Urology Services Inquiry

Oral Hearing

Day 20 – Thursday, 26th January 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

THE INQUIRY RESUMED AT 10.00 A.M. ON THURSDAY, 26TH JANUARY 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Wolfe.

MR. WOLFE KC: Good morning, Chair, members of the Panel. Today we open the Inquiry's MHPS module. 10:06
Before we call our first witness, and with your leave, I propose a very brief opening of this stage of the Inquiry's work to orientate the public and the core participants as to the direction of travel at this stage. 10:07

Chair, the Inquiry has used the opening phase of public hearings to hear from a number of witnesses whose evidence has helped to set the scene, and to bring to life some of the key components of your terms of 10:07
reference. We now commence this term's public hearings, that is the period between today and the Easter recess on 30th March, by conducting a focused investigation into that part of your terms of reference which addresses the implementation of the Maintaining 10:07
High Professional Standards framework, or MHPS As I shall refer to it, by the Southern Trust.

This MHPS module represents the Inquiry's attempt to comply with Paragraph E of the terms of reference, 10:08
which provides as follows:

"To review the implementation of the Department of Health's Maintaining High Professional Standards policy

by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this policy by the Trust was effective, and to make recommendations, if required, to strengthen the policy". 10:08

A cursory consideration of this aspect of the terms of reference indicates that there are three main components to the Inquiry's interest and work. First, it must carefully examine how the Trust used MHPS when 10:09
it conducted an investigation into aspects of the practice of Mr O'Brien.

Second, the Inquiry must determine whether the application of the framework was effective. This will 10:09
require an assessment of the underlying aims of the framework and consideration of the context in which additional concerns regarding Mr O'Brien's clinical practice emerged in 2020, which had not been identified in the MHPS investigation of three years earlier. 10:09

Third, it must consider whether there is a need to make recommendations for the purposes of strengthening the policy. 10:09

As I explained in my opening statement in November of last year, the MHPS framework was published by the then DHSSPS in November 2005. It is described at paragraph 1 of its introduction as providing:

"A new framework for handling concerns about the conduct, clinical performance and health of medical and dental employees. It covers any action to be taken when a concern first arises about a doctor or dentist, and any subsequent action when deciding whether there needs to be any restriction or suspension placed on a doctor's or dentist's practice."

10:10

A copy of the framework can be found at WIT-18490. It is an extensive document. It runs through to WIT-18537.

10:10

The MHPS framework explains that health and social care bodies must have their own internal procedures for handling concerns which, in accordance with paragraph 11 of the introductory section of MHPS, must reflect the framework, and allow for informal resolution of problems where deemed appropriate.

10:11

The Trust did proceed to develop its own internal or local procedures in the shape of its 2010 guidelines, a copy of which appears at TRU-83685. That runs through to 83702. These guidelines were issued on 23rd September 2010, and were in force at the time of the MHPS Investigation concerning Mr O'Brien, which ran from 2017 into 2018.

10:11

It is understood that the Trust guidelines are intended to sit alongside and to be read in conjunction with the provisions of the MHPS framework. The 2010 guidelines were subsequently revised in October 2017. The Inquiry has been advised on behalf of the Trust that the changes were linked to the Trust's reflections on the case involving Mr O'Brien and, in particular, the difficulties at the early stages of the process involving the oversight group, which had led to some confusion about the roles and responsibilities in the management of concerns. That information was provided by Ms. Vivienne Toal, Director of Human Resources, in her Section 21 statement to the Inquiry, which can be found at WIT-41033. 10:12 10:12 10:13

It is the Inquiry's understanding that the MHPS framework or policy published and adopted, as I've said, in 2005, has not been the subject of any revision by the Department despite the passage of time and significant changes in healthcare provision and the regulatory landscape. For example, through the introduction of the role of the responsible office and revalidation in 2010 and 2012 respectively. The Department has, however, advised the Inquiry that reviews of MHPS were initiated in 2011 and 2010, and that submissions were received as part of consultation processes at that time but that the reviews were not finalised. Therefore, it is of interest that as the Inquiry commences this part of its work, the Department 10:13 10:13

of Health is planning to conduct a further review into the workings of MHPS. The Department has advised the Inquiry that it is currently working to finalise membership of a steering group to oversee the review and to identify individuals who will form an expert panel to take forward the review. It is the Department's expectation, we are advised, that upon finalising membership of a steering group and appointing the review panel, that the review will commence before the end of February of this year. 10:14

We are advised that once the review commences, it is expected to complete its work within six months. This time scale, it is proposed, would include the production of a final report setting out key findings and recommendations, and a draft revised version of MHPS. We're told that the precise timings will be agreed between the steering group and the review panel, once appointed. 10:15

I emphasise, Chair, that the Department's plan to examine the workings of their MHPS policy is an exercise which is wholly separate from, and independent of, the work of this Inquiry. However, it is, of course, timely that transcripts of the evidence which the Inquiry will receive as part of this module will be publicly available and will be accessible to those who are charged with conducting the Department's review, should they wish to consider it. 10:15

The Inquiry has now published a timetable to progress this MHPS module. Commencing with the evidence of Mr. Eamon Mackle today, we envisage that you will hear from some 17 witnesses during this phase. The probability is that we will need to use some hearing days at the start of the post-Easter term in order to complete the evidence of all the MHPS witnesses and to conclude the module. It is anticipated that the witnesses from whom you will hear will provide relevant evidence from a variety of important perspectives. You will hear from witnesses such as Mr. Mackle, Associate Medical Director for Surgery & Elective Care from April 2008 to April 2016; Heather Trouton, Assistant Director of Surgery & Elective Care from October 2009 to April 2016, and Martina Corrigan, for all relevant purposes Head of Service in Urology, who provided Section 21 responses to the Inquiry which indicate that they have material evidence to provide in relation to the difficulties which they encountered when trying to manage Mr O'Brien's work across a number of practice issues for several years prior to the decision to initiate the MHPS process in late 2016. 10:16 10:16 10:17 10:17

Their evidence is likely to contain important contextual detail which will enable the Inquiry to gain an understanding of the circumstances which led to the decision to engage with Mr O'Brien at a meeting in March 2016, attended by Mr. Mackle and Ms. Corrigan. At that time, Mr O'Brien was asked to provide a plan to 10:18

address issues of concern but he failed to do so. The Inquiry has an opportunity to explore with these witnesses the application of both professional and operational management, and to assess whether this worked effectively to identify and resolve issues of concern involving Mr. O'Brien, or whether there were missed opportunities.

It will be recalled that in my opening remarks in November, I highlighted that the MHPS Investigation concluded that there were earlier opportunities to address concerns prior to 2016, and that these opportunities were not taken in a consistent, planned or robust manner, TRU-00074. It will be a matter for the Inquiry to consider whether it agrees with this conclusion. The Inquiry may also wish to consider with these witnesses why the MHPS framework had not been used at any point before 2016 to address those concerns.

You will also receive evidence from those witnesses who were party to discussions during the second half of 2016, which considered utilising the informal mechanisms available within the MHPS policy. Those witnesses include Simon Gibson, Assistant Director in the Medical Director's office, and Mr. Charles McAllister, who succeeded Mr. Mackle in the role Associate Medical Director from April 2016 and who remained in that post to November 2016. Their

discussions engaged with or contributed to the work of the Trust's oversight group and, in the case of Mr. Gibson, involved the production of a preliminary report and contact with the NCAS organisation. You will wish to explore with these witnesses, as well as with members of the oversight group led by the then Medical Director, Dr. Richard Wright, the Director of Acute Services, Mrs. Esther Gishkori, and the Director of HR, Vivienne Toal, why an informal approach wasn't then implemented. And you will wish to understand the circumstances which led to the decision to pursue a formal MHPS investigation and the exclusion of Mr. O'Brien from his post for a period of four weeks from December 2016 and the reasons for those decisions. 10:20 10:21 10:21

You will also consider with these witnesses the reasons for the delays which appear to have impacted the progress of the investigation, albeit that there were a number of stages to be worked through. The Inquiry will wish to carefully consider those stages, which will include the steps which were taken to establish the MHPS investigation involving the appointments which were made; the process leading to a determination that there was a case to answer; the development of terms of reference for the investigation; the dissemination of information to the Trust Board, the Department and the General Medical Council, and aspects of the engagement with Mr O'Brien, including the decision to rescind his exclusion, the development of a monitoring plan to 10:21 10:21

oversee the practice concerns which had been identified, and the question of whether support or assistance was provided to him adequately or at all.

You will hear from those witnesses who were appointed to perform key roles during the MHPS investigation itself. Those witnesses include Mr. Weir, Clinical Director for Surgery, who was appointed case investigator before being removed from that role. Dr. Neta Chada, who conducted the investigation and reported. Ms. Siobhan Hynes, a HR manager who assisted Dr. Chada during the investigation. Mr. John Wilkinson, the designated Nonexecutive Director who was assigned to the process. Dr. Ahmed Khan, the MHPS case manager who received the investigation report and issued a set of determinations at the conclusion of the process, which included a requirement for the Trust to establish a conduct hearing and undertake an independent investigation into managerial failings.

It is anticipated that each of these witnesses will be able to assist the Inquiry to better understand the challenges which were encountered when implementing the MHPS framework in this case. It may be expected that the Inquiry will seek an explanation for what ultimately became a very protracted process, and that it will be interested to hear what the witnesses have to say about the strengths and weaknesses of the process which regulated their decision-making and

approach, and what they personally might have done better or differently to address the issues before them.

The Inquiry will hear from Mr. O'Brien. His experience of the MHPS from the perspective of a practitioner, whose conduct was the subject of scrutiny within the MHPS process, has the potential to provide the Inquiry with valuable insights. In particular, the Inquiry will be anxious to consider with him whether he recognised or accepted the need for a formal MHPS investigation; whether he could have taken steps to have avoided that scenario, or whether he considers that it would have been appropriate for the Trust to adopt a different approach. It will be necessary to consider the extent of his cooperation with, and contribution to, the investigation, including the time it took for him to engage with the investigator, as well as the impact which the process had on him and his practice, including the period of exclusion; the requirement to submit to a return-to-work monitoring plan, and whether he received any or adequate assistance and support. 10:24 10:24 10:25 10:25

Finally, the Inquiry will also receive the benefit of an external perspective. On a number of occasions Dr. Grainne Lynn and Dr. Colin Fitzpatrick, then members of the team at the National Clinical Assessment Service, NCAS, now known as the Practitioner 10:25

Performance Advice, were engaged on these issues. You will hear about the services provided by NCAS, and the nature of the contact which both the Trust and Mr. O'Brien had with its advisers as part of the MHPS process. It is understood that Dr. Lynn and Dr. Fitzpatrick are ideally positioned to provide the Inquiry with important insights into the operation of the MHPS framework generally, how it can work well but also its pitfalls. They will also be invited to speak to their input in this particular case, whether their services were well used and whether, from their perspective, the process was appropriately focused and managed. 10:26 10:26

Importantly, it will be recalled that amongst the decisions reached by Dr. Khan after considering Dr. Chada's investigation report was a requirement for the Trust, in conjunction with Mr. O'Brien, to formulate an action plan to address any issues with regard to patient administrative duties. That reference is to be found at AOB-01921. Dr. Khan anticipated that the plan would be put in place using the services of NCAS. No such action plan was ever formulated, nor does there appear to have been any discussions with either Mr O'Brien or NCAS regarding this, despite offers of assistance from NCAS. The Inquiry may consider that this omission is of potential significance. 10:26 10:27 10:27

The provision of answers to these wide-ranging questions is, of course, important, and will be pursued with appropriate vigour during this module. However, as those issues are being addressed, the Inquiry will also have in mind the events of 2020 and what was to be discovered as a result of the lookback, SCRR and SAI processes. The findings of those processes - and we, of course, understand that the SCRR process is yet to be completed - suggest that there were serious clinical failings associated with the practice of Mr. O'Brien, as well as very significant clinical governance shortcomings on the part of the Trust. The Inquiry may reflect that many of those deficits, which were readily identified through those processes and which are said to have caused harm to some patients, or which placed other patients at risk of harm, had existed for some time and were to be found at the time when the MHPS Investigation was being conducted: Had the terms of reference been set broadly enough to permit the inquiry? Had evidence been provided to permit identification? Or had the findings of the MHPS process aroused sufficient suspicion to trigger further inquiry and deeper scrutiny by the Trust of the entirety of Mr. O'Brien's practice and its own governance arrangements. 10:28 10:28 10:29 10:29 10:29

Ultimately, the conduct of this module will cause the Inquiry to critically assess the effectiveness of the MHPS process as it was applied by the Trust in this

case. The MHPS investigation and the action which was proposed as a result of its findings did not reveal all of the problems which we now know existed. It might be argued that the process wasn't established to do so, but why was that? Was this due to an inherent weakness in the MHPS framework so that the policy requires strengthening and, if so, in what way? Or was there, alternatively, a failure on the part of the Trust and its personnel to understand and to unlock the full potential of the MHPS framework to use it appropriately, or to build on what the investigation did discover. 10:30 10:30

In compliance with the task set for the Inquiry by term of reference E, these are the kinds of questions with which the Inquiry will wish to grapple. 10:31

Chair, those are my opening remarks to set what we're about to do over the next six weeks or so in context.

CHAIR: Thank you, Mr. Wolfe. 10:31

MR. WOLFE KC: If there's nothing arising, I think we'll proceed to call Mr. Mackle.

Good morning, Mr. Mackle, if you could stand to take the oath. 10:31

EAMON MACKLE, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

MR. WOLFE KC: Good morning, Mr. Mackle. Make yourself comfortable there. Thank you for coming. 10:32

I'm going to bring up on the screen for you the witness statements or the Section 21 responses that you have provided to the Inquiry, of which there are two. I know that you wish to suggest some amendments to 10:32 parts of them.

If we start with the first Section 21 response which you provided to us on 12th April 2022, that's Section 21, number 4. It is to be found WIT-11337. 10:32 Could we have that up on the screen, please. You'll recognise that?

A. Yes.

MR. WOLFE KC: If we go to the last page, we'll see your signature. WIT-11834. Can I assume that you 10:33 would wish to adopt that as your evidence, Mr. Mackle, subject to the changes I'm about to suggest to you?

A. Yes.

MR. WOLFE KC: If we can go to WIT-11742. Within paragraph 16 on that page, if we look to the right-hand 10:33 side of the page, you can see about halfway down, you say.

"Then in, I believe, July 2014".

I understand you wish to change that to 2007?
A. Yes.
MR. WOLFE KC: Is that right?
A. Yes. 10:34
MR. WOLFE KC: This, just to contextualise it, concerns evidence that we'll look at about Mr. O'Brien requiring or requesting and being granted time off to catch up with administrative issues?
A. Yes. 10:34
MR. WOLFE KC: You don't believe that was 2014, you think it was much earlier?
A. It was much earlier. Well, I have seen evidence since to confirm that. But yes.
MR. WOLFE KC: Thank you. 10:34

Again, a couple of pages further on within this document at WIT-14775 -- sorry, wrong reference. We'll come back to that shortly.
10:35

Let me just deal with your second Section 21. It is dated 7th June 2022. If we go to WIT-14768, you'll recognise that as the first page of the document, Mr. Mackle?
A. Yes. 10:35
MR. WOLFE KC: Then you signed off on that, if we look at WIT-14790. That's your signature?
A. Yes.
MR. WOLFE KC: I assume you would wish to adopt that

statement as part of your evidence.
The second change you wish to make, in fact, is within this statement. If we can go to WIT-14775 and within paragraph 23. We've asked you about training and guidance in connection with the MHPS framework and the Trust's guidelines, and what you are saying is 'I don't recall the Trust delivering any training or guidance...'

I understand you wish to supplement that answer by indicating that you took on a particular role in 2012? 10:36
A. Yes. I was a case manager in a case. When I saw the MHPS bundle, I realise I had been -- I'd completely forgotten that I had been involved in that. So, yes.
MR. WOLFE KC: So you wish to supplement that answer by saying that while you don't recall any further updates -- or any updates or training -- 10:37
A. I had been involved in its implementation on one occasion.
MR. WOLFE KC: Yes. Does the rest of the answer remain valid, that you don't recall receiving training from the Trust -- 10:37
A. From the Southern Trust.
MR. WOLFE KC: -- the Southern Trust?
A. Correct. 10:37
MR. WOLFE KC: Just for completeness so that the Inquiry is aware of it, you made a statement to Dr. Chada's MHPS investigation in 2017. I will just show the Inquiry that document at TRU-00767. You spoke

to her on 24th April 2017. If you scroll down to the end of it, I don't think it is signed. You do recall that?

A. Yes.

MR. WOLFE KC: Giving that statement? 10:38

A. Yes.

MR. WOLFE KC: Again, that would have been a true and accurate statement made at the time to the best of your ability?

A. Yes. 10:38

MR. WOLFE KC: Just by way of signposting, Mr. Mackle. You're our first witness as part of this MHPS module. As much for your benefit as those observing our proceedings, you were Associate Medical Director for eight years between 2008 and 2016; isn't that right? 10:39

A. That's correct, yes.

MR. WOLFE KC: As we shall see, you met with Mr. O'Brien in March 2016 and handed him a letter which set out some Trust concerns, and asked for a plan to address them? 10:39

A. Yes.

MR. WOLFE KC: We'll be looking at that. That's an important staging post, perhaps, because it leads on to the MHPS investigation in the fullness of time. Some of the issues contained in that letter were to be 10:39 included within the MHPS investigation in due course. You were also involved with managing, and certainly had knowledge of, a range of other concerns relating to Mr. O'Brien's practice in the eight years that you were

Associate Medical Director?
A. Yes.
MR. WOLFE KC: Let's start by looking at your career background. You were appointed a consultant surgeon, Mr. Mackle, in what was to become the Southern Trust in 1992; isn't that correct? 10:40
A. Correct. Yes.
MR. WOLFE KC: You spent the most part of your career within the Trust and retired as a consultant surgeon in February 2018? 10:40
A. Correct.
MR. WOLFE KC: Your area of special interest as a surgeon was what?
A. Oesophageal gastric surgery. Oesophageal, gastric, and colorectal. 10:41
MR. WOLFE KC: Since your retirement in February 2018, have you continued to practise medicine?
A. Yes. I'm employed part-time by the Trust, equivalent of two sessions teaching medical students, doing endoscopy sessions, clinics and day surgery, although the day surgery hasn't happened since COVID. 10:41
MR. WOLFE KC: One of the consequences of retirement, I think you explained to us in paragraph 7 of your statement, if we could just have it up. WIT-11739. One of the consequences of retiring is that you disposed of all of your papers and notes which you held at your office at home and office in work, apart from patient records? 10:42
A. Yes. During January/February of '18, I had a bookcase

in my office with box files relating to various specialties. I also had two filing cabinets. All of that was disposed during January/February into confidential waste. I retired in February, I didn't start working part-time until April, and during that time I disposed of anything in my study at home.

MR. WOLFE KC: As we will see, as well as your clinical practice, you took on managerial duties in various guises for the best part of 20 years or more? 10:43

A. Yes. 10:43

MR. WOLFE KC: We'll look at that presently.

To what extent was your destruction of notes involving or focused on the managerial work that you had conducted over those years? 10:43

A. The box files I had, which I generally labelled as regards various specialties, included ad hoc notes of certain meetings or minutes of things. It wasn't a formalised system that I had for everything, but anything I thought half relevant, I put into it over the years. Or put into them over the years. 10:43

MR. WOLFE KC: Has the nonavailability of those records impacted on either your contribution to this Inquiry in terms of your recollection, or the reliability or precision with which you can give evidence? 10:44

A. I suppose if I remembered what was in them, then I would be able to answer that question straight. I have had difficulty recalling everything over the time. In fact, I think in the early part of my

Section 21, the time I was giving, I wasn't allowed to talk to anybody, then I eventually was permitted to talk to individuals as long as I referenced it and then I was able to get more emails. But I can't tell you exactly what was in the boxes. 10:44

MR. WOLFE KC: Yes, okay. Well, we'll see how we get on.

