Urology Services Inquiry

Oral Hearing

Day 94 – Wednesday, 10th April 2024

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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

CHAIR: Morning everyone.

09:56

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

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

09:57

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

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

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

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

A. It doesn't much matter.

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

A. Yes.

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

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

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

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

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

It says:

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

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

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

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

comment, having been excluded, you say:

"Since then any recision of confidence which I had in the integrity of a number of senior personnel in the Trust has been completely..."

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

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

10:03 10:03 10:04 10:04 10:05

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

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

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

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

yourself, was dealing with triage.

A. Mmm.

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

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

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

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

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

9 Q. I get that. 10:12

A. You do get that. But...

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

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

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

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

A. Mmm. Mmm.

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

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

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

13 Q. Take the year 2015.

A. Mmm.

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

A. Mmm.

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

difficulties that that was causing then when doing reviews.

A. Mmm.

16 Q. Triage was a feature. Concerns around triage was a feature of that year. We have seen also that your retention of patient files at home was also a feature of correspondence and communication that year. 10:17

A. Mmm.

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

A. Mmm.

18 Q. Mr. Young also being the clinical lead, and perhaps one of the people in the Trust who knew your practice best. Your reflections on that. If those issues weren't being raised, perhaps the answer is that's not -- appraisal isn't the appropriate place to raise them. But do you think that they, when you think about it, ought to have been raised, and ought you to have been, I suppose, pushed or nudged into a discussion about how you could improve in that setting? 10:17 10:18

A. Well in that period of 2015, you know, my understanding of it was that it had been clarified quite clearly that with regard to triage, as I have stated, that I found it impossible to complete it, and that a default process had been put in place, not necessarily solely because of me, but it was a major contributor to that being put in place. To my mind, I mean I didn't raise it during appraisal because that was the situation at 10:18

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

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

A. Yeah.

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

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

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

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

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

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

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

A. Mmm.

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

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

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

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

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

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

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

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

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

24 Q. Patient 90 I think?

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

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

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

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

A. Yes. 10:34

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

A. Mmm.

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

A. Mmm.

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

A. Mmm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you consider that the systems of governance relating to patient care and safety could have been better, better deployed and better used by, for example, providing you with clearer instruction about what was expected of you, you will no doubt explain that. Furthermore, if you consider that the resources available to you, or the pressures created by the demands on the service caused you to practice as you did, again you'll have an opportunity to address that. So that's, I suppose, a clear signpost as to where we're going for the next -- perhaps the remainder of your evidence into Friday. 10:43 10:44 10:44

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Mmm.

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

A. Mmm.

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

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

A. Mmm. Yes.

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

A. Mmm.

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

A. Mmm.

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

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

46 Q. But that, if I may say so, is you opening up to a colleague that "I'm going to perform this operation"?

A. Or asking "What do you think?", and "Should we?", and "Does it justify it?", and so forth. 11:00

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

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

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

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

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

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

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

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

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

A. Not at all. Not at all.

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

A. Not at all.

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

A. He should have.

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

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

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

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

A. Absolutely. 11:06

55 Q. Or notes.

A. Yes, that's true.

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

A. Yes. 11:06

57 Q. Was that done, in your experience?

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

58 Q. That was 2014?

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

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

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

A. Was there one conducted?

60 Q. Yes?

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

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

A. I don't.

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

A. Mmm.

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

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

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

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

A. Mmm.

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

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

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

66 Q. Yeah.

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

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

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

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

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

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

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

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

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

THE HEARING RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIR: Thank you everyone.

MR. WOLFE: Just to conclude with Mr. Hagan's evidence. 11:33
Another issue that came to his attention in 2000, when he was on rotation, was your management of certain patients with IV fluids and antibiotic therapy. In his evidence he said here were patients who could eat and drink who were being managed on this therapy, an 11:33
approach that he hadn't witnessed in any previous setting or subsequently, and he wasn't clear of the reason for the approach or the evidence base for the therapy, and that was his recollection. I think Mr. Young in dealing with that himself said he would 11:34
agree with Mr. Hagan in the sense that it was maybe not standard practice, indeed. I'm going to come on to ask you about Mr. Young's role in the therapy, but as he explained it he was not at that point a convert to it. You've no recollection of speaking to Mr. Hagan about 11:34
this matter?

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

70 Q. Mr. Fordham?

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

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

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

A. Yes, I did. Oh, sorry.

72 Q. And did you think it was an efficacious thing, something that should be, if you like, used more widely?

A. I did, and for which reason we reported it in the manner in which we did. 11:37

73 Q. But that was to be 11/12 years later that you reported it?

A. Yes. Yes, yes.

74 Q. I suppose Mr. Hagan, young trainee, you don't have any recollection of explaining to him the rational for your 11:37 treatment?

