Urology Services Inquiry

Oral Hearing

Day 63 – Thursday, 21st September 2023

Being heard before: **Ms Christine Smith KC (Chair)**
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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WITNESS PAGE

MR. ANTHONY GLACKIN

EXAMINATION BY MR. WOLFE KC 3

1 THE INQUIRY RESUMED AS FOLLOWS ON THURSDAY,
2 21ST SEPTEMBER 2023
3
4 CHAIR: Good morning everyone. Mr. Wolfe.
5 09:59
6 CONTINUATION OF EXAMINATION OF MR. ANTHONY GLACKIN BY
7 MR. WOLFE KC
8
9 MR. WOLFE KC: Good morning. And good morning,
10 Mr. Glackin. 10:02
11 A. Good morning, Mr. Wolfe.
12 1 Q. Towards the end of yesterday we commenced our journey
13 into some of the aspects of clinical governance. We
14 looked at and considered your views on the use of data
15 within the Trust, we looked at aspects of audit, 10:02
16 quality assurance. This morning we're going to spend a
17 little time looking at incident reporting, serious
18 adverse incidents, and then into the work you did as
19 part of the M&M framework.
20 10:02
21 Let me start with incident reporting. Did you use the
22 Datix or the IR1 system on a regular basis?
23 A. No, I would say it wasn't a regular basis. I would
24 have infrequently completed IR1s.
25 2 Q. We'll come to a little point in the context of SAI in a 10:03
26 moment where you say that you're, I suppose the word is
27 skeptical about the efficacy of that process for
28 particular reasons, and I'll allow you to unpack those
29 at that point in time. But could I make this point,

1 that the Inquiry has noticed, or noted, through
2 evidence received, that there have been instances of
3 failure to report matters that might be regarded as
4 adverse incidents, failure to hold screening meetings
5 on occasions with particular incidents, and sometimes, 10:03
6 ultimately a matter for the panel, what might appear -
7 and certainly appeared to Mrs. Reid last week when I
8 put some examples to her - sometimes a surprising
9 failure to screen an incident into the SAI process when
10 it looks as if it qualifies by reference to the 10:04
11 definition.
12
13 Can you help me with this: Have you ever detected,
14 whether in your own practice or amongst others, a
15 hesitation before completing an incident report? 10:04
16 A. The answer is no. I think to fill out an incident
17 report, you'd need to assess whether or not you thought
18 there was a risk of harm or there had been harm taken
19 place. So, on that basis, that's the basis that I
20 would use incident reporting. Aside from that, you 10:05
21 know, I wasn't involved in screening SAIs, that wasn't
22 a function that I held. So I've no real knowledge of
23 how that process applied.
24 3 Q. Yes, I appreciate that. But take it back to the start
25 of any process that might lead to an SAI. And I'm 10:05
26 struck by, I suppose, what you've just said in terms of
27 you weren't a regular user of the IR system?
28 A. I think infrequent is the word I used.
29 4 Q. Infrequent.

1 A. Yeah.
2 5 Q. Is that because you simply didn't come across incidents
3 or because it wasn't --
4 A. No, I did come across incidents. But one of the issues
5 I suppose as a reporter is that you're often -- in my 10:05
6 experience, there was no feedback to the reporter. So,
7 something went into the system and you didn't, at the
8 end of it, know what had happened.
9 6 Q. Mmm. Is that a --
10 A. That's a criticism of the system. 10:06
11 7 Q. Yeah, but is it a reason in your own mind for --
12 A. No, I think it would be a reason why people may choose
13 not to engage with the system in the future. Because
14 if you're not getting any feedback then you can't be
15 sure that something appropriate has happened. 10:06
16 8 Q. Yeah. Yeah. But that surely can't be a good reason
17 for at least not testing the commitment of the system
18 to look at the incident and put a result back --
19 A. I think it's natural human behaviour that if you're not
20 receiving feedback then you may make the assumption 10:06
21 that the system isn't working.
22 9 Q. So is that something that's borne of your own
23 experience, that you put incidents in --
24 A. Well, I have to say, I have the experience of not
25 receiving feedback to incident reports. So it is my 10:06
26 experience.
27 10 Q. Yes. And that creates, I suppose, a fatigue or a sense
28 it's not worth your while, is that what you're saying?
29 A. I suppose if you consider the severity of the risk and

1 the severity of the harm that has arisen, then clearly
2 in those circumstances you may feel obliged to take
3 action.
4 11 Q. Mmm?
5 A. If it's a much lesser issue then you may feel that "Why 10:07
6 am I bothering the system with this small issue?" I
7 mean, I think in all of this, Mr. Wolfe, you have to
8 appreciate that you have recourse to deal with things
9 at a local level before it ever gets to this, so why
10 aren't you doing that? 10:07
11 12 Q. Have you found yourself in situations where it is a
12 serious incident or a potentially serious incident and
13 --
14 A. I can't think of any off the top of my head. But, you
15 know, if you have evidence to say that I sent in an IR1 10:07
16 about such and such an issue I'll happily read it and
17 comment on it but...
18 13 Q. No, no, that's not where I'm going.
19 A. Yeah. Okay.
20 14 Q. I'm simply asking you whether you've ever faced that 10:07
21 dilemma of "This looks like a poor enough" --
22 A. If I thought it was a serious issue, it would be
23 reported through the IR1 system.
24 15 Q. Yeah. Yeah. As I say, last week with Mrs. Reid we
25 looked at some incidents where, if you like, a strange 10:08
26 turn was taken with the incidents.
27 A. Yeah.
28 16 Q. I'm not suggesting that you were involved in --
29 A. So there's one case that I'm now aware of, having read

1 the evidence bundle, where the patient actually
2 happened to be mine.
3 17 Q. Yes.
4 A. Yeah. And do you want to come to that later?
5 18 Q. Yeah. We will to that one later. 10:08
6 A. Okay.
7 19 Q. I want to deal with those in the context of the
8 operation of the multi disciplinary team. There were a
9 number of --
10 A. Yes. 10:08
11 20 Q. -- concerns about the operation of the MDT exposed by
12 Dr. Hughes, et al., and we'll look at the one you're
13 referring to in that context.
14
15 Let me put one to you. Again, you had no involvement 10:08
16 in it, certainly no direct involvement to the best of
17 my knowledge, but it concerns a Patient 93. And if we
18 could bring up on the screen, please, TRU-274731.
19 You've glanced at the name. Do you know the case at
20 all? 10:09
21 A. No, it doesn't, you know, ring any bells for me.
22 21 Q. Sure. So we can see at the top of the page then, we'll
23 call this Patient 93, but Alannah Coleman is writing to
24 Mark Haynes, 31st August 2016. In terms of our
25 timeline, I suppose that has the significance that you 10:09
26 had just, I assume, commenced your work in relation to
27 the SAI concerning Patient 10?
28 A. I think really that work commenced in about September
29 2016, but I may have been asked before September to

1 take on that role.
2 22 Q. So, with Patient 10's SAI, the incident report was
3 filed in January, and I've no reason to doubt that.
4 But it's around that time that you're getting your work
5 started with Patient 10's case? 10:10
6 A. Mm-hmm.
7 23 Q. So, interestingly, I suppose, from the Inquiry's
8 perspective, that at this time this case was being
9 talked about, this referral went for triage to
10 Mr. O'Brien on 5th May 2016 and was not returned. 10:10
11
12 "We've been advised that if we get no response after
13 chasing missing triage that we're to follow instruction
14 per the referral - the GP originally referred the
15 patient as routine. I have attached what was sent for 10:10
16 triage."
17
18 So what is outlined there is a failure of triage into
19 the default triage process, which I'll look at with you
20 again later this morning. 10:11
21 A. Mm-hmm.
22 24 Q. But let's just see and have your comments upon how this
23 was processed. So, if we go on up to - thank you - we
24 can see that, just let's see the whole of the e-mail,
25 Mr. Haynes is writing in to the head of service, 10:11
26 Mrs. Corrigan, and he's setting out the history of the
27 case, repeating that:
28
29 "██ was referred in his routine, not returned from

1 triage, so on the waiting list as routine. If it had
2 been triaged, it would have been a red flag upgrade,
3 because the PSA was 34 and 30 on repeat."
4
5 Do you agree with that as an analysis? 10:12
6 A. Yes, I do.
7 25 Q. Yeah:
8
9 "Saw Mr. Weir for leg pain and CT showed metastatic
10 disease from the prostate primary. Referred to us and 10:12
11 seen yesterday. As a result of no triage delay in
12 treatment of 3.5 months. Wouldn't change outcome.
13 SAI?"
14
15 If that case had come across your desk in that way -- 10:12
16 A. At which stage, referral or...
17 26 Q. Well, at the stage of Mr. Haynes writing this. I'm
18 seeing this case coming back, it occurs to me that it
19 hadn't been triaged, it should have been triaged, and
20 if it had have been triaged, I would have red flagged 10:13
21 it. Is that --
22 A. Yeah. So I agree I would have red flagged it. I also
23 think it warrants an IR1.
24 27 Q. Yes. And scrolling up, we can see how it was batted
25 around. It comes to Mrs. Corrigan, she wants to 10:13
26 discuss it with Mr. Carroll, the assistant director.
27 Mr. Carroll, if we go up the page, throws it over to
28 the assistant medical director, Dr. McAllister.
29 Dr. McAllister - scrolling up please - decides that the

1 proper process is for it to go to urology lead,
2 Mr. Young, and then on to Mr. Weir, and then back to
3 Mr. Carroll to bat across to Mr. Young.
4
5 Then if we go across to Mr. Young, we can see at 10:13
6 TRU-274751, we can see his views on it. Scrolling
7 down. Post-dating the obvious, it should have been
8 referred as a red flag in the first place:
9
10 "If the booking centre has not received the triage back 10:14
11 then I agree that they follow the GP advice."
12
13 A. So I disagree with that point. And we'll come to that
14 in the case of Patient 10.
15 28 Q. Yeah. Then: 10:14
16
17 "If the recent scan had shown secondaries then they
18 were present at referral. As such this was at an
19 advanced not curable stage even then."
20 10:14
21 Would you agree with me that, in a sense, is besides
22 the point in terms of incident reporting?
23 A. Yes, it is beside the point.
24 29 Q. Yeah. Nevertheless, and maybe he offers to provide
25 some mitigation to his point in saying at point 4: 10:15
26
27 "We would still have offered treatment in the form of
28 antiandrogen therapy at some point over the subsequent
29 few months."

1
2 A. I think it's also a little bit premature to make a
3 clinical diagnosis on the basis of a couple of blood
4 tests and a CT report that hasn't been through the MDT.
5 30 Q. Yes. 10:15
6 A. So, you know, I personally think, you know, this case
7 should have been seen - it was seen clinically and the
8 matter should have been addressed appropriately through
9 the MDT and a decision made on management based on the
10 outcome of the MDT. 10:15
11 31 Q. Yes. There is a collection of further points, but it
12 seems to come back from Mr. Young into the system. The
13 last point is:
14
15 "The apparent delay has not impinged on prognosis." 10:15
16
17 Again, would you agree with me that's not to the point
18 in terms of --
19 A. It's not to the point but I think it's a reasonable
20 clinical point to make. 10:16
21 32 Q. Yes, of course. But in terms of what should be done
22 around reviewing that case for learning --
23 A. Yeah. I mean I think what they saw demonstrates is
24 that the number of people involved in this discussion
25 didn't adhere to process. The process was to report 10:16
26 this as an IR1 and allow that process to run its
27 course. In parallel, the patient could be seen
28 clinically and treated.
29 33 Q. Yes. One of the things that's probably overarching a

1 lot of what we'll discuss in the course of today is
2 the, I suppose, the appetite for challenge and the -
3 how that feeds in to the safety culture. I pick that
4 example. I suppose you would agree with me that it
5 doesn't reflect well on -- 10:16
6 A. I think there's an initial misstep of not doing the
7 IR1. If you had done the IR1 at the very beginning you
8 wouldn't have this issue of the round-robin discussion
9 going on, it would have went through the correct
10 process. 10:17
11 34 Q. Yes. Yes. Yes. And it's not terribly different in
12 substance from the case that you were about to review,
13 Patient 10's case?
14 A. Yeah, there are similarities.
15 35 Q. Yes. I mean the big thing here was a failure to do 10:17
16 triage simply because it was a routine referral?
17 A. Yeah. Yeah, that is true in this case. In Patient 10
18 there were more complex factors than just triage.
19 36 Q. Yes. And it wasn't just about triage, it was about the
20 scanning? 10:17
21 A. Yes.
22 37 Q. And the read out from the scanning?
23 A. Yes.
24 38 Q. And I take that point. Okay. Just at this stage, is
25 something like this, this misstep, your description of 10:17
26 it, is that typical, in your view?
27 A. I don't know. I've only Chaired three SAIs. I don't
28 sit on the --
29 39 Q. Sorry, the misstep in --

1 A. The misstep.
2 40 Q. The misstep in failing to action it for IR1 and
3 consider it for SAI.
4 A. Yeah. I don't really recall many discussions by e-mail
5 or even in person of this kind of nature, and I don't 10:18
6 think I was included in this e-mail trail at all. So
7 I'm not sure whether it's common or not. I don't know.
8 41 Q. The SAI process, you have Chaired three?
9 A. Three that relate to this Inquiry.
10 42 Q. Yeah. And let's just briefly look - we haven't looked 10:18
11 at this document in some time, but just to remind
12 ourselves about the purpose of an SAI. If we go to
13 WIT-84180. And this is the, I suppose, the textbook on
14 the SAI --
15 A. Yeah, the date's quite notable. 10:19
16 43 Q. Sorry?
17 A. The date is quite notable.
18 44 Q. Yeah.
19 A. November 2016.
20 45 Q. Whether it has been updated since we've started to look 10:19
21 at it, I'm not sure. But it's the relevant document
22 for the cases, I suppose, that we're looking at. I
23 just want to refer briefly to a description of, I
24 suppose, the broad purpose of the process. WIT-84201.
25 And just at the bottom of the page, please, it refers 10:20
26 to learning. Am I on the right page? I'll just check
27 the... Sorry, I'm not on the right page.
28 A. Can I perhaps make a comment about that page?
29 46 Q. Of course.

1 A. That I think is really relevant to this process? It
2 mentions training and support. Prior to me undertaking
3 those SAIs, I did not have any training. So, I recall
4 being asked by Eamon Mackle to Chair the first,
5 chronologically whatever the first SAI was that I did. 10:20
6 47 Q. That was --
7 A. I can't recall which one it was.
8 48 Q. Yeah.
9 A. But I sat in the office reading the e-mail and I
10 thought "Am I really ready to do this? Do I really 10:21
11 know how to do this?", and I batted that back to Eamon
12 in a conversation and it was kind of - the answer
13 wasn't "you'll be grand", but it was to that effect.
14 49 Q. Yeah. I was going to ask you about the training, and
15 maybe that was a convenient but accidental point to 10:21
16 stop on.
17 A. I've subsequently had training.
18 50 Q. Yes. You outline in your statement, 19.4 for the
19 panel's reference, that you completed training in
20 structured clinical record reviews in 2021. 10:21
21 A. Yes.
22 51 Q. As well as root cause analysis training.
23 A. Yes.
24 52 Q. The Inquiry is very interested in the nuts and bolts
25 that make up the aspects of the SAI process. Training 10:21
26 in 2021, you did your first SAI, so far as this
27 Inquiry's concerned, in 2015?
28 A. Yes.
29 53 Q. Moving on to - I forget the - I know the name of the

1 patient, but I can't find her...
2 A. Cipher.
3 54 Q. Cipher.
4 A. Yeah.
5 55 Q. But we'll come to that in due course. Patient 10, in 10:22
6 2016/2017. And then into another SEA, I think it was,
7 in 2018/2019. Your training comes in 2021; Mr. Mackle,
8 words to the effect of "You'll be grand", pressing on
9 without training. Was training of value to you when
10 you eventually got it? And would it have been better 10:22
11 in advance?
12 A. Yeah. So as a trainee, I'd had experience of
13 governance processes in at least two of the Trusts
14 towards the end of my training. And that was useful,
15 because it gave me an insight into how these processes 10:22
16 worked. But I'd had no training in the Southern Trust
17 as a consultant prior to undertaking those three SAIs.
18
19 When Dr. O'Kane came into post, she was very keen that
20 training would be provided to consultants who would be 10:23
21 undertaking these kinds of tasks, and it's my
22 understanding that she was really the driving force
23 behind getting the training organised. So, I
24 participated in two different learning events, I can't
25 remember how long they lasted, maybe one or two days 10:23
26 each, for each of those, the RCA and the structured
27 clinical review process.
28 56 Q. Yes. And --
29 A. And it was useful.

