Urology Services Inquiry

Oral Hearing

Day 70 – Tuesday, 14th November 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON TUESDAY, 14TH November 2023 AT 10 A.M. AS FOLLOWS:

CHAIR: Good morning, everyone.

MS. McMAHON BL: Good morning. The witness this morning is Mr. Robin Brown. He is a retired consultant and was the Clinical Director in the Southern Trust, and he wishes to affirm. 10:01

MR. ROBIN BROWN, HAVING AFFIRMED, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:02

1 Q. MS. McMAHON: Thank you, Mr. Brown, for coming in to give evidence to the Panel. My name is Laura McMahon, and I'm junior counsel to the Inquiry. I will be taking you through your evidence today. 10:02

Now, you've provided us with replies to Section 21 Notices we've served you, and I just want to go to those notices, first of all, and ask you if you wish to adopt those as your evidence. So if we could go to WIT-17509. This is Notice 20 of 2022 and the date of the Notice is 29th April 2022. If we go to WIT-17561, you see your name at the top of that page, and if we go to this page we'll see what I hope is your signature. Do you recognise that as your signature? 10:02 10:03

A. I do.

2 Q. And do you wish to adopt that as your evidence?

A. Yes.

3 Q. And your reply is dated 15th June 2022. We then received an addendum statement to that, and that can be found at WIT-100409. Again, your name at the top of that page. If we go to WIT-100418, again at the bottom of that page, is that your signature? 10:03

A. Yes.

4 Q. And do you wish to adopt that as your evidence?

A. Yes.

5 Q. And that's dated 20th September 2023. Then, there was a further addendum statement to your main statement and 10:03 we can find that at WIT-103533, and your name again at the top of that. If we just move down to the end of that - it's the next page - and is that your signature at the bottom?

A. Yes. 10:04

6 Q. It is dated 30/10/2023, and do you wish to adopt that as your evidence?

A. Yes.

7 Q. Now, there have been a few changes in some of the context of your evidence and you have helpfully 10:04 provided that in your addendum statements. What I hope to do, to try and keep things running smoothly, is to simply draw attention to where the changes are relevant to your main evidence. I know in some of the further information you've provided us with, you've given us 10:04 either corrections to some of your knowledge or wider context, and the opportunity is here for you to give your oral evidence as it is correct, so we shall work through, and I'll rely on your answers to provide me

with the information needed, but where I feel I need to add to that or just to clarify a point, I'll go to the addendum statements. So we'll rely, effectively, on your recollection and, where needed, I'll point out where there are some slight changes. 10:05

Now, the context of your evidence is really your role within the Southern Trust. You were Clinical Director for two separate periods during a time relevant to the Inquiry, and you had, therefore, some role within the 10:05 governance structures, and those are the issues that are the focus of this Inquiry and will be the focus of my questions today. The governance issues generally and the way in which the structures were set up, so that any issues could be addressed, will be something 10:05 we'll touch upon, and I know from your statement that you have a couple of incidents where you did have direct contact with Mr. O'Brien, and we use that as an example of governance and how that was dealt with, and we'll look at some of the actions taken generally and 10:06 in relation to Mr. O'Brien, but focusing specifically on governance, so we will try to keep the evidence as relevant to the terms of Inquiry as possible, if that helps in your answers.

10:06

Just from the outset, I wonder if you could set out your career path and your education to date.

A. Well, I qualified as a doctor from Queen's University in 1979. I was appointed to Daisy Hill Hospital in

1991; it became the Southern Trust in 2008. I became a Clinical Director in Daisy Hill in 2003 and continued in that role in the new Trust in 2008 and retired in 2016.

8 Q. And since your retirement, what have your activities been then in relation to your medical practice? 10:06

A. Well, I did a couple of temporary clinical jobs for about a year, but, after that, really what I specialised in was in medical education, and I did that for about four years, overlapping with another job, which is the -- was the lead consultant for appraisal and revalidation, going on, more recently, to be the corporate lead for appraisal and revalidation since my statement was written. 10:07

9 Q. Now, I wonder if I could just ask you to bring the microphone perhaps a little bit closer. You do speak very softly, and I just want to make sure that everything is picked up, and you may need to raise your voice slightly just to make sure that you are heard by the stenographer and the Panel, if that's okay. 10:07

Now, you have said, and we don't need to go to this, but you have said in your statement that you were a consultant general surgeon who had a special interest in urology? 10:08

A. Yes.

10 Q. If you could just -- you weren't a fully trained urologist, I think you have described yourself as, but you did have certain expertise in that area. Could you

just outline that for the Panel?

A. Yes, that's perhaps historical, in that, whenever I became a consultant, there were quite a few general surgeons who were providing urological services in the outlying hospitals. The only urology department was in Belfast, and the services to the peripheries weren't all that good. So there were general surgeons providing urological services in almost all of the peripheral hospitals, and perhaps all of them, except Newry, and I became the one in Newry. 10:08

11 Q. And you stayed in Newry until what year?

A. I stopped practising in Newry in 2016.

12 Q. So all of your clinical practice was based at Daisy Hill?

A. Until 2016, and then I did six months basic urology - the same stuff I was doing as a general surgeon, but in Craigavon. 10:08

13 Q. So that was post-retirement?

A. It was.

14 Q. Yes. So, for our purposes, you were located at Daisy Hill -- 10:09

A. Yes.

15 Q. -- while you were both a surgeon, with some area of expertise in some aspects of urology and while you were Clinical Director? 10:09

A. Yes.

16 Q. If I could just concentrate, just at the moment, on that area of expertise and your interaction with urology generally as a surgeon. What did that look

like on a day-to-day basis as regards your ability to engage with other urologists or contact them about the specific work that you were undertaking for urology? Were you very much a practitioner in Daisy Hill on your own, working within your specialty? 10:09

A. Oh, yes. I mean, I was independent of the urology department. The general practitioners locally referred most things to me. I sorted them out, if you like, into things that I could do, things that I couldn't do and would refer to Craigavon. And, over time, the 10:10 general practitioners locally learned some things that they shouldn't refer to me in the first place, but, still, there was quite a lot of material that came my way, and either during the process of investigation or later on I would then refer to Craigavon, to the 10:10 urology team there, so I only dealt with what I could deal with.

17 Q. So, it was a mutual arrangement, in that you would have -- the more complicated or stuff that was outside your area of expertise, you sent to Craigavon, and 10:10 perhaps they also sent some stuff to you?

A. They didn't send an awful lot of stuff to me until 2013, when they sent an awful lot. At that time, there was quite a backlog of urological cases waiting for surgery, a long list, and I was approached by senior 10:10 management to take some stuff off the waiting list. So, what I did at that time was to take the waiting list, go through it and see what I could do, which is mostly what you maybe understand as N codes, and I took

mostly N-codes off the list and did those.

18 Q. And can you give the Panel a flavour of the type of surgery that you would perform within the area of urology? What sort of work were you doing?

A. N-codes really refers to operations on the genitalia, so, for instance, circumcision, hydroceles. I also did a lot of cystoscopies, which are N codes, but I didn't do any major transurethral surgery, apart from small bladder tumours. I didn't do renal surgery. So it was very basic surgery. 10:11

19 Q. We'll talk later on about the MDMs that developed, the meetings and your involvement in those and some of the issues you've drawn out in your statement about your capacity to get involved in those because of your remoteness. Just as a general point, in relation to you being off site, off the main Craigavon site, if I can put it that way, working in Daisy Hill, what was your experience of your ability to communicate and engage with your colleagues both about urology and any other issues that arose? 10:12

A. I usually phoned them, or we sometimes would have texted occasionally, but not very often. Mostly, I would have phoned them and usually tended to try and use the hospital phones for some reason, and discuss cases, and then, of course, we wrote to each other. But then whenever the MDMs came along, a lot of the referrals, especially -- well, not a lot of the referrals, but all the cancer referrals were basically done at MDM. 10:12

20 Q. So, prior to the MDMs coming in in 2010, it was really more formal methods of communication: lifting the phone and e-mailing?

A. Not so much e-mail, more letters, and maybe, occasionally, telephone calls, if it was very urgent. 10:13
If there was an urgent urological problem on the wards, it was always a telephone call.

21 Q. Now, you've made a few amendments to your explanation of your job description, and I've tried to summarise it in a couple of lines to save us going back and forth, 10:13
but if I've interpreted it incorrectly, please let me know. From your statement, it seems that you were the Clinical Director for Surgery and Elective Care from 2nd January 2008 until 1st September 2010?

A. Yes, I think so. 10:13

22 Q. At that point, Ms. Sam Sloan was appointed the clinical director on the Craigavon site, with responsibility for urology, on 1/10/2010, so you had been responsible for that, roughly, two-and-a-half-year period.

A. Mm-hmm. 10:14

23 Q. Then, Ms. Sloan took over on the Craigavon site, with responsibility for urology, and she was then replaced by Mr. Sam Hall on 12/12/2011, who had responsibility for ENT at that point. Then, at that point, you then took up responsibility for urology again, that seems to 10:14
be the way it worked. There was a slight hiatus in the middle --

A. I believe so.

24 Q. -- where responsibility for urology went to Ms. Sloan;

then, when her post was replaced by Mr. Hall, he took up ENT, and urology came and sat back with you?

A. I think that's fair.

25 Q. So the second period of when you were Clinical Director ran from 12/12/2011 until 31st March 2016, when you retired? 10:14

A. Yes.

26 Q. I wonder if we could look at your second addendum -- or your first addendum statement at WIT-100409, at paragraph 2(a) -- well, at paragraph 1, you wish to amend paragraph 1.5 of your original statement, and I'm going to read out what you say in relation to your role. You've removed the first line of paragraph 1.5, which had said: 10:15

10:15

"There are no other occasions, that I can recall, when I had significant engagement in the Urology Department."

That's been removed. And you start the sentence saying: 10:16

"I was CD for Urology, but this was a difficult role to perform from Daisy Hill Hospital, where my job was largely clinical. I had one PA (4 hours) allocated for management and, for most of my tenure, I was not supported by a lead clinician. Prior to the formation of the SHSCT, I had been a CD in Daisy Hill Hospital alone and had responsibility for surgery and 10:16

anaesthetics. I was able to manage that role effectively. I had agreed job plans with all my consultants and had time to design some important innovations. I was close to my team on a daily basis and had ready access to the soft intelligence that is so important to managing a department. I also had the adjacency and availability of all the managers that facilitated the exchange of information and advice and it worked well." 10:16

10:17

And you also want to add this to paragraph 1.5. You say:

"Things changed with the inception of the new Trust. The management systems in DHH" -- which is Daisy Hill Hospital -- "were largely moved to CAH" -- which we know to be Craigavon. "All of the AMDs for Acute Services were then in CAH and I was remote for the 'nerve centre' of the Trust. My information came through official channels, but even that was not all that effective, given the communication difficulties relating to travel between sites, video conferencing and simply my availability for meetings. The biggest problem was the lack of opportunity for acquiring soft intelligence or the ability to pop into a manager's office for a quick chat, which makes for effective management. I knew a lot about my team in Daisy Hill Hospital but had little knowledge of the teams in Craigavon." 10:17 10:17

I just want to stop there, just for a moment. What you are setting there is the scene. You being off site, I think it's fair to say a summary of that evidence is that you felt that that, in some way, limited your access to information that may have informed your role?

A. Yes. I mean, the most important information in management is the soft intelligence and the popping in and out of offices and stopping people in corridors. I had none of that. I was isolated. So, I mean, the team in Daisy Hill, I was seeing them on a regular basis, I was meeting them in theatre, and so we were chatting about things in the tea room, but there were no tea-room conversations that I could have with the clinicians or the people in Craigavon. When I did meet with management, it was in an official meeting.

27 Q. When you talk about your interactions as Clinical Director in Daisy Hill, and you've mentioned it in your statement, as well as those informal ways of gathering information that you have just described, as Clinical Director, did you have any procedures, formal weekly meetings, any processes set up by which there was a structure to some sort of oversight around governance for you as Clinical Director?

A. Are we talking about pre-2008 or after 2008?

28 Q. Well, when you took up your post as Clinical Director in 2008?

A. In 2008. We had a weekly meeting, a team meeting, as all teams do, we had a team meeting every Friday

morning at 8 o'clock -- sorry, every Tuesday morning at 8 o'clock. There was no agenda for that meeting; it was just simply sit around the table and it was an opportunity for people to bring up issues that concerned them, so it was effectively a meeting of soft intelligence. But there were, otherwise, not a lot of other formal meetings that I can remember in Daisy Hill, unless there was some very major specific issue which arose which needed to be dealt with. 10:19

29 Q. And those were meetings in Daisy Hill with Daisy Hill clinical staff? 10:20

A. Sorry?

30 Q. Were they meetings in Daisy Hill for Daisy Hill clinical staff?

A. Yes, they were team meetings, yes. 10:20

31 Q. And given your role also covered urology in Craigavon, was there any -- did you have anything set up to engage with those clinicians or staff that might have informed you in your role?

A. There were meetings in Craigavon, in urology team meetings, but I found it very difficult to attend those, because if I attended a meeting at Craigavon, I would have to either drive there and drive back again, which took up all my time, or attempt video conferencing, which really was not very successful. 10:20 10:20

32 Q. Now, you address that in your addendum statement, and I just want to read that out, because it provides more detail than your original on the problems that you say you faced. I'll go back to WIT -- just the page we're

on, at 1.7. That's WIT-100410, for the transcript, at paragraph 1.7. You make reference to video conferencing, so I'm just going to read out what you say:

10:21

"Video conferencing was meant to address the problem of communication between the two sites, but it was ineffective, in my view, for the following reasons:

In most cases, I was the only participant from DHH. If the link did not work, meetings often simply proceeded at the CAH side. 10:21

Efforts were made to schedule meetings to suit my availability, but all managers and most other participants were on the CAH side and it was often not practical to schedule a meeting around my availability. 10:21

The meeting room was in CAH and I was the person on the screen in the corner, which did not make for good interaction. It was not like Zoom or Teams. The microphone was placed in the middle of the table and all conversations were picked up and superimposed. There were attempts to introduce protocols so that only one person spoke at a time, but this never worked. 10:22

I do recall that the only VC" -- which is video conferencing -- "that worked well was the urology MDT, because only one person was permitted to speak at a time and this was adhered to. Initially, there were 10:22

two locations in DHH for VC and there was competition for access. In 2011, I got VC access to a laptop, but it was frequently problematic and I had great difficulty connecting to anywhere except the urology MD. However, even this failed me from time to time. 10:22

The biggest problem was that official meetings are no substitute for soft intelligence and opportunistic access to managers. I was aware that a lot of business is done on the way to a meeting or in a huddle outside 10:23 after the meeting. This is what I really missed when the management left DHH; the opportunity for casual exchange of ideas and concerns was lost."