A. I don't have any recollection of explaining to him the rational for the treatment.

75 Q. Yes. Yes. When did the therapy commence? When did you commence using it? 11:38

A. Well, if we were doing it in 2000, I presume it may have been -- I don't think actually I started doing that prior to Mr. Young's appointment. So it probably would have been maybe just a year or two prior to then.

76 Q. Yes. And your rational, as I think you've expressed 11:38 it, you've expressed it variously, but in a nutshell it was, from your perspective, to prevent the acute admission of this group of patients in a worse clinical condition?

A. That's right. 11:38

77 Q. Having, I suppose, tried using pre-emptive oral antibiotics in the community to address their needs, and recognising that that was ineffective or less effective than admission electively at predicted times

for IV therapy?

A. That is correct.

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

A. That's correct.

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

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

80 Q. Yes.

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

81 Q. Yes.

A. Yes.

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

A. Mmm.

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

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

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

84 Q. Yes.

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

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

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

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

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

A. Yes.

87 Q. We'll come on to look at aspects of that. But just briefly if you can help the Inquiry with this.

Mr. Young, in his evidence, drew a distinction between his approach to it and yours. He explained that, in his witness statement: 11:43

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

He said of you in his oral evidence:

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

Whereas by contradistinction he was saying:

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

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

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

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

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

A. Okay.

89 Q. -- of the chronology, if I may? I want to use this controversy, if I can call it that, to look at whether you should have started this form of therapy at all. Whether it was not obvious that you should have been stopping sooner because of the interventions of the Medical Director, and Dr. Rankin, and whether you actually stopped when told to stop. So those are the kinds of issues I want to explore. 11:46 11:47

So the starting point for this would appear, at least in terms of the Trust's engagement with you on it, was a meeting with Mr. Loughran, or Dr. Loughran, who was the Medical Director at that time. 28th April 2009 he met with you in the presence of Dr. McAllister, and I think you'll have seen the record of that? It's at PHA-0439 or 00439. And this meeting raised -- Dr. Damani MD is present as well, and he was the Consultant Microbiologist in the Trust. And a number of issues are raised, and the first issue was compliance with the Trust Antibiotic Guidance. At that time the Trust was consulting, as I understand it, on the guidance, and it was being remarked upon that the urology team had not joined the consultation. That would appear to be relevant in the context of the therapy that you were promoting with this cohort of patients, which the meeting goes on to discuss at Item 2: 11:47 11:48 11:48

"The Trust has identified a cohort of about 30 patients who are admitted as elective cases for IV antibiotics for recurrent UTIs. The evidence base for this was described by Mr. O'Brien and he described a study of outcome which was being prepared for publication." 11:49

So those are the issues. And then a third issue, Mrs. Hanna, MP, or MLA, had engaged with the Health Minister at that time about the use of this therapy, and a preference that the patient might be able to undertake the therapy in the community is the sense of it. 11:49

So that was the first interaction between you and the senior management around this issue. Were you surprised that it was being taken up in this way? 11:49

A. I was surprised. In fact I didn't really appreciate, to the extent that I now appreciate the genesis of the issue, because I think there may indeed be some -- the genesis may have had a number of sources, including that of Dr. Diane Corrigan at the time, looking at operative codes for patient admissions and so forth. So irrespective of it's genesis, it seemed to be that it arose because patients were occupying beds without having an operative procedure, and it seemed that there was an issue arising from that, you know, that if patients are occupying beds without an operative procedure there's something fundamentally wrong with 11:50 11:50

that and, in fact, actually, it touches upon a wider issue that I struggled with for 28 years at the Southern Trust in relation to the treatment of patients with urinary tract infections, because typically patients with urinary tract infections are admitted to anywhere in the Southern Trust but the Urology Ward. They'll be admitted to orthopaedics, cardiology, respiratory or where ever. A typical example is the one that I alluded to, the patient who died after stent manipulation who had been admitted to another hospital rather than being readmitted to the Urology Ward. Leaving that aside, yes, it was top heavy, it was unidirectional, and we had the best interests of our patients at heart. We knew them well. And during the course of discussion of this topic, it's very useful to look at two of the cases that have been referred to in emails, one of mine and one of Mr. Young's, where... 11:51 11:51 11:51

90 Q. We'll come to that. But let me just -- the cases you want to refer to come in 2010?

A. Yes. 11:52

91 Q. After there have been many discussions and an agreed, and apparently an agreed process in how to overcome this controversy.

