IN THE MATTER OF A PUBLIC INQUIRYUNDER THE INQUIRIES ACT 2005

THE UROLOGY SERVICES INQUIRY

CLOSING SUBMISSIONS ON BEHALF OF MR AIDAN O'BRIEN

1. These are the closing written submissions on behalf of Mr Aidan O'Brien. The panel is invited to consider these written submissions alongside Mr O'Brien's original Section 21 response dated 2nd November 2022[1] (and the chronologies which accompanied it), the addendum statement dated 31st August 2023[2] and his further addendum statement[3] submitted prior to Mr O'Brien's return to give evidence to the Inquiry for a second time in April 2024. The panel also has Mr O'Brien's respondent statements to the investigation conducted by Dr Chada[4], his subsequent comments relating to the respondent statement/interview conducted by Dr Chada thereon[5] and the grievance he lodged[6] with his employer, the Southern Health and Social Care Trust ("the Trust").

2. The panel is also invited to consider the very detailed oral evidence that Mr O'Brien gave to it on 19th[7], 20th[8] and 21st[9] April 2023 and on 8th[10], 10th[11] and 12th[12] April 2024.

3. A good deal of oral evidence has been heard and documentation submitted to the Inquiry which touches upon the clinical practice of Mr O'Brien.

4. In relation to Mr O'Brien's clinical practice, the Inquiry's Terms of Reference ("TOR") specifically provide as follows:

[1] WIT-82373 to WIT-82657
[2] WIT-98807 to WIT-98808
[3] WIT-107564
[4] TRU-00821; TRU00830
[5] AOB-01792
[6] AOB-15001 -15316 & AOB-02561 - 02572
[7] TRA-04619-04746
[8] TRA-04747-04883
[9] TRA-04884-05014
[10] TRA-12123-12250
[11] TRA-12359 - 12498
[12] TRA-12499 - 12664

> "(c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty;
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> ….
>
> The clinical practice of Mr O'Brien is being investigated by the General Medical Council (GMC) and it would, therefore, be inappropriate for the Inquiry to encroach on the GMC's remit."

5. Mr O'Brien has noted and has relied upon the observations made by the Chair[13] and Counsel to the Inquiry[14] ("CTI") on the extent to which the Inquiry is minded to consider and make findings relating to his clinical practice, decision making and issues of causation in individual patient cases. For that reason, it is not the intention of these submissions to venture into the particularity of Mr O'Brien's management of individual patients save to the extent that it is necessary for him to do so in order to advance submissions which are consistent with the TOR. As the panel will also know, Mr O'Brien has expressed his grave concern about his ability to respond to issues raised about his clinical practice given that the complete, up to date, medical records relating to the majority of patients on the cipher list have not formed part of the disclosure provided to him.

6. It is unusual for a medical practitioner to find himself in a position where suggestions are made that there are concerns regarding his clinical practice, which it is said may give rise to governance issues, if the reality may well be that the concerns are misplaced so that no governance issues are in fact engaged. Without access to the complete and up to date clinical and administrative records for his scrutiny, it has not been possible for Mr O'Brien to rebut, dispute or accept any such concerns. Be that as it may, Mr O'Brien has endeavoured to strike an appropriate balance in the submissions which follow. If there are any further issues upon which the panel would benefit from additional evidence or submissions, Mr O'Brien is content to co-operate in any way that he can.

The essential context to Mr O'Brien's practice

[13] TRA-09933 - 09934
[14] TRA-09377 & TRA-12388

7. The panel is invited to consider fully and reflect in its report the essential context in which Mr O'Brien practised as a consultant urologist in the Trust.

8. Mr O'Brien singlehandedly set up the urology service in the legacy Craigavon Area Hospital Group Health and Social Care Trust, taking up his appointment as a consultant on 6th July 1992[15]. Thereafter he devoted his entire professional life to the service of the many patients he attended to and cared for over the following 28 years.

9. From the inception of the Trust's urology service until Mr O'Brien's employment ended in July 2020, the Department of Health ("the Department"), the Health & Social Care Board, Craigavon Area Hospital Group Trust and the Southern Health and Social Care Trust have presided over a grossly inadequate and unsafe urology service, causing patients to suffer and come to harm. It was disheartening in the extreme to hear from the Department's permanent secretary, Mr May that, if anything, the situation will continue to deteriorate before there might be some improvement in urology services provision[16].

10. Immediately prior to Mr O'Brien beginning his tenure as a consultant urologist, the consultant urologist/population ratio in Northern Ireland was 1:300,000 compared to 1:180,000 in Great Britain. Notwithstanding this self-evident inadequacy and the increasing need for urological services, the then Director of Public Health of the Southern Health & Social Services Board took a period of eight months to be convinced of the actual need of the Board's then resident population of almost 270,000 for a specialist urology service. This early reluctance to acknowledge the need for a specialist urology service is indicative of an enduring inadequacy in commissioning, staffing, and resourcing which has plagued the service ever since[17].

    As a consequence of these shortcomings, Mr O'Brien found himself having to provide singlehandedly a continuous, acute urological service until a second consultant urologist, Mr Baluch, took up his post in January 1996, in addition to the provision of an elective service until that date. He again had to do so from January 1998 following the departure of Mr Baluch until Mr Young replaced him in May 1998.

[15] See AOB01879 to AOB01886; AOB03498 to AOB03503 for background to development of the Urology Services at the Trust
[16] TRA-12330
[17] See Mr Connolly's email AOB-06264 expressing concern re General Surgeons displacing Urology cases and evidence at TRA-09490 - 09497 Connolly on 4th December 2023

11. Mr O'Brien documented the likelihood of ever-increasing inadequacy and its consequences in his paper of March 1997: 'The Future of Urological Services'[18]. These very early expressions of concerns demonstrate beyond doubt that there can be no suggestion that Mr O'Brien has only invoked the inadequacy of the Trust's urology service as a way of defending alleged inadequacies in his practice or for the purposes of this Inquiry. At the time of the 1997 paper, demand was increasing, and capacity was lacking. There were then 451 patients waiting up to 43 months for inpatient admission. Mr O'Brien anticipated that the Trust would seek to appoint a third consultant in addition to himself and Mr Young in 1998. Yet, almost ten years after advising that "by currently accepted standards, the population of the Southern Area requires a urological service provided by 4 Consultant Urologists" a third consultant had not been appointed. There was an enduring shortfall, the brutal reality of which was that Mr O'Brien and others were required to treat as many patients as they could over time. As a result, Mr O'Brien and Mr Young shared a 1:2 rota for years[19], meaning that on the rare occasions when either of them took some time away, the other continued to provide an acute, emergency service in addition to using vacated theatre sessions to provide an elective service that was not reduced or only minimally so.

12. The McClinton Review in 2004[20], seven years after Mr O'Brien's paper, made a host of recommendations to try and improve the service. It stated: "At the core of an excellent Urological service there must be sufficient Consultant Urologists with access to an adequate number of beds and operating sessions together with the support of appropriate numbers of properly trained nurses and theatre staff"[21].

13. Mr Young's written response to the Trust following the McClinton recommendations is telling: "We do most sincerely hope that this external review now acts as a catalyst for development, as similar recommendations were put to the Trust in the past'[22]. Mr Young had written to the Trust's Medical Director on several occasions expressing concern about the excessive workload and the excessive consultant working time[23].

[18] AOB-00027 to AOB-00035
[19] Young's evidence TRA-08992
[20] WIT-52121 to WIT-52140
[21] WIT-52126
[22] WIT-52148
[23] WIT-51720; WIT-52068-52069

14. The panel is particularly reminded to review the letter which Mr Young wrote to Mr Templeton, Chief Executive of Craigavon Area Hospital Group Trust, on 17 September 2003 as much of its content is as relevant 20 years later as it was then.[24] Mr Young and Mr O'Brien had decided to discontinue the practice of having consultants and registrars conducting two outreach outpatient clinics simultaneously as they both had cause for concern regarding the safety of inpatients at Craigavon Area Hospital while medical staff were off site. The letter reflects the insistence on the reinstatement of the clinics, which the urologists indicate "will be acted upon".

15. The letter expressed concerns at that time regarding the safety of inpatients and of those patients acutely admitted while staff were off site. It also expressed disappointment that "you would give serious consideration to the continued viability of the urology services" before going on to observe "our figures from the recent recovery plan were exceptionally favourable and we have made many suggestions to improve the situation and the service but unfortunately they have not been acted upon." It referred to the decision to have an external review conducted in response to having a third consultant appointed whereas no such review would be considered necessary if any other speciality requested the appointment of an additional consultant. It referred to the demand/capacity mismatch. It referred to the lack of satisfactory job plans and the lack of resources to enable the service to provide safe care to those patients in most need of it. It referred to the consultants having taken on extra lists "on their own volition, without any form of recompense but did so for the enhancement of the service – this is not the best way forward when the service relies on a significant amount of goodwill".

16. Mr Young continued that "unfortunately, this has all been very negative and extremely disillusioning for the personnel in a unit, who have a fabulous capacity and willingness to stride forward despite the enormous challenges to do so." The panel, charged with providing a "comprehensive report of findings related to the governance of patient care and safety within the Trust's urology speciality", may wish to reflect upon why clinicians became disillusioned and disenfranchised from management. Mr Young's letter of 20 years ago provided the answer which was as relevant 20 years later as it may be now.

17. The McClinton review paper observed that two consultant urological surgeons working a 1:2 rota often with no middle grade staff was a situation which was "unacceptable

[24] WIT-52092

and unsustainable"[25] and referred to the inadequacy of the service's capacity in terms of beds and theatre sessions coupled with observations about how "extremely hard" the then "2-man unit" was working and which was "well beyond expected levels"[26].

18. In short, none of this was new; it simply had not been adequately addressed and it still has not been adequately addressed. Is this not one of the most significant governance issues for the panel to fully address?

19. With ever increasing demand clearly outstripping capacity, the working "well beyond expected levels" simply continued for the remainder of Mr O'Brien's tenure as a consultant urologist[27].

20. The year 2009 was a significant inflexion point in time with respect to the inadequate progress being made to expand the inadequate and unsafe urology service. On the one hand, 2009 saw the introduction into legislation of the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the 2009 Act"), which remains in force. The general duties of the Department are detailed in section 2 of the Act. In particular, section 2 stipulated, inter alia, that the Department must develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland, must allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way, and it must hold to account the Regional Agency, RBSO and HSC trusts in the discharge of their functions.

21. The 2009 Act also stipulated in section 21 that it is the duty of a HSC trust to exercise its functions with the aim of improving the health and social well-being of, and reducing health inequalities between, those for whom it provides, or may provide, health and social care.

22. The reconfiguration of inpatient wards in Craigavon Area Hospital was announced in 2009. This was a project, ironically called the "Acute Quality Care Project", led by Mr Simon Gibson with Mr Mackle as its clinical lead. The reconfiguration resulted in the loss of the urology inpatient ward, 2 South. Patients were to be admitted to general surgical wards, staffed by nurses with little or no urological expertise. This

[25] WIT-52127
[26] WIT-52130
[27] Notwithstanding the demands he was given a Clinical Excellence Award in 2009 AOB-00121

was a negative, retrogressive measure inflicted by the Trust upon the urology service.

