Urology Services Inquiry

Oral Hearing

Day 72 – Thursday, 16th November 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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CHAIR: Good morning, everyone. Mr. Wolfe.

ROGER KIRBY, HAVING PREVIOUSLY BEEN SWORN, CONTINUED TO BE EXAMINED BY MR. WOLFE KC:

10:01

MR. WOLFE KC: Good morning, Prof. Kirby. You are hearing us loud and clear?

A. Loud and clear.

1 Q. Perfect.

10:01

Speaking to Mr. Boyle, senior counsel instructed by Tughans, who you will know well, he tells me you have both a hard copy of the bundle and a computer by your side so that you can navigate to the document pages that I'm going to refer to you. When I bring a page up here, I will also give you a reference for your bundle so that you can find it, whether in the hard copy or electronically.

10:01

This morning we're going to look at some of the themes of concern that emerged from the nine Serious Adverse Incident reviews that you examined. I'm conscious that you told us yesterday when you looked at those nine SAIs and you wrote your reports, you were seeking to try to get an understanding of how Mr. O'Brien was working and, as it appears from your reports, very few criticisms of his approach. Generally, your finding is his approach was, you use a phrase "not inappropriate" or "not unreasonable by the standards of a reasonable

10:02

10:02

competent doctor or clinician".

When you wrote your reports, you probably would have been unaware of a broader context. What I mean by that is that in more recent times, the Inquiry will have introduced you to a lot of background material which showed that Mr. O'Brien and his clinical practice and his relationship with the Trust, his employer, was in some degrees of difficulty going back a number of years. Did you pick up on that from your reading? 10:03

A. I did. Yes, I did.

2 Q. Before we descend into some of the finer detail of the themes, did you reach, if you like, a general conclusion or overview of the man, the clinician, that you were, I suppose, writing about in your medical reports? 10:04

A. Well, yes, I did. With the benefit of all the extra information, it was clear that Mr. O'Brien has never been what you could describe as a "mainstream" urologist. He has an unusual approach to urology in some ways, "idiosyncratic" might be a better word to describe that. Also I was able, having read nearly 2,000 pages of evidence over a period of time, he was working in an extremely difficult situation. You know, I think he's one of -- I described to you when we spoke a few days ago that he's a slightly old-fashioned urologist, of the ilk of some of my own teachers way back when, very famous urologists who were also somewhat idiosyncratic in their approach. Very 10:04 10:05

distinguished in their own way but they like to do things in their own way, and perhaps not as collaborative with their colleagues, and certainly not with managers as perhaps nowadays is expected.

10:05

In addition to that, I would say that obviously urology in Northern Ireland is under tremendous pressure. The waiting list is expanding and you could go right back to the years of austerity, George Osborne and David Cameron - our new foreign secretary (reestablished) - 10:06
have lead to increasing pressures on the health service, especially in Northern Ireland perhaps, where you have a large number of quite small hospitals serving a population. There are arguments for rationalisation of the whole set-up there. 10:06

Plus, I think, more specifically to Aidan O'Brien's position, the absence of colleagues specialising in oncology, radiology and pathology in the MDT meetings made some of the decisions he made more difficult. It 10:06
would have been very helpful to have had that extra expertise. When managing some of these elderly, frail, highly symptomatic patients, they are not easy to manage and there isn't one way that is clear that they should be managed. 10:07

I would add in one extra point about MDTs. The disadvantage I always found about MDTs -- and they were established in Aidan's practice in 2010, I think -- the

problem with them is they don't have any input from the patient or from the patient's family. So an MDT can say, well, listen, I think this patient should be treated with hormones and radiotherapy, but you might say that to the clinician then who carries the responsibility, legal responsibility, for the management of that case, who might say to the patient, "This is what the MDT recommends and that means going into Belfast every day for six weeks to have -- every weekday for six weeks to get your treatment", and the patient says, "I don't want to do that. That's not what I want and that's not what my family want". 10:07 10:07

So I don't think that MDT recommendations should be regarded as mandatory. They are -- 10:08

3 Q. Sorry to cut across you, Prof. Kirby, we'll come to that as a theme in a moment. What I want to perhaps focus on, and I'm not sure you intend it entirely as a criticism, but when you describe Mr. O'Brien as idiosyncratic and likening him to your old respected teachers growing up in the profession, how did you see that reflected in the practices that you read about? 10:08

A. I think that obviously one of the key points is the use of Bicalutamide or Casodex as a hormonal therapy, that is a little bit idiosyncratic but I think justifiable; it does have activity in prostate cancer. I think you can see that ideally a urologist should have a good relationship with a radiotherapist because quite a lot of these patients need shared care, partly urology to 10:08

deal with the surgical aspects, and radiotherapy, especially in prostate cancer, which is one of my special interests. So, a good collaborative arrangement with a radiotherapist in the MDT so the patient can be passed seamlessly from one to the other would have been a good advantage. Obviously, that wasn't happening in Aidan's case. 10:09

I would say that then, you know, increasingly we're using oncology, medical oncology, as in one of the cases that we looked at, the patient with the seminoma. So, you would ideally like a medical oncologist, a radiation oncologist in that MDT so there can be a sort of seamless passing of patient from one specialty to the other, rather than -- 10:09 10:10

4 Q. Sticking -- sorry, Prof. Kirby -- with what you described as idiosyncrasy. One is his Bicalutamide use, and we'll look at that in some detail this morning. You described it as "justifiable" so we'll look at why it is justifiable. 10:10

A. Yes.

5 Q. You point out that he was perhaps shorn of good relationships within the MDT, which are important for, if you like, building the quality of the response for the patient. What about nursing; did you pick up on that? 10:10

A. Yes, I did. In an ideal situation, you would like not only a relationship with the clinicians I've already mentioned, of the specialities I mentioned, but also

a good relationship with the senior nurse practitioners, the nurse specialists, who can be very helpful in the ongoing management of patients with cancer particularly, and with stones. I think Mr. O'Brien obviously preferred to work, you know, more in isolation than perhaps was ideal and he didn't employ the help of the specialist nurses quite as well as he might have done. I think it would have helped the patients. It would have helped him, actually. 10:11

6 Q. It is no doubt very difficult, to coin a phrase, to teach an old dog new tricks, if that's the sense of what you're communicating -- 10:11

A. Yes.

7 Q. -- about him in terms of the use of the word "idiosyncratic". Is there a responsibility on the part of clinicians to move with the times to try to embrace new practices and new ways of doing things? 10:11

A. I think, yes, ideally that's what should happen. I think the key relationship in urological surgery is the consultant surgeon and the patient. I think that there is a sort of tryst between the patient and the urologist. When things go wrong, it is the urologist that gets criticised. I think over the passage of time we've seen more and more people deployed into the team who facilitate - the nurses, the radiologists, the radiotherapists, medical oncologists, etcetera - but the key relationship is that urologist with the patient. Some more senior urologists have been understandably reluctant to let go of their own special 10:12 10:12

management of the patient; they feel uneasy about delegating their care to nurses who may have a slightly different view. You know, there's a sense of wanting to keep the patient to yourself because you're the one who carries the can, really. So I do understand where Aidan is coming from, but I don't think it helped his practice.

8 Q. Yes. I mean that sense that you've picked up on of keeping ownership of the patient, would you regard that, certainly in 21st Century urological medicine, as a bit of a blind spot? 10:13

A. It probably is, yes. I think what we've seen is the development of all sorts of individual specialties within urology - stones, cancer. I mean, in my case I only looked at prostate cancer patients in the last five/10 years in my practice. You do need the assistance of other people because you no longer have the necessary knowledge. You can understand why some people feel reluctant to delegate or to hand over the ownership of the patient. I think that's what happened in Aidan's case. 10:14

9 Q. Yes. You will also have picked up on the conflict between him and his employer, which is, I suppose, manifested in a number of processes, including the MHPS investigation from 2017. I think we briefed you with Dr. Chada's report, and you may have seen his response to that? 10:14

A. Yes.

10 Q. You yourself were a medical director in the private

facility we briefly mentioned yesterday obviously Mr. O'Brien was working in a public district general hospital. Have you anything to offer us in terms of your experience of dealing with matters, perhaps of clinicians in difficulty or problems with clinicians, wearing your medical director's hat?

A. Yes. Well, we had about 26 employees in the prostate centre, so nothing like the number of employees in a district general hospital. I was Medical Director. Yes, we did have some disagreements there but, you know, the personal relationships between all of us that worked there, of all the different disciplines required to treat patients with prostate cancer predominantly but also benign enlargement of the prostate, yes, I have experience of that and I can see that Mr. O'Brien did get into conflict with the management of the Trust. I think a lot of his energies were devoted to those sort of struggles with them and probably that was, you know, of emotional detriment to him and possibly affected the way that he managed his practice.

11 Q. We'll come this afternoon perhaps to look at, for example, triage and some of those other issues. We'll maybe ask you to expand on your thoughts at that point.

Let's spend some time now looking at the whole concept of multidisciplinary working and the principles and practices that you think are apt to apply to that approach to medicine. You've said already Mr. O'Brien

was something of an individualist, liked to own his cases, but it should be put in the balance that he was an active participant in the multidisciplinary urology meeting at the Southern Trust. He was its long-time chairperson until the chairing role began to be rotated.

Let's perhaps start. If I can ask you to find within your bundle page 1389, and if we can have up on the screen here WIT-84532. What you should find, Prof. Kirby, at 1389 is the urology cancer MDT operational policy. 10:17 10:18

A. Yes.

12 Q. Okay. It's the policy that, if you like, governed the operations of that MDT. That's the covering page. 10:18

If we can scroll through it to the third page in the document; 1392 for you, 84535 for us. You can see that the purpose of the MDT is there set out. Just perhaps familiarise yourself with that. It probably provides some uncontroversial descriptors of what an MDT generally is directed towards. There's a list of bullet points at the bottom of the page. 10:19

A. Yes.

13 Q. You can probably see within that that the emphasis is very much towards the team, towards multidisciplinary discussion and decision-making with multidisciplinary input. You'll be familiar with those principles. You had an MDT within your NHS sector practice as well as 10:19

your private sector practice; is that right?

A. Yes, at St George's. Yes, MDTs were established about 2010, towards the end of the Tony Blair era of government where he encouraged that. They also introduced a number of targets, which were slightly resented by some of the profession; not everyone agreed with the MDT. I think they have been very successful, but they do depend on the interpersonal relations of the people in the MDT, which is a lot easier to control in a private set-up in the prostate centre where you can choose who you work with, who is included and who isn't included. In an NHS system, people are parachuted in there. 10:20 10:20

I think in Northern Ireland it is especially difficult because there are so many different units that people have to travel from one to another to get together. Back in the days where some of these cases that we're looking at, you know, we didn't have Zoom. Things have been a whole lot easier since COVID and the development of virtual MDTs. In 2018/2019 they weren't possible, they all had to be in person. 10:20 10:21

14 Q. If we just look to the top of that page. I'm trying to get, I suppose, the essence of the purpose of an MDT. It says that the primary aim of the MDT is to ensure equal access to diagnosis and treatment for all patients in the agreed catchment area. It goes on to say: 10:21

"We aim to provide a high standard of care for all patients, efficient and accurate diagnosis, treatment, and ensuring continuity of care. It ensures a" -- I think this is important, perhaps -- "a formal mechanism for multidisciplinary input into treatment, planning and ongoing management and care of patients".

It is very much focused, is it not, on bringing experts together who are from different fields? You mentioned oncology, medical and clinical; obviously the diagnostic people, the urologists themselves and the nurses. In terms of the role of the MDT, it's to look after the patient throughout the process, isn't it, the process of treatment? 10:22

A. Well, that would be ideal but the reality is that most MDTs are deployed at the initiation of treatment because most cases are brought to the MDT at time of diagnosis. The ongoing treatment, because you have so many patients who have ongoing treatment and whose treatment will vary according to the progression of their disease, that, you know, the MDT would be absolutely overloaded with cases if it tried to -- in an ideal world, that's what you'd like, you want every patient to be monitored at every phase of their treatment. The reality is that MDTs focus on the initial diagnosis and the initial management, the decision between using radiotherapy or surgery, for example in prostate cancer; do you remove the prostate or do you irradiate the prostate or do you give 10:23 10:23

chemotherapy to the patient, etcetera, etcetera, etcetera. Once that decision is made, then the patient tends to go down that route without necessarily being referred to the MDT, unless a specific problem arises. If a specific problem arises and there's debate about the right thing to do, then they will be brought back. But you just couldn't manage. You couldn't have any one time -- even at the Prostate Centre, which is not as busy as NHS clinics, we'd have thousands of patients undergoing ongoing management at any one time; you couldn't possibly bring them all back. 10:24 10:24

15 Q. I suppose this provides a more specific definition of the circumstances in which a case should come back. If you go to 1395 in your bundle and we'll go to WIT-84538. It's asking the question -- if we just scroll down towards the middle of the page. It's the middle of the page for you, Prof. Kirby, roughly. 10:25

A. Right.

16 Q. "All new cases of urological cancer and those following urological biopsy will be discussed. Patients with disease progression or treatment-related complications will also be discussed and a treatment plan agreed. Patient's holistic needs will be taken into account as part of the multidisciplinary discussion." 10:25

10:25

I needn't read on. It is identifying, I suppose, two broad areas where the patient should come back or the case should come back to MDM - if there's disease progression or if there are treatment-related

complications. Is that the norm, in your experience?
A. Yes, although it wouldn't include every patient. I think you have to use your common sense in this respect. You know, there's a spectrum of cancers, some of which are more series and life-threatening than others. Bladder cancer is a good example of tiny little papillary tumours within the bladder which can be removed safely without any other treatment. You might see that patient again several times with more little tumours being there but you wouldn't necessarily need to discuss those. But, I mean, a good example of a patient coming back to the MDT would be a patient who had his prostate removed, the PSA remains undetectable for a number of years and suddenly it spikes up and those patients then usually go on to a course of secondary radiotherapy to the prostate bed, that would be the standard, with hormone manipulation as well. So that patient would be brought back to the MDT. 10:26 10:26 10:26

Take another example, a patient with kidney cancer. The kidney is removed, the patient seems to be doing well for a number of years and suddenly, on the chest Xray or CTs, you see a number of metastases appearing, you would have to bring the patient back to the MDT with a view to getting a medical oncologist involved because now there are new treatments that can help patients with recurrent kidney cancer, a situation that wasn't the case only a few years ago. Now we have new treatments coming on board. 10:27 10:27

17 Q. I see. Can I add another piece into the mix? It is the evidence of Dr. Hughes, who oversaw the nine SAIs that you were concerned to look at. He, in partnership with Hugh Gilbert, Mr. Hugh Gilbert -- Gilbert being the urologist, of course -- were responsible for the SAIs that you commented upon. Dr. Hughes, page 683 of your bundle, if we go to TRA-01060. 10:28

A. Yes, right. Getting there.

18 Q. Just at the bottom of the page. He's saying there is a requirement, if you don't implement an MDT recommendation, that you would bring it back to your colleagues and discuss it, and agree how that would be achieved. That's not terrible well expressed, but how treatment would be achieved, I suppose. 10:28

Do you agree with that, that if you leave the MDT with a recommendation under your arm, you review that with the patient and you discover something about the patient that might make the recommendation unimplementable or the patient disagrees with the MDT approach, that comes back to the MDT, does it? 10:29

A. Well, in an ideal world. I think you have to remember that MDTs are already terribly busy. If minor fluctuations or variations on what the clinician decides to do with that particular patient and what the MDTs recommended, if you brought them all back, you'd just would be -- the whole system would be overloaded. I think if there's a major change, then it probably should be brought back, but I don't think it is 10:29

a necessary stipulation that happens in every case.

19 Q. Yes. I suppose if we approach the problem in this way: The essence of the MDT is to get the multidisciplinary input up and running?

A. Yes. 10:30

20 Q. And to have that, I suppose best-available quality care from different perspectives, perhaps different perspectives even within the domain of urology, even leaving aside the other disciplines that come to the meeting. That's why it's important to bring the case 10:30 back, isn't it?

A. Yes, I think I would agree with that. I imagine, I don't know, but in my position as President of the Royal Society of Medicine, I have to deal now with 55 different sections, 55 different specialities. There 10:31 are some specialities where there would be more debate about individual cases; you know, where they would be sometimes quite heated debates about what should be done. I know this firsthand because I've just had my knee operated on, and the orthopaedic surgeons fight 10:31 like billy-o whether somebody should have a partial knee replacement or a total knee replacement. They are at war with each other about this. So, you can imagine an MDT of orthopaedic surgeons having a huge battle about an individual case, which is the best way to do 10:31 it.

