Urology Services Inquiry

Oral Hearing

Day 66 – Wednesday, 18th October 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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INDEX

WITNESS PAGE

MR. KOTHANDARAM SURESH

QUESTIONED BY MS. MCMAHON 3
QUESTIONED BY MR. HANBURY 93
QUESTIONED BY DR. SWART 98
QUESTIONED BY THE CHAIR 106
FURTHER QUESTIONED BY MS. McMAHON 106

THE INQUIRY RESUMED ON WEDNESDAY, 18TH OCTOBER 2023 AS FOLLOWS:

CHAIR: Good morning.

MS. MCMAHON: Good morning, Chair and panel. The witness this morning is Mr. Ram Suresh, who at a period of time was one of the consultant urologists at Craigavon - he is now with the East Anglia Trust - but we are going to hear from Mr. Suresh. He is represented by Mr. Fintan Canavan, who could perhaps introduce himself formally for the record. 10:00 10:00

MR. CANAVAN: Good morning, Madam Chairman, Panel members. My name is Fintan Canavan I am representing Mr. Suresh.

CHAIR: Thank you, Mr. Canavan. 10:01

MS. MCMAHON: Mr. Suresh is going to take an oath on the Holy book.

MR. KOTHANDARAM SURESH, HAVING BEEN SWORN, WAS QUESTIONED BY MS. MCMAHON AS FOLLOWS: 10:01

MS. MCMAHON: Thank you, Mr. Suresh. We have met before, but I'll formally introduce myself for the record. My name is Laura McMahon and I am junior counsel for the Inquiry. I'll be taking you through your evidence this morning. 10:01

A. Okay. Thank you.

1 Q. Now, you have provided some written statements for the Inquiry, and they have those as your evidence, and I

just want to take you to those to confirm that you are happy with those. Section 21 Notice No. 61/2022 can be found at WIT-50332. We'll see your name at the top of that statement. If we go to WIT-50375, it will be dated the 1st September last year, and do you recognise that as your signature?

A. My apologies, it is not opening here, this module, but will it be on another screen?

CHAIR: Mr. Suresh, do you have a bundle that was sent to you? 10:02

A. Yes, that's it, yes. Yes, yes, I have got it.

CHAIR: So do you see the numbers in the top corner, the top right-hand corner, Ms. McMahon has been calling out those page references, and if you check those page references in your bundle you should be able to see what we're seeing. 10:03

A. Yes, I got it. Yes, yeah.

CHAIR: Okay

MS. MCMAHON: Okay. Thank you, Chair. So you recognise that as your signature at the bottom of your statement? 10:03

A. Yes, please. Yes.

2 Q. And do you wish to adopt that as your evidence to the Inquiry?

A. That's right, yes. 10:03

3 Q. You've also provided an addendum statement amending aspects of the Section 21, which can be found at, sorry, WIT-103270. This is the statement that was sent in yesterday. I just want to take you to that and

there are some corrections there, and you have added some information on to that, and we'll come to that in due course. But if we just go to the bottom of that page, it is a one page statement, it is dated the 16th of October this year, and do you recognise that as your signature? 10:03

A. Yes, please. Yeah.

4 Q. And the final addendum, again sent in yesterday, is found at WIT-103271.

A. Yes. 10:04

5 Q. And, again, we see your name at the top of that. And if we go to the next page at the bottom, do you recognise that as your signature?

A. Yes, please. Yeah.

6 Q. It is dated 17th October 2023. And do you wish to adopt that as your evidence? 10:04

A. That's right.

7 Q. Now we'll come to those statements shortly, but that's the totality of your written evidence, and as I said earlier, the Panel have your written evidence, I don't need to take you through it in particular detail, but there are some aspects of your evidence that the Panel may benefit from hearing more about, so I want to focus on those issues. And at the outset I can just say you worked at Craigavon from the 11th December 2013 until the 9th October 2016, and you raise some issues in your statement and we'll look at those. We have you for the full day, I hope to... 10:04 10:04

CHAIR: Sorry to interrupt, but we are seeing a lot of

you rather than the witness, so I just wonder.
MS. MCMAHON: I'm happy to change that. I'm seeing a lot of me as well and it is very off-putting.
CHAIR: I wonder if the communications could perhaps just check the screen so that we can see the witness when you're speaking. 10:05
MS. MCMAHON: That would be helpful.
CHAIR: Because we can see you in person anyway.
MS. MCMAHON: Yes, you can. Two of me is more than enough! So if you can you hear me, Mr. Suresh, I'll just continue on. We have you for the day. 10:05
A. Yes, please.
8 Q. But I hope we finish comfortably within today, and what I have tried do is really just identify the key issues that I need to ask you about to allow you to share your experience on some of the key aspects of governance that are of interest to the Panel. Now, the Panel has heard quite a lot of information and evidence from a variety of witnesses, so I'll try and focus my questions just so that you can assist us where your experience might be beneficial. If that's okay with you? 10:05 10:06
A. Yes, please.
9 Q. And we'll work through the issues. Just at the start, some of those issues will be use of IB antibiotics, the issue around Bicalutamide, some of the concerns that you raised, some issues that you had within your tenure at the Southern Trust, and the management plan that followed that, and some other issues that the Inquiry 10:06

has heard about like triage, MDMs, and I'll ask you general questions around that.

Just at the outset, could I ask you just to give us a brief overview of your career to date and where you're currently working and what your duties are? 10:06

A. Okay. Thank you. Yeah, I did my medical school in India, and after that I did three years of surgical training and then came to the UK and started working in 1996. Again I had to go through the basic surgical training rotation for a couple of years, and since 1998 I have been in Urology, started as an SHO, and then a staff grade, and then moved to Stevenage, I had the great pleasure in my working with Mr. Hanbury and the consultants, two of the consultants in Lister Hospital, Stevenage, for three years, and then moved to Great Yarmouth in 2003, started as a staff grade, associate specialist. Then I was a locum consultant for four to five years. In that period one year I worked as a locum consultant in Belfast, took a sabbatical leave for about nine months, then came back to Great Yarmouth. My first substantial consultant post was in Craigavon in 2013, so worked there for three years and then came back to Great Yarmouth as a urology consultant. 10:07 10:07 10:07 10:08

10 Q. So you were in Craigavon just shy of three years, it wasn't quite, it was almost three years, and then you moved on to your current post?

A. That's right, yes.

11 Q. I wonder if we could go to WIT-50337. This is the description of your duties while in Craigavon. Just at paragraph 5.2 of your original Section 21, if you have it in front of you?

A. 50337 you said, yeah? 10:08

12 Q. Yes. 50337.

A. Yes.

13 Q. I'm just going to read this out.

A. Sorry. Yes, please, yeah.

14 Q. Okay. Paragraph 5.2: 10:09

"My duties and responsibilities as consultant involved conducting urology clinics, endoscopy sessions and theatre sessions and ward rounds, constantly guiding and supervising trainees, administrative work directly 10:09
related to the care of patients, like reviewing the results and acting on them, triaging the referrals, which was later upgraded to advanced triaging, attending urology multi-disciplinary team meetings, engaging in quality improvement projects by involvement 10:09
in audits. I did participate in a few audits but do not have the records of them. Participation in clinical audit meetings, morbidity and mortality meetings."

10:09

And at 5.3:

"Advanced triaging means that while vetting the referral letters from the GPs or from another

department, based on the need, requesting appropriate investigations like ultrasound or CT scan before seeing the patients in the clinic so that the results would be available when the patients were seen in the clinic. It also involved dictating letters to the patients and the GP referrer about the investigations requested. The purpose of this is to speed up the process of assessing the patients."

Now, just before I ask you some questions around triage, what other consultants were working in Craigavon when you were there?

A. Yeah. At that time initially when they started it was Mr. Young, Michael Young, and Mr. Aidan O'Brien, and Mr. Tony Glackin. So we were four of us when I started there. And after a few months Mr. Haynes, Mark Haynes and Mr. O'Donoghue joined. So we were six of us from, you know, from 2015 onwards, mid 2015 or '14, yes.

15 Q. So Mr. Young, Mr. Glackin, Mr. O'Brien, and you were there initially, and then Mr. Haynes and did you say Mr. O'Donoghue as well?

A. That's right, yeah, they joined. Mr. Haynes and Mr. O'Donoghue joined a bit later after I joined, yes.

16 Q. Now you've mentioned in your statement advance triaging, and I just want to ask you some questions around that. Your answer indicates that you consider advanced triaging to involve the planning of tests and perhaps waiting for the results before triaging the patient. Is that the way in which you operated triage

or can you just explain to us the way it worked when you were there?

A. Yes. Now initially when we were triaging, like you know based on the referrals, the patient with a suspected cancer probably, they'll come all red 10:11
flagged, I think they come on different path, they all red flagged. No question of triaging them. Like in all the two weeks (inaudible) two weeks, and other referrals would be urgent or routine. We just used to mark "urgent" or "routine". That was the usual 10:12
triaging we were doing initially. And then it became advanced triaging means like, you know, if you want to see a patient as routine in the clinic, but if I think, oh, a patient need an ultrasound scan or a CT scan before being seen in the clinics, so make a request for 10:12
that. And my working pattern was like to review the result, when the results come through, to review the result and then to see whether the patient can still stay as routine, or to upgrade to urgent, or red flag. So depending on the results how it come. 10:12

17 Q. So the -- just so I'll be clear on your answer. You carried out the triage at the point of vetting the referral letter, you also took a clinical view whether tests were required, and dependant on the results of those tests the categorisation may have changed? 10:12

A. That's right, yes. Yeah. Like you know especially for those with like, if we mark it as a routine one, then I don't want this patient waiting for the CT results, which could be something different, marked as routine,

but I want to see the CT report, and then, if needed, to upgrade, yes.

18 Q. And was that the way triage was done when you arrived at Craigavon, or was that a system that was introduced while you were there? 10:13

A. As I told, initially we were just doing normal triaging, like marking as routine or urgent. We would not be investigating. But I think the advanced triaging started a bit later.

19 Q. And was that something that all the consultants -- was there a view taken that all the consultants would approach it that way, or was it really up to each individual clinician as to what approach they took? 10:13

A. I think this was the policy we agreed within the Department. So I presume every consultant was doing it . 10:13

20 Q. And do you know when that policy came in?

A. I'm sorry not exactly when.

21 Q. But your recollection is that there was a view taken that that is the way in which triage should be carried out? 10:14

A. I felt that it's the better way like, you know patients, rather than waiting for months and months to have a clinic visit, and then to ask for an investigation. So I think this advanced triaging speeded up the process of investigations. 10:14

22 Q. I suppose I am trying to get to -- there's two issues really. The first is what you did as a clinician, and you have explained that. And the second issue is

trying to establish if advanced triage, as it's referred to, was a policy, or a conscious decision made by the Trust at some point. So I think I understand your position at the moment to be that you considered advanced triage to be the most appropriate way for you to assess patients for prioritisation, but the second element of that I just want to make sure your evidence is clear, was there a decision collectively made that advanced triage was to take place in the way you have described? 10:14 10:15

A. Yes.

23 Q. There was?

A. Yes, as I remember, yes, it was.

24 Q. And you can't recollect when that conscious decision was made? 10:15

A. That's I can't recollect. One of the -- during the Department meeting it was discussed and it was all agreed.

25 Q. Was it the case that doing advanced triage in this way took up more time? 10:15

A. It was. Certainly.

26 Q. And was there any suggestion, when this decision was made, that there would be facilitation in the job plan for the time that it took to do this?

A. I'm not sure that the issue of job plan or timing came up, no. As far as I am, no, it didn't come up. 10:15

27 Q. Given that you had to look at the letter and then order the different tests and follow up the results and then revisit the categorisation dependant on the results, as

I understand it, did that take more time for triage to be completed?

A. I mean personally for the clinician this was taking more time, certainly. But for the patient I think it was beneficial in the sense it was speeding up the process. 10:16

28 Q. And was this something that the consultants agreed among themselves, or was it something that came from the clinical lead, or the medical director or anyone else, where they said this is how we want triage done. Do you recall? 10:16

A. I don't particularly recall how it came up, but it's all after discussion in the departmental meeting.

29 Q. Now when you undertook this form of advanced triage did that ever result in you falling behind in the triage that was allocated to you at any point? 10:16

A. Not particularly. It was taking more time, but there was no backlog or anything from my point.

30 Q. And were you aware of any of the other consultants having difficulty completing triage under this particular process? 10:17

A. Not until now the Inquiry came up.

31 Q. And we'll just go to your statement where you discuss triage. It's WIT-50372, at paragraph 66.1. I'll just let you find your way to that, Mr. Suresh? 10:17

A. 372. Yes, I'm on that page, please. Yeah.

32 Q. It's paragraph 66.1. Do you have that in front of you?

A. Yes, I've got it, yes. Yeah.

33 Q. Now the question we asked was:

"Are you now aware of governance concerns arising out of the provision of Urology Services which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why."

And you say:

10:18

"Yes, I now understand that there were issues with Mr. O'Brien in triaging GP referrals. I was not aware of it during my tenure. Had the issue been noticed by anyone I feel it should have been highlighted straight away by reporting the incident on-line or by directly informing the clinical lead, the head of services and, if needed to, the medical director, as a matter of clinical governance."

10:18

10:18

A. Yes.

34 Q. So from your evidence, the issue around triage was something that you became aware of at what point?

A. Only when I saw the news about the Urology Services Inquiry.

35 Q. And you never recall it being mentioned at any meetings or conversations, or anyone bringing it to your attention between 2013 and 2016?

10:19

A. Not to my attention.

36 Q. Were you ever asked to undertake another consultant's

triage while you were urologist of the week or at any other time?

A. No, not for triaging.

37 Q. Do you know if anyone had to undertake any of your triage during that time? 10:19

A. No, I don't think so.

38 Q. Now, there are other issues that have come to light that have resulted in this public inquiry around different aspects of governance within the Trust. Were you aware, are you aware of those issues now? Do you 10:19 have a familiarity with the work of the in Inquiry? I know you have been sent our Terms of Reference with your Section 21 request, but just your general knowledge of the issues that have arisen, do you have an awareness of why we're here? 10:20

A. Yes, I've been given the introduction about what is this Inquiry about. Yes.

39 Q. And have the issues that we have discussed have been brought to your attention, I take it the context of the Inquiry has, you've discussed those with your various 10:20 legal representatives, you've said you've looked at -- you've seen newspaper articles, so you're aware of issues. When you were made aware of those issues, or became aware of them through your own knowledge, did any of those seem familiar to you that you thought 10:20 "Well, actually, that was a problem when I was there", or is all of this new to you?