If I could move to Mr. Young's meeting with Dr. Loughran on the next page, if we scroll down. Mr. Young -- or it's a note between a telephone meeting between Loughran and Young, and he explains the approach, but he confides in Mr. Loughran that he 11:52

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

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

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

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

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

11:55 11:55 11:56 11:56 11:56

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

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

A. Yes.

11:57

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

11:57

11:58

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

11:58

11:59

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

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

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

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

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

So he's looking back at the previous year.

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

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

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

A. Yes.

96 Q. In meeting with the two of you?

A. Yes. Yes.

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

A. No.

98 Q. Between 2009 and 2010?

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

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

A. Mmm.

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

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

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

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

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

A. Not necessarily.

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

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

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

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

"I checked with Shirley..." 12:07 12:08

- Shirley is the nurse, the senior nurse:

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

Is her conclusion right that these remaining patients had not been discussed?

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

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

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

A. Mm-hmm. 12:10

106 Q. And approval process?

A. Mm-hmm.

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

A. Mm-hmm. 12:10

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

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

And he says:

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

And it's recorded that:

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

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

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

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

12:13

12:13

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12:15

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

"Patients may become less well as a result of the

withdrawal of IV antibiotics."

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

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

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

A. In...

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

A. Mm-hmm. 12:16

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

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

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

113 Q. This is -- just to assist you, this is the patient -- we can find it at TRU-259512. Is that who you refer to? 12:17

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

114 Q. Well, is it? Because what we can see in this example, and I'm going to bring up on the screen in a moment the two processes that were tabled on 9th September. 12:17

A. Mmm.

115 Q. And one of the processes was in terms of these patients you must seek the input of the microbiologist before you admit the patient for IV antibiotic. In other words, it wasn't closing down IV antibiotic therapy where it could be demonstrably shown to be needed, and that's an example of this, isn't it, this is the process working, this is Dr. Damani approving, if we scroll down: 12:18 12:18

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

12:18

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

an IV regime.

A. Mm-hmm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Again are they sentiments...

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

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

Infection to which you, Mr. Young, and Vincent Koo put your names, essentially presented an argument based on your experience in favour of the IV fluid and antibiotic treatment of this cohort of patients with chronic or recurrent UTI, and that was published in circumstances where, ringing in your ears was the Trust's view that it could not endorse this treatment in the way that it was performed by you and Mr. Young. The Commissioner was not lending its support to it, and internally you knew of the opposition of the microbiologists. You're familiar with the expression "two fingers", was this you and Mr. Young giving two fingers to the organisation by publishing this article? 12:31 12:31

A. That's amazing! Absolutely not. What we were doing, in fact... 12:31

122 Q. Sorry, what's amazing about it?

A. Because it never occurred to me that that was even -- that never crossed my mind that we were putting two fingers up to everybody who had their concerns. Not at all. I'm just -- my apologies for the reaction, it's just that didn't occur to me. Vincent Coe was a very talented specialist registrar who published a number of papers whilst he was with us, and is a consultant in England, and all we did actually was -- I'm quite a disciplinarian when it comes to publication, because what we were doing was reporting our experience. It wasn't actually promoting anything. It wasn't expecting the rest of the world to agree with us. We reported our experience, and we reported the efficacy 12:32 12:32

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

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

A. No.

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

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

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

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

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

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

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

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

gentamycin this month with no evidence of infection."

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

A. I don't think it was.

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

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

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

certain it was the first email, you haven't actually, "you have planned or you have arranged to take this patient." I'm just responding to a GP can I admit the patient. So that's where I would describe that collision once again between the protocol and the reality. 12:40

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

CHAIR: Lunch. Yeah. We'll do that and we'll come back at 1:50. 12:40

THE HEARING ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:.

CHAIR: Thank you everyone. Mr. Wolfe.

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

A. Good afternoon.

128 Q. Just before lunch I was asking you by reference to several examples whether you complied with the management decision in terms of how patients would be managed if you thought that they required intravenous antibiotics. And I think I've brought you to several examples. Can I bring you back to one of them very briefly. TRU-276833. And that is the example raised with Heather Trouton by, just scrolling down, raised with Heather Trouton by Tracey Boyce three years after the management process had been introduced. And you wondered whether that was a different kind of a case, one not involving IV antibiotics. Could I just scroll through to three pages down to 836 in the sequence. Just on down one more. And Dr. Boyce has, in respect of her consideration of the auditing of your antibiotics use in that period, she has recorded: 13:47 13:48 13:48

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

Sorry:

"240mg once daily. No documentation of antibiotics in

the notes. No documented evidence of infection."

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

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

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

documented evidence of infection. I'm just speculating.