A. Or the filing cabinets, sorry, as well.

MR. WOLFE KC: If we turn to WIT-11751. In ease of the Inquiry's note, you set out at paragraph 48 on the page 10:45 the number of different managerial roles you were able to take on during your career. So I think just at paragraph 48, between 1994 and 1997 you were lead clinician for outpatients?

A. Correct. 10:45

MR. WOLFE KC: Then 1997 to 2004, lead clinician for general surgery?

A. Yes.

MR. WOLFE KC: 2004 to 2008, Clinical Director For Cancer Services. From 2006, Clinical Director for 10:46 Surgery?

A. Correct.

MR. WOLFE KC: Then between January 2008 and April 2016, Associate Medical Director for Surgery & Elective Care. This involved responsibility for the 10:46 urology service?

A. Yes.

MR. WOLFE KC: Taking into account that last role, you were the senior medical manager with responsibility for

clinicians in urology for the period of years preceding the use of the MHPS process in regard to Mr. O'Brien?

A. Yes. The senior medical manager within the directorate, because there was above me also the Medical Director.

MR. WOLFE KC: Yes. So, in hierarchical terms --

A. Yes.

MR. WOLFE KC: -- you were responsible for the issues locally within that directorate, including urology, but obviously there was a tier above you?

A. Yes.

MR. WOLFE KC: In terms of taking on these managerial roles, what was your motivation for that? As appears from that brief chronology, you stepped from one managerial post to another seamlessly, perhaps, and ultimately take on what is a fairly senior managerial role in Associate Medical Director. What was your interest?

A. To try to help improve the service; to try to help improve the conditions in the way we worked. That was really what it was. It was out to improve things.

MR. WOLFE KC: Was it a natural stepping stone to want to reach the level of Associate Medical Director? In a sense were you motivated to obtain that role or was it a case of, perhaps, nobody else wanting to do it? How did that come about?

A. Some of the roles earlier, there would have been there was nobody else really wanted to do it, so I took it on. I was Clinician Director For Cancer Services and

then when Ivan Stirling retired, consultant colleague, retired in 2006, then they needed somebody to do CD for Surgery and I was asked would I do that then. Then I was asked when the new Trust was being set up would I apply for the Associate Medical post. 10:49

MR. WOLFE KC: If we can look at your job description, the Associate Medical Director role. It's to be found at WIT-11836. I think the last page of that document, just for the Inquiry's note, will show that this is the job description as of July 2007, the year before you took up the role. 10:49

Sometimes job descriptions don't reflect, Mr. Mackle, I suppose the practical reality of what the job is about. Before we delve in, have a little look at some of the detail in the job description, what, in broad terms, was the job about? What did it require of you? What was at its core? 10:50

A. I suppose leadership and advice to management; advice to management how we could help develop the service. This was the start of the new Trust when we had combined with Daisy Hill. So, Craigavon Area Hospital Group Trust became the Southern Health and Social Services Trust. So it was that stage advising how we could work, how we could integrate, how we could develop the services. 10:50

One of the things ultimately involved in it was development of orthopaedic services, trauma and

orthopaedics within the Trust. Expansion of urology. It was a wide-ranging and extensive role which was done as part of my -- on top of my full clinical job.

MR. WOLFE KC: I'm conscious, as everybody will appreciate, that we have you along today to reflect upon your experiences of managing a particular doctor who was in difficulty or was causing difficulties, depending on your perspective. Is it fair to suggest that what I've just said is one small element of a much bigger role? 10:51

A. Yes. Urology was one of the smaller sections of my remit. There's all of general surgery in Craigavon, in Daisy Hill. There was development of the trauma and orthopaedic service; there was ENT, and to a lesser extent ophthalmology services to be provided from 10:52 Belfast -- with an orthodontist.

MR. WOLFE KC: I think you reflect at WIT-11750, at paragraph 46, I suppose the impact of the job on you and the toll it had. It was a stressful role?

A. Yes. 10:52

MR. WOLFE KC: You say on a personal level you don't believe you had sufficient support and time available to fulfil all the duties of the role.

A. The role was extensive. The job description is extremely extensive. The role was extensive but this 10:53 was on top of being a full-time clinician. Part of that was - and I said at the time I was asked to take it up, would I apply for it - if I had given up my subspecialists, I would have had more time but if

I ceased to be AMD, I couldn't take those back up again. That was my priority; my priority was the surgical work which I did with my patients for oesophageal surgery and for colorectal.

MR. WOLFE KC: So, the balance was very much tilted towards your clinical practice and maintaining that, because that was your raison d'être? 10:53

A. The vast majority of my PA allowance was for clinical work.

MR. WOLFE KC: We'll come to that shortly. Thank you for those preliminary reflections. 10:54

If we go back to your job description at WIT-11836. Just scrolling through it, you can see at the bottom of that page it talks about key area results, of which there were eight. Strategy and development, service delivery, professional leadership. If we could just pause there. It says within that - this is the third bullet point - that it was part of your role to ensure the highest standards of clinical, effectiveness and medical practice in the directorate, including the implementation of local and national recommendations and NICE guidelines, etcetera. Did you regard that as a key element of your role? 10:54 10:54

A. It was a distinct part, I'm not denying that, but it was part of all of the role. At that time there was a significant push on the Trust as regards performance. A significant amount of our time at managerial meetings were spent on performance, to meet targets, etcetera. 10:55

It is not to say it was discarded, it was part of the -- it was a part of the role but there was a significant amount of time spent on performance.

MR. WOLFE KC: Performance, in a layperson's term, is output, how many bodies can we get through the system? 10:55

A. Yes.

MR. WOLFE KC: I mean, I'm conscious we're talking in sort of high-level general terms, but are you reflecting the view that if performance is the focus, then there's at least the risk that some other 10:56 important things like quality of output is missed or given less emphasis?

A. I would think that quality was not overtly discarded, was not consciously discarded but it probably, as a result, wasn't always given as high -- I'm trying to 10:56 think how to balance it. It is not to say it was ignored. At the same time the big driver from the commissioners was towards service-based agreements and output, etcetera, and that was what we were trying to concentrate on to be sure that we could meet that. 10:56

MR. WOLFE KC: Was that across the board in surgery?

A. Yes.

MR. WOLFE KC: We'll go on in a short while to look at the meetings that you had to conduct with urology practitioners on a Monday evening, I think it was. The 10:57 debates that were had around that table, could they be reduced to debates about performance versus quality or was the driver -- to put it another way, was the driver for those meetings you wishing to take forward the

commissioners' concerns with regard to output and performance?

A. The drive for those meetings largely stemmed from the fact that there was a proposal to have three teams of urology within Northern Ireland. Team South, which we were proposed to be part of, included all the Southern Trust plus as far as Enniskillen. But we weren't -- at least I was told we weren't guaranteed that we would get that. If we couldn't get agreement that we could deliver the service that the commissioners were expecting, then we would not get the expansion we would hope to have. Part of that did include quality of those meetings, but the other part was making sure we could meet the commissioners' desire or else we were not guaranteed to get a Team South urology service. 10:57 10:58 10:58

MR. WOLFE KC: We'll come back to that in a moment. We were looking at key result areas as they were described in your job description. So, that was professional leadership. 10:58

Just scrolling down, another heading is medical education and research. Was that actually something that you were required to do or did that fall within somebody else's remit ultimately? 10:59

A. No. That, as I say in my statement, was not my role. That ended up under the role of Colin Weir was Associate Medical Director for Education and Research.

MR. WOLFE KC: In that sense, that entry in your job

description didn't apply at all?
A. No.
MR. WOLFE KC: Another aspect, if we scroll down, is leading the medical team. I think you told us within your witness statement where it says that you are responsible for management, including appraisal. Just trying to find the bullet point. 10:59
A. The top one.
MR. WOLFE KC: Top one. Yes, of course. That isn't something that you were required to oversee? 11:00
A. No. Appraisals ultimately -- initially, I think, went back to the Medical Director but ultimately to appraisal revalidation office, which came under the remit of the Medical Director. So, appraisals were not -- I would have performed appraisals on clinical directors but I did not perform appraisals on the rest of the staff nor was I expected to be responsible for that. 11:00
MR. WOLFE KC: For example, you didn't appraise Mr O'Brien; that was the responsibility of Mr. Young? 11:00
A. Who was the lead clinician, yes. Then Mr. Young would have been done by Mr. Brown, who was the Clinical Director.
MR. WOLFE KC: In general terms, and we'll look at the role appraisal played as a tool of management shortly, but in general terms being appraised by a close colleague and peer, Mr. Young being the appraiser of Mr. O'Brien, looking back on that do you think that's an appropriate process? 11:01

A. No. At the time I did think the advantage of having somebody who understands what you are doing, who understands therefore the issues and what you can do, how you can develop, understand the nature of the work you're doing, but it is harder to challenge somebody who you rely on for, say, cross-cover at night, etcetera, things like that; who looks after your patients as well. It is harder to challenge. 11:01

In fact, now - at that stage as well to a certain extent - people could choose their appraiser up to a point, now you are assigned an appraiser, an independent person who is not within the specialty. I would say that's a better system. 11:01

MR. WOLFE KC: Just scrolling down again, quality and information management. Just pause there. You are to "support the development of clinical indicators and outcome measures relevant to the directorate clinical specialists." 11:02

Scrolling down. You're to "ensure a programme of multi-professional clinical audit is implemented within the directorate..." 11:02

They are, I suppose, features of an organisation directed to ensuring quality of output. The use of audits, for example, will pull up any problems in delivery, whether at the level of an individual practitioner or the service in general. Was something 11:03

like audit important within surgery generally, or urology in particular in your experience, or did that suffer because of the emphasis on performance?

A. One of the things at the start was we had our mortality meeting, which was purely for the surgeons to discuss, and they discussed amongst themselves. One of the things which I was involved in setting up with John Simpson was to have multi-professional meetings, to have various specialists and to have non-medics at the meeting as well. That has now developed into that role, the consultants picking the cases they discussed; it is done by the Chair of the panel who decides what needs discussed. 11:03 11:04

At that meeting as well there would be audits presented by junior doctors from various things within the specialty. I admit, they would have been chosen by the specialties rather than by myself or management. They were chosen by the clinicians. 11:04

MR. WOLFE KC: We will come and look at this in a bit more detail. What you're saying is audit was a feature of life during your period as Associate Medical Director but it wasn't as well regulated or managed as you would have liked to have seen? 11:04

A. The audits that were performed were really clinical-type audits. They were clinical audits rather than clinical pathways. It did include pathways but you know what I mean. They're ad hoc audits that were performed, and I say usually by the clinician thinking 11:05

what all could we do, our juniors need to do some audits, we'll do these things. But not directed by management.

MR. WOLFE KC: That suggests that really they weren't as well thought out or conceived or targeted as you might have liked, when you think about it? 11:05

A. Yes. Yes, they were not targeted from above. No.

MR. WOLFE KC: Leaving the job description to one side, in terms of how you conducted this role of Associate Medical Director, how much of your time did it take up in a working week? 11:06

A. How much was allocated and how much I spent were two different things. From my job description, I was on 14 PAs. One of those was a responsibility PA. PA is equivalent of four hours of time. When I retired from full-time -- sorry, when I stepped down as AMD, if I had still been doing on-call I would have been on approximately 12.5 PAs. So, theoretically then I had two hours plus a responsibility payment. 11:06

In practice I would have spent Wednesday afternoons involved in it; Friday mornings as well. There would be some audit on Friday -- sorry, governance meetings on Friday mornings. Once every two months, I think, the Medical Director held a meeting in the afternoon. 11:07 There were -- a lot of it was -- a lot of my AMD work was also carried out after five o'clock up on the admin floor, meeting up the heads of service, etcetera, sorting out issues, and the AMD sorting out issues at

that stage. It wasn't a finite Tuesday is AMD day and the other four days you do the rest of your clinical work. It was not like that, it was mix and match.

MR. WOLFE KC: What you are reflecting back to the question is there was some structured meeting-type responsibilities that particular time had to be set aside for. But, in addition to that, you were receiving presumably informal enquiries, informal requests for help for assistance to move issues forward and that kind of thing. So in the round, you were working more hours than you were paid for in this role? 11:07 11:08

A. Yes.

MR. WOLFE KC: Thinking back on it now - I'm going to ask you about the support you had - but in general terms, was it a role, in terms of how it was established and how it was supported, that enabled you to meet the objectives of the post successfully? 11:08

A. Meeting all the issues within the job description, I would say no. I'm not saying I was the best manager ever; far from it. Doing a reasonable job, I would like to think yes, I did. To be honest, that's the type of thing you'd probably get better from somebody else than from me. 11:09

MR. WOLFE KC: Perhaps an unfair question, but from your perspective, thinking about that job description, what were the areas you found able to do most proficiently or most successfully, and what, for whatever reason, did you find just impossible to move forward? 11:09

A. I suppose the strategy side, actively involved in that. Service delivery, actively involved in supporting that. Professional leadership, clinical effectiveness, etcetera; I was involved in the governance section of that part so I think that part would have been covered. 11:10
Medical education, I've already said, was outside of my remit apart from teaching my own trainees. Leading the team and the modernisation, you know parts of that did take a huge amount of time. The Monday evening meetings I considered a huge amount of time on that 11:10
section.

MR. WOLFE KC: This is the Monday meetings with urology?

A. With urology. So there are aspects of it in certain specialties, certain areas, were done very well. There 11:10
were aspects probably in other specialties where they actually were able to manage themselves very well.

MR. WOLFE KC: Obviously the mainstay of your working week was your clinical responsibilities?

A. Yes. 11:10

1 Q. Is there a sense that the responsibilities of the Associate Medical Director's role were something of an add-on that you did when you could, but it was extremely difficult to prioritise them?

A. It was difficult prioritising everything, to be honest. 11:11
I did it -- at least I thought I did it well. The days I had the meetings, for example with Heather Trouton Wednesday afternoon, that was because it suited my clinical activities. The Friday morning meetings

happened to suit what clinical activities I had. So, I could move things round and tend those sort of things. The same thing with the Medical Director's governance meetings on Friday afternoon when they were held, they suited me. 11:11

Tuesday meetings were a no-no; that was main theatre today. Monday mornings were at clinic. Wednesday mornings was endoscopies. Thursday afternoons were either clinic or -- I can't think. But Thursday 11:11
afternoons were attending clinics. Or day surgery, that's it. So, there were certain times of the week when I could make meetings and do things. Other times I would, you know, go from one pillar to the other to try to get things done. 11:12

MR. WOLFE KC: Yes.

Surgery is obviously a very wide and complex territory. Were there particular challenges presented because of this scale of that area, that area of work? 11:12

A. Sorry, I don't really follow your question. Sorry.

MR. WOLFE KC: Okay. Your role as Associate Medical Director for the whole of surgery, you've pointed out in your statement that you had the support for approximately two years of only one clinical director 11:13
but, as you've explained, the support to an Associate Medical Director is now much improved and there are I think three clinical directors.

A. There are three clinical directors now, and there's

also a tier between the Associate Medical Director and the Medical Director, which I understand to be three Assistant Medical Directors. But that I can't say is gospel; I believe that's what it is now.

MR. WOLFE KC: Leaving the precise number aside, in terms of how your role was established and the support that you had within a department as complex and large as surgery, was that support adequate as you were doing your role? 11:13

A. No, I don't believe it was. Having one clinical director who is based in Newry was not the most convenient place to have him. Not all of my colleagues wanted to take on a managerial role. So I was, therefore, left for a while, as I say, with only one, and then up to two. I don't believe I ever had three clinical directors. 11:14 11:14

MR. WOLFE KC: The focus of my next area of questioning is this medical management role, the need, as Associate Medical Director, to ensure, with the input of others, that all doctors, all clinicians, are performing as they should be. As we've already seen, there are various tiers. If we focus on urology, you have a clinical lead and then above that you're into the Clinical Director tier, and then an ability to feed into the Medical Director. What is the role of each tier when it comes to the basics of medical management or practitioner management? 11:14 11:15

A. I suppose the lead clinician provides advice and organisation at the level of consultant, and would

probably include junior doctors in that one more to a great extent -- or would include junior doctors. The Clinical Director would normally draw together the - part of our difference was because we had a separate hospital - but in the normal course of events it would have drawn together several specialties - in the surgical side, that is - and overseen them. Some of the more senior organisational issues to do with it and to a certain extent performance, meeting the targets, etcetera. Then, I was above that. Effectively I was Clinical Director for Surgery on the Craigavon site. I was effectively somewhere around about Clinical Director for the other specialties. Robin Brown was Clinical Director for Urology, but for the other onces for a lot of the time I was effectively it. For a while we did have Sam Sloane in there as well. 11:16 11:16 11:16

MR. WOLFE KC: Just to put names on, within urology the clinical lead was Michael Young and, for the most part of the time, Mr. Brown was Clinical Director For Surgery. 11:17

In terms of I suppose the management of practitioners, were those various tiers joined up effectively? In other words, were you able to communicate with each other on issues or was it somewhat more disparate than that? 11:17

A. I always had an open policy for people contacting me. People could phone me. I had been phoned -- I did get phone calls on Tuesdays when I would have been in

theatre, and I would have taken them between patients or cases. I would have had other consultants in the specialties would have been -- if they would have been in theatre, would have come in and spoken or I would have spoken to them in the coffee room. Ward level or outside of theatre, yes, people could easily approach. There were meetings held with the leads with Heather and myself on a Wednesday, I believe once a month. But a lot of it was they nearly all had my phone number. 11:18

MR. WOLFE KC: The Wednesday meeting was an occasion to formally draw your attention to issues of concern, perhaps, about anything within a particular speciality, including the performance of practitioners? 11:18

A. Yes. Although a lot of it would have been before -- to be honest, most you would have heard beforehand.

MR. WOLFE KC: That's on the medical side but there's also operational management. So within a speciality such as urology, there would be head of service. Then above that, that's organised across a directorate with a Director of Acute and Assistant Director of Acute. What is the relationship between you and either of those three tiers of operational management? 11:19

A. It was very close. I would have -- as I say I spent -- once I would have finished any clinical stuff or any clinical work needed to be performed in a day, I would have gone up to the admin floor and seen the heads of service at that stage and spoken to them in detail. Heather Trouton is on the admin floor; I'd seen her as well. I had a close working relationship with, for 11:19

example, Dr. Gillian Rankin and Mrs. Debbie Burns, who were acute directors.

MR. WOLFE KC: Where was the cut-off, if you understand me? In terms of the management of issues of medical or clinician performance, a clinician isn't performing in the way that's expected of the service; whose responsibility is that? Does that fall on the operational side or the medical management side, or does it embrace both? 11:20

A. I think it embraced both. I didn't see medical management as being divorced from operational. In that respect, no, I didn't. I would have considered both. Sometimes - I can't think of specifics offhand but my recollection is that the acute director would have raised issues that were more clinical than -- by clinician, sorry, not clinical. So it was -- I'm not saying the lines were blurred but there was significant overlap. 11:20 11:21

MR. WOLFE KC: If it came to the point where the issue couldn't be resolved, the practitioner is continuing to behave out with what is expected of him or her, where is that to be brought, and who takes responsibility for bringing it? 11:21

A. I suppose it could have gone several ways. It could have gone from Acute Director to Chief Executive, myself to the Medical Director, or the Acute Director to the Medical Director and/or HR, I suppose. 11:21

MR. WOLFE KC: The description that you provide in your witness statement of the kinds of governance meetings

that are held, if we go to WIT-11755. If we scroll back to the next page.

