Urology Services Inquiry

Oral Hearing

Day 75 – Wednesday, 6th December 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

INDEX

	PAGE
Mr. Michael Young	
Examined by Mr. Wolfe KC (cont'd)	3
Lunch adjournment	70
Questioned by the Inquiry Panel	115

THE INQUIRY CONTINUED, AS FOLLOWS, ON WEDNESDAY, 6TH DECEMBER 2023

CHAIR: Good morning, everyone.

10:01

CONTINUED EXAMINATION OF MR. YOUNG BY MR. WOLFE KC:

1 Q. MR. WOLFE KC: Good morning, Mr. Young. I had a nightmare last night that I was about to question Boris Johnson this morning. That must be some other 10:02 Inquiry.

Just to recap, yesterday we spent some time focusing on the four issues that went to make up the MHPS investigation and I suppose focusing on three of those 10:02 at least, leaving aside the private patients issue. I think you would accept that the three other issues, charts at home, triage, dictation, together might indicate that Mr. O'Brien appeared to be a doctor in difficulty, a doctor who wasn't meeting the standards 10:03 that were expected of him and I think you accepted towards the end of our discussion that more could have been done by you, by other people, to address this, to challenge this, and you, I think, indicated that Mr. O'Brien was not necessarily an easy person to 10:03 challenge.

I want, in the course of this morning, to pose a question in terms of why the issues in relation to

Mr. O'Brien were not detected or addressed at an earlier stage. We'll come on and look at whether appraisal was a useful tool.

You took over appraisal duties with regards to Mr. O'Brien from 2010, with the introduction of the appraisal system. But before we get to that, there's a couple of other issues I wish to explore with you under this broad heading of why the issues surrounding Mr. O'Brien didn't get addressed sooner. I wonder whether you would agree with me that some early warnings were ignored. 10:04 10:04

In that Respect I want to raise with you the evidence given to the Inquiry by Mr. Christopher Hagan, who you will be aware has given a statement to the Inquiry and given evidence. I want to take up his witness statement with you at WIT-98844 and at paragraph 26, just to recap, he recalls that he was a Urology Specialist Registrar in the Craigavon Hospital as part of his rotation. He was there in the year 2000 and he goes on, at paragraph 27, to explain that there was a Thursday morning ward round, that you and Mr. O'Brien had your own sets of patients. He attended this ward round. It meant that you and Mr. O'Brien were involved with each other's patients, that you would have had a knowledge of each other's patients and would have covered for each other at various times. 10:04 10:05 10:05

He goes on at paragraph 29 to set out the fact that he had nine areas of concern in respect of Mr. O'Brien's practice, which he sets out in his witness statement. If I could just list those so that you are oriented.

10:06

He had concerns about IV antibiotic use. He had concerns about a benign cystectomy performed on a patient, apparently simply because she had recurrent UTIs, that's his recollection. He had concerns about the performance of long TURPs, one case going up to nearly two hours in the procedure. Concerns about ureteric stone management and a particular incident where he perforated a ureter. He had concerns about paediatric urology, a radical prostatectomy, concerns about a penile disassembly process, and concerns about outpatient practice administrative delay. So a host of issues set out in his statement.

10:06

10:07

Then, if we just scroll down to paragraph 32, so these are the list of issues I've just read out. Just WIT-98852. He says:

10:07

"I did raise issues with Mr. O'Brien about his practice during my time as a surgical trainee. Mr. O'Brien did not agree with me and was essentially dismissive. I did also raise issues with Mr. O'Brien with his consultant colleague, Mr. Young, during my rotation. This would have been in an informal manner, and I would not have recorded them in written form. It would not

10:08

have occurred to me at the time to do that. It means that I cannot now say precisely what I raised with Mr. Young, or how precisely I said it. My recollection of Mr. Young's response to what I said was 'that's just Aidan'. Mr. Young did not give me the impression that he had any major concerns about the matters I was raising. I don't know if Mr. Young spoke to Mr. O'Brien about anything or if Mr. Young spoke to anyone else about them. I certainly thought at the time that I was brave in speaking to both the consultant himself and to the consultant colleague." 10:08 10:09

If I can leave that there. So your position, as I understand it from your addendum statement, Mr. Young, is while you recall Mr. Hagan's presence at Craigavon as part of his rotation, you don't recall him raising any serious concerns with you? 10:09

A. This goes back 23 years.

2 Q. Of course, yes?

A. And it's a bit hard to get a full recollection of a precise conversation. I don't recall Mr. Hagan raising any of these sort of major concerns. I know that on ward rounds he would be talking about certain patients and I certainly do remember Mr. Hagan and Mr. O'Brien having -- well, both had an interest in prostate cancer and they would have had conversations about treatment plans and the way that it is looked after, but I don't recollect specific points raised by Mr. Hagan here on these points. 10:09 10:10

3 Q. I just want to show you how you put it in your statement. If we go to WIT-103605. Conscious that Mr. Hagan introduces the important caveat that he cannot specifically recall what he specifically raised with you, but it's the sense of his evidence that he 10:11
believes that he raised some of these significant issues with you. You have said there at 1.01:

"There is always the expectation that a registrar, as part of their training, will inquire about care 10:11
pathways for patients. For instance, I recall Mr. Hagan would have discussed prostate cancer management with Mr. O'Brien on ward rounds."

What you have just said a moment or two ago. 10:12

"However, I did not ever interpret this as a concern and I do not recall Mr. Hagan during his six-month attachment ever raising any serious issues because I would have acted upon them." 10:12

We saw yesterday that in terms of the issues that you were aware of, your actions upon them were, I think you would agree, fairly minimal and certainly lacking in any great aggression and they weren't resolved. When 10:12
you say here you would have acted upon them, on what basis would you have acted upon them? How would you have acted upon them if, for example, you were aware of the operation performed on the patient for recurrent

UTIs, the removal of her bladder, benign cystectomy. How would you have acted upon that if you had been aware of it?

A. I would have inquired about why the procedure was performed in the first place from Mr. O'Brien. I am aware of the antibiotics and fluids being used to treat urinary tract infections, that's a detailed discussion, but to do a cystectomy purely for an infective reason is very unusual. I must say, I have had one case myself that I've undertaken a cystectomy for, but that was very detailed. That's one case in 30 years. 10:13 10:14

Now, at this stage I was just a consultant 18 months or a year, I think, so I was taking on board what was being undertaken in the unit, but I am unaware of the precise nature of the case that you are referring to. There are patients who have had a cystectomy who do get urinary tract infections, it is relatively common. So I was maybe taking it that if this case was in front of me that this was an ileal conduit patient who was having a recurrent urinary tract infection as part of that history, but I'm not aware of the case that you're referring to of why she had a cystectomy, I'm afraid. 10:14 10:15

But if you are telling me that it was done for an infective perspective, yes, I would have been more interested in finding out the past history to the case. 10:15

4 Q. Well, let me put it in these terms. Mr. Hagan at that time was a trainee. It would have been unusual, would

it not, for trainees to be as vocal as he claims to be in his statement? In other words, he claims to have raised, both with you and with Mr. O'Brien, a range of issues of concern. That would be unusual for a junior?

A. It would be unusual for a junior. I haven't had any other juniors raising such a list of questions. 10:16

Q. Yes. While you don't recall precisely, it being 23 years ago, do you recall Mr. Hagan as being a particularly interested and perhaps vocal trainee in terms of raising issues? 10:16

A. Mr. Hagan's demeanour of putting a question across, sometimes you didn't realise if he was asking a question or making a statement. That's maybe just a personality thing at the time. I do agree that, as a registrar, as I was a year or two before that, sometimes it is hard to raise things and it takes a bit of courage to actually challenge something, so I do agree with that statement. 10:17

Q. Do you also agree that in terms of the descriptions that he provides, conscious that you don't have access to the particulars, you now don't have access to the particulars of these individual cases, but going on his descriptions, a TURP taking nearly two hours to perform before the case is closed, a penile disassembly, an injury to a ureter in circumstances where the protections that you would usually use for stone fragmentation are not in place, as I say, a benign cystectomy, are those the kinds of cases that would qualify as serious concerns, at least on the face of 10:17 10:18

it?

A. Yes, absolutely on the face of it is the question that you're asking. I was just not aware of him having those raised. If he has raised them, certainly they are very concerning. 10:18

7 Q. Would you agree with me that, as a matter of governance, they each require, if they were raised with you or if you were aware of them, they each require some form of response, in the first instance, perhaps drawing Mr. O'Brien's attention to your concern or the 10:19 trainee's concern, and then escalating appropriately if you are not satisfied with the response you receive?

A. Yes. That's true. A TUR going on for two hours is a long period of time. A perforated ureter, and I understand that this needed an open operative 10:19 procedure to correct, is something that you rarely would want to see.

8 Q. Just thinking about the long TURP issue, because I think you reflect in your statement that while you have no specific memory of Mr. Hagan raising that with 10:20 you, if we go to your statement at WIT-98847 -- sorry, just pause that a moment, I think it's the wrong reference. Yes, WIT-103608. Here you are talking about the TUR being a well-recognised entity in urology. You say that several features are relevant, 10:21 one of which is the duration of resection. But you say:

"The critical point, however, is the fluid balance as

opposed to the precise time scales."

You go on to say it is the aim to finish within the hour. Just scrolling down. It was in association with incident, or this matter, that Mr. Hagan believes that your response might have been something along the lines of 'that's just Aidan'. 10:21

If we scroll down just a little further, you say that that is a phrase that would have been used by yourself and others, in general terms, but it wouldn't have been a phrase that you would have used when responding to something like this, a TURP of this duration. So you're suggesting that if the matter had been raised with you, you would have taken a more serious tone or a more earnest response than that? 10:22 10:22

A. Yes, as I say, a TUR prostrate for up to two hours is going to put people at added risk, even with taking all of the monitoring events of height of fluid and measuring the ins and outs and risk of bleeding. It's not just one feature, it's there are several features that contribute to hyponatremia and glycemias, one is the duration of time. Our teaching in urology is that a TURP is usually done within the hour. There is a little bit of science behind the hour, but it's not a dogma that you have to finish before the hour. Certainly there's occasions that the patient will have absorbed fluid well in advance of the hour. So it is the monitoring of it throughout the whole procedure 10:23 10:23

that is very important. But there is increased risk observed if it goes on beyond the hour. Now, if you are going to put an exact clock on it, that's not wise, because it may take an extra 5 or 10 minutes to complete the operation, and completing the operation meaning to stop any bleeding.

Another issue is maybe a surgical technique but it's all about surface area, so if you can reduce the surface area that's likely to bleed a little bit extra, resection is going to complete the procedure. But I would use the words "a little extra time", and that's where we're coming into what you are talking about. So I do find it unusual. I would say it is not acceptable to go on for two hours. And I'm not aware -- and that's exactly why I said in my statement here, if somebody came to me and said this operation went on far too long, I asked, well, was there a complication of hyponatremia, so that would be a question I would have asked the registrar. 10:24 10:24 10:24 10:25

9 Q. If you are unlikely to have dismissed such a concern as that's just Aidan', where does that phrase come from? It is a phrase that, clearly, Mr. Hagan has heard on his evidence. It is a phrase that you have accepted that you and others have used. What does the phrase -- where does it derive from or what does it convey? 10:25

A. Well I don't know where it derived from. I know I'm quoted here as saying it, but I think it has come from the ward in some capacity. It is not me making that

up. But it is conveying that Mr. O'Brien has certain ways of doing things and that's his plan, that's his policy, that's the way he looks after certain things and I think everybody has their own wee sort of foibles of how they do things. 10:26

10 Q. Maybe we shouldn't read too much into that kind of phrasing, but is it suggestive that in certain circumstances Mr. O'Brien is acting in an unconventional manner outwith what would be expected?

A. Unconventional, I wouldn't accept that. I think there's certain ways people go about doing things. I think if I had seen something that was unconventional, then that would be challenged; if that's fair enough. 10:26

11 Q. Well, not doing triage is unconventional, would you say 'that's just Aidan' or would you say that's... 10:27

A. Well, it's proving to be that way.

12 Q. You go on, at 3.6, just that as you say:

"I have no recollection of having discussions around this issue with others." 10:27

But you do recall being generally aware that Mr. O'Brien had on occasions taken more than one hour for a TURP. You believe you're aware of this informally through theatre tearoom chat? 10:27

A. Yes.

13 Q. Does that suggest that those participating in theatre with Mr. O'Brien, because you would hardly be in

theatre with Mr. O'Brien, are bringing this out as an unusual feature of his approach? In other words, it was so significant that it warranted discussion as an unusual feature in the tea room, is that what you are putting across there? 10:28

A. I'm putting across that if the nurses are talking in theatre that a procedure has taken a long length of time or longer than usual, or if a theatre list has run over because of an excess time attached to a particular procedure. Yes, so it is a topic that maybe somebody has brought up and it may be observed that Mr. O'Brien is performing TURPs for longer than an hour, maybe more than the other team members. 10:28

14 Q. I would venture to suggest that the Panel are not particularly interested in the minutiae of these individual incidents, I would say. What they are interested in, and no doubt you'll hear from them this afternoon with some questions, what they are probably interested in is where you have clinical issues raised such as this, so that they become part of your awareness, whether they come through Mr. Hagan or whether they come through tearoom chat, they're all pointing in the direction of a problem or a potential problem, one that needs investigated and potentially addressed. Did you ever raise excessive time performing TURPs with Mr. O'Brien? 10:29 10:29 10:30

A. No, I don't believe that I have. I mean, if a TURP is going to go on between 15 minutes and 10 or 15 minutes over the hour, that's to complete the operative

procedure. There is an element of how long is a piece of string, okay? So the whole issue is, is there a complication occurring at the end of the day. The major point about TURP is hyponatremia due to glycine absorption. That is the crux of the matter. A very important part of TURPs surgery is to stop bleeding at the end of the operation. So some people may operate more slowly than others and, therefore, it may take them longer to complete the task. So the issue is about complication rather than a precise time. But, coming full circle to the question that you're asking, if I had known that a procedure had gone on for two hours, that is excessive and it needs a conversation to be had of why. Why, for instance, well a TURP going on for two hours, obviously the prostate is large. Why do you not do a hemiprostatectomy, just do the one lobe, and come back a second time and do the second. That's maybe a point of techniques, but it's the risk of complication I might get back to.

10:31

10:31

10:31

But, I mean, I must say, I haven't done a TURP for two hours. I have done TURPs that go over the hour, but you're always very wary of the nurse in your ear saying the time, it is now half an hour, it is now 45 minutes, it is now an hour, do you not -- it is a live interaction with the theatre staff, who are the nurses, and the anaesthetist at the top end. So it is not just you working on, there's a live environment to the whole thing.

10:32

10:32

15 Q. So I think you have helped us as much as you can with that particular issue and Mr. Hagan's input. The point remains that -- just to use the TURP as the vehicle for this governance issue -- the point remains is that you have become aware, tearoom gossip maybe, but the issue has been discussed, assumedly, because people think it is unusual, and it gets to your ears at an early point, perhaps an early point in your working relationship with Mr. O'Brien. You haven't specified the date, but when you think about it now were there issues coming to your attention, even at the level of suspicion, that you should have been addressing with Mr. O'Brien in association with his clinical practice? 10:33 10:33

A. Certainly not at this stage. This is the year 2000. I had just joined the unit. I was building my own practice. I was getting to know the arena. I trained in Belfast, Mr. O'Brien trained in Dublin. It's a different set-up, people might treat things in a slightly different way. You have to take it on board. But, as I say, bringing this to the table about the duration of the operation, as much as the focus, is Mr. O'Brien has a bit of a slow nature. He does everything slowly, so it is going to take him slightly longer. But, coming full circle is was I observing a higher incidence of hyponatremia due to glycine absorption, at this stage no. We, the same as any unit, it has cases of this, but we weren't having excessive numbers of cases with hyponatremia being focused on one particular surgeon. And that continues 10:34 10:34 10:35

for the next ten years that we're talking about.

16 Q. I think you would accept that the longer the TURP procedure goes on, the greater the risk of hyponatremia? It is one factor that should be controlled in order to reduce the risk. Sometimes, as you say, it is not possible to conclude within the hour, shouldn't be dogmatic about that, but it is a risk factor and in Mr. O'Brien's practice it appears to have been a factor that people were talking about? 10:35

A. Yes, I agree with that. Beyond the hour increases risk of complication and, yes, here we have this. But the question is did the complication occur? It increases the risk of it but the important point is did it happen and was the length of the operation due to a safety issue of, for instance, was the patient bleeding. But, yes, I agree, it is a wee bit of an alarm bell to say here is somebody that keeps on operating beyond the hour. 10:36

17 Q. If it's an alarm bell, I suppose the question arises from a governance perspective, what is the clinical lead doing about it? 10:36

A. Well, it's observing if there was a complication. Again, it comes back to how long is a piece of string? An operation starts and finishes. You know, you have to get all the joined up writing in the middle of that. I'm not entirely sure my responsibility of what you're saying here. I mean, this is a team approach. There's the recovery staff, there's the admissions to intensive care, there's the anaesthetic service. It is all very 10:37

live and observing. Are cases like this brought to the Patient Safety Meeting, you know, if there was a complication as such. So I understand what you're saying. There could be a conversation held: Yes, Mr. O'Brien, why are you being observed to be operating for more than an hour? An answer could be: I was completing the operation, you know, and I haven't had any problems. So I'm not certain if, you know, this was one point and, as you're saying, you're adding up all the points together and trying to put the jigsaw together, I understand that. 10:38 10:38

18 Q. Mr. Hagan drew the Inquiry's attention to the use of IV antibiotics and fluids with particular patients. If we just pull up his statement in that respect, WIT-98845. Just scroll down to 31. This is the first of the concerns he set out: 10:39

"There was a group of patients that seemed to me to be being regularly admitted to the ward for antibiotics and IV fluids by Mr. O'Brien. My recollection is that these patients would make contact with Mr. O'Brien in some way and be admitted directly to the ward as an in-patient for treatment. When I asked about this practice, the ward nurses referred to this treatment as "Mr. O'Brien's regime". I would do an unaccompanied ward round every morning during my six months rotation when I would come across these patients. It was often not clear to me the reason for this approach or the evidence base for the treatment. I considered patients 10:39

who fell into this category could have been managed as outpatients as they could eat and drink. I did not encounter this approach in any other urological unit I worked in before or since."