23. Concerns were raised as long ago as January 2010 in relation to the ward reconfiguration and to the loss of radical pelvic surgery, which was then presciently considered to also have the potential to compromise patient care and safety, and with the concomitant impact the same would have on the status of the department and thus the ability to recruit to the department[28]. It is self-evident that if the services a department can offer are not only totally overwhelmed but also limited or limiting then recruitment to such a department will be more challenging.

24. It should be noted that the concern which Mr O'Brien had regarding the loss of radical pelvic surgery having the potential to compromise patient care and safety, related to his fear that the inadequate service capacity of the Department of Urology at Belfast City Hospital could result in older or comorbid patients not being offered potentially curative, radical cystectomy for bladder cancer[29].

25. The Implementation Plan following the 2009 Review of Urology Services in Northern Ireland set objectives which were rightly described in evidence as "grandiose"[30]. The objectives had not been met by the time Mr O'Brien left the service in 2020 (11 years later). This was notwithstanding the hard work of all of the staff in the service.

26. There clearly were difficulties in what have been described as the "Monday meetings" and engagement with Dr Rankin and Mr Mackle. Mr O'Brien felt the meetings were very difficult[31]. Kathryn Robinson in her evidence described meetings with Dr Rankin on a Tuesday where Dr Rankin "would have went (sic) nuts" and that "everybody would have been quite nervous going to this meeting[32]", how they were "stressful meetings"[33] and she questioned in retrospect whether that was a "good environment for people to be working in"[34].

[28] AOB-00138
[29] WIT-82445 at paragraph 124
[30] TRA-12146 - 12147 Mr O'Brien am of 8th April
[31] TRA-05006
[32] TRA-05177-05178
[33] TRA-05184
[34] TRA-05185

27. Mr O'Brien was not alone in expressing concerns about how the urology service was being mismanaged in 2009-2010. See Mr Young's letter to Heather Trouton in November 2009[35]. In terms of engaging with Dr Rankin, high level concerns were also expressed by Mr Young[36] (letter dated 27th October 2010). Some of the suggestions being made by non-urologists about how to run the urology department were being advanced on an out-dated BAUS model, with Mr Young bringing the draft revision to management's attention. In his oral evidence, Mr Young described how he felt that Dr Rankin was not taking on board the consultants' suggestions for the good of the urology service[37]. This echoes the concerns expressed by Mr Young in his letter to Mr Templeton seven years previously. Mr Akhtar also raised concerns and rejected the suggestion being made by Mr Mackle of resistance and obstruction. He felt on the contrary, there was a lack of communication from management[38]. It would be quite wrong in the circumstances to suggest or conclude that Mr O'Brien was an incalcitrant outlier. He was not.

28. In the job planning facilitation process in 2011, Mr O'Brien could not have been clearer about the inadequacy of what management was suggesting, which related directly to "the provision of an effective, efficient and safe service"[39].

29. Mr Mackle suggested he had been accused of bullying or harassing Mr O'Brien and that he brought this to the attention of Dr John Simpson, then Medical Director. In fact, Mr O'Brien had not complained that Mr Mackle was bullying or harassing him. Dr Simpson in his evidence denied that Mr Mackle had raised this with him, going so far as to say that if Mr Mackle had done so he would have directed him to record it and the matter would have been investigated[40]. Zoe Parks, who was pivotal in resolving an issue relating to pay, did not view the issue as bullying or harassment. Nor was she ever made aware that any such complaint had been made[41]. There was a genuine concern in relation to Personal Information redacted by USI (triggered by Mr Mackle) which was resolved in Mr O'Brien's favour. As the panel knows, Mr O'Brien did not progress with his grievance in relation to this matter.

[35] AOB-00134
[36] WIT-52049 to WIT52051
[37] TRA-09060 Young 8th Nov 2023 just after lunch
[38] TRA-08385 - 08386 Akhtar 10th Oct 2023
[39] AOB-00308
[40] TRA-09279 - 09280 Dr John Simpson
[41] TRA-05544 Zoe Parks 18th May 2023

30. When Mr Glackin returned in 2012, he observed that it was clear to him that "there was and remains a persisting problem with excessive waiting times for new appointments, review appointments and surgical procedures",[42] which was in stark contrast to his experience in the West Midlands. He recalled in his oral evidence how Mr O'Brien raised concerns on many occasions about the capacity of the urology service in meetings with Trust management present. Mr Glackin said the response did not amount to much[43]. Self-evidently other Trusts managed to run efficient, well-resourced urology services. The Southern Trust has never done so. Given the obvious and inevitable patient safety issues, this represents an obvious failure in governance that has been present in the Trust and persisted for decades.

31. In his 2012/13 appraisal, Mr O'Brien summarised the nature and extent of the work he was providing, including the time required in preparation for and timely communication after the MDMs which he was chairing[44]. He was raising the compromise to the care of his patients:

> "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 9 clinical sessions per week, Monday to Friday. Almost all inpatient 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 on ongoing cause for concern.[45]"

32. The pressures of time and the inability to implement agreed actions were known to the Trust. See the email from Ms Trouton to the consultants stating: "...as Aidan quite rightly states we often agree actions but often never get to implement due to many competing demands on our time"[46].

33. Mr O'Brien also continued to put forward constructive suggestions to try to find solutions to the mismatch between demand and capacity whilst observing that it "has been most difficult to impress upon authority the notion that those who provide the

[42] WIT-42298
[43] TRA-08118 - 08119 Glackin 21st Sept 2023
[44] AOB-22323
[45] AOB-22325
[46] AOB-06748

service may also be those best equipped to know what is required."[47]. The panel might find echoes here of the attempts made by Mr Young to persuade Dr Rankin of the same, and the consternation expressed by Mr Young and Mr O'Brien about the closure of Ward 2 South. See also Mr O'Brien's suggestions on the Stock Take of the Regional Review in 2014[48] and his positive suggestions in relation to implementing changes to try to reduce the number of incoming referrals[49]. Mr O'Brien's attempts to bring about change also included his email of 17th August 2014 and his proposals such as advanced/enhanced triage, the conduct of triage by nurse specialists rather than consultants and suggesting that as much as could be done in primary care was done before referral into the Trust. These constructive suggestions and proposals were advanced with a view to improving the efficiency of working practices. As Mr O'Brien observed in his email, "the first and overriding priority of every clinician of the week is the provision of round the clock emergency care. It is therefore impossible to provide emergency care if you have a fixed commitment elsewhere."[50]

34. A decade after the McClinton Review, the need for Mr O'Brien and others to work beyond expected or sustainable levels continued. In the period between 2013-2016, Mr O'Brien undertook additional operating sessions in an attempt to reduce patient waiting times. He undertook some 122 additional operating sessions over that period[51] which, when coupled with the preparation and administrative time associated with the same, is likely to have given rise to a conservative total of an additional 730 hours of work[52]. He was, as he put it, "running to stand still"[53].

35. In his attempts to flag the issue of waiting times and risks to patient safety, Mr O'Brien emailed in response to notification of the 62-day pathway breachers that he was "increasingly aware of the cost paid by the non-cancer patients"[54]. He emailed, at close to 1.40am on 28th June 2016, his concern around delays to patients noting, "we cannot continue like this"[55]. He had 275 patients on his operative waiting list, and he had equated red flag patients, cancer patients with no red flag status, those with indwelling stents for up to two years, those with indwelling catheters for over two years, whilst

[47] TRU-01534
[48] AOB-03808 to AOB-0381
[49] AOB-03820 to AOB-03822
[50] AOB-00781
[51] AOB-15274
[52] WIT-82417 paragraph 53
[53] TRA-04637 Mr O'Brien 19th April 2023
[54] AOB-75851
[55] AOB-77568

trying to accommodate other long waiters. This email was sent just days before the departure of Ms Hunter[56] in July 2016 who had emailed in 2015 her concerns about the lack of safety on the ward[57]. Ms Hunter's July departure email was in turn days before Mr O'Brien emailed Ms Andrea Cunningham about the increase in patients being allocated to his clinics[58]. The response to inadequacy was simply to require the practitioners to do more.

36. Between January 2016 and November 2016, before going on sick leave, Mr O'Brien conducted over 83 elective inpatient operating sessions as against a contracted job plan of 58 sessions[59]. The additional, necessary perioperative care and associated administrative time equated to more than 35 sessions. He undertook this additional work in order to minimise the numbers of patients suffering harm and at risk of coming to harm. By doing so, he had reduced the number of patients awaiting inpatient admission from 275 to 232 by the time he went on sick leave in November 2016[60]. As he observed when meeting with Dr Wright at the end of December 2016, there were just not enough hours in the day to be faultless; that he had tried it without sleeping, without food and the reality was he simply had to try and allocate the inadequacy to the area that was least likely to have consequences for patients[61].

37. Mr Young comments on the period in his statement where he says[62] :

> "Undoubtedly, the times of shortfall in the consultant number have had a significant impact and the burden of the backlog has never been adequately addressed (either by the Trust or the DoH, in my opinion)."

38. The risks to patients inherent in patients waiting extraordinarily long periods of time for treatment should have been self-evident to the Trust and the Department. The risks were in any event repeatedly brought to the Trust's attention. Mr O'Brien was not the only practitioner to raise them. See in particular the email from Mr Haynes[63] to Esther Gishkori in May 2018 which begins and ends in the starkest and clearest of terms:

[56] AOB-77594
[57] AOB-75761
[58] AOB-77631
[59] AOB-23225
[60] WIT-82417 at paragraph 53
[61] AOB-56013 to AOB-56014
[62] WIT-51732
[63] AOB-01811 to AOB-01812

> "I write to express serious patient safety concerns of the urology department regarding the current status of our Inpatient theatre waiting lists and the significant risk that is posed to these patients …
>
> Unless immediate action is taken by the Trust to improve the waiting times for urological surgery we are concerned that another potentially avoidable death may occur."

39. The email from Mr Haynes of 8th June 2018[64] included a table showing the disparity in relation to the waiting times urology patients were being exposed to compared to the waiting times for other specialties. This disparity has endured and is reflective of the Trust's mentality from inception that somehow the urology service was undeserving of proper prioritisation. See also the email from Ms Corrigan in January 2019 on the comparative red flag first appointment longest waits. It was urology by a considerable distance[65]. There can be no doubt that these disparities were in contravention of the statutory duty of the Trust as stipulated the 2009 Act. Still, by mid-2019 there was over-booking of Mr O'Brien's clinic to try and ensure patients were seen[66]. This is hardly surprising as by then urology had the majority of breaches of the 62-day pathway and the longest routine wait at some 269 weeks i.e. over 5 years[67].

40. Surely the single greatest governance issue facing the Trust's urology service is that Ms Mullan, the Non-Executive Chair of the Trust, acknowledged when giving evidence to the Inquiry that the focus was on targets and that she could not say that patient safety was the first and foremost concern[68].

