Urology Services Inquiry

Oral Hearing

Day 13 – Wednesday, 30th November 2022

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.

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Gwen Malone Stenography Services

1 THE INQUIRY RESUMED ON WEDNESDAY, 30TH DAY OF
2 NOVEMBER, 2022 AS FOLLOWS:
3
4 CHAIR: Morning, everybody, welcome back, gentlemen.
5 Mr. Wolfe. 10:02
6 MR. WOLFE KC: Good morning. Good morning, Mr. Gilbert
7 and Dr. Hughes. We left off yesterday part way through
8 the document relating to your meeting, Dr. Hughes, with
9 the multidisciplinary team on 18th February 2021.
10 I suppose a point I should make clear from the outset, 10:03
11 as appears from all of these notes of the various
12 meetings that they are not in the form of formal
13 minutes; is that fair to say?
14 A. DR. HUGHES: They are not, yes, that would be fair.
15 They are a note of the themes and discussions. They 10:03
16 are not a word-for-word transcription.
17 1 Q. Yes. I think that's probably obvious. Could we go,
18 please, to WIT-8350, just to finish this meeting off.
19 Sorry, I should have said WIT-84350. That's it, yes.
20 A. DR. HUGHES: I should add that the notes were shared 10:03
21 with the people we had the meetings with for amendments
22 and corrections. I think there are probably one or two
23 went through that process but they all were shared.
24 2 Q. Yes. I think I have seen that. I think the versions
25 we are using are the final versions, I stand to be 10:04
26 corrected on that, but I think that's the case. At the
27 bottom of this page, just dealing with the nursing
28 issue. Let's start with Jenny McMahon, she was a Nurse
29 Specialist, you said:

1
2 "The role of the nurses was central and provides a fail
3 safe process that is benchmarked with other Trusts."
4 She asked if other Trusts have the same issues as the
5 Southern Trust. 10:04
6
7 I assume that you agree with the first part of that,
8 that the nurses are a fail-safe, or maybe a better
9 description perhaps, is a safety net within the system.
10 A. DR. HUGHES: Yeah. We use the word fail-safe in the 10:05
11 reports. That's not their primary role and I think
12 people, I think they felt they were here to check on
13 the work of others, and that's not the case. Their
14 role is defined as holistic assessment, but also taking
15 people through their investigations, scans, informing 10:05
16 them, and as part of that role they would know then of
17 the dates and times. They are a fail-safe if there are
18 slips or misses or trips, or patients miss
19 appointments, and that's part of the supportive role.
20 3 Q. You go on to comment that your understanding was that 10:05
21 nurses meet patients with consultants, or, in the
22 alternative, contact details are made available.
23 I understand it's a point that has come through some of
24 the documentation, that the CNSs wouldn't be directly
25 available, for example, when Mr. O'Brien, or any of the 10:06
26 other Consultants for that matter, were at the clinic
27 in the South-Western Area hospital?
28 A. DR. HUGHES: I believe that to be true, yes.
29 4 Q. That's where you make the point "or contact details can

1 be made available"?
2 A. DR. HUGHES: Yes. I probably should use the word
3 "should be made available". It's pretty standard
4 practice that best practice that the nurses are there
5 at the time of breaking bad news, so they can hear what 10:06
6 is being said and what the baseline understanding is.
7 Then after that, the nurses would usually offer other
8 opportunities for the patients to discuss further with
9 them, and then obviously give them their name and
10 telephone contact for other subsequent conversations. 10:07
11 Usually this type of conversation takes place over many
12 instances and a period of time. There clearly wasn't
13 the ability to have nurses everywhere, but there should
14 have been a process to have their contact details
15 available everywhere. 10:07
16 5 Q. Yes.
17 A. DR. HUGHES: That's pretty standard practice across all
18 of Northern Ireland.
19 6 Q. Just going over the page, the nursing theme continues.
20 Jenny McMahon, it's a point she takes up again when you 10:07
21 meet the nurses specifically at your next meeting, we
22 will come to that in a moment. Jenny McMahon, she
23 makes the point she doesn't think this is unique to one
24 Consultant and suggests that it was a resource issue.
25 Should I understand her as saying through this note 10:07
26 that she didn't think it was just Mr. O'Brien who was
27 not utilising the Nursing Specialists, but it was
28 a broader issue, and it may be related to resources?
29 A. DR. HUGHES: Yeah. I explored that with the

1 Consultants, was it a geographic area, was it
2 a resource issue? I was given assurance that every
3 other Consultant used Clinical Nurse Specialists and
4 all other practice had it embedded into their practice,
5 and that then evolved into one of the assurance 10:08
6 requirements in the action plan, but I did seek
7 assurance because, obviously, we were very concerned
8 about the effect on patients of having care that was
9 unsupported and care in the community that they didn't
10 join up with the many other needs within the community. 10:08
11 7 Q. Yes. Moving down to the middle of the page, please.
12 Mr. Glackin makes the point that -- and maybe you will
13 try to help us with the context for this. Mr. Glackin
14 believes it is a criticism of the other Consultants or
15 other consultants as it says here. Is that an 10:09
16 intervention in the round dealing with your concerns
17 about the MDM and how it functioned, or is that
18 a specific remark in relation to the nursing issue?
19 A. DR. HUGHES: I think it's about the overall issues, and
20 I think that the document we started with yesterday 10:09
21 morning about the GMC, about other professionals'
22 responsibilities when working in multidisciplinary
23 teams was not really understood. When you work in
24 a multidisciplinary team you share the care, but you
25 also share the responsibility for the care to a degree, 10:09
26 and if you are the MDM lead, you have additional
27 responsibilities. I think at this stage the process
28 had moved from what had happened to why it had
29 happened, and a lot of professionals were reflecting on

1 their role on why things had happened and --
2 8 Q. Just pause there, because I think you touch upon this
3 and I want to explore this a little with you. In your
4 witness statement, if we go to WIT-84172, and if we
5 look at the second bullet point, please. You say here: 10:10
6
7 "I believe the Professionals in the Trust found the SAI
8 Review process concerning as the process involved
9 review of patient pathways in a multidisciplinary
10 setting. This moved governance questions from the 10:10
11 actions of a single professional to the
12 responsibilities of the wider team. I believe some
13 felt this unfair, but the SAI report was based on
14 expected care and on standards of care evidenced by the
15 Trust team to Cancer Peer Review of their service". 10:11
16
17 Is that germane to --
18 A. Yeah. It's my experience and my interpretation of how
19 people responded to me. I think everybody understood
20 there were care deficits. I don't think they fully 10:11
21 understood the deficits in the governance that, sort
22 of, was responsible for the deficits being not exactly
23 fully understood, not actioned, and some completely
24 unknown. I think that moved possibly the spotlight of
25 questioning from what happened with the care in the 10:12
26 immediate vicinity of Mr. O'Brien to what was the
27 responsibility of the greater team overseeing the care
28 that was delivered, because as a multidisciplinary
29 team, when you are doing your Peer Review, it's not

1 a Consultant-specific response; it's what the team
2 deliver. The team have to have ownership of the
3 governance and have to have ownership of the deficits,
4 and I think that was a bit of a hard journey.
5 9 Q. Yes. One of the things you reflect upon in your 10:12
6 statement, was that the members -- I think at least two
7 members of this multidisciplinary team had practised in
8 Great Britain?
9 A. DR. HUGHES: Yes.
10 10 Q. Mr. Glackin and certainly Mr. Haynes. They had been 10:12
11 exposed in the MDTs in their former practice which were
12 better resourced for Governance purposes and better
13 supported. I think your reflection was that they knew
14 they could be done better. I think the point that you
15 are making, and you've just made to us, is, but whoever 10:13
16 it was, and we are not individualising this, amongst
17 the group on that MDT, they didn't become proactive in
18 chasing what could be done better?
19 A. DR. HUGHES: Yeah. I think there's a few things.
20 There's experience of how it could be done better and 10:13
21 there's additional resource. The third unspoken thing
22 is culture. There clearly was not a culture of
23 openness and the ability to discuss difficult things.
24 We have heard from Mr. Haynes, when we raised the issue
25 of Bicalutamide, there were very, very difficult 10:13
26 conversations. I think we have heard from other people
27 that there were very difficult conversations. I don't
28 think resource is the only issue here; I think -- and
29 it's a very hard thing to define -- I think the culture

1 was not one that would allow people to raise issues and
2 success -- or feel comfortable in discussing difficult
3 things in that environment. That's where I probably
4 was critical of the senior cancer management, they
5 seemed to know particularly little about the team. You 10:14
6 know, that's where you need the senior management to
7 step in to check the culture. Now there's ways of
8 doing this and there's ways of ensuring, you know,
9 functional MDT working, but that should have been on
10 their radar and that should have been on their horizon, 10:14
11 not simply we can't get a second radiologist and we
12 can't meet all our 31/62 day targets, because it didn't
13 take a lot of exploring to see that it was quite
14 stressed MDT and not totally functional. I don't think
15 it was a particularly happy Service and I think they 10:15
16 would have required support. You could have started
17 with the addressing the additionally. I mean, at times
18 the MDT quorate levels were in 5%, and that clearly
19 shows that the people could not be making fully
20 informed decisions. I think they should have focused, 10:15
21 if they had benchmarked all their MDTs across the Trust
22 they probably would have seen this was the one in most
23 difficulty and it needed the most support, and I don't
24 think that support was being given.
25 11 Q. Let me move to the next meeting that you had. You had 10:15
26 a meeting with Cancer Nurse Specialists on 22nd
27 February 2021, and if we go to WIT-84357. The Nurse
28 Specialists all attended. It's fair to say that during
29 this meeting, a variety of views were expressed?

1 A. DR. HUGHES: Yes.
2 12 Q. If we go to the bottom of the next page, page 58,
3 please, we can see that Kate O'Neill seemed to suggest
4 that resources were an issue, but your response to that
5 was that patients weren't even being given phone 10:16
6 numbers?
7 A. DR. HUGHES: Yes.
8 13 Q. You had been assured elsewhere that adequate resources
9 had been made available, and that's what the Peer
10 Review seemed to suggest? 10:17
11 A. DR. HUGHES: Yeah. There was an increase from three
12 nurses, which is a very poor level of nursing, to five.
13 I'm not saying that was ideal but it was an increase
14 and the response to Peer Review was a very positive
15 one, and that they clearly said that Clinical Nurse 10:17
16 Specialists would be available to all patients. The
17 experience from these nine patients, and it's my belief
18 all other cancer patients who were cared for by
19 Mr. O'Brien, did not get access to this, and that was
20 confirmed by the Urology Manager of eleven years. 10:17
21 14 Q. At the top of the next page then you get a different
22 perspective. Leanne McCourt claimed that he, that is
23 Mr. O'Brien -- taking up the sentence in the previous
24 page -- she felt that he didn't value the Nurse
25 Specialists. She recalled him asking her in the 10:18
26 kitchen what the role of a Nurse Specialist was. He
27 didn't understand the role of a Nurse Specialist, was
28 her perception, whether that's fair or not.
29 A. DR. HUGHES: Yeah. I think that may be true. I think

1 there's a difference between somebody understanding
2 a nurse who does urological procedures, but it was very
3 clear in the Urology guidelines what their roles are
4 and they step it out; holistic baseline, assessment of
5 need, and assessment of need as that changes in the 10:18
6 patient's pathway. Helping people to understand their
7 investigative and diagnostic process, and critically,
8 helping patients understand the MDT and their treatment
9 options. I look at the cohort of patients, they are,
10 by and large, elderly men who have gone through their 10:19
11 first cancer pathway, you know, from a variety of
12 backgrounds, but this is all new to them. A cancer
13 pathway for the first time is incredibly complex and
14 incredibly hard to understand, and the work that
15 Clinical Nurse Specialists, and I have to say the work 10:19
16 the Clinical Nurse Specialists do in the Southern Trust
17 is exemplary. There's a cancer patient experience
18 survey from 2018 I think, and it really shows high
19 quality work. To have that resource and not made
20 available to patients, I really can't understand it. 10:19
21 To listen to patients describe a cancer journey that
22 sounded completely bizarre and traumatic, unnecessarily
23 traumatic is a difficult thing. These were people who
24 were left, and I probably mentioned it yesterday,
25 trying to access care through GPs. GPs were no longer 10:20
26 used to providing this type of care because there was
27 a network to do it, and then ending up in ED at the
28 time of Covid trying to access care, and that's just
29 not an appropriate place and not necessarily a place

1 with the appropriate skills.
2 15 Q. Another perspective, more complementary or warmer to
3 Mr. O'Brien perhaps is Jenny McMahon's, just down the
4 page a little, she had a different experience. She
5 wasn't sure why Mr. O'Brien didn't invite the CNS into 10:20
6 the room, and that's a question for Mr. O'Brien, but
7 she says that Mr. O'Brien spoke very highly of the CNS.
8 She recalls Mr. O'Brien having Review Oncology on
9 Friday, but she wasn't asked to attend. Her position
10 seems to be, Mr. O'Brien did appreciate the role of the 10:21
11 CNS, it was just on occasions he didn't invite them to
12 participate. Is that the core of it for you?
13 A. DR. HUGHES: It's not a statement that makes sense to
14 me. I think if you value somebody's skills and
15 expertise, you ensure that your patients can access 10:21
16 those skills and expertise. To say one thing but not
17 actually put it into action is just pointless. I just
18 don't understand it. It doesn't make sense. If you
19 value their skills, experience and knowledge, then you
20 make sure your patients have those, or indeed the 10:22
21 Southern Trust makes sure their patients have access to
22 those skills.
23 16 Q. Yes. At the bottom of the page -- I forget his name --
24 Jason, another CNS at the meeting. He advised he had
25 worked with Mr. O'Brien, and his experience was again 10:22
26 different from Kate's. He said he may not have been in
27 the room, but would have been introduced after.
28 I think he means with other Consultants, but with
29 Mr. O'Brien he would not have had as much input. He

1 said Mr. O'Brien may have given contact details in the
2 room, he doesn't know. Nevertheless, he said
3 Mr. O'Brien was supportive in other ways and he made
4 him aware of other patients. I'm not sure if you can
5 help us with what that means, but, again, it appears to 10:23
6 be a perspective that Mr. O'Brien didn't have him in
7 the room and there wasn't an opportunity or there
8 wasn't a situation where you'd be introduced to the
9 patient after Mr. O'Brien had finished with the
10 patient. 10:23
11 A. DR. HUGHES: Yeah. I mean, I think there's clear
12 knowledge of at least potential patients weren't being
13 seen, and I think that should have been escalated.
14 I think Martina Corrigan did escalate it and
15 appropriate action wasn't taken. I mean, again, the 10:23
16 simple way around this is to have an Assurance Audit.
17 There were audits of patient experience but they were
18 only obviously the patients who had seen a Clinical
19 Nurse Specialist, and a baseline part of that audit
20 should have been how many patients are getting the 10:23
21 opportunity talk to a Clinical Nurse Specialist.
22 I think it's again a question about the Service that
23 patients are receiving, despite the Service being
24 present in that environment, and that's obviously
25 a governance issue. I think it may be very difficult 10:24
26 for nurses to deal with this in isolation, and I don't
27 think that's appropriate; but I think that should have
28 been part of the bi-yearly business meeting and
29 addressed through normal business.

1 17 Q. Yes. I'm not going to open it just in the interests of
2 some time, but you met with Heather Trouton on
3 23rd February. The reference for the Inquiry's note is
4 WIT-84344. She, at that point, was the Director of
5 Nursing, as I understand it? 10:24
6 A. DR. HUGHES: Mm-hmm.
7 18 Q. Having been, up to March 2016, Assistant Director for
8 Surgery and Elective Care. One point she did make to
9 you was that information, including leaflets and
10 contact numbers, were visible in every consulting room 10:25
11 for the Clinicians, for the Consultants, but she
12 accepted, and this goes back to the point you have just
13 made, that there was no checking mechanism in place.
14 This Inquiry's interest or main interest, I suppose, is
15 that governance focus, the super intendance of what was 10:25
16 going on with patient care?
17 A. DR. HUGHES: Yes. I mean leaflets and booklets,
18 classically when a patient is diagnosed with cancer,
19 they are often overloaded with booklets. I was very
20 conscious when I was Medical Director in the network 10:25
21 that 27% -- and we are not talking about these
22 patients, but a lot -- 20% of Northern Ireland has a
23 literary age of 12 so they needed supported
24 information. When you are going through -- some of the
25 MDT options for these patients would have been, for 10:26
26 example, curative intent treatment or surveillance. To
27 a layperson they are totally different ends of the
28 spectrum. That is a conversation that needs supported.
29 That's a conversation that needs to be done in language

1 that they can understand. That's a conversation that
2 probably needs to be taken over in an iterative way.
3 While leaflets are available, these leaflets are
4 normally given by a CNS and explained by a CNS, with
5 the opportunity to go and read that and come back to me 10:26
6 and a telephone number. That's a human dimension of
7 the Service that these people did not get.
8 19 Q. We shouldn't lose sight of the fact that the MDT
9 operational policy, which I opened to you yesterday,
10 put an onus on the MDT Clinical Lead, and the core 10:27
11 Nurse Practitioner, on at least on that piece of paper
12 as I kept pointing out, to allocate the CNS. Is that
13 a point that, for example, you raise with Mrs. Trouton
14 or where did that point take you?
15 A. DR. HUGHES: I took that point to make sure that nurses 10:27
16 were available, but my personal belief is that the
17 Consultant responsible for the care is the person
18 responsible for referring a patient to a CNS, in the
19 same way they'd refer them to an AHP if they needed
20 that Service, or a social worker if that was needed. 10:27
21 I think that -- my discussion with Ms. Trouton was,
22 there's a high focus on availability of nursing in
23 various areas of enhanced care where there's nursing
24 ratios, and this is part of the Service where we found
25 there was a nursing resource available but not used. 10:28
26 To my mind, that's a professional nursing issue. I was
27 seeking to see if it had been raised at the governance
28 issues to her and it clearly hadn't, and then she was
29 unaware of it. There was an issue known locally, which

1 was attempted to be addressed through the Urology
2 Service manager but it had gone nowhere, and then we
3 were left with -- and the problem -- what we don't know
4 is how long this problem existed. They have done
5 lookback exercise on the basis of Bicalutamide 10:28
6 prescribing, but I believe absence of CNS nurses has
7 a significant issue as well, and it's specifically
8 a significant issue when there is variation from MDT
9 recommendations and about informed consent.
10 10:29
11 I think also that the other issues we have picked up is
12 that MDT recommendations where onward referral was
13 asked to happen.
14 20 Q. Sorry, I missed that?
15 A. MDT recommendations, when there should have been onward 10:29
16 referral to Oncology and it didn't happen. And if
17 there's also a missing CNS in that process, I think
18 that's an issue that needs to be addressed.
19 21 Q. Yes. Mr. Gilbert, I have been ignoring you for the
20 past half day. Back to you. Are there circumstances 10:29
21 in which the Consultant meeting the patient after the
22 MDT can properly decide that, really, the patient seems
23 content, is understanding of the advice I have given,
24 and is exhibiting no worries or concerns, perhaps; I
25 don't really need to trouble them with a CNS or perhaps 10:30
26 mentioning the CNS the patient can say, no, thanks.
27 How does a Consultant --
28 A. MR. GILBERT: Clearly it's the right of any patient to
29 decline treatment of any sort, but, in this

1 circumstance, we must understand that the Cancer Nurse
2 Specialist's role is complementary to, not the same as
3 the Medical Clinician's. A number of models for
4 interacting with patients along the pathway for the CNS
5 and for the Clinicians can be described. My experience 10:30
6 in Gloucestershire would be that all the CNSs would be
7 at the MDT, the cases would be discussed. The
8 Consultant would usually see the patient to describe
9 the options available for treatment, but they would
10 also have an appointment subsequently with a Cancer 10:31
11 Nurse Specialist in order to fulfil their particular
12 role, which has already been described by Dr. Hughes.
13 In addition, they could make sure that they understood
14 what the doctor was saying, and put it in terms that
15 might be more accessible to them. 10:31
16
17 In some models, the Clinical Nurse Specialist will sit
18 in with the Consultant when the bad news is being
19 given. That is a model that is perfectly reasonable.
20 I'm less keen on it because it implies that the 10:31
21 Clinical Nurse Specialist is somehow the Consultant's
22 assistant, and I would like to make sure the patients
23 understand that the roles are quite different. The
24 purpose of the Cancer Nurse Specialist isn't
25 a fail-safe or a safety net; it is continuity. When 10:32
26 the patient presents from that moment, or from the time
27 of diagnosis, the Cancer Nurse Specialist is there by
28 the side of the patient, conducting them through their
29 pathway, irrespective of who is delivering the

1 treatment, whether that's the original diagnostic
2 Clinician or whether it's a Urologist or whether it's
3 an Oncologist. As such, they are a point of access,
4 and so the idea of fail-safe or safety net is simply
5 because you've got somebody there for the patient, and 10:32
6 every patient has a right to that sort of professional
7 by their side.
8 22 Q. It is, however, a fail-safe or a safety net in
9 circumstances where the nurse is fully aware of
10 a recommendation, or an expected course of treatment, 10:32
11 and exceptionally perhaps that isn't being delivered
12 and it would be, in those circumstances, the nurse's
13 role to highlight that?
14 A. Absolutely, by return to the MDT and to a receptive MDT
15 that would understand, because, remember, all the 10:33
16 resources that we have available for the management of
17 patients come to the MDT. The Clinician, they should
18 be there. The Clinicians, the Radiologists, the
19 Pathologists, Cancer Nurse Specialists, some
20 administrative staff who are key to the tracking 10:33
21 practice, and the MDT becomes the focus for business.
22 Why this patient not being referred? Why is the
23 patient not being seen? Why has it become necessary to
24 change treatment? All these questions can be resolved
25 in this weekly meeting, and instead of having 10:33
26 half-conversations in corridors we now have a formal
27 process in which we can safely manage patients, and the
28 key individual in that is the key worker and that, by
29 and large, is the Cancer Nurse Specialist.