10:40

It's fair to say that some of the issues that Mr. Hagan has highlighted have been described by him as not necessarily crystallising when he was at the Craigavon Area Hospital, they may have occurred to him later, perhaps with experience and reflection. This is one issue that he took away with him. He's not suggesting that he raised it with you. Were you aware that this was Mr. O'Brien's regime, as he has described it?

10:40

A. Yes, I recognise that. Mr. O'Brien would have admitted patients who had had a history of urinary tract infection and this was a method of trying to control the situation. This was Mr. O'Brien's regime of looking after the condition.

10:41

19 Q. Yes. This is a trainee who, as I say, it might have been a later crystallisation of a concern, leave the timing to one side, he is describing it as a concern. Was it a concern that you as a more experienced, obviously qualified consultant, had?

10:41

A. I also later partook in the principle of IV fluids and antibiotics. This was further down the line in my career. The treatment pathway of people with urinary tract infections is very common from a urology perspective, predominantly looked after by the GPs. There are a small percentage will come our way for more

10:42

complex discussion with the patient in how to treat them and then there will be those patients that our outpatient consultations and advice aren't working fully. Then you are getting people coming in with sepsis, people coming to our clinics that aren't sensitive to the oral antibiotics and only sensitive to the intravenous ones. Then there's a group that will be responding to the oral antibiotics, will have been on prophylactic antibiotics, and when the treatment stops, the infections come back fairly promptly. 10:43

20 Q. Forgive me, Mr. Young, I asked you whether you had a concern about the approach in the way that Mr. Hagan did?

A. Okay. Right, Mr. O'Brien has obviously been in post considerably longer than I had and I think would have collected more patients than I had; I had only been there a short period of time. So he was entering into a plan of action for admitting people for fluids and antibiotics. Now, you would have to ask Mr. O'Brien his approach to why he did that but there's a small select set of patients that are needing a special approach to. But, again, it is very much on an individual basis and you would have to ask Mr. O'Brien about his approach to those individual ones. But I can comment that I've also had patients that I've admitted for antibiotics, but this was further down in my career. 10:44 10:44

21 Q. Forgive me again, Mr. Young. A very straightforward question: In the year 2000 Mr. Hagan observed this.

His concern about it may have crystallised somewhat later, we don't know. In 2000, did you have a concern, did you have any concern about the practice at in point before The Trust raised it in 2009?

A. In 2000 I wouldn't have, myself, partaken in that approach to treating patients, so I would agree with Mr. Hagan that it was maybe not standard practice in the way of treating a patient with such a condition. 10:45

22 Q. And it not being a standard practice, you being aware that it's happening on the ward, you do a joint ward round with Mr. O'Brien on a Thursday, you're aware of each other's patients. Is it something you raised with him, discussed with him, got to understand? 10:46

A. We would have discussed it on the ward round, about patients having the treatment but it's a two-way conversation. He had felt this was a way of looking after patients with such infections. I agree, I hadn't used that policy in my training in Belfast, it was different. But he was trying to approach a clinical situation. I don't know if Mr. O'Brien had used this in his training in Dublin, for instance. But it was a clinical approach to looking after a condition and I was observing if it was working or not. But, I agree, it's not the standard practice, and I agree with Mr. Hagan making comments on that. So, yes, I do agree with what I was trying to explain earlier, but -- 10:46 10:47 10:47

23 Q. But you didn't so it was a different, unconventional might be an appropriate word. You didn't challenge it?

A. I would have challenged it on the ward rounds about

asking about why you're taking this approach. But there's a conversation coming back and whether you accept that or not, that's a clinical decision.

24 Q. You've gone on to say in your answer a moment or two that you went on to develop a practice of bringing patients in for IV antibiotic management. I'm interested to know whether there's a distinction between your approach and that of Mr. O'Brien. Before I come to that question, let me just bring up on the screen your statement in this respect. WIT-51814, and at paragraph 63.1 you're saying: 10:48 10:48

"My first awareness that The Trust had issues of concern regarding Mr. O'Brien was in 2009."

10:49

I just park that for a moment. We saw yesterday that you were aware of concerns around triage in 2008, I think Mrs. Cunningham's email was fed up to you. But this you are describing was your first awareness that The Trust had concerns with Mr. O'Brien. 2009, he is admitting patients who had a chronic history of urinary tract infections on an elective basis for IV antibiotics and fluids. You say: 10:49

"It should be noted that I also admitted patients for intravenous antibiotics but they either had infections present or were symptomatic. The Medical Director at the time, Dr. Loughran, commissioned an external review of this practice. This resulted in the elective 10:49

admission of these patients stopping, with a new Trust pathway being put in place."

You're differentiating your practice from Mr. O'Brien's practice in this respect. What is the distinction that you're highlighting here? 10:50

A. Mr. O'Brien would have electively admitted patients for the fluids and antibiotics. My approach was for patients that weren't -- that had an infection, that had been through the use of prophylactic antibiotics 10:50 where they had been stopped and the patient had developed a urinary tract infection again and again and again, and the use of oral antibiotics weren't working properly to treat their infection, I would have admitted them for intravenous gentamicin. Now, the 10:51 other aspect of that is patients may -- there are several patients have commented on 'I've been on oral antibiotics for a long time here but when I get the intravenous antibiotics, it lasts six months'; they are getting a good amount of time out of the use of the 10:51 intravenous approach to it.

The other -- although I did have a planned admission for some people, I did try to target their time of admission to be similar to when they were recording 10:51 that their infections were coming back. So if somebody noted that they had been on a course of antibiotics for three months -- sorry, and got three months out of it, then I would be trying to pinpoint their admission to

actually be at the three-month spell. So I was using it to try to target patients when they were having their recurrent infections, and to give them a proper dose of an antibiotic.

25 Q. So is it your suggestion that Mr. O'Brien was admitting patients who did not have evidence of urinary infection and symptoms, whereas your approach was focused on patients who either had infection present, who were symptomatic or, taking your three-month approach who were likely to be symptomatic around that point in time? 10:52 10:53

A. Yes. I was trying to target the therapy to be of the right antibiotic to treat it for the right length of time, and I was very focused on the patients who were symptomatic. 10:53

There are some patients actually, although there was two patients I know of that, although I was planning a date to come in, they had attended casualty and one lady had come in on that planned three months, for instance, and she was well when she came in but got septic on the award, for instance, so I did have it timed right. But it's getting the right antibiotic. 10:53

26 Q. Just to be clear, are you saying Mr. O'Brien's patients, in your experience did not have evidence of the presence of infection or had not developed symptoms of emerging infection whereas, by contrast, yours did? 10:54

A. Sorry, I was answering for myself there. Certainly my observation of Mr. O'Brien's patients is that they were

more often admitted electively without a proven infection. Some may still have had a urine culture done that had been positive but it's the symptomatic nature. So that was my observation, that his set of patients were more likely to be elective.

27 Q. So you were, for a period of some years, aware of Mr. O'Brien admitting patients electively without -- and commencing the treatment without proof of infection?

A. Yes, our unit did a paper on this and it did show that this plan of action did reduce the number of acute admissions to the ward. So there was some science behind it but it probably could have been at a higher level.

CHAIR: Sorry to interrupt, Mr. Wolfe. Forgive me, Mr. Young, I'm trying to get this clear in my head. I'm not entirely clear what you mean by Mr. O'Brien admitting patients electively and how that differed from what you were doing by scheduling an admission in three months' time. So can you please explain, just for my understanding, the difference?

A. I was observing that patients had a time frame between having a treatment and then coming --

CHAIR: Needing it again?

A. -- and then when they would have had an infection again and I was trying to plan that. And sometimes that planning, the patient was ahead of me and would be admitted via casualty. So I was trying to focus more on the patients that were going to get an infection, a

symptomatic infection.
CHAIR: Forgive me, is that not what Mr. O'Brien was doing too? These were people with recurrent infections who -- I'm just trying to see where the difference is.
A. Okay. So I was trying to focus on patients who had symptoms at a certain period of time and try to get in ahead of the game. I think the approach that Mr. O'Brien was he was electively admitting people to have IV fluids and antibiotics to then reduce their risk of subsequently having an infection. It was an elective admission every three or four months that he would have brought them in, whether they had symptoms or a urine culture that was positive. 10:57 10:57
CHAIR: But surely you were doing the same thing In that you were saying come back in three months and we'll give you another dose of this antibiotic. Assuming you -- I mean, you're saying that you had focused on what you thought was the right time period, but I'm just -- you got lucky, if you like, that they were symptomatic when they came in. They may not have been, would you have still given them the antibiotic when they came in? 10:57 10:58
A. No, if they weren't symptomatic. I did have a few patients that I had seen a pattern and I brought them back for their fluids, I mean it's only two or three out of the whole group. My approach to this was that it was the intravenous antibiotics, it's the strength of the antibiotic that is the crux to the matter. I say that, I have three or four of the ladies who said 10:58

that they had been on oral antibiotics and, yes, it worked, but it didn't work for long enough and whenever they stopped the antibiotic, their urinary tract infection was coming back at a much earlier, quick stage. Whereas if they had had -- when they had the intravenous antibiotics of gentamicin, they said I've had a good six months here. That is quite good. 10:59

CHAIR: I get that. I get what you were trying to do and why you were trying to do it. But I'm just still confused as to what Mr. O'Brien was doing that was different from what you were doing? 10:59

A. I was maybe waiting for the patient to be sort of phoning up to say 'I'm getting into trouble here'. Whereas the elective admission is you're well and you just come back in three months' time to have a treatment, to try to stave off the potential. 10:59

28 Q. So Mr. O'Brien was scheduling them to come back in three months' time but you were waiting until you got a phone call to say, 'yes, it's back again, and I have to come in'? 11:00

A. In the vast majority of cases. I do accept I've had cases where I have brought them back. There's a specific lady that I have in mind. In fact we had a case conference on her with the microbiologist and the nephrologist and she was actually put on permanent prophylactic antibiotics on a cyclical basis. So it was a very targeted treatment plan for an individual lady with a urinary tract infection. 11:00

CHAIR: I'm sure we'll hear from Mr. O'Brien in due

course.

A. Yes.

CHAIR: There may be less of a distinction than I'm seeing, I think. But we'll move on, perhaps, Mr. Wolfe. 11:01

29 Q. MR. WOLFE KC: Let's bear in mind that the reason we're even looking at this issue is through the lens of trying to work out, you wearing your clinical lead hat and others who might or should have been aware of an issue such as this, whether you might be said to be 11:01 guilty of ignoring an early warning that Mr. O'Brien was practising in a way that was unconventional, that should have been challenged, just like a collection of other issues that we have looked at and are to look at. That's why we're in this field. 11:01

You have explained to us that the first time you were aware of The Trust being concerned about Mr. O'Brien's practice was this issue, 2009.

A. Yes. 11:02

30 Q. You were aware of this issue for some time and, while you had discussions about it, didn't challenge it. As you've explained to the Chair just now, you would argue that there was a distinction, perhaps a fine distinction between your approach and Mr. O'Brien's 11:02 approach.

Can you help us to understand before we move forward why you didn't, in essence, challenge and perhaps

escalate what was an unconventional medicine on Mr. O'Brien's part?

A. I can't answer that question fully. I do know that our Medical Director, Dr. Loughran, got involved in this and had taken advice outside of The Trust. 11:03
Dr. Loughran and I had a meeting about all of this. He told me what the plan of action was going to be and it was to involve the microbiologist, and I was in full agreement with that because I said to him: If we're going to stop this practice, can you at least allow me 11:03
to speak to the microbiologist to plan a care pathway. Actually, out of this we got our ambulatory ward unit which had -- part and parcel of it was the provision of the IV antibiotics with a care pathway that involved the microbiologist being involved. I was in full 11:04
agreement with that and followed that pathway.

31 Q. Let's just look at some of the contemporaneous documents to tease this through.

The issue arose in 2009. You've explained that 11:04
a protocol or a care pathway was developed. The Trust sought some external advice which Mr. Mark Fordham provided. But we will look at all of that, and thinking about two questions, first of all whether the Trust differentiated between your practice and that of 11:04
Mr. O'Brien's. And, secondly, perhaps more importantly, in terms of the Inquiry's enterprise is whether Mr. O'Brien or indeed yourself complied initially or at all with the new protocol and the new

pathway that was introduced. So with those thoughts in mind let us start with WIT-11850.

1st December 2009, the issue has already been discussed with you and Mr. O'Brien. Here you have a meeting of senior managers, including Acting Chief Executive and Medical Director. If we scroll down, we can see this issue is the subject under "quality and safety". It is described as a key issue: 11:05

"The Evidence base for the current practice of IV antibiotics for up to seven days repeated regularly requires urgent validation. There's a current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr. Loughran at the end of July 2009." 11:06

That's alluding to the fact that both yourself and Mr. O'Brien had met with Dr. Loughran in the summer and apparently a commitment had been given to stop the practice of bringing patients in. Do you recall giving that commitment? 11:06

A. I do, yes.

32 Q. The point being that there's still a cohort of 38 patients, some of which, the majority of which were Mr. O'Brien's, some of which were yours, is that right? 11:06

A. Yes. I've seen the list that you have provided. There was maybe six or seven cases of mine and I can account for their pathway. They were the patients that were

having continued urinary tract infections and had been admitted, for instance, via A&E. So, yes, and I did have a consultation face to face with Dr. Loughran about this. My approach, as I've said there, was as long as I can get speaking to the microbiologist for firm advice, I'm perfectly willing to comply as you point out.

33 Q. I am anxious to move through these issues fairly quickly. Dr. Loughran was going to have a discussion with Mr. Fordham to get urgent professional opinion on the appropriateness and safety of the current practice. 11:07

Then if we go down to TRU-251041. This is a short note. I suppose a couple of key aspects in it, that:

"The current regimes do not have a scientific evidence-base and, number six, there is no need to treat patients who are able to drink normally with IV fluids." 11:08

I suppose from The Trust perspective this is viewed as supportive of their view that before you would engage in intravenous antibiotics with this cadre of patients, you would have to or you should run it through microbiological opinion before commencement. 11:09

I want to take you to then apparent deviation from what had been agreed. Maybe I have your answer to that already but I just want to check it. If we go to

TRU-259410. This is Martina Corrigan writing to Dr. Rankin. It's the summer of the following year. It's a year since this issue was raised with you. And she is saying:

"See attached the update on IV fluids and antibiotic recent admissions. I checked with Shirley if any of these had involvement from bacteriology and she has advised that these are the routine elective patients who are admitted and treated prophylactically, irrespective of positive or negative culture results. To my knowledge the consultants have not discussed any of them with Dr. Damani's team." 11:10

And that's the microbiologist. Just scrolling down, we can see that there's a list of patients behind this. The first list is Mr. O'Brien's. Scrolling on down, the second list, a shorter list, is yours. 11:10

Is it the case that, not withstanding the imposition of a protocol which was to involve microbiology advice, that there was still a residual reluctance to comply? 11:10

A. As I say, here's my list. If it wasn't myself phoning the microbiologist, it was one of the juniors under my instruction. The first patient, it is the second on the list there, was a frequent admission with infection. He had tried his antibiotics at home, would come to casualty and would be admitted to the ward for treatment. On these occasions he came to the 11:11

ambulatory centre with a positive urine. I remember very well phoning the microbiologist myself about him.

The second lady -- sorry, third down, is a lady that I referred to that ended up with case conference and being on the antibiotics for prophylaxis for a year as a treatment plan and she would still be admitted with infection from a symptomatic point of view. 11:12

Five down is a lady, very complex history. Yes, has had IV fluids and antibiotics. This lady was admitted with sepsis. This is the lady that I referred to that I've done a cystectomy on for infection. Very complex. 11:12

34 Q. Is it the case -- I'm not sure we need -- I think your broad answer is the continuation of antibiotics, recommencement of antibiotics in these cases is justifiable. 2nd September of that year, TRU-281845, this is Dr. Rankin writing to Dr. Loughran. If we just scroll down to the bottom of this page, she says it is of concern to her that the agreement -- basically the pathway or the protocol as set out above -- 11:13 11:13

"...has not been followed by Mr. Young and Mr. O'Brien, in particular I understand that there are seven patients remaining on the IV treatment and two or possibly three have permanent intravenous access." 11:14

So the Trust has taken the view that the agreement wasn't being followed in one shape or form. That's not

something you agree with?

A. I've gone through my list there. I can account for why these patients were sick. They were symptomatic patients.

35 Q. And -- 11:14

A. And to take the approach -- sorry for cutting across you -- taking the approach that all urinary tract infections can be treated by taking an oral antibiotic, I mean it's the vast majority but there are some selected cases that do need some strong antibiotics. 11:14 So it's a targeted individual treatment but I can account for my patients.

36 Q. But were you following the process is the question?

A. Yes. Yes, they had positive cultures and the microbiology team were involved. A lot of them would 11:15 have gone through Shirley Tedford in the ambulatory centre, and part of the process was to have urine cultures done and the microbiologist spoken to. I'm accounting for my patients.

37 Q. Just to be clear, it would appear that The Trust hasn't 11:16 differentiated between your practice and Mr. O'Brien's in terms of their approach to you through this correspondence?

A. It would appear to be that way. Well, I'm reading this here as well. 11:16

38 Q. Yes and subsequently, you, with Mr. -- you put your name to an article published in the Journal of Infection signed by yourself, Mr. O'Brien and Mr. Koo, which I suppose was the same hymn sheet

endorsing antibiotic approaches in the field of recurrent IBTs?

A. Yes, we had written the paper on this. It was mainly led by Mr. O'Brien and Mr. Koo, but they had been using my patients as well. 11:17

39 Q. Yes. I am just conscious of the distinction you drew earlier. Do you agree that's a fine line distinction in terms of your approach compared with Mr. O'Brien's?

A. I wouldn't say a fine line. I would say I focused on the more symptomatic patients at the time and getting 11:17 a better response with intravenous antibiotics than ploughing on with oral antibiotics.