A. Maybe a couple of things as I mentioned in my bundle about the Bicalutamide prescription, I came across one

case. And similarly with the IV intravenous antibiotics, again I just came across with one case, yeah.

40 Q. Yes. And we'll come to those two examples. Other than those specific examples, because you've just mentioned the triage as something that you've subsequently became aware of, and I just want to make sure that if that is the only one, that there are no other examples that you can help us with that you can recall experiencing during your time at Craigavon? Is it Bicalutamide 50 and the IV fluids, the two issues that you remember? 10:21 10:21

A. That's right, yes.

41 Q. Just as a general question on triage, I just want to finish this topic off, I have a few specific questions and then we'll move onto the IV antibiotic issue, but did you consider triage to be particularly onerous when it was your duty to carry it out? 10:22

A. Yes. So it is the duty of the clinician to triage, yes. It's part of our work.

42 Q. So it was in the context of it being another task to do among other tasks or was there something specific about it that you found difficult? 10:22

A. I'm sorry, I didn't understand the question?

43 Q. Maybe I misheard your answer. Did you agree with me, did you say that you found triaging onerous? You found it difficult or time consuming when it was your rota to do it? 10:22

A. It was time consuming, but it is a part of our duty.

44 Q. And you felt you could get it done within the time

allocated?

A. That's right, yes. I mean sometimes I had to do my triaging out of hours, like after -- particularly when we were doing on-call, or finishing our routine commitments, all the emergencies, and then I maybe sitting after 5:00 o'clock or 6:00 o'clock triaging, yeah. 10:23

45 Q. I wonder if we can go AOB-70484?

A. I'm sorry that's on a different bundle. If you can please -- yes. Yeah. 10:23

46 Q. I am going to read this out to you, Mr. Suresh?

A. Okay.

47 Q. This is an email that you sent on the 13th March 2014 to Martina Corrigan, and you've copied in Mr. O'Brien, Mr. Glackin, Mr. Young, and it's about triage of red flags, and you say: 10:23

"Dear all,

I do go to the office every day, particularly while on-call, especially to triage the referrals, but I have been able to do this only after 5:00 or 6.00pm (i.e. after finishing my clinical commitments). I think we may have to cut down our clinical activities during the on-call week so that we can clear the desk in a timely fashion and will be able to assess the emergency admissions. Eager to see your views. 10:23 10:24

Regards,

Ram."

Now, I'll just bring you to that email for the Panel's note as well to indicate that at that time you were sending to the Head of Services an email suggesting that there was - you were overcommitted in some respects and thought that the clinical activities may have to be reduced because of triage. So that gives us a flavour, a contemporaneous flavour by the email of perhaps the workload that there was in that, and I just want to have the Panel make a note of that in their considerations of triage. 10:24

One of the issues I suppose for a clinician is: How do you know how busy you're going to be so that you can make time for triage and while you're on-call? Did you consider that to be something that you had to juggle, and as this email suggests, work after hours to complete? 10:25

A. That's right. Mostly when I was on-call, the on-call days used to be, you know, really busy, hectic, and depends when the emergencies come up. But as I told, most of the time I may have to sit in the evening only after sorting out all the emergencies and the other clinical work then to sit on the triaging. So. 10:25

48 Q. I know it's 2014 on the email, but do you recall if there was a reply that the clinical commitments would be reduced when you were on-call? Was there any response to that or action taken as a result, if you remember? 10:25

A. Yes, after that it changed to be like consultant

on-call of the week, consultant week, so our routine commitments were cancelled during that on-call week. But we took up slightly extra work that seem like -- we used to do full ward rounds, that initially take a longer time, and then some hot clinic, like you know, any very urgent cases to be seen in the clinic. So we were seeing them. So that our afternoon commitments were cancelled, yes. 10:26

49 Q. There was some accommodation made. Was that made among the clinicians themselves rather than a decision made by the Trust to facilitate more time, do you remember? 10:26

A. This was all after every discussion in the departmental meeting, like how we are going to address it, yeah. I'm not sure where it came from. It's all a collective decision. 10:26

50 Q. It was a collective decision. Did you get the feeling at the time that the onus was on the clinicians to try and find solutions when work demands perhaps interfered with clinical activities?

A. It's -- I would say it is naturally from, you know, as we started new work, or something came in, it depends on how we feel, and give the feedback, and to act on that. 10:27

51 Q. And did you feel when you raised concerns that they were listened to? 10:27

A. Yes, I mean they could raise their voice, like express their views, and there was open discussion, particularly in the weekly departmental meetings, I found one of the best meetings like, you know, where we

can bring up any issues and discuss.

52 Q. And how often did you have the Departmental meetings?

A. I think it was one every week. Once a week. Lunchtime. Yes.

53 Q. And was that an environment that you felt free to raise any issues of concern? 10:27

A. Yes, absolutely.

54 Q. And was it your experience that when you did raise issues of concern that they were addressed?

A. Yes, I was listened to, and it may not be immediate solution, we can't expect immediate solution for anything, but at least they are being, you know, looked into. 10:28

55 Q. I want to move onto the IV antibiotic issue, and if we could look at your statement, 503 -- WIT-50364. Maybe the previous page, I just want to get the correct? 10:28

A. Yeah, please. Yes.

56 Q. It's 50363, and it's paragraph 49.1(a).

A. Yes, please. Yeah.

57 Q. I just want to read this out, and it's on the issue of whether systems -- sorry, could you just move it up to the start of the sentence or the start of the question. Just keep going, please. I just want to see the very start of the question. And this is the question around concerns that you may have had just generally, and then we've broken it down into subsections, but you have provided a general answer. If we can go back down to 49.1, please? And you say at 49.1(a): 10:29 10:29

"On the clinical aspects there were some discrepancies in the practice of individuals in terms of choice and usage of antibiotics. For example, Mr. Aidan O'Brien admitted a patient for administration of intravenous antibiotic just based on the symptoms. I do not recall 10:29
the exact date or month. I directly discussed with him during the joint ward rounds about seeking the advice of microbiologist. He paid attention to my suggestion and acted accordingly. I recall Mr. O'Brien contacting the microbiologist over the telephone on the same day 10:30
and decided to withhold the antibiotic and to wait for culture reports. I cannot recall the exact date nor the details of the patient."

Now, I just want to ask you about this example you have 10:30
provided under our request for any concerns that you had. I just want to break it down slightly to see if you can recollect some of the facts around it, as you recall them.

10:30

Now, you've said that Mr. O'Brien admitted a patient for administration of intravenous antibiotic just based on the symptoms. Now, can you recall how that patient presented? What sex the patient was? What age they were, and what the symptoms were as you recall them? 10:30

A. Yes, this issue came up during our routine ward rounds and Mr. O'Brien used to be very thorough in explaining about the patient's details, and this lady was probably in her thirties, you know, just from my memory. She

was, you know, sitting very comfortably, and so Mr. O'Brien gave the details, like you know. I just recollect that she had been having recurrent urinary tract infections, so admitting for intravenous antibiotics. So then I was a bit surprised about the -- she was looking too comfortable, the patient, and we looked at the chart and there's no fever or anything. Then the question came up like, you know, then I did raise the question politely like, you know, "Where is the indication, please?", or "Why are we admitting for intravenous antibiotics?". Then I think one of my colleagues was checking the culture report on the computer system and there was no reason to prove a urinary tract infection. So then I questioned like, you know, "Where is the indication?", again I asked the same question, and he says she has been having recurring urinary tract infections and then he asked me "So what shall we do?", and then I suggested "Shall we check with the microbiologist, please?" There are two questions: Whether she needs antibiotics or to choose which one. And there was some discussion about antibiotics, and then he asked "What's your concern?", and then I explained, you know, the two main points, like you know assistance, or other issue of patient getting C. diff, which can be, you know, a serious threat. And so the during ward rounds we were just discussing, like you know, from academic aspect as well about it, about the antibiotics, it was a brief discussion, and then the question is then asked "What

10:31 10:31 10:32 10:32 10:32

should we do?", and then I said "Better check with the microbiologist", and he did. And then came back to say, yes -- he just patted on my back and said "Okay, there's no need for antibiotic. I'll go and speak to her." So then we moved on and I think Mr. O'Brien went to speak to the patient. 10:33

58 Q. So, in summary format, the patient presented in a way that you thought did not warrant the use of IV antibiotics because she looked too comfortable and there was no fever, no obvious indication of infection, which would be the indications medically for such treatment? 10:33

A. That's right, yes.

59 Q. And you then queried the appropriateness of that, or the need for it perhaps is a better description. The patient was complaining of or being treated for a urinary tract infection, I think you said, UTI? 10:33

A. Yes. Mr. O'Brien, you know, explained about the patient, like she has been having -- we were discussing like, you know, if she had a few course of antibiotics before and still having recurrent urinary infections. So that's why he admitted, yeah. 10:34

60 Q. So this is -- sorry, go ahead?

A. Sorry. More of cystitis like symptoms.

61 Q. So cystitis type symptoms and recurrent UTIs, would be that a fair description of her background? 10:34

A. That's right, yes. Yeah.

62 Q. And the admission was for intravenous antibiotic. Can you remember if this patient was admitted from the

Emergency Department, or by the GP, or by what route the patient found their way into the hospital?

A. I'm not entirely sure. I think probably she was seen in the clinic. I don't recall exactly.

63 Q. You don't recall. Would the first port of call in a patient with antibiotic treatment, would it be to provide them with oral antibiotics? 10:34

A. That's generally, yes.

64 Q. And do you know if this patient had been on a course of oral antibiotics or was she currently on one at that point? 10:35

A. I'm not sure about that actually.

65 Q. So your main concern centred on the fact that the patient wasn't presenting in a clinical way that you felt justified IV antibiotic. Is that a fair summary of your concern? 10:35

A. That's right. I felt patient was too well and didn't have any indication, strong indication for admission for intravenous antibiotics, yes.

66 Q. And I think you mentioned that the culture report had come back as being negative? 10:35

A. In the sense like, you know, one of the doctors, the junior doctors doing the ward rounds looked at the culture reports maybe probably for a year, I'm not sure how long she looked at, and she said "There is no reason. Positive culture." 10:35

67 Q. Is it possible to get a false negative from cultures?

A. Yes, if the patient is a lady on antibiotics.

68 Q. And the procedure then would be, I presume, to repeat

the cultures?

A. That's right, yes.

69 Q. So you raised this with Mr. O'Brien at the patient's bed was it during a ward round, was it actually as you were in front of the patient, did you mention to him or ask "What's happening? Why does she need IV antibiotic?" Is that what happened? 10:36

A. Yes, I think within that bay, yes.

70 Q. In the bay?

A. In the bay. 10:36

71 Q. And you say Mr. O'Brien then indicated that he would contact the microbiologist. Was that his suggestion or was that your suggestion?

A. He asked me like, you know, when we discuss about the patient, there was a discussion about antibiotics, and then he asked me "What should we do?", and so I thought it was like a discussion, like not questioning each other or anything, and then I said "Oh, better discuss with the microbiologist", I suggested this to the microbiologist. 10:36 10:37

72 Q. And you say that he then went and phoned the microbiologist on the same day. Do you recall if he did it there and then or was it later on in the day?

A. I think it was same day, like doing the ward rounds and then when we were going to the next patient he said "Call the microbiologist." He did it straight away, yes. Yeah. 10:37

73 Q. And came back and told you that he was not going to administer the IV antibiotics and was going to wait for

culture reports?

A. That's right, yes.

74 Q. And do you recall what happened after that, if the IV antibiotics were administered, or was there a change of tack, do you recall? 10:37

A. I'm not sure. I don't recall seeing the patient again, the ward, so I assume she was discharged later, yes. Yeah.

75 Q. Do you recall seeing other patients who were brought in for IV antibiotics and whom you didn't think had the clinical features of needing that treatment? 10:37

A. No, this was the only case, yeah.

76 Q. And have you ever had to challenge another consultant around IV antibiotic use before in your practice, before then or since? 10:38

A. There'll be slight individual variation about the choice of antibiotics, sometimes maybe from different departments. So every hospital I'm sure there are a lot of issues around antibiotic prescriptions.

77 Q. Now, from your perspective you raised the issue and you felt it had been addressed, so you didn't feel the need to take it any further? 10:38

A. Because this was the only case, and even then I brought up again the same issue in the departmental meeting, because at least on that day, yes, Mr. O'Brien was there, we could discuss directly, and I just brought up the issue like if a patient being admitted for - if I feel, you know, we have the different views, how to address it, and I quoted this example, like Mr. O'Brien 10:38

was there and we discussed and sorted it out, what if nobody is there, how to address it? So that's how I brought up the issue in the Department meeting.

78 Q. So you brought it up in front of other colleagues as an example of "What should I do if this scenario occurs again?" Was it in the context of "Well, if someone is brought in for IV antibiotic use and I have to administered the antibiotics but don't feel that the patient requires them", was that the query? 10:39

A. That's right. I quoted it as an example, and also just included it for everything. Like if you have got different views, how to address it, yes. 10:39

79 Q. And do you recall who was at that meeting?

A. I'm sorry?

80 Q. Do you recall who was at the meeting? Was Mr. O'Brien there? Mr. Young, Mr. Glackin? Were the other consultants present, do you remember? 10:39

A. I'm not sure who were all on that day. But generally, usually Mr. Young, Mr. O'Brien, Mr. Glackin, everyone would have been there. 10:40

81 Q. Do you remember was Mr. O'Brien there? Did he reply or was there any feedback from him when you raised the issue?

A. He was there at the meeting, that's why I told -- you know, Mr. O'Brien was there, I could discuss directly with him so to all sort it, "What if not there?", and everyone said, yeah, did the right thing, same way, like pick up then phone, call directly, or if the consultant is not there, speak to another one and get a 10:40

second opinion. Yeah.

82 Q. And was that the answer from Mr. O'Brien, do you recall, or from someone else?

A. Mr. Young was also there, yes.

83 Q. But do you recall who answered you when you said that? They said "If you're in doubt, lift the phone, find out from the admitting the clinician or the reviewing clinician", do you recall who that particular answer came from? 10:40

A. Yes, Mr. Young. 10:40

84 Q. Mr. Young?

A. Yes, that's right. Yeah.

85 Q. Did you have any knowledge of oversight of IV antibiotic use while you were at the Trust? Any awareness around a pathway that had to be followed if patients were being admitted for IV antibiotic use that involved a multi-disciplinary decision-making framework? Were you aware of any of that during your time? 10:41

A. There was no particular issue I came across, no. But, you know, everyone supposed to follow the antibiotics stewardship, yes. 10:41

86 Q. We'll move on to the stewardship just in a second, but specifically in relation to IV antibiotics, did you have cause to admit or send anyone from your review clinic for admission for IV antibiotic therapy? 10:41

A. Not from the clinic or anything, I don't recall. But from emergency department, so another common admission is patients coming with severe pyelonephritis or

urosepsis, that's very common admission, the patient are getting intravenous antibiotics, yes.

