Urology Services Inquiry

Oral Hearing

Day 74 – Tuesday, 5th December 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

INDEX

THE INQUIRY RESUMED, AS FOLLOWS, ON TUESDAY 5TH DECEMBER 2023

CHAIR: Good morning, everyone.

MR. WOLFE KC: Good morning, Mr. Young. You are very welcome back to the Inquiry and thanks for coming back. 10:17

You'll recall, just by way of recap, Chair, that Mr. Young came to give evidence on the 8th November. The transcript in association with that evidence commences at TRA-08975 and continues through to 09090. When he was last with us, and you'll recall, Mr. Young, we covered a number of issues in your evidence to enable us to better understand the environment in which you worked, the challenges you faced and the role that you performed. We took you through or you helped us to understand how Urology Services in what is now the Southern Trust has grown up and developed over the years, the challenges which those services have faced and still face in meeting the demand for urology care against the backdrop of scarce resources in terms of staffing and facilities. 10:18 10:18 10:18

You introduced us to some of the positive initiatives which have been overseen in Urology Services and which have led to beneficial outcomes for the population that you serve. We discussed some of the tools of governance, notably the Patient Safety meeting, and aspects of audit and we looked at management 10:19

arrangements and your part in them and the approach that you took and your understanding of the role of clinical lead.

Just on the clinical lead point, we spent a little bit of time in the afternoon of the last occasion. Whereas your Section 21 statement tended to emphasise a predominant service aspect associated with that role, I think it's fair to say that when I questioned you about that, you allowed for more of a management involvement in terms of the management of people as being part of that role, perhaps encapsulated by the phrase that you were the "captain" of the team. You'll recall that? 10:19 10:20

A. Yes. 10:20

1 Q. And as part of that you explained to me that in terms of dealing with staff who were maybe not performing or behaving as they should, you did have an involvement with that, particularly with more junior staff, but when it came to your peers, you found that difficult and you considered it to be an unfair ask. Do you remember saying that? 10:20

A. I do.

2 Q. Just I used these words and you agreed with them. I said to you: 10:21

"When it comes to direct responsibility for what consultants are doing in their day-to-day practice, I will speak to them, I will offer advice, I will

convey messages from wider management, but it is not my direct responsibility to manage them."

And you agreed with that as an apt description of your role? 10:21

A. I did, yes.

3 Q. So this morning we're going to start by looking at that distinction. We're going to look at some of your input into dealing with a number of members of staff mentioned in your statement as performing in a way that 10:21 was causing difficulty. Then we're going to look at a number of the clinical approaches or clinical aspects to a urologist's post and your post and that of your peers, and we'll look at that through a number of lenses and I'll explain more about that by way of 10:22 a signpost in just a minute.

If we could start with your witness statement. If we could have up on the screen, please, WIT-51800. Here you introduce us, just at the bottom of the page, to 10:22 the names of four doctors who you explain had a responsibility or perhaps an opportunity to address, in terms of difficulties with their practice, in addition, as you say, to Mr. O'Brien. We'll go on to look at Mr. O'Brien and the difficulties that he was 10:23 presenting as we go on this morning. But if we can start with, if we scroll down a little, and the first doctor you have referred to, we've named him publicly when dealing with Mr. Simpson's evidence, it was

Dr. Aminu. Although it is blanked out on the screen in front of you, it is important we know what we're talking about.

You explain in your witness statement here that you had to produce a competency report for the Clinical Director in respect of that doctor. 10:23

Could I introduce what Mr. Simpson, Dr. Simpson, who was Medical Director at that time, said about that incident or that involvement. If I could take you, please, to Dr. Simpson's statement at WIT-25696. Just at the bottom of the page he refers to being copied into an e-mail. We needn't bring this up in respect of this doctor, Dr. Aminu. Over the page, please. 10:24 10:24

The long and short of it from his perspective, as he explains here, is that there was a query from the General Medical Council in respect of this doctor. The Director of Acute, Dr. Gillian Rankin, had received an Inquiry from the GMC in February 2012 and she had brought that to his attention and the letter was then copied to him. 10:25

Just scrolling down. 10:25

The point that he is making is that Mr. Brown discovered that a senior nurse, Shirley Tedford had raised concerns about the competency of this doctor to

you in your role as lead clinician, but this had not been escalated to either of us, that is to the Medical Director or to Mr. Brown, who was Clinical Director, or indeed to the AMD for Medical Education and Training, Mr. Colin Weir. He says: 10:26

"Although this was a matter of concern, the swift and appropriate response by Mr. O'Brien compensated".

So that is his statement on the point. Just to pull out of that what his concern was. If we turn to a couple of e-mails that he sent around that time, TRU-250599. 10:26

Here he is writing to the Director of Nursing, Francis Rice, in March 2012, just in the middle of this issue. He explains: 10:27

"This was kicked off by a letter I see got from GMC to inform me this doctor is under investigation. Our urology consultants thought he was just about okay, it seems the nurses have a totally different view. My guess is that there is something amiss in urology regarding multi-disciplinary working, never mind professional governance." 10:27 10:27

Then, if we just go to AOB- -- sorry, it is just over the page. Yes. So he is writing to various people. It is just the last piece I want to pick up on, Gillian

and Francis:

"It is a matter for concern that a senior nurse would have significant concerns about the performance of a doctor that don't seem to have been followed through. I think there must be some learning here regarding Clinical Governance."

Now, you wouldn't have, presumably, seen those e-mails in real-time. But his point, as he explains in his evidence, when he came here was that there appeared to be a blockage and it was a blockage not confined to urology in terms of bringing up for the attention of more senior management concerns about the performance of doctors. Here the concern was alive to the nurses, made known to you, but the concern stopped there, it didn't go up to where it needed to be in order to be dealt with. Is that a fair criticism?

A. No, I don't think so. We work as a team on the ward. If you're talking about the interaction between our nursing staff and us on the floor, we do work very much as a team. There's no impediment for the nurse not being able to speak to us as seniors. I would generally, when I'm doing a ward round or going up to the ward, I speak to the sister asking is there any problems going on. So there's very much an open arena that even a staff nurse can speak to the consultant without feeling aggrieved or hard done by or, you know, it's not the environment to speak. That's not the

picture that we have on the urology ward. So there's an open court that way.

4 Q. So how did this problem, which the nurses were drawing to your attention, a concern about this doctor's competency, not percolate up to where Dr. Simpson thought it should arrive at? 10:31

A. Okay. The next step up then would be from our intervention to take it higher to Colin Weir, who was the educational lead, I understand that, or to our Clinical Director, I think that was Robin Brown at the time. So those are our initial steps. Also, we would have discussed this with Martina Corrigan, for instance, as a lead, she would be involved in the process as well. For us to then speak directly to the Medical Director was not really the pathway that we would have taken initially. We take it from an escalation point of view that that is what happens, but I don't think we would skip all the intervening people. 10:31 10:31

5 Q. I suppose what he was pointing to and I suppose what we are aware of broadening this out, this is 2012, broadening this out and taking into account how, as we'll see this morning, concerns in association with Mr. O'Brien were dealt with. Do you see a similar problem there in terms of a blockage? It may not all rest with you, don't get me wrong, there's obviously steps above you, but issues don't seem to get to the top, to the Medical Director's office. 10:32 10:32

A. Right, okay. I accept -- I see where you're coming from there.

Yes, there does appear to be a block in getting information to the top table. I'm not sure where that complete sort of blockage is. It may be a series of blockages.

Q. We'll bear that thought in mind as we proceed this morning. 10:33

I suppose, moving to some of the other cases you mentioned in your statement, I was struck on the last occasion by, I suppose, the distinction which you were drawing about, I suppose, the levels of comfort or ease with which you might deal with doctors less senior than your peers. There's an example given of Dr. Fernando set out in your witness statement, if we go to WIT-51801. You explain at 57.4 if I can summarise, that this was a locum specialty doctor. There was a concern expressed about his temperament. It seemed to come to a head somewhat when he was expected to attend and work at a clinic in the afternoon of a particular day. That was, I suppose, a late arrangement. Something had happened to make it an arrangement that maybe came to him as something of a surprise, but he failed to show up. You arranged to speak with him and when you arrived, I suppose, you found him sitting in your seat and he behaved, I suppose, rather impertinently on your description, in your statement set out here. You dealt with that by, I suppose, ending his contract. Is that fair? 10:33 10:34 10:34 10:35

A. That's fair. I found his behaviour -- I found him

a competent doctor. He knew a lot of the subject of urology. His interaction with patients, I was told, was good, having observed it myself and also via the nursing staff. But I found that he could be a bit of a hothead, if you want to put it that way. And the actual incident arose from in the Thorndale Unit there was two rooms, one needed decontamination and therefore the clinic was swapped to the other room. It seemed a very simple thing to do. But he didn't accept this, for some reason. The nurse, the senior nurse, phoned me saying, 'I think there's going to be a problem here.' She was thinking he's not going to turn up for the afternoon clinics so I said 'well, I'll ring him at ten past two, and see how you are getting on.' He hadn't arrived. I rang him on his phone finding he was already at home, so there's a big flag being raised. 10:36 10:36 10:37

7 Q. I'm not so much, to be frank with you, interested I suppose in the fine detail, although I don't wish to be unfair with you. I suppose what I'm interested in primarily is are you exercising these responsibilities of management of this doctor behaving badly wearing your clinical lead hat? 10:37

A. As part of the team, I am doing that, yes. Just to finish this bit, when I rang this doctor, the HR person, Malcolm Clegg, was in the room with me when I phoned him; we were talking about something else. So we did discuss what the best way to play this was and instead of having a reaction, I thought a face-to-face meeting with him was the right idea, which Mr. Clegg 10:38

agreed with so there was a joint decision there. Then, when the event happened, I phoned Martina Corrigan about it saying, 'look, here's what's happened, here's what I've done'. So there was a joined up writing on the event. But, yes, I was making a decision for us as a group. 10:38

8 Q. I appreciate that. What I'm anxious to understand then is here is, I suppose, a junior doctor behaving in a manner which is not what is expected. He is failing to comply with the standard. You approach that, you manage it, and you deal with it, and we see the outcome in this case. If you are working alongside a peer, a consultant who is not complying with any particular standard, why do you not approach the consultant in the same way? Or perhaps you do. Help us with that. 10:39 10:40

A. Well, that's a different interaction. You're dealing with a locum doctor from an agency here, a junior. You are obviously trying to sort of train them and teach them as they go along, and there's a way of doing it. When you're dealing with your peer, it's a different conversation, you are talking to an equal, if you want to put it that way, and trying to put across your points and see if they engage. But it's a different conversation. 10:40

9 Q. Okay, but what you're telling us is that it's a different conversation but you do have those conversations with peers from time to time? 10:40

A. Yes.

10 Q. Okay. Maybe we'll look now at an example of that.

Mr. Suresh, you explain -- of we just scroll down. The concern with Mr. Suresh is explained in your witness statement as being a problem that arose in terms of his competence in association with the performance of open urological procedures unsupervised, perhaps when on call and the worries around that. Is that a fair summary of it?

A. That's a fair summary. Maybe to go into it in slightly more detail, a standard operation on the kidney, which is tucked at the back of the tummy, is -- you have to be well trained to do renal surgery. And in the elective situation that can be a challenge on its own, but in the emergency situation of an organ that is well supplied by blood vessels and it's bleeding, it's a challenge. If you were a urology registrar at your exams and asked how you deal with renal trauma, the first thing you do is to find a friend and ring a buddy. It's not for the faint hearted. So that's to put this into a wee bit of context.

The other thing about renal trauma, it's not necessarily that common, so your exposure to it is going to be on a limited basis. I think that's a fair assessment.

Now, there is an element of saying that you're not experienced in this field or could be better and, as time goes by, you do lose your -- if you haven't been exposed to it enough, your actual competency in that

arena becomes less. So that's to put this particular case into context and this came to light over a case of renal trauma that had to be dealt with.

11 Q. Yes. And the way of dealing with it was that you with the Clinical Director and I think with Mr. Mackle's oversight brought the body of consultants in the team together and you worked up a solution. Maybe I can assist you by bringing up on the screen the record of a meeting, WIT-53310. 10:44

10:44

"A meeting to discuss the issue took place on 17th December at 2015 at the AMD's office."

You're obviously in attendance. Mr. Mackle in the chair, Messrs. O'Brien, Glackin, Haynes and Mrs. Corrigan in attendance. If we just scroll down here we can see what was discussed. Scrolling down further. I think just at the -- so the proposition here was that there would be a body of support built around Mr. Suresh involving some supervision, consideration of training needs, and ability to contact a colleague when on call if such a situation arose, that kind of thing? 10:44 10:45

A. This was a package that we felt was appropriate and agreed. Mr. Suresh felt that this was good for him as well. We did this as a body and went up the line, as you've seen it went to Mr. Mackle. 10:46

There was conversations before this particular date. This is a formal meeting that we're having here but we had already tried to put in place these activities. Probably the first thing that we wanted to put in place was from a patient safety point of view was there was associated cover of the unit, that if this happened again, there was somebody to ring. So that was the first thing we put into action. But as far as the persons concerned, there was a package here of feeling that there was support, there was education being planned and for it to be kept an eye on and followed through. 10:46 10:47

12 Q. Yes. We can see that there was another meeting to discuss this issue or developments in it around April 2016. I don't think you were in attendance at that meeting but you were obviously keeping abreast of the situation and receiving information in terms of whether there were improvements visited on the issue in terms of Mr. Suresh's progress. 10:47

10:47

You wrote to the Medical Director. If we could pull up WIT-55345. You wrote to the Medical Director in June 2016. You were highlighting the background to the issue and, just to get to the end of the letter, I think what you were communicating was broad confidence that things had improved significantly. Mr. Suresh was fully engaged with the process... 10:48

"...recognising the areas that require attention and he

has recognised the patients under his wing of on call are his responsibility, yet other consultants are available for consultation and he has availed of this facility."

10:48

Over the page you explain that the matter will be kept under review. Again, you are becoming involved and you became involved in that issue as clinical lead. It is one of the aspects of your responsibilities as clinical lead that you would get involved with? 10:49

A. Yes, and as a consultant, yes.

13 Q. But you're taking the lead on it, you're writing the letter to the Medical Director's office, it is not any other consultant that's doing it, you're doing it wearing your clinical lead hat? 10:49

A. I am.

14 Q. And, Mr. O'Brien, he in his statement draws a contrast between how Mr. Suresh was approached and treated with his particular problem or issue and he says, if you can maybe just bring it up on the screen, WIT-82544, 10:50 paragraph 405. He describes concisely how he was available to support Mr. Suresh without receiving any remuneration for doing so. And he says:

"I've since had reason to contrast the support offered 10:50 to him in 2016 to that offered by the same persons to me in 2016."

I suppose we can unpack that with him but 2016, he

received, I suppose, something of an ultimatum in terms of a letter to get his practice back in order, produce a plan, and he's saying here, well, I didn't get the arms round the shoulder support that Mr. Suresh received.

Obviously different issues, different practice issues. Is there a point in that, a good, valid point in what Mr. O'Brien is saying or do you think, by contrast, that he was offered support with the issues he was facing?

A. You're commenting on the word "ultimatum" there in 2016. I wasn't party to that --

Q. Of course?

A. -- but there's an element of help, I think this is what you're asking. I think Mr. Suresh's help was of a slightly -- it was of a different type and nature, and Mr. O'Brien was looking for -- he was looking for something else. So I can't comment on the help required from March, of this letter that we're talking about in March '16. But, you know, was Mr. O'Brien offered help for some other aspect of his practice, the answer to that is yes, it will be of a different nature.