129 Q. Yes.

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

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

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

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

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

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

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

And:

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

Now you were, it would appear from some of the material which the Inquiry has considered, was dissatisfied with that recommendation. For example, within your appraisal signed off in November 2011. If we go to TRU-251248. I always regret pulling up TRU-references. There we go. And you say, I take it you can correct me if I'm wrong, that they are essentially your words, your sentiments, that: 13:55 13:56

"A further change in practice has been the centralisation of radical pelvic cancer surgery imposed by the Department of Health. This has resulted in the loss of this provision at Craigavon and negative consequences for patients. There is general discontentment in the decision-making process conducted by the recent Regional Review of Urology. Aidan has concerns that this will have significant knock-on effects for services in the area in the future." 13:56 13:57

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

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

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

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

A. That's right.

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

by March 2010. There's reference to it being phased. I'm not sure if it's intended to mean phased up to March and then March being the final date, or started in March and phased thereafter, but maybe that's a semantic we don't need to worry about today. What I'm interested in charting is your's and Mr. Young's response to this, and if we look at TRU-259467. And Heather Trouton writes, and this is August 2010: 14:00

"We discussed with Mr. Young the issues around three radical prostatectomies being scheduled for surgery here." 14:00

That is Craigavon, or it should say "here":

"...over the next few weeks. We advised that this was contrary to the new agreement and that these patients must be referred to Belfast for their surgery. Mr. Young emphatically denied having seen any letter saying that they were to stop performing such surgery and advised that they, as a consultant body, would continue to perform such surgery until the Department sent a clear letter." 14:01

Gillian Rankin -- sorry, Heather Trouton says she is looking to contact Beth. That is -- I forget her surname? 14:01

A. Molloy.

134 Q. Molloy. And she was employed in the Commissioner's

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

A. I don't think the letter was, I am sorry, seeking to...

CHAIR: Mr. O'Brien, there is some water there in front of you. 14:02

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

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

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

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

positively. Were you reluctant to transfer patients?
A. No, not at all. What we were -- what we didn't want to have happen, and which subsequently did happen, we asked for notification, let's say it were on the 19th or the following day, if we had been told that from the 14:04
1st October Belfast City Hospital is now prepared and is able to accommodate the transfer of radical pelvic operations to it, that's what we requested so that we would have a transition period to prepare patients for transfer. 14:04
137 Q. Then if we could look at TRU-259513, and just at the bottom of the page, please? So it's 17th September, about a month after Mrs. Trouton has sat down with Mr. Young, and she is writing to Beth Molloy explaining that there are two patients who require a cystectomy 14:05
due to malignancy and she's asking what's to be done about this in terms. And if we scroll up to Beth Molloy's response. There we are. And she is -- just scroll down. I thought we had Beth Molloy's response? Maybe not. Just go on up then, please. So Heather is 14:06
being told by Diane Corrigan, a colleague of Beth Molloy, Dr. Corrigan, in the Commissioner's Office:

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

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

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

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

138 Q. Well eventually it must have been shared with you?

A. It was. On a Wednesday.

139 Q. And you were unhappy with the circumstances in which your patients had to be transferred. Is that fair? 14:08

A. That is fair. As was Mr. Akhtar, because the radical prostatectomies was his patients.

140 Q. Yes.

A. Which we had arranged to do on that Friday morning, you know, two days later. 14:08

141 Q. Yes.

A. But they were transferred. And then there was actually by that time three radical cystectomies to be offered or done.

142 Q. Yes. 14:08

A. And they were transferred.

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

I could ask for your observations in response to what he said in his witness statement. If we go to WIT-98857, and his initial responses here are to set out the terms on which you expressed yourself to both himself and to general practitioners in relation to these patients. So if we just scroll down? So he's setting out there the history in relation to Patient 1, and then at the bottom, towards the bottom of the page, he's saying in your letter to the general practitioner you wrote in the following terms: 14:09

"As you are now aware a decision was made by officials in the Department in conjunction with the Commissioner to cancel Patient 1's admission and to have his further management transferred to Mr. Hagan at the City Hospital." 14:10

And you say:

"The patient and their family has been gravely distressed by the cancellation of their admission. The patient is suffering gravely from severe lower urinary tract symptoms. I do hope that their further management can be expedited as soon as possible." 14:10

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

will take place as soon as possible.

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

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

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

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

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

144 Q. But getting back to...

A. And getting back to the....

145 Q. The premise of my question was these were inappropriate correspondence on the part of you.

A. Well -- yes.

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

14:13 14:14 14:14 14:15 14:15

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

A. Yes.

147 Q. Inappropriate he thought.

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

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

A. Mm-hmm.

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

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

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

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

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

150 Q. Yes?

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

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

"Whilst the letters sent..."