It isn't always entirely clear which is the best way to manage a specific condition, and then you add in all

the added uncertainty of the patient and the patient's family who says, well, the MDT is telling me I ought to have this done but I don't want to have it done; I don't want to travel, I don't like the idea of chemotherapy, I'm too old. Many of these patients that we looked at with Aidan where in their late 80s. It's quite justifiable. In fact, Christopher Witty wrote in the BMJ only a couple of weeks ago that we should be looking at quality of a patient's life, not necessarily their longevity. I think the drawback of an MDT is it looks at how can we keep the patient alive for longer, but it's a perfectly legitimate point of view of the patient to say I don't want to be kept alive longer, I've got a catheter in, I've got all these symptoms, I'm in my late 80s, just leave me in peace and I don't want -- I'm not going to have what the MDT is recommended, I just don't want it. 10:32 10:32 10:32

That's not an uncommon scenario in urology where a lot of our patients are elderly and quality of life, you know, rather than length of life can be more important to them. 10:33

21 Q. I want to look briefly at a couple of the cases that you have helpfully scrutinised from the SAIs.
I wonder, in thinking about the cases again as we go through them, whether you would recognise that there was any omission to properly refer these cases back to the MDM. 10:33

Let me start with Service User A or Patient 1. You'll perhaps remember that case, it was perhaps alluded to it earlier. This is a patient who wanted to travel, wanted to go on holiday. That was, I suppose, a factual feature of it according to Mr. O'Brien's account of the case.

A. Yes.

22 Q. Now, just to orientate you -- you may be very happy in your memory of the facts -- but if we go to your page 4, and we'll going to page DOH-00004. 10:34

In essence, if I can summarise it in this way: This was a prostate cancer case?

A. Yes.

23 Q. Intermediate, confined, Gleason 7. The recommendation that came out of the monthly disciplinary meeting on 31st October was it's described there as a recommendation for ADT and referral for external beam radiation therapy? 10:34

A. Yes. 10:35

24 Q. Mr. O'Brien has explained that was ultimately difficult to implement. He points to the fact this was a patient who didn't want disturbed in terms of his health while he went on holiday. Then, he felt the need to start him on 50mg of Bicalutamide because the patient had run into difficulty when on 150, the larger dose, some months earlier. So, it is only by March 2020 that the patient is put on to the higher dose of 150. 10:35

A. Yes.

25 Q. There has been no referral to oncology for EBRT. In the month of March, the patient runs into difficulty. There is an increased PSA and there is urinary retention requiring catheterisation.

A. Yes. 10:36

26 Q. That is the kind of case classically, is it not, that should go back to the MDT for either/or both of those reasons. Either because Mr. O'Brien couldn't implement the MDT recommendation and/or the patient's disease had clearly progressed? 10:37

A. Yes, not only his disease had progressed but his symptoms. Memorably, his holiday was in Lake Garda, if I remember the case, an extremely nice place and so you can remember why he didn't want to start treatment that would have interrupted that, having paid for it all and 10:37 looking forward to it.

Secondly, the urinary symptoms is a big, big problem with elderly patients with prostate disease. Ideally you would want them to have the chance of cure with 10:37 a six-week course of radiotherapy. Radiotherapy makes urinary symptoms worse. The radiotherapists, at least the radiotherapists that I work with in London, excellent radiotherapists and wonderful people, they really do not like treating patients who already have 10:38 persisting severe urinary symptoms as the radiotherapy makes it worse. If the patient does, as in this case, develop retention of urine and requiring coming in as an emergency and having a catheter in, then the

radiotherapist thinks oh my goodness, I'm going to be blamed for this. They're going to think it is the radiotherapy rather than the prostate disease causing the retention. In our case, we used to operate to relieve the obstruction before they'd even consider the radiotherapy. So, I think even if Mr. O'Brien had referred this patient to Belfast for radiotherapy, the radiotherapist probably would have said, well, we can't treat this patient at the moment, he is passing urine so frequently and we can tell he's going to go into urinary retention soon. 10:38 10:39

27 Q. Sorry, we'll come to referral issues as perhaps a separate theme later. What I'm focused on here is there are, Mr. O'Brien says, good reasons why I can't implement the MDT recommendation; what I'm able to offer the patient is not ADT, it is 50mg Bicalutamide, and that's clearly not what the MDT intended. Surely that kind of case has to go back? 10:39

A. Well, in an ideal world, yes, I would agree with you, but we don't live in an ideal world and the MDTs are already so busy that every variation on what's been advised by the MDT compared with what actually happens to the patient, if you brought them all back, the MDT would be overwhelmed. I think in this specific case, as you say, it is quite a major departure from the recommendation. So yes, another urologist probably would have brought that back. Mr. O'Brien, I think, likes to do things his own way so he chose not to. 10:39 10:40

28 Q. Yes. Equally, come March, when plainly localised

disease is getting worse and there's perhaps a suspicion, or perhaps ought to have been a suspicion of metastatic disease at that point, he is having to be catheterised, again that needs, rather than uni-disciplinary approach, "Well, I'll just manage this" -- which appears to be Mr. O'Brien's thinking -- that should go back to his colleagues to say, right, what have we got here, what are the alternatives, we see he hasn't gone to radiotherapy, we see that you haven't started him on ADT or it's been a slow burn to reach 150mg; again, classically a case that should go back? 10:40 10:41

A. Yes, I would agree. Ideally this case should have been brought back, yes.

29 Q. As I proceed through today, I'm not going to bring you to every case where there's perhaps an argument that the case could go back. I think the issues may be important on a general level. It reflects, perhaps, an approach to medicine that, I think as you indicated at the start, is not ideal and perhaps now frowned upon in terms of particularly urology; that's our focus, but perhaps more generally. Clinicians, in order to offer their patient the best quality of treatment, need to relinquish ownership of the cases and follow, if you like, the rules of the MDT? 10:41 10:42 10:42

A. Yes. I'm not sure "rules" is quite -- I think "advice" is a better word for MDTs. But yes, collaborative working clearly is preferable to working in isolation, especially these days where the complexity of the

treatments that we can offer patients is increasing. But, on the other hand, you know, a sort of counter view is that the patients, especially in urology that we look after, are getting older and more frail. It is not unusual now to look after patients over the age of 10:43
100 years. You will often find that what the MDT, in the absence of the patient or the patient's family, will offer standard therapy when, in reality, you need to tailor that treatment to what this patient, individual patient, needs, and the individual clinician 10:43
who takes overall responsibility for that patient, the urologist who is going to be sued when the patient puts in a claim of negligence, it wouldn't be the nurse and it wouldn't usually be or the radiotherapist, the radiologist or the pathologist, it is the consultant 10:44
surgeon, urologist.

So you have to have flexibility between MDT advice, which is often regarded as best practice, and then you need clinical freedom to make the right decision for 10:44
the right patient and then take medicolegal responsibility for that. So, you have to defend what you've done. If what you've done is counter to what the MDTs has advised, then you are taking an individual risk for yourself if you do that. There are plenty of 10:44
situations where the sensible thing to do is not do what the MDT says but to do what the patient would like.

30 Q. Yes. Just at a tangent to that, you will have seen in

the cases, and beyond that the nine cases -- and we'll come back and look at Bicalutamide in more specificity later but just this discrete point -- you will have observed the tendency of Mr. Mr. O'Brien to use 50mg as a preferred dose?

A. Yes.

31 Q. Quite often we have will have seen that that may have been the approach, notwithstanding the recommendation of the MDT for either expressed as LHRHa or sometimes expressed in their recommendation as ADT. If Mr. O'Brien at the MDT realises he's dealing with a frail patient, an elderly patient, and he is going to leave the room, go to that patient and prescribe 50mg of Bicalutamide, that should be on the table at the MDT and open for discussion, should it?

A. Yes, it should. I think in one of the cases -- I can't remember which one -- it was discussed and nobody raised any objections to it. I forgot which case it was now.

32 Q. I think you make that point in relation to this case, Service User A where -- let me remind you, and I think I've got this right -- patient starts on 150?

A. Yes.

33 Q. I think after MRI but before the bone scan. Then runs into difficulty, hot flushes impacting on his drive and Mr. O'Brien takes him off the Bicalutamide and plans to start him on 1st November 2019 at 50. The MDT happens on 31st October, the day before he planned to restart him on 50. You're right to say that there doesn't

appear to be any adverse comment about the plan to start him on the 50 the next day. But the recommendation from that MDT was to commence on ADT?

A. Yes.

34 Q. So it may well not have been, I suppose, terribly important to say to Mr. O'Brien why do you plan to start him on 50 the next day when, in fact, the plan coming out of the MDT was essentially, I suppose, he had the option, he had the option of LHRHa or starting the dose at 150 to comply with the recommendation? 10:47 10:48

A. Yes. I mean, I'm sure we're going to come on to this when we talk about Bicalutamide and its dosage. Remember, ADT really is castration therapy. In the old days when I first started urology, castration therapy meant literally removing both testicles. So you'd say to a patient, listen, I think your prostate cancer is advancing, we're going to have to remove both your testicles. Now, that's not an easy discussion to have. Then, the LHRH analogues came along; Zoladex was the first one produced by AstraZeneca. That is just a chemical way of castrating patients. I remember the conference that I went to when they were introduced, it is much easier to say we're going to give you this treatment on a monthly or three-monthly basis, and you kind of avoid the word "castration". Then, Bicalutamide came along, which was just a gentler form of castration, it blocks the receptors rather than removing all the testosterone. So it had a different side-effect profile which was more favourable for the 10:48 10:49 10:49

patients, less hot flushes. Sometimes you have severe psychological issues surrounding castration therapy, the patient's life is changed, the masculinity is gone, hot flushes; they sometimes get a change in their whole body, a feminising effect. These are not easy decisions to make. 10:49

I think Mr. O'Brien, from reading these cases and the rest of it, was clearly in favour of using a gentler form of ADT, a gentler form of castration therapy, if you like. That clouded his judgment in certain cases but that influenced his decision, is a better way of putting it. He was trying to help the patients. This was not a deliberate act of sort of medical sabotage; it was the opposite. He was trying to be kind to his patients and use a gentler form of therapy. I think there's a good rationale in some of the cases we looked at. 10:50 10:50

35 Q. I'll not cross swords with you on that at this point. We'll come back to that. We have digressed slightly. 10:50

Let me go to the point, and I think you've made it a couple of times, MDT is a recommendation. It usually is, as you say, best practice, but it may not suit the patient -- 10:50

A. Yes.

36 Q. -- or at the review the clinician, in this case Mr. O'Brien, might say, well, I've heard from the patient, I think I'll explain the advice in a different

way or take a different approach.

Can you tell me this: When there is a departure, for whatever reason, from the MDT recommendation, should that be recorded? 10:51

A. Ideally, yes, along with a plan. Ideally what you'd like to do is to record the plan of management. The MDT advice/recommendation would be not mandatory in my view but it would be another piece of the jigsaw. You'd say, well, this is the jigsaw, we have the MD 10:51 advice for radiotherapy and ADT, the patient has severe urinary symptoms, wants to go off to Lake Garda for his holiday; his wife says, you're kidding, you want to not only castrate my husband but you want to give him six weeks of radiotherapy, which he has to travel to 10:52 Belfast through the traffic to get there for six weeks, when he's already having to get out of the car every 25 minutes to pass urine, on the verge of retention. Then what I would have done is I would have said, listen, we have A, B, C, and D; MDT advice is taken, 10:52 I accept that that's the advice but I'm going to deviate because this is the best way, in my view, that the patient should be managed. I'd record that in the notes and then I'd be prepared to stand up in court and defend that on the basis of all the information. 10:52

The MDT is part of the overall scene but it's not everything and it's certainly not mandatory.

37 Q. Assumedly there's an obligation to do your best to

explain the MDT's thinking to your patient?

A. Yes.

38 Q. In other words, in that case they're recommending ADT and referral for radical radiotherapy with curative intent, and any delay to progressing that recommendation places you at risk? 10:53

A. Yes, I think you should say that. Then the patient might say, well, not only do I not want to go because of the travel, because of my holiday, because of the castration, but I actually put my trust in you, Mr. O'Brien, you're my doctor, now you're telling me I have to go all the way into Belfast and another doctor is going to look after me? I don't want that, I trust you. 10:53

One does form, particularly with these elderly patients, a sort of bond. That is sometimes hard to break and sometimes the patient does not want to break that bond. 10:53

39 Q. We'll move on. 10:54

The issue of quorum looms large in not only these cases but in the history of this MDM; regularly inquorate, struggling to get oncology to attend, even remotely; less of a problem but a regular problem with radiography attendance. Could you help us generally understand the significance of having that kind of gap at your MDT? Is it something you've experienced? 10:54

A. No. I think at the Prostate Centre we have a weekly

MDT and we would always would manage to be quorate. Private medicine is different; less caseload and the doctors are more incentivised to attend for financial reasons. Also, we were a close-knit group of friends so MDTs were fun; fascinating discussions with nice people we all got on with. Also nice in patients to look after as well, I should say.

So not having the radiologist who has detected the metastases in the spine, for example, and can highlight that, the pathologist who looked at the Gleason score of the biopsy, and a radiologist might also help on whether or not it is feasible to biopsy a kidney tumour; then surgeons to discuss, you know radical prostatectomy or nephrectomy; radiotherapists who say no, no, this patient is not suitable for surgery so I think radiotherapy is the best way. Then a medical oncologist who would advise about Carboplatin in the case of seminoma, or other very innovative oncological treatments that are changing week by week almost these days with immunotherapies coming on board. So you can see ideally that's the ideal set-up. This was not the case in Aidan's hospital.

40 Q. One of the cases that you pick out -- or one of the points you make, I should say, when reviewing the cases -- was that, I suppose, the gap in oncology attendance sometimes affected decision-making or weakened decision-making. One case in particular maybe can have your comments on. It was the testicular

disease case. It was Patient 2 or Service User E.

If you go to your bundle at page 65 and we go to DOH-00086. If you go to 65, we get a bit of the description of the events as a reminder. Mr. O'Brien is Dr. 1. He planned to have the case discussed at urology MDM on 18th July but there was a histology delay, I think, so it was discussed on 25th July, with the recommendation that Mr. O'Brien would review in Outpatients and then refer to the regional testicular cancer oncology service. The review with the patient didn't take place until 23rd August, and the referral to the specialist testicular service didn't happen until 25th September. So, a delay of something approaching eight weeks before the referral is made. 10:57 10:58 10:58

I suppose the suggestion through the SAI report is with all cancers, of course, it is important, but with testicular cancer there is an underscoring or an added emphasis to the importance of prompt referral. Is that a fair description? 10:59

A. I think it is. I mean, some testicular tumours are more dangerous than others. This, actually, was a small lesion with a very favourable prognosis, although it sounds rather dramatic that the patient required the chemotherapy within a very short timeframe. I'm not sure most urologists would be aware of that timeframe limit, and it is based on just one bit of evidence, a trial that was done sometime ago 10:59

which showed Carboplatin reduced the risk of recurrence. But even if they recur, seminomas are 100 percent curable. A lot of people argue now that actually giving that dose of Carboplatin, which is not a nice medicine to receive, quite a lot of side-effects with it, can be avoided in many cases because 80 percent never recur. This patient had at least an 80 percent chance of it never recurring. Even if it did recur, he could have received curative chemotherapy. 11:00

I don't think in this case it was dramatic. Mr. O'Brien would have been aided by the presence of a medical oncologist at that MDT who would have pointed out to him the need -- the ideal scenario of an eight-week referral to the medical oncologist. 11:00

41 Q. Just to interpose -- sorry to cut across you -- you make that point at page 513 of your bundle. Just for the Panel's note, AOB-42632. You make the point that in the absence of a medical oncologist at the MDT where the histopathology was available, it is understandable that a general urologist would not necessarily be aware of the view of some oncologists that the timing of postoperative chemotherapy was especially important? 11:01

A. Yes. 11:01

42 Q. That's your point.

Does it really require the presence of a specialist oncologist to have informed those at the meeting that

this should be a prompt referral?

A. Well, no, it doesn't. I think, again from looking more widely, it is clear that Mr. O'Brien's practice of dictating after clinics was less than ideal. Most urologists do dictate immediately, either at the time 11:02
of the clinic -- although that slows the clinic down considerably -- but at least within 24 hours or so. It is hard to remember all the details of the case and you want to have recorded everything. If you dictate immediately after a clinic or the following day, then 11:02
you can remember the facets of the case. If you leave it, as Mr. O'Brien has tended to do, for sometimes weeks, even months, then you're entirely relying on what you've written down and you can run into problems and delays. 11:02

I think in this particular case there were extenuating circumstances because Mr. O'Brien's mother-in-law was very poorly. But I think his practice was deficient in the speed, the celerity with which he dictated after 11:03
seeing patients in the clinic and this is an example of that.

43 Q. It really should have been handled more urgently, even without specialist knowledge of testicular cancer treatment? 11:03

A. It should have been. In quite a few of these cases I've looked through, which reflects the sort of practice of lookback, rather than waiting for patients to actually complain, where you've obviously got

a problem because the patient is unhappy, the problem with lookback is you are kind of looking for mistakes, and some of those mistakes are important in some of the cases, but in other cases the mistakes are actually unimportant. 11:03

This unfortunate delay would not, I believe, have any impact on the patient at all. It might have been better not to have told the patient because now he realises there was a drawback, but actually it is not 11:04 going to affect his prognosis.