Q. We'll come to that later this morning, a little later, about your input by way of assistance around the triage issue and taking on the aspects of that, but -- sorry, go on.

A. But there was more help. I mean it dates back before

my triage help. I mean, part of this issue is to do with outpatients, for instance. Going back to the 2009 urology review, as you know there was some sort of tensions that we did have with the Trust trying to work out what was going to be happening for the Southern Trust, one of which was outpatients and it was the design of the outpatients. We were concerned that the review had taken the premise of the BAUS 2000 document, which set out how many patients that you were meant to see at a clinic. Whereas, you know, we had already set up an ICAP service so the consultants were seeing more of the complex cases that were taking longer to discuss and, therefore, we couldn't see as many patients as were expected. But part of the setting up of the clinic design was that there was time at the end of the clinic for admin and we were keen that it was, you know, a clinic was the start and finish that you managed to get -- so there were discussions set up beforehand to actually put that into action. 10:54 10:54 10:55 10:55

We can fast forward to -- we did clinics in the Southwest Acute Hospital. It takes a fair bit of driving time to get there, as far as I'm concerned. For the day that I went it was 150 miles round journey. So we accommodated that we had part of the travel time within the clinic and part of the travel time in our own time, if you want to put it that way. And the clinic was set at a certain volume. That was a Monday. 10:55

Now, on a Tuesday morning it is usually day surgery unit work in Craigavon which was either between Mr. O'Brien or myself. So we set it -- at that point, we did our scheduling programme once a month that, specifically for Mr. O'Brien, that if he was at the Southwest on the Monday, he didn't do the Tuesday morning day surgery list because that's when he wanted to catch up with the clinic on the day before.

17 Q. Do you mean catch up on administration?

A. Well, administration of the clinic associated with the clinic the day before. Now, I mean, I was able to complete by administration and dictation at the clinic or when I went home at night. Mr. O'Brien was a bit slower, maybe took a little bit longer, but we accommodated that by time out on the Tuesday morning to do that admin. So that's maybe a slightly different type of support, it's more sort of targeted. Again, it is a bit like Mr. Suresh, it was an educational programme he needed to go on to get taught. As far as Mr. O'Brien is concerned, he does not need to be taught surgery. Mr. O'Brien is a very competent surgeon, there's no doubt about that, so that's not what he needed. But he needed support from the admin and that admin was in time. That is just an example.

10:56 10:57 10:57 10:58 10:58

18 Q. Just to summarise from what we have so far looked at this morning, in terms of your role as clinical lead, you did have a responsibility to intervene and show some element of managerial output when it came to dealing with doctors who were in difficulty, for

whatever reason? In the one case, clearly poor behaviour on your account. In another case it was an issue of experience, in Mr. Suresh's case an issue of experience around a particular competency. But you recognise in those examples an obvious role for you, as the captain of the team, to take appropriate action or to ensure that appropriate action was taken? 10:59

A. Yes, but still as part of the team, yes.

19 Q. You have touched on administration. We have touched on triage. I want to go now and look at some of those specific clinical aspects of urology practice. We'll look at them through a number of lenses or for a number of reasons. We need to understand why the clinical aspect or the clinical task is important. We need to understand how you and others would have performed that task, and there will be an opportunity for you to identify or highlight any difficulties in performing the task. And we particularly, with reference to Mr. O'Brien, but others if there were others who were not performing the task adequately, we want to hear from you about that, your knowledge of that, and whether the issue was effectively or appropriately managed or challenged and maybe with some hindsight you will be able to offer some insight into what might have been done better, if you think that was the case. 10:59 11:00 11:00 11:01

Clearly, within your statement, your first statement, you reflect that over the years of your career the volume of administrative work has increased

exponentially, you say without a corresponding increase in time allocated to address it. You give some examples, no doubt by way of example rather than comprehensively, of the type of administrative work that you had to undertake: Triage of referral letters, correspondence with GPs, discharge letters, results sign-off, attendance at and preparation for audit, to name no doubt but a few. Administration work was a challenging feature of your role, is that the point that you are wishing to get across? 11:01 11:02

A. Yes, it seems to -- it doesn't get detracted, it always seems to get more in volume and in content and in time to have it done.

20 Q. And triage specifically, it's obviously a clinical task with an administrative element to it. Let's try and put triage, as you have helpfully done in your statement, into some kind of historical perspective. If we pull up your statement at WIT-51716, you say at 13.1, just at the top, to pick up on a few points here. You are saying that triage was, well, it's evolved over your tenure. It was initially done as part of general administration, and you explain that your understanding was that until the introduction of the IEAP, the Integrated, Elective, I forget what the A stands for, Protocol, there was no specific time limit associated with it. 11:02 11:03 11:03

You go on at 13.2 to explain that there was a degree of impingement of triage on your other clinical duties and

it was rather -- I think you make the point it was sometimes a bit of a juggling exercise knowing what to prioritise so that if you're in theatre all day, for example, it was impossible to reach the triage.

A. Yes. They were keen to have the red flags done within 24 -- the regular flag referrals done within 24 hours. So if you were either at an outreach clinic and went back to pick up the data or all day theatre, long cases, you weren't going to be doing that in between cases. So there was reasons for the trouble with the exact timelines. 11:04 11:04

We generally had a week on call. The routine and urgent cases to be seen in outpatients were weeks and months ahead. To have that letter precisely triaged within 72 hours didn't seem an exact priority. The red flags were slightly different in that those patients obviously were given priority. So the Trust were keen to have them back as soon as possible but within a 24-hour period did seem a little bit tight, when you are trying to do all of the rest. In fact, this was one of the reasons why we moved to the urologist of the week. 11:05 11:05

21 Q. I want to try to put some loose chronological framework around this and we will move to urologist of the week presently and the challenges associated with that move and the opportunities that it may have delivered. But, just in terms of the importance of triage, you made the point that with a significant backlog in terms of 11:06

urgent and routine patients, it didn't always seem terribly important to get those back, those referrals back as quickly, maybe, as the authorities might have liked. But, nevertheless, in terms of the importance of triage, it's significance or its importance didn't change over time, did it? The reason why you were doing triage remained the same?

A. Exactly. All letters, indeed, need to be triaged on a reasonable period of time. Coming back to before the urologist of the week, I believe that we had our on call week and there was an arrangement with The Trust that the week that you were on call, by the end of the week you had the letters triaged, red flags, urgent, and routine, in that order. But the principle has always been that all letters -- all letters -- are triaged.

11:07

11:07

11:08

22 Q. Just spell it out for the record why that is important. There's obviously an importance in terms of directing the next steps for the patient, but there's a significance in the performance of triage, is there not, for the purposes of interrogating the classification which the referrer has placed on the patient?

11:08

A. Absolutely. On a personal note, I do look at what the GP has categorised the patient as but, you know, I read the content of the letter and put my angle on it. Okay, I have more experience than the GP, but the information and the significance of what is being written down, maybe the GP has written the information

11:08

down but hasn't actually twigged to the significance of the content and to try to get the joined up writing on the whole thing. So, yes, it is very important. And we have, in our unit there has been discussion about offloading triage to other people, but we have always 11:09
felt that the consultant is the best person to triage a letter. And in fact, probably the most important letters to read are the routines, and then the urgents and then the red flags because the red flag letters are always going to be red flag. It's very rare that we're 11:10
going to change that. So, actually, the red flag letters should actually just go through on the red flag system, to be honest. But it is reading between the lines of the content of the letter in the routine and the urgent. That's where I felt that the consultant 11:10
comes into the role.

23 Q. We'll come later to ask for your views, if you can offer any views on why Mr. O'Brien might have left so many urgent and routines untriaged. But, from your own perspective, would you ever feel comfortable leaving 11:10
a large quantity of such referrals untriaged?

A. Absolutely not. I wouldn't agree with leaving any -- I would get upset if there was 20 letters in my drawer. In fact, if you go slightly further into that, I have remembered occasions that the booking office would have 11:11
contacted my secretary saying we haven't received the letter back on X, Y and Z person, and all my referrals were put into a special A4 box, so that's where all my communication was. And so if Patient X, Y and Z's

letter wasn't in that, it has been lost, and I asked them to reprint the letter and I would triage that. So that's to the level I do triage, the word is "all".

24 Q. Yes and I think you have agreed with me that this patient safety issue, which is at the heart of why you clinicians perform triage and, if I'm interpreting you accurately, it's why you are so punctilious in performing it, ensuring that it's done. Do you understand that across your team of colleagues over the years, that this appreciation of this patient safety principle was well understood? 11:12 11:12

A. It should have been. I mean, I think we all do sort of realise that there is information in a GP's letter that has to be assessed. I do believe that we all knew that. But maybe coming back to the original comments of administration, it is the volume of it is the challenge. 11:13

25 Q. We can see that from 2008 some witnesses, such as Mr. Mackle, have pointed to earlier concerns about triage. But, certainly, if I can draw your attention to an e-mail or series of e-mails in 2008, you are being pulled into the issue of Mr. O'Brien's delay in dealing with triage as far back as then. I just want to put that up on the screen and we can take that as our starting point: WIT-23742. Just at the bottom of the page Teresa Cunningham is writing to Eamon Mackle and Simon Gibson. She's explaining that, as regards referrals, I am just trying to pick up on an appropriate line there. Essentially they are working 11:13 11:14

to a six week target and Mr. O'Brien's delays in relation to triage is causing that target to become unmanageable and she is asking for assistance to resolve the problem.

11:15

Just going up the page, Simon Gibson is writing to you, copying you into that, presumably, again, wearing your clinical lead hat.

"What solutions could you propose to this continuing problem."

11:15

And there's a bit of back and forward. Mr. Mackle to you suggesting that:

11:16

"If you don't think urology can cope I think we have no choice but to ask Philip Rodgers ..."

Was he a general practitioner with a specialist interest in urology?

11:16

A. He was our GP with specialist interest. He worked certain sessions of the week.

26 Q. Just scrolling up, you are explaining:

"Mr. O'Brien is on leave. I have triaged all the letters in my box. If mine are outstanding, someone else has them. I do note that my triage box letters have not been taken from last week's session to triage, therefore several factors involved. Will speak in

11:16

person."

So I think you are scouting around there for an explanation as to what has gone on. It is one moment in time, one episode in time. But is it fair for me, do you think it's fair for me to pick that as I suppose a starting point by way of illustration that this triage issue remained unresolved, as we'll see various communications over the years, but it has a long history? 11:17

A. It has a long history.

27 Q. One can see as well, and I ask for your comments on this, that the Trust's response to the problem of delay on getting referrals back, ultimately it becomes more than delay but there seems to be a number of responses. 11:18 Mr. Mackle has described circumstances in which Mr. O'Brien was given some time off, a month off to catch up on his administration work. There also seems to have been an element of a stick approach, you reflect in your statement an awareness of the fact that 11:18 Mr. O'Brien was told he couldn't travel to a BAUS conference in Barcelona if he didn't bring himself up to date. A third element of the response would appear to have been for colleagues to volunteer or for the Trust to ask colleagues to intervene and assist. Then 11:19 the fourth element may reflect a degree of giving up on Mr. O'Brien by the introduction of the default system some time in 2014 and formalised in 2015.

I just want to ask you about elements of those four approaches.

In terms of assistance from The Trust, as I say, Mr. Mackle said in his evidence that in or about 2007 or so Mr. O'Brien was given a month off -- or, sorry, clinical work, I should be precise, clinical work was cancelled for a month to enable him to catch up. Do you have any memories of that or other initiatives from The Trust to assist him with his triage? 11:19 11:20

A. There was this period of time, I couldn't tell if it was 2007, but I'm aware that there was time put aside for him to catch up. It was put across as extra admin time. I don't know if that was specifically to do with trying to clear triage, but it was the general principle of being behind on admin and this was time allocated. 11:20

I'm not aware of anything else that the Trust had put in place to help him beyond time, but that's what was needed was obviously time for him to actually do that work. Do you have extra admin time from a secretarial point of view or an audio typist? I don't know if there's any dictation but, I mean, that would have been his dictation, but that time allocated to that would have been, obviously, dealt with by somebody else. So it was time was what he needed, I would have thought, apart from somebody else actually doing the work themselves. 11:21 11:21

28 Q. You say, as regards what I've described as the "stick approach", this is at paragraph 63.4 of your statement. I needn't bring it up, you'll recognise it when I say it. You interpreted the "you're not going to Barcelona unless you catch up approach" as evidence that they regarded this as a more chronic issue, however you were not very appreciative of that fact at the time. 11:22

A. Yes.

29 Q. There's elements, and we'll come to different examples of this, there's elements of your evidence which suggest over the course of many years that you didn't seem to fully appreciate the nature and extent of the problem. In other words, you didn't recognise it was a chronic issue? 11:22

A. I recognised it was a chronic issue, but the point of the example of the event of trying to get to a meeting is that there was outstanding triage to be done and it could be done and was done so that he could have gone. So there's an element there that Mr. O'Brien was able to do it when necessary. 11:23

30 Q. Yes. Let me ask you about that. Mr. O'Brien put forward explanations for why he couldn't do it and they revolve around time and when we get to the urologist of the week part, there's a kind of added element to it in terms of his interpretation of how triage should be performed. 11:24

A. Yes.

31 Q. Which, again, comes back to whether there's sufficient time to do it. What's your response to that over any

of the period of the chronology?

A. Yes --

32 Q. You had demands on your practice, fellow clinicians had other demands. I suppose across the team there are different responsibilities. Mr. O'Brien was heavily involved in NICaN. He ran the MDT for a number of years. But time management is something all clinicians have to grapple with? 11:25

A. Yes. You have used the example that I was going to raise there. Mr. O'Brien was heavily involved in the administration and documentation of the NICaN work. That, undoubtedly, took extra time to do. I would suspect strongly that that was in his own time because I doubt the Trust would add that to your job contract. That would have ate into the time allocated to do everything else and that was one of the reasons why I stepped in to help out for a period, a short period of time. So, yes, there were other constraints. 11:25 11:26

Mr. O'Brien also, in setting up the Trust's MDT Invested a lot of time doing that, and that did take a lot of time. He spent time preparing for it and, okay, he's maybe switching one role for another, but, again, the triage issue is still one of those top-level things that you still do, it may be at the expense of something else. But I agree there was a lot of other things that he was doing that could have impinged on the ability to do it. But, again, it's getting your time arrangements and management at a level that can 11:26 11:26

cover the post.

33 Q. One can see that -- this is fast forwarding somewhat to 2013 -- that management of various hues, whether that's Mrs. Corrigan or, in the example I'm going to give you, Mrs. Trouton, were frequently in touch with you to try to get you, I suppose, to prevail upon Mr. O'Brien to operate in accordance with their tune or with their understanding of the applicable standard. I just draw your attention to this particular example. If we go to TRU-276904 and it's November 2013 and she's writing to you as well as Mr. Brown. She's explaining that this letter, I think, this e-mail is to cover two issues, one is retaining charts at home, which we'll look at a little later, as well as triage. What she's staying is that she's dealing in terms of triage, she's saying: 11:27 11:28 11:29

"Despite the fact that patients not triaged from your office mean that we have breached the access standard before we even start to look for appointments, I am more concerned about the clinical implications who need seeing urgently and possibly even needing upgraded to a red flag status." 11:29

So there she gets the cardinal importance of triage and she says: 11:29

"We really need you to speak with Mr. O'Brien both in the capacity of a colleague but also in your capacity as clinical lead and Clinical Director for Urology as

well of course as patient advocates."