1 57 Q. Yes. And I suppose it's that old chestnut, you don't
2 know what you don't know, but when you took on the SAI
3 in 2015, did you feel something of an innocent abroad?
4 A. Yeah. I was, I was relying on the expertise of the
5 governance team to keep me right. I'd obviously read 10:23
6 the documents in terms of how these things would be
7 conducted. But I was a novice.
8 58 Q. Back to the point I had lost, but have now found again,
9 to start this off, at the bottom of the page there...
10 A. The learning of the SAIs? 10:24
11 59 Q. Yeah. And I suppose the key aim of the SAI procedure
12 is to improve services and reduce the risk of incident
13 recurrence, both within the reporting organisation and
14 regionally.
15 10:24
16 "The dissemination of learning following an SAI is
17 therefore core to achieving this. To ensure shared
18 lessons are embedded in practice and the safety and
19 quality of care provided."
20 10:24
21 An important statement of principle. You reflect in
22 your statement, I suppose, a concern about the efficacy
23 of the SAI process based on your experience of -- I
24 just want to be sure to pick up on the precise wording
25 you use. So if we can go to WIT-42313, and there you 10:25
26 say that:
27
28 "Many concerns and complaints can be resolved
29 informally. Complaints or concerns requiring a formal

1 process can take months to complete, largely because
2 the process relies on the availability of a panel to
3 meet several times to finalise a report. The efficacy
4 of the process is, in my view, questionable. Sharing
5 learning from this activity is challenging. The volume 10:25
6 of information cascading down the management structure
7 means that most of it goes unread and therefore
8 unactioned."
9
10 So, you are reflecting back out of your own experiences 10:26
11 of Chairing or leading three SAIs, and more widely, is
12 that fair?
13 A. Yes. So, my own experience is that they do take too
14 long. And for the reasons I've outlined, I think that
15 is not helpful. Because if there's quick learning 10:26
16 needed then you're not getting that out there as it
17 should be, you know, across the organisation.
18 Secondly, when an SAI report comes down through the
19 governance structure to the M&M patient safety meeting,
20 for instance, what you get is basically a set of 10:26
21 recommendations. It's often very difficult to
22 contextualise those recommendations, to put them in a
23 scenario where the people in the room understand, you
24 know, this is what has happened and this is why we're
25 making these recommendations. 10:27
26
27 And another problem that I think with the
28 recommendations is that I may Chair an SAI, Mr. Haynes
29 may Chair an SAI, Mr. O'Donoghue may Chair an SAI - and

1 this has happened in our department - and we all make
2 slightly different recommendations on the same kind of
3 core issues. I think it would be better if the SAIs
4 are conducted by a team of people who have knowledge of
5 what other recommendations are being made, so that 10:27
6 there is a consistency in the recommendations.
7
8 So, it is not infrequent when you are drafting the
9 agenda for the patient safety meeting to have several
10 SAIs coming down through the governance team, and 10:27
11 really we don't have time to fully consider all of the
12 recommendations and all of the nuances arising from
13 those SAIs.
14
15 So, there are other ways of sharing that information. 10:28
16 You know, you can do case review type presentations at
17 M&M meetings or similar learning events, and I know
18 that that's used in other specialties. And it's
19 probably more effective than just providing us with a
20 summary of recommendations. 10:28
21 60 Q. Let me deal with the, I suppose the time commitment and
22 the risk of delay. You make the unarguable point that
23 if it is a serious adverse incident, the learning needs
24 to get out there quickly. But that runs into the
25 structural difficulty where, if you're relying on a 10:28
26 busy clinician and others to make their diaries
27 coalesce across several meetings, that isn't always
28 possible.
29 A. Yeah.

1 61 Q. You managed to process Patient 128's SAI, that's the
2 first one, Patient 10 and then Patient 90, by
3 comparison with some of the SAIs we've looked at,
4 relatively quickly, completed within the calendar year
5 or thereabouts from the date the incident was reported, 10:29
6 approximately. How do we resolve the issue of busy
7 clinician and SAI team members --
8 A. Okay. So from my perspective what you need is somebody
9 who's properly trained, first of all. You need them
10 properly supported by the administration side. And you 10:29
11 need time in their job plan to allow them to do this
12 work in a timely manner. Because when the governance
13 team came to me, they'd be looking for dates in my
14 diary. Now, unfortunately, they may not realise this,
15 but my diary's actually fixed for at least six weeks, 10:30
16 because I've got operating commitments and clinic
17 commitments, and I'm not going to be cancelling those
18 over this kind of issue. So I'm therefore trying to
19 fit this in at some other time. So that's already set
20 them back four to six weeks. So you need members of 10:30
21 staff, or perhaps independent people employed by the
22 Trust who have time to do this work in a timely and
23 effective manner.
24 62 Q. In terms of the learning point you make, the concern
25 that learning just gets lost in the system and it 10:30
26 doesn't reach those who need to hear it, and perhaps is
27 it an additional point that the kinds of changes,
28 whether they're changes to systems or behaviours, or
29 whatever it might be, will quite often need time and

1 resources; and is it part of your point that you don't
2 see a dedicated resource focused on driving the kinds
3 of change that might be needed arising out of an SAI
4 report?
5 A. I think reflecting on our own department, when you're 10:31
6 understaffed and struggling, it's very difficult to
7 drive change. I'm sure there are other departments in
8 our Trust which actually do this much better, that
9 probably have slightly different, you know, they may be
10 fully resourced. They may also have a different 10:31
11 culture and they may be able to deliver this better.
12 And I'm thinking of listening to, in particular, the
13 way that the obstetric team dealt with their issues;
14 they had a different approach to this. And I think
15 that's probably something that we could learn from. 10:32
16 63 Q. Just help us with that.
17 A. So they would have --
18 64 Q. How did they -- what problem did they have and how did
19 they deal with it?
20 A. So obviously they're a high risk speciality. They 10:32
21 would have lots of events that, you know, require
22 discussion as a consequence. So they employed nurses
23 in a governance role, they had open meetings where
24 their consultants, their trainees, the midwives and the
25 governance lead nurses would be present and would 10:32
26 discuss these issues. You know? So that's a very
27 healthy way of dealing with things. I think other
28 specialties such as ours could learn from that.
29 65 Q. I'm going to look at how the M&M format deals with

1 SAIs, how they are used. Just at this point, leaving
2 the M&Ms to later, but just at this point, extracting
3 learning and implementing learning from SAIs, how, in
4 your experience, was it not done well in urology? And
5 what lessons can be extracted from that? 10:33
6 A. So, I mentioned it briefly before, the fact that we
7 would have recommendations coming back from these SAIs,
8 and we may have several SAIs with similar themes, and
9 then you don't have coherent recommendations coming
10 back. So, you know, that could be better. 10:33
11
12 I think we were all very aware of the cases that had
13 become SAIs in our department, they were openly
14 discussed at the mortality and morbidity meetings.
15 Some of the cases were presented in a wider forum with 10:34
16 all of surgery and all of anaesthetics present. So it
17 wasn't that we weren't aware of the shortcomings and we
18 knew what the solutions were. It's just the
19 consistency of approach was, in my view, at times
20 absent. 10:34
21 66 Q. We'll look in a short time, for example, at stent
22 cases.
23 A. Yes.
24 67 Q. You know --
25 A. That's a good example. 10:34
26 68 Q. We see -- well I picked several examples which I'll
27 work through with you. But the impression might be
28 formed, and we'll look at it specifically in a moment,
29 but the impression might be formed around some issues

1 that the same incidents are happening, or the same
2 issue is arising across multiple cases, but it's a
3 struggle for us, this Inquiry, to see how the lesson
4 and the recommendation written down on the SAI page
5 actually translates into meaningful remedial action. 10:35
6 A. Yeah. I think triage is perhaps something that would
7 have benefited from a more joined up approach. It is
8 something that I'm sure we'll cover perhaps later as to
9 how that should function and as to what policies the
10 Trust should have in implementing triage. 10:35
11 69 Q. Just so that I'm clear, before we leave this issue...
12 A. Yeah.
13 70 Q. Your concerns about the formality of the process and
14 whether it's worthwhile in every case. You're not
15 suggesting bin the SAI process, you're suggesting, are 10:35
16 you, at 40.3, that in some instances it's possibly
17 better to take an informal approach to the issue in
18 order to get the message out, rather than wait for two
19 years, or whatever it might be, to get a nicely printed
20 up SAI report? 10:36
21 A. I think on the ground, if you see something's wrong and
22 you can fix it there and then and you can share that
23 with the team, you should do it. It doesn't
24 necessarily take you to write an IR1, for instance,
25 about that. So, I'll come back to what I told you 10:36
26 before; you have to assess the level of risk and the
27 level of harm that may be applicable at the time and
28 you make a judgment call based on that.
29 71 Q. Can you give us an example, maybe it's unfair off the

1 top of your head, to where you think, "Well, a quick
2 fix is longer than a long gestation period"?
3 A. Yeah. So fire safety is a really obvious one in the
4 Trust, you know? So you're on the ward, somebody has
5 stuck a bed in front of a fire door. You don't leave 10:37
6 that. You move the bed. Now, you might decide to tell
7 the person in charge of the ward, who's actually the
8 fire officer, "Well, you know, this is a problem. You
9 can't be leaving stuff stacked up against the fire
10 door." 10:37
11 72 Q. Let me move to the morbidity and mortality role which
12 you took on from April 2015, is that right?
13 A. Yes.
14 73 Q. And you've said in your statement at paragraph 19.1
15 that if you didn't take on the roles, that is the MDM 10:37
16 role and the M&M role, they would not have been taken
17 up by colleagues.
18 A. (Witness Nods).
19 74 Q. Is that - that's a serious point, I'm surmising. And
20 is it simply reflective of everybody in the team has 10:38
21 their extracurricular responsibilities --
22 A. No, I think I was carrying more than perhaps others
23 were at the time, and that's the reflection I have.
24 75 Q. Yes.
25 A. So you look around the room, Mr. O'Brien had his roles; 10:38
26 in 2015 he was Chair of the local cancer MDT, Mr. Young
27 was lead clinician, I was the next person who'd been
28 there the longest, and then we had a succession of
29 people coming into the department, staying for a short

1 period and then leaving. And then in around 2014/2015
2 I think Mr. Haynes and Mr. O'Donoghue joined the
3 department, Mr. Suresh around a similar time maybe - I
4 can't be sure quite of the dates.
5 10:39
6 So, you know, you look -- when you get asked to take
7 something on, you look around the room and you think,
8 "Well, who is going to take this on?" And that fell to
9 me. The MDT fell to me, not by choice - Mr. O'Brien
10 was taking on the NICaN Chair, he wanted to demit from 10:39
11 the local MDT, which he had been Chair since, I think,
12 2012, and he asked me to take that on. I took it on,
13 knowing that my colleagues didn't want to do it.
14 76 Q. Yeah.
15 A. Okay? I took it on knowing there were problems. I was 10:39
16 not blind to the challenges.
17 77 Q. Yeah. Well, focusing then on the M&M role. You've
18 explained its purpose. Its purpose is to mitigate risk
19 and ensure high standards of patient care.
20 A. Yeah, drive quality improvement. 10:40
21 78 Q. Everybody was expected to attend - by that I mean
22 consultants and other medical staff, senior nursing
23 from the Outpatients Department and urology ward and
24 the head of service.
25 A. Yes. 10:40
26 79 Q. Did the Clinical Director attend?
27 A. I don't think they ever did. Now, they may have been
28 attending their own meeting. And, you know -- so the
29 structure would have been there was a rolling rota

1 across the Trust, and on whatever morning or afternoon,
2 each department would have been holding their own
3 meeting. Three to four times a year there was an all
4 of anaesthetics and all of surgery patient safety
5 meeting. So, you know, when Colin Weir, for instance, 10:40
6 was our CD, I'm sure that he was attending the surgical
7 M&M, so he wouldn't necessarily have been available to
8 attend ours.
9 80 Q. And this meeting in urology, it didn't start off that
10 way. I think you've made the helpful point that it was 10:41
11 Mr. Simpson who thought it better to have an individual
12 or specific M&M for urology, whereas previously it
13 fitted in within the surgical specialty and anaesthesia
14 M&M?
15 A. Yes. Yes. So, Dr. Simpson was the medical director at 10:41
16 that time. It was his driving force to establish
17 specialty specific patient safety meetings.
18 81 Q. And that makes sense to you, does it?
19 A. It does.
20 82 Q. Yes. And how long do these meetings typically last? 10:41
21 A. Three hours, maybe four hours. All of a morning, all
22 of an afternoon.
23 83 Q. And I'm looking at the ambition that you had for it.
24 You explain in your statement that you quickly
25 appreciated that it would be important to move beyond, 10:42
26 I suppose, the traditional activity of looking at
27 mortality lists and the occasional instances of
28 morbidity, to expand it out and look at a range of
29 reporting and data relevant to patient safety?

1 A. Yeah. And that was drawn from my experience of being a
2 trainee in the West Midlands, where I'd seen that in
3 action and I thought it was valuable.
4 84 Q. And in terms of the support that you received in your
5 Chair role, you've described that the administration 10:43
6 fell to you. In your absence, the meetings often
7 didn't take place. You describe the support from the
8 director of -- sorry, department of clinical
9 effectiveness, as nominal?
10 A. Yes. 10:43
11 85 Q. Were they, were all of these things real challenges to
12 --
13 A. That's exactly as I've stated there.
14 86 Q. Well --
15 A. They were - it was clearly a challenge. 10:44
16 87 Q. Yeah. And were there often meetings that didn't take
17 place?
18 A. Well, I've supplied the minutes to the USI and the
19 agendas, and you can see that there are gaps where
20 meetings didn't take place. 10:44
21 88 Q. Yeah.
22 A. I can account for the meetings that I wasn't present
23 at.
24 89 Q. Yes. Obviously you have Dr. Simpson, I think you speak
25 positively when you used the words "a driving force" to 10:44
26 get a specific urology, and other specialisms got their
27 specific M&Ms. That's a positive. On the other side,
28 you're reflecting a lack of adequate, I suppose,
29 support.

1 A. Yes.
2 90 Q. So where do we - how do we gauge the seriousness of the
3 enterprise in the hands of, I suppose, the Trust and
4 the managers who are supposed to support this? Is this
5 a reflection of a determination to embed a safety 10:45
6 culture, or the fact that it wasn't well supported by
7 those who could support it is perhaps an indication of
8 the opposite?
9 A. So when I think about this now, I wonder whether the
10 drive for this came from within the medical director's 10:45
11 office at the time, and whether or not they had any
12 influence or resource to apply to this. Because we
13 were sitting within the acute services directorate. So
14 the two things were not the same. The medical
15 director's office sat outside of that. So, I don't 10:45
16 know what resource was available to the medical
17 director's office to support this activity and whether
18 or not they had enough resource. They clearly didn't
19 have enough, as far as I was concerned, because I was
20 having to draft agendas, write up the minutes, type 10:46
21 them, etc..
22
23 You know, over time it has evolved, it has got to the
24 point now where I would say in the last 18 months a
25 draft agenda is supplied to all teams by the governance 10:46
26 team, and that would include embedded in that hypertext
27 links to various items such as SAI reports, you know,
28 pharmacy issues, etc., lots of different things. But
29 there is still a lot of legwork to be done by the

1 Chair, or the lead clinician for the M&M meeting, and I
2 know that my colleague Mr. O'Donoghue, who now holds
3 that role, complains in the same way that I complained.
4 91 Q. Yes. I want to spend a few minutes just looking at the
5 activity of the M&M. And as you've said, you've kindly 10:47
6 sent through to the Inquiry agendas. We've looked at
7 the report. You were charged, I suppose, with the
8 responsibility of reporting after each meeting.
9 A. Yeah.
10 92 Q. This isn't a criticism. It's, I suppose, difficult to 10:47
11 get a sense from that paperwork as to the intensity of
12 the discussions, the range of the discussions?
13 A. Yeah.
14 93 Q. And I suppose - and this is perhaps most important -
15 the connectedness with which this forum, the M&M, sat, 10:47
16 or connected to other branches of governance. What was
17 the relationship? So, I want to explore that with you.
18
19 If we start with WIT-42312. So, as a basic, all
20 urology inpatient deaths are discussed, is that right? 10:48
21 A. So, we made the decision at the outset of this meeting
22 that we would discuss all deaths.
23 94 Q. Yeah.
24 A. As I mentioned to you yesterday, many deaths that occur
25 in urology patients are actually expected, because 10:48
26 they're coming to the end of their disease process.
27 There are a small number of deaths in our specialty
28 that are not expected, and they are the deaths that are
29 really important to discuss.