1 23 Q. Thank you. I am going to leave nursing for a moment.
2 We might see it on the way back when we look at some of
3 the specific cases. We can see through these meetings,
4 Dr. Hughes, that you have explored managerial issues
5 with their connection with governance, particularly the 10:34
6 Clinical Lead for the MDT, Mr. Glackin, and the cancer
7 management team, if I can put it in those terms. You
8 have focused on nursing through the meeting with the
9 MDT and with the nurses themselves and Ms. Trouton.
10 You next, it appears, take up conversations 10:35
11 specifically in relation to the issue of Bicalutamide.
12 Obviously, that had arisen through Mr. Gilbert's work.
13 You touched on it with Mr. Glackin and the MDT team and
14 with Mr. Haynes as well. What brought you to meeting
15 with Mr. O'Sullivan and Mr. Mitchell, who both practice 10:35
16 outside of the Southern Trust? First of all, who
17 directed you to them or what brought you to them?
18 A. DR. HUGHES: Professor Joe O'Sullivan at that time
19 would have been the Clinical Lead for the Northern
20 Ireland Cancer Centre, who supplied the Oncology 10:35
21 Service to the Southern Trust. So while they are not
22 part of the Southern Trust, they would have been part
23 of the MDT, and part of that issue was about, actually,
24 getting access to clinical Oncology and even more
25 rarer, Medical Oncology. He was the Clinical Director 10:36
26 for the Cancer Services which were part of that MDT, so
27 while being separate, they did have particular
28 responsibilities. The issue about Bicalutamide was
29 a lot of these patients should have been going onward

1 to the Cancer Centre for treatment, and it was likely
2 that the Cancer Centre would have a greater oversight
3 of the issue around Bicalutamide because there wasn't
4 a lot of clarity within the local MDT. The
5 investigations were on the basis of the Bicalutamide 10:36
6 issue and the really quite poor availability of staff.
7 24 Q. Yes. Just to be clear, was it your decision to direct
8 your investigation, if that's the right word --
9 A. DR. HUGHES: Yes.
10 25 Q. -- towards these two practitioners? Let me just look 10:37
11 then at your meeting. I was wrong to suggest, perhaps
12 in my opening of this, that chronologically it came
13 after the nurses. It was the first meeting, the
14 meeting with Mr. O'Sullivan was 4th January. If we can
15 open up that, please? It's WIT-84362. That was via 10:37
16 Zoom, and you explained the process of your SAI review.
17 You asked Mr. O'Sullivan was he aware of any issues
18 regarding the practice of Mr. O'Brien. He told you
19 that when he came into the post initially, about 17
20 years ago, he had concerns in relation to the use of 10:38
21 Bicalutamide and he had frequently challenged
22 Mr. O'Brien about, he made recommendations in clinic
23 letters questioning the use of Bicalutamide instead of
24 what he called the standard 150 milligrams LHRH agonist
25 therapy. In the cases he had seen, the dose of 10:38
26 Bicalutamide would not have resulted in a major
27 detriment to the patient's therapy or outcome and,
28 therefore, wasn't escalated further. He said he was
29 aware that his colleague, and that's Darren Mitchell,

1 is that right?
2 A. DR. HUGHES: Yes.
3 26 Q. As MDT Chair had raised "our concerns", is that the
4 Belfast MDM's concerns?
5 A. DR. HUGHES: Yes. 10:39
6 27 Q. About AOB, Mr. O'Brien's Bicalutamide prescribing with
7 the then Clinical Director from Pathology. Is that
8 Mr. McAleer?
9 A. It's Seamus McAleer, yes.
10 28 Q. Probably in 2011. This conversation seemed to confirm, 10:39
11 to some extent, Mr. Gilbert's analysis that there was
12 a reason to be concerned about Bicalutamide
13 prescribing?
14 A. DR. HUGHES: I think we had a small number of cases and
15 a variable degree of awareness within the local MDT, so 10:40
16 the rationale for asking the Northern Ireland Cancer
17 Network Leads was to actually get their input, and it
18 was very clear there had been concerns for a very long
19 period of time where there was local attempts at
20 resolution through clinic letters and one episode of 10:40
21 escalations but not 100% successful. The other
22 discussions, I'm not sure if it's captured here, was
23 around the quorate nature or lack of quorate or lack of
24 staff locally.
25 29 Q. Just look at one particular issue. You can see there, 10:40
26 Mr. Gilbert, in the middle of that large paragraph,
27 that the concern or the questioning was in respect of
28 the use of 50mgs of Bicalutamide as opposed to what has
29 been described here as standard 150mgs or LHRH. Does

1 that recall our conversation yesterday where you say in
2 certain circumstances, 150mgs of Bicalutamide may be an
3 appropriate treatment?
4 A. MR. GILBERT: Yes. As I said yesterday, it can, under
5 certain circumstances, be an alternative to an LHRH 10:41
6 analogue. I think, in this case, Professor O'Sullivan
7 would have seen patients who had been started off on
8 hormone therapy as a prelude to Radiotherapy.
9 A patient with localised prostate cancer disease
10 confined to the prostate or its immediate vicinity 10:42
11 would have been started on hormone therapy from the
12 Southern MDM, with a referral up for Radiotherapy and,
13 of course, that gives the opportunity to the Oncologist
14 to amend the hormone therapy from what might have been
15 an inappropriate dose of 50 milligrams up to a full 10:42
16 dose. Whether that's an LHRH analogue or 150
17 milligrams of Bicalutamide is an individual decision.
18 It just happens to be my practice, and most of the
19 Oncologists I worked with would have preferred the LHRH
20 analogue, but I maintain that 150 milligrams of 10:42
21 Bicalutamide is an alternative. Okay? The patients
22 that Professor O'Sullivan will have seen, he will have
23 been able to change their treatment to an appropriate
24 hormone regime prior to their Radiotherapy. Patients
25 he won't have seen are those that were started off on 10:42
26 hormone therapy, whatever that is, and then not
27 referred on for an opinion from an Oncologist. It is
28 those patients that I think form part of this cohort,
29 and it's those patients who the Oncologists would not

1 have been aware of, because of the lack of referral on
2 the suggestion of the MDT, or of the recommendation of
3 the MDT that they go and have an opinion from
4 a Radiation Oncologist. That didn't happen.
5 30 Q. Yes. Just going back to your choice of word on the 10:43
6 150, that is an individual decision, I think you said?
7 A. MR. GILBERT: Yes.
8 31 Q. But within parameters?
9 A. MR. GILBERT: The reasons I would recommend an LHRH
10 analogue is that the trials that establish the current 10:43
11 practice within giving external beam Radiotherapy for
12 localised prostate cancer involved LHRH analogue, so
13 why change? We know you get good results with that,
14 stick with that. The other second reason is that the
15 LHRH analogue is clearly licensed for locally advanced 10:44
16 disease, which is a particular staging of prostate
17 cancer. Staging, in its medical terms means how far
18 has the cancer got? Where has it got to? Locally
19 advanced means that the disease has spread just outside
20 the capsule of the prostate and is clearly involving 10:44
21 the surrounding tissues, but there is no evidence of
22 any spread, either to lymph nodes or to bone, which are
23 the two preferred sites for metastatic spread. It's
24 that group of patients for which this drug is licensed.
25 In essence, you could say that if somebody has 10:45
26 generalised localised prostate cancer that is confined
27 to the prostate itself, you shouldn't really be giving
28 the 150 milligrams of Bicalutamide because it's outside
29 the licence. Having said that, I think it's reasonably

1 common practice for people to substitute one for the
2 other.
3 32 Q. Yes. I just want to touch, Dr. Hughes, on the mode of
4 communication here. Dr. O'Sullivan is saying that he
5 has concerns about what he had come across, 50 10:45
6 milligrams being used when he didn't think that was
7 appropriate. His approach is to write to Mr. O'Brien,
8 it seems, repeatedly, with alternative therapeutic or
9 prescribing recommendations, but not to escalate it on
10 the basis that it doesn't appear to be causing 10:46
11 significant harm. But if he is still seeing the cases
12 coming back to him with Mr. O'Brien not listening,
13 perhaps, is one inference from that, or taking
14 a different view, to put it more neutrally; is that
15 a satisfactory approach? 10:46
16 A. DR. HUGHES: No. I think part of the conversation was
17 reflection on Professor O'Sullivan's part and
18 Dr. Mitchell's part that perhaps they should have
19 escalated it through normal practices. I think some of
20 the issues, and this is obviously an issue for this 10:47
21 Inquiry, is how governance is managed between
22 institutions and between a Cancer Network and
23 institutions, where there is knowledge and information.
24 The normal pathway is to escalate that up through your
25 own governance structures. It can be, you know, 10:47
26 Medical Director to the Medical Director discussion.
27 The understanding that they were the Cancer Network, or
28 the Cancer Centre providing care for the patient in the
29 Southern Trust, while they weren't directly related to

1 the governance in the Southern Trust, they actually had
2 a governance responsibility for those patients.
3 I think they know that and I think that they reflect on
4 that as part of the discussions that we had.
5 I hopefully reflected that in my statement, because 10:47
6 I think they felt they should have done more.
7 33 Q. Yes. Indeed that is, I think, reflected in your
8 statement. Just scroll down. I think Mr. O'Sullivan
9 -- you also raised with him the issue of Oncology
10 attendances, as you remembered. Part of the difficulty 10:48
11 was that the MDM on lung cancers and the MDM on Urology
12 clashed, it was the same day?
13 A. DR. HUGHES: It was actually more than that.
14 A single-handed Oncologist was expected to staff the
15 Urology clinics, the lung clinics, and two very high 10:48
16 volume, complex MDMs. The jobs weren't attractive and
17 the roles were very difficult to deliver. I slightly
18 had more information than that because when I was the
19 Medical Director we were sending professionals down to
20 support on a locum basis, but it was actually a role 10:49
21 that was not deliverable, and they needed to be picked
22 apart and more resource put in.
23 34 Q. Mr. O'Sullivan did recognise, nevertheless, that there
24 was a lot of good work going on at the MDT, and he
25 wanted you to reflect that in your report? 10:49
26 A. DR. HUGHES: Yes.
27 35 Q. You next met with Dr. Mitchell. Was that at
28 Mr. O'Sullivan's suggestion?
29 A. DR. HUGHES: Yes, he had mentioned that he had more

1 detailed information about that.
2 36 Q. Yes. Let's look at the record of that meeting.
3 WIT-84363. Just scroll up, please. You explain to him
4 that one of your concerns was nonadherence to MDT
5 recommendations, including non-referral to Oncology 10:50
6 Services. Dr. Mitchell apprised you of his concern
7 about hormone therapy prescribing that had gone back
8 a decade. He said that he took over as Chair of
9 Regional Urology MDM in 2015 and had challenged
10 Mr. O'Brien on his use of Bicalutamide as part of the 10:50
11 development of clinical guidelines whilst Mr. O'Brien
12 was Chair of NICaN. Dr. Mitchell said that his
13 response was to write prescribing guidelines for
14 hormone therapy. We touched on this yesterday. You
15 explained that it was your understanding that the 10:51
16 guidelines were as a direct response specifically to
17 Mr. O'Brien's approach to prescribing?
18 A. DR. HUGHES: Yes. That was one of the major triggers
19 because of the repeated variance from expected
20 practice, and I think that's confirmed by the 10:51
21 Bicalutamide Audit.
22 37 Q. He shared the guidelines with you. The penultimate
23 paragraph there on 64. Dr. Mitchell advised that he
24 had e-mailed the Consultant Mr. O'Brien in '16/'17,
25 about his prescribing outside recommended guidelines, 10:52
26 highlighting that it was his GMC duty to inform
27 patients they were treated outside the recommended
28 guidelines and the patients were misled -- presumably
29 misled in the sense that they weren't informed their

1 treatment was outside of guideline. Did you ask for
2 sight of that e-mail?
3 A. DR. HUGHES: He said he would try and find it. He
4 didn't forward it to me so I'm not sure if he has found
5 it. As part of the discussion, Dr. Mitchell clearly 10:53
6 reflected that he should have escalated the issues.
7 Despite the many actions that he had taken, he was
8 still concerned about the persistent prescribing
9 outside guidelines and felt that he should have done
10 more. 10:53
11 38 Q. Yes. The note of your meeting with Dr. O'Sullivan is
12 specific that the concern was prescribing at 50
13 milligrams, when the standard was 150 for the reasons
14 explained by Mr. Gilbert, or, in the alternative, LHRH.
15 I am not sure I have seen a specific diagnosis of the 10:54
16 problem in what Mr. Mitchell was saying?
17 A. DR. HUGHES: We didn't delve into the details of the
18 issue. The discussion was really about, did you know
19 that this was a problem? How long did you know it was
20 a problem? What actions did you take? Did you 10:54
21 escalate? He obviously clearly did take actions in
22 writing a regional hormone therapy guidelines, which
23 was signed off at the NICaN Regional Clinical Reference
24 Group, and he did take action on a personal basis by
25 e-mailing and writing, but he didn't escalate it. That 10:54
26 was the understanding at that meeting, so, again, we
27 had knowledge of a problem in part of the wider system
28 in Northern Ireland, not appropriate escalation of the
29 governance, and a problem not being necessarily passed

1 back to the Southern Trust and the right actions not
2 being taken, and both professionals did reflect on
3 that.
4 39 Q. Yes. Was Dr. Mitchell still involved in the role as
5 Chair of MDT or in Oncological Services at the point 10:55
6 when you were speaking to him?
7 A. DR. HUGHES: I don't think so. That's the Chair -- the
8 names sound the name. The Regional MDT is the MDT that
9 all the Southern Trusts and the Northwest Trust would
10 feed into on a regular basis, so it's a regular 10:55
11 regional meeting. The NICaN Regional Reference Group
12 is a very separate group that oversees production of
13 guidelines and consistent delivery of guidelines,
14 interfaces with the Commissioners, and does that type
15 of work. Dr. Mitchell was the Chair of the Regional 10:56
16 Urology MDT for specialist cases, and cases that would
17 be passed on from the three cancer unit MDTs.
18 40 Q. Yes. Nevertheless, cases relating to Mr. O'Brien's
19 patients would make it to Cancer Services in Belfast,
20 presumably you were finding the problems in cases in 10:56
21 2019/2020?
22 A. DR. HUGHES: Yes.
23 41 Q. Some cases, as you point out, don't get the referral,
24 notwithstanding the MDM recommendation, but the issue
25 of prescribing outside of the guidelines, as you put it 10:57
26 in your report, must, nevertheless, have been known
27 outside of the Southern Trust, not just in the time of
28 O'Sullivan and Mitchell, but beyond that?
29 A. DR. HUGHES: I think it was known outside of the

1 Southern Trust, and obviously it was known in the
2 Northern Ireland Cancer Network. I mean, it wasn't
3 something I had to -- it was very clear as soon as we
4 had the discussion, they were well-apprised of the
5 issue. 10:57
6 42 Q. I think, as you have said a moment or two ago, that it
7 does raise across institution, across site governance
8 issues that need to be addressed by the Inquiry,
9 perhaps?
10 A. DR. HUGHES: Yes. 10:57
11 43 Q. You have explained that you met with families on three
12 occasions?
13 A. DR. HUGHES: Yeah.
14 44 Q. Not all together as a group, but individual meetings.
15 You have reflected in your statement that you were met 10:58
16 with, on many occasions, upset and anger, and my words,
17 not yours, presumably a sense of bewilderment as to how
18 these things had happened?
19 A. DR. HUGHES: Yeah. The family were very stoic.
20 I think the first three people in Patient 1's family, 10:58
21 Patient 9's family and I think, yeah, probably maybe
22 patient -- I want to get these numbers right, I don't
23 want to -- Patient 2.
24 45 Q. Just repeat that?
25 A. Patient 1, Patient 9 and Patient 2. The first two 10:59
26 patients had prostate cancer. Patient 1 had, sadly,
27 deceased. They had found the process very troubling
28 and a lot of that was about having a coherent care plan
29 about understanding what was happening about accessing

1 basic services, difficulties with catheters, and it
2 seemed -- this is evolving as we discussed, it seemed
3 that the point of contact was the Consultant's
4 secretary for care. I literally couldn't understand
5 that because that was not my understanding how any 10:59
6 Cancer Services work because, in essence, we would be
7 seeking access through Services, probably through
8 a very business secretary who had no clinical
9 background. I was immediately asking what about your
10 Clinical Nurse Specialists? They didn't have access to 11:00
11 that and didn't really know about that. Patient 9 was
12 somebody who had delayed diagnosis of cancer and
13 eventually presented with GI symptoms and presented to
14 the GI MDT with presumed rectal cancer but had actually
15 had locally advanced prostate cancer. Even at that 11:00
16 stage he was referred back out but he wasn't given
17 a Clinical Nurse Specialist at that stage. Obviously
18 because of the locally advanced cancer, he had specific
19 needs and specific nursing needs. I think the
20 conversations, to tell somebody things did not need to 11:00
21 be this way, it was quite difficult for them, and
22 depending on the amount of insight, it probably took
23 a while for that to sink in. Initially we met with
24 families and patients with support, usually of
25 a spouse. That's always a very difficult conversation, 11:01
26 to say you've come to harm, and possibly come to harm
27 because of Services that you haven't received or
28 Services that you haven't received in a timely way. We
29 did that with all the patients. Some had to be by Zoom

1 because of the time of Covid, which was not ideal,
2 because these conversations are always better in the
3 room. We then met at a midpoint, after we stepped
4 through a lot of the information, and then we met
5 finally before issue of final report. I think when we 11:01
6 met the second time, the families had time to digest
7 what happened, and the conversations had moved from the
8 specific professional that was delivering the care to
9 the, how did this happen? I mean, they all knew about
10 the MDT and multidisciplinary input, they had different 11:02
11 ways of describing, but they all expected that cancer
12 care was delivered to a higher standard with greater
13 oversight and greater governance. A lot of them
14 thought the reason they didn't have Specialist Nursing
15 was because of Covid or because services were stressed, 11:02
16 and I think it was really, really difficult for them to
17 understand that other patients -- and they did ask
18 about the standard of the Service for everybody else
19 and the support they got. It was very difficult to
20 find that people were somewhat unique in not having 11:02
21 a basic standard Service, and I think the focus did
22 move from their care to how that care was delivered,
23 seemingly in a multidisciplinary governance supported
24 environment, that their care would have been different.
25 46 Q. This question would probably be better targeted at the 11:03
26 patients and families themselves. From your
27 perspective, taking into account your experience
28 working through these nine SAIs, and indeed your wider
29 experience, how does, and how did in this case, the SAI

1 process work for the patients? Do you believe that, in
2 general terms, patients and families get a degree of
3 understanding and perhaps satisfaction from the
4 process, or are there other shortfalls in the process
5 that might be improved upon? I suppose finally to 11:04
6 reflect in your answer, sorry, a long question, is
7 there anything that you would suggest by way of
8 recommendation in this area?
9 A. DR. HUGHES: I think, I'm careful, I don't really want
10 to be presumptive and speak on the part of the 11:04
11 families. My reflections from this, when I benchmark
12 it to other work I have done, I have done work where
13 people had concerns about their care and maybe had to
14 lobby for quite a while until that care was
15 appropriately reviewed. If they go through that 11:04
16 process and they are vindicated that's a very positive
17 thing, and then people can take something of that.
18 This cohort of families, and four of the patients have
19 sadly died. They just thought their parent or relative
20 had really bad disease, and to be told, actually, you 11:05
21 should have been referred to Oncologists at an earlier
22 stage on many occasions, or you should have a different
23 type of therapy and your care should have been
24 supported in a different way, was a very difficult
25 story to tell. No matter what we found, we are not 11:05
26 going to be able to fix that. I think the process,
27 I know you met the daughter of family 1. She shared
28 many of the things that impacted on her life, and we
29 can never redress that. So, I'm left thinking the SAI

1 process is meant to be patient and family focused in an
2 attempt to show redress and improve the services. It
3 may help for some, but I think it was quite traumatic
4 for many.
5 47 Q. Is there anything you could suggest that might improve 11:06
6 the process or is it a case, in your view, maybe it's
7 not always done in SAIs, but to they involve the
8 families as much as possible, and you have pointed out
9 I am not sure if you can improve upon three meetings,
10 it's specific stages? 11:06
11 A. DR. HUGHES: Yeah, I thought what had happened to these
12 families was that they had a very poor understanding of
13 their care, very poor information, simply because one
14 of the major tenets of how you inform patients and how
15 you support patients was not made available to them, 11:06
16 and their care package was very complex and very
17 difficult. I was as honest and forthright as I could
18 be, but I think Patient 1 obviously found that quite
19 blunt and I'll need to reflect on that. I think these
20 patients would require a wider piece of work done. 11:07
21 I think they would be very concerned if they weren't
22 referred to Oncologists, they would want to know how
23 many people did that also happen to? There needs to be
24 an audit to review non-action on MDT specifically
25 around referral. I know there's a lookback in terms of 11:07
26 Bicalutamide, which is something that may be easier to
27 do, but an MDT recommendation that says please refer on
28 to Oncologist, not actioned, is a significant deficit
29 and they would be very concerned about that. We can

1 easily find out how many people weren't supported by
2 Clinical Nurse Specialists. I think when you know the
3 breadth and depth of the problem you can make an honest
4 statement about fixing it, but unless you know those
5 details, I think the families -- I am speaking on 11:08
6 behalf of the families and I shouldn't do that --
7 I think they would want to know the depth and breadth
8 of the problem and the extent of the remedy. One
9 family and it's Patient 9, the last meeting was with
10 their extended family and they had lots of insight and 11:08
11 they were clearly saying, we want to know why, we want
12 to know how. I think that's the role of this Inquiry.
13 48 Q. Yes. One point you make in your statement at
14 WIT-84173, the first bullet point. If I can skip to
15 the second sentence: 11:09
16
17 "The major issue throughout the reviews was the finding
18 of care deficits that were professional-specific but
19 happened within a multidisciplinary setting. An SAI is
20 ultimately a learning and improvement tool - the 11:09
21 weakness of this process was that those responsible for
22 managing care and service did not have the opportunity
23 to meet the patients and families and contextualize the
24 deficits. The families had offered to be part of the
25 assurance process which considering the trauma suffered 11:09
26 was brave and constructive".
27
28 You ensured this was included in the recommendations,
29 and I understand that that is being taken forward.