87 Q. So during your tenure you did administer IV antibiotic therapy. There were occasions when you had to because of the patient? 10:42

A. The patient coming with urosepsis, yes.

88 Q. Yes. And when you were prescribing the IV antibiotic therapy, were you -- was it brought to your attention or were you aware that there was any regime to follow in doing so, that there had to be some oversight or 10:42 some involvement with the microbiologist, the pharmacy, anything like that, were you aware of any of that?

A. There was local policy. Every hospital follows their antibiotic of choice. So depending on the organisms and the sensitivity in that region, yes. 10:43

89 Q. Well that's a slightly different point. That's your decision-making as a clinician, when you decide the most appropriate antibiotic. This is more of a policy, a procedure. I'm just curious to understand if it was simply a matter of you prescribing on the chart at the 10:43 end of the bed and the IV fluid being put up with the antibiotic in it, was it really just you as a clinician dictating the treatment and you weren't aware of there being any other oversight?

A. I don't think there was any oversight but, you know, 10:43 generally we adhered to the antibiotic policy as, you know, for the local -- as to the local guidelines.

90 Q. If we just go to your statement again at WIT-50369, paragraph 57.1? And this is when we've asked you

around the risk. I'll just let you find that paragraph. It is 57.1?

A. Yes, please.

91 Q. You've said:

"As in section 53, deviation from microbiology policy is a potential risk to patients as it can cause antimicrobial resistance and side effects from the antibiotics." 10:44

10:44

So that was your concern particularly around the IV antibiotics issue?

A. That's right.

92 Q. That there is a risk?

A. Yes. Absolutely. 10:44

93 Q. Now, you mentioned stewardship of antibiotics just a moment ago. During your time there was just such a stewardship carried out when there was an oversight by the Trust of all of the clinicians and their prescribing of antibiotics, and we can go and look at one of those documents that the Trust have provided to us recently. TRU-395996. 10:45

Just by way of background on this particular procedure that was carried out by pharmacy and the microbiologists, do you have any idea why this was introduced, why the stewardship was introduced at all? Was it explained to you that "We'll be having a look at your prescribing regimes and collating them and giving 10:45

you a report"? Did anyone come and say to you that's what's going to be happening?

A. I'm not sure of the background of this audit. I thought -- I didn't know it was initiated, but I thought this like any other audit and, you know, microbiology or infection control team keeping an eye. 10:46

94 Q. Was it something that just started or was it already in place when you arrived?

A. I'm not exactly sure.

95 Q. Now it seems to be from the information that is currently available that there is oversight of each of the consultants, and they look at the indication, which presumably is what it's needed for, and then the choice for that need, and then the frequency, which is the duration, I presume, of the administration. Now, it doesn't seem to indicate the difference between IV and oral antibiotic, but it does provide a summary of various consultants, and if we look down on this reference. You had 10 patients. Indication not recorded in 4 patients. Choice, non-compliant in 7. Now I'll just read your's out because you're the witness in front of me, but no one got a top score, so just to be fair to everyone. That would seem to suggest there's some room for improvement in your prescribing or your choice. When you received this information, if you're saying that it's an audit or if the Panel consider this to be an appropriate governance tool, when you receive this, is there any follow-up with you, any learning, any discussions around "Well, 10:46 10:46 10:47 10:47

why did you make that choice? Why did you think it was indicated it needs to be recorded? The importance of record keeping", was there any conversations like that?

A. No particular discussion about the audit, but the report was circulated to everybody. At least, you know, I got the email, I'm not sure how often, but time to time we had the email about the report of that audit. 10:47

96 Q. So you got this by email?

A. That's right, yes. 10:48

97 Q. And would it be fair to say that was it, you received the email and nothing happened after?

A. That's right, yeah. I'm sorry I would like to just add one more point on that. Like when he had this email, I remember having some discussion in the Department meeting, like you know, the compliance is not 100%, so there was some discussion that we all need to be vigilant and looking at the appropriateness of antibiotics. Yes. 10:48

98 Q. And do you know who would have brought that up at the Departmental meetings? Who would have been the person to say about this particular stewardship? 10:48

A. I don't particularly recall, but I think Mr. Young and Mr. Glackin would have been there. Yes. Yeah. They all discussed about it. 10:49

99 Q. So they would have mentioned this and said everyone is slightly out of sync.

A. That's right. Yes. Yeah.

100 Q. "Can you pay some attention." Would it be no higher

than that really? What they would say was really "We've got these results in. We need to keep an eye on this."

A. That's right, yes.

101 Q. Just bear with me a second, please. And after that incident that you mentioned, or the concern that you raised with Mr. O'Brien, I think you've said there were no other issues around IV antibiotics, no other issues with any of the consultants around that issue at all. I think we've lost the sound here. Maybe you can't here me as well. Can you hear me, Mr. Suresh. You can hear me. I can't hear you. 10:49 10:50

A. Yeah. Sorry.

102 Q. Oh, we're back!

A. Sorry. Yeah. 10:50

103 Q. You can hear me okay. I just wanted to confirm with you that after that particular issue with Mr. O'Brien you didn't have any concerns around IV antibiotics with him or any of the other consultants after that?

A. No. 10:50

104 Q. I just want to move on to the Bicalutamide issue that you've mentioned in your statement. And just by way of background for the Panel, if we could go to Darren Mitchell. We've heard from one of the consultants from the Belfast Trust, and just to put in context what he said about this issue. WIT-96667. And it's paragraph 1(ii)(b). And he was asked about prescribing outside guidelines - which we'll discuss in a moment - but he explains the use of Bicalutamide in this way: 10:51

"The licensed doses for Bicalutamide are either 150mg once daily as a monotherapy or 50mg once daily when used in combination with hormone therapy injections, known as luteinizing hormone releasing hormone agonists. There are no licensed indications that I am aware of for Bicalutamide 50mgs once daily as a monotherapy. As such, I viewed the use of Bicalutamide 50mgs once daily as a monotherapy as being outside the licensed indications." 10:51

Is that a paragraph you would agree with?

A. Yes. Sorry, my apologies. Sorry. My apologies. Can I just -- I'm sorry. Sorry. Yes, please. Yeah.

105 Q. Now, you've mentioned about the licence indications. When you're prescribing Bicalutamide or any other medication in your particular role, what are the guidelines that you follow? 10:52

A. There are NICE guidelines and EAU guidelines.

106 Q. And if you're following those guidelines and prescribing doses within those licensed conditions, is it common in your practice to change the dose in response to any side effects? 10:52

A. With Bicalutamide? Sorry, talking just about Bicalutamide? 10:53

107 Q. Yes, use that as an example, yes.

A. Yes. Yes, yes. So there are mainly two indications for Bicalutamide 50mg. There is one, as you mention, it's to prevent the flare up phenomena, so given for a

short period and then it is given for the first dose of LHRH analogue injections. So it is started before the injection and continued for up to two weeks after the first injection and then it is stopped. So that's one indication. And second for Bicalutamide 50mg is given along with LHRH analogue injection to give maximum antigen blockage. So generally patients will be on LHRH analogue injections for a period, and when they develop features of gastric and prostrate cancer, at that stage to give maximum antigen blockage. So it is given along with LHRH analogue injections. So there is no other indication to give Bicalutamide 50mg as monotherapy. 10:53 10:53

108 Q. So there's no indication to give Bicalutamide 50 as a monotherapy, and what you've described is the applicability of it that incidents to reduce flare? Flare, yes? When there's a raise in the levels initially for the two week period and the reduce? 10:54

A. That's right.

109 Q. And what do -- 10:54

A. And then it's -- sorry.

110 Q. Sorry. And then stopped.

A. It's given for about a period of a month, like you know two weeks before and two weeks after generally, and then it is stopped. Yeah. 10:54

111 Q. What, in your view, are the risks of using Bicalutamide 50 as a monotherapy?

A. It is not, it's not, you know, it's not there in any guidelines to give monotherapy with Bicalutamide 50mg.

112 Q. So one of the patient risks would be that first of all it's not effective as a treatment?

A. First of all, as far as I remember, there is no trial using Bicalutamide 50mg as a monotherapy as a treatment. So there is no question of -- there is no indication at all, I would say. 10:55

113 Q. There's no reason to use it in your view?

A. That's right, yes.

114 Q. And is hormone resistance a possible risk of long-term use of Bicalutamide 50? 10:55

A. First of all, there is no indication for Bicalutamide 50 as a monotherapy.

115 Q. Yes, but if someone was on Bicalutamide 50mg as a monotherapy, if we take that as our starting point, what do you see are the risks of that particular treatment regime? 10:55

A. First of all, no one should be on this monotherapy. So there is no indication at all. And if somebody is on, then that needs to be looked at why -- to explore the alternative treatment. The better recommended treatment. 10:56

116 Q. Are there three possible things? Are there three possible potential risks? If I put these risks to you and you can tell me whether you agree with them or not. If someone is on Bicalutamide 50mg as a monotherapy, first of all it's not deemed to be effective. As you've said, there is no evidence base that it's effective? 10:56

A. That's right.

117 Q. The second issue is that it means that the patient is not on the correct treatment?

A. That's right.

118 Q. So it's masking what they need perhaps. And the third one is there is the potential for hormone resistance to build up? 10:56

A. That's right, hormone resistance. Therefore any hormone treatment, yes

119 Q. So you would agree with those three scenarios as being risks? 10:57

A. That's right, yes. Apart from the side effects of the medication as such.

120 Q. Have you ever had experience of someone building up hormone resistance?

A. It is common. Generally observe those with LHRH analogue injections. Usually they will have -- the PSA relapse starts happening after about average of 18 months. So it is a common phenomena and it is a matter of time when they develop the resistance. 10:57

121 Q. So it does happen with people who are on hormones for a long period of time. It is perhaps one of the in-built risks that you almost accept, I presume, if people are on it for a long period of time, but one of the affects of that is that if you need to then rely on hormones there is a certain resistance from that person's system in how effective that treatment may be down the line? 10:57

A. That's right, yes. We always warn the patient, like you know, on average there'll be about 18 months after which the PSA can start rising, in which case the

patient may need additional treatment.

122 Q. And that's one of the things that a clinician would have in mind, I presume, before putting anyone on hormone therapy, because the potential for that to cause some difficulties down the line, if you needed to rely on that hormone at a greater dosage? 10:58

A. Not a greater dosage, but they may need additional treatment.

123 Q. Sorry I didn't quite catch your answer?

A. Sorry. Most often the patients will need additional treatment. If the patient is on LHRH analogue injections that'll be the mainstay of the treatment that suppress the testosterone to the maximum, and when they then become resistant they will need additional treatment, in addition to regular LHRH analogue injections, yes, to have maximum -- 10:58

124 Q. And if someone -- sorry. Sorry.

A. Sorry. To have maximum antigen blockade, yes. Sorry.

125 Q. And if someone was on Bicalutamide 50mg for a long period, monotherapy for a period of time, is there a potential for there to be harm to other systems in their body? Is there any -- do you have any experience of that? 10:58

A. First of all, as I said, like you know, no one should be on this monotherapy, this 50mg Bicalutamide. It's not recommended by any guidelines, there is no evidence for that. And if somebody is on, then that needs to be addressed why it is on, and they need to be offered the recommended treatment, what is best for the patient. 10:59

Yes.

126 Q. And if someone came to you and they were on Bicalutamide 50 as a monotherapy, what would your approach be?

A. I would explain circumstances why it was on. First thing I would like to check whether the patient is on -- the common scenario will be patient will be on the maximum antigen blockade in addition to the LHRH analogue injections. That's the first thing to clarify. So -- and if somebody is on, just on monotherapy with 50mg Bicalutamide, I would take it seriously why it's on, and patient shouldn't be on -- explain to the patient this is not the conventional treatment, not the recommended treatment. So I would go with alternate to recommended treatment options 10:59 10:59 11:00

127 Q. You've mentioned in your statement that you had an experience such as this in Craigavon when you were there?

A. That's right, yes.

128 Q. If we go to WIT-50364. Mr. Suresh, it's paragraph 49.3. It's just the page before 50363. Do you have that in front of you? 11:00

A. Yes, please. Yeah.

129 Q. And you've said:

11:00

"I can also recall of a patient under the care of Mr. O'Brien being on unconventional treatment for prostate cancer being treated with a low dose tablet (Bicalutamide) over a few years. I noticed it when a

patient turned up at my clinic for the follow-up. I do not recall the exact date."

If we just move down, please:

"I copied my clinic letter to Mr. O'Brien with my concern that it was unconventional treatment and added in the agenda of the next urology multi-disciplinary team meeting. The consensus was that the treatment with long-term low dose Bicalutamide was unconventional and that Mr. O'Brien was to review the patient in the clinic and to discuss the appropriate options with the patient. I remember the presence of Mr. O'Brien in the meeting but I cannot recall the entire attendance." 11:01

Then at 49.53:

"In my view, the deviation from the antibiotic policy or long-term treatment of prostate cancer with low dose Bicalutamide could have had negative impact on patient's care and safety. That's why I acted promptly by discussing the issues directly with Mr. O'Brien and in the relevant meetings as previously mentioned." 11:01

49.64: 11:02

"Mr. Aidan O'Brien was in agreement with views of all other consultants and therefore there was no need for me to get involved further. I do not know whether any

measures were taken to monitor implementing the changes, however there was antibiotic stewardship undertaken by pharmacists reviewing prescriptions of antibiotics for patients."

Obviously the last part is about the antibiotics not the Bicalutamide. So was a patient who came to you at your review clinic as an Outpatient?

A. That's right, yeah.

130 Q. And they were originally a patient of Mr. O'Brien's? 11:02

A. That's right, yes.

131 Q. Now you say they were on an unconventional treatment for prostate cancer. Do you recall what that was, what the treatment was?

A. Yes. Yes, monotherapy with Bicalutamide 50mg, yes. 11:02

132 Q. Now, I don't think you remember too many details of the patient?

A. I am sorry, I don't -- yeah. I don't have the full details. Yes.

133 Q. Do you remember if they were on that dosage for a long period of time? Do you remember any of those details? 11:03

A. Just vaguely remember this was low risk prostate cancer and patient was on Bicalutamide monotherapy for a few years, maybe two or three, maybe longer, sorry, I don't recall. And when I first saw the clinic notes it took time for me to see why the patient is on Bicalutamide 50, and then I had to go back into the records - I could not go back much further to see why it was. So it took time for me before I called the patient in to

see why it was. And then the first thing I wanted to check with the patient is if he is just on monotherapy or is he having regular LHRH analogue injections. So I had -- this was a long discussion with the patient why he was on. 11:03

134 Q. So you discussed it with the patient, you looked back at their notes, you saw that they had been on it two or three years, maybe longer I think you've said, and your clinical assessment was that it wasn't appropriate, and you've said already in evidence that there is no 11:04 licensing condition under which Bicalutamide 50 as a monotherapy is appropriate?

