Urology Services Inquiry

Oral Hearing

Day 62 – Wednesday, 20th September 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.

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THE INQUIRY RESUMED AS FOLLOWS ON WEDNESDAY, 20TH SEPTEMBER 2023

CHAIR: Good morning everyone.

MS. McMAHON: Chair, panel, the witness this morning is Prof. O'Sullivan, a consultant urologist with the Belfast Trust, and he wishes to affirm. 10:04

CHAIR: Just before that, Ms. McMahon, I think is there a new representative in the chamber?

MS. McMAHON: Yes, I was going to do that after, but maybe I'll do that now. Yes, Laura King on behalf of Prof. O'Sullivan. 10:04

MS. KING: Madam, Chairman, panel. My name is Laura King. I represent Prof. O'Sullivan, instructed by Sarah Loughran from DLS. 10:04

CHAIR: Thank you, Ms. King.

PROFESSOR JOSEPH O'SULLIVAN, HAVING AFFIRMED, WAS EXAMINED BY MS. MCMAHON AS FOLLOWS:

10:04

MS. McMAHON: Good morning, Prof. O'Sullivan. Thank you for coming along to give evidence to the Inquiry. My name is Laura McMahon, I'm junior counsel to the Inquiry. We've already met, but just for the record I'll formally introduce myself. You have already 10:05 provided us with a section 21 notice setting out your answers to some of the queries we have raised and, on foot of that, we thought that we should bring you along just to explore some of the issues in your statement a

little bit more fully.

A. Okay.

1 Q. We'll just go to your section 21 first of all. You can find that at WIT-96648. Do see your name at the top of that, it's Notice 25 of 2023. And if we go to WIT-96651, just go to the bottom of that page and we'll see a signature there. Is that your signature? 10:06

A. It is, yes.

2 Q. And it's dated 17th May 2023?

A. Yeah. 10:06

3 Q. Do you wish to adopt that as your evidence to the Inquiry?

A. Yes.

4 Q. Are there any amendments or corrections at this point before we just go through your evidence? 10:06

A. No.

5 Q. Thank you. Now, the context of your evidence and why you're here is that you were interviewed by Dr. Hughes on 4th January 2021 in relation to a number of SAIs concerning former patients of Mr. Aidan O'Brien. 10:06

A. Yes.

6 Q. And you provided us with this evidence. And the purpose of today is to ask you about that in more detail and to allow the panel to raise any issues or queries they may have with you. 10:06

A. Okay.

7 Q. So, we have a limited time, we have this morning to work through that, and hopefully that will be all that's needed. We'll just start off with your

background and your current role.

A. Yeah.

8 Q. Then I want to move on to your engagement with consultants from the Southern Trust, and generally the way in which communications operated between them and the Belfast Trust where you were based. 10:07

A. Okay.

9 Q. And then we'll move on to address some of the issues arising from your section 21, in particular look at the interview with Dr. Hughes, then the prescribing generally around Bicalutamide 50mg as a monotherapy, I'll just ask your views on that. 10:07

A. Yeah.

10 Q. Then some of the concerns you raised around Mr. O'Brien and your interaction with others in relation to those concerns. And then I want to ask you some questions about the e-mail sent by Darren Mitchell, Dr. Mitchell, in 2014, to Mr. O'Brien. 10:07

A. Yeah.

11 Q. And then just some mop up points that you've referred to in your statement. 10:08

A. Okay.

12 Q. I don't know whether you got the chance to listen in to Darren Mitchell and Chris Hagan's evidence yesterday?

A. Not yesterday, no. 10:08

13 Q. Well, just by way of background, we did cover their involvement around their concerns. Obviously some of that interacts with your...

A. Yes.

14 Q. Experience. So, I'm not going to repeat, unless it's necessary for your evidence, the issues. So I'll try and stay nice and focused on what you can bring as regards your own personal experience and, of course, your expertise? 10:08

A. Okay.

15 Q. I wonder if you could just then set out for the panel the background of your clinical experience and your - how you got to Prof. O'Sullivan and your current role?

A. Yeah. So medical school within University College Dublin from 1987 to 1993, after which I did some general medical jobs and then joined a radiotherapy training scheme in Dublin, completing that in 2000, when I moved to Royal Marsden Hospital London to do a fellowship in prostate cancer, where I also did a doctorate thesis, and I left there, joining the staff at Queens University Belfast on 1st January 2004 as a joint appointment between Queens as a senior lecturer in oncology and Belfast City Hospital, as it was then, as a consultant clinical oncologist. And I've worked in the same role for the last 20 years almost. I became a professor in 2011, following an advertised post which I applied for and was successful with, and over the last 20 years I have continued to work as a clinical oncologist. For the last ten years or so purely in prostate cancer, prior to that I would have also covered bladder cancer along with prostate cancer. I currently have a busy academic prostate cancer practice based at Belfast Trust at the Northern Ireland

Cancer Centre, looking after men with prostate cancer as part of a wider oncological team.

16 Q. And in relation to the split of your work, clinical and academic, how does that operate?

A. Well, officially it's meant to be roughly 50/50, but a lot of my research is done with patients, so in clinical trials. So in my standard clinic, maybe half the patients are taking part in some form of clinical trial. And then I also spend time supervising, for example, other researchers like PhD students, organising grants and that type of thing. So it's roughly a 50/50 split between academic and clinical work. 10:10

17 Q. Thank you. For the purposes of today, we'll need to go back and forward in time slightly, because the starting point for some of your knowledge is 2004. 10:10

A. Yes.

18 Q. When you started in the Belfast Trust.

A. Yes.

19 Q. You were consultant at that point? 10:10

A. That's correct, yeah.

20 Q. And so we'll move back and forwards. We're very conscious that you sit now with much more experience than you did at the timeframe that we're referring to?

A. Yes. 10:11

21 Q. And the panel is mindful of that.

A. Yes.

22 Q. But we would like to explore some of the issues and ask, if you can, to bring yourself back to various

times?

A. Sure.

23 Q. So we can try and unpick any governance learning that might be useful for the panel.

A. Yes. 10:11

24 Q. I just want to ask you about your engagement with the Southern Trust, the way in which it operated. We'll come on to look at your, some of the issues you raise in your statement around referrals and how you identified perhaps some issues? 10:11

A. Yeah.

25 Q. That you thought needed rectified.

A. Yeah.

26 Q. But just for the purposes of understanding referrals, how did that operate at that time in 2004? 10:11

A. At that time, well, most of the referrals coming to myself as a Belfast Trust oncologist were coming from the Belfast City Hospital urologists, so the team there. We also would have covered some of Antrim and the Ulster Hospital area as well. Whereas patients who 10:11 were diagnosed in the Southern Trust would have come through the visiting oncologists. So at that time when I started first, Dr. David Stewart was the clinical oncologist who would visit from Belfast to Craigavon, do a weekly clinic, see patients on treatment, and also 10:12 identify new patients for radiotherapy in Belfast, for example. So the vast majority of diagnosis from Southern Trust would come via the visiting oncologist. And it was quite uncommon that referrals came directly

from Southern Trust to myself in Belfast.

27 Q. So, Dr. Stewart would have travelled then to the Southern Trust and dealt with referrals on-site, as such?

A. Yes, he would have done a clinic once, I think on a Wednesday, I think an all day Wednesday clinic. So it would have a mixture of new referrals and patients in follow-up. 10:12

28 Q. And did that also happen in other Trusts?

A. Yes. 10:12

29 Q. That there was, I won't call it outreach, but that there was a travelling by a specialist to the area?

A. Yes, this was very much the model of hub and spoke practice where there were four cancer units, there was Craigavon, Ulster Hospital, Antrim and Altnagelvin, and each of those then had visiting oncologists for the different tumour sites, so urology obviously was the one relevant here, but there was also GI cancer, lung cancer, etc. 10:13

30 Q. And was it as a result of the review in 2009/2010 that it centralised referrals to Belfast or did it happen before that? 10:13

A. I think it happened before that. I think that the unit system had been established from the Campbell Report some years previously. So that system of visiting oncologists to the local units was well established when I arrived here in 2004. 10:13

31 Q. And you said just a moment ago that it was, I think you used the word "rare" or perhaps not frequent?

A. Uncommon I think, yeah.

32 Q. Uncommon. That you would have had referrals directly to you from...

A. Yes.

33 Q. And when would those referrals, what sort of scenario would that take place? 10:13

A. Well, it might have been a patient, for example, who had been looked after - who knew me already or had a family member who had been looked after by me, perhaps had requested that specifically they come to Belfast, or perhaps it was in relation to a clinical trial that might have been open at the time that a patient might have enquired from their urologist "Oh, maybe I'd like to take part in that trial", in which case I would be the person to refer to. 10:14 10:14

34 Q. Just to put in context at this stage questions that I'm going to ask you in a moment around the referrals.

A. Yeah.

35 Q. The ones that you remembered, and I think you numbered them around three... 10:14

A. Yes.

36 Q. Between a period of 2004 and 2008, in which you had concerns around the prescription of Bicalutamide 50mg as a monotherapy?

A. Yes. Yes. 10:14

37 Q. Do you recall if those referrals came to you directly from Craigavon?

A. I think they probably came to the central team and I picked them up. You know, depending on the setup,

there may be two or three of us oncologists in Belfast who would take those referrals, and depending on who had new patient slots available. I don't recall specifically if they were directly referred to me personally or to the wider team.

38 Q. And was it possible that either you could have been the named referred to consultant or --

A. It's entirely possible that I was the named.

39 Q. Or randomly allocated that patient based on the workload of the other consultants at that point? 10:15

A. Yes. Yeah.

40 Q. There were three of you?

A. That's right. At that time, so centrally Dr. Stewart, who also covered Craigavon, would have also done some central urology practice, Dr. Stephan Stranick did the same as well, and then laterally, I think about 2005, another colleague, Dr. Lin Shum came on board as a central oncologist.

41 Q. And at this point when you started in 2004 did you know any of the consultants from Craigavon? 10:15

A. No, I didn't know anybody here at all.

42 Q. Now, Mr. Hagan, who is the Medical Director, as I'm sure you know in Belfast Trust?

A. I do.

43 Q. Yesterday was referring to a period of time around 2010, and his evidence to the Inquiry was at that time all of the other urology units in the region were dialling in to the Regional MDT, apart from Craigavon. And that's in the context of the possibility to discuss

cases that might have been, or could have been or should have been referred.

A. Yeah.

44 Q. And may have been delay in referred. Do you have any recollection of there being, at least from Dr. Hagan's perspective, a disconnect with Craigavon at that point? 10:16

A. I don't remember specifically there being a disconnect, but I do know that they were not involved in the Regional MDT at the time, because I was Chairperson of that MDT at the time. So we had links from - well it was a bit sporadic - from the Ulster hospital, we had links from Antrim and also, depending on the case, from Altnagelvin as well. 10:16

45 Q. When did you take up Chairship of the MDT?

A. I think pretty much as soon as I arrived in Belfast I was handed that lovely job. It was not as organised as MDTs have now become. In those days it was prior to the sort of national reorganisation and I suppose restructuring of MDTs. It was a little bit more ad hoc at that time, and as the new boy in the door I was given the job of Chair very quickly. 10:16 10:17

46 Q. And you stayed in that job until 2014?

A. Correct. Just before I became clinical director.

47 Q. Is ten years as Chair of MDT unusual?

A. Well, it's definitely a long time. I felt it! Again, in the early years it was quite, I wouldn't say ad hoc, but it certainly was not as structured and we didn't have a quorum of people who had to be there, etc. That became much more formalised in subsequent years. So I 10:17

guess it wasn't that much of a burden. And, again, as a new person in, I hadn't got so busy yet. And then all of a sudden I was the only person doing it and...

48 Q. Perhaps you couldn't say no?

A. Probably at that stage. But then luckily, when I became Clinical Director, it became obvious I couldn't do both of those roles. 10:17

49 Q. And we'll speak about that as well. But that was 2014 you became Clinical Director?

A. Correct. 10:18

50 Q. And Darren Mitchell took over then as Chair of MDT?

A. Yes, he did. Yes.

51 Q. And that's where you have that connection at that point in time?

A. Yes. 10:18

52 Q. And we'll look at the e-mail around that time.

A. Yes.

53 Q. Now, just for the completeness of the record, Mr. Hagan did mention that after some events in 2010, which you're not part of and I don't need to go into, that Craigavon started to tele-link into the Belfast MDM, and that was for the purpose of presenting patients who had muscle invasive bladder cancer that might require radical prostatectomy. Now, do you recall that development of the tele-link involvement? 10:18

A. Yes, I remember it changed where surgery became, major pelvic surgery became centralised and, therefore, patients who needed a major operation, for example a cystectomy, or a cystoprostatectomy, or even a

prostatectomy, would be discussed by the Regional MDT team where the pelvic surgeons were present, and they could between them make a decision whether it was appropriate or not for a patient to be considered for major pelvic surgery. 10:19

54 Q. Now, did you consider, as Chair of the MDM meetings at the time, did you consider that that involvement collectively in relation to expertise and knowledge was beneficial?

A. Well, I thought it was absolutely essential. If you're going to recommend a major operation you should have the people who are expert in doing those operations and who are actually doing those operations to give the opinions. So absolutely necessary, yes. 10:19

55 Q. I just want to look at the interview with Dr. Hughes. And if we could go to the typed note at TRU-162262. That's TRU-162262. Oncologist. I just want to read this into the record. So, this was a meeting with you on Monday, 4th January 2021, via Zoom at 11:15. The attendees were Dr. Dermot Hughes and Mrs. Patricia Kingsnorth, who we have -- we have heard from both of those witnesses. So, "DH" obviously is Dr. Hughes and "JOS" is your initials, so I'll just read from the note: 10:19 10:20

"DH thanks JOS for meeting with him and explained the process to date regarding the SAI review involving 9 patients (one with penile cancer, 1 testicular cancer, 5 prostate cancers and 2 renal cancers.) 10:20

He asked if JOS was aware of any issues regarding the practice of Mr. AOB. JOS advised that when he came into post initially about 17 years ago, he had concerns in relation to the use of Bicalutamide and that they had frequently challenged him about the treatment. He made recommendations in clinic letters questioning the use of Bicalutamide 50mg instead of the standard 150mg or LHRH agonist therapy. In the cases he had seen, the dose of Bicalutamide would not have resulted in a major detriment to the patient's therapy/outcome and therefore was not escalated further. JOS said that he was aware that his colleague DM (as MDT Chair) had raised our concerns about AOB's Bicalutamide prescribing with the then CD for oncology, SMcA, probably in 2011. 10:21 10:21 10:21

JOS said that the MDT improved with the attendance of two of the newer consultants about 7 years ago.

DH advised that there were a number of delays of people being referred for oncology/palliative care. 10:21

DH said that there were issues regarding lack of oncologists attending MDM as it was on the same time as lung MDM and that there was inadequate cover for CAH MDM. 10:22

JOS agreed he did want it recognised that there was a

lot of good work from urologist in CAH and good involvement in MDT, in particular he named two consultants, Mr. MH and Mr. AG.

DH wanted to assure JOS that the SAI review will also recognise the good work that the MDT are doing and recognised that the concerns relate to one person's practice. It would seem he worked in isolation despite being involved in a multi disciplinary team. JOS said that that was his impression of Mr. AOB." 10:22

And it ends at that point. Do you recall the interview?

A. Yes.

56 Q. Over Zoom. And when you -- the first contact you had with Dr. Hughes was him informing you that he needed to speak to you? 10:23

A. Yes.

57 Q. Did he say why you had come on to his radar at all?

A. Because I think probably Darren Mitchell had mentioned that I had remembered some cases of Bicalutamide 50mg monotherapy, I think. I think that was the reason. 10:23

58 Q. Now, you had been given this note and asked to comment on it and correct it, and you did indicate some tracked changes. We'll just go to that at TRU-162366. If we just move down. So, where you have made the corrections, you'll see on the - it's highlighted clearly on the screen. 10:23

A. Yeah.

59 Q. And you have made comments on the right. The first one I'd like to bring you to is the second paragraph down, where the comment is made - this is the initial note, subsequently changed into what we have just read:

10:24

"He advised that he had raised concerns to AOB in writing but Mr. AOB produced evidence to support his practice. JOS advised that as the drug did not apparently cause harm, they didn't escalate further."

10:24

In the comment for that, you say:

"I would have made recommendations in clinic letters questioning the use of Bicalutamide 50OD instead of standard 150mg OD dose or LHRH agonist therapy. I 10:24 didn't write any formal letter of concern.

In the cases I had seen the dose of Bicalutamide would not have resulted in a major detriment to the patient's therapy outcome and therefore was not escalated 10:24 further."

Now, your comment is reflected in what we've just read.

A. Yes.

60 Q. But this initial version, I just want to ask you, where 10:24 you've said "Mr. O'Brien produced evidence to support his practice"?

A. Yeah, I don't recall that at all.

61 Q. Do you recall saying that?

A. No.

62 Q. Do you recall if Mr. O'Brien ever did produce evidence to you?

A. Not that I can recall.

63 Q. Or anyone else, and they told you? 10:25

A. Not that I can recall.

64 Q. Do you have any explanation as to why that particular sentence -- I ask you because it does tend to support a view that Mr. O'Brien had engaged at some level with you or others and had supported the prescribing of 10:25 Bicalutamide 50 as a monotherapy with evidence?

A. Certainly never directly to me.

65 Q. But do you have knowledge of it with anyone?

A. I mean, I have vague recollections of there being some evidence produced about 50mg of Bicalutamide, but it 10:25 wasn't directly to me and I don't recall it in detail.

66 Q. Do you recall who it was with?

A. No.

67 Q. And when you say you have vague recollection, is that in the context of that evidence being supportive of the 10:25 appropriateness of prescribing Bicalutamide 50mg as a monotherapy?

A. Yeah, I think it probably was when I was having discussions with colleagues about this practice and somebody said - oh - it might have been mentioned 10:26 somewhere that Mr. O'Brien had some evidence of 50mg daily. But I mean, I'm very well aware of the field of prostate cancer and there are no evidence supporting that.

68 Q. Now, the other issue that's commented there was:

"JOS said that the MDT improved with the attendance of two of the newer consultants 7 years ago. AOB was seen as an outlier." 10:26

A. Yes. I mean the comment about the MDT, that's the Southern Trust MDT, and what I mean by "improved" was that consultants, clinical oncologists from Belfast were as job planned to attend that MDT, where there had been some gaps in oncology cover for the Southern Trust MDT. That was that comment. 10:26

Again, I don't remember saying that Mr. O'Brien was seen as an outlier. I don't recall saying that. 10:27

69 Q. And just the next sentence after that:

"JOS said that Mr. AOB was an objector to recommendations and did not engage with or respect the MDM process." 10:27

A. I definitely didn't say that, those words exactly. I think what I meant was that with the prescribing of 50mg of Bicalutamide that seemed to be outside of standard MDT recommendations. 10:27

70 Q. Just for completeness, if we could look at the handwritten note. Patricia Kingsnorth, who we have heard from, she took the notes from the call.

A. Yeah.

71 Q. TRU-165299. And this is the handwritten note from Mrs. Kingsnorth. You'll see the fifth line down that has writing on it, at the last part on the right-hand side it says:

"Aidan produced evidence base for 50mg use."

And that's the formal note as, as much as a handwritten note can be formal by Zoom?

A. Yeah. Yeah. 10:28

72 Q. But that's the note, the recollection?

A. Yeah.

73 Q. So you may have mentioned at the interview with Dr. Hughes what you've told us, you have a vague recollection? 10:28

A. Yes.

74 Q. And that there was something produced.

A. Yes.

75 Q. And I think you've said, and we'll go on to look at your understanding or your expertise in Bicalutamide 10:28 50mg as a monotherapy, that there is no evidence base for that?

A. Correct.

76 Q. You also, in your section 21, took the opportunity to correct another aspect of Dr. Hughes' note. If we go 10:28 to WIT-96648, at paragraph 1(i). So, we give you an extract from the note that I've just read out and then at point (i) we ask:

"Confirm whether the above is an accurate record of the discussion during interview. To the extent that it is not, please identify any alleged inaccuracies and offer clarification of same."

10:29

And you say:

"The above statement is accurate except I don't recall saying "frequently challenged" in relation to Mr. O'Brien around the Bicalutamide 50 monotherapy prescription.

10:29

My intended phrase was challenged on a number of occasions."

10:29

A. Yes.

77 Q. And then you take the opportunity to also correct the date. Your reference to Darren Mitchell having spoken to Dr. McAleer?

A. Yeah.

10:29

78 Q. And you say at paragraph 1(i)(b):

"I was incorrect about the date Dr. Mitchell discussed with Dr. McAleer. It was 2019 and not 2011. The discussion was about a proposed regional protocol concerning the use of hormone therapy in prostate cancer, rather than specifically about Mr. O'Brien's prescribing. I did have a discussion with Dr. Mitchell in 2014 regarding my recollection of a few cases

10:30

(involving prescription of Bicalutamide 50mg daily as monotherapy in prostate cancer) that I had encountered early in my consultant career."

And those are the totality of your corrections around what you say represents your evidence to Dr. Hughes... 10:30

A. Yeah. Yes.

79 Q. When he spoke to you. You had said in response to what Dr. Hughes had said in the reference that we've looked at, TRU-162262, where Dr. Hughes said a comment to the effect that it would seem Mr. O'Brien worked in isolation, despite being involved in a multi disciplinary team, and you said that was your impression of Mr. O'Brien. How did you form that impression and what was it based on? 10:31

A. I think I may have - I correct that statement further down in that document as well.

80 Q. Yeah.

A. I thought that was a bit of a leading question really. So I don't think I would have phrased it like that. I think my impression, if it was in that vicinity, was in relation purely to the prescribing of Bicalutamide 50mg daily and that being outside of standard guidelines. 10:31

81 Q. We'll just go to paragraph (iii), where you answer that, just to remind you what you said. Sorry, it's WIT-96650. So, we'll see there at paragraph (iii): 10:31

"During the interview referred to above..."

-- we've just read that:

"...in response to a comment by Dr. Hughes to the effect that it would seem he, Mr. O'Brien, worked in isolation, despite being involved in a multi disciplinary team, it is recorded it JOS said that was his impression of Mr. AOB."

And we've asked you what led you to have this impression. And you say: 10:32

"This impression was based on my experience with the cases that had been prescribed Bicalutamide 50mg as monotherapy. My view was that an MDT would be unlikely to recommend this therapy and that it was probably the 10:32 decision of Mr. O'Brien alone."

A. Yeah.

82 Q. So your impression of, your view of Mr. O'Brien in that context was that had the prescribing of 50mg as a 10:32 monotherapy once daily been subjected to MDT oversight then it may not have passed muster?

A. That would be my view, yes.

83 Q. But you didn't have any direct connection or contact --

A. No. 10:33

84 Q. -- with Mr. O'Brien in order to form that view for any other basis?

A. I did not, no.

85 Q. I just want to ask you some questions generally so that

the panel has a baseline based on your area of expertise, but also your clinical experience.