44 Q. Happily this Inquiry is not dealing with causation; we'll leave that to the civil court.

Could I go to the issue of key worker and remind 11:04 ourselves what the MDT operating policy says about that. If you go to page 1402 and we'll pick up at WIT-84545. I preface my consideration of this area to say that there are evidential and factual controversies around the finding of the SAI that all nine patients 11:05 were without the input of a key worker or cancer nurse specialist. So there's a range of different perspectives, perhaps, on the evidence. I suppose the key factor is that, for whatever reason, none of the nine patients that you will have considered in your 11:05 reports had the benefit of key worker cancer nurse specialist input.

The importance of that input is perhaps summarised in this document. Scrolling down, it says:

"Clinical nurse specialists or practitioners should be present at all patient consultations where the patient is informed of a diagnosis of cancer and should be available for the patient to have a further period of discussion and support following consultation with the clinician, if required or requested. They may also be present and should be available when patients attend for further consultations along their pathway". 11:06 11:06

Then there's a number of key responsibilities for the key worker set out at the bottom of that page that you can briefly glance at, perhaps. 11:06

One responsibility is to ensure continuity of care along the patient's pathway. Let me see if I can spot that. The fourth one. 11:07

"Ensure continuity of care along the patient's pathway and that all relevant plans are communicated to all members of the MDT involved in the patient's care."

Your experience, Prof. Kirby, I suppose during the latter part of your practice maybe, is the greater use and reliance upon key workers in your practice? 11:07

A. Yes. I mean, obviously having a key worker, a nurse specialist with good knowledge of urology is a useful

adjunct. I don't think it is absolutely necessary. In private medicine, often I would find that often the sort of high net worth patients we were looking after in Harley Street wouldn't agree to speak to their nurse specialist; they'd say "I want to speak to" -- "I need this from the horse's mouth". "I'm going to ring Roger up at two o'clock in the morning and ask him personally". 11:08

There is the ownership of the patient. I think Mr. O'Brien is obviously reluctant to, as we discussed earlier, relinquish that to nurses. I think there are some areas -- 11:08

45 Q. Sorry to cut across you. That makes the mistake, doesn't it, that the nurses are there to provide the same function in consultation as the clinician? They're there to provide a range of different services that are complementary to and essential to the work of the clinician. 11:08

A. Yes. I think they're a point of contact, which is very important. I mean, another sort of basic tenent of cancer medicine is often the patients, you give them the bad news that they've got a form of cancer, prostate or whatever, their mind goes blank and they'd would like to -- this idea that they can talk to somebody, a nurse specialist, immediately after to have the same information relayed perhaps in a less technical way to reinforce the decision that the clinician has made. Then, you know, especially with 11:09 11:09

ongoing treatment.

A good example, my sister-in-law at the moment is actually undergoing breast cancer chemotherapy. That means weekly doses of really strong chemotherapy and all the side-effects associated with that. Then a key nurse working there is absolutely crucial because things are changing day to day. 11:10

With urology, with the exception of the urinary symptoms requiring retention of urine, the whole process is a lot slower, so maybe the clinical nurse specialist is not as integral or vital as it is in breast cancer. But you could argue about that, it does vary from case to case. 11:10

Certainly I think they had five nurse specialists working there, so I would accept that Mr. O'Brien sort of missed the opportunity of utilising that facility. He must have had his own reasons for that. 11:10

46 Q. Could I seek your comment on the following. If you go to page 103 of your bundle and if we go to DOH-OO124.

A. Yes.

47 Q. This document is the overarching report of the SAIs. It brings together all of the nine cases together in a composite form. Just scroll up so I can see the final bullet point there. 11:11

"Safe cancer patient care and pathway tracking is usually delivered by a three-pronged approach of MDT tracking, consultants and their secretaries, and urology specialist nurses."

11:11

So, it is portraying, at least in public sector NHS medicine, the use of the nurses as part of a three-pronged approach to Patient Safety, ensuring that the appropriate steps along the care pathway are being taken. The last sentence of the paragraph there 11:12 is the important one. If we go over to DOH-00126 and if you go to page 105, Prof. Kirby. It's saying that the use of a CNS is common for all other urologists in the Trust. I'm struggling to find it. The sentence I want is in my note so I'll just read. It is on that 11:13 page:

"The absence of a specialist nurse from care presented a clinical risk".

11:13

What is meant by that is the absence of the nurse meant that there wasn't that -- absent from the equation was that additional level of security to ensure that things got done. We've looked at an example with Patient 1 or Service User A. You've agreed with me that that was 11:13 a case that should have made its way back to the MDM for two reasons. It didn't make its way back to the MDM. If a nurse had been present in that patient's care, he or she would have seen that deficit,

potentially, and ensured that the patient's case was discussed in that way, perhaps with Mr. O'Brien, and then arranged for the case to go back.

Is that a fair understanding of how a nurse might assist in the avoidance of patient risk? 11:14

A. Yes. I think I would have to agree with that.

The key point, really, is the nurse should provide a point of contact. Often it's extremely difficult for 11:14 a patient to speak to his overarching clinician on the telephone, or send an email. They can sometimes speak to their secretary. But if you have a Clinical Nurse Specialist, then usually you have a mobile telephone number that you can ring them directly and say either 11:15 this side-effect has occurred, or I'm having more and more difficulty passing urine, I think I'm going to need a catheter put in because I can't empty my bladder, or I should have had a scan but I don't seem to have had it so can you help me with it. 11:15

I'm not sure why Mr. O'Brien didn't avail himself of the help of one of those -- of all five Clinical Nurse Specialists. I think it's his practice, he decided not to. I don't think he actively stopped them but 11:15 he didn't actively encourage them either. You would have to ask him that question, I suppose.

48 Q. Of course.

Just to take another example to reinforce the point, perhaps. You'll recall the case of Patient 5 or Service User C. That was a case where a CT report was organised by Mr. O'Brien in December 2019?

A. Yes.

49 Q. It was after, earlier that year, a very complicated, I think, partial nephrectomy. I think you are complimentary of the skills deployed for that difficult operation with this elderly man. Come the other end of the year, December '19, Mr. O'Brien arranges for a CT scan. That's available to be read and actioned on 11th January, but, on Mr. O'Brien's account, he doesn't read it for maybe six weeks or so. The scan, if he had read it at that time, he would have noticed that it was demonstrating a suspicion of sclerotic metastatic disease, and obviously further investigations were required. Again, a case where arguably significant delay in actioning the report. But a nurse interposed into that transaction, a specialist nurse, would have expected to be aware of what was going on in that patient's care pathway and would have been expected to intervene and say, listen, this is something we need to move on?

A. Yes, they might have been. I mean, it is quite a difficult scenario where you have a radiological finding. This is a good example, actually. It was one metastasis in the spine that appeared on that CT scan. Remember, this patient had had a -- it wasn't a partial nephrectomy, as you said, it was a total nephrectomy;

11:16 11:16 11:17 11:18 11:18

there was a big 14cm tumour in a patient in his late 8Os. So Mr. O'Brien clearly -- this is a good example -- he is clearly a very proficient urological surgeon with open surgery, which actually, as we are seeing now, open surgery is on the wane because there are so many robots and minimally invasive surgeons around that people are forgetting to do this traditional open surgery. He clearly is an excellent surgeon. 11:18

11:19

But this patient had this abnormal scan. The result should have been really highlighted and red-flagged from the Radiology Department. The radiologist ideally would have got on the phone and said we've picked up this metastasis. The patient did have known cancer, so maybe it wasn't that surprising. What was surprising was it was a second cancer; not the original kidney, it was a prostate cancer. A nurse specialist might have picked that up. 11:19

11:19

But what tends to happen to these reports is they get sent back to the clinician amongst a pile of maybe hundreds of other reports. So, picking out the important red flag report from the 100 or so other irrelevant blood results that are piling up on your desk sometimes is difficult. Maybe a nurse wouldn't have picked it up. It's quite a subtle abnormality here. Then, ideally the patient should be seen in the clinic with the result of the scan. The clinic 11:19

appointment -- this happened during the COVID crisis, of course, in 2020, so the clinic appointment was delayed and that was one of the reasons why --

50 Q. We'll set the issue of Mr. O'Brien's approach to addressing results from diagnostic investigations in a fuller context maybe later today. You make the point a big pile of reports, difficult through on top of everything else. Doesn't that, in essence, make the point that if you have a nurse specialist fully briefed and aware of what's going on in that patient's care pathway, he or she would -- I'm not saying it would be guaranteed, I'm not saying it is an absolute failsafe, it is a word that has been used, but I'm suggesting to you that it at least enhances the prospect, if you have a nurse involved with the care, that the cases that slip through the cracks will be better able to be spotted? 11:20 11:20 11:21 11:21

A. Yes, yes, I would have to agree with that. It does depend on how good the specialist nurses are. This was a subtle finding, not that easy to spot. I'm not sure that a nurse specialist necessarily would have picked it up. 11:21

51 Q. I'm not even making that point. The point I'm making, just to be clear, is you sent that man for a scan in December, it is now late February, or whatever the date was. In fact, this wasn't picked up until July. What's happened; it's that question? I'm not suggesting that she would interpret the scan -- or he -- it is a question of where is the scan? What has 11:21

been done about it?

A. Yes.

52 Q. Just before we take a break, I want to draw your attention and seek your comments on the following remarks in the overarching SAI report. You go to page 103 and we'll go to DOH-00124. 11:22

A. Right. Got it.

53 Q. It is the third bullet point. Let me just read it:

"The urology MDM was under-resourced for appropriate patient pathway tracking. The review team found that patient tracking related only to diagnosis and first treatment. That is the statutory targets of 31 and 62 days. It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care." 11:23 11:23

The point that's being made there is that this MDT, in terms of its governance, did not have a facility that scrutinised the progress of the patient along the care pathways. So if delays in referral happened, for example, it wasn't spotted. If referral didn't happen, it wasn't spotted. 11:23

Can you help us with your own experience, particularly in the public sector in the NHS. Was there good governance, and was that governance around ensuring that patients got what they were expected to get in terms of treatment? 11:24

A. Well, in general they did but I think you have to recognise that the system is overburdened, it's swamped. I think I read that Mr. O'Brien's hospital was getting 160 referrals a week, urology referrals a week, and we'll come on to talk about triage, I'm sure. Of those 160 patients referred in urology, at least half would have cancer. That's 80 patients that need to be discussed every week, and you have a waiting list that's getting longer and longer and longer. Inevitably, delays will come because patients are not coming in to be treated, and you have emergencies pouring in through the Accident & Emergency Department. Inevitably in such an overloaded system, you are going to get delays. It is really hard for individual clinicians to look after their individual patients, or build in systems in a hospital whereby these sort of errors that we're seeing in these cases are bound to occur. I'm afraid COVID had compounded that enormously. It is a system right across the NHS, not just in Northern Ireland, where we're seeing the system is overloaded. 11:25 11:25 11:25 11:26

Clinical Nurse Specialists will help; a really active MDT with a full complement of different specialists will help, but inevitably some cases are going to get delayed and lost in the system because there's too many patients. 11:26

54 Q. Yes. In your experience would an active, job-specific tracker assist in the process of ensuring that care was

delivered appropriately and on time?

A. Yes. You could call a tracker an MDT coordinator, because it's so difficult for the individual clinicians when they have to operate and do Outpatients and dictate on their clinics, and so on and so forth. To try and to keep track of all your own patients is almost impossible. 11:26

I think one or two of the cases illustrate maybe Mr. O'Brien didn't prioritise some of the really urgent cases as well as he could have done. The patient with the penile cancer, for example, was rather slow; methodical but too slow in the way it was dealt with. An MDT coordinator with a specialist nurse badgering and liaising directly with the patient would definitely have improved the situation. 11:27 11:27

55 Q. Thanks for now. It is 11.30. I think it is probably a convenient time to take a short break.

CHAIR: We'll come back again, ladies and gentlemen, at a quarter to 12. 11:27

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

MR. WOLFE KC: 11:46

56 Q. Just before the break, Prof. Kirby, we were discussing how the absence of tracking of patients along the care pathway may have contributed to issues around delayed referrals and sometimes no referrals at all. I want to

come back and look at that theme by reference to the penile cancer case that you introduced yourself just before the break.

Before I do so, just picking up on one of the points I wished to deliberately draw your attention when we were looking at the whole area of nursing and key worker a while ago. If I could just bring you to 1402 on your documents, and WIT-84545. You were making the point that it was for Mr. O'Brien to explain why he didn't actively seek out the nurses when he had cancer patients recently diagnosed come through his review clinic. I draw your attention to the second paragraph on that page. It says: 11:47 11:47 11:48

"It is the joint responsibility of the MDT clinical lead and of the MDT core nurse member to ensure that each urology cancer patient has an identified key worker and that this is documented in the agreed record of patient management." 11:48

It may not do entire justice to Mr. O'Brien's position to say that he thought it was somebody else's or he considered it was somebody else's responsibility to ensure allocation or identification of the key worker in the way that it is explained there and it wasn't for him to actively seek out the nurse. Do you understand the point? 11:48

A. Yes, I do. I think what would be ideal would be that

the MDT allocate a nurse and that that nurse then liaises with the consultant responsible for the care. Just emphasising, the responsibility for the patient is with the individual consultant. You need a leader of the team. You can have a teem but you have to have a leader and that leader has to take legal responsibility for the care. But the assistance of a Clinical Nurse Specialist would have been advantageous in quite a few of these cases. How that nurse specialist is allocated, ideally the MDT would have allocated the case to a nurse, the nurse would have liaised with Mr. O'Brien, and there would have been seamless ongoing care for that patient. But that didn't happen. 11:49 11:49

57 Q. Yes. As I say, I prefaced my remarks earlier by saying that there were lots of evidence around this and different approaches, different views, and that reflects one of them, Mr. O'Brien's view of this. 11:50

Having dealt with that, let's look at the following. If you go to the overarching SAI report at page 103 in your bundle, and we'll pick it up at DOH-00124. 11:50

A. I've got that.

58 Q. Just at the bottom of the page, it makes the point that "The review team noted repeated failure to appropriately refer patients". The word "appropriately" seems to be intended to cover delayed referral as in, for example, the testicular case that we talked about. That is the case of Service User E 11:50

that you can see in a bullet point there, and you have given your evidence and we have your report around that, as well as the penile cancer case. We can see reference there to Service User H at the bottom of the page, and I want to pick up on that one in a moment. 11:51

Service User A, to use another example, we've looked at this morning, with which we're familiar.

Maybe just using Service User A's case as an example on 11:51
the prostate cancer side. I've outlined, and I think you can recall, the recommendation that came out of MDT. It was for adjutant deprivation therapy and referral to EBRT. The referral didn't happen, it didn't happen at least until the summer, and I think 11:52
by that stage Mr. O'Brien was on his way to retirement. The referral happened in the summer about eight months or so after the MDT decision when the patient was really in a very bad way, and I think the prospects at that stage were recognised as being bleak for him. 11:52
I think he died in October 2020.

But just on that recommendation at the end of October, ADT and referred to EBRT, at what point are you expected to make the referral? 11:53

A. Well, I think you're expected to see the patient, convey to them the advice of the MDT, then have a discussion with the patient whose views are preeminent about what they would like to do, and also

to ask that patient has there been any change in the situation that would influence that MDT decision. I think in this specific case, his urinary symptoms were deteriorating, which would have made the journey backwards and forwards to Belfast for the radiotherapy more difficult. He might have been referred to a radiotherapist who rejected him saying I can't possibly irradiate this patient's prostate because we're going to cause a lot more urinary problems, he's already got them. Then there's the Lake Garda holiday issue as well. Although it is not recorded, there may have been issues about whether the patient was able to accept castration ahead of radiotherapy as a treatment option. Some men -- he was in his early 70s, wasn't he? I forget his age now. 74. Sexual function may still be an important consideration in his case and, remember, Bicalutamide is potency preserving compared with ADT, which is castration therapy which completely neglects the sex life. 11:53 11:54 11:54

This wasn't recorded in Mr. O'Brien's notes but this conversation could easily have taken place and that would have been the stimulus for him saying, well, I'm not going to refer this patient now, I'm going to sort out his urinary problems, let him go to Lake Garda and preserve his sex life for a few more months at least, because he's asked for that. 11:55

59 Q. Leaving some of those -- and I quite take your point that every case will depend upon what the patient's

view of the process is, and that's fundamental -- is there room for the clinician to, if you like, try to achieve optimum biochemical response by moving through the gears with of Bicalutamide, as in that case, before making the referral? 11:56

A. Yes, I think that would be justifiable. We know radiotherapy works better when the patient's prostate has shrunk to some extent, and the tumour indeed shrinks so there's less cancer to treat. The results, it's quite clear that ADT preceding radiotherapy has 11:56 better results than radiotherapy alone.