40 Q. Was Mr. Akhtar also a participant in the approach that you and Mr. O'Brien were adopting, allowing you the distinction you draw? 11:18

A. Mr. Akhtar joined the unit in 2007. Again, it may take a period of time to build up a practice of such, but I wasn't aware of Mr. Akhtar being a major contributor to the numbers. He may have used the ambulatory unit, but I'm not aware of his major activity in that arena. 11:18

41 Q. In terms of your compliance you've said, notwithstanding what The Trust may be pointing out here, that you considered that any patient moving forward from 2009/2010 was treated in accordance with the protocol that was adopted so you were in compliance 11:19 and you had no difficulty complying, Mr. O'Brien, I just want to ask you about his approach. If we go to TRU-281944. This is Mr. Mackle writing in June 2011 and he is saying:

"I am seriously concerned that you don't seem to recall our conversation at a meeting last Thursday. At that meeting I informed you that if you wanted to admit a patient for pre-op antibiotics or for IV fluids and antibiotics, that a meeting had to be held with Sam Sloan and a microbiologist and that this was a pre-requisite, non-negotiable. You have also been given this in writing following a previous meeting with Dr. Rankin and myself. I now find that you initially planned to admit a patient this week without having discussion with anyone and then, when challenged, you spoke to Dr. Rajesh Ranjudran." 11:19 11:20

2012, TRU-259904. Mr. Mackle, 30th January 2012 writing to Sam Hall copying Mr. O'Brien in: 11:20

"I have been advised that a patient may have been admitted last week to urology by Mr. O'Brien and under his instruction was given IV antibiotics, the latter necessitating a central line to be inserted. I have checked with Dr. Ranjudran and he advises me that no discussion took place prior to the administration of antibiotics." 11:20

2013, if we could bring up TRU-276833. Just scrolling down, Dr. Tracey Boyce is writing to Heather Trouton: 11:21

"Mr. O'Brien seems to have another patient on gentamicin this month with no evidence of infection.

I am sure Anne has the patient's details if you want to look at their reason for admission further."

Then in, I think it's 2016, if we go to Mr. Suresh's statement at WIT-50361, and at 47.12 he says: 11:21

"On the clinical aspects there were some discrepancies in the practice of individuals in terms of choice and usage of antibiotics. For example, Mr. Aidan O'Brien admitted a patient for administration of intravenous 11:22 antibiotic just based on the symptoms. I do not recall the exact date or month. I directly discussed with him during the joint ward rounds about seeking the advice of microbiologist. He paid attention to my suggestion and acted accordingly." 11:22

A number of contributors suggesting that, notwithstanding the discussions held in 2009, 2010, the introduction of a protocol and pathway, Mr. O'Brien continued to be noncompliant. I'm not terribly 11:22 interested in whether there were vast numbers of these or whether these were isolated cases, but what I want to understand from you is, given that both of you were being brought into, if you like, the room to have these matters discussed and worked through with senior 11:23 managers, that must have necessitated conversations between you and him about the approach of management?

A. The meeting with Dr. Loughran was fairly clear-cut. It was understood by me, I thought it was understood by

Mr. O'Brien what he was saying. It was a very appropriate way of helping us deal with a problem, offering us a unit, a protocol, to actually follow, which I did, as I pointed out. And my practice of this had fallen off. I had very selected patients brought in. Further treatments that we have is the intravesical treatments that were now available. That has made a big difference to our care pathway of urinary tract infections. But, as I say, when needed we had to phone Sam Sloan and a microbiologist to do the same. It was fairly clear-cut. It wasn't high-powered to know that that's what you had to do. I remember doing that on a few occasions and getting it sanctioned for my patients. I can't account for these other ongoing ones for some years. 11:24 11:24 11:25

42 Q. Again, you're the clinical lead, this is happening, more than once Mr. O'Brien is, on the face of this evidence, not compliant with the protocol. Has he discussed that with you at all? Has he discussed his preparedness to comply? 11:25

A. Yes. You are pointing at me knowing that this was going on. No, Mr. O'Brien wasn't telling me that he was continuing to admit people and not speaking to the microbiologist and not speaking to -- so that conversation has not been had with me. I don't know if I was meant to be going and trying to source out that information. I mean I -- I many that's -- to try to keep a check on all that's going on in the department is very hard for me to do. 11:25

43 Q. Yes?
A. Number one, I myself have a busy practice from a general perspective. I ran the stone treatment centre, I was the lead clinician. Am I meant to know all the finer points going on unless told? I am busy. It is hard to know about all the things going on. So it does take people to come and tell me, and Mr. O'Brien didn't come to tell me that he was continuing to admit people, if that's what you're asking. 11:26
44 Q. So for you to know you would either have to be told, and clearly there's a team on the ward, there's access to patient notes and a network through which people could report to you, or indeed report to others. And I suppose there might be an argument for saying that, given the views that might have been expressed to management about the benefits, as Mr. O'Brien perceived them, of this form of treatment, that his compliance with the protocol should have been the subject of some checking or audit by others. Is that a reasonable point to make in governance terms? 11:27
A. That's a very reasonable point to make on terms, yes.
MR. WOLFE KC: It is 11.30.
CHAIR: I think we'll come back at quarter to 12. 11:44
THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
45 Q. MR. WOLFE KC: I want for the next hour or so to look at the whole area of appraisal. You'll recall from

what I said this morning, we are considering these issues under the broad theme of why the issues, of which we're now so familiar, concerning Mr. O'Brien's practice didn't get addressed much before 2017. This morning we've looked at some early warnings, Mr. Hagan's evidence, the IV issue. Now we are going to look at appraisal, and I suppose the focus of my questioning is whether appraisal was an effective tool or an ineffective tool. Was it a sufficiently focused tool at identifying concerns around doctors? 11:45

You told us in your statement, Mr. Young, that you undertook various appraisals for Mr. Akhtar, Mr. Glackin, Mr. Brown, Mr. Suresh, Mr. O'Donoghue, and for the years 2010 through to 2015 you conducted four appraisals for Mr. O'Brien; isn't that right? 11:46

A. Correct.

46 Q. We've had various perspectives, notably from Dr. Simpson, who came into the Medical Director's role and drove appraisal in its early years. He was explaining to us that appraisal wasn't designed, although he had his views about it, it wasn't designed as a performance management tool. It was, to use his words, a formative tool. It was designed to help doctors put their best food forward, it was about personal development. Still and all, if there were issues of concern about a doctor's practice, they could be discussed during appraisal; isn't that right? 11:46 11:46

A. It is a forum for discussion, yes.

47 Q. You said on the last occasion that the quality of appraisal is only as good as the information that is supplied to you?

A. Yes, I said that, yes.

48 Q. When you think back over the five years during which you appraised Mr. O'Brien and you consider the issues that developed, that were investigated, and led ultimately to this Inquiry, do you think appraisal as a tool could have been used by you in any other way, any better way, to have targeted, addressed, sought to remedy some of the issues with which we're concerned? 11:47 11:48

A. Indeed. On reflection, obviously, yes, the issue of triage could have been brought up at the consultation more than is enclosed in the document. But, as I say, it is as good as the information that is being supplied. I do appreciate that appraisal has moved on in its arena and the way it is conducted now. Back when I did my original appraisal training in 2009, 2010, it was all about engaging with the appraisee, trying to encourage an open forum and for the appraisee to showcase what they had to do and offer from a performance perspective. I know you used the word "performance" there, but it was for them to show that they were up to date with their plan of action, their education, that they were meeting standards, being part of the team, these sorts of things. But not -- I understand that appraisal has moved on and is more interrogating, if you want to use that word, now than when I was involved in it originally. 11:48 11:49 11:49

49 Q. We'll see as we move through some of the years that, I think it's fair to say, and maybe you would agree with me, that the issues around triage, around keeping notes at home, around the delays in dictating and issuing correspondence, are nowhere addressed with Mr. O'Brien, at least in writing. Unless I missed something. Is that something you would agree with?

A. I would agree with that.

50 Q. Yes. I'm going, in a moment, just to take you through some of the years. I'm going to use this exercise in order to bring in other issues with which the Inquiry is familiar which occurred during some of those years which, again, don't feature in discussions. I'm going to be asking you, just to give you a heads up, whether, if you were aware of these issues, should they have been discussed. It will also be an opportunity to ask your views, for example, on the issue of actioning results, say, from investigations and that kind of thing.

11:50 11:50 11:51 11:51

Just in terms of what you said there, that there's been changes in how appraisal is done, it's perhaps more interrogating, to use your word, which I take to mean is the style of appraisal now can allow for, or maybe requires greater focus on shortcomings and teasing those out, maybe, with questioning, appraiser to appraisee, and working up solutions perhaps. Is that your understanding of how it now works?

A. That is my understanding of how it now works.

I haven't done appraisal for, appraiser for a considerable number of years.

51 Q. Looking, just to pick one example from 2015 I think it was. If we go to TRU-251319. At the heart of the appraisal process, when you did it was the development of a personal development plan. That allowed doctors to set targets, and you've described these as generally educational or to address a specific project as opposed to target clinical driven output. So there's an example of a personal development plan for 2015. This has been signed off in December 2016, a few days before the MHPS investigation is launched. 11:52 11:53

I'm conscious that the appraisal process worked, at least at that time, worked in arrears. You're signing off in 2016 but looking back at what happened during the calendar year 2015; is that right? 11:53

A. Mr. O'Brien's appraisals were always slow in coming through. They were very delayed in comparison to everybody else's. I think if you look at the dates of all the previous ones signed off, in fact one appraisal may have been involving two years in the one go. 11:53

52 Q. 2012-2013, I think.

A. Yes. And then '13 would have been done because I think he was revalidating in '14, so that was done early. So they were always a year behind. 11:54

53 Q. Yes. So the personal development plan here is I suppose in this respect is somewhat wide ranging.

"To address in a durable and effective manner my long inpatient waiting list and in so doing to reduce inequity in the waiting lists."

He's saying. That is his language is it? 11:54

A. Yes.

54 Q. "To address long waiting list for urological cancer reviews, to reduce the numbers of new patient consultations. To attend course..." 11:55

Is this your handwriting?

A. The bottom line is my handwriting.

55 Q. "To attend a course in urology."

So there are some thoughts here around practice issues about I suppose the clinical challenges he's facing. I suppose it does show the possibility through the appraisal process of directing the appraisee's mind towards gaps in the practice, shortcomings in the practice or challenges in the practice? 11:55

A. Yes.

56 Q. Let me bring you to 2010. This one was signed off November 2011. It is TRU-251244. There it is, just to show you the shape of it. Can we have that on the screen. The form of it is, for a bit of 11:56 a background, a pen pic of the person being appraised and setting out some of the information. So no formal complains nor critical incidents are logged by The Trust. Is that you observing that on the basis of what

The Trust has told you as the appraiser?

A. It would be, yes.

57 Q. There's action agreed for the next appraisal set out. And, just going over the page -- so that is under the heading of good medical care, maintaining good medical practice. I assume there's definitions attaching to each of these headings and you know what ground to cover. 11:57

CHAIR: Could we make it a little bit bigger? I'm struggling to read it. Thank you. 11:57

58 Q. MR. WOLFE KC: This is telling us, telling the reader what Mr. O'Brien has done in terms of maintaining his practice, the kinds of educational-type visits he's made, safety courses he has undertaken, and there regionally being involved in discussions about bladder dysfunction and an MDT. So just scrolling through again so we can see the shape of the form, I'm not terribly concerned with the detail at this point. Setting out working relationships with colleagues which is described as a good relationship with colleagues, nurses and ancillary staff. A reference to a current issue at that time. There was concern around the ward reconfiguration, you dealt with that, the challenges of that in your statement. 11:58

11:58

Scrolling down again, just so we see the full shape of this.

Relations with patients are described in positive terms generally, albeit two complaints have been raised which have been resolved, one a waiting list issue, assumedly, a non-Trust issue as described here, with no action required.

Scrolling down. Teaching and training, self-evident. Further on: Probity, no issues arising. Health, nothing of note there. Keep going, please. "Any other points". It is referring to the IV fluid antibiotic issue is simply referred to. Would that have been something that would have been the subject of a discussion? Both of you, unusually perhaps in this scenario, are in something of the same boat for the reasons we discussed earlier. It doesn't appear there's been any, at least on the note here, there's been any reflection. "We must comply", the appraisee must comply with the protocol or the pathway.

A. I think there's further comments in writing, potentially. It may not have been in that year but it may have been in a subsequent year that it was commented upon. I say these are bullet point, so they will have been discussed. Appraisal can last up to an hour so trying to write down every word written -- it's more of a summary of what was discussed.

59 Q. Yes. One of the issues that is picked up is, just there, is the centralisation of radical pelvic cancer surgery imposed by the Department of Health. You can see the detail:

"Aidan has concerns that this will have significant knock-on effects for services in the future."

Did you know that this issue and Mr. O'Brien's handling of it with regard to three patients, three bladder cancer patients in particular, was the subject of complaint by the Belfast Trust? 12:01

A. Yes.

60 Q. We can see, just to remind you and remind everyone here, AOB-00191. I think it is Mrs. Rankin, Dr. Rankin writing to Mr. O'Brien, September 2010 drawing the Belfast Trust's concern or some of their concerns to Mr. O'Brien's attention. Perhaps the third paragraph picks up the crux of it. 12:02 12:03

"It is of great concern that you indicated to a patient in advance of a care pathway being agreed your preferred management of the case. I believe that this puts inappropriate pressure on the receiving team and is regrettable. I understand that the transfer of these patients, with whom you may have already formed a good therapeutic relationship, was somewhat unexpected." 12:03

Just scrolling down.

"... a warning that since we have an internal agreement that the future care pathway of these patients will be

the subject of a multi-disciplinary decision I do not want you to write to any of these patients individually, it is a matter for the MDT."

That issue of writing to patients, one patient in particular highlighted here, was clearly the subject of concern. Was that the subject of discussion between you and Mr. O'Brien at appraisal? 12:03

A. No, I wasn't aware that Mr. O'Brien had written to the patients ahead of their transfer, so that's the question answered there. But the reason for, I think, Mr. O'Brien writing to the patients, he can confirm this, was that the decision to transfer -- the actual date of transfer of such surgery to Belfast hadn't been defined precisely and we hadn't heard when that transfer was to be by the City Hospital until Dr. Corrigan, I believe, got involved, and said that the transfer was going to start on a certain date. 12:04 12:05

I must say, on a personal note, it's not good to twist a surgeon's arm to do, what to do. So he really should have just transferred the patients without any arm twisting, frankly. So I wouldn't have agreed to any letter being written in such terms. So I wasn't aware of Mr. O'Brien writing to the patients at that time. So I wasn't aware of this letter. 12:05 12:05

61 Q. There's a broader issue which we perhaps don't need to get into this morning, that was Mr. Hagan's concern that the patients were being offered a treatment or

Mr. O'Brien was describing a treatment which was at variance with the MDT's decision, and that's perhaps hidden from the complaints that eventually passed between the Medical Director at Belfast and the Medical Director in the Southern Trust. But you're saying not aware of this, but you would agree that it was inappropriate for Mr. O'Brien to write in the way that he appears to have done, notwithstanding his frustrations with the process? 12:06

A. I can understand the frustration but you do not write a letter. I wouldn't have done that. 12:07

62 Q. In terms of, just thinking here about appraisal as a process, a complaint like that, do you think it should have come to your attention as the appraiser so that it could be properly discussed in the appraisal system as it was designed in those days? Would that have been an appropriate matter to discuss? 12:07

A. It would always be an appropriate thing to discuss. But it's being informed about the information in the first place. 12:07

63 Q. Of course. It is only as good as the information you receive, as you've said.

A. I think as an appraiser, as I say, you do get certain information from The Trust, but it would be good to have had that in the folder supplied by somebody. 12:08

64 Q. Because, presumably -- let me see if you accept this as part of the appraiser's job description -- is it part of the appraiser's job description at that time where you are aware, and in this case you are not aware, but

where you are aware of, let's call them faults, in the approach of the clinician in front of you. If you're aware of those faults, is it part of the appraiser's role to try to shape the thinking of the practitioner, try and tilt the practitioner into a more appropriate way of responding or dealing with matters going forward, or at least to have that conversation? 12:08

A. It is up to the appraisee to be fairly open and clear about what they are aware of and to bring to the table. Is that what you're asking? 12:09

65 Q. Yes. You're suggesting that, at least in terms of how the system was arranged at that time, you were really beholden to the information that you received. But if the information was available to you, I think you're agreeing with me that there was a role to -- a role residing with you to try to tilt or shape the appraisee into a better way of dealing with things? 12:09

A. Yes, if this had been declared it would have been a topic of conversation that you would be putting into one of the four -- 12:10

66 Q. You are aware, you've made mention of it in your statement, that during this appraisal year Mr. O'Brien had received the, if you like, the stick; you can't travel to Barcelona if you don't have your admin, including your triage, up to date. Indeed I think as we scanned through the form there, we could see that his visit to Barcelona was cancelled due to the dust cloud. But we don't see your knowledge and awareness of his administrative issues being a feature of the 12:10

appraisal discussion. The form may not contain everything that was discussed, but what's your response to that?

A. It's clear an issue about triage hasn't been enclosed in this documentation, either by Mr. O'Brien or me investigating it further. I do accept that. 12:11

67 Q. It's convenient to deal with it now, as I think I heralded earlier, across the five years these issues of triage, notes at home and dictation, or the want of dictation, are within your awareness, albeit at different times and ebbing and flowing and improving and disimproving. But at no point do you appear to have recorded any discussion around them. Explain that to us, is it not appropriate to discuss these matters at appraisal? 12:11 12:12

A. Yes, I didn't interrogate that enough. Observing the other appraisals, a lot of this is written by Mr. O'Brien in the first person. Again, the principle being here that Mr. O'Brien was very slow in his appraisals so I was trying to get him to engage in the procedure and getting him to do the writing of the things that he wanted to discuss that he felt was maybe aggrieved about, this was a good opportunity to do so. In the latter years we did discuss capacity demand. We did talk about triage component. I don't think we discussed the notes at home. I wasn't fully aware of the depth of that when actually doing appraisals at that time. So when it came out afterwards that I appreciated the depth of the problem rather than 12:12 12:13

interrogating every fine point. But we had discussed the triage issue as part of the capacity demand, but not written, not written down, but it should have been.