You explain that when you were appointed, Robin Brown was the only Clinical Director. You asked him to oversee urology services and to be line manager for urology lead clinician, Michael Young. That was sensible because Mr. Brown had an interest in urology. Just over the page, for operational issues, Martina Corrigan reported to Heather Trouton. You had a formal weekly governance meeting With Heather Trouton at which you discussed all of the subspecialties. You say you could have or would have been joined by Martina Corrigan at those meetings and, I assume, any other subspeciality head might come in? 11:22 11:23 11:23

A. Yes.

MR. WOLFE KC: Was that the kind of meeting that might have focused on patient safety issues in the context of under-performance by a medical practitioner? Or in what sense were governance issues discussed? 11:24

A. To a certain extent, they were. To a certain extent it was also distribution of advice coming down from the Medical Director's office which had to be disseminated out to the specialties that was performed at that as well. Yes, to a certain extent, yes. 11:24

MR. WOLFE KC: You go on to say that each month at your governance meeting, Heather Trouton and yourself were joined by Michael Young and Robin Brown. Again, what was the purpose in them joining the meeting?

A. That was at the same time to raise any particular issues that they had with the speciality. I'm not saying they attended every month. Particularly Robin would have been in Daisy Hill. But any issues that they had with urology, you know, would have then been discussed at that stage. Likewise it was similar with ENT, etcetera.

MR. WOLFE KC: You say you also met informally at least weekly with Trouton and Corrigan to discuss issues as they arose. 11:25

A. Yes.

2 Q. The pictures that you're painting is of a reasonably tight-knit group of managers at various tiers who have ample opportunities, I suppose, to discuss problems of concern? 11:26

A. Yes.

MR. WOLFE KC: Did you think that worked well in terms of patient safety issues?

A. At the time, yes.

MR. WOLFE KC: Looking back on it now, do you think it was an effective mechanism? 11:26

A. I think with what's happened and come out, it is hard to say that it was effective, you know. Some aspects were covered and sorted; some weren't. In that respect, therefore, it would be impossible -- it would be wrong for me now to turn around and say everything was wonderful. It wasn't, when you look back now. 11:26

MR. WOLFE KC: If we maybe turn up WIT-11... Just scroll down, please, we're on the page. Paragraph 59,

please.
You go on to say that you had one-on-one monthly meetings with the Director. Just to the second half of that paragraph, a monthly one-on-one meeting scheduled with the Medical Director. Across your career in that role of AMD, there were three medical directors, Loughran, Simpson and Wright, at which time you discussed any significant issues that had arisen in the surgical directorate. Again, is that programmed into the diary, those meetings, that they happen regularly? 11:27
A. The Dr. Loughran ones, I cannot be 100 percent sure that it was every month or every other month. I just don't remember. John Simpson's was scheduled as monthly. Sometimes they would be cancelled, but what was usual was at one meeting, you'd get a date for the 11:28
next one, I put it in my diary or we'd agree a date for the next one. Sometimes it was sent out in advance from the office, the Medical Director's office, saying when they wanted to meet. By that stage they would know which sessions I could attend and which sessions 11:28
be impossible form me to attend without stopping clinical duties.
MR. WOLFE KC: That provided you with an opportunity to raise, I suppose, at the highest level within the medical management issues of concerns of any kind, 11:28
including the performance of clinicians, presumably?
A. Yes.
MR. WOLFE KC: Again, looking back on that arrangement now, did you use it as effectively as you might have to

raise issues of concern?
A. Issues were raised and discussed. I would have made a note during the course of a month if there were any particular -- you know, with each speciality or subspeciality from within the surgical directorate, I would have made a note of particular issues I wanted to raise at the next meeting, or raise. Sometimes more inform than raise. So I'd say inform the Medical Director what was happening, I think that's the fairest way of putting it. I would have done it during the course of the month and would have mentioned them to the Medical Director. Can I say I raised all of the things that happened as major concerns? I can't say I did. 11:29 11:29
MR. WOLFE KC: In terms of the data that was available within the system, as Associate Medical Director did you receive data or information in relation to how individual clinicians were performing or how services were performing? For example, would you have received clinical outcome statistics or workload statistics; those kinds of things? 11:30 11:30
A. I don't recall specific clinical outcomes. I think there would have been some data produced, if I recall correctly, on things like length of stay, etcetera. I can't give you a straight answer at the moment, to be honest. 11:30
MR. WOLFE KC: What was the best tool or best information available to you in your role as Associate Medical Director to keep I suppose a check on the

clinicians within your area of management to ensure that proper performance was being achieved?

A. Well, the performance data was produced. I mean of numbers, performance data was produced. There was a performance office at the head down in Trust HQ, and that would have fed back through the director and assistant director; I would have been informed of those sort of things. The individual performance of a clinician would not have been -- I don't recall offhand receiving specific information how an individual consultant was performing, no. 11:31

MR. WOLFE KC: Were you in a position to assess safe practice within any particular speciality? Was the information made available to you to be able to make those assessments or judgments? 11:32

A. No, you relied on clinicians. You relied on other -- you know the lead clinical, the CD, the Clinical Director -- to know what they were like. For me working in Craigavon with my own group of general surgeons to know what they were like. It was done in that fashion rather than formal clinical outcomes like they have, for example, in cardiac surgery; there's an outcome data of how they do. The Association of Coloproctology now run one for colorectal surgery. There was within at one time, a urology one, for which I think Wales and Northern Ireland, I think six procedures Wales and Northern Ireland did not take part in. Intensive care have an ICNARC audit system. Things like that were funded and funded centrally, but 11:32 11:32

there was not funding provided for outcomes data that would drill down to individual clinicians in Northern Ireland during that period at all, that I can recall. In surgical speciality, sorry.

MR. WOLFE KC: We can obviously see, and we will see in the course of your evidence, that there was a fairly regular email correspondence, and presumably when we don't see emails there's also word of mouth telling you about various goings on, in particular in relation to Mr. O'Brien, but no doubt about other clinicians, perhaps, that we're not concerned with. Was that, if you like, your primary source of evidence or information for what was going on on the ground, as opposed to, if you like, hard-edged, objective statistical or data-based information? 11:33 11:33 11:34

A. Yes. It was more that way than, as you say, hard-edged statistical data.

MR. WOLFE KC: When you think about it now, does the absence of hard-edged statistical data, at least in terms of it coming to you or not coming to you, would you agree that that's not necessarily the most reliable way of assessing? If you don't have that, the alternative is, I suppose, anecdotal and not necessarily always the most reliable way of assessing what's going on in a speciality? 11:34 11:35

A. There are pros and cons in hard-edged statistical data. If you have two surgeons, one everybody considers really good, the other one is considered average or thereabouts, and you send your difficult patients to

the really good surgeon, his outcomes can initially look poor. You need to do a lot more drilling down on the fitness, etcetera, of the patient and the complications, etcetera, to decide is his data as poor as it initially seems. That's just one of the disadvantages of it. As an overall tool, it can be very useful for helping to pick things up like that, yes. 11:35

MR. WOLFE KC: You were in this role eight years. Did you feel, at least on a personal level, generally supported by each of the medical directors you worked under? 11:35

A. Reasonably well, yes. Paddy Loughran was new. He had been Daisy Hill based but I worked probably with him. Richard Wright only arrived in the summer before I -- he arrived in the summer and I ceased to be AMD in the following April, so there was not a lot of time or interaction with him in that respect. Most of the time then would have been more John Simpson. I was moderately supported. 11:36

MR. WOLFE KC: That suggests a lot more could have been done to help you?

A. Well, shall we say, I suspected more of an interpersonal relationship. I thought I was alone but then I realised other AMDs had the same, felt there was an interpersonal relationship. I thought initially it was just me, but later on talking to them, they felt it was -- maybe it was the nature of how he did things, how he related to people, etcetera. 11:37

MR. WOLFE KC: If you were to be given a blank sheet of paper to design a way of doing the role that we call Associate Medical Director, and taking into account the importance of that role within medical management, what would be the improvements you would write on that blank piece of paper in light of your experiences? 11:37

A. I think the biggest one is time, time to do the job and do the role. I think the disadvantage of that is you probably exclude anybody - particularly in surgical areas - who has part general and also some speciality from being a medical manager. But I do think that's -- if you have somebody who is a pure subspeciality, it may be easier for them to do it if they don't have a general role. But when you something like general surgery plus subspeciality, I think it is nigh impossible to have the time that you'd want for it. 11:38 11:38

Should it be almost 50/50? Probably should. Added to that, as you say then, I had significant support from the heads of service and the Assistant Director, and the Director. I was actively supported by them but they also had a significant operational role. There was no other role -- nobody supplied to support the associate medical directors in their role as Associate Medical Director, purely driving that forward. That didn't exist. There was nobody there who said -- you know, I think that's the big -- that area, I think, was missing, an active support for medical directors -- 11:38 11:38

or associate medical directors rather than just the operational support, which I appreciated and got a lot of.

MR. WOLFE KC: You didn't have formally any administrative support for the role? 11:39

A. No, no.

MR. WOLFE KC: Did you have any specific training for the role, or indeed for any of your managerial roles over the course of the 20 years?

A. I believe -- I don't remember the exact time but -- 11:39
I can't remember had I just become a CD in cancer services, I think I might have been, or I was a CD. I can't remember, it was around the time of the CD, I went on a CD manager course, which I think was six half days in Lisburn Council offices. I can't remember 11:40
exactly but it was up in Lisburn.

MR. WOLFE KC: Stating the obvious, you went to medical school, you didn't go to managerial school?

A. No, no.

MR. WOLFE KC: I don't mean that flippantly. 11:40
You didn't do a medical degree thinking I'm going to be a medical manager. Do you think in terms of all that goes with management - and this is a particular species of management, it is professional management, and we have seen what goes into the job description - six 11:40
half days, does that really cut it, or should a modern public health service be thinking with cleverly or with greater sophistication about what it wants from its cadre of medical managers?

A. Yes, I agree with you. I did not have an MBA or anything similar to that. As I said, I was a full-time clinician and that was important to me in life. That's why I went into medicine -- well, not to be a surgeon into medicine, but that's what I realised as a medical student I wanted to be and that's what I did. In that respect I do see that there is a role for semi-professional managers or medical managers who have the time. Maybe that role now has been taken up more by the Associate Medical Director -- sorry, Assistant Medical Director. I don't know exactly. I have not actively been involved in looking at the managerial roles or posts in the Trust since 2016. 11:41 11:41

MR. WOLFE KC: With the Chairman's leave, we'll take a short break shortly. Just before doing so, I'm going to ask you some questions after the break about the challenges of managing medical practitioners who are in difficulty or who are causing difficulties. What was the biggest challenge or difficulty that you faced in dealing with, in this instance Mr. O'Brien? I don't mean it specifically with regard to any particular issue, but what was it in general that you found challenging in that aspect of your role? Please keep it general. 11:42 11:42

A. There were two aspects, I think, and even more general than just Mr. O'Brien. One is you work with these people clinically, you require their support clinically, you need them helping you with your patients; that, in itself, makes it difficult. Going 11:42

back to what I said earlier on about appraisal, it is harder to do a full-on challenge when you need people giving you advice and helping with your own patients. I think that is probably one of the biggest things that is hard to divorce, you know, from being a manager having to at the same time making sure your patients get the best possible deal in the end. 11:43

Slightly more specifically, Mr O'Brien was reluctant to change in most aspects. He believed that what he did was the best for his patients and that he was doing the best for his patients and, therefore, probably we were interfering in that. 11:44

MR. WOLFE KC: Okay. I think we can leave it there for now. 11:44

CHAIR: Twelve o'clock.

MR. WOLFE KC: Yes.

THE INQUIRY BRIEFLY ADJOURNED

11:44

CHAIR: Let's continue.

MR. WOLFE KC: Just before the break I was asking you on a general level about the difficulties that you encountered in managing colleagues who were presenting difficulties. The first thing you said was that you work closely with these people who are required to continue delivering clinical services for the benefit of the organisation. Did that reflect a sense that it is an uncomfortable task professionally and personally, 12:01

or were you hinting at something else?

A. No, no. It's not to say that it was always a big issue, but it could potentially -- it was the Craigavon Area Trust, or the Southern Trust, but principally it was the Craigavon Areas Hospital. The hospital, I know it has grown and the staff has increased, but it is pretty much most people know most people type of thing. Interpersonal relationships are how a reasonable amount of work is done. You need to have good interpersonal relationships with other clinicians in other specialties or subspecialties to help look after your patients. So that, I do think, creates a slight stress on it or makes it a bit more difficult. Not to say, you know, oh, I can't fall out with that person just in case. It's not like that, but I'm just saying that is one of the issues that I can think of offhand when you asked me. 12:02 12:02 12:02

MR. WOLFE KC: Particularising this just a little bit more and taking it from the broad to the specific. As we will see in working through this, there were some issues with regard to Mr. O'Brien that were dealt with on a fairly formal level. For example, the issue around the use of intervenous antibiotics. That went right up to the Medical Director and he took a lead on that. There was the formality of a disciplinary investigation on the issue of patient notes being placed in a bin. 12:03 12:03

But is it fair to say that across the general run of

the issues of concern that had to be worked through with Mr. O'Brien, the tendency was to use informal approaches, work-arounds, suggestions, gentle nudges? That is explained, perhaps, by what you just said about the interdependence and the close personal relationships in a small space, which is Craigavon Hospital.

A. Yes. I think one of the biggest influences on how people regarded Aidan O'Brien was that Aidan O'Brien was held in extremely high regard by lots of staff throughout the Trust. He was regarded very highly by other clinicians, anaesthetists, other medical specialties; even non-medics. I remember when I retired, the theatre porter said the only two people who spoke to him as a person were myself and Aidan O'Brien, you know that treated him as a proper person and didn't just bypass him or ignore him. The nurses liked Aidan.

So he also was -- he was hard-working. Aidan, as I said in my statement, he was definitely not the first person to arrive in in the morning but he was almost invariably the last person to leave in the evening. At one stage when I first went to the hospital, his office was next door to mine; then there was a reconfiguration, we moved. If I would be in at nine/ten o'clock at night, Aidan was in his office, and I know that. It is that aspect I think that had the biggest influence in how we judged him, that he was

perceived to be a good clinician and a hard-working clinician who had - I used the term in my statement "foibles", you know, eccentricities. But that was why he was judged the way he was.

MR. WOLFE KC: Knowing what you know now, do you think that created a blind spot, or, to put it another way, a difference of approach in terms of investigation and challenge? 12:06

A. I think it probably did, yes. Not I think probably, I think it did. 12:06

MR. WOLFE KC: You also reflected in your answer just before the break that one of the difficulties particular to Mr. O'Brien was that he felt that he was doing the right thing for his patients --

A. Yes. 12:06

MR. WOLFE KC: -- and was reluctant to change, so that created a difficulty. Were you thinking about one or any particular area when you said that? Presumably that doesn't explain, for example, his approach to triage or his approach to retention of patient notes, for example. 12:07

A. No. I mean things like he would have -- part of this is reputation because I was not on the ward with him. I never had directed clinical oversight on a ward with him, of what he did. It is that he would write up the cardexes himself, the drug cardexes himself to make sure they were correct. He would do a lot of the checking himself. He talked about -- for triage, he did what he called an enhanced triage where he would 12:07

have gone through in detail all the letters, he would have checked all the blood results, he'd have checked the X-rays, he by all accounts phoned the patients before he decided on triage. It is those sort of things. He was unique, probably, if he was unique in that aspect, as far as I know, of doing triage in that aspect. But he believed and expounded the view that he thought his was the correct way of doing it. It's one of those things. If somebody is doing nothing at all, it is easy to criticise them, but when somebody is doing a lot of work, it is harder to criticise them. 12:08 12:08

It is easy if you have -- and this happened in a case in the south of Ireland, where there was a consultant physician was keeping patients in too long, or they thought he would. You couldn't prove it. You can prove if somebody sends everybody home too early but you can't prove if he keeps somebody too long. To a certain extent, he over-devotes time to a patient. It is hard to tie them down in that as it is if somebody doesn't devote any time to patients. 12:08 12:09

MR. WOLFE KC: I suppose we'll come on and look at the issue of the job plan in a short while. But that's an issue in terms of how he did the work and how he thought he should do the work; that was an issue which essentially became the point of difficulty in working that out. 12:09

Just in terms of the process and responsibility of you as Associate Medical Director as compared with others in the management of doctors such as Mr. O'Brien. Recognising the dichotomy between operational and medical management, and you said that that tended to merge and overlap, in practice who had the responsibility during the eight years in your senior management role for resolving these issues, these Mr. O'Brien issues? 12:09

A. It was taken usually as -- well, as I say I work closely with the Assistant Director and the Director of Acute Services, work closely in that aspect, so there would have been a lot of joint conversations and agreement on that one. The Medical Director would have been asked for advice as well on what to do, and regularly was asked for advice on issues as they arose. Not just that, with other things. So, the Medical Director was asked for advice and direction. 12:10 12:10

I never saw my role as, you know, a distinct separate role from managing -- from the Acute Director. I did not see it as that. Perhaps I was meant to have seen it like that but I didn't perceive it that way. 12:10

MR. WOLFE KC: In practice, to take, say, triage as an example, the shortcoming on any particular week or month and the failure to deliver on triage was realised operationally? 12:11

A. Yes.

MR. WOLFE KC: On occasions they might have an attempt

to resolve it at that level, and then in practice to take that example further, it would be escalated to you, or perhaps more typically after 2012 to Mr. Brown or Mr. Young. Is that the way that you remember it?

A. Even before that, it would have been -- that would have quite often gone to the lead clinician to sort. Triage, somebody lagging behind in triage, the lead clinician would generally speak to them. That would happen in other specialties, you know. I can't think of specifics but it would have been the lead clinician usually would have done that, and then if necessary the Clinical Director; then, rarely, myself. 12:11 12:12

MR. WOLFE KC: We know, because you were bringing this issue to the Medical Director in late 2015 or early 2016, just to focus on triage and we'll go into it in a bit more detail presently, that was an issue that was never resolved -- 12:12

A. No.

MR. WOLFE KC: -- in eight years, certainly the eight years of your role as AMD. Does that suggest that either you were ill-equipped managerially in terms of your skill-set to resolve those issues, or does it betray a lack of appetite to actually go after that issue effectively and resolve it? 12:12

A. Issues with triage extended back a lot further than my eight years. They extended right back to when I was a lead for outpatients. At that stage I had informed Osmond Mulligan, who was the then Clinical Director. It continued on. As I said, I think around about 2007, 12:13

2008 or thereabouts, I was maybe asked twice at that stage to speak to him about it. It was an intermittent thing that was known about. It continued as an intermittent thing. Why was it not tackled more to a greater extent? I think, as I said earlier, I think it was a lot we judged him on his reputation and how he worked and that.

When you say it was our lack of appetite, I don't know if it's as much a lack of appetite as we collectively probably didn't appreciate the risks associated with it rather than there was no interest or we couldn't be bothered. I think it was more we didn't appreciate the risks.

MR. WOLFE KC: Yes. 12:14

A. So, for example, when I would have spoken to the Medical Director and mentioned it, I would have mentioned it but not mentioned it as "I really need something done about this", until the December 2015 or thereabouts conversation with Richard Wright. 12:14

MR. WOLFE KC: I didn't mean to go into that in any great depth on the issue of triage at this point, we'll look at it in a moment. In terms of maybe more generally again what you have in the toolkit as a medical manager working with operational management to 12:15 resolve the difficulties caused by certain practitioners, you have job planning, you have appraisal, you have an MHPS process. Did you, as a manager, see those tools as being available to you and

others to address difficulties with clinicians who weren't performing to the standard that the service expected?

