Urology Services Inquiry

Oral Hearing

Day 39 – Friday, 21st April 2023

Being heard before:	**Ms Christine Smith KC (Chair)**
	Dr Sonia Swart (Panel Member)
	Mr Damian Hanbury (Assessor)
Held at:	**Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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1 THE INQUIRY RESUMED ON FRIDAY, 21ST APRIL 2023 AS
2 FOLLOWS:
3
4 CHAIR: Good morning, everyone.
5 MR. WOLFE KC: Good morning, Chair, Good morning, 10:01
6 Panel. Good morning, Mr. O'Brien.
7 THE WITNESS: Good morning.
8
9 MR. AIDAN O'BRIEN CONTINUED TO BE EXAMINED BY MR. WOLFE
10 KC AS FOLLOWS:
11
12
13 1 Q. MR. WOLFE KC: I want to start, Mr. O'Brien, by looking
14 at the implementation of the Monitoring Plan, just by
15 reference to a couple of examples. If we could have up 10:02
16 on the screen, please, TRU-00733. This is the second
17 page of the Monitoring Plan. I just want to draw your
18 attention to two points before we begin.
19
20 On triage, firstly, it provided that -- you can see in 10:02
21 the single sentence paragraph:
22
23 "Red Flag referrals must be completed daily."
24
25 Above that: 10:03
26
27 "The on-call week commences on a Thursday morning, for
28 seven days, therefore triage of all referrals must be
29 completed by 4:00 p.m. on the Friday, after the

1 consultant of the week period ends."
2
3 You understood that you were being monitored to that
4 target?
5 A. Yes. 10:03
6 2 Q. Below that, please, Concern 2 provided that you weren't
7 permitted to remove patient notes off Trust premises.
8
9 "Notes tracked out to you must be tracked for the
10 shortest period of time possible for the management of 10:03
11 a patient.
12
13 Notes must not be stored in your office.
14
15 Notes should remain located in your office for the 10:03
16 shortest period required for the management of a
17 patient."
18
19 You'll recall, Mr. O'Brien, hopefully, that in July of
20 2017, shortly after the commencement -- several months 10:04
21 after the commencement of this plan, your attention was
22 drawn to what was perceived to be slippage around
23 triage and slippage around the issue of patient notes
24 remaining in your office?
25 A. That's correct. 10:04
26 3 Q. Let me ask you about this. If we could have up on the
27 screen, please, TRU-258877. So on 11th July -
28 scrolling down - Martina Corrigan's writing to you and
29 she's setting out the monitoring target around triage.

1 Scrolling down. She has been advised by the Booking
2 Centre that there are 30 paper outpatient referrals not
3 returned from your week on call and this must be
4 addressed urgently, please.
5 10:05
6 Then, if we go to TRU-268995 she is, on 11th July -
7 scrolling down - writing in relation to the storage of
8 notes in your office which, as of that day, stood at
9 90 charts.
10 10:05
11 Can you recall why, in particular, you had a particular
12 problem with triage at that point?
13 A. Yes. It was highlighted by the email exchange
14 surrounding the patient who had attended the Emergency
15 Department -- 10:06
16 4 Q. Let me bring that up. I think I know the email you're
17 referring to?
18 A. Thank you. Yes.
19 5 Q. AOB-01646. This is your, I think, reply of 12th July?
20 A. Of the 12th July; that's right. It's substantially the 10:06
21 next page.
22 6 Q. It is, yes, the very bottom of the page it starts.
23 Thank you for pointing that out.
24
25 Just scroll down so the witness can see the whole of 10:06
26 this page, '47.
27
28 So, you're explaining within that email, if I can
29 summarise, the benefit of advanced triage for the

1 patient, the time it takes, and for some specific
2 factors in that case the reasons for the delay.
3 A. Mmm.
4 7 Q. And you set it out in very robust terms, can I suggest.
5 Does that explain that case or does it explain -- how 10:07
6 do you explain the --
7 A. I think it's important to appreciate that what she was
8 referring to were paper referrals. So paper referrals
9 are predominantly referrals that come from the
10 Emergency Department which, in a sense, carries with it 10:07
11 or is associated with a greater degree of urgency.
12 It's not just, like, some other kind of less urgent
13 consultant-to-consultant letter of referral that is
14 received. So this case, and I was prefacing it by
15 saying it was holiday time. Typically, these patients 10:08
16 who attend, they are acute attendances, I imagine the
17 most common two conditions, either they're in acute
18 urinary retention requiring catheterisation and ongoing
19 management or, alternatively, even more importantly,
20 perhaps, they have ureteric colic. Usually would have 10:08
21 some imagining done - as was the case in that
22 particular case - demonstrating that a stone is in the
23 ureter causing obstruction. What brings the person to
24 the Emergency Department, of course, is not a knowledge
25 of having a stone in their ureter, it's experiencing 10:09
26 pain. So, understandably, what the Emergency
27 Department will do will be to relieve their pain and
28 they very often do so effectively and completely and
29 consider them fit for discharge and onward referral.

1 So, this is the clinical conundrum for the person who
2 is reading that kind of documentation, is wondering
3 whether it's safe or can you assume that you can tick
4 the urgent box and allow them to be offered an
5 appointment six months later or 12 months later, 10:09
6 whatever that may be, or whether you should try to
7 contact them.
8
9 So, what I had done over that weekend was to retain
10 these, to try to contact as many people as possible. 10:09
11 I expressed the general experience at holiday time, it
12 it was difficult, people were away or whatever, and
13 I had retained it for that purpose. This was a very,
14 very good demonstration of a person who had been
15 discharged from the Emergency Department, spent all 10:10
16 weekend in bed taking paracetamol and Brufen for pain
17 relief. I had a golden rule, even when contacting
18 people by mobile phone, I didn't leave a message unless
19 I was in desperation, for patient confidentiality
20 reasons. This lady, having received quite a number of 10:10
21 phone calls from me, she eventually replied. I was
22 relieved that she did. I did discover that she was
23 unwell, that she needed to be admitted and so forth.
24
25 So, that is kind of a general explanation of the 10:10
26 accumulation of paper referrals as opposed to
27 electronic e-referrals.
28 8 Q. I hope it's not unfair to put it in these terms: There
29 was an expectation or target set out in the Monitoring

1 Plan.
2 A. Yes.
3 9 Q. Complete your Red Flag triage on the day they're sent
4 to you.
5 A. Yes. 10:11
6 10 Q. You're saying, as I understand it, okay, I breached
7 that target but in certain cases, if you want to do the
8 job that's necessary, in your view, to make the patient
9 safe or to bring the patient out of difficulty,
10 sometimes that's just a necessary evil? 10:11
11 A. That is correct. And that has been the basis of my
12 conflict. I think it's a conflict. You know, it's a
13 conflict of conscience, as a clinician, to try to deal
14 with the person behind the page or paper.
15 11 Q. Can I broaden it out to this: You have said in several 10:11
16 places, I think, that after your return to work and
17 after the subject of this Monitoring Plan that when
18 you were at the end of the urologist of the week period
19 you would generally not have completed all of the
20 referrals, particularly the urgent and routine -- 10:12
21 A. Yes.
22 12 Q. -- that came your way --
23 A. Yes.
24 13 Q. -- and that you then used your weekends --
25 A. Yes. 10:12
26 14 Q. -- and on occasions, I think you say a Friday --
27 A. Yes.
28 15 Q. -- displacing a clinic on occasions?
29 A. Yes.

1 16 Q. To get the triage done?
2 A. Yes.
3 17 Q. It is the case, is it not, that your method of doing
4 triage and the intensity of that method didn't change
5 as a result of the Monitoring Plan. You continued to 10:12
6 triage in the way that you had always triaged but just
7 made sure it was done, albeit that you stepped across
8 the line of 4:00 p.m. on a Friday when the UOW period
9 ends, you took it into the weekend. So, it was
10 routinely late coming back, in that sense, but 10:13
11 generally, although we've seen some isolated examples
12 between '17 and late '19, but generally that was the
13 pattern?
14 A. That is the pattern and for the reasons that you have
15 stated. 10:13
16 18 Q. I've also brought to your attention the charts in your
17 office. You were the subject -- sorry, not the
18 subject, you were an attendee at a meeting --
19 A. Yes.
20 19 Q. -- in, I think it was 25th July? 10:13
21 A. Yes.
22 20 Q. Mr. Weir, Mrs. Corrigan and Mr. Carroll. And you
23 explained at that meeting -- if we just bring it up on
24 the screen, please, AOB-56211. And if we go down to,
25 I think it's (f) on the left-hand margin. You're 10:14
26 expressing, in a number of places, but if you can just
27 see between (f) and (g), you're being asked about why
28 so many charts were ending up in your office and you
29 say:

1 "I don't want it at all because I don't know why charts
2 are coming to my office at all. There's no need for
3 them to come into the office."
4
5 And elsewhere in this transcript you explain that it 10:15
6 seems to be, I suppose in the interests of the
7 secretaries, they have some reason to bring the charts
8 to your office, but you don't need them?
9 A. Yes. I think that -- well, what transpired from that
10 meeting was a revelation that the secretaries, 10:15
11 including mine, were under a General Directive from
12 their line management that charts had to be returned to
13 consultants' offices with results and reports. And,
14 indeed, Mr. Weir, who was there, was quite adamant that
15 that was not required because we were largely 10:15
16 electronic by that stage and we could consult whatever
17 records we needed.
18
19 So, Mrs. Corrigan didn't appreciate there was such a
20 directive. I had just learnt about it from my 10:16
21 secretary, that that's what they were told to do. So
22 she undertook at the end of that meeting to contact the
23 Operational Services Directorate to have that issue
24 addressed. But it continued. I think there may have
25 been some relief from it at that time because I think 10:16
26 in this transcript I have gone on to explain and
27 enumerate the number of charts that I had actually
28 requested and they were very, very few. And the rest
29 of these numbers I hadn't requested at all and, more to

1 the point, there was no need for them to be there.
2 21 Q. Into early 2018 another issues arises in respect of
3 triage, the Red Flags Appointment Officer in touch with
4 Mrs. Corrigan saying that there are seven outstanding
5 referrals as of 23rd January, by 25th January that's 10:17
6 risen to 23, and on 6th February Mrs. Corrigan tells
7 Mrs. Hynds that she's going to meet with you to discuss
8 this. Do you remember discussing this with
9 Mrs. Corrigan?
10 A. No, but I see in her witness statement she said I had 10:17
11 to be spoken to. So, I don't know by what medium I was
12 spoken to but I think it was just a transient issue.
13 I can't remember the detail of that or the reasons for
14 it. The only thing I would say, just as I have made a
15 general comment about paper referrals is very often the 10:17
16 Red Flag referrals, where you particularly want to get
17 imaging underway in patients with suspect prostate
18 cancer, and indeed other malignancies, and very often
19 that's with MRI scanning or CT scanning. So, I would
20 have actually gone about the business -- if it's CT 10:18
21 scanning they require to have an update of their renal
22 function. And if it's MRI scanning, you have to check
23 on whether the patient is compatible, whether they can
24 have an MRI scan. For various medical reasons, you
25 have to speak to them. So that can actually get in the 10:18
26 way of actually turning them around within a 24-hour
27 period, even if you have the time to do that.
28
29 So, I think there wasn't, you know, any uncaring or

1 intent behind that. You know, I think there were
2 simple explanations for that and it was quite a
3 transient...
4 22 Q. Could I just ask you about something you said in your
5 witness statement around potential breaches of the 10:19
6 plan. If we could have up on the screen, please,
7 WIT-82954.
8 CHAIR: '654?
9 23 Q. MR. WOLFE KC: Let's try that. I don't think it's that
10 either. Let me just... 10:19
11
12 It's WIT-82594. Obliged. Thank you. So bottom of the
13 page, please.
14
15 You say: 10:20
16
17 "No issue was raised by the Trust with me in relation
18 to any potential breach of any plan until November 2019
19 when I received emails from Ms. Corrigan."
20 10:20
21 And here you have an example?
22
23 "Mr. McNaboe and I have been asked to meet with you to
24 discuss a deviation from your Return to Work Action
25 Plan when you were on call in September." 10:20
26
27 Is it not clear, Mr. O'Brien, that issues around
28 deviation were raised with you, as I think I've shown,
29 in the summer of '17 and also in early 2018?

1 A. Well, I --
2 24 Q. Or why did you choose the words you've used in '577?
3 A. Yeah, I didn't actually -- I had overlooked that issue
4 of the charts in the office. I didn't think, actually,
5 that that was a really substantive issue. And 10:21
6 I appreciate that that one -- I apologise for having
7 overlooked that and used that as -- I was thinking more
8 in terms of the breach that you have referred to in
9 terms of triage in February '18 and subsequently.
10 I wasn't actually communicated with in any kind of 10:21
11 formal manner with a view to the meeting and so forth
12 to discuss any breach or deviation, I think it's
13 called, of the Action Plan.
14 25 Q. But you would accept that the Trust management were
15 policing this Monitoring Plan and were raising issues 10:22
16 with you, from time to time, whether you regarded it as
17 a discussion about a deviation --
18 A. Yes.
19 26 Q. -- they were drawing your attention to problems as they
20 saw it? 10:22
21 A. Yes.
22 27 Q. And we've looked at examples of that?
23 A. Yes.
24 28 Q. Very well. Could I briefly have your view on an issue
25 that wasn't the subject of the MHPS investigation but 10:22
26 which was raised by Mr. Carroll when he spoke to
27 Dr. Chada. He put it in these terms. He said --
28 sorry, Mrs. Hynds put it in these terms, that herself
29 "and Dr. Chada were alerted to an issue whereby it

1 appears Mr. O'Brien is not assigning a clinical
2 priority to his theatre lists causing difficulty in
3 prioritising patients when sessions have to be adjusted
4 or cancelled."
5 10:23
6 And that impression was formed by Haynes and Chada on
7 the basis of what Mr. Carroll told them. And he went
8 and produced a typical theatre list and on the form
9 there's a space to include the clinical urgency or the
10 clinical priority of the patient which is important, he 10:23
11 explained, if an emergency came in and a patient needed
12 to be "bumped", if I can use that expression, to take
13 care of the emergency.
14
15 First of all, was that issue ever raised with you? 10:24
16 A. No, it was never raised with me. And I think that it
17 requires some explanation. And I only came to be aware
18 of this in more recent times.
19
20 When I made out my list and emailed it to my secretary, 10:24
21 of course there's a category of urgency on it, which is
22 on the waiting list. But I think that she will be able
23 to explain to you that the template that she used --
24 there wasn't a template provided that had a column - at
25 least to her she wasn't aware that we -- and it would 10:24
26 be no difficulty whatsoever to put in the category of
27 urgency, whether red flag, urgent or routine. There
28 was a comments column that she used, such as if the
29 person was on an anticoagulant or some other drug that

1 was of relevance to surgery and anaesthesia. But she
2 had no awareness that she was also to include in any
3 template that she used the category of urgency, and
4 there would have been absolutely no difficulty in
5 including that information. But it wasn't something 10:25
6 that I was ever told that I had to do, and it would
7 have been very easy for me to do it, if required.
8 29 Q. So just to be clear, you consider that it was a
9 clerical or administrative task for the secretary to
10 insert the clinical priority on this pro forma and not 10:25
11 yourself?
12 A. Yes, it was entirely administrative. I think you will
13 hear from her that she didn't have an awareness that it
14 was required either.
15 30 Q. When was the last time you have spoken to Mrs. Elliott 10:26
16 about any matters of relevance to the Inquiry's work?
17 A. She was down with us the other day. I just, in the
18 last couple of weeks or something, you know, I've
19 spoken to her. She contacted me to see if I would mind
20 or if it would be appropriate for her to come on the 10:26
21 first day because she's trying to acclimatise herself.
22 She's anxious. So, basically, that's it.
23 31 Q. I want to bring you to the investigation now in some
24 aspects of Dr. Chada's investigation that you have
25 commented upon and others have commented upon and 10:26
26 I wish to have your views on that.
27
28 I suppose on the eve of your first interview with
29 Dr. Chada you wrote a lengthy letter to Dr. Khan. It's

1 dated 31st July. It rehearses, at some length and in
2 some detail, your concerns about the process up to
3 date. So, an element of it is looking backwards, isn't
4 it?
5 A. Yes. 10:27
6 32 Q. In fact the majority of the letter.
7
8 The letter is to be found -- I don't need to bring up
9 the first page, at AOB-01689. But there were a number
10 of aspects of the process then currently impacting upon 10:27
11 you which you raised. And just bring that up, please,
12 AOB-01684. I'm going to do an about turn. I suspect
13 I don't need to find this in the text in the time
14 available to me.
15 10:28
16 Two points key points that you were raising, I think.
17 First of all, you're telling Dr. Khan that you
18 still didn't have a full witness list?
19 A. That is correct.
20 33 Q. In other words, you didn't know who the investigation 10:28
21 had pursued for evidence?
22 A. That is correct.
23 34 Q. And why was that of importance to you?
24 A. I think more importantly than having a complete list --
25 but obviously a complete list but I think I was also 10:29
26 enquiring as to why I had not yet been provided with
27 the complete statements that the witnesses had given.
28 35 Q. That's the second point you raise, yes.
29 A. Obviously, you can't have one without the other or you

1 can't have the second without the first.
2 36 Q. I think a third element of concern at that point in
3 time was you still - and this is 31st July, some four
4 or five months into the investigation proper - you
5 still hadn't been provided with the nine patient names 10:29
6 that were, as you understood it at that time, the
7 subject of the private patients concern?
8 A. That's correct.
9 37 Q. As we know, you were interviewed on 3rd August and then
10 again on 6th November. The distance between those two 10:30
11 dates, some three months or so, was that of your
12 making?
13 A. I don't recall it, my contributing to that delay at
14 all. I know there's a lot of contention about who were
15 the major causes of delays at various times and the 10:30
16 contention that I contributed to that delay
17 between June and 3rd August '17. I regarded that as
18 very much a mutually amicable and agreeable delay, but
19 I didn't actually contribute at all to that delay
20 between August and November. 10:31
21 38 Q. Yes. We'll come to the issue of delay in just a few
22 seconds, in fact.
23
24 You make a point in relation to the first interview
25 with Dr. Chada, which I'll put up on the screen and you 10:31
26 can help me understand it. It's at AOB-02048. You
27 say -- if we just scroll down, please, it's in the
28 penultimate paragraph. Yes.
29

1 "Eventually interviewed on 3rd August. This was the
2 first time I had met Dr. Neta Chada, who had been
3 appointed as Case Investigator some six months earlier.
4 This too was contrary to NCAS Guidelines as these
5 advised that the practitioner should be the first to be 10:32
6 interviewed.
7
8 This interview could not cover all of the issues in the
9 case because on the morning of the interview, Dr. Chada
10 had just been provided with an anonymised list of 10:32
11 patients whom the Trust alleged had been electively
12 admitted for surgery after a shorter period of time
13 because they previously had had a private
14 consultation."
15 10:32
16 It's the point that you make about NCAS Guidelines
17 requiring you, the practitioner, to be interviewed
18 first. Can you help us with that. Does it say that in
19 the NCAS Guidelines?
20 A. I think it's a recommendation rather than a 10:32
21 requirement. It's their advice that the practitioners
22 should meet with, and not necessarily regard it as part
23 of as a witness interview, but it was a recommendation
24 from NCAS at that time that the Case Investigator would
25 meet with the practitioner first. And I do believe 10:33
26 that that is a very, very good recommendation in the
27 context of some of the things that we were discussing
28 yesterday about almost the pastoral care to the
29 practitioner in the context of such a stressful

1 investigation.
2 39 Q. Obviously, there was a change of jockey, if I can put
3 it in those terms. The Case Investigator's role moved
4 to Dr. Chada --
5 A. Yeah. 10:33
6 40 Q. -- after Mr. Weir had had an interview with you on 24th
7 January in which he explained how the process would
8 work. That counts as the first interview, doesn't it?
9 A. Oh, I didn't regard it. I thought when you have a new
10 jockey, I thought it would be reasonable that the new 10:34
11 jockey would meet the practitioner. I think, actually,
12 because during that week of July '17, I mean that was a
13 very, very anxious week, particularly in the absence of
14 witness statements, as to have some idea of what is you
15 were name facing when you would first meet this person 10:34
16 whom you hadn't met before in this context.
17 41 Q. We'll come to your perception of the unfairnesses of it
18 in just a moment. I suppose I'm just setting out the
19 groundwork for that now, so I don't want to go too deep
20 just yet. Let's look at when you eventually got 10:34
21 various materials that you thought were important.
22 AOB-01760. We can see that on 28th September, this is
23 now coming up on two months after your interview with
24 Dr. Chada, and now she's saying:
25 10:35
26 "Please find attached information as requested. If you
27 require any further, please let me know."
28
29 This is in relation to the private patients point.