41. Dr O'Kane wrote in her witness statement that, during her tenure as Medical Director from 1st December 2018 to 30th April 2022, the difficulties with waiting lists were compounded by staffing shortages which were brought to her attention by various staff via informal mechanisms. However, "none being raised as specific patient safety issues"[69]. Surely such a lack of professional insight and corporate ignorance of the

[64] AOB-01814
[65] AOB-07451
[66] AOB-08341; AOB-08415; AOB-08448
[67] WIT-100492
[68] TRA-09968 Mrs Mullan 10th January am
[69] WIT-45007

risks to the safety of hundreds of patients waiting on long waiting lists for years for treatment should be a governance issue of the highest order.

42. The Trust management response to the situation facing its urology service has always been inadequate. Even when the number of consultant urologists was increased, there was not an associated increase in theatre time or bed space. In his statement Mr Carroll stated[70]:

> "Concerning the excessively long waiting times for all Urology Services the staffing resources available were insufficient to meet the demand on the Urology Services. These inadequate resources applied to Consultants and supporting middle grade medical staff, CNS's and operating time. Operating time per consultant was 1 all day in-patients list and 1 day case list weekly both of which were inadequate to meet the demand. However, it should be noted that the physical theatre capacity available would not have been able to accommodate more Urology operating sessions.
>
> For 3 South the nursing workforce compliment was sufficient for the commissioned 31 beds. The challenge for 3 south was the number of vacant nursing positions unfilled resulting in an over reliance on nursing agencies providing the nursing staff, both trained and untrained.
>
> …It was apparent that demand for urology was unabating and exceeding the capacity available."

43. Occasional, but invariably inadequate, steps were taken in an attempt to improve the situation. There was an inadequate increase of theatre sessions by only 0.5 sessions, from 10.5 per week to 11 per week for all consultant urologists in December 2018. The most startling example of an inadequate response was a HSCB funded validation exercise which was an administrative exercise to remove patients from the waiting list without a consultation with their doctor[71]. Even when there was a meagre and wholly inadequate increase in theatre capacity of 0.5 sessions per week for all the consultant urologists, that too was reversed, after one month[72]. Such concerns raised by Mr

[70] WIT-13105
[71] AOB-09482 to AOB09500
[72] AOB-81889

O'Brien and his colleagues should have been addressed by the Trust as governance issues, but they were not.

44. In late 2019, Mr Haynes sent a letter to Dr McCarthy which stated[73]:

> "…At our recent group meeting we had in depth discussions on the current challenges with regards demand vs capacity for urological surgery in Northern Ireland with particular reference to waiting times for urological cancer surgery.
>
> The current position is placing the urological cancer surgeons in a position of not being able to consistently offer surgery within expected timescales for cancer treatments. This places surgeons in a difficult position, where there is an increasing expectation placed on clinicians to risk assess patients awaiting cancer treatment to determine priority on the list and the risks associated with this expectation. In practice this means inevitably delaying some patient's cancer treatments in order to expedite another patient's treatment. …
>
> There is concern that these 'low risk' patients may subsequently being (sic) found to have higher risk disease or disease progression when they have their definitive treatment. ...
>
> However, there are limitations, as many urological patients are also at significant risk from benign disease and delivery of these treatments cannot be deferred without harm coming to this group of patients. Effectively, as you are aware, routine inpatient urological surgery is not being delivered at present. You will also be aware of the direct link between increasing waiting times and demand for community/primary care/emergency department/unscheduled care which also consequently can impact on our ability to deliver inpatient treatments."

While Mr Haynes was correct in asserting that by 2019 routine inpatient urological surgery was effectively not undertaken, it should be appreciated that, by then, there were patients awaiting elective admission for urgent urological surgery since 2014.

[73] WIT-54708

45. By November 2019, the longest wait for any patient referred as a Red Flag referral within the Southern Trust was for patients with or suspected of prostate cancer, 'Urology (Prostate),' which had spiralled to 103 days[74].

46. Moreover, by 2018 some 60% of the breaches of the 62-day targets for all red flag referrals to the Trust were urological red flag referrals[75]. Such data reflected the disproportionate and disparate inadequacy of the Trust's urological cancer service, even though the latter was the priority component of the entire urological service. It also undoubtedly contravened the statutory duty of the Trust.

47. In an email headed "Urology Triage" in September 2019, Alana Coleman, referring to the booking time for red flag (RF) patients noted[76] "RF are booking no less than 6 weeks at present," She posed the question "…should we just ask the consultants if they are willing for their clinics to be over-booked to accommodate?".

    Mr Glackin replied[77] :

    > "...If the trust cannot deliver this then there is an issue of demand outstripping supply. Simply relying on me or any other clinician to overbook a clinic will not solve this supply issue and I am not willing to do this work unpaid or to the detriment of my existing workload."

48. This is a classic expression of the invidious choices practitioners were and are having to make in a situation of demand/capacity mismatch which had endured for decades and which left clinicians and those who support them to do their best, sometimes going beyond what is healthy, to try to meet demand while knowing that despite their best efforts more people will be kept waiting for longer[78].

49. In the early part of 2020, notwithstanding the ever-increasing numbers of patients waiting for surgery, there was still a considerable shortfall in the amount of operating time being afforded to the urology department. In February 2020, Mr Haynes calculated he required some 59 hours of operating time but was allocated just 24 hours, less than

[74] AOB-09871
[75] WIT-82431 (and references referred to therein) at paragraph 81
[76] TRU-258588
[77] TRU-258587
[78] TRA-05628 Sharon Glenny 18th May 2023

half of the operating time required[79]. This was notwithstanding articles in the Belfast Telegraph distributed by the Trust's Medical Director on 22nd January 2020 showing that patients referred for a routine urology appointment faced a wait of 141 weeks in September 2018, which had increased to 196 weeks (just over 3 ¾ years) by November 2019. The Trust is recorded as having apologised and said that it "prioritised patients by urgency and in line with guidance"[80].

50. Notwithstanding the pressures the Trust's urology service was under and at the height of the Covid pandemic in June 2020, the Trust refused to allow Mr O'Brien to return to part time employment following his notice of retirement from full time employment and refused to accept his revocation of retirement, without having a replacement for him.

51. Mr Glackin's evidence painted a disheartening picture where the capacity issues have been flagged and known about for years and that there has been no substantial change for over a decade[81].

52. As the panel is aware, the dire situation in the urology service has persisted. Recent data have revealed that there were 4,458 patients awaiting first outpatient appointments on 30 September 2023. Of these, 2,733 (61%) were waiting in excess of one year and 541 patients were waiting in excess of 5 years. Of the total, 1,063 (24%) were awaiting urgent outpatient consultations. In addition, 1,341 patients were awaiting admission for treatment, either as inpatient or day cases[82].

Mr O'Brien's commitment and work ethic

53. To try to mitigate the enduring inadequacies of the Trust's urology service, Mr O'Brien worked incredibly hard. Any alleged or perceived deficiencies or shortcomings in Mr O'Brien's practice cannot be stated to be as a result of any lack of commitment, application, or hard work on his part. He has never been idle.

54. There is a significant amount of evidence before the Inquiry as to Mr O'Brien's level of commitment and work ethic over many years[83].

[79] WIT-34356
[80] AOB-04585 to AOB-04591
[81] TRA-08208 Glackin 21st Sept 2023
[82] TRU-411759
[83] TRA-02104 - 02105 Mr Mackle 26th Jan 2023 early morning

55. The following extract from the statement of Dr Charles McAllister[84] is just part of the chorus of evidence which speaks to the incredibly dedicated and hard-working practitioner Mr O'Brien was throughout his career:

> "Mr O'Brien was generally considered to be extremely hard working, if not the hardest working Surgeon in the Trust, was regarded as technically excellent in Theatre with the most demanding of major urological surgery, and just as importantly excellent in direct pre-op and post-op care.
>
> Personally, although I have anaesthetised for Mr O'Brien I more frequently have looked after his patients in the Intensive Care Unit. What I saw was as good as any surgeon and better than most. He saw his patients in ICU twice a day during the week and at least once a day at the weekend whenever he had a patient there. He was always available for consultation/advice/action on any patient who was admitted to ICU with or who developed urological issues whether they were his patient or not. I never heard any colleague criticise or complain about his clinical work and anaesthetists seem to enjoy working with him. He was one of the very few Consultants I would regularly see in the hospital at night and he was frequently in at weekend. Whenever a patient of his did not have what he thought was an optimal outcome he would present this himself (and not a trainee as most Consultants did) at the monthly Morbidity and Mortality meeting in painstaking or even excruciating detail".

56. There is yet further evidence from nurses, of particular resonance due to the concerns expressed about Mr O'Brien's engagement with CNSs/Key Workers. In her statement Leanne McCourt[85] says this:

> "If I needed advice from him, he was professional and forthcoming. When I was a junior staff nurse, he would have taken time to explain things and help me to learn. He was very dedicated to care of his patients, and I would describe him as "kind and caring" to his patients in clinic. I recall one such time where I was present when a life-changing diagnosis was given to a young man. Mr O'Brien

[84] WIT-14871 to WIT-14872
[85] WIT-85917

offered to drive him to the oncology appointment he had arranged for him later that day as he was concerned the young man was distressed and shaken."

57. Patricia Thompson also confirmed in her evidence to the Inquiry that Mr O'Brien was always professional and engaged with other staff members' opinions without any difficulty[86].

58. Mr O'Brien's work with the charity CURE is further evidence of his commitment and dedication.

59. Mr O'Brien's preparation for, participation in, and steps taken following MDMs is also beyond question. In her statement to the Inquiry, Vicki Graham[87] said:

> "All that I can recall is that while Mr O'Brien was chair of the Urology MDM that he was so committed and dedicated to this role. Prior to Mr O'Brien taking on this role I, as Cancer Tracker, had to compile the clinical summary for each patient that was to be discussed. Mr O'Brien changed this so that each Clinician provided a more comprehensive clinical history[88]…"

60. In addition to his direct, patient-focussed work, Mr O'Brien was also highly regarded as a teacher and a colleague to whom more junior consultants could, and did, turn for advice and assistance. Mr David Connolly[89] said:

> "In my time working with Mr O'Brien, I found him to be very similar to other older Consultants that I had worked with during my training. He had a wealth of experience and was technically a very good surgeon. He was a good teacher and was very patient with trainees. His patients were very fond of him, even to the point where they preferred to see Mr O'Brien personally instead of other Consultants or trainees and they respected his opinion above all others."

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[86] TRA-07709 Thompson 14th Sept 2023 am before break
[87] WIT-60915; See also her evidence on Mr O'Brien's work following MDM TRA-11986 - 11988 16th May 2023
[88] WIT-82503; Mr O'Brien was in fact unsuccessful in his endeavour to have his colleagues compile and submit a clinical summary to the Cancer Tracker when referring a patient for MDM discussion as they declined to do so in addition to, or instead of, dictating a letter addressed to the patient's GP, even though they were advised that it was not the responsibility of, or appropriate for, the Cancer Tracker to compile a clinical summary.
[89] WIT-41995; See also TRA-09512 – 09514 Connolly 7th June 2022; See also Mr Pahuja's statement at WIT-59685

61. Any suggestion that Mr O'Brien was in some way aloof, distant or unapproachable is simply not borne out by the preponderance of the evidence the Inquiry has received[90]. To draw any inference as to Mr O'Brien's character as a practitioner for almost 30 years from a single incident where he reprimanded Mr O'Donoghue for starting an MDM discussion prematurely would be most unfair when the Inquiry has not, so far as one is aware, sought statements from the many anaesthetists and theatre staff who worked incredibly closely with him in theatres for many years in the most stressful of circumstances.