She says:

"If it is not addressed I will be forced to escalate to Debbie and Mr. Mackle as director and AMD for the service. It has already been suggested that Dr. Simpson become involved." 11:30

So a number of issues arising out of that. You e-mailed back, I needn't put it on the screen. You said "I will speak", short and succinct. 11:30

In terms of directing this trouble over to you to sort out as clinical lead, did you think that that was appropriate in the first instance? 11:31

A. It's appropriate to have myself and Robin Brown, as was on the e-mail list, to have a conversation with the person involved with what you're trying to put across, rather than making it very formal. Sometimes something formal is good, sometimes something informal can do the job as well. So here is the management trying to get Mr. O'Brien to do triage. They're trying to have a look to see if there's a different angle can be taken on that, which they had done before in the years before, you know, and -- 11:31 11:31

34 Q. I agree with you, it is not the first time that your door has been rapped?

A. Absolutely not.

35 Q. And it wouldn't be the last.
A. Yes it's not -- absolutely. And I think they're looking at a different angle to try to target the problem. But, you know, I had tried this before by doing the triage. Mr. Brown was involved and knew all about this as well and had spoken to Mr. O'Brien on it. There would have been sort of temporary times of when it went well, and then it would slip. I think that's a reasonable thing to say. And at this period of time I was looking at this, you know, can you help out again? And my thoughts on this was it really needs something at a higher level to have this sorted out. And I see at the very bottom here, you know, involving Mr. Mackle and have suggested that Dr. Simpson be involved. So I don't know how far up the channels this went. I'm talking about this on a firefighting perspective, can you help out here again, would you speak to Mr. O'Brien to try to sort it out, can you come to terms and find a process of making it happen? Now, sometimes it did for a period of months, and then it would tend to slip back again. 11:32 11:32 11:33 11:33
36 Q. We'll bring up your response back to Mrs. Trouton, WIT-11955. Robin Brown, he's making the point that Aidan is an excellent surgeon, so the approach should be how can we help. Your approach, just going further up the page, you have spoken and offered help with the triage issue, "and will reinforce again this week". So that suggests you have spoken to Mr. O'Brien? 11:34
A. Yes.

37 Q. I don't wish to use the word pejoratively, but you seem to have been forced into a position of offering to help again, in other words offering to take some of the triage off of him?

A. You use the word "forced" there. I helped out. I'm part of the team. This is about making the system work. 11:35

38 Q. Okay.

A. But the system to work is a team approach. If it needs a little bit of help here and there, that's fine. But behind all this I really did feel that the higher echelons of the administration needed to find a solution to this problem. 11:35

39 Q. Let's look at aspects of that triangle. You are taking a constructive approach, it is how can I help. You've spoken to Mr. O'Brien. So this is 2013. Do you seek to convince him that he must do what is expected of him? 11:36

A. Well, yes. I mean it's fairly obvious. I take it as fairly obvious that, you know, everybody is harping on about triage having to be done. There's a certain element of reflection to say, right, there's something needs to be done about this, what help do I need to do it? What can I do myself? What do I ask for? 11:36

40 Q. Yes? 11:37

A. And also what other people are coming back to say, how can we help you on this.

41 Q. That seems to be an acceptance on your part that Mr. O'Brien either can't or won't do all that's

expected of him and, no doubt, that is what is communicated to senior management and, indeed, Mrs. Burns meets with Mr. O'Brien in February of the next year, 2014. And the upshot of that is that is that there is an agreement that, save for, if you like, specific or personal referrals to Mr. O'Brien, the urology team would take the rest of the triage. But ultimately that falls on your shoulders? 11:37

A. Yes. So my understanding of that conversation was that the Trust had spoken to -- sorry, I know you said this, it is just to get in my own head here -- that the Trust had spoken to Mr. O'Brien, how can we help with the triage? I think he said that he would do the red flag and the arrangement was named referrals, which leaves all the rest. So there's a help. 11:38

I think the issue is relating to the volume of referrals. I think if there was only X amount to do, then you could cope with this, but its just the endless volume of referrals is the big issue. 11:38

Now, so there was help there and Debbie, Mrs. Burns, said that she would ask the team. I happened to be in the corridor at the time, I think, with -- or in Martina Corrigan's office when Debbie came up to talk in the corridor or in the room about this, asking the team. I said, well, look, I've dealt with this before. Let's see what sort of volume this is. I'll do it to start with before you start asking the rest of the 11:39

team, which I didn't know if they would -- I haven't asked that question, I don't know if they would have agreed to do it or not. I'm sure they would have. I didn't ask the question, but I did offer to do the triage at that time to help out with what Mrs. Burns had arranged, and I would see what volume that was and, if acceptable, I continued. But if it was excessive, I was going to then speak to the rest of the team. But that is the reason I ended up doing it.

11:40

42 Q. Mr. O'Brien, he has reflected -- if I just bring this up on this screen at WIT-82498. So he reflects, just on the last line there, that you generously undertook this triage for a period of about six months or -- six months or more, sorry, during 2014. I think just over the page, yes. If we go to WIT-82562. But he makes the point at 469, paragraph 469 that this was a temporary fix but failed to address the underlying cause which he says was progressively exacerbated by the additional burden of his roles with NICaN and with the Trust's MDT and MDM at the time. So that's right, isn't it, it was a very helpful solution to get over that impasse at that time. But it seems that the Trust really ought to have arrived at a permanent fix, which was either, assumedly, to take the responsibility from Mr. O'Brien or, in the alternative, to require him to do it, whether that came with additional time or not, isn't that right?

11:40

11:41

11:41

11:42

A. That's right. That's what I was saying earlier. This was a temporary fix that I was offering help in 2012

and then again here. There was the expectation that the Trust was going to sort it out rather than me.

43 Q. Yes. We saw in the e-mail from Mrs. Trouton, which started the series of conversations, that she was hinting at the possibility that this would be escalated. Going back to what Mr. Simpson said at the start of our piece this morning, this issue doesn't reach the Medical Director's door until, on the evidence that this Inquiry has received, until probably December 2015 or January 2016 and then there's a delay of a year or so before the MHPS process is instigated. 11:43 11:43

Can you help us with this, in terms of reflecting back in terms of how this issue was dealt with over that time, did management address the issues as well as the public ought to expect from them? 11:44

A. The fact that this had been a chronic issue, it should have gone up the line more so and quicker, I would have thought. Do I reflect myself, should I have gone to the Medical Director? As I said earlier, usually you speak to the next person up the line. Most of us would have spoken to the AMD at the time. But -- 11:44

44 Q. I don't get a sense from your evidence, Mr. Young, and obviously we've looked at your statement, your approach seems to have been let me see if I can help Mr. O'Brien out here, if you like, to keep the service ticking along. It also, if you like, forgive my expression, keeps the wolves from the door. In other words, it doesn't get escalated because you came in with this 11:45

temporary fix. I don't get the impression that you had any hard conversation with the clinical director, for example, your next step up. Perhaps you ought to have had a conversation along the lines of: This is impossible, it's putting a burden on me and others, it's endangering patients, you need to sort this out. Was that the kind of conversation had by you with, for example, Mr. Brown?

A. Yes. And it was evident that from the administration perspective that at the AMD level, I would have thought that there had been conversations. Certainly I knew that Mrs. Trouton had been speaking to Mr. Brown, so I already knew that level was occurring. It's whether the Acute Services team had escalated that higher to the Medical Director, I would have thought it would have been prudent. But my role here, as I'm saying, I'm trying to help out with the expectation that the administration was taking it further and I sort of knew that they knew about it, so that's...

45 Q. It's perhaps an unfair question, but do you have a sense, thinking back on these matters, as so why more effective action to challenge Mr. O'Brien wasn't taken, perhaps, by way of escalation? As I say, that didn't happen until the very end of 2015.

A. I think the conversations that the administration had with Mr. O'Brien had been taken on Board, as we can see here. I have had Mrs. Trouton and Mrs. Burns having spoken to Mr. O'Brien saying, and he coming back saying, yes, I will sort it out myself, I'm doing the

11:45 11:46 11:46 11:47 11:47

extra triage, but then it tends to slip. So there was a period of time where the word was getting through to him, it was being done, and then it appeared to slip. Now, that's the impression given. Now, whether they thought it was done or not, I don't fully know. 11:48

46 Q. Let's, subject to the Chair, take a short break?

CHAIR: Yes, it is time for a break, ladies and gentlemen, five past 12.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:05

CHAIR: Thank you, everyone. Mr. Wolfe.

47 Q. MR. WOLFE KC: So Mr. Young, just before the break we were looking at that point in the timeline when you had taken over, from about February 2014, elements of 12:07 Mr. O'Brien's triage. Could I draw your attention to something Mrs. Corrigan has said about that, WIT-26283. And at paragraph 58.1(a).

"On at least two indications, 2012 and 2014..." 12:08

I'm not sure if 2012 was right, it might have been 2011, but it was two indications.

"Mr. Young did his triage for him to allow him to get 12:08 caught up on his admin. Whilst he agreed to this for a short period of time, on both occasions I was led to believe by Mr. Young that Mr. O'Brien asked to have triage given back to him. In addition, on 19th

September 2014, I received an e-mail from the booking centre advising that Mr. Young was no longer doing Mr. O'Brien's triage. On both occasions this had been done without mine or any of the senior managers' knowledge." 12:08

So I think she is making the point that triage went back to Mr. O'Brien after a period of time and you hadn't notified and Mr. O'Brien hadn't notified management that the arrangement had come to an end. Is that fair? 12:09

A. The first occasion Mr. O'Brien asked to take it back, so it was a temporary fix. The second occasion, September '14, was really meant to be October '14 when the urologist of the week commenced. It was meant to have been in September and, for some reason, it got moved on a month. 12:09

48 Q. Yes?

A. So the point being here was the understanding that it was moving to the -- and triage was part of the urologist of the week -- was going to be incorporated into that. 12:09

49 Q. Yes?

A. And it was my understanding that that was fairly clear.

50 Q. And there were discussions, let's just move to urologist of the week, there were discussions in the build-up to launch date, if you like, about what would be the responsibilities of the urologist of the week for that week, the Thursday to the following Thursday, 12:10

when that duty was held. A system of advanced triage was the agreed approach, isn't that right?

A. That was part of the urologist of the week. There were several components to urologist of the week, but specifically you're asking about the advanced triage, is that this was the opportunity to look at the referral in slightly more detail and if thought a good idea or would have been of advanced information for a clinic appointment, that the investigation would have been done to the advantage. The main one comes out as the red flags, so if somebody was attending a haematuria clinic, they would have had a CT urogram at least booked ahead of the game. Now, whether the scan was done in time for the haematuria clinic is fair enough, but at least it had been booked. The length of time between the referral and getting a flexible cystoscopy, there's a very good chance that that CT urogram would have been done.

Now, at the clinics that were set up in the Thorndale at that time, we already had an ultrasonographer at the clinic, so the patient would have been having ultrasounds. We were planning a one-stop clinic but this was even before that, I believe that we had an ultrasonographer at the clinic to help out. So not all investigations needed to be done but if you were reading between the lines of the referral letter, if you felt there was something additional that could help, that was the idea.

51 Q. Yes. And if one looks at your statement, if we bring it up, WIT-51717, and just scroll down, please. You're explaining -- this is I think looking at IEAP, but you go on to say half way down this paragraph:

12:13

"The original plan for the consultant urologist of the week was to cover the emergency workload, such as ward round, theatre cases and in the afternoon to undertake other activities such as clinics or day surgery. This was the initial plan, but it became obvious that the 12:13 afternoon activities were not practical due to the volume of emergency work and our departmental thoughts that a system of advanced triage would be beneficial. This new system at least provided more of an opportunity to perform triage on..." 12:14

I have lost my place. You go on to say:

"The general compression was that the number of referrals were increasing again contributing to the 12:14 overall time required to triage. The time frame to return all letters did not seem as important..."

A point you made earlier.

12:14

"...as the time from triage to when the patient would be seen was still going to be long. However the point of a timely triage was to spot the particularly urgent case that special arrangements could be made such as to

be seen in a Hot Clinic."

Just scrolling down to the next page. You make the point that:

"Advanced triage involved the assessment category the patient was to be allocated, namely red flag, urgent and routine and, in addition, via a rubber stamp box tick a care pathway to a specific clinic and investigation was defined." 12:15

Did you get consensus across the team that that was what was understood by "advanced triage", a limited number of investigations might be indicated were appropriate for a patient as opposed to, I think, what's been described as a remote clinic? 12:15

A. Yes. This was not designed as a virtual clinic --

52 Q. Virtual clinic, I beg your pardon?

A. A virtual clinic was where we would ring the patient at home and consult over the phone, as we did during COVID. But it wasn't defined to be at that level at all. I use the example here of the stamp box, okay? Do we understand what that is? 12:16

53 Q. The box on the form, yes?

A. When a letter comes in, our booking office, I had designed a stamper which gave -- on one side was red flag, upgrade to red flag, urgent and routine, so the doctor would tick that. On the other side was an investigation like ultrasound, flow rate, trus biopsy, 12:16

flexible cystoscopy. So this was the code that allowed the booking office to put the appropriate person on to the outpatients. So you weren't going to have ten trus biopsies or ten flexibles. It allowed the booking office to make the clinic for a particular session fit. 12:17
And then the bottom third of the box allowed the doctor to write in it some ad hoc statement, "booked a CT urogram" or "I have contacted..." so and so and "we're going to do this" or "put directly on to the waiting list". So that's what that extra was. It wasn't just 12:18
to put somebody into red flag, urgent or routine, there was a little bit more processing.

54 Q. Just to be clear, this was agreed across all of the consultant team?

A. Our stamper had been in -- 12:18

55 Q. But I mean more broadly, this approach to advance triage was agreed across the team?

A. That was my understanding. Everybody else seemed to understand it.

56 Q. Yes. The view expressed by Mr. O'Brien was that, as 12:18
I think became clear to you, that you actually needed to do more by way of advanced triage, certainly for red flag patients and, where possible, and if time allowed, with urgent and routine referrals. When did you begin to understand that his approach to advanced triage was 12:19
not one which you understood was appropriate or practical in the time allowed?

A. Well, it would have come up, obviously, after we introduced the advanced triage and at departmental

meetings there's a couple of occasions that this had been brought up and we would have informed Mr. O'Brien that he is going into it in far too much -- far too much detail. It is very hard to do the advanced triage on all patients in the time allowed but, certainly, you had to try to spot the person that it would have been an advantage to have some information ahead of the game. It was generally a CT scan we were looking at in the knowledge that we had an ultrasonographer at the clinic. But it was the time taken to actually do all of this was important and we sort of learnt as we went along what could be done. I think that's a reasonable phrase. 12:20 12:20

Can I maybe just step back slightly to maybe explain that in a bit more detail. 12:20

57 Q. Of course?

A. Is that we were learning as we were going along. With the introduction and our conversations about setting up the urologist of the week, if we go back one step further than that, our clinical input when on call was you had a day's work, you were on call, and you triaged. Now, hence moving to the urologist of the week, this was all getting far too much of a volume to do a day's work and to be on call at the same time, hence going to the urologist of the week. Trying to put that across to The Trust of saying there's going to be no clinical output, in other words you are not doing a clinic and you are just going to be on call didn't 12:21 12:21

appear very attractive to The Trust's figures to start with. But, at the same time, the Trust was wanting a higher turnover of our beds so they saw that if a consultant was on the ward all the time, that there was a decision to discharge, and turnover was a good carrot, shall we say.