1 Then she explains the process, and it's now
2 11 patients. That was the first time, was it, that you
3 were given information about the private patient case
4 that you had to meet?
5 A. Yes. I mean on 3rd August, if my memory serves me 10:35
6 correctly, we were -- you know, it still remained the
7 case that it was nine patients or -- yes, no, on
8 3rd August we were presented with a list of
9 11 patients. So nine had become 11. And this was just
10 an explanation as to how that information was gathered. 10:36
11 42 Q. Oh, I see. So, you had the names on 3rd August but
12 this is the process being described to you?
13 A. Yes. That's my understanding. I think I'm right in my
14 recollection. So, on 3rd August, Dr. Chada had just
15 been provided with this list of 11 patients, on 10:36
16 3rd August. So she had, obviously, no insight into how
17 nine had become 11 or anything of that nature, and
18 we had enquired as to how that came about in addition
19 to, obviously there was a necessity to have a second
20 meeting to address the issue. 10:37
21 43 Q. Then in terms of witness statements, if we go to
22 TRU-287818. Here, 28th September - scroll down,
23 please - here you're being told, again is this for the
24 first time, the full list of all of the witnesses who
25 have been interviewed? 10:38
26 A. That is correct.
27 44 Q. And if we scroll down a little further, Mrs. Hynds is
28 now attaching five statements out of the 13.
29 A. That is correct.

1 45 Q. If we go to AOB-01766. It's 31st October, you are to
2 be interviewed again in the course of the next week and
3 you find yourself having to request the outstanding
4 statements. Presumably you wanted to see everything
5 before you were to be interviewed? 10:39
6 A. Even though the subject of the second interview
7 largely, you know, was restricted to the private
8 patient issue. But, yes.
9 46 Q. Now, in relation to delay you've said in your grievance
10 at AOB-02048, that the length - it's at the fifth 10:39
11 paragraph - the length of time beyond what you regard
12 as a strict four-week period was egregious in this
13 case. Is that the view you continue to hold?
14 A. Well, you know, I stated my case yesterday. I think
15 what I found to be egregious is the lack of compliance 10:40
16 with a Trust policy. And I do appreciate that there
17 have been arguments put forward due to the complexity
18 of the subjects being investigated and so forth at four
19 weeks was unrealistic, and I would concede that,
20 indeed, in the course of such an investigation, if you 10:40
21 want to actually find out what were the consequences of
22 any perceived shortcomings and so forth, that it wasn't
23 going to be done in four weeks. But I think the point
24 that I'm making is of a Trust who had a policy where it
25 stated, quite clearly, that the formal investigation, 10:41
26 even if you were to consider that it started on
27 26th January rather than 30th December, must be
28 completed within four weeks and had a complete
29 disregard for its need to comply with its own policy.

1 47 Q. As various points you will have heard me speaking to
2 witnesses about the reasons for the delay and the
3 causes of the delay. Can I ask you whether you accept
4 that at any point along the investigative journey you
5 contributed to the delay? 10:41
6 A. Well, I think we have -- July, I don't think, was --
7 I don't think that -- I would be surprised if July '17
8 was considered to be a major issue because it was
9 annual leave time for all parties.
10 48 Q. I think -- just on that particular one, and we can look 10:42
11 at the emails if we have to, Dr. Chada suggested dates
12 in June which were unsuitable for clinical reasons.
13 You came back and suggested 1st July. She had a
14 difficulty on, I think, the morning of 1st July and she
15 suggested the afternoon if that's when you wanted to be 10:42
16 interviewed. It was that kind of phrasing.
17 A. Yes.
18 49 Q. I think you said, well, it might be better if we left
19 this until after the holidays and then August was
20 suggested. 10:42
21 A. Yes.
22 50 Q. So that was one element of delay?
23 A. Yes. But one of the dates that we considered was a
24 Saturday morning.
25 51 Q. Yes, that was the -- 10:43
26 A. When you read -- I found during this whole process that
27 when you re-engage with the whole process, I found it
28 stressful and anxious and particularly in the context
29 of having to request information by the end of that

1 month. The notion, actually, of going along for an
2 interview of this significance on a Saturday morning
3 when I am urologist of the week and having to return to
4 do whatever, it was not a wise suggestion or proposal
5 of mine in the first instance. I was quite happy to 10:43
6 meet with both of them during a week's annual leave
7 in July but I thought that both parties were, at that
8 stage, unnecessarily discommoding themselves for the
9 purpose of an interview which inevitably was taking
10 place maybe six months after the formal investigation 10:44
11 had started at its latest start point, but a month
12 seemed to me not to be terribly important at that time.
13 52 Q. Although it would be wrong of me not to point out that
14 you're the one --
15 A. Who's complaining. 10:44
16 53 Q. Well, I don't wish to put it in those terms, but you're
17 the one who highlights the strict four-week temporal
18 parameters here.
19 A. Yes.
20 54 Q. Come November you have a second interview. 10:44
21 A. Yes.
22 55 Q. You had it in mind to comment on the draft from the
23 first interview. That hasn't been done by that stage
24 and, in fact, you wanted -- you still wanted to comment
25 on that first interview. 10:45
26 A. Yes.
27 56 Q. It didn't make its way to the investigators until
28 2nd April?
29 A. Yes.

1 57 Q. Your comments on the witness statements of others,
2 which you would have had by early November --
3 A. Yes.
4 58 Q. -- again, you didn't comment on those statements until
5 delivering them on 2nd April. Again, those are 10:45
6 matters -- you're a busy practitioner, you were doing
7 your appraisal, you reached an agreement with the
8 investigators to step out of the process to enable you
9 to do your appraisal. But thereafter, in the early
10 months of 2018, you didn't get on with it, is that fair 10:45
11 to say?
12 A. Well, I didn't get on with it because you leave the
13 business of the investigation behind you. I certainly
14 wanted to do all of it in one package, and you have
15 pointed out that I didn't get my second responding 10:46
16 statement until early March, you know, the months of
17 January and February. That is the explanation and, you
18 know, I've contributed to that, to some degree, by
19 giving clinical work priority.
20 10:46
21 I did want to do it in one batch. Then I think in
22 March, if you want to -- March '18 -- basically --
23 March '18. I mean, the one thing I do regret is not
24 communicating in response to Siobhán Hynds to explain
25 that I thought, you know, I could do it by 30th or 31st 10:46
26 March and there was a response to that from Siobhán and
27 on behalf of Dr. Chada, 'that's far too long, it has to
28 be a few days' hence, I think 9th March, which was
29 completely unrealistic for the task that I had to do

1 during that period of time. So, I was organising
2 everything clinically and into April and leaving
3 aside -- I think was the first week of April that year
4 Easter weekend? I'm not quite sure about that, but
5 that was the earliest I could attend to it. 10:47
6
7 So, I have -- if you were to look at it excluding the
8 context of all of us being busy clinicians and having
9 all the other priorities, and just look at the
10 timeframe, I have made some contribution to that delay. 10:47
11 59 Q. Thank you. By any standards it was a lengthy process?
12 A. Yes.
13 60 Q. Lengthy processes don't necessarily mean delayed
14 processes?
15 A. Yes. 10:47
16 61 Q. It will be a matter for the Inquiry to think about
17 that.
18
19 But just in terms of the length of the process, which
20 has, in the evidence to date, in part at least, been 10:48
21 explained by the fact that the Investigator and her HR
22 professional didn't have protected time to deal with
23 their duties. You didn't have time outside of your
24 clinical and other duties to attend to this.
25 A. Mmm. 10:48
26 62 Q. Any reflections on how an MHPS process from these
27 logistical perspectives could be better addressed?
28 A. Yes. I mean, basically, it is -- it's just a feature
29 of the health service that has been spoken to by very

1 many witnesses in this chamber in the last months.
2 Whether they are clinicians, whether they are
3 management, people are working very, very long hours,
4 juggling multiple balls in the air at any one time.
5 I was doing that myself. And without actually 10:49
6 revisiting the whole issue of there being an informal
7 preliminary phase to such an investigation,
8 irrespective of the Guidelines and MHPS and so forth,
9 where people had gone around the table and tried to
10 address that, and that wasn't done. So, if you get 10:49
11 into the formal stage, I think it should be done much
12 more quickly. And it cannot be done much more quickly
13 unless everybody concerned has protected time.
14
15 I think also one issue that has been suggested by many 10:49
16 people as a recommendation to be considered, and that
17 is that someone from outside - and not necessarily from
18 a leadership centre, it could be appropriate people
19 from aligned specialties and who have been recently
20 retired, for example, who would have the time on their 10:50
21 hands to devote to it. But even the clinician -- if
22 the clinician is working, they need to have protected
23 time in order to address it. It's just an unrealistic.
24 It's an unmeetable expectation.
25 63 Q. Thank you for that. Let's turn to some of the critique 10:50
26 that you offer in respect of Dr. Chada's approach and
27 aspects of her findings. You set this out, in the
28 main, in the response that you gave to Dr. Khan, which
29 we started our exchanges with on Wednesday morning.

1 So, something further on that then.
2
3 The first issue which I want to ask you about is the
4 absence of statements, witness statements, as we've
5 seen you didn't get them, you didn't get them until 10:51
6 after the August interview. And you've said in your
7 grievance, and I don't need it up on the screen, I'll
8 just read from my note - AOB-01889 - that you would
9 have considered it reasonable to expect the witness
10 statements would have been provided prior to the 10:51
11 meeting to enable you to address and respond to them.
12 In a nutshell, that's your concern, that it was unfair
13 to require you to go to that meeting to answer
14 questions in respect of first three Terms of Reference
15 without knowing what people had said about you? 10:52
16 A. Mmm. Yeah, I thought that was a reasonable contention.
17 As I sit here, I think it's still a reasonable
18 contention. I think it would have been preferable.
19 I can only imagine there's an adverse view and that is
20 you should be witnessed and relate your experiences in 10:52
21 a sterile atmosphere without -- not contaminated or
22 whatever by the witness statements of others. But...
23 64 Q. In a sense, can I put this to you: The issues that you
24 addressed at that meeting: Triage, dictation, notes at
25 home, and an aspect of the fifth Term of Reference 10:53
26 concerning management, those were issues that you were,
27 in essence, admitting to or accepting, albeit with the
28 kinds of caveats we've already looked at?
29 A. Yes.

1 65 Q. You appear, from the transcript of that interview, to
2 be well able to -- you weren't surprised by the issues
3 raised. So, in that context were you really
4 discomforted by the absence of witness statements?
5 A. I found the lead-up to that interview and the interview 10:53
6 itself very stressful not because of any behaviour or
7 interviewing technique on the part of Dr. Chada,
8 assisted by Dr. Hynds. I think it would have reduced
9 an awful lot of the stress associated with that first
10 encounter if I had had the witness statements, I can 10:54
11 think of is all that impressive in that first
12 interview. I mean I have spoken consistently and I've
13 given my views regarding the three issues and so forth
14 but it was hugely stressful. I think I would have been
15 better prepared, it would have reduced stress, if I had 10:54
16 had the witness statements, I think.
17 66 Q. Yes. Of course you were then able to provide comments
18 on the witness statements --
19 A. At a later date.
20 67 Q. -- that were included as part of Dr. Chada's report. 10:55
21
22 A second issue that you raised is your view that she
23 failed to consider or failed to give adequate
24 consideration to the evidence that you put forward in
25 respect of your workload. We've seen an aspect of this 10:55
26 already on Wednesday morning. You provided, in
27 Appendix 11, a detailed account of your additional
28 surgical duties, commitments to the MDM, commitments to
29 NCAS, and that was set out for her. But you observe in

1 your grievance that this information wasn't included in
2 her report?
3 A. Yes. I think that it lacked balance in that regard.
4 I wondered, and still do, whether my delay in
5 furnishing my responses to the 2nd April and beyond a 10:56
6 date when I was advised that Dr. Chada would start her
7 report, whether it had been relegated to a lesser
8 significance or a lesser status. As you will note, you
9 know, I got the impression in the Investigator's report
10 that this information wasn't provided until whenever. 10:56
11 Even though, actually, that information was provided
12 previously, if my memory serves me correctly. But
13 I just thought -- but for the purposes of providing
14 everything to the Case Manager, we have included it in
15 the appendices. But there you are, this is my view of 10:56
16 the investigation as expressed in the report.
17 68 Q. Just to be clear, is it in the appendices to the
18 report?
19 A. Can you clarify that for me?
20 69 Q. I don't believe it is. 10:57
21 A. You don't believe it is, okay.
22 70 Q. I'm just clarifying your understanding?
23 A. Okay. I can't recall.
24 71 Q. You can't recall.
25 A. So, it wasn't even in the -- yes, okay. 10:57
26 72 Q. So far as I can see. The Trust can clarify that if
27 they think I've got it wrong.
28 A. Yeah. I think you're correct.
29 73 Q. I would be happy to stand corrected.

1 What was your point, what was the point of putting this
2 Appendix 11 - and we've looked at it already --
3 A. Yes.
4 74 Q. And we don't need to bring it up on the screen, we've
5 already seen it, but it's at AOB-10653. What was your 10:57
6 objective in bringing that kind of detailed information
7 into the evidential mix? What did you hope to achieve
8 by it?
9 A. Well, to paint a canvas of my working life and my
10 concerns and to have the Investigator and, ultimately 10:58
11 the Case Manager appreciate the totality of the context
12 and the clinical concerns that I did have and how
13 I went about trying to minimise that as much as
14 possible. And that speaks to that interface between
15 those two domains of professional performance and 10:58
16 operational performance. And my own view is that they
17 cannot be considered as separate entities. It is
18 improper that they should be.
19 75 Q. I wonder, Mr. O'Brien, was the force of your point that
20 you had to prioritise certain work over others and 10:59
21 there wasn't enough time to do everything?
22 A. Absolutely.
23 76 Q. I wonder was that captured, in any event, in your
24 witness statement to the process. I just want to bring
25 up what you said, at least in one part of your witness 10:59
26 statement. There may be other parts that I could refer
27 to, but let me bring this up, TRU-00828.
28
29 So, you set the context of the 23rd March letter and

1 Mr. Mackle's response to "what do you want me to do?"
2
3 "After I got the letter I just worked harder. I looked
4 at the review backlog and did entire clinics. I find
5 it distressing to look back over those nine months. 11:00
6 There were times before I had my surgery when I was in
7 so much pain but I worked when I was ill.
8
9 I did additional review lists and sacrificed my admin
10 time. I wish it was otherwise, but it was for the good 11:00
11 of the patients. It was better to have relieved
12 discomfort of a patient.
13
14 I have spent time operating from 9:00 a.m. to 8:00 p.m.
15 for years when it was not part of my job plan. 11:00
16 Michael Young has also done it.
17
18 All the additionalities that have been done were
19 additional to my job plan activity which was in place
20 of SPA time, admin time and my own time. I had to do 11:00
21 this activity when I was recovering from my surgery.
22 Management did not offer any support."
23
24 I suppose in some respects, I wonder if you would agree
25 with me, that the granular detail of Appendix 11 tells 11:01
26 the story in that way. Your statement here captures
27 the essence of your point, is that fair?
28 A. Fair.
29 77 Q. Thank you. You also make the point that Dr. Chada

1 failed to grasp the concern that you were bringing to
2 her attention that the number of undictated clinics
3 wasn't 66 undictated clinics. I think the figure is
4 668?
5 A. 668. 11:01
6 78 Q. You thought it was much lower and you told her that.
7 And we, I think, saw the other day your workings. Just
8 maybe bring it up again to remind me. AOB-10671. This
9 is Appendix 12 that you provided to her. Over the page
10 we'll remind ourselves of that. You'd worked through 11:02
11 what the Trust had produced in terms of clinics which
12 were said to be undictated. And if we were to count
13 down through them, as I think I have, it comes to 66.
14 But you're saying -- so, for example, where we are on
15 the screen here, 2nd November '15 Armagh Clinic, at one 11:02
16 point that might have been not fully dictated but by
17 this date it was.
18
19 When we scroll down to the next page, and it comes to a
20 breakdown of 189 unprocessed with 110 to go on a review 11:03
21 list. 35 to be discharged, ten didn't attend, 13 to
22 Thorndale for urodynamics, seven for day surgery and 14
23 for in-patient waiting list.
24
25 I think you said that broadly correlates with the 11:03
26 figures that Mrs. Corrigan was to produce and set out
27 in an email, which I think we've opened already when
28 we had Mr. Carroll, but we'll do it again now. So let
29 me, just before we lose sight of this document, are you

1 saying that the figures along the bottom here are to be
2 seen in Mrs. Corrigan's email?
3 A. Just some of them. The only ones that really -- she
4 hasn't included the discharges or the DNAs. So,
5 basically, she was relating the patients who were to be 11:04
6 put on lists for review and the patients who were to be
7 put on lists for either in-patient surgery, day
8 surgery, or for diagnostics like urodynamics at the
9 Thorndale Unit. And she was reporting that they didn't
10 suffer any delay in their management because of the 11:04
11 long review and waiting list figures.
12 79 Q. Let me just bring her email up then, before we go too
13 much further, and the Inquiry can consider that.
14 TRU-283422, I think is the email you're alluding to.
15 11:05
16 So, 7th June Martina Corrigan is writing to
17 Siobhán Hynds and she's providing the investigation -
18 that is Martina Corrigan is providing the investigation
19 - with an update on what the clinicians who are looking
20 at your undictated cases, what they have produced in 11:06
21 terms of conclusions, is that a fair way to describe
22 this email?
23 A. Yes. Just for accuracy sake, Martina herself was the
24 person who reviewed a lot of them. Not all of the
25 undictated charts were reviewed by clinicians. 11:06
26 80 Q. As with the document that you had produced -- you
27 hadn't seen this email, had you?
28 A. No.
29 81 Q. So, you're working up Appendix 12 for the purposes of

1 giving an answer to Dr. Chada's investigation,
2 meanwhile she has this information --
3 A. Yes.
4 82 Q. -- from Martina Corrigan. And it seems to tally with
5 your document that there are 110 patients who are to be 11:06
6 added to the review list and, if we look down, it says
7 there are 35 who need to be added to theatre waiting
8 lists. I don't see that figure on your document but if
9 I counted Thorndale in-patients, day case surgery and
10 one other -- 11:07
11 A. Day cases and in-patients.
12 83 Q. -- I think I get to a figure of 34?
13 A. Yes. I mean they're pretty accurate, you know.
14 84 Q. No, I'm not pulling you over the coals for one case.
15 But I think your broad point is this: You were making 11:07
16 it clear to Dr. Chada that the number of undictated
17 cases is much less than what the Trust might have
18 thought when the investigation started?
19 A. Of course.
20 85 Q. And what Martina Corrigan would appear to have known 11:07
21 and communicated to the investigation through this
22 email?
23 A. Yes.
24 86 Q. Is that your point?
25 A. I'd just add a little point and that is, that email 11:07
26 from Martina is addressed to Siobhán Hynds only and not
27 to Dr. Chada, and at a time when -- the date of that
28 email is, I think, 7th June.
29 87 Q. 7th June?

1 A. Yes. At a time when Siobhán Hynds was drafting the
2 report for consideration by Dr. Chada. I just raise
3 that point --
4 88 Q. It's a year before.
5 A. Yes. 11:08
6 89 Q. Yes.
7 A. Oh, it's a year before.
8 90 Q. Yes.
9 A. I'm left wondering whether Dr. Chada was fully
10 informed. 11:08
11 91 Q. Of course, Dr. Chada gets to see that detail as well.
12 A. Okay. Okay.
13 92 Q. If we just go to Dr. Chada's report.
14 CHAIR: Mr. Wolfe, might this be an appropriate time to
15 take a short break before we do? 11:08
16 MR. WOLFE KC: I would like to finish this, please.
17 CHAIR: Okay.
18 93 Q. MR. WOLFE KC: TRU-00696. If we scroll down the page,
19 please. So, at the very bottom of the page,
20 Mr. O'Brien, is that what you're upset about, if I can 11:09
21 put it in those terms?
22 A. Yes.
23 94 Q. That's what you're concerned about?
24 A. Yes.
25 95 Q. She has said that you acknowledged there were 66 11:09
26 undictated clinics and no dictated outcome for these.
27 And you say that the delivery of Appendix 12 to her on
28 6th November interview establishes that you didn't
29 acknowledge or accept that finding.