A. Straight off I'd say appraisal, no, because of the way the appraisal system was structured. It was not through the Clinician Director or Associate Medical Director. It was directly through to the -- the reports were sent through to the Medical Director and, more recently, the Appraisal Revalidation Office. So appraisal was of no benefit, really, in assessing issues like that. 12:16 12:16

MR. WOLFE KC: Just focusing on appraisal for a moment. Are you saying that appraisal held out little or no prospect of picking up on and challenging and resolving clinical performance issues? 12:16

A. The clinical issues -- well, I suppose not to say that -- obviously complaints were fed into it, and ultimately with revaluation five-yearly patient and clinician feedback. But as a direct thing of other direct aspects of the job, it was not included in it, you know. I don't think appraisal worked in that aspect, no. 12:17

MR. WOLFE KC: Should, when you think about it, Michael Young - to take the relationship with Mr O'Brien - being aware of issues in his practice, pick up any of them -- issues that were causing concern to you as a manager and you were speaking to Mr. Young, Mr. Brown about them, should that have featured as an appraisal issue, and should Mr. Young in turn have been saying, 12:17

right, we need to focus on how we might address that in the year ahead and write it into a personal development plan that's focused, targeted and perhaps supported?

A. Personal development plans at that stage were generally -- by the time people were doing their appraisals, quite often the year was almost up probably. The 2020 appraisal was probably done late 2021, which meant what went into in the personal development plan quite often was what people had done during 2021. They wrote down "I want to go to a meeting". They had been to the meeting but that's what they wrote down. 12:18 12:18

I think appraisal as a tool in that aspect hasn't worked. I don't think it has changed. It's changed from the point of view now - at least our Trust - it is no longer the clinician choosing who appraises them and they are not listed within the specialty. I think that has a greater chance of challenge. But then I don't think they have the data or the knowledge to then do a challenge on it. The section on safety and quality within the appraisal, yes. But as I say, there was a collective failure, I think, for us to recognise the safety issue, and therefore that in itself wouldn't have featured as a challenge. 12:18 12:18 12:19

MR. WOLFE KC: The job planning aspect, did that create an opportunity to push the clinician to improve or focus more time on issues of concern? Or again, is that a blunt instrument that didn't really --

A. That's a blunt instrument, I think. In fact, our issue with job planning was that the number of PAs that Mr. O'Brien had for admin back in the time before it went to facilitation was in excess of any other clinicians. It wasn't a useful tool in that respect, you know.

MR. WOLFE KC: I've asked you about MHPS. Again, one would presume, given the working title to MHPS and the attendant guidelines, that any manager, whether on the operational or medical side, and perhaps more particularly on the medical side, would be very fully versed in that tool, not because it should be the item of first resort but it may well be the tool of eventual resort. Is it fair to say that your statement gives the impression of very little working knowledge or experience of that tool?

A. I would admit that I had little active knowledge of it. I would have relied, where I was concerned, of speaking to the Medical Director for direction, which is what I did in most cases.

MR. WOLFE KC: You were invited, in 2008 -- if I could have up on the screen, please, WIT-14769, paragraph 3. You were invited or asked by the Western Trust to assist with the review for them back, you think in 2008, and attended a training session on the framework which they ran for their staff. However, afterwards your assistance with the actual practical case of that review wasn't necessary, for whatever reason, so you didn't engage in the actual conduct.

A. They said initially I would have to -- oh, had I been trained in it. I said no. They said we'll organise that. I think probably the length of time they took to organise a session for a collection of people is probably why I was not used. I don't know exactly why I was not used. 12:22

MR. WOLFE KC: You said, as we dealt with this morning, that in 2012 you were invited to perform a role in MHPS. Did that actually take place?

A. 2012. I think the Medical Director of that set up an MHPS process in connection with a junior doctor -- sorry, a locum doctor that the GMC had written to the Trust about. I was case manager of that, which was investigated, a report produced, and I met with the case manager and HR and the determination then went -- he had ceased working at the Trust so we had to inform the GMC about the outcome. 12:22 12:23

MR. WOLFE KC: Does that suggest at least at that point and with that case, you would have had a familiarity with the framework, both the policy and the local guidelines? 12:23

A. There was probably more of I was instructed that he will do the investigation and then the determination we'll make with you, and it was done in connection with HR. Rather than me, did I sit down and actively reread the MHPS at that stage? No, I didn't. 12:23

MR. WOLFE KC: I think what you are telling us in terms of the prominence of MHPS and the associated local guidelines, as a manager they just weren't on your

radar?

A. The draft local guidelines, from reviewing it when I checked through, were presented at a meeting in September 2011. I can't remember exactly the date. It was an AMD governance meeting. I was on holiday leave at that stage. Issues were raised by clinicians -- sorry, by other AMD at the meeting and it was to be redrafted. I don't ever recall a redraft being presented at the AMD meeting. 12:24

MR. WOLFE KC: I think you've said to us that in terms of MHPS and your engagement with issues pertaining to Mr. O'Brien, it was not something you ever thought of suggesting or using, whether through HR, the Medical Director's office or otherwise? 12:24

A. Correct. Neither was it suggested in January '16 by Dr. Wright when we met him. 12:25

MR. WOLFE KC: Presumably you were agree with the proposition that an associate medical director should be well versed in MHPS and its guidelines?

A. Yes. 12:25

MR. WOLFE KC: And should be trained on when it is appropriate to suggest using them. I don't suggest that you are alone in that but there must be, I suppose, a partnership with the Medical Director's office and human resources in that respect? 12:26

A. Yes. I mean, I accept that as a failing on my part; I wasn't fully versed with it. By that stage I, though, would have been very cautious about -- I mean it talks in it about the Clinical Director initiating

it and then informing the Chief Executive, etcetera. I would not have been in a position to do that. In fact, I don't think any of the AMDs in the Southern Trust would have been instigating full MHPS without having talked to the Medical Director and probably the Acute Director as well. I think that would be unlikely and I don't know of any that -- I can't say if anybody did do it without it, but I don't think there was a -- I think people would not have tended to do that. 12:26 12:27

MR. WOLFE KC: That's an understandable, perhaps, confidence issue or an issue of expertise. It does seem to me - and I'm grateful for your comments on it - that you were at such distance from the policy in terms of you might have known it was out there but it didn't even enter your thinking to have a conversation with HR or the Medical Director's office about maybe we need to reach that stage of using this policy in the case of Mr. O'Brien; it never featured? 12:27

A. Well, when we met with -- when Heather Trouton and myself met with Dr. Wright in January 2016 and raised it, we had significant concerns, it was never mentioned or raised to us to consider it. As I said, in most things I did in this aspect, if I had concerns, I spoke to the Medical Director, and not just urology concerns. 12:27 12:28

MR. WOLFE KC: Looked at it at in the round, if you thought that there was an issue that required escalation, your assumed direction of travel would be to the Medical Director's office, and you would have

had, I suppose, the expectation that if MHPS was an appropriate tool, that someone within that office, perhaps through HR as well, should be suggesting it?

A. Yes.

MR. WOLFE KC: And that, across all of the issues that we're going to look at now, didn't arise? 12:28

A. No.

MR. WOLFE KC: Now, you stepped down from the role of Associate Medical Director in April 2017?

A. '16. Sorry. 12:29

MR. WOLFE KC: '16, of course. You were succeeded by Dr. Charles McAllister?

A. Yes.

MR. WOLFE KC: Did you hand over to him in any formal or informal way? 12:29

A. Well, Dr. McAllister and I worked together on a Tuesday. He was my anaesthetist. We worked very closely on a Tuesday; all-day Tuesday lists. If I had private practice, he would anaesthetise those patients for me, so we regularly discussed what was happening in 12:29 both directorates, the surgical directorate and the anaesthetic directorate, and he was aware of most things from within surgery. The hand-over at that stage would have been informal. I did not have a formal sit-down meeting with him or I did not have a 12:30 formal list of items and instructions and things.

MR. WOLFE KC: When he took over the role, he wrote to the then Medical Director, Dr. Wright. If we could have on the screen, please, WIT-14875. He is writing

to Dr. Wright, the Director of Acute, Esther Gishkori, and the recently appointed Deputy Director, Ronan Carroll. He's setting out what he has observed since taking over surgery as AMD. He provides quite a list of concerns. Just scrolling down, we can see at paragraph 6 a focus on urology. 12:31

"Issues of competencies, backlog, triaging referral letters, not writing outcomes in notes, taking notes home, and questions being asked regarding inappropriate prioritisation onto NHS of patients seen privately." 12:31

Some of those items are specific, it appears, to Mr. O'Brien?

A. Yes. The issues of competencies was not to do with him, that was to do with another consultant within the speciality, who, it turned out, was not confident with open surgery. 12:31

MR. WOLFE KC: Items 7 and 8 might have resonance with urology as well. In general, just scrolling down to the bottom, the Inquiry can pick up on some of the issues: Significant backlog of IR1s and SAIs, creating a governance risk. Just over the page, please. He says. 12:32

"That's what has appeared so far. Basically a very disturbing picture with significant governance risks. I'd be interested in your thoughts." 12:32

A bit of a state of the nation read out from him on assuming this role. Has he got it right? Is that an accurate and fair description of the service that you had recently departed after eight years?

A. Of the issues that were unresolved, there were -- yes, I think there were a lot of issues that were ongoing, unresolved. It ignored the things that were resolved and were not an issue. But I do accept that there were, reading through, things like that. Like number 13, junior doctors moving up -- can we scroll up, please? 12:33 12:33

MR. WOLFE KC: Sure.

A. Number 18, breast service teetering. Radiology support was precarious. That was outside my remit. There was also a difficulty attracting breast surgeons to the Trust. There still is. Interface between gastroenterology and GI surgeons was to do with the principle who looks after acute GI bleeders and who looks after jaundice and assesses them, and who looks after anaemia. Traditionally they were performed by the surgeons. In nearly every other hospital those sort of things went under a physician or gastroenterologist but we had no agreement from gastroenterology that it would take those own. 12:33 12:34 12:34

Moving up, the colorectal interface difficulty was we had two surgeons, colorectal surgeons, who had moved from Daisy Hill to Craigavon because they felt it should only be practised in the Craigavon site. They

were not in favour of a further colorectal service developing on the Daisy Hill site, having just moved from it. As it says, perhaps agenda collapse Daisy Hill in order to have two surgical rotas. That's now exactly what happened. It has taken six years for it to be seen that this is the best way forward for delivering the service. 12:34

Junior doctors are low and limited in middle grade allocation. That's true. The staffing for urology was low. NIMDTA, I think, supplied two registrars and two staff grades but appointing those sorts of people were difficult to find and it was not enough to run rotas. 12:35

SOW hand-over. That was specific with one surgeon who stayed on the old contract and therefore we were restricted how we worked that one. 12:35

Ortho job plans. That was -- well, they were in expansion and still having difficulty doing it. ENT, not enough theatre at times with extended lists. Same problem with urology, there was not enough theatre space within Craigavon Hospital. The specialties had agreed to do longer days but it turned out those were not as efficient as -- a three-session day was not as sufficient as two sessions. Two three-session days was not as efficient as three two-session days. 12:35

Middle grade cover scant. That was, as I said, through

general surgery I organised they provided cover. Not enough Craigavon list. That's what I mentioned, the same as urology.

Number 6 I think you are probably going to deal in more detail later on. 12:36

So, there were a lot of things there. F1 rotas, issues, not enough, noncompliant. That was an issue not just in our own hospital but in other hospitals across the province. Anaesthetics where he worked principally, there was a different way of staffing so he didn't have the issues that we did. 12:36

Paeds interface was an ongoing one, still not completely resolved after -- who looks after under -- kids under the age of five. Should they be under the joint care or should they be solely under surgeons, and hyponitremia led into that. 12:36

A lot of those issues are there, are still there. To say that the place was left just -- and then you can change it, a lot of them are still there. 12:37

MR. WOLFE KC: I'm just looking at number 14 on the list, sign-off of results. That's an issue, as we'll see in a moment, that you attempted to grapple with in 2011, I think. 12:37

A. I can't remember the year, but yes.

MR. WOLFE KC: We'll look at it presently.

An issue around number 13. Junior doctor numbers being low having an impact on more senior doctors in terms of their ability to dictate outcomes; is that how to read that? 12:37

A. I am assuming that. I am not sure which specific speciality he had been referring to at that time. It had never been raised with me that I can recall, that there was trouble with a backlog of dictation, you know, the 2016 issue. But apart from that, it was not 12:38 raised with me that there was an issue with junior doctors and dictation and getting it done.

MR. WOLFE KC: Are you saying, just so that I understand it, that in any hospital, perhaps, a list of these kind of concerns wouldn't be unusual and 12:38 there's always issues to be addressed, or does this list reflect a particular difficulty in the Southern Trust with addressing governance issues, as Dr. McAllister says at the end, that point to something specific and unusual about life in that Trust? 12:39

A. I think any -- well, Craigavon, in Northern Ireland terms, is a reasonable size but it is not big by UK standards. It is not the size of a DTH in the UK. I say Craigavon, I'm not trying to ignore Daisy Hill in that aspect, please. But as a result, staffing and 12:39 junior doctor staffing is always a problem. A lot of those issues there, I think, would be seen in most others smaller-sized hospitals by UK standards. I mean, the supply of registrars or middle grade

doctors by NIMDTA is always biased towards the two Belfast hospitals. At a consultant level, most consultants -- not most, a lot of consultants, a majority of consultants would prefer to live in the Belfast region and work there. Therefore, you have difficulty attracting consultant staff, or sometimes you do. I think a lot of hospitals outside of Belfast in 2016 would have had similar problems. 12:40

MR. WOLFE KC: In terms of your knowledge of Mr. O'Brien, I'm going to work through a number of instances where you're engaged, or your managerial colleagues are engaged, with issues of concern over a period of eight years and perhaps predating that. I want to start by asking you what was your knowledge and relationship with him at that point in time in 2008 when you took up the reins of the Associate Medical Director? 12:40 12:40

A. I had, and I can't remember for long, at one stage we used to operate, he would be in Theatre 2, I would be in Theatre 1. From he was appointed, it was that way. When that ceased and he moved to the Wednesday list, I cannot remember. By that stage we would have worked closely from a clinical point of view. He would have come in and helped out with some patients in my theatre and vice versa. Then he moved to Wednesday and Michael Young ended up being in the theatre next door to me. 12:41 12:41

When you say clinically, that's -- the way the ward system where, urology was ultimately in a separate ward

from general surgery. We ended up towards the end of my time -- for most of my time, we were on the top floor, urology was down on the third floor. ENT were in the ward. So, I didn't work closely with him in that aspect. I didn't routinely have my patients in his ward or urology's ward, or their patients -- well, they would be sometimes up in our ward but it wasn't a routine working together in that respect. 12:42

MR. WOLFE KC: We'll come on to look at triage in some detail shortly. You, in your role in the '90s, engaged with him on the issue of triage? 12:42

A. Yes.

MR. WOLFE KC: Was that the only professional or managerial collision that you had with him prior to taking up the AMD role in 2008? 12:42

A. I wouldn't call it a collision, it was more of a look, Aidan, you need to get your triaging done, it has been reported to me that you haven't been doing it. And his reply -- I cannot remember, I'm paraphrasing, I don't remember his exact reply, but he would have agreed to catch up and get it done. So, there was not a confrontational aspect of that at all. 12:42

MR. WOLFE KC: Yes, and sorry if I suggested that.

In 2008 then, you've come into this role. As you have set it out in your statement, one of the tasks that you had to perform following the regional review of urology was to engage with the three consultant urologists. This is from about 2009, going forwards. You would 12:43

have attended a series of meetings with them, usually on a Monday night?

A. Yes.

MR. WOLFE KC: With a view to discussing the implementation of urology reform. 12:43

A. Yes.

MR. WOLFE KC: Maybe you didn't use that language but it was with a view to discussing what the commissioner envisaged in a modern urology service?

A. Yes. 12:44

MR. WOLFE KC: You say, if we can open at WIT-11740 at paragraph 11, that you would have had in the room the three urologists. Do you need a page reference?

A. No, no. It is just for some reason I'm missing between 11736... 11740, did you say? Sorry, it's further 12:44 forward. My apologies. I've got it, yes.

MR. WOLFE KC: You've got it.

These meetings went on for what period of time, Can you recall. 12:44

A. I think approximately 18 months. I can't remember exactly but I think approximately 18 months. It started off initially with Joy Youart, who was the Director of Acute Services, ad then continued with Gillian Rankin and finished with Gillian Rankin. 12:45

MR. WOLFE KC: You set out in this statement the kinds of changes in practice which were required, including the management of red flags, triage issues, pre-op assessment, length of stay, throughput of patients in

clinics, transfer of radical pelvic surgery to the Belfast centre, role of nurse specialists, etcetera. So these issues, as you're depicting it, had to be worked through almost in an -- it sounds like an industrial relations format of agreeing these changes or attempting to go these changes?

A. Yes.

MR. WOLFE KC: That was a difficult process?

A. Yes.

MR. WOLFE KC: Why was it difficult? 12:46

A. The urologists were reluctant to change and agree to what we were requesting. We were told we had to get them to agree if they were going to implement Team South and expand the urology service in the Southern Trust. I wrote down there, it's true, I think Aidan was probably the main resistance but he did get active support from his two colleagues in resisting. He was not alone. So it was the three urologists -- I wouldn't say "versus" but effectively versus Gillian Rankin and myself. I believe Heather Trouton was there. I can't remember if Martina Corrigan attended those meetings or not. They were difficult meetings and they were not easy meetings.

MR. WOLFE KC: Is it fair to characterise these meetings as a sort of clash of perspectives? You, on behalf of the Trust, were trying to deliver what the commissioner might expect if Craigavon, if the Southern Trust, was to be granted this service, and it was obviously important to get this service for the

local population. But from the other side of the fence, you had three consultant urologists who had other priorities or perhaps competing priorities, including the need, as they might see it, to protect the quality of care and their own role in delivering that care? 12:47

A. I think they were out to protect their way of practice as they were doing at that point in time.

MR. WOLFE KC: Yes.

A. As I say, Mr. O'Brien -- and I think he did believe that his method of care was the best, you know, and therefore he fought his corner. But I say, he was not unsupported. You know, it was not a -- the meetings were -- there were three of them united, largely, in their views. We would have a pre-meeting before. I think the meeting was at 6.00. We would have a meeting from 5.00 to discuss tactics, and then we would have a meeting after it finished. We would have a debrief and work out where we'd got before we started the following week. And I think I wrote it down there somewhere in my statement, Gillian Rankin believed one of their aims was kind of talk us into submission. She said I'm not going to be talked into submission. You know, there was a dogged determination in her part not to just roll over, you know. 12:48 12:48 12:48 12:49

MR. WOLFE KC: They sound like bruising encounters?

A. They were -- it wasn't shouting at each other or things like that, but they were forceful encounters.

MR. WOLFE KC: When you say that it was your impression

that the main resistance to embracing change came from Mr. O'Brien, can you suggest any specific examples?

A. I'm sorry, I can't. You know, I can't remember exactly. But I say -- as I said, he was not the only who was one opposed to change. However, you notice in some of the documents, they always had agreed to patient numbers, etcetera, pooling lists, and he was reluctant to do things like that. So, he was the slowest to get to change. 12:49

MR. WOLFE KC: I'm trying to work out whether you are being critical of him in that context or whether, if you were in his shoes, you might have adopted the same approach from a protective perspective in the sense of the care that you would have wanted to deliver and perhaps suspicions about what was in the mind of the commissioners. 12:50 12:50

A. It's difficult to put myself in his shoes in this one. If this was general surgical service or an expansion of this, I would have seen the expansion of it would have been for us. In general surgery, it would have been good from the point of view of improving subspecification, improving patient care, etcetera. I think what the commissioners were offering was worth taking, an expanded service which would help improve your staffing levels and at the same time allow you to sub specialise and to advance that, and to guarantee a service that lasts. I saw a lot of advantages in what the commissioners were -- I saw a lot of advantages in the carrot that they were dangling of expansion. 12:50 12:51

I think it was worth it. If this had been an aspect of general surgery, I would be saying yes, we should go for that from what they were being offered.