Just in that last sentence when you've said "what 10:23 I really missed when the management left DHH", what does that mean?

A. Well, the management structures that were represented in the Southern Trust were represented largely in a smaller way in Daisy Hill prior to the amalgamation. 10:23 So, we would have had, for instance, the Medical Director and the Director of Acute Services were both the same person, so it wouldn't have been two separate departments, but we had the equivalent in a smaller scale in Daisy Hill. So there was a management 10:23 department at Daisy Hill, a management department at Craigavon. After the amalgamation, there was only one in Craigavon. There was nothing in Daisy Hill.

33 Q. And that would have happened fairly early on in your

tenure?

A. It happened in 2008, rather abruptly.

34 Q. So, whenever you took up post, that was the position as was. I know you had been working as a consultant prior to that, so you had some experience of that local, if I can call it, the localised management structure, but, as Clinical Director, that had happened when you took up post, and did you see that from the outset as being something that was a challenge immediately to you fulfilling your Clinical Director role? 10:24

A. I can't say that I spotted it in advance. I think we didn't realise. There were no AMDs in the Acute Services stationed in Daisy Hill. The only people in Daisy Hill were CDs, and I don't think any of us realised -- had realised that the management structure was going to leave the hospital completely, so we were taken a bit by surprise. 10:25

35 Q. Just in relation to, if I can call it the command structure from your perspective, could you just run us through who you worked with, who was your direct line of seniority and what other key personnel you engaged with? 10:25

A. Well, prior to the amalgamation, my direct line was the Medical Director/Director of Acute Services, there only was one, and there was nothing in between. In the new Trust -- 10:25

36 Q. Sorry, if you could just tell us the names as well, so we --

A. That's Dr. Loughran.

37 Q. Dr. Loughran, Patrick Loughran.
A. And in the new Trust then, my AMD was Eamon Mackle. The Medical Director was actually Paddy Loughran again, temporarily. Then, I also worked with Heather Trouton, who was the Assistant Director, and there were a number of heads of service, but they changed from time to time, and the first Director of Acute Services was Jim McCall, followed by Joy Youart, etc, etc. 10:26
38 Q. Now, you've mentioned about video conferencing, and I know things have changed a lot since, in technology. You mentioned about the difficulties in engaging. Was there ever a stage where there was any effort made or system set up whereby you could videoconference into a general meeting as Clinical Director, not just a clinical meeting but a meeting that allowed other issues to be discussed, as you've described you had on Tuesday mornings in Daisy Hill? 10:26
A. Yes. I mean, the IT did help. They would sometimes come along and make adjustments to my computer, and I've only given a sample in the evidence of the e-mails, but there were endless e-mails, because they would come along and then I wouldn't be able to communicate with somebody properly or, for instance, the -- if you use the urology MDT as an example, I could either see a big screen of me and a small screen of them or a big screen of me and the X-ray screen, but I never could get it to the point where I wanted to have a big screen of either the X-rays and pathology or them but not me. There was always looking 10:27 10:27

at -- every time I looked at the screen, I saw myself, and they couldn't actually get that degree of technology to work.

39 Q. And was that for the entire duration during your tenure? 10:27

A. It never got any better.

40 Q. Never got any better. And you left in 2016 and it hadn't improved?

A. Say again?

41 Q. You left in 2016 and it hadn't improved much? 10:28

A. No, it hadn't improved. If there was a very important meeting - and this happened quite a lot - if there was a very important meeting which was a video conference, I didn't even attempt it; I just drove to Craigavon.

42 Q. And how often would you have gone to Craigavon? 10:28

A. Well, I was on a one-in-five rota with surgeon of the week, so for one week in five I would have been unavailable completely. But because it was a prospective cover rota, effectively it was every fourth week that I was on emergency, so, those weeks, 10:28 never. The other weeks, at least once.

43 Q. So that leaves two weeks that you were there at least once, is that right, if I've heard your evidence correctly?

A. Three out of four weeks, I would be in Craigavon once 10:28 or more.

44 Q. And when you were in Craigavon, the purpose of you being there was what?

A. The main purpose was a job. So, for instance, I spent

an awful lot of time doing MHPS investigations, and that was a big bulk of my work as a CD; job planning, going to meetings. My diary was full of meetings, which often clashed with clinical sessions, so I could only pick and choose which ones I could go to. 10:29

45 Q. And was there any time when you were there that would have allowed you to meet with other clinicians and other, perhaps, AMDs, the heads of service, and have a sit-down meeting? Did that ever take place?

A. There were occasions whenever I was able to attend the urology general meeting, the team meeting, and I know that I attended at least two of those that I can think of, but I wasn't a regular attender; it just wouldn't have been practical. I know I have minutes of two meetings that I could find where I was definitely there and I definitely made a contribution. 10:29

46 Q. Well, I know in general terms from your statement that you say that you didn't have any issues brought to your attention regarding governance in urology?

A. Apart from those mentioned. 10:30

47 Q. Apart from the two incidents that you've mentioned, and we'll move on to. But I wonder if we could just -- you've mentioned job planning, and I just want to go to an e-mail where you've made reference to that, at TRU-260032. You'll see the message below is from Eamonn Mackle, dated 19th February 2013, to you, and Sam Hall, Heather Trouton and Gillian Rankin are copied in, and the subject is "job plans". He says: 10:30

"Hi Robin,
I have been talking to Gillian about job plans and she needs them finished in the next month. I appreciate your workload, so we need to split them up. Therefore, can you do Adrian`s and Damian`s. Also, you have done the two associate specs and the permanent staff grades.

Sam Hall has agreed to do four of the CAH cons: Gareth, Mohammed and Alistair, and I will do the remainder. 10:31

Also, when can I see the new urology job plans to check if they match the principles agreed with Gillian at the Monday evening meetings?

Eamon."

Your reply is sent on the same date, 19th February 2013, at 7 p.m. in the evening, and you say: 10:31

"The attached charts show where we are with the job plans at present. I am struggling to find the time to progress so many job plans at the same time and so some assistance would be appreciated." 10:31

Now, the Panel have heard a bit of information, a bit of evidence around job plans and the amount of time they seem to have taken up, various personnel, in

trying to get them completed or agreed or set up in the first place. This appears to be an e-mail were you are indicating that you have a lot to do with job plans and it's perhaps taking up a disproportionate amount of your time, would that be fair? 10:32

A. Yes, it was. I was just completing two very big MHPS investigations, which either were just finished or were finishing around that time. Simultaneously, I had done the job plans in Daisy Hill for the seven or eight consultants - I think there were eight consultants and 10:32 middle grades in Daisy Hill, I'd just finished those. Somewhere around that time, Eamon had asked me to do the general surgeries in Craigavon, and I think in an e-mail before or after that I'd said I don't think I can do this, and Sam Hall stepped in, and I was sort 10:32 of just indicating that I was behind because I was very slow, but I did get there.

48 Q. When you asked for assistance - I know you mentioned the e-mail with Sam Hall before or after this - did you get assistance to complete these? 10:33

A. Yes, Sam -- not the urology ones, no, but Sam did some of the general surgeries in Craigavon, which I was allocated as well.

49 Q. Was there ever -- when you indicate in an e-mail like this that you are struggling around getting that aspect 10:33 of your role completed, was there ever any conversations with either Mr. Mackle or Mr. Loughran or anyone, that you needed to increase your capacity to be able to fulfil your role?

A. No, not really. This would have been well past Dr. Loughran's time; this would have been into John Simpson's time. There was a later e-mail as well indicating that I was also behind later on with some job plans and John Simpson -- with job plans and appraisal, and John Simpson had suggested reallocating some of the appraisals to other people, so, yes, assistance would have been offered.

50 Q. And what's your view on the time allocated for you to fulfil your role as Clinical Director, including job plans and appraisals, the time allocated by the Trust; did you feel that that was insufficient, as this e-mail would seem to suggest? 10:34

A. I just, at that time, felt that I was struggling because I was getting behind, but seen from that point, I thought I could get over this hill as opposed to being bogged down forever, but I do realise now that there are a lot more CDs on the ground than there used to be. 10:34

51 Q. Well, when you left in 2016, had you got over the hill and were you up to date, or did you leave your post and retire feeling that you still were overstretched as regards the requirements of your role? 10:34

A. I was less stretched in 2016 than I was in 2013. 2013 was a particularly bad year. 10:34

52 Q. What was it about that that made it a bad year, compared to 2016, for example?

A. 2013, I'd just finished those MHPS investigations. I was behind with job plans. And then the rotas in

Daisy Hill became unstable at all levels. I had particular difficulty with the fact that I had a five-man consultant team, but I was the only person in that team that was there at the start of the year and there at the end of the year. There were so many locums. The team was made up of locums, retired consultants who were part-time, short-term appointments who only stayed two or three years. The difficulty with all of those types of employees is that they don't take on the regular tasks that other, more permanent consultants would take on, like, for instance, doing the rota or being just representatives on various committees and things, they don't take those on. So I had everything in 2013. Whilst I gathered things from people who retired and then had difficulty in delegating them, a particularly difficult year. Also, that was a year whenever the rotas became unstable. I had difficulty recruiting and retaining staff at the three junior levels: houseman, SHO and registrar level. Increasingly, the junior doctors were getting restless about the sort of hours they were working. So I was trying to keep the place together with a very skeleton staff of, often, very junior staff, with a lot of vacancies. So it was very difficult. 10:35 10:35 10:36 10:36 10:36

53 Q. Now, you mention about your knowledge around some of the difficulties in urology and in a couple of your statements and I just want to read those out. In your first statement, at WIT-17523, at paragraph 17.1, and you say: 10:36

"From about 1995, I became aware that the Urology Service had long waiting times for outpatient and inpatient services. I knew about the long waiting times because I referred patients to the service. I do not know if this was due to staffing or demand. I do not know how, or if, this changed over time as more staff were recruited or if waiting times were significantly different to other urological units in the region. I was not involved in the recruitment process in the Urology Department. I think Michael Young or Heather Trouton would be able to answer that question." 10:37 10:37

Then, in your addendum statement at WIT- -- sorry, just before we leave there, sorry, if we move to paragraph 19.1, just to finish that point about your view on staffing problems. You say: 10:37

"In my view, practically every department in the HSC is underresourced and understaffed. I do not know if the stresses felt in Urology were greater than other specialties. I do not know if there were staffing problems and, if there were, whether they impacted upon management and governance. I have had minimal managerial involvement in the Urology Unit for nearly 12 years, so I am not familiar with these issues." 10:38 10:38

Then, we'll go to WIT-100413. And you say at

paragraph 9 that you would like to amend paragraph 20.1 in the following way:

"I had clinical engagement with the Urology Service from 1993 to 2017. I provided a basic, and mainly diagnostic, urological service in Daisy Hill Hospital, and I referred a lot of patients to the CAH Urology Department. I observed the department developed from a single-handed consultant (Aidan O'Brien) to a team of six or seven consultants (I'm not sure exactly) and a complement of junior staff and trainees. During the first period from 2008 to 2010 when I was CD, I think the number of consultants increased to three. I know that there was Aidan O'Brien and Mr. Young, but I'm not completely sure if there was a third or of the name." 10:39

Then, you add:

"During the second period from 2011 to 2016, there were several consultant appointments, several resignations and a number of temporary locums. There was also an expansion of the middle tier."

So, you have outlined there the problems in urology historically dated back before the Trust, under the old system, from 1995, but during your period of tenure as Clinical Director, there were clearly staffing issues, and would it be unfair for me to suggest that your knowledge of those staffing issues is quite vague?

A. Certainly, my memory is very vague. I can't remember people's names my more and, having listened to quite a lot of the Inquiry, I have heard some names that then have become more familiar to me, so I do remember Mr. Pahuja and I do remember Mr. Akhtar, etc, but I didn't remember their names whenever I was writing this report.

54 Q. Well, apart from their names, were staffing issues brought to your attention, as Clinical Director, at any point? 10:40

A. Not to me as a problem that I could solve, but I was aware that there were staffing issues in that department and several other departments. I wouldn't be -- I wouldn't like to say for sure that I was certain that that was the most understaffed department in the hospital, because I don't know. 10:41

55 Q. And the issues would appear to have been, from your knowledge, around recruitment and retention?

A. Yes. There just weren't people to appoint. I think there was a willingness to appoint people, as far as I can remember, but there were few people available to appoint. 10:41

56 Q. In relation to your responsibility in your role, you set that out at WIT-17525. It starts at WIT-17524, for the transcript. And you say at paragraph 21.1: 10:41

"Governance is part of the role of any clinical manager. Clinical managers include the Clinical Director, Associate Medical Director, Medical Director

and Director of Acute Services. The CD's role was mainly dealing with high, and often immediate, priority issues, such as staffing, recruitment, rotas timetables, etc. Governance was part of it, but I would not have had an in-depth knowledge or total overview of all the governance arrangements and issues in all of the six departments for which I had responsibility. These six departments were: General Surgery in DHH, General Surgery in CAH, Urology CAH, ENT CAH, Orthopaedic CAH and Ophthalmology CAH." 10:42

You say then:

"I was CD for SEC, including Urology, for two years and nine months." 10:42

And we've looked at that issue. The last sentence of that paragraph said:

"During that time, my contribution to governance in Urology was mostly reactive, in that I addressed issues brought to my attention." 10:42

Now, just in relation to that last line, before we move on to some of the substance of the issues that were brought to your attention and look at the detail, you've mentioned that there were meetings in Daisy Hill Hospital. Did you proactively seek any meetings or any engagement specifically with Urology in order to either 10:43

ascertain or explore were there any issues that you, as Clinical Director, should know about?

A. No, I wasn't able to do that; I just didn't have the time and the access. I know that there were meetings organised, I think either by Martina Corrigan or Michael Young, and I did try to attend some of them, but I wouldn't have been able to attend them all on a regular basis from Daisy Hill.