A. That's right, yes. Yeah.

135 Q. Now you mentioned that you copied your clinic letter to Mr. O'Brien with your concern that it was 11:04 unconventional treatment. Before you did that, did you change the treatment regime?

A. No, I explained to the patient that this was not the conventional treatment, but the gentleman was, he was happy with the medication he was on and he said he 11:04 would like to talk to Mr. O'Brien about stopping it, or I explained other alternative treatment options like reimaging or repeating biopsies, but he said, you know, he was so happy with Mr. O'Brien's approach he said "No, I would like to see him before making any change." 11:05

136 Q. So the patient wanted to stay on the Bicalutamide 50. You explained that it wasn't the appropriate or the conventional treatment, and he said he wanted to speak to Mr. O'Brien before he came off it?

A. That's right, yes.

137 Q. Now, you sent a letter to Mr. O'Brien. Do you recall if you sent a letter to the GP as well? Did a copy go to the GP at that point?

A. Yes, all clinic letters mostly will be addressed to the GP, and I copied the letter to Mr. O'Brien. Yes. 11:05

138 Q. Do you know how long it was going to be until the patient saw Mr. O'Brien again? Was it going to be a fairly quick turnaround review or was the patient just going back into the system for a routine follow-up? Do you remember? 11:05

A. I don't recall whether the patient was, how quickly he was seen, but some of the patients we prioritise like to be seen urgently, or then going on the routine. Yeah. 11:06

139 Q. Now if you were to put a patient on an unlicensed medication, or off-licence medication, what would be the procedure that you would follow in order to do that? If this was your patient and you wanted to put them on Bicalutamide 50 monotherapy. And I know you wouldn't from what you've said. 11:06

A. I wouldn't. Yes.

140 Q. But let's just say that you were going to, what would you do? How would you go about that?

A. I can't think of scenario where I would go completely outside, you know, and not recommend treatment or anything. But sometimes we have to go slightly outside the guidelines, not major breach. Like, for example, antibiotic policy or something. The patient may not be 11:06

suitable. In those cases I first of all explain to the patient that this is going slightly outside the local guidelines, or the guidelines, copy a letter to the GP, and also bring it up in the forum, the multi-disciplinary team meeting, so to see if there is any better options, better views. Yes.

141 Q. So you would inform the patient, tell them that this was slightly unconventional, the basis on which you were doing it, and then bring it back, I think you said, to other colleagues? 11:07

A. That's right, yes.

142 Q. And would you record that in the patient notes that you had the conversation and that the patient had consented to that?

A. Yeah, absolutely. But as I told, hardly ever we have to go completely outside the guidelines, maybe slight deviation with a patient's need requirements, so we have to just tailor it according to individual patients. But only, if at all, slight adjustments. Not a major one like this Bicalutamide 50. No. 11:07

143 Q. So a non-standard protocol, based on your own experience, would be an example where you think "Actually, this may work better", and then you follow the procedure you have just explained?

A. Not -- I won't think of my own experience. What is there on the research ward, there on the trials, what is on the guidelines. So. 11:08

144 Q. Now, you said that your clinic letter, you copied Mr. O'Brien into that. Did Mr. O'Brien ever come and

speak to you about this issue?

A. I think that we discussed about the gentleman in the next MDT meeting. Mr. O'Brien was there. So.

145 Q. Was it Mr. O'Brien or you that brought up this patient?

A. I think I remember it was discussed in the MDT meeting. 11:08
I'm not sure through what channel. Generally if you want to present a patient in the MDT meeting, usually you inform the MDT coordinator to add it in the agenda, either by copying my clinic letter, or sending an email, or sometimes if I leave a message over phone, 11:09
please, either for the MDT, then I send the summary later. So, yes. But this -- I very much remember discussing about this patient in the MDT, yeah.

146 Q. And the Bicalutamide 50 monotherapy issue, do you remember if it was you that raised that? 11:09

A. That's right. The reason for discussion, obviously, when it comes up suddenly, then, yeah, I did raise this issue. Yes.

147 Q. And was the purpose of you raising that a bit like the IV fluid issue, where you wanted to find out what the 11:09
position is? What's normally done in circumstances like that?

A. That's right, because it's unconventional treatment. So.

148 Q. And do you remember what the discussion was around that 11:09
whenever you brought this issue up?

A. Yeah. Obviously there was some question about -- first question was whether, as I told before like, "Oh, the patient is on maximum antigen blockade. It is given

along with LHRH analogue injections?", and that's the thing I told. Like this is the first thing I wanted to clarify. But I asked for the records, and as for the patient, he was not on any other treatment, he was just on this monotherapy. That's why I am bringing it up. 11:10

149 Q. So the first port of call was to confirm with you that there was no justification for Bicalutamide 50 monotherapy in that particular patient, and once that was confirmed then do you recall what the discussion moved to about this regime? Did people say "Well, I have done that", or "I've seen that", or "I've never heard of that", was there any discussion around that? 11:10

A. No, the discussion was mainly the indication like, as I told like with -- first question is whether "Is he on just purely on monotherapy, or are you sure that he is not on LHRH analogue injections as well?", and I said "No, that's why I am bringing up this issue". And they said "Oh, in that case the patient shouldn't be on", and then I told the patient wanted to see Mr. O'Brien to make the choice of different options, so they all agreed, yes, for to have the appointment with Mr. O'Brien for this patient to see in the clinic and to stop and then -- yes. 11:10

150 Q. Did Mr. O'Brien say "Yeah, that's fine", or "No, that's a mistake", or "you've perhaps got that wrong", or anything like that? Was there any detail that would indicate to you that Mr. O'Brien had a view on the appropriateness of Bicalutamide 50 monotherapy for that patient? 11:11

A. He said "I'll just go through the records and see the patient and discuss with him."

151 Q. And did any of the other clinicians say anything about that?

A. Not particularly. Like in the sense like there are discussion about the question of the indication, repeatedly they are asking, "Oh, are you sure he's just on monotherapy, not on LHRH analogue injections?", and is said "No, as well as I could see from the notes from the patient he was just on this monotherapy", and they said "Yes, he shouldn't be and what does the patient want?", and I said "He wants to see Mr. O'Brien in the clinic and then to decide", and then all agreed, yes, he shouldn't be on this monotherapy. So Mr. O'Brien was to see the patient in the clinic and then make up a choice. 11:11 11:11 11:12

152 Q. Do you recall who else was at the meeting? I know Mr. O'Brien was there and you were there. Were the other clinicians present?

A. Not exactly sure. I don't want to say from my vague memory. 11:12

153 Q. But you remember there was more than just you and Mr. O'Brien?

A. That's right, yes. Yeah.

154 Q. Do you have any knowledge of the patient after this event? Do you recall if he remained well or what his prognosis was at all? 11:12

A. I'm sorry about this particular patient?

155 Q. About this particular patient. Was there any follow-up

by you or by the MDM around this patient, given he had been on the Bicalutamide 50 for two, three, maybe more years?

A. No, I don't recall the same patient coming up for the MDT again. Yes. 11:13

156 Q. Do you remember if it was -- whether continued management of this patient with Bicalutamide 50 was considered an option for this patient at the MDM? Did people say "Well, he's keeping well, we'll keep him on it"? 11:13

A. No.

157 Q. Did anyone at the meeting indicate any positive response that that Bicalutamide 50 monotherapy was appropriate?

A. No. 11:13

158 Q. And given that patient that you recall, what would you have considered to be the appropriate management options for him?

A. Yes. As far as I recall this was low risk prostate cancer, I would low grade, like maybe Gleason 6. So -- 11:14 and the PSA was low. I don't recall the exact figure. But ideally it is to stop the Bicalutamide, and repeat imaging with the MRI scan, and repeat prostate biopsies.

159 Q. So you would have had more tests done in order to make 11:14 an informed choice about what would be the appropriate treatment regime?

A. That's right, yes. Yeah.

160 Q. Chair, if you'll just indulge me, I just want to finish

this topic?

CHAIR: We can take a short break -- no, we can take a break after this topic.

MS. MCMAHON: This topic. Okay. Thank you.

161 Q. If a patient wants to remain on the Bicalutamide 50 monotherapy, and I know this patient did and you referred him on to Mr. O'Brien to discuss that, as he was his patient, the patient said to you "I want to stay on this", and you know that it's outside the licence conditions, and the risks we discussed earlier, what would be your response to that? 11:15 11:15

A. As I told, nobody should be on this monotherapy because there's no -- absolute no indication at all for this treatment. So I would explain to the patient that it's not the conventional treatment, it's not indicated, so the appropriate actions will be, there are other choices, like patient could be on active surveillance, depending on the stage and, you know, Gleason score, whether these categories. So other treatment options are either active surveillance, or curative treatment, or watch/waiting, depending on the staging and grading of the prostate cancer. 11:15 11:16

162 Q. So you would provide the patient with information to explain to them why it wasn't appropriate?

A. Yes, absolutely. 11:16

163 Q. Would you continue to prescribe it to them because of their belief that it was helping them when clinically that isn't an evidenced based belief?

A. No, I wouldn't personally recommend to continue. Yes.

164 Q. Now, you obviously felt that there was, the issue was dealt with at the MDM. You raised it as an issue. Mr. O'Brien said he would go and review the patient. And you formed a view that you didn't need to take the matter any further? 11:16

A. That's right, because I thought this is the first case I came across then. So I thought it was properly addressed at that point, like this.

165 Q. Did you ever encounter this issue again, the Bicalutamide 50 as a monotherapy, while you were at Craigavon? 11:17

A. Not in Craigavon.

166 Q. What about any of the other consultants? Did anyone mention to you at any point that they had come across the same issue? 11:17

A. No, not when I was there.

167 Q. When you were there during that time, was it the case that most consultants saw the same patients, rather than rotating them at Outpatient? Would you have had your regular patients come back to you? 11:17

A. This particular patient came up -- generally we see our own patients as the follow-up. Because of the backlog, I think I was undertaking some extra clinics, so it would have been like pulled patients, like patients from other consultants also coming up for the follow-up, so I saw this gentlemen. 11:17

168 Q. So it was just in relation to the clear up of the backlog that you happened to see other people's patients?

A. That's right.
169 Q. But generally you saw your own patients?
A. That's right, yes.
MS. McMAHON: Chair, I wonder if that's a convenient time? 11:18
CHAIR: Okay. We'll come back, ladies and gentlemen, at twenty five to twelve. Thank you.

THE HEARING ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS 11:18

CHAIR: Thank you everyone.
MS. MCMAHON: Thank you, Chair. Mr. Suresh, just before we had the short break I had asked you had you ever experience of a Bicalutamide 50 as a monotherapy 11:34 being prescribed in Craigavon, being prescribed before and after that, and you said not in Craigavon, and that takes us on to your third witness statement that we received yesterday, and I just want to read this out. It's a short statement and it can be found at 11:34 WIT-103271. Do you have a copy of that in front of you, Mr. Suresh?
A. Yeah. The one I sent yesterday?
170 Q. Yes.
A. Yes, please. Yeah. 11:34
171 Q. I'm just going to read it out into the record and then I'll ask you some questions.
A. Yes, please. Yeah.
172 Q.

"This is the third statement made by me to the Inquiry. In it I want to provide further detail on an issue which arose during discussions with the Inquiry counsel which are relevant to the issues before this Inquiry.

11:34

While in practice outside of Northern Ireland I became aware of a gentleman who was found to have localised intermediate risk prostate cancer in 2013. Gleason 7PT2 or CAS prostate.

11:35

In the local and regional MDT in the relevant hospital, the case came up for discussion and for proposals as to how we should treat this condition. The consensus was to offer him curative treatment in the form of surgery or radiotherapy. The various options were discussed with him and the patient opted for active surveillance.

11:35

In 2015 he indicated that he wanted only hormonal therapy. He declined the various curative treatment options discussed with him. He was started on monotherapy with Bicalutamide 150mg by another consultant who was his treating consultant.
Some time later the patient reduced the dose he was taking by himself to only 50mg, due to the side effects was experiencing.

11:35

He was seen by a different consultant in 2016 who explained to him the treatment he was on was not a suggested treatment from any point of view, and

suggested either he could have proper treatment or active surveillance.

When I saw him first in 2017, the patient was taking tablet Bicalutamide on intermittent basis (a few months on and a few months off). I explained to him that monotherapy with low dose Bicalutamide 50mg was not recommended by any guidelines and went through other recommended treatment options. He was not keen on any of the recommended treatments available nor for repeat prostate biopsy. 11:36

He was later seen by two other colleagues who also counselled him appropriately and he again indicated that he was not keen on any other treatments. 11:36

I did a telephone consultation with him in February 2021, as his liver function test was indicating derangements, and as a result of this discussion he agreed to stop Bicalutamide and agreed to attend for prostate biopsies. 11:37

However, within a few days he wrote to me saying that he did not wish to have biopsies. I discussed again in the Urology MDT meeting and wrote to him confirming the consensus from the meeting that he should not continue Bicalutamide and a review would be set up in two months with PSA. 11:37

A month later we received a letter from the GP that the patient wanted cyber knife surgery (not offered by the NHS). I intended to see him within two weeks to discuss his request before making the referral. Unfortunately due to Covid his follow-up appointment was delayed until May 2021. 11:37

After the telephone consultation in May 2021, I referred him to oncologist, my consultant colleague, who has subspeciality interest in radiotherapy. The patient made a complaint that his Bicalutamide treatment was stopped and around the delay in his follow-up appointment, which was beyond my control and was triggered by the Covid situation. 11:37

11:38

The case records were reviewed by my clinical lead. His report was supportive of my actions and he refuted all the allegations made by the patient. No one, neither I nor any other urologist prescribed a low dose Bicalutamide treatment. This patient made a decision, having been advised of alternative treatments, to stay on this monotherapy and elected to take a low dose because of side effects. 11:38

The patient made a complaint to the GMC and a formal investigation was conducted. The report obtained by the GMC from another expert also are supportive of my actions. The case was closed with no action." 11:38

And as we've seen earlier this morning, that is dated 17th October 2023.