A lot of what is down there, we had already changed and switched in general surgery. We had felt that those things were the way forward. We were embracing pre-op assessment. I was admitting patients for -- I can't say every single one, but the majority. My total of thoracic esophagectomies, which is quite complex major surgery on the day of surgery, because we had them worked up and preassessed and everything else. 12:51 12:51

We improved length of stay. Length of stay allowed us greater access to beds, improved our beds. We had more beds available for other patients. So I think, you know... I thought -- I still believe what was being offered was for the best of urology. In fact, Mr. Belus -- sorry, Mahmood Akhtar, at the end in 2012, when he was leaving, came up to me and said that he had come to realise that we had urology's best interests at heart. It's a pity he hasn't said it on the nights but he admitted it at the end to me. That I found, you know, very reassuring that we had been right. 12:52 12:52

MR. WOLFE KC: In terms of the process then of resolving these issues, working through them and assumedly resolving, at least to the extent that the service could be commissioned, did that leave difficulties within the relationships, you and 12:52

Mr. O'Brien, you and others?

A. I think it probably made the relationship with Mr. O'Brien more difficult. Mr. Young I did maintain quite a good working relationship with. He was next door in theatre. We continued to talk and chat as normally. But I think it probably was a bigger affect with Mr. O'Brien than with Mr. Young. 12:53

MR. WOLFE KC: Another, I suppose, thorny issue that you had to grasp with Mr. O'Brien was the issue of the job plan. We can see that in 2011 that issue was to come to life and create some difficulties. Ultimately, to summarise, you had a role to -- I hesitate to use the word "negotiate" with Mr. O'Brien but maybe that's an apt word in this context about what he could be granted in terms of PAs. That didn't lead to a resolution and so the matter went on to facilitation, a form of review or appeal, and Mr. O'Brien was left dissatisfied by that outcome. I just want to look at that in the period before lunch. 12:53 12:54

Job planning came up at a meeting with Mr. O'Brien on 9th June 2011. If we can pull up, AOB-00256. Just go to the page before that, please. There had been a discussion on 9th June with Mr. O'Brien, and it is produced in this memorandum on job planning. You are working obviously with Mrs. Trouton on this issue. Mr. O'Brien is to submit a breakdown of activities to you for planning into an updated job plan as per Trust action for consultants Trust wide to agree an updated 12:54 12:56

plan. That was done.
Could you just go down to the bottom of the next page, please? There was some discussion around the issue of the cancer pathway at that time. I just want to pick up on this because it is in this document. 12:56

"There was discussion regarding the leadership requirement of all senior staff, inclusive of consultants, to give confidence to all ward/department nursing staff regarding patient care and to take action 12:57 to improve patient management rather than projecting a negative and critical attitude within the clinical team."

Can you help us? Can you remember that and whether 12:57 that was of general concern or was that particular to Mr. O'Brien?

A. I can't remember, sorry.

MR. WOLFE KC: Moving on through the stages of the job plan process, if we go to AOB-00262. Here, Mr. O'Brien 12:57 is providing comments on the job plan proposals, as he had been requested to in the previous memo. If we scroll on to the next page, please, scrolling down to the issue of administration. Mr. O'Brien says that the allocation of 2.5 hours per week for all of the 12:58 administration involved in the effective execution of his job is wholly inadequate. He says there are four main planks of administration which require allocation of adequate time, and he sets those out.

If we go on to your perspective on this - I needn't bring it up on the screen - but your view on administration was that he had adequate allocation within the job plan as you proposed. Is that fair?

A. He had at least similar to his colleagues and to other surgical surgeons throughout the Trust. It was in that we were judging him, that his colleagues were agreeing to it. Other surgeons in the Trust had a similar amount. That's why I felt it was adequate. 12:59

MR. WOLFE KC: Let's just perhaps bring that up. AOB-00285. Here we can see you writing to Mrs. Corrigan. If you just scroll down to the -- 12:59

A. No. Hold on, sorry. Go back a little bit. I wrote to Aidan O'Brien.

MR. WOLFE KC: You wrote to Mr. O'Brien, copying in Mrs. Corrigan. That's right. 13:00

If we look to the fourth bullet point, you say:

"I note the comment re: Administration time and following reassessment of the admin time allocation to your colleagues, I have reduced your allocation to 4.25 hours per week which is now similar to your colleagues." 13:00

The point you were making. 13:00

A. Yes.

MR. WOLFE KC: Was that a fair approach? In measuring him against his colleagues, are you necessarily

comparing like with like? In other words, different colleagues have different ways of working or had different administrative responsibilities.

A. Well, the different administrative responsibilities wouldn't have applied in that respect. It was similar. 13:01
So it's back down to -- I accept what you are saying, how you do your practice. Well, we were also being encouraged from above, from the Medical Director's office, etcetera, that we were not -- you were not meant to give out lots of PAs just because somebody 13:01
says I want lots of PAs. When the original consultant contract came out, people put down what they were doing and then they realised that, you know, people were putting down a lot more than they were actually doing so then they started a facilitation process towards it. 13:01
The facilitation process was designed to get accommodation and agreement between what was being proposed and what the clinician said. I, to be honest, did not expect him to accept what I was saying because he was - at 15 PAs - the highest paid consultants of 13:02
all the surgeons. I can't say about all the Trusts but he is the highest paid surgeon -- the highest number of PAs for a surgical consultant within the Trust, and therefore -- sorry, the analogy I can think of offhand is just turkeys wouldn't vote for Christmas. If you 13:02
agree to something less than that, you take a pay cut. Why would you? And the longer you don't agree, the longer you continue to be paid for it at the higher rate.

Therefore, there was an element -- my last sentence at the end "If you are not able to agree it, I'm happy to request facilitation", was I expected I was going to have to go that route because I was not going to get agreement.

MR. WOLFE KC: The negotiating difficulty from your perspective is that the precedent had been set and he had been granted more PAs historically than you --

A. He had been granted it following the initial facilitation that took place in, I think, 2006. I can't remember exactly, whatever year the original consultant contract came out. I think a year or two -- 2007, I think I was clinical director. I was asked to discuss it with him and he wouldn't agree to a job plan. I see in the end of the email I made the mistake of saying "If you are not happy with what we're suggesting, request facilitation from Dr. Steven Hall" who was the Acting Medical Director at that stage. That rolled over into the new Trust and got pushed back whilst we were moving things forward that way. So, for several years he was being paid at an extremely high rate compared to other clinicians in the Trust.

MR. WOLFE KC: We'll resume after lunch by looking at this, but plainly this issue is of some significance given that, by 2016 and your going to see Dr. Wright, issues around Mr. O'Brien's time of completion of administrative tasks was very much top of your agenda, or on your agenda at any rate. I suppose the origin

13:02 13:02 13:03 13:03 13:03

for the difficulty, I don't know if you would agree, starts around here with the cutting of his administrative time or at least the cutting of his PAs in that respect?

A. Except for the fact that triaging had been an issue before that. So, when he had the enhanced, the increased number of PAs, triaging was still an issue. 13:04

MR. WOLFE KC: Yes.

A. There had been intermittent issues with it.

MR. WOLFE KC: The point being with less time available to him, we'll explore, I suppose, the attitude or the position he displays in correspondence after lunch. It is not going to improve, perhaps, or maybe you thought it would, by reducing the PAs available? 13:04

A. Sorry, I have to go back a wee bit on what you asked me there. You said it is not going to improve. Sorry, which bit is not going to improve? Apologies for asking. 13:05

MR. WOLFE KC: His administrative output.

A. Well, his administrative output, it's... I would say that he was offered, after facilitation that time, that he could -- you know, I wrote -- I organised a meeting with him to discuss what we could do towards helping it. He declined to come. I wrote to him after that. So, he had been offered help towards things like that. He was very traditional in how he did things. He didn't embrace technology; he didn't embrace digital dictation; he didn't embrace the use of -- for a long time his secretary had to print out emails for him. 13:05

MR. WOLFE KC: We'll come to that in a bit more depth after lunch, I think.
CHAIR: Five past two, then.

THE INQUIRY ADJOURNED FOR LUNCH 13:06

CHAIR: Good afternoon, everyone. Mr. Wolfe.
MR. WOLFE KC: Good afternoon, Chair.

We were looking, Mr. Mackle, at the job planning issue which led to some disagreement and facilitation in 2011. 14:07

Dr. Murphy, who was the Associate Medical Director for Medicine & Unscheduled Care, he stepped into the role of facilitator with a view to, I suppose, trying to resolve the disagreement between yourself and Mr. O'Brien on this issue. If we can look at how that was resolved, if "resolved" is the right word. 14:07

TRU-265964. This is correspondence dated 12th October 2011 from Mr. Murphy in his role as facilitator to Dr. O'Brien, or Mr. O'Brien. Just scrolling down, he has compared Mr. O'Brien's proposed job with colleagues in urology and is "content that the time you have been allowed for administration seems appropriate". One of the colleagues had been allowed slightly more time but that was in the context of an additional clinic, which I suppose by definition, would generate more administration, let's say. 14:08 14:08

He says:

"I do accept, however, that you have historically worked significant amounts of administrative time and as a result, I feel it is appropriate for me to agree a traditional period to allow you time to adjust your working practices." 14:09

What was introduced here was a stepping down from, I think 15, the 15 PAs at the commencement of this process, stepping down to finally agree to 12 PAs as of 1st March 2012. I suppose the important point I wish to focus on, Mr. Mackle, is this. Dr. Murphy says: 14:09

"This will undoubtedly require you to change your current working practices and administration methods. The Trust will provide any advice and support it can to assist you with this." 14:09

Just scrolling down, I think that was the end.

"In the meantime, it is important for you to be aware that if you are not satisfied with the outcome... you can proceed to a formal appeal." 14:10

Can I just pick up with current working practices and administrative methods. You said just before lunch that Mr. O'Brien didn't tend to embrace technology. Is

that in the context of administration?
A. Yes.
MR. WOLFE KC: What was it about his then current working practice and administration methods that was problematic? Did you have direct information on that? 14:10
A. I can't say specifically in that respect. I do recall that, you know, he was -- I say in the early stages -- at one stage - I can't remember timings on this, I'm afraid - he wouldn't have used email. The emails would have been sent to his secretary, printed out by her and 14:10
given out for him. He would have written handwritten notes to his secretary rather than dictate a quick note. He didn't have a commuter on his desk for some considerable time whereas the rest of us did have. That's what I meant by embracing technology. I'm not 14:11
talking about clinically, I'm talking about non-clinically.
MR. WOLFE KC: Mr. O'Brien responds to this by writing to a Malcolm Clegg. Let me just open that correspondence for you. It is WIT-90292. He is 14:11
writing on 10th November 2011. He's saying to Mr. Clegg (it is obviously following a meeting):

"As discussed with you yesterday... disappointed, disillusioned and cynical of the job planning 14:12
facilitation. Even though I brought attention in writing and verbally over a period of two years to the physical impossibility of earlier job plans... a possible (whether acceptable) job plan was submitted

for the first time on 31st October 2011. If acceptable, it was to further defy all possibility by being effective retroactively from 1st December 2011. Upon query, now it is to be effective from 1st October 2011, a month before it was offered and on the grounds that another consultant's job plan, presumably both possible and accepted, had become effective from that date. Surreal relativism comes to mind."

14:12

He is unhappy with the outcome of facilitation, and indeed as part of that, the start date for the new job plan. He goes on to say - I'm going to pick up on this in the next paragraph - he feels:

14:12

"Compelled to accept the job plan as amended".

14:13

He is not going to appeal it, clearly. He says:

"I have endeavoured to ensure that management is fully aware of the time which I believe was required to undertake the clinical duties and responsibilities included in the job plan to completion with safety. Particularly during the coming months leading to the further reduction in allocated time, I will make every effort to ensure that I will spend only that time allocated, whilst believing that it will be inadequate."

14:13

14:13

I don't know if this was discussed with you at the

time, Mr. Mackle.

A. No.

MR. WOLFE KC: Is there an alarm sounding in that? Is it suggesting that he will only work the hours allocated to him and if there's further work to be done, it won't be done. Is that what you would take from that? 14:14

A. I can see that and read it that way. Equally, there was a three PA reduction in his salary which he was not happy with. So, I wouldn't have expected him to write, you know, cheerfully that he was really happy with the outcome of it. That's why, in fact, I referred him to facilitation because I expected there would be -- not expected, because I knew I was never going to get him to agree to a job plan that had anything less than 15 in it. In fact, he would have suggested he needed more than that. 14:14 14:14

MR. WOLFE KC: Could we turn to WIT-90296? If we look at the top of the page. You may not remember this in light of your last answer but it does seem that these issues were drawn to your attention. Mr. Clegg is writing to say that, if we look at the last sentence: 14:15

"Mr. O'Brien was informed in his notification letter following facilitation that the new job plan will require him to change his working practices and administration methods and that the Trust will provide any advice and support it can to assist him with this. It is important therefore in view of the comments made 14:15

by Mr. O'Brien that we follow through with this."

This was a recognition on Mr. Clegg's part that the warnings sounded by Mr. O'Brien in his correspondence couldn't go without response; is that fair? 14:16

A. I would think so, yes.

MR. WOLFE KC: You then write to Mr. O'Brien on 5th December. WIT-90291. You quote the outcome of the facilitation process and you organised a meeting to discuss that. Mr. O'Brien cancelled the meeting. 14:17
You're concerned that you hadn't been able to meet with him to agree any support that may be required. You would appreciate if he contacted you directly to discuss, to organise a meeting.

14:17

"If, however, you are happy that you can change your working practices without need for support, then you obviously do not need to contact me to organise a meeting."

14:17

I think Mr. O'Brien confirms that there was no contact between you, and that's your recollection?

A. Not that I can recall.

MR. WOLFE KC: Was that the end of that issue so far as you can recall? 14:18

A. I think so, yes.

MR. WOLFE KC: It wasn't the end of the issue in the sense that you must have been left wondering whether and how Mr. O'Brien could change his administration

practices. Was that the subject of discussion, notwithstanding the absence of a response from him?

A. I can't recall -- I mean, in that respect I can't say. I mean, I had offered advice or I had offered to meet him. He didn't take me up on it. By that stage I wasn't totally surprised that he wouldn't meet with me, I suppose. Was I abdicating out of my role by not? You could read it that way. I felt he also at other times didn't say that he wasn't doing his role. At this stage I can't give you a straight answer, I'm sorry. 14:18 14:19

MR. WOLFE KC: I suppose we could list a variety of issues or types of work that required administrative output from him, everything from triage to post-clinic reporting and, for that matter, the reading of results and actioning results. All of those issues required administrative output, and all of them were to continue to be or to turn into issues over the next several years and were only, I suppose, formally grappled with in March 2016. It does seem, on one view - and I would be anxious for your comments on this - that there was no active attempt made to ascertain whether his working practices had changed or could be changed. 14:19 14:20

A. I think that's factual. We didn't, as a group, try to ascertain if he had changed his working practices. No, we didn't. 14:20

MR. WOLFE KC: You clearly wrote to him; you offered him a process. Is that any better than a box-ticking exercise if the engagement doesn't actually happen?

A. With hindsight, I can see why you would say that. At the time we had gone through by that stage, May 11th, a large proportion of the whole time on the loyalty review, Team South and a lot of long meetings with that. He didn't choose to take up the offer. With reflection, should we have continued to have followed that up? Yes, I think we probably should have. I mean collectively we all knew that he hadn't met and hadn't done it. We didn't follow up on it, no. I admit that. 14:21

MR. WOLFE KC: Another issue that straddled that period commencing in 2009, and your involvement with the issue didn't cease until perhaps into 2012, concerned the use by Mr. O'Brien and Mr. Michael Young of antibiotic IV fluids prophylactically in the management of patients with chronic urinary tract infections. Do you recall that issue? 14:21 14:22

A. Yes.

MR. WOLFE KC: You set out in your statement, if we can just orientate ourselves first by going there, WIT-11743. At paragraph 18, if we just take some time to scroll through that, you summarise the issue. 14:22

"In early 2009, we became aware of a practice in the Urology Department of admitting certain patients with urinary attract infections for administration of IV fluids and antibiotics." 14:23

That issue was brought to the attention of the then Medical Director, Paddy Loughran; isn't that right?

A. Yes.
MR. WOLFE KC: It got there through the commissioner, and that was a Diane Corrigan?
A. Dr. Diane Corrigan.
MR. WOLFE KC: She drew that issue. From their perspective, was it both a resource issue and a patient safety issue? Patients coming on to wards apparently not for an operation process and not for theatre process, and then, as it was explored and discovered more about it, issues around the safety of the administration and the necessity for the administration of IV antibiotics for these patients had to be grappled with? 14:23
A. My recollection is that it was picked up -- I could be wrong on this but I think it was picked up by Mark Fordham, who was the urologist from Liverpool who was brought into Northern Ireland to do the urology review. He had picked it up, fed it back to Diane Corrigan and then Diane raised it with the Trust. 14:24
MR. WOLFE KC: You go on then to say that it being an issue - and we'll look at some of the finer detail in a moment, this helpfully just summarises the position in your statement - that a pathway or a protocol was introduced, isn't that right, whereby if you wanted to treat a patient in this way, it had to go through a process which involved microbiology opinion? 14:24
A. Yes.
MR. WOLFE KC: You say that pathway was introduced, but despite an agreement from Michael Young and Aidan

O'Brien, we became aware in July 2010 that the pathway was not being followed and 13 patients were still being treated in this way. In September 2010, a formal protocol was tabled. We'll look at that in a moment.

14:25

"In June 2011, I believe there was a breach of the protocol and then a week later, and despite a meeting to reinforce the protocol, I was made aware of a planned further breach. Following this, I sent an email to Aidan O'Brien and I'm not aware of any further breaches occurring after that."

14:25

That wasn't an issue you brought to medical directors, as you've said, but it was an issue that in your role as the Associate Medical Director, in concert with, I think Mrs. Trouton, correct me if I'm wrong, you were required to manage locally?

14:25

A. Yes.

MR. WOLFE KC: So the issue arises in 2009. There's discussion about it. If we go to TRU-281832. Here you're sending an email on 19th July 2010 and you're telling Anne Brennan -- is that the Medical Director's secretary, or support?

14:26

A. Well, to be honest I can't remember the exact title, but she was maybe an Assistant Director to the Medical Director, I can't be sure. But it was that level.

14:26

MR. WOLFE KC: In any event you're saying.

"Paddy, as you know a report from Mark Fordham

regarding the use of long-term IV antibiotics for urology patients."

You say you mentioned to Paddy recently that they were still not adhering to the guidance which he, that is Paddy, gave to them, in conjunction with advice from Dr. Damani. That's the microbiologist? 14:27

A. The microbiologist, yes.

MR. WOLFE KC:

14:27

"Paddy stated that I should check the numbers concerned and then if necessary meet with them".

You say you have discovered there are 13 or 14 patients still getting IV treatment. 14:27

"I am organising a meeting but would appreciate if you could forward me a copy of Mark Fordham's report."

At that stage is it your understanding that the treatment of patients in this way ought to have stopped or, if not stopped, ought to have been approved through the process, the microbiology process? 14:28

A. Yes. My understanding was that it was meant to have stopped. These were patients who didn't necessarily have proven urinary infections but had symptoms. The process that had been sent up was that they were to be reviewed by a microbiologist at a meeting chaired by Sam Sloane, who at that stage was the clinician 14:28

director in surgery, and then a decision made whether they could be brought in for IV fluids and IV antibiotics or not, or whether they required oral antibiotics as a treatment instead, or none at all.