57 Q. Would you have expected, as Clinical Director, to have been made aware of governance issues that arose that may impact on patient care and patient safety and patient risk? 10:43

A. Yes, I think I was.

58 Q. You were or you would have expected to have been?

A. I would have expected to have been, yes. 10:44

59 Q. You've said that you have listened to the Inquiry, and you are obviously more knowledgeable, perhaps, now about the issues than you were at the time, I think that's probably self-evident from your statement?

A. Yes. 10:44

60 Q. Just on the back of your last answer, where you said you would have expected to have been told, the issues that you've heard brought to the Inquiry's attention, are they issues that you would have expected to have been made aware of during your tenure as Clinical Director? 10:44

A. Could you specify some of them?

61 Q. Well, some of the issues around triage, for example; I know you had some basic knowledge of that, but the

extent of that issue, would you have expected to have been made aware of that?

A. I think so, yes. I was made aware of it and I did address it. But I'm trying to think of some of the other things that were -- like, the retained swab, I wasn't told about that, or the Bicalutamide, I wasn't told about that, and I am not sure that it was widely known outside of his clinical practice, I don't know, but... 10:44

62 Q. Were you aware of any MDM recommendation divergence? 10:45

A. I was aware that the radiologist wasn't there and that they were trying to recruit a second radiologist, but I didn't really notice the missing pathologist, to be honest, because I was on the other side of the screen.

63 Q. Well, that's a slightly different question now, that's about quoracy and capacity. 10:45

A. Yeah.

64 Q. And specifically in relation to MDM recommendations that may have been diverged from post-MDM, was anything like that ever brought to your attention? 10:45

A. No, it was never brought to my attention.

65 Q. Now, when you say that they might have been brought to your attention, or in fact I think you said they should have been brought to your attention as Clinical Director, any issue that raised a potential patient risk? 10:46

A. There were various pathways for governance to go through. For instance, I -- excuse me. Some things were raised as IR1s, that was a pathway I was not

involved in at all, so I wasn't made aware of any IR1s, even the ones from my own site. They went through a different pathway, through the AMD and the CD, assisted by, I think, someone from ENT, which someone -- kept changing, but I wasn't involved in IR1s so I never knew about those. Other issues might have been drawn directly to the attention of Mr. Mackle, for instance, and I might not have been involved because of my remoteness, so it's possible that I missed out on things. There were other things that were presented at M&M and I would have picked those up if I was there. 10:46 10:47

66 Q. Now, you've mentioned Mr. Mackle. Would you have expected him to have told you some of the issues that he became aware of?

A. I think so, but I would -- because we didn't meet all that frequently, it is possible that some things didn't get mentioned, but I would have thought, yes. 10:47

67 Q. Was there a sense that the person on site - for example, Mr. Mackle based in Craigavon - was there a sense that he was better placed to deal with those issues and, therefore, you just expected him to do so or he expected you to do the same in Daisy Hill? 10:47

A. I think there's a little bit of that, yes. I mean, I sort of dealt with everything in Daisy Hill and there's very little that we didn't sort out on site because just the practical issue of being there, and I expect the same thing happened on the Craigavon site. If I wasn't there, the information sort of got to Mr. Mackle before it was going to get to me. 10:47

68 Q. I wonder if we could go to your addendum statement at WIT-100415, and this is where you've mentioned about some of the procedures in place. This amends paragraph 33.1 of your original statement. And you say:

"Governance was part of the role of all the clinical and nonclinical managers, supported by the Medical Director, the Director of Acute Services and a number of departments in the Trust. Given my remote location, I had very little day-to-day oversight of governance in Urology. I was aware that the consultants engaged in the morbidity and mortality meetings and were subject to yearly appraisal. Other governance processes, such as incident reporting, MDMs and mandatory training, were developed during my tenure. Governance arrangements have developed considerably since inception of the Trust and continue to do so. Morbidity and mortality processes were in place at inception of the Trust. Incident reporting was introduced in January 2009. I was never involved in reviewing IR1s, incident reports. I was never involved in reviewing complaints. The Urology MDMs started on 01/04/2010, mandatory training was introduced on 24/11/2009, and mandatory trainings modules are added from time to time."

You have appended most of that. So, what you set out there is the formal governance processes by which

issues may arise or become apparent to you; if, for example, the IR1s might have been shared with you, you might have known about things?

A. IR1s were not shared with me.

69 Q. And you have mentioned earlier in your evidence about what you call the soft intelligence, the conversations that people have on a daily basis that may have alerted you to other issues that you didn't become alert to because of your remoteness, as you call it? 10:50

A. Yes. I think, I mean, that's the most important thing. The soft intelligence is probably of greater value than all of those other formal routes because that's when you really find out how things work. 10:50

70 Q. I'm just aware that two Panel members are not from this jurisdiction. When I talk about remoteness from Daisy Hill to Craigavon, what's the time it would have taken you to travel between those sites? 10:50

A. Well, it is 22 miles -- according to Google Maps, it is 38 minutes, I think, if there aren't any tractors on the road, but it is a rural road, and whenever you get to Craigavon, you have to park your car and then you have got to find the Hospital from the car park. So it usually -- I usually set aside an hour of the journey. To be fair, it was an hour there. If I was going back to Daisy Hill, it was an hour back. If I was coming back home, it was half an hour, because I live between the two hospitals. So the overall travel time for a trip to and from Craigavon was either two hours or 1.5 hours. 10:50 10:51

71 Q. So, just in context in relation to Mr. O'Brien, what was your knowledge or relationship with Mr. O'Brien? How long have you known him and what was your engagement with him during your tenure?

A. I know Mr. O'Brien since he started in the Trust in 1992. He was, if you like, my mentor when I started up, because I was a general surgeon, and I wasn't quite sure what I was capable of doing, in terms of Urology, what I needed to do and what -- if I didn't do it, nobody else was going to do it. So he helped me to work out what my clinical practice was going to be. He was very supportive, and we had a strong clinical relationship, though never actually socialised, we were never personal friends; it was always clinical. 10:51 10:51

72 Q. And we don't need to go to it, but you've mentioned specifically in your statement, at paragraph 28.2, at WIT-17528, that the Chair of the MDM rotated, including Aidan O'Brien, and you always considered that it was chaired very professionally? 10:52

A. Yes. 10:52

73 Q. And what was your view of Mr. O'Brien? You'd never heard anything about him, apart from the two incidents that we're going to discuss?

A. I'm sorry?

74 Q. In relation to Mr. O'Brien, you didn't hear anything else about his clinical practice or administrative work, apart from the two incidents that we're about to discuss? 10:52

A. That's all.

75 Q. Just before we do that, I just -- you've said something in your statement where you said you were "happy with the systems and processes in place at the time in relation to governance."
Now, given what you now know, is that something you can stand over? 10:53
A. Well, at that time, that was what governance looked like in terms of morbidity, mortality, complaints, IR1s. These were all developed during that time, so I was happy this was a system in development, all of those things that I have mentioned. I suspect - I'm not really working in the Trust anymore - but I'm sure what passed as governance ten years ago wouldn't pass for governance now; it would be a lot tighter now, I should think. 10:53
76 Q. Yes. Even if we stand aside from the evolution of governance - and it's been something that has been evidence for the Inquiry and the Panel may wish to know more about that from other witnesses - given what you now know and given the procedures and processes that were in place at that time, do you feel that the issues that you're now aware of should have made their way through those processes to your attention as Clinical Director for Urology? 10:53
A. Yes. 10:54
77 Q. Now, I wonder if I could ask you just about one issue. The Panel have heard evidence about the admission of patients for prophylactic treatment with IV antibiotics for recurrent UTIs. Now, this was an issue that arose

during your tenure as Clinical Director. Is that something that you were familiar with at the time?

A. I knew about it in a sort of casual way, in that I was friendly with Dr. Loughran and we would have had soft intelligence chats and he told me that this was a process that he was involved with, but I was never actually involved with it in a managerial capacity. It was dealt with by Dr. Loughran, Dr. Damani and Mr. Mackle. 10:54

78 Q. And when you spoke to Mr. Loughran about that, was that within the context of clinical practice or patient risk, potentially, or both or neither? 10:55

A. It really wasn't any of that. It was really just a tea-room conversation where he said -- this is what -- maybe with other things, "these are the sort of things I'm dealing with at the minute". But he wasn't informing me in terms of, "this is something you need to deal with". He was saying, "I'm dealing with this". 10:55

79 Q. And did you enquire into what the background of the need for his involvement was? 10:55

A. To some extent, only in that this was a particularly difficult group of patients and I was getting a lot of patients referred to me with this particular problem, and I was interested to find out whether what Dr. Damani was recommending with the guidelines would be helpful or whether Mr. O'Brien and Mr. Young were actually right. So I was interested to see the outcome of that, but it was from a purely clinical point of view because I equally find those people difficult to 10:56

deal with, though I wasn't using IV antibiotics.

80 Q. I was just about to ask, was that a practice that you engaged in, prophylactic treatment for recurrent UTIs?

A. No.

81 Q. There is an e-mail chain, I'll take the Panel briefly to it just for their note as well, at TRU-250738. We don't need to look at this in any detail. What it is, is an e-mail chain about the revision of the guidelines about antibiotic prophylaxis from 2009. Sorry, I have got the wrong reference. I'll give the Panel the correct reference for that. But there was correspondence from Gillian Rankin on this issue in -- at the end of March 2009, which would have been around the time you just were Clinical Director as well, explaining that there had been a new procedure set up around the admission of patients for that? 10:56 10:57 10:57

A. Yes.

82 Q. Then, as you say, Mr. Loughran sent a letter to Mr. O'Brien and Mr. Young, that the Panel have seen, dated 2nd September 2010, setting out the findings of his review or looking at the issue. So did you receive any formal correspondence from Mr. Loughran on this issue or was it conversations just between the two of you? 10:57

A. We had conversations. I was aware that he was setting up panels to look at individual cases whenever either Mr. Young or Mr. O'Brien wanted to bring somebody in for antibiotics, but I was not on that group. I think that was -- it was Sam Sloan, and then when Sam Sloan 10:58

retired, Sam Hall took over that responsibility, so I never sat on that group.

83 Q. And was the antibiotic issue as dealt with by Mr. Loughran or as looked at by him, was that something that you were aware of was happening in Daisy Hill at all? 10:58

A. There was nothing like that happening in Daisy Hill.

MS. MCMAHON: Chair, I wonder if this would be a convenient time to take a short break?

CHAIR: Yes. We'll come back again at 11:20. 10:59

THE INQUIRY ADJOURNED AND THEN RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

84 Q. MS. McMAHON: Mr. Brown, I just want to move on to the two occasions that you had cause to get involved with issues that had been raised with you in relation to Mr. O'Brien, and I just want to read out a couple of different sections from your statement. The two occasions, the first one was in relation to disposal of 11:20 chart material by Mr. O'Brien, and you were involved in carrying out an investigation into that and reporting back on that. That was in 2011. The second occasion was in around June or July 2013 and was concerned with taking patients' charts home and I think there was also 11:21 an issue around triage at that point as well. So if we just look at those separately.

If we go to WIT-17526, and at 24.1, this is your own

Section 21, you say the following:

"There were two occasions when concerns were raised with me. On both of these occasions, I wasn't CD for Urology, though I think that we probably all worked together and didn't apply rigid boundaries. In the first instance, as set out in paragraph 24.2, the CD was Samantha Sloan." 11:21

In the second instance, you say that the CD was Sam Hall, but you have since corrected that to say that you, in fact, were the Clinical Director on the occasion around the charts at home? 11:22

A. Yes.

85 Q. So, on the first occasion that we're going to look at, the disposal of the notes, the Clinical Director was Sam Sloan? 11:22

A. Yes.

86 Q. Do you recall at the time when this issue around the charts being disposed of, did you discuss it with Ms. Sloan at the time, as your Clinical Director? 11:22

A. No. I was asked by someone in HR to do this investigation. I had done quite a few in the past and I presumed it was because I was -- had experience. I didn't really understand why I was asked, but I didn't question it; I tended to just take on tasks without question. 11:22

87 Q. Now, you've mentioned in your statement that this was an MHPS investigation, and you've since corrected that,

you've had the opportunity to look at some documents and accept now that this was a procedure carried out as an investigation under the Trust's own procedure?

A. Yes.

88 Q. At the time, it wasn't actually an MHPS. I'll read that into the record. It's at WIT-103533. This is your third addendum statement, and you say at paragraph 1: 11:23

"At paragraph 24.2 (WIT-17526) I have stated 'the first was in respect of inappropriate disposal of chart material by Mr. Aidan O'Brien. I was asked by Zoe Parks, HR, to carry out an investigation. I had training in MHPS investigations delivered by the National Clinical Assessment Service on 22nd February 2008.' On further reading of archived e-mails, I now know that the investigation into the disposal of chart material in a bin was carried out using the Trust Disciplinary Policy rather than MHPS, as stated in paragraph 24.2 of my Section 21 response. 11:23 11:24

From a practical point of view, the process for me was identical, no matter which protocol was in place. It involved interviewing witnesses, preparing statements, writing a report and issuing a warning. The final report was sent by Zoe Parks to Eamon Mackle and Heather Trouton for approval prior to issue of an informal warning." 11:24

And you were not copied into their responses. Now, you've set out in some detail the way in which you carried out the investigation and, as you say, there was an initial complaint, or it was brought to staff attention by one of the ward staff that notes had been retrieved from a bin by, I think, one of the domestics in the ward at the time, and left on the ward clerk's desk. If I can just summarise it, the background. Then, you were asked to look into this as an issue. Could you just summarise your involvement in that and the steps that you took. 11:24 11:25

A. My role was basically as case investigator. I carried this out in the same way as I would have done an MHPS investigation, where I interviewed, first, Mr. O'Brien, and then interviewed the various witnesses, and then formulated a report, which was sent to Mr. Mackle and Mrs. Trouton. 11:25

89 Q. And we'll just go to that report at WIT-103538. And we can see at the bottom of this, it's a report of disciplinary investigation - Mr. O'Brien. The date is June 2011, and again, the purpose of looking at this again is to look at the governance procedures that were undertaken and the effectiveness of those for the Panel. So if we just move to the conclusions at WIT-103544. 11:25 11:26

Now, you spoke to Mr. O'Brien as well to get his version of events, and this is the conclusion of your report. I'm just going to read it out.