1 A. Yes.
2 96 Q. She has appended to the report your commentary on
3 various statements which does reveal the 189 figure.
4 I should say that in the interest of fairness. 189 as
5 opposed to 600-and-odd, it still reveals a substantial 11:10
6 number of cases not triaged?
7 A. Yes.
8 97 Q. And Dr. Chada made that point, I suppose, that --
9 A. Not dictated.
10 98 Q. Not dictated, thank you. 11:10
11
12 Dr. Chada made that point, that to some extent she
13 found a complication around the figures that were being
14 produced but at the end of the day it didn't seem to be
15 a matter of too much concern to her whether it is 100 11:11
16 or 600, it's a substantial number she was being told,
17 even on your account and that was, she says, the
18 important message to bring home. Why do you consider
19 the matter of, I suppose, absolute precision around the
20 figures to be important? 11:11
21 A. Well, I mean, I would have expected that there would
22 have been absolute precision or close to it around the
23 figures in the report of an investigation by the
24 Investigator. I think it's very reasonable. And
25 I couldn't understand why nothing had changed from the 11:11
26 starting point. So, in terms of the 189 as opposed to
27 668 that they considered were there initially, I have
28 reported that I attended or made every attempt to
29 attend to those that I considered to be most urgent.

1 I think that's also reflected in the information that
2 is imparted to the Investigation Team by
3 Martina Corrigan. I'm not deflecting or diminishing
4 the significance of the fact that dictation hadn't been
5 done on those patients for communication reasons, and 11:12
6 for the multi-professional body and so forth. I would
7 have done it if I had had time to do all of that, in
8 addition to the things that I was drawing attention to
9 in Appendix 11.
10 MR. WOLFE KC: I think that's a convenient point. 11:13
11 CHAIR: Let's say 25 to 12, an extra five minutes
12 today.
13
14 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
15
16 CHAIR: Mr. O'Brien. Mr. Wolfe.
17 MR. WOLFE KC: Thank you.
18
19 MR. AIDAN O'BRIEN CONTINUED TO BE EXAMINED BY MR. WOLFE
20 KC AS FOLLOWS: 11:27
21
22 99 Q. MR. WOLFE KC: Mr. O'Brien, just before the break we
23 were working through some reflections that you had on
24 Dr. Chada's approach and the factors that did or
25 perhaps didn't, more importantly, feature in her 11:37
26 report. The final aspect of that that I wish to draw
27 your attention to - I should make the point that the
28 Inquiry has your position where you explain that there
29 was a failure on Dr. Chada's part to interrogate the

1 evidence she was provided with, that she didn't go
2 looking for additional evidence to make good the points
3 that were made to her, that kind of thing. So, we have
4 that point and I don't propose to deal with it in
5 detail. 11:37
6
7 Her comments on your insight or lack thereof is
8 something I should give you an opportunity to explain.
9 If we go to TRU-00705. Towards the bottom of the page,
10 please, she said of you that during interviews and 11:38
11 correspondence you have displayed some lack of
12 reflection and insight into the potential seriousness
13 of the above issues. And she draws specific attention
14 to your reflection on the five patients with delayed
15 diagnoses. And she says of that: 11:38
16
17 "He did not seem to accept the importance of
18 administration processes. He did not feel regular
19 dictation was important and he does his own thing about
20 replacing admin time with extra operating lists whilst 11:38
21 at the same time reporting lack of administration time.
22 He felt he couldn't do the triage in the way it was
23 expected, but was also clear that he didn't agree with
24 it anyway. I believe it appropriate and relevant to
25 raise this with the Case Manager." 11:39
26
27 And just at the top of the next page, please. Oh,
28 that's the end of it. My apologies.
29

1 So, I'll put beside that something you said in your
2 response, I think, to Dr. Khan. AOB-01893. And
3 you say -- it's about four paragraphs down. Yes, just
4 before "Terms of Reference". You say:
5 11:39
6 "The report states that Mr. O'Brien displayed some lack
7 of insight and reflection into the potential
8 seriousness of the above issues. This I would
9 completely dispute. I believe that this impression has
10 been gained due to my disbelief at the lack of insight 11:40
11 on the part of the Trust into the harm and risk of harm
12 suffered by patients already on the longest waiting
13 list. It has also been disappointing to read the
14 report, after 18 months of investigation, concluding
15 that I did not agree with triage anyway." 11:40
16
17 So you dispute her analysis or contention that you
18 lacked insight.
19
20 You did make the case, and we can go to it if you want, 11:40
21 that you were surprised there were so few patients who
22 hadn't been triaged who were then escalated to Red Flag
23 or who had gone on to suffer cancer. I think that, in
24 substantial part, was triggering her comment around
25 lack of insight; is that how you understood it? 11:41
26 A. Well, you know, it's -- one can only speculate as to
27 why she came to that conclusion. And to take a comment
28 like that, which I made at that time, it was difficult
29 to understand how such a small number of patients had

1 been upgraded to Red Flag status. I think I came to
2 appreciate at a later stage, when I would have been
3 doing all of the referrals resulting from urologist of
4 the week. I mean, I would have been upgrading a
5 greater percentage of referrals to Red Flag status. 11:41
6 I think, actually, that I had probably done a greater
7 degree of triage of urgent and routine referrals than
8 I had considered at the time. I think I probably had
9 reduced the number of patients who still remained
10 untriaged and who were upgraded to Red Flag status. 11:42
11 Have I made myself clear or is that confusing?
12 100 Q. Yes, but on --
13 A. On the point?
14 101 Q. -- on the point of your insight, I wonder if I could
15 put it this way, and perhaps by reference to this 11:42
16 description of your work which comes from the summer of
17 2016. Let me just put this up and then the question
18 which follows from it. AOB-77631. This is
19 12th July 2016. The context for this is that you are
20 raising questions about the numbers of patients placed 11:43
21 into your SWAH Clinic. It started out as a clinic with
22 eight in the morning, and then eight in the afternoon
23 were added. And by this point in time - we don't have
24 the time today to scroll through all of the emails -
25 you're pointing out that sometimes you can have 20 and 11:43
26 21 patients queued up for this clinic. Yes, it's in
27 the meat of this email. And you say:
28
29 "At the last clinic which I did in SWAH on th June '16,

1 21 patients were appointed, of whom two did not attend.
2 This required me to conduct a clinic from 10:00 a.m. to
3 5.15 p.m. without a break, without anything to eat, and
4 one cup of coffee to drink. Then the dictation and
5 administration begins." 11:44
6
7 Do you think, Mr. O'Brien, when you were explaining
8 yourself to Dr. Chada, obviously you didn't make
9 mention of this specific email, but I think -- is it
10 fair to say that your broad defence or your broad 11:44
11 argument in mitigation to Dr. Chada was this kind of
12 thing: 'This is my world. I know that some things
13 don't get done. I don't diminish the importance of
14 those things, but some things are more important than
15 others'? 11:45
16 A. I agree entirely. And not to dwell on this particular
17 email and the outpatient clinic, the SWAH Outpatient
18 Clinic, but alongside my clinic was the clinic
19 conducted by the Clinical Nurse Specialist and there
20 was a lot of toing and froing. So, she would ask me to 11:45
21 see some of her patients, or even do part of an
22 examination of her patients. And vice versa. It was a
23 very, very collaborative clinic and sometimes I would
24 go to see patients on the ward at the request of other
25 consultants. So, everything is bigger than is planned 11:45
26 on paper. And I was citing that as mitigation.
27 102 Q. Just finally on your comments on the insight issue.
28 A. Yes.
29 103 Q. You appear to think that comment unfair. Why did

1 you consider it unfair?
2 A. Would you like me to go back to that last paragraph of
3 that previous --
4 104 Q. We can do, yes.
5 A. Yeah, just because there's a lot of detail in it. 11:46
6 105 Q. If we go back then to -- just allow me a moment. It's
7 TRU-00705.
8 A. Yes. So without being tedious and laborious about it.
9 So:
10 11:46
11 "Mr. O'Brien had displayed some lack of reflection and
12 insight into the potential seriousness of the above
13 issues".
14
15 I would just completely refute that that is the case. 11:47
16
17 "His reflection on the patients with delayed diagnoses
18 was disappointing and is noted above."
19
20 And I think that there was a reference made, perhaps 11:47
21 above - it's not necessary to bring one to it - but
22 I think I made some comments on the patients who had
23 delayed diagnoses of early stage prostate cancer and
24 I was --
25 106 Q. We could bring you to that if it assists. It's 11:47
26 TRU-00686.
27 A. Yes.
28 107 Q. You see it there in the second paragraph.
29 A. Not only were there two cases at such an early stage

1 and with low risk prostate cancer that the management
2 recommendation was they would be managed by active
3 surveillance, and those of us familiar with the
4 diagnosis and management of prostate cancer are well
5 aware of the whole issue of lead time that the person 11:48
6 who has a diagnosis of such an early stage low risk
7 prostate cancer today almost certainly did have it one
8 year previously, and by having it diagnosed today
9 rather than one year previously, the patient has
10 avoided having the concern and the anxiety that is well 11:48
11 recognised in the literature. That's what I meant by
12 -- it's been written extensively in the literature.
13 There's such a thing called PSA anxiety. So these are
14 issues that Mr. Hanbury and I would be familiar with.
15 In the course of making a comment like that, one can 11:49
16 inappropriately draw the conclusion that I lacked some
17 kind of insight into a delay in diagnosis in general,
18 and that's not the case.
19 108 Q. Thank you. Now, we started on Wednesday with, I think,
20 your acknowledgment or your acceptance, as has always 11:49
21 been the case, around the triage notes at home and
22 dictation issues, subject to the caveats we frequently
23 return to as well. Obviously, the private patient
24 issue is something you didn't accept and you don't
25 accept and I want to look at that now for a short 11:49
26 period of time, please.
27
28 Could we have on the screen TRU-00702. Let me just see
29 the bottom of the previous page. Scroll down, please.

1 I think that's the main point I wanted to just
2 illustrate. So, she's saying she's not persuaded by
3 your justifications provided for why the nine private
4 patients were seen in the timeframes outlined. She
5 concludes that these patients seen privately were 11:50
6 scheduled for surgeries earlier than their clinical
7 needs dictated. These patients, she says, were
8 advantaged over HSC patients with the same clinical
9 priority. She then goes on to deal with a particular
10 patient. You'll note that we provided you -- I hope 11:51
11 it's in front of you, I can't see it from where I'm
12 standing --
13 A. It is here, yes.
14 109 Q. -- a designation list?
15 A. Mmm. 11:51
16 110 Q. If you feel the need in the next exchanges to refer to
17 any particular patient, and I may do so myself, we'll
18 use the designation list. I think it's the last page
19 that contains the names that we'll be perhaps most
20 particularly interested in. 11:51
21
22 I suppose your chief complaint about this conclusion,
23 or your chief complaint about her approach is that in
24 getting to that conclusion she, or those providing
25 information to her, failed to provide a comparative 11:52
26 exercise to robustly assess whether these patients were
27 treated appropriately.
28 A. Yes, and I would also, before you leave, probably, this
29 particular page, I also think it is a conflict between

1 "clinical priority", the last two words in the first
2 paragraph, and "chronological order" in the second
3 paragraph.
4 111 Q. Let's just look at that a moment. In terms of a
5 principle in relation to how clinicians who have a 11:52
6 public or an NHS practice as well as a fee-paying or
7 private practice, I suppose, would you subscribe to the
8 view that, of course, any patient is entitled to a
9 private consultation but it should not lead to
10 prioritisation, then, if the patient transfers across 11:53
11 to the NHS?
12 A. I do, yes.
13 112 Q. When we look at "chronological status" and "clinical
14 priority", is the proper way to look at this -- is it
15 by trying to recognise that patients may have similar 11:54
16 needs in terms of the procedure to be applied, whether
17 diagnostic or surgical, but you could be on the waiting
18 list two years for that procedure but then somebody
19 comes along needing the same procedure but their
20 clinical needs are more urgent? 11:54
21 A. Yes. And not just their clinical needs, there could be
22 other needs in a more holistic assessment. It's very
23 important to take those into account, you know, if they
24 are comorbid, if they have a disability, and as is
25 increasingly common in our modern society, if they are 11:54
26 carers, their caring burden.
27 113 Q. We'll come back and look at some of those points in a
28 moment. I just want to work through the process which
29 the Trust, and then the investigation, appeared to

1 pursue leading into these conclusions.
2
3 TRU-283681. This is from Mrs. Corrigan to
4 Siobhán Hynds, copied to Dr. Chada, 14th September '17.
5 We looked yesterday at your meeting with Mr. Weir, 24th 11:55
6 January '17, you're told that there's concern in
7 relation to nine TURP patients but I highlighted that
8 investigations continued. And the investigations, as
9 they continued, led, it appears, to the shedding of
10 some of those TURP patients in terms of concerns around 11:56
11 how you'd handled them and broadening it out to include
12 a total of 11 patients of mixed needs in terms of
13 diagnostics and surgery.
14
15 Martina Corrigan is then explaining what happened when 11:56
16 the matter came to her. She says that when the 11
17 patients were identified, she then asked Mr. Young if
18 he could look at these letters and gauge from his
19 clinical opinion should they have been as soon as they
20 had been. I think there's a word missing there. 11:56
21
22 "...should have been seen as soon as they had been or
23 should they be on the NHS waiting list to wait and be
24 picked chronologically."
25 11:57
26 If that's his task, have you any concerns about it?
27 A. Yes, I have, because not all of the information that
28 includes -- or that should be included, in my view, in
29 arriving at a prioritisation was necessarily even

1 detailed on the letter that he was asked to look at.
2 It's a similar issue to whether it's triage or
3 assessing that clinical priority on the basis of what's
4 in a letter, I found that that was a rather limited and
5 rather disappointing assessment of clinical priority. 11:57
6 114 Q. Okay, and we'll come and look at that, maybe shortly.
7
8 At the point when you have been told that it's a TURP
9 patient concern, you did a piece of work on that, isn't
10 that right? 11:58
11 A. That's right.
12 115 Q. Let's bring it up on the screen. It is TRU-01090. The
13 title in the top left is "TURP 2016" and we can see
14 that the first patient, we can see towards the right,
15 attended privately. So what you've done is you've gone 11:58
16 through all of your TURP procedures 2016, private and
17 NHS. Scroll down, please. You're showing us -- just
18 before we do, I beg your pardon, "date of surgery",
19 "waiting time". That's important to note.
20 A. Yes. 11:59
21 116 Q. At the end of that, if we go to page '92 in the
22 sequence, two pages down. Thank you. So, at the end
23 of that you're able to bring together an analysis of
24 both private patients and be in a position to compare
25 waiting times, I suppose with NHS patients. If you 11:59
26 would care to explain your summary, please.
27 A. Well, basically, I was comparing -- all together there
28 were 46 TURPs done electively and I excluded some
29 people who may have had both we'll say a bladder tumour

1 resection and a prostate resection as part of bladder
2 tumour management. So, these were straightforward
3 elective TURPs. So, nine patients who had attended
4 privately, I looked at the length of period that had
5 elapsed from the decision to treat until the date of 12:00
6 their surgery. So, I thought I would break them up in
7 this way. So, basically 44 percent of the patients who
8 had attended privately, in other words they're small
9 numbers, four out of nine, had their surgery done in
10 less than 100 days which, actually, was less than the 12:00
11 percentage of the 37 who hadn't attended privately who
12 had their surgery done in a relatively short period of
13 time. I was making the point that if I compared these
14 two cohorts of patients, patients who had never been
15 seen privately had also a very -- you know, they were 12:01
16 treated in very much the same manner. I was
17 demonstrating my refutation of the notion that I was
18 treating patients who had attended privately in some
19 preferential manner.
20 117 Q. So, you would say, whatever the statistical 12:01
21 significance of this might be, it certainly doesn't
22 suggest any great advantage being given to patients who
23 were once private, in terms of how you managed them?
24 A. That is correct. You see the mean waiting time,
25 202 days for those nine patients who attended 12:01
26 privately, as opposed to 219 for those who hadn't
27 attended privately.
28 118 Q. When you spoke to Dr. Chada and realised that the case
29 against you had expanded into 11 patients, you told

1 her -- if I can get this up on the screen so we get it
2 absolutely right, AOB-01889. It's the last paragraph.
3
4 On 6th November, when you're discussing this in some
5 detail with Dr. Chada, you submitted a detailed account 12:03
6 of the management of each of the 11 patients, and we'll
7 look at that. You say you also shared your conviction
8 that an analysis of all the TURP patients of 2016 had
9 not complied with the anecdotal allegation that those
10 who had attended privately had had their surgery 12:03
11 performed after a significantly shorter period of time
12 and that this finding had led those compiling the
13 information for the Case Investigator to find patients
14 who had had other procedures performed following
15 private consultation and who better fitted the 12:04
16 allegation.
17
18 Do I interpret that as you saying that this has been
19 contrived, this 11 patients -- the scenarios within the
20 11 patients and the allegation that flows from that; is 12:04
21 that being contrived in your view?
22 A. It was the only conclusion that I could come to at that
23 time.
24 119 Q. On the basis of what you know about how this was
25 arrived at, who do you think was responsible for this, 12:04
26 who do you see as being responsible for contriving
27 this?
28 A. Well, the case in point, that led to the allegation in
29 the first place, and that is Patient 119, where

1 Mr. Haynes had reviewed this patient after he had had
2 his prostate resected by me, he having attended
3 privately previously, and read the private patient
4 letter that pertained to that patient and, I firmly
5 believe, came to the wrong conclusions from that 12:05
6 letter. So, I was of the view that here's another
7 patient who has had his surgery done within whatever,
8 16 days, after he has been seen on a particular date
9 and they're not the only ones. In fact, he may not be
10 the only clinician who is behaving in this manner, so 12:05
11 look at the other TURPs. I believe when a more sober
12 analysis was done of the nine TURPs, they didn't all
13 fit the allegation and, therefore, they went looking
14 for more. And the comparator, importantly, as was
15 described yesterday or the day before or previously, 12:06
16 was: Look for all of the patients who had had a
17 private patient letter dictated and typed on my behalf
18 on ECR who had had anything done and which appeared,
19 actually, to be after a shorter interval than if people
20 were taken in strict chronological order. 12:06
21 120 Q. And what was the problem with that?
22 A. Well, the problem with that is -- there's no problem
23 with it at all if you do believe and if everybody is of
24 the view and insists that all patients are diagnosed or
25 assessed or operated on in strict chronological order 12:07
26 and without any assessment of clinical priority which,
27 as I've stated my stall, when you have long waiting
28 lists, in my view is indefensible.
29 121 Q. Do you think that that's the way that Mr. Young

1 approached it? Because, clearly, as we can see when
2 you look at the list of 11 patients, he was able to
3 see, thinking about clinical priority or clinical need
4 that two of them, two out of the 11 were treated
5 perfectly properly having regard to the waiting list, 12:07
6 having regard to their clinical condition, and those
7 kind of factors.
8 A. I think, actually, that he was coming to those
9 conclusions with inadequate information, depending
10 entirely only on the information that was in one 12:08
11 letter.
12 122 Q. So, in terms of Mr. Young and his approach, is it your
13 sense that he sought to take clinical need into account
14 and it wasn't just a chronological approach but your
15 concern for him or for his approach was that he didn't 12:08
16 have all of the information available to him from the
17 letters to be able to fully assess clinical need?
18 A. I agree with that assessment.
19 123 Q. Thank you. Thank you.
20 12:08
21 Help us with this: In terms of your private practice,
22 what was your way of doing it? And you didn't have a
23 surgical private practice, isn't that right?
24 A. No. An operative one. I have an operative one.
25 124 Q. So it was nonoperative. It was consultation? 12:09
26 A. Yes.
27 125 Q. And you offered that facility from your home?
28 A. That's right.
29 126 Q. Could patients come to you from the NHS into your

1 private practice?
2 A. You mean if they were already being seen for --
3 127 Q. If they were already being managed?
4 A. -- the same condition? Yes, of course.
5 128 Q. Yes. 12:09
6 A. I mean anybody can request and be afforded a
7 consultation. Of course.
8 129 Q. Can they then, from your private practice, go back into
9 the NHS?
10 A. They could do. Yes. 12:10
11 130 Q. And what is the process around that, when a patient who
12 you are seeing privately in consultation needs either
13 diagnostics or surgical intervention?
14 A. Basically, it falls into two cohorts which is very,
15 very applicable in this context. That is, those people 12:10
16 who require assessment or surgery or both, but usually
17 in a particular order, and there is no -- there's no
18 clinical urgency to it, you're not sitting in front of
19 a person in distress or suffering severely from their
20 symptoms and they have no greater clinical priority 12:11
21 than anybody else that you've seen in your NHS clinic
22 the day before. So, they will go on to the NHS waiting
23 list with the effective date being the date that you
24 have recommended that they have that procedure or
25 investigative process. And if you're looking at 12:11
26 another cohort of people who have to be dealt with more
27 urgently, and back in those days, you know, I would
28 have arranged their attendance or their admission or,
29 indeed, I, on occasion, have admitted people directly

1 to the hospital having come in with acute urinary
2 retention, or something of that nature, or the ureteric
3 colic that we were speaking about previously. And
4 people have come, you know, that are not always fee
5 paying, and people have come just to seek a second 12:11
6 opinion or a view as to their management or to seek
7 advice or -- so it is a small, very rural practice
8 where people know one another and a lot of people know
9 me over quite a lengthy geographical radius and, you
10 know -- I mean they were welcome to come to see me. It 12:12
11 is a practice that basically was consultation only. It
12 was not one that I solicited much because I didn't have
13 the time for it. But, at the same time I didn't feel
14 when people wanted to see you that I would turn them
15 away. 12:12
16 131 Q. Just so that I understand, if somebody is seeing you
17 privately and you decide that diagnostics are required,
18 such as a scan, blood test, where would they have that
19 done?
20 A. They would have it done at the place that's nearest to 12:12
21 them geographically and where it's available,
22 obviously. Or so it could be Craigavon Area Hospital,
23 it could have been South West Acute Hospital, it could
24 be South Tyrone or Armagh, any of the local hospitals.
25 132 Q. And is there a process to be undertaken by you in order 12:13
26 to move that person from your private rooms into the
27 list, if there is a list, for --
28 A. For a scan?
29 133 Q. For a scan.