1
2 Your observations about a weakness of the process being
3 that the families and patients on one side never get to
4 engage with the treating Clinicians or the MDT on the
5 other, and vice versa, I'm not sure you are suggesting 11:10
6 that that is something that could be put into
7 a process. Is that reflection contained in your
8 statement, does that derive from a concern on your part
9 that those responsible for managing care didn't seem to
10 get the Patient Safety issues that arose from the work 11:10
11 that they were supposed to be doing?
12 A. DR. HUGHES: No, I think they understood the Patient
13 Safety issues, I think they heard the deficits.
14 I don't think they understood the experience of the
15 families and patients. I think part of the problem 11:10
16 was, these deficits were parked with a named
17 individual, and the wider ownership and the wider
18 responsibility was not fully understood because it's
19 easier to park it with an individual. The families had
20 moved past that, several of the families said, this is 11:11
21 not about Mr. O'Brien, this is about the Southern Trust
22 and indeed the wider network. The families clearly had
23 insight because it's not what happened, it's why it
24 happened and how it happened.
25 49 Q. One person who you didn't hear from as part of the 11:11
26 process, and who you wished to hear from, was
27 Mr. O'Brien. I want to explore that in the next 10 or
28 15 minutes or so before our break. Can I bring you to
29 your witness statement, please, at WIT-84154: You say

1 in the last couple of lines of that paragraph:
2
3 "The review team considered the clinical care and
4 pathways for all 9 patients. The investigation team
5 wrote to Mr. O'Brien with specific questions for 11:12
6 clarification. These questions were not responded to
7 despite extension of deadlines."
8
9 Can we just look at another aspect of your statement in
10 similar context? If we go to WIT-84172. You say: 11:12
11
12 "The major deficit within the review was the inability
13 to engage with the professional who was the named
14 consultant for all the patients. This would have
15 allowed some insight into variations from expected 11:13
16 practice, as defined by the regional and national
17 guidelines. Despite repeated communications and
18 extended timelines responses to the questions regarding
19 patient care were not received."
20 11:13
21 Paragraph 19, and you are asked:
22
23 "Having regard to any difficulty identified above" --
24 the difficulty being Mr. O'Brien's non-response, as you
25 put it -- "are you of the opinion that it undermined or 11:14
26 impacted upon the quality of the SAI Review process?"
27
28 You say: "I do not believe that non-engagement by the
29 named Consultant hindered the 'finding of fact' aspect

1 of the SAI process - this was a process of benchmarking
2 patient timelines, patient stories and patient outcomes
3 against regional and national guidelines common to all
4 urology cancer care. It is not unusual for an SAI
5 process to be carried out independent of the 11:14
6 professional delivering the care. We were however
7 unable to ascertain why therapeutic choices were made,
8 often at variance with regional guidelines and
9 recommendations of the Urology Cancer MDM."
10 11:15
11 I want to ask you, Dr. Hughes, the purpose in making
12 contact with Mr. O'Brien was, as I understand it from
13 your answer here, to understand why the therapeutic
14 choices were reached outside of the guidelines?
15 A. DR. HUGHES: Yeah. We wrote in December to meet and to 11:15
16 explain the process. It was a Level 3 SAI where an
17 independent component and the clinical --
18 50 Q. Let's just have that on the screen. You wrote in
19 December. It was 11th December. TRU-162602. A short
20 letter: 11:16
21
22 "As part of the normal SAI process we have been
23 carrying out interviews with all relevant members of
24 staff who have been involved in these patients' care.
25 These interviews are based on the patients' journey and 11:16
26 are aimed at identifying learning and making
27 recommendations. We are seeking to complete the staff
28 interviews before Christmas in order to keep the time
29 frames of the review. We would be keen to have your

1 input into this process."
2
3 By this stage you had met patients. By this stage
4 Mr. Gilbert had delivered his first draft. Was there
5 any thought given to engaging with Mr. O'Brien at an 11:17
6 earlier stage before Mr. Gilbert had finalised his
7 first draft, which I suppose, by definition, had come
8 to specific conclusions about shortcomings?
9 A. DR. HUGHES: Yeah. It's a Level 3 SAI with an
10 independent component, and part of the independent 11:17
11 component is an independent external clinical opinion,
12 and that's the structure of how I chose to do the Level
13 3 SAI. It's similar to a similar process I did for
14 another Trust involving nine thoracic cancers where the
15 Royal College of Surgeons provided an independent 11:17
16 clinical opinion of the work done by professionals.
17 Then you have seen the learning from that and our
18 questions from that. There are questions for a range
19 of professionals, and we would have had the same
20 process for Mr. O'Brien. It's not litigation where you 11:18
21 have one professional counter-arguing against another
22 clinical opinion. We took a road to get an independent
23 external appointed clinical adviser, Mr. Gilbert, and
24 it was his role to give an external independent
25 opinion. The variance from accepted best practice 11:18
26 would be the themes, then we would that variance, be it
27 Clinical Nurse Specialist, be it Oncology or be it the
28 work of Mr. O'Brien, so while the input on was on that
29 basis it was not necessary to argue the clinical

1 opinion with Mr. O'Brien as part of the process. That
2 is how I have done other Level 3 SAIs where the
3 clinical opinion is given separate to the people who
4 would have been involved in care, because we are
5 looking for, has harm or potential harm occurred? 11:19
6 There's an obvious conflict of interest if you are
7 involved in delivering that care. I think that may not
8 be fully understood, so that was one part of the reason
9 for our initial meeting. We themed the questions that
10 we would liked answered and bring forward for 11:19
11 discussion through Mr. O'Brien's legal team. I should
12 say this is what we explained to the families, that the
13 clinical opinion given would be independent of Northern
14 Ireland and of the Southern Trust, and that was part of
15 the engagement process. Without that I don't think we 11:19
16 would have got truly proper engagement.
17 51 Q. Implicit in your answer, Dr. Hughes -- sorry to cut
18 across you -- is that Mr. Gilbert's opinion is not
19 something that is open to debate within the process, as
20 you imagine it, but is it not, nevertheless, important 11:20
21 in matters which occasionally can give rise to clinical
22 judgment, where two practitioners might have room for
23 legitimate debate, where the clinician has access to
24 the patient, whereas Mr. Gilbert doesn't; given those
25 kinds of factors, is it not, nevertheless, appropriate, 11:20
26 even within an SAI process, to want to hear the
27 clinician's views so that Mr. Gilbert, he may not
28 change his mind, but would have a more rounded
29 understanding of what was going on in any individual

1 patient's case?
2 A. DR. HUGHES: Yeah, I think that's reasonable. We
3 formed our questions on the basis of not general themes
4 but on the basis of individual patients, and we asked
5 about the Bicalutamide, we asked about non-inclusion of 11:21
6 nurses, non-referral, so we did ask and gave him the
7 opportunity respond to questions on each individual
8 patient.
9 52 Q. Let me just work through some of the stages in this.
10 That letter that you wrote, which is up in front of us 11:21
11 on the screen, was met with a response from
12 Mr. O'Brien's legal representatives on 23rd December.
13 Just to pull that up, please. It is at AOB-03095.
14 They, I think, apologise for the delay in responding.
15 Mr. O'Brien has been unwell. They, as a legal firm, 11:22
16 were tied up with the medical practitioners tribunal on
17 related issues. It's not mentioned here, I don't
18 think. I think there had been a bereavement in
19 Mr. O'Brien's family and there was to be a subsequent
20 illness and bereavement in early January. That's the 11:22
21 context in which they are responding. I think, as it
22 appears from that, they are anxious to get across the
23 point that Mr. O'Brien has received your correspondence
24 and wishes to assist.
25 A. DR. HUGHES: Yeah. 11:22
26 53 Q. They ask for some information, if you scroll down to
27 the bottom of the page. In the context where you, in
28 your earlier correspondence, haven't been entirely
29 specific about why you wished to meet Mr. O'Brien, they

1 are trying to tease that out, and they ask for
2 materials relevant to the cases. The Terms of
3 Reference, the review methodology, a description of the
4 incident case, the timeline drafted by the SAI group,
5 the threshold criteria for each SAI engaged, the 11:23
6 specific issues which you are inviting Mr. O'Brien to
7 address, and complete copies of patient records and
8 complete data available from the NICaN system. You had
9 no difficulty in agreeing to provide that?
10 A. DR. HUGHES: No, no. 11:23
11 54 Q. We know in your response, if we look at AOB-03112, you
12 have attached the various documents. You emphasise
13 that:
14
15 "As we are facing time constraints from the HSCB", you 11:24
16 would ask that answers to the questions posed would be
17 received within two weeks, by 29th January.
18
19 If we just look at the specific questions that you were
20 raising. The questions were identified following 11:24
21 a meeting or at a meeting of the team; is that right?
22 A. DR. HUGHES: Yes.
23 55 Q. Of the Review Team. You ask three or four questions on
24 each case, which were primarily focused on -- well,
25 they cover the broad range of concerns, but fairly 11:25
26 narrow questions. Was that deliberate?
27 A. DR. HUGHES: Yes. It's the same process that we would
28 have had for everybody else who had contributed to the
29 team. We had the core team and then we took advice and

1 information and input from all the other professionals
2 in the care. We had an independent note review already
3 in place, and we were asking clarification of items
4 that we could not form an opinion on. Incidentally,
5 the involvement of clinical specialists is the MDT, and 11:26
6 it's an independent process with access from those
7 delivering care.
8 56 Q. Yes. Throughout this period there's a flurry of
9 correspondence. On 19th January, in answer to this
10 correspondence. Mr. O'Brien's solicitors are advising 11:26
11 that there's been a bereavement in the family, they
12 were unable to take instructions until the following
13 week. Then on 22nd January -- if we can just put up on
14 the screen, please, TRU-162611. This is a request for
15 further information coming your way. The solicitors on 11:27
16 Mr. O'Brien's behalf wish to see the Datix forms. Ask
17 questions about whether the draft Terms of Reference
18 are finalised. Asking questions about family
19 engagement. Asking questions about the review
20 methodology. I'm not going to go through this in any 11:27
21 greater detail. But scrolling down we can see that in
22 relation to the questions document that you had sent
23 the week before, they ask a series of questions in
24 relation to that. Again, Mr. O'Brien's facing into
25 a GMC process? 11:28
26 A. DR. HUGHES: Yes.
27 57 Q. The Inquiry has been announced, and you are asking
28 questions, quite appropriately, I'm sure nobody doubts
29 that, about the nine patients. It's understandable

1 that a cautiously cooperative approach is being adopted
2 here?
3 A. DR. HUGHES: Yeah, I can understand that. An SAI is
4 not a legal process. It's a family and patient-centred
5 process. I can understand how we ended up going 11:28
6 through documents and iteration of documents, but we
7 did get involvement from everybody else we asked, and
8 at times those people were in equally difficult
9 circumstances, who will probably be giving evidence
10 here, and questioning their roles. We tried to make 11:29
11 the burden as little as possible because the
12 independent clinical opinion had been given by
13 Mr. Gilbert and we needed input from the professionals
14 delivering care. It was the same ask of the Specialist
15 Nurses. I can understand the legal process but 11:29
16 I think, I know there's a timeline from the Department
17 of Health to have this done and to get a greater
18 understanding of the depth and breadth of the problems,
19 but there was a human dimension to this that two family
20 members had already died and two further members had 11:29
21 died earlier that year, I think not quite at that stage
22 but by the time the document was submitted four members
23 had -- four patients had died.
24 58 Q. Yes. If we jump ahead a month to mid-February, if we
25 can go to AOB-3225. By this stage, this is 11:30
26 Mr. Anthony, who is Mr. O'Brien's legal representative.
27 He's writing to Mrs. Kingsnorth and he is telling,
28 I suppose, your review process that Mr. O'Brien is
29 working through the voluminous documentation provided.

1 Incidentally, he had only received some of the last
2 documents requested as recently as 16th February?
3 A. DR. HUGHES: Yeah, I was not aware of that fact.
4 59 Q. Yes. I needn't open up the document to you, but it's
5 recorded that he received the Datix material he had 11:31
6 requested on 8th February and the full NICAR records on
7 16th February. Do you understand it took some seven
8 weeks, I suppose, if you take the timeline from the
9 23rd December when he first started making requests for
10 material, through to mid-February? 11:32
11 A. DR. HUGHES: I do understand. I should say the Datix
12 reports were not part of our review. We received post
13 triage, so we were not retrospectively reviewing how it
14 came to be in our review process, so I am not quite
15 sure why -- I can understand why some people would want 11:32
16 to know that, but we certainly weren't asking questions
17 about how a case was triaged into the process so
18 I don't think that should have delayed the issue.
19 60 Q. It's recorded here:
20 11:32
21 "We are progressing well with comments in Service users
22 A and B. Mr. Anthony is on leave next week and hopes
23 to have comments to you on these two cases by the end
24 of next week or the following week."
25 11:32
26 It's clear from this correspondence that Mr. O'Brien is
27 intending to cooperate with you and is cooperating with
28 you; is that fair?
29 A. DR. HUGHES: To that point, yeah.

1 61 Q. Yes. There then followed some correspondence between
2 the lawyers, Tughans for Mr. O'Brien and the
3 Directorate of Legal Service on behalf of the Trust.
4 If we can bring up on the screen, please, AOB-03349.
5 This is Business Service Organisation Directorate of 11:33
6 Legal Services on behalf of the Trust. This is 5th
7 March and the lawyers on behalf of the Trust say they
8 intend sending the draft patient report and draft
9 overarching report with recommendations to each patient
10 and family on 8th March. So three days later. That's, 11:34
11 I suppose, on the back of the correspondence of the
12 19th February saying Mr. O'Brien is mindfully working
13 through these.
14
15 In that period of two weeks between those pieces of 11:34
16 correspondence, had you or anybody else on your team,
17 perhaps Mrs. Kingsnorth, chased to see what was
18 happening or are we going to have a response to the
19 questions?
20 A. DR. HUGHES: I believe Mrs. Kingsnorth did. 11:35
21 62 Q. Okay.
22 A. I did not.
23 63 Q. Okay. In any event, somebody had made a decision that
24 these were going to be disseminated and published by
25 this date, even implicitly even if we don't have 11:35
26 a response from Mr. O'Brien?
27 A. DR. HUGHES: I think that's the case, yes.
28 64 Q. Yes. Can you help us, what was the pressure for that?
29 A. DR. HUGHES: I think the pressure was three-fold. The

1 Southern Trust were required to get clarity for the
2 overarching supervision, I can't remember the name of
3 the group, but the Department of Health. I think the
4 other pressure was the families wanted access to these,
5 especially those who had been recently bereaved. 11:36
6 65 Q. Yes. I started this sequence by pointing out the
7 sections of your statement which, in terms, said
8 Mr. O'Brien had been asked questions and, despite
9 extended time limits or deadlines, he never responded.
10 The suggestion there is that Mr. O'Brien wasn't 11:36
11 cooperating?
12 A. DR. HUGHES: We didn't receive responses in the
13 timelines I would have expected to relatively simple
14 questions and perhaps that, on reflection, is wrong.
15 When I was writing my witness statement I probably 11:36
16 reflected part of that in that it would have been
17 better to wait, so I think you do have a point.
18 66 Q. Just to be clear, in light of what we have seen from
19 the correspondence, Mr. O'Brien was showing
20 cooperation. Quite plainly he didn't dismiss your 11:37
21 questions. It's been said on his behalf he is working
22 through them. You are facing the competing pressure,
23 threefold pressure of having to publish and, with the
24 benefit of some hindsight perhaps, it might have been
25 better to wait? 11:37
26 A. DR. HUGHES: Yes, I think that's fair.
27 67 Q. It might have been better to wait because, if you had
28 received responses from Mr. O'Brien, you would have
29 obtained an understanding and Mr. Gilbert would have

1 obtained an understanding of his thinking around
2 treatments?
3 A. DR. HUGHES: Yes. I think some of the issues that are
4 clearly benchmarked against international standards
5 probably wouldn't have changed because we were 11:38
6 benchmarking against known best practice, and I don't
7 think those views would have changed. I think the
8 underlying question is why some of this happened? You
9 know, why referrals weren't made? Why nurses weren't
10 involved? I think that would have been appropriate, 11:38
11 yeah.
12 MR. WOLFE KC: Would this be a convenient time, Chair,
13 for a short break?
14 CHAIR: Five to 12.
15 MR. WOLFE KC: Thank you. 11:38
16
17 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
18
19 CHAIR: Mr. Wolfe.
20 MR. WOLFE KC: As appears from Mr. O'Brien's witness 11:55
21 statement to the Inquiry, he has had opportunity to
22 review three of the cases that were the subject of an
23 SAI Review, and he has provided comments, which, to
24 some extent, put a challenge up to some of the findings
25 contained within the reviews and I wish to go through 11:56
26 some of that now with you, primarily, Mr. Gilbert. The
27 Inquiry's Term of Reference C is primarily driven and
28 focused upon the governance aspects of these cases,
29 but, clearly, where there is a challenge being

1 expressed to some of the clinical aspects of the cases,
2 it's important to take a look. The first case I wish
3 to explore with you, Mr. Gilbert, concerns Service User
4 A or Patient 1. Let me just start by looking at the
5 MDM recommendation in that case. If I could have up on 11:56
6 the screen, please, PAT-001481. You are familiar with
7 this case, Mr. Gilbert, I'm sure? It can be seen that
8 he was first discussed at an MDM on 29th August 2019.
9 It was recommended that various investigations would be
10 conducted, bone scans, CT chest, abdomen, pelvis and 11:57
11 for further discussion at a future MDM.
12
13 The primary issue in this case, Mr. Gilbert, in terms
14 of your review, was the prescribing of Bicalutamide
15 and, in addition, the failure, as you saw it, to refer 11:58
16 to Oncology; is that right?
17 A. MR. GILBERT: Yes. I report the second before the
18 first.
19 68 Q. Okay. I'll bear that in mind. Let's pick up on
20 something of the prescribing history here. We can see 11:58
21 it recorded that the patient had been prescribed
22 Bicalutamide 150 milligrams daily and Tamoxifen 10
23 milligrams daily while awaiting completion of imaging.
24 The medication however was accompanied by intolerable
25 adverse toxicity, and that was mainly in the form of 11:59
26 light-headedness, to the extent that the patient lost
27 the confidence to drive. He was asked, by Mr. O'Brien
28 assumedly, to discontinue taking both and to resume
29 taking Bicalutamide at only 50 milligrams daily from

1 1st November. A bone scan, et cetera, was requested,
2 and he was for review on the November.
3
4 The CT scan reports here on 28th October, no evidence
5 of metastatic disease, and then into the MDM, I think 12:00
6 a couple of days later. Discussed at the MDM on 31st
7 October, where it was found that Patient 1 has
8 intermediate risk of prostate cancer and he is to start
9 ADT and refer to ERBT. That's a form of Radiology, is
10 that right? Radiotherapy? 12:00
11 A. MR. GILBERT: External beam radiotherapy.
12 69 Q. Yes. The next stage is for Mr. O'Brien to see the
13 patient. He sees him in November. If we could just
14 have up on the screen, please, the note of that review.
15 PAT-001453. Would you anticipate, Mr. Gilbert, that 12:01
16 this is the opportunity to discuss the recommendation
17 of the MDM, the next review between treating clinician
18 and patient?
19 A. MR. GILBERT: No, I would have thought the opportunity
20 had come before then. The patient was referred -- I'm 12:01
21 sorry, the dates are not clear. The histology was
22 obtained. He had had an MRI scan which showed he had
23 localised prostate cancer, that is disease within the
24 gland itself. The MDM had recommended that he attend
25 a specialist MDT, that is the one based in Belfast that 12:01
26 can offer radical therapy, to discuss whether or not
27 this disease should be managed by so-called active
28 surveillance or by active treatment. That didn't
29 happen. It was recommended also that he should have

1 staging scans at that stage.
2 70 Q. Just in terms of the dates, sorry. The MDT was at the
3 end of October, 31st October. This is the review on
4 11th November immediately following --
5 A. MR. GILBERT: Okay. 12:02
6 71 Q. -- the MDT. Just so I understand the process. The
7 clinician, in this case Mr. O'Brien, has the
8 recommendation of the MDM. He takes that with him to
9 meet the patient as soon as may be and, for whatever
10 reason, the review takes place eleven days -- 12:03
11 A. MR. GILBERT: Sorry, yes. That was the opportunity for
12 him to request the staging scans, a CT scan and a bone
13 scan.
14 72 Q. Sorry, no, just to be clear. They have been done --
15 A. MR. GILBERT: Yeah. 12:03
16 73 Q. -- for the MDM on 31st October?
17 A. MR. GILBERT: Yes.
18 74 Q. You have seen the recommendation?
19 A. MR. GILBERT: Yes.
20 75 Q. This is the meeting between patient and clinician 12:03
21 immediately after that?
22 A. MR. GILBERT: Okay, right. Sorry, I got the dates mixed
23 up.
24 76 Q. Yes. The recommendation, as you know, is to start ADT
25 and to refer for EBRT? 12:03
26 A. MR. GILBERT: Yes.
27 77 Q. What we see in this note is that there's a lower
28 urinary tract issue, it's unchanged, and the plan is
29 query EBRT and review.