A. Yes. Yes.

86 Q. In relation to cancer guidelines, what guidelines do you follow? 10:33

A. Well, it really depends on the situation. With regards drugs that are reimbursed it would be the NICE Guidelines would be a big guide within the UK system as to what both the protocols for diagnosis and treatment, as well as what drugs are available, are funded within 10:33 the UK. So that would be one core. The ESMO Guidelines would be another guideline in oncology generally, that's the European Society of Medical Oncology. To a certain extent the EAU, that's European Association of Urology. But I would say for 10:34 oncologists in practice in the UK it would be the NICE Guidelines and ESMO Guidelines would be the dominant guidelines we would adhere to.

87 Q. And those guidelines, are they updated and reviewed?

A. Yes. 10:34

88 Q. Dependant on advances in technology.

A. Exactly.

89 Q. And medical research?

A. Yes, I think most of them get a standard revamp every two to three years, but if a new piece of evidence, a 10:34 new strong piece of evidence comes out then it would be incorporated fairly quickly within that guidelines.

90 Q. We've heard evidence around the NICE Guidelines and they seem to overarch a lot of the clinical practice

generally...

A. Yes.

91 Q. In the UK.

A. Yes.

92 Q. Are those guidelines informed by these other guidelines? Do they work in collaboration in any way? 10:34

A. I would say they're informed by the same evidence base that informs all the guidelines. Each guideline committee has a slightly different agenda or different emphasis, I suppose. But essentially they would be influenced by each other but mostly because they are based on the same sets of evidence, large clinical trials mostly. 10:34

93 Q. Are there ever examples of tension between guidelines that allow people to exercise discretion about their prescribing? 10:35

A. Yeah, sure, there would be some differences. Because - especially the European guidelines have to cover a lot of different jurisdictions where practices are organised differently and health services are organised differently. So, yes, there will be some gaps between them. And there also are some areas where there are evidenced gaps. You don't have a clinical trial to tell you how to do everything, so there are sometimes when you need consensus opinion type thing and there can be disagreements on those type of consensus views. 10:35 10:35

94 Q. And in the same context, the guidelines are guidelines, and clinicians clearly have to exercise their own professional judgment.

A. Yes.
95 Q. Depending on the clinical presentation of any particular patient?
A. Exactly. So each individual patient, especially relevant in cancer, where the differences between patients can, you know, their lifestyle, their priorities mightn't fit exactly with what the guidelines were written for. So, yes, you have to have some flexibility in applying those to an individual person. 10:35 10:36
96 Q. So keeping in mind that potential flexibility and the discretion that's exercisable by the clinicians...
A. Yeah.
97 Q. Are there circumstances in which you would use Bicalutamide 50mg once daily as a monotherapy? 10:36
A. No. Apart from the few weeks around. So what it's normally - it's used in two broad categories. It is used for, one, is to prevent testosterone flare in patients commencing treatment with LHRH agonists or castration therapy. So usually a week or two prior to 10:36 the first injection patients are on Bicalutamide 50mg daily, and that's to prevent something called testosterone flare. So I use that frequently. And the second circumstance is used in combination with LHRH agonist therapy. And a patient who is on that type of 10:36 therapy, but their cancer is starting to progress, sometimes we add Bicalutamide 50mg daily to the hormone injection. But it's not as a monotherapy.
98 Q. And what are the risks of Bicalutamide 50mg as a

monotherapy?

A. I don't think there are any particular toxicity risks. I think the risk, biggest risk I guess in this context would be a patient not having adequate therapy for their cancer, perhaps starting definitive therapy for their cancer later than they should have done or -- it would depend on how long the patient was on the monotherapy for. If they were on it for a very extended period of time, like years, that would certainly compromise their chance of being cured by other surgery or radiotherapy, depending on which was the curative treatment being suggested. 10:37 10:37

99 Q. So in those circumstances would you consider it to be a suboptimal treatment?

A. I would definitely consider - if it was being used a cancer therapy, then certainly 50mg daily is suboptimal, yes. 10:37

100 Q. The panel heard evidence yesterday around the hormone resistance --

A. Yes. 10:38

101 Q. -- building up if someone is on this for a long period of time, and the body naturally becomes resistant to that.

A. Yeah.

102 Q. If there is a need then to, as you say, use it in combination with another form of treatment, that they may actually, it may prove ineffective because of that. Is that -- 10:38

A. Yeah, I mean any patient exposed to hormone therapy

will eventually become resistant if they're continually exposed to it. I think my bigger concern about the lower dose of Bicalutamide is that it would have inadequate control of the cancer. And while it might control certain aspects, I suspect the cancer would progress sooner compared to a patient on full dose Bicalutamide. 10:38

103 Q. Would it be common in your practice to change dosage of Bicalutamide in response to side effects?

A. No, no, not really. I mean when Bicalutamide 150 is used there are a number of side effects that patients can experience. We try to mitigate those, but patients can experience fatigue, hot flushes, mood swings, and breast growth and breast pain, which we normally treat with a drug called Tamoxifen. 10:39

104 Q. And what are the circumstances, the clinical circumstances under which you would prescribe Bicalutamide 150?

A. Yeah. That's commonly used in patients with intermediate risk prostate cancer who are intended to have curative treatment with radiation therapy. And normally - it depends on the risk group of the patient, in other words how bad their cancer is, that will dictate the duration of hormone therapy. But the minimum will be six months of Bicalutamide 150, and normally that's three months therapy before the radiation treatment, a month during the radiation, and then six or eight weeks following the radiation therapy, and that's in conjunction with the radiation. 10:39 10:39

105 Q. And that treatment regime involving Bicalutamide 150, has that been a longstanding regime?

A. Very much so. I've been doing that for 25 years or so. It's well established. It's in the NICE Guidelines.

106 Q. As well as being well established, is that a reflection that it is an efficient and effective form of treatment? 10:40

A. It is an evidence based form of treatment, yes. It's been proven to be effective. It improves the outcomes from radiation therapy in those patients. 10:40

107 Q. When would you expect to see a referral to you as an oncologist with someone who fits some of the patient profiles that you've just described?

A. These days generally it's at the point they've just been officially confirmed as having prostate cancer and that they would be potentially suitable for an opinion from oncology. So that would be anything from very low risk early prostate cancer, which might be suitable for active surveillance, right through to patients with very advanced metastatic disease. So we would see all of those patients. But from my perspective as an oncologist, we really only hear about the patients once they have been officially diagnosed with prostate cancer, and that's when they're discussed at the MDT. Sometimes a patient might have what we call a clinical diagnosis of prostate cancer where they haven't had a biopsy because they're maybe unfit for other reasons, and in those patients we have to make a sort of clinical decision that they have prostate cancer. And, 10:40 10:41 10:41

again, that would be at the MDT, and that would be the first point of involvement for oncology.

108 Q. And what are the risks of late referral to oncology?

A. Again, that would depend on the patient category. It would depend on the aggressiveness of the cancer. Many different factors in relation to the patient. So for some patients it might make no difference at all, some patients with very low risk prostate cancer probably are better off not being diagnosed in the first place, and for those patients a delay is not going to make much difference. Other patients at the more advanced disease ending might either miss a chance, the window of opportunity for cure by radiation or surgery or brachytherapy, or a later stage patient might become more symptomatic by the time they were seen by us, for example, developing pain or symptoms of advanced cancer progression. 10:41 10:41 10:42

109 Q. And given your area of expertise and your academic research profile as well, are there times when you would prescribe a non standard protocol based on your own experience or for research purposes, rather than on the published evidence? 10:42

A. Well, in a research trial there would be an ethically approved, you know, very carefully controlled experiment. So if a patient's going into there, it would be very much that we look at the ethical as well as the scientific rationale for that study. So that would be a very controlled environment. In a sort of non clinical trial standard clinical practice setting, 10:42

yes, of course we have to make decisions that are maybe outside the guidelines at times. I think proudly in Belfast we do this as a group. So if we're going to do something that's well outside the guidelines, or something that's, you know, that could be questioned later, then we tend to have a peer group discussion about that beforehand.

110 Q. And when you referred to outside the guidelines, is that the same as saying that the use would be unlicensed? 10:43

A. Yeah. No, not necessarily, no. It might be using a licensed drug but maybe in a different circumstance than the guideline. The guidelines and the licence are different things really. The licence has more to do with the pharmaceutical, is it a proven pharmaceutical? 10:43 Is it safe? Are the production appropriate, etc.? Whereas the guidelines is telling you where you should use that or where the evidence base supports using that therapy or drug.

111 Q. So you can use a licensed drug but in an non evidence based way? 10:43

A. Or in a non guideline way. Yes. You know, there may be an evidence -- usually it would be a situation where there is an evidence gap, where there is no specific evidence to guide a particular clinical scenario. And 10:43 that could be a patient who has a big comorbidity, for example a heart disease, or a lung disease, or liver disease, something which makes it difficult to give them standard therapy and you have to be a little bit

more flexible.

112 Q. And if you were to step to the side of the guidelines, or outside the guidelines, as you say with how the patient presents...

A. Yes. 10:44

113 Q. What would you tell the patient about that? What way would you inform them and how would you record that?

A. Yeah, generally we'd be very straight with patients, saying that "In your particular situation this would be the standard treatment, but for whatever reason in your 10:44 situation we can't do that", and we would have a discussion about it, "and here's what we've decided to do based on our best opinion." As I say, we would make them aware.

114 Q. And would you record that in the notes or is that not 10:44 normal practice?

A. I would say generally if something is very much outside the guidelines I would dictate in the notes that I've discussed with my colleague, and probably name them so that they're in there too. 10:44

115 Q. At what point, if you were -- at what point would you consider experimental therapy for patients with prostate cancer?

A. I consider that for every single patient I see, because that's my job is to be experimental with designing new 10:45 treatments. So I really try to think about - in our clinical practice in Belfast we try to have a clinical trial for each, as much as possible, each different clinical scenario. So I think of research for most

patients. However, thankfully things have improved a lot in prostate cancer care, so we know a lot more. Compared to when I started 20 years ago, we're a lot better at managing, especially high risk and advanced prostate cancer.

116 Q. And in practical terms how do you go about arranging that sort of therapy?

A. Experimental therapy?

117 Q. Yes.

A. That's a long journey. So it depends on the type of clinical trial. Let's say a clinical trial that I've designed myself, which we've had a few of those, you start with an idea, then you build a team of scientists and clinicians around that. It usually takes three or four years to go from an idea to a clinical trial opening, and what's done in that time is you make sure that you have the ethical approval, you've a protocol that's acceptable to everybody, and you have to meet the regulations, for example the NHRA, the various different national guidelines have to be met. And then once it's been approved for opening, and that's usually by a sponsor, so in trials that I would run, Belfast Trust would be the sponsor for a number of trials, and they do the overall I suppose governance of the trial to make sure it's reason properly, and then we have clinical research nurses, as well as my colleagues, who would tell the patient about the trial, would give them information and then they take part. But it's usually a two or three-year gestation to get a trial from idea

to opening.

118 Q. Now we've talked about outside guidelines in prescribing and I've just asked you a question about experimental therapy.

A. Yeah. 10:46

119 Q. What would be the definition of experimental therapy in the context that you've just described? That sounds like a research project that has obviously a great deal of oversight.

A. Well, to me experimental therapy, in the context of how I work, is therapy that's being offered as part of a clinical trial, that it's something which has not yet been proven to be of use or in a particular clinical scenario, and you're either testing to see how safe or how toxic it is, or you're deciding - you're comparing that to a current standard therapy. So there are different -- it depends on the phase of clinical trial. If it's one where it's almost to the patient, we cause that a Phase 3 trial, and you're basically comparing the experimental or the unproven treatment to the current standard guideline treatment and you see is it better or worse or whatever. So that's how I would design experimental. 10:46 10:47 10:47

120 Q. And that's a way of trying to establish if there's a new evidence base for new treatment? 10:47

A. Yes. So you would be based on some sort of scientific or clinical hypothesis that you think, well, I think this therapy might work in these patients because of X, Y and Z reason. Then in order to get a trial open you

have to, other people have to agree with you that that is a reasonable experiment or a reasonable question to ask, and then, depending on the type of trial, it might be comparing that idea, or that new treatment, or that new way of doing the treatment to a current standard of care. 10:47

121 Q. And from what you've said, it would appear to be the case that that's the pathway for a drug to become licensed?

A. In general terms, yes, especially pharmaceutical. So if the pharmaceutical company has a new product in development, they will tend to do the large Phase 3 trial, and exactly that, the purpose of that trial, it's called a registration trial, would be to get the drug licensed or available for a particular disease situation. 10:48 10:48

122 Q. So everyone could look back and say "We got to this point with this licensed drug based on that research, this evidence base, and we know about the efficacy of the drug"? 10:48

A. Yes. Yeah, efficacy and safety as well, yes.

123 Q. In relation to standards and guidelines that are adopted in your practice...

A. Yeah.

124 Q. Are they analysed or reviewed by departments within hospital, or within the Trusts, or what way does that work from your clinical experience? 10:48

A. Yeah, well, certainly when the NICE, when NICE come up with a new therapy, or they've approved a new therapy,

for example, I will normally get an e-mail from somebody in the pharmacy department in the Trust saying "NICE have just approved this. We have three or six months to implement. What are the plans?", and you know, whenever I've been in positions where I've been the lead for a particular drug coming in, then I would liaise with pharmacy to make sure the drug is available for our patients, according to NICE Guidelines. We have a certain amount of time to implement that.

125 Q. And if you wanted to deviate from those guidelines, NICE Guidelines, if you would at all, how would that happen? 10:49

A. Yeah. I mean I would say it's not that common that we deviate, because essentially NICE Guidelines particularly covers drug therapies, and if NICE haven't approved it then we can't afford the drug. So. Or we can't offer the patients the drug. 10:49

126 Q. What about a deviation from the MDT or the MDM opinion or view?

A. Yeah. 10:49

127 Q. I know it's only a recommendation and, of course, things may change, it's a point of contact post MDM...

A. Yes.

128 Q. But if you wanted to deviate from a recommendation, how would you go about that? 10:49

A. Again, I think that would be fairly uncommon in my situation. But a lot of MDT recommendations are quite general. For example, it might say something like "Patient should have, should be offered curative

therapy", and in that case then they go and discuss surgery with one of the urologists, they discuss radiation therapy or brachytherapy with ourselves, and then we have a shared decision. So the MDT is not saying this patient should have surgery or should have -- or even, it won't even say what type of hormone therapy they should have, for example, it just says "This patient should be considered for curative treatment". That's one example. So even though -- in my view that's quite a broad group of recommendations. If you were to say, if the MDT was to recommend that a patient should have curative, or should be considered for curative therapy and you decided, no, they shouldn't be considered for curative therapy, that would be a very big deviation from the MDT, in my view. So if I saw the patient and I go "No, I don't agree with the MDT, this patient is palliative or not for treatment." 10:50 10:50 10:50

129 Q. And what would you do about that?

A. I mean I would definitely discuss that with other colleagues and say -- well, I would ideally have it rediscussed at the MDT and say "Well, actually, we've got further information now." For example, "This patient has very severe dementia and they're probably not suitable for radical treatment", something that may have been missed in the diagnostic pathway. 10:51 10:51

130 Q. And what are the ways in which you might be aware that a colleague or practitioner has deviated from guidelines or recommendations?

A. It might be difficult to know that for sure. In our practice in Belfast it's very much a group practice, so I think it would be unusual, because we tend to, as a group, we see the patients as a group of doctors, we don't have individual patients allocated to ourselves. 10:51
So I think it would be unusual that that would happen in any kind of frequent basis without us having discussed with each other.

131 Q. So you don't always see the same patients if they come back? You share patients? 10:51

A. Correct. Yes.

132 Q. And is that a way of having some peer oversight?

A. It's a mixture -- I think that's one, definitely one benefit of that practice. It also means that individuals don't have to be there every clinic, so we 10:51
can share the practice. But definitely one benefit of that is maybe identifying if there's somebody sort of going on a solo run of some description.

133 Q. And if you saw a solo run, how would you deal with that? 10:52

A. I would say that would be a conversation we would have together quite informally as colleagues. I can't imagine that happening in our current setup, but if it did, it would be very easy to have a conversation with each other as a group of doctors. 10:52

134 Q. And when -- the setup that you've just described, how long has that been in place in the Belfast Trust in your particular team where that --

A. Pretty much since I started. This was a practice I

brought from Royal Marsden, where I had spent four years, and the way we do it is, before each clinic - so we have two big clinics in the week, Tuesday and Thursday mornings - and for the one hour before each clinic we sit down as a group of doctors, we talk through all the patients who are coming to clinic, what the purpose of the clinic visit is, is it the results of scans, or is it a decision on treatment, or is it just a follow-up visit, and as a group we decide, "Yes, this gentleman needs to start chemotherapy", or this gentleman needs to stop something or change to something else. So we will have a group discussion about each and every patient coming. And I have been doing that since I arrived back in Belfast. Initially it was just myself and one of the nurses, but now it's about 30 people in the room. 10:52 10:53 10:53

135 Q. And since 2004?

A. 2004 was myself and maybe one nurse, and then we built it up over time as the team built, yes.

136 Q. I just want to go back to your statement and turn to some of the concerns around Mr. O'Brien's referral to you, or referrals that you picked up. 10:53

A. Yeah.

137 Q. And if we go to WIT-96649, paragraph 1(iii). So question: 10:53

"When did you first become concerned about the use of Bicalutamide?"

And you say:

"I can't recall the exact time I became aware of the issue, but it was during my initial few years as a consultant in Belfast (2004 to 2008). The vast majority of my referrals were from the Belfast City Hospital urology team, however I also received occasional referrals from Mr. O'Brien or other members of the Southern Trust urology team. 10:54

(iv) What was the cause of your initial concern? 10:54

My concern was about the use of the oral antiandrogen Bicalutamide 50mg as monotherapy for the treatment of localised prostate cancer. The correct monotherapy dose of Bicalutamide is 150mg or alternatively LHRH agonist therapy. I noticed several cases where patients had been on Bicalutamide 50mg as a monotherapy, prescribed by Mr. O'Brien. My concern was that Bicalutamide 50mg was a suboptimal dose of hormone therapy when used as a monotherapy." 10:54

Then you're asked at (v):

"Please indicate at that time your specific concerns in relation to the use of Bicalutamide were?" 10:55

And your answer is:

"My specific concern was that patients were receiving a non evidenced based hormone therapy dose which might be suboptimal therapy for patients with prostate cancer."

We'll just stop there and discuss the detail of your issues at that point. 10:55

A. Yes.

138 Q. So, as set out, you start in 2004, referrals either came in through a named route or as a general referral and you may have picked up one? 10:55

A. Yeah.

139 Q. You've mentioned in your statement that you had a few concerns. Do you recall the number, the number of patients that raised concerns with you?

A. In thinking about this, it was three is the number that comes to me. 10:55

140 Q. And you don't -- do you have any specific recollection of those patients?

A. I do not, no. No.

141 Q. Now, when you first noticed this, was it when you spoke to the patient or based on the referral letter? When did you first recognise that Bicalutamide 50mg as a monotherapy had been prescribed? 10:56

A. In taking a history from the patient.

142 Q. Would the referral letter have included that information? 10:56

A. Possibly. But I don't recall that specifically. But I would have, you know, part of the assessment of a patient is going through, "Okay, what treatment have

you had so far? When did you start that?"

143 Q. And in 2004, when a patient was being referred to an oncologist, was a letter sent to the GP?

A. I would think that would be pretty standard practice. But I don't recall specifically if these had copied a GP. But, yes, usually the GP is aware, yes, or is made aware. 10:56

144 Q. And the GP would be responsible for issuing the prescription for treatment, or would that have been picked up at the hospital do you know? 10:57

A. Yeah. Usually in Northern Ireland the way it works is you write an outpatient prescription form that you either give to the patient or sent to the GP practice, and then the GP practice then puts that on to a script that's brought to a chemist. Generally in hospital medicine here you don't prescribe directly to pharmacies. 10:57

145 Q. And we have spoken about the longstanding nature of Bicalutamide prescribing.

A. Yeah. 10:57

146 Q. Would that have been information that one might have expected a GP to know, that standardised dose of 150?

A. I don't think so, no.

147 Q. Is that because of the area of specialty, that if they hadn't of experienced a patient on that, they may not necessarily have that brought to their attention? 10:57

A. Yeah. I think it's quite niche area of expertise, especially with regards different doses of Bicalutamide. GPs would be well aware of Bicalutamide,

but they may not be as aware of the subtleties and difference in dose.

148 Q. Do you recall the clinical presentation of the three patients at all?

A. I don't. But my assumption, based on the fact that it was 50mg, was that they were patients with potentially curable prostate cancer, but I can't recall their particular risk groups. 10:57

149 Q. Now, you've given us scenarios, I think earlier you gave us two scenarios in which Bicalutamide 50mg may be used in combination with another as part of a regime. 10:58

A. Yes. Yes.

150 Q. Given the concerns that you identified with three patients, is it fair to say that those patients didn't fit that profile? They weren't on a combined regime in any way? 10:58

A. Correct. So, they would have been ones where they were solely, the sole treatment for, at least for the cancer, was Bicalutamide 50mg daily. And that would have stood out as being outside standard practice to me. 10:58

151 Q. So, the way they presented didn't justify in any way, in your view, them being on Bicalutamide 50mg as a monotherapy?

A. No. 10:58

152 Q. Now, just you've mentioned the time period that you were aware of this from 2004 to 2008.

A. Yes.

153 Q. And the Inquiry has seen an e-mail then from Darren

Mitchell, which you obviously had sight of in 2014?

A. Yeah.

154 Q. Which is obviously a decade later.

A. Yes.

155 Q. When the issue was continuing to be raised. 10:59

A. Yeah.

156 Q. When you first -- if I can ask you, and I appreciate that you can't recall particular details.

A. Yes.

157 Q. When you saw the first patient, was there any sense from you that this was an error, that you just didn't understand it, or did it alert you right away that there was a concern? 10:59

A. I can't remember specifically the order of patients, but it certainly jumped out as something which was not standard care, standard of care. But it didn't raise any major alarm bells, you know. It could have been an error. There's a number of explanations why -- you know perhaps the patient had been planned to receive the hormone injection, in which case being on Bicalutamide monotherapy for a few weeks would be okay. But clearly these cases it was longer than a few weeks. I can't remember exactly, but certainly it stood out as being not being prescribed in preparation for an injection of hormone therapy. 10:59 11:00

158 Q. And that applies to all three patients that you recall?

A. Yes.

159 Q. Now, I know that you've said in your evidence, and we'll go on to that, that you corrected the

prescription to 150mg, but did you say anything to the patient at the time?

A. I can't recall. But I certainly would have explained that I'm putting you on to a higher dose of Bicalutamide. I'm not sure if I would have discussed any detail as to whether I thought that was right or wrong or -- I can't remember. 11:00

160 Q. And you recall that this patient was referred to you, or was the referring clinician Mr. O'Brien?

A. Yes. 11:00

161 Q. Now, the second time that it happened and the same issue arose, you can't help us with what timeframe there may have been between that?