A. Yes.

90 Q. At paragraph 5:

"The investigating team took into account the information provided by Mr. O'Brien in relation to this matter and would conclude that the following allegation is proven..." 11:26

Then, you go on to say that:

11:26

"Mr. O'Brien admitted that he inappropriately disposed of patient information in the confidential waste. He readily admits that this was an error, that he should not have done it and will not do it again."

11:26

And you say this:

"I think that it is also important to note that Mr. O'Brien says that he spends more time writing in and filling in charts than probably any other consultant and, from my own personal experience, I confirm that this is the case. Mr. O'Brien has the utmost respect for patients, for their information and for the storage of records. This was an unusual behaviour which was the result of frustration from dealing with a large unwieldy chart, difficulties retrieving important information from the chart and from the difficulty finding anywhere suitable to make good quality records. 11:26 11:27

The motivation for the incident was honourable, in that Mr. O'Brien was trying to make an entry in the chart, though the solution to the problem was clearly wrong. I am satisfied that Mr. O'Brien has accepted his error and agreed that it will not happen again. I do not think that a formal warning is appropriate to the scale of the case and I would recommend an informal warning. This has effectively already taken place." 11:27

11:27

And you see your signature at the bottom. Just bear with me for a second, Mr. Brown. If you just bear with me one second, I just want to see if I can find a reference.

11:28

Just in relation to the statement that you have made:

"Mr. O'Brien..."

We've read it out. 11:29

"Mr. O'Brien has the utmost respect for patients, for their information and for the storage of records."

Is that what Mr. O'Brien said to you -- 11:29

A. Yes.

91 Q. -- or was that the view that you formed?

A. No, no, that was reflecting what he said. I think the policy does suggest that you should look for

mitigations and previous good conduct and, in his mitigation, this was what he told me and I was reflecting it in the report.

92 Q. Now, it has been put to a previous witness - Mr. Wolfe, my senior, put it to Mr. Mackle in evidence that there was a suggestion that that sentence could have been taken to mean that that was evidence from you, effectively, about your appreciation of Mr. O'Brien's reputation. Is it your evidence that, actually, that's information you garnered from Mr. O'Brien, just so we can get the record straight? 11:29

A. I can see that interpretation, but what I'm actually saying is, I can confirm that what he said is actually true.

93 Q. Because he told you that or because you believed it -- 11:30

A. No, because I was perfectly aware of it because I've seen the charts that he writes, and he writes in very flamboyant, detailed writing.

94 Q. I suppose that perhaps does make good the point that Mr. Wolfe was raising with Mr. Mackle, in that it does seem that you were providing some evidence of character for Mr. O'Brien in this investigation? 11:30

A. Yes, it does look like that. That's not how I saw it at the time. I was corroborating his evidence, saying I could confirm that that was the case. 11:30

95 Q. Just for the Panel to note, the transcript of the evidence for Mr. Mackle and Mr. Wolfe is at TRA-02160 to 02162, page 650-656. And I think the point of raising that with Mr. Mackle and giving the context of

the bullying allegation he alleges, we'll come on to in a moment, the context of Mr. Wolfe raising that with Mr. Mackle was to try and explore the possibility that, in some way, you or others who might have noticed some governance concerns, were perhaps blinded by Mr. O'Brien's reputation or his standing or his long tenure in Urology. Would you accept any of that?

A. I will accept that people who have a very good reputation clinically would be able to, to some extent, blind you a little bit for their shortcomings, I would agree with that, yes. 11:31

96 Q. And was that the occasion with you? Did you find you had difficulty or were perhaps, with hindsight, less robust in your investigations around this issue or other issues in relation to Mr. O'Brien than you might have been? 11:31

A. To some extent, I'll accept that, yes.

97 Q. Now, there wasn't any other issue around note disposal or anything on a par with this ever brought to your attention again? 11:32

A. No, I never heard of it happening again.

98 Q. Now, the second occasion that you refer to in your statement where you were asked to engage with Mr. O'Brien, if that's an example of a formal governance process, then this is, perhaps, an example of an informal process that you were involved in, and this occurred around June or July 2013. I'll just read from your statement at WIT-17526, at paragraph 24.3. You say: 11:32

"On a second occasion, in June or July 2013, Heather Trouton (AD) asked me to speak to Mr. O'Brien regarding his practice of taking patients' charts home. I met him informally at the end of a clinic in the Outpatient Department of CAH in June or July. I advised him that the practice was inappropriate as charts may be needed for other services. There was a verbal exchange, there is no written record. To my recollection, he accepted that the practice was not appropriate." 11:33

Just if we stop there, because you go on to talk about another time that you spoke to him in November 2013. But just on this occasion, Heather Trouton brought it to your attention, and we have heard that the issue around charts found its way -- it percolated up from administrative staff, who had responsibility for both knowing where charts were located and retrieving them for the relevant physician or clinic, or wherever it may be. So this issue had reached Heather Trouton. When she contacted you in June or July 2013, was that the first time you had heard that there was an issue around charts? 11:33 11:33

A. To be fair, I am not actually sure it was Heather Trouton. It may have been Debbie Burns, possibly Martina Corrigan, I'm not absolutely sure, because it was verbal. It was the first time I'd heard of it. It wasn't unusual for consultants to take charts home for different reasons. I know I did, for 11:34

very legitimate reasons, take charts home at times. But I think he was a bigger offender than most at that time.

99 Q. You think he was, sorry?

A. I think he was a greater offender than most of taking charts home, although many consultants did take them home for different reasons. 11:34

100 Q. And what would those reasons be?

A. Well, I personally would have taken charts home at the end of a Banbridge clinic because there was no other way of getting them back to the hospital. And if I wasn't in the hospital the next day for some reason - for instance, I do remember once, I was in Craigavon the next day all day, so I stored them in my house, out of the car, and then brought them back on Friday. 11:34 11:35 I also would have taken notes out whenever I did domiciliary visits, whenever I went -- I did a lot of work with disabled people and I would have went to visit them in their houses, and that was like an outpatient clinic appointment, so I brought the chart with me. And if a patient was being admitted to hospital that night, I had to go back with the chart, but if they weren't being admitted, I took the chart home. 11:35

101 Q. And when you had these charts for legitimate clinical reasons, what was the turnaround getting them back into the hospital? 11:35

A. A couple of days.

102 Q. And what you've described as scenarios in which

he would have kept charts away from their main location in the hospital, would that have been your experience, be also the reasons other clinicians would have kept charts out of the main hospital?

A. I was aware, but I wouldn't be able to put a figure on it. 11:35

103 Q. But just from experience, it was reasons just as the ones you've described that other clinicians kept notes?

A. Yeah, I did know on occasions that charts weren't available for my clinic and they were tracked out to a consultant, but they couldn't find them, so I don't know. 11:36

104 Q. Now, the Panel has heard evidence in relation to the reasoning about why charts may not be brought back - for example, dictation, backlogs, and that's one such example. Was it ever brought to your attention as Clinical Director that the capacity for administrative roles by consultants needed to be increased in order for them to fulfil the requirements of their job? 11:36

A. I think we all complained that we didn't have enough time for administration, to be honest. I personally had a great deal of difficulty with administration. I didn't do any of it, practically, during the week, so I did my administration during the weekends and early mornings and evenings, because there wasn't enough time. I think I had that discussion with Aidan O'Brien, about when to do administration. I found it much easier to come in and do the administration in the hospital than to take the charts 11:36 11:37

home and do the administration at home.

105 Q. Now, when you spoke to Mr. O'Brien in June or July 2013, do you remember where you had the conversation?

A. He was in his outpatient clinic. 11:37

106 Q. So you went to him?

A. I did, I drove to Craigavon specifically for that purpose.

107 Q. And did he know you were coming over to speak to him?

A. Yes, but he thought I was coming to speak to him about a patient, I think. I didn't tell him what the meeting was about. 11:37

108 Q. So, you asked to meet him, didn't indicate what the meeting was about, and you believe that he thought it was a clinical issue? 11:38

A. Regrettably, yes.

109 Q. And when you say "regrettably", why do you say that?

A. Well, on the principle of no surprises, I don't think I should have sprung a rebuke on him like that, so I felt a bit embarrassed, because I should have told him in advance that I wasn't under -- talking about a clinical matter but a management matter. That wasn't fair. 11:38

110 Q. Now, you've said the word "rebuke". I just want to get some sort of sense of the way in which the conversation unfolded. Given that Heather Trouton had brought it to your attention, it's perhaps fair to say that it had reached a fairly high level to bring you in to speak to Mr. O'Brien -- 11:38

A. Yes, yeah.
111 Q. -- and the Panel have heard evidence of various informal ways in which the issue around charts was sought to be addressed. So would you agree that the fact that you were brought in and Heather Trouton was involved, that, if I use a colloquialism and say they were bringing in the big guns to try and sort this out, would you agree with that? 11:38
A. Well, I'm a sort of a middle-sized gun, not the very big gun, but, yes. If it was important for me to drive the whole way to Craigavon and back for one single issue, yes, it was important. 11:39
112 Q. So can you give the Panel a flavour of the way in which the conversation and the discussions took place between you and Mr. O'Brien on this particular issue? 11:39
A. From ten years ago, it is very difficult to remember a conversation. I remember a couple of things about it. I remember that it was very long and that we discussed for a very long time -- he told me why he took the charts home, which we also discussed triage -- I think we discussed triage, because I have it in my mind that I thought the two things were related, in that he was bringing the charts home to consult the chart for further information before making a decision about triage, and that was my -- that's an impression I have in my mind, but it may not be absolutely true. I would have described to him -- I'm pretty certain I told him that there were other options to bringing charts home. I described to him the sort of things 11:39 11:39

that I did to address my administration, which was, basically, Sunday mornings, early mornings and evenings, and that I also -- I know, for certain, I told him that if he took charts home and they were needed for a clinic, that that was a patient safety issue.

113 Q. You specifically raised that as an issue with him?

A. Yes, I did, yes.

114 Q. And was that something that you understood to be the case just from your own knowledge as a clinician or had someone mentioned to you that there was a clinical risk issue? 11:40

A. I had plenty of my own experience of knowing how difficult it is to see a patient in a clinic without the notes, though that's almost irrelevant now with the -- whenever the electronic service came in. But at that time, notes were pretty important. 11:40

115 Q. Now, at the end of the meeting, you've said that Mr. O'Brien explained his reasoning for having charts and you seem to have, at least in part, understood those reasons? 11:41

A. Yes, I try to understand people's reasons. He said that he didn't have enough time in the day and, again, he said he didn't have enough time in the day to do his work so he had to take work home with him and, again, I explained to him that that probably wasn't the best way even to do that; it would be better to spend more time in the hospital. I do remember one thing that he said that I remember for a long time, was, he said 11:41

there just weren't enough hours in the day. I said, well, you know, just -- you know, start earlier, leave later. He said: "no, I mean there aren't enough hours in the day, as in 24 hours". I remember that as, sort of, his comment. 11:41

116 Q. At that point, did you have any information about the number of charts that were under discussion between you?

A. I had a list of IR1s, but an IR1 could have related to two charts, I don't know, but I think -- I can't remember. It's in the information. It may have been 10 or 15, I don't know, maybe less, because IR1s are issued and then the chart comes back. So at any one time, it wasn't a huge number, it wasn't the hundreds that I recently heard of. 11:42 11:42

117 Q. And what was the outcome of the meeting? What was the plan or what was the suggestion from either Mr. O'Brien or to Mr. O'Brien about how this matter could be resolved?

A. Well, I think I'd said in the e-mail that we'd agreed a remedy, but I can't exactly remember the detail of that. I may have written that down in my little black book, which I no longer have, but I can't remember what the exact remedy was, but it almost certainly would have been about starting earlier, leaving later. 11:42 11:42

118 Q. And the fact that Mr. O'Brien had identified that he didn't have enough hours in the day, did that ring any alarm bells with you that the inability to add any extra hours to the day meant that this problem wasn't

going to go away?

A. No, not really.

119 Q. Do you think, in hindsight, it might have?

A. I don't know how we could add more hours to the day. I'd already described to him, you know, you need to do some work at the weekends, do some work in the evenings, but not in the hospital. 11:43

120 Q. Do you think there was any other suggestions that might have been made at that time, given the chart issue that emerged and that became quite chronic and significant, according to the evidence? Do you think that there may have been something suggested at that point in 2013 that might have limited the potential for things to get worse? 11:43

A. Other than what I've said, I can't think of anything else that I could have added to that. 11:43

121 Q. Now, just going back to your statement at 24.3. I just stopped mid-paragraph. So we'll pick up again on the second time you spoke to Mr. O'Brien, and you say: 11:44

"I spoke with him again in November 2013 by telephone in relation to the same issue and also regarding missing triage. Again, this was a verbal exchange and, whilst there is no written record, it is mentioned in the e-mail trail. This e-mail trail documents the efforts of Heather Trouton, Martina Corrigan, Michael Young, myself and others to address the issue of missing triage. I have removed the list of patient names from the original e-mail. The outcome of that 11:44

exchange of e-mails was that Aidan O'Brien advised that he would catch up."

And you've said in quotations:

"'I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion.' Michael Young also agreed that he and his colleagues in the Urology Unit would assist with the backlog." 11:44

So from July -- June or July 2013 and then again in November, what was it triggered this need for you to phone Mr. O'Brien now in relation to two issues, charts and triage, can you recall? 11:45

A. I can't recall. I can't recall the conversation, either. But if it had been recorded, I would have remembered that I had that conversation. But it probably was because either Martina or Heather had reminded me or told me, yeah. 11:45

122 Q. And they perhaps would have indicated, self-evidently, that the problem had not improved?

A. Yes.

123 Q. Now, this time, you contacted him by phone, by telephone. Given that it's still ongoing by November 2013, would that suggest to you that the problem is no better and, perhaps, arguably worse? 11:45

A. It is persistent anyway, yes.

124 Q. On this indication, you didn't go to see him but you

called him?

A. I had a little bit of difficulty with mobility at that time.

125 Q. Now, whenever you spoke to Mr. O'Brien about, first of all, the chart issue, I know it is difficult to recall conversations, but given the significance of this as a governance issue, and you've said it was -- you identified it as a potential clinical risk, do you have any recollection of whether the tenure of your conversation was more robust or you were asking Mr. O'Brien to put in place or suggesting that plans were put in place to deal with this once and for all? Was there any improvement in tone that might have focused his mind? 11:46 11:46

A. I have no recollection. 11:46

126 Q. And you've mentioned missing triage. Do you remember what the context of that was that you had to mention it to him?