How you define ADT, most people would use the stronger LHRH analogue agonist, which is Degarelix. Some people prefer Casodex and you'd have to individualise the 11:56 patient. Those who want to keep their sexual potency, very important to them. Maybe married to a much younger woman, for example, that might be an influential factor.

60 Q. But the MDT is saying commence the patient with a form 11:57 of ADT and refer. It's surely not the business of, if you like, the local clinician to delay the referral while seeing whether the Bicalutamide in this incidence at 50mg is going to have a effective response?

A. I think maybe you might be putting too big an emphasis 11:57 on the MDT recommendation. This is not, you know, the law says you have to do this; it is a recommendation. You might easily have a conversation with the patient saying the MDT is recommending this, and they'll say

who the hell are the MDT, I've never met the MDT, they are just a bunch of doctors out there; they are ordaining that I should issued have this but I don't want that; you're my doctor, I want to take your advice; I couldn't give a tinker's cuss about the MDT. And I've had conversations like that with my patients; it's not unusual. 11:58

61 Q. For it to be a sensible and intelligent conversation, all of the thinking of the MDT must be reflected. In a case like that, they're referring to oncology with curative intent. I think as we agreed earlier, delaying on that, if that's the patient wish, so be it. I think that's probably controversial in this particular case and I want to steer clear of the personal traits of the case. 11:58

A. Yes.

62 Q. But you've got to -- maybe this is where we can leave it -- you've got to fully explain to the patient that delay may not be in the patient's best interests and if the patient says, well, so be it, then that's the answer. 11:59

A. There are risks and benefits. There are risks and benefits of both approaches, and that should be not only explained to the patient but documented in the notes ideally. 11:59

63 Q. Let's turn to, as I say, this summary. We have it up on the screen in front of you and in the bullet points at the bottom of the page. I think you will have observed in your reports that there has been delays in

the patient pathway and failures of referral or delays in referral for a range of reasons, some of which are systemic and some of which Mr. O'Brien has contributed to the delay; is that fair?

A. Yes, that's fair. 12:00

64 Q. Just before our break, you drew attention to the penile cancer case. If I could refer you to -- if we can pull up DOH-00093. I am not sure of the page reference for you but if you go to page 70, we'll try and marry it up. 12:00

A. Yes, I've got that.

65 Q. I think we're starting at page 93 in the series. DOH-00093 should be at the top of your page. Page 72 for you, I believe.

A. Yes, got it. 12:01

66 Q. It provides a description of the case. I don't need to worry too much about all of the facts. What it appears to come down to is that this patient was referred to the Urology Service on 20th February with a mass under the foreskin. Various procedures and investigations 12:01 throughout much of that year, including latterly a left inguinal lymphadanectomy; is that how you pronounce it? Excising the nodule in the groin?

A. Lymphadanectomy. It's the removal all the lymph nodes in the groin. 12:02

67 Q. It wasn't until 17th February 2020 when this patient was referred to a penile cancer MDT. In the findings of the SAI, if you go to page 74. Perhaps page 75 and it's our 96. DOH-00096 for us and it's your page 95,

I believe. Your page 75, I beg your pardon.

A. Got it.

68 Q. Just scrolling down, please. It says:

"Although there was a five-week delay between the revert and initial appointment, the management of this case was appropriate up to the MDM on 18th April 2019. At this point the MDM should have recommended an urgent staging CT scan and simultaneous referral onward to the regional or supraregional penile cancer specialist group, or to a surgeon with the appropriate expertise for all subsequent management." 12:03 12:03

This is a situation where the region, that is Northern Ireland, didn't have an operable specialist MDT until 2020. The point remains, according to this SAI, that given, I suppose, the rarity of this disease, it was one that required specialist input at a much earlier stage than February of 2000, in other words almost a year after referral. Is that something you would agree with? 12:04 12:04

A. Yes. I think it's unfortunate that Northern Ireland didn't have a supraregional cancer set-up until I think it was December 2020, wasn't it, when it came into play. So, I think Mr. O'Brien can be defended along those lines. He couldn't refer him to Manchester where now the supraregional penile cancer expertise lies, because that hadn't been set up. But he could have taken things into his own hands and referred that 12:05

patient himself. It's quite a big step to refer somebody from Northern Ireland to Manchester, to fly across there, in the absence of a network having been set up.

12:05

You know, I think the steps that Mr. O'Brien took in this particular case were defensible and applicable. It was just that the process was too slow. But, you know, that has to be seen against the background of overloaded clinics, waiting lists spiraling out of control, and all the other issues that Mr. O'Brien was facing at the time, including ongoing battles with hospital administration and so on.

12:05

In all the nine cases I'm defending Mr. O'Brien because I think he did his best. His best might not have been the best available in the world for these patients but he was doing his utmost best. There's nothing I could pick up that indicated that he deliberately delayed things or made any deliberate mistakes. Any mistakes he made reflected his training, the way he practised medicine. I would have to agree that this patient in particular's case was not ideal.

12:06

12:06

I do argue at the end of my report that some of these cases of penile cancer, a very aggressive cancer, are extremely difficult to treat because the cancer spreads so fast. Trying to remove a cancer before it spreads is actually a bit of a no-hope situation, you are

12:06

playing catch up. By the time you get it out, the lymph node has already spread out further away and you end up having to chop out all sorts of bits for no good outcome in the end.

69 Q. That rather underscores the point, does it, that a cancer of this nature really ought to be placed in specialist hands, even for advice, if not referral, at the earliest opportunity? Because as we can see here, as time went on, they almost lost control of it. Maybe that's an issue for the MDT in general, that you've got to recognise -- this is perhaps the key learning -- you've got to recognise when cases need to leave the locale and go into the hands of those who have the specialism? 12:07 12:07

A. Yes, I would agree with that. I counted to some extent that the original lesion was a small lesion and only on the foreskin. Mr. O'Brien thought he completely removed it, he thought he cured it. He was surprised when the CT scan showed recurrence in the groin. We all know that that can occur. Then there was delay after that. It begs the question of what a patient like this with a relatively rare but serious condition comes through. Is it the responsibility of the MDT in general to provide the care of that patient, or is it the individual clinician to whom he's designated? In terms of the legal responsibility, as I've mentioned before, it still lies with the clinician. You can't sue an MDT, it is quite difficult to do that, but you can sue an individual clinician. So there's a bit of 12:08 12:08 12:08

a tension there, which we've talked about.

70 Q. Your report usefully sets out a chronology of this case. If you would kindly go to 556, 557. We'll open at AOB-42638. Scroll down. Maybe it's the next page, is it? There we are. It is at the bottom. Back up again. Thank you. It should be a page with AOB-42639 at the top, continuing into AOB-42640. 12:09

A. Yes.

71 Q. You set out the chronology of the diagnosis for that case. I think you go on to highlight that at Item 7 and then Item 12. As regards those items, you say: 12:10

"During the 12 month interval between the original referral by the GP and Mr. O'Brien's onward referral to a specialist in penile cancer, only steps 7 and 12 can be legitimately considered to be directly under Mr. O'Brien's control." 12:10

In time terms, they were fairly significant, were they?

A. Well, overall, you know, cumulative delays were obviously too many. But waiting for Outpatient slots and waiting for CT scans to be performed in an NHS under extreme stress, inevitably these delays are built in. Each time Mr. O'Brien saw him and then had to do a surgical intervention, circumcision in the first place, lymph node section secondarily, that was done in quite a short time space. But waiting for the scans, then waiting to see the patient with the result of the scans, that's where the main delays came in. 12:11 12:11

72 Q. I suppose the glib point in response to that is that this case should never have stayed at this hospital. There was a responsibility on somebody's shoulders, and there was obviously a governance issue given that the case stayed there and nobody appears to have had the understanding to action it over to a specialist, even for advice. As we know, the specialist MDT had not yet been established. Is that a fair analysis?

A. Yes. I suppose in an ideal situation, the time when they knew there was a problem was when the lymph nodes from the lymphadanectomy from the groin came back positive. That was a surprise; the disease had spread. At that stage, you could have anticipated that if it had already spread to the lymph nodes, it would have been elsewhere in the body too. Then radiotherapy and chemotherapy -- oncology rather surgery -- is going to be the way ahead. Having said that, squamous cell carcinomas of the penis are notoriously resistant to either chemotherapy or radiotherapy. What tends to happen when the patient is like this, unfortunately, is they get all this extra treatment but it doesn't make any difference. He would have had to be flown across to Manchester for quite a lot of that treatment.

12:12 12:12 12:13 12:13

You know, the patient might have said, had it been explained to him, listen, you are going to have to go to Manchester for your treatment, he might have said I don't want to do that. I think this man had a history of alcoholism, diabetes, lots of

12:13

co-morbidities. It's not entirely clear who is going to pay for him to fly across to Manchester to have therapy.

73 Q. As I say, across a range of these cases there are referral issues. As I say sometimes delay, sometimes, in Patient 1 SUA's case, no referral at all. 12:14
I suppose, again, there's a governance issue to be explored in terms of a responsibility on those who support the MDT to drive these things forward, to recognise where there is avoidable slowdown and get cases appropriately on track? 12:14

A. Yes. A red flag system aided and abetted by the specialist nurses, and probably some better IT working in the MDT, rather than relying on the patient's notes and all these bits of paper flying all over the place which, unfortunately, was a characteristic of the NHS then and probably still is now. 12:15

74 Q. Could I bring you to the next question of the management of prostate cancer patients with Bicalutamide? 12:15

A. Yes.

75 Q. We have, amongst the nine cases that you've looked at, several where the dosage of Bicalutamide introduced at an early stage is said, by the SAI reports, to be unlicensed and suboptimal, the dosage being 50mg typically. There is, I suppose you know now having had a chance to look at the documentation, a longer history to this problem than simply the cases that emerged in 2019 and 2020. 12:15

Could I start our discussion around this by introducing to you some of the various evidential strands that the Inquiry has had to look at and generally get your comment as we work through some of them. I'll start with a gentlemen called Dr. Darren Mitchell who gave evidence to the Inquiry relatively recently. He practises in The Cancer Centre in Belfast, to whom many of Mr. O'Brien's patients would have been referred. In his witness statement to the Inquiry, which you can see at 2229, we can pick it up at WIT-96667.

A. I've got that.

76 Q. You're ahead of me. We're waiting for it to come up on the screen.

12:17

I'm just trying to find the reference. Do you have that? "Prescribing Outside Guidelines" is at the top of the page?

A. Yes.

77 Q. Here he is explaining the licensed doses for Bicalutamide. He explains that they are either 100mg once daily as a monotherapy, or 50 once daily when used in combination with hormone therapy injections, known as lutenising hormone releasing hormone agonists. There are no licensed indications that I am aware of for Bicalutamide 50mg once daily as a monotherapy. As such, he says:

"I viewed the use of the Bicalutamide 50mg once daily

as a monotherapy as being outside the licensed indications."

Is there anything in that paragraph with which you disagree? 12:19

A. No.

78 Q. He, as I've said, has a long history, relatively long history of working with Mr. O'Brien. In 2014 he wrote to Mr. O'Brien on this subject. You'll see the email at page 2203 of your pack, and we'll go to AOB-71990. 12:19 So it's 2014, six years before these SAIs with which you have been interested in occurred.

Mr. Mitchell is the regional MDT Chair for urological cancers. He is reporting back to Mr. O'Brien in 12:20 respect of a patient of Mr. O'Brien's. You can see the history of the prostatic disease set out there. It is a high grade organ-confined disease dating from 2012. Just a couple of lines down, he is explaining:

12:21

"A hormone therapy in this case that we would use is the LHRHa or occasionally Bicalutamide 150 once daily as a monotherapy".

That's a description of what he set out earlier in his 12:21 statement; that's the licensed and recognised approach for a cancer of this type?

A. Yes.

79 Q. He's saying:

"I'm told he has only just been referred for radiotherapy at two years after initial presentation."

He goes on, if we can scroll down, to say: 12:22

"I'm also told that he was on Bicalutamide 50mg once daily for the first year of his management."

Now, we don't know what the conversation was between 12:22
Mr. O'Brien and that patient. We don't know what the patient's desires or intentions were. Ideally, that patient should have been started on 50mg as an anti-flare, moving on to one of the LHRHa preparations with a view to referral for radical radiotherapy. Is 12:22
that how you would read it?

A. Yes, but there may have been circumstances that would account for his decision not to do that.

80 Q. This was, if you like, by way of correction to Mr. O'Brien's approach. Dr. Mitchell, in the last 12:23
line, as you can see at the bottom, is referring Mr. O'Brien to the relevant website providing information in relation to a clinician's responsibilities when prescribing off-label. 12:23

Mr. O'Brien has no recollection of replying to this, but the message that is being sent here by Dr. Mitchell is then to be reflected in some guidelines which he developed at a time when Mr. O'Brien was Chair of the

regional urology network in Northern Ireland called NICaN. Let me bring you to the regional hormone therapy guidelines. You will find them at page 1378.

A. Yes.

81 Q. We can find them at WIT-84426. 12:24

A. Yes.

82 Q. That's the first page. I think the relevant page I want to turn to is the next page. It's saying that men with intermediate or high risk prostate cancer should be offered neoadjuvant hormone therapy for at 12:25 least three months before the commencement of radical radiotherapy. It goes on to say:

"Men with intermediate or high risk prostate cancer should continue their hormone therapy through the 12:25 course of radiotherapy. Men with intermediate risk prostate cancer should receive a total of six months of hormone therapy before, during, and after the radiotherapy is complete. Up to three years of adjuvant hormone therapy after radical radiotherapy 12:25 should be considered for men with high risk prostate cancer".

Then it sets out the recognised therapies, and there they are set out. 12:26

Just scroll down, so we can see the rest of that. Referring to Bicalutamide in particular:

"In order to prevent testosterone flare, anti-adjuvant cover with Bicalutamide 50mg is given for three weeks in total, with the first LHRHa given one week after the start of Bicalutamide".

12:26

Then it goes on to describe the usage for 150mg. You can read that.

That is one strand of the evidence that the Inquiry has received. As I understand your answers to my question, 12:26 you're agreeing that that is an appropriate and accurate description of the licensed indication for hormone therapy with patients of this type?

A. Yes.

83 Q. Another strand, a similar strand of evidence has come 12:27 from Prof. Joe O'Sullivan, again Belfast Cancer Centre. To summarise, he has explained in his evidence that he was seeing cases coming to him from Mr. O'Brien before 2010 on 50mg of monotherapy Bicalutamide, and he would have corrected that and Mr. O'Brien should have seen 12:28 that it was being corrected. His concern, much like Mr. Mitchell's concern, or Dr. Mitchell's concern, was that on 50mg, the patient was receiving suboptimal treatment; it wasn't as effectively as LHRHa or the 150mg dose, and for that reason it should not have been 12:28 given.

You have looked at a number of cases, and it doesn't appear on the face of it that you have criticised the

approach of using 50mg in the treatment of intermediate or high risk prostatic cancer?

A. Right. Well, I'll give you a slightly roundabout answer. By chance, I happen to be the lead clinician in the launch of Bicalutamide Casodex in the UK manufactured by AstraZeneca. The original dose that was advocated and received a licence for the treatment of prostate cancer was 50mg. That was back in the 1990s. I remember it because I put the programme together and we held it in the Intercontinental Hotel at the bottom of Park Lane. There was subsequent data that showed 150mg was more effective. There's a lot of evidence that 50mg works, maybe 150mg works better. There's a lot of evidence that it's equivalent to LHRH analogues in locally advanced prostate cancer but not in metastatic prostate cancer, which is already spread outside the prostate. I think there are 25 publications on the use of Bicalutamide, some of which in the early days the use of 50mg, and then updated, more recent ones, to 150mg. 12:29 12:29 12:30 12:30

You would have to ask Mr. O'Brien himself why he was so beloved of the 50mg dosage. That seems to be his preference. There is some effect at 50mg, it is not a treatment that has no value and no impact. Just 150mg would work better and has a licence for it, but doctors often use medications outside their licence; it is not at all unusual for doctors to do that. The 150mg dosage does have more side-effects than the 50mg, 12:30

particularly breast enlargement, hot flushes; those two things.

The use of Casodex, as I mentioned before, is potency preserving and doesn't give some of the other quite dramatic side-effects of castration therapy using LHRH analogue. So I think Mr. O'Brien certainly could be criticised for the use of that drug. I can't explain why that's -- why that was his choice, but I don't think you could say he was negligent in using that. It's not the wrong treatment, it's a less than ideal treatment. Remember, the background of prostate cancer is highly controversial because you can go from active surveillance to radical prostatectomy with robots and so on. Open prostatectomy, radiotherapy with hormones and now high intensity focused ultrasound and all sorts of new treatments coming in, many of which don't have licences for that either but patients are getting them. Prostate cancer is one of the most controversial treatment areas out there clinically, and Mr. O'Brien had his own idiosyncratic way of dealing with it.