1 A. No, not that I'm aware of. Just for procedural
2 operations and the likes of urodynamics studies and so
3 forth.
4 134 Q. So do you, as the private practitioner, arrange for the
5 diagnostics -- if it's a diagnostics case, do 12:13
6 you arrange for that to be done within the NHS for the
7 patient?
8 A. Yes.
9 135 Q. And can that patient come back to you as a private
10 patient? 12:13
11 A. Well, they could do or they could be reviewed, probably
12 much more commonly, in an outpatient clinic, in an NHS
13 outpatient clinic. So, if that happens you put them on
14 the NHS waiting list to attend your NHS clinic.
15 136 Q. Just sticking with diagnostics for a moment. There are 12:14
16 demands on those services --
17 A. Mmm.
18 137 Q. -- and there are waiting times to be seen. Who
19 determines the priority for the patient emerging from
20 your private rooms in terms of those diagnostic 12:14
21 procedures?
22 A. Well, I think, actually, the radiologists will be quick
23 to tell us all, and have done so, that we may we may
24 request a scan but they will determine the clinical
25 priority. So, in terms of having something of, like 12:15
26 flexible cystoscopy, or something of a diagnostic
27 nature that is procedural, I would have made a
28 judgement call on that, depending upon the priority.
29 So, either there was no great priority or there was a

1 priority to it.
2 138 Q. Is there a requirement to complete a change of status
3 form when a patient is moving from you wearing a
4 private hat, into the NHS?
5 A. Yes, there is. Since 2017, certainly, there is one 12:15
6 that's available online.
7 139 Q. I think we have one. TRU-164798.
8
9 For how long has this been a feature of the process,
10 the completion of this form? 12:16
11 A. I don't know when it started. I couldn't tell you when
12 this was available and online. I certainly know since
13 this issue arose and entered the investigative process
14 in 2016, I have been using those since then.
15 140 Q. Had you been using them in conjunction with the 11 12:16
16 patients that were the subject of the investigation?
17 A. I cannot recall whether I had done so and I cannot --
18 I think probably not. I don't know whether they were
19 available at that time. And I think that I may have
20 had a misinterpretation of them because there was a 12:17
21 time when patients came into the hospital through the
22 Emergency Department and they were NHS patients and
23 they wanted to change their status during the episode.
24 And I think that I may actually have misinterpreted.
25 I thought that the change of status form, which I think 12:17
26 is what these are referred to, even though the title
27 says "application for the transfer of private patient
28 to the NHS" was applicable to people who were changing
29 in episode.

1 141 Q. So, you didn't understand the need to fill them in in
2 those circumstances?
3 A. I can't recall when I started but I know that certainly
4 since it became an issue I certainly was doing it
5 scrupulously. 12:18
6 142 Q. In terms of these forms, it's the completion of this
7 form, isn't it, that provides the vehicle for the
8 change of status. Until this form is completed you
9 don't have an effective date for their transfer on to
10 an HSC list? 12:18
11 A. Well, my understanding of this form is to notify the
12 Trust that a person -- a patient is being transferred
13 from private to NHS. I wouldn't have used this form as
14 the vehicle for putting the patient on the list, I'd
15 have been doing that by email separately to this 12:18
16 function. I regarded it as a notification. And, in
17 fact, I was surprised, during the course of this
18 investigation, to learn that there had been a delay in
19 the approval of this transfer. I didn't realise that
20 this was, really, an application for transfer. 12:19
21 I thought everybody had the entitlement to be
22 transferred and it was notifying the NHS Trust of that
23 transfer. And I didn't use it as the mechanism for
24 putting the patient on the list.
25 143 Q. Is it your now understanding that the completion of 12:19
26 these forms should then go to the Medical Director's
27 office, not necessarily him or her but to that office
28 for the approval of the transfer?
29 A. That's what I've learnt in looking at documentation.

1 But it certainly was new learning for me.
2 144 Q. Yes.
3
4 In terms of the position of a patient on the waiting
5 list, could you explain to us, if you're not completing 12:20
6 these forms, I take there to be a bit of frailty in
7 your memory around these 11 patients. I think on
8 balance you think you probably didn't complete them for
9 the 11 patients?
10 A. I think on balance probably not. But that's not a 12:20
11 certainty.
12 145 Q. So, that being the case, what was the process that you
13 understood you were following in terms of getting these
14 patients into the HSC system and, if you like, finding
15 their way on to the waiting list, whether for 12:20
16 diagnostics or for theatre?
17 A. Well, up until 2016 one of the secretaries in the
18 hospital - not my own secretary - she typed all of my
19 private dictation.
20 146 Q. This is Mrs. Hanvey? 12:21
21 A. That's right. So, if I wanted to put a patient on a
22 waiting list for the TURP, I just asked her to put the
23 person on the waiting list for a TURP. I wasn't aware
24 that you had to apply to do so. It was as simple as
25 that. 12:21
26 147 Q. Yes.
27 A. And if, on the other hand, I had come to a conclusion
28 that someone had to be treated with a greater degree of
29 urgency, I would have said, you know, that I'm

1 admitting -- I would have dictated in a letter that I'm
2 admitting this person on 20th September 2016. And
3 then, unfortunately, I didn't ask her, in retrospect,
4 if I hadn't done so already, to have put that person on
5 the waiting list retroactively with the effective date 12:22
6 for decision to treat, you know, if I had seen them
7 previously. I'm thinking particularly of that
8 particular patient.
9 148 Q. We'll maybe come to that in a moment. I think I know
10 what you're explaining. It's somewhat complicated. 12:22
11 But can I ask you this, just before going into some of
12 the particular cases.
13
14 The determination as to urgency, that was a decision
15 for you; is that right? 12:22
16 A. Yes.
17 149 Q. And there was no placing of that within the system.
18 So, if I can put this scenario. You are seeing a
19 patient privately on a Saturday morning at your home
20 and you decide that this patient, who you may have seen 12:23
21 privately over a number of years but you're reaching
22 the view now, on the Saturday morning, that a TURP is
23 indicated. And, as we've seen from some of these
24 cases, the TURP is performed within a relatively short
25 period of time. The decision as to when to bring him 12:23
26 into theatre, and the urgency of that, is one that you
27 make?
28 A. Yes.
29 150 Q. And you've got full autonomy on that?

1 A. Yes.
2 151 Q. And you're not aware of anything in the Southern Trust
3 system that superintends that process?
4 A. No.
5 152 Q. In terms of the process that then follows from that 12:24
6 decision, you have the private patient's notes --
7 A. Yes.
8 153 Q. -- at home?
9 A. Of course, yes.
10 154 Q. Is that, in essence, the same thing as the NHS chart? 12:24
11 A. No.
12 155 Q. You have the private notes but they're also included
13 within the NHS chart?
14 A. No, I had a private patient folder that I retained for
15 my own purposes and prior to December '16 I thought it 12:24
16 was good practice to make a handwritten note. I would
17 duplicate -- very often, actually, if the NHS chart, if
18 I had asked for it, if I knew that someone was coming
19 on a Saturday morning and I had it available to me,
20 I would have both the hospital chart and the patient 12:25
21 folder, and I would make my own handwritten note, like
22 symptoms or whatever, in the hospital chart and then
23 whenever I would dictate a letter and have it typed by
24 Leanne, I would have a copy of it put in the hospital
25 chart and a copy put in my private patient folder. 12:25
26 156 Q. Yes. You've made the decision this patient is for
27 TURP. You would like it done quickly, or not, as the
28 case might be.
29 A. Yes.

1 157 Q. What comes next? How do you get that patient into the
2 hospital?
3 A. Well, if there was no particular urgency to it, and
4 they may still, actually, have fallen inside the urgent
5 or routine, not because of the use or the non-use of a 12:26
6 change of status form, but you still have two
7 categories on which to place any and all patients on
8 the waiting list - urgent or routine. So, I would have
9 asked the secretary, by whatever means, to place the
10 patient on a waiting list on a particular date and with 12:26
11 a particular category of urgency. So, they could have
12 attended privately and been placed on the waiting list
13 for TURP with an urgency category as "routine".
14 158 Q. Could I ask you to comment on Mrs. Elliott's
15 description of the process. WIT-76345. She explains - 12:26
16 just scroll down, please - that she has no input into
17 your private practice. That's Mrs. Hanvey's domain,
18 isn't that right?
19 A. No, that was prior to December '16.
20 159 Q. Okay. 12:27
21 A. She still has no -- none of that administrative in my
22 pra -- because thereafter I did my own typing of
23 private patient letters.
24 160 Q. Okay. So, she explains, this is Mrs. Elliott,
25 explains: 12:27
26
27 "I would have received phone calls from patients'
28 relatives enquiring into private appointments and these
29 were redirected..." to your private telephone number.

1 She recalls that you were "the first consultant that
2 she had worked for who also had a private practice.
3 And that private practice was at home. And these
4 patients would have been then transferred to the NHS
5 for their surgery. 12:28
6
7 Mr. O'Brien would have given me a list of patients for
8 his Wednesday theatre list. On receipt of this list of
9 patients I would have pre-admitted the patients
10 accordingly. However, the patients Mr. O'Brien had 12:28
11 seen privately were not on the Trust PAS (Patient
12 Administrative System) waiting list. I was able to
13 check the chart tracker on PAS to see when the
14 patient's chart was tracked to Mr. O'Brien's PP filing
15 cabinet by Leanne Hanvey (who did all Mr. O'Brien's 12:28
16 private patient typing) and this was the date I used to
17 put the patient, originally seen as a private patient
18 by Mr. O'Brien, on the NHS waiting list. I was then
19 able to pre-admit the patient for surgery.
20 12:29
21 Then there was the instruction of the transfer status
22 form (not sure of the date). Upon receipt of a
23 transfer status form (transferring patients from the
24 private practice to the NHS) these patients would have
25 been put on the waiting list in accordance with the 12:29
26 'effective date' logged on the transfer status form."
27
28 Scrolling back up to this paragraph - stop there,
29 please. So she is receiving your list, checking what

1 she describes as the chart tracker, seeing when these
2 private patients reach the cabinet, reach the filing
3 cabinet, and using that as the date for the waiting
4 list purposes. Is that your understanding of what she
5 was doing? 12:30
6 A. At the risk of -- I just want to avoid any confusion
7 because there's a distinction to be made between two
8 groups of patients. So, the ones that I was describing
9 up until now are those patients actually who attended
10 privately; a decision was made that they would go on to 12:30
11 a waiting list for a TURP list - let's just use that as
12 a shorthand. And there was no particular clinical
13 urgency to the situation. So, when I would dictate a
14 letter and I'd have it typed by Leanne Hanvey, in the
15 years leading up to 2016, I'd have asked her to put the 12:31
16 patient on the waiting list. And those people -- there
17 were people on the waiting list for TURP who had
18 attended privately in 2016, they might have been on the
19 waiting list since 2014 but they hadn't been admitted
20 because there was no clinical urgency to them. They 12:31
21 are very, very distinct from another cohort of patient
22 where, in those years, if there was a real clinical
23 urgency, as assessed by me, that they really needed to
24 have this surgery done or procedure done in a month's
25 time, I would have dictated the letter, had it typed by 12:31
26 Leanne, and I would stated in that letter that I'm
27 admitting the person on admitted on 26th September, and
28 omitting and having failed to have that person placed
29 on the waiting list retroactively, leading Noleen into

1 this situation which I've just learnt about recently,
2 on reading her evidence bundle, where, instead of
3 finding out when the decision to treat had been made if
4 the person hadn't been own a waiting list, I had asked
5 along the way sometime for his NHS chart for the 12:32
6 purposes I described earlier, and she used that date,
7 which, very often was the wrong date.
8 161 Q. Well, is she not using the date when the file hits the
9 cabinet, the private patients' cabinet, which is
10 indicative of your decision that this patient now needs 12:32
11 the procedure?
12 A. No. Because I -- all patients, whether they needed any
13 procedure or not, I requested an NHS chart for all of
14 them. So, as I described earlier, I reviewed people
15 privately but actually entered their details in their 12:32
16 NHS chart. I thought that was a good way of, in those
17 years, pre-digital, that the NHS, if required, would
18 have a record of their attendance privately for a
19 particular condition. So, it wasn't limited to
20 procedures at all. 12:33
21
22 So, it's an anomaly that is unfortunate and contributed
23 to patients not having been placed retroactively on the
24 appropriate and accurate effective date.
25 162 Q. Let's see if we can better understand that by reference 12:33
26 to some of the specific cases that were looked at as
27 part of the investigation, obviously. I'll draw your
28 attention again to the designation list.
29

1 If we go to TRU-01088. I'll just take a moment to
2 explain this form.
3
4 So, this is a table which the Inquiry understands was
5 produced as a result of Mr. Young's assessment of the 12:34
6 11 cases. And the columns, I hope, speak for
7 themselves. An important column is the third one,
8 "Date on Waiting List" followed by "Date of Procedure",
9 followed by a calculation of days typed, which is a
10 subtraction sum. Then, on the far right-hand column, 12:35
11 his assessment as to whether there's a clinical reason
12 why the patient should have waited such a short time,
13 "yes", "no" or "reasonable" was the language of choice.
14 Overwritten some of these figures, in fact many of the
15 figures in the third and fifth column is your 12:35
16 handwriting, Mr. O'Brien, isn't that right?
17 A. Yes.
18 163 Q. Here we have on the screen a bit of logistical
19 difficulty, but you can take it from me that if
20 we scroll down to the patient that you have marked 12:35
21 "428 days" against, that's a patient whose case number
22 is ending with digits '93.
23 A. Yes.
24 164 Q. I think that is Patient --
25 A. 119. 12:36
26 165 Q. -- 119.
27 A. Yes.
28 166 Q. Thank you. And Patient 119 was the patient that
29 Mr. Haynes raised with the Medical Director's office in

1 December of 2016 and that was the catalyst for private
2 patients becoming an issue within the MHPS
3 investigation?
4 A. Yes.
5 167 Q. The document, as I've said, is populated by answering 12:36
6 the question, "Date on Waiting List". And for this
7 particular patient, Patient 119, you have replaced
8 20th July '16 with 20th July '15 and you've made a
9 calculation of 428 days. Now, does that mean that this
10 patient was placed on the NHS waiting list on 12:37
11 20th July 2015?
12 A. No.
13 168 Q. Help me with that. That is the intention of that
14 column, isn't it? It's asking the author to insert the
15 date the patient is placed on the waiting list? 12:38
16 A. The third column?
17 169 Q. Yes.
18 A. Yes. Yes, and that was -- in that particular case --
19 when I saw the date that the patient was placed on the
20 waiting list in real-time after this issue arose, 12:38
21 I thought, actually, that's a typographical error
22 because it really should be 2015 because that's when
23 I -- it was the only time I met this patient,
24 in July 2015, when I advised him that he should have
25 his prostate resected, or he would be best served by 12:38
26 having his prostate resected. But in fact, actually,
27 it turned out that one year later is when I requested
28 his hospital chart and it went into the filing cabinet,
29 and that's the date that Noleen used to actually

1 identify the date of his going on to the waiting list,
2 which was inaccurate by a long way.
3 170 Q. So, I'm asking, hopefully, a straightforward question.
4 This patient went on the NHS waiting list in or
5 about July 2016? 12:39
6 A. That's right.
7 171 Q. You have written July '15?
8 A. That was when it was -- the date when I decided that
9 he should have his prostate resected.
10 172 Q. But he didn't go on the waiting list? 12:39
11 A. But he didn't go on the waiting list.
12 173 Q. And so your entries on this form are meaningless in
13 terms of the intention of the form. The intention of
14 the form is not intended to record when you thought
15 he should have gone on the waiting list, it's intended 12:39
16 to record when he went on the waiting list?
17 A. That's right.
18 174 Q. Could I bring you just to Mr. Haynes's view of this.
19 TRU-00071. He talks in terms of this case as a patient
20 seen on 5th September privately, given the headed paper 12:40
21 the letter is on. We'll come to the letter. And
22 placed on the NHS theatre list on 21st September -
23 these dates are 2016. Waiting on his analysis, a total
24 of 16 days.
25 12:40
26 "The NHS waiting list has many other patients awaiting
27 a routine TURP (which this man had) waiting significant
28 lengths of time. I believe if his theatre lists were
29 scrutinised, over the past year a significant number of

1 similar patient admissions would be identified.
2
3 A practice which he views as "totally unacceptable".
4
5 He's right, isn't he, Mr. O'Brien, that in terms of the 12:41
6 waiting list this man waited for his TURP a very short
7 period of time?
8 A. He waited since July '15.
9 175 Q. In terms of the NHS waiting list, this man waited a
10 very short period of time? 12:41
11 A. According to that, yes, he waited a shorter period of
12 time.
13 176 Q. If you're seeking to suggest the man was on the waiting
14 list --
15 A. I'm not. 12:41
16 177 Q. -- from September '15?
17 A. No, I'm not.
18 178 Q. -- then please be plain with me.
19 A. No, no, I'm not.
20 179 Q. You're not?
21 A. I'm not.
22 180 Q. I'm talking about the waiting list, do you understand
23 that?
24 A. Yeah. I do understand that, yes.
25 181 Q. Why was it that you corrected Mr. Young's analysis to 12:42
26 seek to suggest that he was on the waiting list from
27 the previous year?
28 A. In his case, actually, I thought that that was a
29 typographical error because the dates are very, very