58 Q. Yes?

A. So it sold itself well. Also, there was an endless amounts of patients in the casualty department that were sitting there and waiting for a decision to be made so here was the opportunity of the urology team going to A&E and trying to sort it out at base camp, shall we say. So there was a few good sell points.

12:22

12:22

And the other point, as I say, we had the idea of a hot clinic. Those patients that really did need to be seen could be seen in the outpatient department rather than necessarily being admitted to the ward and being processed that way.

12:23

Now, I had observed that where this, the urologist of the week, had been in other units or I had heard that they would do emergencies in the morning and they would do a clinical session in the afternoon -- I'm going to smile at this point here -- I sort of knew that that wasn't going to really be a frontrunner but it was part of the sell to The Trust that here's something that we might be able to do. But, as I say, we all realised very, very quickly that having a clinical session in

12:23

the afternoon wasn't going to work.

So then coming back to not just doing triage of red flag, urgent and routine, we were trying to add in something further that could help the overall process. I don't think we all had fully worked our way through it precisely what was to be done, but the point again, which I brought up earlier, is that you complete the triage and some weeks are going to be more free to arrange more scans and if you had a busy week, you weren't going to be able to do as much. So we were learning on the job, so to speak. 12:24 12:24

59 Q. Sorry to cut across you, but in terms of your approach to triage, taking into account each of the three possible categories of referral, how did you approach that ultimately after this period of learning in terms of the depth of the triage? 12:24

A. Yes. Where it was appropriate in the red flags, I would have booked the appropriate scan. For the routine and urgents I would look at the letter in more detail and if there was a hint that there was something of advantage to know ahead of that, I would book it. For instance, somebody who had a prostate problem and the GP said their renal function was off, I would book an ultrasound. There's a wee flag there sort of letting you know that something else would be more appropriate to do. A lot of the GPs would have sent referrals in without any blood tests or it needed a second blood test done. You might write back and ask 12:25 12:25

them to do that.

60 Q. I want to move down and draw a contrast between your approach and the approach of your colleagues and that of Mr. O'Brien. I think you said, well, in a couple of places in your statement, if I could bring up WIT-51822. You explain at this top paragraph that: 12:26

"Mr. O'Brien was a great advocate for the principle of advanced triage, however his concern was the depth of the added work involved rather than an emphasis on the number of referrals, which we all knew. The level of triage he was aspiring to achieve was difficult to attain, possibly, and some may comment that he was almost trying to do it in too much detail, and as such the totality took too long. He complained that others may not have done it properly. It was appreciated that triage was taxing but the other consultants felt that if they were able to complete the task, then they could not understand why Mr. O'Brien could not also do so. The nature of these discussions would note the detail of depth of triage as arranging of first line investigations which were mainly to book a radiological test. The triage was not set to the level of a virtual clinic." 12:26 12:27 12:27

So the latter you judged as being Mr. O'Brien's preferred approach. The more appropriate and given the resource of time that was available was, in appropriate cases you booked the first line investigation?

A. Yes. The triage would not necessarily involve -- well, it wouldn't involve having to phone the patient and have a consult about it and discuss it further. Yes, we will all have a slightly different level of tests performed but, again, it is trying to read between the lines. It wasn't about having advanced tests done on all patients before they came.

61 Q. In terms of Mr. O'Brien's approach, it appears to be part of his thinking that, in order to do it properly, particularly where the waiting lists, the pressures faced by the Trust for the treatment of routine and urgents, that there's almost at the level of an ethical responsibility to look more deeply into those cases and triage at a depth commensurate with discovering whether they had any morbidity that needed immediate or more immediate investigation than your approach would necessarily allow. Do you recognise that distinction and that thinking in what Mr. O'Brien was putting across?

A. I can understand that but it is -- it's the information that you are given on the original letter from the GP that you have to interpret. The understanding that you book a scan for everybody that has been referred into the system is not a practical -- it's not practical to actually do all of that. But, I mean, you can understand it's nice to know that information ahead of the game. I think there's two edges to what you've said is, yes, it's nice to have a detailed test on a patient but you have to offer the same to all the

referrals coming through, so there is a balancing act here to be done. If that's the level that you want to do, you have to do it for everybody. So we've been sailing close to the wind for a long time. We have to make up a decision pathway for all patients rather than just a selected amount. If it is going to take you a whole week of just doing triage, you have to fit it all into the week.

62 Q. The piece we've just read from, or I've just read from, appears to recognise that Mr. O'Brien wasn't doing what was expected of him in terms of the completion of triage in that you are reflecting that colleagues were saying back to him at a meeting, well, we can all get it done in time. It is the case, as you reflect in your statement, that Mr. O'Brien was vocal, as you say at paragraph 64.4 about saying that he had difficulty completing triage. You seem to be saying that you didn't understand that he was failing to do triage?

A. I'm just saying that he couldn't -- he was having difficulty completing it and it was taking him longer to get through it than the rest of us because he was doing it in more detail than the rest of us. So, okay, the rest of us were maybe doing it in less detail but at least we were able to get it completed. Is that what you're asking?

63 Q. Am I to understand -- let me approach it in these terms, come January 2017 at the commencement of the MHPS investigation, a significant number, let's call it in round terms 700 referrals emerged from his office

apparently untriaged. Mr. O'Brien adds a caveat to that, that he kept an eye on cases to make sure that they were coming into the system and action was being taken. But the cases were largely untriaged. We can argue about the precise number. You knew, indeed, wasn't there a meeting at the start of 2015 which examined and had a discussion about the default system that was in place to cope with delayed triage? You knew that there was a significant problem here? 12:33

A. Yes. There was a delay in the triage letters coming back. So the term "default" was used. We were not -- I was going to use the word "happy". We did not agree with the whole principle of the default. The point about triage is that the letter is triaged. Coming back to the original point earlier is that if there is a letter sent in as routine and we re-triage it as a red flag, that's the point about doing triage. 12:34 12:35

64 Q. Yes?

A. Now, I can understand the principle of the default. If you take the exact sort of figures that you are talking about here of a letter comes into the system, it's put in the drawer, it's then forgotten about and, unless that letter goes back to the booking office, it's not going to get -- it's going to be lost completely. Whereas the principle of the default was at least if the clock was started and the bell rang, then that's when the booking office went by the GP. 12:35 12:35

So I can understand why it was brought in. At least it was a process that a patient's letter wasn't lost and they would still get an appointment based on the GP.

65 Q. Let me come back to the advantages and dangers of the default in a moment. I just want to be sure. You seem to be saying it was your appreciation that Mr. O'Brien was merely delayed and perhaps substantially delayed in doing triage. But was it not more than that? Did you not appreciate that, in fact, in terms of routine and urgent referrals, he had, for very many cases, and I'm not sure what he will say about how many he actually did perform, but the impression, perhaps formed by the Trust, is that he had stopped, largely stopped doing urgent and routine referrals. Did you fail to appreciate that? 12:36 12:37 12:37

A. Failed to appreciate he had stopped. We weren't told by -- no, we thought they were still being triaged but being dreadfully slow on it. So the whole idea of having stopped doing triage, that wasn't being put across. I do think if somebody -- if I said I was stopping triage, I would have let everybody know quite precisely. 12:37

66 Q. I'm going to later look at the appraisals that you overseen. Could I bring you to TRU-25132. My mistake. Let me check. If we go to AOB-25132. No. I'll come back to that reference. 12:38

Mr. O'Brien, in his evidence to the Inquiry, rather than phrasing it in terms of him having a difficulty

with completing triage, he says that during these meetings he used the word "impossible", he found it impossible to complete triage. Maybe, for some, a matter of semantics, but was that not the impression that he was giving to you? 12:40

A. He used the word "impossible". I do understand that from the transcripts. I don't think he put that -- I think he was using that word as it was he was having significant difficulty with it. But I don't think the rest of us picked up on the word "impossible" meaning 12:40 that he wasn't doing. We took it that he was having difficulty with it and it was part -- it was one word used in the conversation we would have had with him to say, look, there is an alternative way of doing triage, you're putting too much effort in here, here's our idea 12:41 and it is part of a conversation. I certainly didn't take it as "no, I'm not doing triage".

67 Q. Perhaps an illustration of him not doing it is to be reflected in an e-mail that Martina Corrigan sends you in November 2015, about a year into the introduction of 12:41 urologist of the week. If we can have up TRU-258498. Just scrolling down. As I say, 30th November 2015:

"Please see attached. I have got eight more of these similar e-mails this morning asking for my action. 12:42 I am only forwarding this to you as an example and I will really need help at getting this resolved as there are currently 277 not triaged letters from when AOB has been on call dating back to October 2014."

So she's saying the earliest of these is a year stale, a year unactioned. Is that not very clear evidence to you that he had stopped?

A. He was certainly -- well, he certainly had slowed up quite, quite considerably. It's not the 277, it's actually, it's the October '14 is the key to that sentence. Again, this was at the end November '15. This was already -- I observed this was already building up to an issue and I understand that this is an e-mail but a lot of my conversations with Martina weren't necessarily on the e-mail, it would have been in the office to discuss this issue. 12:43 12:43

68 Q. But obviously the default arrangement had been implemented. Did you appreciate that, at least in substantial part, that this was a response to the problem which was Mr. O'Brien's failure to complete triage? 12:44

A. The default process was meant to be brought in for all triage not coming in, but it was obviously purposefully targeted at Mr. O'Brien's practice because the rest of us were, wouldn't have fallen into this sort of category. So, yes, it is appreciated that there was a problem, it was becoming an increasing problem. We had tried to help out, something more needed to be done. 12:44 12:44

CHAIR: I hesitate to interrupt but if you look at the line beginning "I have no doubt":

"I have no doubt that Aidan does look at these while he is on call, but it would just appear that he doesn't return them with instructions to the booking centre."

Which seems to suggest that Mrs. Corrigan at least felt that he may have been looking at the matters but not returning the forms. Would that be fair? 12:45

69 Q. MR. WOLFE KC: Yes. I was about to say that.

A. Yes, we had the assumption that the letters were at least screened or sort of flicked through. That was a miss -- I don't know if they were or not, that was an assumption that we had. 12:45

70 Q. I think you've reflected in your statement that so far as the default arrangement is concerned, that had been put in place as, if you like, an immediate stopgap, pending amendment to the consultant's assessment later, if necessary. In other words, it wouldn't be -- the use of this system wouldn't absolve the clinician from completing the triage process? 12:46

A. Yes. So as Chair has mentioned, the red flags at this time seem to have been all sorted. The understanding is that the rest would be then screened. If the letters didn't come back to the booking office on time, then if they had been screened and looked at and triaged, then the appropriate changes could be made by the booking office. So if somebody was, in fact, late in getting back on their routine letter and they were looked at, then, and they were upgraded to urgent or to red flag, then that obviously takes the default out of 12:46

the system.

71 Q. As you will have by now appreciated, Mr. O'Brien wasn't, despite what might be suggested by Mrs. Corrigan here, Mr. O'Brien wasn't going back to these referrals and looking at them to see if they needed upgraded. That much is obvious from the series of SAIs that arose out of his failure to triage. 12:47

You've said, if you bring up on the screen WIT-51842. Just scroll down, please, 79.2: 12:48

"I would have expected Mr. O'Brien to have come to me and alerted me about the referrals not being triaged. I hadn't spotted that it had been such an issue. I'm not in charge of his practice but I thought he would have afforded me the opportunity to speak to him on a personal level. There was no reason why he couldn't approach me, I had helped him in the past." 12:48

Et cetera. Plainly, when you're in discussion around the default triage and you're realising that that is put in as a device because there's a problem here, when you get e-mails such as what we have seen from Mrs. Corrigan, backlog of 12 months, it really shouldn't have needed Mr. O'Brien to come to you. It should have been obvious to you, wearing your clinical lead hat, that there was a dangerous patient risk issue that needed firmly grappled with? 12:48 12:49

A. So it was my expectation to go and speak with him.

That could be said. But it's -- I was not aware of the volume. When it came to our January '17 meeting, we were all rather aghast by the number and we really weren't aware of the volume of what was going on. So, yes, there would have been an opportunity in November to have had that conversation, but it is also fair enough to say that if I had that number of letters in the top drawer, I would have been the one to go and mention to somebody, rather than the other way around. 12:50

72 Q. Maybe it comes back to something you said on the last occasion, about, I suppose, a sense of awkwardness or reluctance to be able to challenge a peer about an obvious shortcoming in his practice. We've seen how in the past you've helped out, I suppose, rather than have a confrontation. 12:50 12:51

A. Yes.

73 Q. This was clearly a time for a confrontation, was it not, whether you to him or by escalating it to a clinical director, so that this could be finally resolved? 12:51

A. Yes, that's a fair comment, as a peer-to-peer that I could have, I should have. On reflection that's a very valid comment. But, having done this before and offered help and received, you know, it may have been more appropriate that somebody much higher than myself was actually doing that. And, potentially as a friend and a colleague, yes, I potentially could have. 12:52

74 Q. I lost the reference earlier and I just want to seek your view on this. It is Mr. O'Brien's appraisal form

from 2015, which wasn't signed off until 2016. Hopefully this is the reference, TRU-25132?

CHAIR: That was the reference you gave last time.

MR. MURPHY: 253210? TRU-253210.

MR. WOLFE KC: Try that? Best laid plans. 251320. So he is setting out in this form -- you'll recognise the format -- he's giving, in these boxes, details of his work. In terms of details of any other clinical work at 2.5 he tells you how triage red flag referrals when urologist of the week. It doesn't appear that that's interrogated in any way. Indeed it's a feature of the appraisals, and we'll look at these this afternoon, that his problems with triage are not addressed through this process. It is perhaps not obvious now, maybe with some hindsight, that he is telling you that he doesn't triage anything else apart from red flags? 12:53 12:55 12:55

A. I have gone over these appraisals and what's written in this first section is often a copy from the year before and it's only in recent times, when I have reviewed the whole document, that I saw that one line. 12:56

75 Q. It stood out for you as well?

A. Well, I have had to read the document several times. It's only in recent times that I've -- I saw that one sentence. Having done appraisals before, I accept that. 12:56

76 Q. Now, in terms of your management role, and you helpfully tried to describe it for us on the last occasion, and, indeed, when we were asking Dr. Simpson about the role of clinical lead, he had it might be

described as a degree of sympathy for the role. It wasn't particularly well defined, there being no job description, et cetera. When it came to March of 2016, Mr. O'Brien is handed a letter in a meeting which he was asked to attend with Mrs. Corrigan and Mr. Mackle. You knew nothing about that meeting, is that right?

A. Correct. I didn't know about that meeting or a letter or anything had been undertaken. I wasn't part of that process and didn't hear about that until afterwards.

77 Q. Perhaps that is a reflection of how others perceived the role of clinical lead, that you were kept out of that loop. Would it have been helpful, given what was being asked of you in terms of trying to manage the triage issue, for you to have been appraised of the fact that this process was starting?

A. It may have been advantageous. I had been involved before, helped out, it hadn't worked, it was needing a higher level of input to make it get sorted out. Whether I should have been appraised of it or not or at least know about it is a question, but I wasn't.

78 Q. Clearly you weren't. But the Inquiry will have to reflect upon how management works, how it did work in this situation, or how it failed to work and whether any lessons are to be drawn from it. So you're cast in the role of clinical lead. We can see not infrequently people are rapping your door to ask you to help out to try to resolve, to take this example, triage. They meet with Mr. O'Brien to discuss triage, amongst other issues, and you are not advised that this process is

happening. How can the management of that kind of scenario be improved for the future?

A. It would be improved by involving the full team in the situation, yes. I think I probably should have been at least informed of what was going on. 12:59

MR. WOLFE KC: Thank you. Is it just gone past 1 o'clock.