12:31
12:31
12:32
12:32

But I can see that would bring him into conflict -- well, into disagreement, not conflict maybe -- with radiation therapists in Belfast, which probably explains why Mr. O'Brien seemed quite reluctant to refer his patients into Belfast for radiotherapy. That reflects his desire to keep his own patients under his own care, even if it is a bit idiosyncratic.

12:32

Again, reading from what I have, it seems to me the patients seem to buy into this with Mr. O'Brien. They trusted him. He must have been a good communicator with them. I'm not sure he would have explained absolutely the pros and cons of all the things he did, but he seems to care for his patients to a great extent. But he was using idiosyncratic ways of treating them that he may or may not have explained to them. 12:33

84 Q. Idiosyncratic ways of treating them is maybe a polite way of explaining to us that it is not something you would endorse for your own patients?

A. Yes. I wouldn't have used 50mg unless I was forced into that position by a patient saying I want to preserve my potency, I'm getting bad side-effects from 150mg so give me a lower dose. I think in a couple of cases that was the situation here amongst the nine cases. 12:33

85 Q. Let's go back to brass tax a little. You recognise that by the date on which Mr. O'Brien is prescribing this treatment that the days of 50mg being regarded as an effective treatment had gone, the licence was for 150 monotherapy, or, in the alternative, as an anti-flare agent. So it was off licence? 12:34

A. Yes.

86 Q. If you are prescribing off licence, you have an obligation to explain to your patient and record why you are doing so?

A. Yes.

87 Q. The efficacy of the approach must also come into question in terms of its optimalisation. A patient receiving 50mg as a monotherapy may be receiving some benefit but it's not the optimal benefit, and that's why 150mg is realised as the appropriate approach? 12:35

A. Yes. I would agree with that, yes.

88 Q. You have suggested that perhaps one thought around this -- we'll have to ask Mr. O'Brien -- a patient struggling with 150 or he suspects he might struggle with 150, there are side-effects so we'll use 50, that view is not uncontroversial, is it? The dosage may not be terribly relevant to the question of side-effects? 12:36

A. Well, a good question, really. I don't think anybody has actually studied the incidence of side-effects of 50 verses 150. There are no trials so we don't know for certain. But I suppose empirically you could argue that giving three times the dose is likely to produce more side-effects. The dominant side-effect is gastrointestinal side effects, which I think one of them, Patient A, got, and gynaecomastic breast enlargement that is quite troublesome with patients with Casodex. I don't know if anybody knows whether that's more likely to occur with 150 than 50. The effects on PSA is stronger with 150. 12:36 12:37

Again I think it was in Patient A, the PSA did come down on 50mg quite dramatically so it shows it has an effect. If it didn't have an effect, it wouldn't be

used as an anti-flare therapy. It blocks the receptors, the androgen receptors, but doesn't block it as effectively as 150mg.

89 Q. We know in Patient A's case that Mr. O'Brien was, for whatever reason -- and he can maybe best it explain the science -- endeavouring to step it up 50mg in November, up to 100 at the end of January, finally into 150 in March. Maybe it was some kind of titration approach? 12:37

A. Yes.

90 Q. Then ultimately in June, eight months after the MDT had made the recommendation, finally a move into LHRHa as the approach. 12:38

You say he wasn't doing anything wrong but if the recommendation inevitably in these kinds of cases is ADT; the patient isn't getting ADT if he's not on the 150mg dose? 12:38

A. He's not getting maximal ADT. He's getting -- it is ADT, it's a treatment to block testosterone stimulation on the prostate but it's perhaps not at the optimum level. In other situations, you take a patient with hypertension, you want to get their blood pressure down so you give them an anti-hypertensive therapy but they get terrible side-effects, so you have to titrate the dose of the treatment against the response that you see. It is not quite as clear in prostate cancer because PSA is not a reliable marker, not as a reliable marker as blood pressure measurement. 12:39 12:39

He was, I think, trying to titrate the dose against the side-effects and also looking at the PSA reduction. We did see some good PSA reductions with 150mg dosage.

91 Q. You will have seen from your readings that the Royal College have looked at Mr. O'Brien's practice across 100 cases and expressed some concerns in a number of cases about Bicalutamide. The Trust itself has done an audit and then a lookback exercise. Can I just have your views on a couple of points that emerge from the lookback. 12:40

Patient 18. I know you'll be unfamiliar with the patient but you have a sheet, I think, beside you. His name doesn't much matter?

A. Yes. 12:40

92 Q. If you can turn to 2037 and we'll turn to PAT-001804. This is Mr. Haynes, a consultant urologist in the Southern Trust, writing to a patient -- and we'll not use his name, we'll use Patient 18 -- writing to the patient in November 2020. If we scroll down, we can see that this patient came to see Mr. Haynes in the Outpatient Department following review of his notes. He is being treated with a low dose of Bicalutamide since diagnosis with a localised intermediate risk prostate cancer back in 2010. From memory, [Patient 18] and his daughter could not recall having any discussion -- I want to check an issue that has been drawn to my attention. It should be Patient 82, not Patient 18. 12:41 12:41

"The patient and his daughter could not recall having any discussion regarding alternative radical treatment options such as radiotherapy or any discussions concerning active surveillance or watchful waiting".

12:43

I don't wish to get into the facts of this with you, Prof. Kirby, Mr. O'Brien may have something to say about these examples which I use in due course. I suppose the question I have for you is do you recognise in any guidance an indication for the use of 50mg of Bicalutamide over a ten-year period in a case like this?

12:44

A. Well, yes, there's good clinical evidence that 150mg is effective treatment in patients with locally advanced prostate cancer. The definition of what is localised and what is locally advanced is actually a bit indistinct because it is quite difficult to tell whether the capsule of the prostate is or is not actively infiltrated. Even with state-of-the-art MRI scanning, you can't tell whether the tumour is locally advanced, i.e. extending a little bit outside the prostate. I can imagine a scenario that Mr. O'Brien felt this was a tumour likely to progress if left untreated entirely with active surveillance, but the patient may not have been keen, or suitable even, for radiotherapy, or surgery. You could do radical surgery and remove the whole prostate in this case; that would be another approach. Perhaps he discussed the use of this medication with his relatively favourable

12:44

12:45

12:45

side-effect profile, especially in terms of sexual function, and scaled back the dose to perhaps reduce the impact of breast enlargement or hot flushes or gastrointestinal disturbance. I can imagine a scenario where it would be more justifiable; we'd need more information about that individual patient.

In an ideal world, that conversation with those options would have been had with the patient but, in the end, you must allow the patient to make his own decision. I think you pointed out the daughter couldn't remember that conversation, but I have two daughters and they don't always remember the conversations I've had with them either.

93 Q. I think we are all familiar with that, perhaps. My question was in terms of the guidance, the licensing?

A. Yes.

94 Q. I know they are two different things. Is there an indication, whether in guidance or as per the licensing, for, if you like, a prescription, a lifetime prescription of 50mg of Bicalutamide?

A. No, that's not a licence indication. But, as I say, doctors do treat patients off licence. You can treat patients on what they call a named patient basis. Before we had a licence for Sildenafil, Viagra, I prescribed it for thousands of patients off licence with a named patient basis, because while we were waiting for the licence to come through, they were desperate to get hold of it. That's what we did.

Mr. O'Brien, he could be criticised but I think it's not a -- what's the word? -- not negligence to prescribe that dosage. We need more information about why he choose to do that but you could ask him about that yourself. 12:47

95 Q. I think the concern, and there are other cases which the lookback has demonstrated where men, where patients have this lifetime prescription, multiple year prescription of Bicalutamide. 12:48

Returning to Dr. Mitchell and the concerns he was expressing here, here he was writing in 2014 to Mr. O'Brien, saying I'm hearing that this patient first came in to MDT two years ago and you're only sending him to me now; you've had him on 50mg of Bicalutamide for a year and he's eventually coming in to radiotherapy. 12:48

If we pull up Mr. Mitchell's statement again -- sorry, his transcript again, I should say. We'll orient ourselves to what he is saying precisely. Page 2242 for you, Prof. Kirby, and TRA-07771. Just around about line 14. Just bear with me, Prof. Kirby. 12:48

12:49

He is being asked about the 50mg dose, he is being asked about the impact of it, and he is being asked what's the issue for you as a clinician if you don't think it is clinically mandated. He said:

"I think it is very difficult to prove in the short term that it really changes their management, but it has the possibility to induce delay to referral. So we would be keener to see patients and make hormone decisions ourselves rather than a wrong dose be prescribed and a patient referred at a much later date."

The suspicion, perhaps, is that Mr. O'Brien is trying to manage the patients on 50mg before making the referral, and that inevitably, given its less than optimal dose, is taking much longer to produce good fruit. Do you recognise the problem there? 12:50

A. Yes, I do see the problem. Again, it is something I think you have to ask Mr. O'Brien himself. 12:51

I think am another factor you have to remember, there is some rivalry between urological surgeons and the radiotherapists that deal with some of the cancers for us. There have been many arguments about surgery to remove the prostate verses radiotherapy to treat it and sometimes that has got acrimonious. I think we can see that Mr. O'Brien has a preference for the use of Bicalutamide, at an admittedly suboptimal dose, and a reticence to refer patients for radiotherapy. I think probably you're going to have to ask him why he does that, why that comes from some deep belief that he has. I can see the patients who have gone along 12:51 12:51

with him in that. It's true that radiotherapy can have some rather devastating side-effects, and he may have seen patient with rectal injuries, bad urinary problems, bladder problems from radiotherapy. So I think you have to address him with that. 12:52

I would say Casodex is an anti prostate cancer treatment, best used at 150 rather than 50. Some of these patients will have actively wanted to avoid radiotherapy, which is given over this long period and 12:52 involves a lot of travel.

96 Q. There may be some debate on the evidence before this Inquiry about the relative transparency of Mr. O'Brien's approach. As I understand it, he would say that it was perfectly obvious or ought to have been 12:53 perfectly obvious to the MDT that he was treating some patients with 50mg and he was never called up on it. There's other evidence that's perhaps contrary to that. We clearly have the email from Dr. Mitchell in 2014 laying down, as he saw it, the rules or the guidance in 12:53 relation to that, and then it is reflected in the guidance.

You say that Mr. O'Brien did nothing wrong here, it was merely a suboptimal dose and it was a matter for him 12:53 and the patient. Forgive me if I'm repeating myself but if he's providing a suboptimal dose, the patient needs to be given a full explanation in relation to that and it needs to be set out and documented in the

clinical notes. Is that fair?

A. Sorry, I missed that. My Internet connection was... Could you just repeat the last two sentences?

97 Q. Yes. If the patient is to be prescribed a suboptimal dose -- you say Mr. O'Brien did nothing wrong but if he is being prescribed 50mg outside of the guidelines and outside of the licence, 50mg as a monotherapy, that has to be explained to the patient in terms of it being off licence and potentially suboptimal, and it has to be documented? 12:54

A. Yes, I would agree with that. That should definitely have been the case, yes. A discussion should have taken place and it should have been documented.

98 Q. What's more, we need to look to see where the evidence takes us on this, but in terms of communication with your multidisciplinary team colleagues, if it's your practice over a period of time to use 50mg as a monotherapy when you are otherwise recommended to use LHRHa or ADT, I think the members of the MDT would regard ADT as either the LHRHa or 150mg monotherapy. 12:55 So if you are proposing to use less than that, again there should be full transparency around that in terms of discussing that with your team members?

A. Yes, there should. In governance terms, it's surprising that it wasn't an issue that could have been 12:56 brought up by the MDT and, you know, agreement reached amongst all the partners there. I think it implies there's a bit of a dysfunction in the way the MDT works. You know, the issue was raised back in 2012 but

still not resolved until 2023; that's 11 years where no challenge was made and no mutual agreement was reached.

99 Q. Thank you.

MR. WOLFE KC: It is coming up to one o'clock. A convenient time for a break? 12:56

CHAIR: Yes. We'll stop now and come back at two o'clock.

THE INQUIRY THEN ADJOURNED FOR LUNCH

14:01

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Chair, good afternoon Panel. Good afternoon, Prof. Kirby.

We'll get through your evidence in the course of the afternoon, Prof. Kirby. The next issue I want to raise with you is borne out of your consideration of the kinds of issues that arose in Patient 5's case. That's Service User C. 14:02

A. Yes. 14:02

100 Q. We used it at an earlier point in our discussion this morning to, at my suggestion, illustrate the benefit that a key worker or a cancer nurse specialist might bring to a case where things are delayed or might have been forgotten. This was the case where Mr. O'Brien had the results of a CT scan showing a possible sclerotic metastatic disease. I'll come back to that case in a moment. 14:02

I want to bring it to a slightly wider context and indicate to you that the Inquiry is aware of, I suppose, Mr. O'Brien's approach of actioning scan results that date back some years before it, before this incident. I want to just look at the issue through that lens as well.

If I can draw your attention then. Perhaps you read this Serious Adverse Incident report concerning Patient 95. If you go, please, to page 1483 of your bundle. We will have page WIT-17471. That's the cover page. Do you have that? 14:03

A. Yes.

101 Q. Good.

Let me just summarise the facts of this case, if I may. Patient in for abdominal surgery in 2009. There was, unfortunately, a misstep in retrieving the swabs from her cavity -- or a swab -- so they weren't accurately counted in or counted out. So, a retained swab case. I think the profession would call that a "never event", or it's categorised as a "never event". The patient comes in for a routine scan four months later and it identifies an abnormality. It was described in no more detail than that. 14:04 14:05

If we could pick up then on what was done or not done with that report. If we invite you to go to page 1490, and we'll move forward to 17478.

A. Got that, yes.

102 Q. The author describes two issues. The primary issue is the retention of the swab. The second issue was the delay in diagnosis. There was a three-month follow-up scan of the abdomen. A diagnosis of retained swab was not made on this scan but the reporting consulting radiologist described a mass measuring 6.5cm in the region of the right renal bed. The differential given for this mass included a seroma or a local occurrence. The high density areas within the mass lesion were described as multiple surgical clips. 14:06 14:06

"Although a diagnosis of a retained swab was not made, this report...". I'll reread that.

14:06

"Although a diagnosis of a retained swab was not made on the CT scan report, a pathological abnormality was described. However, this report was not seen by the consultant urologist as it is his routine practice to review radiological and laboratory reports when the patient returns for postoperative follow-up. The planned four-month follow-up never took place due to the waiting times for review at Outpatients". 14:07

Then, belatedly, the patient came back into the system as an emergency in some distress and was operated upon and relieved, I think, six or eight months later. 14:07

This failure to read the report and to pick up on the abnormality as soon as it could be picked up was addressed in email correspondence By Trust managers with Mr. O'Brien and, indeed, his consultant colleagues. The standard set was 'read your scans reports promptly as soon as they are available to you'. Mr. O'Brien's response to that, I wish you to have a look at. If we go to page 1666 of your bundle, and we'll go to TRU-276805. You're on 1666. This is 2011 and this is Mr. O'Brien writing to Martina Corrigan, who is the head of the service, the Head of the Urology Service: 14:08 14:09

"I write in response to the email informing us that there is an expectation that investigative results and reports be reviewed as soon as they become available and that one does not wait until patients' review appointments. I presume that this relates to Outpatients and arises as a consequence of patients not being reviewed when intended. I am concerned for several reasons." 14:09 14:09

He sets out a number of questions and a number of issues. I probably oversimplify it to say there are resource issues, there are time management issues, asking questions about what actions are to be taken, other legal implications, etcetera. 14:09

Help us with this, Prof. Kirby. In your own practice,

one understands that clinicians get an avalanche of investigative reports placed on their desk, but do you have a method of ensuring, back in the day when you worked in the NHS, that you got to see the reports of investigations in a timely fashion? 14:10

A. Yes, ideally. Just a general comment first about this case. Leaving a swab inside a patient is a never event, but it does happen, especially if you have a change in nursing staff during the operation, as I think occurred in this case. So really it was the 14:10 nurse's job to hand you the swabs and count as they come out, and then they should display them on a rack so you can count them off, 10x10x10. At the end there should be a number of swabs checked. It shouldn't happen but it does happen. When it happens, the 14:11 surgeon is responsible but really the nurse -- the surgeon himself -- or herself these days -- doesn't count the swabs in and out, that's the nurse's job so you do rely on the nurses giving you the right information. That's the first thing. 14:11

That report, it was unfortunate that the radiologist didn't make the right diagnosis of a retained swab, which would have been a major red flag event, but, as you say, there was an abnormal finding 14:11 there. That should have been a sort of lesser red flag. Retained swab is a major one because it nearly always leads to litigation because the patients nearly always sue for that particular reason. But had it been

a recurrence or another tumour, that would be very important to the patient too.

103 Q. I dare say, professor, you would be sued if you don't read your reports for eight months?

A. Yes. Yes, you would, really. 14:12

Then it comes back to a sort of administration issue. I think you can see with Mr. O'Brien, he was a very good surgeon, a good communicator with patients, formed good relationships with patients. Where he fell down 14:12 was dealing with the administration. I mean keeping some of his notes at home, as we've seen, for example, but then not checking the results as they come through.