1 A. MR. GILBERT: Yes.
2 78 Q. Let me take you to your SAI findings in this context.
3 If we start at PAT-001304. All the way down to the
4 next page. The Executive summary reminds us that he's
5 been discussed on 31st October at MDM and it says: 12:04
6
7 "A recommendation to commence LHRH analogue and refer
8 for an opinion was agreed."
9
10 The specific recommendation, Mr. Gilbert, was to start 12:05
11 ADT?
12 A. MR. GILBERT: Specifically as neoantigen treatment for
13 external beam radiotherapy. It wasn't started as the
14 definitive treatment. This patient would normally have
15 been treated in most MDTs by being referred to the 12:05
16 specialist MDT, following the staging scans, for
17 consideration of external beam radiotherapy, and the
18 effects of external beam radiotherapy are improved if
19 they are proceeded by a four to six month period of
20 hormone therapy with ADT. 12:05
21 79 Q. Yes.
22 A. MR. GILBERT: This ADT was specifically given as
23 a prelude to external beam radiotherapy. Under these
24 circumstances where you have localised prostate cancer,
25 ADT is specifically not included in the recommended 12:06
26 treatments. Okay?
27 80 Q. Sorry, I need to go over that again. Just factually
28 and specifically, the recommendation --
29 A. MR. GILBERT: Yes.

1 81 Q. -- it doesn't say we recommend LHRH; it says we
2 recommend ADT. The specific question, I suppose, is:
3 Mr. O'Brien had started this patient on 150 milligrams
4 per day seven months prior to the MDM. The patient ran
5 into difficulty with side effects and it was to be 12:06
6 reduced to 50 milligrams going forward. The MDM
7 intervenes and says, radiotherapy and start ADT.
8 A. MR. GILBERT: Okay.
9 82 Q. Is it fair to say that Bicalutamide, at 150 milligrams,
10 would be a form of ADT? 12:07
11 A. MR. GILBERT: It is a form of ADT. Some people would
12 use it, yes.
13 83 Q. Yes.
14 A. MR. GILBERT: It is as a prelude to external beam
15 radiotherapy. Think of that treatment as one treatment 12:07
16 modality; hormones for four months and then the
17 radiotherapy.
18 84 Q. Yes.
19 A. MR. GILBERT: That is how you treat localised prostate
20 cancer with radiotherapy. Okay? 12:07
21 85 Q. Yes.
22 A. MR. GILBERT: To treat localised prostate cancer with
23 ADT is against guidelines. The treatment options for
24 the continuing treatment of localised prostate cancer
25 are either to maintain active surveillance, which is 12:08
26 essentially just monitoring the disease, not on any
27 hormones, or to seek external beam radiotherapy as an
28 alternative. Okay? For this patient, who had
29 localised prostate cancer, what should have happened at

1 the outset is that as soon as he was known not to have
2 metastasise he could start hormone therapy pending his
3 immediate referral to the specialist MDT which is
4 capable of delivering radiotherapy and they would make
5 the definitive decision about treatment, which, in my 12:08
6 mind, is pretty obvious that that is the path the
7 patient should have taken.
8 86 Q. To summarise: In your view, this patient should have
9 immediately after the MDM, it should have been
10 recommended to him that he recommences on Bicalutamide 12:09
11 50 milligrams as an anti-flare moving to LHRH and
12 referral to Oncology?
13 A. MR. GILBERT: Yes. You could have started an anti-flare
14 treatment for a period of three weeks, is what they say
15 in NICaN. It could be anything between two and four 12:09
16 but there it is, three weeks. He would start his LHRH
17 analogue, he would have a month's dose initially to
18 make sure he tolerated it, and if he tolerated it, 19
19 out of 20 men do, then he would have a dose that would
20 last him for three months. During that period of time, 12:09
21 the sooner the better so the patient is informed about
22 what their best options are, he should have met or been
23 discussed within the specialist MDT to decide whether
24 it was reasonable to continue on active surveillance,
25 but because he had intermediate disease that would have 12:09
26 been not in his best interest, or whether he should
27 have active treatment. The option that had been
28 steered by the local MDT in the Southern Trust was that
29 he should have external beam radiotherapy.

1 87 Q. Yes.
2 A. MR. GILBERT: As opposed to radical surgery.
3 88 Q. Just turning to the SAI report. Just scroll down to
4 the key findings at PAT-001309. The Review Team's
5 finding that initial assessment was satisfactory. You 12:10
6 go on to say:
7
8 "The initial treatment should have been reversible ADT,
9 most commonly LHRH analogue, pending the results of the
10 scans." 12:10
11
12 As we know, Mr. Gilbert, the patient was started on 150
13 Bicalutamide. Mr. O'Brien's rationale for that was
14 that this patient had a history of, I believe, cardio
15 -- 12:11
16 A. MR. GILBERT: Miocardial infarction.
17 89 Q. Yes, cardiovascular disease. We discussed this
18 earlier. In the circumstances where you've, I think,
19 acknowledged that 150 milligrams Bicalutamide is a call
20 that can be made by clinicians -- 12:11
21 A. MR. GILBERT: Certainly a proportion of Urologists may
22 offer that as treatment, but the majority would offer
23 an LHRH analogue in the first instance.
24 90 Q. Yes. Is there any great criticism to be made that he
25 elected to start with 150? 12:12
26 A. MR. GILBERT: No.
27 91 Q. You go on to say that the prescribing didn't conform
28 with the 2016 NICaN guidelines, or the hormone therapy
29 guidelines. Is that a reference to the 150 at the

1 start, or is that a reference to the 50 milligrams
2 which the patient commenced after the MDM in November?
3 A. MR. GILBERT: Specifically the 50 milligram dose.
4 92 Q. Just scrolling down. You say:
5 12:12
6 "The subsequent management" -- again that's the 50
7 milligrams -- "with unlicensed anti-androgenic
8 treatment at best delayed definitive treatment. It's
9 only currently indicated as a preliminary anti-flare."
10 12:13
11 The thinking of Mr. O'Brien at that point is set out in
12 a letter which, no doubt, was available to you, to the
13 General Practitioner. I want to bring that up on the
14 screen. PAT-001487. This is the period after the MDT.
15 The patient hadn't tolerated well the 150, had come off 12:14
16 it for a short time before the MDT and was recommenced
17 on 50. This is a letter written after the 11th
18 November clinic, which I had just opened to you. It
19 says:
20 12:14
21 "It would be ideal for the patient to have an optimal
22 biochemical response to the androgen blockade or
23 androgen deprivation prior to consideration of radical
24 radiotherapy. If his PSA level has not decreased
25 further it may be necessary to take an incremental 12:15
26 approach to increased androgen blockade by increasing
27 the dose of Bicalutamide to 50 milligrams twice daily
28 and hopefully subsequently to take the higher dose of
29 150 milligrams once again, as I suspect that the

1 addition of LHRH agonist may be more intolerable."
2
3 Therefore you have the thinking, the patient, his case
4 is considered at MDM, the Clinician knows that the
5 patient has a history of intolerance towards 150 12:15
6 Bicalutamide, and he wants to get an effective
7 biochemical response prior to referral to Radiotherapy.
8 That's a perfectly acceptable way of thinking, is it?
9 A. MR. GILBERT: I would question it. The aim of the
10 hormone therapy is to render the patient castrate. 12:16
11 Sorry to use that term but that's the term that is
12 used. Indeed, under certain circumstances, it's
13 possible to do so, it's not appropriate in this case
14 because you want a reversible situation, but you could
15 take the testicles off to achieve exactly the same 12:16
16 effect. In fact, that was the first treatment for
17 metastatic prostate cancer.
18 93 Q. Yes.
19 A. MR. GILBERT: The fact that this gentleman had side
20 effects to 150 milligrams is peculiar and particular to 12:16
21 that agent. Reducing it may well have alleviated his
22 symptoms, but under normal practice I think most
23 clinicians would have said he wasn't suitable for
24 Bicalutamide. The 50 milligram dose would be
25 ineffective in achieving the castrate level, and, 12:17
26 therefore, he should go on to an LHRH analogue, and
27 that to me is the logical sequence of decision-making.
28 94 Q. You say ineffective. Are you saying that, on the face
29 of it, 50 milligrams was simply under-treating the

1 patient if the desired objective is to reduce the size
2 of the prostate and the tumour with a view to
3 radiotherapy?
4 A. MR. GILBERT: Yes, in effect.
5 95 Q. If we go to PAT-001311, just into the conclusions 12:17
6 section. What you say is, after explaining your view,
7 that this should have been handled with at least four
8 months' ADT, with a referral to Oncology, that:
9
10 "The opportunity to offer the patient radical treatment 12:18
11 with curative intent was recommended by the MDM but not
12 actioned by those responsible for his care. The local
13 progression of the disease should have been considered
14 in the light of both the symptomatic deterioration and
15 PSA changes." 12:19
16
17 That was your view essentially, accepted by the team?
18 A. MR. GILBERT: Yes.
19 96 Q. You plainly thought that this was inadequate treatment,
20 and that allowed for disease progression? 12:19
21 A. MR. GILBERT: That was my conclusion, yes.
22 97 Q. Yes. Can I ask you this -- let's just pull up
23 PAT-001310. That's the wrong reference. Allow me
24 a moment. If we could have WIT-82635, please. Sorry
25 about that. 12:20
26
27 This is Mr. O'Brien's statement. He's picking up on
28 your conclusion, and sets out the reference there, that
29 he developed metastasis while being inadequately

1 treated for high risk prostate cancer. Mr O'Brien
2 argues that risks the inference that to develop the
3 metastasis because he was inadequately treated. His
4 position is that what caused the difficulty here was
5 not inadequacy of treatment, but because the patient 12:21
6 suffered adverse side effects from adequate hormonal
7 treatment, which -- that was the obstacle that caused
8 the difficulty, that there was no other adequate
9 treatment, in his view. He was on the right treatment
10 path, but it was slowed up because of the patient's 12:22
11 inability, at various stages, to cope with it. The
12 goal was always, inferring from this, the goal was
13 always to get him back on to 150 milligrams of
14 Bicalutamide, and that would have addressed the issue.
15 A. MR. GILBERT: There's quite a lot to comment on in that. 12:22
16 It feels slightly knotted. We've discussed what I felt
17 the treatment should be. An impressive PSA response
18 would be 4 to 0.1 or less, that would be an impressive
19 response, and indeed expected response. For it to have
20 fallen down to 2 and 3 -- sorry I can't remember the 12:23
21 precise figures -- is not impressive, it is inadequate.
22 They need to be suppressed. The prostate and the
23 prostate cancer needs to start shrinking. Okay? The
24 Bicalutamide is essentially a competitive antagonist.
25 What that means it's like a key that locks into a lock 12:23
26 and blocks the real key from going into cause its
27 damage. Okay? If that's reasonable way of describing
28 it.
29 98 Q. Yes.

1 A. MR. GILBERT: There are lots of these locks on the
2 cancer cell and so what you do is you give a dose of
3 these inactive keys to block up all the locks. If you
4 give insufficient keys to block up all the locks, you
5 leave some of them open which allows the processes that 12:24
6 allow progression of prostate cancer to happen. I have
7 tried to explain something that even I find difficult
8 to understand, that's a terrible thing to say. Anyway,
9 he was clearly on inadequate treatment. Okay? That's
10 the first thing to say. Next thing to say is, okay, he 12:24
11 developed symptoms as a consequence of the treatment.
12 Those symptoms may be due to the effect of the
13 treatment, that is the reduction in testosterone, that
14 may be why he was having those, or they may be a direct
15 consequence of the drug itself. No one can tell you 12:24
16 what that is. Experience might give you a feel for it,
17 but no one will tell you which of those is applying,
18 and indeed they may both be applying. The answer is
19 not to move to an inadequate treatment, the answer is
20 to use a reasonable alternative. In this case, the 12:25
21 reasonable alternative is the more commonly used
22 treatment by Urologists across the spectrum, and that
23 would have been an LHRH analogue. My difficulty with
24 this is that that was not the step that was taken.
25 12:25
26 The second difficulty I have with this case
27 specifically around this, was that the diagnostic
28 clinician, Mr. O'Brien, should have, at the time of the
29 MDM discussion, for referral, and knowing that there is

1 no metastatic disease, have referred the patient
2 immediately to a specialist MDT, where his treatment
3 could be continued definitively. Because that didn't
4 happen, I think there was potential opportunity for the
5 disease to have progressed when it may not have needed 12:26
6 to. However, I would put a big caveat on that by
7 saying that's speculation. I don't know that even if
8 he had done what I think most Urologists would have
9 done that the same events would not have happened and
10 the disease would have progressed, for whatever reason. 12:26
11 All I'm saying is that he didn't take the steps, the
12 fair and reasonable steps to ensure that this gentleman
13 had the best chance of avoiding that happening.
14 99 Q. The history of ischaemic heart disease would appear to
15 be prominent in Mr. O'Brien's reasoning for placing 12:26
16 a reliance on Bicalutamide initially, and it seemed
17 a determination to get back up to 150 milligrams,
18 notwithstanding the earlier side effects. Is that
19 thinking or that rationale a justification, an adequate
20 justification for the approach adopted? 12:27
21 A. MR. GILBERT: The hormone treatment was going to be
22 given for four months. Any evidence for the
23 deleterious effect of low testosterone on men's health,
24 particularly their cardiac health, relates to men who
25 are on the drug for longer periods of time, essentially 12:27
26 men who are being treated for metastatic disease for
27 which hormone therapy is the definitive treatment.
28 Under these circumstances, I can see no reason to
29 consider that. Most of the decisions about whether or

1 not you treat somebody for prostate cancer are based on
2 their performance status, that's how active they are,
3 and there are a number of schemes, the most commonly
4 used is the WHO and if somebody is fit and active WHO
5 zero, even if they have had a myocardial infraction, 12:28
6 you are going to treat them the same way. This is the
7 difficulty I have in reviewing these notes is I don't
8 actually see the patient.
9 100 Q. Yes.
10 A. MR. GILBERT: Okay? I would clearly admit that is 12:28
11 a substantial deficiency in being able to make
12 a judgment about individual patients, so I'd rather
13 stick to the principles here of treatment rather than
14 the specific events. To me, the theme that needs to be
15 explored is the non-referral or the lack of referral 12:28
16 for specialist, advice regarding specialist treatment.
17 The non-referral to the support of a Cancer Nurse
18 Specialist, who would have been helpful under these
19 circumstances as things turned out, and a prescribing
20 practice which is readily questionable. Those are the 12:29
21 three themes.
22 101 Q. Yes. Is there a fourth theme? If the recommendation
23 of the MDT is not capable of being implemented in the
24 eyes of the clinician, does that go back, in your view,
25 to the local MDM? 12:29
26 A. MR. GILBERT: It would certainly do so in my practice
27 and, I think, in the practice of most Urologists.
28 102 Q. I opened the correspondence to the General Practitioner
29 written by Mr. O'Brien in late January, eight weeks or

1 so after the MDM, and he is explaining to the General
2 Practitioner that I want to see a sufficient
3 biochemical response prior to referral or prior to
4 possible referral. Bearing in mind that the MDM set
5 out its recommendation at the end of October, as 12:30
6 a matter of practice, is the Clinician to make that
7 referral after consultation with the patient
8 immediately or is he to deliver a satisfactory
9 biochemical response prior to putting it in the hands
10 of the specialists? 12:30
11 A. MR. GILBERT: The difficulty with answering these
12 questions is that you are asking me to take a journey
13 I wouldn't have taken and to comment how would I have
14 reversed my tracks if I had gone down them
15 inadvertently. 12:31
16 103 Q. Put it in simpler terms. If the recommendation is to
17 start ADT and to refer for EBRT, or an opinion as to
18 whether EBRT is to be done, what is the sequencing for
19 that? When do you make the EBRT referral, assuming
20 your patient is amenable to that? 12:31
21 A. MR. GILBERT: As soon as you've fully staged the disease
22 and it's been discussed in the MDM, there should be an
23 action. Before other mechanisms were in place, I would
24 go and sit down in my office and write letters to
25 a specialist as matters of referral and make sure they 12:31
26 were sent off urgently.
27 104 Q. We know in this case the referral on to Oncology
28 doesn't take place until June 2020, some seven or eight
29 months after the MDM recommendation. I think

1 Mr. Haynes makes that referral when he, coincidentally,
2 sees the patient when Mr. O'Brien was off duty, for
3 whatever reason. Just to be clear, the Clinician
4 waiting for an adequate biochemical response, that's
5 not the time to make the referral; you make it -- 12:32
6 A. MR. GILBERT: No, you make the referral immediately. 19
7 out of 20 patients, probably more, are going to
8 respond. What's the point in delaying to see
9 a non-response in one patient? Anyway, if there's
10 a non-response in a patient, then a specialist MDT 12:32
11 should have been informed because they are going to
12 look at alternative treatments, which would not be
13 provided locally. All patients for consideration of
14 radical treatment, and this is plainly given in all the
15 guidelines, all patients for consideration of 12:33
16 specialist MDT must be referred to the specialist MDT
17 as soon as possible so that they can be considered for
18 the appropriate radical treatment.
19 105 Q. Yes. Let me move on to a second case that Mr. O'Brien
20 helpfully deals with in his statement. It concerns 12:33
21 Service User B, who is Patient 9. If we can bring up
22 the SAI report at DOH-00026. On the next page we will
23 see the Executive summary.
24
25 This is a case, Mr. Gilbert, you will remember, where 12:34
26 the patient came into the emergency Department at the
27 Southern Trust with severe pain and urinary retention
28 on or about 1st May 2019. He saw Mr. O'Brien on
29 24th May 2019, and it was a suspicion of cancer of the

1 prostate. Mr. O'Brien commenced on 50 milligrams of
2 Bicalutamide, arranged for a TURP on 12th June, and
3 that took place. He reviewed the patient on 2nd July
4 and advised the General Practitioner that he planned to
5 see the patient, there was some doubt as to whether it 12:35
6 was August or September but I think Mr. O'Brien says it
7 was to be August, when he planned for an ultrasound and
8 an MRI for diagnostic purposes.
9
10 Within the Executive summary, you've set some of that 12:35
11 history out. What ultimately happened was that the
12 review, it says here, that was planned for September --
13 as I say, Mr. O'Brien thinks it was planned for August
14 and he made that clear in a letter to the General
15 Practitioner -- that didn't happen and the patient 12:35
16 wasn't seen again until a year later, or a year from
17 his original presentation, May 2020, by which stage he
18 was found to have a large rectal mass and a fistula.
19
20 Let me address some of Mr. O'Brien's concerns about 12:36
21 your findings. He makes four broad points. If we
22 could open WIT-82636. As I say, his first point,
23 Mr. Gilbert, is that he specifically deferred the
24 prostatic biopsy until a planned review in August.
25 That is a response, I suppose, to the concern expressed 12:37
26 in the SAI Review, presumably by you, that there was
27 a failure to get on with diagnostics quickly enough?
28 A. MR. GILBERT: Yes. There was a suspicion of prostate
29 cancer that was expressed at the time of his initial

1 presentation. There was a wait until he had a TURP,
2 a short wait. That didn't prove the diagnosis, as
3 I try and recall.
4 106 Q. Yes.
5 A. MR. GILBERT: That is a pit fall into which Urologists 12:38
6 can fall.
7 107 Q. Yes. Another point you make in the report is that
8 there was no digital rectal examination, and that was
9 a concern you expressed. Just scrolling down to number
10 4, we will come on to 2 and 3 in a moment, Mr. O'Brien 12:38
11 says, just to be clear:
12
13 "The report found there was no record in the medical
14 notes of DRE. This is incorrect as a DRE was performed
15 and it's written into his consultation note" 12:38
16
17 I am sorry, I don't have that consultation note to show
18 you. But those findings, T3, query T4?
19 A. MR. GILBERT: The first thing I would like to say is
20 I apologise for missing that. I put my hands up. 12:39
21 However, there are levels of suspicion for prostate
22 cancer. If the PSA had been marginally raised and the
23 prostate was a little bit hard on one side, then
24 I might accept that it would be reasonable to defer
25 things. If, however, the PSA was significantly raised 12:39
26 and the prostate felt obviously cancerous, which is
27 what is being alluded to here, T3/T4, the finger is
28 telling you the diagnosis, then I think that puts even
29 more urgency than I actually implied in my report.