CHAIR: We'll come back, ladies and gentlemen, at 2.05

THE INQUIRY THEN ADJOURNED FOR LUNCH 13:00

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Mr. Young. Just before lunch I was asking you about the meeting that took place in March with Mr. O'Brien, Mrs. Corrigan and 14:05 Mr. Mackle. I was asking you about both the implications, in a management sense, that you weren't involved in that and not informed about it.

I suggested to you that that might appear unusual if you were the man they were coming to regularly to try 14:06 to sort things out. I just want to illustrate that point again, perhaps, by reference to an e-mail that you received from Mrs. Corrigan in February 2016, just a month before this meeting, TRU-258510. And so Mrs. Muldrew in the booking centre is telling 14:06 Mrs. Corrigan, February 2016:

"There are referrals, see below, that we are awaiting come back from triage. Could you please chase these up

for us."

Then, up the page, Mrs. Corrigan:

"See blow. In light of previous conversations I am just escalating to you. I have already forwarded to Aidan, but I'm under pressure to get this sorted out." 14:07

I don't think there's a reply from you on this page. Maybe that was the subject of, no doubt, frequent conversations, she alludes to conversations. She has it in mind that she's escalating to you, that you're the appropriate rung on the ladder to deal with it. That's the regular flavour of it. I haven't taken you to the whole catalogue of emails that Mrs. Corrigan sends to you on triage and other issues, but you're uncomfortable that you were cast in that role? 14:07 14:08

A. I'm frustrated that the issue wasn't getting resolved. I felt there was a fair bit of pressure on me to try to do so. I had spoken to Mr. O'Brien on several occasions over the previous few years and it seemed to get sorted out for a while and then it goes backwards. So I'm not entirely sure what more I was going to be able to offer fully. 14:08

79 Q. Did you, in any sense, take that stand with her and say, listen, this isn't for me to resolve, it's for the Clinical Director or higher? 14:08

A. I would have had that conversation. I thought it should have at least been sorted out at the

Acute Services level and to take further afield.
I felt I had done my bit and had said so.

80 Q. But maybe March was the -- the March meeting was the final coming to terms with it, perhaps at last is the caveat that might be added to it. 14:09

Come the summer of that year, plainly the wagons were being circled to some extent behind the scenes.
Mr. Weir, if I can bring up his witness statement at WIT-19904. He writes that, this is paragraph 10: 14:10

"I recorded in my handwritten notebook a meeting with Mr. Young on 9th August 2016. I noted: 'Aidan MY will discuss with him'."

14:10

That's referring to you --

"Meaning that, as lead consultant, Mr. Young would discuss with Mr. O'Brien issues in relation to some or all of the four concerns raised above." 14:11

Those are the concerns that had been raised in the March meeting. Do you recall that kind of conversation with Mr. Weir who, at that time, was Clinical Director?

A. Mr. Weir -- yes, is the answer. Mr. Weir had come into 14:11 the post that April or June, I think, might have been June. He was freshly into the post as CD.
I remember Mr. Weir coming to speak to me and it was -- he was trying to find out how urology ticked over. He

was a general surgeon and had a vascular interest. He wanted to know how we worked. He was interested in our ward. We talked about the equipment that we used in urology, we were relatively high-tech. And, as part of that conversation, he had mentioned about Mr. O'Brien and some of the issues. 14:12

It says here "all four concerns". I'm afraid I don't fully recollect all the topics that we had discussed. It was discussed at the end of finding out about urology and, from my recollection, we talked about triage. But I'm not entirely sure about the other topics that are referred to. I don't know what the other topics were in the March letter. 14:12

81 Q. But they were triaged? 14:13

A. Triaged.

82 Q. They were a failure of dictation of clinical episodes?

A. All right.

83 Q. They were the issue to do with review backlogs and the fourth issue was retaining charts at home? 14:13

A. Okay. I can't recollect a discussion about them all. That's not saying that we didn't, but I can't remember. But I do know that we had talked about --

84 Q. Yes, the upshot would appear to be that he's recording that you're going to speak with Aidan? 14:14

A. Yes.

85 Q. Just before you address that, if I could add into the mix, e-mails between you and Martina Corrigan two or three weeks after that, 24th August. If we can bring

up TRU-258526. If you go to 258528. This is an issue we'll come on to look at in a little bit in a bit more detail. It concerns on the failure of Mr. O'Brien to follow-up on a clinic with dictation and an indication of how the patient is to be treated in next steps. So that's the question being posed.

"Please advise if we need to review this patient or expedite the procedure."

14:15

It comes to you, Martina Corrigan asking you how to advise. So you obviously go and have a look at what is, in essence, Mr. O'Brien's patient and provide the advice that presumably he should have advised or provided following the clinical episode, the meeting with the patient.

Just going on up, please. So Martina Corrigan is explaining that this is one example of a developing problem. Just going on up to the top of the page because some of this isn't -- you say, ultimately I think an office conversation is about to happen before CW, Colin Weir, gets to him. So, as I understand it, putting these pieces together, Mr. Weir, from his statement, is telling us he's met with you. You recall that?

A. Yes.

86 Q. It is a discussion mainly about how urology ticks?

A. Yes.

87 Q. But you get into on your recollection a discussion about triage, and then this additional problem is raised with you by Mrs. Corrigan about dictation, essentially. Is that you indicating that you would speak to Mr. O'Brien before Colin Weir gets to him? 14:17

A. Yes. That's what I'm saying there. I think it is prudent for me to go and a have a chat, a conversation.

88 Q. You say in your statement that there was a meeting in December or a discussion with Mr. O'Brien in December, probably around the time of the appraisal. Did 14:17 you immediately -- was there any other meeting with Mr. O'Brien to work through these issues?

A. Yes. I'm looking at the dates of this. After Mr. Weir came to see me at the beginning of the month, I had a meeting with Mr. O'Brien to discuss what Mr. Weir had 14:18 been speaking to me about. Now, I don't have the precise date of this but we did discuss the triage issue. But, this will be a sensitive comment to pass now, the conversation I had with Mr. O'Brien was of a clinical nature here but it also switched to 14:18 a personal discussion with Mr. O'Brien. If you want me to go into that in more detail, I can. He was due to go off on sick leave.

89 Q. Okay. So you're putting the date of the conversation before he went off on sick leave, I think that is 14:19 towards the end of October, start of November 2016. The dates may be perhaps not terribly important. What was the upshot of that conversation in terms of Mr. O'Brien's professional life and the shortcomings

that were well known to you but which were also being discussed with you by Mr. Weir?

A. Yes, I was -- Mr. Weir is logging four things discussed. I can't fully remember all of those four, but when I went back to speak to Mr. O'Brien it would have been about the triage issue. I can't remember -- I know Mr. Weir has logged the date of when we met because he had written in a diary. I'm afraid I don't keep such a diary so I can't remember the precise date when I spoke to Mr. O'Brien, but the actual gist of it was there was two things discussed, one of which was the personal issue, which I think maybe sort of sidelined what the rest of the conversation was about. 14:19 14:20

90 Q. Okay.

A. And maybe I missed the opportunity of being more forthright with the issue but, as I say, the personal issue then became the topic of the conversation. 14:20

91 Q. Yes. There was, as you reflect in your statement, paragraph 64.9, I don't need it on the screen, I'll just summarise it. You say in the latter part of 2016 you had a conversation with Mr. O'Brien and he spoke about not being keen to take new patients on as he wanted to deal only with his waiting list. At this point Mr. O'Brien said something to you about a communication from The Trust about several issues but he didn't elaborate. That rather suggests you weren't fully in the loop? 14:20 14:21

A. Yes.

92 Q. But do you regret that all of these bubbled up and

reached a fairly dramatic conclusion at the end of 2016 leading into the MHPS investigation when, taking the triage issue as a key example, it was on the agenda for the better part of ten years and hadn't been addressed. Is that something, upon reflection, you think you could have done better with? 14:22

A. Yes, I could have been more forthright with the whole thing, I suppose. As I say, it's maybe hard to challenge Mr. O'Brien on occasions and, yes, instead of being as polite, maybe I should have been a bit more forthright in the whole situation. I do agree. It's getting the joined up writing with all the different aspects. One person would know about one thing, somebody might know about something else. But it would have been -- I think if I was involved in the situation in the March issue a little bit more, I would have been able to stand up to the occasion a little bit better. 14:22 14:22

93 Q. I wonder in all of this was the Patient Safety factor or the risk factor neglected and perhaps even ignored, because as we now know there was this pile up of triage that wasn't performed. You, I think, insist that whether or not you should have recognised that it wasn't being performed, you merely thought it was a delay issue? 14:23

A. Yes. 14:23

94 Q. You were written to in the summer of 2016 in connection with Patient 93?

A. Yes.

95 Q. You have the designation list in front of you. And as

we can see, if we pull up the e-mail chain starting at TRU-274751, at the bottom of the page, please. So Mr. Haynes summarises the clinical background. He's saying that the patient's case wasn't returned from triage so the patient was entered on the waiting list as routine. If the patient had been triaged, given the PSA findings on repeat, it would have been a case of red flag upgrade. Fortunately, the patient came back in to the system and his metastatic disease was diagnosed. He says: 14:25 14:26

"As a result of no triage, the delay in treatment was of the order of three and a half months."

I suppose that case to some extent, mirrored the situation in association with Patient 10, Patient 10's case being what has been described as the index case or the index case for the purposes of the triage SAIs. 14:26

A. Yes.

96 Q. Just scrolling up back from whence we came, and we can observe your response. This e-mail from Mr. Haynes has been put into the system so that, and thank you for that, to express a view as to whether an SAI review should be undertaken. I think the Trust has told us candidly that no SAI review was performed. We have your answer there in front of us in terms of the various issues that you say in the case. 14:26 14:27

You're not pushing -- and maybe you didn't think you were being asked this question -- you weren't pushing for an SAI review in this one?

A. Patients coming to me from Martina are asking is there something urgently needed to be done? So I might have misinterpreted the e-mail on that front but, also, there was an opportunity for me to expand on that a little bit more to say, look, should a Datix be put into the situation. But I was aware that there were other people involved in this loop, not just myself. As you say, Mr. Haynes had already seen a patient, I think, isn't that right? So I'm looking at the letter, I think I'm looking at the letter of referral here. I think the first line says it all, that the GP should have referred it in as a red flag. The blood tests for the prostate was high enough to be recognised as that. 14:27 14:28 14:28

97 Q. That's the whole point of triage, isn't it?

A. It comes back to what we were talking about earlier, it's the point of the GP referring it in as routine and why the letter is looked at and looked at and to an element of what I was saying, how I do it is I don't regard the GP's triage code, I look at the content of the letter. 14:28

98 Q. I suppose just to get back to the thrust of the point I'm bringing to you, urologist of the week was instituted tail end of 2014. Into 2015, in the early part of it, you realise that there's a default procedure in place for late triaging. Late '15 you're 14:29

told by Martina Corrigan, I've got this pile of triage, some dating back a year, and it hasn't been completed by Mr. O'Brien. And into 2016 we have Mr. Haynes picking up on Patient 10's case, starting a Datix which eventually becomes an SAI. Here's another one, and no doubt, and we know there to have been many others which were only looked at in 2017 and 30 or so cases were triaged by the group of consultants in Mr. O'Brien's absence and 30 cases were upgraded to red flag. 14:30

Do you accept that this was a period of time where the information was there, people knew what was going on and there was a failure to grapple with the patient risk issue that was at the heart of this?

A. 2016 was very important. I agree fully with what you're saying. There was a missed opportunity there. I don't think we realised the volume of what we were talking about but, certainly, here's a further example that should have been escalated. It's only been picked up whenever the patient is coming through the system again. So it's knowing -- it's getting ahold of those untriaged letters was the crux of the point. 14:31 14:31

99 Q. But it was perfectly obvious to some, wasn't it?

A. Yes.

100 Q. You might say it wasn't perfectly obvious to you, but if the letter has not come back, there's a way of tracking that isn't there? 14:31

A. Yes, it is via the booking office, not knowing it's coming back.

101 Q. Mr. O'Brien was, obviously, excluded from work and he returned and was the subject of a monitoring arrangement, and we'll come to your knowledge of that maybe later this afternoon. But I think you've said in your statement that there was a rostering of the Friday clinical sessions upon his return and these were left free or taken as leave. I think Mr. O'Brien would insist that all of those Fridays were taken as leave to enable him to perform triage in the way that he wished to. It was obvious to you, was it, that he was continuing to triage -- well, I'll remove the word "continuing". He was now being required, or at least being monitored, to ensure that all of the triage was carried out, Mrs. Corrigan had a primary role in that. But he triaged using that, a deeper method of triage which wasn't required of him, is that fair? 14:32 14:33 14:33

A. I think he was performing his triage to the same depth that he wanted to do beforehand.

102 Q. And that was the subject of a discussion, I'll just briefly deal with this, at a urological departmental meeting in September 2018. And arising out of that meeting is the following minute, if we turn to WIT-52833. You'll recall that in advance of this meeting Mr. O'Brien provided a paper and, dealing with the triage of new referrals, the following observations are made. Just scrolling down: 14:34 14:35

"The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of

triage. This must include recognition of time constraints and time commitment required to complete triage including time spent speaking to patients, booking scans, reviewing results and mitigating risks for patients on the current long outpatient waiting list. Consideration was given to decoupling the triage activity from that of the urologist of the week."

Is it wide of the mark to suggest that this has been the message that Mr. O'Brien had been preaching for some time from the institution of the urologist of the week mode of working? 14:35

A. Yes, this is what he wanted to be included.

103 Q. Does that reflect -- does what was written there reflect solely his views or is it the view of the urology department that this is what is required? 14:36

A. No. It's not necessarily to speak to the patient. It is scans are booked appropriately. It says "current long outpatient waiting list", that's not triage. And the bottom line is -- there was discussions in general terms about decoupling the activity of triage, to do it at some other occasion by somebody else or whatever, but it wasn't linked. That was a topic that was up for discussion but it never really got that far. It may be fair to say it is an active thing that the trust may be looking at at the moment. But certainly throughout all of this we never got as far as talking about decoupling of the two situations. And it would be -- it would have been advantageous for us to have been formally 14:37 14:37

told what was expected of us during triage. We had made up our own rules to a certain degree, what we are talking about, but there is the document, the IEAP that tells us that they want triage done within the 72 hours. So there is information out there that had been available and had been worked to for the previous eight years. So there is an element of documentation there but the documentation to go with the advance triage, I agree, was a bit on the cloudy side, it was our interpretation. But the very important point is it is all the triage and what you can do on top of that. And we were learning as we were going along. And I think, okay, some people can triage faster than some other people, but the principle is it's completed. I don't think triage involves having to speak to a patient. 14:38 14:39 14:39

104 Q. Yes, but from Mr. O'Brien's perspective it might, and that's why I'm posing the question in this way. Is this minute reflective of each of your views which tends to be the purpose of a minute, or it might require -- sometimes minutes record dissenting views. This looks as if there's a consensus that as a group of clinicians you require recognition from the Trust that appropriate triage might involve each of those things, including speaking to patients. But I think you're telling me that is not the consensus? 14:39 14:40

A. Correct, yes. This paragraph is trying to put everybody in the room's view on to the page.

105 Q. I see. But the bottom line is -- well, it's not the

bottom line, it's the top line in that minute that what you were looking for as a group was a detailed plan or description of what was expected of you guys as triaging consultants?