I mean, having said that, dealing with so many new 14:12 patients and old patients and backlogs, it is easy to see how you could miss that. What I used to do at St George's, even more so in the Prostate Centre, is have the results put on my desk for me to check before they got filed away in the patients' notes. These days 14:13 it is all switching over to digital but there are ways of having red flags set out for clearly abnormal results. The kind of results you would look for is, you know -- I mean, take the example of the Lucy Letby case where the children there were being poisoned by 14:13 her, but there were results coming back suggesting there were very high insulin levels in the blood but they just got filed away in the patients' notes and nobody looked at them so she went on to damage more, to

injure more children. It is a big issue right across the NHS and it is a sort of governance issue.

X-ray reports, CT reports and histology results showing cancer or noncancer, abnormal blood sugars, abnormal insulin levels as in the Lucy Letby example, there are certain things that are crucial to pick up amongst a whole load of background noise, which is just routine results coming through, all of which look perfectly satisfactory. Sometimes looking at the result separate from the patient's notes, so all you have is a result, not all the other information, makes it even more difficult. Ideally, you want the notes and the results, check them and then they go back to filing, and the patient is seen in a timely way. 14:14

Of course, the doctor's strike, where they are now rebooking clinics again and again and again is making this even harder to manage at the current time.

104 Q. I think you are agreeing with me then that healthcare professionals, healthcare managers, are entitled to expect that their clinicians should action results promptly. No doubt they can provide some kind of systems assistance for the clinician, but primarily the responsibility rests with the doctor to get it done promptly? 14:14 14:15

A. Yes. If you order a scan and then you're unaware of the results and the results show something sinister and you missed that, then you're the one responsible

really. Again, you need a good back-up system to help you deal with that, a medical secretary or a nurse specialist.

105 Q. Yes. I think the system is assisted now by some form of electronic sign-off so that a failure to read or engage with the report will be noted electronically by the system auditing facility and you will get a rebuke -- I'm not sure if it is a sharp rebuke -- but you'll get a rebuke or reminder if you don't do that? 14:15

A. Sure. 14:16

106 Q. We will, of course, speak to Mr. O'Brien in due course about his approach; is this a one-off case or is it reflective of a wider approach or a broader approach to these cases? We know, for example, Patient 92's case, which was the subject of an SAI report in 2020 -- not one you've considered but if I can invite you to take a look at it. If you go to TRU-162180 -- sorry, if we go to TRU-162180, and if you can pull up 1584, Prof. Kirby. Just scroll down so we can see that. 14:16 14:17

To summarise, professor, this was a patient who attended for a repeat CT scan in March 2018. It reported a solid nodule suspicious of renal cell carcinoma. There was a failure to follow-up on the scan. The patient came in when her general practitioner realised the deficit some months later. 14:17

If we just go through the report to some of the analysis. If you go to 1587 and we'll go to

TRU-162183, just a few pages along. Just at the bottom of the page, please. It's explaining at the bottom of the page just some of the finer facts of this in terms of when the report was communicated to the consultant urologist, Dr. 3, who was Mr. O'Brien. It says, just the last few lines: 14:18

"The review team have used that the report was completed in a timely manner and escalated to the referring consultant immediately by the radiology team. 14:19
The review team, on the other hand, cannot confirm that the doctor read the report. The secretary has advised the review team that in an instance like this, one whereby an urgent report is emailed, the secretary would print off the report and leave it in the 14:19
consultant's office for follow-up. The review team can neither confirm or rule out that Mr. O'Brien received the email or a paper copy of the actual report".

That would be a fairly standard approach in your 14:19
experience. The report would come in, the secretary -- an experienced secretary -- would see it and put it out for your retention. You're the referring doctor; you're only referred for a report because you think there might be something interesting or important to 14:20
see, and therefore you would consider it a priority to look at the report fairly quickly to either rule in or rule out the need for further steps?

A. Yes. Ideally the secretary would pick that up, put it

on your desk, and put some yellow highlights on the crucial point to bring it to your attention, or put a sticky on it or something, yes.

107 Q. I think one of the problems here, as Mr. O'Brien appears to have seen it, was that he, judged by this case and perhaps judged by the case we're going to look at and which you did look at, the case, I think it is Patient 8, isn't it? No, Patient 5; we'll come to Patient 5 in a minute. His approach appears to be I realise I've referred for a report; probably recognise that that report is coming back but I have other demands on my time and I will read the report at the time the patient comes back for review. The problem with that in this particular service, which was under stress for resources -- it had a demand/capacity mismatch of some significance -- was that the reviews often didn't happen. I will ask Mr. O'Brien whether he must have appreciated the risk that they wouldn't happen. 14:20 14:21 14:21

Have you experience of working in an establishment where there was that level of stress on resources, that reviews would be sometimes difficult to arrange, put on, if not the long finger but certainly they took some time to filtered through, even for urgent cases? 14:22 14:22

A. Well, I think, you know, it is indicative of a service under stress but also somewhat indicative of Mr. O'Brien, the way he managed his administration. As I say, he's a good surgeon, a good communicator, an

academic, started a charity, etcetera, etcetera, but dealing with the paperwork is something that is integral to running a surgical practice. It's perhaps the least interesting aspect of what you have to do but it has to be done and, ideally, done in a timely way where you keep up to date. I think things sort of snowed -- he became snowed under and things sort of ran out of control for a number of reasons, which he'll be able to explain to you himself. 14:23

As I say, there might be 100 results on your desk in the evening and only one or two would show a renal cell carcinoma on a CT scan, but you need some way of that being flagged up and put on the very top. I think in one sense, Mr. O'Brien says his secretary sometimes used to put the results on his chair so he couldn't sit down until he'd looked at them because, you know, that's her way of flagging up important results. There probably would a more efficient way of doing it than that but that's what she did. 14:23 14:24

108 Q. The Trust itself had developed what they called a failsafe called DARO. It's an acronym; the meaning of it escapes me for the moment.

CHAIR: Discharge awaiting results.

MR. WOLFE KC: Yes. I'm told it's discharge awaiting results. 14:24

The idea was that rather than list or attempt to list the patient for review, you would discharge the patient

until the results came in, then you would be triggered to view the results and that would mean that the results would be read, that the patient wouldn't be missed. If the results showed an abnormality, then, as in this case that we've just looked at, I would venture 14:24
to suggest that the consultant would then deploy a red flag approach to getting the patient in very quickly. That was a workaround, I suppose. Mr. O'Brien disagreed with it and wouldn't use it, it appears.

14:25

Would you understand or would you acknowledge where healthcare providers are under resource stress for whatever reason, it is appropriate to find workarounds or mitigation to try and keep everything safe.

A. Sure. It is a governance issue, isn't it, for the 14:25
Trust, so you have to find a way of doing it. It reflects an NHS that offers everything to everybody with limited resources. I think a lot of Trusts are finding themselves more and more swamped and more and more difficult to avoid errors due to overwork. 14:26
I think that's probably what's happened in this case. But it does rely on the senior -- on the consultants to run an administration on behalf of their patients that works okay. DARO is one way of doing it but I can see that's a lot of extra work for the consultants. You 14:26
have to negotiate that work with them, and I think that's where Mr. O'Brien ran into problems.

109 Q. Yes. I think his concern as well, just to be absolutely fair to him and his position, he feared,

rightly or wrongly, that discharging while they await results was a fancy way of taking patients who needed reviews in any event, regardless of results, taking them out of the system. He disagreed with that, he thought that was alien to his philosophy of providing holistic and ongoing care to urological patients on his list. 14:27

A. Yes. Well, the ideal scenario is whatever result you have, it's looked at in a timely way, red flag if there is an obvious abnormality, and then you have the result, the patient, and the patient's notes all in the same place so you can make a sensible decision on behalf of that patient. But that is in an ideal world. Remember, this is pre any kind of electronic patient record. We still don't have that in many Trusts now. But if you have an electronic patient record system, at least you could connect the patient's notes with the results rather than having the results only in isolation. 14:27

110 Q. I think in light of what we discussed, we can deal briefly again with Patient 5's case. You have provided a report on that. If I can remind you, that was the CT scan, 17th December. It showed a possible sclerotic metastasis. Report available 11th January. 14:27

Mr. O'Brien had it in mind to review the patient in January, but there was no booking made for a review appointment so far as we can see. He didn't read the report at that time. I think in his evidence he can't be absolutely sure when he read the report but he 14:28

believes it was some time in or about February or March, perhaps a period of six weeks later. But then doesn't take any steps because we're into COVID. By that I mean doesn't notify the patient, doesn't get the patient in, doesn't notify the general practitioner that perhaps a new PSA test would be helpful to advance the diagnosis.

You've looked at that, as I say. If you can go to 498 of your bundle, you'll find your report on this. We'll go to AOB-42578. 14:29

A. Got that.

111 Q. I think it's towards the bottom of the page. It was after Mr. O'Brien had left the Trust in July of that year that this case comes to the attention of Mr. Haynes, one of his former colleagues, and then steps have to be taken to further investigate the condition. You make the point that the blame for this delay cannot be laid entirely at the door of Mr. O'Brien, it must be attributed partly to the Trust itself with the lack of sufficient Outpatient slots available for patient SUC to be seen in clinic in January 2020. 14:30 14:30

"Had that clinic attendance and consultation been possible, the serum PSA could have been measured and a radio nucleoid bone scan booked which would have alerted Mr. O'Brien to the presence of metastatic cancer". 14:30

Plainly Mr. O'Brien must have recognised he wasn't working in an ideal world and, although he will point to other demands on his administrative time, should he not have recognised that having referred this gentlemen for a CT scan in a context where review slots weren't always available, that that mandated him, really, to read the report in a timely fashion? 14:31

A. Yes. The answer to that is yes. I suppose in mitigation (A) that scan was done as a routine follow-up for renal cancer and the fact that a metastasis from prostate cancer was picked up on it was unexpected. The report doesn't make it entirely clear, you know, it's not a red flag report, it's just a suspicion of abnormality that needs follow up. Ideally, I suppose it would have been sent back to his secretary, who would have put it on his chair so he couldn't sit down without looking at it, as he describes. But that didn't happen. Then, there was a great long delay until the summer before the patient was seen, but that did coincide with COVID, didn't it? One of the reasons they didn't come back for clinic is because clinics were cancelled because of COVID and so on. This was an elderly patient. 14:31 14:32 14:32

Actually, once you have got metastatic prostate cancer, there isn't much evidence that the timing of intervention with hormone -- with castration therapy makes a huge amount of difference. I think in the end

that patient received hormonal therapy, so he hasn't suffered too much as a result. But it is, I have to admit, an omission. That result should have been seen and should have been acted upon.

112 Q. I think Mr. O'Brien fairly concedes that he could and perhaps should have written to the general practitioner when he was aware of this suspicion, even if he didn't want to, perhaps, annoy an elderly gentlemen during the COVID period and what have you. That's right, of course, isn't it? The patient's autonomy and right to know has to be respected in a case like this and perhaps the best way to do it is through the general or family doctor? 14:33 14:33

A. Yes. A letter could have been written to the GP saying this could be prostate cancer, so we couldn't make that -- metastatic prostate cancer, so we couldn't make that it diagnosis with a PSA. When they did the PSA, it came back at over 100. Or more than that, I think. 14:33

113 Q. Let me move on to another administrative-type issue that has the potential and, as we have observed from some SAI cases, the real risk of causing harm to patients if it's not performed. That's the whole area of triage. 14:34

Triage appears to have been an issue in the practice of Mr. O'Brien for quite a number of years before the Trust determined, in 2017, to exclude Mr. O'Brien from practice for a period of four weeks and run an MHPS investigation. As part and parcel of that, they 14:34

imposed a monitoring arrangement in relation to his practice to make sure that the triage was being performed. At the point when the MHPS investigation started its work, it was found -- I don't think that these figures are uncontroversial -- that there were 783 untriaged referrals stored in Mr. O'Brien's office of the routine or urgent variety, and he hadn't found his way to triaging them. 14:35

You will have triaged, no doubt, in your time in the NHS? 14:35

A. Yes. And in the Prostate Centre, yes.

114 Q. Perhaps its importance or significance is well understood. From your perspective, working in a busy NHS facility, no doubt -- if we focus on that rather than your private practice -- how was it performed by you and the team you worked with, and was it a struggle sometimes to get through it? 14:35

A. To be honest, not really. Well, it depends on the volume of referral letters. There has been a bit of a change. There's been a change from GPs referring in to a specific consultant to referring in to the hospital or the Urology Department in general. Over time there's more referred now into the unit rather than the individual as the number of consultants has grown in most departments. 14:36 14:36

I mean, obviously, it's common sense that if you have a patient with a palpable mass in the abdomen, that

could be a kidney tumour or blood in the urine, or a PSA of 1,000 or something like that, that's going to be urgent, that's quite easy. Less easy to find the sort of nonurgent or routine because you always worry that you might miss something. I mean, a good example is the lad with the seminoma; that was triaged as routine and yet he had a testicular tumour. But he had a lump in his testicle for ten years before, you would think why they would think that can't be a tumour, it has been there for so long. So sometimes triage will make a mistake, but you make an honest effort to differentiate urgent from semi-urgent and routine. You do so at your peril of occasionally making a mistake because you don't have all the information. Some GP letter will say, you know, Prof. Kirby, please see this patient, full stop. How are you supposed to triage that? The more information you have... 14:37 14:37 14:37

I think Mr. O'Brien got in a bit of a muddle, he wanted to do advanced triage whereby he looked at the letter and tried to decide which investigation to do on the basis of the letter rather than seeing the patient and having more information. I think that risked doing the wrong investigation -- wasting time doing investigations that weren't really necessary. Then not really paying attention to the ones that he thought were routine and storing them away in his desk drawer and getting behind on his administration with those, which was obviously not good. 14:38 14:38

115 Q. Yes. Plainly, within a healthcare setting that is under stress, it is important to be able to sort the urgent out from the red flags. I think we use the expression "red flag" for the top of the severity spectrum, through urgent down to routine. It's important to be able to upgrade, to triage for the purposes of upgrade, if you think that the referrer has got it wrong. That appears to be the big problem here, that when these 700-odd cases were picked up on eventually, it was found that there were 24 referrals that warranted upgrading to red flag, five of whom were diagnosed with a cancer of one form or another. So there, diagnosis and treatment was thereby delayed. In that context, you can understand the importance of triage? 14:39 14:39 14:40

A. You can. 700 sounds an awful lot but, remember, there are 160 referrals coming in each week. You can see how that's quite a bit of work to look through 160 letters and try and differentiate the super urgent from the urgent from the routine. It takes time to do that. You need some time and to pay attention to it, obviously. 14:40

116 Q. You will have observed, if you read the MHPS investigation report, for example, that triage coupled with the retention of patient charts at home were long-running issues. You probably will have observed that management at different levels were communicating informally with Mr. O'Brien. His clinical lead, Mr. Young, might have been having a word with him, 14:40

occasionally taking the burden of triage off of him but having to hand it back at particular points. It was always Mr. O'Brien's responsibility then.

Can you offer us any thoughts, based on your experience, of the management of that? You were a medical director in private practice. I'm not sure if we asked you whether you had any managerial or team-leading roles in your public practice. This was a problem that went on for some years and wasn't effectively tackled; presumably not a positive thing, whether from a morale or a Patient Safety perspective? 14:41 14:41

A. Yes. You know, I think dealing with very senior clinicians -- surgeons may be more difficult to deal with than some other specialists -- a senior clinician working in the Trust for 30 years or so, coming towards the end of his career, that is not an easy situation to deal with because often it has to be dealt with either by more junior clinical colleagues or by the hospital management. You can see it could have been handled in a more tactful way, in a more positive way. I think what happened, it sort of became a downward spiral and the situation deteriorated rather than improved, people took sides and conflict developed to add to -- what's the word? -- the potential harm to patients. A lot of energy was put into sort of battles within the system. But it is quite hard to get senior clinicians to do what you want them to do. I'm thinking back to -- I mentioned it before -- my own training with very 14:42 14:42 14:42

senior, very famous urologists in London, Prof. Blandy and Richard Turner Warwick, super famous. They had their own rather bizarre way of practising which, you know, people accepted. We just found a way of running the department kind of around their idiosyncrasies. 14:43
We wouldn't have dared to challenge them because they are a bit like James Robertson Justice in Doctor In the House house, you would have got an earful.

I think Mr. O'Brien, I don't know him, but I think he's 14:43
slightly old-fashioned in his approach, and that comes from the fact that he has been in practice for many years and has found it difficult to adapt to a changing landscape of the way that medicine is practised.

117 Q. Another administrative-type issue that you will have 14:44
picked up on was his tendency to retain patient charts at his home, which would appear to have been a by-product of his inability to expedite the dictation that presumably necessarily follows or should follow from a clinical encounter with a patient, whether in 14:44
a review clinic or other settings. We know from the MHPS report that he returned 307 sets of patient notes or charts from his home in January 2017.

