the time that when referrals were received, they weren't actually put on a list in accordance with the clinical priority that the referrer allocated to them, although referrers did not always allocated any clinical priority. Then you had them triaged, and it could be altered. 16:18 16:18

Then to read down the line that the default, what they call a default, would be actually done away with because it is unsafe. How do you know when to triage? These people are not on the list at all. So I thought perhaps I'll check that patients have been given appointments, and that's what I was working through as well. But a greater point is I wish I had handed them back; not necessarily to Mr. Young but to the referral and booking centre. 16:19 16:19

224 Q. You make the point about the default system. You recall, I think, in your statement that on the occasion in early 2015 when that was discussed at a meeting with the consultants, again you highlighted what you were finding was the impossibility of doing triage. Who led that meeting? Who was rolling out the defaults or 16:19

explaining the defaults?

A. That was the staff from the regional booking centre. I remember Leigh-Anne Brown and Katherine Robinson being there. I remember more myself being there, where I was sitting and who I was sitting beside. I wasn't rushing in with glee to tell my colleagues that I found this impossible, and I didn't want to elaborate how I considered some of them found it to be possible by not giving due attention, as I saw it, to the other greater priorities when urologist of the week. So, I said it was impossible for me to do it all. 16:20 16:20

225 Q. Would you agree that the existence of the default mechanism and the awareness that it was necessary is perhaps the clearest illustration that you weren't doing triage? 16:21

A. On that day actually we were told that, you know, there were -- I wasn't the only difficulty with regard to triage, and our speciality wasn't the only speciality having difficulty with triage in terms of turnaround times. So the advice, and my understanding of it is we now have this system where people are at least on a waiting list. And I thought, yeah, that makes sense. Yet other people have viewed it differently, as a weakness, that it masked triage not being done. That's a different -- that's not to detract from the arguments surrounding triage. 16:21 16:22

226 Q. The concern more specifically might be it became a sticking plaster for triage not being done rather than leading to any particular initiative to address

why triage wasn't being done.

A. Yes.

227 Q. That's the concern?

A. Yes.

228 Q. Could I move to the final few things for this afternoon. In the same way that I asked whether triage and your failure from the Trust perspective of progressing triage was raised with you by Trust managers regularly, was the same approach taken with patient notes that you were retaining at home? 16:22 16:23

A. Not to the same frequency at all. The most frequent mischief, as you have referred to it, was in relation to triage. I was being repeatedly asked for charts for particular reasons, and I returned them, having "processed" them. That word I used earlier. 16:23

If you are about to ask me about dictation, the first I was aware of any frustration about my not having dictated on patients was when I received the letter of 23rd March. 16:23

229 Q. Yes. Let's deal with them in order and see if we can get through the three issues in the little time that remains this afternoon.

Patient notes. If we could look at WIT-11963. This is the 5th September 2013. Mrs. Corrigan is writing to Mrs. Burns. The subject is "Charts to Consultant's Home". Martina is saying to Debbie: 16:24

"I will speak with him again today and then let Robin follow up on this. One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for. I will let you now how I get on".

We will obviously hear from Mrs. Corrigan in relation to that. There were several emails of discussion or intended discussion with you to ask you to return patient notes, whether individual notes or what you might have at home. Do you recall being told, essentially, you shouldn't be keeping notes at home? 16:24 16:25

A. I think, yes, maybe once or twice in terms of the generality, whereas much more frequently - I think someone quoted 60-odd emails requesting 60-odd charts individually. I think someone has said that -- has testified to the fact that I always returned them and returned them expeditiously and so forth. If that answers your question. 16:25 16:26

230 Q. I think one is right. If one were to do a survey on the emails on triage, I think that would be at the top of the list. I can take you through them individually if required, but there's certainly indications of conversations with you asking you to get charts back. 16:26

A. Yes.

231 Q. Were you aware of what was the position on 12th February 2014, that the Trust was creating incident reports when charts which were clearly in your

position weren't to hand within the hospital when another clinician may have required them?

A. No. I'm only smiling because I had never heard tell of incident report forms until a few years after that, when someone said to me that they had filled in an incident report. I thought it was something to do with the Inland Revenue and went and Googled it. I have never filled out myself. No, I didn't know about that.

232 Q. Again, a pattern is noted in how you deal with patient charts. If we bring up on the screen TRU-277892. In October 2014 -- just scroll between a little, please. Heather Trouton is asking Martina Corrigan: 16:27

"Are you aware that this issue of notes with Aidan O'Brien is still a problem? Has it improved at all". Up the page. "It had improved but I feel it may be slipping again and I will talk to Aidan again". 16:28

Was there, again, a pattern, rather like triage but perhaps for different reasons, of you complying with the request to get notes back and then falling into the difficulty for whatever reason of not getting them back or not getting them back quickly enough? 16:28

A. That wouldn't be my recall of it at all. I'm not denying that Martina may have spoken to me. I don't have any recall of any word with me about charts at home following any documented intent to do so. I don't recall it and I don't deny it. I just don't have any recall of it. 16:29

233 Q. Was it, to the best of your recollection, to take the figure at or around December 2016 or early January 2017 when you returned circa 300 charts - it's a bit less, I think, by your estimate - but was that generally the order of the number of charts you'd have kept at home, returning them when you did the dictation? But generally was it of that order retained at home?