A. I think that's fair. 14:40

106 Q. Did that ever materialise during your time with The Trust?

A. No. Just the first document of the IEAP.

107 Q. That was issued in 2008. I'm conscious I don't need to bring it up but something of the flavour of that first 14:41 line in 1.2 the need for a plan detailing what The Trust expects was also part of the conclusion written into the SAI report dealing with the five patients. You know the one I'm referring to? The five patients that weren't triaged in or about 2014 that report being 14:41 finalised in 2020. So what you're saying is although the SAI called for a detailed plan and you, as a body of consultants were, through this minute, asking the Trust for a detailed plan, that has never materialised, to the best of your understanding? 14:42

A. To the best of my understanding, no.

108 Q. Where would this minute have been directed to? Just scrolling up, I think Mrs. Corrigan was in attendance, wasn't she? No.

A. I'm not entirely sure if this was forwarded. I didn't 14:42 take these minutes and I think Mrs. Corrigan might have been off at that stage.

109 Q. I suppose, whether these minutes were forwarded or not, was it made known to those holding the levers of power

that, as a group of urologists, you were unhappy with the current arrangements for triage and they needed clarified?

A. I'm not sure if the higher echelons ever received that. I don't know. You would have to ask. I'm not aware of the higher echelons being aware of this. 14:43

110 Q. As clinical lead, you didn't take this forward?

A. Well, these are the minutes of the meeting and I had thought that they had gone higher. It wasn't me taking the minutes. I had thought that they had moved on but I have been told that they weren't. 14:43

111 Q. I suppose if you, as clinical lead, are not going to bring this issue forward, whose responsibility should it be?

A. I thought these sorts of minutes go to -- if we're taking a minute from the departmental meeting, it goes to Martina Corrigan and I would have thought that, you know, it would go up the chain from there. I didn't take it to the AMD or any level like that. These were discussions that we had on that day and taking them further, I'm not aware. Apologies. 14:44 14:44

112 Q. Just to reconcile that from a position where a failure to triage had caused considerable difficulty, of which you were aware, for a large number of patients and here you have a meeting which is getting close to looking at those kinds of issues through the lens of you clinicians, some of you are struggling with the whole concept. Surely, recognising the problem, there was an onus on the clinical lead to take these matters forward 14:45

and make sure they were addressed?

A. I accept that.

113 Q. Can I bring you to another clinical aspect or clinical-type activity, that is the area of handling patient charts. Handling patient charts is part and parcel of your daily experience as a clinician and you would have understood that there are management arrangements around the handling of charts, no doubt to protect the sensitivity of the information contained within them. But, broader than that, to ensure that the chart is in the right place at the right time so that colleagues who need access to them can get to them when the patient is in front of them. 14:46 14:46

We know from Dr. Chada's report that a large number of charts were brought from Mr. O'Brien's home, others contained within his office in January 2017. Part of the explanation for that revolved around the fact that he had a clinic remotely in the Southwestern, but another part of the explanation for it is interlinked with his slowness at producing dictation. He needed the charts by his side at home so that he could dictate when he had the time to do so. 14:47 14:47

Tell me about your practice. Did you retain charts at home? 14:47

A. I also covered the Southwest Acute Hospital outpatient clinic. The clinic was on a Monday. Either Martina Corrigan would have taken the notes down or the

notes were provided to me in a sealed box to take down. As I said earlier, it was 150 mile round trip, I wasn't going to drop off at the hospital to pick them up and then go on to the clinic. So I would have had a sealed box of charts which I took to the clinic. At the clinic I used the charts and dictated on them there. They went back into the box and on a Tuesday morning I would have phoned my secretary and she would have met me at the front door and she would have taken the box off to her office to type with the outcome sheet. 14:48 14:49

So, yes, I did have charts. They were at home for as minimal a period of time as possible, purely because of the location of the clinic. I also did outreach clinics in Banbridge Hospital at the poly clinic and, well, I used to do a clinic in Armagh but when the Southwest started, I dropped that one. But I would never have taken charts home from Banbridge or Armagh, it wasn't appropriate, there was a hospital system for it. 14:49 14:50

Yes, the hospital system -- yes, the Banbridge in Armagh is still within our Southern Trust area so it had the transport system to make that work, whereas the Southwest is in the Western Trust, different board, different transport arrangements, it wasn't the usual traffic, so there wasn't a way of getting the charts down there other than in a taxi. A taxi there, taxi home would have been an option but I don't think the 14:50

Trust was, potentially felt that was as safe, don't know. So, yes, I did have charts at home but only from that clinic.

114 Q. Yes, and one can understand that the practical features of that narrative that required them to be at your home for a short period of time. Mr. O'Brien's approach seemed to be, for reasons that I explained, to be different. You would have been told from time to time that this was causing a problem for colleagues? 14:51

A. Yes. I heard that charts weren't available at a clinic. Where those charts were, I don't know. The hospital does have a tracking system for charts so they should know if -- it should be as defined as is it in your office or is it in your secretary's office, it's that well tracked. But also sometimes charts do get misplaced and you're given a temporary chart but, you know, that's infrequent. 14:51 14:51

115 Q. Can I bring you to just a couple of e-mails which help to highlight the problem. TRU-278656. Pamela Lawson, just scrolling down, is highlighting that a number, I count more than 50, incident reports submitted regarding charts that Mr. O'Brien has had to bring in from his home for clinics and admissions. Just scrolling up the page, I can see you're not copied into these particular e-mails. We know from the e-mail we looked at this morning, which Mrs. Trouton wrote to you concerning both triage as well as the charts issue, that you are by this stage, by 2014, well aware of the problem. Were you aware of the fact that it was at this scale that colleagues were having to file incident reports to document the problem in significant numbers? 14:53 14:53

A. I wasn't aware of the significant numbers. I was aware that there were charts. I had thought that they solely related to the Southwest clinic. That was a supposition, I think. I couldn't have seen any other reason for having a chart at home from a clinic so I was assuming that. 14:53 14:54

Yes, I was aware that there were charts at home and they were delivered back and it was for clinicians that were in our unit and were seeing some of Mr. O'Brien's patients. Mr. O'Brien and my patients are -- well, you know, we didn't really overlap so I wouldn't necessarily have seen a lot of Mr. O'Brien's patients when I had enough to do with my own. 14:54

116 Q. I think there was one patient, at least one patient who

through, I think, a political representative perhaps complained that his chart could not be found. You had took over that patient's care I think from Mr. O'Brien and a temporary chart, unsatisfactorily, had to be completed in order to corral the new material. But the chart containing the history was absent and was causing you difficulty as a clinician?

A. Yes. I said a wee while ago, sometimes a temporary chart has to be and a chart can't be found. I have that off my patients. The chart has been tracked to another clinic and I may get a temporary chart. They may be diabetic and they've gone to the endocrine clinic for instance. So to have the odd temporary chart is fair enough, but to have a large volume is different. So, yes, there are temporary charts but it should really be very small and it often relates that the patient's chart is tracked to a different clinic.

117 Q. One can see this e-mail is 2014. A year later, TRU-258477, just down at the bottom of the page, I think, Pamela Lawson to Helen Ford and Marina Corrigan, 23rd January '15.

"The situation is getting worse. Mr. O'Brien is taking more charts home with him and we are spending more and more time looking for charts that end up at his home. We are wasting a lot of time that we do not have and I'm having to give out overtime to get all the charts for the clinics. The two charts we are currently requiring..."

And those are set out. This is forwarded for your attention, I think, if we scroll up the page. Martina Corrigan escalates to you:

"See below another two charts. These will be escalated through to Anita Carroll, and then on to Heather and I am concerned that it will go to Debbie."

A bit of a pattern here, a concern that we might have to escalate this to somebody who we might be afraid of, who might take more aggressive action than we're prepared to do. Is that a flavour of this? 14:57

A. It should be passed up. Yes, it should be passed up the channels and it indicates that this was the indication that they were going to do that. 14:58

118 Q. But it doesn't, as I say, get there until well into 2016, this being a pattern of behaviour that's gone on for 4 or 5 years, perhaps longer. As I say, it is being escalated to you so that we might avoid it going any higher. Did you ever speak to Mr. O'Brien about it? 14:58

A. The charts at home, it was the return of the south-west acute charts I thought that this was about. I can't remember a precise conversation, a dated thing, but charts would have come up in a verbal conversation that they should be returned. Again, an undated commentary. And, you know, I'm interpreting -- you're saying that it's an escalation to me to go and sort out but, you 14:59

know, charts are a trust point to try to track back. This is already at quite a high level of Heather and Debbie, that is Heather Trouton and Debbie Burns. These are the administrators making charts work.

15:00

I will have had conversations with Mr. O'Brien, whether I should been more forthright in the conversation, I do accept that but there is an element of taking a horse to water.

119 Q. If Dr. Chada is right that, I think there's no real disagreement, maybe a bit of disagreement over the final figures, but 300 charts sitting at home, plainly you can see the problem with that. Is your evidence really that it is not for me to change his behaviour, that this should have been brought to a higher level? 15:00 15:01

A. I was unaware of the volume of charts at home. There's no need to have 300 charts at home. I was not aware of that volume until the January 17th meeting. I wasn't aware of the degree. Just before this e-mail you showed us a list of one or two charts here and there. That's one or two charts, that's slightly different from 300 charts. 15:01

120 Q. I also showed you 50 incident reports.

A. Yes, on different -- yes, but they were one chart for each of the dates. I know they add up to the 50, I agree. So I thought it was small volume, not coming back, completely unaware that it was 300 charts. 15:02

121 Q. That, I suppose, tells its own tale in terms of communication within urology. It's clearly more than

a couple of charts at a time.

A. Absolutely.

122 Q. That information was there to be extracted. If it's right that it's not being communicated to you, it perhaps reveals a gap in the governance of this important issue. 15:02

A. Yes, now I am aware of the triage letter volumes, as documented earlier, but the actual volumes of the charts here was not passed to me until such time -- I knew there was an issue with it but not the volume. 15:03

123 Q. As I say, a companion piece to the charts at home is the absence of --

A. Dictation.

124 Q. -- dictation on these clinical episodes. I think you made the point earlier that at least as regards the Southwestern clinic which Mr. O'Brien took fortnightly or once a month, was it, on a Monday? 15:03

A. We had a monthly, yes there was a fortnightly clinic, one by Mr. O'Brien, one by me.

125 Q. He had been facilitated, you explain, by being granted Tuesday free of clinical duties in order to perform whatever administrative catchup he required following the Monday clinic? 15:04

A. Yes. We worked with that. It wasn't available at the beginning. I think we started going to the Southwest in 2013, January, I believe, but I'm not entirely sure if that facility was available to Mr. O'Brien right from the word go. But it is something that as time went on he was asking for and we felt that that was 15:04

a good idea. But it was within a fairly short period of time, I think, that we then -- I mean it was fine to have Tuesday morning free because it was either day surgery or admin and, as I said, I did the rota so it was easy enough to switch somebody around from doing a Tuesday day list. So it was easy for us to accommodate that request. So, yes, it was fairly soon after going to the southwest that there was the facility of the Tuesday to be free for him to do. 15:05

126 Q. In terms of your own practice and your understanding of other practitioners in your own group, when you conduct a clinic, say at the Southwestern, what are the, if you like, the documentation obligations that flow from that? I suppose it can vary from patient to patient, but assuming you make an entry in the chart and if further steps are required you dictate what those steps should be to an audience that might be variable as well. Can you just take us through that? 15:05 15:06

A. The cycle of a clinic would be an engagement with the patient. You would write a note in the chart. You would dictate a letter to the GP. It would have been common practice, certainly for everybody I would think, would be to fill in an outcome sheet. And we had discussed outcome sheets and the importance of them over a good number because if the dictation tape didn't come out you have to redo the clinic, and therefore there is a document to know what you were trying to do. 15:06 15:07

Secondly when the dictation tape went back to the secretary, there may be important things to do first. So, in other words, the last patient on the clinic might be the most important person of the day but would have been the last dictated on the tape. So if you put the outcome sheet down with the name at the bottom "please sort this patient out urgently, it's a red flag", or whatever, then that's what the secretary would go to first. That's my practice and I assume it's others'. So the whole idea of the outcome sheet was to keep separate the chart, keep separate from the dictation so if one got lost there was a way of trying to track things. 15:07 15:08

So, you know, if you were behind on dictation, you know, at least there was the outcome sheet for the secretary to work from. 15:08

127 Q. How promptly would you normally expect to make each of those documents?

A. The outcome sheet is -- you're talking about my practice? 15:09

128 Q. Yes?

A. I do it, I see a patient, I take a sticky from the chart, it goes on to the outcome sheet, I write beside it what it is so it's live. The outcome sheet for me is produced at the end of the clinic. If I don't do it then, it gets displaced and I lose track of time. It has to be done at the time, for me. Dictation for me is either done immediately after seeing the patient. 15:09

If I run over slightly into the next patient's time, I will dictate at the end of the clinic.

I mentioned earlier that our outpatient design was meant to have had some time at the end of the clinic to incorporate admin. That was fine, I think, at the beginning when we were setting up after the 2010 regional review. That's the way we had set it then. I think that's more than likely slipped and there's not precise time at the end. But in theory the clinic slot time should incorporate both a consult, the writing, and the dictation. Now, again, if you are a bit slow most -- well, most of my clinics are on in the afternoon, I stay until that dictation is done, whether that is 7 o'clock at night or 5:30, but for me it's there and then. To take the chart off to an office to do is up to the -- it is up to the clinician, but most of the charts are bundled up and put into a box and sent to the secretary from the outpatients' department. 15:10 15:10 15:11 15:11

129 Q. You talked about dictating a letter to the general practitioner, a copy of that would go on the chart, would it?

A. When that's dictated it goes into the chart and in modern times now it goes on to the NIECR.

130 Q. Just a point of fine detail. Do you ever see fit to dictate a letter to the patient directly arising out of such a clinical episode? 15:11

A. There has been a move now to copy the patients more into the correspondence. For me that's relatively new.

Some clinics have been doing that for years, that what written to the GP goes to the patient as well. I have a little bit of concern about that because sometimes there can be -- there can be big words used that you have to interpret for the patient and, yet, you want to give the right information to the GP. But certainly having a letter written to the patient is becoming more common practice. But I would specifically write to the patient if there was something that the patient needed to know and to take away from the consultation, shall we say.

131 Q. Yes. Just in terms of Mr. O'Brien's practice, I want to just dwell for a few moments on how Mr. O'Brien's practice appeared to impact on his colleagues.

If I can bring you to something that Mr. Haynes said in evidence. It is at TRA-00867. So he's explaining the context where this is that when both Mr. Haynes and Mr. O'Donaghue commenced in The Trust in 2013, to some extent they took on some of Mr. O'Brien's cases. It was a review of his backlog, as I understand it, and that was part and parcel of it. Mr. Haynes recounts that:

"Progressively as I recognised that that was the way he worked, I would have raised -- so during them times when we moved up to six when Mr. O'Donaghue started, we would have tried to work as a team and as individuals and as new starters. Myself and Mr. O'Donaghue seeing

some patients who Mr. O'Brien had seen previously and both of us raised a concern, along with Mr. Glackin and Mr. Young when they were doing it that you didn't have any documentation about the decision making that had gone on before. There wasn't a letter available and so it made reviewing these patients very difficult."

Mr. O'Donoghue in his evidence last month recalled that when he was taking patients to theatre and going to the chart he was sometimes left wondering what the purpose of the visit to the theatre was. Is that something that was recounted to you, perhaps, as a complaint and was it something you experienced yourself?