I suppose the mischief there, as described by some of 14:45
his colleagues, was the chart oftentimes wasn't available at the right time, at the right place, when a patient perhaps came in as an emergency or unexpected, or sometimes came in to a review clinic and

the chart simply couldn't be found. Again, you would appreciate or understand the importance of not bringing charts out of the premise?

A. Oh, yes. You know, I think that obviously is something to be discouraged. But again in mitigation, I think that to do these clinics in the numerous small hospitals that you have in Northern Ireland, the consultant is expected to drive to the clinic with all the notes, see the patients, load the notes back into their car and then deliver them back into the main hospital. I mean, I don't think that would happen in London, at least. It may happen in other places. 14:45 14:46

Ideally, you want a centralised Outpatient Department with scanning facilities handy and, ideally, electronic notes. It does rather reflect the antiquated way of doing clinics that date back 50 years rather than reflect the modern medical practice, really. 14:46

118 Q. Yes. I think that practice has undoubtedly changed with the use of the Northern Ireland electronic care record, where it is less important for clinicians to have the paper copy. 14:46

Could I just ask you, as I say a subset of this is the delay in record-making which may significantly explain the retention of the charts at home for a long period of time. When you see a patient, whether publicly or privately, what do you anticipate is the expectation of you in terms of record-keeping, both within the chart 14:47

and externally?

A. Well, I think the rules are changing with that. Ideally -- we don't live in an ideal world -- but (A) you need a complete record of the interaction with you and the patient, especially in terms of a plan, especially in terms of the explanation you gave to that patient, so it has to be written down. Then a letter ideally to both the patient and general practitioner; some people send it to the patient with a copy to the GP, sometimes the other way around. That should be done within a reasonable timeframe. 24 hours is probably too short a timeframe. But the faster you do it, the easier it is to do because you can remember all the aspects of the patient without looking it all up again and trying to find the results in the notes. It is better to do it, really, at the end of the clinic but the trouble is you're tired at the end of the clinic. If it's in a place where you have to drive back home with the notes, take the notes somewhere else, you can see how there might be a temptation to delay the dictation and perhaps forgot to do it all together. 14:47 14:48 14:48 14:48

119 Q. Just on directing a letter to the patient and/or the GP, what was your experience? Did you do both?

A. Yes. Actually, I think we were one of the first people, particularly the Prostate Centre, to write to the patient and copy the GP in. You know, because the patient, somebody like yourself, for example, you want to know what your PSA is and what the management is for 14:48

your prostate. Your GP is interested and needs the record but he is not nearly as involved as you are yourself. But that does depend on having good communication with patients and that depends on the patients you're dealing with. If you're dealing with very elderly patients, hearing difficulties and visual difficulties, etcetera, etcetera, you know, relying on them to understand what you're saying about complex urological issues can be difficult. 14:49

That comes back to the nurses, the nurse specialists who would help communicate with the patients and help avoid some of the mistakes that were made in these cases.

120 Q. Help me, if you can. Is that decision to write to the patient being the person primarily interested in the results or the outcome or the next step in the investigation, whatever might be the content of the letter, is that new thinking where you are in England or has that been in place for a while, and does it vary from setting to setting? 14:50 14:50

A. It does vary. It is relatively new. We started in 2005, so nearly 20 years ago now. I think in private practice where the patient is not only -- they made the decision to come and see you, they are paying for the consultation fee, and they want the results pronto, pronto, pronto. If they have a very engaged GP, the GP wants results too. In some cases, if it's a GP whom you know personally, you'd write two slightly different 14:50

letters, one to the patient and one to the GP. Often just a letter to the patient copying the GP was quite a good way to do it.

121 Q. That, with all due respect to Mr. O'Brien, seems like a luxury position compared to what was observed here for several years under his practice. The key to dictating a good outcome letter promptly, or the importance of it, is to ensure good communication with, for example, the general practitioner, and also perhaps other specialisms within the secondary care setting, so that everybody knows what has gone on and what the intended next steps are? 14:51 14:51

A. Correct. Of course, there's another step because you dictate the letter, it's typed out traditionally by a secretary. All that is changing, specialists are beginning to type out their own letters now, but usually typed out by a secretary. Then it has to be checked to make sure they, you know, have done it accurately because it is done from a dictation. 14:52

One example. I dictated a letter saying this patient has a narrow urethra, had restriction in the urethra, and the secretary typed out "This patient has a marrow in his urethra". Luckily I picked that up before sending it to the patient and the GP. 14:52

122 Q. I suppose the expectation is do it promptly, do it as soon as possible; that's both the notes in the charts, which can still be handwritten, of course, although in many settings the clinicians will be typing it into the

record, and, as well as that, to dictate the letter promptly. To the extent that there's any specific or prescriptive guidance on this, Good Medical Practice speaks of -- I don't think we have it on your bundle but you'll probably be well familiar with it: 14:53

"Documents you make to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards". 14:53

It may not be entirely pointless but doing it a year after the event, or six months after the event, is in nobody's interest; isn't that right?

A. Yes, that's right. You have to write down, physically write down or these days type it into your phone or something, the consultation and the outcome from that, the plan, and then separately send a letter to the patient and to the general practitioner summarising the outcome of the interaction you've had. That is part of the job of being a consultant clinician, really. It's often regarded as the dullest part of your job but somehow you have to keep up with that. 14:54 14:54

123 Q. Can you understand the perspective, and it is echoed through Mr. O'Brien's statement where he's saying -- we don't need to bring it up on the screen but WIT-82572 for our reference. His approach to this is that he was very concerned to use clinic time to engage fully with the patient, to engage in verbal 14:54

communication so that the patient and him developed a rapport and an understanding of what the patient's needs and the clinician's response to those needs would be. So, he placed an emphasis on that, it would appear, to the detriment of using that time to get on the Dictaphone, or to, in some cases, make a clinical outcome note.

While that is understandable, you do have to find the time to make adequate notes; isn't that right? 14:55

A. Yes, that's right. As I said before, Mr. O'Brien would regard himself first and foremost a surgeon, second an excellent communicator. If you asked him if he was a brilliant administrator documenting what he had done, he almost certainly would agree that he's not. You know, everybody has a flaw in their nature, I suppose, of some sort. 14:56

124 Q. But there's a danger, is there not. However innocently downplaying these matters as mere administration, chore-like though it may be, there are potentially significant adverse clinical consequences if administration isn't done appropriately? 14:56

A. Yes, there obviously is. But again, a mitigation would be that there's a tsunami of work coming through the system as the patient's age and the number of referrals goes up. You can see how it is easy to become despondent about this side of it and let things lapse. But obviously you shouldn't. 14:57

125 Q. Could I turn to the issue of preoperative assessment.

We've included on your bundle -- and hopefully you've had an opportunity, however brief, to pick up on some of the issues -- there's maybe not large in number but several cases where clinicians operating within the Southern Trust have not carried out an effective preoperative assessment before bringing the patient to theatre. The importance of that, first of all -- maybe it is obvious -- could you spell that out for us? 14:57

A. It is critical to perform a preoperative assessment for Patient Safety reasons, number one; for administrative reasons, number two. If you bring patients in for surgery either the night before or often these days on the day of surgery, and then you find that you can't operate because they haven't stopped their blood-thinning tablet or they've got some other kind of problem, then you lose a slot on the operating list and the waiting list gets longer and longer. 14:58 14:58

The reason I'm not with you today is I've had my knee replaced about five weeks ago, and I had a preoperative assessment there which nowadays you can do remotely, and it was done with a nurse, just to check that it was okay to go ahead and do the operation. 14:58

If you are dealing in urology with elderly patients and overweight patients, etcetera, diabetic patients, then it's particularly important for Patient Safety reasons that you do that. They often have comorbidities, 14:59

particularly cardiovascular comorbidities, which would be another reason not to go ahead and operate.

126 Q. Cardiovascular comorbidity was the issue, I think, in the case of Patient 90. You will have been sent a copy of the serious event audit report. In that case, 14:59
essentially, Mr. O'Brien was the surgeon who conducted extensive surgery on this patient, including bilateral ureterolysis against the background of comorbidities. If you go to 1554 and if we go to TRU-161142. This patient, unfortunately, died following surgery on 15:00
9th May 2018.

One of the issues, as explained -- just scrolling down under "Contributory Factors" -- it explains that a CT scan back almost a year and a half, I think -- 15:00
yes, a year and a half prior to surgery, noted a potentially haemodynamically significant coronary atheroma. "The review team can find no evidence that follow-up investigations were organised for this finding". It goes on to say despite the discharge 15:01
letter from 2016 indicating that an outpatient echocardiogram was required for the patient, the review team were unable to identify that this was completed before surgery.

15:01

This, of course, might have been spotted had a preoperative assessment been conducted. If we go over on to the next page, your 1546, it explains the position around preoperative assessment. The patient

was added to Mr. O'Brien's list some 12 months prior to the surgery actually taking place, pre-admitted for surgery, as you see there, 3rd May 2018, but did not have a formal outpatient preoperative assessment. Mr. O'Brien's views on that, if we go over the page again, please, to your 1546 -- just back a page, sorry. Yes, just at the bottom of the page. Mr. O'Brien, it is noted, says he didn't regret the surgery as the patient's quality of life was terrible due to the affects of indwelling ureteric stents. He does, however, regret not sending the patient for a cardiac work-up, including echo and coronary angiography. When he did have the CT scan in December 2016, he was reported to have the problem set out there. 15:02 15:03

In your experience is this a difficult issue for hospital governance to get right, clinicians ploughing on with surgery notwithstanding known risks with the patient which could be addressed by a timely preoperative assessment? 15:03 15:04

A. Well, another way around this governance issue is to have a formal nurse-led preoperative assessment clinic whereby each patient is contacted, asked which medications they are on, whether they had any cardiac difficulties, especially these days COVID, I suppose. For safety reasons, that's crucial to do that. That's much better than expecting the surgeons themselves to do it. 15:04

I mean, another specialty where this sort of case might occur is orthopaedics, where they are doing hips and knees day in and day out. Of course, they will have some patients who have high cardiac risk, and what you need is a nurse-led clinic and then those patients are filtered out and sent for a cardiovascular assessment. It wouldn't be unusual for the cardiologist to say, listen, you can't operate on this patient, his heart is not good enough; if you operate, he won't survive. 15:04

But then, in this patient's case his quality of life was terrible because of the stents. You can see the dilemma that Mr. O'Brien was faced with. 15:05

127 Q. Yes. We've seen another patient -- Mr. O'Brien wasn't the surgeon -- but there was a failure to preoperatively assess the patient and, in particular, a failure to conduct a midstream urine test before a procedure crossing the mucosa in association with stent replacement. So, it's a problem that's not unknown within This Trust. You think the solution is in dedicating a particular member of staff, perhaps a nurse, to ensure that that check is done in every case? 15:05 15:06

A. Yes. A nurse-led preoperative clinic do a safety check before even quite minor surgery, and a urine culture done for patients, and a cardiac review organised by a consultant cardiologist, if necessary. 15:06

128 Q. Okay. Well, that's all the questions that I have for you, Prof. Kirby. I'm going to hand you over to the

Panel, who will introduce themselves. They may have further issues for you.

CHAIR: Thank you, Mr. Wolfe.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 15:07

CHAIR: Thank you, Prof. Kirby. We do have some few questions for you. I'm going to hand you over to Mr. Hanbury, who you may well know, who will have some 15:07 questions for you first of all.

A. I do know Damian very well. A very good cricketer.

MR. HANBURY: Thank you very much, Prof. Kirby, for your evidence, which has been enlightening. I just have a few clinical things which you might help us in 15:07 the Inquiry out, in no particular order. I'm going to start with some MDT and prostate cancer management side of things.

You mentioned many patients indeed do have lower tract 15:07 symptoms when we are thinking about treating their proposed radiotherapy or other treatments for prostate cancer. There's controversy in the literature about using an LHRH agonist verses Bicalutamide or anti-androgens in favour of LHRH potentially for 15:07 shrinking the prostate. What's your view on that?

A. I think they are more efficient prostate shrinkers, if you like. The profound castration effect does lead to shrinkage of the total prostate volume and the tumour

within the prostate. The downside of them is that, as I mentioned before, the hot flushes, the impact of long-term very profound testosterone depletion. You know, there's this emerging, again controversial, about whether they have cardiovascular risks in at-risk patients; whether there's higher risk of cardiovascular complications from them. It is certainly in the literature at the moment as a point of debate. 15:08

129 Q. Just to go on from that, if the lower attract symptoms is the only thing holding up a patient from proposed radiotherapy, maybe that might be worth considering. We don't seem to see Mr. O'Brien changing tact from Bicalutamide to an LHRH, at least, for that? 15:09

A. That might be something that he might -- I mean, shrinking the prostate doesn't always improve lower urinary tract symptoms, does it? Some of these patients were profoundly obstructed with residual urine, 300 or so. I think a lot of radiotherapists would say, well, I really don't want to irradiate the prostate with this much obstruction because as the prostate becomes inflamed as a result of radiotherapy, I'm very worried they are going to go into retention and then I'll be blamed for the retention; could you deal with the outflow obstruction first, often by a TURP or something equivalent, then do the radiotherapy? 15:09 15:09

There are the other issues, Damian. You know, the patient having to travel to Belfast. There may have been resistance to the patients in wanting to undergo

what is quite a demanding course of prostate radiotherapy, especially in an elderly patient.

130 Q. Thank you. Just moving on, another technique Mr. O'Brien liked was to see a PSA response to hormone therapy, if we broaden that, prior to referring to radiotherapists. Is that something you are familiar with or would you see any merit to that? 15:10

A. I think that is a bit idiosyncratic. I did say that Mr. O'Brien is not mainstream in his approach, but I think you can see there was a logic in his own mind about that. It may have been sort of -- another factor is he seems to want to keep the patient for himself rather than refer him on. He failed, I think, to develop a good relationship with a radiation oncologist. If you are dealing with prostate cancer, ideally you want to work in close partnership with a radiation oncologist because often this decision of surgery verses radiotherapy is a difficult one to decide between, and you do need an MDT collaborative approach rather than try and do the whole thing yourself. 15:10 15:11 15:11

131 Q. Okay. Just moving on to one of the nine cases. There was one case, one man that presented with acute urinary retention. On analysis, they felt that the patient had not had a digital rectal examination at presentation. What's your comment about that? Sort of placed on the list without ... 15:11

A. Ideally, what's the expression? If you're a urologist, if you don't put your finger in it, you put your foot

in it, because you make a mistake by not doing that. Ideally, especially in acute retention, a digital rectal examination will give you two pieces of information - what is the volume of the prostate, very roughly, and is it a hard malignant-feeling prostate as opposed to a large benign-feeling prostate which will, you know, clearly alter the management. Although both patients, once they have a catheter in, will require something to get the catheter out. 15:12

Actually I recently did some medial work with catheters in in the UK who are waiting, waiting and waiting to have their surgery done, and the misery That these chaps are subjected to by long-term catheterisation, with frequent infections and bleeding and so on is rather miserable. You know those issues yourself. 15:12

132 Q. Certainly. On the same subject, there was another case in the nine SAIs where, in fact, Mr. O'Brien had done a digital rectal examination, had clinically suspected prostate cancer but went ahead with the TURP as opposed to perhaps other diagnostic manoeuvres. I read your response to that but do you still feel that was a reasonable course of action? 15:13

A. Well, generally speaking, if prostate cancer is bad enough to produce acute retention, you'd expect to get some histological tissue to confirm it was prostate cancer. It relates a bit to the discomfort of having a catheter in for a long period of time. With long waiting lists for prostate biopsies and then waiting 15:13

the results of the biopsies, then seeing the patient again, then getting them in for their TURP, he may have felt that the kindest thing to do was do a TURP and get the histology that way.

I think Hugh Gilbert suggested he could have done some transrectal biopsies at the time of the TURP. Of course, that does carry infective risk. You can cause -- you can get septicaemia as a result of the transrectal biopsy. I think he was unlucky that the histology came back misleadingly showing benign disease when in fact posteriorly there was aggressive prostate cancer. 15:14

133 Q. Just lastly, one or two examples of Mr. O'Brien using low dose Bicalutamide the pre-op scenario with an anxious patient. Is that something you have used yourself? I know there is some literature, certainly over COVID when there were enforced delays. Generally speaking, do you use that technique yourself? 15:14

A. I haven't done but I can see the rationale for that. There's no question that Mr. O'Brien is a kind, caring, clinician who forms very good relationships with his patients. Most of his problems seem to come from his administration rather than the way he handles patients. I think a kindly clinician giving somebody bad news that they've got prostate cancer so we're going to need to verify this, but in the meantime I'm going to give you a tablet with not many side-effects that will put the situation on hold with an anxious patient, anxious 15:15

family, you could see that scenario might arise.