Now, that scenario arose on the basis of me having asked you about Bicalutamide 50 and whether you had ever prescribed it or seen it prescribed before. What this statement indicates is that a patient who was not prescribed Bicalutamide 50, self-prescribed it outside the regime of the clinicians who were treating him, and you sought to persuade the patient and to indicate to him the risks of that and the dangers of that, and events subsequently followed that were not related to Bicalutamide 50 prescribing by you or any other clinician, and you have provided that statement merely just to tie up any loose ends around that particular issue and to answer the question fully for the assistance of the Inquiry? 11:38 11:39 11:39

A. That's right, yes.

173 Q. I don't have any questions in relation to that. That's clearly a patient doing his own thing, if I can put it that way, and the outworking of that for you as a clinician, but thank you for providing us with that information. 11:39

A. Okay.

174 Q. You also gave us the second statement that we referred to this morning, but I also wish to read in, and this - the context of this statement is an issue that arose while you were working in Craigavon and you were on-call, and we'll speak about the events of that. 11:39

Just at the outset, if I can say, Mr. Suresh, we're interested in the governance aspects of this issue and all issues before the Inquiry, so when I ask questions it will be directed at the processes that followed and any learning the Panel may derive from that. I read this statement to provide a context for that, for those questions. 11:40

So this statement can be found at WIT-103270. You take the opportunity in this statement to make some amendments and corrections and I'll read it in full. 11:40

You say:

"This is my second statement to the Inquiry and is by way of clarification and amendment to my earlier statement dated the 1st September 2022. 11:40

On page 24 of the bundle with the reference WIT-50334, where I refer to MBBS, December 1990, the date should read December 1991. 11:41

At WIT-50339, page 29, where it reads:
"8.1 In my view the roles and responsibilities of those who had governance responsibilities are..." 11:41
I would ask that it now reads:
"In my view the roles and responsibilities of those who had operational and governance responsibilities are..."

Paragraph 4 you say:

"At WIT-50360, page 50, it says "(v) the associate medical director", 47.5 "To have my job plan approved the interactions were through emails, I had no issues", 11:41
and you wish to add the following:
"After an incident in autumn 2015 during my on-call day, when a patient had to undergo an emergency nephrectomy for which I had to seek help from another senior consultant. Mr. O'Brien, there was a meeting 11:42
with Mr. Mackle and Ms. Corrigan. During the meeting, I raised my apprehension about open major urological operations. It was recognised that my main scope of work was endourology. I was assured that support would be available from another senior consultant whom I 11:42
could contact if needed. I was also encouraged to attend other theatres and relevant course to build up my confidence. I fully engaged with what were discussed in the meeting. After that incident I was accompanied by another consultant during the ward 11:42
rounds on ad hoc basis and to my knowledge they were satisfied with my approach and no concern was raised."

Then you say at paragraph 5:

11:42

"At WIT-50365, page 55, where it states:
"51.1 Personally, I did not feel any need for any extra support, but to boost up my confidence in major open surgeries when I asked for support the support was

provided by facilitating me to join theatres with other consultants and to attend a cadaveric course."

I would like to amend this to say:

"Personally I did not feel any need for any extra support except for emergency major open urological operations. To boost up my confidence in major open surgeries when I asked for support, the support was provided by facilitating me to join theatres with other consultants and to attend a cadaveric course. Also I was assured support would be available if needed for major open urological operations." 11:43 11:43

Now, I just want to ask some questions about the general background of that incident and then we'll move on to what governance processes were triggered by it and your views on the effectiveness of those and any learning the Panel may derive from your experience, if that's okay, Mr. Suresh. 11:44

A. Yes, please.

175 Q. Now you've mentioned the incident happened in autumn 2015. Would you be able to just give us an outline of what the incident was? You were on-call at that time. Do you remember if it was day-time, night-time, early morning, do you remember when the patient first appeared before you? 11:44 11:44

A. Yes. Just telling really from my memory.

176 Q. Yes.

A. And I don't have the full records of the patient or details now, but very much remember the events. Like

the patient was admitted the night before. The gentleman had a partial nephrectomy by Mr. Aidan O'Brien, it was an open operation, but ten days later, seven to ten days later he was admitted in Southwest Acute Hospital with abdominal pain, where he had the CT scan and then was transferred to Craigavon Area Hospital. 11:45

So this case was handed over to me when I was doing ward rounds in the morning, maybe around 10:00 o'clock, I don't know the exact time. 11:45

So when I saw the gentleman he was comfortable, stable, slight abdominal pain, which is expected after the major open operation, and he was haemodynamically stable, and I noticed there was slight drop in the haemoglobin, which was again expected after an open operation. Not drastic. So I did discuss the CT scan with the consultant radiologist, and after going through the majors, he went through the majors, and there was some collection just close to around the kidney, and there was definitely more fluid around the liver, but he felt it could be Walsh bleeding, so was not too worried about that. So still, as I say, I thought I would let Mr. O'Brien know about this admission. I tried to call him. I'm sure he was doing a clinic in another hospital, and I don't exactly recall whether his phone was switched off or went to answering machine so, but I couldn't, you know, I could 11:45 11:45 11:46

not inform him about the admission anyway. I just tried once. And I thought the patient was stable enough, so I didn't pursue it any further.

Only in the evening, late in the evening, like around 9:00 o'clock/10:00 o'clock I was called that the patient has gone into shock, most hypertensive, and needed resuscitation. So, as I say, I rushed to the hospital. And while on the way, even before leaving, I contacted Mr. O'Brien and told him about the admission, and he said yes to resuscitate, and I told him probably he will need operation, so we needed help, and immediately he also joined. So patient had to have resuscitation with the blood transfusion and everything, all geared up to take him to theatre. So. And Mr. O'Brien was there. We had to explore and do the emergency nephrectomy. So it was all night process. Yes. 11:46 11:46 11:47 11:47

177 Q. So the patient was first day post-op after a partial nephrectomy carried out by Mr. O'Brien?

A. Sorry, not first day post-op. It is about a week or ten days later he was admitted. Yes. Yeah.

178 Q. But Mr. O'Brien was the surgeon who carried out the partial nephrectomy?

A. That's right, yes. 11:47

179 Q. The patient was admitted and subsequently developed signs of hypovolemia and was returned to the theatre?

A. That's right.

180 Q. And you contacted Mr. O'Brien. And I think you've

indicated that he was -- it was evening time, he was off site I think. Was he at home when you contacted him and he came in or was he in the hospital?

A. No, he was at home. Like, you know, it was late in the night, 9:00 o'clock or 10:00 o'clock in the night. 11:47

181 Q. So, Mr. O'Brien came in to hospital and assisted with the procedure?

A. Yeah, he performed the procedure and I assisted him, yeah.

182 Q. He performed the laparoscopy. Was it a full nephrectomy then that was carried out? Do you recall? 11:48

A. Yeah, not laparoscopy. It was a laparotomy.

183 Q. Laparotomy. I beg your pardon.

A. Like going through the same incision. Yeah. And then we all knew that the patient would land up in nephrectomy because of the blood loss and shock he was in. So the nephrectomy was carried out, yes. 11:48

184 Q. Now you were on-call. Would there have been an expectation at that time that you would have managed that issue yourself, or was it the case that better practice would be to bring in the original surgeon if he was available in order to gain from their expertise around this particular patient? 11:48

A. Naturally I would ask for help and expertise, because my scope of work is mainly endoscopic work. 11:48

185 Q. So you identified that one of the other consultants was better placed to deal with this?

A. Absolutely.

186 Q. And you assisted with that?

A. That's right, yes.

187 Q. Okay. Now, you've mentioned at a couple of points in your witness statement, and we don't need to go to them, but just for the Panel's note and just to put it on the record. There were no concerns raised regarding your practice and there was no -- you're not subject to any performance review at any point. This is just an isolated incident that you have informed us about, as have others, and for the Panel's note the reference to not subject to performance review is WIT-50352 at paragraph 29.2, and the reference to no concerns around Mr. Suresh's practice is at WIT-50362 at paragraphs 48.1 and paragraph 48.3. 11:49 11:49

Charles McAllister mentions this in his statement. If we go to WIT-14851? Paragraph 43: 11:50

"There was also an issue with another urology consultant at the time who was reputedly uncomfortable with open urological surgery as opposed to endoscopic surgery and whose judgment and management plans for the more complex urological cases was a point of concern. 11:50

I was informed I believe by Martina Corrigan, Head of Service; Heather Troughton, outgoing AD for surgery, but it may have been by Mr. Mackle, that before I started the surgical management role this had also been escalated to the service director and a management plan had been put in place that this surgeon would be 11:50

shadowed by another consultant urologist and a second consultant urologist would be on-call when this surgeon was on-call. I do not know if this had been shared with the medical director, but I assumed so. That consultant left the Trust later that year." 11:51

Now, those circumstances described there, your name is not mentioned, but it would seem to suggest it falls into the framework that applied to you. Would you agree with that? 11:51

A. Yes, I would agree.

188 Q. Now, the point of interest for the Panel is what happened then, what happened next, and we have an email in the bundle from Martina Corrigan, and this is at WIT-11946. Now, this is dated March 2016, and it's 11:51 clear that there have been meetings prior to this. So just before we go into that email - you don't have the documentation - I wonder if you can recall the sequencing after the actual event? If you -- self-identified learning, if others came to you? Just 11:52 give us a flavour of how we get to the point in March where there is an attempt at a formalised action plan?

A. Yes. This major, especially major, any emergency major open surgery, it is always there in the back of my mind. As I told you, my endoscope -- I work mainly in 11:52 endoscopic work, and so if the patient needs any emergency major open operation, so you always talk about ureteric injuries or emergency nephrectomies. So. And I was very clear that I would need help if

that happens. Extreme -- I mean very dire situations. So. And particularly when this position happened, like you know, patient was in serious shock. So it -- to get me more, so just swift into action, rather than fine. At least on that day Mr. O'Brien was there ready 11:53
for help. So what if somebody is not there? So the question always came up. So by the very next day everyone in the Department came to know about this case happened. So I had a meeting with Mr. Young, and especially to raise the issue "What to do if it happens 11:53
again?" Those are very dire situations. So that's how we talked about it, what to do, like you know. And then I was told, yes, there will be -- you could contact anyone. It was not formalised at that initial meeting like whom to contact. They said "One of us 11:53
will be around, so we'll let you know nearer the time when you are on-call those days, who will be available."

And also I said, yes, I want to have just a boost to my 11:53
confidence, not that I am going to deal with the emergency on my own, still I will need help, but still to boost my confidence. So I said I would like to attend, you know, any open operations for the theatres. So I utilised my SPA time and admin time, went to other 11:54
theatres, and also went for a cadaveric course. So it was almost like a valid process I was thinking, and I was taking advice of my friends and from my colleagues as well. So everyone -- yeah, that's how we came up

with this.

189 Q. So you mentioned the departmental meeting and I think you said Mr. Young was the person you spoke to about it?

A. That's right, yes. 11:54

190 Q. And you self-identified, as was perhaps evident by the incident or the emergency, that you maybe had some potential learning gaps, and you brought that to the meeting and sought some advice about "What will I do if something like that happens again? Is there a 11:54 particular procedure or protocol?", and the advice was that there would be someone available if something like that happened and that you should utilise that. That was your collegial advice?

A. That's right, yes. 11:55

191 Q. In relation to anyone else but Mr. Young, for example Mr. Mackle, or discussions with Martina Corrigan, did you have any meetings with them? Did they come and speak to you and discuss the issue with you after December or in and around December? 11:55

A. Yes, there was. Yeah, there was a meeting with Mr. Mackle and Martina Corrigan. There were three of us. So essentially we went through what was already discussed, and that they all agreed with the action plan, and especially there will be some named 11:55 consultant, and Mr. Mackle was also kind enough to say -- because I already applied for another course -- I was looking for a cadaveric course, and he said the extra funding would be available, "We can grant extra

funding if you want to go for any specific course" there's also the study budget, and so also facilitated, like you know, I could attend other theatres, but that's my own SPA time. So I felt reassured and I felt supported. 11:56

192 Q. So you felt supported and reassured, and the indication was that if there was a cost involved in facilitating you accessing further training then that would be met by the Trust?

A. That's right, yes. 11:56

193 Q. Now, we'll just look at this email because it provides some detail. It's about you, but you're not copied into it. I know you've seen it. It's at WIT-11946. I think you have it in front of you, do you? Do you have this email open, Mr. Suresh? 11:56

A. I'm sorry, could you please read it?

194 Q. It's the email of the 4th March from Martina Corrigan to Eamon Mackle, Mark Haynes, Anthony Glackin, Mr. O'Brien, Michael Young and Mr. O'Donoghue. The subject is "Actions from AMD and Urology Consultant Meeting", and it says: 11:56

"Dear all,

To formalise, please see the note actions arising from today's meeting. 11:56

Present: Mr. Mackle

Mr. Young

Mr. Glackin

Mr. O'Donoghue,

M Corrigan.

Apologies: Mr. O'Brien and Mr. Haynes.

Mr. Mackle advised that the purpose of the meeting today was to follow on from the last meeting which was held on the 17th December 2015, as he has a meeting with the medical director at the end of the March and he will need to update him on what has been put in place. 11:57

Actions agreed:
1. Mr. Young to meet with..."

-- you, and we know that that is you: 11:57

"...this week/early next week and explain what processes are being put in place for cover/support/mentorship for him, and also to explain to him why the team are doing this for him. Mr. Young to update when this happens. 11:57

Mr. Mackle to meet with Mr. Suresh on Wednesday, 16th March 2016 at 2:30pm in the AMD office. M Corrigan to organise. 11:57

Mr. Mackle and Mr. Young to advise him that he should be seeking appropriate courses that will assist him in building up his surgical and decision-making skills and

that Mr. Mackle will approve if these are appropriate.

A multi-disciplinary feedback questionnaire should be completed and collated with the team - not linked to the 360 feedback. M Corrigan to organise and will collate responses. This will be used as constructive feedback from Mr. Suresh. 11:58

Formalise evening cover. The purpose of this will be explained to Mr. Suresh in his meeting with Mr. Mackle and Mr. Young. 11:58

Mr. Young to formalise after discussions with the rest of the team that this should be shared with all of the team, Mr. Mackle and Ms. Corrigan. 11:58

Mr. Suresh is going back on-call on Thursday, 17th March (bank holiday). Mr. Young has agreed that he will do the handover ward round and cover Mr. Suresh on this day. 11:58

Formalise the ward rounds with one of the consultant team accompanying Mr. Suresh each day (except Thursday). 11:58

Weekends to be agreed on what cover needs to be provided and the team are going to work this up and share with Mr. Mackle and Ms. Corrigan. The consultants involved in the second on-call and ward

rounds will be remunerated by half PA. M Corrigan to organise.

A further meeting in three months to be organised in order to update on progress. M Corrigan to confirm dates.

Regards Martina."