That is the letters sent by you:

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

And he then proceeds to set out in a little bit of detail how he considers the care of the patients has been mismanaged, and he -- I don't propose to go into the detail of it. Just scrolling down onto the next page, please. He deals with the five patients who were lined up for treatment at the City Hospital following transfer, but his focus was on the three cystectomies, and he says with regard to those three: 14:19 14:20

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

And he goes on to say:

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

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

A. No.

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

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

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

A. Mmm

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

A. Mmm.

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

A. Mm-hmm.

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

A. Mmm.

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

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

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

A. That's all.

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

A. Yes.

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

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

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

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

A. Okay.

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

"The Commissioner is concerned about a disproportionate rate of cystectomy undertaken in Craigavon."

14:27

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

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

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

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

A. He blotted his copybook, yes.

164 Q. In your view.

A. Yes. Yes.

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

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

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

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

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

167 Q. Yes.

A. So...

168 Q. So you were disappointed that you weren't directly engaged by his work? 14:30

A. Yeah, very much so, yes.

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

A. Mmm.

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

A. Mmm.

171 Q. In 10 years. 14:31

A. That's correct, yes.

172 Q. And he offers some positive conclusions, clearly.

"The majority of cases have been managed with

compassion and consideration."

And he goes on to say importantly:

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

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

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

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

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

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

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

173 Q. The point that's perhaps of most interest to the Panel arising out of a scenario such as this, is that cystectomy is obviously a very significant procedure, a life changing procedure for many people, it carries risk. Interested in your views as a clinician who practised in the Southern Trust for 28 years as a surgeon, operating every week, coming across other colleagues operating every week, how would you measure, if you like, the state of governance attending surgery and surgical procedures and how things were managed in theatre? To what extent was that area of the Trust's output the subject of auditing, monitoring, supervision, in a way which would have made meaningful for observers, issues such as risk and patient safety? 14:35 14:36 14:36 14:37

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

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

174 Q. Mm-hmm.

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

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

A. Mmm. Mmm.

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

A. Mmm.

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

A. Yes, of course. Yeah.

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

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

and I went in and was able to rectify the situation. And, do you know, in a relatively small hospital like Craigavon was, and remains, I mean, that was, you know -- there was a wide awareness of that particular incident, so it had to be addressed. 14:42

With regard to simple cystectomy for benign pathologies over the period of years that we were allowed to do it from 1992 until 2010, whatever, I mean I didn't have any issues, or I didn't have any awareness of -- I can 14:42
think of one patient whom I, looking back, regret doing an ileal conduit urinary diversion on, because she really had much more significant mental health issues than we all appreciated, and this was a case that I discussed with my colleagues at the time, because she 14:43
went on to self-harm her stoma and so forth. But apart from that, I don't think that there is a parallel situation -- I don't think it applies to benign cystectomies.

179 Q. Thank you for that. Could I move to the fourth issue 14:43
under the heading of "Cystectomy", and it involved the bladder, the muscle invasive bladder cancer which was referred into the Belfast Trust by Mr. O'Donoghue, or through the multi-disciplinary team and on to Mr. Hagan in 2016, and I want to deal with this fairly succinctly 14:44
if I can. If we go to WIT-98871. Sorry, false alarm! If we go to WIT-98874 first of all. And just scroll down to the bottom. Thank you, just there. And Mr. Hagan is writing to a colleague in the Belfast

Trust, Davina Lee, and he is saying:

"I am very concerned about delays in intra-Trust transfer from Craigavon and how we raise this. Is it possibly an interface Serious Adverse Incident?" 14:44

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

"The original resection was 16th February..." 14:45

- that should say 2016:

"...with multiple local MDT discussions before a regional discussion on 9th June 2016 and I see her today." 14:45

So four and a half months have passed by:

"In my view there are multiple avoidable delays which potentially lead to an adverse outcome. She is not fit for cystectomy today." 14:45

And then he contrasts this with what he describes as an exemplar where a muscle invasive cancer was turned around from the TURBT, T-U-R-B-T, in May 2016, to be seen for radical surgery by the middle of June 2016. 14:45
So he considers this issue with colleagues. It goes to Dr. Hagan. Sorry not Dr. Hagan, Dr. Mitchell, at

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

14:46 14:47 14:47 14:48 14:48

A. I do, yes.

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

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

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

A. Mmm. 14:49

182 Q. As I say, she was the MDT Coordinator at that time. She'd copied into this email, she thinks appropriately. And if we go to WIT-105875? She sets out that she fully understands the reason for being copied into the email. 14:50

"When a matter arises regionally I would expect to be copied in."