A. I can't. They may be quite close together. I really can't recall the timeframe. I know it was -- all I know is it was early in my consultant years here. I was quite a junior consultant at the time. So I can't remember the exact sequence of - they may have been reasonably close together, I can't recall. 11:01

162 Q. And did that engender any concerns within you that "here we go again"? 11:01

A. Not particularly, no. I don't recall thinking like that. I guess it was still relatively early days, getting to know Northern Ireland and the health service here as well, so... 11:01

163 Q. But you do recall that the referring clinician was Mr. O'Brien?

A. I do, yeah.

164 Q. And then on the third occasion when this happened and

you noticed it, was this a potential trigger point for there being an issue here?

A. Possibly so. But I don't recall it being that, and I certainly didn't escalate it at the time. I probably dealt with it in the same way, which was just writing back saying "I've now switched him to the full dose of Bicalutamide." 11:01

165 Q. Was the commonality of all of the patients were that they were referred from the same clinician on a drug regime that was suboptimal and not prescribed? 11:02

A. Yes.

166 Q. -- for licensed use?

A. Yeah. And I had never encountered Bicalutamide 50mg as a monotherapy before from any other doctor.

167 Q. I suppose the point I'm asking you to comment on: Was the commonality of those issues sufficient for you to identify that there was something going on? 11:02

A. In retrospect, that seems to be the case. But at the time, I don't think it occurred to me, no.

168 Q. Now, you described earlier that you could be a named referral or random, I think you used the word "randomly" -- 11:02

A. Yeah, it would be "Dear Oncologist".

169 Q. "Dear Oncologist" or "Dear" --

A. Or "Dear" -- if there was -- I think the only reason it would be specifically to my name might have been perhaps a patient who I'd looked after a friend or a relative of theirs already and... 11:02

170 Q. Or if Mr. O'Brien knew of your reputation perhaps and

wanted to refer to you specifically?

A. Perhaps. I don't think he knew much about me in those days though. I was fairly new on the scene, so.

171 Q. But the referral nature and the way in which allocations were made... 11:03

A. Yes.

172 Q. Did that increase the possibility that other people may have been also receiving referrals from Mr. O'Brien?

A. Well I'd say most of Mr. O'Brien's referrals would have gone, at that point, to Dr. Stewart, who was the visiting oncologist from Belfast Trust. 11:03

173 Q. And how did they get around him to get to you then?

A. I don't know. I mean it didn't really occur to me at the time. But, you know, generally the radiotherapy, which is I guess what a lot of patients were referred for, only takes place in Belfast. So I guess it didn't really matter where the patients were seen initially at that point. The treatment would be in Belfast ultimately anyway. 11:03

174 Q. So there was a route to get into Belfast and it was either through Dr. Stewart or yourself? 11:03

A. Yes. I mean, by far and away the most common was through Dr. Stewart, who was attending the unit.

175 Q. Did you have any concerns about the risk that the patients were being exposed to by not being on the correct clinical regime, given that earlier in your evidence you said that the patients not having adequate therapy for their cancer was the risk of this suboptimal regime? 11:04

A. Yeah. I think at the time I probably made an assessment that these particular patients I saw, once I switched them on to the correct dose and lined them up for radiotherapy, that they were going to be okay, I think was my assumption. I think if any of those patients, if I had felt they were at a major deficit in terms of their likely long-term outcome, I probably would have raised more concerns about it at the time. 11:04

176 Q. And if you had of considered that there was a greater risk or that there was harm - and we'll look at that in a moment... 11:04

A. Yeah.

177 Q. What would you have done at that time?

A. I think if I was convinced that there was definite harm to patients, I would have raised it with my Clinical Director. That would have been the usual route at that stage of my career. 11:04

178 Q. And I know you were a consultant at this point?

A. Yes.

179 Q. Would you have any expectation of the steps that a Clinical Director may take when presented with that sort of information? 11:04

A. I would assume they would talk to their equal number in the Southern Trust and see is there a wider concern, or probably have a conversation with the individual consultant involved. 11:05

180 Q. So, as we mentioned earlier, the informal approach to try and see if this is perhaps a misunderstanding, lack of --

A. Yes.

181 Q. -- proper information, or if there was something else going on.

A. Yes.

182 Q. And if that wasn't then resolved, would it be your view that, or expectation, that formal governance processes would be triggered? 11:05

A. Yes, I think if somebody - if somebody was identified as practising outside the guidelines without good reason then I think that would be a governance issue, yes. 11:05

183 Q. If you were to see letters like this, containing information where clinical regimes are not evidence based and acting outside guidelines currently, what would you do? What would you do now today about this? 11:05

A. Yeah. I think - first of all, I think the easiest thing would be talking to my colleagues and see is this just an error or is this a one-off or what? You know, try and understand the situation. If it was a pattern of behaviour then I think Clinical Director is the first route in the sense of my line management to let them know. So that would be my first port of call. 11:06

184 Q. So, the modes of dealing with this issue are effectively the same as they were in 2004?

A. I think so, yeah. Yeah. Where it goes from there may have changed, but as a clinician operating, or working in Belfast Trust, my line manager would be Clinical Director, and that be would the first person I would notify. 11:06

185 Q. And from your earlier evidence it would seem that your view is that something like this could happen again, couldn't happen again, because there is greater collective vision on documents and patient pathways?

A. Well, I can only speak for the practice we have in Belfast. It would certainly be very unlikely to happen in our practice the way it is right now in Belfast with peer oversight. 11:06

186 Q. And I think from your statement, you didn't actually speak to anyone about this at the time? 11:07

A. No.

187 Q. Was the first time that you mentioned it in 2014, when Darren Mitchell brought up the issue that he had identified, and indicated that he was going to send an e-mail? 11:07

A. Yeah, that certainly -- when he brought up a case, that refreshed my memory that I had encountered some cases earlier in my career, yes.

188 Q. Just on the law of averages, you have seen, you think you recall three cases between 2004 and 2008? 11:07

A. (Witness Nods).

189 Q. Darren Mitchell then from 2008 to 2014 thinks he saw three cases.

A. Right.

190 Q. Do you think that there's a possibility that other clinicians had cases like this? 11:07

A. It's possible, yeah.

191 Q. What sort of team numbers, what sort of numbers are we talking about potentially who could have got referrals

or had knowledge of this?

A. So, oncologists who would have -- over the course of the last 20 years you mean? Probably eight to ten oncologists, something like that. Yeah. There were some oncologists who spent a short time as locums servicing the Southern Trust, they would have had some --

192 Q. Moving around, staff morning around?

A. Yes. Yes. So there would have been some people sort of filling in for a while and then more substantive posts. There were a few people who stayed for a while and then moved on. So probably about ten people altogether. 11:08

193 Q. And you don't remember anyone discussing this issue with you? 11:08

A. Not particularly, no. No.

194 Q. When you say "not particularly", I suppose I need to try and get a firmer answer, if possible.

A. Well, I don't recall specific conversations about this prescribing pattern. I probably had forgotten about it by the time Dr. Mitchell raised it again in 2014. 11:08

195 Q. Have you ever seen anything like that at all in your career, where you're getting more than a couple of referrals with inappropriate clinical treatment on your view? 11:09

A. I can't recall any specific - no, I can't recall any specific episodes of that, no.

196 Q. Did you have any sense, whenever Darren Mitchell spoke to you in 2014, did you have any sense of ten years

later this problem is still here?

A. Yeah, probably to a certain extent, yeah. Probably surprised, yeah.

197 Q. Did it cause you any concern?

A. Not specifically. But, you know, I suppose on reflection, with all this going on, yes, I suppose perhaps I sort of felt maybe I should have made more of it back in the early days. 11:09

198 Q. And given what you've said at the start of your evidence around the risks, do you see that there was at least a potential for an existing patient risk? 11:09

A. Yes. Yeah.

199 Q. Now, you've said that you changed the patient regime. I'll just finish up just on this topic, if that's convenient for the Chair. You said you changed the patient regime to Bicalutamide 150mg. 11:10

A. Yeah.

200 Q. In doing so, you would have written a letter to the GP, or the referring consultant or both?

A. Both. Usually you would write to the referring consultant saying "Thank you for the referral", but you'd also copy that same letter to the GP so that the GP had the plan of action for the patient in their notes. 11:10

201 Q. And do you recall how you might have addressed in that correspondence the fact, first of all, that you had changed the treatment regime and, secondly, that the first treatment regime was in your professional view inappropriate? 11:10

A. I may not have commented on the appropriateness of it, but I would have just said that I've now switched to the standard dose of Bicalutamide and the plan is for radiotherapy after a period of months, or something like that. 11:11

202 Q. Would there be a reluctance to have put something on paper that might have suggested that you were challenging the initial treatment?

A. Probably, yes, as a junior consultant, yeah, I would say so, yeah. 11:11

203 Q. Do you recall if you ever saw any of those patients again?

A. Not specifically. I'm certain we would have done, because if they were -- I assume they were radiotherapy patients, so we tend to follow those men up for five years or so after their treatment. So, probably, yes. 11:11

204 Q. So it wasn't in your mind, or you weren't sufficiently concerned to look at their notes when you saw them again to make sure that the 150mg prescription regime had been adhered to? 11:11

A. Well, I would have assumed that the 150 had been adhered to, yes.

MS. McMAHON: Chair, I wonder if this is a convenient time?

CHAIR: Yes, we'll come back at half past eleven. 11:12

MS. McMAHON: Thank you.

SHORT ADJOURNMENT

CHAIR: Thank you everyone.

MS. McMAHON: Prof. O'Sullivan, before the break we were discussing the dosage of Bicalutamide and the 150/50 issue generally. When Darren Mitchell gave evidence yesterday, Dr. Mitchell, he had referred to the fact in his evidence, written evidence as well as oral evidence, that patients not given the correct information or on incorrect treatment regimes can be viewed as having been misled. Would you agree with that? 11:29 11:30

A. Sorry, could you rephrase that question? Sorry, I didn't quite get...

205 Q. Well, Dr. Mitchell was being asked about a variety of patients in relation to bladder cancer in particular...

A. Yeah. 11:30

206 Q. But the general point to him was, concerned whether patients, if they were on the incorrect treatment pathway, or have been treated in a way that would not be the norm, then there's a possibility, in his view, that they have been misled. 11:30

A. Yeah. Yes, that's true, yes. Yeah.

207 Q. I appreciate it's easy in hindsight for us to use phrases such as that when you are talking about isolated cases in your mind of three over a four-year period. 11:30

A. Yes.

208 Q. Can I take it from your evidence so far this morning that the idea that a patient had been misled didn't enter your head back then, or would you just not have

framed it that way?

A. I was probably more focused on making sure the patient got the right treatment henceforth, and that was probably my major focus, to make sure they were hopefully offered the best advice with regards treating their cancer and getting them on to the correct dose of Bicalutamide and then organising their radiotherapy, was probably my major focus, rather than worrying whether they were misled or not. 11:31

209 Q. And I had asked you if you had spoken to anyone about it and you said "not particularly"? 11:31

A. Yeah. Yeah.

210 Q. Did you speak to David Stewart about it?

A. I don't recall specifically. I mean if I was talking to anybody, it would have been him, but I don't recall specifically talking to him about it. 11:31

211 Q. Did he ever raise this issue with you?

A. Not that I can recall.

212 Q. Do you think it might have been a useful approach at that time to gauge the experience of your colleagues to see if this was a wider problem? 11:31

A. Yes, I think with more experienced years behind me, that's certainly what I would do now. But those days I guess I was still finding my feet as a consultant, so I probably wasn't as well able to do that type of move. 11:32

213 Q. So, if I refer to it as inaction, but I'm not saying that in a critical way, just in a factual way.

A. Sure.

214 Q. If I can phrase my question in that way?

A. Sure.

215 Q. You're saying it was based on your lack of experience rather than the absence of any governance processes that would have allowed you to address it?

A. Yeah. I mean, looking back, probably I wasn't so aware of the governance processes at that stage of my career. And also I probably had, yeah, not seen it as serious enough to merit escalation at that time. 11:32

216 Q. And how do you become aware of governance processes as you progress through your career? Is it trial and error literally, or is it training, updating? How does that work? 11:32

A. It's all of the above. But for me, also it was gaining experience in roles not -- outside the standard consultant looking after patient role. So in medical management. So various roles over the years, MDT Chair, Lead for Radiotherapy, and then Clinical Director, you pick up a lot of skills and you meet a lot of people who have knowledge of these systems and you learn from them. 11:33 11:33

217 Q. And do you think that the culture within an organisation and within departments, and even within clinics, has a part to play on whether people feel comfortable raising governance issues?

A. I do. Yeah, I do. And I think looking back, you know, when I think when I arrived here from London I didn't know anybody here, I was very, you know, not quite isolated, but certainly didn't know how things worked. So that takes a while to get - not just to understand 11:33

the governance structures, but also to understand exactly, as you say, the culture. Just coming in from it cold, it takes a while to understand the culture.

218 Q. And the two parts of that maybe are the confidence of the person who needs to speak about something and also a listening ear or a willing recipient of that information? 11:33

A. Yes, both of those things, exactly, yeah.

219 Q. What would make it easier, in your view, for junior colleagues, or indeed any colleagues, to raise concerns such as this? 11:34

A. Yeah, I think first of all, it is a culture where everything gets discussed in a friendly, non-confrontational manner, and essentially just leading from the front as a more senior consultant now, I certainly would encourage open discussion in our peer chats when we're discussing patients, and we try not to have a hierarchical approach to that, but we do bring -- I have a lot of experience now, so I bring that to the table. But we really try and create a culture where junior members of staff feel empowered, and that's really just by having a friendly attitude to how we operate. 11:34 11:34

220 Q. And have you had to talk to colleagues over the years informally about issues maybe just that you needed clarity on or were concerned about? Have you had experience of that? 11:34

A. Sure. Certainly as Clinical Director that would be a weekly occurrence, yeah.

221 Q. And as Clinical Director, is that something that, in your experience, has brought about the necessary change, or have you had to then instigate formal governance processes?

A. There have been occasions where formal governance processes were required. But as I say, for the most part a more informal discussion solved a lot of things. 11:35

222 Q. And again from your experience as Clinical Director, when the governance processes are instigated, whichever pathway that involves... 11:35

A. Yeah.

223 Q. Is it your experience that the learning from the outcome of those processes is fed back?

A. Yeah. Well, I can only really talk about Belfast Trust, but that was certainly my experience when I was Clinical Director, that whenever incidents happened or learnings were found, that it was fed back in a pretty good way, I think. 11:35

224 Q. When were you Clinical Director? Do you remember the -- 11:35

A. Yes, I do, very well. September 2014 to September 2017. For three years.

225 Q. Until September, sorry?

A. So it was probably the end of August 2017.

226 Q. So you'll know, I'm coming onto the e-mail in November 2014. 11:36

A. Yes.

227 Q. And if we could just have that e-mail? The panel looked at this yesterday in detail, but I just want to

bring it up again. AOB-71990.

A. Yeah.

228 Q. Now, we've looked at this, and that's the content of the e-mail for the purposes of the transcript.

A. Yes. 11:36

229 Q. And then if we go to WIT-96678? This is the e-mail forwarded to you with this e-mail attached to it or in the train of it.

A. Yeah.

230 Q. So you'll see at the top of the page, the date on this 11:37
e-mail is 20th November. So you were just a couple of months in...

A. Yeah.

231 Q. -- in post. 20th November 2014 from Darren Mitchell to Lucy Jellett, Joe O'Sullivan and... 11:37

A. Suneil Jain.

232 Q. Sorry, I couldn't see the name. Suneil Jain. And this is from Darren Mitchell, and he says:

"I've e-mailed Aidan to open discussion on this case. 11:37
Copy below for your information only."

Now, Dr. Mitchell indicated yesterday when I asked him, that he didn't discuss the contents of the e-mail with anyone before sending it. He was surprised, having 11:37
read it again, by his tone. I asked him had anyone helped him draft it to see if there was a collective view as to the level of robustness perhaps that should be reflected in the e-mail, and he said that it was his

e-mail alone. Did you have any discussions with Dr. Mitchell in the lead up to this?

A. Just as we discussed earlier, just my recollection that there had been cases earlier in my consultant career.

233 Q. And how did that conversation come about? 11:38

A. I can't remember precisely how it came about, but it probably would have been in our pre clinic meetings on a Tuesday or Thursday, something around "Oh, I have this case. Here's the story. What do you think?"

234 Q. And you said that or -- 11:38

A. No, that would have been probably Darren telling me about this particular case that is referenced in this e-mail.

235 Q. And it was at that point that that triggered your recollection? 11:38

A. Yes.

236 Q. And do you recall then the extent of your conversation with him?

A. No, just that I had recalled early in my career that there had been some cases. I wasn't very specific, 11:38 because I still can't be very specific about that, I can't recall the individual cases, but I told him that I had recalled an issue with Bicalutamide 50mg monotherapy in my early days as consultant.

237 Q. Now, you have seen the e-mail that he sent? 11:39

A. Yeah.

238 Q. And he has set out the clinical presentation of the patient?

A. Yeah.

239 Q. In order to provide, in his mind, his evidence base for his effectively a challenge...

A. Yes.

240 Q. To Dr. O'Brien's prescription regime.

A. Yes. 11:39

241 Q. Did you talk about that specific case with him?

A. I don't recall precise details, except that this seemed to be a two year period that this patient was on Bicalutamide, and that was a lot longer than I would have recalled from my cases. Two years is a very long 11:39 time for monotherapy.

242 Q. And that two-year period, does that result, by the nature of its duration, in an increase in risk?

A. It would depend on the exact type of prostate cancer being dealt with here, whether it was high risk, low 11:39 risk, etc. But I think the assumption is that it was a detriment to this patient.

243 Q. That there was a risk and a patient safety issue arising?

A. Yes. Yes. Yes. 11:40

244 Q. Now, you were the Clinical Director at this point?

A. Yes.

245 Q. If we just step away from the process of the e-mail and the expectation around it.

A. Yeah. 11:40

246 Q. And your conversation with Darren Mitchell, and then your view of the clinical detail that he provided in his e-mail...

A. Yes.

247 Q. Did you consider that, having now said that it was a risk and a patient safety issue, that that might have been something that you should have explored further?

A. Perhaps. In retrospect, I guess the e-mail was very much to me as a colleague rather than as a Clinical Director. 11:40

248 Q. And how do we know that from the e-mail?

A. Well, just looking, the fact that my other uro-oncology colleagues were copied, it wasn't specifically to me as Clinical Director, it was me being copied in as a uro-oncology colleague. 11:40

249 Q. Is it your view, when working as a Clinical Director, that unless someone directs it to you as a Clinical Director, that there are no governance concerns arising? 11:41

A. I mean, probably if this had been two or three years into my clinical directorship I may have handled it differently. But at this stage my impression was very much that this was including me as a colleague in prostate cancer oncology, rather than as Clinical Director. 11:41

250 Q. I just want to be clear on your evidence. You've said that you perhaps might have done something and you may have handled it differently.

A. Yeah. 11:41

251 Q. If you're presented with information that someone is at risk and patient harm is in existence, given a two-year delay...

A. Yes.

252 Q. I'm just keen to explore what your baseline is for triggering the use of governance processes. Is that not enough?

A. In retrospect, it does look like that. And probably with a bit more experience as Clinical Director I probably would have escalated this. 11:41

253 Q. So we're still equivocal?

A. Yeah, I mean, it's hard to know. Because this was one case. The way the e-mail was sent, certainly the way I read it now is I was being copied in for information rather than for action directly. So looking at -- my impression was that certainly my receipt of the e-mail at the time was very much as a colleague rather than as Clinical Director. 11:42

254 Q. If we just, I just want to be absolutely clear. Your receipt of the e-mail, your evidence is that you were -- this was for information purposes only rather than any expectation? 11:42

A. Yes.

255 Q. And the panel have your evidence on that? 11:42

A. Yes.

256 Q. As Clinical Director at that time.

A. Yes.

257 Q. But I just want to make sure we're clear on your evidence on the clinical issue arising. 11:42

A. Yeah.

258 Q. Where it's clearly articulated clinical evidenced patient harm issue has been put in writing. And I asked you earlier on is there a reluctance to put

things in writing and you agreed. And here we have Darren Mitchell taking the bull by the horns in one respect and putting this in writing.

A. Yeah.

259 Q. And at this stage you're in post ten years. 11:43

A. Yes.

260 Q. So, what others might not have done previously in formal language, he has committed to.

A. Yes.

261 Q. And he also, in this e-mail, attaches the MDU guidelines around the safety and the prescribing of Bicalutamide. You recall that from the e-mail? 11:43

A. Yeah, yeah.

262 Q. So, in many respects, it's quite a robust approach?

A. Yes. 11:43

263 Q. And specifically in relation to the patient, did that not trigger in you any expectation, either as a fellow clinician or as most particularly the Clinical Director, that that patient issue needed to be considered, even if we consider an informal route first of all? 11:43

A. Yes. Yes. Well, I mean, my assumption was that that was happening by virtue of this e-mail. And I guess I handled this e-mail as a colleague rather than as Clinical Director. Perhaps I would have approached that differently with a bit more time in the Clinical Director role. 11:44

264 Q. Would you handle it differently now?

A. Yes.

265 Q. I mean you were -- you would?
A. Yes.
266 Q. You're sure about that?
A. I am, yeah.
267 Q. When I asked you earlier about what you would do in 2004 if the scenario arose where you had been recurrent prescribing off licences, as you experienced then. 11:44
A. Yeah.
268 Q. You said you would speak to your Clinical Director...
A. Yes. 11:44
269 Q. And expect them to speak to their counterpart.
A. Yes.
270 Q. Informally in the other Trust --
A. Yeah.
271 Q. Is this an opportunity that you might have taken at the time to do that? 11:44
A. Yeah, probably, yes. Yeah.
272 Q. Now, Dr. Mitchell has told us that there was no reply to the e-mail, there was no discussion, the expectation obviously from his wording of the e-mail is that it would instigate perhaps a response. 11:44
A. Yeah.
273 Q. His evidence, in summary form, just in general terms, was that he anticipated that it would start a conversation that would allow some clarification. 11:45
A. Yeah.
274 Q. And that didn't happen. Did you follow this up with Dr. Mitchell and say "What happened with the e-mail? Did anyone get back to you?"

A. I don't recall. But the e-mail, as it's written there, didn't really ask for action specifically.

275 Q. It didn't ask for action from you, but --

A. No.

276 Q. And I don't want to labour the point, but as Clinical Director, on notification of a patient safety issue, it didn't really have to, did it? 11:45

A. I guess you could say that, yeah.

277 Q. Now, one of the other things that Dr. Mitchell thought he might utilise to address this concern was the guidelines. 11:45

A. Yeah.

278 Q. I'm not sure if you were involved in the drafting or...

A. Not specifically, no.

279 Q. Any input into them? 11:46

A. No.

280 Q. Were you involved in them at all?

A. Not specifically, no. I wasn't involved in NICaN at that point.

281 Q. Were you aware of the guidelines being drafted? 11:46

A. Yes.

282 Q. And were you aware that Dr. Mitchell was hoping to use the guidelines as a route to address?

A. Yes.

283 Q. And how did that, your knowledge about the intended use of the guidelines by Dr. Mitchell arise? Did you have a conversation with him? 11:46

A. Yes, he would have spoken to me and my other colleagues at our weekly meetings.

284 Q. So would it have been collectively known that the guidelines were being drafted to address what had been identified as a potential patient risk issue?