68 Q. You've explained that Mr. O'Brien was typically slow at turning around his part of the appraisal exercise and that resulted in delayed sign-off. As we explained earlier, 2012/2013 was a combined appraisal exercise. As we can see at TRU-251278, this appraisal was signed off on 22nd April 2014. 12:14

12:15

We can see, just going back to the top of it, TRU-251265, that he provides additional information. This is characteristic, I think, of his approach in the next appraisal year as well, it may even have been part of his previous appraisal year. But he's pointing out the difficulties or the challenges of workload within his practice. He says, I'll read it out in full: 12:15

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

There is something that might be described as a cry for help or a need for support indicated within that; is that fair? Is that what you understood it as?

A. That's fair. He's commenting on a heavy workload.

69 Q. And you have seen the manifestations of his workload in terms of him describing an inability to complete triage, for example, during this year and other years. 12:17

In terms of his workload at that time, he's taken on the NICaN role, no doubt a prestigious role, but outside of his Trust work. He, the evidence before this Inquiry tends to suggest he works in ways, or others have described as idiosyncratic, not delegating, not using the administrative support that he has in necessarily the most optimal fashion. Looking at that package of issues, any suggestion if he can't cope with the pressures of his workload that he should be giving up extra curricular activities, prestigious though they are, such as NICaN? 12:17 12:18

A. Yes. He would not have been job planned for nine clinical sessions. I think he took on extra clinics. He may have swapped clinics for theatre lists due to what he is seeing as the volume of work to get through. But he would have taken on those sessions himself. I don't think he would be scheduled for nine sessions. And, yes, he was trying to maybe juggle far too much at the time, but that would have been his choice. I mean, he took on the NICaN role. You can always not do that job, you know, but he chose to take that on. But if 12:18 12:19

you're going to choose to take it on you have to take the responsibility with that. And if something else has to give, then it's maybe up to the individual to take charge of his or her own practice to accommodate that.

70 Q. You have told us the last time that in your role as clinical lead you have to be aware of whether a clinician should be offered additional sessions?

A. Yes.

71 Q. You found yourself from time to time saying -- I think this was a general comment, not necessarily directed to Mr. O'Brien -- saying to people, no, I'll not offer you that extra session because you are already oversubscribed. 12:20

A. Yes. 12:20

72 Q. But was that part of -- just to be clear, was that ever part of a conversation that you had about Mr. O'Brien, whether at appraisal or more generally?

A. Specifically that would have been brought up at the rota meeting. 12:20

73 Q. Of course.

A. That I alluded to maybe before. Certainly our unit was trying to use our clinical sessions and theatre lits to its maximum, I appreciate that. We often moved the clinical sessions around to accommodate this. And if extra theatre sessions came up because of other departments being on holiday, for instance, we would pick those up. And then, as I say, most importantly there was the best attended departmental meeting, the 12:21

whole team were there, and we tried to hand out those extra sessions as necessary, and certainly Mr. O'Brien would have been one to try to pick up on them. Certainly on several occasions I said 'this isn't appropriate, Aidan, you have got a heavy enough week there'. 12:21

We all do have varying weeks. Looking at myself, some weeks I may have two or three outpatients a month for my clinics, one week I would have four and one week in four I will have had five clinics myself and I was aware that that's very much a limit. So I said to Mr. O'Brien 'I think this is not appropriate that you take on extra sessions', and would have given it to somebody else. 12:22

74 Q. It may, and help us with this, it may be a limitation of the appraisal process as it stood at that time that this kind of thing, this kind of fairly important thing can be said by a clinician: My workload is compromising, I suppose he is saying, my ability to care for patients as well as I would like. That can be said but it doesn't go anywhere. There's no practical engagement with that, I'm not saying necessarily by you, but by the higher ups who receive this information? 12:23

A. It's information that is received. It's what you use with the information. My understanding is that part of appraisal is to take to your job plan. I know the job plan is part of appraisal, it's a documentation, but

part of this is also that you can take it to your job planner and use appropriately.

75 Q. Yes?

A. So if in part of your personal development plan that you see that there is a deficiency in something that is hindering you from accomplishing something, at least it is already documented here and can transcribe on to a job plan. But this would have been something to take to his job plan with. 12:24

76 Q. In terms of your role, hearing this from Mr. O'Brien, perhaps appreciating it already because you are the appraiser but also a clinical lead and colleague with Mr. O'Brien, is this not an opportunity to get lots of these issues out on the table; 'well, I can see how you are compromised, you are not getting your triage back, you're not doing your dictation on time, how can I help you make that better?' Would appear to be an appropriate question or was that outwith the appraisal process, as you understood it? 12:24 12:25

A. Well, as part of that departmental meeting about assigning a clinic to somebody, this would have been a discussion here, do you not think that you're taking on too much in other arenas to allow you to catch up. 12:25

77 Q. The pro forma goes on to look at relationships. Can I just pick up an aspect of that. If you go down to TRU-251270, I think it's five pages on. Just scroll down. So this is discussion of relationships: 12:25

"I believe that my relationships with many colleagues

of many disciplines is at least satisfactory. Even though I have on occasion been outspoken in my views, particularly in relation to patient care, I have endeavoured to do so in a non-confrontational manner and hopefully with minimal offence to others." 12:26

And it continues. In or around 2012 Mr. Mackle has described for the Inquiry a breakdown in his relationship with Mr. O'Brien. On Mr. Mackle's account he had been told that Mr. O'Brien had a complaint to 12:26
make about him allegedly harassing or bullying Mr. O'Brien and, on Mr. Mackle's account again, he stepped back from any direct engagement with Mr. O'Brien and Mr. Brown was pushed more slightly forward and became more involved in issues that 12:27
Mr. Mackle would otherwise have tackled. On Mr. O'Brien's account, while he disputes any suggestion that he was making a complaint through Mrs. Brownlee or through anybody else, he understood that he had an agreement, I think, with Dr. Rankin that Mr. Mackle 12:27
would have no further involvement with him in the round.

I ask this in the context of relationships which are otherwise described in positive or fairly positive 12:27
terms; were you aware of this breakdown in the relationship between Messrs Mackle and O'Brien?

A. I was aware that Mr. O'Brien didn't see eye to eye with Mr. Mackle. I didn't take it to the level of the words

used by you just now about sort of bullying, I wasn't aware of that. But I knew that their interrelationship wasn't healthy.

78 Q. Were you aware of the practical manifestation of that in terms of a senior manager in this context, Associate Medical Director, Mr. Mackle, stepping back and not having, on the face of it, direct contact with Mr. O'Brien? 12:28

A. No, I wasn't aware of that.

79 Q. That wasn't discussed with you? 12:29

A. I wasn't aware to the degree that we're talking about here about stepping back.

80 Q. Also within that year there was an issue raised arising out of an SAI or a Serious Adverse Incident that had taken place in 2009. There was a so-called "never event". A swab had been retained in the cavity of a female patient. That led to a review, an SAI review, and that was written up in 2010. But the issue came back again in 2011, and it came back in this way: A concern was expressed that the clinician who performed the surgery in relation to the never event, Mr. O'Brien, might have been better able to discover the problem if he had looked at the post surgery scans. There was a scan performed I think four months post surgery. He didn't read it because the patient hadn't come back for review. A waiting list issue prevented her coming back for review in a timely fashion. And the issue was, I suppose, in the round, should you read your reports, the investigation reports coming back, in 12:29 12:30 12:30

this case from X-ray, from radiography, should you read them as soon as they are available to be read or within, a period of promptitude.

Could I ask you, just before I ask you for your thoughts on that, let me just introduce you to the e-mail correspondence around that. If we go to TRU-276805. So under the heading of "results". Managers have been told: 12:31

"I know I addressed this verbally with you a few months ago, but just to be sure can you please check with your consultants that investigations which have requested that the results are reviewed as soon as the results are available and that one does not wait until the review appointment to look at them." 12:32

If you scroll on back to what Mr. O'Brien has said about it. I'm conscious that this is directed to Mrs. Corrigan. You're not copied in. He writes to express his concern that this would be the expectation and he sets out a series of reasons for that in the form of questions. So he appears, and I don't think I've asked Mr. O'Brien about this, I will in due course, but he appears to be suggesting that there are impediments or obstacles in the way of practising in the manner which The Trust's management would expect and that any attempt to change his practice in this regard would need to be -- would first need to address 12:32 12:33

these kinds of questions.

First of all, were you aware of his practice, that he would read results only, it appears, and I hope this isn't a gross generalisation, but we've seen it in other situations where he will not read the results until the patient appears at review. Were you aware of that? 12:34

A. I wasn't aware of it this far back. He did bring up this topic at some departmental meetings, I don't have precise dates, I'm sure they're available, that he had an issue with reviewing the results. He had this approach of saying, you know, he would wait until the clinic appointment. But these results would have been, back in this time, was all done on paper. So the x-ray department would have sent a report to him via the secretary or directly to him. So there would have been a printed version to have been reviewed. As you say, whether he looked at it or not, they would have been supplied to him. This would have come under the view of administration, time. This is what admin was for, to follow-up on outpatient X-rays. And the reason why it was set up this way indeed was, if there was such a long delay in the review, at least you had the X-ray results available or blood tests available to you that if you wanted to make a change in your action plan. Although he said he had difficulty with this, it was assumed that he did -- assumed -- that he had looked at the results because, as I say, they were all done on 12:34 12:34 12:35 12:35

paper, they would all end up in your office and, you know, if it wasn't looked at there would be a very big bundle. So this practice here, at that time I wasn't fully aware that -- well, I was not aware that he didn't -- is he saying here that he did not look at the results? 12:36

81 Q. Well, the SAI report on I think it was Patient 95, yes, the SAI report on Patient 95 indicated that this was a part of his practice, that was his way of doing it. You said in that year, 2011, you didn't know and, therefore you didn't, presumably, engage with him on it on appraisal? 12:37

A. No, I didn't engage with him during appraisal.

82 Q. Back to the system generating information. Is that the kind of thing, if it comes to a dispute between the Trust's preferred way of doing it and the clinician's preferred way of doing it. No doubt that should be refereed and resolved in a number of places, but if it is a problem should it be discussed as part of appraisal, if it is drawn to your attention? Is that an appropriate forum? 12:37 12:38

A. It is an appropriate forum for an appraisee to bring forward to say this is an area I have some difficulty with. But, as I say, appraisal is to showcase your engagement and commitment to the job. Whether the appraisee should be bringing that to discuss or not, I think this topic is more at The Trust level to try to sort out. That is going against a bit of governance to the whole thing, which is part of appraisal. There's 12:38

a bit of it in both camps. I don't think that's solely an appraisal point but should be enclosed.

83 Q. We also know, Mr. Young, that, scrolling on to 2019, that in the context of a conversation about DARO, which is closely related to the issue we're talking about for obvious reasons, that Mr. O'Brien is at that point engaging with Mr. Haynes about his concerns around the use of DARO. I just want to seek your views on that and then we'll pull these related issues together. WIT-55862, if you go to 864, please, 55864. 12:39 12:40

Colette McCall is, in January 2019, writing to a group of medical secretaries, I assume yours is amongst the list here. She is explaining what should be done in order to comply with the DARO process. Could you just help us in terms of, while the Panel are reading that, could you help us in terms of somehow you practice, Mr. Young, taking into account both the DARO process and the message which I read from 2011 which was that management expected clinicians to read the results and, if necessary, action them as promptly as possible. How did you deal with that? 12:40 12:41

A. My approach to this is that a patient may have been seen in the clinic and given an appointment for X period of time at a later date, it could have been a year, and if there was a blood test or an X-ray requested from the first occasion, is that that needed to be reviewed to see if it was appropriate for the next date. So if something unusual had cropped up in 12:41

the blood test or in the X-ray, that needed to be -- should be expedited, then that action is taken. So you had to review the test result and that seemed appropriate.

84 Q. Did you have a system in place, perhaps using your secretary, in terms of when you would read the result and how would that be draw your attention? 12:42

A. Okay. Going back before the ECR system kicked in well that it was all done on the computer, it was all done by paper. I mentioned before about my black box. That was an A4 box in my office that my secretary would put all the printed X-ray results and bloods into. She would put the important ones to the top. The black box also took at the time any referral letters from other consultants or admin that didn't go via the booking office all went into this box. And those test results that she screened that were exceptionally important she put on my chair so, you know, those were done first. 12:42 12:43

The administration of that, again might have been a wee bit like the triage we talked about before, are they done on a daily basis, are they done at 72 hours or is it done on a weekly basis? But certainly I like to clear my box at least once a week. 12:43

85 Q. I just want to take your views on DARO. If we just scroll up, please. You'll see Mr. O'Brien coming back on this 6th February. He is greatly concerned, alarmed, "to learn of the directive which has been shared with me", presumably by his secretary, about a 12:43

similar concern. I suppose, in a nutshell, he's objecting to the use of DARO. He has the view that DARO is standing in the way of the clinician's decision that there should be a review, because a review is in the clinician's view needed. And if you're not listing the patient for review but, instead, putting them on DARO pending receipt of results, that's diminishing the clinician's role and avoiding or preventing the patient coming in for review as per the clinician's decision. Did you use DARO? 12:44 12:45

A. We all used DARO. But if you wanted to make sure you saw somebody on a certain date you would instruct your secretary to actually offer that date. I mean some people I would have brought back within a fortnight just to see how they were doing, knowing fine rightly that some other investigation might have been after that. So there was a way of making sure that your patients were seen. So my understanding of this is that patients are still to be seen in the outpatients department, but the whole idea is that the secretary knows to expect a test result by a certain time. 12:45 12:46

86 Q. Yes. Mr. Haynes, I think, comes in on this debate. If we just scroll up, please. He explains that the DARO process is a Trust wide process.

12:46

"It is, in light of the reality that patients in many specialties do not get an outpatient's review at the time intended, to ensure that scans are reviewed and, in particular, anticipated findings actioned."

He goes on to say:

"I have no issue as a clinician or as an AMD with the process described as it does not risk a patient not being seen and acts as a safety net."

Is that sentiments with which you agree?

A. Yes. It's a safety net that the secretary is expecting a result back and for the secretary to look out for that. 12:47

87 Q. We've seen various cases. I take you to one example where Mr. O'Brien was the clinician. It concerns Patient 92 on the list. If I bring up TRU-162180. Just before I refer to that, just in fairness to put Mr. O'Brien's Perspective once again and clearly as I can, I don't need to bring the witness statement up on the screen, it's WIT-82540, paragraph 39.7, for the Panel's note. 12:47

12:48

He, Mr. Young, sorry to bring you away from reading that, just Mr. O'Brien's perspective on DARO. He concerns the practice to be concerning as he believed that it presented a very real risk that patients would not be reviewed at all. Is that something you understand? Is that the real risk of DARO or does your previous answer hold, that you can instruct your secretary? 12:48

A. Yes, my previous -- yes, my understanding is that the

patients were going to be given a review appointment but the point about a DARO report was the expectation of the result.

88 Q. This is a case, Patient 92, who was referred to Craigavon 2nd November 2017. Discharged home the following day, plan for outpatient renal tract ultrasound, which she had 16th November, reported for further investigation to exclude malignancy. I think fast forwarding really to March where it is recorded that she received a follow-up urology appointment, had a repeat CT scan on 13th March which reported a solid nodule suspicious of renal cell carcinoma, and there was no follow-up following the CT report. She attended her GP in July of that year complaining of right side abdominal pain. The GP noted that the CT report was overlooked and immediately forwarded a red flag referral to Craigavon Area Hospital. 12:49 12:49 12:50

Just in terms of the clinician, Mr. O'Brien's role in this, if we go to the findings at TRU-162813 of this review. Just at the bottom of the page, I think. Sorry, I think I'll come back to that one, a rogue reference. Thank you, my apologies. Just at the bottom of the page, please. 12:50

12:52

It's recorded that the referred to the scan took place in March and the review team have confirmed communication was e-mailed to the referring consultant urologist and his secretary and an additional secretary

because Mr. O'Brien's secretary was off on leave. The e-mail advised in all correspondence an urgent report was available, and the review team have identified that the patient's report was completed in a timely manner and escalated to the referring consultant immediately. 12:52
The review team, on the other hand, cannot confirm that the consultant read the report.

"Secretary two has advised the review team that in an instance like this one whereby an urgent report is 12:52
e-mailed, she would print off the report and leave it in the consultant's office for follow-up."

That is I suppose an object lesson where, if it isn't read, it falls through the cracks, and the patient, 12:53
fortuitously in this case, shows up because her symptoms arise and her general practitioner is alert to the failure to action on the CT report.

You mentioned earlier that you weren't alive to the 12:53
problem of Mr. O'Brien not reading results promptly when the issue was raised in 2011, but it was subsequently to become an issue that was discussed at departmental meetings. Take us through that, was there a challenge to Mr. O'Brien in terms of his approach? 12:54

A. We all would have contributed to that conversation, noting that the results should still be -- should be read. So it was challenged on a verbal basis at the departmental meeting, saying that these results are

very important to be reviewed in the knowledge that we have such a long waiting list to be reviewed.

It is absolutely fine that if you book an X-ray and the patient is known to be coming back in the month, there's your face to face and can put it across to the patient. If there's the expectation that the patient comes back in the month, but doesn't get back for a year, then we know there's a distinct problem there. So we are already aware, with our very long outpatient backlog, even with our request for the patient to come back at a certain date, it doesn't happen, so this is very important that the results are looked at. This has been brought up at the departmental meetings and said how important it is to do. But, you know, it's following through on that and making sure that the person does it, obviously, is the issue. But it was discussed and the importance of it mentioned. 12:54 12:55 12:55

89 Q. Was it discussed in a general sense: Listen up, all of you in the team, or was it recognised that Mr. O'Brien was an outrider and it was discussed for his benefit, if you like? 12:56

A. It was discussed for his benefit. Everybody else looks at -- well, as far as I know -- I do, I know that Mr. Haynes does, and I know that the other two, Mr. Glackin and Mr. O'Donoghue do so and comment on the amount of results that we're expected to sign off in our admin time, but it's done. 12:56

90 Q. Just the current arrangement, I know that you work now

on a part-time basis having formally retired. In terms of the safety net in place to ensure that unactioned or unread results is known to the wider system, I understand that there's an electronic facility that draws to the attention of both the referring consultant and the Associate Medical Director and perhaps others if there's a problem?