A. In the telephone call?

127 Q. In your evidence, you've said you spoke to him by telephone in relation to the same issue and also regarding missing triage. 11:46

A. I have no recollection of that telephone call, I'm sorry.

128 Q. Do you remember the issue around triage? 11:46

A. Oh, yes.

129 Q. Tell me what you know about that?

A. Well, I know that he was behind on triage. I don't know for certain -- I think I did discuss it with him

in June, though I can't be sure, for certain. But it was addressed with him in November, by -- I mentioned by telephone call and in the e-mail exchanges, and Aidan gave an assurance that he was going to catch up.

130 Q. So was the outcome of your interventions on -- and I think you've said you might have spoken in June as well -- the outcome of your interventions in relation to triage and charts at home, was Mr. O'Brien giving you an undertaking that he would improve? 11:47

A. Yes. 11:47

131 Q. And do you think now, with hindsight, from a governance perspective and clinical-risk perspective and given that the Inquiry is here discussing these issues, that that was an effective approach?

A. It wasn't. Clearly, he relapsed after that. 11:47

132 Q. And does that go back slightly to the point that I was asking you about before, whenever a clinician has a good reputation among fellow surgeons or is so intrinsically linked with the foundation of Urology Services, that do you feel there was any reluctance to tackle him head-on? 11:48

A. I think it's a factor.

133 Q. Did anyone ever bring to your attention any discussions about the capacity of urologists to undertake triage within the IEAP time frame? 11:48

A. Other urologists? Urologists in general?

134 Q. Well, any of the surgical specialties, did they raise issues --

A. No.

135 Q. -- around the time frame that was required on the rules for triaging patients?
A. Well, not in terms of time scale. There were lots and lot of debates about who should triage what, when and how and who they triaged to, lots of debate about that, but not a case of how long it takes you to do it. 11:49
136 Q. So it was more about the technique rather than the time frame?
A. Style, yes.
137 Q. Was there anything about the triage issue at that time, as you were aware, that might have triggered you now, when you look at it, might have triggered you to, perhaps, do a bit of a deeper dive into what exactly the problems were? 11:49
A. At that time, what I knew about was the triage and the notes, the charts, and it didn't trigger me to have a deeper dive. It probably would nowadays, given what I've learned from this Inquiry and the other Inquiry, that whenever there are issues with regard to patient administration, that there may be other issues there as well. That's something I've learned. 11:49
138 Q. And that applies whether it is administration for all consultants or perhaps, more acutely, if there were several administrative issues with one?
A. I think be it's the latter, yes. 11:50
139 Q. I'll just go to an e-mail correspondence at TRU-282921. Now, this is -- I'll give the Panel the note. I don't need to read all of this e-mail correspondence, but the full reference is TRU-282921 to TRU-283000.

So this is just an example of correspondence between various members of staff in relation to the issue around triage and Mr. O'Brien. I just want to make sure you're mentioned in the one. There's quite a few here. I know the Panel have seen e-mails on this issue. So this picks up on the point that you've mentioned, that we read out in your statement where you had anticipated that Michael Young and others would help at that point. 11:51 11:52

A. Yes.

140 Q. This is from Heather Trouton on 4th December 2001, so this is a month after your conversation with Mr. O'Brien. This is to Michael Young and to you. And Heater writes: 11:52

"Michael,

I certainly didn't expect it to be sorted within a few days and, to be honest, was surprised to be advised that triage was being taken over, as I agree it is not fair to ask the other three surgeons to bear this workload. Robin and I had discussed just yesterday and were planning to meet with Aidan next week to fully discuss the issue. I'm sorry that I was given not totally correct information. 11:52 11:52

Thank you for helping with the backlog. Happy to discuss further next week to try to come up with

a sustainable solution.
Heather."

Now, I just wanted to bring that e-mail to your attention because you are mentioned in it and it's clear that you are discussing this with Heather Trouton. There is an expectation that Michael Young and others would undertake some of the backlog? 11:53

A. Yes. 11:53

141 Q. Given what you've said earlier about surgeons and the doctors being generally concerned with the capacity to do their admin, did you think that was a viable solution, that others would undertake that role to help Mr. O'Brien catch up? 11:53

A. To catch up, yes. Not in the long term. You know, similar things -- not exactly the same, but similar things existed with my team in Daisy Hill, the team that I worked within, where we had issues with triage and, eventually, one of the solutions was that I ended up doing most of it, but I was very quick at it, and maybe that's good and bad. I did triage very quickly and could get rid of them. Aidan was very slow at triage and there's no doubt that he spent a long time at it. Michael picking up the backlog to help him to catch up, I thought was quite a good thing. 11:53 11:54

142 Q. Now, obviously, Mr. Young, there's been some -- at least a certain degree of kickback in relation to undertaking that role on any long-term basis --

A. Yes.
143 Q. -- but were you satisfied at this point that the measure put in place would remedy the problem with triage?
A. I don't remember what I thought ten years ago, but it would appear that I thought that was a fix. 11:54
144 Q. Well, perhaps I'll ask the question in a different way. Do you recall, after December 2013, having to be involved in triage again, as an issue?
A. I wasn't. 11:54
145 Q. And did that generate in your mind a belief that the issue around triage had been sorted?
A. I expect so, though I regret not following it up personally.
146 Q. Was there any plan that anyone would follow up and keep an eye on this as an oversight issue, to make sure that it didn't happen again, from your understanding? 11:55
A. Well, it would be monitored by the non-clinical, the non-medical team, by Heather and by Martina, yes.
147 Q. Given you've said in your statement - we don't need to go to it - but you've made a statement in your original Section 21, WIT-17546, I think it is, it's paragraph 49(c), where you've said: 11:55

"I think that the potential risk to patients were properly considered by all concerned." 11:55

Now, in relation to triage, would you agree that there is a potential risk to patients if triage is not

carried out properly?
A. Yes, yes.
148 Q. Now, that sentence that I've read out would seem to suggest that your minds were turned to consideration of patient risk or the potential for patient risk when you were dealing with these issues? 11:56
A. Yes.
149 Q. And was that done -- I just want to try to understand the way in which you say you considered potential patient risk. Was that something you did automatically as a clinician, knowing that triage was important, or was there any other investigation undertaken to see the nature of the problem, the extent of the issues, the longest delay triage, the types of triage that weren't being done, were any of those analytical steps undertaken in order to properly, perhaps, address potential risk? 11:56
A. I don't believe so.
150 Q. Do you think they might have been or they should have been? 11:57
A. In retrospect, yes.
151 Q. In relation to Mr. O'Brien's job plan, did you have any knowledge that he did not, in fact, have any time allocated to him to undertake the role of lead clinician and chair of NICaN's Clinical Reference Group for Urology since January 2013? 11:57
A. No, I didn't, but --
152 Q. Would you have anticipated that he might have?
A. Well, there were certain roles that we undertook which

came with a PA allocation. I'm not sure that that one came with a PA allocation, but, if it did happen, it happened over and above a job plan, so it was added on to a job plan that someone already had. So, if someone, for instance, was chair of M&M - that's the one I did know about - or if someone was a regional adviser for NIMDTA, for education, they would have got an extra PA. I was the undergraduate lead for undergraduate education, but I didn't get an extra PA. So, some of them got PAs and some of them didn't. I wasn't aware that individual M&M chairs were given a PA, I wasn't aware of that. 11:57 11:58

153 Q. And what about in his role, his post as lead clinician of the Trust Urology MDT since April 2012?

A. That would have been that role lead of MDM. 11:58

154 Q. Would he have time allocated to him for that post?

A. I don't think so.

155 Q. Might he have? Might that have been of assistance?

A. Yes, it would be, it would be now. I think if you did a role like that now, or anything like that, you would certainly have time allocated and perhaps extra PAs allocated, but at that time it wasn't really job planned for. 11:58

156 Q. And it wasn't throughout the Trust, I take it then? It wasn't throughout the Trust for chairs of MDTs? 11:59

A. No, I don't think so. I'm not absolutely sure about that. I not sure when chairs started to get remunerated. I couldn't answer that.

157 Q. Mr. O'Brien was also involved in preparing NICaN's

Clinical Reference Group and the Trust's Urology MDT for a national peer review in June 2015. Did you have any understanding that that would have involved taking time away for him to undertake those roles and no time allocated for that? 11:59

A. Not really.

158 Q. When you say "not really", did you know if he was given extra time for those functions?

A. I knew that -- I was never chair of an MDM, I was never a core member of an MDM. I knew that chairs did do 11:59 a report at the end of the year, but, likewise for undergraduate education, I did a report at the end of the year. I wasn't sure how long -- I couldn't have told you how long that would have taken, to do a report like that, or whether or not it needed a PA allocation 11:59 to do a report, I wouldn't have known that.

159 Q. And it was also his role to review all of the cases for discussion at MDM while he was chair as well. I know the chair post rotated --

A. Yes. 12:00

160 Q. -- but you've mentioned that his administrative practice was somewhat slower, I think was the phrase you used.

A. Yes.

161 Q. So when he was having to take more time to prepare and 12:00 review the cases for discussion at MDM, is it your understanding that anyone got any extra time for that?

A. I don't know. It wasn't -- there was MDM time in the job plans to attend MDM, but I don't know whether there

was anybody allocating extra time for the chair, as it was a rotating chair.

162 Q. Were you ever made aware at any time that, during 2013, Mr. O'Brien conducted an additional 43 in-patient operating sessions to try and impact on the long waiting list? Was that information ever provided to you? 12:01

A. No.

163 Q. Were you ever informed of extra clinics being undertaken or extra surgical slots being made available? 12:01

A. No, that was never dealt with at my level. I think it was -- they were organised by the non-clinical team. There were payments associated with those lists. I have very little knowledge of them because I never did any; I wouldn't have had time. 12:01

164 Q. Just, you mention MDMs. I just want to ask you a couple of questions on that issue just now. If we go to WIT-17556, paragraph 67.1. You say at 67.1:

12:01

"I never knew that Mr. O'Brien's treatment of cancer patients was different to anyone else's. The principle of MDMs is that treatment plans are agreed by the team based upon guidelines and best practice. I don't know why he chose to treat his patient differently to guidelines or how this came to light. I do not know the reason why he did not apply the treatment plans agreed at MDM." 12:02

Now, just your knowledge base for that particular paragraph, I just want to ask you, is that information that you have gleaned or interpreted from what you've heard in relation to the Inquiry?

A. I knew about the fact that he had stepped outside guidelines in terms of Bicalutamide because I had received a telephone call, prior to the Inquiry, from Mark Haynes asking me if I would do a lookback, because there were issues about his Bicalutamide prescriptions. I expressed some reluctance because I worked so closely with him, and he was quite persistent, that eventually I didn't do that lookback, someone else did it. So I did know about that, but only through the telephone conversation with Mark Haynes. 12:02 12:03

165 Q. And for the Panel's note, that reference in your statement, you've made reference to that at WIT-17548 to 17552, specifically at paragraph 54.3, and I would just like to read that out, actually. If we could go to that, WIT-17548, down to paragraph 54.3, please. This is what you say on that issue: 12:03 12:03

"I first became aware of the more recent issues of concern about three-and-a-half years after I retired on 31 March 2016. Mr. Mark Haynes texted me on 14/10/2020 requesting a Zoom meeting, which we had immediately. He advised me that issues had been raised about Mr. O'Brien's management of some cancer patients and asked me if I could assist with a lookback exercise of patients' charts. I can't exactly remember what the 12:04

issues were, but I think it was something about differences between his treatment of some cancer patients and guidelines. I advised him that I had a long and good professional relationship with Mr. O'Brien and that I might not be considered sufficiently impartial. Mr. Haynes advised me that my basic knowledge of urology placed me in an ideal position to do the exercise. I reluctantly agreed, but I did not hear from Mr. Haynes again. I did not assist with the lookback exercise. I had no idea until that telephone contact that there were any issues with Mr. O'Brien's management of cancer patients." 12:04 12:04

So that provides the context of your previous paragraph we looked at -- 12:05

A. Yes.

166 Q. -- when you have said about the difference in treatment.

Just on the MDM point, I know that your involvement in MDM was slightly tangential to some of the issues that are raised in the Inquiry, but from a clinician's perspective, if the MDM makes a recommendation and there is, in your view, post-MDM recommendation, to be a change in plan, if you decide you are going to do something else, what's the procedure for undertaking your alternative to the MDM recommendation? 12:05 12:05

A. You go back to MDM.

167 Q. So you would bring it back to the MDM and discuss it

then?

A. Unless it's obvious that you've -- if it's so really obvious; like, for instance, the patient is in terminal care, you would maybe make an executive decision not to proceed with treatment, but for the majority of cases it is simply a case of bringing it back to MDM. 12:06

168 Q. And in relation to your discussions with the patient about the MDM recommendation or, indeed, a plan of action that you may feel is more appropriate, is it your practice, or has it been your practice, that you would take the patient through the options and perhaps get informed consent about movement away from the MDM recommendation or an alternative pathway? 12:06

A. It would be the patient's decision what treatment they want to follow. If I were in that position and I had an MDM recommendation, I would make that recommendation to the patient. It would be unlikely, to be honest, that I would offer them many alternatives if a decision from best practice has been agreed, unless there are reasons why an alternative might be appropriate to that patient, and they should be give the option to make that decision. 12:06

169 Q. Now, we don't need to look at it, but you've mentioned at paragraph 70.3 in your statement, at WIT-17559, you express the view that you do not know how an individual consultant would be stopped from changing a patient's treatment plan agreed at MDM. Now, the Panel have heard information and evidence around tracker, MDM tracker system. I know that's probably not something 12:07

that existed during your time, someone following the recommendations and the outcomes, but is that one way in which, from your perspective as a clinician, that there could be good governance carried out in relation to recommendations? 12:07

A. Yes.

170 Q. Do you think if there wasn't that sort of oversight or structure, that it would be much more difficult to keep an eye on what was suggested had been followed through?

A. Well, given what we know now, I certainly think that oversight of -- particularly of medication, is almost certainly vital. 12:07

171 Q. Now, you've mentioned Bicalutamide 50mg issue as a monotherapy. The Panel has heard evidence on that. Is that a drug that you would have been involved in prescribing? 12:08

A. I wouldn't have prescribed Bicalutamide unless it was under the direction of a urologist. So there was times whenever I had cancer patients in Daisy Hill with -- who were discussed at MDM, and they would ask me to write a prescription, I would just write the standard prescription; in fact, I had it typed out. 12:08

172 Q. And would you be following the prescription of the prescribing urologist?

A. Oh, yes. 12:08

173 Q. Did you ever have cause for concern about any of the prescriptions for Bicalutamide that you were asked to replicate?