1 95 Q. Yeah. And, as I say, that's probably the basic role of
2 the M&M. But you set out at paragraph 39.1, I suppose
3 the broad range of material or issues that you
4 encouraged on to your M&M agenda. Is that right?
5 A. Yes. And that list grew with time. At the beginning 10:49
6 the list wouldn't have included all of those issues,
7 but certainly by the time I was handing over to
8 Mr. O'Donoghue, all of these issues were embedded in
9 the meetings.
10 96 Q. And would you say that the M&M and its agenda was 10:49
11 responsive to the problems that were occurring in the
12 clinical setting?
13 A. Well, we were able to drive the agenda. So, if I was
14 aware of an issue happening within the department that
15 I thought needed discussed at the patient safety 10:49
16 meeting, I would put that item on the agenda.
17 Similarly, I would ask my colleagues "Are there any
18 issues that you want to list for the patient safety
19 meeting?" And, you know, that was very open. We would
20 have discussed that. There was never, to my mind, any 10:49
21 barrier to any member of our team, whether it be
22 nursing staff, medical manager, junior doctor, adding
23 an item to the agenda.
24 97 Q. Yes. Let's just - we'll pull up a few agendas, and
25 just maybe not terribly interesting, but just to 10:50
26 highlight some of the activities that this Inquiry has
27 heard about already. We can see them making their way
28 on to the agenda. This doesn't in any sense pretend to
29 be comprehensive, it's merely a couple of steps through

1 it.
2
3 So, if we go to TRU-38252. No, that's not what I
4 expected to find. Failed at the first hurdle. Just
5 scroll back a page. Forward a page. No. 10:51
6 CHAIR: The note I have is 28352. But I could have
7 that wrong. 282 - 28352, not 382.
8 MR. WOLFE KC: I think it is 38252 is what we have just
9 up. Let me just make the point without the page. 19th
10 October 2016, an audit was presented in relation to 10:51
11 high risk muscle invasive bladder cancers.
12 A. I think it was probably non muscle invasive cancers,
13 but...
14 98 Q. Sorry. Do you know why that issue was the subject of
15 audit? 10:52
16 A. Well, I think it's a really important topic in any
17 department that's doing bladder tumour resection that
18 you understand what's happening with your high risk,
19 non muscle invasive bladder cancer cases. So, if I'm
20 correct in surmising it was non muscle invasive without 10:52
21 reference to the thing.
22 99 Q. Yeah.
23 A. So, yeah, it would have been a very standard thing for
24 us to look at. It's one of those areas where patients
25 come to harm if they don't get timely treatment. 10:52
26 100 Q. We just might try 387... no. We'll come back to it
27 maybe. Let me take you to TRU-387263. And we can see
28 that, if we just scroll down, and we can see that
29 learning from the SAIs is on the agenda. And one of

1 those SAIs is that of Patient 10, I'm advised.
2 A. Okay.
3 101 Q. So, this is 17th February 2017. We'll look
4 specifically at the learning from that SAI later, but
5 just briefly in terms of how your meeting is conducted, 10:53
6 is that issue presented by the author of the SAI? Is
7 the report, sorry, presented by the author of the SAI?
8 A. So, the recommendations would have been discussed, and
9 obviously the reasons for making the recommendations
10 would have been discussed. Obviously I have personal 10:54
11 knowledge of this case, so it was quite straightforward
12 for me to advise the team as to why the recommendations
13 had been made. But not all SAIs that we are advised of
14 from the governance team, would we have personal
15 knowledge of. So in those cases we'd be relying on 10:54
16 what was written in the information given to us.
17 102 Q. And I did ask a question earlier about, or I did
18 suggest that one of our interests is connectedness. So
19 that's discussed, you will no doubt receive
20 contributions from the floor on any particular case, 10:54
21 observations --
22 A. Yeah.
23 103 Q. -- "we should be doing that", "we can't do that", "we
24 really need this." Is there a mechanism through which
25 the important voices heard in that forum can be shared, 10:55
26 their ideas can be shared back to the service which is
27 responsible for implementing?
28 A. So, present at the meeting would have been the
29 consultant, typically, Mr. Young as lead clinician.

1 I'm not sure what role Mr. Haynes held at that time,
2 more laterally he's been an associate medical director.
3 And Mrs. Corrigan would have been invited to all of
4 these meetings. I don't know if this is just the
5 agenda, or whether it's the minutes, whether it's 10:55
6 recorded that she was present.
7
8 So, clearly those people in the room would, some of
9 those people in the room would have management
10 responsibility, and I would expect that any discussion 10:56
11 that they would take forward the issues.
12
13 Issues that were also discussed at the patient safety
14 meeting would also make their way onto the agenda of
15 the Urology Departmental meetings, which took place 10:56
16 typically on a Thursday. So, for instance, I think
17 some of the issues pertinent to Patient 10 were
18 discussed at the Urology Departmental meetings as well.
19 104 Q. You used the word "facilitate", you were the
20 facilitator of this meeting. 10:56
21 A. Yeah.
22 105 Q. Did you see yourself as having any additional role in
23 terms of taking the learning that is being reported
24 into these meetings and making sure that it's pushed
25 through the service and brought into practice? 10:56
26 A. So these, the outcomes from these meetings, or rather
27 the minutes from these meetings were fed back to the
28 governance team, and at that time that sat, as far as I
29 understood, within the medical director's office. In

1 addition, the wider surgical and anaesthetic patient
2 safety meeting was Chaired by another doctor, and there
3 was always -- they had a lot of trouble getting
4 interesting stuff to come to their meeting basically,
5 so they were always looking for us to bring things to 10:57
6 them. So I can think of at least one of these cases
7 went for presentation at that meeting.
8
9 So that's, you know, the learning there was shared with
10 a wider -- in fact two of the SAIs that I Chaired went 10:57
11 to that meeting.
12 106 Q. What must have been the next meeting -- no, let me
13 bring you to the next year. TRU-387300. And we can --
14 just scroll down the page. Yeah. So somebody has
15 unhelpfully blacked out the entire left portion. We 10:58
16 see on the, halfway down, a presentation by
17 Mr. O'Brien, and we await the outcome of the SAI. Now,
18 from memory, that is the case of Patient 90, who had --
19 A. Okay. Yeah.
20 107 Q. -- died following surgery in May of that year. It 10:58
21 might have been April, but April/May of that year, and
22 you were ultimately appointed to take on what I think
23 was a Level 1 or an SEA?
24 A. I think it was SEA.
25 108 Q. It was. Explain for us, so we can understand, why 10:59
26 would Mr. O'Brien be presenting on a mortality before
27 the SAI or, sorry, the SEA as it was in this case, had
28 done its work?
29 A. I think it's quite reasonable to present the clinical

1 aspects of any case at a morbidity and mortality
2 meeting for learning of the other people in the team.
3 It was presented by Mr. O'Brien in a very open,
4 transparent manner. You know, I think it's normal. It
5 was clearly a very significant event and there were 11:00
6 aspects of the care which, in the ultimate SEA, you
7 know, there were recommendations made about the aspects
8 of the care. But I think it's very important for us as
9 a group of surgeons, and for the doctors in training
10 working with us, that we have an open culture to 11:00
11 discuss when things go wrong.
12 109 Q. The two issues -- two of the issues in that case, I
13 suppose, were the absence of a formal pre-op assessment
14 and a failure to sign off and action some preoperative
15 investigations, I think an echo -- 11:00
16 A. Echocardiogram, yeah.
17 110 Q. Had been recommended several years previously following
18 a CT scan. We'll look at those as themes later with
19 some other cases relating to preoperative assessment,
20 but was that the kind of learning that was obvious to 11:01
21 Mr. O'Brien from the outset, can you remember?
22 A. It's difficult to recall at this point, but I think
23 this was presented first locally and, secondarily, at
24 the anaesthetic and surgical PSM. Mr. O'Brien
25 presented it first at the local meeting and I presented 11:01
26 it on behalf of the group at the larger meeting. I
27 think Mr. O'Brien was entirely accepting of the issues
28 around the preoperative assessment and noting the
29 comorbidity of this patient, and that he reflected that

1 the patient should have had that workup prior to
2 surgery. So, I think that was accepted without any -
3 difficulty is not the right word, but without any
4 objection.
5 111 Q. Yes. I'm just thinking, and you made the point 11:02
6 earlier, that sometimes it's good to get out into the
7 open at an early stage.
8 A. Yeah.
9 112 Q. -- learning from an incident, rather than having to
10 wait to the very end of a process. In this instance, 11:02
11 we had both, I suppose?
12 A. I would reflect this: These events are traumatic for
13 the patient and their family, but they're also
14 traumatic for the staff involved. And there is a
15 therapeutic benefit to us to discuss these issues and 11:02
16 to be supportive of each other. Because we all have
17 these problems over time, we all have issues that are
18 difficult, we all have cases that don't go well and
19 where patients come to harm. And there is a collegiate
20 responsibility to support your colleagues when they 11:03
21 have these difficult issues.
22 113 Q. Thank you for that. Just showing you another couple of
23 agendas before we look at a number of specific issues
24 in a bit more depth. We can see that on 13th August
25 2020, if we can pull up TRU-387392? Scrolling down. 11:03
26 It's simply illustrative of the point. The two SAIs
27 listed at 9 were those concerning Patient 16 and
28 Patients 11 through 15, the other triage case.
29 A. Okay.

1 114 Q. These cases were incidents, as you know, dating back to
2 2016, in the case of the stent case of Patient 16 --
3 A. Sorry, Mr. Wolfe, can you just remind me when this
4 meeting took place?
5 115 Q. Yes, of course. It is the -- if we scroll up? It's 11:04
6 16th October 2020, I believe.
7 A. Okay.
8 116 Q. Sorry, 13th August 2020. There we are. So, would you
9 have, as the M&M Chair, would you have been aware that
10 cases were coming through the SAI system and were slow 11:05
11 to reach their destination? In other words, these two
12 specific cases were taking three years to reach a
13 conclusion?
14 A. Okay. So the date of this is notable, because it's
15 August 2020. Mr. O'Brien had retired by that time. 11:05
16 And the cases that you refer to, I think it was numbers
17 - Patients 11 through to 15?
18 117 Q. Yes, indeed.
19 A. I wasn't involved in that SAI process. Mr. Haynes was.
20 118 Q. Yeah. 11:05
21 A. So I would have been aware that he was involved in a
22 process. I wouldn't have been aware of the individual
23 cases. I think at that point in time I may not have
24 read, or I may have only just received around that
25 point in time the actual SAI outcome for those cases. 11:05
26 So I think that's when it was provided to us, within a
27 very short number of weeks of that date.
28 119 Q. Yes.
29 A. I was aware of the other case. But you'll also see

1 from the minutes there that the only two people present
2 at the meeting, and it is August, is myself and
3 Mr. Haynes.
4 120 Q. Yes.
5 A. Now, that particular snapshot captures the regional 11:06
6 morbidity and mortality system which was, I suppose it
7 was in part developed under the direction of Dr. Julian
8 Johnston, who you may be aware Chaired those SAIs. So
9 this system really only captures mortality, it doesn't
10 capture morbidity, and it only captures, in terms of 11:06
11 attendance, those people who have a cipher code. So
12 that's generally doctors or nurses. So there may have
13 been others in attendance who aren't captured in that
14 aspect of the minutes. If you scroll up, you may find
15 that there were others in attendance. 11:06
16 121 Q. Yes. We'll just scroll up. Scroll up again.
17 A. So you can see that it really was only the two of us at
18 the meeting. Because I would have captured everybody
19 else's attendance if they were there.
20 122 Q. Yes. Yes. I suppose I brought you to a sprinkling of 11:07
21 examples of agenda items which we know something about
22 the items for the purpose, I suppose, primarily of
23 showing that these things did make it through.
24 A. Yeah.
25 123 Q. I suppose it's difficult for us reading the agendas to 11:07
26 get a sense of the intensity of discussion.
27 A. Yeah, I think that's a fair observation.
28 124 Q. No, no, it's not --
29 A. I understand you're not making a criticism.

1 125 Q. No, no.
2 A. But from my perspective, I'm not a professional note
3 taker. I was left trying to capture the essence, or
4 not the essence, but perhaps the items that were
5 discussed more than the essence of the discussion. 11:08
6 126 Q. Yes. And I suppose that's why I'm -- I'm raising it
7 simply so that you can generally reflect for the
8 Inquiry and give us a sense of how - any particular
9 example, or generally, these discussions went.
10 A. So, I would also like to point out to you that if you 11:08
11 just scroll down the page, there's a bit of a summary
12 from the RMMS system. And what that's -- what we're
13 only capturing here is what we agreed the outcome was.
14 127 Q. Yes. This is the mortality?
15 A. Yeah. Yeah, that's right. 11:08
16 128 Q. Yeah.
17 A. So, because if you actually go into NIECR and you look
18 at the record of each patient for the M&M discussion,
19 there are several free text boxes that are completed
20 along parts of the pathway. So, when a patient dies, 11:08
21 for instance, the first free text box is completed by
22 the person who is completing the MCCD. There's then
23 the -- that then closes and the opportunity then goes
24 to the consultant responsible for the case to make
25 their comments in the free text box, in a separate free 11:09
26 text box, and then it comes to the meeting, where I
27 then, as the lead clinician, have the opportunity to
28 record the reflections and thoughts of the team at the
29 discussion. So you don't have that here, but it exists

1 on an NIECR.
2 129 Q. Okay. And I suppose taking a death as an example, I
3 mean, is it fair to assume that the incident and the
4 clinical history is all set out at the meeting and...
5 A. Yes. 11:09
6 130 Q. And pulled apart, if necessary?
7 A. Yes.
8 131 Q. And how long, typically, would a mortality case take to
9 --
10 A. Well, as I told you earlier, if it's an expected death 11:10
11 then that's really quite a straightforward issue in
12 most cases and it may take just a number of minutes.
13 Because, you know, patients come to the end of their
14 disease, it's usually a cancer related death. But if
15 it's something like - let me just take one example... 11:10
16 132 Q. Like Patient 90, for example.
17 A. Yeah, I think that's the one I'm thinking of as well.
18 Yeah, Patient 90. That was discussed at length. There
19 was, you know, at least 20 minutes discussion about a
20 case like that. 11:10
21 133 Q. And I mean, if we can imagine that part of that
22 discussion was about the failure to conduct a
23 preoperative assessment - as I say, I'm going to look
24 at a series of cases in that context later - but is
25 this an opportunity for, whether it's the person 11:10
26 presenting it, in this case Mr. O'Brien, or senior
27 colleagues such as yourself, to drive the message
28 through to perhaps more junior colleagues that, you
29 know, this is an essential, we've been not so much

1 caught out here, but we've had this difficulty here,
2 "open your ears and apply"?
3 A. Yeah, and, you know --
4 134 Q. Is it that tone?
5 A. No, I think the tone that I try to strike at these 11:11
6 meetings is one of learning. It isn't about blame.
7 And it's not threatening people to take action, it's
8 advising people that this is why we do this, because
9 this is safe practice. And that's the culture that I
10 want, both that I wanted at the patient safety meeting 11:11
11 and it's the culture that I have at the MDT.
12 135 Q. Yes. Let me move to a couple of specific examples. I
13 suppose they're both benign disease type issues. The
14 indwelling ureteric stent theme, I suppose, has
15 preoccupied the Inquiry from a number of witnesses, and 11:12
16 we can see, for example, TRU-387305, that, just
17 scrolling down, there are a number of suggested audits
18 at number 5(ii) at (b) is:
19
20 "An audit of waiting times for surgery of patients with 11:12
21 indwelling ureteric stents. Mr. Hiew and Mr. Young to
22 go and have a think about that."
23
24 Then we can see that it appears that an audit was
25 presented in January 2019. We haven't been able to 11:13
26 find that on documents from the Trust.
27 A. Okay.
28 136 Q. We may have an interest in getting that in due course.
29 But just let me bring up the agenda item. TRU-387310.