MR. WOLFE KC: Dr. Paddy Loughran responds. If we look at his correspondence to you and Mrs. Rankin, TRU-281845. I think I might earlier have suggested that it was Mrs. Trouton who was handling this issue with you; it was Mrs. Rankin primarily; is that right? 14:28

A. Sorry, it was Dr. Rankin. 14:29

MR. WOLFE KC: My fault. Dr. Rankin.

The Medical Director is addressing this memo to Dr. Rankin, who was Interim Director of Acute Services, and copying you in. Scrolling down, please. He sets out the background. He has received expert advice from Mark Fordham. He has had several meetings with Mr. O'Brien and Mr. Young. Those meetings led to agreements that they would compile a list of patients involved in the programme, that those patients would be reviewed, and that a multi-disciplinary group would be convened to look at each treatment plan with a view to converting the patient from IV to oral therapy or another nonintravenous treatment. 14:29 14:29

14:30

Scrolling down, please. He says that in the intervening period, he understands there has been a significant reduction in the number of patients within the cohort, but he had expected that the number of

patients would be extremely small by now, and that the patients with central venous lines or long peripheral lines would have had those lines removed. He says you, Dr. Rankin and Mr. Mackle met on Wednesday 1st September to discuss progress. He says it is of concern to him that the agreement, as set out, has not been followed. In particular, he understands that there are at least seven patients remaining on IV treatment and that two and possibly three have permanent IV access. It has been agreed that Mr. Young and Mr. O'Brien should be informed of the meeting on Tuesday and should be informed that he, the Medical Director, remains concerned that any patient is receiving this treatment. 14:30 14:31

Scrolling down. He asks you - penultimate paragraph - and Dr. Rankin to meet with Messrs Young and O'Brien to address the issue. 14:31

You had that meeting; isn't that correct?

A. Yes.

MR. WOLFE KC: The process of the protocol covering this is set out. Just let's have a look at that at TRU-251143. These are the steps that are required. You presented that to the clinicians at the meeting in September? 14:32

A. We did, yes.

MR. WOLFE KC: Was their response one of compliance?

A. We got the impression it would be accepted, yes.

Reluctantly, but would be accepted.

MR. WOLFE KC: Now, into the following year, into June 2011, you have occasion to write to Mr. O'Brien. If I could ask you to look at TRU-281944. This is 15th June, almost a year after you had met them and assumed you had compliance. This email has obviously been written on the back of a conversation the previous week. You say: 14:33

"I am seriously concerned that you don't seem to recall our conversation at the meeting last Thursday. At that meeting I informed you that if you want to admit a patient for pre-op antibodies or for IV fluids and antibiotics, that a meeting had to be held with Sam Sloane" -- 14:33

A. She was Clinical Director for Surgery, yes.

MR. WOLFE KC:

-- "and the microbiologist, and this prequisite was non-negotiable". 14:34

You are saying that's the clear message you conveyed to Mr. O'Brien?

A. We had a meeting on 9th June, Dr. Rankin, Heather Trouton and myself. There are minutes of that meeting which have been supplied. At that one he was informed that if he was admitting a patient for IV fluids and antibiotics, then that protocol had to be followed. 14:34

MR. WOLFE KC: You say.

"I now find that you initially planned to admit a patient this week without having discussion with anyone and then, when challenged, you only spoke to Dr. Rajesh Rajendran". 14:34

A. Who was a microbiologist.

MR. WOLFE KC: In terms of what had been handed down in the protocol, that wasn't good enough. Is that the position you are outlining here? 14:34

A. Yes.

MR. WOLFE KC: This email which you've copied to Mrs. Rankin and Mrs. Trouton - Dr. Rankin, I should say - can you recall receiving any response from Mr. O'Brien on it or any discussion on it? 14:35

A. I can't recall what the response was but I think -- no, I can't remember at all.

MR. WOLFE KC: You were plainly concerned that an issue that you had thought perhaps had gone away had not gone away? 14:35

A. I was irritated, to say the least. That's six days -- whatever it was, five or six days later, to hear somebody else had been admitted despite Dr. Rankin and I having had a meeting with him on the 9th. 14:35

MR. WOLFE KC: On 30th January of the next year, 2012, you're writing to Dr. Sam Hall in relation to the issue. If we can have that up at TRU-259904. As I say, late January 2012. We'll not name the patient.

"I have been advised that a patient may have been admitted last week to urology by Mr. O'Brien and under his instruction given IV antibiotics, the latter necessitating a central line to be inserted.

"I have checked with Dr. Rajendran and he advises me that no discussion took place prior to the administration of the antibiotics".

Again, is that pointing to another breach of the protocol?

A. Yes.

3 Q. And you would be grateful if this could be investigated. Any recollection of how that was resolved?

A. No, I'm sorry. I expect it was done verbally back to Gillian Rankin and myself but I can't remember. In fact, looking at my witness statement, I didn't even have that in my witness statement. I say in it on -- sorry, after 13th December I said - 2011 - I wasn't aware of any others. That is another mistake.

MR. WOLFE KC: That is fair of you to point out. You thought that the last time of dealing with it was at the time of the previous correspondence.

A. I didn't remember this and I didn't find it for some reason on the search of emails.

MR. WOLFE KC: Yes, that's entirely fair and thank you for pointing that out. Certainly you point to no

further and we're not aware of any further issues in this respect.

This IV antibiotic issue, the advice to the Trust from Mr. Fordham and others was that there was no peer review or scientific support - or clinical support is maybe the appropriate word - for this method of treatment. The Trust came in through the Medical Director and said this isn't to be done, or if it is to be done, it has to go through this protocol. You found breaches of that or suspected breaches of that happening in 2010, '11 and possibly into 2012. Does that tell you anything about the difficulties in managing Mr. O'Brien, and what does it tell us? 14:38 14:38

A. That he didn't always follow up what was requested. He did his -- he did ultimately comply but very, very, very, very reluctantly before he would comply. 14:39

MR. WOLFE KC: He had a view that this treatment was appropriate and that it was safe, and the Trust disagreed. In the face of his disagreement and, as is suggested here, his non-compliance from a managerial perspective, what was done? 14:39

A. Not that I recall anything specific. The Medical Director was informed of, you know -- breaches like that, in a one-on-one meeting with him, he would have been informed "we've had another one". I suppose we've got it sorted, for the moment anyway. But nothing specifically managerial was done, No. 14:40

MR. WOLFE KC: Is this issue typical of a significant

patient safety issue that the Trust, rather than, I suppose, grabbing the initiative in a very firm way at the outset, let the matter drift and drift with the potential for impact on patients and their safety? Or, in the alternative, is that the way you have to manage? 14:40
You negotiate, you get a bit, you get a bit, and then finally it's resolved.

A. I think that's probably a bit more accurate summary, the last bit. That's why we did it, in increments. As I said early on, we judged him on the basis that he 14:41
was a good clinician overall, he was hard-working and respected by everybody. That was probably -- that was an overarching thing in how we dealt with him. On reflection, and when you see everything tabulated, you see all the emails tabulated one after the other, you 14:41
start to think why did we not?

But it was one -- I mean, as I say, he was not the sole person. Mr. Young was also involved in the IV fluids and IV antibiotics. My recollection, but I couldn't 14:41
prove, is I think he was also involved - I know it is coming up after - the benign cystectomies. I believe he was involved in that although I couldn't easily identify that when I was doing my Section 21. So, he was not alone. Therefore, we had two out of three 14:42
urologists who believed in this as a method of practice. The other one wasn't saying to us this is seriously wrong, you need to stop this or this has to be stopped.

As I say, he was respected, and that did influence how we looked at him and how we managed him.

MR. WOLFE KC: You're right to say that at or about the same time, an issue around benign cystectomies and the question of whether they were, as a procedure, being used too often and without clinical justification arose for you to investigate. Isn't that right? 14:42

A. Yes.

MR. WOLFE KC: You deal with that in your witness statement at WIT-11813. This issue came into the Trust via the same route, in that Diane Corrigan - I know you mentioned Mr. Fordham in the context - but Diane Corrigan in the PHA was to take the initiative with the Medical Director on this issue as well. 14:43

A. My recollection of this - and I believe what I'm saying is factual but I can't remember exactly - is I knew Mark Fordham through a committee we sat on in English College in ICBSE. I remember talking about to him. He raised the fact he thought there was an issue there. I remember talking to Diane Corrigan, and then ultimately she said she was going to conduct the Trust or the Northern Ireland-wide audit, and then following that she wrote in to the Trust. 14:44

MR. WOLFE KC: She is saying here in paragraph 203: 14:44

"Dr. Corrigan, on 1st September 2010, wrote to paddy Loughran and copied in Gillian Rankin and yourself, noting that when she read the review of the IV fluid

and IV antibiotic therapies", the issue we have just been dealing with, "that there was comment regarding major bladder surgery. She had recently informed me that she was going to conduct a Northern Ireland-wide audited of the number of procedures being performed. This she reported as showing a higher than expected number of cystectomy and/or conduit process for benign disease than would be expected". 14:44

Scrolling on down, please. 14:45

"At a meeting in September held by Gillian Rankin and yourself attended by Messrs O'Brien and Young, a statement regarding the screening process the Trust was planning to undertake was tabled. At this point Mark Fordham was appointed to carry out a review". 14:45

I think that is in relation to the --

A. No, sorry. Aidan O'Brien said he would not engage if Mark Fordham was appointed to carry out a review of it; the process of benign cystectomy. 14:45

MR. WOLFE KC: Yes. So a decision is made to instruct a Dr. Drake or Mr. Drake to carry out the review?

A. Yes.

MR. WOLFE KC: I just want to turn briefly to that. His task was to review the most recent set of cystectomies undertaken in the Trust and to try to assess whether they were clinically justified. Is that it in a nutshell? 14:45

A. Well, I was tasked originally to do that. In some areas I've written 13, others I have 12 but I think in an email I have said -- well, anyway 12 or 13, I reviewed them. I couldn't reassure the Trust on at least six of the cases; it was outside my field of expertise. So on going back, I was then told to get advice on who should be an independent assessor. We wanted somebody from outside the province rather than somebody in Belfast. That's why I approached Mark Fordham, because I knew him separately, to ask his advice on who he would suggest seeing Aidan had objected to having him conduct it. 14:46 14:46

MR. WOLFE KC: Do you know what the reason for that objection was?

A. He didn't like the outcome of the urology review. They decided at that stage to move malignant cystectomies to Belfast, and he wasn't allowed to keep -- continue to do radical -- well, Mahmood Akhtar was doing radical prostatectomies but that all had to go to Belfast. He didn't agree with that aspect of it. I can't say if there were any other reasons but that I know is one of the reasons he disagreed with. 14:46 14:47

MR. WOLFE KC: Mr. Fordham's, I suppose, fingerprints were on that recommendation?

A. Yes. 14:47

MR. WOLFE KC: Just turning briefly to Mr. Drake's report. We will find it at TRU-281930. That's the first page. It is described as "Cystectomy cases undertaken for benign urinary conditions,

Southern Trust".

His particular concern which emerges in the report is that -- just scroll to paragraph 9.2, down the page to -- sorry, six pages down, 281936. At 9.2 he says: 14:48

"The cases in general appear to have been supportable clinical grounds".

However, at 9.3, he says: 14:48

"The document is insufficiently comprehensive, and in order to warrant proceeding to cystectomy, clear description of the following is needed: Severe pathology, substantial function and impairment 14:48 impacting quality of life. Attempts to undertake conservative measures or discussion of risks involved."

There's some of the good examples which would justify this procedure. He couldn't find those documented on 14:49 the notes that you had supplied him with, is that it?

A. Correct.

MR. WOLFE KC: You undertook a search for further documentation; is that right?

A. Well, Mrs. Corrigan actually did. 14:49

MR. WOLFE KC: And nothing else at this point?

A. We couldn't find anything else.

MR. WOLFE KC: Is it fair to say that that is where the matter sat? Paddy Loughran, Dr. Paddy Loughran emailed

Dr. Corrigan to say that a draft report has been received from Mr. Drake which indicates that a final report will be produced which will be supportive and indeterminate. If you turn to TRU-281958. That's how the matter sat ultimately, that this wasn't regarded as an issue of any particular concern once it had been explored by Dr. Drake? 14:50

A. That and, I suppose, the fact that the decision was that benign cystectomies would be transferred to Belfast, as well as malignant. 14:50

MR. WOLFE KC: At that point the recommendation from the urology review was to send malignant cystectomies to Belfast. Clarification was sought from the commissioner about benign cystectomies, and they were also to be transferred? 14:51

A. Yes.

MR. WOLFE KC: In that context, there was to be no going forward concern because the procedure wasn't to be done in Craigavon.

A. Yes. 14:51

4 Q. Just on this issue of looking backward to see whether the clinicians responsible, including Mr. O'Brien, for cystectomies in the Southern Trust had done them in a clinically appropriate way or had chosen that procedure for clinically appropriate reasons, the report of Mr. Drake left you with a question essentially. There has been a failure to document in a sufficiently comprehensive way the supportable clinical grounds for doing this. 14:51

Was that issue pursued with Mr. O'Brien or any of the other urologists concerned?

A. No. As I said, Dr. Loughran accepted the report as it was once he knew there was nothing else could be found, and instructed me to write to Dr. Corrigan with the summary. 14:52

MR. WOLFE KC: On one view what Mr. Drake was saying in order to get to the stage of supporting this procedure, I need to know the reasons; it appears okay on the surface, but the reasons, the clinically supporting reasons for the process aren't there. I know this is possibly a decision for the Medical Director, Mr. Loughran, but the bar was being set very low, wasn't it, in giving this a clean bill of health in the absence of documented reasons? 14:52 14:53

A. I do remember when we met with -- well, I believe I picked him up and brought him to the hospital and dropped him back again afterwards. I think he come up from Dublin on the train or something like that. 14:53

MR. WOLFE KC: This is Mr. Drake?

A. Mr. Drake. Sorry, yes, my apologies, Mr. Drake, yes. He had afterwards discussed the fact he thought, yes, these are difficult patients, a difficult group of patients, they are hard to manage, they're not straightforward. You know, his actual -- there appeared to have been supportable clinical grounds. He did feel there was enough there to justify doing with him. The documentation wasn't all there that he would 14:53

have liked to have had. I think he wanted different pathological studies, etcetera. But he didn't turn around and say there's a serious issue here, and Dr. Loughran accepted the report.

MR. WOLFE KC: Another issue - again this is in 2011 - that came to your attention as Associate Medical Director was the disposal of medical notes and records, or some medical notes and records, belonging to two patients into a ward bin by Mr. O'Brien? 14:54

A. Yes. 14:54

MR. WOLFE KC: That was the subject of a formal disciplinary investigation that was conducted by Mr. Brown; isn't that correct?

A. Yes.

MR. WOLFE KC: To what extent did you have input in directing that or was it just something you became aware of because of your managerial responsibilities? 14:54

A. I recall being told this has happened. I know one of the patients involved had been in hospital for a long time and so had extremely multiple charts and all extremely thick, and he had "culled" the chart to reduce it down in size, but that was binned. I got informed of it. It is not acceptable. Heather Trouton and I discussed it, and then I think it was following discussion with Heather Trouton, we referred or I referred him to HR. I think that is the way it is. I can't be 100 percent sure but I think that's what happened. 14:55 14:55

MR. WOLFE KC: We know that Mr. O'Brien accepted that

he had put the clinical record or aspects of the clinical record in the bin in respect of the two patients, and ultimately accepted that was inappropriate, albeit I think he in mitigation advanced the argument that the file as it stood was unmanageable.

A. (Indecipherable).

MR. WOLFE KC: Mr. Brown, as I've said, was the responsible supported by HR for carrying out the investigation. I just want to turn to his report briefly. If we go to WIT-90268. This is the conclusion. 14:56

Mr. Brown was Clinical Director. He was based in Daisy Hill. As we'll come on to look at in a short period, you delegated to him, in 2012, responsibility for more directly managing Mr. O'Brien for reasons that we'll examine. Is it fair to say that Mr. Brown was particularly sympathetic to Mr. O'Brien and the way he practised? 14:57

A. He held him in high regard. There's an email where he says -- it was in connection with triage, where he says we should treat him gently because he's very good and I might need him sooner or later; words to that effect. But he held him in high regard clinically, yes. 14:58

MR. WOLFE KC: He was, I suppose, charged with the responsibility of carrying out an independent disciplinary investigation and deciding on sanction if appropriate here. I just want to draw your attention

to what he says in his conclusion. Just scrolling down a little bit. He refers to Mr. O'Brien readily admitting that he inappropriately disposed of the patient information in the confidential waste. "This was an error. Shouldn't have done it; won't do it again. He says: 14:58

"It is important to note that Mr. O'Brien says that he spends more time writing and filing in charts than probably any other consultant". 14:59

This is Mr. Brown's words, I suppose the independent investigator of this disciplinary matter. He says:

"From my own personal experience I can confirm this is the case. Mr. O'Brien has the utmost respect for patients, for their information, and for the storage of records. This was an unusual behaviour which was the result of frustration from dealing with a large unwieldy chart, difficulties retrieving important information from the chart, and from the difficulty finding anywhere suitable to make good quality records." 14:59 14:59

Reading that, does that jar with you to any extent, Mr. Brown carrying out an investigation but turning himself into a witness to vouch for Mr. O'Brien and his dedication to patient files in the course of concluding on a disciplinary issue? 14:59

A. Reflecting now, yes, I agree with you. At that time I didn't pick up on that, no.

MR. WOLFE KC: I know you reflected earlier, I suppose, about the challenges facing managers dealing with colleagues. It's a small world; we depended on each other; the clinical work still had to be done. I suppose - these are my words, not yours - it was probably important not to fall out with each other. Maybe we shouldn't take too much from an isolated example but is this characteristic of the softly-softly approach in the management of clinicians who are breaching the rules? 15:00 15:01

A. I can't say offhand. I mean, the number of cases that consultants or people would be involved in -- consultants involved in disciplinary issues, from my experience from a certain point of view were low. I suppose you can come back and ask me, well, is that because we didn't refer enough. I don't think that was necessarily the situation. What he discarded, to be honest, he probably was right, wasn't going to be of great use unless the person was going to sue the hospital. It was not of great benefit. But it was still -- you know, this patient was in hospital, I think, for 300 -- in total ended up in hospital, I think, for 364 days. It was a really long-stay patient. So, what he had disposed of was probably not going to make any difference anyway from a medical/legal point of view but was wrong from a medical/legal point of view in case that was required 15:01 15:01 15:02

for evidence. Do I think it made any clinical difference to the patient? No.

MR. WOLFE KC: But in terms of medical management --

A. What I'm saying is from the point of view as a clinician and thinking from a clinical point of view, would a patient have come to harm from this? I don't believe the patient would have. From a medical management point of view and from HR's involvement, they felt that was a reasonable approach as well. You know, to take it as an informal warning. 15:02

MR. WOLFE KC: The issue of clinicians reviewing the results of investigations was to arise in the context of a never event involving the retention of a swab in patient cavity following an operation in 2009 where Mr. O'Brien was the lead surgeon. That came to your attention, at least the issue of dealing or failing to deal with the results of radiography. Can you recall for us how the issue arose and came to be on your desk? 15:03

A. The SAI was performed, and one of the things that Diane Corrigan herself picked up later on was there was no mention of the fact why was the result of the scan not looked at or the X-ray when it was abnormal. Through that then, my recollection is that we raised it as a -- my recollection is that Martina -- I think we had approached Aidan, discovered he wasn't doing it. I think then it was Martina contacted me. I contacted Dr. Rankin and wrote to her that there was a significant governance issue. 15:03 15:04

MR. WOLFE KC: Yes. Let's just look at some of the

emails to help you through this. If we turn to TRU-276807. On 25th July 2011, Heather Trouton writes to Martina Corrigan, was the head of service. The other people named there?