A. No.

174 Q. Do you ever remember being asked to prescribe Bicalutamide 50 as a monotherapy?

A. I don't remember ever doing that. I wouldn't have had the knowledge of the management of prostate cancer in depth compared to the urologists, so I just basically did what I was told. 12:09

175 Q. I want to just cover the issue of triage again with you. I just want to make sure -- I think you've mentioned it in your third addendum statement. Apologies, I've lost my third statement, I will have to call on some assistance for a reference for the first page of the most recent. 12:10

CHAIR: I think it's 103533, Ms. McMahon.

MS. McMAHON BL: At least my memory didn't fail me, but my paperwork has. 12:10

176 Q. You mentioned outstanding triage, I just want to put this in the record, you've mentioned this in your most recent statement, information that hadn't found its way into your original statement, and you say at WIT-103533: 12:10

"Outstanding triage, September 2011: Heather Trouton asked me to speak to a consultant in another specialty (not urology) in September 2011 regarding outstanding triage. He had 141 letters stretching back 27 weeks. 12:11 This practitioner was an employee of the Belfast Health and Social Care Trust, who had an outreach clinic in DHH, where he saw patients from the Southern Trust. I have extracted the information relating to

outstanding triage and numbers of patients waiting for new and review appointments. Initially, I had difficulty contacting him as his single clinic clashed with my operating list. I did speak to him, and, whilst it was 12 years ago, to the best of my recollection he did complete his outstanding triage. Of note, at that time, Aidan O'Brien had two patients awaiting triage. I do not recall being informed about Mr. O'Brien having an issue keeping up with triage before 2013. Therefore, when Mr. O'Brien assured me in November 2013 that he would catch up with his triage, I accepted that assurance and believed that he would keep it under control." 12:11 12:12

Now, if we could go to WIT-103573, and this is a document that you have created of information that you had available at the time in relation to numbers. Now, that paragraph illustrates that there was someone else who had a significant volume of triage unattended to and you had carried out an analysis to give you an overview, and you have provided that table, which is not contemporaneous, I understand. You created this -- did you create this at the time or -- 12:12 12:12

A. No, I created this recently from the information which is also attached, which is the bigger list, but it is very hard to extract information from it, so I did that for your convenience. 12:12

177 Q. Thank you for that. And you've provided that in this statement. Just for the Panel's note, they can see

"outstanding triage", second box on that sheet, "new urgents", "urgent reviews", "August-September 2011". We can see we have noted Mr. O'Brien triaged two; Mr. Young, four; Mr. Akhtar, one. Then, on the urgent review, the figures are slightly higher, and you have provided that information. So, at that point of August-September 2011, the triage turnaround for Mr. O'Brien and others in Urology was low to minimal, I think; that's your analysis of the information? 12:13

A. Yes. 12:13

178 Q. That's what the information tells you?

A. Yes.

179 Q. And you have brought that to our attention, so thank you for that.

A. There was one clinician with outstanding triage and I addressed that. 12:13

180 Q. Just going back to your statement again at WIT-103534. This is your third -- your second addendum statement, at paragraph 3, just to complete the triage narrative from you. You say: 12:14

"Triage in Daisy Hill.

Triage was an issue in other parts of the Trust. In particular, it was an ongoing issue in Daisy Hill in 2013 and 2014. The problems there related to new staff appointments and their preferences, i.e. what they wished to undertake in triage and what they did not want to be triaged by others on their behalf. 12:14

Negotiations were complicated and protracted."

And you have included two e-mails referencing the issues with that. Just in relation to that point, there seems to be -- well, it is explicitly stated in that paragraph that there was some clinician preference into what triage was undertaken by what clinician and what some people didn't want to triage by others. Just so the Panel, from a governance perspective, can understand those sort of demands that existed at that time, could you give that paragraph a little bit of context? 12:14 12:15

A. Well, the biggest problem was colorectal surgery, in that colorectal surgery was far too big for the colorectal surgeons to triage, and we divided it into general and specialty-specific triage, which got very complicated, because not only did it matter who did the triage, but then whose clinic they were triaged to. There was another issue about a condition which was, shall we say, ethical, and one of the consultants didn't want to triage that or even to see the letters, and, whilst that was initially palatable to the group, I thought it was better to respect cultural issues and I did those. 12:15 12:15

181 Q. So the Panel have an understanding that -- or the evidence has been that the structures around triage are a certain way, and what you are bringing information around is that it can be more personality-driven than perhaps would be more widely known? 12:16

A. Well, that's a very individual one, but, I mean, ideally -- well, let's go back in time. Whenever I started in Daisy Hill, every individual consultant did their triage, but it wasn't very timely. We decided that we would have it done by the surgeon of the week so that it would be timely, so that people weren't doing triage or having triage allocated to them when they were on holidays, but then that tended to cause difficulties with, for instance, whenever my colleagues were doing triage, they weren't quite sure what to do with the urology patients, whether they were urgent or non-urgent, so they tended to send them to me. So we had primary and secondary triage and then with subsections for colorectal and then there was triage for those things that people didn't want to see, etc. So it became an algorithm, eventually, which we worked with. There was a workaround of types, but we worked with it. 12:16 12:16 12:17

182 Q. And was that resolved to your satisfaction at the time?

A. It was an ongoing issue. It was resolved -- it was amicable. We resolved this very well. And then as new consultants came in - and they kept changing continuously over the next three or four years - they would have different preferences and we'd change the algorithm. 12:17 12:17

183 Q. And when you left in 2016, were there any problems around triage that you were aware of?

A. No.

184 Q. I just want to ask you briefly about waiting lists.

The Panel has heard information about long waiting lists, and I'm sure it is something you are very familiar with?

A. Yes.

185 Q. Both during your time and since then. Waiting lists as a governance issue, was that ever discussed? Did people sit down and say these waiting lists are increasing, there's a problem? What was the mood around waiting lists during your time as Clinical Director? 12:18

A. I think waiting lists was the biggest governance issue and I think it was recognised as such. The Trust did everything in its power, whenever I was in management, to reduce waiting lists and to make the Trust more efficient. There's no doubt the performance, as it was called, was the order of the day, that was the most important issue, and it's difficult to see it separate from governance, because the longer people wait, the more morbidity they will develop, so it was key in the Trust at that time. 12:18

186 Q. And when you say it was "key in the Trust", does that mean that there were regular meetings discussing waiting lists or that you -- initiatives were being brought in or --

A. Yes. 12:18

187 Q. -- that people were asking for suggestions? What does that mean?

A. All of that.

188 Q. Did you take part in discussions about waiting lists?

A. Oh, yes.
189 Q. And who were those with?
A. With Debbie Burns, Heather Trouton. The waiting lists that I would have most to do with was the general surgical waiting lists, so it would have been within general surgery, but I also had a lot to do with the urology waiting list, because, in 2013 in particular, there was a drive to shift low-level urology from Craigavon to Daisy Hill, and at one time it was decided that I would stop doing general surgery and do only urology because the urology waiting list was much higher than general surgery. So, yes, the Trust was very interested in getting waiting lists down and getting equitable. 12:19
190 Q. And do you ever remember having discussions with urology clinicians around what they could suggest or what might help them with waiting lists? 12:19
A. No.
191 Q. Do you think that might have been a helpful step to take? 12:19
A. If I had had the time and the access, yes, it would have been, and it would have been great if I had had so much time that I could have had those sort of discussions.
192 Q. I suppose from one perspective, it may be unusual that the clinicians who were providing the service weren't engaged in those sort of conversations, as to how they saw the problem and how they might be assisted. Do you think that that sort of -- a conversation might have 12:20

taken place and you not know about it, or would you have expected to have been involved?

A. I think there were a lot of conversations between, particularly, Martina Corrigan, who worked extremely hard on waiting lists, and the urologists, yes. 12:20

193 Q. But you don't have any personal knowledge of that; you just believe that to be the case?

A. Other than when they interacted with me.

194 Q. And how did the interactions with you come about and what did that involve? 12:20

A. It involved sending me the waiting list on a regular basis and then I selected off the waiting list those things that I could do, and then those patients were transferred to me, either direct to list or to a clinic for a meet-and-greet before coming to a list. 12:21

195 Q. So you received data in relation to waiting lists?

A. Yes, I did.

196 Q. And was it numerical date simply in the length of time people have been waiting?

A. Because I do names, just a long list of names. 12:21

197 Q. Just names. Was there ever any exercise undertaken or proposed to look beyond the names, to the clinical presentation of patients, to try and gauge just if there was -- well, I think it probably can be taken as read that waiting lists do, potentially, create harm, 12:21 patient harm, people waiting longer than they need to?

A. Oh, yes.

198 Q. And if we take that as being the real potential, was there ever any suggestion that you should look below

the figures and below the names and see what the priority was for people and were people coming to harm waiting?

A. No, the waiting lists were stratified according to urgency and time waiting. So there would have been routine, urgent, semi-urgent, and, among that, then you would also have known the length of time that people were waiting. So I was generally taking from the routine list and the red-flag list, I was taking mostly from those two lists, and I would have known how long they were waiting. 12:22 12:22

199 Q. When you talk about those designations of red flag and routine, were they designations that were initially applied to patients at the outset of their introduction? 12:22

A. Yes, yes.

200 Q. And was there any review ever undertaken of upgrading or downgrading patients, depending -- given the length of time? Did anyone think, well, we need to go back and look at these patients because what might be a red flag -- or what might be a routine, may now be a red flag? 12:22

A. There would have been validations of waiting lists generally across the Trust where people would have looked at waiting lists to see if anybody's status has changed or whether they had, in fact, passed on. 12:22

201 Q. And that was during your time as Clinical Director?

A. It was a regular thing; that it wouldn't be something that I would have done, it would happen at non-clinical

level.

202 Q. So when you say "non-clinical level", was it an administrative process undertaken?

A. Yes, it was, yes.

203 Q. So the person doing that wouldn't have had the clinical experience to perhaps assess the patient? 12:23

A. They would have in case with a clinician. So if there was a validation waiting list that I was engaged in, they would have asked me to look at them as well.

204 Q. So did that involve going back asking -- phoning the patient and saying, "are you as you were when you first came into the system?" or checking if the patient had been back to their GP or presented in ED or -- how would you know if the patient had got worse, I suppose that's the key question I'm trying to find out? 12:23

A. I am not sure I can give you a straight answer to that. I can't really remember how validations were done. It's a long time ago.

205 Q. Do you have any sense that there was a lack of appreciation on the part of the Trust management as to the harm and the risk of harm patients could suffer due to the length of time they were waiting for treatment? 12:24

A. No, I don't think that was ever the case. I think it was always fully appreciated that patients languishing on lists are going to suffer from morbidity. 12:24

206 Q. I know that you have listened to the Inquiry and you're aware of the issues and I think you listened to the evidence of Mr. Mackle.

A. I did.

207 Q. Now, you'll know that Mr. Mackle believes there's an allegation around bullying made in relation to him from Mr. O'Brien, and I just want to read the extract from that in relation to his evidence. WIT-11769 at 92. Yes, paragraph 92, Mr. Mackle says: 12:25

"In 2012 (I am unsure of the exact date) I was informed that the chair of the Trust, Mrs. Roberta Brownlee, reported to senior management that Aidan O'Brien had made a complaint to her that I been bullying and 12:25 harassing him. I was called into an office on the administrative floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and left and 12:25 went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the 12:25 time that it was Helen walker, AD for HR. I now have a memory of same, but can't be 100 percent sure that it is correct. I recall having a conversation with Dr. Rankin, who advised that, for my sake, I should step back from overseeing Urology and I was advised 12:26 that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Mr. O'Brien unless I was accompanied by a head of service."

And Mr. Mackle goes on. The key part of that is that Mr. Mackle's understanding was that you would take over direct responsibility in relation to Mr. O'Brien. Now, you've mentioned this in your addendum statement at WIT-100414, and you say at paragraph 14 -- sorry, we'll go to paragraph 13, my mistake. You have made two addendums. You refer to paragraph 30.1 in your statement and you said "should be amended to the following". 30.1 should be amended. 12:26 12:27

"During my tenure, the AMD was Eamonn Mackle, the Head of Service was Martina Corrigan and the Assistant Directors were Simon Gibson, followed by Heather Trouton. It was my experience that the urologists worked very well together and with me. I was not aware of any difficulties interacting with me or any of the clinical or nonclinical managers, apart from Mr. Mackle (see additional paragraph 30.2)." 12:27

Which I shall read in a moment.

"Any management interaction I had with the urologists, and for which I have some recollection, was always very professional. I do clearly recall a lot of interaction with the urologists when I was employed as a locum in the Urology Department from 1st September 2016 to 31st March 2017 and it was always amicable. I saw the urologists interact with each other and with Martina 12:27

Corrigan, Head of Service, and on all occasions the conversations were very professional."

Then, at paragraph 14 you say:

"I would like to add the following paragraph after paragraph 30.1."

And you add this paragraph in as 30.2:

"Mr. Mackle stated in his evidence that he was accused of bullying and harassment by Mr. O'Brien. Whilst I would not question the factual accuracy of his evidence, I cannot recall ever knowing about it. I do now recall that there was a period of time when Mr. Mackle was not on good terms with Mr. O'Brien. I think this was around 2012, but I have nothing on record to confirm. I know that Mr. Mackle and Mr. O'Brien had been engaged in some difficult negotiations. The two things that I recall related to his job plan and his outpatient new/review ratio. I recall that Mr. O'Brien had a job plan for more than 15 PAs. There was a push at that time to get all job plans down to 12 PAs or less, in keeping with European working time regulations. I remember being impressed by Mr. Mackle's achievement, as a similar situation with one of my consultants in the legacy DHH Trust proved much more difficult to resolve. I was previously unaware of the facilitation carried out by

Dr. Murphy. I do remember Mr. Mackle telling me that Mr. O'Brien had so many review patient at his clinic that there were very few remaining slots for new patients. The service-based agreements agreed with the Department of Health related to quantities and access times for new patients and elective access. There were no access targets for outpatient/review patients. I was not party to any of the negotiations with the Department of Health or subsequently with the Urology team. I do not know if it was one of these two issues or something else which led to the disagreement between Mr. Mackle and Mr. O'Brien. I only recall that Mr. Mackle did stop engaging directly with Mr. O'Brien, but I do not recollect that he had any issues with anyone else in Urology." 12:29 12:29 12:30

So you remember that there were some issues between Mr. O'Brien, Mr. Mackle. You don't have any direct knowledge of those?