A. I'm not sure if it was widely known, but certainly part of the reason for the guidelines was to formalise a description of what the correct doses of hormone therapies were. 11:46

285 Q. Well, was it not a little bit more than that? That it wasn't just about standardising, it was about highlighting and indicating that there could be no doubt, given that there appeared to be doubt? 11:47

A. I would call that standardising.

286 Q. In the absence of the issues that arose in relation to the referrals by Mr. O'Brien, do you think the guidelines would have been drafted anyway? 11:47

A. Yeah, I think eventually, yes. I think we have guidelines for most things, so...

287 Q. In relation to Bicalutamide dosage, the evidence has been that that was so widely known that that was the licensed dosage, 150. 11:47

A. I think in most guidelines they tend to specify doses, I would think, yeah.

288 Q. Did you generally just feel this wasn't an issue?

A. Not generally -- that what wasn't an issue specifically? 11:47

289 Q. The Bicalutamide 50mg monotherapy being prescribed for people who clinically presented as needing other clinical regimes.

A. Okay. I guess this e-mail highlighted that it was

still an issue, yes.

290 Q. I did generalise my question earlier and said it was "widely known". What I meant was that it was known among the colleagues with who whom you worked?

A. Yes. 11:48

291 Q. Who would have been aware. They would have been aware that Bicalutamide 50mg monotherapy was being prescribed or had been prescribed?

A. I'm not sure how many of my colleagues were aware, but certainly myself and Dr. Mitchell would have discussed 11:48 it for sure, yeah.

292 Q. Was there any reflection among you or any others who you may have spoken to, who you can't recall, that given this had lasted over a ten-year period that maybe someone needed to have a look at this and perhaps see 11:48 if this was a wider issue?

A. I think with regard to the 50mg, I thought this e-mail discussion was going to hopefully solve things and then the rewriting of the guidelines or the clarification of the guidelines. 11:48

293 Q. Well, I'll just ask it again just before we move on.

A. Yeah.

294 Q. This was ten years later.

A. Yes.

295 Q. Was there any concern in your mind that for the past 11:49 decade this could have been happening? This is a clear patient risk. You've identified that e-mail does establish harm, two years. 5?

A. Yes.

296 Q. Was there any triggering in your mind, "Oh, that has been going on for ten years at this point"?

A. Not particularly. But in retrospect, yes. At the time probably not. But in retrospect, yes.

297 Q. I just want to bring you to an e-mail, AOB-78095. I just need to find the start. Some of the sequencing can be slightly backwards in the e-mails. So this is an e-mail chain, the content is largely irrelevant. It's contact at the time at which you were Clinical Director. 11:49 11:50

A. Yeah.

298 Q. So this is the start of an e-mail chain from Fiona Reddick to you, 8th September 2016. I just want to read it out to give you the opportunity.

A. Yeah. 11:50

299 Q. It's e-mails you've sent, I know you'll be familiar with them, and it's just a general point.

A. Yeah.

300 Q. But for the record. An e-mail was sent to you, Debbie Whiteman, Gillian Traub, copied in to Aidan O'Brien and Rory Convery, and the subject is "Urology MDT each Thursday", and it says: 11:51

"Joe,

On behalf of the urology MDT at Craigavon Area Hospital I wish to highlight our concerns at the inadequacy of attendance by videolink of an oncologist at the Southern Trust weekly urology MDT. This was highlighted as a serious concern following last year 11:51

year's cancer peer review visit and unfortunately the attendance is actually worse this year to date.

We are happy to meet at your earliest convenient to try to resolve this situation as the urology MDT is not quorate." 11:51

So, the panel has heard quite a bit of information about the quoracy and staffing issues, and this is another example in 2016. 11:51

You reply and say -- sorry, Dr. O'Brien replies on the 9th, or Mr. O'Brien replies on 9th September to you and Fiona Reddick, and says: 11:52

"Dear Joe,
I would like to echo the concern expressed by Fiona.

For some time we did have an improved input from oncology when Fionnuala Houghton linked in and Judith Carser attended (even though neither were available for a whole meeting). Since their deployment elsewhere, the input from oncology has deteriorated to the extent that it has become nonexistent. The last time we had a link in from oncology was in July. 11:52 11:52

I have had the view expressed to my colleagues that it is no longer tenable for us to continue as a MDT unless this issue is resolved satisfactorily.

I do believe that this does need to be addressed so that it can be determined whether we can continue as an MDT.

11:52

Thank you,
Aidan."

So Mr. O'Brien is articulating and putting in writing his concerns about the viability of the MDT, given the absence of an oncologist. I presume this is all familiar territory around staffing for you? 11:52

A. Oh, yeah.

301 Q. And then you reply on 9th September 2016:

11:53

"Dear Aidan and Fiona,
I agree that cover for the SHSCT Urology MDT has been less than ideal in recent months. As you know this has resulted largely from an SHSCT vacancy which remains unfulfilled since Dr. Carcer's departure last year. 11:53
This gap has placed significant strain on the GU/lung clinic.

I am delighted to inform you that we in BHSCT have appointed an excellent locum consultant, Dr. Ciara 11:53
Lyons to join Dr. O'Hare in covering the GU/lung clinic.

Dr. Lyons will link with the URO MTD from next week

onwards. She has outstanding uro-oncology credentials, having just completed a three year PhD fellowship in prostate cancer here at QUB/BHSCT.

We clearly need a more sustainable long-term solution in due course and discussions are in train in this regard. 11:53

Kind regard,
Joe." 11:54

So this was - the absence of cover in oncology and the potential for a consultant to come back and say the viability's actually threatened --

A. Yes. 11:54

302 Q. Is a governance concern?

A. Absolutely.

303 Q. And this is, it's almost an informal/formal way of try trying to deal with it. I presume they're contacting you as Clinical Director? 11:54

A. Correct.

304 Q. And action was taken to try and fill the gap to allow the quoracy to be maintained?

A. Yes.

305 Q. And then Mr. O'Brien writes back on 9th September and copies in his colleagues; Michael Young, Anthony Glackin, Ram Suresh, Mark Haynes, John O'Donoghue, Gareth McClean, Mark Williams, and Shauna McVeigh, and says: 11:54

"Dear all,
Pleased to share with you some positive news regarding oncology at MDM.

Hope that this proves satisfactory."

Then Tony Glackin replies saying:

"Very good news. I have always found Dr. Lyons' patients' letters to be of a very high standard.
Tony."

So that's an example, perhaps from this remove, at least for our purposes, of a problem being raised, cross Trust communication taking place to try and remedy it.

A. Yeah.

306 Q. And there being an effective solution. It does lead me slightly back to what we have discussed; given that you were in contact with Mr. O'Brien by e-mail at this point, might it have been appropriate for you to take the opportunity to raise any concern or issue with him about Bicalutamide?

A. I think at that point the problems were much larger than Bicalutamide in terms of what we were trying to sort out, which was inadequate oncology coverage of a major MDT. So I think those kind of issues would have been well down my agenda, in dealing with Mr. O'Brien

11:54
11:55
11:55
11:55

at this point.

307 Q. Yes, but I suppose the point in relation to that is, if you're e-mailing in 2016 about issues and are able to go back and forth to find solutions, was that an option available in 2014? 11:56

A. It was certainly an option to e-mail Mr. O'Brien, but obviously I didn't. But this issue of coverage of the MDT was a completely separate issue. I didn't feel like just because the lines of communication were open on that, I could then go back and talk about something from... 11:56

308 Q. Yeah, the suggestion is really that the route of contact has been used in informal ways and been successful. That's really just the suggestion that's being made. 11:56

A. Okay.

309 Q. Not that you should PS on the end of a 2016 e-mail, more that as a method of communication, that that was an option open?

A. Sure. 11:56

310 Q. That was the direction, I think, behind that question.

A. Okay.

311 Q. I know we have run around the houses slightly in order to try and figure out what the landscape was like, and really the context of the questioning is for learning, it's for governance learning, to identify flaws that existed that might help explain why things happen, but also to identify areas of continued vulnerability that the panel may turn their minds to for recommendations 11:57

and to understand how things have changed. So, really it's, that's the global context of the questioning, and I hope that came across in my - in the way in which I phrased my questions. But now, at the end of my questions, I just wanted to ask you around governance generally, improvements that you might have seen, given the breadth of your involvement, both in prescribing as a clinician, but also as an academic coming and having to introduce new ways of thinking and, not sell, but certainly develop thinking so that you're leading with best practice. 11:57 11:58

A. Yeah.

312 Q. I mean what's your sense of how governance has developed since 2004?

A. I think there have been a lot of improvements. I think nationally within the UK reorganisation of cancer services has made a big difference, and that was the standardisation of the MDTs so that decision-making, that each patient has really got access to expert multi disciplinary opinion. So that was a big change nationally within the UK. 11:58 11:58

I think within Northern Ireland specifically, or Belfast Trust specifically where I have been working, I think that certainly during my time as Clinical Director I saw improvements in how incidents were handled, the openness of approach in dealing with those incidents, and the attempt at finding learnings from if something happened, assessing it, what happened, but 11:58

very importantly, trying to have new learning from that. So I certainly saw that improve in my time as Clinical Director and beyond that.

I think the MDTs have also improved, but we have a lot of challenges. I think the coverage of the Southern Trust with oncology is one example. That's a mixture of inadequate funding, which I think the cancer services probably are inadequately funded, and I think also we're practising based on the Campbell Report, which is well over 20 years old now. So I think that while things have improved, I do think we need a new assessment of how oncology is organised, particularly with regard to the hub and spoke model. I think that governance would be improved a lot more if we were a more, a more coherent and better funded service. 11:59 11:59

313 Q. Well, it's a combination of both the funding, but also the willingness to engage with new ways of thinking around governance?

A. I think organisation around that could be improved. But certainly in my 20 years here in Belfast I've seen big improvements in both identifying incidents and then learning from them. 11:59

314 Q. Just in relation to anything I've asked or anything we've covered, is there anything else you want to say at this point before the panel may have some questions for you? 12:00

A. No.

MS. McMAHON: Thank you very much. I'll just hand you

over to the Chair.

QUESTIONS BY THE PANEL

12:00

CHAIR: Thank you. Professor, I'm going to ask Mr. Hanbury to ask you some questions first of all.

MR. HANBURY: Thank you very much for your evidence, you've answered a lot of my questions so far. I've just got a few little things.

12:00

A. Okay.

315 Q. You say in the early days when you picked up the Bicalutamide 50 question it was really in the context of low grade localised disease. Were you aware of any patients that came with high grade disease that you saw?

12:00

A. I can't specifically recall, but I know that they were likely to be patients who were in the curable bracket in that they were localised. But the actual risk group, I'm not sure exactly.

12:00

316 Q. Okay.

A. But the fact that they were being referred for radiotherapy makes me think they're probably intermediate, most likely intermediate to high risk patients.

12:00

317 Q. The Inquiry are aware certainly in this of nine SAIs we saw later of two patients particularly who had high grade disease but were given Bicalutamide 50 and it progressed actually very rapidly.

A. Yes. Yes.
318 Q. From what you say, that wouldn't surprise you --
A. Well, I mean, certainly if a high risk patient is receiving Bicalutamide, one would expect they would progress, yeah. 12:01
319 Q. Mr. O'Brien had a particular style where he would monitor the PSA and refer on to oncology when he was happy there was a response. Is that something that you've come across from other clinicians or something you'd recommend? 12:01
A. Certainly not something I recommend. I think that the evidence base for the duration of hormone therapy is very strong, we have level one evidence from several randomised trials showing that the hormone therapy, what, what the duration should be; for example, three 12:01 months before the radiotherapy and then, depending on the risk group, continuing for two to three years. So that's pretty clear what the evidence base for that is. And the idea of just trying a hormone therapy and seeing how it goes, does not fit any evidence base that 12:02 I'm aware of.
320 Q. In fact the opposite might be true; if you didn't have a response to hormones, it might be more important --
A. Yes.
321 Q. That oncologists see -- 12:02
A. Agreed. Yes.
322 Q. So bouncing on from that, there's one clinical scenario which faced colleagues at Southern Trust, and this was really with relation to a triage issue.

A. Yeah.
323 Q. Where a patient was sent in with a PSA of 34 and pain - I'm not exactly sure where the pain was.
A. Okay.
324 Q. And subsequently shown to have high grade prostate cancer with lymph node mets, and was actually seen by a different type of surgeon, a vascular surgeon, and when it was being decided whether or not to flag this up as an SAI, a comment was made, "Well, it was probably a three month delay in diagnosis, but that wouldn't have affected survival." 12:02 12:02
A. Yeah.
325 Q. Which is a slightly curious response.
A. Yes.
326 Q. It didn't seem right to me. But anyway. What was your view on that, just off the top of your head? 12:03
A. Yeah. I mean it's certainly difficult to estimate what effect that would have on survival, but one would assume if a patient with node positive prostate cancer, any delay will result in more likely chance of spreading or becoming less curable, I would have thought. But it's hard to quantify that though. 12:03
327 Q. Yes. There was a study back in the '90s, a sort of randomised study with metastatic disease, between early and delayed hormone therapy? 12:03
A. Yes, the MRC trial, yes.
328 Q. The MRC trial. But do you think that comment may have come from that study or...
A. Possibly so. But I mean, I think to me, a patient who

has developed lymph node metastases is somebody who is going to die from prostate cancer if they're not treated properly. So the longer you the wait, the more likely the cancer has to spread. I think the difficulty is that even with a patient who is classically high risk or has developed lymph node metastases, the trajectory of that disease is still hard to assess just from the fact you've outlined. If you saw a couple of years of PSAs or you had some idea of the rate of growth, then you could have a better estimate of the impact on that particular patient. 12:04 12:04

329 Q. Thank you. Just lastly really on this sort of quoracy issue. I mean from your evidence, it was actually quite impressive how well Southern Trust were served when Dr. Stewart was there and there were really no problems. 12:04

A. Yes.

330 Q. And we've just seen in e-mail correspondence you did find a colleague to come in. I'm not sure did Dr. Lyons come in and, if so, for how long was that for? 12:04

A. She certainly did come in. But how long she was there, I'm not quite sure. She then subsequently moved on. The difficulty is filling these sort of locum positions, that people will tend to move on if they get a substantive post somewhere. So I think she got a substantive post in the south of Ireland and moved on. But I'm not sure how long she was in that particular role. 12:04

331 Q. So, going back to the sort of colleagues at the

Southern Trust who were, as to quote you, the sort of cover was patchy?

A. At best.

332 Q. So they were then back and unsupported again. I suppose my question is really: How do you see the responsibility of the host cancer centre to say "Listen, colleagues are really struggling in this particular place. Who can do this? Are there any sessions? Can we back up?" 12:05

A. Yeah. 12:05

333 Q. I mean as Clinical Director, pretty much at that time.

A. Yeah.

334 Q. Did you feel a responsibility for that? There was just no solution? How did you handle that?

A. Yeah. It was a very frustrating period, and I mean one of the challenges as Clinical Director of Oncology in Belfast Trust, you sort of assume running the whole of the cancer service, which is not within the role and certainly not within the timeframe allocated within that. But we'd an excellent team in Belfast Trust. And, again, the regional cancer service tended to default to Belfast Trust, I think, both formally and informally. So we did, as the Belfast Trust team, we did feel responsible for the regional cancer service and for gaps within that. 12:05 12:06

The consultants who were attending, oncology consultants attending the various unit clinics were employed by Belfast Trust, so we had that

responsibility, except for one, which was Dr. Carser, who was a direct Southern Trust employee. So, yes, we did feel responsible. There were no easy solutions, so I think we were quite pleased with that innovative solution at that time. Dr. Lyons was just finishing a PhD with myself, she was expert in GU cancer, but there were no easy solutions. And, also, we also looked at hiring locums. And, again, that was done at different times. But it was very challenging to find people. There are not that many oncologists who can take on a GU practice like that who are locums. 12:06 12:06

MR. HANBURY: Okay. Thank you very much. That's all I've got.

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

DR. SWART: Thank you. Just earlier on you said something which I think is fairly clear, I just wanted to clarify that. 12:06

A. Okay.

335 Q. It was when you were being asked about experimental treatments. And from my reading the tenor of your evidence was that if you're going to use something that's not absolutely standard, that should be done within the auspices of a clinical trial. And that is the preferred route. But -- unless there are exceptional circumstances. So I think that's what you were saying? 12:07 12:07

A. I think I was saying -- well I think the question was around experimental therapy.

336 Q. It was.

A. And my understanding of experimental therapy is that that should be within a clinical trial. There are circumstances where one might use a non guideline therapy, or even an off label therapy, outside of an experiment and outside of standard clinical practice, but that would be rare.

337 Q. And that would be a discussion, a documented discussion with colleagues and so on?

A. Correct. Yes.

12:07

338 Q. But not the systematic use of something that's not in a trial and not evidence based?

12:07

A. Correct. Yes.

339 Q. Okay. Yeah. Is it your view that compliance with NICE Guidelines should be audited regularly? Is it audited regularly?

12:08

A. Yes, and yes. I think especially when new guidance comes out about a new therapeutic intervention, yeah, we tend to have an implementation plan, part of which is auditing a year later, two years later to see are we --

12:08

340 Q. I think they have an audit tool quite often, don't they?

A. Yes, yeah. It's part of the implementation process.

341 Q. Yeah. And do you audit compliance with MDM decisions at all?

12:08

A. Personally, no. But, yes, there is an audit of MDT.

342 Q. So that is a part of the culture, shall I say?

A. Yeah, very much so, yeah.

343 Q. Yeah. Okay. Patient information. We've heard varying

sort of bits of evidence on this. Overall it does not seem that historically patients were copied in to all their letters.

A. Yeah.

344 Q. And patients were not necessarily given full information about the different choices, certainly not about things like doses of drugs. 12:08

A. Right.

345 Q. If you saw these patients today who were on 50, and you had to change the dose, would you deal with that any differently in terms of telling the patient about the implications of this? 12:09

A. I suppose it would depend on the scenario, how long they were on. But say, for example, it was that two year patient. 12:09

346 Q. Yes. Say it's two years.

A. Yes, I think -- I guess I would say to the patient that that's been non standard therapy.

347 Q. Because we have heard from some patients as part of this Inquiry... 12:09

A. Yes.

348 Q. And it appears that in many cases they had not been fully informed.

A. Sure.

349 Q. Do you think it should be mandatory that patients are copied in to all letters? 12:09

A. I think that's becoming the culture now. I have some issues regarding certain circumstances, especially where the patient has got very short survival who don't

want to know about that.

350 Q. Yes.

A. So there are some challenges. But overall, yes, I think patients, and patients, with the new IT systems coming, will have full access to their health records. 12:09
So I strongly support that.

351 Q. What do you think the barriers to that have been?

A. I think cultural and paternalistic approach to medicine over the years. "Doctor knows right".

352 Q. And going back to the 2014 e-mail, it's quite an important e-mail in the sense that it's quite clear, it's strongly worded. 12:10

A. Yes.

353 Q. And it sort of sat there.

A. Yeah. 12:10

354 Q. It wasn't acted on by either Trust, for a variety of reasons.

A. Yeah.

355 Q. It seems evident that there was a widespread practice outside of licence and evidence base. How do you think 12:10
that should have been dealt with in its entirety? If that sort of thing happened today, what do you think would be different?

A. Yeah. I think a formal letter to the Clinical Director saying "I have these concerns" I think would have a 12:10
different response nowadays. So I think that would escalate things quite well these days.

356 Q. And then going back to the cancer unit, cancer centre thing. Effectively you can't really have an effective

MDT in urology without an oncology presence, can you?

A. Correct. That's correct.

357 Q. I mean it's -- and yet there was a limping along going for quite a long time, the difficulty with recruitment and so on. What should the Southern Trust have done about that, do you think? What would have galvanised people more effectively or what would have helped with the solution? 12:11

A. I'm not sure, because one of the challenges was the lack of -- there was funding available for consultant posts, we had both funding in the Southern Trust for an acute oncologist, we also had funding in the Belfast Trust. We actually advertised and couldn't find people. So one of the big challenges was, although we know what the solution was, we had the funding to fix that, there were not the available oncologists. So I don't think Southern Trust could have effected that. Whether there would have been more willingness to put money forward for a longer term locum or something like that? But those monies weren't on the table at the time. 12:11

358 Q. No, but this is, you know, extremely serious for patients, isn't it?

A. Yes.

359 Q. And it's the sort of thing that would normally come - in England it would come to the Chief Executive of the Trust? 12:12

A. Yes.

360 Q. And there would be big discussions. And it takes you

back to: Is the organisation of cancer services in Northern Ireland in need of an overhaul in order to make the jobs more sustainable, more attractive?

A. Absolutely, yes.

361 Q. More research based? Because we have people who don't get oncology, their access to clinical trials is limited. 12:12

A. Yeah.

362 Q. And most people would say that full access to clinical trials is part of a standard of cancer care these days. So what efforts are being made to push for that for the patients for Northern Ireland, do you know? 12:12

A. Yeah. I'm not aware of any specific efforts right at this very present time, but I know the Bengoa Report included cancer services and the reorganisation of hospital services, and I think that's, in my view, certainly required. But also I think cancer care has really dramatically changed since the Campbell Report, which is over 20 years ago. The numbers of patients have increased, the complexity of treatment has increased, the expectation of patients has increased, and the way oncologists are trained has changed as well, as well as urologists. So I think we absolutely need a revamp. And looking back at those e-mails when I was Clinical Director, it was a little ridiculous to be expected to be sort of the Chief Executive of cancer services in Northern Ireland with one day a week allocation to be Clinical Director looking after 50 consultants and... 12:12 12:13 12:13

363 Q. Yeah. So there's a recurring team of where does responsibility sit?

A. Yeah.

364 Q. And I think what I'm trying to get out of you is what is the appetite really for people really contributing to - taking the various reports that we already have, taking the evidence, taking the situation we have today and looking at things differently - do you think that appetite is there? 12:13

A. Yeah. Very much so. 12:13

365 Q. From a clinical perspective?

A. Absolutely. And really because of the problems described there, and there are other pressures and gaps within the regional oncology service delivery, and for sure a reorganisation, it is not just more money, it is reorganisation and restructuring. 12:14

366 Q. Yeah.

A. And I think among my oncology colleagues there would be a very big appetite for that. We have engaged with whatever, you know, the redesign of cancer services, I think it's been in stagnation a bit recently I think in the last few years, to say the least. But within the oncology community we are certainly very keen to engage with that and we want to do better for our patients. 12:14

367 Q. And, finally, what do you think is the thing that most attracts oncologists to jobs? What is the thing that really, you know, this is the thing that brings people in? 12:14

A. I don't know. I can't answer that for other

oncologists.