1 similar apart from the fact that they're one year
2 apart. And I didn't appreciate the explanation for
3 that until relatively recently.
4 182 Q. If we look at the letter that you wrote?
5 A. Yes. 12:42
6 183 Q. TRU-01057. 5th September 2016. It's written on your
7 private practice notepaper?
8 A. Yes.
9 184 Q. He remains a private patient at that point?
10 A. Yes, that's true. 12:43
11 185 Q. It records that you met the patient - his name is on
12 the screen and we'll not use it - in July '15?
13 A. Yes.
14 186 Q. You are now writing 5th September '16?
15 A. That's true. 12:43
16 187 Q. And if we scroll to the bottom of the page, you're
17 telling his general practitioner that you've arranged
18 for him to be admitted on Wednesday the 21st for
19 endoscopic resection of his prostate, which is a TURP
20 procedure, isn't it? 12:43
21 A. That's right.
22 188 Q. What has happened in the period from seeing him in July
23 '15 to bring you to write this letter in September '16?
24 A. Well, I've referred to having correspondence from
25 Kathy Travers, who's the Clinical Nurse Specialist that 12:44
26 I was referring to earlier, in South West Acute
27 Hospital reporting that he was increasingly
28 dependent -- I don't have access to that record,
29 unfortunately. To report he was more or less entirely

1 dependent on self-catheterisation. The bladder voiding
2 has remained satisfactory, but my understanding of that
3 was bladder voiding achieved by self-catheterisation.
4 As I recall what really precipitated this admission was
5 a contact between the patient's wife and my secretary's 12:44
6 office to say that he actually had fainted or collapsed
7 in the course of self-catheterisation. So, I felt, on
8 clinical grounds, irrespective of when I had seen him,
9 that this was a patient who is self-catheterising and
10 increasingly dependent upon doing so, finding it 12:45
11 increasingly difficult to do so and, by any measure,
12 it's not a situation that you can expect the patient to
13 tolerate for much longer.
14 189 Q. You put, if I can describe it as a pen picture or
15 summary, of each case that you were having to account 12:45
16 for when you spoke to Dr. Chada. You can find that at
17 TRU-01094. Patient 119 is -- how do I do this?
18 CHAIR: Could you say maybe what paragraph it is on
19 this page?
20 MR. WOLFE KC: If we go to that paragraph and stop 12:46
21 there, please.
22 CHAIR: The third paragraph down, just to be clear,
23 Mr. O'Brien. Is that the one we're talking about.
24 THE WITNESS: Yes.
25 CHAIR: Thank you. 12:46
26 190 Q. MR. WOLFE KC: As regards this patient, you record that
27 you saw him in July '15 and the point is made that he
28 is suffering severe LUT symptoms due to bladder
29 obstruction resulting in chronic urinary retention,

1 necessitating self-catheterisation and you advised him
2 then that he would be best served having his prostate
3 resected.
4
5 The account you've given of him becoming very urgent 12:47
6 for resection because of fainting or collapsing isn't
7 recorded either in your letter to the general
8 practitioner or in this note?
9 A. That's right.
10 191 Q. Is the reality of this, Mr. O'Brien, that this man has 12:47
11 special access to you, if you like, as compared to NHS
12 patients and he is nothing more and nothing less, with
13 all due respect to him, than a routine TURP patient,
14 many of which you will find on your waiting list,
15 waiting patiently in queue to be seen and, as Mr. Young 12:48
16 found, there was no good reason to treat him in
17 September 2016, given the demands of the waiting list
18 and the needs of other patients. He was, in essence,
19 jumping the queue?
20 A. Well, I'll come back to the queue-jumping label in a 12:48
21 moment.
22
23 I disagree that every patient or all the patients have
24 similar clinical priority. I was -- every month at
25 least I would have spent several hours going through my 12:48
26 NHS waiting list, creating subsections of the category
27 of urgency, and so forth, so that a patient who has got
28 the ureteric stent in would be treated with an urgency
29 that someone with a stone in the kidney will have, and

1 so forth.
2
3 There are patients on those waiting lists, even on the
4 waiting list that is categorised as "Urgency
5 Category 2", who maybe are rising four or five times at 12:49
6 night, or whatever, of that nature, who are very, very
7 deserving of that category of urgency. Having to
8 self-catheterise, having anybody to self-catheterise in
9 order achieve satisfactory bladder emptying due to the
10 bladder's inability to do that itself because of 12:49
11 obstruction due to a large prostate is placing, in my
12 view, the patient in a category of urgency and priority
13 far, far greater than the large group of people who
14 would even be on the urgent waiting list. And to learn
15 that that is becoming an increasingly greater problem 12:50
16 for that person and to cause him discomfort and to
17 result in some kind of faint or vasovagal episode in
18 the course of doing so, to my mind I would find it
19 very, very difficult to say to that person, 'well,
20 actually, the truth of the matter, as you have 12:50
21 portrayed, is you are not to receive any greater
22 urgency in your treatment than someone who doesn't have
23 to depend upon self-catheterisation at all.' The fact
24 that I saw that person once as a private patient was
25 completely irrelevant. I would have done the same if 12:50
26 that person had never seen me privately.
27 192 Q. So, if you were having this debate with Mr. Haynes or
28 Mr. Young, you would say: 'You've got this terribly
29 wrong. I would treat an NHS patient coming to me in

1 early September 2016 through his wife saying I'm in
2 greater difficulty than I was a year ago --
3 A. Yes, I would.
4 193 Q. -- and I need the procedure now?
5 A. Yeah. You know, they don't use that kind of language. 12:51
6 They report their increasing difficulty, and so forth,
7 and can you help.
8 194 Q. Of course. So, what was it in the material that
9 Mr. Young had available to him, and, as I understand
10 it, he had the letter that we looked at a moment or two 12:51
11 ago, what was the missing piece of the jigsaw, if you
12 like, that, had he seen it, would have led him to the
13 view that you're articulating?
14 A. I just think it is the greater dependence upon
15 self-catheterisation and the increasing difficulty that 12:52
16 he was in in performing it and the fact that, you know,
17 if my memory serves me correctly -- because one of the
18 things that this investigation actually resulted,
19 I have never contacted this man since then, in case it
20 would be seen at any time as impeding an investigation. 12:52
21 So, that is my recall of it, that he had actually
22 fainted or collapsed on the bathroom floor in the
23 course of so doing.
24 195 Q. We'll go back to TRU-01088. And the third case on that
25 list, hopefully you'll take my word for it again, is 12:53
26 Patient 116.
27 A. Yes.
28 196 Q. Again, there's, I suppose, a dramatic difference
29 between your analysis of the period spent on the

1 waiting list prior to operation date and that reached
2 by Mr. Young. You haven't inserted, in the way you've
3 done for some others, a date for when this patient,
4 Patient 116 went on the waiting list. Are you telling
5 us with the figure of 349 that he was on the NHS 12:53
6 waiting list 349 days prior to his procedure?
7 A. No, I'm not telling you that at all. And I don't
8 have -- you know, I don't have the ability to access
9 any and to check on the veracity and the accuracy of
10 what I've written. So, when you contrast the -- 12:54
11 197 Q. If we could maybe bring you to - sorry to cut across
12 you - the letter that you wrote in relation to
13 Patient 116. It's TRU-01061. And it's dated 11th
14 April 2016. It's again written on your private paper.
15 And you recall that this man was referred by his 12:54
16 general practitioner in December '14. And when he
17 attended in May '15, those symptoms were reported. And
18 it takes that course. He receives ultrasound scanning
19 - if you could look down to the third paragraph below
20 that - in September '15. And then it's recorded you 12:55
21 spoke with Patient 116 "recently", and the "recently"
22 appears to have led then to your view that he should be
23 arranged to attend the Department for Urodynamics
24 Studies & Flexible Cystoscopy in April of '16. And the
25 "recently" must have given rise to the 11th April 12:56
26 waiting list date, which we find on Mr. Young's form.
27 Does that appear to be a reasonable analysis?
28 A. It could very well be, yes.
29 198 Q. The implication being that in terms of the management

1 of this man, although he had been with you as a private
2 patient for some time, he had had some, presumably,
3 ultrasound scanning in the NHS in September '15, he
4 comes back to you for a private telephone consultation
5 in April '16 and four days layers he finds himself 12:56
6 accessing services within the NHS which otherwise have
7 a heavy demand and are waiting list heavy.
8
9 What would be a typical period of time in April '16 to
10 wait for cystoscopy and urodynamics studies? 12:57
11 A. Approximately 12 months. That would be the longest
12 waiting time.
13 199 Q. If we go - I hope it's not unhelpful to call it a pen
14 pic - to your summary of the case. If we go to
15 TRU-01093. And they're now redacted for me. I didn't 12:57
16 anticipate that and I'll not be able to...
17
18 If you could bring me to TRU-01057.
19 MR. WOLFE KC: I didn't anticipate they would be
20 redacted. 12:58
21 CHAIR: I appreciate that. Can we find the original?
22 MR. WOLFE KC: I can find the original and read it and
23 hopefully that will assist Mr. O'Brien.
24 CHAIR: If you use the original.
25 MR. WOLFE KC: I'll use my original in trying to find 12:58
26 it. If we go back to --
27 CHAIR: TRU-10094?
28 MR. WOLFE KC: Yes. Let me just see --
29 CHAIR: It would appear the preceding page is redacted

1 but not the following.
2 200 Q. MR. WOLFE KC: Yes. If you go then to the fifth page.
3 So the relevant entry is at the bottom of the page.
4 This is Patient 116. And you record that he was
5 referred by his general practitioner in December '14 12:59
6 for assessment of troublesome urinary symptoms, and
7 later referred by a dermatologist in February '15 for
8 assessment of balanitis.
9
10 "He attended privately on 2nd May '15 when he reported 13:00
11 that he was most troubled by urgency and urge
12 incontinence."
13
14 Just bringing you to:
15 13:00
16 "Even though anticholinergic therapy reduced the
17 severity of the incontinence, the persistence of
18 urgency made it very difficult for him to care and
19 visit his..."
20 13:00
21 I think if we simply say --
22 A. Wife.
23 201 Q. -- his sick wife.
24 A. Yes.
25 202 Q. "It was for that reason that I expedited his further 13:00
26 assessment by flexible cystoscopy and urodynamics
27 studies on 15th April 2016, after 349 days, and as an
28 additional patient in SPA time."
29

1 So, in terms of that one, Mr. O'Brien, the need for
2 this procedure wasn't something that you had calculated
3 or determined 349 days previously, it was something you
4 had determined four days before he was seen?
5 A. That is true. And the reason that I did that is that 13:01
6 this man actually contacted me by telephone trying to
7 retain as much patient privacy and confidentiality as
8 possible. But this man, at that period of time, was
9 undergoing therapy for a malignancy of his own and his
10 wife was terminally ill in a hospital with another 13:01
11 malignancy. And he had a degree of urgency and
12 incontinence that not only resulted in him not being
13 able to stray away from his toilet at home, but the big
14 issue for him and which led to the telephone call,
15 'I can't even get -- I can't go out and visit my 13:02
16 terminally ill wife.' So in that kind of -- when I was
17 faced with that, yes, I arranged for him to have these
18 studies done as soon as is possible diagnostically to
19 see how best I could assist him in that situation.
20 And, in fact, we did so. I contacted the urodynamicist 13:02
21 and we did so in my SPA time when, otherwise, there was
22 none lifted.
23 203 Q. Dr. Chada makes the point that if you are to see
24 additional patients they should be seen chronologically
25 by reference to need? 13:02
26 A. No, in chronological order. There is no urgent and
27 routine on the urodynamics waiting list at all. It is
28 typically around about a 12-month waiting list.
29 We have kept it quite static at that. And faced with a

1 patient in this kind of situation, I felt it was
2 entirely justified to try to assist him in this regard.
3 204 Q. Mr. Young, of course, differed.
4 A. Yes.
5 205 Q. He saw this as - and I'm perhaps putting words in his 13:03
6 mouth because we haven't heard from him yet, but I'm
7 surmising that this is all too typical. 'We have lots
8 of patients needing these services. We don't have the
9 resource to see them as quickly as we would, but they
10 all have their own patient backstory, all their own 13:03
11 family, social and medical circumstances that need to
12 be catered for. But by seeing people out of turn
13 coming out of the advantage of a private consultation
14 is the wrong way to do it.'
15 A. That's his view. And I entirely disagree with it. 13:03
16 206 Q. Can I put one final case to you before we break for
17 lunch. And that it is case of Patient 124. And
18 Patient 124 is the daughter of a Personal Information redacted by the USI friend of
19 yours, Personal Information redacted by the USI. And she was seen, if
20 we go back to our table at TRU-01088, and she is the 13:04
21 last entry on that page. And there's not too much
22 disagreement between you on the timeframe here?
23 A. No.
24 207 Q. But, again, when you say she was on the waiting list on
25 30th January 2016, had she been placed on the waiting 13:05
26 list?
27 A. No. That's -- she had not been. So, there was another
28 case of Noleen coming to that conclusion on the basis
29 of when the NHS chart was sought.

1 208 Q. If we look at your letter at TRU-01051. You explain
2 how she had been in pain and came to your attention in
3 January 2016. This is just halfway down the page.
4 Obviously there was a background to it, Mr. O'Brien,
5 I don't wish to gloss over that, but the most 13:06
6 immediate -- the immediate circumstances leading up to
7 her attendance in February are set out in the context
8 of events from January. And you saw her privately in
9 January, isn't that right?
10 A. Yes. 13:07
11 209 Q. And having reviewed her, you arranged for her to be
12 seen for ultrasound scanning on 5th February?
13 A. Yes.
14 210 Q. Then she attended for urodynamics studies on the 16th
15 of the month. And, just over the page, down the page, 13:07
16 you've arranged to see her Personal Information redacted by the USI
17 on 24th February.
18
19 Again, Mr. Young takes the view this was a case where
20 the timeframe of, on your figures, a little over a 13:08
21 month can't be justified by reference to her clinical
22 condition. She was seen privately and she was given
23 the benefit of NHS treatment because you were friendly
24 with her father, he was a Personal Information redacted by the USI, and
25 she obtained an advantage by dint of that relationship 13:08
26 rather than by drawing a connection between her
27 condition and a connection with the needs of others who
28 were otherwise patiently waiting on the waiting list.
29 Is that a fair analysis?

1 A. No.
2 211 Q. If she hadn't been the daughter of your
3 Personal Information redacted by the USI friend, she would still have been seen
4 in that timeframe?
5 A. Yeah, because if I could ask the person to scroll up or 13:09
6 scroll down.
7 212 Q. Of course.
8 A. So, the important point is that this is a young woman
9 who had been having constant left-sided abdominal pain,
10 Personal Information redacted by the USI 13:09
11
12
13
14
15 13:10
16
17
18
19
20 13:10
21
22
23
24
25 13:10
26
27
28
29

1 Personal Information redacted by the USI
2
3 And I was going to ask you if you would do the same
4 exercise with regard to the pen picture?
5 213 Q. Of course. I hope we don't have the same problem with 13:11
6 redaction. It's to be found at TRU-01095.
7 214 Q. MR. WOLFE KC: I'll leave the floor to Mr. O'Brien. He
8 has asked for this entry to be brought up to help him
9 explain or further explain his answer. You were, in
10 essence, explaining your justification for treating 13:15
11 this young lady at the time you did and you were citing
12 aspects of her clinical history and you asked to be
13 brought to this document which is TRU-01095.
14 A. Yes, indeed. And the first lines on this page just
15 repeat what I have already said. So if you could 13:15
16 scroll down, please. Yeah. So she was in constant
17 pain throughout 2016 when that person - her father -
18 asked me to review her. So in doing so, on 30th
19 January '16 I found her to have recurrence of the same
20 Personal Information redacted by the USI pain as previously. I was also struck by the 13:16
21 severity of those Personal Information redacted by the USI symptoms that she
22 reported, and I was, therefore, keen for her to have
23 those symptoms assessed diagnostically prior to me
24 undertaking the same procedure that she had done
25 previously in February '13 to relieve her of her pain. 13:16
26 So, the urodynamicist offered to do the urodynamics
27 studies on Tuesday, 16th February 2015, after a period
28 of 17 days, whilst I was doing a new patient clinical,
29 and without displacing any patient on a scheduled

1 session of urodynamics studies.
2 215 Q. Does that of itself, Mr. O'Brien, point to the fact
3 that, if you like, flexibility has been shown or
4 favours are being done to facilitate this patient
5 because of where she has originated from? 13:17
6 A. No. If I wanted to proceed with Personal Information redacted by the USI management
7 of her persistent Personal Information redacted by the USI pain, in the same way
8 that I had done in February '13, but with the
9 additional complication that she has Personal Information redacted by the USI
10 symptoms, to see what I could do about those in 13:17
11 addition. So, the primary driver was the Personal Information redacted by the USI.
12 216 Q. Okay. Just, finally on private patients, can I ask you
13 this: In terms of the guidance or training or advice
14 that was available from the Trust in the period
15 relating to your management of these patients, which 13:17
16 was primary 2016, what had you received from the Trust
17 in terms of advice around the management of private
18 patients on to NHS lists?
19 A. Well, I was aware of the Trust Private Patient Policy.
20 I had read it because it's important to be aware of its 13:18
21 contents. And after Dr. Wright took up post as the
22 Medical Director, he had a series of educational
23 workshops where we could attend to make sure that
24 clinicians who did have a private practice of any kind
25 would be aware of the Trust Policy, and I attended one 13:18
26 of those.
27 217 Q. When you reflect upon it now, and I know you're holding
28 your ground for the justification of each of these nine
29 patients and, obviously, in the interests of brevity

1 we've selected a few to look at. You're holding your
2 ground on that. When you reflect on it, procedurally,
3 in order to improve the transparency of the
4 transaction, could you have done any better?
5 A. I could have done. 13:19
6 218 Q. In what particular respects?
7 A. Making sure that actually people were on the waiting
8 list for a procedure when I advised them that the
9 procedure was required. And after my return to work in
10 '17, I hope that's the way it turned out to be because 13:19
11 it was much better in that regard.
12
13 So, I do agree that I have contributed to the confusion
14 but I -- others may disagree with my views with regard
15 to prioritisation and clinical urgency, but I never 13:19
16 discriminated against one or the other. I treated all
17 of those people similarly. And it wouldn't have
18 mattered whether this patient was the daughter of a
19 friend or I had met in the Emergency Department that
20 afternoon, I would have gone about trying to arrange 13:20
21 the same thing.
22 MR. WOLFE KC: Chair, I see I have considerably
23 overshot. I probably have another half hour
24 for Mr. O'Brien, I'd like to get him finished today. I
25 understand you have questions. Would it be possible to 13:20
26 have a shorter lunch break today, maybe 2 o'clock?
27 CHAIR: Yes, I think we could. If that is agreeable to
28 everybody. We do need to finish, by the very latest,
29 about quarter past three this afternoon. So I think if

1 we can start then again at 2 o'clock and hopefully that
2 will give us about 45 minutes, Mr. Wolfe, if you can be
3 confined to the half hour to allow any questions we may
4 have. So.
5 13:21
6 So 2 o'clock, ladies and gentlemen.
7
8 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:
9
10 CHAIR: Good afternoon, everyone. Mr. Wolfe. 14:01
11 MR. WOLFE KC: Good afternoon.
12
13 MR. AIDAN O'BRIEN CONTINUED TO BE EXAMINED BY MR. WOLFE
14 KC AS FOLLOWS:
15 14:01
16 219 Q. MR. WOLFE KC: The Case Manager's determination,
17 Mr. O'Brien, the determination of Dr. Khan, within your
18 grievance you've reflected a number of concerns about
19 that. You've commented that he mischaracterised the
20 issue in relation to undictated clinics, the point 14:01
21 being he's described it as, in one part of his report,
22 as an issue in terms of the recording of patient notes
23 as opposed to a different issue, a distinct issue of
24 dictation. And we have your points on that and I don't
25 intend to dilate on those this afternoon. 14:02
26
27 Additionally, we have your concerns in relation to what
28 you say around mitigation. He had information, just
29 like Dr. Chada had, around your work pressures and what

1 have you, and we don't find, according to your
2 argument, much reference to those within his report.
3 So we have those points. I think you would say he
4 makes the same mistake as Dr. Chada around the number
5 of dictated clinics, another point that we have, and 14:03
6 it's well set out in your grievance.
7
8 What I want to ask you about is his actual conclusions.
9 We know that he determined that there should be a
10 conduct hearing; that there was a need for a robust 14:03
11 Action Plan with NCAS input and, thirdly, concerning
12 the activities of management and what he saw as
13 systemic failures. He asked for an independent review
14 of administration. I just want to seek your views on
15 aspects of that in the little time we have left this 14:03
16 afternoon.
17
18 Could I start with the NCAS advice around that, please.
19 AOB-01901. If we just go to the bottom of the page,
20 please. Sorry, actually it's the next part of the 14:04
21 page.
22
23 That is the advice. You'll recall reading, perhaps,
24 Mr. O'Brien, that in advance of read his determination,
25 Dr. Khan Sought advice of Dr. Lynn. 14:04
26 A. That's correct.
27 220 Q. Scrolling on down, please. So at the bottom of the
28 page she says that:
29 "We discussed the issues identified in the report were