A. I think that was its peak and it's unfortunate it should have been so large. And, like, 88 of them were simply the hospital charts, the NHS charts of people whom I had seen privately, literally with no need for it at all. But there you are.

234 Q. Yes. You were pre-empting me earlier on dictation. Just to put the question to you succinctly. You were never approached until March 2016 when you met with Mr. Mackle in relation to the issue of tardiness or delay in respect of dictation.

A. I have no recall of anyone ever raising it with me. Unless you can find some evidence to the contrary?

235 Q. No, I was going to suggest to you that the origin of this concern, according to Mrs. Trouton's evidence - and I'll just give the reference, I don't think I need to bring it up on the screen, it is WIT-12127 - she says that towards the end of her tenure as Assistant Director for SEC in 2015, a new concern was raised with her and Mr. Mackle by the Head of Urology - that would have been, of course, Mrs. Corrigan - as to Mr. O'Brien not regarding patient outcomes on the electronic patient centre administration system, and she says, "or

often in patient notes".

What she got from your fellow clinicians who were new to the Trust or relatively new to the Trust and who were carrying out a validation process on backlogs, including on some of your cases was this revelation issue, and we'll stick to dictation rather than get into a debate about what all of it was, that it wasn't done. 16:32

Should the Trust have been otherwise aware that you weren't doing it or weren't able to do it? 16:32

A. Should I have told them?

236 Q. Well, that was going to be the next question. Should you have told them? 16:32

A. I don't know the answer to that. What disappointed me most was that I wasn't told by my colleagues, that no one raised it with me. But that's one of the disappointments throughout all of this process, is the days of horizontal communication with one another seemed to have gone completely and replaced by escalation. I don't know the answer to your question, sorry. 16:33

237 Q. Well, we saw this morning with a particular patient, the young female, you had failed to dictate; you accepted you should have dictated and referred the patient to Mr. Haynes because of the particular pathology or issue. That sort of shortcoming you would have recognised, had you thought about it or reflected 16:33

on it, was causing difficulty?

A. Yes.

238 Q. You would also have appreciated that you were in difficulty in being able to progress your dictation --

A. Yes. 16:34

239 Q. -- in the manner that you must have known was expected of you by the Trust?

A. Yes.

240 Q. In that kind of context, should you not be going and saying, listen, it may not be entirely visible to you 16:34 but I have these notes at home because I'm running behind with my dictation and I will endeavour to catch up, in much the same way you said to Mrs. Corrigan in the autumn of 2016 as you were going into some period of absence. Should you have been more transparent 16:34 about that?

A. I hadn't thought about it. On thinking about it now, possibly, yes. In the course of asking the question, you referred to dictation as something that was expected of me. I hadn't read or heard of that 16:35 expectation prior to this issue arising. I wasn't aware that there was any expectation on the part of the Trust, certainly, that there should be dictation done at the end of each consultation. I'm not saying that it's not optimal to do so, I'm just making that point. 16:35 I suppose, actually, that that contributes to my not reporting to the Trust in a more transparent way.

Then, I would have to confess, in addition to that, I would ask myself in advance, you know, what support are they really going to give me? I felt I was on my own to tackle it. Maybe that I mistaken on my part, and perhaps it would have been better, and particularly for Patient Safety concerns, to do otherwise. But that's how I felt at the time. 16:36

241 Q. There may be some surprise at what you've just said, that you didn't understand that it would be the expectation that you would dictate following a clinical encounter. Now, we discussed this morning the range of tasks that are associated with completing a clinical encounter, which included letter to the general practitioner, making arrangements to place the patient on whatever appropriate waiting list, or to discharge, depending. So, a range of things may have to be done after the clinical encounter. You prioritised matters, you've explained. You dealt with the urgent ones first and then had intended to make your way through the less urgent ones as time allowed. 16:36 16:37

Is that not at least an implicit admission on your part that you realised that the norm, the normative position was dictate and complete the clinical encounter?

A. All I'm just saying is that it is possible to have all of those blood tests done, all of those urine cultures done, to have requested the CT scan or whatever, and arrange to review the person in one month's time with an outcome entered on PAS. It is possible to do that 16:37

without necessarily dictating a letter as well to the GP. It is optimal that a letter would additionally be sent to the GP and anybody else to whom it may need to be sent, including the patient. All I'm just stating is, apart from that, I wasn't aware of any expectation on the part of The Trust that every encounter should include all of those things, including the dictation.