62. As the panel is aware, Mr O'Brien was appointed Lead Clinician of the Trust's Urological Multidisciplinary Team (MDT) and Chair of the Urological Cancer MDM in April 2012. He volunteered for that role following the departure of Mr Akhtar in March 2012. Mr Young had other commitments and both he and Mr O'Brien were of the view that it was unfair to expect the newly appointed Mr Glackin to undertake it[91]. He remained as Lead Clinician until December 2016. He was sole chair of the MDM until the introduction of Urologist of the Week in November 2014 and remained as a rotating chair thereafter until December 2019.

63. In January 2013, he was appointed Clinical Lead and Chair of the Northern Ireland Cancer Network (NICaN) Clinical Reference Group in Urology, a post he held until January 2016. He was approached by the previous incumbent and the secretariat to take it on. In the end he felt he had to take it on as no one else had stepped forward[92]. This was a Northern Ireland wide appointment, and it was part of his additional responsibilities to ensure clinical management guidelines were drafted for the first ever national peer review of all Urology MDTs in Northern Ireland in June 2015.

64. The panel is also aware that during 2016, Mr O'Brien put his commitment to the patients and the Trust ahead of his health by delaying his personal medical treatment to ensure there remained sufficient support in place for Mr Suresh[93].

65. The panel also knows that Mr O'Brien, aware of and open about the backlog in relation to his administration, volunteered to address the same while he was on sick leave

[90] See also the evidence of Matthew Tyson TRA-08808 - 08809 7th Nov 2023; Mr Robin Brown TRA-09124 14th Nov 2023; Mr Suresh TRA-08668 17th Oct 2023
[91] TRA-12174 lines 10-25
[92] TRA-12174 lines 1-8
[93] AOB-22956

Personal Information redacted by the USI in November 2016. There was little governance intervention then to encourage and support him to rest and recuperate. It was an offer that could have been gracefully declined, but it was not[94]. The Trust thereby permitted and condoned Mr O'Brien having patient records at home to work on them.

66. If anything, as indicated by this experience, Mr O'Brien was trying to do too much. In his addendum statement, Mr O'Brien has endeavoured to assist the Inquiry by drawing attention to the time that had historically been allocated in proposed job plans for administration, compared to that which Mr Haynes found to be necessary in 2018, as well as that since allocated to his former colleagues, in addition to time allocated for their fulfilling those roles that had been undertaken by Mr O'Brien and for which no time had been allocated[95].

67. Yet, one has a sense when something did go wrong, the Trust looked not to the painfully obvious demand/capacity mismatch but instead placed the responsibility upon the shoulders of the clinicians themselves. This complete transfer of all responsibility from the Trust to the clinicians was exemplified by the case of the retained swab addressed by Mr O'Brien in his addendum statement[96] The Root Cause Analysis recommendations included that outpatient backlog reviews should be cleared (the patient had waited 12 months post-operatively for review). Dr Diane Corrigan of the Public Health Agency stated[97] that the

> "…recommendation relating to this issue was that outpatient backlog reviews should be cleared. This recommendation is reasonable, albeit not necessarily easy for the Trust to implement given the resources required to do so."

Dr Corrigan suggested that the Trust consider

> "…whether there is a need for a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting outpatient review"

Thus, while the reasonable recommendation that the Trust clear outpatient backlog reviews would not be easy, given the resources required to do so, the responsibility

[94] AOB-01226 to AOB-01225
[95] WIT-107613 at paragraphs 153 to 158
[96] WIT-107564 to WIT-107568
[97] PHA-00632

could be transferred to clinicians to review all results for all patients without any consideration of any additional resources or time required to enable them to do so.

68. Throughout his entire career, Mr O'Brien worked far beyond his contractual obligations, he worked when on leave[98] it being noted that he was "working even harder during holidays"[99] and even when on sick leave. He did additionality whenever it was offered, whether paid or unpaid, including longer days of operating and operating lists on Saturdays[100].

69. The panel is invited to reflect upon the evidence Mr O'Brien gave in April 2024:-[101]

> "One has to make choices with regard to actually reading or being able to deal with all of the emails that you receive each day, which is the more important things to do as you walk into the hospital each morning? Is it go to deal with the in-patients? Is it to sit down and read your emails? You know, I think that when you look at the differing practices that evolved, whether it's Mark Haynes getting up at 5:00 o'clock in the morning to do all of his administration, and spending some 15 hours a week in doing so, or whether it's me doing it until 3:00 o'clock in the morning, or whether actually increasingly it's people saying "actually I'm not prepared do either and I walk away from it". In fact, I have been reading recently some interesting literature talking about the impact of what's called discrepant services on individual clinicians when issues like compassion and empathy and support that they're able to give to patients during their caring for them is squeezed out because of the priorities that the employer or management would have. So, there are serious issues indeed. So, yep, there is no doubt about it, I agree entirely with Mark Haynes. This is the -- he described it very appropriately as the unmeetable expectation arising from that mismatch between demand and capacity."

70. The impact of the system was, as suggested to him, compelling him to make choices and, as he put it himself, "trade offs"[102] in terms of how to try and cause the least suffering. This was the invidious position he referred to in his witness statement. He made essentially the same point in his grievance document, i.e. it was the time he was

[98] AOB-82710;
[99] AOB-71498
[100] AOB-05688
[101] TRA-12169 line 9 to TRA-12170 line 5
[102] TRA-12170 lines 6-9

taking to reduce an ever-increasing backlog that had caused him to fall behind in his administrative work[103].

71. Mr O'Brien did not feel that he could so easily compartmentalise resource issues and agree that the waiting list problem was a "Trust issue". The panel will recall his description of the 'third leg' of that stool and how ultimately a waiting list problem is by far and away and, most importantly, a problem for the patient. The patients will be the ones who continue to suffer until they receive their treatment. Thus, he felt compelled to take on the additionality whenever he could[104]. As he observed[105]:

> "I just found that ethically and compassionately, if you are reading and trying to respond to cries of desperation every day, I couldn't pass up the opportunity to operate on two or three more patients. I think I'm correct in saying -- I was reading some of my own notes in recent days where I think I did something like 26 additional operating sessions during 2019, and yet my urgent in-patient waiting list is longer than ever..."

72. Given the inadequacies of the system within which he worked, Mr O'Brien was required to make decisions in terms of what aspects of his practice should be prioritised. It was suggested to him that the counterbalance in relation to shortcomings was that he was delivering what some might consider "an excessively high standard of service" to some patients and whether the "balance tilted too far on occasions", which he accepted was possibly the case[106]. However, he has been in no doubt that many more patients benefited as a consequence of his prioritising, removing them from harm's way, in the context of the Trust's failure to do so.

73. It is also fair to observe that the Trust was aware of the 'trade offs' Mr O'Brien was making between the different aspects of his clinical practice. The Trust knew he was hard working, but also knew there were aspects of his clinical practice that were suffering. In his witness statement, Mr O'Brien set out at length and cross-referenced to numerous email evidence showing that the Trust knew there were elements of his

[103] AOB-02029
[104] TRA-12171 lines 10-24
[105] TRA-12172 lines 5-13
[106] TRA-12183 lines 20-28

practice with which he was struggling, the introduction of the 'default' system in relation to triage being the most obvious example of all.

74. However, it must be emphasised that the primary reason for Mr O'Brien being unable to complete all administrative aspects of his practice was that he did not ignore the suffering of patients waiting years for admission for treatment, or the risks of patients coming to serious harm due to their waiting for years for admission for treatment, including delayed diagnoses of and deterioration in significant pathology. Conversely, if the Department of Health had met its statutory duty by directing a service sufficiently adequate as to be safe, and if the Health & Social Care Board had commissioned such a service, it would then have been possible for Mr O'Brien, and his colleagues, to have fulfilled all of their ethical and moral obligations to their patients.

75. As he related in his primary witness statement[107], Mr O'Brien's motivation throughout his career has only ever been, to the very best of his ability, to provide the best care that he could possibly give to the maximum number of patients whom he considered were in most need of it at any particular time. He regarded it as a vocation and a privilege to do so. He worked beyond any contractual obligations, as has been acknowledged. He worked when on leave. He worked when on sick leave. He alleviated suffering and reduced the numbers of patients coming to harm. However, he found it impossible to achieve that for all patients whose suffering required to be alleviated and impossible to eliminate the risk of all patients coming to harm. It is only fair to observe that there has never been any element of bad faith or malign intent in relation to his treatment of patients and rightly none has been suggested.

76. The panel should recognise and take into account in its consideration of other issues just how committed and hardworking Mr O'Brien was. The Trust was well aware of this. Of course, it suited the Trust's needs to have Mr O'Brien (and others) working late into the night, at weekends and on annual leave in their selfless attempts to mitigate the risk of harm resulting from the Trust's urology patients being on the longest urology waiting lists in Western Europe.

General observations on Mr O'Brien's character

[107] WIT-82435 paragraph 95

77. The Inquiry has received quite a lot of evidence about Mr O'Brien's character and personality, much of it ill-informed and it is hoped that the panel will not attach any weight or significance to such evidence.

78. The panel is encouraged not to be swayed by evidence of 'impression' formed or expressed by those who did not know the facts, did not work with Mr O'Brien, were not treated by him as a patient or, indeed, had never met him - as in the case of Dr O'Kane. Contrast Dr O'Kane's evidence in particular with that of Mr Mackle who, despite his differences with Mr O'Brien, observed that Mr O'Brien was "extremely polite … pleasant … a gentleman" and who was held in high regard"[108]. Ms Trouton described him as very polite and a gentleman[109]. Kathryn Robinson described him as an "absolute gentleman"[110]. Mrs Corrigan's description of Mr O'Brien's behaviour was also rejected by Mr Akthar. It was never "his way or no way"[111]. In his witness statement to Dr Chada in 2017, Mr Young stated, referring to Mr O'Brien, that "we have always had a good relationship and speak openly about a wide variety of things. We have had only two cross words in the 20 years we've worked together".[112] He also stated that he "had absolutely no concern about Mr O'Brien's clinical competence" and that he and his family "would go to him personally if needed[113]".

79. Nor should the panel reach conclusions based on throw away remarks such as causing "havoc in theatres" when there is no direct evidence that Mr O'Brien did so in terms of listing of surgery (the one case Ms Gishkori relied upon was not in fact as a result of Mr O'Brien listing the patient[114]), nor any evidence from those who worked with him in theatres or analysis done in terms of his scheduling or time taken in theatre. On the contrary, Mr Suresh, with whom Mr O'Brien did work in theatre, described Mr O'Brien as being meticulous, with excellent communication skills in theatre and experienced no sense of 'havoc' at all[115].