1 And just down the page... just go up a little. No, I'm
2 struggling with my references this morning, it seems.
3 Yes, I suppose it was making the point that the audit
4 wasn't ready for presentation. Is it the case that an
5 audit was ultimately presented? 11:14
6 A. Yeah, I think it was presented by Mr. Hiew. So
7 Mr. Hiew was a trainee in the department at the time.
8 As I've said before, Mr. Young's main interest was
9 stone surgery, so Mr. Young was supervising Mr. Hiew in
10 this regard. But my recollection is that Mr. Hiew did 11:15
11 present this at a later date.
12 137 Q. Yes. And can you set that in context for us? As I
13 say, the Inquiry has heard already about a number of
14 stent cases. And I suppose at the heart of it was; is
15 a sense that there was not perhaps sufficient active 11:15
16 management of non stent cases, whether for replacement
17 or removal...
18 A. Yeah.
19 138 Q. Leading to delays and risk of sepsis. I think, in
20 summary, that's the theme as it appears to us. Is that 11:15
21 right? Is that the experience of the service?
22 A. So, my experience is that stents are put in for a
23 variety of reasons. So, you have stents put in acutely
24 for obstructing stones, for instance. And then you
25 have stents put in for perhaps - some benign conditions 11:16
26 require stents, and also many cancer patients with
27 advanced disease require stents. So, you're then in a
28 situation whereby you've placed the stent, you record
29 that in your theatre notes, you dictate a letter that

1 you've done it, and you then have to have some form of
2 mechanism for keeping an eye on when this stent needs
3 to come out.
4
5 So, I have never worked in any Trust that has a robust 11:16
6 mechanism for sorting this. My way of dealing with
7 this was that I typed the vast majority of my theatre
8 notes, and that any stent that was put in by a trainee
9 on my behalf, I insisted that they provided me with the
10 details of that. And I kept a folder of paper notes 11:17
11 initially and, subsequently, any e-mail correspondence
12 about stents was kept in a folder. And I went through
13 that on a monthly basis to see that these patients were
14 kept on track.
15 11:17
16 Now, that was my intention. However, as I told you
17 yesterday, the resource in theatre was insufficient,
18 and it was not uncommon for patients to go beyond their
19 expected date for change or removal of stent. And that
20 was, I think, the common experience of all the 11:17
21 consultants in the department. And I think it's the
22 common experience of all urology urologists practising
23 in Northern Ireland.
24 139 Q. I'll pick up on a couple of those points just now. I
25 just want to put on the screen an intervention from one 11:18
26 of your colleagues in 2019. If we go to TRU-387331.
27 We can see, just scrolling down -- yes. So there's a
28 complaint for investigation and:
29

1 "The case highlighted the need for the operating
2 surgeon to make a plan for the removal of a ureteric
3 stent at the time of insertion. All agreed that the
4 surgeon placing the stent is responsible for actioning
5 the removal in a timely manner. There is no agreed 11:18
6 Trust protocol in place for this scenario.
7 Various suggestions were made as to how to manage this
8 situation but no consensus was reached at the meeting."
9
10 So, I'm setting that on top of your explanation of how 11:19
11 you tried to manage the situation.
12 A. Yeah.
13 140 Q. You say your efforts were confounded by the capacity
14 issues in terms of trying to get patients into theatre
15 in accordance with a timetable which you thought was 11:19
16 reasonable.
17 A. It's not only what I thought reasonable, but what was
18 clinically appropriate. And you had too many competing
19 interests for the theatre time available. I'd like to
20 point out to you that we use a booking form for 11:19
21 theatres, and on the booking form I would record that
22 the patient had a stent in, and that information would
23 be transcribed by my secretary on to PAS. So, when you
24 ran the waiting list, as I did, you would be very
25 easily able to filter the waiting list to see if there 11:20
26 was a stent mentioned. So, that was one way that I had
27 of making sure that that information was recorded.
28
29 Secondly, in recent times we have developed, across the

1 whole team, a system for coding the stents for the
2 waiting list. And that's a good development, because
3 it means we're all doing something consistently. It
4 also will help the newly appointed tracker, or, rather,
5 not tracker, scheduler, to help us manage those cases 11:20
6 in a more timely manner. And we have given individual
7 codes according to the particular circumstances. So,
8 for instance, if a patient has a single kidney, they
9 have one particular code, because obviously their need
10 is perhaps slightly greater than the need of a patient 11:20
11 who has two kidneys.
12 141 Q. Yes. Can I just pull up another illustration of, I
13 suppose, the interest and perhaps the agitation around
14 stent issues which was affecting the team? AOB-73717.
15 A. Sorry just before you leave that screen... 11:21
16 142 Q. Sure.
17 A. Mr. Hiew's audit was presented that day. It was on
18 the minutes there.
19 143 Q. Is that right?
20 A. Yeah. 11:21
21 144 Q. Sorry. We must have missed that. Thank you for
22 pointing that out. AOB-73717. And I suppose this
23 neatly illustrates a point you made earlier about the,
24 I suppose, the appetite of the team, or maybe some
25 members of the team, and you, to get issues on the 11:21
26 agenda. So, Mr. Suresh, bottom of the page, writes to
27 you:
28
29 "I have seen a couple of patients recently with

1 forgotten stents, with no mention about the stents in
2 the discharge letter. I have filled in incident forms.
3 Can we discuss about this issue in the next governance
4 meeting, please, particularly about the need for stent
5 registry." 11:22
6
7 A. Yeah.
8 145 Q. This is 2015. Sorry, I'm jumping about a little bit in
9 terms of the timeline. If you go up to the top of the
10 page then, you explain that the next meeting is on 16th 11:22
11 June and you would be grateful if he could:
12
13 "...present these cases formally so that we can share
14 learning and plan some action points."
15 11:22
16 So, another example of this issue on the agenda. We
17 have additionally noted Patient 16, as we mentioned a
18 while ago.
19 A. Mm-hmm.
20 146 Q. Patient 91, with which you're familiar, all involving - 11:23
21 I'll let you just...
22 A. I am, yes.
23 147 Q. Yes. All of these cases are stent cases, all of them
24 make it to the patient safety M&M meeting and are
25 discussed. The SAIs in Patient 16's case, the SAI in 11:23
26 Patient 91's case all talk, all make recommendations in
27 relation to stent management. Perhaps just we'll pull
28 up Patient 91's case? It's WIT-33320. This was a case
29 where the patient had a left ureteric stent inserted on

1 4th March 2018. He was admitted for a ureteroscopy?
2 A. Ureteroscopy, yes.
3 148 Q. Thank you! And laser, on 18th May 2018. And he
4 deteriorated postoperatively and died. And that was in
5 the setting also of a failure to do microbiology -- 11:24
6 A. To check the --
7 149 Q. Yeah.
8 A. Yeah.
9 150 Q. And we'll look at that in the pre-op context as well
10 later. But the recommendations here, if we just scroll 11:24
11 down, yeah, Recommendations 3 to 6:
12
13 "Urology: Waiting lists should be standardised to
14 include standardised description of ureteric stent
15 change/removal procedures. 11:25
16
17 4. Consultant urologists should ensure that they have
18 a system in place which ensures that patients with
19 ureteric stents inserted are recorded with planned
20 removal or exchange dates in order to ensure patients 11:25
21 do not have stents in place for longer than intended.
22
23 5. All patients who have stents inserted for
24 management of urinary tract stones should have plans
25 for definitive management within 1 month, unless there 11:25
26 are clinical indications for a longer interval to
27 definitive treatment."
28
29 So, those recommendations particular to that case. But

1 I think the point that you're perhaps making is that
2 even if you have all of that good planning recorded and
3 in place and appropriately notified, you were still, or
4 colleagues, were still running into problems because of
5 capacity issues? 11:26
6 A. Yeah. It's very well illustrated by this case. This
7 gentleman waited ten weeks, essentially, to have this
8 procedure done. I inserted the first stent for this
9 gentleman and in the theatre note I wrote six to eight
10 weeks, which would have been our custom and practice at 11:26
11 the time. So he waited longer than he should have
12 waited. And, obviously, there are other issues
13 relating to his second episode of care.
14 151 Q. Yes. So breaking the stent issue down. Is it, in some
15 cases, part clinicians not getting themselves organised 11:26
16 to properly register and plan for removal or
17 replacement, but it's also in significant part running
18 into capacity issues in terms of the ability to get the
19 patient into theatre for the procedure --
20 A. Okay. I'm going to deal with your first bit. It's not 11:27
21 disorganisation on my part.
22 152 Q. And I'm not suggesting...
23 A. Yeah.
24 153 Q. But more broadly, are you seeing cases --
25 A. Well, I'm answering about my practice. 11:27
26 154 Q. Of course.
27 A. So my practice is well organised. The paperwork's done
28 appropriately. Patients are listed. There is a very
29 clear instruction as to when they should be coming

1 back. There's a definite capacity issue with theatres.
2 155 Q. And as of yet, we talked yesterday about the resource
3 at Lagan Valley I think?
4 A. Yes, and that has helped.
5 156 Q. Yes. But is there, as we saw reported in your M&M 11:27
6 minute in 2019, an onus placed on the surgeon, but no
7 protocol developed. Is there yet an absence of a
8 protocol?
9 A. So I referred a few moments ago to the fact that we
10 have now coded things, and that is what is expected of 11:28
11 everybody in the department, to use these codes, so
12 that it is very clear on the waiting lists where these
13 patients are. We will operate on each others' patients
14 to, as far as we can, ensure that they have timely
15 surgery. I think there's perhaps a blind spot that 11:28
16 hasn't been discussed so far, in that stents are often
17 put in by other specialties, and maybe put in by
18 radiologists, for instance, and it's not easy for us to
19 capture that. And some of the cases that have been
20 referred to here as missing stents, that's true of 11:28
21 those cases.
22 MR. WOLFE KC: Chair, would this be a suitable time for
23 a short break?
24 CHAIR: Yes. We'll come back at a quarter to twelve.
25 11:29
26 SHORT ADJOURNMENT
27
28 CHAIR: Thank you everyone. Mr. Wolfe.
29 MR. WOLFE KC: Just finishing with the stent issue.

1 When you reflect upon the collection of activity which
2 coalesced around this issue, from frequent visits to
3 the agenda of the M&M meeting, frequent cases making it
4 into incident reports and some into SAIs, you, as a
5 service, a team, are not seeing progress on the ground 11:45
6 to fix the capacity issues. As I said earlier, there
7 may be issues around individual practice, you've made
8 yourself clear that you were precise and considered in
9 terms of planning, others may not always have been as
10 good as that. But on the bigger structural issue of 11:46
11 finding a solution to this, there's people at this
12 meeting who have the power to take it away and get
13 something done. Can you reflect for us your views on
14 why it wasn't done? Why something so significant in
15 terms of morbidity, and potentially mortality, wasn't 11:46
16 resolved?
17 A. I don't have a good answer for that. The people in the
18 room at the meetings would not have been decision
19 makers in terms of whether we got two new theatres or X
20 number of lists per week. Those discussions would have 11:47
21 taken place in another forum. We flagged up the need
22 for more capacity. It's still, you know, I mentioned
23 today, and yesterday, the very important benefit of now
24 having Lagan Valley and Daisy Hill available to us, and
25 that has improved the situation. But I'm afraid for as 11:47
26 long as I've been in the Trust we've had discussions
27 about improving the infrastructure in terms of the
28 physical buildings, capacity, etc., and really there's
29 been no substantial change in ten years or more.

1 157 Q. Can I move on to a second patient issue, patient safety
2 issue, which flickers for the Inquiry, and that is the
3 area of TUR syndrome?
4 A. Yes.
5 158 Q. We've looked carefully at the M&M patient safety 11:48
6 agendas as carefully as we can, and we don't see that
7 that issue was on any agenda, and particularly I'm
8 wondering whether it ever made the agenda in the
9 context of the changes that were commended to Trusts in
10 Northern Ireland following the Coroner's case and the 11:48
11 instruction that practitioners should move to bipolar
12 --
13 A. Resection.
14 159 Q. -- instruments, and resecting saline as opposed to
15 glycine? 11:49
16 A. Yes. So I accept that that is a patient safety issue.
17 However, that letter came to the Trust, I think, rather
18 than to us as individual clinicians. I'm aware of the
19 case that was the origin of that. And Mr. Young
20 brought that to the departmental meeting. So, that 11:49
21 became the forum at which we discussed this issue. I
22 think that's quite reasonable, because it involved more
23 than just the Urology Department, it involved the
24 Theatre Department, which was managed under a different
25 head of service, and it would have involved us 11:50
26 discussing with them purchasing this equipment and
27 trialling this equipment, which we did.
28 160 Q. Mm-hmm.
29 A. So, I had experience of using bipolar resection

1 techniques prior to returning here to be a consultant.
2 I was quite happy with the equipment that I'd used
3 previously, and we agreed as a team that we would
4 instigate a trial of equipment. So that took place.
5 We tried, I think equipment from three to four 11:50
6 different manufacturers, and they obviously then costed
7 up the equipment. We scored the equipment in terms of
8 our findings on using the equipment, and two
9 manufacturers' equipments came out essentially equal.
10 When it came to cost, one manufacturer's equipment - 11:50
11 which I won't name - was significantly more expensive,
12 and I think all urologists would understand which
13 company that was, and we opted to buy equipment from
14 another company. The equipment, in my view, was
15 perfectly suitable for the job of doing both 11:51
16 transurethral resection of the prostate and
17 transurethral resection of bladder tumours.
18
19 So, there was agreement amongst the majority of the
20 team about using this technology. Mr. O'Brien was of 11:51
21 the view that he would trial the equipment, and he did,
22 to the best of my knowledge, trial the equipment. But
23 he expressed the view at the meetings that he thought
24 that monopolar was technically superior in aspects of
25 doing TURP. I didn't agree with that. I told him so 11:51
26 at the meetings. And I also made the point, as did
27 others at the meetings, that the next patient that we
28 sent to ITU with hyponatraemia or TUR syndrome, and
29 you've used monopolar system to do that surgery, you

1 haven't got a leg to stand on.
2 161 Q. Much of what you say is reflected in the documentation,
3 which I think we'll just bring out and raise a number
4 of other points with you. So, if we could start at the
5 top of the timeline and just briefly look at the 11:52
6 coroner's letter to the Chief Medical Officer, 21st
7 October 2013. WIT-99098: And the coroner, Mr. Leckey
8 is writing in connection with that patient's case, it's
9 a well publicised case, it was featured in the media at
10 the time, and he is requesting - just if we scroll 11:52
11 down:
12
13 "He would ask the medical directors to provide him with
14 a collegiate response to the surgical and anaesthetic
15 failings that the Inquest had identified." 11:53
16
17 That then moved forward with the Deputy Chief Medical
18 Officer issuing a policy. If we just bring it up to
19 illustrate the point, WIT-54032. And this letter
20 issued on 18th August 2015. And the letter attached a 11:53
21 policy setting out 12 recommendations. If we go to
22 WIT-54052, and it explains that the policies to be
23 implemented after agreement with each of the Trusts and
24 its implementation was to be audited or monitored.
25 11:54
26 We can see then the Trust's action plan, WIT-54023.
27 And just scrolling down. It's broken down along the 12
28 recommendations that came from the Chief Medical
29 Officer's office. And you can glance, members of the

1 panel, at the recommendations on the left-hand side and
2 then a deadline for completion.
3
4 Interestingly, this is one that - item number 2 is an
5 item that Mr. Haynes was to highlight in an e-mail that 11:55
6 I will refer you to in a moment:
7
8 "Introduce bipolar resection equipment. During the
9 switchover to bipolar equipment, limit the use of
10 glycine following careful risk assessment of individual 11:55
11 patients. If glycine is still being used strictly
12 monitor as detailed in Recommendation 5."
13
14 I suppose just to get a little bit technical - and you
15 can obviously help me with this - historically the 11:55
16 standard resection tool was a monopolar electrode which
17 required an electrically non conductive irrigation
18 fluid to enable it to work and that was typically
19 glycine?
20 A. Yeah, it's glycine. 11:56
21 162 Q. Glycine. Thank you.
22 A. So, the older equipment was a monopolar electrode, a
23 return electrode pad placed on the patient's skin, and
24 then the current was conducted through - from the
25 monopolar, through the patient's tissue, out to the 11:56
26 return electrode.
27 163 Q. And the use of glycine was --
28 A. Glycine. Yeah. Was commonplace.
29 164 Q. And if not well managed or in certain characteristic

1 situations --
2 A. No, I think it is not fair to say that it was not well
3 managed.
4 165 Q. Sorry, there was an "if" before that. If it wasn't
5 well managed, or in, for example, a lengthy TURP 11:57
6 procedure, you could increase the risk of, for example,
7 hyponatraemia?
8 A. Okay. Yes, amongst other complications. So I think
9 it's very important to understand that urologists as a
10 group of surgeons were very well aware of this issue. 11:57
11 This issue may not have been as well understood by
12 other surgeons. Okay? And this had arisen in a non
13 urological case. So, in all of our training, we would
14 have been made fully aware of the risks of using
15 glycine as a resecting medium. We would have 11:57
16 understood the risks of fluid absorption and subsequent
17 dilutional hyponatraemia. We would have understood the
18 risks of glycine toxicity, and we would have understood
19 the risks of fluid overload. So they would have been
20 things that would have been on the radar of every 11:57
21 competent urologist.
22 166 Q. Yes. So just illustrating this policy, and we'll come
23 back to some of those points. So just scrolling on
24 down, please. So you see again some recommendations,
25 the process, or the action plan of the Trust, some 11:58
26 deadlines, some are ongoing. Features.
27
28 Scrolling on down. I'm just inviting the panel to
29 glance at aspects of this. On down, please. Go again.