A. Yes. Louise Devlin is the head of service for T&O. And Trudy Reid was head of service for general surgery, I think, was she, at that stage. 15:05

MR. WOLFE KC: Copied into it are you, Robin Brown and Samantha Sloane, two clinical directors and the Associate Medical Director. The subject is "Results". Ms. Trouton was saying: 15:05

"I know I have addressed this verbally with you a few months ago, but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them." 15:05

Then we're going to go back the other direction. Do you recall getting that email? You recall the issue? 15:05

A. I do recall the issue of results but I can't recall exactly when -- what -- yes, I do recall the issue of results being discussed.

MR. WOLFE KC: Let's see how it unfolds. If we go up two pages to 276805. Here we find Martina Corrigan... 15:06

A. I don't think there was an attachment on that one.

MR. WOLFE KC: She forwards that message to her three consultants, the message from Heather Trouton. We can

see how Mr. O'Brien responds to that. I suppose the message for him and other consultants is that they should read the results when they are available or as soon as practicable. He writes in response to Mrs. Corrigan and says that he is concerned with this direction for several reasons, and he sets those reasons out.

Just scroll down slightly. He asks those pertinent questions which, I suppose, speak to an inability for time reasons and perhaps other reasons to be able to do what is being asked of him by his head of service and/or to prioritise what should be done. Is his perspective understandable and acceptable? 15:07

A. No. 15:08

MR. WOLFE KC: Why not?

A. From when I went to the hospital when we organised investigations, x-rays and that, when they came back, they were set out for me to check, I would have signed it -- well, I initialled them to show my secretary I had read it, and if there's anything significant, the chart was got or we followed on and did something at that time with it or, you know, on directly. So, to not look at those results, at radiology reports, I didn't consider acceptable. No. 15:08 15:08

MR. WOLFE KC: In your practice, you have commissioned or directed a scan --

A. Or my junior doctor requests it.

MR. WOLFE KC: -- or pathology.

A. Yes. Pathology reports, radiology reports automatically came back.

MR. WOLFE KC: Just so I can follow it through, they come back via your medical secretary; is that right?

A. They came back in those days largely in paper form, at that stage, to the secretaries. 15:09

MR. WOLFE KC: Was she or he expected to do anything other than append them to the patient chart or put them on your desk?

A. No. They didn't append them. In fact, I think they sat on my secretary's desk and then when I would be in the office, I would through them. They weren't with the charts at that point in time. I went through them. If they all looked formal, fine. Anything that was abnormal, the chart was immediately got so I could go through it that way. 15:09

MR. WOLFE KC: So it if was abnormal, you would dictate or write --

A. Organise further investigation.

MR. WOLFE KC: -- follow-up action. 15:10

A. Yes, action was then taken, you know.

MR. WOLFE KC: Was your process of dealing with it when the report comes in in hard copies, as you suggest in those days, your secretary makes sure it is accessible to you, and you would look at it there and then in the course of that working day or in the next working day or whatever? 15:10

A. I would be honest, that week I can't say we looked at them every day but it is at least once a week I would

have gone through them. She would have - I'll be honest - my secretary but some other secretaries as well likewise, if they had spotted anything obvious, they would have highlighted to you in advance. But it wasn't expected to be the secretary's job to highlight issues on it. That rested with the clinician. 15:10

MR. WOLFE KC: TRU-276804. Next page up. Thank you. Just the bottom of the page.

Mr. Mackle, you are picking up on Mr. O'Brien's list of questions which, I suppose, are by way of protest to what he is being asked to do. You say to Dr. Rankin: 15:11

"I have been forwarded this email by Martina". Martina Corrigan. "I think it raises a governance issue as to what happens to the results of tests performed on Aidan's patient. It appears that at present he does not review the results until the patient appears back in the Outpatient's Department." 15:11

Is that suggesting that he reads them when the patient is next in for review?

A. Yes.

MR. WOLFE KC: For the reasons you outlined, you don't find that acceptable? 15:12

A. No.

MR. WOLFE KC: So you are calling it a governance issue. Just go further up, please. Dr. Rankin is writing back just over a week later. "Dear all",

that's Martina Corrigan, yourself and Heather Trouton. She is concerned that this hasn't been sorted out despite, she says, trying to have a conversation with Mr. O'Brien. She is asking Heather Trouton if, when she is meeting the three surgeons, to discuss this issue. The secretaries need to be given a brief, she says, as to what is expected of them and this would need discussed and agreed. Perhaps a protocol for secretaries is needed when there's not currently a system in place, which she says she hopes is not widespread. 15:12 15:13

In terms of your involvement, Mr. Mackle, can you recall how that issue sat then?

A. There was a further email on 2nd September, TRU-250590. 15:13

MR. WOLFE KC: Thank you for that. Can we pull that up, please? TRU-250590.

A. Yes. I have done a lot of reflection and I think that is an email in response to that because both of us were due -- Gillian was going on leave, whatever day that was is, 7th or 8th September, and I was due to go off soon after that. I think that was when she tried initially to meet with John Simpson and Kieran Donaghy regarding it. That is what I believe it is. I don't have a definitive memory of it but I think that's what it was. 15:14 15:14

MR. WOLFE KC: So it was being escalated to Medical Director level?

A. Yes. Then she followed on with the other email because

we couldn't get a meeting -- or there was no meeting.
MR. WOLFE KC: So, in terms of a protocol for explaining or determining how consultants and their secretaries are supposed to work when in receipt of results, did that materialised? 15:15
A. Eventually one did. There was effectively an edict come out from Dr. Rankin that it had to be done. I have not found it, at least I don't recall seeing it, but it was set out that you had to do this. The disadvantage of that I found, to be honest, I hadn't 15:15 reviewed all my blood results, routine things like that. I did from then on to comply with it. I always viewed pathology reports and radiology reports but I can't say I always did the blood results before that. But I did after that. 15:15
MR. WOLFE KC: In terms of Mr. O'Brien's compliance with what you call the edict, was any particular steps taken to ensure that he complied?
A. I don't recall any.
MR. WOLFE KC: We have a particular example of a 15:16 clinician who has protested somewhat vehemently with a range of questions against a background of a patient with a retained swab, radiography had shown a problem there in a report which had not been read; she comes back in through emergency department, quite ill. 15:16 I emphasise that the radiography didn't point out the presence of a swab but pointed out a pathological abnormality there that needed addressed.

Why, against that background, and a protest from Mr. O'Brien, was his practice in that regard not the subject of particular scrutiny?

A. I don't have a straight answer for you on that one. I'm sorry, I don't. With hindsight and looking back now, you think we should have been. It wasn't. I think the decision was that they weren't to be filed in charts because what, I think, had been happening before that, I believe the results actually just had been filed in the chart where they would normally be filed, they weren't being filed -- they weren't to be filed until they had been looked at, so they sat on the front of the chart or stapled to the front until that happened. At that stage results were -- it was only when I initialled the result that my secretary then put it into the chart. And that was meant to -- in a way, the method was meant detected - obviously looking back on it now - obviously not a guaranteed method of ensuring that didn't happen, but that was what was decided on at the time. 15:17

MR. WOLFE KC: We know that two of the 2020 SAIs, Patient 5 - these numbers will be unfamiliar to you - and, from recollection Patient 7, were cases where on the face of it -- this is obviously nine years after this issue has arisen, but nine years later in 2020, patients have not had their results actioned. One was a CT scan, the other was histological. Mr. O'Brien explains he did read them but didn't take any action because of COVID-related issues in the main. We'll 15:18

work through that with him. But are you confident that in terms of the steps that were taken arising out of this Never event and the follow-up emails, that the problem with regards to Mr. O'Brien had been resolved?

A. Looking back now, no. At the time, you know, a process was put in place, they weren't to be filed unless they had been viewed and signed. Yeah, we didn't follow it up. None of us did. 15:19

MR. WOLFE KC: An email was issued in 2017 around this. If we look at TRU-277936. 18th January. Heather Trouton, and you're a close signature, is writing in respect of radiography and pathology results. It is in the context of several SAIs. 15:19

"We are writing to remind all consultants that it is their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results have been missed. 15:20

"Any concerns regarding the process of how these get to your attention should be raised with your secretary in the first instance." 15:20

Scrolling up, please. This is to be sent to all consultant surgeons. That issue arises again in the context of SAI, it is not specific to Mr. O'Brien. 15:20

A. I can't remember the specifics of that. I don't know if Heather would be able to remember them or not. I don't think it was specifically with him. In fact,

I think at that stage in January '16 if it had have been specifically him, it would have featured in our report to Dr. Wright and followed on from that.

MR. WOLFE KC: In terms of the secretarial role in the governance of this, clearly he or she is in a pivotal position, first of all to know that a results report has come in, and he or she will know whether the consultant has picked it up off their desk and read it. Was there any particular responsibility, so far as you understood it, resting with the medical secretary to address shortcomings in this sphere? 15:21 15:21

A. Not actually to say definitively if anything was wrong with the report or not, some things are obvious. Say there was a query carcinoma and the secretary noticed that, then she would automatically flag it. But we were not expecting the secretaries to do that aspect of it. That was not in their remit and would be outside their skill set. More the fact -- largely these were all coming back by paper; now stuff comes back electronically. But the paper version from radiology reports were coming back, blood results, pathology reports were coming back on paper and that was posted to the secretary's office. It was her job to sort them. If they were, say, blood results and pathology and X-ray reports, put those together for each patient. But not to put them -- no, they weren't putting them in the charts at all until somebody had initialled them. I say initialled, signed. It is actually initialled is what we were doing. 15:22 15:22 15:22

MR. WOLFE KC: In terms of the consultant failing to do his job in that respect in accordance with what you described earlier is the edict - read them as soon as possible, and action - is the secretary not to report that in to her line manager if that -- 15:23

A. I couldn't tell you what was arranged in that respect, no. That would be operational.

MR. WOLFE KC: I want to turn -- it is 3.20. If we took a short break now, maybe we could sit just a little later, maybe to 4.30? 15:23

CHAIR: If we sit again then at 3.40?

MR. WOLFE KC: I'm asking maybe for a short break in ease of other people. But 20 to?

CHAIR: 20 to.

15:23

THE INQUIRY BRIEFLY ADJOURNED

CHAIR: So, you think about 4.20?

MR. WOLFE KC: I think so. I think it is inevitable Mr. Mackle will come back to us on Tuesday. I hope 15:39 that doesn't inconvenience him.

CHAIR: I am sure you are very pleased to hear that, Mr. Mackle.

A. I'm delighted. I was hoping he would say that.

MR. WOLFE KC: Could I just ask for comments on a 15:39 discrete email, Mr. Mackle, which we can find at TRU-290590.

A. That's one I commented on --

MR. WOLFE KC: It's that the one you were looking at

earlier?
A. That's the one I commented on earlier. Yes.
MR. WOLFE KC: That's right. You believe, you can't put your finger on it with certainty?
A. Correct, but I can think of no other member of senior staff that there was an issue on at that point in time. It fitted with having written to Gillian Rankin earlier the week before or the week before, and the fact that both of us were going on leave, and then her follow-on. Yes, I believe that is related to that. 15:40
MR. WOLFE KC: Just to be clear, I didn't listen carefully enough to your earlier answer, do you think that meeting took place?
A. No, I don't think -- no, I do not recall that meeting. I think that's one I would have remembered. If Kieran Donaghy and John Simpson were there, I would have remembered that one. I mightn't have remembered exactly what was said and when it was said at it, but I would have remembered that one. 15:40
MR. WOLFE KC: But you're confident that further work was nevertheless done on this issue? 15:41
A. Yes.
MR. WOLFE KC: Through Mrs. Rankin and the protocol. I think did you call it as an edict earlier?
A. An edict, yes. It referred to this. 15:41
MR. WOLFE KC: The other issue, maybe for most of the issue of today, is the issue of triage, which we touched on already in passing on various occasions today. That was an ongoing problem, Mr. Mackle, which

first came to your attention in 1996, I think you have said?

A. Approximately.

MR. WOLFE KC: You deal with it helpfully in a number of places within your Section 21. Let me just pick up on those and sketch them out for the Panel. If we go to WIT-11784. At paragraph 128 at the bottom of the page, you say regarding triage, the first time you became aware of it was approximately 1996. At that time, you were wearing the hat of clinical -- 15:41 15:42

A. Lead clinician for outpatients.

MR. WOLFE KC: Lead clinician for outpatients. In what way did that duty or that responsibility bring you into contact with the triage issue?

A. At that point in time, my recollection is outpatient staff had the responsibility for booking patients, and that Hazel Neale, who was the then outpatient manager, made me aware that -- no, I can't remember whether she made me aware. There was a folder -- I think she did make me aware there was a folder in Aidan's office that had untriaged letters in it, or whether they knew there were letters that hasn't been triaged and ultimately turned out being -- I don't remember which way around that was. She made me aware there was an issue and asked me to speak to him, and I did. 15:42 15:43 15:43

MR. WOLFE KC: I unhelpfully earlier described it as a collision. You recall it as a formal but a sensible conversation?

A. Yes.

MR. WOLFE KC: You raised the issue and he said he would deal with it?

A. Yes.

MR. WOLFE KC: At that time that was all you had to say about it and you moved on, obviously, through different managerial roles. 15:43

The issue, as you explain here, is that intermittently it would be noticed he was behind on his triage and, when challenged, would catch up. So, it was a kind of ebb and flow thing. There would a problem, you would have spoken to him formally and it would be addressed. 15:43

You say Heather Trouton and the directors, Gillian Rankin and Debbie Burns, were aware that he was slow at performing triage but that when he was challenged, he would do it. You then say the medical directors, Paddy Loughran and John Simpson, were informed of the issue. Was that by you? 15:44

A. Yes. 15:44

MR. WOLFE KC: Yes, you did?

A. Yes.

Q. But you admit that you didn't raise it as a serious governance concern and neither did they question it as being one. 15:44

"On reflection, due to the repeated failure to perform timely triage, a thorough investigation should have been undertaken".

A. I admit that, yes.
MR. WOLFE KC: Then if we scroll down over the page, you talk about the introduction of what has been described as a default system. That was introduced, you think, in 2014 by Debbie Burns? 15:44
A. Yes. I believe that to be right.
MR. WOLFE KC: If I could just describe the components of that system and you can tell me if I've got it right. If triage wasn't performed by a clinician, the booking office would take the grading applied by the 15:45
general practitioner. For the sake of argument, let's say the general practitioner has classified it as urgent and then the case would be entered into the booking system or the waiting list on an urgent basis pending the completion of triage, whenever that might 15:45
happen?
A. Yes. At the start you say if triage wasn't completed. I'm not sure when they put it on, whether it was if they didn't get it back quickly or whether they put it on at the start. I think it was they put it on at the 15:46
start but I can't -- I don't know the exact mechanism of that. Basically the effect was the GP decided whether routine, urgent or red flag. Until there was something to say otherwise, they remained on the list as routine, urgent or red flag. 15:46
MR. WOLFE KC: As you go on to say there, the patients would be upgraded if necessary when triage was completed.

You say:

"I wasn't informed if there was ongoing monitoring of compliance, the results of any monitoring or did I request any audits of this practice. On reflection, in light of his past history there should have been continuing audit. It was only at the end of 2015 that I was made aware that there appeared to be an issue."

What is condensed into that last sentence? What do you mean that it was only at the end of 2015 that it appeared to you as an issue? 15:46 15:47

A. There still was a significant backlog of -- there was still a significant backlog of triage.

MR. WOLFE KC: We know, looking at this paragraph, that the introduction of this system didn't resolve the issue. Is there an argument, Mr. Mackle, that it served only to take some of the light off what was a serious issue in that patients were being placed on the waiting list in accordance with the classification of their general practitioner and that's where they stayed unless they were upgraded, and, if triage wasn't done, there was no process, so far as you are aware, of enforcing it, of requiring it to be done, or at least no process that you used for that purpose? 15:47 15:47 15:48

A. I can't say that there was no process but I'm not aware of what process was done to check that at that stage. I don't think there was one but I could be totally wrong on that. I don't know.

MR. WOLFE KC: What we do know is that the letter you served on Mr. O'Brien in March 2016 showed that dating back to December 2014. That's looking back from the perspective in March 2015, dating back to December of the -- sorry, I will get that right. March 2016 the letter was served, and the data within that letter - and we'll look at it presently - showed there were 253 outstanding triage cases going back nearly a year and a half to December '14. 15:48

A. I think that needed -- I'm not sure. I am not the best one to answer this. I think that needed an actual manual trawl to find out that rather than an electronic system just spewing out the number. But I'm not sure. I don't know the exact process on that. 15:49

MR. WOLFE KC: What you are reflecting here in paragraph 129 is that against this background, you say going back to 1996 but probably more sharply focused from you from 2008, here is a senior clinician under your watch who is not doing his triage duties. We know he is not doing his triage duties, or, to put it fairly, not doing all of his triage duties. If it had been audited, we would have known exactly what was going on or more precisely what was going on? 15:49 15:50

A. You mean after 2014? Sorry? I'm not sure when you mean. Sorry. 15:50

MR. WOLFE KC: At any point.

A. Except -- sorry, I wasn't sure if you meant specifically after that time, after the new process had been introduced or not, sorry.

I think particularly on reflection, and it is on reflection, when I look at the fact and you see all this tabulated together, all the times that things have happened, you know, I suppose it is akin to mission creep. You recognise it is gradually continuing, it is not going away. But when you have to change a process really, I think we should have been saying, look, why are we changing the process, we need to do something about the individual. That's with hindsight and reflection. 15:50 15:51

MR. WOLFE KC: If we look just later on in this witness statement, WIT-11805, at paragraph 181, you reflect that:

15:51

"The issue had been identified, was known to be a recurring problem. It was assumed that the extent of the problem was known. However, it became obvious in early 2016 the problem, far from having been managed by the system introduced in 2014, had continued unabated and a significant number of patients had been put at risk". 15:51

You would possibly have heard in 2016 that a failure to triage a patient led to a serious adverse incident? 15:52

A. No.

MR. WOLFE KC: Okay.

A. I was not aware of any of that. That was actually -- the time I knew about basically what had happened that

way clinically was around about the time of knowing the Urology Inquiry was going to happen, or that there was an inquiry happening and I was likely to be called. Then I heard about the SAIs. I was not aware of them at the time. I was not involved in that or made aware of them. 15:52

MR. WOLFE KC: You've reflected in your statement - we just looked at it a moment or two ago - that in speaking to the medical directors on this issue, neither you, and assumedly them, identified this as a patient safety issue. When you think about that now, can you understand your thinking or do you think your thinking -- 15:52

A. Yes. In many ways what you think is -- the number of patients that would be upgraded are small. I did a review myself which was published in the Ulster Medical Journal, I think early 2017, where, with a registrar we had looked - Rob Spence - we had looked at the incidence of a number of patients that we triaged and the percentage was low single figures. Sorry, that we upgraded from triage. Of those, the vast majority were not -- we didn't have full data on what they turned out to be but there was not a huge -- there was not four or five percent of cancers turning up that hadn't been from the upgrades. 15:53

Maybe I look at it from my own practice, from a general surgical practice, a colorectal practice, the upgrades did not produce lots of cancers. But looking back from

knowing what I did in around about - when was it - 2020 when the Inquiry was being talked about and hearing what had happened in the SAIs, then I realised there was patients being put at risk, and we accept we should have been thinking of that. We didn't. 15:54

MR. WOLFE KC: Did you fall into the trap of thinking, based on your own practice, well, failing to triage is really neither here nor there. It's --

A. No -- sorry, I interrupted you. Apologies.

MR. WOLFE KC: You didn't regard it as a whole hill of beans from a safety perspective? 15:54

A. No. We followed triage, we actively did it, we believed in it. The ones we would have upgraded more were not the cancers. Maybe in my own practice it was inflammatory bowel disease. When the service delivery unit, I think, introduced a system of upgrading, we were told originally we were only allowed two grades. We used to have urgent, soon and routine. We were told we had to have two and that would solve all the problems. Well, it didn't. They then introduced a 15:54 15:55 third grade, which was red flag for cancers. It meant for us in GI surgery, the benign conditions like inflammatory bowel disease didn't fit into the red flag and were urgent and weren't being dealt with as quickly. We actually upgraded them to red flag 15:55 although technically they weren't.