368 Q. Well, you must have some idea. There are jobs that nobody can recruit to and there are jobs that everybody wants. So what makes the difference?

A. Yeah, I think it's more the negatives probably are things that put people off, and that would be workload, needing to do sort of -- if a job is felt to be a patchwork of various things. For example, my job is very clear, it's prostate cancer. But some of the jobs advertised will be a bit of lung cancer, a bit of prostate cancer. "Oh, no, by the way this MDT hasn't had a urologist or it hasn't had an oncologist a few years. How would you come like to come in and solve all those problems?" That mightn't suit everybody's personality. Yeah. 12:14 12:15 12:15

DR. SWART: No. Okay. Thank you.

CHAIR: Just following on, Professor, from what Dr. Swart was saying, you were saying about the appetite for change within the cancer --

A. Yes. 12:15

369 Q. What do you want to see happen?

A. Well, I mean, I don't have the answers to what it should look like, but certainly we need some sort of system that reorganises the way patients come through the system. Personally I am in favour of, you know, expert centralisation. That already happens in terms of radiotherapy. So the Northwest Cancer Centre and the Northern Ireland Cancer Centre deliver the radiotherapy and that acts as sort of a hub for cancer 12:15

expertise.
I think it's good that patients can visit their local hospital and meet an oncologist, but I really think that the majority of therapies should be delivered centrally. 12:16

370 Q. Okay.

A. Then with regards -- a lot of things can be devolved to units as well. But that's a huge project of reorganisation and looking at the way different cancers are treated. Compared to 20 years ago it's totally 12:16 different how most cancers are managed. They have all become more complex. Thankfully there are more life extending therapies. But the decisions are much more nuanced and much more expert now than they were before. So I think that, I personally don't have the exact 12:16 solution, but I just know the current setup is not fit for purpose, in my view.

CHAIR: Thank you very much. You'll be glad to know that that is us finished with your evidence.

A. Great. 12:16

CHAIR: Two o'clock then, Ms. McMahon?

MS. McMAHON: Two o'clock. Anthony Glackin will be giving evidence.

CHAIR: Yes, you got a short lunch yesterday, ladies and gentlemen, you get a longer one today. 12:16

LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON ADJOURNMENT

CHAIR: Good afternoon everyone. Mr. Wolfe.

MR. WOLFE KC: Good afternoon. Your witness this afternoon is Mr. Anthony Glackin, and he proposes to affirm. 14:02

MR. ANTHONY GLACKIN, HAVING AFFIRMED, WAS EXAMINED BY MR. WOLFE AS FOLLOWS: 14:02

MR. WOLFE KC: Good afternoon, Mr. Glackin.

A. Good afternoon, Mr. Wolfe.

371 Q. Welcome to the Urology Services Inquiry. Thank you for coming along. The first thing I should do with you is 14:03 put your witness statements on the screen and have you formally adopt them as part of your evidence. So, the first document is your primary response to our section 21 Notice. If we go to WIT-42279. And you can see that the date of the Notice was 31st May of last year, 14:03 2022, number 57. And just scrolling down, you'll recognise that as the first page of your response. Just scrolling up, we've annotated the top of it to reflect the fact that you have recently submitted an addendum statement. 14:04

So, just to the last page then of this document, which we find at 42336. And you'll recognise your signature, I hope.

A. I do.

372 Q. And would you wish to adopt that statement, subject to some addendum corrections, subject to those do you wish to adopt that?

A. Yes. 14:04

373 Q. Thank you. And then the short addendum which corrects two small factual inaccuracies, WIT-100352. And, again, you'll recognise the front page. As I say, two small corrections. One relates to whether or not - scrolling down - if I remember his name, yes, whether 14:05 or not Mr. Mackle was at a meeting in January 2013 which you attended. Your first statement said he was, this corrects it --

A. That's correct.

374 Q. -- to tell us that he wasn't. And the second 14:05 correction relates to the period of time in which you held the role of lead for the M&M?

A. That's correct.

375 Q. So, straightforward matters. And if we go to the last page then, it's at 5.3 in this series, a couple of 14:05 pages down, if we scroll down. There we have your signature. And again --

A. Yes.

376 Q. Do you wish to adopt that?

A. I do. 14:06

377 Q. One further source of evidence is your statement to Dr. Chada. The Inquiry has heard generally about the process which was undertaken for gathering those statements. You went along, I assume like others, and

spoke to Dr. Chada and?

A. Siobhan Hynes.

378 Q. Siobhan Hynes. Thank you. And that conversation was sculpted into a statement for your approval?

A. It was drafted by Mrs. Hynes and I approved her draft. 14:06

379 Q. Yeah. And so just if we put that on the screen, just to remind ourselves. TRU-00771. And it goes through to 00777. And I assume that you've had an opportunity maybe to review that ahead of today?

A. Yes, I have reviewed it. 14:07

380 Q. You're content with its accuracy?

A. Yes.

381 Q. I'm obliged. Now, as I say, thank you for coming to speak to us today. I'll take a moment just to outline really a bit of a road map to assist you and to assist 14:07 the panel and those out there who may be watching or listening to us. So, as was said yesterday in our opening, calling clinicians to give evidence as part of this phase of the Inquiry's work provides the Inquiry with an opportunity to engage with clinicians and for 14:07 you to engage with us. I know that you will be able to describe the practices of the urology specialty in the Southern Trust, its culture and behaviours, how it functioned, how it was led and supported, and the difficulties which it faced. I want to explore with 14:08 you the context in which you worked. It appears to have been a specialty or an environment under constant capacity pressures, and you can tell us about that, how it impinged on your work and the health of your

patients.

You performed a number of roles which appear to be at the heart of the governance arrangements. We will hear that you had duties with the mortality and morbidity - 14:08
have I got that the right way around?

A. (Witness Nods).

382 Q. Otherwise known as the Patient Safety Committee, with -- you had responsibilities with the multi disciplinary team, which you can tell us about, and in the conduct 14:09
of some SAIs. So, we want to hear from you about how those arrangements operated, whether they were effective in supporting the objective of safe patient care.

14:09

Then there's a number of specific issues which will be examined. For example, the management of stent patients has been a feature of the evidence before the Inquiry so far. We want to try to unpack some of the issues around that from your perspective. 14:09

I want to look at a particular issue that's maybe just arisen relatively recently in terms of the sight of it, of this Inquiry, and that's TUR syndrome, and what you can say about that. 14:09

We will also want to know about the use that was made of some of the key ingredients which support or inform good governance, and you've said something in your

witness statement already about some of these, including appraisal, job planning, the use of data, audit and incident reporting.

It will be important to establish how you and your fellow consultants practised in a range of important matters. Inevitably, we will be interested to examine your knowledge of the practice of Mr. O'Brien. I will explore with you issues including triage, dictation, preoperative assessment, sign off and actioning of diagnostic results, prescribing in the cancer context, conduct in association with the operation of the MDM, including the use of nurse specialists or key workers. I'll also maybe touch upon the issue of private patients. 14:10 14:10 14:11

As was said yesterday, the Inquiry will wish to understand the extent to which there were variations in practice and whether adherence to best practice was viewed as necessary, and whether the pressures we're about to look at in urology services had any impact on compliance with best standards. 14:11

So, that's a bit of a road map. Hopefully we'll get through the majority of that across today and tomorrow, although I understand that a spillover slot has been booked with your diary, if that becomes necessary. 14:11

So, let's start with your career history, Mr. Glackin.

We can see -- perhaps put it up on the screen, please, at WIT-42279, and you outline - just scrolling down - your academic background, graduating from University College Dublin in June 1998.

14:12

The first matter of note perhaps is your first encounter with, professionally at least, with the Craigavon Hospital, and you did a round as a senior house officer in general surgery in August 2001 through to July 2002. Did that bring you into contact with urology or was that a broader experience? 14:12

A. So, I was attached to the general surgery department. You may have met Mr. Mackle at this Inquiry, I'm not sure if you have. So, Mr. Mackle would have been one of the supervising consultants in that department, amongst others. So I was working for them at that time. But I would have cross-covered urology in the evening for on-call, I would have known Mr. O'Brien prior to this anyway, but it would have been my first opportunity to meet Mr. Young. 14:13

383 Q. And perhaps you had it already, but did that spark an interest in urology, or was that always your direction?

A. So essentially I took this job because I was waiting for a slot to become available to undertake urology research. I'd already established during my basic surgical training that I wanted to pursue a urological career, and I was waiting basically for the opportunity to start research and undertake a higher degree, which you'll see later I did. 14:13

384 Q. Yes. And that research, we can see it at the bottom of the page in front of us, that research post became available and commenced in August 2002, split between Craigavon and the University?

A. Yes. So, I had a clinical commitment in Craigavon which amounted to two to three clinical sessions per week, except in the case where the higher surgical trainee was on leave, in which case there were two clinical fellows, myself and another. We would have substituted completely for that person when they were on leave. So that meant that during that period of time I had a fair bit of clinical experience, both in terms of outpatient work, in terms of doing flexible cystoscopy diagnostics, alongside my research at Queens. 14:14 14:14 14:15

385 Q. Yes. And who was your clinical supervisor during --

A. So during the research project that was primarily Mr. Young, from a clinical perspective. From Queens' perspective I was supervised by Dr. Kate Williamson, who was a, I think at that time she was a lecturer, I'm not sure if she was a senior lecturer. 14:15

386 Q. Yes. And your attendance at Craigavon was how many hours or how many days per week?

A. So, it varied. It could be as little as two sessions, which is one full day's work, up to some weeks it could be two and a half days a week. And at other times if the SPR was on leave, it could be a full week's work. 14:15

387 Q. And at that time the urology service was just staffed by two consultants, is that correct?

A. Two consultants; Mr. Young and Mr. O'Brien. There was a single SPR, there was an SHO, and there were house officers assigned to the Urology Department.

388 Q. And you knew Mr. O'Brien from I suppose the area where you grew up? 14:16

A. Yeah, that's right. Family connections. And it's no secret, before I entered medical school I sought Mr. O'Brien's advice.

389 Q. And you spoke to him about?

A. A career in medicine. 14:16

390 Q. A career pathway?

A. Yeah.

391 Q. Perhaps spoke to him about a practice in urology?

A. Not so much a practice in urology, more at that point it was a career in medicine. I think my interest in 14:16 urology grew when I became a clinical medical student in perhaps the third or fourth year at UCD. I spent a whole month in the Urology Department as that was, I was assigned to that, it wasn't a choice, but I actually loved it, so that's why my interest grew from 14:16 that point.

392 Q. And we may have formed the impression that even as early as that time - and here we're talking about the summer of 2002 - you stayed in Craigavon as part of this research fellowship for how long? 14:17

A. A little over three years.

393 Q. Yes. The impression could be formed that, even at that time, that it was a service under strain?

A. Yeah.

394 Q. But perhaps by comparison with now, it was?
A. I suppose what I would say there is I wouldn't have had a comparator at that time. This was my first experience to the specialty.
395 Q. Yeah. 14:17
A. But we were a service under pressure. There's no doubt.
396 Q. Yeah. And in terms of the work that you carry out, or the work that you were able to see being performed by others, such as Mr. Young and Mr. O'Brien, did you get 14:18
to see the range of urological care and procedures that were available?
A. So, at that point in my career I'd completed three years of surgical training. So, I was quite competent to do many smaller procedures independently, as was 14:18
kind of the norm at the time. It wouldn't perhaps be the norm now for SHOs. So, I was able to undertake things like flexible cystoscopy, with limited supervision. I could run that clinic without any immediate help on hand, and the consultants were freely 14:18
available by telephone to support me should I need help.

Similarly, I had experience of running - working in outpatient clinics, so I could work alongside the 14:19
consultants relatively independently. Now, clearly the case mix would mean that I would have to discuss some cases with the consultant, and that's normal. But that help was on hand.

During my clinical research fellowship, my exposure to inpatient operating would have been very limited, because that was really the prerogative of the SPR, the higher surgical trainee, and so my opportunity to do that kind of work would have been limited perhaps to out of hours or weekends, when emergencies needed to be dealt with. So, things like putting in a stent or taking a torsion to theatre. And I would have been quite competent at doing those things, with limited supervision, but I can recall evenings where I would be in theatre and I might need some help, and I would phone either Mr. Young or Mr. O'Brien, and there was no issue, they'd either come in, or they'd tell me what to do, and I'd get on and do it. And, you know, the support was good. 14:19 14:19 14:19

397 Q. And in terms of your ability to observe their practices, was that available to you for learning purposes?

A. Yeah. So, I would have worked in their clinics. So I would have had sight of how they ran their outpatient clinics. I would have had support and, I suppose, training, for want of a better term, in the clinical environment. I would have participated on ward rounds, particularly at weekends. And because I was relatively junior, they would often be present for the ward round, because, you know, you wouldn't leave an inexperienced person to do the ward round unsupervised, so they would come in. So I would observe how they interacted with 14:20 14:20

patients, how they interacted with the staff, how they interacted with the likes of me, other consultants, etc.

398 Q. I know that you probably had an opportunity to review aspects of the statement prepared for the Inquiry by Mr. Chris Hagan. He outlined his experience as a surgical trainee just before this period. 14:20

A. Yes.

399 Q. In or about 2000. And he set out in his statement, I suppose, what might be described as a catalogue of concerns about the practice of Mr. O'Brien in particular at that time. Did you observe any issues of concern during your period of three months? 14:21

A. Three years.

400 Q. Three years, of course. Between 2002 and 2005. 14:21

A. Yeah. I found the department on the whole to be very supportive of me as a trainee learning. I observed that same supportive attitude displayed to other trainees coming through the department. I never once felt belittled or dismissed by Mr. Young or Mr. O'Brien. And, similarly, the nursing staff behaved in a very professional manner towards us as well. So, you know, I had very good relationships with everybody in that department. 14:21

14:22

To perhaps mention some of the issues that Mr. Hagan brought up. I am aware of patients admitted for intravenous fluids and antibiotics. At the time I was relatively junior in the specialty and I wouldn't

necessarily have had the knowledge-base to question that. And I also, when I've read the list of patients that were in the bundle who were affected by that particular issue, I recognised lots of those names. But I also recall looking after lots of those patients when they were profoundly unwell. I recall some of them coming in with sepsis, requiring intravenous antibiotics and fluids, requiring the input of the ITU. I recall some of those -- I now, looking at those names, know some of those patients who are deceased. 14:22 14:23

401 Q. Yes.

A. And, you know -- so my experience of that particular issue was that my recollection is that some of these patients, in my experience, I met them when they were at their sickest. 14:23

There were other patients admitted at the weekends at the same time and they were patients who were admitted for chemotherapy for kidney cancer. Now, the chemotherapy that was available for kidney cancer at the time was pretty toxic, and these patients had a propensity to get sick at the weekend, which, me being the registrar who would typically be doing the weekends and maybe not seeing people during the week, you were looking after these folk who were having two particular drugs that I can recall that made them very unwell. 14:23 14:23

So, you know, that was my experience of that.

I said to you before I didn't really have that much experience of operating during the week in theatre, and at the level of seniority that I had, I have to say to you that a lot of the big operations would have been beyond my skill set, and the understanding of them as a junior trainee wouldn't have been there. That understanding developed as I developed as a trainee.

402 Q. Yes. So, to summarise, to the extent that you were able to observe the practices of both Mr. O'Brien and Mr. Young, given your, I suppose, relative inexperience in urology discipline, you didn't pick up on anything of particular note to concern you? 14:24

A. No. And I'm only now aware of the issues relating to the intravenous therapies because of the evidence bundle. I'm only aware of the discussions that happened with other more senior members of the Trust, such as the Medical Director, as a result of reading the evidence bundle. 14:24

403 Q. So, those, when you saw --

A. They were not live issues for me in 2003 to 2005. 14:25

404 Q. Yes. Yes.

A. Yeah, I think that was the period.

405 Q. To focus on that perhaps as an example, you've said some of the names of the people who were the subject of intravenous antibiotic fluid management are familiar to you? 14:25

A. Yes.

406 Q. You saw them at their sickest. What you seem to be suggesting is that you had no reason to suspect that

patients were being brought into hospital for days at a time to receive IV antibiotic management...

A. Yeah.

407 Q. When there was no good cause to do so?

A. So, I'll bring you back to what I said earlier. I had no comparator. I had no knowledge of another unit doing something different or not doing this. 14:25

408 Q. Yes. Can you -- is it useful to think back on it now and reflect that the treatment that you were seeing had no scientific base? 14:26

A. So, as you will come to, I'm sure, I entered higher surgical training in 2006, and on the basis of that, my experience and knowledge base increased, such that by 2012 I was ready to take up a consultant appointment. So I'm now aware that there was no evidence base for that. It's not part of my practice then in 2012, it's not part of my practice now. 14:26

Lots of things have changed in urology, you know. I reflect on a conversation that I had with a very senior consultant in Birmingham, and he had spent his life doing reconstructive surgery, and he had come to the realisation that a lot of this reconstructive surgery doesn't actually benefit the patient in the long-term. 14:26

So, you know, when you hear things like that, you reflect on what went before, and you think, were we actually serving the patients well by doing these major operations or was there an alternative way?

409 Q. So, one issue you do pick up on during that time, as I understand it - and we'll come and look at it in a little bit more detail in a broader context later - was a sense that Mr. O'Brien was behind with his administration? 14:27

A. (Witness Nods).

410 Q. That there were obvious backlogs --

A. Yeah.

411 Q. In his correspondence.

A. Yeah, that's correct. I would have noted that it took time for letters to be typed and appear in the chart. Back in the early two thousands I'm not sure that we would have had access to letters electronically in the same way that we have now. I'm fairly certain that I would not have had access to Patient Centre, which is the software on which the letters are generated, as a trainee. So, you know, we were reliant on letters being printed and placed into a paper chart. 14:27 14:27

412 Q. Now, you decided upon the conclusion and the award of your doctor of medicine, following that research period, to commence higher urological training in the West Midlands, is that correct? 14:28

A. Yeah. So as was customary at the time, you needed a higher degree to even get yourself in the door for the interview. I trotted around all the regions, as we did at the time, interviewing, and I was appointed in Birmingham, and I grabbed it with both hands. 14:28

413 Q. Yes. And that, upon completion of that, I suppose you were brought full circle then and an opportunity arose

to take up a consultant's post in Craigavon?

A. Yes.

414 Q. The Southern Trust, in 2012?

A. Yes.

415 Q. And as we can see from - if we scroll down, please, to paragraph 1.3, you outline your duties, and it goes over on to the other pages as well. Those duties - and we'll come to this in a moment - those primary duties were added to or supplemented to - and I think you see, yes, it's set out at (g) - your participation in the MDT and morbidity and mortality meetings. In fact as we will see, it was more than mere participation; you were, from April 2015, lead clinician for the M&M, if I can call it that? 14:29 14:29

A. Yes. 14:30

416 Q. And from November '16, lead clinician for the urology cancer MDT?

A. Yes.

417 Q. You remain in that latter post?

A. Regrettably, yes. 14:30

418 Q. And you've handed over the reins, as of 2021, of the M&M post.

A. I have.

419 Q. To Mr. O'Donoghue?

A. Yes. 14:30

420 Q. So, we can see what appears to be a heavy load. One other post I think I should mention is, you're Urology Training Programme Director at NIMDT?

A. I am.

421 Q. That's the Medical and Dental Training Agency. And you've been in that role for four years, since February 2019?

A. Yes.

422 Q. Do you also have a private practice? 14:31

A. I do.

423 Q. And is that a practice that consults as well as treats?

A. So, my private practice takes place outside of the Southern Trust. I consult at two clinics and I operate at a third private hospital. 14:31

424 Q. And how many hours per week currently do you --

A. It varies between four and eight.

425 Q. And your duties set out here are, I suppose, set within the framework of the urologist of the week model?

A. Yes. 14:31

426 Q. Take us briefly through a typical week for you in Southern Trust, in terms of your activities, embroidering in, if you can, the times when you were both lead in the M&M and the MDT.

A. So, I suppose there are three ways that my weeks work. 14:32 So, there's the elective weeks. And typically I would have a uro-oncology clinic on a Monday afternoon. That is largely seeing post MDT discussion patients and other cancer patients who need review. There's typically six to ten patients to that clinic in person. 14:32 If there's only six, then there will be at least four virtual consultations for patients who don't wish to travel to have an appointment.

Tuesdays then, often I will have day case surgery and an out-patient clinic in Dungannon. That happens - currently it happens twice a month. And on the alternate Tuesdays I may be doing private work.

14:33

Then on Wednesdays I would have a new patient clinic. Wednesday afternoon most weeks I would be doing private work.

Then Thursday is taken up with departmental activities, 14:33
primarily in the morning and at lunchtime, and then the cancer MDT in the afternoon. I Chair the cancer MDT on a rotational basis, until recently it was with three other consultants, but as of August it has become two others, so it's me plus two others. 14:33

Then on Friday I've typically operated, ever since as I arrived at Craigavon, it's an all day inpatient operating list.

14:33

So that would be my normal week, if you like.

You'll note in my statement recently that I've reduced my hours in the Trust, okay? So on the third -- on the week where the third Tuesday falls, I have reduced my 14:34
clinical commitments. And the reason I did that was because, first of all, I enjoy my private practice and it allows me to deliver the private practice safely in a time that I am not conflicted with clinical activity

from the Trust. So, that's safe for me, it's safe for the patients, and it's clearly discussed with my managers.

427 Q. Yes.

A. So, on the week that I'm urologist of the week, so that begins on a Thursday morning. There's a handover between the consultant finishing and the consultant starting. There is a ward round conducted with the middle grade staff. The patients are all seen in person. That usually takes most of a morning. And then in the afternoon, whatever other activity is required. So, we would undertake the triage. If there's patients who need to go to the emergency theatre, we would deal with those. If there are consults to be seen, the consults would be seen, any correspondence would be dealt with, that kind of thing. And the same on the Friday. 14:34 14:34 14:34

On the weekends I tend to do a ward round, if I'm the urologist of the week, I'll do a ward round on a Saturday morning. I will come in, go round with the registrar, we'll see everybody, troubleshoot any problems, see any consults, etc. 14:35

Then depending on the experience of the registrar, I may or may not come in on a Sunday morning. At the moment we have one registrar who is post exams, so, you know, he's more than able to do a ward round with limited supervision, whereas at other times we have a 14:35

very junior trainee who needs a lot more supervision and can't do things independently.

So the urologist of the week then would extend Monday, Tuesday and Wednesday, and we would complete the triage activity during that time. We would, you know, interact with other specialties as necessary, take patients to theatre on the emergency list, all of that kind of activity.

428 Q. I'm going to resist asking you questions about triage at this stage? 14:35

A. Yeah, sure.

429 Q. No doubt in the clinics on a Monday you would have had the support of the nurse specialists?

A. Yeah. 14:36

430 Q. I may ask you about that in due course. But just a couple of things arising out of that. We're going, in a short period of time, to look at the capacity issues.