1 108 Q. Yes.
2 A. MR GILBERT: The biopsy should have been done in May.
3 109 Q. Yes. Sorry to jump a little bit about here, I just
4 want to put your conclusions in front of us so we have
5 them absolutely clear. It's DOH-00028, and second 12:40
6 paragraph down. What you say is:
7
8 "The patient was seen on 24th May. Dr. O'Brien noted
9 a history of lower urinary tract symptoms and a failed
10 trial removal of catheter. A serum prostate specific 12:40
11 antigen was elevated. Following an examination
12 Mr. O'Brien was suspicious of the presence of
13 significant prostate cancer. He initiated partial
14 androgen blockade by prescribing Bicalutamide while
15 awaiting a TURP which was arranged for 12th June." 12:41
16
17 Just going down to DOH-00030, down to the bottom of the
18 page, please. What you are saying is that:
19
20 "the patient presented with urinary retention and 12:41
21 demonstrated features of possible prostate cancer.
22 This possibility should have been pursued by the
23 request of an MRI of the prostate and pelvis and
24 ultrasound guided needle biopsy. Alternatively an
25 urgent TURP and the needle biopsies could have been 12:42
26 performed simultaneously after the MRI scan. This
27 would have established the diagnosis and following
28 staging with a bone scan, the patient could have been
29 referred for special opinion on radical therapy."

1
2 The Review Team believe that Mr. O'Brien suspected
3 prostate cancer based on clinical examination and, in
4 essence, shouldn't have planned to wait until August or
5 September to carry out appropriate diagnostics. That's 12:42
6 the position you reached?
7 A. MR. GILBERT: In the light of the digital rectal
8 examination, I think reinforced, yes, absolutely.
9 110 Q. Yes.
10 A. MR. GILBERT: There was a suspicion in May when he 12:42
11 presented that he had locally advanced prostate cancer,
12 the digital rectal T refers to the stage, before how
13 far the cancer has got in the organ itself, how far it
14 has spread within the body. T refers to tumour, which
15 is the primary tumour and tells you the relationship of 12:43
16 the cancer to the original organ itself. T3 means that
17 the cancer has grown outside the capsule of the
18 prostate. T4 means it has become attached to adjacent
19 structures. This is locally advanced disease. This is
20 a dangerous disease. It is my practice, and I didn't 12:43
21 put this in because it's slightly unconventional, most
22 people would send the patient off to have a formal
23 biopsy, but I would have given the patient antibiotics
24 in the clinic and taken a biopsy there and then, and
25 the diagnosis would have been available four days 12:43
26 later, the staging scans could have been done within
27 a couple of weeks, and this patient could have been
28 discussed at the MDT, although -- should have been
29 discussed at the MDT and then referred on for

1 specialist treatment.
2 111 Q. Yes. The point, though, from Mr. O'Brien's
3 perspective, set out in his statement, and we will turn
4 to the detail of it in a moment. He didn't pursue the
5 diagnostics in June. He consciously, intentionally was 12:44
6 waiting to see the patient again in August. He was
7 planning to MRI at that point, and the rest of the
8 diagnostics. A short wait was inconsequential but for
9 the fact that the Trust, he argues, failed to deliver
10 that patient for review in August. He wasn't given an 12:45
11 appointment and was lost until the following year when
12 he presents in May 2020 with these great difficulties,
13 including a fistula. That's reasonable, isn't it, to
14 wait until a few months, maybe not even two months,
15 until August, to see the patient for diagnostics. What 12:45
16 was the rush to pursue it in June?
17 A. MR. GILBERT: The rush was to obtain a diagnosis, proper
18 staging of the disease, and to allow him to enjoy
19 treatment as soon as possible. You are dealing with
20 cancer. 12:46
21 112 Q. Is it the position that as soon as you have
22 a suspicion, whether it's DRE or through other
23 investigations, once you had that suspicion you should
24 move as quickly as possible?
25 A. MR. GILBERT: Within the constraints of any particular 12:46
26 system you work within, yes. There are waiting lists
27 for, say, biopsies, and so on and so forth. I don't
28 see the point of putting a wait into a wait, if you see
29 what I mean. A wait to start a wait for your MRI scan,

1 why not just get the MRI scan done?
2 113 Q. If you have the patient in for a TURP on, I think it's
3 12th June, is there any obstacle, when you have him
4 there, to carrying out, for example, the biopsy at that
5 point? 12:47
6 A. MR. GILBERT: That was an absolute and clear opportunity
7 TO perform a biopsy. The problem with prostate cancer
8 is it tends to affect the peripheral outer part of the
9 gland, so it's easy to feel sometimes. It's not if
10 it's at the front of the gland. Most cancers are at 12:47
11 the back of the grand at the periphery, at the outside.
12 When you are doing a TURP what you are doing is you are
13 actually coring out the prostate. If you imagine an
14 apple, the TURP is taking out the core to allow the
15 urine to flow properly, but the cancers tend to be 12:47
16 located in the flesh of the apple, not in the core.
17 So, taking out the core does not necessarily lead to
18 a histological diagnosis, and this is a pit fall that
19 most Urologists would acknowledge. If you put your
20 finger inside the tail-end and you can feel the clear 12:47
21 cancer then, for the sake of two minutes, you could
22 obtain two pieces of issue that would have given you
23 the diagnosis there and then.
24 114 Q. In general, Dr. Hughes, and Mr. Gilbert, there is no
25 particular focus within your reports on the 12:48
26 circumstances of the Trust and, in this particular
27 case, on Mr. O'Brien's account, the fact that this
28 patient didn't get the appointment which Mr. O'Brien
29 had planned for him, which may be worthy of further

1 investigation; we may look at it. Plainly there were
2 significant waiting lists, pressures, maybe this is
3 a mere clerical or administrative error and he dropped
4 out of the system with any possible number of reasons,
5 perhaps. This context of the Trust not delivering, not 12:48
6 being in a position, perhaps, to deliver an adequate
7 Service more widely as a contextual factor, is that
8 something you were conscious of?
9 A. DR. HUGHES: We certainly were conscious of the
10 pressures on the Trust and the fact that the Trust has 12:49
11 expanded its catchment area and the volume of work was
12 increasing. In this case, with a positive T3/T4 on
13 DRE, I mean that would be an indication to immediately
14 start the re-diagnostic pathway. The diagnostic
15 pathway includes a transrectal ultrasound services 12:49
16 provided by the Specialist Nurses, and there would have
17 been no reason why that could not have been instigated
18 on 23rd May.
19 115 Q. Yes.
20 A. DR. HUGHES: But it wasn't. They will have their 12:49
21 waiting lists, but as long as you make that referral
22 into the system, people will not be lost. This is not
23 a classical pathway. This is addressing a urological
24 TURP issue and then, at a later stage, addressing
25 a T3/T4 significant cancer issue. I would question 12:50
26 that. Obviously, the primary focus should have been at
27 what was considered clinically at T3/T4 cancer, and
28 there are expedient challenges to do that.
29 116 Q. Just from a Governance perspective on this case, is

1 there anything that could have been done from
2 a tracking monitoring perspective in the particular
3 circumstances of this case?
4 A. DR. HUGHES: Tracking traditionally kicks in when
5 somebody has an appropriate -- a formal tissue 12:50
6 diagnosis of a cancer, which is a failing in many types
7 of cancer, and two other patients had, radiologically,
8 renal cancer, but because they didn't have a tissue
9 diagnosis, didn't have a clinical nurse. I think, in
10 this instance, and one of the reasons I reflected on 12:51
11 a previous SAI, the clinical administration in
12 Mr. O'Brien's practice was known to be under stress,
13 was known to be replete with problems, so there's
14 a delay or a loss of a patient in this case, but it's
15 not the only one in this cohort of nine patients. The 12:51
16 Trust already knew this and possibly should have put
17 steps in place to address this, because if there's an
18 issue with, and some of the work was with the front end
19 of the pathway, the triage in cases, but you would have
20 to make this assumption there may be clerical and 12:51
21 administration processes elsewhere in the pathway.
22 When I look at this, the clinical thought process
23 should be if you detect, query T3/T4 locally advanced
24 cancer, that should be your primary focus, and the
25 focus seemed to be on doing further PSAs, then do your 12:52
26 TURP and then perhaps doing -- which could have been
27 possibly an aggressive cancer, as it turned out to be.
28 117 Q. Yes. Just one final point on this case, Mr. Gilbert,
29 if I could trouble you for your comment. If we go to

1 WIT-82637 at number 3, please. I am conscious that you
2 won't have the opportunity to review any notes, so
3 I ask this question with a degree of hesitation:
4
5 "Mr. O'Brien says when Service User B was reviewed by 12:53
6 the Cancer Centre in Belfast City Hospital on 5th
7 November 2020" -- that was after he had come back into
8 the system obviously and had been referred from the
9 Southern Trust's MDT to the regional centre -- "he was
10 prescribed Bicalutamide 50 milligrams daily". 12:53
11
12 This is contrary to the assertion from the Review Team,
13 primarily you, Mr. Gilbert, that Bicalutamide 50
14 milligrams is only indicated for the prevention of
15 tumour flare associated with the first injection. 12:53
16
17 Do you understand that --
18 A. MR. GILBERT: I understand precisely what's being said
19 but I maintain my position. I don't know why anyone in
20 Belfast City Hospital, on 5th November 2020, would have 12:54
21 prescribed 50 milligrams of Bicalutamide for this
22 patient. Unless it was a preliminary to starting an
23 LHRH analogue if he hadn't started it at that stage.
24 118 Q. We will maybe have an opportunity to look at that
25 further. Can I move then to the case of service F, who 12:54
26 is Patient 6. The SAI report for that case can be
27 found at DOH-00073. You are familiar with that case,
28 Mr. Gilbert?
29 A. MR. GILBERT: Yeah.

1 119 Q. Just down to the next page, please. The Executive
2 summary tells us that:
3 "The patient was commenced on a low dose, described as
4 sub-therapeutic dose of Bicalutamide for prostate
5 cancer. There was no documentary evidence of any 12:55
6 discussion of the radical treatment options for the
7 prostate cancer recommended by the multidisciplinary
8 meeting."
9
10 Mr. O'Brien in his witness statement makes the 12:55
11 following points. He says that the so-called
12 multidisciplinary meeting on the August, I think it
13 should say 2019, was not an MDM at all. It was
14 a review by Mr. Haynes because the MDM didn't happen
15 that day. It wasn't possible to arrange because of 12:56
16 attendance issues. Prior to that consideration of the
17 case by Mr. Haynes, the patient had been started on 50
18 milligrams of Bicalutamide by Mr. O'Brien, and he sets
19 out the reasons for that. Just before looking at the
20 reasons, let's examine the conclusions reached by your 12:56
21 review. If we can scroll down, please, to the
22 conclusions section. Sorry I don't have a reference
23 for it. It says:
24
25 "A standard pathway for this man was followed up to and 12:57
26 including the first MDM"
27
28 I will put a caveat against MDM and ask for your
29 comments in a moment.

1
2 "At that point acceptable practice should have been to
3 discuss the options available as recommended by the
4 MDT. Most urological centres would have requested
5 a bone scan to complete staging, and should the patient 12:57
6 have chosen to pursue radical therapy it would have
7 been reasonable to start ADT."
8
9 A number of points, Mr. Gilbert. Could we have up on
10 the screen, please, WIT-82637. Number 1. He comments, 12:58
11 in response to your opinion expressed in the report,
12 Mr. Gilbert, that your view that the commencement on
13 a low dose of Bicalutamide was sub-therapeutic is
14 incorrect, in his view. He was commenced on 50
15 milligrams of Bicalutamide to relieve the patient's 12:58
16 concern regarding the risk of progression of any
17 presumed prostate cancer while awaiting confirmation of
18 its presence by biopsy.
19
20 I think that's a view or that's a fact that is 12:59
21 acknowledged within the SAI. You pick up on that and
22 report on that. Is it appropriate, in your view, to
23 commence on 50 milligrams of Bicalutamide while
24 awaiting full diagnosis as a reassurance approach?
25 A. MR. GILBERT: No. 12:59
26 120 Q. Is it appropriate to start it prior to a full
27 diagnostic investigation on the basis of a suspicion
28 that we will eventually see a confirmed diagnosis?
29 A. MR. GILBERT: No, and I will give a specific reason on

1 this occasion. Certainly, in my hospitals, I have been
2 encouraged to obtain histology prior to any
3 commencement of hormone therapy. Starting hormone
4 therapy can affect the histological interpretation of
5 prostate cancer. We haven't even touched on this, but 13:00
6 how you manage prostate cancer is determined by what's
7 called the grade of the disease or differentiation of
8 the disease. Differentiation refers to, in lay terms,
9 the aggressiveness of the cancer. The more aggressive
10 the cancer various treatment options are given. Scores 13:00
11 for this, Gleason score which measures the
12 aggressiveness of the cancer runs from, for technical
13 reasons, from 6 to 10. 6 is a very quiescent disease,
14 indolent disease, and is usually managed by
15 observation. 10 is a very, very aggressive disease, 13:01
16 rarely seen it has to be said. This gentleman's cancer
17 I think was Gleason 7, but our Pathologist would have
18 sent me a fairly smart and tetchy e-mail if I had
19 started hormone therapy beforehand because the
20 distinctions that can be made, which are critical to 13:01
21 the allocation to the treatment options for the
22 patient, may be obscured by pretreating the patient
23 with hormones.
24 121 Q. The rationale here is to commence him on the
25 Bicalutamide to relieve concern because there's a fear 13:02
26 on the part of the patient that disease will progress
27 in the meantime. Does that make sense as an assurance
28 mechanism on any level?
29 A. MR. GILBERT: No, not on any. As it transpired, this

1 man had localised prostate cancer, and sorry to use
2 technical terms again, to re-iterate this is a disease
3 confined to the prostate, this was going to be amenable
4 either being managed by active surveillance or to
5 radical therapy, which, as an aside, is dependent on 13:02
6 the Gleason score that I just alluded to. The one
7 treatment option that is not indicated under these
8 circumstances is hormone treatment, ADT. Even less,
9 a lower dose of ADT than is conventional. If the
10 patient needed to be reassured, there were two possible 13:03
11 things. Mr. O'Brien himself could have exercised his
12 professional expertise and reassured the patient that
13 this did not happen, and it is a common concern of
14 patients that things will progress but the correct
15 words will assuage that. Secondly, there could have 13:03
16 been a Cancer Nurse Specialist available so that any of
17 his immediate concerns could have been addressed
18 immediately. He would have had access to support and
19 advice that would have ameliorated his concerns.
20 122 Q. Yes. 13:03
21 A. MR. GILBERT: I think actually giving a sub-optimal
22 dose of ADT for all those reasons was inappropriate.
23 MR. WOLFE KC: Chair, there's a few more points that
24 might me take to take probably ten minutes to complete
25 on this particular case, probably wise I think just to 13:04
26 break for lunch, unless you want me to?
27 CHAIR: If you are going to take ten minutes we will
28 continue on and come back later after lunch.
29 MR. WOLFE KC: Very well.

1 123 Q. So just moving over to the next page, please. The
2 second point which is raised is that the MDM on 8th
3 August, as I alluded to earlier, was, in fact, an
4 online review conducted by Mr. Haynes, as it not been
5 possible to hold MDM due to the lack of availability of 13:04
6 other Consultants. There was no discussion of Patient
7 F or agreement concerning his diagnosis, there was
8 nothing multidisciplinary about this MDM.
9
10 I am quite sure that the paperwork that you received 13:05
11 for the purposes of your review, correct me if I'm
12 wrong, would have indicated that it was the minute of
13 an MDM?
14 A. MR. GILBERT: It appeared to me to be a minute of an
15 MDM. Whether it was a triaged session or not, I'm not 13:05
16 clear about.
17 124 Q. Yes. So does this --
18 A. MR. GILBERT: I would have no issue with this at all.
19 125 Q. It takes you by surprise but you have no issue with it?
20 A. MR. GILBERT: It doesn't take me by surprise because 13:05
21 I would point to many other of the so-called MDMs that
22 the Southern Trust has held and they were not quorate.
23 What makes this one in particular not an MDM when
24 others are not quorate because, in my view, those are
25 not MDMs either. 13:06
26 126 Q. The surprise I am alluding to is that you didn't know,
27 when writing your report, that this case had only been
28 looked at by Mr. Haynes?
29 A. MR. GILBERT: I knew that on several occasions the MDMs

1 included what might be termed a skeleton crew.
2 I wasn't aware that it was him on his own without
3 anybody else being present.
4 127 Q. What emerged from Mr. Haynes' consideration of the case
5 was that the recommendation -- just allow me a moment, 13:06
6 please. Sorry, I have just lost my note.
7 CHAIR: Do you want us to rise give you some time to
8 locate the note? Do you want us to rise and we can
9 come back then?
10 MR. WOLFE KC: Sorry, if you go on to the bottom of the 13:07
11 page, paragraph 8. Yes, maybe we should rise, it's not
12 working for me. Apologies for that.
13 CHAIR: Ten past two.
14 MR. WOLFE KC: Thank you.
15 13:08
16 THE INQUIRY ADJOURNED FOR LUNCH
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1 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:
2
3 CHAIR: Afternoon, everyone.
4 MR. WOLFE KC: Two brief matters of housekeeping, if
5 I may, before we start. I have mentioned to the 14:10
6 witnesses over lunchtime that it's unlikely that I will
7 get them through their evidence today, and I know the
8 Panel may need some time to ask questions, so I propose
9 working through to 4 o'clock, hopefully without a need
10 for a break, and then I have spoken to the witnesses 14:10
11 about their availability to come back, subject to the
12 Secretariat. Both of them are available for 25th
13 January so we are having a patient day on the 24th.
14 CHAIR: The 25th, then, if you could, gentlemen, please
15 put that into your diaries. We will have some 14:10
16 questions to ask you, and we have discussed it and we
17 think it would be better to have our questions until we
18 have had all of your evidence delivered to us, and then
19 we will ask you some questions at the very end, on the
20 25th hopefully. 14:11
21 MR. WOLFE KC: I am happy to correct something I dealt
22 with yesterday, and I will mention it now. The
23 transcript for yesterday at page 130 commencing at line
24 5, reads, and this is a preface to a question from me:
25 14:11
26 "Mr. Carroll, we know has worked in the Trust for some
27 years and has worked closely with Mr. O'Brien over
28 those years and he provides quite a personal response
29 to it".