1 And to the last page, I think. And one more. So,
2 you've highlighted, Mr. Glackin, that as a department
3 you met on this issue --
4 A. More than once.
5 167 Q. -- and trialled the equipment and brought that back for 11:59
6 discussion.
7 A. Mm-hmm.
8 168 Q. We can see aspects of that. Let's bring up, please,
9 TRU-39595. If we try 39597? No. I'm going to have
10 one more go. 395977. Just scroll down. I'm 12:00
11 determined to find this one. If I can maybe ask for
12 some assistance from Mr. Lunny, who is stellar at these
13 things. I'm looking for Mr. O'Brien's e-mail of 7th
14 February 2016 to his colleagues. Yes. Thank you. And
15 this is Mr. O'Brien's e-mail to you and other 12:01
16 colleagues on 7th February 2016. And he's reflecting
17 the fact that he has trialled a particular product and
18 he wasn't bowled over by it, and he set out the
19 deficiencies which he experienced during the resection
20 of two small prostates, and he sets those out. 12:02
21
22 Scrolling down please, he concludes by saying:
23
24 "I was so glad that neither prostate was large as I
25 certainly would not have used the bipolar." 12:02
26
27 So, plainly youse were conducting an audit or a survey?
28 A. Yeah, a trial.
29 169 Q. Around the product or the instrument. And would he be

1 happy to use it? His answer is "no". But he will do
2 it if he has to. But he just hopes that the operating
3 procedure to be developed will allow him to continue to
4 use monopolar, as it is very superior.
5 12:02
6 If we can go down then to 395978, I hope. And a month
7 or so later he is updating you as a team as to his
8 further experiences. He last used bipolar two weeks
9 ago to resect a moderately enlarged prostate gland, and
10 the intraoperative comparison of both systems, he says, 12:03
11 was remarkable. Bipolar resection, he says:
12
13 "...placed this patient in intraoperative danger and it
14 was salvaged by monopolar resection."
15 12:03
16 And then he says:
17
18 "I pledged not to do so again. I will not use or try
19 bipolar section again."
20 12:04
21 And so that was fed back to you as a team. You say
22 this matter was handled as a department. You would
23 have all known about the Chief Medical Officer's
24 intervention --
25 A. That was the premise for it being discussed. 12:04
26 170 Q. I know that Mr. Haynes comes back in on this at a later
27 point and I'll come to it. But just before doing so,
28 WIT-54057. There is a meeting, 22nd September 2016,
29 and all in attendance. And the discussion is around

1 which piece of equipment to purchase. And if we scroll
2 to the bottom -- well, just before we do. Mr. O'Brien
3 is in attendance. It says:
4
5 "We all agreed the appraisal form used was of good 12:05
6 standard and certainly adequate to make a surgeon's
7 assessment of each scope."
8
9 Then going down, it says, just at the bottom of the
10 page, I think - on over the page. Keep going. I'll 12:05
11 tell you when to stop. So the conclusion is - you can
12 stop there - is that this particular instrument is the
13 one that is preferred. It says:
14
15 "All the urologists have backed this decision with a 12:05
16 unanimous vote."
17
18 Did Mr. O'Brien support the purchase?
19 A. I'd have to rely on what Mr. Young has written in the
20 minutes of this meeting. I don't recall how we voted, 12:06
21 whether we went around the table and said "yes", "no",
22 whatever.
23 171 Q. Yeah. Yeah. I don't see any -- while I, I think
24 fairly set Mr. O'Brien's dissent from the project out
25 in his earlier e-mails, I don't see it -- 12:06
26 A. Yeah. Well, I'm not aware of any further dissenting
27 e-mail following this.
28 172 Q. Yes. But if we could fast forward then to the
29 following year, 19th November 2017? WIT-54021. And

1 Mr. Haynes is writing in to Ms. Gishkori and
2 Mr. Carroll and he's discussing the capital expenditure
3 with respect to saline resectoscopes and infusion
4 pumps, and he attaches the guidance that had been
5 issued to the region, which we've discussed earlier. 12:07
6 He also attaches the Trust's response to this guidance,
7 including the action plan. And you will note, as I
8 highlighted earlier, that Item 1, the introduction to
9 bipolar resection equipment was, I think, due to be
10 installed and completed by 31st March 2016. 12:07
11
12 Scrolling down. And he highlights that the need to
13 investigate the irrigation fluid monitor or controller
14 was to be completed by 31st December 2015, subject then
15 to an addendum. 12:08
16
17 So, the point I'm bringing this to is what he says at
18 the bottom:
19
20 "From a region-wide perspective, Southern Trust is the 12:08
21 only urological team that are unable to meet this
22 guidance with saline resections being routine in other
23 units."
24
25 He says, referring to a recent e-mail from Mr. Young: 12:08
26
27 "The Southern Trust urology team are in a vulnerable
28 position were TUR syndrome, death or significant
29 morbidity to occur where glycine was used as a

1 resection medium."
2
3 A. Yes.
4 173 Q. So, can you help us with this? We haven't raised this
5 with Mr. Haynes, who came to give evidence way back in 12:08
6 November or December. So, saying this now, putting
7 this out here for the first time, so what has gone on
8 in the period since agreement to purchase the
9 agreement?
10 A. Yeah. So I'm making some assumptions here, but I think 12:09
11 Mark Haynes has canvassed informally our colleagues in
12 the other Trusts to see did they have this equipment in
13 place, and has been told by them that they do have this
14 in place.
15 12:09
16 Secondly, items such as this go on a capital purchase
17 list, and those items are discussed at a meeting called
18 "THUGs" - not a great name for a meeting, but it's
19 Theatre Users Group, and so Mr. Young would have been
20 our representative on that group and he would have, 12:09
21 together with Mary McGeough, who is mentioned there,
22 she is the head of the - she was head of service for
23 theatres, they would have listed this on the list of
24 items to be purchased.
25 12:09
26 Now, as you can imagine, a busy operating department
27 has a large number of items to purchase every year,
28 some of which are more pressing than others in terms of
29 their need. This item may well have sat on THUG's

1 wishlist for some time, and I suspect that's what's
2 happened.
3 174 Q. In terms of your memory of when you were able to make
4 the move from glycine to saline and use a bipolar
5 instrument, when did that first occur? 12:10
6 A. It would only have occurred when we had the equipment.
7 So, you know, I can't give you an answer to that,
8 Mr. Wolfe.
9 175 Q. Well, was the equipment eventually purchased?
10 A. Yeah, the equipment was purchased. It was purchased in 12:10
11 enough quantity that we had enough to deliver all
12 resections using this equipment should the surgeons
13 wish to do so. So, if you listed perhaps three or four
14 resections on an all day list, there certainly would
15 have been enough kit to complete the list. 12:11
16 176 Q. And did you change your practice then?
17 A. Immediately.
18 177 Q. Immediately.
19 A. And we also, when we went to Daisy Hill, we made
20 provision to have the same equipment available at Daisy 12:11
21 Hill, and the same equipment, or a different
22 manufacturer's equipment is available to us at Lagan
23 Valley.
24 178 Q. And did all your colleagues on the urology team change
25 their practice? 12:11
26 A. I can't answer for Mr. O'Brien, but I have the
27 understanding that my other colleagues all moved to
28 saline resection.
29 179 Q. And you can't answer for Mr. O'Brien because --

1 A. I just don't know.
2 180 Q. You don't know. We could see from his earlier e-mail
3 that he was intending to refuse to practice using
4 saline and bipolar instrumentation. Was that the
5 subject of discussion, whether a critical discussion, 12:12
6 or a persuasive discussion, or a supportive discussion?
7 A. So the exact point that's made by Mark Haynes at the
8 bottom of this e-mail on the screen is that we would be
9 vulnerable if we had a TUR syndrome death or morbidity.
10 That point was made more than once in the departmental 12:12
11 meetings in the presence of Mr. O'Brien.
12 181 Q. And did he respond, to the best of your memory?
13 A. I can't remember his exact response.
14 182 Q. Was it constructive, his response?
15 A. Well, I can't remember the response, so I'm not going 12:12
16 to speculate on whether I thought it was constructive
17 or not.
18 183 Q. Could I bring you to the evidence of Mr. Chris Hagan?
19 A. Yes.
20 184 Q. If we could just turn up his statement, please? 12:13
21 WIT-98867. And paragraph 59. And he's explaining that
22 at some point, he believes it to be sometime between
23 2017 and 2019, he was contacted by Dr. Charlie
24 McAllister from the Southern Trust, and he has
25 explained that McAllister wished to discuss TUR 12:13
26 surgery. Would that be - is that properly expressed?
27 A. Yes.
28 185 Q. Yes. And TUR syndrome, and the use of bipolar
29 resection. He explained that they had an issue in

1 Craigavon with an individual surgeon carrying out
2 prolonged TURP resections with glycine and with some
3 bad TUR syndromes.
4
5 "He did not name the surgeon specifically. He wanted 12:14
6 to know my experience with introducing TURP in saline.
7 I explained that the experience in Belfast was good,
8 that the technique was similar to monopolar TURP with
9 glycine and that with modern equipment, in my view, it
10 was unjustified and unsafe to continue to use glycine 12:14
11 due to the safety profile of it as an irrigating fluid.
12 From a personal perspective, I have carried out TURP in
13 saline for around 10 years and see no justification for
14 the use of glycine."
15 12:15
16 Now, do you recognise the narrative there as a feature
17 of life with one of your colleagues in Southern Trust?
18 A. Dr. McAllister or...
19 186 Q. The issue being raised by Dr. McAllister is that one of
20 your colleagues carrying out TURPs -- TURP, sorry, 12:15
21 procedures, engaged in prolonged procedure --
22 A. Okay. Well --
23 187 Q. He's not using bipolar resection and he's ending up
24 with some bad outcomes.
25 A. Yeah. So, first of all, I'm surprised that 12:15
26 Dr. McAllister didn't speak to one of us about this.
27 That's the first thing to say. The second thing to say
28 is that prolonged TUR resection is a known risk factor
29 for developing so-called TUR syndrome. And, secondly,

1 or rather thirdly, by this stage I certainly wasn't
2 using glycine to do TUR resection. As far as I was
3 aware, my other colleagues weren't. So I'm therefore
4 making the deduction that he's referring to
5 Mr. O'Brien. 12:16
6 188 Q. And if these procedures are ongoing using monopolar
7 equipment in glycine and you're seeing morbidity in the
8 form of TUR syndrome, is it fair to say that that
9 should be the subject of discussion --
10 A. Yeah. 12:16
11 189 Q. Either departmentally or at the M&M?
12 A. Yes, it is fair to say that.
13 190 Q. And you're saying Dr. McAllister didn't raise it with
14 you or your colleagues --
15 A. No, he didn't. And I'm rather surprised that he chose 12:17
16 to go -- well, I mean he is free to speak to whomever
17 he wishes. But if there's an issue in our department
18 about this, why isn't he speaking to us?
19 191 Q. You gave me an answer earlier that you simply didn't
20 know or you couldn't speak for Mr. O'Brien. 12:17
21 A. Yeah, because I --
22 192 Q. Can I press you on that?
23 A. Yeah, of course.
24 193 Q. Is it really the case that in a small team, such as
25 this, where he has already gone on record as saying he 12:17
26 wasn't going to do it, that you remain in the dark
27 after the equipment was purchased, in terms of his
28 attitude at the point of installation of the equipment?
29 A. So, I'm not in his theatre when he does his cases. I'm

1 not responsible for listing his theatre list. Neither,
2 similarly, am I responsible or in the theatre of my
3 other colleagues when they're operating. So unless I
4 meet a patient on the ward afterwards and I read the
5 theatre note and see that it was a monopolar TURP, I 12:18
6 wouldn't necessarily have knowledge of that. Now, my
7 theatre notes would record what equipment I used to do
8 the operation
9 194 Q. The incidents of TUR syndrome, in a context where the
10 coroner, through the Chief Medical Officer, has 12:18
11 reported of those risks and said, in essence,
12 "modernise and put your house in order", is it
13 surprising that, if this timeline is right, that TUR
14 syndrome in the context of continued monopolar
15 instrumentation wasn't a topic of discussion to be 12:19
16 brought up and resolved?
17 A. Yeah, it's more than surprising. To read this, that
18 Charlie McAllister was aware of TUR syndrome patients
19 and for it not to make it on to our radar, for it to be
20 discussed at the patient safety meeting, I'm -- there's 12:19
21 no good explanation for that. That should have
22 happened.
23 195 Q. Mr. Haynes has said in his statement, if I could just
24 bring it up, please, WIT-53948, and paragraph 69.10,
25 please. He refers to the policy coming down from the 12:20
26 CMO's office, and he explains that, and it goes on in
27 the last line:
28
29 "Mr. O'Brien engaged in a process of assessment of the

1 new bipolar resection equipment - as we've seen.
2 However, he has subsequently expressed the view that he
3 would be continuing to use monopolar resection and
4 glycine, thereby not confirming with the policy."
5 12:20
6 And we've seen that. So, he says:
7
8 "On reflection, this unwillingness to confirm with
9 recommendations from others should have provoked
10 concern regarding wider aspects of his practice, 12:20
11 especially with regards to delivering treatment in line
12 with NICE guidance/MDM recommendations."
13
14 Your observations on that, if I can ask you to focus, I
15 suppose, on this, or these parameters? The Chief 12:21
16 Medical Officer's office is saying it's essential that
17 practice is changed, because this is potentially, even
18 in the hands of an experienced consultant urologist,
19 potentially mortality stuff. There is significant risk
20 with this. And, yet, Mr. O'Brien, it appears, 12:21
21 continued with his old ways?
22 A. Yeah. So, two points I want to make. First of all,
23 there isn't a zero risk with bipolar resection. There
24 still remains the fluid overload risk with bipolar
25 resection. 12:22
26
27 The second point is that this does demonstrate
28 Mr. O'Brien's unwillingness to conform to this policy.
29 And if he continued to resection using monopolar after

1 this, then that was demonstration of his noncompliance,
2 if you like, and it was not the practice of the other
3 consultants in the department.
4 196 Q. I suppose another feature of this transaction is that
5 you say you didn't know, Mr. Haynes seemingly he is 12:22
6 saying he did know, but is regretting not having -
7 reading between the lines - challenged it or realised
8 that it was perhaps indicative of other risk taking
9 behaviours.
10 A. So, I would ask you, or I would, rather, want to 12:23
11 understand how Mr. Haynes knew. So, did Mr. Haynes
12 actively seek out this information? Did he go and
13 review notes? Did he do some form of audit? I'm not
14 aware that he did. I certainly didn't. So, on that
15 basis, I didn't have an awareness of it. 12:23
16 197 Q. Yes. You've said that - you make the technical point
17 that in the context of using saline there's
18 nevertheless still a risk of dilutional hyponatraemia?
19 A. Yes.
20 198 Q. Although that's -- 12:23
21 A. It's a lesser risk.
22 199 Q. Lesser risk.
23 A. Actually there's more risk of fluid overload than
24 dilutional hyponatraemia.
25 200 Q. More of a risk of hyponatraemia? 12:23
26 A. Fluid overload, which therefore can cause problems for
27 the patient's heart and lungs.
28 201 Q. Yeah. The cases that we are aware of, of TUR syndrome,
29 seem to predate the debate that we've just worked our

1 way through. Just for completeness, I'll bring those
2 to the screen. TRU-395973. And this one dates from
3 2011.
4
5 "Patient for TURP subsequently developed TUR syndrome 12:24
6 and is presently in recovery ward on prolonged
7 observation. Staff went through 10 boxes of irrigation
8 fluid and he received 3 units of blood and required
9 cardiology input."
10 12:25
11 Ten boxes of irrigation fluid, is that, in essence, is
12 that the glycine?
13 A. It shouldn't be at that point.
14 202 Q. This is 2011.
15 A. Yeah, but you wouldn't irrigate with glycine after the 12:25
16 procedure.
17 203 Q. Oh, it's after the procedure --
18 A. Yeah. So I'm not sure whether they're referring to
19 sterile water or whether they're referring to normal
20 saline. 12:25
21 204 Q. Yes. And if we go to I think 39597 - let's try 2. No.
22 Let's try 4. 395974. Thank you. And here you have
23 two further cases that have been drawn to our
24 attention. Let's see if we can find the date. Yeah.
25 So one appears to be January 2014 at the bottom and the 12:26
26 other March 2015. If we go across and find the
27 narratives.
28
29 "Patient developing acute severe hyponatraemia during