A. Yeah.

431 Q. And it's notable, and I of course mean no criticism by this question, but your decision to devote more time to a private practice on a Tuesday, reducing your hours, you've had conversations with your Southern Trust employer -- 14:36

A. Yeah. I think it's really important for you to understand that I was over-delivering, okay? 14:36

432 Q. Yeah.

A. So, my contract was more than twelve and a half PAs. So I have no contractual obligation to continue with

that.

433 Q. Yeah.

A. So, over time I've reduced that, such that my contract as from October will be 11 PAs.

434 Q. Yes. And I was simply going to ask you this: No doubt, for the good reasons you outline, no contractual obligation to do more than what you're doing, but your decision in that respect takes place within, as you've described in your statement, an environment where there is currently, and for some years gone by, pressure in terms of the consultant resource. 14:37

A. Yeah.

435 Q. It's a seven consultant setup, but you've never - that is the Trust - has never been in a position to deliver seven permanent full-time consultants. 14:37

A. Yeah.

436 Q. That kind of conversation that you were having, is there a pressure on consultants to do more than their, I suppose, strictly contracted hours? Is that one way round, or one attempt to mitigate the difficulties in recruitment? 14:38

A. So, you're continually asked to do more and more. Okay? And, you know, one of the out workings of the 2017 meeting was that we were asked to do more. One of the out workings of locums leaving is that you're asked to pick up after them. So, you know, working in our department, with so few people on the ground, there's always somebody coming to you asking can you do this, can you do that, can you do an extra clinic? So, you 14:38

know, over time that builds up, and over time it means that you're actually looking after more than you should be looking after, because there is potential for you to be missing things because you're snowed under with work, there's the potential that you're not able to do things properly. So, I recognise that potential, I recognise that risk, and I've had an open conversation with the head of service and with the AMD, and I said, you know, "I'm doing this for me, because I feel it's safer for me to practise in this manner, and I can't continually be asked to do more and more." 14:39 14:39

437 Q. Yes.

A. I was very clear about that.

438 Q. And in fairness, I should have drawn your attention to -- you've as much as said that in your witness statement; you've reduced your contracted hours to avoid risks to both yourself... 14:39

A. Yeah.

439 Q. And your patients and remain capable of delivering a safe service. 14:39

A. Yeah. I have reduced it, but I'm actually delivering more than full-time at 11 PAs.

440 Q. Yeah. The urologist of the week model.

A. Yeah.

441 Q. Introduced around 2014? 14:40

A. So...

442 Q. Or thereabouts.

A. It was.

443 Q. I was going to make the point to you in terms of your

career consultant urologist level, you've known very little else apart from that model --

A. So I was familiar with this model as a trainee. It had been adopted in a few of the units that I had worked in. And when I came to the department, there were just three of us, I was quickly joined by two other colleagues, and we stayed at a stable five for only a short period of time and then those two people left and two further colleagues joined. So, we were at the point where at one point we got up to six people. 14:40

And it became quite clear that the inpatients were getting a raw deal. They needed more input from a senior person every day, and there were too many inpatients for us just to be dipping in and dipping out, as would have been the practice in the past. So we agreed that by doing a consultant led ward round every day, the patients would all be seen, that they'd be safe, there'd be a senior decision maker, and we all felt that that was a good thing to do. 14:41

444 Q. I want to briefly put to you, I suppose, by contrast with what I take to be your relatively positive view of the framework as a way of doing the business of delivering urology, I want to set aside that, or set beside that, I suppose, Mr. O'Brien's view of it. If we pull up AOB-01904. And I'm not going to do justice perhaps to the time and thought that he has put into this document, which was to be, I think it was submitted with a view to meeting management on that day

and I think the meeting was cancelled - and we'll come back to this for other reasons later. But I suppose, just scrolling down, he -- I'm not sure if you're familiar with this document, but...

A. I am familiar with it. 14:42

445 Q. Yeah. I suppose to summarise, within the document he, I suppose he speaks, and it's clear in front of us, that he found the discussions around the UOW to be frustrating and incomprehensible, and as he goes into the substance of what he's trying to get across, I 14:43 think at the heart of it seems to be a concern that the ward round in particular has been sacrificed on the altar of having to run to standstill to deliver surgery, an over reliance on inexperienced registrars who - my words, not his - are receiving tasks that 14:43 they're not necessarily able to deliver on and are ending up having to refer back in to the system for him to, him or you, or your colleagues, to eventually catch up on.

14:43

So, it's not a model, it appears, that works for him. Is there -- you've talked about the fundamentals of the model just a moment or two ago. Is that the best way of doing business, so far as you can see, notwithstanding the resource pressures and all of that? 14:44

A. I can only tell you how I operated the model. I was present on time every day to do the ward round. I supervised the trainees doing the operating, if they needed supervision. So, you know, from my perspective,

this model did work well. It was better than what went before it.

Mr. O'Brien, in this document, expresses concerns about how some of our colleagues operated the model. That's for them to address. But from my perspective, it was working well. 14:44

446 Q. In terms of the model then, it's --

A. In terms of the model and in terms of enhancing inpatient care. 14:44

447 Q. Yes.

A. In terms of having senior input on the ward round on a daily basis.

448 Q. Now, let me move to what you describe as your overarching concern since taking up the post. If we go back to Mr. Glackin's statement at WIT-42281, and scroll down to 1.7, please. So, I suppose this is one of your statements of faith contained within this statement. Since 2012 you have had patient safety concerns, and you explain that they are due to inadequate numbers of consultants in the department to deliver a timely service. 14:45 14:45

Scrolling down. Since 2002, or you acquired knowledge in 2002, and upon your return in 2012, it was clear to you that there was, and remains, a persisting problem with waits. 14:46

Just, I suppose, to help people understand this in

context, we'll bring up some figures. If we go to TRU-98238. And if we can just highlight those, please.

So, this table relates to the period in 2016. It's taken from 2016 and it illustrates, as the heading indicates, the number of patients waiting on a consultant led first outpatient appointment for regional urology specialty, and we can see it's split - it's allocated along consultant lines. 14:46

But let me just bring us across to the far right and the headline figure is 2,743 patients, of which 420, I think - yes - we can see are waiting more than 52 weeks. 14:47

If we then go to a table, keeping those figures in mind, if we go to the similar exercise for September 2021 at TRU-98244. And we can see that the 52 week measurement has increased from 420 in 2016 to more than three and a half thousand people, 3683, and the total waits, the total of those waiting to see a consultant for a first outpatient appointment has risen by just under 100% to 5237. Those figures, no doubt, don't surprise you? 14:47 14:48

A. They're not surprising to me in the least. I'm very familiar with the data. I would have reviewed the data. This is not a surprise to me. 14:48

449 Q. Yes. Maybe if we put another set of figures up, those awaiting inpatient or day cases, TRU-98245. These are

the figures for May 2016. And we can see that there's a total of 1047 patients on that waiting list, with 240 waiting for more than 52 weeks.

Then if we go to figures for September 2021, TRU-98251, 14:49
and we can see that the 52 week wait is now showing at 1321, increasing from, as I've said, the previous figure of 241, five or six years earlier. Again, part of your daily awareness, I suspect, Mr. Glackin?

A. Yeah, very aware of this as an issue. It's a live 14:50
issue for me, it's a live issue for all of the consultants, it's a live issue for the secretarial staff who have to deal with all the enquiries from these patients and their families, who are waiting excessively for treatment and appointments. 14:50

450 Q. Yes.

A. So...

451 Q. I'm going to go on and maybe drill down into some of the implications or consequences that lie behind those figures. 14:50

Just one final set of figures, I'll not bring them up on the screen, in ease of our time, but if the panel wish to consult TRU-98356, they will see an outpatient review backlog in 2016 of just over 2,000 patients, 14:51
that's 2041. And the position is a little worse in 2021. If you go to TRU-98361, there is a total number on the outpatient backlog of 2386.

Now, you were a trainee in West Midlands?

A. Yes.

452 Q. Do you retain contact with practitioners in other jurisdictions?

A. Yes, I do. I had recent reason to go to Birmingham for a benign prostate meeting and I met up with many of the people that I'd worked with, and we were discussing how to recover services after Covid, and my colleagues in Birmingham and Wolverhampton in particular were bemoaning the fact that they had some patients waiting for BPH surgery more than a year. I didn't really want to tell them that we had patients waiting six and seven years, but I did. It's appalling! 14:52 14:52

453 Q. Is it, to diagnose the problem, all about money? Birmingham gets more resources. Or is it part of this bigger NI problem that we oft see reported in the media of systemic issues in the structuring? 14:52

A. So, to take the benign prostate scenario as an example, there are now a plethora of options available to treat these patients, and one of the good things that's happened in the last couple of years is the development of the regional day case centre at Lagan Valley Hospital. That has allowed us to take those patients who are fit to that environment to have their prostate surgery done. So that has allowed us to have an impact for those patients. But one of the problems with that approach is that Lagan Valley is a standalone small unit, they can't take patients who are ASA3 or more. And, unfortunately, that affects a lot of the men who 14:53 14:53

are waiting on prostate surgery.

So what you're left with is a tail of patients who are not fit to go to this day case environment, who need care in an inpatient environment and who aren't getting any care because they've been displaced by all the other things that are going on in the acute hospital sector. 14:53

You can quite clearly see by the number of names who are on the screen there that we've had loads of consultants coming through our departments, small periods of time these locums have stayed and generated work which has been largely left undone. We have never really had a full complement of people in the 12, nearly 12 years that I'm there now, and you do need a full complement of people. 14:54

454 Q. Could I just pause, pause that thought?

A. Yeah.

455 Q. And we can bring up on the screen, just to illustrate the point you're beginning to make, that the Urology Department has been, I suppose, forever inadequately staffed since you arrived. If we go to WIT-42298, and at paragraph 16.1. Just continue, I think you're making the point -- 14:54 14:55

A. Yeah, so.

456 Q. -- about the current complement.

A. So the current complement means that if we run a one in six or one in seven urologist of the week rota, one or

more of us has to step out during our elective time to deliver that emergency care. Now, the emergency care is really important, so it has to happen. But it means that the elective care isn't happening as a consequence. So that's a negative impact. 14:55

You know, the Trust and the wider health service here, have identified that we need seven consultants to deliver the service. So, if we haven't got seven consultants, it is quite clear to me that you can't deliver the services required. 14:55

And the same goes for the nurses; you know, we had the situation of too few clinical nurse specialists. You know, you need middle grade staff. We found that very hard to recruit to. 14:55

So if you don't have enough people on the ground, you're not going to be able to deliver the volume of service that you need to do for the population. 14:55

457 Q. I think you've -- yes, sorry, I can't see it just in front of me, but what you've described in your statement is a, I suppose a constant cycle I think is the phrase you used --

A. Yeah. 14:56

458 Q. -- of recruitment.

A. Yeah.

459 Q. Quite often you go to recruitment and you're finding, you've expressed this, that you aren't able to recruit

because candidates are not appointable as a safe day one NHS consultant?

A. That's correct. I mean, I recall two particular instances. One is where the Chair of the Trust was Chairing our appointments panel, and she made it very clear that the person that we had interviewed was not suitable for appointment and she did not want that person working in the Trust. 14:56

And on another occasion, a very senior urologist from the East Midlands was our external, and he was scathing of the quality of the candidates that were presenting for interview. 14:56

So, you know, when you're interviewing people for what are very important roles, where they have to be able to perform at a safe level, you want to be appointing people who are appropriate, and to bring people into those roles who are not appropriate generates problems for the patients, it generates problems for us. It's just a disaster. 14:57 14:57

460 Q. You've also, just a moment or two ago, said it's not just a clinician or consultant issue, it's also a nursing issue. And if we go down through your statement to paragraph 25.3 at WIT-42303, you make the point that: 14:57

"The ward situation has been difficult over the last ten years, with a heavy reliance on agency staff and a

lack of consistent senior management."

I can see there you also bemoan the lose of a dedicated ward.

A. Yes. 14:58

461 Q. That was more recently reinstated, am I correct to say that?

A. Yeah. So everything that I've said here is correct. We now have a situation where we have a dedicated ward. And that's very, very recent. We have a ward manager 14:58 who, in my view, is doing an excellent job. It has really turned the thing around. And we have a very good elective admissions ward, which is separate from our inpatient ward. So, in recent times things have improved, but for a long time we struggled with this. 14:58 We had a merry-go-round of different senior nurses leading the ward who didn't stay, because of the challenges they faced. We've had agency staff who know nothing about looking after urology patients. That, for me, was scary. That gave me sleepless nights. You 14:58 do major operations, particularly on a Friday, and you think, "Well, who's going to be seeing my patients over the weekend?" So even though I wasn't on-call, I'd come in and see them myself.

462 Q. You also, in terms of the contributory factors towards 14:59 this inability to deliver to the demand, refer to theatre provision in Craigavon Hospital as being inadequate for the demands of modern urology service. This is, just for the panel's note, at paragraphs 15.5

to 15.7 of Mr. Glackin's statement.

You point to the limited number of sessions that have been available historically for the urology team, and you point to the shortage of trained theatre staff? 15:00

A. Yes.

463 Q. As all being contributors to --

A. Yeah.

464 Q. To this broader difficulty. Has there been any improvement across those indices recently or not? 15:00

A. So, one really good example of this problem is that Theatre 4 in Craigavon was the urology theatre since I arrived in 2012. Since just before Covid, Theatre 4 has been a storeroom. We have not got back into Theatre 4. As a consequence, when things opened up 15:00 again a little after Covid, I have been operating in Theatre 6. And those nurses, their specialism is actually ENT. Okay?

So, the nursing shortage is real, it's a problem. I've 15:00 no issue with the theatre staff in 6, they're excellent. But they're not urology staff. We had a urology team before Covid who knew all the kit, who anticipate your next move, all of that stuff that makes your day operating much safer and easier. 15:01

So, you know, when you walk into a theatre, Mr. Wolfe, and you look around you and you think "I've never seen you assist me do this operation ever", and you say to

the nurse, "Have you ever seen this operation? Have you ever helped anybody do it?", and they tell you it's their first time, it doesn't really build a lot of confidence.

465 Q. Does that impact on efficiency as well in terms of -- 15:01

A. Absolutely.

466 Q. Does it mean you get five cases done instead of six, or is it not as bad as that?

A. No, it probably is as bad as that. Yeah.

467 Q. We've seen the data, I think you've explained in your witness statement in various parts the limited extent to which data is used within the Trust - and we'll go on to look at audit and quality improvement in just a little while. But the messages around performance, the data around performance, you explain in terms of cancer 15:01 15:02 wait times, new referral numbers, waiting times for routine and urgent, all of the stuff we've seen on the screen as well, that was readily available and regularly discussed?

A. Yes. 15:02

468 Q. And I think as you say in your statement, it demonstrated a self-evident risk to patients. You also, if we go back to 17.1 of your statement, WIT-42298, you point at the bottom of the page to, I suppose, something of a vicious circle as being the 15:03 impact of all of this. So --

A. Yeah.

469 Q. Patients on waiting lists. These are typically benign patients?

A. That's correct, benign patients have probably suffered more, because they're not prioritised in the same way that the cancer patients are, for perhaps understandable reasons. But that's, nonetheless, it doesn't negate their suffering, coming in with a stent related problem, coming in with a catheter related problem. You know, the patients who are waiting the longest on our list are those with the benign conditions, and they're probably the ones who have suffered the most out of this. 15:03

470 Q. I'll take you in a moment just to some, I suppose, staff agitation around this, a number of interventions by your colleagues on that very point. But as I think you paint eloquently in that paragraph, these patients are coming back, being seen more often as their -- 15:04

A. Yeah.

471 Q. -- morbidity increases.

A. It would be clearly in the patient's best interests to have their issue dealt with definitively on their first attendance or in a planned manner electively. 15:04

472 Q. Yeah. Yeah.

A. But if you're waiting five or six years with a catheter in, you're going to have multiple attendances with problems.

473 Q. And there's obviously resource implications associated with that. 15:04

A. Which cancer patient do I displace from the theatre list to deal with this man who needs a TURP?

474 Q. Yes. And you go on just over the page then to, I

suppose, describe the impact on staffing. If you're, I suppose, being sucked in to trying to resolve these problems, whether you, your secretary or management staff, it's obviously inefficient?

A. Yes. I've huge empathy for the patients and their families. You know, the service that they're being offered is not acceptable. And I understand that. But it does have a negative impact on our working, in terms of our secretaries being verbally abused down the telephone, that happens, you know. You know, the patients and their families are frustrated by the poor level of service that we're able to offer, and we spend inordinate amounts of time answering their queries, when we'd all be better served if we'd a better service and we could just get on with doing the job when it should be done, in a timely manner. 15:05 15:05 15:05

475 Q. And it would appear that staff are not silent about these concerns. They are regularly articulated?

A. They are, openly discussed, yes.

476 Q. You say in your witness statement you met regularly with Debbie Burns, although I think you point out and maybe comment on this, but not with either Mrs. Rankin, I think Dr. Rankin, or with Mrs. Gishkori. But you met with Debbie Burns on a regular basis to discuss service improvement and management of waiting lists, and with Mrs. McClements more recently? 15:06 15:06

A. Yeah.

477 Q. Insisting with her that these issues are placed, if they weren't already placed, on the risk register. And

I think they are on the risk register and have been for some time?

A. Yeah. So my recollection is that around the period that Mrs. Burns was in post, there was quite a bit of work going on with the Health and Social Care Board and we would have had meetings with the Health and Social Care Board about urology in the region, and it's really, I think, on the basis of that that she would have been meeting with us and we would have -- I recall going to meetings on the administration floor and she was present, along with the consultant urologist, and I'm fairly sure Martina Corrigan was present, and we would have discussed all of these issues. She was receptive to the discussion. I'm afraid the others didn't engage, didn't engage with me anyway I suppose is probably the more correct way to put that. And my engagement with Mrs. McClements only began after the announcement of this Inquiry. 15:07 15:07 15:07

478 Q. Let me pick up on a couple of examples just to, I suppose, illustrate the concern of staff and the energy with which they appear to have pursued the points on behalf of, I suppose, the service and their patients. So, we've already referred to the concern that you observed about the nursing complement and their skills or otherwise in urology. Could I bring up on the screen, please, AOB-75761? And this is, Mr. Glackin, a short report penned by Catherine Hunter. 15:07 15:08

A. Yes.

479 Q. With whom I'm sure you're familiar?

A. I am. And I'm familiar with the report.

480 Q. She's copied you in to this e-mail, and a list of others, on 12th November 2015. I think the panel will have seen this e-mail when hearing from Mrs. Gishkori, and I think off the top of my head Mrs. Trouton as well. But we don't need to go to the report which sits behind this e-mail. The e-mail, in essence, encapsulates the point very well. She is saying that she has a lack of staff and, I suppose, a deficient skills mix at present. She, just to be clear, managed the urology ward, is that right? 15:09 15:09

A. I think at this point in time she was relatively new to the post. She'd come in from another position, I'm not quite sure where, and she'd identified all of these issues, quite correctly. She'd discussed them informally with us as consultants when we were doing ward rounds and, to her credit, she brought that to the attention of her management. 15:09

481 Q. And I suppose the headline is that:

15:10

"Currently the standard of care being given to patients is being compromised and I would consider the ward to be clinically unsafe at times."

Were you in a position to see or know what the, I suppose the governance response through management to that was? She does refer here to what might be described as a couple of short-term fixes which she considered inadequate, which was the getting staff to 15:10

cover unfilled shifts.

A. Yeah.

482 Q. But would you --

A. So I'm not aware of what governance or what management response there was from the Director of Nursing side of things. Neither am I aware of what response there was from the assistant director or the head of service responsible for urology, you know. So I'm not sure what their response to Catherine Hunter was at this point in time. These were not new issues. Catherine was not the first person to raise these issues. And some of these issues persist. 15:10 15:11

483 Q. Going back to, I suppose, the point in relation to benign patients. If we go to AOB-01811. And this is a note penned by Mr. Haynes to Mrs. Gishkori. Again, you and your fellow consultants copied in. And it's May 2018. And what he is saying, to summarise this note, is that: 15:11

"There are serious patient safety concerns within the Urology Department regarding the current status of our inpatient theatre waiting list and the significant risk that this poses to patients." 15:11

If we just scroll down a little bit. The impact, as he sees it, is on the, primarily the clinically urgent cases, and he makes the point that only limited numbers of non-cancer cases are being seen. They belong within the urgent classification. And no routine patients, or 15:12

very few, classified as routine are being seen.

Just in the last paragraph. "Tragically", he refers, without naming Patient 91, you'll see on your list, or at least I take that to be Patient 91, who was a 15:13
patient who came in with some comorbidities, but for a stent replacement or removal, I can't quite --

A. So I'm very familiar with that patient. Yeah.

484 Q. Yeah. And we'll come to it in some detail. But I think we can -- I suppose the thrust of the point is 15:13
delays with the management of, for example, stent patients, risks, infection, sepsis, and in this case there may have been other contributory factors, but "This is what we're up against, this is the risk we face." 15:13

A. Yeah, he was laying it out in very clear terms to Mrs. Gishkori. And, you know, this was about the inpatient operating capacity and the clear disconnect that we had between the volume of patients that we had to deal with versus the capacity that we had to deliver 15:14
care for them. And, you know, we didn't have anywhere else to send these people. Our colleagues in other units were under similar pressures. It's not that we could pick up the phone and ask the Ulster or the City or somebody else to take these people. On occasions 15:14
that kind of thing did happen. But, you know, we just had no capacity to sort these people out, which is shocking.

485 Q. If we scroll just down three pages to AOB-01814, a

couple of weeks later, it seems, following a meeting, as we can pick up from the first line of this e-mail, Mr. Haynes writing to Mrs. Gishkori again, says that:

"The meeting was to resolve the issues of the impact of the loss of the extended day operating." 15:15

A. (Witness Nods).

486 Q. And we'll come to some of these initiatives in a short moment. "But the meeting did not result", it says: 15:15

"...in urology having its full number of weekly theatres, nor was it intended to address any increase in urology operating to address the waiting list backlog." 15:15

So --

A. So, my point there would be that, first of all, 11 half day slots for a team that's supposed to be six or seven consultants is not enough. But that's what we had. 15:15

487 Q. Yeah.

A. We weren't able to get back to that position. So, we were never going to be able to play catchup.

Secondly, there's a disparity in the waiting times across the specialties, and that was something that was discussed. You can see that some of the larger specialties like orthopedics and general surgery have huge waiting lists as well. We have terrible waiting 15:15

lists. But there are other specialties that didn't have such bad waiting lists. So there was a discussion as to whether or not the Trust should be applying some form of quantitative metric as to who gets what proportion of the available theatre time.

It's also - I think this was written in May, is that correct?