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

14:50

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

14:51

She goes on in the next paragraph to say:

"This matter should have been brought up for noting at the MDT meeting to highlight the delay and the issue and see what could be done differently." 14:51

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

"I agree with Dr. Mitchell's observations and understand why I was included in the email. This email 14:51 should have triggered a response and a feedback from ourselves."

She inaccurately ascribes the ownership of the patient to you, but we know that you were sent the email in 14:51 your -- wearing your MDT lead hat. So is it the case, Mr. O'Brien, that you haven't found any record, documentary record of having discussed this issue, it having been referred back to you by Dr. Mitchell?

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

183 Q. And there's no record of any correspondence back to Dr. Mitchell? 14:52

A. No.

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

A. I apologise for that, because if you want to look at the elements of our discussion, which I clearly 14:52 remember, but we should have actually out of -- it would have been polite, at least, and courteous, to confirm that we had discussed this matter even though we concluded that there was nothing regional to be learnt from it, that we were the only ones to have 14:53 finally taken on board that we did not need to routinely do bone scans and staging muscle invasive bladder cancer. Even though it was somewhat ironic. We had a very, very good consultant radiologist, who has given evidence here, in Marc Williams, and Marc was 14:53 never a great fan of radioisotope bone scans and the staging of anything, because they're very insensitive. So he was delighted that we had taken that on board. Even though ironically it is my understanding that we actually did have two discussions at regional MDM, and 14:53 when there was some concern about the appearance of the left scapula, it was recommended by regional MDM that we would get a CT scan done, which further delayed matters.

185 Q. But with respect, all those issues are in the rearview mirror.
A. Sorry.
186 Q. And I have your addendum statement where you say you can recall, following Dr. Mitchell's intervention, discussing this with your MDM colleagues. 14:54

"We recognised that in light of Dr. Mitchell's intervention the bone scan was unnecessary."

14:54

A. Mmm.
187 Q. And you say, if I can say so, somewhat strangely:

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

A. Yes.
188 Q. I mean, how would you know that there's no learning to be derived from it? And is it more than professional courtesy that merits a response back to the centre? 14:54
A. Yes.
189 Q. It's an important governance issue to show to the centre that you've understood the problem?
A. Yes. 14:55
190 Q. And how you're going to repair it going forward?
A. Yes. I accept that criticism. As lead clinician, and even if I wasn't Chairing that day, because I may not have, it was addressed to me and I should have

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

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

A. They did not, no. 14:55

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

CHAIR: Until 3.15, ladies and gentlemen.

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

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

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

Report in connection with Patient 95, and within this document there is a summary of the chronology. Just scrolling down a little. Let me see the whole page. Yeah. Yeah, just scroll down to Episode 2. Thank you. Just stop there. So this female patient was the subject of surgery in July 2009, and discharged from hospital 25th July 2009 with arrangements for a CT scan to be performed. This CT scan as we can see.

A. October.

193 Q. It was, yeah. The important one was October 2010. It might be over the page on the chronology. Scroll down. Well, I think it's in there somewhere. It was performed on 1st October 2009. An outpatient's review planned for four months didn't happen, isn't that correct, and that was a product of untold pressure on slots for review. Into the following year, into 2010, she attended Accident & Emergency in July with a two week history of abdominal pain. Abdominal x-rays were performed and she was discharged. Coming back in to the hospital four days later, when a re-review of those x-rays showed the possibility of a retained swab, and she underwent a laparotomy on 21st July 2010, roughly 12 months after her initial surgery, for the removal of that retained swab. You would have had access, would you not, to the surveillance scan that was performed four months after her surgery in October 2009?

A. Well if I had read it I would have acted upon it. I am aware that the Inquiry does have my statement in relation to the report that I did for the root cause

analysis at that time.

194 Q. Yeah.

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

195 Q. Could I take you to one of the key findings of this report on the facts? It's three pages down at WIT-17478, and it says, just scrolling down: 15:17

"Although a diagnosis of a retained swab was not made on the CT scan..." 15:17

- that's the CT scan of October 2009, four months after the surgery:

"...a pathological abnormality was described. However, this report was not seen by the consultant urologist as it is his routine practice to review radiological and laboratory reports when the patient returns for post-operative follow-up. The planned four month follow-up never took place due to the waiting times for review." 15:17 15:18

So that's something you don't disagree with, is it? In the round you tended to wait for the review to take place before you would consult the investigation report? 15:18

A. I don't think it's necessarily entirely accurate, if I may put it that way? I think it's interesting to note my comments on that in the statement that I've made in

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

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

A. Mmm.

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

A. Mmm. 15:20

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

across all of your colleagues?