A. I never heard about the bullying episode until I heard it in this Inquiry. That was news to me. I know that when I first wrote my Section 21, I didn't remember any difficulty between Mr. Mackle and Mr. O'Brien, and then I could then recall, on reflection, something that Mr. O'Brien said to me about Mr. Mackle confirming that they perhaps weren't on best terms, and that's how I remember, but it wasn't prominent in my mind. 12:30 12:30

208 Q. Do you have any recollection of, whatever the reason, being deployed specifically to manage Mr. O'Brien or to

be his point of contact?

A. I can't remember that.

209 Q. Can't remember. Did you have any role or requirement, as part of your job as Clinical Director, to recommend or place any issues on a risk register or any of the formal Trust documentation? 12:31

A. No, it wasn't really something we did as clinicians.

210 Q. And who did you understand to be responsible for -- well, presumably the clinician, first of all, can raise a risk? 12:31

A. Yes.

211 Q. And if one were to be raised, who do you see as being responsible to make sure that finds its way to the right people, for example, by being on a risk register?

A. Heather Trouton, probably. 12:32

212 Q. Heather Trouton. Now, Mr. Mackle also makes reference - I just want to put it in for the note - it is at WIT-11798, where Mr. Mackle mentioned specifically your involvement in governance. I just want to read it out to you, 157. He says -- Mr. Mackle says: 12:32

"Robin Brown, upon appointment, was given responsibility for Daisy Hill and for Urology."

12:32

If I just pause there and say we have sorted out the relevant dates for your CD role.

A. Yeah.

213 Q. "Robin did not take part in the Monday evening meetings

held by Gillian Rankin regarding implementation of the Urology review. Robin did, however, attend the monthly governance meetings chaired by Heather Trouton and myself and would bring the perspective of a general surgeon with an interest in urology." 12:33

Now, just stopping there. Was that -- those monthly meetings, again just to make the same point, there was never an opportunity taken to raise any governance issues around urology with you at those monthly 12:33
meetings?

A. I don't recall any governance issues raised about urology at those meetings. To be fair, I wasn't always there. Again, it was a difficulty with access, and when they were video-conferenced, it didn't always 12:33
work. So I do remember being at meetings, but probably not all of them.

214 Q. Now, Mr. Mackle also - we don't need to go to it - but he also says in his Section 21, and for the Panel's note this is at WIT-11822 at paragraph 235, he's 12:33
speaking about the triage issue and the attempts to get on top of that, and he says:

"On reflection, it is apparent that the monitoring of compliance by Aidan O'Brien should have been 12:34
continued."

Now, the Panel has heard different time periods in which this issue was tried to be grappled with.

I think you've already said, but I just want to make sure your evidence is clear, do you feel that there should have been more monitoring of compliance by Mr. O'Brien in relation to both the charts issue that you knew about and the triage issue that you knew about? 12:34

A. Yes.

215 Q. I do want to ask you from Heather Trouton's Section 21, WIT-12010, at paragraph 75, and Mrs. Trouton says: 12:34

"There is no doubt that, while not overtly clinical, managers were very aware of the patient safety risks associated with his admin practices."

And "he" in this context is Mr. O'Brien. 12:35

"These concerns were highlighted, articulated, and escalated to all directors of Acute Services and medical directors. Mr. O'Brien was engaged with and supported with his practice and Mrs. Corrigan, in particular, spent many hours trying to manage around his preferred practice to ensure that patients had access to care. I was also assured by the Clinical Director, Mr. Robin Brown, as to the clinical excellence of Mr. O'Brien and advised to support rather than challenge his administrative practices." 12:35 12:35

Now, what do you say to that, particularly the last sentence?

A. It refers to that e-mail where I said that he was clinically excellent and we should be offering him some support to catch up with his triage, which we did. Maybe she thought at that time I should have challenged him more. Fair enough. 12:36

216 Q. I just want to make sure you have the opportunity if anyone mentions you or you might helpfully comment, just to give you that opportunity while you're here.

A. Yes.

217 Q. Mr. O'Brien also references you in relation to appraisal; I just want to go to that, WIT-82514. This is Mr. O'Brien's Section 21 at 336: 12:36

"Mr. Robin Brown was scheduled to carry out an assessment of my appraisal documents to ensure that they complied with and satisfied the requirements of revalidation in 2019. Mr. Brown did so, finding my documentation to be entirely satisfactory and complimenting me on its quality." 12:36 12:37

Is that your recollection?

A. No. More detail?

218 Q. Yes, please.

A. Mr. O'Brien was due to revalidate on 5th April 2019. Revalidation is based on appraisal. Appraisals are done retrospectively. So the appraisal that would have been completed for that revalidation, believe it or not, would be his 2017 appraisal, which was due to be completed during 2018. His 2018 appraisal would not 12:37

have been due for completion until maybe May/June 2019. So he was revalidating on his 2017 appraisal. I met him for what was called the initial meeting, before he met my senior colleague, and that was to see if there were any gaps in his appraisal. There were gaps, and I pointed them out to him and said "you can't revalidate until you've closed those gaps", and that was in his 2017 appraisal. He then went for his second meeting with Damian Scullion, who was my senior colleague at that time; he was the corporate lead. I think at that meeting, a decision was taken not to revalidate him. Subsequent to that, he then completed his 2018 appraisal, which I -- it was completed in 2019 by Damian Scullion, so it was a good appraisal. I was then doing the second sign-off, which was the quality assurance on the appraisal, and I looked through it and I said it was fine. But, no, his 2017 appraisal wasn't complete. 12:37 12:38 12:38

219 Q. So, in relation to the chronology and the date, there was perhaps more detail behind what Mr. O'Brien has said? 12:38

A. There is. I think what he is referring to is the fact that I commented on the quality of his reflection, and I consider reflection to be the most important part of appraisal, and his reflections were very extensive, as you'd expect. 12:39

220 Q. Mr. O'Brien again, at WIT-82524, paragraph 357, just back to the job-plan issue, just what Mr. O'Brien says about that.

A. Yes.

221 Q. "I received a new job plan on 1st April 2012 which was in discussion with an allocation of 11.28 total PAs, 9.8 PAs for direct clinical care and 0.80 PA for administrative time. I did not accept this job plan as 12:39
I felt it wholly inadequate. I received a further proposed job plan in February 2013 that proposed an 11 PA job, which, again, was never agreed. By April 2013, there was a further proposed job plan, which allocated 12.275 total PA, 9.80 PAs for direct clinical care 12:40
and 0.80 PA administration time. This job plan was also never agreed. It was noted during this time that Dr. Rankin and Mr. Brown were keen on having 11 PA job plans. It is my belief that the idea of having an 11 PA job plan is directly related to the salaries of the 12:40
consultant urologists as opposed to making an allowance for patient safety and care."

I just ask your comment on the last sentence there; what was the driver behind the 11 PA? 12:40

A. Dr. Rankin.

222 Q. But in relation to Mr. O'Brien's belief that it was directly related to salaries rather than to make an allowance for patient safety and care?

A. Well, I'm not sure what to make of that comment. 12:41
I don't think Mr. O'Brien was completely comfortable with the initial reduction in his PAs from 15 to 11-point-something. I thought that was quite good work by Mr. Mackle and I certainly wasn't going to undo his

good work. It was hard to get to that point. It was the feeling in the Trust at that time that job plans should be below 12 PAs. That allowance of 0.8 is pretty average for administration at that time.

223 Q. Now, I did read out Heather Trouton's comment about you asking to be helpful. And then just to close that circle, I'm going to go to the e-mail. Just to be fair to you, the way you've worded that is, better getting your own words on that. Mr. O'Brien refers to that. We'll go to that in his statement, and then I'll give you the WIT reference. But if we go to WIT-82604. WIT-82604, at 608. Mr. O'Brien says this: 12:41 12:41

"As is apparent from elsewhere in this statement, there was an ongoing issue in relation to triage. I had a particular view of how triage was best carried out for patients (advanced triage), against a background of increasing numbers of referred patients waiting increasingly long periods of time for first outpatient appointments, without any diagnostic or therapeutic measures being taken while waiting. In the context of triage and issues in relation to health records not being found, there was an e-mail change in late November/early December 2013 when Mr. O'Brien made the following comments..." 12:42 12:42 12:42

This is your e-mail that you referred to. I just wanted to put it in this context so we can see what Mr. O'Brien said.

"I had a lengthy one-off meeting with AOB in July on this subject and I talked to him again on the phone about it last week.

12:43

I agree that we are not making a lot of headway, but, at the same time, I do recognise that he devotes every wakeful hour to his work and is still way behind. Perhaps some of us - maybe Michael, Aidan and I - could meet and agree a way forward."

And just pausing there. We've looked at the way forward, which was the consultants taking that role on temporarily. And then you finish:

12:43

"Aidan is an excellent surgeon and I'd be more than happy to be his patient (that can be sooner than I hope!) so I would prefer the approach to be 'how can we help'."

12:43

Just, we will avoid that last comment from you. But that last sentence, I think, encapsulates your approach was, let's see how we can sort this out, rather than let's go in with sanctions?

A. Yes, yes, I think I learned that skill after being somewhat too robust in my earlier days, and to approach situations saying, first of all, what's the problem? How can we help you? But I didn't think one of those helps was to give him excessive PAs over and above his

12:43

colleagues. If I was going to say to Aidan, "okay, you can have double the PAs for administration", I think his colleagues will rightly say, "well, why are we not getting that as well?" So I wasn't going to -- it is a team job plan. I mean, I had written the original job plans. It was a team job plan, and I wasn't about to break down that arrangement where everybody was paid the same. Team job plans were very powerful. I felt, really, that it wasn't about, you know, paying you to work slower, but you need to speed up, as it were. 12:44

224 Q. Now, I had asked you a question earlier, and I'm just going to give the Panel a reference for the answer and explain it to you. I had asked you about how you knew about the triage -- or the charts at home issue, and you weren't sure. Debbie Burns covers this in her statement at WIT-96923. 12:44

A. Yes.

225 Q. We don't need to go to that. And she says at that point:

12:44

"AD functional services, Anita Carroll e-mailed me regarding 14 charts and eight IR1s from May 2013 to August 2013 being at Mr. O'Brien's home over this four-month period. This had already been escalated to AD Heather Trouton and Head of Service by Helen Ford, Anita's Head of Service. On the same day, I escalated the issue to Martina Corrigan, Head of Service; AMD, Eamon Mackle; and CD, Robin Brown. I asked them to discuss and agree with Mr. O'Brien or escalate further 12:45

as it was a governance issue.

On 4th September 2013, Robin Brown replied, indicating he cannot address the issue for two weeks. On 5th September 2013, I re-escalate to AMD and HOS to address immediately. 12:45

Martina replies on 5/9/2013 saying she will follow up with Robin Brown and let the AMD and myself know. She also goes on to state that Mr. O'Brien is not the only one who participates in this practice." 12:45

So that was the instigation of you then speaking to Mr. O'Brien in the November 2013?

A. Yes, yeah. 12:46

226 Q. I just want the Panel to have that for their note. I just want to briefly run through some of the learning you've identified or some of the reflections you've provided in your statement at WIT-17556, at 66.2. We've just asked you to provide us with some of your thoughts on some of the issues. You say: 12:46

"In relation to the missing triage and charts at home, I understood that agreement had been reached then to address the issue. If there was an ongoing issue with triage, I would expect it to have been drawn to the attention of one of the clinical or nonclinical managers on the CAH site. I was not aware of an ongoing issue with triage." 12:46

And I understand you weren't -- until you got the information from the Inquiry, until you found out from the Inquiry, the issue of triage was much more significant than perhaps you had realised? 12:47

A. Yes, it was much greater than I had ever understood, but, equally, I should have checked.

227 Q. And you reflect that again at 68.2. Just the last sentence of that, I think, is just what you've effectively said, in relation to triage: 12:47

"I do not know if the problem with triage persisted or recurred. If it was persistent, I do not know who knew about it or who was dealing with the issue. In terms of learning then, maybe a more robust approach to 12:48 Mr. O'Brien's triage may have been appropriate."

A. Yes.

228 Q. You say, again: "I am not aware of issues relating to the Urology Unit as a whole, but only to Mr. O'Brien specifically." 12:48

We have covered a lot of this already in discussions. I think I've covered most of your reflection on the topics as we discussed them. Unless there's anything else that you would like to add at this point that you 12:48 think I haven't covered or that you would like to say?

A. No, I would just like to apologise for any part I played in this difficult situation.

229 Q. Now, I'll just check my note to make sure I haven't

missed anything, but, in the meantime, I'll hand you over to the Panel. I think we have covered everything, but I'll hand you over, and if they have any questions, and if I need to pick anything up, I will do, subject to the Chair, of course. 12:49

CHAIR: Thank you, Ms. McMahon. We will have some questions for you. I'm going to ask Mr. Hanbury to start.

THE WITNESS WAS QUESTIONED BY THE PANEL MEMBERS AS FOLLOWS: 12:49

230 Q. MR. HANBURY: I was quite interested in your urology subspecialty, having gone through the conventional general surgical training. What led to that? Was that your choice or part of the rotation? I think it was in Glasgow; is that right? 12:49

A. It just so happened that I tended to pass through a lot of units that had general surgeons who did urology, in total three years. Then, at the end of my time, I was approached by the surgeons in Daisy Hill to say that we are really stuck, we need somebody who can do a little bit of basic urology, can you help us out? So I went to Glasgow and did six months in a urology unit in Glasgow. I had no intention of being a full urologist, 12:49 12:50 but just to be able to handle, particularly, the emergencies and to provide a basic service. So someone who could be an expert in circumcisions and little more.

231 Q. Going on to that, your main CPD interests were obviously in general surgical matters, but did you keep up to date and go to BAUS and other meetings like that?