A. Mr. O'Brien's patients and myself didn't really interlink because we had our own lists to look after. Mr. O'Donaghue and Mr. Haynes were coming as new and they were taking, as you say, the backlog of Mr. O'Brien's list here. Now, this had been brought up at some of our departmental meetings, you know, and I did ask Mr. O'Brien why, you know, there wasn't something in the chart. Mr. O'Brien usually liked to have maybe one letter to cover the whole episode of the patient, not the episode of the date, but the whole arena of what that patient's journey was.

That is a fine approach if everything is all very sort of concerted and quick but in our arena to get somebody back for a review was taking a long time. Now, I'm not so sure about the writing in the chart, I'm not aware

of that. But I know that he would have written in the charts. I don't know if it was as infrequent as is commenting here but, certainly, there didn't appear to be a dictated letter. I mean, I do remember one occasion at a departmental meeting, I was getting rather frustrated with the situation. Even if somebody comes to your outpatients and you consultant with them and there's no change in the plan, you know, let's just run with what was going, you know, that's what you write down "no change in plan". But at least that lets the next person coming along know that that's what your train of thought was. But if there's no letter or nothing written in the chart, as you pointed out there. But undoubtedly a dictated letter is the best, in my view. And the reason for that is that that now goes on to the NIECR system, so it's on the computer. Written notes on the chart, I must confess the chart issue in Craigavon, you know, they're a bit higgledy-piggledy and sometimes you might miss somebody's writing. That's maybe a finer point. If you look through a chart you probably will find it but sometimes it can be a little bit on the difficult side. But certainly a dictated letter is the way to go and even, as I say, if there's no change in plan, at least write that. 15:17 15:17 15:18 15:18

132 Q. As we've observed from Mr. Haynes' remarks, there's an importance residing in the principle of continuity of communication that was, it appears, somewhat frequently missing from Mr. O'Brien's clinical practice. I think there is a dispute on the final numbers as found by 15:19

Dr. Chada. Dr. Chada talked about dictation not completed for 66 clinics affecting 668 patients. Mr. O'Brien says it was 189 patients across 41 clinics. Whatever be the precise number on that, do I draw from your evidence that you regard it as a shortcoming that dictation was not done promptly by way of letter so that everybody concerned would know what was going on by way of next step?

A. It's a distinct shortage, yes, shortfall.

133 Q. Are you at all sympathetic to the view of Mr. O'Brien, there's a number of layers to this, that, first of all, clinical encounters with patients are important and it's important to speak to the patient and use the time to communicate well so that they understand face to face what's going on and that that inevitably eats into the time available for note making or dictation? 15:20

A. Yes, it's the complete clinic slot. So it needs to have adequate time for that slot to complete all of those points that you just made. Obviously, the most important person is the patient sitting in front of you. That's who you are communicating to with advice, but that advice also needs to be transcribed so that the next in line knows who's carrying the baton. You need to pass the baton down the line. So the GP needs to know what you talked to the patient about. But, yes, most of the time -- I mean most of the consultation time is the talking and the examination of the patient. You know, you can make -- you could spend half an hour talking to somebody and yet you could 15:20 15:21 15:21

summarise the consult within a couple of minutes by a dictation. But, as you say, there are other features that go on in the consultation if you're going to book an X-ray you have to fill in a green form. If you want to log somebody for theatre -- you know, there's admin to go with the whole situation. It's actually that wee bit that often takes a little bit longer. Yes, it's the complete clinic slot time that is the complete journey. 15:22

134 Q. His other point, the other layer to this is, as I think you highlighted, he would have a "some time" approach to dictation, that he would do it at the end-of-the patient's journey or after a number of clinical interactions. 15:22

A. Yes. 15:23

135 Q. Is that a wise approach?

A. In my view, if you can -- well, the answer is no in short form, but to explain it, you know, if the consultations are all very short in time between and you can complete the journey -- if the whole thing is a month or two, you can do it. But if there's a lot-of-time between clinics, it's going to be hard to fully remember what you discussed with the patient. You are going to miss, well, speaking for myself here, you would miss the finer nuances of what you discussed with the patient I think. Well, I would. 15:23 15:24

MR. WOLFE KC: 3:25 should we take a short break?

CHAIR: Yes.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone. Hopefully it will be a little bit cooler.

136 Q. MR. WOLFE KC: Mr. Young, I'm going to rewind slightly before moving forward again. If I just take you back to patient charts issue and bring up on the screen please, if you would, AOB-01225. This is 14th November, 2016. Mr. O'Brien has gone off work to have surgery and he's asking Mrs. Corrigan for permission to work on dictation from home. He says: 15:43 15:44

"I expect that I will be well enough to dictate correspondence concerning patients and have the charts delivered to Noleen's office for typing. I would greatly appreciate if I could be afforded this opportunity to have all charts returned in this manner." 15:45

Were you aware of that plan on the part of Mr. O'Brien? I should just say, for completeness, scrolling up, that Mrs. Corrigan was content with that: 15:45

"I am more than happy with this plan. Please let me know if there is anything I can do to assist." 15:45

Were you aware of that plan?

A. This is when he was meant to be off sick.

137 Q. Yes?

A. I'm not too sure I was. I can't say one way or the other, but I really don't recollect that.

138 Q. Plainly, come January, 300 or so charts are coming back from his house. This e-mail from Mrs. Corrigan would certainly appear to acknowledge that she was aware the charts were at home because work was going to be done on them and she was giving her blessing for that, rather than raise any noise about the fact that the charts were at home. But you have no recollection of engaging with that? 15:46

A. No.

139 Q. Thank you. Could we turn to the issue of private patients. This is the fourth of the issues that we've gone through. Triage, dictation, charts at home, private patients being the fourth of the issues that Dr. Chada grappled with during her investigation. 15:46

Could I open with you your statement to Dr. Chada. If we go to TRU-00756 and you are speaking to Dr. Chada on 3rd April 2017. At paragraph 34, if you just focus on that. So you're saying: 15:47

"I can't comment on the placement of private patients in the NHS queue. I don't track Mr. O'Brien's patients. Any concerns I heard about private patients were just hearsay. I had no idea when patients were seen by Mr. O'Brien at his home. I would have thought patients go on to the NHS waiting list as per clinical priority. I have subsequently heard that some private 15:47

patients might have been given dates sooner on the list but I was not aware if this was down to clinical priority. While I have recently heard this, I personally had no evidence of it."

15:48

When you say this was just hearsay, was that an apt description of what you were told or were aware of at the time?

A. No. That's not the right word to use. This was a consultation with Dr. Chada and Siobhán Hynds. So 15:48 this was a transcript of what I had said that day. I probably hadn't had enough time to reconsider or inwardly digest what I was trying to put across. So the word "hearsay" isn't quite true, but I am aware that there had been some e-mail conversations and I do 15:49 specifically remember -- I think what I'm really referring to here is what I do clearly remember is having a conversation with Mr. Haynes at the sisters' nursing station at the front of the ward one Wednesday probably because I would have generally done a post 15:50 surgical ward round. My day was Tuesday, so I would have seen my patients afterwards. No matter who was on call, I would generally go and see my patients. But on a Wednesday morning after that I would, I had a stone clinic. So I remember Mr. Haynes mentioning to me or 15:50 having a conversation about a private patient being in the ward and he was concerned about the issue. And although I was in a hurry, I asked was there a clinical reason, did he think, for that happening. So that's my

main point. I really hadn't heard anything along this line about private patients before him actually raising that point on the ward. So that was a quick remark said and the word "hearsay" is taken in the context of just what I've said. 15:51

140 Q. I suppose the further and you might agree the more accurately way of portraying this to Dr. Chada would be to say I received two e-mails six months apart from one of my senior colleagues, Mr. Haynes, who is very concerned about the morality and the probity of what he thinks is going on? 15:51

A. Yes.

141 Q. Just turning to Mr. Haynes' intervention on this subject matter. He wrote to you and Mrs. Corrigan in May 2015, TRU-274504. Just scrolling down. I'll let you digest that and the Panel digest it. To summarise, he's draw your attention to two patients who have come in for treatment on the NHS and it's his belief that those patients had been relatively recently seen by Mr. O'Brien in a private capacity and he's comparing the lot of those patients with others of whom he's aware who have, in similar need, have been waiting up to 92 weeks. He rounds off by saying: "This behaviour needs challenged, a stop put to it." He is unwilling to take the long waiting urgent patients while a member of the team offers preferential NHS treatment to patients he sees privately. He suggests that an audit be conducted for us all to have an honest discussion about what is happening. He says the alternative is to 15:52 15:53 15:53

remove waiting list management from individual consultants and give it up to an admin team which would manage the waiting list in a strict chronological order. Your response to that, just up the page, is the point is taken and you agree, play a straight, honest game.

"We are best placed defining our lists but at risk if the above comments are not taken on Board." 15:54

You say management are not playing it straight either by resetting the patient's clock. What does that mean?

A. Patients may be put on to the waiting list at a specific date but due to reasons like pre-op assessment, patient unfit for surgery, patient doesn't attend, patient changes their mind, then their date of going back on to the waiting list can change. 15:55

142 Q. But it's not a repost to the merits of Mr. Haynes' point?

A. No. No, it's not. 15:55

143 Q. You say there are a few issues that you're not prepared to put on paper about the process so you'll discuss later. Can you help us in terms of what they are?

A. I can't remember.

144 Q. Is it what process do you think you're referring to? 15:55

A. I honestly don't know. It may not be actually that that I was referring to. It might have been a list of other things. I can't remember, honestly.

145 Q. You go on to finish with:

"Mark's points are valid. I fully appreciate the questions raised".

Certainly it would appear from the next e-mail sent by Mr. Haynes that maybe he didn't get any response beyond that from you. Let's just look at his e-mail, and you can comment. So we're now in November '15, six months along, it is TRU-270115. So he is saying to you, 26th November: "I e-mailed you on 2nd June" -- I'm never quite sure where that 2nd June date comes from. It would appear he e-mailed you on 27th May, but that fine detail aside, it's about the ongoing issue of patients on waiting lists not being managed chronologically, in particular private patients. That, in essence, is the issue. The rest of the detail is not terribly significant. I suppose it is your response I'm more interested in. He's raising the same point and you say by way of response: 15:56 15:57 15:57 15:58

"I have spoken before to the person in question regarding this issue in general and the justification of urgency, and since the waiting list for some things are so long, example urodynamics, I will have to speak to him again." 15:58

The person concerned here is Mr. O'Brien; isn't that right?

A. Yes.

146 Q. Are you being deliberately careful about committing names to writing?
A. No, that's not meant.
147 Q. Sorry?
A. That's not meant to be deliberate. 15:58
148 Q. Okay.
A. I could have put in there: I have spoken before to Mr. O'Brien.
149 Q. Had you spoken to Mr. O'Brien about it and did you speak to him again? 15:59
A. If I put this in an e-mail then I have spoken to him but, again, a precise date of which I haven't got in a diary, I'm afraid. It's not something that I would keep in a diary. But from the e-mail here, I obviously have spoken to him. 15:59
150 Q. Yes. I suppose this is a serious concern on the part of Mr. Haynes, he's suggesting an audit of the cases. That wasn't done?
A. No. No, it wasn't done.
151 Q. Just in case anything pops out of it, the e-mail from 15:59
Mr. Haynes, WIT-54106. I'm not sure if anything more turns on it, but that's the reference. While that's coming up -- yes, there it is. So it's a patient apparently referred September 2015, seen on a Saturday, 10th October, and then in for treatment on 6th 16:00
November. It's one of the cases that you go on to look at as part of Dr. Chada's investigation, Dr. Chada's MHPS process.

Then another patient seen by Mr. O'Brien, again privately, it would appear, Saturday 7th November and then cystoscopy on the 25th November 2015. On the face of it, those bald dates would cause you concern that patients are being seen a lot quicker than the NHS average, given the state of your lists?

A. Yes, these dates are short.

152 Q. Why was an audit -- fancy word for an investigation in one form or another, not performed at that time?

A. Apologies, I'm afraid the ball was dropped on this one. It was a word used in the middle of a long e-mail. I probably should have had a look at it in more detail at that time. I do accept that we didn't follow through on it and, certainly after this second e-mail, this was at the end of November into December, which is usually a fairly active time in the Trust looking after patients and I didn't follow through.

153 Q. Mrs. Corrigan has said that to the best of her knowledge this concern about Mr. O'Brien's private practice and the mingling with NHS work was not addressed until into 2017 and the commencement of the MHPS investigation. You said you had a word with Mr. O'Brien. What did that amount to can you remember?

A. I can't remember the precise wording but, as per my e-mail there, I've obviously had a general conversation with him. I use that "in general". I think used the words urodynamics there, so I know there was a long urodynamics list. So I have obviously had a conversation, I can't remember the precise detail of

it but I am logging that I've had one. Again, the forcefulness of the conversation may not have got fully through, but...

154 Q. He certainly, when he gave evidence before the Inquiry in the spring of this year, I'll just bring it up at TRA-04742, the last line. I am asking him the questions. "Do you recall Mr. Young?" He clearly pre-empts what I'm about to say. He says: 16:04

"I have no recall of, if you're asking specifically, whether there was ever a discussion between Mr. Young and myself about any allegation that any private patients of mine were ever given preferential treatment in the view of anybody else in the form of jumping the queue, the answer to that is no. I have my own view on queue jumpers." 16:04 16:05

He's emphatic or adamant that there was no such discussion with you. You caveat your memory or your recollection that there was a discussion by saying it may not have been terribly forceful. 16:05

A. Yes. I can't remember the content of it and it may not have come across as strong as it should do.

155 Q. In terms of the approach which clinicians should adopt when carrying a private list as well as an NHS list, it should have been well known to you and Mr. O'Brien and other colleagues by that time, isn't that right? 16:05

A. Correct.

156 Q. You worked privately. Could I draw your attention to

the following and ask for your views. At AOB-77753, this is August 2016 and Mr. Williams, the radiologist, who is part of the urology MDT in the Southern Trust invites Mr. O'Brien to discuss the issue of private patients being discussed at the urology MDT. He says: 16:06

"I understand that the trust does not indemnify us for discussing these cases so if an error is made, we are personally liable".

16:07

He ultimately says:

"I will not be providing any radiology input into these cases until I receive clarification".

16:07

It would appear that that issue may have been prompted by a need to discuss or a desire on your part that one of your patients might be discussed at this MDT. Let me bring you to this, if we go to AOB-77844.
Mr. O'Brien is writing to you and he's explaining that: 16:08

"Today on reviewing and amending the outcome of the MDM of 4th August I realised I had not been in contact with regard to the above case."

16:08

He says:

"I regret that it was not possible to have the case discussed at MDM for the sake of the patient. Mark

declined to make any comment upon the CT images imported from UIC."

That's the Ulster Independent Clinic, which is a private facility. 16:08

"... as he is not indemnified to do so."

We can see the rest of it. You respond to that and you say that: 16:09

"As far as I am aware there is no MDM facility for private patients. Frankly, this is a poor show. It does sound as if certain members of the team are not interested. The CT scans have all been reported by 16:09
Dr. Rice and I do not get a chance to present when my patients are being discussed."

Is this a case of you using an NHS facility or wanting to use an NHS facility for the purposes of 16:09
consideration of one of your private patients?

A. Yes is the answer to the question. The full history is that this lady had had a radical nephrectomy a good number of years beforehand and, very unusually, had developed pain in a rib. She was having annual CT 16:10
scans and this had shown up a very small lesion in her left second rib, very small, reported on by Dr. Rice who works within The Trust but working privately outside. So this was a very unusual case. I didn't

know -- she had come to see me privately because of the pain but having been followed up otherwise. So I got a CT scan done, read the report, it just wasn't straightforward, something more to this and wanted to know what my colleagues would do in this case. And the 16:10
private basis there, there is no MDT, or at least there wasn't at this stage, and I was just asking my colleagues what their view on a care pathway would be. I thought that was a simple enough question.