242 Q. Thank you. Your position is clear.

Finally, just to complete, I suppose, the pathway to what was to come later in 2016, let me just ask you about private patients. We know obviously from what you said to Dr. Khan, and Dr. Chada before that, that you maintain a population of no fault, and you have explained that. I just want to ask you in the same way I asked you in relation to the other three issues, was any concern about private patients and your management of them into the NHS for treatment whether in diagnostics or in theatre ever raised as an issue by operational management or medical management? 16:38 16:38 16:39 16:39

A. No.

243 Q. Thank you.

If I could just show you Mr. Young's response to Mr. Haynes around this. If we could have up on the screen, please, TRU-270116, so you can see the email. Perhaps you are familiar with it already. 16:39

Earlier in 2015, in April or May time, Mr. Haynes had written to Mr. Young expressing concerns about how he understood or how he perceived private patients were being given an advantage by you. He alludes to that. He says, 2nd June, just the bottom of the email there: 16:40

"I emailed you on 2nd June 2016 about the ongoing issues of patients on waiting lists not being managed chronologically and in particular private PA". 16:40

Mr. Young responds, 26th November:

"I had spoken before to the person in question regarding this issue in general and the justification of urgency, and I agree since the waiting list for some 16:41 things are so long, for example, urodynamics. Will have to speak again then".

He is saying - he doesn't name you - but he says he has spoken to the person and the justification of urgency and suggesting to Mr. Mackle will have to speak again. 16:41 So, he is suggesting to Mr. Haynes that he will have to speak again to you, assumedly. A suggestion of two possible conversations with you.

A. Yes.

244 Q. We will have to ask Mr. Young for his view on whether 16:41 they happened.

A. Yes.

245 Q. Do you recall Mr. Young --

A. I have no recall of -- if you're asking specifically

whether there was ever a discussion between Mr. Young and myself about any allegation that any private patients of mine were ever given preferential treatment in the view of anybody else in the form of jumping the queue, the answer to that is no. I have my own view on queue jumpers.

246 Q. Just if I can make the question more general then. You've narrowed the parameters of your answers to the question I have posed to you. Did he ever say to you, for example, generally, as regards your private practice, you just have to be careful that people moving from your private practice on to NHS treatment have to be -- that move has to be clinically justified in a context where we have a massive waiting list concern? 16:42 16:43

A. No. I remember actually one conversation that we did have that followed shortly after a multi-disciplinary meeting, where Mr. Young had submitted a case to be discussed, a patient who he had performed a radical nephrectomy on years previously, then years later, having remained well, she had a single lesion in her rib and it looked like as if it was a metastatic lesion. Should he biopsy it or should he just ask a thoracic surgeon to re-site that part of the rib. I think I was Chairing that MDM. Mr. Haynes objected to us discussing, at an NHS MDM, a patient who was being followed up by another person privately. I remember Michael -- I was doing appraisal at the time, so that's interesting. It could have been around 16:42 16:43

about this time in November/December '15. He raised with me about, you know, Mr. Haynes having a concern about private patients, and I couldn't understand why he would have any such concern. It was in the context of this particular event happening at MDM. We both -- 16:44
I certainly passed it off as Mr. Haynes having a particular antipathy to private practice, and I have heard him express that before. He did conduct a private practice, as I recall, in Sheffield, and he didn't enjoy the experience. I think he felt that 16:45
patients came along with a lot of expectations, that possibly they would be treated preferentially.

So apart from that single episode, but I didn't come away from that with any concern that people thought 16:45
I was giving any private patients of mine preferential treatment. I knew all private patients had the right to go on to an NHS waiting list of whatever kind.

247 Q. So if nobody, Mr. Young in particular, didn't send a shot across your bows or mention Mr. Haynes' concern, 16:45
were you nevertheless confident in your understanding of what the rules of the game were in terms of private patients moving across into the NHS?

A. Yes. I think the only omission on my part is that in '15 and certainly until this was raised as an issue and 16:46
I moved over entirely to digital dictation and so forth, I don't think, and I cannot recall whether there were these change of status forms that were available online. I certainly used them after January '17 or

after 30th December '16.

At this period of time with regard to the rules, as you refer to them, in terms of clinical priority, I had major reservations in general terms about there just being two categories of clinical priority, urgent and routine.

You know, you've heard how Mr. Haynes' views with regard to admitting people in chronological order. I've even seen it referred to in the documentation as "strict chronological order". It is clinically indefensible to be organising the treatment of people who are on waiting lists up to six years long because things change all the time, whether they are NHS patients or private patients. 16:46 16:47 16:47

248 Q. In broad terms, and we can maybe descend into some of the specifics tomorrow, your view of the proper approach was regardless of the origin of the patient and regardless of their position on a chronological waiting list, there is a need to carry out a clinical assessment of the patient's urgency or priority, and, if the patient passes this clinical test, for example, a TURP patient may be more or less urgent in terms of the need for the process for the procedure. Is that the way you worked it? 16:47 16:48

A. Absolutely.

249 Q. Thank you.

MR. WOLFE KC: It is now 4.50, I think we should close

for today.

CHAIR: Yes. Thank you, Mr. Wolfe. Thank you, Mr. O'Brien. We'll see you again in the morning. Ten o'clock. Thank you.

16:48

THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 20TH APRIL 2023