1 TURP surgery."
2
3 And perhaps you could help us with the - certainly the
4 indication of --
5 A. So the patient had a low sodium presumably on a blood 12:26
6 gas sample. That sodium is concerning at 131.
7 205 Q. Yeah.
8 A. That should alert both the anaesthetist and the surgeon
9 that there's a significant problem. The sodium has
10 fallen from 140, which would be within the normal 12:26
11 range. So that is a significant concern. To me, that
12 would be you need to finish up this surgery very
13 promptly, get haemostasis and stop irrigating with
14 glycine.
15 12:27
16 So the patient was given Furosemide, I see. 15 minutes
17 later a sodium of 122? That is alarm bells!
18 206 Q. Yeah. That's low hyponatraemia?
19 A. Well that's, you know, patients die with sodiums of
20 122. 12:27
21 207 Q. Yes. That was one -- well, in another context we've
22 seen patients die from that.
23 A. Yeah.
24 208 Q. Then the second case is the more recent of the cases,
25 it was again TURP using glycine. At the commencement 12:27
26 baseline was 141, dropping to 138. And then I think
27 130 is generally taken to be - below 130 is generally
28 taken to be --
29 A. So normal levels are serum sodium are 135 to 145. If

1 you see very quick drops in sodium level, that
2 indicates a significant problem.
3 209 Q. Yes.
4 A. So I think two things that you can take from this case
5 is clearly the anaesthetists were monitoring the sodium 12:28
6 in these cases, because without that you wouldn't know
7 those values. So there was point of care testing going
8 on, which was good practice. But to allow a sodium to
9 get down to 122, or not to allow, but for it to get as
10 far as that is profoundly concerning. And, similarly, 12:28
11 for it to go from 141 to 138, that's not a big change.
12 But for it to get to 127, which is clearly well below
13 normal, is a substantial change.
14 210 Q. Yes. I bring those cases out, I suppose, just to --
15 A. Yeah. 12:28
16 211 Q. You did make the point that urologists are keenly aware
17 of the dangers of operating with glycine as an
18 irrigation fluid.
19 A. Yeah.
20 212 Q. Yet and all, we have -- we don't know who the 12:28
21 clinicians were, whether they were experienced or
22 otherwise?
23 A. We know who the clinician is for the second case. He's
24 named.
25 213 Q. Is he? Okay. Regardless of who they are, the thrust 12:29
26 of the CMO's advice, or direction, probably more
27 appropriately put, is reinforced by these cases?
28 A. Yeah. So, if you use glycine as a resection medium,
29 there is a relatively unpredictable risk of these

1 things happening. If you open up a large venous
2 channel, for instance, in doing the resection, and a
3 large amount of fluid is absorbed, you may not be aware
4 of that immediately. And that can have a profound
5 impact on the patient's sodium levels. 12:29
6 214 Q. Could I ask you then, just looking at this through a
7 governance filter, in circumstances - and let's assume
8 this to be correct, subject to anything Mr. O'Brien
9 wishes to say about it, but if he is behaving in a
10 recalcitrant manner and is refusing to observe and 12:30
11 practice in accordance with the direction handed down
12 from the medical director's office, or whoever is
13 responsible for this new standard --
14 A. Yeah.
15 215 Q. -- what should the governance response be, in your 12:30
16 view?
17 A. I think now a better response here would have been to
18 limit the access to glycine. Because then you've no
19 choice, you have to move.
20 216 Q. And if he wishes to continue to practice in the way he 12:30
21 always had, to remove him from that surgery?
22 A. I think, you know, how many times do you have to get
23 your fingers burnt with these cases before you realise
24 that there's a safer way of practicing? It might not
25 have been his fingers getting burnt on each occasion, 12:31
26 but these two patients came to harm.
27 217 Q. I think you've made the point that really this -- if
28 this was a continuing feature of his practice, it
29 should have gone back to the department meeting?

1 A. I think so, yes.
2 218 Q. And given the broader ramifications - and generally it
3 appears that it's the consultants who come along to
4 these meetings, certainly the consultants were those
5 persons in attendance at those meetings -- 12:31
6 A. Yeah, that's correct.
7 219 Q. -- that discussed the instrumentation, it was only the
8 consultants copied into the trialling exercise in
9 Mr. O'Brien's view of it, I think Mrs. Corrigan was
10 maybe in there as well, but was there not a case for 12:32
11 bringing this issue to M&M?
12 A. So, I don't know for sure whether these particular
13 issues that you've on screen now went through our M&M
14 process. I think they're dated - is one of them 2014?
15 Maybe 2015? 12:32
16 220 Q. 2014/2015. Or indeed if Mr. Hagan is right and later
17 cases were reported to him by --
18 A. By Dr. McAllister.
19 221 Q. By Mr. McAllister.
20 A. Yeah. So in this time period they wouldn't have come 12:32
21 through a specialty specific meeting, but they should
22 have come through an M&M, they definitely should have.
23 And if the time period referred to by Dr. McAllister is
24 correct, they should have been coming through our
25 urology specific patient safety meeting. 12:32
26 222 Q. Can I just conclude on the M&M patient safety area by
27 asking you this: You were in the role six years, six
28 and a bit years?
29 A. Hmm.

1 223 Q. How would you assess the importance of the mortality
2 and morbidity Forum in terms of urology services,
3 patient safety output?
4 A. So, it was probably the primary place where that
5 happened. And, you know, it was my view that it was a 12:33
6 very important meeting, and that's why I extended the
7 invite to all the members of the team. I think there's
8 a very valid point about capturing morbidity.
9 Morbidity is not as well captured as mortality.
10 Mortality is a very easy event to note, but morbidity 12:33
11 is more difficult to capture. And these are
12 morbidities. And the regional M&M system that's on
13 NIECR does not facilitate the capturing of morbidity at
14 all. And, therefore, we are left to the discretion of
15 individual clinicians to report morbidity items, 12:34
16 whether they do that by listing them for discussion at
17 a meeting, or whether they complete an IR1, or in some
18 other way bring it to the attention of the teams and
19 the governance structures within the Trust.
20 224 Q. And is that, I suppose, one of the major learnings or 12:34
21 one of the major improvements that you take away from
22 your leadership of that process?
23 A. Yeah.
24 225 Q. You're obviously still a member of the - or an
25 attendee? 12:34
26 A. I am. Active participant is the way I would describe
27 it. So, you know, we have had many discussions about
28 how we try and improve the capture of morbidity.
29 Simple ideas like keeping a morbidity book on the ward

1 and information being recorded, an e-mail address being
2 used to forward morbidity items so that they're
3 captured in that way. But you are reliant on people
4 spotting that something has happened and reporting it.
5 226 Q. To take another example, the consequences -- or, sorry, 12:35
6 complications following post-operative processes. Is
7 that kind of --
8 A. The same applies.
9 227 Q. -- clinically featured? Is there any attempt to corral
10 those kinds of issues and get them in there somewhere? 12:35
11 A. So, again, that broadly falls under the context of
12 morbidity. And unless you are specifically looking and
13 recording complications then you're not going to
14 capture them. So we would have discussions at the
15 patient safety meeting outlining to trainees as they 12:35
16 come into the unit that we - and indeed at the
17 induction - we would outline to them that we want you
18 to report these events, whether that be a wound
19 infection, whether that be a patient requiring
20 transfusion, all of these kind of things are issues 12:36
21 that we need to look at and that we need to make sure
22 that we're addressing appropriately and that patients
23 are receiving appropriate care.
24
25 It also comes down to things like making sure consent 12:36
26 is taken properly, making sure VTE checks are done when
27 patients are admitted to the hospital for procedures or
28 on an emergency basis. There's lots of things that we
29 have regular discussions with all of the doctors in our

1 department about capturing that information.
2 228 Q. I'm struck by, I suppose, the discretion point you make
3 and the informality.
4 A. Yeah.
5 229 Q. It really depends upon, I suppose, the efficiency and 12:37
6 sometimes the goodwill of people picking up on the
7 points and recording them somewhere?
8 A. Yeah. So --
9 230 Q. Have you experience of anywhere where morbidity is
10 tracked somewhat better than that, so that it can flow 12:37
11 on to the agenda in a more formal way?
12 A. I don't, I have to say. I think I'm not aware of a
13 Trust that I've worked in in the past - and, you know,
14 obviously I have worked in this Trust for 11 years now
15 - I'm not aware that the Trusts that I trained in had 12:37
16 better systems for capturing this at that time. They
17 may do now, but not when I was there.
18 231 Q. Yes. I think you referred yesterday, or I referred you
19 to the point you make that patient outcomes and the
20 data around that is now perhaps more very recently 12:37
21 beginning to be used, is that the kind of stuff that's
22 --
23 A. Yeah. So I think there are other specialties that we
24 can learn from. Orthopedics have had patient related
25 outcomes for a long time, and I think that that's 12:38
26 something that we could definitely, as a specialty,
27 adopt and adapt to our needs. You know, the Trust
28 could invest in very simple things like surveys of
29 patients to ask them what has happened every time

1 somebody comes into the hospital, you know. How was
2 your experience? Did you have a complication? Well,
3 the patient is going to tell you if they had a
4 complication. So there's a very easy way of picking up
5 morbidity, you know. 12:38
6
7 There are other safety systems that other Trusts that I
8 have worked in have used such that you cannot get to
9 theatre if your VTE assessment is not completed. You
10 cannot prescribe medication on the system unless you 12:38
11 have put in the patient's weight and their VTE status.
12 So, these are safeguards that are built into the system
13 to allow safe practice.
14 232 Q. Obviously you've described where you tried to take M&M?
15 A. Yeah. 12:39
16 233 Q. You brought, I suppose, additional information on to
17 the agenda, you made the agenda more flexible and more
18 open. I suppose in terms of measuring the success or
19 the journey of the M&M in your hands, and handing it
20 then over to Mr. O'Donoghue, do you think it's a more 12:39
21 successful, by whatever indices, forum for looking at
22 patient safety issues than it was when you took it on,
23 and were you stymied or restricted in any way in where
24 you would have wanted to have developed it? I mean,
25 you've made the morbidity point, so -- 12:40
26 A. So, the specialties specific meeting didn't exist
27 before I started that in 2015 at the request of
28 Dr. Simpson. But certainly the specialty specific
29 meeting, in my view, was a much more conducive

1 environment to learning and discussing cases in an open
2 and transparent manner than what had went before, which
3 I described to you yesterday as a most combative and
4 unfriendly environment for learning.
5 12:40
6 So, in that regard, what we have had since 2015 is much
7 better. Where the difficulties lie is translating what
8 we know we need to do into policies, actions, embedded
9 practice, to make sure things are as safe as they can
10 be. 12:41
11 234 Q. Okay. Thank you for that. We're going to move on now
12 and spend some time looking at the operation of the
13 multi disciplinary team in urology. And that's going
14 to take us across a number of the challenges you faced:
15 Quoracy, and then - for example. And then in to some 12:41
16 of the issues that have arisen as part of the 2020/21
17 SAIs, the Bicalutamide issue, other issues such as the
18 nursing issue and what have you. So, let's start that
19 now.
20 12:41
21 If we can commence by, I suppose, reminding ourselves
22 of a document we pulled up, I think, during the
23 scene-setting phase of the Inquiry last autumn,
24 WIT-84532. And the panel will remember, hopefully,
25 this document, which is the Urology/Cancer MDT 12:42
26 Operational Policy. It contains all sorts of
27 directions and missives for the conduct of this MDT.
28
29 It says, if we just go to 84535, that's WIT-84535, we

1 have something of an outline of the purpose of the MDT.
2 It's again helpful to remind ourselves of that. They
3 bring together staff with the necessary knowledge,
4 skills and experience to ensure high quality diagnosis,
5 treatment and care for patients with cancer. And it 12:42
6 goes on to say:
7
8 "The primary aim is to ensure equal access to diagnosis
9 and treatment for all patients. In order to achieve
10 this, we aim to provide a high standard of care." 12:43
11
12 And some broad, high level principles. But, in
13 essence, this was a forum, a meeting, a team, a
14 versatile team wearing different hats, so that - and by
15 that I mean different disciplines. 12:43
16 A. Yes.
17 235 Q. To enable accurate decision-making to be made around
18 diagnosis and future care.
19 A. That's correct.
20 236 Q. And you were its lead clinician from 2016, and you 12:43
21 still are. You took over that role from Mr. O'Brien?
22 A. Yeah, I think it was October or perhaps November of
23 that year.
24 237 Q. And you've explained that all cancer cases are
25 presented. 12:44
26 A. Yes, that was the policy.
27 238 Q. And it meets weekly. And I think you added, your
28 statement says "four consultants chairing in rotation".
29 That's recently changed?

1 A. So at the time of writing that, that was correct.
2 Mr. Tyson, who is one of our colleagues, has stepped
3 back from that, and there are now three consultants
4 rotating the Chairmanship.
5 239 Q. And you've explained that one of the advantages of 12:44
6 rotating the Chair is that it allows oversight of the
7 practise of all colleagues and permits challenge and
8 discussion?
9 A. Yeah.
10 240 Q. Does that mean that as Chair, you are responsible for 12:44
11 taking the patient's chart and relevant notes and
12 reading, as best you can, in the time allowed to you,
13 the background to the case?
14 A. So, I suppose a little bit of background to how this
15 developed is helpful. 12:45
16
17 So, prior to Mr. O'Brien being the Chair of this
18 meeting, there was a colleague called Mr. Akhtar who
19 Chaired the meeting when it was set up, and I
20 understand that the practice at that time was for the 12:45
21 person who was Chairing the meeting to present all of
22 the cases. So that became very onerous for Mr. O'Brien
23 when he was the Chair, because clearly to do that every
24 week was a big workload, and he would do it
25 meticulously, he would spend a lot of time preparing 12:45
26 the cases. So, when I joined the MDT, and laterally
27 when Mr. Haynes and Mr. O'Donoghue joined the MDT, we
28 came to an agreement that rather than Mr. O'Brien
29 Chairing every meeting, that we would rotate the Chair.

1
2 So, that's how it came about. It meant that in turn we
3 would each proportionately take a meeting, we would
4 prepare the cases. Originally we would have had the
5 paper notes available, and then the Trust decided, for 12:46
6 some reason which I can't recall, that they wouldn't be
7 providing the notes. But by that stage NIECR had
8 become available and, broadly speaking, the vast
9 majority of the information that we needed to conduct
10 the meeting was available on NIECR, so it didn't seem 12:46
11 that we really needed the paper notes.
12
13 So, we would have prepared the cases in advance, and
14 the Chairperson on the day would lead the discussion
15 and would open the discussion up then to the other 12:46
16 members of the team to add their input, and that then
17 would allow us to formulate a management plan which the
18 cancer tracker would record.
19 241 Q. And as Chair, would you review the cases, I suppose the
20 night before the MDM, so that you had immediate, I 12:47
21 suppose, familiarity --
22 A. So, we had a cutoff agreed, which was - I think it was
23 midday on Tuesdays. And the cancer tracker would then
24 provide the list of patients and the summaries from the
25 CaPPS system to the person who was Chairing the 12:47
26 meeting. Ideally we would have liked to have received
27 that on Tuesday afternoon, but frequently it didn't
28 arrive until Wednesday. So that meant for the majority
29 of us we spent Wednesday evening preparing the cases.