A. Yes.

91 Q. Can you just briefly describe that for us?

A. So the results are, now, produced from the NICR, it's not a paper version, it is the results given a date to come back from -- they're produced, and then there is a time line, and it does x-rays, bloods, microscopy, and it does it on a two-week basis. I think it's yellow, orange, red. 12:57 12:58

92 Q. I'm not sure if we have that precise example.

A. Is that what you are referring to?

93 Q. I hope so. TRU-301800. I want to see if this illustrates your point?

A. I think that might illustrate it better. Yes, that's exactly -- 12:58

94 Q. This is directed to you last year?

A. This is directed at me. My take on this is that this was relatively recent. This is a fabulous way of ensuring that the results are up to date and it lets everybody see that. It's all on the one page, as you can see here. So this will record, as I say, x-rays, bloods and microscopy. It's done on a fortnightly basis, that if you haven't signed it off, it goes into 12:58

the next box. If you're behind in a month it goes into the red. And the important point with that, I'm led to believe from Mr. Haynes, is that if it gets to the 7th week, then it does get lost in the system. It doesn't do a "+36". So that's why it's red, to actually let you know. So it's very clear what's going on. 12:59

I understand that this might have been done for some time, but I retired in June 2022. I think this might have started before that but I wasn't aware of that process, but it certainly has become more published to us all over the summer of '22. And this is produced on a weekly basis. I'm taking it it is sent to us. 12:59
I appreciate that this has been specifically sent to me but there is a general report of this sent to all of the consultants on a weekly basis. 13:00
MR. WOLFE KC: Very well. It is 1:00 o'clock, we'll leave it at that for lunchtime.
CHAIR: It is just after 1:00. We'll come back at 2.05, ladies and gentlemen. 13:00

THE INQUIRY THEN ADJOURNED FOR LUNCH.

CHAIR: Thank you, everyone.
MR. WOLFE KC: Hopefully the final lap, Mr. Young. 14:03

Just briefly before lunch we touched on, in your evidence, a discussion you said took place at a departmental meeting, focused on Mr. O'Brien's issues

in relation to actioning results, reading results and actioning them. Can you remember approximately when that was discussed? Was it triggered by any particular event or incident?

A. Triggered by an event or incident, apologies, it might have come up as part of a general discussion about the likes of triage and how you handle data. But it wasn't brought up as a specific topic, from what I can remember. It wasn't on our list of tonics. I don't know what dates, but it wasn't just brought up once. We have -- it was part of a general discussion about how a practice is run, shall we say. Is that fair enough? I can't be more specific. 14:04 14:04

95 Q. Is that back in the mist of time or more recent times? In other words, there's a couple of pillars there, the was the 2011 intervention, which I mentioned, the patients case I mentioned to you, which is a 2018 case but the SAI wasn't reported until 2020. 14:05

A. Okay. Our departmental meetings had been more active with the arrival of Mr. Haynes and Mr. O'Donoghue. We would have had some meetings before that, when Mr. Suresh and Mr. Connolly were here. But it's been, you know, between '14 and now. 14:05

96 Q. Okay, thank you. Let me bring you to the last of the appraisals, 2015. We can see that it wasn't signed off until 23rd December 2016, which was, as I think I remarked earlier, on the eve of the MHPS process which a decision had been made to pursue that process a day or two so before, Mr. O'Brien wouldn't have been 14:06

aware of it, I don't think. But, certainly, in the course of that year, 2016, he had been brought to a meeting, as we'll recall, a March 2016 meeting. You'd had a conversation with Mr. Weir. There was a sense that things were coming to a head. You wanted to speak to him. You wanted to have an office meeting before Mr. Weir got to them, and we got all of that. 14:06

In that context, is it not remarkable that the appraisal didn't deal with any of the issues that were, at least on the face of the paperwork, didn't deal with any of the issues that were to be part of the MHPS and which you were aware of? 14:07

A. This appraisal was his 2015, so it was meant to be the activity during that year. As I said, his appraisal was always rather delayed in it being done. So it is all out of sync, so to speak. It should have been -- I mean his 2015 appraisal should have been done, certainly, in the first few months of the year. 14:07

97 Q. Sorry to cut across you, it must be a difficult exercise involving some mental gymnastics. If you're aware of issues that have come to a head in 2016, you're having the conversation in 2016, do you keep it rigidly to what has happened the year before? 14:08

A. I was trying to deal with the year in question. It may have been the wrong thing to do, I accept that, but it is meant to be the appraisal for that particular year and dealing with the information that is supplied to you that is actually covering that year. 14:08

98 Q. That was the year, 2015, where Mr. Haynes had raised the private patients issue with you on two occasions. I don't know whether you consider it would be appropriate, but no mention of it in the appraisal correspondence? 14:09

A. That's correct. As I mentioned to you earlier, I'm afraid that those emails had -- I had forgotten about the importance of.

99 Q. Yes. One issue that was certainly live but maybe developed after 2015 was the issue around the safety 14:09 alert that came via the coroner into the deputy medical officer --

CHAIR: Chief Medical Officer?

100 Q. MR. WOLFE KC: His or her deputy at the time, I think, took the lead on the issue with the correspondence. So 14:09 that was an issue that came in to The Trust, I think it was 2015. But what I want to ask you about is Mr. O'Brien's response to it, indeed, the response of you and your colleagues to the policy that was handed down by the Deputy CMO in August 2015. You'll recall 14:10 that there was a need for The Trust to develop an action plan?

A. Yes.

101 Q. We can just look briefly at -- well, I'm not sure -- in the interests of time, the Inquiry is familiar with 14:10 that background.

Once the policy was written, the Urology Service obtained the use of a number of bipolar instruments to

trial. I just want to bring up Mr. O'Brien's response to that. It's TRU-395975. He sets out his experience of using it and he finishes by saying:

"The audit asks the question whether the trialists would be happy to use it. His answer was a definite no. I will do if I have to. I just do hope that the operating procedure will allow me to continue to use monopolar, as it is very much superior." 14:11

That was his view at that point. If we go to TRU-395978, a month or so later. He's explaining he last used the bipolar two weeks ago to resect a moderately enlarged prostrate gland. He had to abandon after ten minutes because of bleeding and poor irrigation, and moved presumably to monopolar and glycine. He explains his experience that bipolar had placed the patient in interoperative danger and he salvaged the situation by switching to monopolar. 14:12

"I have therefore pledged not to do so again. I will not use or try bipolar resection again." 14:13

It was to be I think a full two years from that point before The Trust acquired the equipment. In fact, at one point you wrote to the powers that be to say this is a safety requirement handed down to us by the Chief Medical Officer's office. We're going to stop TURP -- this is towards the end of 2017 -- we're going to stop 14:13

TURP until you get the equipment in place. That quickly led to the situation whereby in I think March 2018 the equipment was in place?

A. Yes.

102 Q. You said in, I think it's, I'm not sure if it is your statement or -- let's bring it up, WIT-54057. This is a record of a discussion in a departmental meeting, essentially about which equipment to buy. There's a number of options. I think if we go to the bottom of it, just over the page. So there was a vote on which to buy and all the urologists, it's recorded, have backed this decision with a unanimous vote. Mr. O'Brien being an attendee at that meeting, and yourself and others, Mr. Haynes was the only absentee. Does that suggest that Mr. O'Brien was in favour of the purchase of the equipment, not necessarily committing to use it, or was he committing -- was it your understanding that he was committing to use it? 14:14 14:14 14:15 14:15

A. This study was to look at four bits of equipment by these suppliers logged here and we were assessing which we felt suited Craigavon Area Hospital and all of the surgeons involved in the system. So we were trying to accommodate everybody's wish. This was an assessment of the kit and the kit was obviously one that we knew could be interchanged fairly easily between the use of saline and the use of glycine. This was, as I say, to accommodate the team's approach to the introduction, gradual change over to the system. The operative technique is fairly similar between the use of 14:15 14:16

monopolar and bipolar. It's not a new technique, it's just a slight change in how you do the resection.

103 Q. Why, just very briefly, if you can, why was it considered to be a safer method to resection, the use of sodium and the bipolar particular instrumentation, why was that regarded as a less risk environment for the patient? 14:17

A. Okay. This morning we talked about hyponatremia and glycine and changing to saline changes that dynamic in that you are cutting out the hyponatremia component of it. The use of saline is not without its risk factors either. If you get an excessive amount of saline on board you can get cardiac issues, but in general it is noted to be a safer option. And it comes back to the original coroner's case. This was a resection of the uterus in a female. If you don't mind me passing comment, hyponatremia in a female is much more risky, and that's what happened in that particular case. So trying to transpose all of that information over into the use in a gynaecological setting in the hospital as well as from a urology perspective, it was the way to go. 14:17 14:18 14:18

104 Q. Yes.

A. Hence --

105 Q. You've recalled in your statement, this is paragraph 6.6 for the Panel's note: 14:18

"There was an adaption required to our surgical technique but overall the majority observed that it

wasn't a major issue."

A. Yes. So it's the same instrumentation, it's the same use of the mechanisms within the scopes, it just -- when you're resecting with a monopolar, it's quicker with the loop, it's like using an ice cream scooper, if you want to use it that way, as an analogy. You just had to use the loop or the scoop a little slower to get the cut right. So it's a little adaption. 14:19

The second point to it is that I observed that the haemostasis used during the surgery isn't maybe quite as good as the instruments used in glycine, but it still works, and it's a fair swap from a safety perspective. 14:20

106 Q. Now, you observe in your statement -- maybe just bring it up, WIT-103617, paragraph 6. So you personally discontinued the use of glycine when the new resective scope system was on site. And you understood, next paragraph, the other urologists had also changed to the saline system. Why did you change? Did you feel it was an obligation to change given the direction signaled by the Chief Medical Officer's office and the adoption of a policy by the Trust? 14:20

A. Yes. It was a directive. But, in saying that, having used the use of glycine for 25 years and well used to it, I observed that this was coming through as a safer option. It was easy to learn and, as a comment, that the use of the cut and the diathermy were not quite as 14:21

good as the glycine, but was a fair swap because of the safety issue.

107 Q. You go on to reflect there, paragraph 6.9, that you were aware, and we've seen the emails, that Mr. O'Brien did not like the saline system, he regarded it as an inferior system. You personally thought he needed a further period of time to get used to the saline system. It has only come to your knowledge recently that he never did convert to using saline and continued to use glycine. How was it not obvious that he had failed to make the transition? 14:21 14:22

A. We all operate independently. I don't go to Mr. O'Brien's theatre list. I don't think any of the rest of us go. We all have our theatre days, and there's very little overlap. I had thought that, and again hadn't heard until I directly asked the question from theatre, had he actually moved over. So I thought that we were -- 14:22

108 Q. When did you ask that question?

A. Very, very recently. 14:23

109 Q. Yes. Of course, upon the purchase of the equipment it might be suggested that clinical lead or perhaps the clinical director would assemble the team and say, right, we have the equipment, you know the policy, you know our expectation, I expect each member of the team to enter into a commitment to use it, because it is safer, it has been directed upon us by the CMO. Was there no such conversation or communication with Mr. O'Brien? 14:23

A. I think there was the expectation that he would move like the rest of us too. I don't remember him informing us that he had not moved over. I agree, it's a question maybe I should have asked. This is a theatre directive as well. It's not just me in the department --

110 Q. Of course?

A. -- it's not just me in the department asking the question. There's CDs and AMDs. I'm not entirely sure if they knew Mr. O'Brien hadn't moved over either. 14:24

111 Q. We can see, if we bring it up briefly, it's the policy or the directive coming down from the CMO at WIT-54052. Under the heading of "monitoring", it is said that the Trust's audit department will need to monitor that the recommendations are implemented. An audit would have 14:25 revealed outliers in terms of the expected practice, enquiries aware of no contemporaneous audit. Was this matter audited?

A. Not to my knowledge.

112 Q. You, as I noted, reflected in your statement that you 14:25 have recently became aware that he never did covert. The Trust has recently supplied the Inquiry with the findings of an audit which Mrs. Corrigan has overseen. I just want to bring that to your attention and have your comments, please. It is at TRU-396059. Take it 14:25 from the top of the page. Thank you.

So the question posed by the Inquiry is:

"Do we know whether Mr. O'Brien did, in fact, use the bipolar equipment or did he continue to use monopolar in glycine, as his emails suggest was his intention?"

The methodology is briefly explained: 14:26

"As part of this audit it was felt that the best period to look at and determine did Mr. O'Brien use this equipment was January to December 2019, which was a year after its purchase, and to ensure equity of the 14:27 process the audit was conducted across all of the consultant urologists."

If we scroll down we can see more detail in this document and the Panel can look at it. If we scroll 14:27 down to the next page, please. Just there. This is the number of charts requested for the purposes of analysis. So they didn't, for the purposes of this audit, look at every case but they took a pro rata sample, making sure that there was similar equity or 14:27 a similar pro rata applied to each consultant. The results are just down the page and we can see each of the consultants. Maybe jump immediately to Mr. O'Brien's. On the left-hand column is the instrumentation. He performed nine cases with 14:28 monopolar. One other patient of his was operated upon by Mr. O'Donoghue, who used bipolar. Seven of these cases were conducted in glycine. Two other of the monopolar cases had no indication of the fluid used in

the fluid balance notes. When Mr. O'Donoghue was the operator on that one case it was sodium chloride used.

You can observe, yours is at the bottom of the list, towards the bottom of the list. So three bipolar and two for which the product was awaiting notes. I assume that might be updated for us in due course. So of the three that they looked at in yours, sodium chloride was the irrigation fluid used. We can see across the other consultants that bipolar is the instrumentation of choice in sodium chloride as the irrigation fluid. 14:29 14:29

So your sense of it now is that maybe making real your suspicions that Mr. O'Brien didn't comply and was an outlier here? 14:30

A. Yes, correct. This is the proof.

113 Q. If I could just bring up something Mr. Haynes has said. It is WIT-53949. It is 69. So he's discussing his own knowledge of the approach adopted around this issue and he's referring to Mr. O'Brien at the top of the page here as: 14:31

"Subsequently expressing the view that he would continue to use monopolar resection glycine and therefore not conforming with the policy." 14:31

On reflection he says:

"This unwillingness to conform with recommendations

from others should have provoked concern regarding wider aspects of his practice, especially with regard to delivering treatment in line with NICE guidance and MDM recommendations."

14:31

I suppose the broader point, and I'll ask for your comments on whether you agree with that, is that you have a number of practice issues which, I suppose, any one of them in isolation may not be regarded as too bad or terribly worrisome. But when you join them all 14:31
together, and take this example, a very clear recommendation or direction coming down from on high for good reason, and Mr. O'Brien, on the face of it, and we can ask him about his reasons, says, no, I don't propose to do that and it's not properly overseen by 14:32
The Trust. The Trust, through people like yourself, Mr. Haynes, have an appreciation or a suspicion, perhaps, that he's not going to comply, but it's not properly supervised; would you agree with that?

A. I would agree with that. It's not -- we had a plan of 14:32
action to put this in. There was a training scheme to do it, and it wasn't conformed. And there's an element, also, that he didn't continue to say that he wasn't using it. There was a learning curve and there was the expectation that somebody would come back and 14:33
say, look, I still can't use this. So there's a bit of an onus there as well. But it is two-sided. The other option would have been to take glycine out of the hospital completely. I had that with the use of water.

There was water used for irrigation at one stage on the ward and in A&E. And that was found that they had three litres of water used for irrigation, which is not good. So there was an action plan, again, I can't remember dates exactly, but myself and the Chief Pharmacist went around all the wards and to A&E to take out water as an irrigating system, and it wasn't purchased anymore, from what I gather. So there was an action plan for water which was used for a bit of irrigation and that has been taken out of The Trust, actioned by myself and the pharmacist. But, yes, you are correct here, it wasn't followed through as part of The Trust. 14:34 14:34

114 Q. I introduced this issue in the context of appraisal, the point being that within the timeline, the Medical Director's directive came in in 2015. I fully accept that it wasn't until 2018, perhaps, that anyone would have realised that Mr. O'Brien wasn't compliant. 14:34

Having said all of that, and thinking about appraisal overall in light of your evidence, do you consider that appraisal in your hands with Mr. O'Brien was poorly focused and ought to, but failed to, get to grips with some of the issues that we've discussed? Or, in the alternative, do you consider that appraisal at that time it in its development wasn't a particularly effective tool anyway to address these issues? 14:35 14:35

A. I think it's the latter. I could have challenged him more but I don't think appraisal was set at that level.

It was the information supplied. At that time you chose your appraiser, whereas the more recent method, which is good, is that you are actually given an appraiser, and I think that's meant to change every three years. So if you have a five-year cycle, you're going to get two appraisers. 14:36

Now, would the new system pick up on what I didn't ask or what wasn't asked? Would the new appraiser know to ask about the untriaged letters unless the appraiser was told about that in the first place? So, again, there's an element of the information that you're supplied at the time and it is a retrospective collection rather than a forward-thinking one. So there is advantages to the new appraisal system. It is more robust, I understand that, and inquisitive, and the appraiser is from a different specialty and, therefore, might not be as closely attached to the clinician. Again, maybe I found it a little bit too close a situation within the same department to sort of challenge things. There's an element of being told if there's an answer for everything, that Mr. O'Brien seems to have, he always seems to have an answer to explain something, then it seems to cover the situation a little bit. So I think there's a balancing act and, again, it is going back ten years to when I did the appraisal. But, yes, I agree with your latter comment. 14:36 14:37 14:37 14:38

115 Q. Moving full circle, perhaps, to the early months of 2017, the consultant team is told that Mr. O'Brien has

been excluded from the workplace, that a process is to commence and your assistance and the assistance of the team is sought in order to engage with the work that Mr. O'Brien has not performed with regard, in particular, to triage. Those clinical episodes which he has participated in but hasn't written up or hasn't taken the next steps in terms of correspondence, you've described in your witness statement as this having come out of the blue. I just want to be sure I understand what you mean. The issues hadn't come out of the blue, certainly, for you; is that fair? You were aware of the issues, it was the volume of the issues; is that right? 14:39 14:39

A. It's the volume of -- it is the volume of all three components and certainly the undictated outpatient letters in clinics was something I hadn't been fully aware of the degree of volume. 14:40

116 Q. When you came to do the triage work, just pull up your statement to highlight what you found, WIT-51823, and at paragraph 65, just at the top. So you explain that you're asked to participate in an exercise to triage these outstanding referrals. You say those: 14:40

"Of those referrals I triaged several were upgraded to red flag and I asked a colleague if he agreed with my decisions. Some were clearly red flag referrals. I am also aware my colleagues upgraded some referrals. All untriaged referrals had the potential for patients to come to harm." 14:40

And you go on to add that it seems that the red flag letters that Mr. O'Brien had received had been triaged.