A. Yeah.

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

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

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

A. Mm-hmm.

201 Q. And this was to prompt email correspondence with the consultants, including yourself. And if we could look at that? TRU-276805. And just scrolling down to the bottom of the page. So Martina Corrigan is writing to a range of consultants, including yourself. Just scroll down to see what she says. She's referring to Mrs. Trouton's message below, and it is that -- sorry: 15:22 15:23

"Dear All,

I know it has been addressed verbally with you a few months ago but just to be sure can you please check

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

15:23

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

15:24

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

15:24

15:24

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

A. Okay.

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

15:25

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

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

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

A. Mmm.

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

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

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

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

A. Mm-hmm.

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

A. Mmm. 15:27

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Mm-hmm.

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

A. Mm-hmm. 15:33

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

A. Mmm.

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

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

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

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

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

217 Q. Of course, in general.

A. Yep. 15:36

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

less likely to happen?

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

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

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

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

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

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

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

221 Q. Patient 92?

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

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

A. Mm-hmm. 15:41

223 Q. Concerned Patient 128.

A. Mm-hmm.

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

manage.

A. Mmm.

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

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

is set out at TRU-161137. That was a case where the patient had an identified need to have his coronary condition investigated by way of echocardiogram, and you -- that was known from December 2016, when a CT of his chest and abdomen revealed this potential difficulty which would be a risk factor for future surgery. He came into your care in June 2017, when you listed him for surgery, and then he was operated upon a year later in May 2018. Now, two points arising out of that. In listing him for surgery, should you have been asking questions or raising enquiries as to the completion of the coronary investigations that were indicated at the end of 2016? 15:44 15:45

A. Yes, I should have. I've stated that in my statement. I mean it's important to point out that the patient wasn't under my care in December '16. 15:45

226 Q. No. That's correct, of course.

A. Yes. And, you know, it wasn't requested by my team. In fact I was on sick leave at that time. So irrespective of whether it was requested by me, or even by our own department, I still felt, you know, that it was something that I should have been cognisant of. 15:46

227 Q. You say in your response to the incident that you had no regrets in terms of the surgery itself, but you do regret not sending him for a cardiac workup? 15:46

A. Yes.

228 Q. I mean just thinking, thinking through that, is that distinction simply logically incoherent in the sense that the obligation as a surgeon is to ensure that your

patient is optimally prepared for surgery, and this patient wasn't, and if he wasn't optimally prepared for surgery because he didn't have that investigation and there was no pre-operative assessment in this case, he simply shouldn't have been anywhere near theatre? 15:47

A. Mmm. Well I take your point, but one thing that I didn't include in that report is that I parked my car in a street in Portadown to go to a shop, I think the Saturday week before, and I met him on the footpath and he literally was in such severe pain because of his 15:47 indwelling stents, and he begged me to do his operation. Now that doesn't excuse, as you said at an earlier time, like we didn't plough ahead with his operation. I did take -- I arranged for him to be -- attend the clinical day centre, I think it's called, 15:48 day clinical centre, to have a transfusion of blood preoperatively. I did arrange for him to attend for pre-operative assessment the Friday before, and I have discussed this with the consultant anaesthetists on a number of occasions since then, and in view of the 15:48 distress that the man did have with pain -- and the consultant anaesthetist was happy to proceed. But, looking back, I think actually that even more importantly than his cardiac status was to establish whether or not he had a bleeding tendency, because it 15:48 was the bleeding tendency that resulted in his cardiac vulnerability coming to the fore and resulting in his demise.

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

major contributory factor in his demise.

A. Mm-hmm. Mmm.

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

A. Mmm.

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

A. Mmm.

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

A. Mmm.

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

A. Mm-hmm. Mmm.

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

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

15:51

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

15:51

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

15:52

15:52

236 Q. Yes. This is an email 2015, Mary McGeough, to a range of people, including Martina Corrigan, and it's referring to a number of patients listed below the email who are listed for the next day's surgery under your care, and it says:

15:52

"As you will see, three out of the five patients have not been to pre-op."

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

"We are now in a position where we are unable to get these three patients preassessed due to the extremely tight timeframe before their surgery."