1 242 Q. And help me with this: Your role as lead on the MDM or
2 for this multi disciplinary team --
3 A. Yes.
4 243 Q. -- what duties does that entail, obviously over, above
5 and separately from that of Chair? 12:47
6 A. So, there are duties listed in this operational policy
7 which you will see. But I suppose one of the
8 criticisms I would have, and the point that I've made
9 in my statement to the USI, is that there's no job
10 description provided for this role, there was no 12:48
11 training provided for this role at the outset.
12 244 Q. We can go to the guidelines, but in a nutshell, the
13 lead --
14 A. So, I was really responsible for the smooth running of
15 the meeting, ensuring that the people who should be 12:48
16 there were there, ensuring that we had safe processes
17 in place, ensuring that there was a degree of quality
18 assurance as to what was happening. They were the kind
19 of responsibilities that I had.
20 245 Q. Yes. 12:48
21 A. And remain those responsibilities.
22 246 Q. And I suppose we'll see it in a moment, but to take a
23 very specific example, an endemic problem with this MDT
24 was the quorate issue?
25 A. Yes. 12:49
26 247 Q. Radiology and oncology.
27 A. Yeah.
28 248 Q. And so it fell to you to at least identify the problem
29 and, as we'll see, we'll go into it in a wee moment,

1 but to take that on and try and get it resolved by
2 those who were in a position to resolve it?
3 A. Yeah. That problem had already been clearly identified
4 before I took up the lead clinician role for the MDT.
5 249 Q. Yes. But it's those kinds of issues that fall within 12:49
6 the unwritten job description of the lead?
7 A. Yeah, it's a responsibility the lead would have.
8 250 Q. Yeah. And your experience of this MDT in Craigavon can
9 be juxtaposed or compared with your experience of,
10 albeit as a trainee, of the forum in your previous 12:49
11 place of work, West Midlands?
12 A. So, I worked in a variety of settings. I worked in
13 large university teaching hospitals, I worked in one
14 particularly small DGH, and I worked in other units
15 providing the full gamut of urological surgery, 12:50
16 everything from pelvic surgery, RPLNDs, you know,
17 kidney surgery, complex penile cancer, all of that, I
18 had all of that experience from my training in the West
19 Midlands. And the MDT structure was, in my view,
20 better supported from an administrative perspective, 12:50
21 but it was also - most of the MDTs were perhaps bigger
22 than our group. And that had benefits, because it
23 meant that, for instance, you would have two to three
24 radiologists attending the meeting, you would have two
25 pathologists, you would have lots of surgeons, lots of 12:51
26 oncologists. So you had lots of staff, particularly at
27 the bigger Trusts, where they had urology cancer MDTs.
28
29 In the smaller Trusts it was a challenge, and I recall

1 in the small DGH that I worked in as a first year
2 trainee that they faced similar issues to those that we
3 face, in that if their radiologist was absent, they
4 weren't quorate either.
5 12:51
6 There was a more well developed network structure in
7 the West Midlands for cancer care at that time that I
8 recall, such that when I worked in Wolverhampton, they
9 were networked with both Stoke and with Shrewsbury.
10 Stoke was actually a very large Trust, and I had worked 12:51
11 there prior to - at an earlier stage in my career as
12 well. So, what you had was a sizable number of
13 clinicians inputting into the MDT, with multiple
14 specialists giving their expert opinion and, you know,
15 that seemed to work well, particularly for things like 12:52
16 the pelvic oncology cases, it seemed to work well to my
17 point of view, from my observation.
18 251 Q. I'm struck by some of the observations which Dr. Hughes
19 and Mr. Gilbert made about the, I suppose the resource
20 shortcomings of Craigavon's MDT. I'll not put it up on 12:52
21 the screen, but just to summarise - I'll give the page
22 reference numbers; DOH-00123, they reflect that there
23 was no mechanism to check or track that actions were
24 implemented. That's the actions arising out of the
25 MDM's discussion and recommendation. 12:53
26 A. Yeah.
27 252 Q. They say at 00124 that it was underresourced for
28 appropriate patient pathway tracking, that tracking
29 only related to diagnosis and first treatment, and

1 expressing concerns about the role, the triumvirate,
2 and whether they worked well together, the tracker, the
3 consultant and the secretary.
4
5 At DOH-00127, they point out the limited assurance 12:53
6 audits of patient pathways at the Craigavon MDT.
7
8 Are those expressions of concern, are they concerns
9 that you identify with and didn't need to be told that
10 they were lacuna in how you were doing business, 12:53
11 because you knew about the need for that kind of
12 support from elsewhere, or do you reflect that perhaps
13 these are exercises in resource perfection and you
14 didn't have those resources and few people had those
15 resources? 12:54
16 A. I think you've termed that very well "resource
17 perfection". So, my reading of that was that we knew
18 that the tracking only went to first definitive
19 treatment. We understood, we discussed that that was
20 a problem. It would have been much better if tracking 12:54
21 was extended beyond that and resourced beyond that.
22 But it wasn't, because we'd already explored that.
23
24 Dr. Hughes was coming from a perspective, as I
25 understand it, that he had been a medical director in 12:54
26 another Trust and he had also been, I think, a NICaN
27 lead at one point in time. And he should have been
28 very well aware that tracking in the Trusts here was
29 only resourced to first definitive treatment.

1
2 Now, he may have made different decisions in the
3 Western Trust as to how to resource their tracking, and
4 he may well have done that, I'm not aware, but I think
5 that's where he was coming from. 12:55
6
7 I've maybe lost the second point. Oh, yeah, the
8 quality assurance about whether MDT outcomes would have
9 been adhered to.
10 12:55
11 So, at the time, as a group we would agree the MDT
12 outcome for each individual patient. That would be
13 spoken out loud in the room, the tracker would record
14 that, and then the tracker would type that information
15 into CaPPS, usually at a later time, and that would be 12:55
16 provided to the person who Chaired the meeting to
17 review the outcomes as they had been recorded for
18 factual accuracy. And once that had been agreed, that
19 would go back to the tracker to be circulated out to
20 the whole MDT and that would then allow the CaPPS 12:56
21 letters to be generated to the GPs and they would be
22 posted out to the GPs.
23
24 So, that's how that happened. So that was that bit of
25 quality assurance to make sure that the outcomes were 12:56
26 correct as discussed at the meeting.
27
28 Now, it comes then to whether or not individual
29 clinicians adhered to the outcomes when they met the

1 patient. We now have in place, in very recent times,
2 less than the last 12 months, support available within
3 cancer services whereby we run a random audit of
4 whether or not outcomes have been adhered to. That
5 information is brought back to the MDT and shared with 12:56
6 the MDT. I also receive that report as the lead
7 clinician, and if there are cases that don't appear to
8 match what the outcome was, then those cases are
9 addressed on an individual basis.
10 253 Q. Thank you. And this afternoon we'll look at some of 12:57
11 the particular cases where perhaps this recent
12 introduction or recent solution may have been helpful
13 at the time.
14
15 Just a couple of points before we break for lunch. You 12:57
16 regarded, or it was recognised, I suppose is a better
17 way to put it, that the Clinical Director for cancer
18 services was, in essence, your line manager, or the
19 person to report to as lead clinician?
20 A. -- the cancer MDT, yes. 12:57
21 254 Q. Yes. And you have reflected that there was a
22 disconnect between that Clinical Director and the
23 urology cancer MDT?
24 A. Yes. And I think that was also reflected by
25 Dr. Hughes. 12:58
26 255 Q. Yes. And he said at DOH-00127 that there was no
27 functioning process within cancer services to at least
28 be aware of the concerns of the MDT. You're looking a
29 little bemused by that. Do you think there was a

1 functioning process but it just wasn't used or
2 activated by the Clinical Director?
3 A. So, we may come to this in later evidence, but I
4 brought issues of concern to the attention of the
5 Clinical Directors responsible and their shrug of the 12:58
6 shoulders attitude was remarkable.
7 256 Q. Yes. And I think -- you say the shrug of the
8 shoulders, at least you communicated it in those terms,
9 I think, to Dr. Hughes in the context of quorum?
10 A. Okay. Well, at least I'm being consistent. 12:59
11 MR. WOLFE KC: Yes. And maybe that's a useful point to
12 break.
13 CHAIR: Spot on one o'clock. We'll come back then at
14 two o'clock everyone.
15 12:59
16 LUNCHEON ADJOURNMENT
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1 THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON
2 ADJOURNMENT
3
4 CHAIR: Good afternoon everyone. Mr. Wolfe.
5 MR. WOLFE KC: Two housekeeping points before we start, 14:05
6 Chair, if I may?
7
8 First of all, with due apologies to Mr. Glackin, it
9 seems unlikely that I'll be finished with his evidence
10 this afternoon and from his point of view, I suspect 14:05
11 unfortunately, or regrettably, he will have to come
12 back. And I think we're trying to line up 19th
13 October. The doubt at the minute is to whether
14 Mr. Glackin can come in the afternoon of the 19th. I
15 suspect I will need him to come in the afternoon, or at 14:06
16 least I will need a second session on top of a morning
17 session. So, we'll resolve that behind the scenes.
18
19 The second point is this: Mr. Lunny properly and fairly
20 drew my attention to a concern in terms of my 14:06
21 presentation of the issue around the bipolar, or
22 monopolar instrument. And I think it is fair to say
23 that I may have unfairly created the impression that
24 the state of the evidence is that Mr. O'Brien continued
25 to resect in glycine after new equipment was purchased. 14:06
26 The evidence by no means goes that far at this stage.
27 And if I did create that impression, and I may have
28 done so, then I wish to correct that.
29

1 The matter can be precisely resolved, I would have
2 thought, by taking it up with a combination of
3 Mr. O'Brien, Dr. McAllister and Mr. Haynes in further
4 notices, or orally, if it comes to that. So hopefully
5 that's enough said on that point. 14:07
6 CHAIR: Yes, I think we appreciated that that could be
7 an impression that was left. But it certainly wasn't
8 our understanding, and I know it wasn't your intention
9 to do so.
10 MR. WOLFE KC: Yes. I know Mr. Haynes made the point 14:07
11 he did in his statement and I read from that. That
12 assertion that he made could belong to the period
13 before the equipment was purchased and not necessarily
14 after.
15 CHAIR: Equipment. Yes. 14:07
16 MR. WOLFE KC: And we'll have to clarify that with him.
17 And Mr. O'Brien will, of course, be able to contribute
18 to that as well.
19 CHAIR: Thank you.
20 MR. WOLFE KC: And perhaps Dr. McAllister. 14:07
21 So, without further ado, Mr. Glackin, we'll get into
22 the quoracy issue.
23 A. Yes.
24 257 Q. One of a series of issues around the MDT which I want
25 to explore with you this afternoon. I suppose we've 14:08
26 had evidence around the quoracy issue already. The
27 contours of it are reasonably well defined in the
28 Inquiry's mind, I suspect. But could I start by asking
29 you some general questions about the importance of

1 quoracy, the implications of a non-quorate meeting, an
2 non-quorate MDT meeting in urology, and what was your
3 thinking or concerns around that in live time over that
4 period of, I suppose, five years before we had the 2020
5 SAIs that drew attention to it? 14:08
6 A. So, where one of the disciplines was absent from the
7 meeting, be that ordinarily it was either radiology, or
8 medical or clinical oncology, it meant that on
9 occasions we had to defer discussion of individual
10 patients. So that led to a delay in their care. It 14:09
11 also made us very uneasy about making decisions,
12 particularly when radiology was absent. Because we're,
13 as urologists, very experienced at looking at scans
14 from a urological perspective, but what's to say that
15 if we looked at a scan we would pick up the other 14:09
16 things that the radiologist is actually expert at
17 picking up all of those things?
18
19 So, we had a hesitancy about progressing cases without
20 the input of the radiologist in particular. 14:09
21
22 Lots of the core work of the urology MDT is about cases
23 which are straightforward, there is no real debate as
24 to what needs to happen, the guidelines are very
25 straightforward. And in that respect, many of the 14:10
26 cases did not require the input of the clinical
27 oncologist or the medical oncologist, they were purely
28 urological management, and those cases could be
29 progressed.

1
2 But there were cases where the input of both the
3 medical and clinical oncologists would have been
4 valuable. And without them -- and there were prolonged
5 periods where we had no input from those services - we 14:10
6 would either have to defer the case or we would have to
7 shoehorn it in perhaps somewhat inappropriately into
8 the specialist MDT with which we linked virtually by
9 videolink. And over time, reasonably fairly in my
10 view, they became dissatisfied with that. 14:10
11
12 But it was a function of the fact that we were not
13 being provided with the service from the centre.
14 258 Q. And it appears on, perhaps on your description and the
15 others - I've now, at this time of the afternoon, 14:11
16 forgotten the name of the radiologist we've heard from.
17 Dr. Marc?
18 A. Dr. Marc Williams.
19 259 Q. Williams. I am very grateful. Is this another
20 example, in your view, of a required governance feature 14:11
21 of the process, in other words the need for these multi
22 disciplinary disciplines to be in one place, meeting
23 the immovable object of a lack of resources, or is that
24 how it was portrayed to you?
25 A. I fully recognise the difficulties that Trusts have 14:11
26 recruiting and employing specialists. That is
27 applicable to uro-radiology in particular. It's also
28 applicable to medical and clinical oncology. It's also
29 applicable to urology. So, we were in a situation

1 whereby the Southern Trust did not directly employ the
2 clinical oncologist, for a short period they employed
3 an acute oncologist who had a medical oncology
4 background, but other than that it was not within our
5 gift to provide the oncology service. We had 14:12
6 longstanding recruitment issues in radiology. For a
7 period we did have two consultant urologists attending
8 the meeting. One of them left the employment of the
9 Trust. That left Dr. Williams on his own.
10 Dr. Williams, in my view very correctly identified that 14:12
11 as a risk, escalated that to his managers. He
12 discussed that with us as an MDT. We fully appreciated
13 where he was coming from. We appreciated that as a
14 sole practitioner at the MDT he would be open to
15 criticism if he gave an opinion and there was no other 14:12
16 opinion available. So, we were alert to these issues.
17 260 Q. Is it the case that any decision-making was compromised
18 due to the absence of either discipline, or was it, in
19 the alternative, the general approach to delay
20 decision-making and thereby delay care in cases where 14:13
21 you needed these inputs?
22 A. I think it was delay more than anything else. There
23 was a period where we had a practice, when we knew that
24 we couldn't be quorate, of doing what was described as
25 a virtual MDT. Now, when I took over as Chair, I very 14:13
26 quickly realised that all the issues that Marc Williams
27 had raised were applicable to that situation and we
28 ceased that practice. Because what you had was a
29 situation of one of us reviewing ECR prior to the

1 meeting, agreeing what outcomes would be, and then
2 progressing the cases that could be progressed.
3
4 Now, that may work very well when the information is
5 indisputable and when the pathways are very clear, and 14:14
6 indeed we have developed, and I know the Belfast Trust
7 have explored developing protocolised care. And that's
8 fine. But you have to have some form of quality
9 assurance for the protocolised care, and that wasn't in
10 place. 14:14
11
12 So I felt that that practice would be open to
13 criticism, and for that reason we stopped it.
14 261 Q. I want to draw your attention to something that's, I
15 suppose, recorded against your name. And I think the 14:14
16 sentiment rings true in light of something -- something
17 you said earlier. I'll just bring it up. WIT-84349.
18 And let me see if I can find it. It records... Yeah.
19 So it's just about a third of the way down there.
20 Sorry, just to orientate us, 18th February 2021, 14:15
21 Dr. Hughes came along to meet with members of the MDM
22 --
23 A. Yes.
24 262 Q. -- as part of his conversations, information gathering
25 in association with the SAIs, which were just about to 14:15
26 be finalised in the month or so that followed. And
27 he's asking you, I think he's asking you:
28
29 "Dr. Hughes advised he had spoken to AD in cancer

1 services who was not aware of the issues."
2
3 You say, or you're recorded as saying you advised that
4 you, or they:
5 14:15
6 "...did bring issues of concern a number of years ago.
7 Their reaction was a shrug of shoulders and said "what
8 do you want us to do?"."
9
10 A. Yeah. 14:16
11 263 Q. Now, I know we talk at meetings in sort of colourful
12 terms, but does that capture the sentiment that you
13 brought issues of concern around quoracy, you and
14 others brought issues of concern around quoracy to the
15 clinical directors for both radiology and cancer 14:16
16 services, and the response that you received was less
17 than constructive?
18 A. That's correct.
19 264 Q. And I just want to, in fairness, give you an
20 opportunity to respond to, I take it to be something of 14:16
21 a criticism from Dr. Hughes. When he came to give
22 evidence he said:
23
24 "I think there's a very clear pathway. I think that
25 should have been escalated to the cancer services and 14:16
26 the AMD for cancer services. This should have been
27 taken to the Chief Executive or the Medical Director in
28 the first instance."
29

1 So the reference is TRA-01957. Do you think you did
2 everything in your power as lead to the MDM to try and
3 address these issues?
4 A. So I think Dr. Hughes' view is coloured by his
5 experience of being a medical director. My experience 14:17
6 as a clinician on the ground was that the people who
7 were responsible for this service were the head of
8 service, who was Fiona Reddick, who was incidentally
9 partaking in this exercise. She was well aware of
10 these issues. 14:17
11
12 Secondarily, I brought it to the attention of the CD
13 for cancer services, who was Mr. McCaul. I had an
14 informal conversation with him. I backed it up with
15 e-mail. 14:17
16
17 So, the people who were responsible for the service
18 from my perspective were informed.
19 265 Q. Yes.
20 A. Secondarily, I also brought it to the attention of the 14:18
21 radiology CD. And I appreciate the issues that they
22 have in recruitment, and that's very real for them, but
23 it was important that they understood that we weren't
24 quorate and that we were having a problem as a
25 consequence. 14:18
26 266 Q. Yes. And just to enable you to support the point I
27 think you've just made, your engagement with
28 Mrs. Reddick, head of cancer services, WIT-57924. So,
29 this is January 2017, and you're saying to her:

1
2 "Can I meet with you to discuss ongoing problems with
3 quoracy at the MDM? Urologists are coming to the view
4 that this meeting is no longer sustainable in view of
5 the pressures on our single handed radiologist and the 14:19
6 infrequent oncology attendance."
7
8 So, it was pithy and to the point and forceful to the
9 point of saying "Listen, this committee is being
10 jeopardised", or its sustainability is being 14:19
11 jeopardised?
12 A. This was just plain speaking, telling them where we
13 were. This wasn't something new. Fiona Reddick was
14 fully aware of this issue. You can see the other
15 people who were copied in. You know, these were 14:19
16 decision makers within the Trust.
17 267 Q. Yes. If we go just to the, I think the end of that
18 month, AOB-78680. And just to the bottom of the page,
19 please. So, this is Mrs. McVeigh copying others in,
20 giving you the news that Dr. Williams won't be at MDT 14:20
21 until 2nd March. So, you've got three or four meetings
22 before 2nd March, I suspect?
23 A. Yes.
24 268 Q. And he's the single handed radiologist?
25 A. I think that's correct at that point in time, yes. 14:20
26 269 Q. And you respond - again, if we scroll up the page,
27 please, going to Fiona Reddick and saying "We're at the
28 point of closure". Plainly, you never closed down the
29 meeting. And just, I suppose, is that kind of a little