Just in terms of categorising, I suppose, the significance of what you discovered on the triage front, you had historically been aware of delayed triage. You have given evidence that you didn't quite come to the realisation that he wasn't doing it. But here you have in front of you a collection of cases and you are finding maybe months, a significant period of months, perhaps, after the referral had gone in, that you're having to upgrade. How significant was that in your view? 14:41 14:41

A. It's very significant. It's not spotting the red flag patient in all of the correspondence that you get. So yesterday or before I commented on, it is very important to look at all the letters to spot the issue. I personally feel, as I think I maybe said before, is that the routine and the urgent referral letters are probably the most important ones to be looking at because the red flag ones are going to automatically be seen anyway. So it is the screening of these routine and urgents are the most important. 14:42 14:42

I had conversations with Mr. O'Brien to say that these are the most important ones to look at and he had agreed that that was the case. 14:43

117 Q. When is this --

A. I was about to add that. This would have been -- I certainly do remember one of these occasions, it would have been after this event, but certainly conversations had been had before to note that a review of these letters were important. Well, I understand from some of the MHPS conversations that he also noted that that was important.

118 Q. Yes?

A. But my observations and conversations were that these were the important ones and he had agreed. So my assumption had been that he had at least viewed these letters, maybe not processed them, but at least had, shall we say, flicked through them, if you want to use that sort of terminology, to at least have them screened. Now, that was an assumption, a missed assumption, unfortunately.

119 Q. Because, plainly, you are looking at cases which appeared obvious to you to be deserving of upgrading, and Mr. O'Brien, had he looked at them in the manner that you had, would have seen that?

A. Yes. I put in this document here that I screened the letters. I would have upgraded them, and that would have been the end of it. But due to what was going on, I passed them to my colleague saying would you do the same thing? So --

120 Q. Could I bring you, briefly, to the second element of the work, the cases where Mr. O'Brien hadn't dictated or indicated the next steps for the patient following a clinical meeting or clinical review. How did you go

about that work? I understand from what Mrs. Corrigan told the Inquiry and contained in her evidence that the consultants, when doing this work, preferred to go with Mr. O'Brien's outcome as set out in an outcome sheet. Was that the approach, to go with that and then write up the next steps for the patient?

A. The outcome sheet was a separate piece of paper.

121 Q. Yes?

A. Okay, rather than what was in the notes. I say the outcome sheet was a safety net to make sure that all the information was connected. So it would have been a combination so there was a review of the chart from what I remember. I don't remember it all quite precisely, it is a wee while ago, but the charts were reviewed and if an outcome sheet was supplied, then at least you knew what was planned.

122 Q. Just maybe to assist you and your memory in this respect. If you go to TRU-268814. Mrs. Corrigan is -- at this point this is June 2017. She is, I suppose, summarising the findings of the exercise. So there's 110 patients needed added to the review outpatient list, 35 to be added to the theatre waiting list. You can see there are three patients the consultants have particular concerns about. Then some comments at the bottom giving an indication of the delays in Mr. O'Brien's dictation work. It maybe gives you a refresher from your memory.

Can I ask you this. When she gave evidence earlier this year, Mrs. Toal, who you may know from The Trust, she reflected that given the wider concerns that came to the fore in 2020 with regards to Mr. O'Brien's practice, is it not worrisome that the exercise that the consultants performed in 2007 didn't pick up on some of the themes that were to emerge later? I'm thinking, perhaps, about the Bicalutamide issue, about delays in referral, that kind of thing. How carefully and how intensively was the process that you and your fellow consultants were asked to participate in, how was that conducted? 14:48 14:49

A. There was a list of exercises to complete, one of which we've covered as the untriaged. This is a further example. We were processing the information supplied to us to give back to The Trust to put it into some form of an action plan. Now, we as consultants weren't asked our opinion on what we thought should be done, if that's what you're asking. But, I mean, we were aware of the joined up writing here to a degree with the untriaged letters, we were doing it. We were doing these outpatients that weren't being actioned with the admin. So we were aware of this but, by the time all of this was going on, Mr. O'Brien I think was back at work and had been a decision by the Trust to -- that that's what was happening. 14:49 14:50 14:50

123 Q. You'd obviously worked with Mr. O'Brien by this stage, this is 2017, for the better part of two decades, just a little shy of that, perhaps. You, presumably, had

a high degree of trust and confidence in his abilities as a clinician. Did what you see here through this exercise cause you a crisis of confidence in him?

A. Yes, it certainly did. I was surprised that the Trust hadn't asked our opinion at this time of whether his return was as prompt as it had been. I personally thought that added time should have been set aside to let the dust settle, find out what was coming out of all of this. I thought that was an alarm bell to me but, again, we weren't asked. I may have commented that I thought this was a little strange, that he was coming back so early, but, again this decision I understand was taken at the top level. There may be a process involved in all of this about exclusion for a month and beyond. But taking it as it stands, I was rather amazed that he was allowed back to work, frankly. 14:51 14:52 14:52

124 Q. As part of that answer does it suggest that, if he was coming back to work, there ought to have been -- I use the phrase deeper dive, some people use 360 degree consideration. In other words, a comprehensive exploration of his practice to see what else there might be of concern. Do you reflect back and think, well, that would have been appropriate? 14:53

A. Yes, reflecting back that certainly would have appropriate. Again, should we have been suggesting that to The Trust? But, again, I think the Trust's higher echelons of administration and management and at the Medical Director level, you know, probably should 14:53

have been making that decision along with us, obviously.

125 Q. For the voidance of doubt, in case it might be suggested that the problems of 2020 were there to be found in the 2017 notes or exercise, what I'm suggesting to you is broader than that. 14:54

A. Yes.

126 Q. While there might have been other issues to be found in the 2017 notes, the question which I'm asking embraces looking at Mr. O'Brien's practices within the MDM, for example; his prescribing practices, for example; the timing of his referrals to oncology. That would all be capable of being scrutinised, would you agree? 14:54

A. It would have been. Sorry, I thought you were referring to these letters of us screening them. That's not what you're asking. A deeper dive is not what our role was doing here. 14:54

127 Q. Of course.

A. But, yes, I agree, there was lots of pointers here that was giving the trust an opportunity to say, look, I think there might something more to this. So you are correct. 14:55

128 Q. You said a few moments ago that you had spoken to Mr. O'Brien, you think, both before this and after this about his approach to triage, that the routines are almost the most important, they should be the ones you start with. You explained yesterday that is because a red flag is a red flag, it's not likely to change in all likelihood. Now you haven't mentioned such 14:55

conversations in your statement. Did you follow that up with him at any point?

A. The last conversation I had with Mr. O'Brien on this very topic was in a corridor with a very direct question, you know, a one-liner, and he agreed fully that this was the way to do it. So I was taking it that he agreed with what I was saying. It wasn't just a conversation, it was a little bit more pointed. 14:56

129 Q. Just to orientate us in time, is that after this all came out in the wash? 14:56

A. That particular one was after 2017.

130 Q. Yes. Could I bring you to the outcome of the MHPS process. I want to draw your attention to Dr. Khan's conclusions. He was the then-acting Medical Director and he was also the, I think his title was Case Manager for the MHPS, the investigation having been conducted by Dr. Chada. If we go to AOB-01923, just the final conclusions at the bottom. And he describes that the investigation focused on the administrative practices of Mr. O'Brien. 14:57 14:57

"The investigation report presented to him focused centrally on the specific terms of reference set for the investigation. While the report is outlined above, there have been failings identified on the part of Mr. O'Brien which require to be addressed by The Trust through A Trust conduct Panel and a formal action plan." 14:58

The next bit is the bit directed to management.

"The report highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. 14:58
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." 14:58

Scrolling just down a little bit, the last paragraph:

"In order for the Trust to understand fully the failings in this case, I recommended The Trust to carry 14:59
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."
14:59

MHPS is an employee/employer process, there's no doubt confidentiality and sensitivity issues around findings. But here you have a specific conclusions directed towards management of all hues. Were those conclusions ever drawn to your attention? 15:00

A. I've only been drawn to the conclusion of this, I believe it was October '18; is that right?

131 Q. Yes, that's when this was published or thereabouts?

A. I was unaware of the publication, that hadn't been

supplied.

132 Q. Regardless of whether you saw the document, it's the sentiment, it is the message?

A. The message, okay, I thought you were asking me if I knew about this. I agree with the sentiment here. This was the conclusion that an external review should have been undertaken. And, from what I said earlier, I would have agreed with that. It obviously needed somebody else to have a look at it, from a supportive point of view and correction. 15:00

133 Q. And my question is those being, I suppose, the damning findings of the performance of management at all levels with operational and medical, you being in the management framework, albeit at a first-step level, I suppose, did anybody sit down with you at any point and say this is what we have found about the performance of management, we need to talk about this? 15:01

A. No. I don't recognise that.

134 Q. Did anybody come to you and say, listen, you were the clinical lead for all of these years, you appraised Mr. O'Brien for all of these years, you never once raised an incident report in respect of his conduct and these things went on and on and on and were never resolved, this is what you need to think about going forward. Any conversation like that? 15:01 15:02

A. I don't remember anybody going into that depth.

135 Q. It is right to say that at no point did you ever raise an incident report in respect of Mr. O'Brien's behaviours?

A. I preferred to talk about it. I would have gone to the likes of Martina to discuss it. I do have one incident that the Trust wouldn't have been aware of, and that related to the prescription of the tablet called desmopressin. It's rarely used. It's used for nocturnal polyuria. It's a specific drug used in the elderly. It has to be used with a bit of care. Its very infrequently used. I prescribed it maybe two or three times. It's of a low incidence.

15:02

136 Q. Just to assist the Panel with this, we can draw your remarks on this to the Panel's attention through your statement. If we go to WIT-104217. This is one of your addendum statements and you're explaining, just scrolling down to paragraph 7. You say when you were triaging this particular patient you observed in correspondence that Mr. O'Brien had commenced on 200 micrograms of the preparation whereas the appropriate dose, I think you say somewhere, yes, was 25 micrograms. The patient, presumably because of a correlation with the excessively high dose came back into the system with hyponatremia which happily resolved.

15:03

15:03

15:04

A. Yes.

137 Q. This is July 2018. The MHPS investigation had just reported, Dr. Khan was about to write his determination, which I've read to you. You've indicated just at the bottom here that you wrote to Mr. O'Brien about this issue but, having reflected on it, you acknowledged that an option open to you in 2018

15:04

would have been to complete an IR1 form?

A. Yes, I agree with that. I did this correspondence having triaged the letter on that date. I thought it was important to try to correct early. I thought a correspondence with Mr. O'Brien on the issue would have been the appropriate thing to do to correct the issue fairly promptly.

138 Q. While you are speaking I'll pull up the e-mail, it is WIT-104223. That's you writing to him explaining concisely the problem. Did you, in writing that, give any consideration to, I suppose, the many years of dealing informally with Mr. O'Brien and the problems that were being drawn to your attention? Was this not a situation where as well, perhaps, as writing to him, the issue should have been placed on a formal footing through the governance professors. It was a medication error, potentially a serious one giving rise to harm to the patient. On any analysis that is something that needs closely scrutinised? 15:05 15:06 15:06

A. Yes, I agree. I was obviously doing triage at the time. That's a large volume of information to try to get through in a sitting. I saw this, I wrote an e-mail to have it corrected. I should indeed have filled in an IR1 form, I do accept that. But having observed myself sometimes the length of time to get the full circle of an IR1 back, in my own case that took 18 months of a report on me. I thought this was appropriate to address at that precise time rather than to wait for the cycle of the IR1. I should have done 15:07 15:07

both, I did this option.

139 Q. Can I move briefly to discuss some MDT or MDM issues with you. I'm conscious that your role in the urology multidisciplinary team certainly wasn't a regular one from 2016 or thereabouts, but on occasions your patients would be discussed at MDT. 15:08

If your patients are discussed, does that necessarily require your attendance?

A. When the MDT was set up originally, we were informed there was -- two of the urologists were meant to attend to it and not the full team. As time went on I understand that the team was meant to be there. In saying that, with us in Craigavon, they realised that I didn't have enough clinic space for my new patients and on a Thursday was the MDT, was meant to be my new patient clinic and for the last hour of the MDT they were meant to wait until I had finished my client to go to it. But either MDT finished early or my clinic went on beyond the time, and my colleagues discussed my cases with an MDM outcome, having supplied them with a clinical report to start with. 15:08 15:09 15:09

140 Q. Yes. One of the themes that the Serious Adverse Incident reviews explored in 2020 was the whole area of whether the MDT was appropriately resourced, was it sensitive to the need to ensure appropriate patient care pathway for the purposes of tracking to ensure that MDT decisions were implemented and that kind of thing. It observed that, in its conclusions that there 15:10

was a repeated failure to appropriately refer patients and it suggested, by way of recommendation, that one of the ways to catch that or identify it and remedy it is to have better tracking and better, I suppose, use of governance resources to get to grips with any problem. 15:11

You refer in your witness statement to two cases or two patients for whose care you were responsible where a problem arose in terms of the referral. And, no doubt, in any system these things can happen but the 15:11 problem being, perhaps, that it wasn't immediately picked up upon by The Trust's system because the safety net -- and maybe you'll help us understand if there was a safety net -- the safety net, if there was one, didn't work or there wasn't an effective safety 15:12 net.

So the two issues that you describe concerned patients 166 and 137. I just want to deal with these very briefly, if you would. 15:12

Patient 166, an incident report was raised in relation to that patient. We can see this at TRU-165621. So this is August 2017. The description is what I wanted to bring you to. It says that the patient's wife 15:14 contacted the reporter, that's Nurse Campbell...

"As they were expecting an appointment with oncology or surgery to discuss curative treatment for prostate

cancer. Upon checking with Belfast they had no record of a referral having been received."

The action taken was to bring this matter back to an MDT meeting and, as I understand it, correspondence with the Belfast Trust to get the patient seen quickly, given that the problem had been identified after, I think, the passage of three or four months. What had happened in this case to the best of your understanding? What has caused the problem? 15:15

A. This man and his wife had attended post an MDT for a record of their treatment options, which was either oncology or surgery. I had written a letter to the GP and, unusual for me, I sent a copy of the letter to the cancer tracker, asking if she would forward it on to the oncology and surgical team. So there was the expectation that that was sent on. Now that, I must confess, is not my normal approach. I usually would have written directly to the oncologist and the surgeon. I'm not entirely clear why I didn't copy them in. So there was the expectation -- it was a triangulation of the communication, but maybe that didn't get through properly. Then, when the patient's wife rang through to Thorndale to inform us of this, this information was passed from Dolores to Kate O'Neill who was then to investigate it, came to speak to me and I then dictated a fresh letter to the oncologists who then processed it through their MDT. 15:15 15:16 15:16

141 Q. So the safety net here, if it can be called that, is

the GP becoming aware of the situation and, I think it was the GP, wasn't it? The patient themselves.

A. It was the patient ringing back into Thorndale and speaking to the nursing team, who was the sister at the time, and then passing it to the CNS. 15:17

142 Q. In the 2020 SAIs that we've looked at, the safety net is of the described as the key worker, the specialist nurse, in a triangle with the secretary for the consultant, with the consultant in there, as well as the tracker, perhaps. What happened that the safety net, in this instance, appears to have failed? 15:18

A. The communication, obviously, didn't get to the city. If you go back one step, maybe either -- well, either there wasn't a copy of the letter available to the tracker, or the tracker didn't send it on or there was a paper chase issue of not being passed on appropriately. Is that answering -- 15:18

143 Q. How could that be avoided today?

A. Undoubtedly --

144 Q. Or how would it be avoided today? 15:18

A. Well, on my opinion the new process of what's coming through is of the audit. I mean, I think a letter should be -- I think the letter to the oncology service or the ongoing service should be copied into the cancer tracker system and there's a physical letter to prove you have done what you said you were going to do and, you know, there's a good audit trail. You know, each month there's the opportunity of tracking to make sure that all the MDT outcomes have been processed as they 15:19

were meant to be, one, in their content and, two, that they have gone to the right place, and I think that possibly would have picked that up.

145 Q. Could I bring you to the case of patient 137, the second patient that you mentioned in your statement. 15:20
The IR form is to be found at WIT-100386. Just scrolling down to get the description from Mr. Haynes. So the patient was discussed at an MDM on 12th January 2017. The outcome was that he was to be referred to the endocrine MDM. Unfortunately 15:20
this didn't happen. A further GP referring on 12th May 2017 brought this to my attention -- that's Mr. Haynes' attention -- and a referral has now been done. So there has been a four-month delay in this process. 15:21

I think if we scroll down four pages to 100390. It describes the action taken is that the consultant has been spoken to, that's you, and the importance of follow-up stressed. 15:21

"it was an oversight on his behalf as he was not at the meeting."

So this is the MDM meeting. 15:21

A. Yes.

146 Q. The action that came out of it was endocrine and MDM referral. You missed it, you weren't at the meeting, the letter of referral didn't issue?

A. Yes.

147 Q. Does that sum it up?

A. Not fully.

148 Q. Okay.

A. This man was discussed on 12th January. He had a clinic appointment with me on 19th January, which is the week later after MDT. This is my normal practice is that patients who attended MDT came for a consult. This man was from the Southwest Acute Hospital area, so it is a fair journey up to Craigavon. My understanding is that there was a phone consultant between the cancer tracker and my secretary saying, look, it doesn't need a consult as Mr. Young normally does, a letter will do. So, now, I'm sure that correspondence was passed on to me but I missed that then. When I went to the clinic I would have observed that this man had DNA'd and when that happens then there's a cycle of bringing the patient back to the next clinic. But that got lost because it was meant to be a phone call to the patient and then a letter. 15:22 15:22 15:22 15:23

So, again, coming back to the exact comment we were talking about just before, tracking of the outcome at a month would have actually picked that up.