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[108] TRA-02199 & 02210 Mackle 31st January 2023
[109] See also TRA-02326 Ms Trouton 31st Jan 2023 am he was 'very polite' and 'a gentleman'
[110] TRA-05222 K Robinson 27th April 2020 after morning break
[111] TRA-08403 Mr Akhtar 10th Oct 2023
[112] TRU-00754
[113] TRU-00755
[114] Ms Gishkori also wrongly assumed that Mr O'Brien had deliberately and coincidentally absented himself on sick leave in the Autumn of 2016 which the panel know was incorrect. TRA-06821 Gishkori 14th June 2023 am. That was a classic example of how ill-informed assumption, unless checked, can lead to adverse and unfair perceptions.
[115] TRA-08699 – 08700 Suresh 17th oct 2023

80. There are other examples of such ill-informed and mistaken views, such as Mr O'Donoghue being under the impression Mr O'Brien had "hidden away" records which was simply not the case[116] and his assertions that Mr O'Brien's triage "went on certainly for a couple of weeks after he finished on-call" and that "he dictated letters on a few of his patients which were four pages long[117]" with no paragraphs. The Inquiry has not put to Mr O'Brien an example of a referral triaged by him two weeks following completion of Urologist of the Week, or an example of one letter, four pages long, with or without paragraphs, dictated upon triage. It is these kind of baseless stereotypes for which there is no corroborative evidence that should give the panel pause for thought in terms of making findings of fact without cogent, reliable evidence.

81. Exaggerated and uncorroborated allegations such as these have been used to characterise Mr O'Brien as a clinician who has provided an unnecessarily high standard of care to some patients to the detriment of others. In addition, they have been used to portray Mr O'Brien as a clinician who has been inefficient in his practice, with the implication that such inefficiency prevented him from achieving more in the time allocated, if any, even if the time allocated was demonstrated by Mr Haynes in 2018 to be a fraction of that which was required.

82. As indicated above, many of the stereotypical characterisations of Mr O'Brien have been proffered to the Inquiry by witnesses, some of whom had never met him, based entirely upon impressions. Their impressions have been contradicted by other witnesses who had worked with Mr O'Brien for years. The Inquiry is familiar with such characterisations of Mr O'Brien by Mrs Corrigan and Mr Carroll who, with Mr Haynes, were the main sources of information, or impressions with which Dr O'Kane formed her own sense and impressions of Mr O'Brien. She certainly formed and gave witness to these impressionistic characterisations without having met with Mr O'Brien or sought his views in order to ascertain their reliability.

83. From the interactions Dr O'Kane had with these medical and professional managers, she had the *sense* that "they did and do work well together with the exception of the working relationship with Mr O'Brien"[118]. Her *impression* was that "the remaining staff had the greatest respect for each other regardless of discipline and were very professional in their interactions with their patients and each other. They appeared to

[116] TRA-08577 - 08578 O'Donoghue 11th Oct 2023 am
[117] TRA-08466
[118] TRA-01480

work well together outside the challenges of having to manage and work with Mr O'Brien". Another *impression* was "that over the years Mr O'Brien's colleagues had developed ways of not confronting him for fear of having to deal with unpleasantness…"[119]

84. Almost two years after the event, Dr O'Kane persisted in reporting in her witness statement of 23rd August 2022 that the long waiting lists "hid in plain sight the issue that was uncovered on 7th June 2020 when Mr O'Brien emailed Mr Haynes re placing patients on surgical waiting lists. This revealed that patients had not been placed on waiting lists at all following their initial consultation or following investigations or a cancer MDM". As the Inquiry is aware, this assertion was completely incorrect.

85. In a similar vein, Dr O'Kane included in her list of "difficulties" with Mr O'Brien in the past the "prescribing of IV antibiotics and opiates". Difficulties with the prescribing of opiates has not been raised before.

86. She proceeded to state that he was also described as spending long hours on the wards at times when he was neither required or expected to be there and then was asking for additional payment recognition for this. It is not the case that he requested additional payment recognition for this.

87. Moreover, she claimed that Mr O'Brien only signed off his job plan or plans before he retired to allow his pension to be finalised. This allegation was also unfounded.

88. Dr O'Kane's characterisation of Mr O'Brien reached its apotheosis in paragraph 55.36 of her witness statement of 23rd August 2022 when she embarked upon an appraisal based upon impressions, appearances and beliefs. It should be a matter of concern that any Medical Director and Responsible Officer, since Chief Executive, of a Health Trust should characterise a clinician in such a manner without considering the necessity to meet with the clinician, discuss any concerns or issues as to their character and allow them an opportunity to respond before arriving at a proper appreciation of the character of that clinician.

89. Concern has also been expressed about a supposed "chill" factor or a supposed inability to challenge Mr O'Brien. A rather meaningless expression was used by Mr

[119] TRA-01481

Haynes suggesting that he was a "challenge to challenge"[120]. If someone challenges an individual and they happen to disagree or have their own views and are capable of expressing them clearly either orally or in writing, they could be said to be a 'challenge to challenge.' However, the views of the person challenged may in fact prove to be right and prevail. Any suggestion that it may have been Mr O'Brien's position as the most senior urologist in the Trust that made him a 'challenge to challenge' does not sit easily with the relative lack of challenge that emanated from the Belfast Trust's oncologists in relation to Mr O'Brien's use of Bicalutamide. Professor O'Sullivan and Dr Mitchell are senior clinicians working in a different Trust. Why did they not challenge Mr O'Brien in rather more direct terms? This cannot be explained on the basis of any fear of Mr O'Brien or "chill factor".

90. If there was a "chill" factor surrounding Mr O'Brien, this is not something Mr O'Brien created, fostered, encouraged or contributed to. One element of this was the fact that he had family members who were lawyers[121]. He cannot help that fact. If others had a perception that because he had family members who were lawyers, and that consequently they were in some way inhibited from questioning him or managing him, it speaks more to them and the robustness of the Trust's governance arrangements than it does about Mr O'Brien. Further, individuals are entitled to have a lawyer present in the MHPS process and are entitled to take legal advice, just as they are entitled to challenge management when errors have been made about their pay. The reality, as opposed to unsubstantiated mythical perception, is that at no stage in his career did Mr O'Brien actually bring legal proceedings against the Trust or any fellow employee.

91. Equally, if Mr O'Brien was afforded a degree of deference based on his experience, or the high regard he was held in by practitioners and patients alike, he had no control over this. As Mr Devlin observed, patient safety issues could have been brought to the attention of the Chief Executive, formally or informally, regardless of the views anyone had of Mr O'Brien.

92. During the course of the Inquiry, was alleged that the Chair of the Trust Board had advocated on behalf of Mr O'Brien who was asked whether he had ever solicited her to do so. He resolutely refuted any suggestion that he had done so, or even considered

[120] TRA-00842
[121] Accepted by Dr Chada as nor more than a personal impression see TRA-04120 - 04121 Chada 29th March 2023

doing so[122]. The Chair of the Trust likewise denied that Mr O'Brien had ever asked her to do so and there is no evidence that he in fact did.

93. In a similar vein, and more seriously, it was suggested during the course of the Inquiry that Mr O'Brien may have commissioned his former secretary to procure for him letters relating to Patient 139, or whether she had provided him with said letters without his requesting her to do so.[123] Mr O'Brien robustly refuted that either of these serious suggestions had occurred, there being no evidence that either had.[124]

94. For all of the above reasons, it is submitted that the Inquiry panel should exercise caution in arriving at conclusive findings concerning Mr O'Brien's character.

Evidence of Mr Hagan

95. The panel is invited to treat the evidence of Mr Hagan with considerable caution. It is historic and the clinical and administrative records of the individual to whom he referred have not been disclosed to enable Mr O'Brien to comment upon them. One partial exception to that is a ureteric stone case where Mr Hagan suggested (a) that there were energy sources available other than EHL, and (b) that when he had a complication through use of EHL, he was being directly supervised in theatre during the procedure by Mr O'Brien who had to take over. The incomplete records disclosed undermine both of those claims[125].

96. This example also underscores Mr O'Brien's more broadly held concern about the panel reaching conclusions as to matters of fact in clinical cases where the patient records have not been disclosed and subjected to forensic interrogation. But for the fact that these incomplete records materialised, the panel may have been invited to comment adversely in relation to Mr O'Brien, which obviously would have been unfair and unjust.

97. Mr Hagan says he spoke to Mr Young to raise concerns, but Mr Young has no recollection of him doing so[126].

[122] TRA-04844 – 04845 Mr O'Brien 20th April 2023
[123] TRU-320464
[124] TRA-12602
[125] WIT-107586 at paragraph 64(ii) to (iii)
[126] TRA-09686 and WIT-103605

98. In his witness statement, Mr Hagan also claimed to have received a telephone call from Dr McAllister about TUR surgery. Dr McAllister not only had absolutely no recollection of any such telephone conversation, which it was suggested he had initiated, but went so far as to observe it was not possible for him to have made such a call and said he had no memory of it because he believed it did not happen[127].

99. Mr O'Brien has set out his response to the Hagan concerns in his addendum witness statement[128] and the panel is invited to prefer his evidence.

Intravenous fluids and antibiotic therapy

100. Mr O'Brien addressed the issue of intravenous fluids and antibiotics in his original Section 21 statement;[129] which was submitted prior to disclosure of records from the Public Health Agency to the Inquiry[130]. The Inquiry will note at PHA-00440 that there is a record of a call with Mr O'Brien on 22nd April 2009 in which it is recorded that Mr O'Brien wanted "an in depth look at the cohort … not just telephone contact with specialists". This is indicative of Mr O'Brien positively inviting scrutiny of the practice so that the decision making could be properly informed. This of course flies in the face of the assertion that he was a "challenge to challenge" (whatever that may mean). The kind of investigation he invited did not take place.

101. What followed is described in Mr O'Brien's addendum statement and not repeated here[131]. As Mr O'Brien explained in his oral evidence to the Inquiry, this practice of elective admission of patients was for a relatively small number of patients for whom oral antibiotics, whether prescribed therapeutically or prophylactically, had been unsuccessful and who became repeatedly and acutely unwell, to a severe and life-threatening extent in some cases, requiring acute re-admission, and its aim was to try to prevent this cycle repeating itself[132]. These characteristics were clearly reported

[127] WIT-102756 at paragraphs 2.02 to 2.03
[128] WIT-107578 to WIT-107593
[129] WIT-82547 at paragraphs 417 to 424
[130] PHA-00430 to PHA-00553
[131] WIT-107569 at paragraphs 17 to 23
[132] TRA-12398 – 10th April early am

in the letter to the editor of the Journal of Infection, co-authored by Mr Young and Mr O'Brien[133].

102. The management of this issue remains a concern for Mr O'Brien.

103. The properly rigorous investigation requested by Mr O'Brien should have entailed a detailed analysis of the data to be published and should have entailed a multidisciplinary review of individual patients, including the participation of their caring clinicians. Most importantly, it should have been conducted by persons wholly independent of the Department of Health and of its arms-length bodies in Northern Ireland. It would have been most beneficial if there had been such a wholly independent body to which clinicians could have referred an issue such as this for investigation. It remains a matter of regret for Mr O'Brien that he did not insist that such a proper investigation be conducted.