134 Q. I guess just to push you a little bit more on that point, we're aware of another patient who was on low dose Bicalutamide 50 for some time and then did develop metastatic disease a few years later, in fact after radiotherapy, and had almost no response to conventional hormone therapy at the time. There's been some discussion about the development of hormone resistance disease as a potential side-effect of Bicalutamide. I wonder if you had any thoughts on that? 15:15 15:16

A. It's a theoretical possibility but I don't know of any scientific date to verify that. I mean you are blocking the engine receptors so I suppose you might get mutations within the cancer to make it more hormone resistant, theoretically. I think the science behind that needs to be teased out more. 15:16

135 Q. Thank you. I'm going to move to MDT and quorum. The team at Southern Trust obviously had difficulty with radiology, clinician oncology attendance. At what level do you think the urologists should have said we just can't do this, or we're just not supported enough to run a decent MDT? Because there's certainly some reports of single urologists with no one else there, which, I'm sure you would agree, is not right? "Not ideal" to quote you. 15:16 15:17

A. I think that is a governance issue. Obviously it had been looming for some time. They needed help, especially in the form of a radiation oncologist.

I think the situation in Northern Ireland, as I said before, with so many small hospitals and such a massive workload coming through, getting people in the right place at the right time obviously was difficult. This was in the pre-Zoom era. Much easier now to do an MDT using the technology we're speaking with now. I think there are lessons to be learned in terms of that. To make sure it doesn't happen again, to have a quorate MDT with virtual input from oncology, radiation oncology, histopathology and radiology would be the way forward. 15:17 15:18

136 Q. Thank you. Just a couple of questions about specialist surgery referrals, firstly in the cancer scenario. The small renal mass or small kidney mass-type referrals with colleagues at Belfast seem to be somewhat patchy, was my assessment. I mean, is there a way around that, in your view? If you were sitting around that table, would you have done something differently? 15:18

A. I mean, the case in point that I looked at actually was a small, very slow growing, relevantly benign renal mass. It didn't make any difference at all when it was referred. The scenario we have now with small renal masses is that partial nephrectomy can be done, especially robotically now. People like Ben Challacombe at Guy's are especially good at it and they can remove the small tumours with very low morbidity. It is becoming more and more important to refer patients to the people who have the skills to deal with them, and also the experience, to have a better system. 15:18 15:19

I think laparoscopic partial nephrectomy seems to be working well in Belfast but I don't know whether they are doing it robotically there yet. That's definitely a better way of doing it.

137 Q. That's sort of my point in a way because it started at 2cm and ended up at 4cm, by which time the patient needed a radical nephrectomy, so they by definition missed a chance for ablative, minimally invasive treatment. I guess one could always refer directly to the team in the old-fashioned way of writing a letter. 15:19 15:20

A. Yes, absolutely.

138 Q. The penile cancer case is another case in point. The original IOG and Northern Ireland NICaN guidance does have a clause, which in fact we've used in England, that if the patient can't or won't travel to a specialist centre, then the local team could do the biopsies and communicate, and the specialist centre would run it through their MDT and give you remote advice. 15:20

A. Yes. 15:20

139 Q. That's something that I think most DGH urologists use. Understanding there are transport difficulties and sort of historical opinions about going to specialist centres in England, would you think that that was possibly a missed opportunity as well with that case? 15:20

A. Yes. It would have been good to have more oncological advice, particularly earlier on. But Mr. O'Brien did, I think, quite a good lymphadanectomy. He got five nodes, two of which were positive. He is a very

experienced urologist in the kind of general urologist way that we don't really see any more. We are more and more are specialised within our specialty, or super-specialised, I suppose. I can understand why he thought he could deal with this case himself. I think, obviously looking back, he would have been better to have more advice. Whether or not it would have changed his patient's outcome. I think he had a really aggressive penile cancer that spread like wildfire so actually you would be playing catch-up Whatever you did. Unfortunately chemo and radio, these tumours are not very sensitive to that. 15:21 15:21

140 Q. I agree up to a point. The patient was only [redacted], very young. You elegantly pointed out all the delays, many of which were known about. In a way, that might have been a push to ask a specialist colleague, at least for an opinion, let alone transfer of care? 15:22

A. Yes, I agree with that. In a well-functioning MDT, that would have been flagged up as a sort of MDT -- it would be the urology unit as a whole looking after that patient rather than one individual clinician. A well-functioning MDT would have got round that problem. 15:22

141 Q. I just have another question on specialist surgery on the benign side. We have noticed Mr. O'Brien -- you have been show a case of a poor outcome after a urethrolysis. The only other thing I would add to the pre-op assessment there is the patient was known to have myelodysplasia but did seem to have been seen by 15:22

a haematologist. These are relative rare major operations now which, certainly, in England are being sub-specialised. Does that paediatric sort of invasive Botox bicystoscopy for overactive bladders in the teenage paediatric population, and historically cystectomy reconstruction and Mitrofanoff procedures for young women with pelvic pain, UTI, I mean what's your view on a generalist urologist and a DGH doing that kind of stuff? 15:23

A. Clearly, the advantages of sub-specialisation is that people get better and better doing smaller numbers of operations. In the end, the only operation I did was robotic prostatectomy, virtually nothing else at all. But Mr. O'Brien is sort of -- although he is younger than me, he sort of comes from a different era. 15:23 15:24

I remember when I was training with Richard Turner Warwick, we operated on a patient to do a urological procedure and he felt a lump in the stomach, so he said we better do a gastrectomy whilst we're here. He not only did a urology operation, he took the stomach out at the same time. These very general surgeons with a lot of general surgery -- urologists with general surgery experience used to do everything, and Mr. O'Brien, I think, is slightly locked in the idea that he has this very broad experience and expertise so he can do everything, whilst more and more people of a younger generation are specialising and doing less and less. That has its disadvantages too because 15:24 15:24

we may end up with super-specialists who can't do some of the very general things that need to be done.

142 Q. Just to push you on that last point. You're someone who has a very general experience in a long career, similar to Mr. O'Brien's stage, I won't say age, but you have sub-specialised. Obviously what would you say the advantages to your patients would have been with that? 15:25

A. Well, I followed one route but you remember my friend and colleague, Tim Christmas, a brilliant surgeon who went to the Royal Marsden. He used to love doing all types of surgery. He opted to do open major cancer surgery for lymph nodes testicular teratoma, for example. I found it much more reassuring to just do a few things and do them really well. My anxiety levels were lessened by that. Other people say it is just boring doing the same operation endlessly, why don't you spread your wings and do what you can do, which I think Mr. O'Brien's approach. 15:25

143 Q. Thank you very much. I have no other questions. Thank you, Prof. Kirby. 15:26

CHAIR: Thank you, Mr. Hanbury.

Dr. Swart.

DR. SWART: Thank you for your evidence. I'm not going to go into specific urology things, not being a urologist, so just some general questions. 15:26

You have talked about your practice of writing to patients and GPs. I think in England that has been mandated for quite a long time now anyway. Since 2008, it's actually an edict.

A. Yes. 15:26

144 Q. Before that, I think the cancer world had adopted it to a varying degree. What is your view about the benefit that brings? I'm thinking particularly of the fact patients aren't in the MDT and thinking of the need to summarise the discussions in terms of a treatment plan 15:27 and the MDT decisions. What have you found about that? The reason I'm asking the question is it's not mandated in Northern Ireland and it hasn't been consistent practice here. I would like your view on what it has taught you in your own practice. 15:27

A. Well, we at the Prostate Centre found it really helpful and the patients really liked it. There are issues with it because technically you would want to put more information in to the general practitioner with a medical degree, whilst to the patient you want to 15:27 make it clear and concise and understandable. I used to take a bit of pride in -- I like writing in general, it's something I enjoy doing. So writing, communicating with patients by letter and copying in the GP worked for me. I don't think we had any 15:27 complaints about it.

I used to sometimes worry that the GPs would feel, you know, they were the second order, but the GPs didn't

seem to mind either as long as they got the information they wanted in a timely fashion. And, yes, we would never keep a patient waiting more than a week before they got the letter and the GP got the copy.

145 Q. Thank you. 15:28

Another thing which has been of interest is in relation to the way things operated at the Southern Trust, and to some extent more broadly in terms of governance, but also whose role it is to spot things that are going 15:28 wrong. Could you give me your view of the importance of the collegiate atmosphere amongst the consultant body in a department with respect to keeping patients safe? What has been your experience of (A), the importance and (B), the results when that becomes 15:29 dysfunctional?

A. Well, it is crucial, really. I think there were, you know, red flag warning signs that there was dysfunction within this unit that could have been picked up. But then, it is quite easy to sweep things under the carpet 15:29 because it is so difficult. Some people are very difficult to deal with, especially senior surgeons perhaps.

In quite a few units we've seen around the UK, 15:29 interpersonal rivalries develop, and one surgeon will say to the nurse on the ward, "I would never have done that operation and my colleague can't operate for toffee", something like that. Then that can get out of

control and sort of vendettas develop. You are dealing with human nature. But when problems arise, they need to be addressed. Most hospitals now have -- it used to be three wise men but now I'm not sure, that system is out of date now. But the equivalent of that, sort of troubleshooters. In this case I think the troubleshooters should have gone in there, shaken the system up and devised better ways of doing things. 15:30

146 Q. Have you ever had to work in a dysfunctional department like that? 15:30

A. I'm lucky I didn't. I had a lovely department with two wonderful urologists at Bart's, and then St George's was a great team. Then we set up the Prostate Centre where we handpick the people we worked with.
I personally haven't but I do know of other places. The Royal College of Surgeons have a sort of troubleshooting team that parachute in and deal with these things when they get out of hand. Maybe they should have had the Royal College of Surgeons in Aidan's hospital to sort it out. 15:30

147 Q. Then just a final question. This will be obvious to you but could you just make some comments on the value of cancer guidelines, cancer networks and so on in terms of standardising therapy to some degree and so thereby reducing inequality, you know, between the wealthiest, the poorest, the best informed, the worst informed. What have you seen in terms of answers to that. Do you have any comments? 15:31

A. I do. They're very helpful. In fact, I went to the

funeral of Prof. Sir Mike Rawlins, who set up the NICE, National Institute For Clinical Excellence. Mike Rawlins lived up in Newcastle and died aged 90 just a few months ago. Him and Prof. Gill Leng, my successor as President of the Royal Society of Medicine 15:31
came up with the idea of the NICE guidelines and they have got better and better, I think, and more accepted. I think that guidelines are guidelines, they're not rules, they're not mandatory. They help us make decisions because, in the end, as I've said several 15:32
times today, that the patient's choice has to be preeminent, guided by the clinician who understands the patient and patient's family and takes into account guidelines as well as the view of the MDT. So all of these things need to be put into the mix to end up with 15:32
a patient who is happy with what's being recommended and what treatment is being given to him.

Guidelines are very important. I think we're lucky to live in a country where such good guidelines are 15:32
produced and constantly updated in such an admirable way.

148 Q. Would you agree that it does improve equality of access for the population?

A. Absolutely. In my career over 50 years now of 15:32
medicine, it's improved dramatically. Guidelines have been one of the major facets in improvement.

DR. SWART: Thank you. That's all from me.

149 Q. CHAIR: Just a couple of things to pick up on some of

the things you told us, Prof. Kirby, if I may and I wonder what your view is.

You variously described Mr. O'Brien as an excellent surgeon, you described him as someone who was kind, caring, and a good communicator with his patients. Now, you've told us you only ever met the man on one Zoom call so I wonder where you were getting that information from? 15:33

A. Well, I've read nearly 2,000 pages about Aidan O'Brien so I feel I know a lot about him now. Actually, he mentions in his own -- one of his submissions - that he trained one of our professors in London here, Prof. Shamim Khan, who received the OBE and professorship at Guy's Hospital and, actually, St Peter's Medal just recently at the British Association of Urological Surgeons. So I did send an email, yesterday or the day before, to Shamim, who was trained by Aidan, asking for his opinion of him. He said just what you said to me, that he's an excellent surgeon, a kind, caring clinician, but he is not mainstream in his view of the management of some conditions. His strong point is definitely not administration and dealing with correspondence or stashing notes in the place where they are supposed to be stashed. 15:33 15:34 15:34 15:34

150 Q. Would you accept from me, perhaps, that having excellent knife skills does not an excellent surgeon necessarily make?

A. No. You do need the administration, the communication

and the surgical dexterity. So, there is an issue there with Mr. O'Brien.

151 Q. I'm sure it's just we all have different ways of speaking and it may be just your own particular verbal tick, but I was struck by the fact that you kept refer 15:35
to "ideally" things would happen. You used it in connection when you were explaining the risk and benefit to document discussions with patients in the notes. You used the word "ideally" in that sense. But I`m sure that you would accept, would you not, that 15:35
that is actually something basic rather than ideal?

A. Yes. I think the more that is written down now, the more important it is. You know, for example, the issue of consent. We just used to originally ask the patient to sign the form consent for a TURP, sign it, and go. 15:35
Now you need a long explanation of what you've said to the patient and what they're committing themselves to. So, things are changing. The better the documentation, the better for the patient.

152 Q. The better for the patient and, arguably, for the 15:36
surgeon also?

A. Yes.

153 Q. Because you have speculated about whether or not some of Mr. O'Brien's patients would not have wanted to travel to Belfast to get radiotherapy. We'll never 15:36
know because it is not documented in some cases. Whether they would have wanted to retain their sexual function rather than have the particular androgen therapy; we again won't know because it is not

documented. So while protecting the patient, it also protects the surgeon?

A. Yes, absolutely right. That's more and more important in an increasingly litigious society.

154 Q. One other thing just in relation to -- we were talking about actioning scans. Would you accept that if the waiting lists are long and a review appointment cannot be held as soon as the clinician would like them to be, it is more incumbent upon the clinician to check scans as soon as they come back, or results as soon as they come back? 15:37 15:37

A. Yes, I mean, ideally what we need is a joined-up electronic system. The technology is there now to do remote consultations, order scans online, look at the results online and, you know, action urgent cases, you know, literally within a few days. It could be done but the problem is that we're dealing with such an overloaded system. It is quite hard to change things within the system because doctors are brought up to do things in a certain way. We were all brought up in the sort of paper era where we had to have the notes and the patient in front of us, but now suddenly all these things can be done online. You can see that there are all sorts of issues. Dealing with the very senior surgeons in the department can be the trickiest issue, really. It is hard to get them to change. 15:37 15:37 15:38

155 Q. Clearly in the 2,000 or so pages that you've read and your conversation with a colleague, you formed an opinion of Mr. O'Brien. I just wonder if you would

share some of these views; that he was someone who worked in isolation rather than as a team player?

A. Yes, I think he obviously did. To his detriment, I think, to the patient's detriment. He didn't seem to want to collaborate with his colleagues as well as he should have done, especially the radiotherapists in Belfast. That would have been -- a close relationship would have been ideal. And he had his own way of doing things and perhaps was reluctant to change. I think a lot of energy has been wasted in battles about who should do the triage and who should be the urologist on call and the urologist of the week, and how should we run the MDTs, instead of dealing with the issues. They were allowed to sort of spiral out of control. 15:38 15:38 15:39

That does raise the issue, if you have a problem within a department within a hospital, it shouldn't be left just to deteriorate further and further and further and end up with an inquiry. A lot of these problems could have been addressed and dealt with at a much lower level than what's happened now. 15:39

156 Q. You may well be right and we'll certainly be reflecting on that when we come to write our report.

Thank you very much, Prof. Kirby. You're not getting away just yet. Mr. Wolfe wants to speak to you again. 15:39

THE WITNESS WAS FURTHER EXAMINED BY MR. WOLFE KC:

157 Q. MR. WOLFE KC: Just one other issue. I think you said you wrote to -- was it Dr. Khan -- to seek information by way of his experience or her experience of working with Mr. O'Brien? 15:39

A. Just a one-line email to Mr. Khan. I'm not sure, was I allowed to do that or is that ...

158 Q. It's not something I'm raising any controversy about. What I'm really asking you or wanting to ask you is did you seek the views of anyone else? 15:40

A. No, only Mr. Khan. Because I read Mr. Khan's name in some of the documents I received just a few days ago being used as an exemplar of a trainee who'd benefitted from Mr. O'Brien's experience, and he certainly has been a major asset to urology. 15:40

That's another facet of Mr. O'Brien's career that we haven`t really covered, that as a trainer of other surgeons and as a generator of, I think you call it the CURE charity where he raised £85,000, I think, and so on and so forth. He has made contributions as a trainer and as a researcher. I think he sees himself as one of the leading, most senior urologists in Northern Ireland but, unfortunately, he seems to have become a bit isolated towards the end of his career. 15:40 15:41

159 Q. Thank you for that. That was just that one query. Everybody else content?

Thank you for your evidence, Prof. Kirby.

CHAIR: Thank you, Professor.

Ladies and gentlemen, that concludes this week's evidence. We will be back again on 4th December for a rather long week because we have four days sitting that week. 15:41

THE INQUIRY ADJOURNED TO MONDAY 4TH DECEMBER 2023