149 Q. Yes. You were the subject of correspondence in relation to that incident. It is WIT-100383. It's sent by 14th August 2018. So the processing of the issues has taken a while to come through the system and back to you for what they asked for here is for you to: 15:23

"Provide reassurance that you now have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner." 15:24

I don't think we have any written response to this correspondence. Were you pressed in any way provide reassurance?

A. I had a face-to-face meeting with Mr. Haynes about this issue in my office. We had a long conversation. 15:24

150 Q. What kind of assurance did you give in that kind of situation? Was an important gap in this your absence from the MDT, is that considered to be a relevant factor? 15:24

A. No. I'm annoyed that I didn't action this particular case. It's a little -- this is very unusual for me to have skipped or even my secretary to have skipped the point. At the end of the MDT meeting there's -- originally the list came out as one big, long list 15:25 alphabetically of the patients and you had to try to find your patient on the list. Then it moved to the cancer system, logging a list of patients per consultant, so you actually knew your list, and also -- so Kate O'Neill would come down after MDT and say, 15:25 Mr. Young, here is your list, here is what we talked about and the outcome is going to be printed off and it's sort of cross-referenced, what you're meant to do. And especially trying to catch these odd cases. In

other words, the odd cases being the ones that maybe aren't coming back to the clinic which then would be caught. There was a process of catching, the phone call or the letter. But, as I say, the vast majority of my patients come back to actually see me in person. It's just the way I like to run my practice.

MR. WOLFE KC: Chair, I have three short issues to complete Mr. Young's evidence.

CHAIR: Shall we take a shorter break then, maybe ten minutes, and come back at twenty to. 15:26

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

151 Q. MR. WOLFE KC: Good afternoon again, Mr. Young. I want to deal briefly with the Bicalutamide issue as we know it. Concern has been expressed through the Serious Adverse Incident review and some of the cases that made up that review and, subsequently, the Trust's look back and audit that Bicalutamide was being prescribed inappropriately. Sometimes patients were getting a suboptimal dose of 50 mg, in other cases there seemed to be a tendency towards maintaining patients on 50 mg over a lengthy period of time when surveillance, for example, might have been the appropriate response and Bicalutamide unnecessary. 15:39 15:40 15:40

Could I draw your attention to a patient's case that has your name on it. It's Patient 141. The case comes

out of a Multi-Disciplinary Meeting in September 2019, AOB-09572, Patient 141. You're the surgeon, and the description on this MDT read-out is that this gentleman with a clinical diagnose of prostate cancer, four years. He has been on Casodex 50 mg for some time. His PSA is now, could that be right, 105?

A. Sorry.

152 Q. His PSA is 105, is that right?

A. I know the case.

153 Q. Okay. Can you help us out in terms of the description here of the patient having been on Casodex, which is the generic name for Bicalutamide, for some time. 15:42

A. I can clarify that more.

154 Q. Please.

A. I can clarify the case and why he was on this dose. So this patient is from Fermanagh. I'd seen him at the clinic there. He had prostate symptoms, poor flow, and then in 2014, when he was 80, examination of his prostate I felt just wasn't quite normal. It felt as if there was a tumour within the gland but his PSA was acceptable, it was below 10 at that stage, this is 2014. I explained to him at that stage my concern but he was resistant to investigation and didn't want treatment unless it was necessary. 15:42 15:43

So I reviewed him on an annual basis. His PSA did climb. I think in 2016 it was up at 26. I again explained to him, you know, there is a treatment path for this if you wish to avail of it. He was keen just

to have therapy if necessary. So, to me, I twigged that, right, we would do a bone scan and see if it had spread anywhere, which would indicate a strong indication to move on, and the bone scan at that stage was clear. 15:44

So he continued to be reviewed on an annual basis. His PSA then got to 62. He was still very resistant to having therapy or investigation unless it was necessary. Then it got to the stage that his PSA got 15:45 to 112. Now at this stage my conversation with him changed from, you know, 'look, don't be sitting on this, you should be having a therapy', and he asked what was the most simple to look after the situation. At which I told him to start on the Casodex at 50 with 15:45 the subsequent option of either converting to 150, the standard dose, or, my preference was to start the injection treatment.

He then, instead of an annual review at that stage, he 15:45 came back at three months and had his PSA checked. I found that it had dramatically dropped from 112 down to 16, which I thought was a good response.

Now, going on from that he then had a review either 6 15:46 or 9 months later, again with myself. On checking the notes I then realised that I thought I had changed him to the other treatments, although he had a good response to the 50. And I told him, right, our

standard practice now is not to accept this but to have the injection treatment, which I thought was a better treatment plan for him. So he was keen to have the lowest dose and if you're going to have injection treatment, you have 50 mg of Casodex before you have the injection so it was going to cover that approach. Although I had thought that I'd asked for -- I think I might have actually written to the GP to say, look, here's an option to add in the injections but, as I say, it was only when he came back to see me six months later that I appreciated that he was on the wrong dose. I don't think that 150 milligrams was the right thing to do, I thought the injection treatment was better, which I started. 15:46 15:47

155 Q. In starting him on the 50, I think your point is that it was with the intention, eventually, of moving on to the LHRHA agonist; is that right? 15:47

A. Here is a man that I was trying to persuade to have treatment and he was resistant to it. So he was asking what the lowest treatment was and, yes, this was it, but with the intention of either converting him to the one -- in my letter I said it's either the 150 mgs or the injections, but in my head I was really looking to start him on the injection treatment. 15:47

156 Q. You would appreciate, would you, that 50 mgs is, as per the regional guidelines, to be used as an anti-flare agent as you're describing, prior to the injections, it has no other licensed or indicated use; is that right? 15:48

A. I use a lot of Casodex 50 and it is always before the

injection treatment. It is not used on its own. If I use Casodex on its own, it's the 150.

157 Q. How long, if you can recall, did this patient run on 50 without moving to the injections?

A. My understanding is I saw him in September of whatever year, and I reviewed him the following summer. 15:49

158 Q. He's coming to this meeting in 2019, having been on it for some time. Does that suggest that he's been on it for several years?

A. No. He was on -- no. He was on this for a short period of time until he started the injection treatment. 15:49

159 Q. Did he start the injection treatment at this point?

A. He had started -- no, I think he --

160 Q. He is coming to this meeting with metastatic disease of the prostate? 15:49

A. He had been on the 50 mgs and I had asked for the injection treatment to be started and he had agreed to that and then here's the September. So he must have come in at that stage. So I was asking the GP to start the injection treatment. But he has come in ill at this stage. 15:50

161 Q. This letter reads as if he is on 50 mgs as a monotherapy. There's no mention of the other element to the hormone regime? 15:50

A. No, I have read the letter. I asked for the GP to start him on the injection treatment. So there was the clear intention of starting him on the injection treatment.

162 Q. We have seen a range of cases where -- and this is particularly coming through The Trust's audit, where 50 mgs as a monotherapy seems to have been the approach of Mr. O'Brien and, indeed, we received evidence from Belfast Trust clinicians that as far back as 2008, 2009, perhaps into the next decade, they're observing 50 mgs as a monotherapy preference on the part of Mr. O'Brien. Were you familiar with that, that that was an approach he favoured? 15:51

A. I wasn't aware of his approach to that. I hadn't seen it in scripts. Again, our patient load doesn't cross over on a clinic appointment. So I wasn't aware of him regularly using 50 mg, I'm afraid. 15:51

163 Q. An awareness might come from discussion of patients in multi-disciplinary meetings. Did you not pick up on his preference for this monotherapy at such meetings? 15:52

A. Well, again, I was outside of the MDT on a regular basis from 2015 and, prior to that, I hadn't twigged that he was using it on a long-term basis. My clear understanding is that 50 mgs is used before the introduction of the injection. So you may see on an MDT script that that 50 mgs had been prescribed, but there was the assumption that the injection treatment was going to be following. 15:52

164 Q. Could I bring you to a concern you expressed in your witness statement that I suppose post 2018's publication of the MHPS investigation you received what I think you describe as unwanted telephone calls from members of Mr. O'Brien's family. You say that, this is 15:53

paragraph 55 -- sorry, paragraph 81 of your statement. You say:

"In mid November 2018 I received two phone calls from Mr. O'Brien's family. The first was from Mrs. O'Brien noting her anxiety that none of her husband's colleagues had rang to ask how he had been."

And, paraphrasing here, you took that telephone call to be, really, the expression of some sense of being distraught on the part of his spouse.

The second call, two days later, was from a Mr. Michael O'Brien, who I understand to be Mr. O'Brien's son, and he phoned asking more pointed questions about the process of triage and how the system works for putting patients on waiting lists and theatre lists. The conversation progressed but with what you felt was an air of intimidation. So it appears to be that both calls were somewhat unwelcome but the second of the calls from Mr. O'Brien, you're seeming to suggest, was particularly inappropriate?

A. Yes.

165 Q. What was it, in terms of its content, that you found to be intimidating? 15:55

A. Just a passing comment halfway through that this might create trouble for you and your colleagues.

166 Q. Was he alluding to any particular issue?

A. The fact that he commented on it at all I didn't

approve of, so I thought it was inappropriate to continue the conversation further.

167 Q. Did you tell him that?

A. Politely I told him this was the end of the conversation. 15:55

168 Q. Yes. He was, that is Michael O'Brien, was somebody you had met. You had attended his wedding as a guest; is that right?

A. Correct.

169 Q. Did you previously tell Mr. O'Brien that you would be prepared to take a call from Michael O'Brien to discuss matters? 15:56

A. Both conversations were out of the blue.

170 Q. In other words, you hadn't solicited them and hadn't agreed to them taking place? 15:56

A. No. They were both unexpected phone calls.

171 Q. You obviously spoke to Mr. Weir about this?

A. I thought that was appropriate to inform Mr. Weir of it, just to express my concern in case a similar phone call was going to happen to anybody else. 15:57

172 Q. Did you speak to Mr. O'Brien about your disquiet?

A. No, I just mentioned it to Mr. Weir who then, I understand, took action.

173 Q. Could I finally seek your views on the circumstances of Mr. O'Brien's retirement. He says in his witness statement, this is WIT-82628, paragraph 675, just down the page, please. He said it was never his intention to completely retire, whether on 30th June 2020 or 17th July. It was his intention, after much 15:57

consideration, to retire from full-time employment with The Trust on 30th June 2020 and to return to part-time employment from Monday 3rd August 2020. He had discussed his intentions with Mr. Young, with Mr. Haynes, and with Mrs. Corrigan. He says if he had been advised of the possibility of any impediment to him returning to part-time working, he would not have retired from full-time employment. 15:58

Do you recall discussing with Mr. O'Brien his preference to return part-time, having retired formally from a full-time position? 15:58

A. Yes. Mr. O'Brien discussed -- well, informed me that his intention was to retire in mid 2020. This conversation was, to my recollection, around Christmas time '19. And he said he was keen to return in some form to do work. My conversation with him at that time was that he needed to engage with The Trust to enquire about returning to work but I had mentioned to him that in view of his past history he may -- and difficulty with The Trust -- that he needed to resolve that issue before he was going to take that further. So I said to him that his return may not be as easy as he was hoping for. I also informed him that it was not within my gift to say yea or nay, it wasn't my decision. But I informed him he needed to engage and find out exactly where he stood. 15:59 15:59 16:00

174 Q. Did you express to him any support for his plan to return part time?

A. I suggested to Mr. O'Brien that he needed to be very careful about what he wanted to come back and do. I had said to him you're aged 67 at this stage, and I said you really should be considering what you want to do and, with that, what The Trust would agree to. But it was really asking him did he really think this was a good idea. But, yes, I -- and I said, you know, you need to be very careful. You don't want to do any on call, you want to just look after outpatients or something simple that is not going to be of a stressful nature. So I was -- I personally was happy enough for him to come back if he gave great thought to why he was actually really wanting to come back. 16:01 16:01

175 Q. It doesn't suggest that you were expressing support in any kind of enthusiastic way. It seems to be suggesting you need to be careful here and if you work out it is the best thing for you, I'll support it. Is it more that? 16:01

A. Yes. It was more that. I was trying to be protective of him in saying that he needed to give due concern to what he wanted to come back to do, but also telling him that what he wanted to do had to be agreed by The Trust and, indeed, the other way round. 16:02

I think -- I've retired. I would have a difficulty just walking out the door and switching off. It is nice to ease into retirement slightly. I think that's what Mr. O'Brien was trying to do as well. 16:02

176 Q. Did colleagues within The Trust seek your views on

whether it would be a good thing or otherwise for Mr. O'Brien to return?

A. The only discussion I had was that Mr. Haynes had asked me of my opinion. I don't think we all got round the table to actually discuss that, that's not my understanding of what happened. I think it was individual conversations. And, as I say, Mr. Haynes was speaking to me and I said, look, I think we have to be careful here of what he's actually going to do. Make sure he's not doing too much. You know, he is meant to be retired, he is meant to be coming back and helping out, but try to create the right air. 16:03 16:03

177 Q. Did Mr. Haynes ever communicate back to you a view as to he was the Associate Medical Directors at that point so he had, I suppose, a dominant influence on whether Mr. O'Brien would come back or could come back. 16:04

A. Yes.

178 Q. Did Mr. Haynes articulate to you at any point in that journey during the early part of 2020 what conclusion he had reached? 16:04

A. He was concluding that, I think the words are "strings attached to it". I would agree with that sentiment. That would have been sort of covering -- that would cover the notation of our conversation. Again, he was also -- I mean I had my own views on what he should be coming back to do and Mr. Haynes was independently saying the same thing when he came to speak to me. 16:04

179 Q. It was communicated to Mr. O'Brien on, I think, 8th June 2020 that any hope of returning or any

expectation of returning part-time would be -- was extinguished. He wasn't being permitted to return. Were you advised or consulted in advance of that decision, that the strings attached proposition had gone, it was now into he cannot return? 16:05

A. Further discussions on the strings attached, of what that involved, was never a conversation. And Mr. O'Brien not returning was not -- not returning to work, that information was not given to me before 8th June. It was away at the end of the month and, in 16:06 fact, I was organising Mr. O'Brien's leaving do and had written to members of The Trust who he had worked with and had actually written a letter or an email to past colleagues. I think that's dated 22nd June. And I, you know, if I had known that at that stage I wouldn't 16:06 have been writing that email. This was all in the middle of Covid as well, we have to remember. So there was a bit of planning that I was trying to do but, you know, it wasn't -- so it was the end of June before I was informed. 16:06

180 Q. Okay, Mr. Young. Thank you for answering my questions. I have nothing more for you. The Panel may have some questions to address to you.

CHAIR: We'll hopefully not keep you too much longer, Mr. Young. I'm going to hand you over, first of all, 16:07 to Mr. Hanbury for some questions.

MR. YOUNG EXAMINED BY THE PANEL:

181 Q. MR. HANBURY: Mr. Young, thank you very much for your evidence. I have three short questions which hopefully shouldn't be too onerous.

First of all, one thing on triage, essentially this is a GP asking a specialist for an opinion. Do you agree with that? 16:07

A. Yes.

182 Q. When you were having your discussion as a department there was some opinions expressed that The Trust should tell you how to do it. Did that... 16:07

A. There's an element of the information supplied by the GP could be better, more information that is of relevance to what we're trying to inform us about. For instance, if somebody comes in with haematuria, we would like to book a CT, urogram, we need to know what the renal function is. That sort of thing would have been good to include on the letter for instance, it might save us a little bit of time looking up. 16:08

183 Q. It is just the concept of trust interfering or telling you how you should be doing it seems to go against the principles of, I would guess, most urologists. 16:08

A. Sorry, I misinterpreted. Correct, no, it is nice for us to know how to triage.

184 Q. And make the appropriate decision? 16:08

A. And make a decision from that.

185 Q. Thank you. Early on in your career there was a weekly uroradiology meeting, separate or rather before I think MDT started. This is, obviously, an opportunity to

discuss complicated cases, seek opinions from colleagues. As an endourologist or as someone with that interest you must have appreciated that meeting. I guess my question is it seemed to disappear. I suppose my question is was there a forum for you to ask colleagues difficult cases, to swap ideas and experience after the time the MDT started and the uroradiology meeting seemed to disappear?

A. On a personal note, our benign radiology meeting was the best of the week, frankly. It was a disappointment that it stopped. But there was plenty of opportunity to go down and speak to the radiologist team. It's good to go to the person who actually did the radiology, but there was a very open court there that you could go and discuss. It was a miss that we weren't all in the room at the same time, but there was free speech between us all that we could bounce cases back and forth off each other. But as a group together, unfortunately that meeting was run by the same radiologist that ran the MDT and it was going to be difficult to get engaged there as well.

186 Q. I think you've answered my next question. So the reason was there wasn't -- the radiologist couldn't do two meetings a week, is that correct?

A. Yes. We had a uroradiologist. In fact we had two you uroradiologists, but one left, and the other radiologist had their own meetings. So we were short a radiologist to actually cover our service. Our nephrostomy service insertion, you know, wasn't a 24/7,

it was only done on certain sessions. If we needed a nephrostomy, that patient had to go to Belfast to have it done. So we were short, undoubtedly for years, of uroradiologists. Of the guys that are there, they are excellent but they have been pulled right, left and centre. 16:11

187 Q. Last question, hopefully right up your street, about urethroscopy and stone fragmentation. We have heard the early days of stone fragmentation using the electrohydraulic lithotripsy in many units, which we have all worked in, used that. You pick out one pertinent point is that if you have got a safety wire, you can rescue a situation if you have inadvertent ureteric damage. I guess my question here is did you discuss this case in a Patient Safety or departmental meeting and were you able to persuade other colleagues that the safety wire was a good idea and did it change their practice? 16:12 16:12

A. All of my colleagues use safety wires. Most of the colleagues who have joined the unit has been in the last ten years so they will all have been brought up in their teaching before they arrived on site. Maybe going back to the 2000s when I first joined the department, Mr. O'Brien wasn't observed, from speaking to the registrars, to be using a safety wire and fluoroscopy. But I changed that practice, from my understanding. Certainly, we've been inserting stents under fluoroscopy since I arrived basically. 16:12 16:13

188 Q. So he did change his practice after this case?

A. There was an element of having an image intensifier available. We've now got quite a few image intensifiers fires, but back at the beginning it was a combination of an image intensifier and a radiographer. Now, when I was in the City and training, you didn't have a radiographer, you were able to step on the pedal yourself. But when it came to us in Craigavon, any radiography work had to be supervised by a radiographer and getting that out of hours was a bit of a challenge at the beginnings, but, again, patient safety wise, I had spoken to the radiology team and they felt, yes, this is a good idea. 16:13 16:14

189 Q. So you changed that successfully.

A. Yes, we changed that very early in the whole -- well, I wasn't prepared to put in a stent without fluoroscopy. 16:14

190 Q. Thank you very much. That's all I have to ask.

CHAIR: Dr. Swart.