1 serious, and that whilst there are clearly systemic
2 issues and failings for The Trust to address..." -
3 that's a reference to the management issues - "...it is
4 unlikely that in these circumstances the concerns about
5 Mr. O'Brien could be managed without formal action. 14:05
6 We also discussed that whilst the issues did have
7 clinical consequences for patients as some of the
8 concerns appear to be due to a failure to follow
9 policies an d protocols and possibly also a breach of
10 data protection law, these might be considered to be 14:05
11 matters of conduct rather than capability."
12
13 We'll look at that. Because you disagreed with the
14 notion that there were conduct issues here?
15 A. Yes, I did. On the whole I did disagree with that 14:06
16 conclusion.
17 221 Q. Yes. As I say, we'll look at that in a moment.
18
19 Going over the page, please. She noted that it would
20 be open to Dr. Khan in his role as Case Manager to 14:06
21 forward to a conduct hearing. But she also said that
22 you could be offered support going forward to ensure
23 that in future you're able to meet and sustain the
24 required and expected standards. And she indicates in
25 the next paragraph that NCAS could provide some expert 14:06
26 input in that respect through its practitioner
27 performance advice service or the PSR team, the
28 Professional Support and Remediation Team. So that's
29 aspects of the advice that Dr. Khan received. And

1 we can see that that fed into his decision. And if
2 we pull up his decision at AOB-01921. If we scroll
3 down, please.
4
5 He's saying that: 14:08
6
7 "While there are some wider systemic failings that must
8 be addressed by the Trust, I am of the view that this
9 does not detract from Mr. O'Brien's own individual
10 professional responsibilities." 14:08
11
12 Go on down, please. He says that he sought advice from
13 NCAS. At this point he's determined that there's no
14 requirement for formal consideration by Practitioner
15 Performance Advice or referral to the GMC. The Trust 14:08
16 should conclude its own processes, and he sets out the
17 conduct issues that he's concerned about in light of
18 reading the report. And, scrolling on down, given
19 those issues, he's concluded that your failings must be
20 put to a panel. 14:08
21
22 This was to be the subject of your grievance, isn't
23 that right, this determination?
24 A. That's correct.
25 222 Q. Just before we look to the grievance, another aspect of 14:09
26 this was -- I think if we scroll down a little further.
27 I can't find it on the text but the nub of it is that
28 he was endorsing or following or seeking to follow the
29 advice of NCAS in terms of the need for a further

1 robust Monitoring Plan in respect of you.
2
3 Just dealing with that aspect, just quickly, before
4 going to conduct issues. Is that something that you
5 would have thought beneficial or necessary for yourself 14:10
6 at this stage?
7 A. I think it would have been beneficial to both parties,
8 if I can describe it in that manner. Whether it was
9 necessary or not is another matter. Its necessity is
10 almost irrelevant because, I think, actually, it had 14:10
11 been so beneficial all around that advantage should
12 have been taken of that offer. That's my view.
13 I think, actually, to have fresh input, external input,
14 into two parties that could be described as becoming
15 increasingly estranged at that time, I think it would 14:11
16 have been very, very helpful.
17 223 Q. We know that it was the Trust's view that the extant
18 Monitoring Plan, which was conceived in February of
19 2017, it was the Trust's view that it continued to live
20 and regulate its approach to you. Was that a view that 14:11
21 you took?
22 A. Absolutely not, no.
23 224 Q. You will recall that Dr. Khan wrote to you
24 in October 2017 and at that time he was asking in his
25 correspondence whether you continued to comply with the 14:11
26 Monitoring Plan. You didn't answer that
27 correspondence?
28 A. I answered the correspondence but I didn't answer that
29 question --

1 225 Q. Okay?
2 A. -- and said I would answer it at a later date.
3 226 Q. Okay. Thank you. That's right. I don't disagree with
4 that. I'd forgotten that.
5 14:12
6 Various things going on this point, as I say. The
7 Trust thought you continued to be bound by the
8 Monitoring Plan. The clearest indication that you
9 thought you weren't I think comes in 2019 when
10 Mrs. Corrigan writes to you to suggest a meeting with 14:12
11 her and Mr. McNaboe. And you write back and firmly
12 say: 'I don't consider myself bound by that plan or
13 the plan doesn't exist anymore. I'm happy to meet
14 you.' Why did you consider that the Monitoring Plan no
15 longer existed? 14:13
16 A. Because it was stated that it was to be in place during
17 the course of the investigation and the investigation
18 was over.
19 227 Q. In terms of the standards contained within the plan
20 around triage, do Red Flags, the day they arrive with 14:13
21 you, complete the rest of it by 4:00 p.m. Friday of
22 your urologist of the week? Don't take notes home with
23 you, don't store them in the office, dictation. The
24 standards contained therein, did they continue to bind
25 you? 14:13
26 A. Was I obliged to adhere to them?
27 228 Q. Yes.
28 A. I wasn't obliging to adhere to a plan that I was
29 stating was no longer in existence. I was entirely --

1 I mean I strove all the time to continue to do so.
2 I was just stating a fact, in my view, and I don't
3 think I was implying that there were any implications.
4 I was just stating it. I was very -- it was important
5 for me to state that I was entirely prepared to meet 14:14
6 them, to discuss any issues at any time. And, as you
7 know, there's lots of documentation into us trying to
8 arrange meetings to discuss various issues. So I was
9 happy to -- I was just stating a fact that these
10 alleged deviations cannot be considered to be 14:14
11 deviations from an Action Plan which has expired last
12 year.
13 229 Q. In terms of the Case Manager's determination suggesting
14 of the need for a fresh Action Plan, and he's given
15 evidence to the Inquiry about what he saw as the 14:15
16 deficiencies in the plan that he had in place and there
17 doesn't appear to have been any discussion between you
18 and the Trust management or vice versa in terms of
19 giving life to a new plan?
20 A. There was none. 14:15
21 230 Q. Maybe now that I've found the reference which I should
22 have been very familiar with, I'll put it up on the
23 screen - AOB-01921. Middle of the page, please. He
24 says:
25 14:15
26 "It is my view that in order to ensure the Trust
27 continues to have an assurance about Mr. O'Brien's
28 administrative practises in managing his workload, an
29 Action Plan should be put in place with the input of

1 NCAS."
2
3 And the subsequent paragraph as well.
4
5 It may be in the Trust Evidence, the Trust witnesses 14:16
6 giving evidence to date seem to suggest that the
7 arrival of your grievance placed a red light in front
8 of progressing any of the matters which were the
9 subject of the determination - the Action Plan
10 included. If you thought it was something that might 14:16
11 have been beneficial or helpful, even if it wasn't
12 strictly necessary, and helpful, as you say, to both
13 parties as such, why didn't you make any
14 representations to at least look at it, to get into
15 discussions about how it might be brought to life? 14:17
16 A. Well, I didn't do so, obviously. I mean we had
17 attempted -- you know my views on this whole issue
18 right from the very, very start is we should have had
19 that kind of collaborative, supportive approach.
20 231 Q. Yes. 14:17
21 A. In fact, I think when you look at the transcripts of
22 the recordings of the meetings that I did have with
23 Mr. Wilkinson, it was very much geared to that approach
24 as well. The only thing that I stated specifically in
25 my correspondence on submitting the grievance or, 14:17
26 indeed, I think it was to Dr. Khan in the days after
27 I had done so, was that the grievance contained an
28 appeal of his decision of conduct and, therefore, I was
29 quite insistent that there would be no progression to a

1 conduct panel until that appeal had been attended to.
2 But I certainly didn't obstruct, and in fact on the
3 contrary, I would have very, very much welcomed that
4 kind of input.
5 14:18
6 I think the input from NCAS at that time would have
7 been most beneficial and, in terms of, where we were --
8 where I was at that time, I mean I had received this
9 determination on 1st October; I was shocked by its
10 findings on a number of fronts, including those that 14:18
11 you have already referred to, like I accepted --
12 absolutely astounded that a written report could state
13 that I accepted there were 61 clinics with
14 668 patients, you know, after not only I had provided
15 the information but then to discover that it was it 14:19
16 provided by their own team.
17
18 And then, you know, on that evening, to once again ask
19 for all of the information that we had asked for
20 repeatedly previously, to have to remind Dr. Khan of 14:19
21 that on 21st October, that I still wanted these
22 documents, and the documents that are really important
23 are the minutes of the Oversight Group meeting of
24 22nd December '16 - so, I'm requesting this again
25 almost two years later - and of the NCAS advice that 14:19
26 was given in December 2016. And having already found
27 out that NCAS advice had been given in September '16,
28 we didn't even know at that stage that there had been
29 Oversight meetings in September and October. We were

1 still devoid of a lot of information that we had been
2 requesting. And then on 23rd October, when I received
3 that correspondence from Dr. Khan, attached to which is
4 the action note, it was called, detailing the minutes
5 of the Oversight Group meeting of 22nd December 2016, 14:20
6 to then see it related in that note that there was an
7 earlier Oversight meeting in September '16. So by this
8 stage, additionally, I had this experience of a person
9 whom I'd never met before or since coming to my office,
10 requesting three charts - that was okay - one of which 14:21
11 was one of the 13 missing charts that had -- we had
12 already established I had not lost or mislaid or
13 whatever, and it was in pigeonhole form. At this stage
14 I was almost paranoid, is it possible that someone
15 could actually mislay, let me put it that way, a 14:21
16 patient record in a pigeonhole in my office only to
17 find it two years after I have said the particular one
18 in question was never a patient of the Trust or of a
19 previous Trust, never mind my patient.
20 14:22
21 So, going back to your question and that's a
22 long-winded answer --
23 232 Q. Thank you.
24 A. -- I think actually that an Action Plan with an input
25 enter NCAS would have been a very helpful mediating 14:22
26 influence at that stage.
27 233 Q. Is there any indication that you communicated that
28 would have welcomed NCAS's input in your conversations
29 with the Trust?

1 A. No.
2 234 Q. Can you explain why you didn't give encouragement to
3 the idea that an NCAS-led initiative or an involvement
4 from NCAS would have assisted you at that time?
5 A. Well, I mean I did indirectly by speaking to 14:22
6 Grainne Lynn and she indicated that she was most
7 prepared to meet with Dr. Khan and any other personnel
8 from the Trust not to advocate, because that wasn't the
9 role of NCAS, but maybe, if I may, if it's not
10 inappropriate to use the term mediate in its loosest 14:23
11 form to see if it can have a constructive role. But
12 that was rebuffed. So, Grainne Lynn asked my
13 permission, am I agreeable to such an approach by her
14 on my behalf? And I was entirely agreeable to that.
15 235 Q. Moving to the conduct issue; you obviously raised a 14:23
16 grievance with the Trust, as was your right.
17 A. Mmm.
18 236 Q. In raising that grievance, did you give consideration
19 to your awareness that NCAS had advised the Trust that
20 this was a conduct issue and that it could be directed 14:24
21 to a conduct hearing and didn't appear to relate to
22 clinical performance issues?
23 A. I did. And I think, you know, when I had those first
24 conversations with Dr. Grainne Lynn of NCAS, and then
25 incrementally and after some delay that resulted from 14:24
26 having to request or be provided with this information
27 through Freedom of Information requests and so forth,
28 I think that... what's the question again? I'm just
29 not --

1 237 Q. I suppose what I'm asking you is this: You bring a
2 grievance --
3 A. Oh, yes. Yes.
4 238 Q. -- and the procedure -- just to set it in its fullest
5 context. The procedure allows a practitioner who 14:25
6 considers that his actions have been wrongly
7 classified, they classified this as a conduct issue,
8 can use the employer's grievance procedure, and that's
9 what you were doing.
10 A. Yes. Yes. 14:25
11 239 Q. My question to you is that you would probably have been
12 aware that NCAS had advised this was a conduct issue,
13 it could be construed as a conduct issue, and yet and
14 all you decided that that was a position worth
15 challenging? 14:25
16 A. I'm sorry for getting off the tracks but I think the
17 reason -- my view of that was I firmly did believe, and
18 I still do believe, that NCAS wasn't fully appraised of
19 everything that went on or didn't go on in 2016.
20 Whether that was done intentionally or otherwise, leave 14:26
21 that aside. It was my view that if they had a full
22 account from both parties as to what went on and didn't
23 go on in 2016, they may have had a different view in
24 that regard.
25 240 Q. But that's a rather different point, Mr. O'Brien, to 14:26
26 the question of whether failing to do your dictation,
27 failing to triage, whether they were conduct issues.
28 The fact that NCAS, as you believe, may not have been
29 accurately informed or honestly informed, as you

1 sometimes put it, of the entire background to this, is
2 a quite different point to the categorisation of your
3 shortcomings.
4 A. Okay. So, I regarded those shortcomings to be
5 performance issues. 14:27
6 241 Q. Yes.
7 A. And I regarded them as very different -- they were not
8 capability. And I think capability, I understood,
9 refers to competence.
10 242 Q. Let's just see how you set it out in your grievance. 14:27
11 If we could have on the screen, please, AOB-02054. At
12 the bottom, please. You are calling this "Wrongful
13 Classification of Misconduct". The right to grieve is
14 set out there pursuant to Appendix 3 of the Trust
15 Guidelines. At the bottom of the page: 14:27
16
17 "It is my view that the Case Manager has erred in
18 coming to the view that if the issues are not related
19 to my clinical ability, then they must be related to
20 conducts. I contend that it does not follow that these 14:27
21 issues are acts of misconduct, even taken at their
22 reasonable height."
23
24 If we just go over the page please. You expand upon
25 that, about halfway down the next page where you say: 14:28
26
27 "Taken at its very height, a reasonable employer would
28 not consider this to be a misconduct issue but rather a
29 performance issue."

1
2 At the bottom of the page you set out some factors to
3 support that.
4
5 "This is not about misconduct. I was working to the 14:28
6 best of my ability to clear this backlog and I had been
7 open about asking for time to address it. Taken at its
8 height, a reasonable employer would have considered
9 this to be a performance issue, and a performance issue
10 that has since resolved." 14:28
11
12 Is this not an argument that says, 'I recognise that
13 I failed to behave as the Trust expected me to behave
14 with regards to triage and dictation and notes, but my
15 explanation or mitigation is I was working all of the 14:29
16 hours to deal with other things'?
17 A. Well, taking the issues of concern, with regard to
18 notes at home, I think that falls more clearly into the
19 conduct category. With regard to triage, the agreement
20 that we had come to as part of urologist of the week 14:29
21 was amongst us as a small body of consultants, and it
22 was not with the Trust. I've heard Mr. Haynes'
23 argument that we are the Trust but, no, I disagree with
24 that. There may have been an expectation claimed by
25 the Trust that we would dictate after every patient 14:30
26 encounter, but that was new to me and, of course, when
27 they met to discuss whether they could have such an
28 expectation in January '20 there was no standard within
29 the Trust or, indeed, throughout the UK that they could

1 insist upon, upon which to base such an expectation.
2 And with regard to, you know, the review backlog or
3 whatever, I mean basically my overriding argument was
4 that I was running to stand still. We'll not detail
5 that again. And -- 14:30
6 243 Q. You weren't making the argument, Mr. O'Brien, that
7 these were clinical performance issues, were you?
8 A. No, performance.
9 244 Q. I ask the question just because of how it is set out in
10 the MHPS document. If I can just have your views on 14:31
11 this to finish this aspect, WIT-18494. Paragraph 2
12 says:
13
14 "Throughout This framework where the term 'performance'
15 is used..." - the term you use in your grievance - 14:31
16 "...it should be interpreted as referring to all
17 aspects of a practitioner's work, including conduct,
18 health and clinical performance."
19
20 Rather unhelpfully it goes on to say: 14:31
21
22 "Where the term 'clinical performance' is used, it
23 should be interpreted as referring only to those
24 aspects of a practitioner's work that require the
25 exercise of clinical judgement or skill.", 14:32
26
27 So, you weren't putting your shortcoming into the
28 latter view of clinical performance
29 A. No.

1 245 Q. You were saying, essentially, 'I did my best to perform
2 in the way I was performing. I don't believe it's
3 misconduct that I wasn't able to meet your target and,
4 therefore, you shouldn't be pushing me towards a
5 conduct hearing.' 14:32
6 A. On the whole, that's right.
7 246 Q. But is that not an exercise that should have been
8 conducted at a conduct hearing. In other words, it
9 does prompt the question: Were you seeking to kick
10 this can down the road and avoid the inevitable conduct 14:32
11 hearing by time wasting, perhaps, over these pedantic
12 distinctions?
13 A. Absolutely not. I mean, if you're asking why
14 I submitted a grievance, it's because by this stage
15 I was aggrieved. You know, I mean, I was aggrieved 14:33
16 because of the lack of transparency. I was aggrieved
17 by the experience of a drip feed in information. I was
18 aggrieved by repeatedly having to ask for information
19 that wasn't provided and then, when it was provided -
20 not weeks or months later but two years later, and 14:33
21 having to go to NCAS to realise that previous advice
22 had been given, I felt profoundly aggrieved.
23 247 Q. Yes. Your ability to comply with what the Trust
24 regarded as a continuing Monitoring Plan and targets
25 set within that was to be the subject of one or two 14:33
26 deviations in 2018 when Mrs. Corrigan was absent; were
27 you taking advantage of her absence during that period?
28 A. I wouldn't have been particularly conscious every day
29 of being monitored. I didn't know who was doing the

1 monitoring or by what means monitoring was being done.
2 I didn't appreciate, you know, that they were
3 continuing to count charts in my office. Some of --
4 I mean during those months -- this was kind of
5 initiated in June in 2018 by, first of all, getting the 14:34
6 Investigator's report just before going to the annual
7 meeting of the British Association of Urological
8 Surgeons in Liverpool that year; asking for an
9 extension to allow me some time to provide it; having
10 to engage with this process again. I was reviewing, to 14:35
11 the best of my ability, that period because I also had
12 to do some additionality, and I think it coincided with
13 one of my colleagues sustaining an injury requiring
14 hospitalisation at that time.
15 14:35
16 Then if you move on to 2019, if that's okay. Once
17 again, taking on that opportunity that presents itself
18 to all of us during June, July, August and September,
19 when the weather is better and your colleagues go on
20 holidays, to try to make hay whilst the sun shines 14:35
21 because winter descends upon the health service very,
22 very rapidly and we've had that experience of having to
23 cut back greatly on operative work, in particular.
24
25 It's interesting, once again during that period, I was 14:36
26 just reviewing this yesterday evening to the best of my
27 ability, that I don't know how many TURPs I did during
28 that four or five-month period, but six of those
29 actually had prostate cancer diagnosed, unexpectedly,

1 coincidentally, at TURP. One of them, actually, is
2 Patient 4. The other five do not appear as SAIs or, to
3 the best of my knowledge, on a designated list. I'm
4 making a point that here you are, delayed diagnoses,
5 the longest waiting was 24 months. I'm just making a 14:36
6 point. And it's not necessarily for my particular
7 advantage in mitigation terms today, I'm just
8 presenting to you the reality of what it's like as a
9 clinician, carrying responsibility, whether it's from
10 the triage letter at one end to dealing with emergency 14:37
11 surgery or elective surgery at the other end. It's
12 trying to do your utmost every day to try to reduce the
13 risk posed to patients.
14 MR. WOLFE KC: I think that's a convenient place to
15 stop, Mr. O'Brien. Thank you for answering my 14:37
16 questions over a lengthy session - or three! And the
17 Chairman will now speak to you.
18 CHAIR: Yes, unfortunately that's not the end of it,
19 Mr. O'Brien. We are going to try to confine our
20 questions today to aspects of the MHPS process that you 14:37
21 underwent. I'm going to ask Mr. Hanbury, first of all,
22 to ask you some questions about that.
23
24 MR. AIDAN O'BRIEN WAS QUESTIONED BY THE PANEL AS
25 FOLLOWS: 14:38
26
27 248 Q. MR. HANBURY: Thank you very much for your evidence so
28 far, Mr. O'Brien. You'll be relieved to know I'm just
29 going to look at clinical aspects particularly.