We did consider triage worthwhile, very worthwhile, but I can't say it was solely for the cancers. It wasn't

just for that, it was for other conditions. Even some routine ones we upgraded to urgent because we didn't think they should be waiting a long time. People with an anal fissure; it is not a red flag condition. It is not -- in one sense, if a GP puts it down as routine, 15:55
yes, but it is painful so we brought those up as well. Things like that. So I did see a benefit of triage, you know. I'm not saying triage wasn't worth doing, it was.

MR. WOLFE KC: Just looking at some of your specific 15:55
interventions on the issue. If we look at WIT-23742, towards the bottom of the page. This is your first year as Associate Medical Director. Teresa Cunningham is writing to you and Simon Gibson, who was in the Medical Director's office at that time. 15:56

A. No. Simon Gibson at that time who have been the Assistant Director prior to Heather Trouton taking over in October. I think it was October 2008, maybe 2009. Sorry I can't remember exactly when, but he was assistant director at that stage. 15:56

MR. WOLFE KC: What is being described for you here is that she's attaching a spreadsheet showing the numbers of referrals which have not yet been triaged. She is saying:

15:57

"As you both know, this problem has been raised on a number of occasions and for a short while the situation had improved."

That's what you say in your witness statement, it would be raised, you get improvement and then back again. She is saying that:

"He was triaging last week and I appreciate he only returned from a week's leave. Unfortunately, however, as we are working to a six-week target, the current situation is intolerable". 15:57

Just scroll down. She talks about the unfairness of the pressure that is being exerted on her to ensure patients are treated within target dates, and subsequently on the appointment staff. So, it is having a knock-on effect not just on patients but on staff as well. 15:57

You write, just going to the top of the page...

A. Sam Gibson wrote.

MR. WOLFE KC: Sam Gibson wrote.

15:58

I think I wrote to say - I'm sorry, I don't have the reference - you wrote to Michael Young:

"If you don't think urology can cope, I think we have no choice but to ask Philip Rogers". 15:58

A. Philip Rogers was a GPSI, that is a GP with Special Interest. He had a special interest in urology and worked with in urology service. There was a urology

ICTS, Integrated Care and Treatment Service, which was not the same as the orthopaedic one. The orthopaedic ones sat outside TNO. The patient would be referred to the ICTS, the orthopaedic ICTS, and then processed through that. Then somebody would be referred on to the orthopods, others would be referred to physio, etcetera, things like that.

What I said was the orthopaedic ones sat outside the orthopaedic service in that GPS would refer directly to the orthopaedic ICTS. They would then decide on whether they needed some investigations, whether they needed to be seen by consultants or referred to physiotherapy.

15:59

The urology one was different in that it sat within the urology service. So they controlled it, they oversaw it, they did the triage for it. At that stage, Dr. Philip Rogers was working in the service but he wasn't being involved in doing the triage. Personally I did think he should have been doing it but he wasn't. They didn't want him to do that. That is what that entailed; that's what that's about.

MR. WOLFE KC: Your intervention here on that was to suggest that this might inevitably be another way of having to do this if we're to get this right?

A. Yes.

MR. WOLFE KC: I'm anxious as we go through this to see what fixes were tried, because over a period of time

various attempts to fix this, as we'll see, did that come to anything or did you get reassurance that it would be done?

A. I think we got reassurance that it would be done and then ultimately Philip Rogers took off on long-term sick leave and, I believe, was medically discharged -- or retired, sorry. Retired, sorry. 16:00

MR. WOLFE KC: Into the next year, 2009. If we have up on the screen AOB-00131. You are writing to Mr. Gibson and it's in respect of a discussion that he has had with you where he has set out Mr. O'Brien's request to cancel all clinical work until July to allow him to clear the backlog of paperwork. Now, I know that Mr. O'Brien comes in after this and says that's not how it happened, this isn't correct, but that's the narrative presented to you by Mr. Gibson. There's a proposal by Mr. O'Brien that he would cancel his clinical work during his summer month to allow him to clear the backlog. You articulate your concerns about that. 16:01 16:01 16:02

The first one you touch on is that approximately two years earlier, this is 2007 - this was the subject of your correction this morning of your witness statement - but what you're saying is that you think the two years earlier, 2007, the Trust funded a similar initiative to allow Mr. O'Brien to catch up. It was agreed then that this was a one-off and it was his responsibility as per his contract to prevent such a 16:02

backlog developing again.

When you refer to the events of two years earlier, what was your role and your knowledge of the facility that was granted to Mr. O'Brien in 2007 or thereabouts? 16:03

A. I think I was Clinical Director Surgery at the time. He had requested it. I can't remember who the Acute Director was at that stage, whether it was... Sorry, I can't remember who. But it was basically he had requested at the time to catch up with his backlog and 16:03 that was granted for July. I think it was actually a July, if I remember. It was a summer month and I think it was July.

MR. WOLFE KC: That enabled to catch up?

A. Yes. 16:03

MR. WOLFE KC: The story you're being told is that he wants a similar arrangement for 2009?

A. Yes.

MR. WOLFE KC: You go on to say that there are already PAs in his current job plan, which is well in excess of 16:04 other consultants. We have dealt with the job planning issue and how that was removed from him. Paragraph 3:

"To expect the trust to fund such a shortfall in clinical activity would be unreasonable." 16:04

Finally, number 4:

"If as you state Aidan feels there is now a clinical

risk because he has allowed the backlog to develop, then there is a serious governance issue regarding this practice. I am copying this email to him so as to get an urgent response to the risk issues".

16:04

He does respond to you, isn't that correct?

A. Yes.

MR. WOLFE KC: We can see his response at AOB-00133, just a couple of pages along. 12th June 2009. He says that he opened your email several days ago and, 16:05 scrolling down, he says that he is flabbergasted on reading it and shocked beyond words. He says:

"In your email, addressed to Simon (and sent to Joy), you thank Simon for discussing with you Aidan's request 16:05 to cancel all clinical work during July to allow him to clear the backlog of paperwork. I certainly did not make or submit to anyone any request to do so."

He goes on to say: 16:05

"These past three months have been the most stressful and distressing that I (and everyone else caring for urological patients) have had to endure."

16:06

It there talks about the fragmentation of inpatient urological services, etcetera. He departs into that. Then he says he reads your email:

"I do believe that it would be reasonable to request and expect an acknowledgment, in writing, that I did not make or submit the request recorded in your email".

Clearly, Mr. O'Brien unhappy that Mr. Gibson would appear to have misinterpreted his request. Perhaps were you able to get to the bottom of the confusion here? Did you check, for example, with Mr. Gibson to seek to discover what was really going on? 16:06

A. I don't recall specifically but I would have been -- I met with Simon Gibson the same way as I then in later years, subsequent years, met With Heather Trouton. I met him regularly and I would have told him about the email. 16:06

16:07

The last sentence, however, it was "I did not make". I could not say whether he did or did not make or submit the request recorded. Therefore, I didn't see it was for me to apologise for something which I had not said. I quoted Simon Gibson so I wasn't going to apologise on behalf of Simon Gibson, but I believe I let Simon know about the email. 16:07

MR. WOLFE KC: Leaving that, if you like, personal nicety to one side.

A. That's what I mean. That's why I did not reply, if you were going to ask me that part. That's what I'm saying. 16:07

MR. WOLFE KC: The bigger issue is whether or not he is requiring or requesting a month off to catch up.

I assume, correct me if I'm wrong, but triage remained an issue in 2009 and it remained to be addressed?

A. The backlog of paperwork wouldn't necessarily have just have been triage. It may have been discharge letters, things like that. I mean, I can't say. It's the totally of the practice rather than specifically triage. 16:08

MR. WOLFE KC: Later in 2009 the issue of triage is noted at what appears to be, at least in terms of our experience, the Inquiry's experience of looking at urology issues. This one is being addressed by the Chief Executive. I just want to look at that one with you. WIT-16552. So Tuesday, 1st December. You can see the attendees, including yourself. The Medical Director is Patrick Loughran in attendance, and the acting Chief Executive. I suppose, uniquely perhaps, the Chief Executive has convened a meeting to deal with urology issues. We don't see too many events of that nature over the chronology with which the Inquiry is specifically interested. Just looking down the agenda items there, demand in capacity is being discussed. It talks about a service model here; is this the washout from the urology review? 16:08 16:09 16:09

A. Yes.

MR. WOLFE KC: Then there's a range of quality and safety issues which appear to have been discussed with the Chief Executive and Medical Director. The key issues are the evidence base of the current practice of IV antibiotics, which we discussed a moment or two ago 16:10

or an hour or two ago. A certain action is suggested; you can see that. Triage of referrals is on this agenda. It is said that these are undertaken by one of the three consultants within the required time scale. One consultant's triage is three weeks, and he appears to refuse to change to meet the current standard of 72 hours. Is that an allusion to Mr. O'Brien or is it an allusion to the second -- 16:10

A. It is not Mr. Akhtar and I'm assuming it's Mr. O'Brien.

MR. WOLFE KC: Was Mr. Akhtar also tardy with his output? 16:11

A. No.

MR. WOLFE KC: Mr. Young then?

A. No. That's what I'm saying. Knowing Mahmood Akhtar, I know it was not Mahmood Akhtar. I'm assuming it was not Mr. Young. 16:11

MR. WOLFE KC: It says it is undertaken by one of the three consultants within the time scale.

A. I misread that, yes.

MR. WOLFE KC: My reading of that is suggesting that two are not up to scratch. 16:11

A. Yes. Mr. Akhtar would have been the one that was within the time scale.

MR. WOLFE KC: One of the consultants is maybe worse than the others. 16:11

A. Yes.

MR. WOLFE KC: Would it be speculation to say that it was Mr. O'Brien?

A. It is speculation to say which one it is. All I can

tell you is Mr. Akhtar would have been the one within the 72 hours.

MR. WOLFE KC: There's another issue around red flag requirements for cancer patients.

16:11

"One consultant refuses to adopt the standard that all potential cancers require a red flag and are tracked separately. This results in patients with potential cancers not being clinically managed within agreed time scales". 16:12

Do you recall that issue?

A. I can't recall offhand, no.

MR. WOLFE KC: Then:

16:12

"One consultant keeps patient details locked in the desk and refuses to make this available. Current breaches of up to 24 weeks, which may or may not include urgent patients, while nonurgent vasectomies are booked for two weeks after listing". 16:12

Who does in a refer to?

A. I'm assuming once again Mr. O'Brien.

MR. WOLFE KC: Do you have any understanding of the logic of this or what it was about his practice that 16:12 required him or led him to keep patient details locked in his desk?

A. I suppose in one sense he controlled his practice. He controlled when his patients were coming. He would

contact them quite often himself. From a patient point of view, if a consultant phones you up to organise to see -- to tell you when they're bringing you in, it is a brilliant service, but it meant it made it more difficult from the point of booking them chronologically. The chronological bit isn't just for his own practice but across the specialty. If one surgeon has a short waiting list and the other one has a long one, you'd cross between them and they can go either direction depending on the procedure and what slots are available. 16:13 16:13

MR. WOLFE KC: Just scroll down. Yes, other issues are raised. Those action points, 2, 3 and 4, first of all, why are these issues being brought forward in this way to the Chief Executive? 16:13

A. I can't remember specifically why the meeting was held but this was also -- this was still around the time, I believe of the -- it was around the time of the Monday meetings. It was with a view to helping to get resolution and sort that, to get the change we needed to get the funding for Team South. 16:14

MR. WOLFE KC: The action points for 2, 3 and 4 are set out.

"There needs to be a written approach from Dr. Rankin to the consultants to require patient list details to be made available immediately in order that all urgent patients can be booked. If no compliance, further written correspondence to be drafted on issues of lack 16:14

of conformance for triage and red flag requirements, clearly setting out the implications of referral to NCAS if appropriate clinical action not taken".

NCAS, as you probably know, provides advice to Trusts about, for example - and not limited to this - with regard to various types of remediation or remedial action which could, in certain circumstances, lead to MHPS processes. 16:14

16:15

Do you know if further work was done about that by Dr. Rankin?

A. I can't recall, sorry. Knowing Dr. Rankin, I think it's unlikely that she didn't. She was tenacious in what she did. So, I suspect -- I would be highly surprised if she didn't. 16:15

MR. WOLFE KC: We'll look at that with her. But certainly, if we go into the next year as this cycle of not complying with triage obligations continues, let me just pull up TRU-281814. 30th March 2010. You're copied into an email from Mrs. Trouton to Michael and Aidan. Just scroll down. She appreciates it has been extremely busy; however, it has been brought to her attention that there are still 60 patients that urgently need to be triaged. "Can I request that you give this matter your urgent attention". 16:15 16:16

Then at the top of the page, please. Michael Young is perhaps suggesting it is not particularly his problem.

His longest wait or longest outstanding triage is no more than 25th March, Heather Trouton writing to him on 25th March. The implication being it is Mr. O'Brien who is primarily the concern here.

16:17

The next month, you may recall, I think, as you've said in your statement, you threatened to cancel Mr. O'Brien's study leave because he had not caught up sufficiently with his administrative work, including triage.

16:17

A. Specifically triage.

MR. WOLFE KC: If we go to TRU-259492. Just before we look at that, your intervention in April 2010 threatening to stop his study leave; he'd planned to travel to a conference, isn't that right?

16:18

A. Yes.

MR. WOLFE KC: Ultimately those of us old enough to remember what we call the ash cloud which prevented travel on that particular day. You allude to that in your witness statement, I think.

16:18

A. That's how I was working out when it happened. I remember it was the day before air travel was cancelled that Gillian Rankin said to me that I should inform him she would cancel his study leave if it hasn't been done. The next point, it had been done but travel was not possible because of the ash cloud. That's how I remember the approximate date of it.

16:18

MR. WOLFE KC: What interference do you draw from that view with one of your operational managers

contemplating a sanction: Do it or you can't travel, and it's done?

A. I suppose you could say that he listened to -- when there were sanctions going to be held, that he then would comply, yes. 16:19

MR. WOLFE KC: Well, that's actually the answer I expected --

A. I don't fully follow what you are asking, sorry.

MR. WOLFE KC: If there is a logic to that, does it follow that those who are paid to manage Mr. O'Brien 16:19 may have thought, well, that worked, we need to adopt a more robust approach to this in order to finally fix a problem that's been with us for many, many years? But that doesn't appear to happen.

A. No. 16:20

MR. WOLFE KC: Again, it is possible to explain the lack of robust response?

A. Not now, not looking back. No, it isn't. As I said at the start, you know, it's the way we judged him and the way he was considered and held by everybody in the 16:20 hospital. I think at that stage Gillian Rankin was exasperated. She said right, it will be cancelled. We had gone through the Monday meetings so I think she decided, right, if we're not getting anywhere, tell him it's going to be cancelled, and it was done. I think 16:20 that was out of exasperation at that time rather than a formal plan to try a stick rather than a carrot.

MR. WOLFE KC: What we can see in this email, just very briefly, four or five months later it's again an

occasion for Mrs. Corrigan, September 2010, to highlight, once again to Dr. Rankin, the failure to triage once again.

Finally in this sequence, if we can go to TRU-281926. In March 2011, according to this document, there was a total of 120 letters for triage from Mr. O'Brien's office, the longest dating back two months earlier to the start of February. A mixture of GP and other consultant referral letters. Scrolling down, the fix around that was Mr. Young and Mr. Akhtar taking up the work that Mr. O'Brien was otherwise responsible for; is that a correct interpretation? 16:21 16:22

A. Yes.

MR. WOLFE KC: Did you meet with Mr. O'Brien around that time? 16:22

A. Yeah. Around about 7th April, a meeting was held, Gillian Rankin, myself, Heather Trouton with Mr. O'Brien to discuss it. But I have no minutes of that.

MR. WOLFE KC: Go down to, is it the page before? Mrs. Corrigan is writing to you and Dr. Rankin. What we have just looked at in that document setting out, I suppose, the statistical analysis of what was outstanding and how it was being dealt with, that highlights that that paper had been prepared as a briefing paper in advance of the meeting that was to take place on 7th April. 16:23 16:23

A. That's why I said there was a meeting on the 7th because I assume it did happen, having seen that.

MR. WOLFE KC: Yes. It's my analysis from the papers that in terms of your involvement in trying to manage the triage issue, if that meeting happened, it was, I suppose, the last significant input that you had on that issue before 2012 when you understood that you were the subject of a complaint from Mr. O'Brien that you had subjected him to bullying and harassment?

A. Sometime in 2012. Yes.

MR. WOLFE KC: We'll look at that issue in some detail on the next occasion. 16:24

In terms of your management style across these issues, and we've looked at how you had to engage with Mr. O'Brien around the reform agenda following the review of urology services; we've looked at the job plan; we've looked at the IV fluids issue; triage; we've looked at your input on the reporting of results issue, would Mr. O'Brien have regarded you, so far as you understand it, as his manager? 16:25

A. Do I think Mr. O'Brien would have considered that if I said something should be done, it should be done? No. I think in particular the Monday evening meetings, he resented a lot of what was happening there. He resented that I was supporting the position being channeled by Dr. Rankin towards reform and change. He did not appreciate that. 16:25 16:26

So, therefore, would I -- I mean, it depends what you consider a manager does. If it's something a manager

comes along and says to a person 'I would like you to do this', would I expect him automatically to do it? No.

MR. WOLFE KC: Is that the position you were coming from, that you expected him to comply across any of these issues? 16:26

A. Well, within reason, yes. Consultants largely practised as independent practitioners. As a consultant, you had a lot of autonomy. That style of medicine is changing; for the better, I think. I think there's a lot more team working, a lot more involvement with the multi-disciplinary teams, etcetera. That is changing in that respect. You know, Aidan was still more from the era of you looked after your own patients, you did your own thing, you managed yourself, and I was seen as a catalyst towards change, which he didn't appreciate. And I think that was -- I would say whilst he was not overtly rude to me. That was not his style; he is a charming person and very pleasant. My negative things against him; still at the same time he was extremely polite and pleasant. Maybe you'd say he was thran or whatever, you know. 16:26 16:27 16:27

MR. WOLFE KC: Outwardly at least you didn't detect a breakdown in your relationship with him?

A. Let's say I knew he did not appreciate management, but not directly to me. He would never voice or shout at you or things like that, that was not his style, but you knew he just didn't appreciate it. It's hard to put an exact figure on it. But the relationship 16:27

I had -- Michael Young's relationship with him was different. Michael didn't appreciate it but Michael and I got on quite well, and we could see -- whereas Aidan, I could see that there was probably more of a distance between us. Whilst superficially he would be very pleasant and polite to you, I don't think I would have -- I knew I would not have been a bosom buddy. 16:28

MR. WOLFE KC: Okay. We'll take up on the next occasion how this may have manifested itself or not. There are some issues around the allegation of bullying and harassment that we need to explore with you. We'll take that up on Tuesday. 16:28

CHAIR: 10 o'clock on Tuesday, everyone.

16:28

THE INQUIRY ADJOURNED TO 10.00 A.M. ON TUESDAY 31ST JANUARY 2023