1
2 You will recall the remarks that Mr. Carroll made to
3 Dr. Hughes about Mr. O'Brien. It appears to be the
4 case, certainly from Mr. Carroll's written evidence to
5 the Inquiry, that he never met with Mr. O'Brien. So, 14:11
6 my emphasis on him working closely with Mr. O'Brien is
7 in that sort of personal context sense, incorrect, or
8 so it appears from Mr. Carroll's statement, albeit he
9 did mention in the area in which Mr. O'Brien worked,
10 the Acute Directorate in which Mr. O'Brien worked for 14:12
11 some years. I am happy to provide that clarification
12 CHAIR: Thank you, Mr. Wolfe.
13 MR. WOLFE KC: Just before the break, I was stumbling
14 over my note, and the point I wanted to get to,
15 Mr. Gilbert, was this: As regards Patient 6, Service 14:12
16 User F, as you know, he was, as it appeared to you,
17 discussed at a multidisciplinary meeting on 8th August
18 2019. Mr. O'Brien says that wasn't a multidisciplinary
19 meeting, that was Mr. Haynes dealing with the matter
20 remotely by himself. What emerged from that -- and 14:13
21 this is the point where I got lost, but just to be
22 clear. What emerged from that was a recommendation
23 that Mr. O'Brien would review the patient in
24 Outpatients and that he would discuss management with
25 curative intent or surveillance. You make the point in 14:13
26 the SAI that, at that point, post-MDM, as you took it
27 to be, acceptable practice should have been to discuss
28 the options recommended by the MDT.
29

1 If you can pull up on the screen WIT-82639, paragraph
2 9, please. Back up slightly to paragraph 8.
3 Mr. O'Brien takes the point, quite properly, that
4 notwithstanding this wasn't an MDM:
5 14:14
6 "I would have discussed both options recommended by
7 Mr. Haynes, though advising Service User F that all of
8 the features of his confirmed prostate cancer indicated
9 that would be best served by proceeding with management
10 with curative intent. I would not have recommended 14:15
11 active surveillance and did not recommend it.
12 I recommended androgen deprivation prior to radical
13 radiotherapy as indicated in my letter to the patient's
14 general practitioner dated 27th October 2019."
15 14:15
16 There you have it, MDM, or a version of the MDM, put it
17 in those terms, make its recommendation. Mr. O'Brien
18 says he did discuss it and, indeed, he refers to the
19 letter that went to the General Practitioner setting
20 out his view that ADT, leading into radical 14:15
21 radiotherapy, was his view of the way to go. I think
22 the point that you make in the SAI report is that there
23 was no documentary evidence of any discussion of the
24 radical treatment options. Certainly Mr. O'Brien sees
25 the patient on 27th September, and there is no note of 14:16
26 a discussion of those options, albeit a month or so
27 later he writes to the General Practitioner, 27th
28 October, to refer to his view of a curative approach.
29 In terms of medical practice, in discussing options

1 arising from an MDM, is the expectation that there they
2 would be recorded into the clinical note?
3 A. MR. GILBERT: Yes.
4 128 Q. Is that provided for maybe, Dr Hughes, in GMC
5 provisions about record-keeping? 14:17
6 A. DR. HUGHES: Yes, you'd take a note of all pertinent
7 information given to the patient.
8 129 Q. Is the governance assumption that if you don't make the
9 note you haven't had the conversation, or was that the
10 assumption you made, Mr. Gilbert? 14:17
11 A. MR. GILBERT: No, it wasn't an assumption I made. I was
12 simply pointing out that it hadn't been recorded, and
13 it would have been normal practice to have dictated
14 a letter immediately after the clinic, or during the
15 clinic indeed, indicating that conversation had taken 14:17
16 place at that time; the options included, the reasons
17 for them being dismissed as inappropriate, or the
18 reasons given as to which is the preferred treatment.
19 Then that letter should also form part of a referral to
20 somebody who can provide that treatment. 14:18
21
22 There is one sort of caveat that I'd like to expand on,
23 and that is the notion of what might be termed local
24 MDTs and regional MDTs or specialist MDTs. Local MDTs
25 tend to be those that are in district general 14:18
26 hospitals, deal with a lot of diagnostic work, and it
27 is clear from Outcomes guidance that was published in
28 2001/2002, that any patient considered for radical
29 therapy should be referred up to the centre, not for

1 the treatment but for discussion of the options
2 available to them. There's a critical difference in
3 there between saying, I'm deciding that you are going
4 to have external beam radiotherapy at the local level,
5 and somebody with specialist expertise talking to the 14:19
6 patient as well.
7 130 Q. Thank you.
8 A. MR. GILBERT: That's the main point of the referral, to
9 get the patient to the appropriate expertise.
10 131 Q. Is that a point which, in your experience, has to be 14:19
11 made? The immediate clinician can tell the patient
12 about the recommendation, but are you saying the advice
13 should be you really need to put yourself in front of
14 the Oncologist?
15 A. MR. GILBERT: A patient in this position should have 14:19
16 (1), a cancer Nurse Specialist would be helpful in
17 order to explain the options available. There is no
18 reason why a local clinician shouldn't have the
19 expertise to explain the options to a patient and point
20 out the advantages of, say, Radiotherapy over surgery. 14:20
21 The patient probably should have the opportunity to
22 have a discussion with those who deliver that
23 treatment, so the idea of a joint Oncology clinic is
24 prevalent in other parts of the United Kingdom, where
25 the patient will go to find out about Radiotherapy, its 14:20
26 process and its complications and its outcomes and the
27 same for surgery, and the Cancer Nurse Specialist,
28 because remember about that continuity, is the very
29 person who the patient could go back to and say look,

1 I have just been given this huge amount of information,
2 I can't make up my mind, that's what the Cancer Nurse
3 Specialist is for. Because I haven't worked in the
4 Southern Trust, I'm not exactly familiar with their
5 processes and how things work, but there seemed to be 14:21
6 some leeway in the timing of getting those experts'
7 opinions for patients so that they could make
8 appropriate decisions about their own management.
9 132 Q. Yes. As the SAI report highlights at DOH-00078, there
10 was no Oncology referral, and Mr. O'Brien deals with 14:21
11 that and he puts forward a clear explanation as to why
12 there was none.
13
14 If we could have up on the screen, please, WIT-82639,
15 paragraph 6. The report, which I have just read out, 14:22
16 the report finds there's no Oncology referral.
17
18 "This is correct as I considered it inappropriate to
19 refer Patient F for radical radiotherapy until he had
20 undergone assessment and management of his severe lower 14:22
21 urinary tract symptoms in compliance with NICE
22 guideline NG131, paragraph 1.3.4".
23
24 You have just indicated that the patient should have
25 the benefit of the oncological advice, the referral, 14:22
26 but the treating Clinician, who knows the patient very
27 well, in this case knows that he, as we can see from
28 the GP notes and records -- sorry, not in the GP notes
29 and records, from Mr. O'Brien's note keeping, that the

1 lower urinary tract issue is something that is
2 a frequent reference point within the notes.
3 Mr. O'Brien is entitled to judge the timing of the
4 referral based on other comorbidities?
5 A. MR. GILBERT: Clearly. However, what I would say is 14:23
6 that there is no reason why the information and
7 education of the patient should not happen in parallel;
8 that is to say, the referral should have gone
9 immediately. Do remember that even the patient was
10 going to be on hormones for a period of a minimum of 14:23
11 four months prior to the radiotherapy, and it is my
12 practice in this not uncommon situation, this happens
13 frequently, remember we are dealing with old men who
14 have enlarged prostates and therefore have lower
15 urinary tract symptoms, who have concomitant cancer 14:24
16 that those two aspects are dealt with in parallel.
17 I would normally say to them get them started on
18 hormone therapy. I would personally review them some
19 weeks, maybe even three months later, to see whether
20 the hormone therapy had improved matters, and that 14:24
21 allows time for assessment of the lower urinary tract
22 symptoms to ascertain whether or not a surgical
23 procedure is going to improve for the patient. Those
24 things happen in parallel. There is no reason to wait
25 with a patient in ignorance of their future to sort out 14:24
26 the waterworks; you do that, you know, that's your own
27 duty to get on with things. Meanwhile the patient can
28 go on, plan their treatment, plan their lives around
29 their treatment whilst you are sorting out their

1 waterworks.
2 133 Q. Yes. As you say, this kind of development, or perhaps
3 comorbidity, is not uncommon. If the thinking is this
4 man has this difficulty, he may not be at the moment
5 suitable for radiotherapy; is that the kind of thing 14:25
6 that generally should go back to the MDM to have it out
7 there, or is that something that the clinician really,
8 as your last answer suggested, should get on with and
9 refer to the oncologist?
10 A. MR. GILBERT: If the clinician thinks that the lower 14:25
11 urinary tract symptoms should exclude the patient from
12 radiotherapy then, yes, it should go back to the MDT.
13 However, I don't think that would be a common scenario.
14 The job is to sort out the cancer by referring to the
15 specialist MDT, period. You have a period of time to 14:26
16 sort out the urinary tract symptoms, and that is the
17 job of a general Urologist. In my own practice, with
18 this patient, I would have referred at the time of the
19 decision-making. In the meantime I would have arranged
20 urodynamics to ensure or ascertain exactly what sort of 14:26
21 treatment might alleviate his lower urinary tract
22 symptoms, and if that involved a TURP, then he could
23 come in and have it done because you have got a window
24 of opportunity.
25 134 Q. Dr. Hughes it's a nuance I think in my question to date 14:26
26 that was somewhat lost on me. Mr. O'Brien makes the
27 perfectly reasonable point that this wasn't an MDM, and
28 I have looked at the MDM record and while it's in the
29 usual stationery for the MDM with the title of MDM and

1 all, it's not distinctive from any of the other MDM
2 records. You, as the author of this report with
3 Mr. Gilbert, might be forgiven for thinking this was
4 a standard MDM, but just for clarity, in this one in
5 particular or in any others that you were looking at, 14:27
6 was it your assumption, based on the paperwork, that
7 this was a fully functioning MDM, multidisciplinary
8 meeting that looked at this case?
9 A. DR. HUGHES: We didn't make that assumption for any of
10 the MDMs. 14:27
11 135 Q. Sorry, you didn't?
12 A. DR. HUGHES: We didn't make that assumption for any of
13 the MDMs in the Southern Trust, because when you
14 actually look at the attendance and the reports are
15 peppered with the annual quorate rates, very, very few 14:28
16 of the MDMs were appropriately quorate. We did drill
17 down at times by year. We didn't drill down into every
18 individual MDM to see if it was quorate, but the
19 overall figures were so low that the assumption that it
20 was not a quorate MDM. There were some virtual MDMs 14:28
21 because at the time of Covid and the attendances did
22 vary. The recommendation in this case, as in many
23 cases at MDMs, is through standardised regional
24 protocols and the output, although it wasn't a quorate
25 meeting, is not an unusual recommendation. 14:28
26 A. MR. GILBERT: No. If I may, this is what I would call,
27 without being disparaging to the patient,
28 a straightforward case. The actions required for this
29 patient are clear and obvious. The patient should be

1 referred to discuss the options available to him for
2 treatment of their prostate cancer at the specialist
3 centre.
4 136 Q. I just want to put up on the screen DOH-00079,
5 Dr. Hughes. The predominance of the recommendations in 14:29
6 this case were around MDMs. That might give an
7 indicator of your suspicion that it possibly wasn't an
8 MDM, whether or not you drilled down into the fine
9 detail of this one, you make the point at
10 recommendation 2 that the MDMs should be quorate, and 14:29
11 you make the point that the Chair's responsibilities
12 must include regular quality assurance activity, which
13 is a broader point that runs across all of the cases,
14 I think?
15 A. DR. HUGHES: Yes. Those are recommendations that apply 14:29
16 across quite a lot of the reviews, if not all. The MDM
17 quorate levels were at 0.or 5%, which was largely due
18 to absence of Oncology.
19 137 Q. Moving away from the individual cases. I want to ask
20 you about the issue of assurances that you were anxious 14:30
21 to seek during your review process and apparently
22 received. Could I bring up on the screen, please,
23 WIT-84155. Just go down to (iii), please. The
24 question at (iii) is:
25 14:31
26 "What was the purpose of speaking to these
27 individuals?"
28
29 The individuals being the core members of the MDT,

1 meetings with management and those with managerial
2 roles followed. You say the purpose, possibly one of
3 several purposes, was to gain a detailed understanding
4 of how cancer patient pathways were delivered.
5 14:31
6 "The meetings also sought assurance regarding how
7 others delivered care within the Urology Service given
8 the clinical deficits identified. This was critical to
9 provide assurance regarding ongoing care quality. This
10 would be a requirement of any SAI Review. Discussions 14:31
11 with Managers and Clinicians with managerial
12 responsibility focused on governance of care and
13 governance of those who provided care. Lastly, the
14 meetings were to discuss how the care experienced by
15 the patients under review varied from best practice.", 14:32
16 et cetera.
17
18 I want to go back to this issue of assurance. You said
19 it's important to ask for and to receive it. How was
20 the assurance given to you? 14:32
21 A. DR. HUGHES: This was during the process of SAI when
22 we'd learned the initial themes. The themes were
23 failure to refer on to specialist care, failure to have
24 a Clinical Nurse Specialist supporting patients, off
25 guidance use of medication, and failure to bring cases 14:32
26 back to MDT and re-discuss patients. I would call this
27 early learning, early action, and we had to provide
28 assurance to the Southern Trust that the services they
29 currently provided were fit for purpose and did meet

1 the expectations. We asked about did everybody use
2 a Clinical Nurse Specialist? Did everybody adhere to
3 MDT guidance? Did people re-refer patients back to MDM
4 as the disease progressed? Did everybody adhere to
5 regional guidance around prescriptions? On 14:33
6 a professional level we got verbal assurance around
7 that, but that's not an assurance that would stand up
8 to families or public, so the assurance required was
9 written into the action plan, so the action plan really
10 detailed the expectations of a functioning MDT. It 14:33
11 then detailed how they would provide assurance to the
12 public and to the rest of the healthcare community.
13 It gives them dates by when they would do that. This
14 was what I would call an immediacy that was required to
15 seek assurances around the Services. At that stage we 14:34
16 needed to know was it endemic? Did everybody use
17 Clinical Nurse Specialists? Was the prescribing
18 problem beyond a single individual? We got assurances
19 based on proof as the professionals gave that
20 commitment, but we had to follow that up with a robust 14:34
21 action plan that would give detailed audited assurance.
22 138 Q. Yes. I asked the question, and let me pose it in this
23 way. Yesterday we saw the 2017 Peer Review document,
24 signed off by Mr. Glackin. It assured the Peer Review
25 that they, that is the MDT, followed the regional 14:35
26 guidelines. That must mean the MDT, for example,
27 follows the regional guidelines as regards prescribing.
28 Secondly, we could see in that assurance document, if
29 I can call it that, Mr. Glackin telling the Peer Review

1 people that all first diagnosed cancer patients within
2 Urology receive the services of a Cancer Nurse
3 Specialist. Against that background, you had
4 discovered those assurances to the Peer Review, for
5 whatever reason, didn't stand up. Is it fair to say 14:36
6 that you weren't able to check? It wasn't your job to
7 check the assurances that you were being given by these
8 professionals?
9 A. DR. HUGHES: Yeah. I think it was my job to point out
10 what you have just pointed out, and I think it was my 14:36
11 job to say this is what you said to an external
12 accrediting body and this is what we have found; are
13 you aware of a deficit and your responsibility for
14 that? Everybody I talked to I referenced the Peer
15 Review document, because sometimes, you know, people 14:36
16 have a slightly optimistic view or over-optimistic view
17 of how functioning their service is, but these are
18 clear and different deficits. This is saying everybody
19 got something, when clearly everybody didn't, and
20 everybody was adhering to guidance. The underlying end 14:37
21 point of that discussion was that these things were
22 being said without data, without audit, without proper
23 assurance, and then that fed into the action plan,
24 which was very prescriptive and people probably found
25 it a bit difficult. It was explained to them that to 14:37
26 provide the public, patients and other professionals
27 with assurances about the Service they would have to do
28 this. Part of the deficit was they have already said
29 one thing and that was not proven to be true.

1 139 Q. Yes. Just so that I can fully understand it, you
2 recognised, I suppose, the deficits of the assurances
3 that had been given to the Peer Review?
4 A. DR. HUGHES: Yes.
5 140 Q. You needed to obtain some assurance from the 14:37
6 professionals that they worked in accordance with what
7 the Peer Review had been told?
8 A. DR. HUGHES: Yeah.
9 141 Q. You weren't able to test that assurance, but what you
10 did was write in to your recommendations and action 14:38
11 plan a series of methodologies or mechanisms by which
12 those assurances could be tested going forward?
13 A. DR. HUGHES: Yeah. The discussions probably would have
14 happened around December/January, and the final report
15 and action plan probably would have been available in 14:38
16 April, but they would have been shared a draft to know
17 their expectations. Some of the issues around the
18 action plan and dates were people saying oh, we can't
19 do that, we don't have the resources, they are
20 unreasonable timelines, but I had to push back on that. 14:38
21 142 Q. I want to move on for the rest of this afternoon to
22 look at some of the key findings that emerged from your
23 series of reviews and ultimately integrated into an
24 overarching report, and just to focus on those.
25 14:39
26 Can I turn, first of all, to your witness statement at
27 WIT-84166. Just scroll up so we can see 15. What the
28 Inquiry asked you was to outline in broad terms the key
29 themes, trends, findings or conclusions which the

1 Review Team reached across the nine reviews. Let me
2 just set them out because they follow down in your
3 statement. The first thing you say is professional
4 delivering care without a multidisciplinary input was
5 a finding. A failure of onward referral to Oncology or 14:40
6 palliative care was a key finding. You've said that
7 prolonged treatment pathways was a key thing. Care
8 varying from regional/national best practice; and
9 separately, departures from MDT recommendations;
10 a failure to action the results; the Bicalutamide 14:40
11 issue; no input from the CNS; quorum; and an absence of
12 assurance, audits or a coherent escalation in
13 governance structures.
14
15 I want to work through those with you between the rest 14:41
16 of this afternoon and the next occasion. Looking at
17 what you have said here as a kind of high level
18 introduction to some of these issues, you have said:
19
20 "International best practice indicates that cancer care 14:41
21 is best delivered on an agreed evidence base by teams
22 of professionals with differing but complementary skill
23 sets. This should ensure patients are partners in
24 care, informed about their care and supported
25 throughout their journey - including the palliative 14:42
26 phase of disease. Cancer care in Northern Ireland has
27 been resourced to a considerable degree to achieve
28 these outcomes. Each cancer type has a regional group
29 which includes patients, to determine best treatment

1 pathways for each aspect of care - this is founded on
2 research and international, national, and regional
3 guidelines. The guidelines explain best care and how
4 it should be delivered. Adherence to such guidelines
5 is delivered at Trusts / Hospital levels through 14:42
6 patient discussion at the multidisciplinary team
7 meeting."
8
9 That is the context, I think, you are saying within
10 which the Southern Trust Urology Multidisciplinary Team 14:42
11 was expected to work. The knowledge, based on
12 international research and experience, should have been
13 well known?
14 A. DR. HUGHES: Yes, yes.
15 143 Q. The system was funded? 14:43
16 A. DR. HUGHES: It was funded and it obviously could be
17 better, but when I was Medical Director everybody
18 complained that cancer got most of the money, so it was
19 funded.
20 144 Q. In essence, this multidisciplinary team, supported by 14:43
21 the Cancer Service Management, should have known how to
22 do it, and do it well?
23 A. DR. HUGHES: Yes.
24 145 Q. You go on at 84174, a few pages further on, at the last
25 bullet point, you say: 14:44
26
27 "Much of the SAI Reviews are framed in terms of what
28 care and support patients did or did not receive.
29 Patients with urological cancers often fall within the

1 older age group and may be more often be passive
2 recipients of decisions and advice."
3
4 Sorry, I think -- I was at the right place. The piece
5 I want to focus, on, Dr. Hughes was: 14:44
6
7 "Individual decisions of a single professional took
8 precedence over patients' rights to best care based on
9 evidence and best supported care."
10 14:45
11 You've set out the context, and this is one of your key
12 findings?
13 A. DR. HUGHES: Yes.
14 146 Q. That one professional didn't work within
15 a multidisciplinary environment, or didn't comply with 14:45
16 the working principles of that multidisciplinary team?
17 A. DR. HUGHES: Yes.
18 147 Q. But the bigger focus, I think, at least so far as the
19 Inquiry is concerned, is how and why that was allowed
20 to happen in governance terms? 14:45
21 A. DR. HUGHES: Yes. To be fair, that's what the families
22 reflected back to me after meetings 2 and 3, that it's
23 not what happened, it's why and how.
24 148 Q. I suppose, in a nutshell, the answer to that question
25 across a number of themes is that this could have been 14:46
26 prevented with appropriate tracking and audit, and
27 quality assurance?
28 A. DR. HUGHES: And culture. I think it's important to
29 say, an SAI is not the way to pick up deficits in

1 a service because, by definition, something bad has
2 happened. The patients have suffered or potentially
3 suffered a deficit. The culture should be that you can
4 raise any concern at any time, preferably when it's
5 a minor concern, and the MDT is ready and willing and 14:46
6 in acceptance of that approach. If you leave things to
7 dwell, they may become too difficult to deal with, and
8 with poor consequences. I think culture needs to be
9 called out as well.
10 149 Q. The first of the main themes then is professional 14:47
11 delivering without multidisciplinary input. If we go
12 to 84167, please, WIT-84167. There you set out the key
13 guideline that we are by now familiar with, and that's
14 the benchmark that you use to assess the patient
15 experience. You found that the use of a CNS was common 14:47
16 for all other Urologists?
17 A. DR HUGHES: Yes.
18 150 Q. Were you entirely satisfied about that, even in the
19 absence of audit or assurance documents?
20 A. DR. HUGHES: I cannot say that I had complete 14:48
21 certainty, but the reason we put in the strict
22 assurance processes within the recommendations and
23 action plan was to address that. As part of early
24 learning and early action, I had discussions with the
25 Medical Director about the deficits, and the team were 14:48
26 informed by their line managers and their professional
27 officers what was expected, so I think that helped as
28 well.
29 151 Q. Just to be clear, your finding, as set out in the