104. Instead, the outcome of the management of this issue has been framed as an example of clinicians not being compliant with a Trust policy. Mr O'Brien recalled in his evidence to the Inquiry that, in one instance, he was responding to a general practitioner's request for the acute admission of a patient from the patient's home. This example highlights the difficulty that may arise for both primary and secondary care clinicians, and the danger for patients, when compliance with protocol conflicts with clinical reality, as the need for the patient's acute admission would have been avoided if compliance with the policy and protocol had not been required.

Cystectomies

105. Mr O'Brien addressed the issue of simple cystectomies performed for benign, non-malignant pathology and Professor Drake's review in his original Section 21 statement[134] and further in his addendum statement[135].

106. With regard to the provision of radical cystectomy for bladder cancer, there was consternation on the part of both Mr O'Brien and Mr Akhtar regarding the late notice given for the transfer of patients to Belfast, patients who were understandably dreading yet further delay in their treatment. Perhaps the more significant issue from a

[133] WIT-82743
[134] WIT-82550 paragraphs 425 to 429
[135] WIT-107570

governance perspective is that Mr Hagan's view that patients had been poorly managed was not raised with the treating clinicians, even though Mr Hagan advised that this was the substantive issue. The only issue Mr O'Brien was made aware of was the content of contemporaneous correspondence. Once again, without access to or the provision of complete clinical records, Mr O'Brien has been disabled from assisting the Inquiry regarding these patients.

107. Mr O'Brien addressed the case of Patient 127, who had a bladder tumour resection in February 2016, and the consequent correspondence sent to the Trust, in his addendum statement[136]. Mr O'Brien emphasised in his addendum statement that the concern expressed in relation to the delay in referral of this patient due to her having a bone scan was indeed subsequently discussed at MDM. He also accepted in his evidence to the Inquiry that a response to the Belfast Trust should have been provided[137], confirming that the Southern Trust MDT had taken on board that bone scanning was not indicated in the staging of bladder cancer.

108. Mr O'Brien also explained in his addendum statement that a reason he was able to recall this case having been discussed at MDM was the MDT noting that it would probably have made little, if any, difference concerning decisions regarding the patient's further management if there had been no delay in the patient's referral. This patient was one of a number of patients considered by Southern Trust clinicians to be fit for radical cystectomy only to be considered unfit by Belfast Trust clinicians. This was an issue addressed with the Regional MDT on individual occasions previously, and since, to no avail. Nevertheless, Mr O'Brien regrets that he did not avail of the opportunity provided by this case to advocate for this patient, as he had done previously, by responding to the Belfast Trust, raising this governance issue.

Glycine

109. Mr O'Brien was entirely open about his ongoing use of glycine and the patient safety issues he had encountered when he performed bipolar, as opposed to monopolar[138], resection of the prostate. Again, it would be unfair to criticise Mr O'Brien

[136] WIT-107591 paragraphs 83 to 89
[137] TRA-12458 - 12459 10th April
[138] TRU-395975

for continuing to use a method of resection that was certainly facilitated by the Trust, in the absence of a formal direction to stop doing so, and where he had made the Trust aware of the patient safety concerns he experienced when trialling the new system. As he told the Inquiry, he was at all times vigilant in relation to biochemical derangement[139] and there is no evidence of any adverse outcomes from his continued practice of using glycine as an irrigating fluid during endoscopic resection.

Formal (MHPS) Investigation

110. Mr O'Brien was called to a meeting on 30th December 2016, whilst on sick leave Personal Information redacted by the USI, at which he was informed he was to be excluded from the workplace. The panel has heard about the traumatic impact this draconian action had upon him[140] and the lack of support on a human level for him as a long serving Trust employee. It is understood the MHPS process remains subject to review, and it is hoped that the review will reflect on the impact a decision to exclude can have on the individual practitioner and recommend a robust system to ensure the safety and wellbeing of those who are subject to such a step.

111. Nevertheless, the Inquiry will be aware of a presentation prepared by Ms Zoe Parks, Head of Medical HR, in advance of a Workshop in 2023, notably entitled 'Handling a Concern about a doctor or dentist to Maintain High Professional Standards'[141]. In the 'Overview of MHPS', Ms Parks records that MHPS was introduced by DHSSPS Circular, that it became effective from 1st December 2005, that a formal departmental direction requires all Trusts to comply with MHPS and that MHPS is incorporated into contracts of employment of individual doctors.

112. It is worthy of note that DHSSPS communicated with all Trusts in Northern Ireland on 30th November 2005 requesting that all Trusts advise the Department of their implementation of MHPS by 31st January 2006. In her witness statement of 26th September 2022, Dr O'Kane advised that she in turn had been informed by Ms Parks that neither the Southern Trust nor the Department of Health held any records confirming that the Trust had notified the Department of its implementation of MHPS[142].

[139] TRA-12507 Mr O'Brien morning of 12th April 2024
[140]TRA-04833 Mr O'Brien 20th April 2023 after lunch
[141] TRU-411613
[142] WIT-57941

It is doubtful if the Trust did ever advise the Department of its arrangements for implementation, and there is no record of MHPS having been incorporated into his contract of employment of individual doctors. Mr O'Brien certainly did not receive any communication from the Trust to that effect. Indeed, he had never heard of MHPS until he met with Dr Wright and Ms Hainey on 30 December 2016.

113. The emphasis of Ms Parks' presentation in 2023 was "ensuring that people are properly trained and competent to carry out their roles"[143]. Yet when Dr O'Kane provided in her witness statement of 26 September 2022, a record of the training received by those who decided at the meeting of the Oversight Group on 22 December 2016 to commence a Formal Investigation in accordance with the Trust Policy of 2010, none attending had received formal training in the MHPS framework[144]. While there was no record of Dr Wright having been formally trained, Dr O'Kane could recall that he had attended training with her when they were both Assistant Medical Directors in the Belfast Trust in or around 2014[145]. Remarkably, while Ms Vivienne Toal herself had not received any formal training in MHPS, she had been involved in training others in the Trust Guidelines of 2010[146]. While Dr O'Kane recorded that Mr Simon Gibson had received training on an unspecified date in August 2016, it would appear that this was through "formal and informal discussions, updates and assurances" provided by the Medical Director, by the Operational Director who had not received any training, and by the Director of HROD who had not received any training[147].

114. The presentation for the Workshop in 2023 emphasised that it was "imperative that exclusion is not misused or seen as the only course of action"[148]. The presentation related that the subject is much debated in case law, citing the case of Kamath v Blackpool Teaching Hospital 2021 in which it was stated that *'an act of [exclusion] by an employer can constitute a breach of the implied term where, by in combination with other acts or omissions it (i) destroys or seriously damages the relationship of trust and confidence and (ii) is without reasonable and proper cause'.* The Inquiry is invited to find that this exactly summarises the consequences of Mr O'Brien's exclusion.

[143] TRU-411618
[144] WIT-57959
[145] WIT-57959
[146] WIT-57961
[147] WIT-57962
[148] TRU-411621

115. Mr O'Brien commented on the MHPS process in his Section 21 statement[149] and in his Response to Report of Formal Investigation[150] which, together with all of the appendices attached thereto, is commended to the panel in its entirety. In combination with the above comments, it is Mr O'Brien's position that the concerns which the Trust raised with Mr O'Brien by letter in March 2016 were not managed at all as they should have been and were then managed by a formal investigation from December 2016 until October 2018, with exclusion until 26 January 2017, when they could have been managed informally. The panel is also invited to consider the negative impact which the period of exclusion had upon the arranged management and review of patients, all of which was cancelled and for which Dr Wright reassured Mr O'Brien he would take responsibility, but evidently did not do so.

116. The panel is also reminded of the grievance[151] submitted on Mr O'Brien's behalf. From a governance perspective, Mr O'Brien's concerns are set out in his Section 21 statement and in the grievance and so are not repeated herein. The time taken to complete the underlying investigation and then resolve the consequent grievance was unacceptable. By his contract of employment, the grievance process required to be completed in 20 working days of its presentation on 28 November 2018. His grievance had yet to reach a hearing by the time the Trust ended his employment 20 months later, in July 2020. This speaks volumes about the robustness of the Trust's governance policies and procedures. The time taken to complete the underlying investigation and to then resolve the consequent grievance was not only utterly unreasonable but, in breach of his contract of employment, entirely unacceptable. In addition, Mr O'Brien had this process hanging over him from 30th December 2016 until his employment was ended by the Trust in July 2020. The process was not concluded until months later.

117. The panel is equally reminded of the fact that Mr O'Brien's grievance of November 2018 clearly included an appeal of the Case Manager's Determination that he should be referred to a Conduct Hearing. This appeal was not considered or heard prior to termination of his employment in July 2020.

[149] WIT-82517 to WIT-82620
[150] AOB-10585
[151] AOB-15001 -15316 & AOB-02561 -02572

118. Most importantly, the grievance disclosed grave concerns of public interest. These were not considered or addressed by the Trust prior to termination of Mr O'Brien's employment in July 2020. However, Ms Shirley Young, Chair of the Grievance Panel, drew attention to this disclosure that could have been regarded as whistleblowing on 15 July 2020[152], two days prior to his last day in the employment of the Trust.

119. The panel will have noted the failure of the Trust to comply with the Case Manager's Final Conclusions/Recommendations regarding the systemic failures on the part of the Trust that were identified by the investigation report:

> "The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.
>
> …
>
> In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings."[153]

120. Pauline Leeson, who has been a Non-Executive Director of the Board since 2017, was only provided with Mr Khan's report which called for an independent review shortly before she gave evidence to the Inquiry in January 2024. The report had not been shared with the Trust Board. Mr Pengelly confirmed it had not been shared with the Department[154]. In short, the evidence suggests that the above recommendations critical of the Trust were ignored.

121. It also resonates with the Trust likewise failing to correct the false allegation that "2 out of 10" patients had not been added to the waiting list for readmission when

[152] TRU-292396
[153] TRU-158356 – TRU-158357
[154] TRA-10419 - 10421 Pengelly 16th Jan 2024

they should have been. The fact that this allegation was false had not been brought to the attention of the Board by January 2024. These failings are indicative of a Trust that is content for individual clinicians to shoulder personal responsibility for shortcomings without addressing the broader picture when systemic failings have been identified and brought to its attention.

122. Nevertheless, Mr O'Brien applied himself to the best of his ability to address the issue of triage, one of the concerns that gave rise to the Formal Investigation initiated in December 2016. He did this at considerable cost, foregoing one day's annual leave following each UOW, and so that the priorities of UOW were not compromised by triage.

123. Mr O'Brien was unaware that Mr Haynes had been escalating such a breach of the Return-to-Work plan concerning triage to Dr O'Kane in March 2019 until the escalation by email was disclosed by the Inquiry.[155] Mr Haynes reported that there were still 79 referrals awaiting triage on 31st March 2019, including 16 red flag referrals, four days following competition of Mr O'Brien's UOW. He included a screen shot of seven patients awaiting triage since 26th March 2019. He advised Dr O'Kane that he was unaware of the reporting and escalating that may have occurred following Mr O'Brien's return to work.