191 Q. DR. SWART: Going back to the dreaded triage for a moment. We saw yesterday some minutes of a meeting that you had and we heard quite a lot about triage. Generally it seems, and you can tell me if I've got this wrong, that in the main, as a consultant group you had a common understanding about the importance of it, the way you were going to do it, giving conversation to your time constraints and so on, but that Mr. O'Brien really didn't agree with you. That meeting didn't come to a proper conclusion other than to say The Trust should sort this out. One will ask oneself who is The 16:14 16:15

Trust and it is, of course, partly all of you. Was that the case, did you feel you couldn't agree and you needed some help with it? Was that the case? Because it wasn't really clear where that was going to go.

A. Yes. The vast majority of us knew what -- had interpreted what triage was involving. And Mr. O'Brien was making it too complex in that it was taking too long. 16:15

192 Q. So other than -- so that was the problem. Did you then go and talk to your Clinical Director or anyone else to say look, we can't sort this out. Clearly we're the urologists, we need to sort it out because we know about this, but we are having his difficulty, can you recommend how we deal with it. Did you do that conversation-wise or formally? 16:16

A. Well, our conversations were with the Acute Service Director level who was running the admin and the --

193 Q. But this is a clinical issue really, isn't it?

A. Yes, I suppose it is. It had been going on so long we assumed that everybody knew about it, and that the likes of the CD and the AMD level -- we were aware that -- 16:16

194 Q. You didn't have a a mediation meeting to sort it out or anything like that?

A. No. 16:17

195 Q. Okay. One of the things you said today was around as clinical lead you can't know everything, which is clearly true. You only know what people tell you or what data you are provided with. What is difficult to

see is what discussions did you have and did it lead to any data to help you with this in terms of complication rates for operations, blood loss, return to theatre, efficacy of pre-op assessment, these kinds of things. Did you sit down as a team to say we need to have some measures to know if our care is safe, we need to decide what those are and can someone collect that information for us. Did you do that? 16:17

A. We do have an audit department. It was --

196 Q. I know that but did you, as a group of clinicians, say this is what we think matters for urology? 16:17

A. Okay. I don't think so.

197 Q. And do you think that would be helpful?

A. Absolutely.

198 Q. Why do you think you didn't feel you could ask for that? Do you think -- was it pressure of work? Was it a scant audit result? Because I'm sure every surgeon wants to know these things? 16:18

A. Yes, we do have our readmission rates --

199 Q. That comes from the Hospital episode statistics, doesn't it? 16:18

A. Exactly. So that's length of stay, readmission rates.

200 Q. But I'm thinking of -- we're talking about prostatectomy, and you said, really, it's not just the length of operation, it is is the patient all right, did they lose too much blood, was the sodium too low, all these kind of things. That kind of data can be collected in a department if somebody is minded to do it. Now, you can't just do it on top of everything 16:18

else, clearly. But were you aware of that, the need to do these things?

A. We were aware of these things that we should be doing. But, again, it's in the background of the overall volume of what we were trying to get through. A lead point is what's the waiting list. So those were -- 16:19

201 Q. I can see that in the data. Did you have any direction from what you might have called, I think you referred to it as the higher echelons, in terms of what kind of things you should be looking at in terms of quality? 16:19

A. Yes. We certainly have this through our Patient Safety Meeting now, that's --

202 Q. Has that changed in recent years?

A. Our Patient Safety Meeting is fabulous now. If I may say, it was a breath of fresh air to have all the young consultants coming when Mr. Glackin arrived, he took charge of that and did a marvellous job. 16:19

203 Q. But you still don't have these measures?

A. No. But it is our audit and our audit department has improved considerably. There's now an audit coordinator and we have -- where we would have had maybe one or two audits a year, we now have a specified list that we go through. Some can be maybe more complex. Some are short-term snap audits. It's very audit driven now at the moment. For the last two moments I have been at, our audit tracker has been at them and we have discussed all of that. And, in fact, our Patient Safety Meeting used to always start off with deaths, morbidity, then audits and any other 16:20 16:20

comments. Now Mr. O'Donoghue has switched it round completely. The first things discussed on the meeting are the audits and the morbidity because our mortality patients are, well touch wood, are fairly predictable.

204 Q. We hadn't heard about that. It's good to hear that covered? 16:21

A. It's really good. I'm very impressed with what Mr. O'Donoghue is doing with the system.

205 Q. On the more mundane side, a basic patient safety issue is things like writing a letter to the GP, doing the triage, following your guidelines, looking at results, and I get the sense that it was too easy, in the past anyway, to do the wrong thing in some of this. Therefore there wasn't really a track on whether everybody got a letter, whether everybody looked at results. 16:21 16:22

Now, you showed us a little scorecard for results which is clearly an improvement and I would imagine some other metrics will come. But this business of the culture where it is too easy to do your own thing is key in patient safety, as I'm sure you're aware. Why do you think there was this tolerance of people just doing what they liked a bit? 16:22

A. It's the pressure of the volume of work to get through. 16:22

206 Q. Just that? Who should sort it out? We talked about the Trust, but where do you think the responsibility lies for ensuring these things are not tolerated. Because they are very basic patient safety things,

really?

A. These are within the department yourselves. And if it's not being done then maybe a stern conversation is maybe required, or a specific sort of focus on these things at a departmental meeting saying here's what we want to -- 16:23

207 Q. Do you think there was enough emphasis from the top of the tree on these things as opposed to targets, money, waiting lists, whatever?

A. There could have been more support from above, probably, yes. 16:23

DR. SWART: That's all from me. Thank you.

208 Q. CHAIR: A few things. I take it you're aware of the nine SAIs that fundamentally led to this Inquiry being set up in the first place. One of the things that is common to all of them is that there was no CNS, there was no key worker? 16:24

A. Yes.

209 Q. You, on 8th November when you were last here you talked about the value that the key worker brings to the cancer pathway. I just wondered, when you discovered that none of those nine patients had a key worker, how did you feel? Were you surprised? Were you shocked, or what was your view? 16:24

A. I was a bit surprised because in my practice I had somebody attached to it, which was a Friday afternoon staff nurse. So I had somebody. So I found it a little bit unusual. 16:24

It is the depth of involvement by the CNS. Are they physically in the room? Is that very important? The important -- you may think that may be important, but it's the importance of having the nurse talking to the patient after you've spoken to them. 16:25

210 Q. Isn't it even just the patient having the contact detail of who to contact?

A. Yes. So there's lots of stages. As I say, in the room, as I do, maybe the patient comes in, I then introduce the CNS and I go over a summary of the 16:25 situation. That's another one.

Outside the room the nurse has the opportunity to go over that again and to have the holistic attachment to it that doctors maybe aren't the best at. Then, as you 16:25 say, that --

211 Q. If a CNS isn't available --

A. That's what I'm saying, on a Friday I get a staff nurse, and we give them the pamphlet and say here's the CNS's phone number and it is open court for the patient 16:26 to either ring in --

212 Q. If I have interpreted what you're saying, is really there's really no excuse for the patient not getting the information to allow them to have a key worker; is that fair? 16:26

A. Yes, yes. It might not be delivered on that exact day.

213 Q. But they should have the contact information given to them at the least?

A. Yes. Yes, that's right.

214 Q. Thank you. Just in terms of your role as clinical lead, am I right in thinking that you preferred to deal with things informally, you don't like confrontation, would that be fair?

A. I think that's fair. 16:26

215 Q. I think it's clear from what the Inquiry has heard that Mr. O'Brien would be a dominant force within the department. Would that be a fair comment?

A. That's a fair comment. I know the words challenge to challenge. I would use the interpretation that when 16:27 Mr. O'Brien has made up his mind he's hard to shift. Your idea has to be considerably better than his. So that's my interpretation. It's a slightly different twist to challenge to challenge. I would give my idea, he would give his idea, if mine wasn't better... 16:27

216 Q. You had no chance?

A. Yes, well, that's coming -- in saying that, to be fair, on a clinical point of view, on the old sort of ward rounds, you know, Mr. O'Brien would ask my opinion on something and if he hadn't already made up his mind on 16:27 it --

217 Q. He was open to be persuaded?

A. He was open to talk on a clinical ground and we actually got on well that way. But I think if there's a pathway to follow, it is his way. 16:28

218 Q. That seems, perhaps, most obvious in the issue of triage?

A. Yes.

219 Q. Just in terms of your -- you seem to have had a good

relationship. He was the first in the department, you were the second in the department. Did you feel that he was more senior to you, even though you were both consultants because he is the initiator of the department, if you like? 16:28

A. Yes, you will always have a senior and a junior, but I wouldn't let him know that.

220 Q. Did that mean you found it more difficult in your role as clinical lead?

A. Yes. I'm always -- I think you're always going to feel that way talking to a senior person. 16:28

221 Q. I take it, I mean you just mentioned earlier that you had been to his son's wedding so I take it you had a good social relationship with him. He described in his appraisals about, you know, having a good relationship with the staff even if he was somewhat direct at times? 16:29

A. Yes.

222 Q. What I'm trying to get at is if he never discussed receiving the March 2016 letter with you. He never came to you and said, look, I've got this letter, how am I supposed to deal with all of this? You never had that conversation with him? 16:29

A. No, I never had that conversation. He passed comments that he had received information from The Trust but wasn't allowed to discuss it with me. But I think that related to something later on. 16:29

223 Q. Yes. I mean he was given a letter at a meeting with Eamon Mackle and, I think, Martina Corrigan in

March 2016 and said -- he never told you that he had got that letter or that he was expected to do anything about it?

A. I would have appreciated that if he had done that I might have been able to help out. 16:30

224 Q. That was my next question.

A. But no, I never -- Aidan likes to sort everything out himself.

225 Q. Would that be to his detriment do you think?

A. Oh, absolutely. 16:30

226 Q. The other thing I just wanted to be clear about, you talked about a triage sheet. I'm not sure, and it may be some of the junior lawyers may have seen such a sheet, but you talked about when you had -- is there an example of that sheet? 16:30

A. Is this the actual stamper we're talking about?

227 Q. Yes.

A. I'm sure we can supply one.

228 Q. I mean we may well have one in the bundle somewhere but I know I haven't come across it yet. It's not to say 16:30 it's not there. Was this something that you devised?

A. This is a stamper I devised.

229 Q. Was this to try to get over the issue about the difficulties with triage with Mr. O'Brien particularly or not? 16:31

A. No. It was for -- it was not designed for one person, it was designed for all of us. It was actually to help the booking office and it was to quicken up what you -- instead of writing everything on the GP's referral, it

gave you the opportunity to put a tick in it.

230 Q. So a standard template, essentially?

A. It's a template. On the one side it was red flags and the opportunity to upgrade. Then there was urgent and routine. And then on the other side of the box it was the intention of the investigation to be done at the clinics. So you wanted an ultrasound, you wanted a flexible cystoscopy or you wanted a TRUS prostate biopsy. Now, that was the code for the booking office -- 16:31 16:32

231 Q. To organise?

A. No, not so much to organise but not to overbook one clinic with an excessive amount of one thing. In other words, you don't want ten TRUS prostate biopsies on your outpatient -- you will not get through the list adequately or -- well, one, in time and, two, there wouldn't be enough probes to actually make it happen. 16:32

232 Q. Am I right in thinking that this template document would have speeded up triage for all of the consultants if they just used that? 16:32

A. It was a mechanism -- yes, well it helped, in a way, to code what clinic you wanted it to go to. Then in the bottom half you could do a free text "I've booked a CT urogram". So it was more for the booking office to book to the appropriate clinic, so it wasn't overbooked or underbooked. And also whenever the patient came to the clinic and the chart was in front of the nurses with the referral letter on it, if they saw that there was an ultrasound to be done, that ultrasound -- 16:33

233 Q. Would be done then?
A. -- which was done at the clinic, but could be done ahead of the consultation.
234 Q. It speeded up the whole process?
A. It was to speed up the process of booking. There was an element of helping the triager -- 16:33
235 Q. Focus?
A. It was a focus in the clinic, it gave you a box to write in. It wasn't a replacement for the triage.
236 Q. Very well. Talking about the TURP procedure and the length of time and you are saying that the issue was about complications rather than the precise amount of time that was taken, but surely there's an issue here as well about the theatre time that was being used up and the other staff commitments that were being used up, is there not? If someone is particularly slow, that is something that should feed down into the department for the department to address as a group? 16:33 16:34
A. An operation will take as long as an operation takes. It may have a standard name to it but, you know, one TURP might be small, might take you half an hour -- 16:34
237 Q. I appreciate that. My point is that if there is one person in the department who is taking much longer than other people, what I'm saying is the department should be aware of that as a group so that they can find out why that might be. There may be good explanations in individual cases, but if it's a common problem and it seems to be if it was the subject of tea room conversation, it sounds as though it was more than just 16:34

a one-off.

A. Okay. As we said, Mr. O'Brien is maybe a bit slower than most things. He does everything slowly. But it's all about the safety of doing an operation. I remember very clearly when I was a registrar in the City Hospital that it was the charge nurse ran the theatre list. It's the old version of a scheduler. And she would schedule four TURPs for one consultant and two or three for another consultant. She knew how long it took him to do the procedure safely, and that's how the unit runs. So everybody runs at a different rate. And it's about scheduling your list appropriately, and not overrunning. Says me, smiling, when I overrun my theatre list, but....

16:35 16:36

238 Q. Two other matters. The DARO system was designed to ensure two things. To ensure that people weren't lost to the system, that the results would come through and that they would be put on to the waiting list appropriately when those results came through. But there is another, it was also designed, was it not, to reduce the waiting lists for people so that, for example, if the results come back and there's nothing to see here, you know, a short phone call to a patient might be don't need to see you for review, come back if there's any difficulty. That frees up a slot for somebody else to move up he list; isn't that true?

16:36 16:36 16:37

A. That's exactly right.

239 Q. So it served two purposes?

A. It served certainly more than one. We were maybe

concentrating on the writing of seeing the result but, yes, it had a knock-on effect that you could just say, 'dear sir, your X-ray is fine'. As we do an awful lot now, I mean at our stone clinic it has turned around quite immensely. We tend to write a lot to patients. 16:37
Going maybe to the dark ages when I ran the clinic, you know, I did a clinic, I saw the patient, I did an X-ray at the time, when the patient was in front of us, and I had a long waiting list. That's really why, in the mid of last decade, that I realised that we were 16:37
getting behind on the situation and needed a change. So this is exactly an example. It is less personal but patients, I think, do appreciate having the earlier consultation with a letter saying you don't have a stone anymore or whatever the case might be. So it 16:38
works both ways.

A consultation, I'm a wee bit old school, I think consultation is good. A letter is a one-way conversation. 16:38

240 Q. I appreciate that. But it could be there is a short telephone conversation with the patient, for example, rather than bringing them all the way back from Fermanagh or somewhere?

A. Again, that's what our system at the moment is. 16:38
Dr. McAuley, a big influence in our stone service with and Mr. Tyson and I'm sure you have heard what he has been going through.

241 Q. One final thing. We heard -- I think it is important

that all this Inquiry is hearing is put into the context of what you all had to deal with and it is clear that there were extraordinary pressures on this department. But I just wanted to be clear that the pressures that were on Mr. O'Brien were no different to those on yourself, for example, or on any of the other consultants; is that fair? 16:39

A. Yes. The pressures were not on one shoulder. It was very much the department. And even on our nursing staff. I mean, I think I said away back at the beginning when we were getting the original McClinten report, said we needed some CNS's and that the department says why, one will do, and I asked for two. I wished to heck I had asked for four because it took so long to get there. So it's the load on the nursing staff expected to have covered both the administration of nursing in Thorndale as well as producing a nursing output. Now that has been taken off them and with the expansion of the service in nursing staff, it has been remarkably fabulous. 16:39 16:40 16:40

242 Q. In that light what would you say, since all of this has come to light and this Inquiry has been set up, what would you see as the most beneficial change that there has been in the urology department, having retired and come back in on a part-time basis? 16:40

A. I see the input of the CNS service has been a major, major change. It's at that level of nursing has been very important. We've had staff nurses stepping up to the mark and helping out. It is the independence of

the nursing staff and giving them the support, knowing that there's a consultant there to ask. Maybe it is going back quite far. I talk about Thorndale 1 and Thorndale 2.

243 Q. We're aware of the change. 16:41

A. I know we had a lot of tensions with The Trust about trying to -- after the regional review and 9 and 10 there was talk, but we knew which direction that we wanted our urology department to go, had to put that across. But I certainly knew that once we got the new 16:41 floor space, the right size, the right number of rooms, all under one roof, and with our nursing staff there and auxiliaries, all there, knowing that there was the support of somebody coming in all the time that they could bounce questions off. That gave them more oomph 16:42 to go on and do more things. As you'll have heard, our nurses do the transparineal prostate biopsies. That's pretty good going. It is not commonly see. Our benign service, the likes of Jenny does the Botox, you know, and that's great. And we now have a stone MDT as well. 16:42

244 Q. The corollary of that is that that takes pressure off you as a consultant body?

A. I've forgotten how to do it nearly -- not quite. We have a stone nurse as well who runs a clinic and has got well involved in that. So, you know, that's -- so 16:43 that's probably the main thing. I haven't talked about a doctor there, so that's all about nursing. We could do with the full complement of consultants. Maybe also giving time to think, what you were saying as well, you

know, and having time to do the right audits and not just do the face to face. It needs the other joined up writing to make the service run very well and all the points that you're -- and having time to actually get it across. 16:43

CHAIR: Mr. Young, thank you very much. It has been a long three days I know for you. But we appreciate you coming, as we do all of the witnesses that we hear from. So thank you. You will be glad to know that's you finished with us. Thank you. 16:44

Thank you everyone, back tomorrow morning, 10 o'clock.

THE INQUIRY ADJOURNED TO THURSDAY 7TH DECEMBER AT 10:00 A.M. 16:44