488 Q. It's into June with this one.

A. Okay. Yeah. June. So this is the summer. You know, this is just an example of how there are year-round pressures. You know, we can't even operate at full capacity in the summer months. That's -- and that has been my experience now for I would say probably six to seven years. Now, you know, I have a recent example. I went on to the ward on a Friday morning to be greeted by the ward manager, whom I have known for 20 years, and she said "We've got outliers in our elective beds. They promised me they wouldn't put outliers in the elective beds. We're going to have to cancel some surgery." This was August.

489 Q. I suppose I can detect perhaps an end of tether moment on the part of Mr. O'Brien a year later, when perhaps his tether is longer than that. But in 2019 he wrote to you and colleagues. If you just bring up on the screen, please, WIT-55757?

A. It feels like I'm telling you tales of woe.

490 Q. Well, I think it's important to put this context in place before we get on to some of the other substance

we have to explore.

A. Yeah.

491 Q. So, Mr. Haynes is again pointing up the risks of urosepsis, and he's saying: Going forward can we document this? Can we, I suppose, better put it on the in-tray of those who need to know by filing incident reports where there has been unreasonable waits? I see you smiling. I don't know how you responded to that? Was that -- 15:18

A. I... 15:18

492 Q. Is it correct, I suppose, to describe it as a "Where do we go?", end of tether moment?

A. I think Mr. Haynes here is very clearly outlining how we have to flag to the Trust that there's a significant problem. However, I would say that the Trust should very well know that there's a significant problem by the volume of the waiting lists. All the procedures that go on the waiting list are coded. All you have to do is run a coding and you can understand very clearly what's waiting on the waiting list. 15:19 15:19

493 Q. I don't need to bring you to it, but we'll perhaps come to it later.

A. Yeah.

494 Q. In terms of the dissemination of these key messages, we know, for example, in Patient 91's case, and in other cases, his SEA report or review pointed up the need for the Trust to deal with capacity issues. It was one of the... 15:19

A. Yeah.

495 Q. The recommendations.
A. I suppose a little bit of good news on that front, Mr. Wolfe, would be that Lagan Valley has actually given us quite a good outlet for the stented patients. A lot of them are fit enough to go there. And that has meant that to a large extent that has improved in recent times. 15:20
496 Q. I focused some attention on Mr. Haynes' energy in lifting this issue on to the agenda; you reflect in your witness statement that Mr. O'Brien raised concerns on many occasions about the needs of urology service, whether that was at departmental meetings with the assistant directors and with commissioners from the -- 15:20
A. Yes.
497 Q. -- Health and Social Care Board. I don't wish to disrespect his input, but was similar messages to what we have seen already... 15:20
A. So, I referred earlier to the meetings that we had with Mrs. Burns. So, around that time there was engagement with the Health and Social Care Board about how services should be, you know, progressing. And Mr. O'Brien would have raised, very clearly, these exact concerns at those meetings. 15:21
498 Q. And you're at those meetings as well?
A. Yeah, I was at some of them, yes. 15:21
499 Q. Yeah. The Commissioner -- I mean --
A. I'm telling you it happened first hand. I heard it happening.
500 Q. Yeah.

A. Yeah.
501 Q. The Trust is clearly, Trust management, hopefully --
A. Present.
502 Q. -- senior management and Board are aware of these issues. It has the -- 15:21
A. I can't speak about the Board.
503 Q. Well...
A. But Trust management, in terms of the Acute Services Director, would have been aware.
504 Q. Yeah. And certainly the Acute Directorate Risk Register has, if you like, had this issue stamped upon it from, I think, in or around 2012, possibly 2014? 15:22
A. I've never had sight of the Risk Register, but I did, on one occasion, on a video conference meeting, ask Mrs. McClements were these issues on the Risk Register, and she assured me that they were. 15:22
505 Q. Yeah. So, we can see through various sources that the issues aren't hiding behind the trolley.
A. No, they were fully out in the open.
506 Q. Yes. What is the Health and Social Care Board saying at these meetings that you've attended? Noting the issue and taking it away? 15:22
A. I can't honestly recall what Mr. Sullivan's responses were. It didn't come to very much, Mr. Wolfe. Nothing has really changed. 15:23
507 Q. So, in terms of progress, you've highlighted the assistance that the Lagan Valley has brought to the stent issue?
A. Yeah.

508 Q. But more broadly, looking at the range of new patient capacity issues, follow-up capacity, surgical --

A. Yeah. In fairness, I should add that during the Covid pandemic, services in Craigavon were severely restricted. So, we took the opportunity to establish a small amount of surgery for urology at Daisy Hill Hospital. That was entirely new. It had never been done before. We, as a team, were flexible, we worked together to identify the patients who could go there. We were very warmly received by the theatre and ward teams in Daisy Hill, we found them to be excellent. And we had a long held -- prior to Covid, we had a long held wish to establish services in Daisy Hill, and we would hope to build on that going forward. So that remains in place. We have theatre lists in Daisy Hill that we never had before, patients are largely having day case surgery, the occasional 23-hour stay, and that's working well. We need more of it. 15:23 15:24 15:24

509 Q. Can I ask you some questions about the extent to which, as well as very properly complaining about the issues and seeking improvement, to what extent the urology team, supported by management, were able to engage in discussion or reflection about how things, I suppose, might be done better, more efficiently, to try to improve the lot, or are you telling me clearly that there's no blue sky thinking here, or there's appetite for blue sky thinking, but it is difficult to improve without resource? 15:24 15:25

A. So, you don't have to reinvent the wheel. Okay? Lots

of these things are being done in other places very well. You may be familiar with GIRFT. It's a project that I think began in an orthopedic setting but has been extended to other specialties. We've had a recent GIRFT visit. I think on the whole GIRFT were impressed with many of the things that we were doing within the department, but they recognised the shortcomings that we have in terms of resource. 15:25

We are very open to moving towards, as far as possible, day case operating for all the patients who are fit for it. We've tried to deliver that, as far as we can within the resource that we've got at the moment. We have shifted things out of theatre that used to be done in theatre, we've moved them to Outpatient Department activity. So, all of that, you know, that's not that we've suddenly seen the light, we've been doing this for the last ten years. It's just you need the resource to deliver these good ideas. And if you haven't got the resource, you're going to struggle to do it. 15:25 15:26 15:26

510 Q. In outpatients, I think you've reflected in your statement that Thorndale, at least physically, is a good setting, you have good staff, well managed, a cohesive team. 15:26

A. (Witness Nods).

511 Q. But nevertheless, there is a time lag in terms of outpatients being seen. Is there effective use of the nursing resource? Are things managed efficiently?

A. So the nursing resource has evolved over time. When I joined the department there were two people who were working as CNSs, and we now have a CNS team of five staff, plus two people who have been appointed in the last few months on what's known as "expression of interest", and I've had that clarified for me, because I wasn't quite clear what that meant, but basically it's nonrecurrent funding. 15:27

So we would be hopeful that these two new appointees, who are both known to us, they both worked as urology staff nurses in the past, would be appointable in the future as permanent members of the team, because it's no secret but some of the members of our CNS team are coming towards the end of their clinical careers and we need to do a bit of succession planning. 15:27 15:27

So, our nurses perform, many of them perform at advanced nurse practitioner level, a lot of the activity that they undertake, it's beyond just what would be considered CNS activity. And we have supported that as a group of consultants, we've mentored the nurses in various aspects. I've personally mentored them in prescribing, administration of flexi and Botox. I've mentored two of the nurses to undertake perhaps transperineal biopsy of the prostate. So we have a very supportive cohesive team. You will have heard from Patricia Thompson, when she gave evidence a few days ago, about nurse led clinical 15:28 15:28

activity, and as the team has expanded, we have been able to expand that.

So, you know, you need - it's coming back to my point - you need enough resource to allow you to deliver these things. 15:28

The nurses that we have are extremely capable, they're pro-active, and they're well regarded by us. And I think in reverse they regard our support well. 15:29

512 Q. Could I ask you about, I suppose, theatre, surgical? We'll come on to look at performance management more specifically in a moment, but are efforts made to measure comparable efficiency within theatre across the team? 15:29

A. So, we all have slightly differing interests. Okay? So if I take, for example, Mr. Young is primarily a stone surgeon now, okay? His practice was perhaps wider than that in the past. So he does operations that I don't do. So, to compare his practice with mine, you wouldn't be comparing apples with apples. But there are things that we all do in terms of a commonality. We would all do things like TURBT, we would all do things like simple ureteroscopy, many of us would do bladder outlet surgery, although some of us don't do any. So the theatre utilisation, the theatre management team would go through a utilisation and they present data on that. I've never found it to be that helpful or meaningful. 15:29 15:30

Mark Haynes went through an exercise at one time where he looked, kind of on a coding basis, as to how long each procedure should take, roughly, and then used that as a way of gauging what capacity we had to deliver what was on our waiting list. 15:30

We have come to the view more recently that we needed a scheduler. Okay? And we came to that view for a couple of reasons. Firstly, it would mean that certain procedures would essentially be pooled - and they have been for a while now. So, for instance, anybody needing a transurethral resection of a bladder tumour, we would just pick that up. We wouldn't necessarily - that wouldn't go under a named person, we would just get them the first possible date. So that's where a scheduler comes in, because they're very - they can very easily pick that off the waiting list, make sure the patient is pre-oped and put them on the first available list. So that person has only just joined the team this past maybe two weeks, and that will be a change for our department. It's something we've been asking for for a long time, and I think that will be a positive benefit. It will also mean that as far as we can, we will draw patients from the waiting list in chronological order, based on their clinical urgency. 15:30 15:31 15:31

Now, you may or may not be aware of a document issued by the FSSA, which was about prioritising surgery

during Covid. We have largely maintained that prioritisation process. And when patients go on our waiting list, they are coded according to that process. So this is a way that we have of reassuring ourselves that we are using the resource that we're provided with most appropriately.

513 Q. The importance of a scheduler, does that point to perhaps recent historic weaknesses in terms of giving consultants too much autonomy in terms of the management and allocation of patients to waiting lists, perhaps allowing their preferences to take priority ahead of the wider needs of the service? 15:31 15:32

A. So, I think the scheduler will work in concert with the consultants, because clearly the scheduler doesn't have the clinical insight that the consultants have. But it will level the playing field for patients of a similar clinical urgency being called in chronological order. 15:32

We haven't yet, but I think we will have, work up an SOP so that it's a very clear for the scheduler how we wish to organise things. And naturally, you know, I alluded to Mr. Young earlier doing stone cases, he's now semi-retired, but my other colleague does stone work, so there will be things that only will go on his list that won't go on my list and vice versa. And that applies across the team, because we have different skill sets across the team. 15:33 15:33

514 Q. I perhaps should have come to this a little earlier in the piece, but you do, in your witness statement,

describe certain initiatives to try, in particular, to remove -- sorry, to move surgery along. You talk about --

A. Yeah.

515 Q. -- working Saturdays for a period, a couple of years maybe, and then it ran into the brick wall of bed issues. 15:33

A. (Witness Nods).

516 Q. You talk about the three session week. Again, it ran into difficulty. So, in fairness to the Trust, is it appropriate to say that they have looked at trying to address these issues, but they have been faced with -- 15:34

A. I think it's in fairness to the Trust, yes, I agree. It's also in fairness to the clinicians. You know, the urologists and the anaesthetists and the nurses agreed to do the extra lists. 15:34

The Saturdays, as you pointed out, became untenable because of essentially nursing shortages and bed pressures. And the extended days, it was a three session day on a Tuesday and a Wednesday. I didn't operate on those particular days, I operated on a Friday. So, the productivity wasn't as good as we had hoped. The final session of the day was never quite as productive as the first two. And then there became an issue with, I think it was primarily anaesthetic staffing of those lists. 15:34

So, you know, that fell by the wayside for that reason.

But I come back to what I said about the 11 sessions; it's just not enough.

517 Q. Yes. I think, I suppose the solution, as you see it, and hopefully that's not unfair to put it in those terms, is set out in your witness statement at WIT-42297, and that is, I suppose, at paragraph 15.5. Your, I suppose, proposal - if you had the keys to the kingdom - would be for three to four sessions per consultant per week, giving you 21 to 28, instead of the current, is it 11? 15:35 15:35

A. Yes.

518 Q. At the time of the writing that statement.

A. Yeah, I think consultants in the NHS operate too little. Surgical consultants. If you go to other health care systems, they spend three or four days a week operating. We are not using the resource that we have appropriately. You know, you have trainees who -- I'm a TPD, so I hear this from the trainees' side. They go off and do a fellowship in another country and they tell you that they're in theatre five days a week. Now maybe that's not the right balance - it isn't the right balance. But, you know, we are lucky if we get two days in theatre a week, you know, and it shouldn't be that way. And if we were able to offer more timely surgery, the patients are the people who would benefit. 15:36 15:36 15:36

519 Q. Can I just pick up on two points that you make in your statement which, if I interpret you correctly, you are putting them forward as perhaps impediments to progress

on capacity, which are, I suppose, a separate issue to the bigger resources issue? So you see resources as being the primary issue, but you make a point about job planning.

A. Yes. 15:37

520 Q. Which I would be grateful if you could expand for me. If we go to WIT-42315, and if we scroll down to 46.1. You make the case that:

"Performance objectives are not utilised for consultant 15:37
medical staff. A consultant job plan sets out sections of direct clinical care and SPA. It records the frequency of clinics, theatre lists, on-call activity. In my case it also captures the time allocated to..."

15:38

-- your roles as:

"...educational supervisor, TPD, Chair of Urology MDT, preparation time for the MDT.

15:38

My job plan does not..."

And this is your point:

"...specify how many patients I am expected to see per 15:38
clinic or theatre list."

Although it does specify how many clinic and theatre/procedural sessions you're expected to deliver

over the course of a year.

Just scrolling down, so we can take both related points together, you say that:

15:38

"Job planning happens in isolation from the whole team. There is no discussion with the team about the overarching view of the needs of the service. I am not aware of any standard setting for productivity across the team."

15:39

So, would I be right in saying that you think that the resource, the human resource in terms of consultants, could be used better, could be used more efficiently if greater emphasis was given to performance managing and directing the staff towards their area, the areas needed by the service?

15:39

A. Yeah, I do agree with that. And, you know, in my view what should be happening is that we, as a consultant team, should be sitting down with the management, having the data available to us to see what it is that we can deliver within the resource that we've got, and agreeing how we're going to do that, benchmarking practice in terms of numbers of patients coming to certain types of clinics. I appreciate that, you know, perhaps if you're breaking bad news you might need more time than whether you're counseling somebody for a circumcision. So that all could be factored in.

15:40

15:40

521 Q. Yes.

A. You know. So these discussions haven't taken place until very recently in our team. We've had a couple of away days where this kind of, I've raised this kind of topic, and we would like -- I personally would like to travel in this direction. 15:40

522 Q. Yes. And was that - I think you told me when we spoke before you gave evidence - was that experience, that kind of bringing the data into a monthly meeting and crunching through it as a team, was that your experience elsewhere? 15:40

A. Yeah. So, towards the end of my training I worked in two units, one was in Birmingham and the other was a Wolverhampton. I was a post-exam trainee in both units. And you're in a much different position as a post-exam trainee to understand what's going on. 15:41 You're -- also it was the practice of those units to invite the post-exam trainees in to the business meetings that the consultants attended. And that was a useful experience, because you got to see how they interacted with their management. 15:41

So, the data, in terms of the numbers of patients presenting to their departments, the workload, all of that was presented at these meetings. It was openly discussed. You know, strategies were discussed as to 15:41 how we're going to manage this, that and the other, you know, and we haven't had that. We have had elements of it at times --

523 Q. Sorry to cut across you, and just as part of this

answer. Why is that?

A. Yeah.

524 Q. It seems relatively obvious that this should be done, but maybe I'm missing something.

A. So, it has begun. Last week perhaps we had our first meeting where this kind of data was presented. Okay? And I congratulated the person who did it and I said - because this is exactly what we need to see, this is what we need to hear, okay, we need to be aware of this. It hadn't happened I think in our department before this, because for one, Martina Corrigan had far too much on her plate. She was being pulled from pillar to post looking after ourselves, ENT, ophthalmology, and outpatients. Everything was reactive. She didn't have the time to have this prepared and bring it to us in a structured manner on a monthly basis. 15:42 15:42

When we had departmental meetings, Martina would often not be able to be present for the meeting because she had a conflicting meeting with ENT, and we were therefore not getting, to my mind, the full benefit of having the head of service present at the meeting. 15:42

525 Q. I know that you're not saying that as a criticism of Mrs. Corrigan? 15:43

A. It's not a criticism of her, because in my experience she was extremely hard-working, she worked often 18-hour days. It was -- she was -- there was just simply too much being asked of one person. The

consequence of that is that you don't have the structures in place to have these regular discussions about how you're doing, where you're going, what you need to do to address shortcomings, things that are coming on the horizon, plan for the future, etc.. 15:43

526 Q. You say in your statement, I think I've got the right reference, hopefully I've got the right reference. It's WIT-42294, 13.2, if I can see it. Yeah. Yeah. You make the point towards the very bottom that to the most extent, to a large extent, the waiting lists are a 15:43 function of inadequate resource. But I think you add this other point as a contributing factor to --

A. Yeah.

527 Q. -- inefficiency, that there is also an aspect of individual working styles and differing case mix. So: 15:44

"If a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters, then inevitably the waiting list will grow more quickly than that of a colleague who lists 15:44 chronologically."

A. Yes.

528 Q. Was that a problem?

A. It's still a problem. Because, you know, if you look 15:44 at our current waiting list, the patients who are waiting longest are waiting for bladder outlet obstruction surgery, there is the occasional Nesbit's that's waiting. So clearly other cases have been

picked ahead of them.

I didn't make the comment when you put up the data of the waiting lists, by the way, but if you look at that in great detail you'll see that there are differences across the team.

529 Q. Yes.

A. Okay? There are people, I think in the 2016 data that you presented, who don't have patients waiting more than a year. 15:45

530 Q. Yes.

A. So, there is an element as to how you choose to run your practice.

531 Q. Yes. And the kind of forum or approach that had its first meeting last week, is that the kind of structure that could potentially bring discipline - and I don't mean discipline in the nastier sense, but organisation or build a common approach towards --

A. I think consensus is important. We need to build consensus as to how we move forward. I notice from reading Mr. Young's contributions that he shared that view. But you need the data to demonstrate to people where we are. Without it, you're just talking anecdotes. 15:45

532 Q. Within your statement you speak about your ability to progress matters, I think with hard work, I suppose, and targeting. You say, if we go to WIT-42293, 12.2 at the bottom, that you were given access - and maybe you'll unpack this for us - to business objects through 15:46

Mrs. Corrigan and using, I suppose, the data available to you through that, you were able to better target long waiters and over time reduce your backlog. I don't understand that as you suggesting this is the magic solution that will alleviate waiting lists in toto, but what are you alluding to there? 15:47

A. Yeah. So, waiting lists are held on the patient administration system. Business objects is a suite of software that allows you to generate reports and to query things on the waiting list. And from that, you can then download Excel files, or pdfs or whatever you want to download, and have a full view of what the waiting list contains. It also allows you to download activity. So, I could quite clearly see from the activity how many outpatients we were seeing every month, it was coded by both clinic code, it was also coded by consultant, nurse, registrar, whatever it happened to be. So, I had a very clear view of what the activity was. I had also a very clear view of what the waiting lists were. 15:47 15:48

So I inherited a waiting list when I came to the Trust of another consultant who had left, and at that stage I took on his work, and I wasn't familiar, clearly, with his patient workload, so I had to go through his waiting lists and see what was there. So, I requested access to this, because it was the only way that I was going to be able to understand the data and understand how many patients were waiting to see me. And, you 15:48

know, the review backlog was substantial, I cleared it. My practice meant that you don't get a review in my clinic unless you need one. I discharge people who don't need to be coming back. You know, patients who get results, they'll come, if it's a post-MDT, they'll have a face to face discussion, if that's what they want, and after that then, if they're having follow-up by imaging, they will receive a letter with the results, with an open invitation that if they want to come back to my clinic, please contact me, please contact my secretary, there's no problem about seeing you. 15:48 15:49

So, by working in that manner it means you don't have a review backlog, you have capacity to bring people in who need to be seen when they need to be seen, and you can do it in a timely way. 15:49

So that's the reason I wanted business objects, so that I could get a firm handle on my practice and understand where I was. 15:49

CHAIR: Mr. Wolfe, it's now ten to four. I think we all need a break.

MR. WOLFE KC: I was going to suggest that and I think everybody could benefit from one. 15:49

CHAIR: Yes. So five past four.

MR. WOLFE KC: Very well. Thank you.

SHORT ADJOURNMENT

CHAIR: Thank you everyone. I think we have had the temperature adjusted to try and make it a little cooler in here, because it has been quite hot this afternoon. And that's not a reflection on you, Mr. Glackin. 16:06

MR. WOLFE KC: I propose to stop about a quarter to five and then pick up again tomorrow.

CHAIR: Okay.

533 Q. MR. WOLFE KC: So we were talking just before the break, Mr. Glackin, about the initiative commenced last week - no doubt it had been in planning for some time - to bring data to a meeting, to number crunch and decide on, I suppose, better ways of attacking service related problems. 16:06

16:06

You were a participant with your colleagues in the Thursday lunchtime departmental meeting.

A. Yes.

534 Q. That was, I suppose, a standard or regular date in the diary, and the diary of every member of the team, or it should have been? 16:07

A. Correct.

535 Q. And you say within your statement, I'll just read it out, 34.2, that this meeting, it lasted 45 to 60 minutes. Chaired by Mr. Young. Attended by urology consultants and Mrs. Corrigan. 16:07

"The purpose of the meeting was to provide an update on matters concerning the running of the department, such

as waiting times, referral data, reports from theatre user groups, equipment issues, and plans to purchase new equipment, etc.."

So, it's a fairly broad agenda, but essentially anything could go on the agenda if it related to the running of this service? 16:07

A. Yeah. All items relevant to the running of the department.

536 Q. Yeah. In terms of the functioning of the team, does it occur to you upon reflection that the kind of purposeful meeting that you refer to as having taken place for the first time last week, should have been a feature of a properly functioning team well before now, given the range of problems that were being faced by the service? 16:08 16:08

A. Okay. To be fair, on occasions Martina Corrigan or Sharon Glenny would have brought data to the meeting, but that was - I wouldn't describe that as frequent or routine, that happened on occasions. And to my mind, that should have been frequent and routine. 16:08

The meetings often lacked structure, often there wasn't an agenda, attendance was poor. I reflect in the statement that too often I'd be sitting across the table looking at Michael Young and the two of us would ask each other "Where are the others?" They were doing other things. They had prioritised other activity. They were in the building, they just weren't in the 16:09

meeting.