124. This contrasts with the screen shots of referrals awaiting triage by Mr Haynes, by Mr Young and by Mr O'Donoghue on 7th June 2020.[156] Mr Haynes had urgent referrals awaiting his triage dating back to 20th April 2020, almost seven weeks previously, and at least one red flag referral awaiting his triage since 13th May 2020, over three weeks previously. It is not known if there has been any reporting or escalation or governance related action in relation to these referrals awaiting triage over these periods.

125. Mr O'Brien has acknowledged that he struggled to dictate letters on all patients on the days when they attended his outpatient clinics, as he was increasingly unable to remain in the hospital in the evenings to do so, due to having increased caring commitments within his family, as was acknowledged in September 2019. However,

[155] TRU-251571 – TRU-251573
[156] WIT-83408

he endeavoured to promptly dictate letters regarding those patients whose management required to be progressed in a timely manner.

126. Mr O'Brien has refuted the allegation that he had prioritised the admissions of patients who had attended privately, and which was first raised by Mr Haynes in his email to Mr Young and Mrs Corrigan in May 2015[157]. Mr O'Brien has always rigorously endeavoured to arrange the management of all patients, including their admissions for treatment, in order of their clinical priority rather than in the chronological order of their position on waiting lists, as these have been crudely insensitive to clinical need and priority. His practice did not change in that regard during or following completion of the Formal Investigation.

Key Workers

127. In his Section 21 statement[158] Mr O'Brien reflected upon the significant contribution made by the CNSs over time including Kate O'Neill, Jenny McMahon and Leanne McCourt. It had been his understanding that the urological medical and nursing staff had worked well together, enjoyed good relations and "were supportive of each other in endeavouring to provide the best care they could to those most in need of it". In her evidence, Kate O'Neill confirmed that they had an excellent working relationship with Mr O'Brien[159].

128. As Mr O'Brien observed in his addendum statement,[160] the allegation that he did not value the role of specialist nurses has probably caused him more hurt than any other. Through the work of CURE, he contributed significantly to a process that enabled urology nurses to gain valuable knowledge, expertise and experience[161]. The suggestion that he would then take steps to positively exclude them from providing assistance is as illogical and profoundly offensive as it is highly unlikely. Kate O'Neill in her evidence said this did not happen[162]. Leanne McCourt said she was in fact the

[157] TRU-274504
[158] WIT-82488 at paragraphs 248 to 251
[159] TRA-12043 16th May 2023
[160] WIT-107605 at paragraph 127
[161] WIT-107605 at paragraph 128
[162] TRA-12069 - 12070 16th May 2023

key worker for a number of Mr O'Brien's patients[163]. The panel will recall Ms McCourt took exception to the suggestion she had said Mr O'Brien did not understand the role of key worker/CNS and felt that she had been misrepresented. She said Mr O'Brien absolutely did understand and value the role[164].

129. In his original Section 21 statement,[165] Mr O'Brien set out the terms of the Trust Urology Cancer MDT's Operational Policy of 1st September 2017[166] which states that it is the joint responsibility of the MDT Lead Clinician and the MDT Core Nurse Member to ensure that all newly diagnosed cancer patients have a key worker allocated. Mr O'Brien was first aware that there was any issue or criticism of patients not having had a key worker allocated upon sight of the SAIs. No one had raised this issue with him beforehand.

130. Mr O'Brien has also set out in detail in his addendum statement how concerned he is as to how the narrative around this particular issue developed during the course of the SAI review. The panel is invited to consider his observations in some detail. Kate O'Neill expressed concerns in her evidence to the panel,[167]as did Patricia Thompson[168].

131. Kate O'Neill also flatly denied suggestions put to her based on the evidence of Mrs Corrigan and Mr Carroll who, she said, had "no understanding" of their working relationship with Mr O'Brien, and "never witnessed it".[169] Patricia Thompson also rejected the evidence of Mr Carroll that they were afraid of Mr O'Brien. That was not something she had ever heard or ever said[170].

132. In 2015, the Northern Ireland Cancer Patient Experience Survey 2015 showed that in the Southern Trust only 68% of patients were given the name of the CNS in charge of their care[171]. This was a Trust-wide inadequacy. There were clearly systemic issues at play, which is reinforced by the evidence of the nursing staff themselves.

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[163] TRA-05453 Leanne McCourt 17th May 2023
[164] TRA-05468 Leanne McCourt as above
[165] WIT-82582 at paragraphs 536 to 537
[166] AOB-03859
[167] TRA-12068 - 12070 16th May 2023
[168] TRA-07713 - 07718 14th Sept 2023 post am break; Professor O'Sullivan also had to correct a note of a discussion with Mr Hughes which had failed to accurately reflect his evidence – see TRA-08006 – 08007
[169] TRA-12094 - 12095 16th May 2023
[170] TRA-07726 - 07727 14th Sept 2023
[171] WIT-98668

133. In her statement, Kate O'Neill observed as follows[172] :

> "I do not consider that the role and functions of the CNS were resourced properly from the outset. The absence of a unit manager, lack of dedicated clerical support and being counted within core nursing staff for all clinical activity severely restricted my ability to progress, advance and develop my role in providing independent nurse led services and to provide adequate keyworker input. The prolonged process to appoint additional CNS members contributed further to delays in further service development.
>
> As service development progress was delayed, the impact upon patient care would have been most evident in the inability to provide keyworker input for every patient with a cancer diagnosis."

134. See also the witness statement of Leanne McCourt[173] where she states:

> "My view of why there was an absence of or inadequate CNS provision is there was a chronic, longstanding underfunding of this area of the workforce…"

Mr O'Brien reminded the Inquiry in his addendum statement of the terms of the MDM Operational Policy, where the responsibility for the allocation of a key worker is set out. It would be quite wrong, therefore, to conclude that Mr O'Brien bore responsibility for their allocation, and, equally, the panel will want to consider how it could have remained the case that patients may not have had a key worker allocated as and when they had further clinical input for which Mr O'Brien was not responsible[174]. In her evidence to the Inquiry, Patricia Thompson referred to the fact that there were other points in the patients' pathways where other practitioners were involved and when nurses could have been allocated as key workers. She was of the view that the SAI findings might better have represented those points rather than blaming Mr O'Brien as the only individual[175]. There were clearly systemic issues involved.

Bicalutamide

[172] WIT-80935
[173] WIT-85941
[174] WIT-107611 at paragraphs 146 to 150
[175] TRA-07721 Thompson 14th Sept 2023

135. Mr O'Brien addressed the issue of Bicalutamide in relation to individual patient cases in his original s21 statement[176]. He also provided a very brief synopsis of the historical development of the anti-androgen, Bicalutamide, and of its use in the management of prostate cancer in his addendum statement of March 2024[177]. The panel is invited to consider the same. The panel also has the benefit of the expert reports and oral testimony of Prof Kirby where he expressed supportive views on Bicalutamide use by Mr O'Brien. In his primary witness statement of November 2022, Mr O'Brien reported in good faith that he had never been challenged for using Bicalutamide 50mg. However, in his addendum statement of July 2023 he reported that he had since discovered an email sent by Dr Mitchell, Consultant Oncologist at the Cancer Centre at Belfast City Hospital, in November 2014 requesting that Mr O'Brien look into the circumstances that gave rise to a patient having been initially prescribed Bicalutamide 50 mg daily for high risk, organ confined, prostate cancer in 2012, before having the dose increased to 150 mg daily one year later and on which he remained until his referral for radiotherapy in 2014[178].

136. Mr O'Brien regrets that he is unable to recall whether he was aware of Dr Mitchell's email, whether he replied to it in writing rather than by email, though he is unable to locate the latter. He remains keen to address the issues surrounding this patient, for which he would require the complete, up-to-date, clinical records.

MDT/MDM

137. The suggestion that Mr O'Brien was practising in a 'uni-professional' manner or found the MDT process difficult to embrace as it required him to 'surrender his autonomy' as a practitioner, is simply not borne out by the evidence. His commitment to the MDT process is beyond question. He was its lead for years, prepared for MDMs assiduously and attended meetings regularly, which is more than can be said for colleagues from other specialties. As he described in his evidence, he made every effort to make the meetings as comprehensive as possible[179]. As stated previously, preparation for MDM was rendered all the more time consuming due to his colleagues

[176] WIT-82631 to WIT-82641
[177] WIT-107571
[178] AOB-71990
[179] TRA-12517 - 12518 Mr O'Brien morning of 12th April 2024

refusing to provide a clinical summary or updates as required, instead of or in addition to providing a copy of a dictated letter to the patient's GP.

138. Whilst there is reference in the lookback exercise to some cases not being recorded as having been discussed at MDM, in the absence of a detailed examination of the patient records and the systems extant at the time for recording MDM discussion (one of which reviews discussed in evidence did not even include the year when it may have happened[180]), it would be wrong to conclude that it was Mr O'Brien's culture or practice not to refer patients to MDM. That is simply not the case. There has been no evidence led from people who actually attended MDMs that Mr O'Brien's cases were not routinely discussed. In fact, there is clear evidence to the contrary. See the evidence of Vicki Graham[181], including her rebuttal of the claim made by it seems, Mr Carroll, that staff avoided challenge at MDM.

139. An element of this arises from the SAI review process where Dr Hughes produced a note of a discussion with Professor O'Sullivan in which he had recorded Professor O'Sullivan as having said that Mr O'Brien "did not engage" with the MDM process. Professor O'Sullivan told the Inquiry that he definitely did not say that Mr O'Brien "did not engage"[182]. See also the email from Mr O'Brien to Dr Mitchell in March 2015 expressing the frustration of the Trust's clinicians that the Belfast Trust's radiologists did not remain for discussion of cases in the Regional MDM[183].

140. In his evidence to the Inquiry, Mr O'Brien expressed his grave concern at the claim by Dr Hughes that patients entered a contract with the MDT to have their management directed or dictated by the MDT, and that the MDT required to be informed and to sign off any divergence from its decisions. While he acknowledges that Dr Hughes resiled from use of the term "contract" when challenged, Mr O'Brien nevertheless maintained that he has been unaware of any patient being informed of or being asked to consent to his/her management being determined by a MDT. Moreover, it would be wholly improper for that to be the case as it would be tantamount to asking a patient to surrender their own bodily autonomy.