1 overarching SAI -- I needn't bring it up on the screen,
2 but it's DOH-00128 -- your finding was that all nine of
3 the patients that you were looking at were deprived of
4 access to a CNS and, as a result, used what you
5 describe as uni-professional care, despite the 14:49
6 availability of a multidisciplinary resource?
7 A. DR. HUGHES: Yes. Most of a cancer patient's journey
8 is actually in the community, and that's where they
9 often need resource and support. You really do need
10 that link between secondary care and primary care, and 14:49
11 that's provided by the Clinical Nurse Specialist who
12 can address these issues, and none of the nine patients
13 had a Clinical Nurse Specialist.
14 152 Q. Was it of any interest to you to establish not so much
15 how that's happened, I think that was your primary, but 14:49
16 why it happened? Why, in the sense of, why had the
17 clinician taken this route?
18 A. DR. HUGHES: Yeah, and that formed some of the
19 questions that we sent to Mr. O'Brien. I should say
20 part of me didn't not care, it was a standard of care. 14:50
21 It was a standard of best cancer care recognised
22 everywhere, and I don't think there would be a logical
23 reason to give to say that nurses should not be there
24 to provide their skills and support. While it may be
25 a useful discussion to have, I'm not sure if I could 14:50
26 actually internalise any reason to exclude nurses from
27 care.
28 153 Q. We know, Mr. Gilbert, that the MDT operating policy,
29 that I referred to yesterday, puts an onus, one might

1 say, on the Clinical Lead in the MDT, on the core nurse
2 member, to ensure that an allocation has been made.
3 It's Mr. O'Brien's earnest belief that that's how it
4 should have been done. Let's follow that along. If
5 that's how it should be done and you are the Clinician 14:51
6 treating the patient realising that it hasn't been
7 done, that your patient is without a Nurse Specialist
8 at his or her side; is that something, (a) that you
9 would realise or you would see it, would it be visible
10 to you, and if so, is it something you would be 14:51
11 inquiring about?
12 A. MR. GILBERT: Yes, it would be visible, mainly because
13 you'd simply ask who the Nurse Specialist was whenever
14 you saw the patient so he or she could be copied into
15 the correspondence that might be generated. 14:52
16 154 Q. It's something you would make an inquiry about?
17 A. MR. GILBERT: Yes. If there was clearly no Cancer Nurse
18 Specialist allocated, then I would either directly
19 approach or e-mail the Cancer Nurse Specialist team and
20 say, come on, whose patient is this, or please can you 14:52
21 allocate somebody? That would probably be followed up
22 with a conversation. It's a slightly uncomfortable
23 position for me to describe because if you're working
24 within a functional MDT it all just happens. There's
25 no question of the Lead having to do things, it's the 14:52
26 question of the nursing team present at the MDT putting
27 up their hands or talking amongst themselves saying oh,
28 that chap lives in this particular geographical area,
29 he is one of yours, can you get in touch? I really

1 need to impress on you the collegiate, collaborative
2 nature of well functioning MDTs, and it is that
3 function that benefits patients. If somebody has
4 fallen through the net and they haven't got them, then
5 it's clear they haven't got a Cancer Nurse Specialist 14:53
6 and it would be incumbent upon the clinician, whether
7 that's a Consultant or a Registrar, to make sure that
8 they were teamed up, for whatever reason.
9 155 Q. Does the specialist nurse add value to your work? Or
10 to put it a slightly different way, does it assist the 14:53
11 Clinician's work in that complementary sense that you
12 have described?
13 A. MR. GILBERT: I will turn your question on its head,
14 I would ask whether my work contributes anything to the
15 Cancer Nurse Specialist's work. My job has become 14:54
16 increasingly technical, in the sense of I go through
17 a diagnostic process, which is well described,
18 well-documented, well-evidenced, and, to a certain
19 extent, I may have less involvement with the patient.
20 The person who is looking after the person, the 14:54
21 patient, is the Cancer Nurse Specialist; she knows, he
22 knows, about the everyday worries and concerns of
23 somebody living with cancer, and that used to be, to
24 a degree, a clinician's role, but in the way in which
25 our responsibilities have shifted, doctors have become 14:54
26 much more technical in their approach and it's the
27 Cancer Nurse Specialist. If I had cancer and you asked
28 me would I rather have a Consultant or a Nurse
29 Specialist, dead easy, Cancer Nurse Specialist, because

1 they are going to address your whole life.
2 156 Q. Another aspect of the role I just want to touch on one
3 example because I think we have been over the ground
4 here quite a bit, but just one example of a patient
5 that you have made a recommendation in respect of. 14:55
6 It's, by way of example only, Patient 5 or C. We can
7 find this at WIT-00041. It should have been DOH.
8 Thank you. If we scroll down to the recommendations,
9 and what you say here, recommendation 1 is that:
10 14:57
11 "All patients receiving in the Trust Urology Cancer
12 Services should be appropriately supported and informed
13 about their cancer care. This should meet the
14 standards set out in the regional national and national
15 guidance and meet the expectation of cancer Peer 14:57
16 Review. This must be supported by a Urology Cancer
17 Nurse Specialist at an early point in their
18 surveillance journey."
19
20 Is the early point usually after the diagnosis has been 14:57
21 made and the MDM's recommendations are known?
22 A. DR. HUGHES: This was a renal cell tumour, a kidney
23 cancer. It's slightly different. The first offer of
24 a Urology Cancer Nurse Specialist came after tissue
25 diagnosis, whereas somebody who was undergoing 14:58
26 surveillance with a radiologically known or potential
27 cancer and was being reviewed on a regular basis, and
28 most of them found that very concerning, and really
29 quite unsupported, so the recommendation was to have

1 a Clinical Nurse Specialist at the early part of their
2 stage, which would have helped regularise the rather
3 sporadic way the patient was being reviewed, and it
4 would have supported people because, in essence, they
5 are living with a 90% knowledge or certainty of cancer, 14:58
6 and that issue was the point in that case.
7 157 Q. Just going back to the findings in this case. If we
8 can go back to page 41 in this series DOH-00041. At
9 the middle of the page what you say is:
10 14:59
11 "The patient was not referred to a cancer nurse nor any
12 contact details given."
13
14 You set out the recommendations of Peer Review and make
15 the point in the next bullet point: 14:59
16
17 "The Review Team are of the opinion that a specialist
18 nurse would also have been a fail-safe for identifying
19 the delayed scan report and bringing it to the MDM
20 sooner." 14:59
21
22 That was the case where there had been a CT scan
23 ordered and it sat un-actioned for some time, leading
24 to delay in the care pathway. To what extent,
25 Dr. Hughes, or Mr. Gilbert, would a Nurse Specialist be 15:00
26 of practical assistance in that kind of scenario?
27 Would he or she be expected to know, for example, that
28 the scan had been ordered and be alive to the need to
29 follow up, or does it work in a different way?

1 A. MR. GILBERT: It depends on the way in which the Cancer
2 Nurse Specialists operate within a particular Trust,
3 but the short answer to your question is yes, because
4 of that continuity of care they would be aware of the
5 follow-up appointments, and they would be aware of 15:00
6 somebody falling through, or they would be a point of
7 access for somebody who said, I haven't heard about my
8 CT scan. This case was managed perfectly well in an
9 exemplary fashion by Mr. O'Brien, period. The
10 follow-up CT scan discovered a coincidental problem. 15:01
11 It just happens that it was a coincidental cancer
12 within the same subspeciality but remember we are
13 dealing with five different cancers, none of which are
14 connected biologically, they are separate diseases.
15 The only criticism here that can be levelled is that 15:01
16 that result wasn't picked up. The source of who should
17 have picked it up is for other people to deliberate on.
18 I would suggest there should have been some sort of
19 alerting system so if a Radiologist saw a result that
20 was unusual, and this was what the CT scan was looking 15:01
21 for was chest deposits, which is the common case for
22 metastases after kidney cancer but coincidentally
23 another finding which happened to be related to
24 prostate cancer, and there should have been a mechanism
25 in place to allow direct contact between a Radiologist 15:02
26 and the Clinician in question. That system, if not in
27 place, would have been helped, but who is to say why
28 the result didn't come through? That would have been
29 helped had there been a Cancer Nurse Specialist in

1 place. I'm not saying that it would be an absolute
2 safety net but it would certainly be a great
3 assistance.
4 158 Q. Yes. The next broad theme that you depict in your
5 statement, Dr. Hughes, is let's move to WIT-84167. 15:02
6 This is a failure of onward referral of patients to
7 oncological or palliative care. You identify seven
8 patients who had this problem or this obstacle in their
9 care pathway. It wasn't only a problem of Mr. O'Brien,
10 as you point out in your overarching report. There was 15:03
11 one case out of the seven, where the problem of
12 referral was a decision of the multidisciplinary team
13 itself. I think that was the case of Patient 3 or
14 Patient H, which was a penile cancer case; is that
15 right? 15:04
16 A. DR. HUGHES: Yes, that's correct.
17 159 Q. If we look at that one, if we go to some of the
18 findings in the report, DOH-00095. Just before we look
19 at it; in context, where a regional Cancer Centre, such
20 as the Southern Trust, has a case of penile cancer 15:04
21 coming through its doors, what are you saying within
22 the report was the appropriate response?
23 A. DR. HUGHES: Penile cancer is very rare. Northern
24 Ireland would have about 20 cases a year. So there's
25 very limited experience. Penile cancer is arranged in 15:05
26 supra-regional groupings Northern Ireland links with
27 the Christie in Manchester. This work is not normally
28 done in a district general hospital. It's normally
29 referred to a large centre or supra-regional centre

1 where there is high volume care and better outcomes.
2 It's a basic standard of practising within your field
3 of competence and suggesting it should have been
4 referred on. The local MDT didn't seem to make that
5 connection until very late in the pathway. 15:05
6 160 Q. Yes. We can see, I think, if we go to the conclusions
7 on the next page, please, this patient ultimately
8 succumbed to his illness; isn't that right?
9 A. DR. HUGHES: Yes, indeed.
10 161 Q. You say: 15:06
11
12 "Although there was a five-week delay in initial
13 referral and appointment, the management of the case
14 was appropriate up to the MDM on 18th April. At this
15 point the MDM should have recommended an urgent CT scan 15:06
16 and simultaneous referral on to the regional centre
17 specialist group", which you say is in Manchester for
18 Northern Ireland cases?
19 A. DR. HUGHES: Yes.
20 162 Q. "For all subsequent management. Penile cancer is an 15:07
21 unpredictable disease. In this case appropriate
22 management could have provided a 90% five year
23 survival. The patient wasn't offered this
24 opportunity."
25 15:07
26 Were you able to establish why, because as I think we
27 looked at yesterday, the 2016 NICaN document provide
28 chapter and verse, in its penile cancer section, of the
29 need to avoid local treatment beyond the initial

1 management and make the referral. Were you able to
2 establish what had gone wrong here?
3 A. DR. HUGHES: Yes. Commissioning of a service in
4 Northern Ireland would have been appropriate but they
5 did need to have a regional link that linked to 15:07
6 Manchester and that seemed to take at least three
7 years. They eventually set up a Northern Ireland hub
8 of the Christie system in the Western Trust.
9 163 Q. In Altnagelvin?
10 A. DR. HUGHES: Yes. So that said, I think Mr. Gilbert 15:08
11 will say from 2008 professionals would have been
12 self-selecting to send their cases on to a regional
13 centre.
14 A. MR. GILBERT: Yes. Certainly my personal experience,
15 and those of my peers, would have been at the 15:08
16 instigation of supra-regional networks which initially
17 covered four million population. For the southwest of
18 England, Bristol is the centre and it covers
19 Gloucestershire out to Wiltshire and right down to
20 Cornwall, so a very large geographical area. Certainly 15:08
21 we would refer all suspected penile cancer cases for,
22 initially advice. That was the first function for the
23 MDT. They would write back and say, go on and do
24 a circumcision, because sometimes that's all you need
25 to do, or they will write back and say no, we need to 15:09
26 see this patient, we will take over management. As
27 time has gone by, that relationship has become less
28 fluid and the referrals are much, much stricter, and
29 that has been probably the case for at least the last

1 ten years, if not longer. There's no room for somebody
2 to try their hand at a rare operation.
3 164 Q. As I have said, there's seven examples of inappropriate
4 behaviour in association with onward referral. We
5 touched on one this morning, the failure to refer 15:10
6 Patient 1, Patient A, until June 2020, some eight
7 months after the MDM had made its recommendation. We
8 will touch in some detail as we go on, on the
9 overarching recommendations but in governance terms can
10 you give us a taster on how you saw this as being 15:10
11 preventible? What precisely are the mechanisms of
12 governance that need to be embedded in order to pick up
13 on this kind of shortcoming?
14 A. DR. HUGHES: Past experience that we would have.
15 People have called it enhanced tracking, but it's just 15:11
16 what I would call normal tracking. The tracking team
17 would actually check that a referral has been done and
18 sent and received, and that was designed to, you know,
19 pick up misses or forgetfulness. It's not initially
20 designed as a governance pathway to check that the 15:11
21 right thing has been done. It's to check that somebody
22 hasn't forgotten to do something and that things have
23 happened in a timely fashion. In fact, if the tracking
24 team is empowered they would often have a very good
25 relationship with the receivers, or if it's particular 15:11
26 scans, they will be able to schedule them and they are
27 invaluable to good functioning cancer care. The
28 positive added value to that is you have immediate
29 feedback when things aren't being done and when things

1 are being done differently. But the initial reasoning
2 for having that tracking system is to ensure everybody
3 gets the best care delivered along the agreed lines and
4 at the best time.
5 165 Q. You make it sound as if it's commonplace and not rocket 15:12
6 science.
7 A. DR. HUGHES: It's commonplace where I work. As well as
8 having a function in MDT, the clinical community would
9 have been very respectful of the tracking team, because
10 very often the tracking team are, have you done this, 15:12
11 have you done that, and are pestering Radiology to get
12 scans done. They were the engine that drove the system
13 forward. You do need that mutual respect for all
14 professionals delivering cancer care, because this is
15 very much the engine in the background, the 15:13
16 unrecognised team. I regard it as normal practice and
17 I found this quite strange because, in essence, it was
18 very focused on the 31 and 62-day targets.
19 166 Q. Yes. Mr. Gilbert, you go to an MDM in north Bristol
20 and you have four or five of your patients being 15:13
21 discussed and you leave the meeting that late afternoon
22 with five recommendations for, let's stick with
23 prostate cancer, ADT and onward referral for
24 oncological opinion, but you forget to do two of those,
25 or it's been a busy week and two aren't referred. How 15:13
26 does the tracker practically, on the ground, spot that?
27 Is it an electronic system or do they rap your door
28 every couple of days?
29 A. MR. GILBERT: Each patient has a formal e-mail pro forma

1 sent to me and, in that, the outcome of the MDT is
2 described and the actions required and the response
3 from the person responsible for those actions will be
4 given as well. For example, if a patient has a recent
5 diagnosis of prostate cancer and they need to have the 15:14
6 options treated, it will say at the bottom, I don't
7 need to do anything because the patient is going to see
8 a Cancer Nurse Specialist in three days' time. Or it
9 might say, this patient has no cancer on their biopsy,
10 and then it becomes my responsibility to arrange some 15:14
11 form of follow-up to inform them of that, although the
12 MDT will also generate a standard letter to let them
13 know. I think that's a little bit formulaic. They
14 need somebody to speak to so I will arrange to speak to
15 them during the course of the following week to say the 15:14
16 biopsies are fine, and this is what we are going to do
17 as future management. It's all done by people, it's
18 always very easy to disguise these tracking things
19 behind electronics, but ultimately the people who are
20 running this are the coordinators we call them, 15:15
21 coordinators because they are responsible for guiding
22 the patients into the MDT process, watching them go
23 through it, coming out the other end and making sure
24 that there's good communication with the patients, and
25 each stage is confirmed to have happened. For example, 15:15
26 if I forget to request an MRI scan during the course of
27 a busy clinic, they will be on to me the following day
28 and saying you haven't requested this, get on with it.
29 It's incredibly reassuring.

1 167 Q. Yes.
2 A. MR GILBERT: Incredibly reassuring.
3 168 Q. Yes. Dr. Hughes, is it your sense that this is a wider
4 Northern Ireland Trust problem, or is it your
5 experience that THE Southern Trust was an outlier when 15:16
6 it comes to this kind of apparently straightforward
7 tracking arrangement, or do you not know?
8 A. DR. HUGHES: Perhaps my assumption was that this is how
9 everybody worked. The only one I would have detailed
10 knowledge of now is the Southern Trust because of this 15:16
11 case. That doesn't reflect my normal, but I couldn't
12 comment on the other three Trusts because I generally
13 have not had an opportunity to look at them.
14 169 Q. Yes. Your experience was of the Western Trust,
15 I think did you say in an earlier answer in my place we 15:16
16 tracked, no?
17 A. DR. HUGHES: Yeah, I was employed in the Western Trust.
18 170 Q. Yes. When you gave that answer, do they track for this
19 kind of thing when you were in the Western Trust?
20 A. DR. HUGHES: Yes. Part of the process, as Mr. Gilbert 15:17
21 says, it's about empowering the coordinators to do
22 that, and when they are doing their job they are
23 respected for doing their job. People are grateful to
24 be reminded because ultimately Clinicians are
25 incredibly busy and it's not unknown for things to be 15:17
26 forgotten or misplaced, and you have this supporting
27 infrastructure, which is not available in many or
28 clinical specialties, making sure the right thing is
29 done within the right short time frames.

1 171 Q. I don't want to get into healthcare funding this
2 afternoon, but in commissioning terms and resources
3 terms, if you are commissioned, and thereby funded to
4 provide a cancer service or urological cancer service
5 within your Trust, and given that resources has been 15:17
6 identified by some of these managers and practitioners
7 as being an issue around some of these shortcomings, is
8 it a resources issue in that sense?
9 A. DR. HUGHES: Yes.
10 172 Q. When you as a Trust are commissioned, should you only 15:18
11 accept the commission if you are funded for the process
12 of providing it safely?
13 A. DR. HUGHES: Yeah. I think it's how we explain the
14 role of these professionals. Classically, they are
15 banded within the clerical administration group, but 15:18
16 the role is about getting patient care done in a timely
17 fashion and about keeping patients safe. I think if
18 you explain that role the commissioners would be more
19 responsive. I think if it's imagined there is some
20 sort of administration, I think that really undersells 15:19
21 and doesn't really describe their role. They are
22 really essential to good patient care. Are the
23 Commissioners is always responsive to that? Possibly
24 not due the other pressures of direct clinical care.
25 173 Q. In practical terms I think you are accepting of the 15:19
26 view that if you are going to provide prostate cancer
27 care to a patient, it should be part of the care
28 package --
29 A. DR. HUGHES: Yes.