537 Q. Yes. I'll allow you to pick the descriptor, but was this a dysfunctional team or, to put it at a slightly, on a slightly softer surface, did it not coalesce or gel sufficiently to have conversations around problems that were, if not soluble, were at least capable of mitigation? 16:09

A. I suppose there's always degrees of dysfunction. I don't think we had interpersonal problems. I think we could all have a civil conversation with each other in a room. So I don't think that was the problem. I think, you know, our workloads were very heavy and I think that was a challenge for people to give up time to come to a meeting when they had other competing interests. I'm not making excuses for my colleagues, because I went to the meetings every week and I thought they were important, but I'm just trying to see it from their perspective. 16:10 16:10

538 Q. As a team member with, say, experience of the Wolverhampton approach, did you reflect that maybe I could have done a bit more to agitate for reform in terms of how we make these decisions, suggesting that really there's no excuse for not bringing this data every week and having this kind of conversation? 16:10

A. Yeah. These things were discussed, Mr. Wolfe. You know, on more than one occasion I said we need the data. On more than one occasion I said we need an agenda at this meeting, we need proper minutes taken at this meeting, you know? So there comes a point when 16:11

you've said these things so many times that you're just hearing yourself repeatedly saying the same thing, the same mantra.

539 Q. You refer in your witness statement to, I suppose, a lack of leadership or a lack of direction from management, or at least that is implied. You say - if we can bring up on the screen, please, WIT-42307, just at 31.1 there, you say that in your opinion: 16:11

"...the senior managers did not work well with urology." 16:12

And you point out that:

"...engagement with the department by the clinical directors, medical directors, assistant directors for surgery and directors for acute services was very limited and infrequent in my experience." 16:12

And I think elsewhere you say that the connection between cancer services, and the management structure within cancer services and urology was, I'm not sure if you used the word nonexistent, but there was a disconnect there? 16:12

A. I think nonexistent is probably correct. Can I just say that, you know, there was a short period where Mrs. Burns did interact with us, but she was the only person in that role who did. As for the AN or the assistant director for surgery, very infrequent 16:12

attendance at any meetings regarding our department, from my recollection. Didn't meet the Medical Director at any meetings for our department, which I think is very relevant for 2017, and we'll come to that I'm sure. And the Clinical Directors were never at our meetings.

540 Q. And we have your evidence on Mrs. Corrigan running to standstill, and you compliment her on her work ethic, but she was being pulled in too many directions?

A. Yeah. 16:13

541 Q. To offer strategic leadership?

A. And I think that may also apply to some of the other managers that we're speaking about here. You know, I'm fairly certain that Ronan Carol was pulled in multiple directions as well. The whole aspect of the acute or unscheduled care delivered by the Trust versus the elective aspect - and urology is largely an elective specialty - they were overwhelmed with the unscheduled or emergency care aspect, in the emergency department, on the wards, and that had a negative consequence then for elective care. They were firefighting every day. 16:13 16:14

542 Q. Yes. I'm thinking about the other important roles/responsibilities you had, quite apart from, I suppose, the basic consultancy. You had responsibility for the Patient Safety Committee? 16:14

A. Yeah.

543 Q. You had responsibility from 2016, '15, for the multi disciplinary team.

A. Yeah.

544 Q. You were the clinical lead?
A. (Witness Nods).
545 Q. Is it surprising, or are you expressing your surprise that notwithstanding your involvement in those roles, you had no contact with any of the people you've just listed, or little contact? 16:15
A. So, little contact. But what I would say is this: The patient safety meeting, that terminology actually came from Dr. John Simpson. He had been the Medical Director. And he had taken a view that the M&M structure within the Trust wasn't really delivering and he wanted to change that. He wanted to bring that activity closer to each department, which I think was a good move, and he supported that. 16:15

16:15
So, I borrowed that term from him, it's not that I generated that term. And what had gone before it in terms of M&M was all of surgery and all of anaesthetics sitting in a room, not much smaller than this, and it was a bun fight, it was adversarial, there was no learning, it was juniors standing up presenting cases and then get taken apart by senior consultants. It was not a pleasant place to be. So, Dr. Simpson was very right in suggesting what he did. So he then, he sought volunteers, basically, to run the M&M or patient safety meetings in each department. 16:15 16:16

I was relatively new through the door at that stage, I had seen how it had worked well in other places, I

thought we can do something with this, we can develop this, we can bring in more than just the doctors - because up until that stage it had just been the doctors.

16:16

So at the outset I spoke to my consultant colleagues and I said "We need to include the whole team here. We need to ask the nurses from the Outpatient Department", which was the Thorndale, "We need to ask the nursing, the senior nursing staff from the ward. We need to 16:16 seek input from the management team." So that's what we did. And we started drafting agendas that would allow us to discuss both the mortality and morbidity aspects, but also the other things like the SAIs, the complements, the complaints, the learning letters, the 16:17 coroner's reports, all of the things that cascades down from the management to the departments. It included audit.

546 Q. Could I --

A. You're going to pause. 16:17

547 Q. Those items then, and audit, are on my agenda.

A. Yeah. Good.

548 Q. In a short period of time, or perhaps in the morning. But it's the, it's, I suppose, what could have been done with better management support across any of your 16:17 interests, which I suppose I'm interested in at this point.

A. Yeah. So --

549 Q. If you - and this is, I suppose, largely leaving aside

your traineeship, the only place that you have worked, and you have, I suppose, on your account, experienced largely a default in proper leadership and proper management, for perhaps understandable reasons if people are not resourced and are pulled in other directions, but do you have a sense of the implications of this deficit for the urology service?

A. Yeah, I have --

550 Q. Is it possible to articulate that knowing --

A. I had a very strong sense of the deficits. And in drafting the agendas, as I've outlined, we were trying to bring out all of those things that needed to be discussed. And, you know, audit was not well supported within the Trust at that point in time. I'm pleased to say that's actually changed quite substantially in the last year, you know? There was no support to me as a lead clinician for this meeting, so I had to draft the agenda, I had to then write - type the minutes - and as you can imagine, I'm a surgeon, I'm not very good at typing minutes, you know, so there was a delay in getting the minutes out. You know. It just - everything was done on a shoestring.

16:18

16:18

16:18

16:18

551 Q. Who did you go to then if you had issues?

A. These issues were known by our team. You know, Mr. Young was lead clinician, Mrs. Corrigan was aware of this. We would feedback the minutes of the meetings up through the governance chain. They were shared both with the governance team, but also the Medical Director's team. They were also shared with the other

16:19

Chair, or the other lead clinicians of the other M&Ms. So I would receive, for instance, minutes of the orthopedic meeting, so I would have a read through of those to see were there any issues in the orthopedic meeting that would have read across our specialty. 16:19

552 Q. I think you reflect within your statement that things changed in terms of management interest in urology after the announcement of this Inquiry?

A. Yeah, they did change. We now, both -- in the audit setting we have a much better support, we have several members of the governance team who interact with us, we've set a firm audit plan, it's agreed as a team, it's monitored, the work is presented, and as it's presented it's ticked off and we move on to the next thing. So these things have improved a lot. 16:20

553 Q. Can I move on? We'll look at aspects of management in a short moment when we move on to look more closely at governance issues, but let me ask you about appraisal, briefly.

16:20

You set out in your statement, if we could go just over the page, I think, to 32.2 - on down the page a little. So, you make the point that you're the subject of appraisal for the purposes of validation, and it's said on a number of occasions, so I get the impression that 16:21 you think it important to say it repeatedly that this is not a performance related review, and in answer to other questions you make the point that consultants are outside of the performance management loop.

Tell me about your thinking on that. Are you suggesting in those answers that you think it would be a good idea, in light of experiences within urology services at the Southern Trust, and perhaps elsewhere, for you and your colleagues to be subject to some form of performance management?

A. Yeah, I think it's very important that there is a degree of performance management for all members of the staff, not just consultants. And, you know, you can quite easily go through the whole appraisal process without anybody raising any questions as to what kind of work you've done and to what standard.

554 Q. You refer to it as, I don't think I need to bring that up on the screen, it's paragraph 47.2. You seem to value the opportunity, if it had stayed like this, for a confidential reflective exercise in professional development; you see advantages or benefits in that. But what you say is that the process has now morphed into something akin to bean counting - my words - it's a formulaic capture of documents - your words?

A. Yes. I think bean counting is equally good as a descriptor.

555 Q. So, moving from the positive side of that spectrum to the negative, why was this opportunity for reflective discussion around professional development, why was that useful and what has it now become?

A. So, when I first became a consultant, the appraisal process was between two peers and was largely a

discussion, and you felt that you could have a confidential discussion about the challenges that you faced, the difficulties that there were, perhaps share the successes that you'd had, all of that kind of thing. Now nobody's really interested in that. They 16:23
just want to make sure that you meet all the domains that the GMC have set out, that all of those -- in our Trust they use an electronic method for capturing all of that, I think it's common across Northern Ireland, and, you know, as long as you've got a tick in every 16:24
domain, that's really what it's about.

You know, you can see from the spread of specialties that have been my appraiser, many of them don't have that much insight into my specialty. Maybe I don't 16:24
have that much insight into theirs. So, you know, there's something of questioning the value of that conversation.

They don't have the performance data, they can't 16:24
possibly meaningfully interpret the performance data in the different specialty, you know. How would, for instance, an emergency medicine consultant interpret the data of a surgeon? It's difficult for them, I would think. It would be difficult for me to interpret 16:24
the outcomes of their work. I don't do their job.

556 Q. So, if, as you imply, it is, to use another metaphor, a box ticking exercise, are there implications of that if, for example, the practitioner has some frailties or

--

A. So, a point that was made to me by Robin Brown, who was at one time CD for urology quite some years ago, and more laterally has been one of the senior members of the revalidation team, he said to me "I'm not looking for all the good points in your appraisals. What I'm looking for are the little indicators that there are problems", and I think that's largely what it has become, and it may be very difficult through this appraisal process for the Trust to actually pick up where there are problems. Not too many people present warts and all in their appraisal, I would suggest. 16:25 16:26

557 Q. And your seeming endorsement of some form of performance management, whether integrated within the appraisal process or standing separately from that -- 16:26

A. I actually think that should be taking place on a team basis. I think that should be out in the open. I think we should all be able to discuss openly with our colleagues how we're performing as a team, what our outcomes are, you know, is somebody doing a lot more work than somebody else and what are the reasons for that? There may be good reasons for it. 16:26

558 Q. And safety of practice?

A. Absolutely.

559 Q. Knowing what we know, and there may be a bit of a debate about what precisely we know has emerged out of urology services in the last few years, particularly arising out of the processes relating to Mr. O'Brien, do you see in that particular context a specific merit 16:27

around performance management or --

A. Yes, I do. Because I think if you identify these things at an early point and they're out in the open, then it allows the team to, first of all, identify and name the issue and, secondly, then to think of ways that the team can address the issue together. It means a more consensual collegiate way of working, you know. So I think there are merits to that. 16:27

560 Q. You have said in your witness statement that you can't recall any discussion - if I could pick up my note... Yes. If we go to paragraph 65.3 at WIT-42331. So, in terms of patient safety and governance then, if we just focus on what you say in that paragraph, if we scroll down. So, the second aspect of that paragraph: 16:28

"I do not recall a single meeting to discuss governance issues or patient safety concerns related to Mr. O'Brien or the Urology Department with any of the following post holders who held tenure in the period following the meeting in January 2017 up until June 2020." 16:29

So, the problem, or aspects of the problem as viewed from the Trust's perspective, emerged in January 2017, and you were told about it in some form, and we'll look maybe at it in a bit more detail. And then you draw the other temporal parameter, June 2020. So, you have this meeting with -- in January 2017, to tell you about aspects of the problem, and what you're saying is that 16:29

thereafter no further discussion?

A. Yeah. There was a vacuum of information. The meeting on 3rd January came as a shock. Okay? And the number of issues that were raised and explained to us by Ronan Carol primarily, and I think also Colin Weir, came as a 16:30
shock to me, and obviously then Mr. O'Brien wasn't coming back to work immediately after that meeting. You know, for a consultant to be excluded I think is a rare event. I was, I was annoyed that the Medical Director didn't see fit to come and speak to us, you 16:30
know. He excludes one of our colleagues. We are going to be struggling as a consequence, and yet he doesn't deem that it's important enough to come and speak to us. Now, I don't know what else was on his plate, I'm sure medical directors have lots to do, but excluding 16:30
somebody from a work is a big deal as far as I'm concerned.

So that's the first thing.

16:31

Then, you know, throughout whatever process took place after that, I was completely unaware of what was going on behind the scenes. Nobody came to explain that to us. We were not told about any measures that had been put in place for Mr. O'Brien when he came back to work, 16:31
we weren't told about any supports that were put in place. You know, there was an absence of communication.

561 Q. You say, just focusing on the Mr. O'Brien scenario and

communication and discussions that evolved around that, if any, you say - if we go to WIT-42320, you say just at the bottom of the page you had frequent discussions with Mr. Young.

A. Yeah. 16:31

562 Q. In his role as lead clinician, discussing matters concerning the running of the department informally, and you discussed concerns regarding the performance of medical staff. And you then refer us to the paragraphs where particular medical staff are named. 16:32

A. Yes.

563 Q. And we don't need to go into the details around that, but I may pick up on an issue around Mr. Suresh as we go along. But you don't name Mr. O'Brien in the - in those paragraphs. I'm wondering to what extent there 16:32 were conversations between you as a team about the shortfall caused by Mr. O'Brien's exclusion on the one part.

A. Yeah.

564 Q. And, I suppose perhaps more importantly, the patient 16:32 safety implications of what you were being told?

A. So, in the period prior to 3rd January 2017, the issues that concerned me relating to Mr. O'Brien's practice, or the issues that I had concern about, were things like late dictation of letters, or letters not being 16:33 present in the chart when I was seeing a patient. I was concerned about the review backlog. I was concerned about the waiting lists. I did not have sight or knowledge of the other issues that were then

outlaid to us in terms of -- I had a concern about triage -- but I wasn't, I wasn't aware of the volume of these things. So it came to me as a shock when we were told these things on 3rd January.

16:33

You will be aware that I Chaired an SAI related to Patient 10. So in the course of that SAI, it became apparent that that patient's letter hadn't been triaged on that particular week, and a lookback was conducted to find out had any other letters not been triaged and 16:34
I think seven other patients were identified as not being triaged.

So that SAI was coming to its final version in December of 2016, and on the basis of that, I got a couple of 16:34
prompts - one from Connie Connolly "Have you got this nearly ready?" I got the draft finalised. And then before the draft was sent up I think to the Medical Director, we then had the meeting of 3rd December.

565 Q. Yes. 16:34

A. Or 3rd January.

566 Q. Yeah. And I suppose what I'm - and we'll maybe go into some depth on those just in the fullness of time - but broadly speaking maybe just on this simple point, are you pointing to a failure on the part of management of 16:34
whatever hue to engage with consultant staff about the implications in their entirety of Mr. O'Brien's coming into difficulty?

A. Yeah. So, you know, from my perspective, I knew that

he was having a difficulty dictating his letters on time. That was widely known. When I went to a meeting on the admin floor, in some period before 2016, I had a very brief conversation with Heather Trouton as we left the meeting and she expressed to me concerns about how Mr. O'Brien was managing his workload. Now, you know, she was the AD, she clearly had those concerns, she mentioned them. I would have shared the concerns, because we were all working hard and we were all struggling to deliver. 16:35

Was he an outlier in terms of having his dictation done? I'd say he was an outlier relative to me. You know.

16:36

So these issues were known by others, they were not hidden, but the quantity of that dimension of it was not clear to me at that time.

567 Q. And nor, it seems - and this is the focus of my question - nor, it seems, was it particularly discussed with you, even as the problems were put out on the table in January of 2017. 16:36

A. No, the January meeting was quite short. And it was also, you know, Ronan Carol reiterated "You're not to discuss this outside the room." Now, what's the first thing that we're all going to do as soon as we leave? We all say, "Well, what's going on here?" You know. I just found the whole approach, I found it really disconcerting. You know, we've clearly got a problem, 16:36

yet you're not to talk about it. You know, this is -- who's going to fix the problem? It's not going to be the managers on their own.

568 Q. Yes. And I suppose that is the point I'm looking to focus upon before I broaden it out into wider governance leadership issues. 16:37

Were you ever, as a team or as an individual, engaged by management of whatever hue between that 2017 and 2020 date, to discuss with them, I suppose, the patient safety and/or governance implications for you as a team working with a colleague who, at least from the Trust's perspective, had difficulties? 16:37

A. No, I don't think there were those discussions.

569 Q. Yes. And you say, as I say, broadening it out a little, if we go down, or back up to WIT-42310, perhaps illustrative of just what you said, during your tenure: 16:38

"...no one person held responsibility for quality assurance of urology services. In a broad sense, each clinician was responsible for their own practice, and the degree to which individuals engaged with quality improvement or audit was variable. There was no mandatory element or structure to this activity." 16:38

And that's where I suppose I wish to stop with that aspect of the quote. You go on elsewhere in your statement to say that as busy clinicians you needed support, "robust support", to use your language, for

data collection, in order to support sound clinical governance, and you found that that wasn't there?

A. Correct.

570 Q. So, moving into some of these specific instruments or ingredients of governance, let's briefly deal with the use of data before we finish this afternoon. You say in your statement that - this is 14.2 - that the Trust used, can we say "CHKS"? C-H-K-S 16:39

A. C-H-K-S would be the terminology I'm familiar with, yeah. 16:39

571 Q. CHKS.

A. Yeah.

572 Q. And that was used to provide comparative data in the annual clipboard -- Clip Report, sorry?

A. Yes. 16:40

573 Q. So there were some useful metrics in that around age -- sorry, length of stay, mortality, new to review ratios, that kind of thing. But some of the data was misleading, because it --

A. Yeah, it's just it's not sophisticated enough. 16:40

574 Q. It allocated your name to patients you maybe weren't operating on that day and vice versa?

A. I don't think it's that. I think it's -- the urology of the week model meant that, you know, individual clinicians would hand over care to another oncoming consultant and, therefore, complications that might arise - you might have been the admitting consultant, but they might have been in for a few weeks and they have a complication that arises down the line. So, the 16:40

data wasn't sophisticated enough to pick out who was actually delivering the care, and the care for the inpatients was largely delivered as a team, so that wasn't really reflected well in the Clip Report.

575 Q. The bigger point I think that you make around data concerns the absence of any data collection mechanism to support key performance indicators, and here you emphasise data around patient safety, and this is 37.1 of your statement. So, data, at least until relatively recently, I think you're telling us, was not gathered around, for example, positive surgical margin rates during partial nephrectomy? 16:41 16:41

A. Yeah.

576 Q. Transfusion rates during cross date.

A. Yeah. 16:41

577 Q. Those kinds of valuable patient outcomes data that will speak to morbidity, but perhaps more particularly will speak to performance issues around the members of the clinical team?

A. Yeah. And, you know, there's a lot to be learned from morbidity. Probably in our specialty there's more to be learned from morbidity and understanding those aspects than there is from mortality. Because most of the mortalities in our specialty are expected. It is the exception that is unexpected. Obviously that's worthy of investigation in that circumstance. 16:42 16:42

578 Q. You have said, at 37.3 of your statement, these patient related -- bring it up, would you please? WIT-42311. This is a straightforward point. These measures are

now coming in to the currency of the Trust?

A. Yeah, you need support to collect these important bits of data. You need somebody to collect them. You need, obviously, somebody to analyse them and then present them to the team. You know? So, it's well recognised in surgery that if you ask surgeons to collect their own data you get a very skewed view of what's happening, and that probably applies to other disciplines, but it certainly applies to surgery. 16:43

579 Q. What do you think the implications are of not collecting the data and presenting it? 16:43

A. So if you don't know what your outcomes are like you don't really know if you're doing a good job, and if you don't ask the patients what their experience is then you're not going to know whether or not the patients thought you were doing a good job. So you have to collect the data to know that. 16:43

580 Q. You say that within the world you were operating in, and notwithstanding the health warning you put against it a second or two ago, you did feel it appropriate to carry out your own personal outcome related audits? 16:44

A. Yeah. So BAUS, which is the British Association of Urological Surgeons, ran a number of audit projects in the past. Certainly I did nephrectomy, I continue to do nephrectomy surgery and I would have contributed to the national audit, so did Mark Haynes, and we would have been able to compare our data to that of peers across the UK and Ireland, and we would have been able to compare our unit to comparator units in the same 16:44

jurisdiction. So, you know, that gave us a good feel for where we were. But I caveat it with the thing that I said a moment ago; you know, we were collecting the data. So, I mean, I was pretty scrupulous about mine, I have to tell you, but, you know, it's well recognised that surgeon reported data is not as reliable as independently collected data. 16:44

581 Q. And again, just briefly, you say several times in your statement that audit was poorly supported within the Trust. We see some audits coming up through your patient safety meeting. 16:45

A. Yeah.

582 Q. Maybe some were better than others. You do say that some - and this is at paragraph 7.5 of your statement - some audits that came up were not fit for purpose, they didn't complete the full circle, the audit loop. Just explain what you mean by that? 16:45

A. So, I suppose in many departments audit would have been delegated to trainees, and trainees may have little insight into what they're actually auditing, because they're trainees and they haven't enough experience to know otherwise. So you could have a trainee undertaking an audit and not really understanding what they were doing, and there is some value in that, because if the trainee has support from an experienced practitioner then it's a learning experience for the trainee. However, the situation that we're in now is much better. We have support from the audit department, we agreed a programme of audit, we 16:46 16:46

participate in audits across four domains, the first of which would be national audits, and they go all the way down to, like, local audits is number four. So, we now have a structured programme. We've been pushing for that for a long time. But without the support of the audit department, or the governance team, we wouldn't have been able to deliver on that. So that has been really helpful. We've had the first of those audits being presented in the past year. And on a similar vein, in the cancer services domain, we have support for audit within cancer services, which is very welcome, and it allows us to demonstrate patient safety. Because that's really what the audits are about. 16:46 16:47

583 Q. Yes, and we'll come to that in the context of the SAI recommendations perhaps tomorrow. But we have heard, and I think your evidence around the lack of support for audits echoes evidence that the Inquiry has received from several of the governance co-ordinators within the acute directorate who have, I suppose, said that resources simply weren't available to do audit, which I suppose viewed from another perspective, it could be articulated as them not being seen as important or as important as other things that the Trust -- 16:47 16:47 16:48

A. I think my point on that would be that audit is important and quality improvement is important. But when you're in a service that is struggling, and you have too few people to deliver that service, then it is

often those type of activities that are sacrificed rather than direct clinical care.

584 Q. And is that, in your view, the explanation for why audit wasn't done, as opposed to something like a lack of appetite, or a lack of interest, or a lack of appreciation of its fundamental importance? 16:48

A. I've expressed my view. I think you'd have to ask others what their view is. You know, you've seen from my statement I participated in audit to the best of my capability, even though we weren't supported. I value its importance. You'll have to ask others what their view is. 16:49

MR. WOLFE KC: Yeah. Okay. Thank you for your evidence this afternoon. Subject to the Chair, we'll stop now and pick up again at ten o'clock. 16:49

CHAIR: Yeah. Ten o'clock tomorrow morning. Thank you, Mr. Glackin. See you again tomorrow.

THE INQUIRY WAS THEN ADJOURNED UNTIL THURSDAY, 21ST SEPTEMBER 2023 AT 10:00 A.M. 16:50