A. Oh, yes. I was a member of BAUS, yes.

232 Q. Okay. Thank you. 12:50

Just going to the waiting list side of things. Obviously, as a general surgeon you struggled with waiting lists of your own. There was, the Panel have heard, some interspeciality differences, i.e. it seems 12:50 the urology patients were waiting longer than general -- maybe not general surgery, but other. In your position as CD, did you think there was anything you could do to equilibrate those waiting times? Access to theatre and those kind of -- 12:51

A. We were able to equilibrate the waiting lists across general surgery in the two hospitals to some extent, although there were difficulties there with that as well. But we -- in terms of equilibrating general surgery with urology, that could be a difficult enough 12:51 nut to crack. Very difficult.

I would say one solution to that was that I was planning to be a full-time basic urologist for at least six months. It didn't actually happen because the 12:51 locum who was coming to replace me ended up very sick and he didn't actually come. Also, I had very serious reservations about being a urologist by day and a general surgeon by night. Because I think it is

unsafe for any length of time to be doing work at night that you're not doing during the day. You'll get deskilled. So I wasn't happy with it anyway.

233 Q. Leading on from that, we found during COVID that there seemed to be some theatre space that appeared at Daisy Hill and the urologists from Craigavon came and did day surgery at Daisy Hill. Looking back, do you think that -- was there spare theatre capacity at Daisy Hill that could have happened at an earlier time? 12:52

A. Difficult to say. It's a completely different profile now at the two hospitals, and the emergency surgery has left Daisy Hill, it created a vacuum, created a vacancy, so that there are spare theatres and \the urologists can come there. It is a different dynamic. 12:52

234 Q. That wasn't the case, say, ten years earlier? All the theatres were full? 12:52

A. Yes.

235 Q. Thank you.

You made a comment about outreach clinics being less efficient. Could you expand on that? It is something that other witnesses have -- 12:53

A. I'm not sure I --

236 Q. Maybe to help you in that, obviously you're taken away from your main base if there's no junior support, maybe not a specialist nurse support. But that seemed to be a big theme of the urology department, that the clinicians did a lot of outreach clinics. Would you have any comment on that? 12:53

A. They are not as efficient, if you are working away from home.

237 Q. So there's an efficiency argument actually centralised?

A. It is. Very much so.

238 Q. Was that something that you suggested when you were CD as a potential remedy? 12:53

A. Not in terms of urology. We did have outreach for general surgery, which I was very keen to stop because it was very inefficient.

239 Q. That's interesting. Thank. 12:54

You mentioned how you did your surgery of the week. There were five of you, it sounds as though you did respective cover as well. That didn't seem to be quite as smooth a process for the Craigavon urologists. They seemed to work a one in seven, but there were never seven of them. As a result of that, we hear there was some covered by locums, and then the planning was more difficult, hence this rota meeting. What was your view on that? 12:54

A. It was historic in that we set up the surgeon of the week in 2003 in Daisy Hill. It was on the go for a long time. It was a very well-established practice. If we tried to set it up in 2013, as the urologists did we wouldn't have got away with doing that with five surgeons. Because we had established it, it was going well -- well, it was going well until 2013, then as the new people came in, it got much more difficult to keep order, shall we say. 12:54

One in five is a very, very tight rota for surgeon of the week. I entertained the Royal College of Surgeons from England back in, I think it was 2010. They came to visit the hospital and we presented to them. And I remember the president at that time said to me, How do you do surgeon of the week without nine surgeons? Because I`m told you can only do it with nine. And I, as I say, was doing it with five. So It was pretty tight. But I felt we were never going to get more than five and I felt that five was better than what we were doing, which was ad hoc emergency work. 12:55 12:55

240 Q. When you did that, did you do on call every night --

A. Oh, no, you couldn't do that.

241 Q. -- that week? 12:55

A. No. The on call for general surgery is much greater than urology. You could be on call for urology for a week but two nights in a row in general surgery, you would be --

242 Q. So there is a difference in intensity? 12:56

A. In general surgery in Daisy Hill I could expect to be in most of the night about every second or third night on call.

243 Q. Thank you. 12:56

Just in terms of meetings, from your evidence it was hard for you to go to the departmental meetings at Craigavon with the urologists. Did you ever go to their management meetings on the Thursday lunchtime?

A. Yes. Yes. They probably were much the same thing, much the same meeting. Yes, I was at some of those. Because I have been searching through my e-mails, I have minutes of meetings where I expressed my opinion at those meetings. Yes, I was at some. They weren't always minuted and they didn't always happen and I wasn't always there. 12:56

244 Q. Thank you.

Just one quick thing on the notes-at-home issue. Did Mr. O'Brien say to you that one purpose was for him to catch up dictation or was that not something that he said at the time? 12:57

A. He didn't tell me, but then I didn't ask that. I didn't really explore why he had them at home, to be perfectly honest. 12:57

245 Q. Right. Okay. Thank you.

You made a comment about you would never have had time to do waiting list initiative, extra clinics, extra -- 12:57

A. No.

246 Q. Were you surprised that Mr. O'Brien did those when he was struggling, seemingly, to catch up with his admin?

A. I don't think he should have been doing extra --

247 Q. Is that something you said to him? 12:57

A. I didn't know he was doing extra lists. I personally couldn't do extra lists. I was working every Sunday to do my paperwork. I was coming in at 5 o'clock in the morning to do paperwork. I wasn't working as hard as

Martina Corrigan, but I was working very, very hard. There's no question I was going to do waiting list initiative work. I was surprised to hear that Aidan was, to be honest.

248 Q. Thank you. 12:58

Did you have a cancer special interest in general surgery?

A. No.

249 Q. Hence your comment about not being part of -- 12:58

A. I wasn't a core member of any MDM.

250 Q. Okay.

What was your practice with results? We heard about X-ray results coming back, pathology coming back and 12:58 not being actioned. What was the general surgical angle on that problem?

A. We were surveyed, I presume, after the swab incident. I never knew of the swab incident at all, but we were surveyed after that how we managed results and we all 12:58 responded the same way which is the standard practice in Daisy Hill was that the secretaries picked up the results as they came in. If it was pathology or X-ray you automatically got to see it on that day. If it was blood results and the patient was coming back to clinic 12:59 and there was nothing obvious on them they were filed for the clinic. But X-ray and pathology, we saw them immediately and dictated them very quickly.

MR. HANBURY: Thank you very much. I have no other

questions.
CHAIR: Dr. Swart.
DR. SWART: Thank you.

One of the things you talked about was Mr. O'Brien was a very careful note keeper in terms of writing, spent a lot of time on it. However, it came to light a lot of patients did not have dictated letters for a long period of time, which I think we would all agree is a significant Patient Safety issue. Did that come to you in that for at all? 12:59 12:59

A. No.

251 Q. In a sort of related thing, you didn't know about the swab issue. Did you have an opportunity to regularly find out what serious incidents had happened and what had been done about changing processes? 13:00

A. I was not involved in IR1s, decision about SAIs, complaints --

252 Q. But no learning either?

A. But if they came to an SAI and were presented at an M&M meeting, chances are I would have heard about it because I would have been at, roughly, 60, 70 percent of those meetings. Most likely I would have heard about it. 13:00

13:00

But a swab, as you know -- a retained swab is a very, very significant incident. So there was one in my time that I was aware of and whenever I became aware of it -- I was the operating surgeon who picked it up --

I phoned the Chief Executive. I mean it is that serious. For a swab incident to have occurred and me not know about it, that's very strange.

253 Q. It is. It is also strange that there wasn't a clear operational arm in terms of causation, in terms of actions been taken as a result of that serious incident. When you went to these governance meetings, was it clear to you who it was that had to take action or take the learning forward? Was that clear in the meeting? 13:01

A. Probably not.

254 Q. No.

A. I think the concept was that we were all taking that learning forward. But I don't know that one person was taking ownership of it. 13:01

255 Q. You talked about your Clinical Director role and you talked about management leaving Daisy Hill hospital.

A. Yes.

256 Q. Now, clearly the role of Clinical Director is always a difficult role. I think over the years it may have changed considerably, but it is a big responsibility. Did you have the opportunity to talk about that with your colleagues in terms of how you could most effectively exercise that, what the problems were about your distance from the higher management? Were there any forums where you were invited to come and give your views, for example? 13:01 13:02

A. I don't think so. I think I probably moaned about it.

257 Q. Who did you moan to?

A. Probably I moaned to anybody prepared to listen. I can't remember.

258 Q. But you didn't have a regular forum?

A. No.

259 Q. Because it is quite a common complaint of clinicians involved in management to do with time, direct access to senior people and with a big change in structure you might anticipate that some time was spent on that but you can't you can't remember? 13:02

A. I can't remember. But the location was the big problem. 13:02

260 Q. Okay.

Now we've talked here about adherence to MDM for cancer and there is now a big audit tracker programme in place, which I presume you would regard as a welcome improvement? 13:02

A. Oh, yes.

261 Q. I've also asked a few people about standards and guidelines generally in terms of how would you know, in your role as Clinical Director, whether or not in your specialties your consultants are adhering to best practice, more broadly than cancer now. Is there a way of keeping track of that? Would you be able to assure the chief executive that the consultants are all adhering to best practice and that that is measured in some way? 13:03 13:03

A. Well, I retired seven years ago so I don't know what the standard is now.

262 Q. Well, when you were there?
A. Guidelines were distributed and, I suppose -- I don't know that we monitor them an awful lot. There were audits but the audit wasn't as well developed as it should have been at that time. Audits tended to be done by junior doctors at the behest of a consultant and usually to measure something you were quite proud of. 13:03
263 Q. Yes.
A. Audits need to be done independently by people who are not providing that service and not at your request as to what should be audited. 13:03

There were independent audits, like national CPOD which I contributed to for many years, which was independent, but I think -- I get the impression there's more independent audit now and more of it. 13:04
264 Q. Back in 2009 there was a review and a new plan for urology, if I can call it that, and you were not involved, I think, in the meetings. Eamonn Mackle and Gillian Rankin met with the urologists at that time very regularly. Did they update you what the decisions were and what changes were being made? 13:04
A. No.
265 Q. No. 13:04

Were you aware at that time that there was a huge lack of day case surgery facility for urology? That was part of the explanation for not being able to meet the

demand?

A. Well, there was a report which I read recently, and I'm sure I read at the time, but it wasn't brought to my attention --

266 Q. It wasn't on your radar? 13:05

A. Not that I remember. Perhaps it was and I don't remember. I don't remember.

267 Q. So the waiting list initiatives, it's hard to understand why somebody with not enough time still has lots of waiting list initiatives. Is that done, do you 13:05 think, in a properly controlled way in terms of ensuring that the doctor is not putting themselves at risk with additional hours and ensuring that other things don't fall by the wayside? Do you think that is sufficiently well monitored? 13:05

A. I'm not sure it was.

268 Q. Just the last one from me. There's a lot of talk about triage, lots of different things have been brought into that and, on the one hand, there has been a sort of suggestion that management must decide how triage 13:05 should be done. Clearly triage is really a clinician activity. What is your view? Who should be deciding how triage is done in a department. Whose job is that?

A. The consultant's.

CHAIR: Thank you, Dr. Swart. 13:06

A few questions from me, Mr. Brown.

269 Q. You mentioned that you had received training in MHPS --

A. Yes.

270 Q. -- from NICAS. I just wondered if you could tell us a little bit more about that: how often you received that training, was it something that was general to all Clinical Directors or what can you remember about the training that you received? 13:06

A. I received training in 2008, of which I remember almost nothing. To the extent that whenever I did the training again in 2016, I looked back at my information from 2008 to see if it was similar and, yes, it was, but in 2016 it was like brand new to me. 13:06

I did it in 2016 because I was asked to do a particularly tricky case and I felt out of my depth. Reading the MHPS guidelines, it is a very difficult document. It will not help you. So I went to London 13:07 urgently and was trained in London. It was really excellent. We did role plays and I felt really good at the end of it. We're not experts, we're neither policemen or barristers, but I felt a lot more confident in what I was doing. 13:07

271 Q. We have been discussing the MHPS process and what recommendations that we might make, and I'm just wondering what your view might be about that. Do you think there is a role for a specialist team to do this kind of work? 13:07

A. You can't tag this on to the work of a CD. It was very difficult at the best of times but for all of 2012 I was utterly overwhelmed by two smallish -- no, two normal -- if you like two normal MHPS ones and a

massive one that went on a year and involved challenges from the legal profession, which took me a year to do because of all the challenges. But it can't be done on the back of a CD role. It has to be a team. It also should be a very experienced team, and it shouldn't be people who know each other. That's not great, either. The suggestion, obviously, is that it should be retired people. I think -- well, I won't be doing any.

CHAIR: Mr. O'Brien has clearly said to the Inquiry, and he said to you, there weren't enough hours in the day to do what was expected of him. Was he any different to any other of the urologists or, indeed, to any of the other surgeons that you had to deal with as a Clinical Director? 13:08

A. Maybe the difference was that he wasn't being given more work to do but the way he chose to do it was very meticulous. Aidan I have known for many, many years, his work is absolutely perfect. When he does something clinically in theatre, and I have seen him in theatre, it is meticulous. When he writes notes, they are meticulous. It takes too long. You can't be meticulous in heath care. 13:09

272 Q. You've said that you weren't a core member of the MDM and there was some discussion about what would happen if a recommendation was made by the MDM and then, after discussion with the patient, there was a change of plan and you said that it should be referred back to the MDM. In any case, should that be recorded somewhere, even if it is not referred back to the MDM? 13:09

A. Well, if you change -- let's say, for example, as an extreme example, the patient was in palliative care and it was totally impossible to prescribe what you had been asked to prescribe. I think you would record it in the notes. You would certainly record you made a change of plan. If it is a regular just change of plan because of patient choice, that should come back.

273 Q. That should come back to the MDM?

Just in terms of -- would you accept that the one case that you had to deal with in terms of Mr. O'Brien relating to the charts in the bin, that was a formal disciplinary process which proved to be effective. You had then to deal with him on an informal basis in terms of the charts at home and the triage, and we now know that those -- while you may have thought had borne fruit, in fact hadn't. Is there a lesson there to be learned about how to approach these matters?

A. I'll accept that.

CHAIR: Thank you very much.

No further questions, Ms. McMahon?

MS. McMAHON BL: No.

CHAIR: Thank you, Mr. Brown. I'm delighted to say you are free to go.

We will see everyone at 10 o'clock tomorrow morning.

THE INQUIRY THEN ADJOURNED UNTIL WEDNESDAY, 15TH NOVEMBER 2023 AT 10 A.M.