Now, the incident happened in the autumn 2015. There was a meeting clearly referenced in the December, and this is the March, and there is a further follow-up in three months. So there's -- at least from the paperwork, there's a suggestion of a six month oversight in different aspects in order to ensure you're supported. Is that how you felt about these plans that were put in place? 11:59 11:59 11:59

A. I think the plan was there already, although not in writing. As I told, the very next day, or the very next working day we had the meeting, and so the issue all addressed, and everyone at the department came to know about this case. And, so, the first question is what -- if there's an emergency situation happens again, what's next? So they said, yes. Mr. Young was, you know, making an informal rota. Used to tell me if anyone called, you know on-call week, who would be available to contact. So this was already put in action, I would say. 11:59 12:00

195 Q. Yes. So this is the written version of what was

happening, but it also adds to that because it gives specific dates, specific procedures, the way in which there will be some layers of support for you. So it puts in writing what you say was already being put in place after the event? 12:00

A. That's right, yes.

196 Q. Now, it seems that the consultant team as a group were involved in stepping up, if I can put it that way, in order to ensure that you were supported. Does this email content ring true about the level of support you received? Did all of this come to pass? 12:00

A. I'm sorry, I couldn't get it?

197 Q. We've looked at the detail of the email and there's clearly a package of measures that are anticipated or are already in place in order to support you. Did all of this happen, as is set out here, or did you feel that you weren't supported in any aspect of this? 12:01

A. No, this was almost happening. And the extra thing, as I told, like I'm looking -- I was already looking for a course and looking for the budget as well, so that -- after the meeting with Mr. Mackle -- and he said the funding would be available. So there was an extra measure as well after that meeting. 12:01

198 Q. Just aside from the course, and you've mentioned that. In relation to the support from the team, and from medical management, and from the head of services, did you feel that this action plan was put in place? 12:01

A. That's right, yes. Yeah.

199 Q. And as regards the detail in this, did you suggest any

of this, or was this all suggested by others? Did you come to them and say "This is what I'd like you to do. This is what needs to happen", or was this a package that was collectively agreed, or did it come from management solely? 12:02

A. No, this was -- like it was going through a parallel from different directions. As I told I was also working on that, how to boost my confidence, what steps should be taken. And so again with the discussion with Mr. Young as well, I'm sure he would have spoken to 12:02 also the medical director. So was all going in parallel and so it was put together as a collective issue.

200 Q. And certainly on reading this in the overview, but also the detail, it seems that they have -- there has been 12:02 some consideration given to when there may be potential for issues to arise in the daily life of a clinician, and they've sought to plug the gap of support. There's different things about the ward round, evening cover, bank holiday, when there may be particular 12:03 vulnerabilities or increased traffic into the hospital. It seems to be quite focused. Was that your experience of the support, that it hit the spot, as it were?

A. Yeah. Exactly for the ward rounds, the criticism which was raised about the decision-making on this particular 12:03 patient, personally I too felt, you know, there was a mistake on my part, in the sense that the patient was seen in the morning and then my intention was to review in the evening, and I felt very bad that I couldn't go

back and see the patient - probably forgot, workload or whatever reason, you know. That's the part which I regret very much. Probably had I seen the patient reviewed in the evening, again could have been, the decision could have been slightly better. So that was 12:03
my mistake and it was a big lesson for me. So that's all the criticism like, you know, "Why didn't you go back and see if there was any issue with the decision-making?", and that's why they said -- like all concern was mainly about this particular patient, 12:04
particular incident, and as I say, they thought to observe me doing the ward rounds. And then on ad hoc basis, I remember Mr. Young or Mr. O'Brien joining me in the ward rounds, maybe Mr. Glackin as well, and they are all happy with my approach, you know. As an 12:04
informal feedback I was getting basically everything was fine, so they kept assuring me this all happened because of this particular case.

201 Q. I suppose the point I am trying to draw out of this and to see if you'll have any view on it, it does seem as 12:04
if there was a concerted effort as a team to support you to overcome any potential vulnerabilities rather than any ones that actually exist. There was a package put in place. Would that be your experience?

A. That's right, yes. And they were all trying to 12:05
accommodate me, in that just to like join theatres when there was open surgery and, you know, they were happy for me to scrub in and assist. And, yes.

202 Q. There's mention at point 4 on the email of a

multi-disciplinary feedback questionnaire to be completed and collated within the team to be used as constructive feedback. Do you have any recollection of that?

A. I was told Martina would be collecting it what but I did not get any feedback after that, yeah. 12:05

203 Q. You didn't get any feedback from that?

A. No.

204 Q. No.

A. Not a formal one, yeah. 12:05

205 Q. Not formally?

A. Yeah. I mean I did not receive the 360 feedback, but generally speaking to the consultants they were all happy with my approach.

206 Q. Do you know who carried out or who collated the questionnaire or who collated the responses, no? 12:05

A. No, I don't know.

207 Q. Just for completion if we go to TRU-258602. It's an email of the 2nd April 2016. TRU-258602. So this is the email to you separately from the other clinicians and it just sets out the actions agreed just to confirm that you had sight of those and that you saw what was being discussed. Mr. O'Brien makes reference to this in his statement at WIT-82541? 12:06

A. I'm sorry, I can't open the document. Could you please read out, please, if you don't mind. 12:07

208 Q. Are you content that I read it out? This is the section from Mr. O'Brien's statement. I'm just going to read it out for the Panel that they have note he

mentions this issue specifically at 401:

"I did not have any reason for concern regarding the clinical practices of Mr. Anthony Glackin or of Matthew Tyson, Consultant Urologist, or of Mr. Derek Hennessy, or of Mr. Thomas Jacob, locum consultant urologist. However, the assessment and management of an in-patient by Mr. Ram Suresh, Consultant Urologist, following the transfer of the patient from Southwestern Acute Hospital in late 2015, with evidence of a significant intra-abdominal secondary haemorrhage following an earlier partial nephrectomy did give rise to concern regarding his clinical acumen and ability to undertake emergency surgery in a life-threatening situation when UOW. This case was discussed with me and his remaining colleagues by Mr. Mackle, then associate medical director, and Mrs. Corrigan Head of Service in early 2016, when we were requested by them to provide backup support for Mr. Suresh when UOW. 12:07 12:07 12:08 12:08

As can be seen from the email from Martina Corrigan dated 4th March 2016, AOB-76726, a meeting took place on 17th December 2015 following the above incident and then a follow-up meeting took place on 4th March 2016. I was not present at that meeting but the email indicates that Mr. Mackle, Mr. Young, Mr. Glackin, Mr. O'Donoghue and Ms. Corrigan were present." 12:08

And then he lists the support measures that were put in

place. Just go on down, please. He embeds the email into that. Just move down, please. Just keep going just past those emails back on to the statement. Thanks. Just he then puts other action plans in place and sets it out. I just want to pick this up again. 12:09
Then at 405 he says:

"I've continued to provide support to Mr. Suresh until he returned to take up another post in England in October 2016. I did not receive any remuneration for 12:09
having done so. I have since had reason to contrast the support offered to him in 2016 to that offered by the same persons to me in 2016."

Now, that's a note for the Panel and for Mr. O'Brien's 12:09
reference. Can I ask you just at this point, were you ever asked to assist Mr. O'Brien in his clinical practice or his administrative practice at any point while you were at Craigavon, apart from the triage we mentioned earlier this morning? 12:09

A. No.

209 Q. And for the Panel's note, the letter of March 2016 to Mr. O'Brien asking him to make some suggestions is at TRU-274672. As a fellow clinician, what was your relationship like with Mr. O'Brien? I know he came in 12:10
to support you on this particular issue, but how did you find him as a clinician? The Panel has heard various evidence and I would like to ask you your view, having worked with him?

A. Personally, you know, I have high regards for Mr. O'Brien because he is a very pleasant gentleman to work along, very sincere, hard working and, you know, often seen emails coming from the night times or early morning. So I could see he is very hard working, and very empathetic and compassionate to the patients. Very thorough. Every patient he used to know, but a very detailed history. So, hard working, sincere, pleasant gentleman, taking personal care of colleagues and patients really. 12:11

210 Q. In relation to the MDMs, I just want to ask you a couple of general questions, and we've sort of touched on them with the Bicalutamide 50 and the examples you've given. If you were to change a treatment regime that had been agreed at an MDM for a patient, how would you go about bringing that into effect? If a decision had been made at the MDM for a certain treatment regime and you subsequently made a decision, or considered that another course of action was more appropriate, what steps would you take in relation to that? 12:11 12:12

A. Generally the MDT coordinator, we have a big team working along with the MDT, so they take down the notes and act on that, like the patient to be seen in the clinic within two weeks or something, then they liaise with the booking coordinator to make sure all the MDT patients, they get a timely appointment to the clinics. They have separate slots in each clinic for MDT patients, post MDT patients. So the whole team ensures the patients have follow-up appointment in the clinic, 12:12

in a timely fashion.

211 Q. And would you bring the decision back for discussion with your colleagues?

A. I'm sorry to -- so the first point is getting the clinic appointment. So it's all done by the team, the coordinator and the booking team. 12:13

212 Q. Yes. But if a decision was made that a certain treatment regime was to be followed, and then you move on to the next patient at the MDM, that patient then -- you see that patient subsequently and take a decision that "Actually, that MDM decision, I am going to depart from that decision and prescribe a certain other treatment regime, or not do what the MDM recommendation is", and we know it's not something that has to be followed, it's a recommendation. But if you make a decision to depart from it, are there any particular steps you would take as the clinician, having made the decision to change the treatment? 12:13 12:13

A. Yeah, if you have to go against the MDM recommendation is a rare thing, but time to time we may have to, then usually document everything clearly and copy the letter to the GP and see a nurse, cancer nurse specialist, and sometimes we have to bring back to the MDT to re-address the issue. 12:13

213 Q. So you would inform the GP by correspondence, but if you thought it was appropriate I think the thrust of your answer is you would bring it back to the MDM for discussion? 12:14

A. If it was something very straightforward for -- I can

quote an example. Like sometimes, you know, often what happens like a patient with high risk DCC bladder, like G3PT1 or CAS, so there may be some -- sometimes like not all information may be available at the time of MDT, maybe they can still be to follow the standard protocol policy or alternative care -- BCG, but when we see the patient at clinic, the patient can be completely different picture, maybe very elderly, frail, maybe even on wheelchair, with constant urinary incontinence. So the patient may not be a fit candidate to have BCG treatment, in terms of the BCG. So when we get more picture and we see the patients, sometimes we have to go slightly outside the MDM decision like not suitable for BCG, so explain the circumstances, copy letter to the GP. So if something is very straightforward generally we don't bring back to MDT, but if something different, like patient may be suitable for something different, then, yes, bring back to MDT. 12:14 12:15 12:15

214 Q. Did you ever Chair the MDMs when you were at Craigavon? Did you ever act as Chair? 12:15

A. Maybe just once or twice when the colleagues are on leave.

215 Q. And in relation to -- sorry.

A. Sorry. Yeah. When I was there all the meetings were chaired by Mr. O'Brien. 12:15

216 Q. And in relation to the time allocation to allow you to prepare your reports for the MDM, or to fill in your clinical summaries so that the MDM had the information

they needed, did you feel that you had adequate time to do that?

A. It was taking slightly extra time, but my initial practice was when I do see the patient at clinic later, the clinic letter will be a detailed one with all the relevant details under the headline "diagnosis", but bullet points, and summary and action plan. So I was copying the letter to the MDT coordinator with a request to put it on the MDT, and later I was told that may not be enough, we want a separate pro forma to be filled in. So it was slightly, you know, extra work duplicating the work to submit the same data on a different format. Yes, it was. 12:16 12:16

217 Q. So the system changed slightly so that there was a pro forma so that everyone knew what was needed to inform the decision making at the MDM? 12:16

A. That's right, yeah.

218 Q. Did you have any recollection of issues around quoracy, the number of people who were at the MDM, and the different specialities? Was that a problem while you were at Craigavon?" 12:17

A. Yes, the main issue -- I don't think anything from a urological aspect. I think they were -- mostly there'll be at least two consultants. But from Radiology was a bit shortage. I think I remember Dr. Marc Williams, used to be the uro-radiologist. He was the only one mainly coming for Urology MDT. But when he was on leave there were a few meetings where we had to go without the radiologists, which was not 12:17

ideal. That issue was...

219 Q. And did you -- sorry, go ahead.

A. Yeah. No, that was brought up on a few occasions, every time when he was on leave then -- that was issue which came up again and again, yes. 12:17

220 Q. And did you or anyone else raise that formally with, or informally with the clinical lead or Mr. Mackle, for example? Was that ever escalated up as an issue or was it known?

A. I'm not sure to what extent it was escalated. 12:18

221 Q. Did you ever feel that there was a time when the quality of your decision was disadvantaged by the unavailability of one of the specialists?

A. Obviously it is a multi-disciplinary team meeting and we would like to have the consultants of every 12:18 speciality was needed. When the radiologist wasn't there it was certainly sub-optimal. But there was some plan of action put in place, like anything needed, Radiology input, then we had the separate summary was made, a separate list was made, and the MDT Chair, the 12:18 plan was to discuss with the radiologists to ask for their input and then to make the decision.

222 Q. And was the lack of available specialist ever -- did that ever result in a delay for the patient being considered? Did they have to be put off until the next 12:19 meeting to allow someone to attend?

A. Yep, that could have happened, yes.

223 Q. Do you recall?

A. I don't know how often.

224 Q. Did it happen with you? Theoretically it could have happened, but do you recall did it happen when you were there, that you had to put people back because you weren't quorate?

A. Yes, some other patients will be straightforward where we go with the report of the radiologists, the radiology report. Some of the patients would need to go through the images, so these are brought up for the next meeting, yes. 12:19

225 Q. Did you get the feeling that there was an attempt or there was efforts being made to increase the capacity so that you could meet quoracy, or was it the case that it was just the way was and everyone sort of accepted that it wasn't always going to be possible? 12:19

A. No, I think this issue was discussed again and again in our Departmental meeting, and even during the MDT meeting. So I vaguely remember some emails from Marc Williams to finding alternate -- like to arrange cover for the MDT. 12:19

226 Q. The Inquiry has heard evidence around the allocation of cancer nurse specialists, clinical nurse specialists and the like. I think it was early days in that process when you were there. But do you have any specific recollection at the MDMs as to the way in which the cancer nurse specialists were allocated? Was that something that you were aware of at all? 12:20 12:20

A. Not, well cancer specialists are there, you know, the two of them are there, they are always available in Thorndale Unit, where we used to run the clinics. So,

um, I'm not sure -- sorry, the question?