16:11

Now, as it transpires, she had come to see me and then I transferred her on to the NHS system for her subsequent care, which she had. I followed Mr. O'Brien's advice, that was his thought process, so we did get a second CT scan which showed the lesion to 16:11
have increased in size, so I was right in my suspicion. Subsequent to this she was discussed at MDT and I was referring her to the thoracic surgeons for their opinion, which subsequently followed, and she had her second rib resected, which is rather sore. But in 16:12
saying that, I did transfer her over to the NHS. I was asking, and if the answer was no, the answer was no, they weren't prepared to do it, that's fine, I'm just expressing a bit of frustration.

157 Q. The point being, and I think you recognise it, is there 16:12
was a procedure in place for the treatment of patients who were private if they wished to receive treatment, including radiographic, in the NHS, then they should pay for it or else, in the alternative, a transfer form

should be completed and sent to the Medical Director's office for approval. It would appear that you're describing a process here that was eventually done but wasn't done at the time that this request was visited upon this MDT? 16:13

A. Yes, I accept I was asking for an opinion on an X-ray. I probably could have just taken the X-ray to another radiologist to pass comment on but it wasn't a radiological opinion I was looking for, I was looking for a urological opinion. 16:13

158 Q. I wonder, Mr. Young, was there a cosiness between you and Mr. O'Brien which might explain why you didn't effectively challenge him on the complaint that Mr. Haynes had raised about the use of NHS facilities for what were private patients? 16:14

A. It's not a cosiness. No, I don't --

159 Q. Are you not doing something not dissimilar, albeit in a different context to what Mr. O'Brien is said to have been doing?

A. Right, okay, but I was transferring this lady over to the NHS to have it done. There was a certain element of oncology based here that was time dependent. And it does take time to get the process of transfer over. Now, whether that time frame didn't just fall into the exact timelines or in the right order, should I say, in the right order, but... 16:14 16:15

160 Q. The principles governing the transfer of private patients into the NHS sector is set out in "A Guide to Paying Patients". There was an iteration of that in

2016, there's probably a subsequent version and there's certainly previous versions. Let me just bring that up. We'll take a quick look at it, TRU-267673. This is described as a change of status between private and NHS and you can see the description set out there. An important one in terms of the work that you were to perform for the MHPS investigation -- I am just going to move on to that -- is perhaps 7.4.1: 16:16

"A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient." 16:16

In other words, there is to be no advantage gained from having seen a clinician privately. You go to that point in the queue which is appropriate for an NHS patient. Is that a principle that was well understood, do you think, amongst your colleagues? 16:16

A. The sentence is maybe not fully understood. When somebody is seen on a certain date and, say, is to be reviewed or to have surgery as a routine patient, they then transfer into the system as a routine patient. 16:17

161 Q. Was that understood?

A. Yes. Well, that's what I work on. I think it is understood that, you know, when the patient transfers over, their date is X and they go on to the list at whatever -- I mean if they are a red flag, they will be processed as a red flag. If it is routine they should 16:17

go on to the list as per that date.
162 Q. Yes, but the operative date is the completion of a patient transfer form, isn't that right? So the completion of the patient transfer form is, according to the rule book, a condition precedent to you being accepted. 16:18
A. Yes. It would probably be the date of the consultation. Whether the transfer form is completed exactly the same day, but it's -- well, I take it as the date of the consultation. 16:18
163 Q. Is that right? Should it not be the approval of the application to become an NHS patient?
A. Approval --
164 Q. You're supposed to completed a form and send it to the Medical Director's office? 16:19
A. Yes.
165 Q. Was that routinely done?
A. The forms are filled in but who puts them on to the list at that date would be, you know, if the letter goes into the system, your secretary will put the patient on to the list as per the date. 16:19
166 Q. You, as I said, became involved in the MHPS process not only as a statement giver, and we've looked briefly at your statement, but you also took a look at 11 patients who Mr. O'Brien had consulted with in a private capacity and were asked to assess, it would appear, whether the time frame within which they were seen for a procedure within the NHS was reasonable. I just want to ask you some aspects of the process or the 16:20

methodology that you followed.

Let me start with what Mrs. Corrigan says about the work that you did. TRU-283681. She is explaining to Siobhán Hynds and Dr. Chada what work had been performed by you. So the process undertaken was that Ronan Carroll had requested Wendy Clayton to request a report to be run on all Mr. O'Brien's surgery during 2016. 16:21

"Any patients that had a short wait time between being added to the waiting list and been operated on had their record checked on NIECR to see if they had a private patient letter. Out of this list there were 11 patients for which all the letters were printed off. 16:22
I then asked Mr. Young if he could look at these letters and gauge, from his clinical opinion, should they have been seen as soon as they had been or should they have been added to the NHS waiting list to wait and to be picked chronologically." 16:22

Just that paragraph there that I have just read, does that match with your understanding of your instructions?

A. I was asked to review the letters to see if it was a reasonable time frame. 16:22

167 Q. Yes. So you don't disagree with that?

A. No.

168 Q. She goes on to say that you agreed:

"... took away the letters and using NIECR, i.e. checking lab results, imaging and any other diagnostics available, made his decision on whether in his opinion they were seen sooner than they should have been." 16:23

And she attaches letters with your comments which you went through and advised whether you felt it was reasonable or not. 16:23

I understand that you would say that you didn't use the records viable on NIECR when completing your work.

A. I just looked at the letter. I didn't go into it in any more depth.

169 Q. Would it have been feasible or possible for you to look at other records when conducting this work? 16:23

A. Most letters will have a health and care number on it. But I was asked to look at time frames so I looked at the start date and I looked at the finish date.

170 Q. And you would have seen the history that the patient presented with, the patient's interactions with Mr. O'Brien or the health service generally and what ultimately was offered and took place by way of procedure? 16:24

A. Yes. I passed comment earlier that Mr. O'Brien generally does one letter to cover the whole thing. So I sort of knew that that existed. 16:24

171 Q. We can see what was produced. I understand that this is Mrs. Corrigan's work, populating a table with your

comments which were written on to the letters. So the table which the Inquiry is familiar with, this table, but we'll bring it up on the screen just to assist you. TRU-01069. So the question at the top of the -- the issue at the top is described as: 16:25

"Patients seen privately by Mr. O'Brien and added to the waiting list and came in for a procedure within a short time frame". 16:25

One can see the details of the patients on the left-hand side. They're there before redaction, obviously. The number of days is recorded between added to the waiting list to the operation date, and then the question is is there a clinical reason why 16:25 they should have waited such a short time? And you, it would appear, have advised that in two out of the 11 cases it was a reasonable time frame but the rest were unreasonable. Now, I understand from your amended statement that you have reflected upon this and that 16:26 your view has changed in respect of a number of cases. Starting with this -- just do this gently --

A. Could I make a point, please?

172 Q. Of course.

A. Third down, it says four. On my original assessment of 16:26 this I believe I was unable to make an assessment of the time frame. It was either 200 or four or something similar. And I think I put that down as uncertain, and therefore accept.

173 Q. Let me help you with that and illustrate it for the Inquiry. What you are pointing to is the third entry on the table, where it is four days?

A. That's right.

174 Q. And it's recorded as, no, this isn't reasonable. You say that that has been misinterpreted. You've given Mr. O'Brien the benefit of the doubt. Let me just slow the Inquiry what you mean by that. If we go to TRU-01082. This is a typical private letter that you would have received. Just scroll up to the top. So it has got Mr. O'Brien's private notepaper and what you did by way of report back to Mrs. Corrigan across these 11 cases is to add a Post-It, which we can see here on the right-hand side. And what you've said in respect of this patient, this is the third one on the table, "not sure of timelines, accept". So you are saying not sure of the timelines, accept this was a reasonable approach. Is that, in essence, it? 16:27 16:27 16:28

A. That's, in essence, what I'm trying to put across.

175 Q. Additionally, if we can bring up your addendum statement at WIT-104219, this is paragraph D3. You say: 16:28

"I have revised my opinion in respect of four of the 11 patients, three in light of Mr. O'Brien's responses and one in response to my own..."

16:29

So this revision is summarised below in ease of the Inquiry. So the first patient that you highlight here is Patient 118. And we can, if we were to go back to the original table we would see that you had, as it said, expressed the view that it was not reasonable 16:29 that he was seen in the time frame. You have now taken the view that it is reasonable. Can you help us understand why you have come to that view?

A. It relates to the added information that Mr. O'Brien produced after his original letter. The original 16:30 letter didn't contain that information. If you want to refer to that, that's fine. But it wasn't included in the original letter and I felt that the original letter content didn't sort of justify such a short period of time. 16:30

176 Q. So on the face of the private letter --

A. On the first letter, yes.

177 Q. You looked at that and decided that's not reasonable, this man has been seen too quickly compared to the other NHS patients, but then you picked up on what 16:31 Mr. O'Brien said outside of that letter and you reached a different view.

What he has said is set out in the following document, I think. If we go to TRU-01094. Actually, if you just go back. I think it is contained in what is written on that statement. Maybe if we go back to that for ease of reference. That's WIT-104218. 16:31

What you're picking up on is that this man's symptoms were so severe that they were leading to him and his wife sleeping in separate beds with resulting marital strife, and this provided you with additional 16:32 information, and that was good reason to permit him to be seen as quickly as he was?

A. Yes. Well, it -- whether you accept it as good or not, it was additional information and there's a bit of sympathy involved here. So... 16:32

178 Q. Yes. Did you wrestle with whether an NHS patient, as opposed to a private patient would attract the same sympathy and be seen as quickly as this patient?

A. If somebody had come in to an NHS arena and had said this, I think you might also take a bit of sympathy. 16:33 This man was for urodynamics I believe. Most urodynamics are done on a routine, sort of chronological order. There will be some that are off an urgent basis. I do urodynamic, I have a urodynamic practice, and I've been asked to do urodynamics, maybe 16:33 slightly out of order. An example would have been -- the one that comes to mind is a man who was waiting for a renal transplant and it depended on the function of his bladder. That is a time dependent thing so there

may be certain features that you might want to take into account. I'm erring on the side of --

179 Q. Generosity?

A. Generosity.

180 Q. Very well. The next patient that you have gone back and looked at is 119. You are saying that you have presumably listened to Mr. O'Brien's evidence and he was making the case that this was a 14 month wait for this patient rather than two months. 16:34

A. This might have been the one that I changed. I think I misinterpreted my writing on my Post-It note. I thought it was two months but in fact it was a year and two months. Maybe you want to have a look at that. I'm going by my Post-It note rather than... 16:34

181 Q. Yes. Well, the description for this patient is to be found at TRU-01078. So just scrolling down so we can see, this is a patient that is being seen privately but he has had some involvement with the NHS. Just scrolling down, Mr. O'Brien says that: 16:35

16:36

"I advised the patient in July 2015 that he would be better served by having his prostate gland resected. As you may be aware from recent correspondence from Kathy Travers..."

16:36

That's the nurse is it?

A. Yes.

182 Q. "She has found his flow rate to be very poor".

Just scrolling up. July '15, the patient is being advised, this letter is being written, I think the 5th September 2016. That's where you get your 14 months from, is it?

A. Yes. I was interpreting advised to have a TURP as, you know, taking that, again the benefit of the doubt possibly, sorry. But there was a mention of July '15 of having a TURP. 16:36

183 Q. Mr. O'Brien was asked about this case when he came along to give evidence and let me just draw your attention to what he says and what is perhaps a problem in many of these cases, and its TRA-04948. He was being asked by me about when this patient would have gone on to the waiting list. So if he went on to the NHS waiting list in July 2015, then your maths is correct, he has waited 14 months. But I'm asking him, as you can see at line 9: 16:37 16:37

"Does that mean that this patient was placed on the NHS waiting list on 20th July 2015?" 16:38

And his answer is "no". And I say "help me with that." His evidence seems to be accepting of the view that one can only calculate 14 months if you take it from the date when the patient went on the NHS list and it would appear that he didn't go on the NHS list until July 2016, which would have been two months from the procedure. 16:38

A. So my first assessment was correct.

184 Q. Yes. The upshot of this, I don't intend to go through all four of the patients that you have changed your view on, but I suppose, taking into account what you have said in your addendum statement, that you have been prepared to take a generous approach with one of the patients, a bit of a question mark now over what you are saying about this last one, but it remains, in light of your further analysis, that there are at least four of the patients that you looked at that you remain convinced, and perhaps this is a fifth one -- 16:39

A. Yes.

185 Q. -- you remain convinced that they were seen and treated in the NHS unreasonably quickly.

A. Yes.

186 Q. Could I just draw your attention to Dr. Chada's conclusions. If we go to TRU-00702 at the top of the page she's reflecting on Mr. O'Brien's justifications in respect of the nine patients that you had said were seen unreasonably quickly. She has concluded that: 16:39 16:40

"These patients seen privately by Mr. O'Brien were scheduled for surgeries earlier than their clinical need dictated. These patients were advantaged over NHS patients with the same clinical priority." 16:41

And she plainly relies upon your analysis to reach that view. Is that what your analysis was saying, that comparing the wait that these nine patients experienced, it was a shorter wait and they were seen

more quickly than HSC patients with the same conditions?

A. It appeared to be an assessment that they were shorter. I don't have any comparators, I just felt that this was a shorter period of time than you would expect. 16:41
I mean, our waiting lists for prostate surgery is months and months and months, even with a catheter in. I appreciate there may be an analysis made of the time frames between both, but I'm given X number of patients here and they seem to have been admitted sooner. 16:42
I mean some were within the month.

187 Q. Yes?

A. It's very hard to treat most people within the month.

188 Q. Yes. Mr. O'Brien would quarrel with the conclusion on the basis that you haven't engaged in a comparative 16:42
exercise using his typical approach to his own patient list where the inference from what he's saying is he would treat all patients with these conditions in a similar way, within a similar time frame, give or take. Is that a valid point in your view, given what 16:43
you know of the lists in Craigavon or the lists in the Southern Trust?

A. Our lists are very long, even for the more urgent. Patients with a catheter in are given preference over a non-catheterised patient for all sorts of reasons, 16:43
mainly sepsis. But to be able to offer somebody surgery within a month seems to be a bit short.
I didn't compare Mr. O'Brien's patients. I didn't do an analysis of that. I was asked to do: Does this

seem to be reasonable or not? And that's the answer that I gave. As you saw, I did this on a Post-It. Post-Its aren't Mr. Young's usual way of completing his reports, and there were certain reasons for that.

189 Q. Did your findings, if I can call them findings, and you modestly explain that really it was a post-it note kind of exercise, but did your findings cause you concern and did they cause you to reflect that maybe I should have more thoroughly and forensically investigated this or brought other people in to forensically investigate it when Mr. Haynes raised the issue two years earlier? 16:44 16:44

A. Forensically look at this, these cases?

190 Q. He raised the issue, suggested an audit, that wasn't done.

A. So you're looking at the complete picture. Yes, I do agree fully with you, it should have been looked at in more detail before and after. 16:45

191 Q. Okay. I think that completes business for today?

CHAIR: Unfortunately you are going to have to come back tomorrow, Mr. Young, as are all of us. I'll see everyone at 10 o'clock in the morning, then. 16:45

THE INQUIRY ADJOURNED TO WEDNESDAY 6TH DECEMBER 2023