1
2 Urologists are often early adopters of new ways of
3 working and urologist of the week was one of these that
4 urologists of your generation and mine had to go
5 through. You did briefly go through the 14:38
6 responsibilities of urologist of the week. I just
7 wondered if I could ask you to say approximately how
8 many patients would you see in a morning ward round?
9 A. Well, that could have varied from what would be the
10 minimum, I suppose 25, up to, including outliers, 40, 14:38
11 let's say. I would imagine it most commonly falls into
12 that of range.
13 249 Q. You did a slightly unusual thing, compared to many
14 departments, to see the electives as well as the
15 emergencies, which you probably have views. I'm 14:39
16 interested in roughly what proportion of that 25 to 40
17 would have been elective cases, often under other
18 colleagues - approximately.
19 A. Maybe 50 - 40 to 60 percent. I'd imagine it varies
20 greatly later. It would have been quite evenly 14:39
21 balanced. In fact, it would be worthwhile having that
22 question addressed in a quantitative manner. It might
23 be actually that the emergencies are the majority.
24 250 Q. Roughly how long would that ward round take?
25 A. It depends, once again, on how complex they are. It 14:39
26 depended greatly on comorbid status and all of that.
27 251 Q. Okay. Roughly?
28 A. So it could take, actually, usually three hours. It
29 depended upon how many outliers there were and,

1 critically, it depended -- I did not know how the
2 registrars of times -- we had a concern about how
3 frequently they were taking phone calls from other
4 parts of the hospital, from other hospitals in our
5 catchment area, and to the extent that one of the 14:40
6 concerns that my colleagues and I did share was to
7 develop a robust logging system of calls so that
8 we wouldn't overlook people. So, I always insisted
9 upon having a lunch break, particularly, it's draining
10 and tiring if you're doing ward rounds. So, sometimes 14:40
11 I have seen us actually go into a dining room at 12:30,
12 or thereabouts, having attended to our own in-patient
13 ward, and then leaving the outliers until after lunch.
14 So, I have seen, certainly, ward rounds continuing into
15 3:00 or 3:30 in the afternoon. 14:41
16 252 Q. So, considering that, did you row back on your original
17 decision to see the elective patients as well and
18 discuss that with your colleagues?
19 A. No, because the duration of those ward rounds already
20 included the looking after of the electives. So, 14:41
21 we very, very quickly came to the conclusion that there
22 was a great merit in having urologist of the week in
23 terms of in-patient management in its totality, but it
24 also freed up the elective colleagues to conduct their
25 business electively. And very often not even on the 14:41
26 Craigavon site. It didn't bar them from coming in to
27 see their patient and to liaise with us, but we found
28 that there was great value in having the clinical
29 experience and expertise at consultant level, looking

1 after your elective patient post-operatively.
2 253 Q. Thank you. You mentioned also your personal hands-on
3 approach to emergency surgery. Did you look at that as
4 a training opportunity for your registrars?
5 A. Oh, absolutely. Yes. I looked upon it as almost like 14:42
6 the grand round that I -- we did have previously at an
7 earlier time. And, you know, you can conduct ward
8 rounds on a daily basis in different fashions and
9 there's no point in going along as a consultant to meet
10 a patient for the first time who has had their prostate 14:42
11 resected the previous day by a colleague and the
12 registrar who is familiar will say, 'how did you get on
13 overnight?' And so forth, because I wanted them to be
14 presenting the case as they would. That kind of thing.
15 So, it was teaching, yes. 14:42
16 254 Q. Thank you. So, one of the down sides of it is losing
17 your regular schedule of operating?
18 A. Yes.
19 255 Q. So in your case all day Wednesday. Presumably your
20 colleagues picked up that? 14:43
21 A. Yes.
22 256 Q. And on the times that you weren't urologist of the
23 week, would you pick up other lists?
24 A. Absolutely. Yes. Yes. We made every attempt to
25 prevent anybody else taking our operating sessions. 14:43
26 257 Q. So, you make a point that the greatest things is
27 theatre time, so I was surprised at a comment that you
28 said, after the Enniskillen clinics you'd sometimes
29 give up the day surgery, obviously there's been a big

1 boom in day surgery. Why were you sort of neutral
2 about giving up day surgery?
3 A. That's a misinterpretation that carried over into the
4 Investigator's report. I spent quite some time trying
5 to convince Dr. Chada that I hadn't given up anything. 14:43
6
7 We had very, very limited day case facilities in a day
8 surgical unit that was historically the Nosocomial
9 Unit. And in fact, actually, we only had a session
10 from -- patients could arrive at 7:30 at the earliest 14:44
11 and had to be out by 1:30 to accommodate an afternoon
12 operating session by a different speciality. So, I had
13 two sessions per month. So, I didn't give up anything.
14 So, I continued to do my monthly allocation, just not
15 on the Tuesday morning after the Monday that I would 14:44
16 have spent in Southwest.
17 258 Q. Thank you. Just moving on to the sort of triage time
18 things. Under the Integrated Access Protocol or
19 handbook of what we should do, your duties for Red Flag
20 is to triage and for urgent and routine is to 14:44
21 prioritise. Obviously we all interpret this as
22 clinicians in different ways. When you found yourself
23 overwhelmed with the amount of time this took - and
24 we've seen in the Inquiry that you are allocating
25 roughly four hours a day sometimes in your estimate, 14:45
26 compared to one hour of your colleagues - and when
27 we're evolving new techniques, as a team did you think
28 of going to your colleagues and saying, 'how do you do
29 it so quickly? Are there any tricks? Can you give us

1 some advice.' Did you have a feeling that you could
2 learn how to do it more efficiently or did you not?
3 A. I knew how all the tricks -- I knew how to do it more
4 quickly. I've stated that in my witness statement, and
5 you may wish to hear it again. You know, you 14:45
6 compromise what you can do or that patient behind the
7 referral in the context of very, very long waiting
8 lists. Or you could compromise in-patient care. And,
9 really, I want to emphasise, because it hasn't really
10 been dealt with much in this module because it's not 14:46
11 really MHPS, but behind the scenes my colleagues and
12 I wanted to meet with senior management to get a clear,
13 written -- we wanted a memorandum of understanding.
14 What is it that you, first of all, want of us as
15 urologist of the week, in terms of hands-on, for 14:46
16 example, versus less hands-on. And what do you want
17 from us from triage. Do you want the quick version or
18 whatever? We wanted, actually, a shared responsibility
19 for the consequences. But we never succeeded in
20 achieving that meeting of minds and having that 14:46
21 discussion. I asked for it in my response to the
22 Patient 10 SAI in January '17 and my employment ended
23 in mid '20. We're no further on.
24 259 Q. So, you made initially an observation as well as the
25 Red Flag referrals would often get allocated very 14:47
26 quickly and almost whatever triage you did, or
27 pre-investigations, but the "urgents" and "soons" were
28 allocated according to a default mechanism if you
29 hasn't seen. Mr. Wolfe made the point with you, you

1 agreed, that two of them, a visible haematuria and
2 someone with a high PSA bounced out of the page at you.
3 I mean do you think, on reflection, your time would be
4 better spent looking at that group, where you could
5 have prioritised? 14:47
6 A. Yes. It could have been, I agree with you. I concede
7 that point from a historical point of view. Equally
8 well, did it require any consultant urologist to look
9 for that keyword? But this is a discussion that never
10 progressed. And I contributed, I think, as much as 14:48
11 I could possibly do, and garnered the support of my
12 colleagues to have it addressed, but it wasn't
13 addressed. We really felt that it was something that
14 we needed the input of the Trust management to share
15 responsibility for that. 14:48
16 260 Q. Although I guess you never reached an agreement with
17 your colleagues about how to do the triage?
18 A. Well, you know, we didn't reach agreement. But you
19 will have read various people's statements, you know,
20 that everybody was doing it to some degree or some 14:48
21 people were doing it to varying degrees and so forth.
22 It was an issue of concern for me. It was an issue
23 like in mid 2019 we had patients waiting up to 107 days
24 for a first outpatient appointment with suspect
25 prostate cancer. In that context, in order to mitigate 14:49
26 the risks associated with that it was my view at least
27 we could get an MRI scan done if you thought,
28 biochemically, it's likely to be non-metastatic, if you
29 know what I mean, to forward the things on.

1
2 The only reason I raise that point once again is we
3 were time limited. There was very little time
4 available, reasonably, sustainably, whilst urologist of
5 the week to do these things. 14:49
6 261 Q. Okay, thank you. I just have a couple more, if that's
7 all right.
8
9 I'm moving on to outpatients and the backlog. This is
10 something that happens to every department around 14:49
11 England, as well as Northern Ireland as well. If you
12 have 1,000 patients waiting to come in, approximately,
13 do you think it's your problem as a clinician, is it
14 a Trust problem? How do you -- do you discuss it as a
15 group? 14:50
16 A. The backlog?
17 262 Q. Outpatient, review outpatient, for example.
18 A. Oh review outpatient. I think predominantly it's
19 a Trust issue. I think that it's not like as if, you
20 know, outpatient review backlogs appear out of nowhere 14:50
21 as a singular anomaly or aberration associated with a
22 particular service or a particular hospital. I think
23 it's just another manifestation of the inadequacy of
24 the service.
25 263 Q. Okay. But the Trust can't solve it themselves, they 14:50
26 need us as medics to do it?
27 A. Yes.
28 264 Q. So, was there an initiative, for example, to look at
29 those thousand patients and say, it is a huge number,

1 so ten patients a clinic, 100 clinics, five colleagues,
2 that's 20 a colleague, you could do one a week for,
3 say, six months and you fix the problem.
4 A. Yes.
5 265 Q. Did you go to the management with that sort of 14:51
6 initiative?
7 A. We did those kind of initiatives historically and they
8 relieved the pressure and reduced the backlogs to some
9 degree for a period of time, but the balloon was
10 inflating all the time. 14:51
11 266 Q. Okay. Okay. Thank you. So, on a similar sort of
12 thing about efficiencies, would you double up your
13 clinics with, say, a specialist nurse or a middle grade
14 where available? Or were they primarily single
15 clinician clinics? 14:51
16 A. They were provided by consultants and by registrars
17 predominantly. We did have CNS provide review clinics
18 like looks review, in particular, and of longstanding.
19 At an earlier stage we had stable prostate cancer
20 review clinics provided by a staff grade. So, we had 14:52
21 made every attempt to do that.
22 267 Q. So to move on. In your timetable you had the slightly
23 unusual thing, a combined flexible cystoscopy and
24 urodynamics clinic --
25 A. Yeah. 14:52
26 268 Q. -- which you headed up or did. Did you think, I mean
27 obviously there was huge pressure on your time, did you
28 think of delegating that to a middle grade or
29 specialist nurse?

1 A. Well, a specialist nurse did the urodynamics studies,
2 and one specialist nurse who was very able and was also
3 competent in doing flexible cystoscopy, sometimes the
4 urodynamics studies, the CNS doing the urodynamics
5 studies was unable to do the flexible cystoscopy, and 14:52
6 I would do the flexible cystoscopy and the nurse would
7 do the urodynamics studies. But, then, I met the
8 patient afterwards in any case to organise -- to go
9 through the findings and come up with a management
10 plan. 14:52
11 269 Q. Okay. Thank you. Just two more short things.
12 We've not talked about MDM in this section but there
13 was one particular thing towards the end whereby, in a
14 very forward-thinking way, you were obviously thinking
15 about spending time preparing, which I think was a 14:53
16 necessity with problems with your quorum. When given
17 the opportunity to maybe spend half a Wednesday
18 afternoon, when it was your turn, did you think of
19 doing it on the Wednesday afternoon, perhaps with a
20 coordinator and specialist nurse, in daylight hours? 14:53
21 A. To preview.
22 270 Q. To preview?
23 A. Actually, in reality, even though that was proposed at
24 the time and appeared, I think, on paper on a proposed
25 job plan, in fact I ended up -- I did it on a Thursday 14:53
26 morning instead because as often as not, actually,
27 I took up the availability of operating on that
28 Wednesday morning session. So, rather than doing it
29 from 11:00 p.m. at night until 3 o'clock on a morning

1 on a Thursday morning, I was doing it on a Thursday
2 morning in daylight hours instead.
3 MR. HANBURY: I think I'll stop there. Thank you very
4 much.
5 CHAIR: Dr. Swart. 14:54
6 271 Q. DR. SWART: Thank you for the last two and a half days.
7 I've got some quite general questions that relate to
8 MHPS as far as possible. It's sometimes a bit
9 difficult to divvy it up.
10 14:54
11 I'm going to start with something, which is around how
12 doctors are supported through MHPS and any other what
13 I might call tricky disciplinary-type issue.
14
15 So, starting with MHPS per se, doctors are unique in 14:54
16 that they have the availability of a non-exec director,
17 and you and others have told us of some of the
18 difficulties about that. When you started this
19 process, did you have a clear expectation of what that
20 Non-Executive Director was here for? 14:55
21 A. Well, I considered it to be clear, just by reading what
22 the functions were. I just thought it was as evident
23 as what it said on the tin, as it were.
24 272 Q. And when did it become clear to you that it wasn't
25 really quite that simple? 14:55
26 A. I think, as I said to Mr. Wolfe yesterday, that when
27 I saw that autonomy and the independence of this person
28 wasn't what I expected it to be, though actually
29 I might take this opportunity of just saying that in

1 the case of Mr. Wilkinson, I think, actually, that the
2 questions that we put to him and which he had submitted
3 to Dr. Khan, may very well have contributed to the
4 development of the fifth Term of Reference with regard
5 to systemic feelings. So maybe, actually, he was not 14:55
6 as useless in his role as I had considered. But I do
7 think it was a new experience for me and we'll not
8 iterate how stressful it was, but I didn't even know
9 what MHPS was. So, I found it very, very reassuring.
10 I think it would be vital. You do, certainly, need to 14:56
11 have a skill base and an experience in doing it.
12 273 Q. So, if I said to you will you agree it would be very
13 helpful to more precisely define that role so that
14 everybody was clear about what it involved?
15 A. Yes. I think the whole thing can be tightened up. 14:56
16 I mean, obviously, the Inquiry is interested in, and
17 obviously it is going to make some recommendations.
18 From the clinicians' point of view, if you find
19 yourself on the wrong end of this process, and it's
20 very, very stressful, and you're trying to navigate 14:57
21 this new journey, and you do not know what the
22 destination is. And we don't even know, actually, what
23 words mean by definition, and all of the things that we
24 have just been discussing. To have some kind of
25 external person that you can go to, that you can 14:57
26 discuss it with. I mean, I found actually meeting with
27 Mr. Wilkinson very, very helpful, almost in a pastoral
28 sense.
29 274 Q. So moving on to that, I think people have recognised

1 that that is probably helpful. I, personally, feel
2 quite strongly about it on a the basis of my own
3 experience. But people have told us they recognise the
4 need for more support. What kind of person would have
5 been most helpful to you, do you think? Because the 14:57
6 Non-Exec Director is a board member and that's a quite
7 distinct role. But what other people would have been
8 able to help you through this? You have described,
9 very clearly, the impact on you and your family and
10 it's not difficult to understand that, it's a very 14:58
11 difficult process to go through. So, what would make a
12 big difference do you think, for the next person who
13 has to go through this?
14 A. I think what the Southern Trust - it doesn't have to be
15 the Southern Trust but any Trust - would need to sort 14:58
16 out in the first instance or consider what is the
17 necessity to have a liaison with the Trust Board.
18 Because the Trust Board, it seems to me, performs an
19 accountability role. I mean, that is the essence of
20 the Trust Board. Yet, actually, the Trust Board or 14:58
21 some of its members may be called upon in some appeal
22 at a later date. So there needs to be some separation
23 of powers in that regard.
24
25 So, having given consideration to that, and whether the 14:58
26 person/the adviser/the external person that we're
27 considering needs to be one and the same person is
28 something that's worth considering. I haven't given
29 much consideration to that but you probably have.

1
2 I don't think, actually, that it necessarily requires a
3 legally qualified person at all. I think that it
4 requires a person who not only has been to the training
5 course but has experience in it. As you've heard many 14:59
6 people say, you know, on completion of the training
7 you've just your L plates up and the experience comes
8 after that. So, it requires a skill base, I've no
9 doubt about it. It requires the ability to listen, as
10 Mr. Wilkinson certainly was very able in doing. 14:59
11
12 So, I ended up disillusioned with the role rather than
13 the man. He couldn't help it. He was new to it as
14 well. And these are important processes that are
15 involving people like me and it has a profound effect 15:00
16 not just on the individual but on the colleagues as
17 well. So, I think their attention should be made to
18 it. I'm not sure from my singular experience I can
19 give you any more advice.
20 275 Q. Thank you for that. So, moving on to other things now. 15:00
21 MHPS should not operate in a vacuum, it operates in a
22 whole system of management for doctors. We can't go
23 into all of that today, but one of them is what I would
24 call normal medical management. And I'll talk to you a
25 little bit about that. One is job planning, briefly 15:00
26 about that, then it comes on to appraisal and Clinical
27 Governance, which will be the subject of probably later
28 interviews, and so on. I don't know any Senior Medical
29 Manager who has not gone through this in terms of

1 different policies and looking at MHPS and other things
2 and hasn't struggled a bit with some of it, or got the
3 process wrong. But the purpose of it is to deal fairly
4 with doctors, and all the documents say try not to get
5 straight into far more difficult investigations. That 15:01
6 would be my experience and you yourself have mentioned
7 this several times.
8
9 So, if we go back to the March 16th letter and the way
10 it was delivered and the events that led up to it, and 15:01
11 we don't need to rehearse that, but you say that letter
12 was out of process. I would say it seems to me like it
13 was, in effect, what we might call a reasonable
14 management instruction of some sort. Will you agree
15 with that? 15:01
16 A. Yes.
17 276 Q. And it was delivered by some senior people.
18 A. Yes.
19 277 Q. Now, when you got that letter you were clearly quite
20 shocked by it. Did you realise that it was of such 15:02
21 significance and that those people were giving you --
22 well, it wasn't presented as an ultimatum, was it, but
23 they were giving you some very clear indication that
24 you were meant to come back to them. Did you realise
25 the significance of it? 15:02
26 A. I realised the significance of it but for the reasons
27 I have stated already, I didn't realise for one moment
28 that I had to come back to them with a written plan.
29 That's unfortunate because that may have initiated some

1 further kind of engagement.
2 278 Q. But you accept their right to do that in terms of --
3 A. Oh, absolutely. Yes.
4 279 Q. Did you ring anyone up? I mean who was your 'phone a
5 friend' in terms of a senior medical colleague to say 15:02
6 'what do I do with this?' Because you said, didn't
7 you? "What am I to do?"
8 A. I didn't ring anybody else.
9 280 Q. Why didn't you?
10 A. Because after all of those years I was in that same 15:02
11 place, dealing with those same concerns, and the more
12 -- the other concerns I have articulated. In an
13 organisation -- and I'm not being critical of the
14 organisation for the sake of criticism or to be
15 critical of this organisation in which I worked for 15:03
16 28 years. You know, in a circumstance, let's call it
17 that, that hadn't seen adequate progression in
18 providing a service adequate enough to enable us to
19 work.
20 281 Q. I'll come on to some job planning in bits in a moment. 15:03
21 But you didn't ring anyone. You didn't think of it.
22 You didn't think, 'I know a senior, wise person to
23 ring'?
24 A. No, not at all.
25 282 Q. Now, if at that meeting you'd been signposted to a 15:03
26 senior medical critical friend, would that have been
27 helpful?
28 A. That would have been helpful, yes.
29 283 Q. Okay. So, I'm going to ask a little bit about job