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

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

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

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

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

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

A. Mmm.

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

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

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

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

A. Mmm. Mmm. Mmm.

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

A. Well I think actually, you know, I've described the circumstances in which Patient 90 came in, and I made comments on Monday with regard to Patient 91, and I do believe that the lessons learned, which are entirely valid, were not the most important lessons learned with regard to that patient. If I had to relive the pre-operative arrangements for Patient 90, I would do it very differently, and I would ignore his pleas and I would have ensured that -- I do hope, actually, that I would have noted the CT that he had done in December '16 under the care of a general surgeon and made the necessary arrangement, which I did many, many times with a fantastic Echo Department at Craigavon Area Hospital, who did echos for me at the drop of a hat, would have done it within a day. So. And also more importantly, and I do think it is the more important thing, is that he would have been referred to a haematologist in order to determine his coagulation status, because he had -- he had a haemoglobin of 86, in modern parlance, when he attended for transfusion of two units of packed cells on the day prior to his surgery, and the following morning pre-operatively his haemoglobin was still 86. There was something going on 15:59 15:59 16:00 16:00

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

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

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

243 Q. Yes.
CHAIR: Mr. Wolfe, I'm very conscious of the time. I know you're going to move on to a new issue, but it might take some time.
MR. WOLFE: Yes, I've also got one eye on what we've got to cover on Friday. 16:03
CHAIR: Friday.
MR. WOLFE: So if it's okay with you, we'll continue for maybe ten minutes.
CHAIR: Very well. 16:03
244 Q. MR. WOLFE: You've mentioned already, or you looked at the sheet in front of you and we came to the understanding that Patient 92 was another patient of yours whose result was missed.
A. Yes. 16:03
245 Q. And she was found to have an abscess resolved, but on scan it was found that there was a solid nodule suspicious of renal cell carcinoma. That report, it appears from the SAI Review, was forwarded to you in March 2018. The report shows the communications to you 16:04 and your secretary, but they can't say whether it was read by you.
A. Mmm.
246 Q. Have you any recollection of reading it?
A. I don't have any recollection of reading it, and if I 16:04 had read it, you know, it would have been acted upon. I think it's important to appreciate the enormity of the results that you get. Not just of radiological investigations, and not just pathology, because

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

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

16:04 16:05 16:05 16:06 16:06

A. Of course, yes.

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

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

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

A. No.

250 Q. No. Okay?

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

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

A. Well...

252 Q. They surely ought to go hand in hand so that if there's something sinister within the report, you can't detect that without an image or without pathology. You need the report. You then sit with your patient in review and explain the report and the actions that you would recommend. Is that not the proper sequence? 16:10

A. Of course it's the proper sequence. That's what's always intended, that a patient will have a CT scan in three months time and they will be reviewed during the following month.

253 Q. Yes. 16:10

A. I've been doing that for 28 years. That has been the intended plan. But if I may refer to that email that I sent in response to the diktat at the end January '19, I believe, I think I sent it on the....

254 Q. So Mrs. McCall wrote to your secretary. 16:11

A. Yes.

255 Q. And your secretary sent it on to you and you responded.

A. Yes.

256 Q. So let's just look at Mrs. McCall's email first. It's to be found at WIT-27887. And she's telling the group of secretaries that: 16:11

"If a consultant states in a letter "I am requesting CT or bloods and will review with the result" these

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

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

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

257 Q. Yes. 16:12

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

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

discharge and await that result.

A. Mmm.

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

16:14

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

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

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

260 Q. Let me bring you, sorry, to your emails, if you need to speak to it as well. Just on up the page, please. 16:15

MR BOYLE: I'm sorry, if I may? Mr. O'Brien was in the middle of giving answer to a question which he was asked, and I wonder...

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

CHAIR: Yes. It has been a long day.

MR. WOLFE: Yes. We'll finish DARO surely.

A. Yes. 16:16

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

266 Q. Just say it again for the record?

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

267 Q. Paragraph 6 I think, is it?

A. What's that?

268 Q. Paragraph?

A. 6. 16:20

269 Q. 6. Yeah.

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

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

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

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

271 Q. But if a patient needed -- just to finalise on this -- 16:22

if a patient needed a review?
A. Yes.
272 Q. An urgent review. There would be no difficulty posed by DARO in you arranging that and identifying a slot for that patient. DARO wouldn't stand in the way of that? 16:23
A. To bring the review forward?
273 Q. If you saw -- say in the case of that patient you mentioned?
A. Yes,. 16:23
274 Q. No, it's not up on the screen in front of us. Where you obliterated a stone and you needed to check on her progress within a fixed period of time.
A. Mmm.
275 Q. You could decide "I don't need to see a report", an investigation report, "I can review her in the absence of an investigation report", and you could fix a date for that. 16:23
A. Yes.
276 Q. DARO isn't so inflexible, or the system isn't so inflexible that it would stand in your way of consulting with that patient? 16:23
A. Except for the long review waiting lists.
277 Q. Of course.
A. Of course. Yes. 16:24
MR. WOLFE: Thank you, Mr. O'Brien. That brings us to a close this afternoon. I'm sorry and grateful to you for staying on that little bit extra. And we'll see you on Friday morning.

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

THE HEARING ADJOURNED UNTIL FRIDAY, 12TH APRIL 2024 AT 10:00 A.M. 16:24