227 Q. Well the Inquiry has heard evidence that the policy was that the Chair of the MDM and the core nurse allocated clinical nurse specialists, and I just wondered if you had any recollection of that issue at all when you were there? Was there any issue around that or discussions at MDM about allocation, that you can recall? 12:21

A. No.

228 Q. Now, you mentioned CNS at your statement at WIT-50349, at paragraph 23.1, and you say this: 12:21

"The specialist cancer nurses offered support to cancer patients at every step, vetting the two week pathway referrals, supporting the newly diagnosed cancer patients in the clinic by giving them their contact details, information leaflets, and addressing their emotional and mental health issues, and any personal need that would help the patients in making the decision on their definitive treatment." 12:21

23.2:

"We had constant interactions with the specialist cancer nurses. They joined the clinics while seeing newly diagnosed cancer cases and while breaking bad news." 12:22

Now those two paragraphs, are they a description of the way in which you worked with the cancer nurses? Is

that how it operated for your particular practice?

A. Yes.

229 Q. Now in particular in relation to the vetting the two week pathway referrals, you've mentioned that, do you know how that was carried out by the nurses? How they vetted the two week pathway referrals? 12:22

A. I could say from my memory, like you know some straightforward parties, they were given clinic appointments. So that's what my understanding was. So only if there is any doubt or something, they were kept -- they were brought to our knowledge for triaging or to action on that. So they were doing some initial workup, and if anything -- if something was straightforward so they would have been given appointment straight away. If there was any doubt or anything missing, so they were brought to our attention. 12:23 12:23

230 Q. And was it your practice to bring the nurse, or to ask for the nurse to attend if you were breaking bad news, or you say, newly diagnosed. Did you ask the nurse to attend with you? 12:23

A. Yes, absolutely. Absolutely. Yes.

231 Q. Did you ever carry out clinics where you broke bad news or gave people diagnosis without the nurse being there?

A. Yes, sometimes it may not be physically possible for one of the nurse to be always available because a few clinics will be running around, and one may not be physically possible to attend all the rooms at the same time, or if they are on leave. So I usually give the 12:23

contact details of them to the patient, and the relevant booklets. Either they are there in the clinic in the room or they would be contacting the patient later.

232 Q. And when the nurse wasn't available, did you give out leaflets or contact details to the patient when you dealt with them yourself? 12:24

A. That's right. There were some booklets available readily, so, yes.

233 Q. Do you ever recall being told or hearing about Mr. O'Brien not engaging with the nurse specialists? Was that something that was ever brought to your attention? 12:24

A. No.

234 Q. Just in relation to results and follow-ups of investigations and tests ordered. What was your particular procedure for checking up on results when you had ordered a test or had asked one of the nurses to carry out a test on your behalf? 12:24

A. Yeah, mostly investigations. So I would be requesting my own like ultrasound or CT scan from the clinic. Some of the straightforward blood tests, by the time, you know, I approve the letter, the very next day the results will be available. So I check that straight away then and then. But if something, like ultrasound or CT, which will happen later on, usually the secretaries usually keep a track of that and when the results are available they are brought to my attention, and they're kept in a separate folder. I usually go 12:25 12:25

through my results folder periodically and act on them.

235 Q. Did you have any system with your secretarial staff where they alerted you, or with the nurses? Did you have anything set up that would allow the information to be fed back to you if it was more significant than perhaps just a routine result? 12:25

A. No, it will be usually through the secretaries. As I told, like you know, all those who needs tracking, they will keep it in a separate folder to keep tracking all the results, and once it is reported, the copy would be kept in my folder, so I would check them and act on them. 12:26

236 Q. So if they got an adverse report back, or review, they would put it into a certain folder and then you would look at that folder. Would that be something that you would do periodically, daily/weekly? What was your own system of practice? 12:26

A. Yeah, it is usually, you know, mostly every week, after my routine clinic where I used to go to the office, it will be in there, in the folder it will be kept. But if someone needs something very urgent or something, they would have got the email alert from either Radiology Department, I don't remember exactly, or some secretary might have emailed me or "Could you please look at this it is more urgent", something flagged up on the MR report, so I would just, you know, just speed up the process. So it would be on an almost daily basis, I used to go to my -- there would be a separate admin session were I would be looking at it, apart from 12:26 12:26

that almost every day it is in the office in the evening, to pick up and act on them.

237 Q. So I know it's 2013, '14, '15, and the systems have changed, but it very much was a very heavy dependent paper base then, it was hard copy rather than any electronic trigger for reminder. So it was depending on the individual you were working with, your secretary, to build your own system? 12:27

A. That's right, yes. Yeah.

238 Q. And in relation to notes, having patient notes, what was your practice around the retrieval and use of notes, and what happened to those notes when you finished with them? Did you have a certain system for getting them to your secretary, getting them back to notes and records? What was your own particular practice? 12:27

A. I think mostly the notes are brought to the clinic or anything, they would be -- I thought they would be taken back to secretaries. So I wasn't involved with the transfer of the records. 12:28

239 Q. Did you ever have cause to bring notes home with you or to take them off site at all?

A. No.

240 Q. And what about dictation? That might suggest what happened to the notes. Did you do dictation immediately after your clinic or did you wait until a certain time in the week and do them altogether? What was your procedure for that? 12:28

A. Usually I do it then and then in the same clinic.

241 Q. So after the patient left you would dictate the outcome and then move on, was that what you did?

A. That's right, yes.

242 Q. Did you ever fall behind on dictation?

A. No. Like, you know, the clinics, all clinics are supposed to be finished by the -- the end of the clinic I will dictate a letter. If anything missing, like a patient might have DNA'd or something, my secretary would think "Oh, there's no dictation for this patient", and you would do a letter on the same day. I would say "Oh, patient DNA'd", so I would have dictated the letter. 12:28 12:29

243 Q. So you would try and have it all done on the day of the clinic?

A. That's right, yes. Yeah. 12:29

244 Q. Now, you've made some comments in your statement around the clinical governance systems in place, and I just want to go to that. WIT-50351, and at paragraph 26.2, and you say this:

12:29

"There was an effective clinical governance system. As far as I was aware all staff had access to the incident reporting system through which any concern by any staff could be notified. However, I did not get any automated feedback on the actions taken for incidents. I did highlight the issue in one of the governance meetings of the surgical division, but cannot recall the exact date. I felt the clinical governance system was effective in that all staff had access to an 12:29

on-line reporting system of any incident or concern. Patients had access to PALS (Patient Advice and Liaison Services) and the complaint system.

I do expect to get the feedback report on actions taken on review of incidents and complaints as we all have to learn from the mistakes. We are obliged to know what went wrong, why did it happen, and how to prevent such incidents happening again. But during my tenure, I did not receive the reports of the incidents I filed. 12:30

I raised this issue in the combined surgical division audit governance meetings but do not recall the dates. Most of my colleagues echoed my concern in that meeting. We were told by the Chair (cannot recall the name) that any learning point from the incident would be circulated to all the relevant staff. However, I do not think the final reports on all incidents were circulated." 12:30

12:31

And you also say at WIT-50358, paragraph 45.1:

"As far as I was aware, there were several ways to raise concerns: Direct reporting to the lead line manager, operational manager, medical director, or Chief Executive. (Their names are already provided). There was also PALS (Patient Advice and Liaison Service) and the Complaints Office to whom the patients or relative could directly contact." 12:31

Just move down slightly for me. Now, we have in our documents some of the IR1s that you have raised. One, for example, is the accidental splashing of contaminated fluid. I'll just give the Inquiry some of these references and for others. WIT-50444, that's the accidental splashing of the contaminated fluid. WIT-50451, relates to the cancellation of procedure. And there are a couple of others at WIT-50458, WIT-50473, and WIT-50481. Now, you've mentioned about the importance of feedback, whatever the purpose of the IR1 is. So you were familiar with the governance formal procedures, that you had to trigger them on a couple of occasions, and is it the case, can we take from what you've said in your statement that no one ever came back to you and said "This is the outcome"? 12:31 12:32 12:32

A. That's right, yes. I did not get any report or action of what was -- that would come off that.

245 Q. I just wonder if we could go to AOB-73717. AOB-73717. Sorry, I just want to make sure I am reading these in order - they can be out of sequence. So this is an email from you to Mr. Glackin on 26th May 2015, and you saying: 12:34

"Dear Mr. Glackin,?

I have seen a couple of patients recently with "forgotten stents" with no mention about the stents in the discharge letter. I have filled in incident forms. 12:34

Can we discuss about this issue in the next governance meeting, please, particularly about the need for a stent registry?"

And just go up, please? Mr. Glackin replies to you on 26th May 2015, and copies in Mr. Young, Mr. O'Brien, Mr. Haynes, Mr. O'Donoghue and Martina Corrigan, and says: 12:34

"Ram, 12:34
I would be most grateful if you could present these cases formally so that we can share learning and plan some action points. Please let me know the dating codes associated with the cases. The next meeting is on the 16th June. 12:35

Tony."

Now, you've mentioned about the forgotten stents and your triggering of the governance. Does that email that you have sent to Mr. Glackin indicate that you hadn't heard anything back, having put those issues into the system? 12:35

A. No, these particular two incidents I remember the stents and then, you know, Mr. Glackin emailing me to present those cases. I did remember presenting those cases in the urology governance meeting. 12:35

246 Q. And were they discussed at the governance meeting?

A. Yes, I presented those two cases in the governance

meeting, yes.

247 Q. So you were the one that presented the cases, the details that you had gathered. Had anyone else information on this particular issue and they brought that to that meeting? 12:35

A. No, particularly about only those two cases.

248 Q. Now, Mr. Glackin talks in his email about presenting them formally, which you did, and shared learning, and planned some action points. Do you recall what shared learning there might have been and what action points might have followed? Have you any recollection of that at this point? 12:36

A. I think there was discussion again, especially where my point was to maintain a stent registry. That's what I was emphasising on that. I'm not sure what exact action taken after that. Everyone agreed, yes, there should be a registry -- it is the responsibility of the individual surgeon who puts the stent in to keep a track. 12:36

249 Q. The subject matter of the email is "Stent Registry", that you have just mentioned. Do you recall if that was developed, if that was something that came into place as a result of you having identified that there were stents that hadn't been removed, but also that they hadn't been referenced in the discharge letter? 12:36

A. I don't recall the invitation of a stent registry, no. I mean this was brought up in a meeting, and everyone agreed, yes, there should be. But I don't recall a stent register was, you know, started at that time.

250 Q. Do you recall if there was any clarity at that meeting about who would take that forward? Who was to take that idea and make it a reality?

A. No, I don't recall particularly, yes.

251 Q. But your recollection is that it didn't happen or you don't remember it? 12:37

A. No, if it happened I would remember it, but probably it didn't happen, yes.

252 Q. Do you remember if any of those two cases progressed to an SAI? Do you remember any of that information? 12:37

A. No, I don't know the outcome of that, actually. I filed the incidents and I didn't get any feedback -- it is not just to I think going back, I think filed about five or six incidents, and I did not get any feedback of those - the outcome of this review. 12:38

253 Q. And in relation to you having identified it and reporting it as an incident in the first place, is it your understanding that then others would look at that and take a view as to whether it met the criteria for an SAI? 12:38

A. That's right, yes.

254 Q. And if that were to happen then perhaps someone would speak to you about it to get more facts?

A. That's right, yes. Exactly.

255 Q. And did anyone ever come to you to get more facts about that? 12:38

A. No.

256 Q. If you just give me a moment, Mr. Suresh, just I want to make sure...

A. Sorry. Sorry, my apologies.

MS. McMAHON: Chair, I think I've covered all of the main issues that I had marked for Mr. Suresh. Mr. Suresh, I have no further questions for you. The Panel may have some. Thank you. 12:39

CHAIR: Thank you very much, Mr. Suresh. I am going to hand you over first of all to Mr. Hanbury, who will have some questions for you.

QUESTIONED BY MR. HANBURY 12:39

MR. HANBURY: Thank you very much for your evidence so far, and your kind remarks about Lister Hospital. What took you to Craigavon initially?

A. Oh, it's a good question actually. I think maybe 2008 12:39 I was trying to expand my skills, especially on the lasers and PCNL, so I was exploring the options, and I was lucky to get sabbatical leave and got a job in Belfast as a locum consultant for nearly nine months I was there, and I very much liked Northern Ireland. 12:40 There's a lot of places like, you know, schools and very lovely people. So when I got, when I went into specialist registrar, I was looking for a substantial consultant post, so I was looking for a place where there would be grammar schools - that was my first 12:40 priority for my kids, because they are going to private schools there. So, Northern Ireland was my first choice. Of course I was looking for jobs that were open, and when it came up, yes. I had a good idea

before and so I liked it.

257 Q. Okay. So then why did you leave?

A. Again, for -- purely for family circumstances. Initially my kids at that time, my daughter was in A-level, and they're both medicine, and so she wanted to apply mainly for England. I thought she would chose Belfast, you know, city, but because of pressures she said "No, I want to go to England", and my wife also couldn't -- she was a lecturer here in the sixth form, and she couldn't get a suitable job in Northern Ireland, so it was mainly family circumstances. 12:41 12:41

258 Q. So moving back to urology a bit more. The case for Bicalutamide 50 when you presented that at the MDT, just tell us a little bit more about the conversation when that case was presented? Did Mr. O'Brien give an explanation for why the patient was on that particular dose or was there a debate, shall we say? 12:41

A. There was question about -- then everyone asked me "Are you sure he is just on monotherapy? It is not as a part of maximum antigen blockade? What's the background? What's the story?" Then I told, as far as I could go back on the record, there was only low risk prostate cancer, the PSA was in single digit, and the patient was not an LHRH analogue injections, but just purely on this monotherapy at 50mg. And so that's why bringing up the whole case here at MDT, that's how I presented it. And there was, again, the question of: "Are you sure not on LHRH analogue injections?" The discussion was about it mainly. And then the consensus 12:41 12:42

was, yes, the patient shouldn't be on this monotherapy, and they asked me "What did you tell the patient?", and I said "No, long discussion, and the patient choice is the patient want to see Mr. O'Brien before making any change in the plan."

259 Q. The Panel decision after you presented it was that the patient should not have been on that dose?

A. That's right.

260 Q. All right. Okay. Thank you. In your statement you said you kindly did some extra outpatients when we've heard about big backlogs, but you also comment in some of them there were no nurses or receptionists, was that just a one-off or was that a regular occurrence, because it is not easy doing clinics without support?

A. No, there are a lot of backlog and in the department meeting they said "Does anybody want to do clinics?", and I did offer a few weekends, but some of them had declined because of the no staff nurse or receptionist. So the clinic was cancelled, not accepted, because of lack of staff.