1 planning. Now, this is a really difficult area for
2 most trusts, for most doctors. On the one hand it's
3 really just about payment for time in some ways.
4 However, generally it goes with some reasonable
5 expectation of what you do in that time and 15:04
6 productivity and all of that. Your job plan was never
7 signed off because you didn't agree with it.
8 Nevertheless, there's a missed opportunity. Did
9 you sit down with your urology colleagues and do a kind
10 of a team job planning exercise ever? 15:04
11 A. Never.
12 284 Q. No. So, you didn't discuss with each other roughly
13 what sort of balance you should have between different
14 kinds of programmed activities or anything like that?
15 A. No. You know, in terms of, for example, what 15:04
16 Mr. Hanbury was talking about, in terms of our
17 outpatient templates, they were quite uniform, you
18 know. At the new clinic -- new patient clinic where
19 you do as much as possible, as it were, the one-stop,
20 so it was nine new patients per consultant, and if you 15:05
21 had a registrar with you, it was another six, and
22 reviews were 12, and so forth.
23 285 Q. But you didn't sit down as a team and say --
24 A. We did --
25 286 Q. What I'm trying to get to, did you sit down and say: 15:05
26 'We've got this much work to get through; we've got
27 this many urologists, this is the capacity for theatre,
28 this is the gap, this is what we need to make a case
29 for. Were those discussions facilitated in any way by

1 a Clinical Director. Did you have anything like that?
2 A. Yeah, particularly in earlier years when there was --
3 it was always a mismatch. I think in my witness
4 statement I have detailed how the mismatch was through
5 various exercises where they were called waiting list 15:05
6 initiatives --
7 287 Q. I understand that. What I'm trying to get to is was
8 the culture in the Trust such that you would, every
9 year, go through the requirements for the Department,
10 the requirements on individual -- 15:06
11 A. No, no. It wasn't organised, no.
12 288 Q. -- and attached to the job planning some sort of team
13 or individual objectives as to what you were trying to
14 do. Did you do it or not?
15 A. No. 15:06
16 289 Q. Can you describe any mechanism by which, on an annual
17 basis, for example, you were able to highlight the
18 demand capacity mismatch and attach it to strategic
19 plans for the service. Were you involved in that on a
20 regular basis. 15:06
21 A. No, not on a regular basis.
22 DR. SWART: That's all from me. Thank you.
23 290 Q. CHAIR: Thank you. Just a couple of things from me.
24 You talked there in answer, I think to Mr. Hanbury,
25 about the issue of triage and disagreement among you 15:06
26 and your colleagues about what that should be, and then
27 there was, I think Mr. Glackin wrote to the Trust sort
28 of saying - I think we've seen a letter somewhere, it
29 wasn't drawn up in this - but saying what is expected

1 of us in terms of triage and being urologist of the
2 week? Did that meeting come out of a meeting that you
3 all had together?
4 A. Is that my document called "Issues of Concern" or --
5 291 Q. No, no, this is a letter - I don't have any reference 15:07
6 for it but I'm sure we can find it. It's somewhere in
7 the papers that I've looked at, Mr. Glackin wrote a
8 letter, and I think you made some reference to it
9 there, about trying to set up a meeting with management
10 to define what was understood as your duties as it 15:07
11 were, as urologist of the week and what they expected
12 of you from triage?
13 A. Yes.
14 292 Q. Did that come out of that meeting that you had with
15 fellow consultants for which we don't have a recording, 15:07
16 we have a meeting the first part of it, there's then a
17 coffee break, and the second part of that meeting is
18 not recorded?
19 A. Yes. So --
20 293 Q. My question about that is: Given that you were so 15:07
21 fastidious at this time about recording meetings, why
22 was that discussion not recorded? Can you recall?
23 A. I just discarded it because we hadn't, for the second
24 time, managed to meet with senior management.
25 294 Q. So, can I take it from that that meeting was in fact 15:08
26 recorded by you covertly?
27 A. Yes, that one.
28 295 Q. That discussion was, but you no longer have a copy of
29 that recording, is that what you're saying?

1 A. Do you mean the first meeting?
2 296 Q. I'm talking about -- there was a meeting that recorded
3 where you and your consultant colleagues were present.
4 A. Yes.
5 297 Q. You were discussing issues with them? 15:08
6 A. Yes.
7 298 Q. And the end of that was: "And we will come back after
8 coffee to discuss the issue of triage."
9 A. Yes.
10 299 Q. And it seems to me that arising from that meeting 15:08
11 Mr. Glackin then writes to the Trust to try to set up a
12 meeting to determine what the requirements of the Trust
13 were with regard to the issue of triage?
14 A. Right.
15 300 Q. Am I correct in my reading of that? 15:09
16 A. I would need to clarify. Is that the September meeting
17 or the December meeting.
18 301 Q. I don't have it before me and I don't have the date.
19 In any event, am I right in thinking that far from our
20 understanding that you didn't record that discussion 15:09
21 about triage, you in fact did but you no longer keep
22 that?
23 A. No, I don't have any other recordings. I think that
24 may arise from the meeting of late September. I can't
25 remember the exact date. So, that was the meeting, 15:09
26 actually, where meeting senior management was cancelled
27 because of Martina Corrigan's continued recovery. And
28 that was fine, I was disappointed about that because in
29 scheduling we had left that day aside for this very

1 purpose. And that was, like, in the context of what
2 we're just talking about, mismatch, that was a rare
3 event.
4 302 Q. Yes, and rather than waste of the time you decided to
5 go ahead and have a meeting amongst yourselves? 15:10
6 A. Absolutely. And I had submitted my issues of concerns
7 that because we were all asked to do that, to make that
8 contribution. Obviously it didn't happen. There was
9 some degree of a reason for that. That wasn't a big
10 issue. What was a greater issue still was we have to 15:10
11 arrange another one of these, I think for Monday
12 23rd December '18 --
13 303 Q. But my point that I'm trying to get at, Mr. O'Brien,
14 was you didn't waste time you had all set aside?
15 A. We didn't waste the time. 15:10
16 304 Q. You had brought the concerns to your colleagues.
17 A. Yes.
18 305 Q. There was a discussion after the coffee break about
19 this major concern of yours about what are we supposed
20 to do when we're asked to triage these cases? 15:10
21 A. Yeah.
22 306 Q. And Mr. Glackin writes to the Trust as a result of
23 that, writes to senior management, I should say.
24 A. Yes.
25 307 Q. But I'm trying to understand what happened. Why was 15:10
26 that aspect of that meeting not recorded after the
27 coffee break?
28 A. I do not know. I don't think there's any particular
29 reason. I cannot answer that. I think it has to be

1 emphasised, certainly from my perspective -- the really
2 important thing here was to seek an engagement with
3 senior management. So rather than me not having
4 recorded or retained a recording of the discussions
5 that we had surrounding triage, there was by this 15:11
6 stage -- we really -- the demand was increasing, the
7 number of referrals was increasing. I think we're now
8 into 8,000 per year referrals by 2018. The numbers in
9 the ward are increasing. I was doing -- the likes of
10 me and my colleagues were doing 21 emergency operations 15:11
11 per urologist of the week, and all of that there. I'm
12 just saying --
13 308 Q. I understand the context, Mr. O'Brien, please don't get
14 me wrong. I'm just trying to get to the nub of a
15 particular question. At this point in time you're 15:12
16 recording all of these, what you perceive to be
17 important meetings.
18 A. Yes.
19 309 Q. And I've no doubt that this was a matter of concern
20 that you had brought to this meeting, that you wanted 15:12
21 to discuss with your colleagues, and it certainly seems
22 that you recorded the first part of it?
23 A. Yes.
24 310 Q. Triage is not reached by the coffee break?
25 A. Yes. Yes. 15:12
26 311 Q. I'm just curious to know: Did you record the second
27 part of it and has that recording disappeared or was it
28 never recorded?
29 A. I don't think it was ever recorded.

1 312 Q. I suppose the next question is: Is there any
2 particular reason for not recording that when it was
3 such a matter of concern to you?
4 A. No. I think that we had -- we had got to a stage by
5 2018, and in spite of the effects of this 15:12
6 investigation, and so forth, on relations with
7 colleagues, that we were able to sit down and
8 we actually wanted to try to resolve this issue of
9 urologist of the week. There had been some discussions
10 going on in the wings as to whether we should take 15:13
11 triage out of urologist of the week all together and
12 put is a large part in the hands of a Clinical Nurse
13 Specialist. Maybe actually have even one session
14 outside of urologist of the week, or we could sit down
15 with a residuum of referrals that the CNS couldn't sort 15:13
16 out as to what's the most appropriate thing to do and
17 you could deal with it in that manner.
18
19 So, there were innovative ways of doing it. But we all
20 shared a view that we really needed to meet with senior 15:13
21 management to share this responsibility with us.
22 I felt that was very important. And we arranged again
23 for 3rd December, and then it was cancelled the
24 previous Friday.
25 313 Q. Okay. Can I move on to a completely different issue. 15:14
26 One of the things - you may not recall it because it
27 has been a long week for all of us - but one of the
28 things, I think it was on Wednesday that you said to
29 Mr. Wolfe when he was asking you about the whole issue

1 about Eamonn Mackle and you said to him that you felt
2 harassed at the meetings with him and Gillian Rankin,
3 and you said they were not conducted as they should
4 have been. And I just wondered what you meant by that?
5 A. They were very aggressive. You know, I preface my 15:14
6 words with stating that these are not the words that
7 you would hear the week after or even the year after,
8 so some distance apart and so forth. I used those
9 words in reply to Mr. Wolfe's questioning about it.
10 They were brutal. And I use it advisedly. 15:15
11
12 They started off with, usually an allegation.
13 I remember one such meeting was: 'You reviewed a
14 patient, the parent of one of our administrative
15 colleagues on this floor, and you explained to them 15:15
16 that their review was delayed because of a backlog and
17 that it was a Trust fault.' And I said, 'Who was the
18 patient? Who's the father or who's the daughter? ' You
19 know. 'You will apologise on the part of the Trust.'
20 And you might actually have seen some documentary 15:15
21 evidence of that where I declined to be apologising on
22 the part of the Trust. That's mild. That's sort of
23 like an anecdotal thing. They were conducted in a
24 manner they shouldn't have been conducted. They
25 weren't professional, they weren't courteous, and they 15:16
26 shouldn't have been tolerated and they occurred over a
27 period from 2010 maybe -- 2010 certainly into 2012,
28 '13. And I felt -- I have no doubt I was harassed but
29 I certainly didn't complain about it for the reasons

1 that I have stated.
2 314 Q. Although there's a question mark about that, you don't
3 recall complaining about it but certainly you seemed to
4 tell Mr. Wilkinson that you had complained to
5 Mrs. Rankin about it, that you weren't going to meet 15:16
6 with Mr. Mackle and you weren't going to have any
7 further dealings with him?
8 A. Dr. Rankin was the witness to all of that. She was
9 there. I was asked by Mr. Wolfe to possibly speculate
10 as to the source of this conveyancing of harassment and 15:16
11 bullying to Mr. Mackle and it may not have been too far
12 from that source. It wasn't from me because I thought
13 I would only be adding to my troubles in that regard.
14
15 And I wanted to take this opportunity to emphasise 15:17
16 because sometimes actually, even when you're speaking
17 words, as I'm doing now, you don't use all of them to
18 get across your meaning. I have no difficulty in
19 meeting with anybody on any grounds provided that
20 we deal with one another in a courteous and polite 15:17
21 manner. I've always dealt with people in that manner.
22 I tolerated this in a non-confrontational way for a
23 long period of time until I just couldn't, actually,
24 take another one. So, I sought an assurance that such
25 a meeting with Mr. Mackle would not happen again. 15:17
26 I had no idea, actually, on -- even though, actually,
27 Mr. Brown on occasion -- I've known him for a long
28 time. I would have communication with him or do
29 business with him. I didn't know that there was, like,

1 a planned arrangement. I'd no difficulty meeting with
2 Mr. Mackle on 30th March '16 and he had his loss in the
3 meantime, and all of that sort of thing. So, it was
4 just -- actually, most importantly of all, I found --
5 15:18
6 I was so traumatised by all of that experience,
7 I remember some months later Mr. Young conveying to me
8 that Dr. Rankin wanted to meet with him and I about -
9 I can't remember the issue now - some ongoing issue,
10 could we meet up in her office? And I actually 15:18
11 declined only one thing. I just couldn't go up those
12 stairs. There was a long time I couldn't go up the
13 stairs to the administration floor. And Dr. Rankin
14 came down to facilitate me, meeting with her and Eamonn
15 in a seminar room. I have met her since at a regional 15:19
16 level whether we were discussing things.
17
18 So, you know, water can flow under the bridge and it
19 did flow under the bridge with regard to Mr. Mackle as
20 well, but during that period of time it was difficult 15:19
21 and they should not have been conducted in the manner
22 in which they were.
23 315 Q. Just in relation to the Non-Executive Director. I
24 mean, you complained that he didn't answer your
25 questions. Your complaint was that the answers were 15:19
26 not in a letter from him. But he did get you the
27 answers to the questions and, at the end of the day,
28 did it really manner from where those answers came?
29 A. I think at the time they did, you know, because,

1 I think at that time they did. Maybe in retrospect
2 it didn't matter as much as it appeared to matter at
3 that time.
4 316 Q. Okay.
5 A. So when you're going through this process in real-time, 15:19
6 the world is a distorted, asymmetrical and unjust
7 place.
8 317 Q. I've no doubt that it was a very difficult experience
9 for you, Mr. O'Brien.
10 15:20
11 I suppose, one of the things -- even reading there was
12 a Non-Executive Director of the Trust Board who was in
13 this role, my question is: Should you ever have
14 expected any autonomy from him?
15 A. Yes, because, actually -- I mean the Trust Board 15:20
16 supposedly has an autonomy as well. So, yes,
17 I expected -- I expected, you know, him to go in and
18 say -- I think we submitted too many questions for him
19 in retrospect. So, I think he was grossly overloaded.
20 And I think if we had given him five questions and 15:20
21 said, 'look, this guy wants these five questions
22 answered, I'll give you a week to provide me with the
23 answers and I'll be replying and if I find some of
24 yours answers to be inadequate, I'll be holding you to
25 account.' This is what I expected. So, I think our 15:20
26 expectations were too great. There were too many at a
27 particular time. He was overloaded. He was new to it.
28 We have rehearsed all of these things. But I -- in
29 retrospect I think he conducted himself in a manner

1 that was less useless than I stated at the time.
2 318 Q. Maybe just a couple more questions. I've gone over the
3 time that I said we were going to finish today.
4 A. That's okay.
5 319 Q. One of the things that you just said in answer, again 15:21
6 I think to Mr. Hanbury, is that you disagreed with
7 Mr. Haynes that consultants were the Trust or, may
8 I put it this way, that you formed part of the Trust
9 team?
10 A. Yes. 15:21
11 320 Q. So who, in your mind, is the Trust?
12 A. There's a good question, indeed. I think, you know,
13 there requires to be some clear blue water between the
14 clinicians on the one hand - even singular, the
15 clinician. I mean you are the patient's advocate. 15:22
16
17 I regarded the arrangement best in the time of
18 John Templeton being the Chief Executive, because he
19 always said he was just a clerk whose job it was to
20 facilitate doctors and nurses and other professionals 15:22
21 looking after as many people as possible who were in
22 need of it. And I think that, you know -- it's been
23 alleged I wasn't a team player. When I read that
24 I wanted to ask well I wonder which team they're
25 talking about, because I felt that I was a team player 15:22
26 very much with my colleagues, both medical and nursing.
27 But was I a member of the Trust? Was I part of that
28 team? I was to varying degrees. Was I part of
29 management? No. Would I have ever been tempted to be

1 so? Absolutely not because it's not Aidan O'Brien.
2
3 So, who are the Trust? The Trust, actually, is a body
4 that is a health service provider. There needs to be
5 some distinction and autonomy and separation of 15:23
6 function and accountabilities between whether it's the
7 Commissioner and the Trust and the professional body
8 below them. So there may be some overlap. I've never
9 really been an advocate for clinicians continuing in
10 clinical practice being senior managers. I think that 15:23
11 you cannot have -- I think they just fooled themselves
12 at the end of the day, even you're riding two horses at
13 one time and sitting on the fence and you can't just do
14 it.
15 321 Q. If I might tease that out little bit with you. Most 15:23
16 doctors would prefer to be managed by their peers, by
17 people who understand the job you have to do. So you
18 would have a different view?
19 A. It depends, actually, what the management team is. You
20 know, we had -- we had a small team. I was a lead 15:24
21 clinician of the Urology MDT. So I played a management
22 role. Our department had a lead clinician in
23 Michael Young. I appointed, when I was lead clinician
24 of the cancer MDT, Tony Glackin to be our governance
25 lead in that role. So, yes, we can manage one another, 15:24
26 but with regard to --
27 322 Q. The line management.
28 A. Yeah. You can take that so far. I think that when you
29 get up to Associate Medical Director - and I have seen

1 it too many times over the years - there may come a
2 time for any individual in that role, where they have
3 to toe the party line rather than the role that they
4 used to do. And some people stepped down from that
5 management role because they couldn't do so and others 15:25
6 have toed the party line. So, I think I'm speaking a
7 truth and I'm speaking it in moderate terms.
8
9 I preferred the situation where you went along with
10 your shopping list and even though I got frustrated 15:25
11 after a few years as to the productivity of it,
12 I preferred there was an honest separation, go along,
13 this is what we need, and whoever it was would say,
14 well you're not getting it and we can't facilitate that
15 and so forth. Now, whether there's some bridges across 15:26
16 the water that's another matter and how they should be
17 is another matter. But --
18 323 Q. That's your view?
19 A. -- that's my view.
20 324 Q. And I know I have one further question and it's just in 15:26
21 respect of MHPS, because we will be talking to you
22 again, Mr. O'Brien. But just in respect of having been
23 through this process, do you have any further
24 reflections or suggestions that you'd like to make to
25 the Inquiry, other than what we've already heard, about 15:26
26 needing some greater support for the practitioner and
27 an external person. I mean we've talked about whether
28 you bring someone in externally who is there solely to
29 carry out this MHPS process, to perhaps speed things

1 up, or whether you have a person within the Trust who
2 has dedicated time to do that. Apart from those two
3 suggestions, is there any other further reflections,
4 having been through this, that you would like to share
5 with us? 15:27
6 A. No, I would just take the opportunity of reinforcing
7 what - I was so pleased when Dr. Swart a few days back
8 said "why don't you not just use common sense?" I just
9 think that MHPS is a process that should hopefully only
10 require to be used as a last resort. Perhaps people 15:27
11 considered that the informal attempts that they made
12 intermittently with me over the years was enough and
13 they'd come to the end of their tether, but I don't
14 think that that was right and proper and I think it
15 should have been done in a commonsensical way with a 15:27
16 particular intent and destination in mind. And also an
17 opportunity that facilitates the import of the
18 clinicians' concerns as well, as I would have had. And
19 how are we going to accommodate all of those? It may
20 have been the case, ultimately, as reflected in some of 15:28
21 Mr. Wolfe's questions, that they may have said, 'well,
22 sorry, in the real world, I'm sorry about your concerns
23 but that's it.' And I would just have had to accept
24 it. But that would have come in that memorandum of
25 understanding. I think that was so much the 15:28
26 frustration.
27
28 So, in addition to what you have said, I just did have
29 a concern about a kind of -- I was rather attracted to

1 the idea - I'm not putting myself forward for the role,
2 by the way - I was rather attracted to the idea of
3 across broad specialties, like surgery or medicine or
4 paediatrics or obstetrics and gynaecology, if you could
5 recruit a body of recently retired consultants in 15:28
6 Northern Ireland, it's a relevantly small place, who
7 would be able to come in and offer some support and
8 some advice - it may not work out at all. I was rather
9 attracted to NCAS, both Dr. Fitzpatrick and Dr. Lynn,
10 they impressed me greatly in their input, and their 15:29
11 inputs are limited, they are advisory.
12
13 So, I think there's a role for external input, whether
14 it's as an NED or whether it's in some other advisory
15 role, in order to get two parties at a stage where 15:29
16 they're considering - now I'm not talking about issues
17 like criminal or other really serious issues, I'm
18 talking about these kind of performance issues or
19 whatever you label them, to get people around the table
20 to try to address it. 15:29
21 CHAIR: Okay. Thank you, Mr. O'Brien. That's been
22 very helpful. I'm sorry that you've had to be here as
23 long as you have. I know it's not easy for anyone
24 giving evidence before us and you've had quite a long
25 stint this week. So, I hope you do have some rest this 15:30
26 weekend. We'll see everyone else on Tuesday morning.
27 THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 25TH
28 APRIL 2023 AT 10:00 A.M.
29