[180] TRU-309747
[181] TRA-11988 16th May 2023
[182] TRA-08003 Prof Sullivan 20th Sept 2023
[183] AOB-72888

141. However, there possibly remains a subtle suggestion that the decisions concluded at MDM to be recommended to the patient carry a weight consequent upon their being agreed by a MDT, that the patient's right to disagree with the recommendation is less rational, and to the extent that their right to their own autonomy is compromised. But their right to autonomy is inalienable. This was eloquently articulated by Sir Brian Langstaff in delivering his Final Report of the Infected Blood Inquiry on Monday 20 May 2024 when he said:

> "Respecting people's right to control what happens to their own body has always been an ethical cornerstone of medicine, always. A booklet produced by the Medical Defence Union in or around 1953 explained that consent had to be quote "genuine consent, a real expressed willingness by the patient to undergo the treatment after its nature, its risks and its objective have been clearly explained". In 1980, the British Medical Association's handbook on medical ethics said "consent is freely given if the patient understands the nature and consequences of what is proposed" and the next year they added, quote "doctors offer advice but it is the patient who decides whether or not to accept the advice".[184]

142. This is a wholly different matter from that of the responsible clinician providing the patient with the recommendations of MDT at subsequent review, and of systems in place to ensure that has been done. Mr O'Brien has been explicit in his primary witness statement and in evidence to the Inquiry that he always took the time to ensure that each patient had a complete understanding of all the management options available to him/her, the benefits and risks associated with each, including those recommended by MDT, and the reasons for the recommendations. He asserted how those recommendations may have had to be modified in view of factors, such as comorbidities, not wholly known to MDT on arriving at its recommendations. He advised of his practice of ensuring that patients were afforded the time to arrive at their own decisions. It would have been beneficial if a key worker had been appointed and available to attend consultations with each patient, or alternatively had contacted the patient subsequently to ensure that their understanding was complete, as a component of their holistic needs assessment.

[184] https://www.youtube.com/watch?v=x3c_zZAh4TE

143. As the panel has heard, there was no general practice or mechanism to bring patients back to the MDM where different treatment was required[185] or the patient may have chosen different treatment[186] from that recommended by the MDM. Professor O'Sullivan gave evidence about how often the recommendation from MDM may not be overly-prescriptive in terms of the type of hormone therapy and referred to how one might "ideally" re-discuss at MDM[187]. Professor Kirby used the same phraseology[188]. There was no hard and fast rule about the situations in which a clinician was required to bring patients back to MDM, and no formal process in place to do so. It is nevertheless clear that the circumstances at the Trust were not ideal circumstances in which to re-consider significant numbers of cases given how busy clinicians and the MDM was trying to address new patient cases.

Pre-operative Assessment

144. The issue of pre-operative assessment was highlighted by the case of Patient 90 who sadly died following bilateral ureterolysis. He did not have a formal pre-operative assessment performed during the period that had elapsed since being placed on Mr O'Brien's waiting list on 7th June 2017 for urgent readmission and his elective admission on 9th May 2018 being arranged on 3rd May 2018 as documented in the report of the Root Cause Analysis of the subsequent SAI investigation[189].

145. An appointment was arranged for Patient 90 to attend for pre-operative assessment on the afternoon of 4th May 2018, but he did not attend. The patient had been deemed fit to proceed but Mr O'Brien did not appreciate that he had not had a pre-operative assessment until the SAI investigation was conducted. It is regrettable that he did not have, as even a preliminary assessment may have raised concerns with regard to proceeding with surgery within days.

146. Mr O'Brien wrote of his regret that he had not noted pre-operatively the reported findings of CT scanning indicative of cardiac disease when previously under the care of physicians, as he would have referred Patient 90 for further cardiac assessment prior

[185] See email from Patricia Kingsnorth at TRU-09830
[186] TRA-12532 - 12533 Mr O'Brien morning of 12th April 2024
[187] TRA-08020 - 08021 Prof Sullivan 20th Sept 2023
[188] TRA-09366 Prof Kirby
[189] TRU-255064

to surgery. He has since expressed his regret that he did not additionally refer him for a haematological assessment in view of the history of myelodysplasia. Mr O'Brien acknowledged his responsibilities and failings in optimising the condition of Patient 90 for surgery. In his evidence to the Inquiry, Mr Glackin reported that Mr O'Brien personally presented this case of mortality as an SEA and that he reflected upon it openly[190]. Mr O'Brien very much regrets the outcome.

Results, Reports and DARO

147. The principle that clinicians should carry a responsibility for reviewing and acting appropriately upon the results and reports of investigations which they have requested for their patients is common sensical. It can also be complicated by various scenarios, such as consultant clinicians being expected to carry the responsibility for investigations requested by their junior clinical staff or the need for other clinicians to take responsibility when the requesting clinician is on leave.

148. Mr O'Brien related in his primary witness statement the evolving context that gave rise to the expectation that clinicians would review and act upon the results and reports of investigations[191]. By 2010, as in all aspects of the urology service provided by the Trust, there was an increasing disparity between the numbers of patients requiring outpatient review and the capacity to do so. The risks arising from the diverging capacity to review patients with the reports of requested investigations was highlighted by the case of Patient 95.

149. Mr O'Brien has related in detail in his addendum statement of March 2024 how the response to the recommendations in the report of the SAI investigation resulted in an expectation by the Trust that all results and reports of investigations would be reviewed and acted upon by the requesting clinicians[192]. Mr O'Brien raised his concerns regarding the practicalities, reliability and capacity of clinicians and secretarial staff to accept this additional responsibility[193]. He also referred to his concern regarding the time which would be required to undertake the responsibility, a quantum of time which had yet to be quantified, in preparation for a facilitation meeting concerning job planning

[190] TRA-08193 Glackin 21st Sept 2023
[191] WIT-82414
[192] WIT-107564
[193] TRU-276805

in September 2011[194]. The outcome of facilitation was a reduction in time for administration in Mr O'Brien's job plan rather than an increase to undertake the additional responsibility[195].

150. The Trust expectation that all results and reports would be reviewed and acted upon was formalised as Discharge Awaiting Result-Outpatients (DARO). Though deprived of any time to undertake the review of results and reports, Mr O'Brien certainly did review results and reports, but simply did not have the time to review all of them. When pressed by Counsel to the Inquiry about what he did with his own practice Mr O'Brien's response was telling: "I tried to do more of all of it"[196].

151. Mr O'Brien has explained that he did use DARO on the misunderstanding that the DARO was applied to those patients whose definitive discharge from review was anticipated, but pending a final investigation being reported to be normal. It was not until February 2019 that he learned that DARO was applied to every outpatient who had an investigation requested and that none of these patients were to be placed on any waiting list of any kind until the result or report was reviewed and acted upon. This interpretation of its application was a misinterpretation of the original intent that DARO was only to be applied when the patient's further management could not be determined until the result or report of the investigation was reviewed.

152. The Inquiry is familiar with Mr O'Brien's expressed concerns[197]. Mr O'Brien's concerns were amplified by the discovery later in 2019 that DARO was also being applied to all patients referred and who had any investigation requested upon triage. These patients were to be discharged before they ever had an outpatient appointment. It was further alarming to discover that Mr Young had expressed concerns about the same action in 2015[198].

153. The Inquiry is aware that the Trust met in January 2020 to consider the issue of the dictation of letters following review of patients and following review of results and reports. The Trust acknowledged that there were no written standards in relation to what was considered reasonable for dictation of results and letters after dictation. The

[194] AOB-00308
[195] AOB-00326
[196] TRA-12473 10th April pm
[197] WIT-22785
[198] TRU-274539

Trust had never stated a standard (even though one had been imposed upon Mr O'Brien in 2017) and the Trust was unaware of any standard set externally by Royal Colleges or other organisations[199].

154. Mr O'Brien regrets that he had not had the time to review all results and reports of all investigations over the years, despite trying "to do more of it all". He very much regrets that he had not reviewed the report of the CT scan of Patient 95 in 2010, and that of Patient 92 in 2018.

Structured Clinical Record Reviews (SCRR)

155. Mr O'Brien is in considerable difficulty being able to comment upon the SCRR process given the relative lack of information in relation to the cases, including the criteria for selection. He is equally in difficulty in relation to SAIs.

156. Mr O'Brien has not had an opportunity of scrutinising the records of the patients and their care, with a view to disputing or accepting the findings and particularly whether the findings are accurate reflections of their care. As a core participant in the Inquiry, it has deprived Mr O'Brien of contributing to its mandate to provide comprehensive recommendations concerning governance of patient care and safety in the urology service at the Southern Trust.

Termination of Employment

157. In February 2020, Mr O'Brien decided that it was time to reduce his working hours and move to part time employment. It is a common practice for consultants to end full time employment, draw down their pension and return part time, particularly in view of the desperate need for doctors to meet the ever-expanding health care needs of patients. Mr O'Brien proposed that he would cease full time employment at the end of June 2020, take July 2020 off and return in August 2020 to work part time.

158. On the 8th June 2020, Mr Haynes advised Mr O'Brien by telephone that he would not be permitted to return to work after 30th June 2020. It was suggested that

[199] TRU-251814 – see under 'Expectation re compliance'

there was a practice in the Trust that employees who have outstanding HR processes are not allowed to return to work. This was another example of the harm caused to Mr O'Brien by the Trust's failure to deal with his grievance, which had been outstanding for 20 months, and any disciplinary hearing that may still have to have taken place following the conclusion of the grievance. These are real material consequences of the Trust's mishandling of the MHPS investigation, failures in governance and the damage done to the relationship between the Trust and Mr O'Brien.

Recommendations

159. This Inquiry has been precipitated by concerns raised about and has revolved around the 'clinical practice' of Mr O'Brien. The Inquiry has heard of Mr O'Brien's inability to compartmentalise his 'clinical practice', unable to ignore the plight of patients suffering on long waiting lists for first outpatient appointments when it came to triage, or on even longer waiting lists awaiting admission for treatment. What are the perimeters of 'clinical practice'? Is it the case that it can ethically be confined to a distinct zone of activity, legitimately and defensively disregarding or transferring the audible plight of those beyond the perimeter? It would be of great service to current and future clinicians for the Inquiry to consider recommendations concerning the confines or boundaries of clinical practice, if there are any.

160. Healthcare professionals should be encouraged to report their concerns regarding the adequacy and safety of services commissioned and provided to their patients to bodies such as the Regulation and Quality Improvement Authority and the General Medical Council, wholly independent of the Department of Health, the commissioning body and the employing Trust.

161. Serious Adverse Incidents (SAIs) may legitimately be precipitated by 'incidents' but often do not adequately address the patient's experience in a longitudinal manner. SAIs have been 'incident centred' rather than 'patient centred' for too long. The Inquiry could consider recommending that SAI be renamed as Serious Adverse Experience (SAE) which of course does not exclude the investigation of an incident.

162. The Inquiry is requested to advise that it be mandatory for all doctors and dentists to have formal and regular training in their employers' policies for Managing

Concerns and in the MHPS Framework (or any successor) so that all are fully acquainted with them.

Summary

163. It is indisputably the case that the urology service directed by the Department of Health, commissioned by the Health & Social Care Board and provided by Craigavon Area Hospital Group Trust and by the Southern Health & Social Care Trust has been disproportionately inadequate over a period of 30 years, to the extent that it has caused very many patients to suffer for prolonged periods of time, during which they remained at increasing risk of coming to increasingly severe harm. It has been regrettable that has been the case.

164. Mr O'Brien and his colleagues have done their utmost to bring the plight of these patients to the attention of all those ultimately responsible for their care. Mr O'Brien and his colleagues have worked relentlessly for many years, endeavouring to reduce suffering and the risk of harm.

165. Mr O'Brien repeats his regret[200] that he could not have done more that would have made a positive difference. Most importantly, Mr O'Brien regrets any suffering or harm that patients may have experienced due to any decisions, actions or failings on his part.

31 May 2024

G Boyle KC, R Millar, and Tughans

[200] TRA-12664