261 Q. Oh, I misunderstood then. So if that be the case the clinics would not go ahead?

A. That's right, yes.

262 Q. Okay. Thank you. In your statement there's a table of waiting times showing your waiting times for surgery were rather shorter than Mr. O'Brien particularly, but other urologists too. Did anything happen as a result of those figures? Was there any pooling of patients, such that patients waiting longer would be done in a

shorter timescale?

A. Only for the clinics there was a pooling. I can't recall extra theatres running at that time.

263 Q. Not so much extra theatres, it is sort of patients transferred from one consultant to another. Was that happening or did that not? 12:44

A. Probably not, maybe one or two patients, occasional patients, yes.

264 Q. Right. Okay. Thank you. You say you did a stone audit in 2014, but you didn't tell the details of that, but you did say it led to a change in practice. What was that? 12:44

A. I am sorry, Mr. Hanbury, I don't particularly recall. Sorry. I should have kept it on my folder.

265 Q. It was in one of your appraisals. Going back to the CT results and acting on results, you mentioned one case where the result of a CT, the radiologist suspected an underlying myeloma or haematological, and your comment when you saw that straight away would be "Happy to see the patient as an extra", obviously implying that you would see the patient very soon, but then the patient didn't actually come back for nine months or so. 12:44 12:45

A. That's right.

266 Q. Why do you think that happened? Where did the arrangements fall down? 12:45

A. That's, you know, I was really shocked like the patient took nearly nine months or one year to come to the clinic, and although I made a very clear note wanted to see the patient in the next two weeks, "Happy to see

you as an extra patient", so a the clear note was made, and looking back, now I got the feedback from just now, you know, and they said the human error happened. So, I don't know how it got overlooked.

267 Q. Okay. Thank you. Just a couple of things about the partial nephrectomy bleed. That was an open partial nephrectomy, the original case, was it? 12:46

A. That's right.

268 Q. Okay. Thank you. And when you went down and discussed the CT scan with the radiologist, there was a bit of fluid. Was that, and this is slightly technical and I am sorry, but was it an arterial phase CT, do you remember? 12:46

A. No, I don't think it was CT angiogram. It was CT abdomen. There is the thing which was looking at whether should I ask for CT angiogram at that point? We did have some discussion with the radiologists and they said "If there is no active bleeding it may not change anything, the patient is stable now, so shall we wait?", and that was the, you know, discussion we had. 12:46 12:47

269 Q. But --

A. -- looking --

270 Q. -- the angiogram wasn't offered, but you didn't push it either?

A. I should have pushed it, now looking back, yes. 12:47

271 Q. I mean would the radiologists have been in a position to do an embolization if the patient needed it? Did you have interventional radiology, I guess is my question?

A. Yeah. I don't think there was one at that point in Craigavon, if at all, the patient would have been taken to Belfast for that.

272 Q. You don't think there was an interventional radiologist who could have done an embolization? 12:47

A. Not that I could recall at that point, yes.

273 Q. Just obviously from a governance point of view...

A. Yes. Yeah.

274 Q. That's good backup for a unit that's doing partial nephrectomy. Okay. I'll ask others for that. Just in terms of your job plans. We have noticed that you had quite long waiting times for flexible cystoscopy, and I didn't see a flexibly cystoscopy list on your job plan. Do you remember doing -- 12:47

A. Yes. Yeah. I think cystoscopy was done by the registrars and other colleagues. I don't recall doing a dedicated flexible cystoscopy. Said that, it took us some extra weekend list or something, or doing -- but I'm not sure whether it was there in my regular job plan. I can't remember. 12:48

MR. HANBURY: Right. I think that's it. Thank you very much.

CHAIR: Thank you, Mr. Hanbury. Dr. Swart.

<u>QUESTIONED BY DR. SWART</u> 12:48

DR. SWART: I just want to ask you the antibiotic audit figures that was presented to you. On first reading it looks from those that there was a lot of non-compliance

with best practice. How was that actually handled in terms of the Department discussions? For example, did somebody from pharmacy come and talk to you about that? Did the microbiologists come down and talk to you? Was there a meeting? Was it taken further on a regular basis? Can you just give us a flavour? 12:49

A. Whenever this email came around about the report, we used to discuss in the department meeting like, you know, that's minors list like. There was a formal discussion why it was happening. So one point we, or at least I raised was, antibiotics usually prescribed by another team doing emergency admission and then, you know, we go and change it to make appropriate action, and to make it -- like everyone -- the discussion was that, yes, we all should be vigilant and adhere to the policy. And I think there was one meeting arranged with a microbiologist to come and give a talk. I'm not sure that, yeah, there was -- one microbiologist was supposed to come and give a talk about the local policy guidelines, yes. 12:49 12:50

275 Q. But not regularly. Did you have, for example, a regular report that would tell you are you getting better or worse, or to ask you for a formal reply to say "What are you doing about this?", because it doesn't look very acceptable just on first reading? 12:50

A. That's it.

276 Q. Did that happen?

A. Yeah. Sorry. Only information was given to us, so I thought it is the responsibility of the consultant to

look into and adhere to the policy.

277 Q. Yes. So you had a patient safety meeting with your colleagues, didn't you? I think it's changed it's name a bit over the years, but it was a place to discuss incidents and so on. If you take the stent issue, for example, was there an occasion where a series of stent incidents were brought to that meeting and somebody was given the job of putting in a new way of dealing with this? Did that happen as an individual item? 12:50

A. No, as far as I recall only these two cases I brought up. 12:51

278 Q. But you said you didn't get any feedback on them, so what I'm trying to say is did anybody bring them as a group to the meeting and say, "Dear urologists, we need a plan for this", did that happen? 12:51

A. During that governance meeting when we discussed about those two cases, everyone agreed, yes, there should -- we should make a stent register.

279 Q. But did somebody get the job card of sorting it out?

A. No. As far as I know, no. 12:51

280 Q. No. In those meetings generally was the tone of the meeting supportive, was it a meeting that ended up with a list of jobs for people to take on? What was the atmosphere of that meeting generally?

A. I remember Mr. Glackin sending out one email, I recollect it after going through the bundle, about the bullet points of actions taken, yes. 12:52

281 Q. But when you were sitting in the meeting, were you clear at the end of the meeting if you had a job to do?

A. No.

282 Q. Okay.

A. There's no individual delegation or no definite action plan.

283 Q. And did everybody come to the meetings? 12:52

A. I don't recall about the full attendance, but generally attended all the registrars, consultants. Everyone was supposed to attend the meeting.

284 Q. I know they were supposed to come, but was the attendance good or not? 12:52

A. I remember only a few meetings -- sorry, I can't say, from my memory. Yes.

285 Q. Okay. So there were some incidents discussed on occasion. What other regular items got a lot of air time at the safety meetings? What did you spend most 12:53 of your time talking about?

A. I'm sorry, in that governance meeting particularly?

286 Q. In the safety meetings. What took the most time? Was it complications of surgery?

A. Yeah. 12:53

287 Q. Was it audits? Was it other issues? Was it patient complaints? What took the most time?

A. Yeah. Yeah, I think mostly the morbidity and mortality. That was the main thing.

288 Q. So what morbidity things did you talk about? Give me 12:53 an example of something that you would talk about? Did you have specific information brought to the meeting about complications, for example, or did you just talk about the things you experienced yourself?

A. No, usually generally all morbidity send a list. For example, I can quote like the patient who had had the emergency nephrectomy, I think Mr. O'Brien was chairing that meeting, so he presented that case.

289 Q. So who brought the cases? Who identified the morbidity cases? Was it the consultants themselves? 12:53

A. Yes, and I think who was Chairing -- probably for say from Urology is Chairing, then I would have fed this information to "Oh, this patient to be presented" as a collective one. I don't think there was any specific record to maintain all the -- 12:54

290 Q. Okay. In terms of mortality, did you have, for example, a system whereby every death after elective surgery was talked about? Was what automatic?

A. I'm not sure how those mortalities were picked up. There should be some mortality register. 12:54

291 Q. And can you tell me what your view was of the amount of audit going on in the department at that time?

A. At that time -- but there are two things we need to talk about. One is quantity and quality. And quantity wise I don't think there was too many audits going on because there was already a shortage of registrars and consultants, there was a shortage of staff, and the two audits that I think I recall were, you know, good quality base audit one, there was about -- I mean we started the new clinic, there was an audit, which was a thorough robust one. So I would say, quantity wise there were not enough as expected for a big unit, the number of audits. 12:54 12:55

292 Q. Because quite a few people have told us there was not a big emphasis on audit, and was it your view that there wasn't time for audit and that people did a bit when they could? Is that what you're saying?

A. That's it, because the one is I would say lack of staff and lack of time -- 12:55

293 Q. And --

A. -- going on, yes.

294 Q. So you've worked in other hospitals as well as in Craigavon. How busy did you find the Department? Did you find it much busier than other places or did you find it about the same? 12:55

A. I would say busier on the number of catchment, because the wider catchment area, patient coming from different parts of the county. And, secondly, this advanced triaging was taking more time and more admin work. Yes, it was busier. Yes. 12:56

295 Q. In terms of clinical governance. You have talked about incidents, but not really about other aspects much in terms of audit, regular systems, and so on. What is your view about the duty of individual doctors to actually raise issues and act on them? Do you think that was emphasised at Craigavon or do you think the Department was overwhelmed with other things? 12:56

A. I would say this is part of a mandatory part of any clinician like to -- the audit and looking back, what's happening, incident report. 12:56

296 Q. But how much emphasis was there? Was that really pushed or were you all overwhelmed?

A. Maybe I don't think anyone needs to be pushed to do that, because it should happen automatically. But I don't know the system whether how much the incident report --

297 Q. So when you came, for example, did you have a whole session as part of your induction on how to deal with serious incidents, or how the incident process worked at Craigavon? Was that explained to you? 12:57

A. No. No, there was no proper induction, but I picked it up as work along. 12:57

298 Q. Was there a regular learning from serious incidents throughout the hospital? Did you have any part in those events?

A. That was my main emphasise. Like I myself reported a few incidents. 12:58

299 Q. Yeah.

A. I didn't get any feedback on those. So the wider circulation I feel that any lessons learnt from anything should be circulated to all, those 11 team, not just only to the particular consultant or clinician or staff. 12:58

300 Q. So you didn't get personal learning, but also you weren't aware of general learning activities made available to you?

A. That's right, yes. 12:58

301 Q. Okay. In terms of planning for Urology, you have a very busy department here, lots of issues which we've heard about. How much time was the departmental meeting able to allocate to considering solutions for

long-term planning in Urology? Were there sessions set aside for that so you could contribute to the future?

A. Yes. The one important meeting I would say the most important meetings happening in Craigavon was the weekly department meeting where we could bring up all issues, and also there was, you know, Martina Corrigan was regularly there and she used to present, like you know, these are the waiting lists, backlog, backlog. And so action plan was discussed every time. 12:58

302 Q. But what was the long-term plan? Were you allowed to contribute to what the long-term plans for the hospital were? I mean I know you discussed waiting lists. So what ideas did you come up in those meetings, for example, in terms of improving things for the future? 12:59

A. Yeah, there was -- about to do one, because I think -- just we went back on holiday and we came back, and then there were was supposed to be a meeting within the next couple of days, so I sent my presentations, like you know, starting from every aspect, how could we speed up the process of the -- every clinic, Outpatients, for endoscopies, or datas, and each category, I just came up with some action plan and I presented it in the departmental meeting. But, of course, you know, it would not just happen overnight in the Department. It needed input of wider -- 12:59 13:00

303 Q. Yes, that's what I'm talking about, the bigger picture.

A. Yeah.

DR. SWART: Thank you.

QUESTIONED BY THE CHAIR

CHAIR: Thank you, Dr. Swart. Thank you, Mr. Suresh. Just in regards to the incident in 2015. If I have understood you correctly, you say there were two 13:00
parallel processes. Mr. O'Brien reported that to the patient safety meeting, or the morbidity and mortality meeting I think as it was probably then called, and as a result of him doing that, you also, I take it, were quite shaken by the fact that you were on-call this 13:00
night and this had happened on your watch, as it were. So you sought help yourself. So there were two parallel -- Mr. O'Brien reporting it to this meeting, obviously it was a serious incident for the patient, and you seeking to improve your skills and seek 13:00
training and to gain confidence, and this whole action plan then was put in place around you, and you felt, as you've said, supported by that. Have I got that right? Have I got the actual mechanism correct? It was a two-pronged attack, as it were? You felt the need to 13:01
get help, and you asked for it, and your colleagues recognised that you needed help and they provided it. Would that be a fair summation of what happened?

A. That's it exactly, yes.

CHAIR: Okay. Thank you, Mr. Suresh. I have nothing 13:01
further. But I think Ms. McMahon might have one or two questions still.

FURTHER QUESTIONED BY MS. McMAHON

MS. MCMAHON: I just want to just clarify a further point. We've heard that you did work with Mr. O'Brien in the theatre on the night of the incident that the Chair has just referred to. Did you have other experience of working in the operating theatre with Mr. O'Brien? 13:01

A. Yes, particularly after that incident like I want to have experience with open surgeons, so I attended maybe two or three. I don't recall how many, but, yes, at least two, three. Yes, I remember operating with him. Yes. 13:02

304 Q. What was your view of Mr. O'Brien's surgical competence?

A. He was a very meticulous surgeon with good surgical hands. 13:02

305 Q. I'm sorry I didn't hear the answer?

A. I'm sorry. Very meticulous surgeon with very good surgical hands. Yes.

306 Q. Did you consider him to be an excessively slow surgeon? 13:02

A. I saw only a few, but that could be a bit subjective in its lower force, but for that case it took the appropriate time. It was not too lengthy or anything.

307 Q. And in your experience how did he communicate with other personnel in the theatre? 13:02

A. Oh, he had excellent communication skills. Always, you know, friendly.

308 Q. Now the Inquiry have heard evidence from Ms. Gishkori alleging that there was -- Mr. O'Brien created havoc in

theatre. Was that your experience at all?

A. Not with my limited experience, no.

MS. McMAHON: I have no further questions. Thank you.

CHAIR: I think actually in fairness to Ms. Gishkori, her evidence was that it was the theatre lists rather than actually in theatre. 13:03

MS. MCMAHON: Yes. No, I should clarify that, it was theatre lists. So put that on the record. But thank you.

CHAIR: Thank you. Well what concludes today's sitting then, Ms. McMahon? I think we're due to resume with Mr. Glackin tomorrow morning at 10:00 o'clock. Thank you, Mr. Suresh. Thank you everyone. See you tomorrow. 13:03

13:03

THE HEARING ADJOURNED UNTIL 10:00 A.M. ON THURSDAY, 19TH OCTOBER 2023