1 174 Q. -- to, as much as putting an injection in the man's
2 arm, it's also part of the care package to ensure that
3 when he needs the referral to Oncology, you are to
4 refer is known, that's part of the care, and yet, part
5 of the explanation given to you is oh, we are not 15:20
6 funded to do that, that's why we didn't do it?
7 A. DR. HUGHES: Yes. That was rehearsed repeatedly. Part
8 of it may be that their understanding, back to
9 yesterday morning when we discussed the
10 responsibilities of people with leadership, that their 15:20
11 role is to sort of promote their services in the Trusts
12 and lobby for additional resources, albeit from within
13 Trust funds. These organisations are billion pound
14 organisations, you are looking for relatively small
15 sums of money to keep patients safe, and I think 15:20
16 a leadership role is also about ensuring that your
17 service is appropriately resourced, and clinicians have
18 lots of power to do that.
19 175 Q. Just in conducting this conversation, you are really at
20 a relatively high level, but did you reflect on whether 15:21
21 it really and truly was a resources issue or whether,
22 in fact, more particularly, it could have been an
23 insight, understanding, cultural issue, because there
24 was a coordinator for this MDT?
25 A. DR. HUGHES: Mm-hmm. 15:21
26 176 Q. Mr. Gilbert explains that it's the coordinator's role
27 to do the follow-up, the tracking, it's a human
28 interaction and it's done, you know, rapping the door,
29 telephoning, chasing them up, so it should fall within

1 that kind of job description, no doubt the coordinator
2 in the Southern Trust was a busy person. Part of what
3 was reflected to you, particularly from the cancer
4 management people that we will see in a moment, seemed
5 to portray a lack of understanding that these things 15:22
6 were important?
7 A. DR. HUGHES: I think that is fair to say. I think the
8 mechanisms of how things worked weren't completely
9 clear to them. I think the statement about we are not
10 funded to do that was somewhat defensive, because it 15:22
11 explains how the systems were at the time. I am not
12 sure if they had explored, could it have been done
13 better. I should say Urology MDT is an incredibly busy
14 service and it certainly needs more than one person to
15 deliver on that, not least for continuity but just the 15:22
16 sheer volume of cases.
17 A. MR. GILBERT: I think it would be worth remembering at
18 this juncture one of the comments made by the
19 oncologists in their conversation, which was that
20 actually two of the Consultant Urologists interacted 15:23
21 extremely well, so somehow the resources were working
22 for some of the people within the Trust. A lot of the
23 times clinicians, we find that we have to fill in gaps
24 for roles that we would like other people to have
25 alongside, like the coordinator, like tracking results 15:23
26 and so on and so forth. Clearly in Southern Trust,
27 irrespective of whether they were in full complement or
28 not, at least two of the clinicians responsible for
29 cancer seemed, on the basis of the reports of the

1 oncologists, that they were performing well.
2 177 Q. Thank you. Let's move on to the third of the themes
3 picked up in your witness statement, Dr. Hughes.
4 Prolonged treatment pathways, if you go to WIT-84167.
5 You say, Dr. Hughes: 15:24
6
7 "5 of the 9 patients in this review experienced
8 significant delay in diagnosis of their cancer -- We
9 looked at one this morning -- "this was related to
10 patients with prostate cancer and reflected variable 15:24
11 adherence to regionally agreed diagnostic pathways".
12 Service User B was the case we looked at this morning.
13
14 Again, were you able to establish why that was
15 a feature of this MDT and this one practitioner? 15:25
16 A. DR. HUGHES: Yes. Service User B is the case we looked
17 at this morning where there was a clinical diagnosis of
18 prostate cancer T3/T4 based on digital examination, yet
19 the thought processes then went down the pathway of
20 TURP and a range of additional things. Clearly, if 15:25
21 that was your first clinical impression from the first
22 appointment you should click into the well-defined
23 diagnostic pathways for prostate cancer. I don't
24 believe the working patterns were systematized and
25 focused the way normal cancer diagnostic pathways are. 15:26
26 It is a bit industrialised, and it is high volume, but
27 to do things in very tight timelines is best practice
28 is that you adhere to the regional and national
29 guidelines, and I think there was regular variance from

1 that and, in a more disjointed way.
2 178 Q. Again, is this a matter of adequately tracking or,
3 I suppose, with the patient we looked at this morning,
4 the tracking wouldn't have kicked in to post diagnosis?
5 A. DR. HUGHES: The tracking wouldn't have kicked into 15:26
6 diagnosis, although, that being said, 60% of patients
7 come in through the red flag referral route, give or
8 take. There would be a range of people coming through
9 that pathway for their diagnostic process, and that
10 should be managed. It may not be the tracker but it 15:27
11 should be managed in another way. In the Southern
12 system for prostate cancer the Trust biopsy service is
13 actually provided by the Clinical Nurse Specialist, so
14 there is a systemised process way of doing that.
15 179 Q. One of the cases that you identify as having 15:27
16 a prolonged pathway is Patient 4 or Patient D. If you
17 go to the conclusions in that report at DOH-000107.
18 This was a patient that presented with urinary
19 retention, a little like Patient B we saw this morning.
20 Again, you say the initial assessment should have 15:28
21 included a DRE.
22
23 "The TURP was expedited by a significant development of
24 haematuria rather than as a result of clinical
25 judgment. The histology was an indicator of prognosis 15:28
26 disease and urgent staging, including a CT chest,
27 abdomen and pelvis, together with a bone scan, should
28 have been reported within four weeks. The
29 investigations from those investigations should have

1 been presented at MDM whose recommendations should have
2 included, even if not present, an urgent referral
3 onwards to the oncology service for expert
4 consideration."
5 15:29
6 You go on to say over the page:
7
8 "Through inadequate treatment this gentleman's poorly
9 differentiated prostate cancer is allowed to progress
10 and cause him severe and unnecessary distress. There's 15:29
11 a chance that despite this, the clinical course might
12 not have been any different but he should have been
13 given every opportunity to consider proper and adequate
14 treatment options."
15 15:29
16 Mr. Gilbert, this, as we will see across a collection
17 of five out of the nine cases, delayed or prolonged the
18 diagnostic pathway. In the context of prostate cancer,
19 urgent intervention is sometimes, perhaps mostly
20 important? 15:29
21 A. MR. GILBERT: Prostate cancer is a wide spectrum of
22 disease from very indolent disease that doesn't need to
23 be treated and just needs to be observed, through to
24 extremely aggressive disease which defies treatment.
25 This was an elderly gentleman, as I recall. He's 15:30
26 presenting with the, if you remember I described the
27 Gleason scale running from 6, which is relatively inert
28 or indolent disease, through to Gleason 10. This is
29 Gleason 10, which is very poorly differentiated, very

1 aggressive, was not producing much PSA, which is the
2 blood test for the discussion, that prostate cancer
3 produces, but this is so bizarre tissue, so distant
4 from prostate disease that it's not even producing the
5 normal chemicals that the prostate produces. It's 15:30
6 undergone very, very severe transformation into cancer,
7 and it's likely that any treatment option might have
8 been difficult, or might not have had any difference on
9 the pathway, the prognosis, and the outcome. However,
10 it would have been appropriate to consider giving 15:31
11 hormone therapy. It may not have worked under these
12 circumstances, but it could have been tried. In fact,
13 this might be the sort of case in which you might
14 consider 150 milligrams of Bicalutamide as the
15 preferred treatment. It's an elderly man whom you 15:31
16 don't want to generate too many side effects, but
17 that's another point for discussion. It could have
18 been tried. Equally, the disease itself could, in
19 part, at least, be controlled with either palliative
20 radiotherapy, that is radiotherapy designed to hold the 15:31
21 disease in check, as opposed to radical radiotherapy
22 which would be intended to cure. I don't think that
23 would have been an appropriate option for this man.
24 But certainly the consideration of other modalities,
25 hormones, maybe palliative radiotherapy, should have 15:32
26 been considered. The sooner it's done the better, for
27 two reasons. One, biologically, and, secondly, because
28 the patient feels something has been done.
29 A. DR. HUGHES: I think this gentleman should have also

1 been referred to the palliative care team because he
2 was presenting with an aggressive disease. He was
3 elderly and he would have a time limited disease, so
4 a plan would be in place and coordinated.
5 Unfortunately that wasn't and the family had to keep 15:32
6 going back, I think through a Consultant's secretary,
7 to try and get access to the appropriate services.
8 180 Q. Yes. Certainly in your findings in this one, at
9 DOH-00107, we see that point being made. He wasn't
10 even given so much as a phone number. You say: 15:33
11
12 "Absence of the Cancer Nurse Specialist resulted in
13 uncoordinated care and difficulty accessing this
14 support in the community".
15 15:33
16 Just take a look at the key lessons in that case. Yes,
17 thank you. What you found was that the effective
18 management of urological cancer requires a cooperative
19 multidisciplinary team working collectively and
20 interdependently. 15:34
21
22 "A single member of the team should not choose to be
23 expected to manage all the clinical supportive and
24 administrative steps of a patient's care."
25 15:34
26 Just on that, what is the dynamic within the MDT that
27 should pick up on the fact that a Consultant is taking
28 it all on himself for whatever reason? Is there
29 something that should --

1 A. DR. HUGHES: Normal course of action, when a patient's
2 disease progresses, their case is brought back to the
3 MDT for discussion because the MDT will have palliative
4 Nurse Specialists and palliative physicians, and that's
5 the focus for discussion. I think there should have 15:34
6 been an awareness that cases weren't being brought back
7 to palliative care team. Palliative care teams usually
8 audit their ongoing work, and it would be unusual that
9 the single professional wasn't having that cohort of
10 patients coming back to the MDT. The MDT needs to be 15:35
11 functioning to provide all care needs, just not simply
12 new diagnosis and 62 day targets. It needs to be there
13 to consider and determine the care needs of those whose
14 disease is progressing.
15 181 Q. You again refer in the findings, the lessons learned -- 15:35
16 sorry, I should say, the importance of the key worker
17 and a Nurse Specialist, that the clinical record should
18 include the reasons for any delay in management. The
19 record didn't make any mention of the reasons. Prompt
20 communication with the general practitioner following 15:35
21 interaction with the patient; why is that important?
22 A. DR. HUGHES: Patients spend most of their time in the
23 community and somebody who is in a care role will need
24 community care, coordinated care, and the GP will be
25 providing oversight for that care. The GP needs to be 15:36
26 closely embedded in the discussions and understanding
27 of the discussions as to opposed to maybe a family
28 member having to go up and explain it secondhand to
29 a GP that that's not coordinated care or appropriate

1 care.
2 182 Q. Is another feature of the importance of communicating
3 well with the GP so that the GP can pick up any
4 unexplained delay and advocate for the patient, because
5 we have seen cases, for example, earlier in the 15:36
6 evidence where the fact that a scan had been performed
7 was reported to the GP, the fact that the scan hadn't
8 been actioned became obvious to the GP eventually, and
9 then he was able to red flag the patient into the
10 system. Is that knowledge of what's going on on the 15:37
11 part of the GP important from that perspective?
12 A. DR. HUGHES: I think it would be inappropriate to
13 expect GPs to be a safety net for missed examinations.
14 The reason GPs are copied into all the work was that
15 these are their patients and they will have possibly 15:37
16 lots, multiple comorbidities and other issues, but the
17 GP will be involved in the care, and the GP wider team,
18 and we have lots of multidisciplinary teams in GP
19 practices now, will be part of that. This rather
20 complex sort of inter disciplinary team which involves 15:37
21 secondary care and primary care, and that's usually
22 managed by palliative care nurses or Clinical Nurse
23 Specialists. It's about providing what a patient needs
24 in their home and community, as well as in secondary
25 care. 15:38
26 183 Q. Mr. Gilbert, in the England or where you work, is there
27 a feature of the system which involves writing to the
28 patient, him or herself, following each important stage
29 in the pathway, or does that not exist?

1 A. MR. GILBERT: Every letter I write is copied to the
2 patient. I still, because I am a little old-fashioned,
3 write to the GP and copy the patient, but a lot of my
4 colleagues will write to the patient and copy the GP.
5 So, yes, every interaction is covered with 15:38
6 correspondence to the patient.
7 184 Q. That's not generally a feature of practice here, is it,
8 Dr. Hughes?
9 A. DR. HUGHES: Yes, it is.
10 185 Q. It is? 15:39
11 A. DR. HUGHES: Yes. That has been. Patients get a copy
12 of the right patient letter and that should happen.
13 That has been evolving for the past decade. The first
14 cohort to do this was cancer care but it's quite common
15 practice in a range of other care, and it's about 15:39
16 having patients as partners in care.
17 186 Q. We don't always see that as a feature of care in these
18 cases?
19 A. DR. HUGHES: It should be in cancer care.
20 187 Q. Maybe we will look at that. It's certainly not 15:39
21 a deficit you picked up on?
22 A. DR. HUGHES: No, no.
23 188 Q. Going down the page to WIT-84168. Here we pick up,
24 Dr. Hughes, on another theme you extract from the nine,
25 ten reports, and that's care varying from regional and 15:40
26 national best, and you found that in eight of the nine
27 cases. Do you recall what was the one case that was
28 consistent with best practice? Can you recall?
29 A. DR. HUGHES: I think it's [name redacted], we are

1 working without notes here.
2 MR. WOLFE KC: Call that Patient 5.
3 CHAIR: We will pause. It's easily done.
4 A. DR. HUGHES: Can I apologise for that.
5 CHAIR: We will stop the recording, we have built in 15:41
6 a delay so that we can just make sure that the name
7 doesn't go in.
8 A. DR. HUGHES: Thanks very much for that. I am just very
9 conscious that I shouldn't have done that.
10 CHAIR: As I say, it's easily done. We have built in 15:41
11 a system to ensure that these things don't happen. So
12 the IT will tell me when we are ready to resume again.
13 We can return to that, but to make absolutely clear the
14 name did not come on the live-stream.
15 MR. WOLFE KC: Yes. We were wondering which was the 15:42
16 case. That sounds rather like an exam question.
17 A. DR. HUGHES: Patient 5, a gentleman with a kidney
18 tumour, and the care was exemplary, but then had a late
19 diagnosis of prostate.
20 189 Q. That is the case where the result from the CT scan was 15:43
21 missed and delayed the process, but the recommendation
22 emerging from the MDT was appropriate in that case?
23 A. DR. HUGHES: Yes.
24 190 Q. Whereas as you have said, eight out of the nine, when
25 they were to be implemented didn't make the mark, and 15:43
26 that's where you get to with the next theme. If we
27 scroll down. Departures from MDT recommendations were
28 eight out of the nine cases.
29

1 If we can go to your overarching report at DOH-00123.
2 Here you have fully summarised -- it's a useful note
3 for the Panel -- each of the derogations from the
4 recommendations; is that right?
5 A. DR. HUGHES: Yes, yes. 15:44
6 191 Q. The most significant number were the prostate cases
7 obviously?
8 A. DR. HUGHES: Yes.
9 192 Q. The derogations were primarily around the Bicalutamide
10 and the failure of onward referral, either at all or in 15:45
11 a timely fashion?
12 A. DR. HUGHES: Yes.
13 A. MR. GILBERT: Yes. Sorry.
14 193 Q. We obviously had the penile case and there was also
15 a testicular case that notably failed to comply with 15:45
16 the guidelines as well. Again, Dr. Hughes, all of
17 these derogations, regardless of type or
18 classification, should all of them be amenable to some
19 kind of tracking mechanism to ensure compliance with
20 the guidelines and to quality-assure the care process? 15:46
21 A. DR. HUGHES: Yes, the tracking mechanism is set up to
22 ensure that actions are taken. It isn't really set up
23 as a governance tool, as an oversight tool because
24 there's a professional responsibility to refer back to
25 the MDT if there's a change in plan, or if a plan does 15:46
26 not happen, and there should be a governance tool
27 around that. I think, as a by-product of a tracking
28 procedure you would get that knowledge, but we have to
29 say it's the professional's responsibility to reinform

1 his colleagues or the colleagues of the MDT that a plan
2 has changed and the rationale for that plan and that
3 you plan, and the MDT would have the opportunity to
4 re-discuss, agree or disagree or seek a third opinion.
5 But the process of treatment plan and an expectation 15:47
6 for a patient and then something else happening and
7 hearing about it is not governance.
8 194 Q. I think we discussed yesterday the proposition that
9 a recommendation properly made by an MDM, in accordance
10 with the guidelines, may not be implementable for 15:47
11 a variety of reasons. Mr. O'Brien, helpfully in his
12 Section 21 response, sets out some of that, just by way
13 of an example, the patient won't buy into the
14 recommendation or the patient's circumstances or
15 clinical condition has changed. They are all perfectly 15:48
16 acceptable reasons to depart from the recommendation or
17 to pause the recommendation.
18 A. DR. HUGHES: Yes.
19 195 Q. But what -- sorry. Answer.
20 A. DR. HUGHES: My experience is if that happens, 15:48
21 professionals always bring it back to the MDT for
22 a couple of reasons, to inform the MDT there's an
23 appropriate record of the patient's care and not the
24 outstanding information, which would be on the cancer
25 patient pathway system, so you have information. But 15:48
26 the other way professionals bring it back is to ensure
27 they have got governance and power and support for
28 their diagnosis. We don't want to portray this as big
29 procedure looking over your shoulder. This is your MDT

1 supporting you through your decisions, and if decisions
2 change that could be for very good reasons but you need
3 support and you need the MDT to agree to that.
4 196 Q. Let's just look at the testicular case, by way of
5 a specific example. That was Patient 2 or Patient E on 15:49
6 your list.
7 A. DR. HUGHES: Yes.
8 197 Q. If we go to DOH-00086. We can see that the MDT took
9 place on 25th July 2019, second paragraph, with the
10 recommendation that Mr. O'Brien would review the 15:49
11 patient in Outpatients and refer him to the Regional
12 Testicular Cancer Oncology Service. Scrolling down,
13 this referral was not made until 25th September.
14 Scrolling over the page, I think, if we just go to
15 DOH-00088, Mr. Gilbert. Is the management of 15:50
16 testicular cancer particularly time-critical?
17 A. MR. GILBERT: Yes. It's been clearly demonstrated that
18 the shorter the period between diagnosis and treatment
19 in any of its stages, the better the outcomes.
20 198 Q. We see in the recommendations, just scrolling down, 15:50
21 some very specific recommendations. There should be an
22 audit of all aspects of the MDT's primary function,
23 which includes the timing of access to definitive
24 treatment, and that a Chair should be appointed to
25 oversee the quality assurance of this. Just to break 15:51
26 that down for us, Dr. Hughes. What does the audit of
27 the timings of access to definitive treatment mean?
28 What would that look like?
29 A. DR. HUGHES: Classically, the timings have been divided

1 into 31 and 62 days, but that's based on ministerial
2 targets, so you what need to do is audit all times and
3 all outcomes. Where cases are particularly long, you
4 run an exception report and you review each case and
5 you pick up, at your business meeting, the causes for 15:51
6 that. It might be bottlenecks at Radiology, it might
7 be bottlenecks to PET scans or whatever, and you
8 address those individual problems. So timeliness of
9 service is often seen as a ministerial or a
10 departmental return, but timeliness of service is 15:52
11 a patient quality issue and, in this case, a Patient
12 Safety issue. It's to make sure they have ownership of
13 that and a responsibility for that, and those
14 recommendations go into the overarching plan as part of
15 the assurance process. 15:52
16 199 Q. The next recommendation is what we have just been
17 talking about a moment or two ago:
18
19 "Any divergence from an MDT recommendation should be
20 justified about further discussion and informed consent 15:52
21 of the patient."
22
23 In this context, I want to ask you about observations
24 that you made, Dr. Hughes, in the context of
25 a particular patient. If I can go to PAT-001323. This 15:53
26 was the meeting which took place between yourself and
27 Patient 1's family back in November 2020. Just scroll
28 down, please. Yes. You conceptualise the MDT here as
29 a contract between the medical team and the patient,

1 and it's based on international best practice
2 guidelines. You say:
3
4 "Individuals do not have the right to deviate from
5 that." 15:54
6
7 Just on that, is that intended to suggest that the MDT
8 and the patient are in a bargain with each other; the
9 MDT makes a recommendation and the patient and treating
10 Clinician must follow it? 15:55
11 A. DR. HUGHES: Yeah. I suppose the language isn't the
12 best of language. It was an attempt to explain that we
13 practice Cancer Services in a multidisciplinary way
14 based on guidance and based on guidelines, and that the
15 determination of the MDT is the recommendation that 15:55
16 should be offered to the patients, and that you cannot
17 have unilateral deviation from that without
18 re-discussing it with your MDT colleagues. That is
19 best practice. It's best practice for patients. It's
20 also best practice for professionals because then they 15:55
21 have the governance. It is not suggested that it is
22 contracting as you would probably understand it, but it
23 is an expectation from your employers that if these are
24 the best -- if an MDT is the internationally agreed way
25 of delivering best cancer care and it makes 15:56
26 a recommendation, that should be the recommendation
27 offered to the patient. If you vary from that
28 recommendation it should be described, noted and
29 explained. I don't believe that can be explained

1 without the input of a Clinical Nurse Specialist who
2 can -- in essence, you are going into a conversation
3 that is quite difficult, where you say this has been
4 recommended against international best practice and
5 agreed by my colleagues, but we are offering you or 15:56
6 I am going to offer you something different. That's an
7 incredibly complex conversation and I don't believe
8 that conversation could have happened in an appropriate
9 way without being supported by a Clinical Nurse
10 Specialist, so that other supporting mechanism to have 15:56
11 that conversation wasn't present. I believe if there
12 was an agreement to change the treatment plan, that
13 should have gone back to the MDT.
14 200 Q. Yes. For the avoidance of doubt, across the nine cases
15 you are not saying contractually, or otherwise, that 15:57
16 Mr. O'Brien was obliged to deliver that outcome through
17 the patient; what you are saying is that he ought to
18 have advised the patient of the MDT recommendation and
19 noted that, and if there was any dissent from that,
20 whether from the patient or from Mr. O'Brien, perhaps 15:57
21 because of the discovery of a fresh circumstance, that
22 should also be noted --
23 A. DR. HUGHES: Yes.
24 201 Q. -- and best practice would be that a fresh decision
25 shouldn't be made unilaterally by Mr. O'Brien with the 15:58
26 patient unless it's extremely urgent, I suppose, but
27 generally speaking, it should go back to the following
28 week's MDM for further discussion?
29 A. DR. HUGHES: Yes.

1 202 Q. I suppose -- sorry.
2 A. DR. HUGHES: If it was an extreme emergency and action
3 had to be taken, the action should have been brought
4 back so at least the MDT would know about it.
5 203 Q. Yes, yes. 15:58
6 A. MR. GILBERT: It's also possible to have emergency MDMs,
7 which means essentially finding one of your colleagues,
8 discussing the case, saying this is what I'm going to
9 do, agreeing that will be brought to the next MDT, but
10 the action will be pursued before the formal 15:59
11 ratification.
12 MR WOLFE KC: I think, just in terms of my note this
13 afternoon, I realise that we are facing into at least
14 the best part of a day to finish off, maybe half a day
15 from my perspective, but I know that the Panel has 15:59
16 questions. Would this be a convenient point?
17 CHAIR: Yes, I think so. Thank you, Mr. Wolfe. Thank
18 you both, gentlemen, for coming along and giving us so
19 much of your time already. We are very grateful that
20 you have indicated you are willing to come back and 15:59
21 speaking to us again in January. We look forward to
22 seeing you both again then, and in the meantime, I hope
23 you have a happy Christmas.
24
25 I think tomorrow we have Mr. Haynes again, Mr. Wolfe; 15:59
26 isn't that correct?
27 MR. WOLFE KC: Yes, starting with Mr. Haynes, to finish
28 him tomorrow --
29 CHAIR: At 10:00.

1 MR. WOLFE KC: -- from the first day of his evidence.
2 Tomorrow at 10:00.
3 CHAIR: Thank you.
4
5 THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 1ST
6 DECEMBER 2022 AT 10AM
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