1 bit of hyperbole to get the point across that really
2 this is unsustainable?
3 A. Well, you had -- I'm in this job, well maybe two to
4 three months at this point of view. These issues have
5 been going on while Aidan O'Brien had been Chairing or 14:21
6 lead clinician for the MDT. It hadn't been resolved.
7 We are clearly identifying that there's an issue, that
8 we're not quorate. That has obvious patient safety
9 issues. You know, how much more forcefully can I tell
10 the management that this is where we're at? 14:21
11 270 Q. And it goes on, of course. I'm, in the interests of
12 brevity, stepping through some of the correspondence
13 around this, no doubt there's more conversations, and
14 if you need to say more to the point, then do so. But
15 let me just bring you, finally in terms of the 14:22
16 correspondence, to WIT-4250. As I say, we're in the
17 late November 2018 at this stage. And on 26th November
18 you e-mail... WIT-4250. Thank you. Scrolling down
19 until we get to the start of this. So, you're writing
20 about radiology presence and you're explaining that 14:22
21 since the departure of Dr. McClure, Dr. Williams has
22 been the sole radiologist attending. And due to other
23 clinical priorities, he hasn't been able to attend
24 every week. And he explained in his evidence to the
25 Inquiry why that was unavoidably the case. And 14:23
26 underlined in bold:
27
28 "I am seeking your advice on how we should proceed
29 until such time as a radiologist can attend all

1 meetings."
2
3 A different recipient of your correspondence this time,
4 Dr. Imran Yousuf.
5 A. Yes. 14:23
6 271 Q. Was he the Clinical Director for Radiology?
7 A. CD for Radiology, and David McCaul, CD for cancer
8 services.
9 272 Q. Yes. And we can see, scrolling up, his response. I
10 suppose it's stating the obvious resources point. He's 14:24
11 aware of the situation:
12
13 "We do not have any other radiologists who feel
14 competent to cover urology MDT."
15 14:24
16 And he expresses that there's a big workload associated
17 with it, which you know, and he's expressing the view
18 that he's hoping to find ways to reduce Marc's other
19 clinical commitments to try to improve the situation.
20 And I think Dr. Williams, I suppose spoke to that as 14:24
21 well; there was some effort on the part of Dr. Yousuf
22 to try and allow him to put to one side his other
23 radiological clinical commitments and more often come
24 to the Thursday MDM. But your experience was that it
25 was piecemeal improvement? 14:25
26 A. The data would confirm how many meetings Dr. Williams
27 was able to attend. I can't quote that off the top of
28 my head.
29 273 Q. Yeah.

1 A. But Dr. Williams, in my view, made every effort that he
2 could to be available for the meetings.
3 274 Q. Yes. And if we scroll up. David McCaul, as you say,
4 was CD of cancer services?
5 A. (Witness Nods). 14:25
6 275 Q. And a fairly pithy response from him. So, no further
7 on. And did this essentially continue to be an issue
8 until relatively recently?
9 A. Well, I wouldn't call it pithy, I'd call it inadequate.
10 276 Q. We know, if we pull up the stats for last year, 14:26
11 WIT-24251, for the first half of last year. And
12 counting these meetings up in the darkness of last
13 night, I think I got to 21 meetings across those first
14 five months of the year. And it would appear, if my
15 trembling finger count is correct, that there were 12 14:26
16 meetings, looking down the red, which weren't quorate,
17 as recently as 2022. I understand that there has been
18 improvement in recruitment of a radiologist?
19 A. Yes. So, there is an issue about how quoracy is
20 counted, okay? And I'll explain that in a moment. But 14:27
21 we now have the situation where we have two
22 radiologists, and that has helped a lot. We are also
23 in the position where we have a single clinical
24 oncologist linking in from Belfast, and her attendance
25 is probably in the order of high 70s to 80%. We have 14:27
26 two medical oncologists, one who usually physically
27 attends the meeting and the second person links in by
28 video. So, those aspects have improved.
29

1 However, when you count quoracy, you have to count all
2 the core members. And if one of those core members is
3 absent, you're not quorate that week. So, as you can
4 see from the top line there, on that particular week
5 there was no clinical oncologist. So, technically we 14:27
6 are not quorate.
7
8 Quoracy has never really been an issue for pathology,
9 urology, clinical nurse specialists, and the tracker,
10 the coordinator. So really the quoracy issues lie in 14:28
11 radiology and oncology.
12 277 Q. And, of course, one always will anticipate that there
13 will be a meeting here and there where one of those
14 disciplines can't attend.
15 A. Yeah. 14:28
16 278 Q. And you've explained the setback that that causes in
17 terms of some cases. Because, as you say, you don't
18 necessarily need an oncology discussion around every
19 case, or for that matter a radiology discussion around
20 every case? 14:28
21 A. That's correct.
22 279 Q. But I'm just trying to assist the panel to gauge where
23 we're at now in 2023.
24 A. We're in a stronger position, but we are reliant on a
25 single clinical oncologist. And if that person is 14:29
26 sick, or that person takes leave, then we don't have
27 their valuable input.
28 280 Q. I want to move now to more practical issues or practice
29 issues around the MDT. And when - help me understand

1 the culture of this MDT.
2 A. Mm-hmm.
3 281 Q. The impression to be formed from your evidence so far
4 is that a lot of the cases, maybe you could put a
5 percentage on it, are uncontroversial, don't require 14:29
6 any debate, require maybe a little bit of discussion,
7 and then on to the next one?
8 A. Yeah, I think that's probably true for perhaps 70% of
9 the cases. Because if you're talking about non muscle
10 invasive bladder cancer, low and intermediate risk 14:30
11 prostate cancer, they don't really take an awful lot of
12 discussion. The cases that need discussion are perhaps
13 things like the higher risk prostate cancers, higher
14 risk bladder cancer, some of the kidney cancer requires
15 discussion in our local meeting and then, you know, 14:30
16 things like pelvic oncology, complex kidney cancer
17 surgery, that's all referred through to the specialist
18 MDTs. Penile cancer really only touches our MDT in
19 terms of noting that we've had a histology now, because
20 that all goes directly to the team at the -- 14:30
21 282 Q. Yes.
22 A. -- Northwest Cancer Centre. And the final thing then
23 I think was testis cancer.
24 283 Q. Yes.
25 A. So testis cancer again really only touches our team in 14:30
26 terms of it getting discussed and staging organised,
27 and that's referred to a specialised MDT which is
28 hosted in the Belfast Trust.
29 284 Q. Some of those cases obviously came up as part of the

1 SAIs?
2 A. Yeah.
3 285 Q. And I want to just test with you your reaction to the
4 practice issues that were raised with those. But let's
5 start with the Bicalutamide issue. 14:31
6
7 Could I ask you this: If the MDT recommends androgen
8 deprivation therapy, do you have a standard method of
9 prescribing - or maybe method is the wrong word - do
10 you have a standard product approach to it? 14:31
11 A. Yeah. I do. My standard approach for initiation for
12 patients with metastatic disease is that I would
13 typically request the GP to administer an LHRH
14 analogue. So we now - we have a standard letter, it
15 describes the duration of Bicalutamide 50 for flare 14:32
16 cover, and it also describes the LHRH analogue that we
17 would wish the GP to initiate.
18
19 In certain cases where patients are at a high risk of
20 spinal cord compression, we would initiate a medicine 14:32
21 called Degarelix. And that, I think, is an accepted
22 approach to managing that. So that's an alternative to
23 that.
24
25 I think ADT is quite a loose term, and we have 14:32
26 recognised that within our own meeting. And our
27 outcomes now, we would try to ensure that, rather than
28 using the term "ADT", we would specify LHRH analogue,
29 so that there is no doubt and no ambiguity as to what

1 the MDT is recommending.
2
3 Now, the other issue regarding that is that patients
4 who are going for curative treatment with radical
5 therapy, with radical radiotherapy for prostate cancer, 14:33
6 those patients will require a period of androgen
7 deprivation therapy prior to radiotherapy. So the
8 practice in our department or in our meeting now is to
9 ask Dr. Baird, who is the clinical oncologist, what her
10 preference would be, whether she wants us as the 14:33
11 urologist to initiate treatment with the patient when
12 we meet them in the first clinic after MDT, or whether
13 she would prefer that we leave that discussion to her
14 when she meets the patient at her clinic.
15 286 Q. Sorry, is that a recent development? 14:33
16 A. Fairly recent. And Dr. Baird would give her guidance,
17 she would say "I would like you to do this" or "I would
18 like you to do that", we would note that in the minutes
19 of the, or in the summary for the patient. So it may
20 be the case that we would initiate an LHRH analogue for 14:33
21 that patient on her advice.
22
23 You may be aware that as from the evidence given by
24 Prof. O'Sullivan yesterday, that some patients who go
25 on to have radical radiotherapy for prostate cancer 14:34
26 have Bicalutamide 150mg. That's largely a decision of
27 the treating clinical oncologist.
28 287 Q. And is that not common, but is that --
29 A. Well, actually I think it's fairly common. We would

1 see a lot of patients that are treated by our colleague
2 Dr. Baird who will have had 150mg as their androgen
3 deprivation therapy around their curative radiotherapy
4 for prostate cancer.
5 288 Q. And is the indicator for 150 Bicalutamide cases where 14:34
6 there's a risk or presence of metastatic disease?
7 A. No, if they're metastatic you would be using - you
8 wouldn't be likely giving them radiotherapy with that
9 intent. And, secondly, you'd probably be giving one of
10 the other agents, the LHRH or the Degarelix. 14:34
11 289 Q. Yes. Yes. And prior to this facility through
12 Dr. Baird, if you had a recommendation through MDM,
13 consented with your patient in a review after MDM for
14 ADT or LHRH analogue, plus referral for radical
15 radiotherapy with curative intent, when would you be 14:35
16 thinking of making the referral?
17 A. So, there are two ways that that referral can be made.
18 There is a facility to make what's known as a direct
19 referral at the time of the meeting. So, that referral
20 is made over the videolink. We would say to Dr. Baird: 14:35
21 "Dr. Baird, I'd like to make a direct referral for this
22 patient." We would have reviewed the case, and through
23 the imaging, the staging, and she would say "Yeah,
24 that's fine, I will see that patient." So, she has
25 accepted at that point that she will be seeing that 14:35
26 patient. The tracker transfers that patient to the
27 Belfast Trust.
28
29 So, I think the name of that process is ITT, Intertrust

1 Transfer. So that's completed.
2
3 The second part of that is that it would be my
4 practice, when I meet the patient - because they will
5 not have been informed of this at that point - when I 14:36
6 meet them in my clinic I will say to them, you know,
7 "We're referring you on to Belfast for consideration of
8 external beam radiotherapy", the patient will be
9 provided with written information about their treatment
10 and diagnosis, they will be told that it will be 14:36
11 Dr. Baird that I will be sending them to, and as well
12 as that, I would then dictate at the clinic a summary
13 of the care so far, so that when Dr. Baird sees the
14 patient it's all laid out there for her.
15 290 Q. One of the practices of Mr. O'Brien which we have 14:36
16 observed through some cases, and I'll refer you to the
17 Trust's audit presently, is the use of Bicalutamide 50
18 as a , apparently as a monotherapy.
19 A. Yeah.
20 291 Q. Is that a practice that you would subscribe to in any 14:37
21 situation?
22 A. Okay. Well, I know that you've said "any situation",
23 and we may come to that, but it is not my practice to
24 initiate Bicalutamide 50mg as monotherapy. I have on
25 very few occasions used Bicalutamide 150 as monotherapy 14:37
26 in patients who have been started on an LHRH analogue
27 and have been intolerant of it, and following
28 discussions with the patient, and consent, switched
29 them to monotherapy with 150mg.

1 292 Q. The situation I alluded to, the use of 50 as a
2 monotherapy, we have seen that practice in cases
3 associated also with cases of what would appear to be
4 delayed referral to --
5 A. Yes. 14:38
6 293 Q. -- oncology, in some cases non referral, with the
7 patient staying on 50mg --
8 A. For extended periods.
9 294 Q. For a lifetime.
10 A. Yeah. 14:38
11 295 Q. Or for a period of years. We've also heard from, for
12 example, Dr. Mitchell on Tuesday, about the risks
13 associated with prolonged low dose Bicalutamide in the
14 form of hormone resistance.
15 A. Yeah. 14:38
16 296 Q. We've also seen cases reported through the SCRR process
17 - I don't assume that you would know this case, but
18 Patient 35, for example, we can see that he was one of
19 a number of cases where the finding was that the low
20 dose was unnecessary, in that surveillance would simply 14:39
21 have done, and caused some side effects.
22 A. Yeah.
23 297 Q. The gravity of those side effects --
24 A. So what I would reflect there, Mr. Wolfe, is that
25 patients will develop hormone resistance to all of the 14:39
26 treatments, irrespective of whether you're using 50,
27 150, or whether you're using an LHRH analogue, if
28 they're on the treatment for long enough. Because
29 that's the nature of prostate cancer, it escapes the

1 control of the therapy. So, fortunately we now have
2 other therapies to follow on from those therapies, and
3 those new therapies have been available for perhaps a
4 little more than ten years. So that's the importance
5 of having the medical oncologist at the meeting, 14:39
6 because they are able to give expert advice about the
7 management of hormone refractory prostate cancer.
8
9 It's not my practice to manage people for long periods
10 with 50mg of Bicalutamide. 14:40
11 298 Q. You would manage them on 50mg --
12 A. They either have a watchful waiting strategy, which may
13 be entirely appropriate given the circumstances of the
14 patient, or they get an LHRH analogue if they are
15 metastatic disease. And if they're for curative 14:40
16 treatment then that's really the realm of the clinical
17 oncologist to decide what the appropriate treatment for
18 them is.
19
20 Now, the other aspect of that that has just almost 14:40
21 escaped my -- yeah. In some ways the Bicalutamide
22 issue is a bit of a red herring. It's not quite seeing
23 the wood for the trees. The bigger issue is not
24 referring the patients to the oncologists for
25 radiotherapy. That is the definitive treatment, and 14:40
26 that is the thing that would be the key to managing the
27 patient's disease.
28 299 Q. Yes. It appears there's probably two, maybe more,
29 categories of problem here.

1 A. Yes.
2 300 Q. One is managing the patient on 50mg Bicalutamide for a
3 long period of time; it's not licensed for that and
4 it's not likely to be efficacious of anything, is it?
5 A. I suppose the only way you would know that is if you 14:41
6 had a way of assessing the disease progression. And we
7 can assess disease progression to an extent by
8 measuring things such as PSA and testosterone, you can
9 also use alkaline phosphatase as a surrogate for bone
10 disease. We now have new tools available to us, things 14:41
11 like PMSA PET scans, which would actually show you,
12 with quite high degrees of accuracy, whether patients'
13 disease is progressing. They're not in routine
14 clinical use here for that purpose and they're not
15 funded. 14:42
16 301 Q. Yes.
17 A. So the technology has moved on, but I think we would
18 all agree in our MDT that managing people long-term on
19 Bicalutamide 50mg is inappropriate.
20 302 Q. Yes. And the second, I suppose category of case, is 14:42
21 the ones that should be sent to --
22 A. Yeah.
23 303 Q. -- oncology in a timely fashion.
24 A. Yes.
25 304 Q. But we have examples of cases where the monotherapy has 14:42
26 been deployed apparently as an alternative. Maybe
27 that's not Mr. O'Brien's thinking, but it certainly
28 implies that?
29 A. I'm not inside his mind. I don't know.

1 305 Q. Yes. The regional guidelines, which have featured in
2 evidence, is that - maybe it's not something you reach
3 for everyday, but you'll know the content of them
4 broadly. It doesn't provide for 50mg monotherapy?
5 A. You're correct, I don't reach for them everyday, 14:43
6 because I have in my own head what I'll be doing and
7 it's as I've described to you, yes.
8 306 Q. Yeah. And plainly, the Trust, when it picked up on
9 this issue in 2020, it ran an audit, I suppose a
10 headline from the audit was of the 466 patients 14:43
11 identified as forming part of a low dose cohort, 34 of
12 them were on the incorrect treatment, as viewed by, I
13 suppose, Mr. Haynes, who led on the audit. He was
14 applying the standard or the test set out in the
15 regional guidelines. 14:44
16 A. Yeah. I think - and a very important point about that
17 is that I think Prof. O'Sullivan made this point to you
18 yesterday: In Northern Ireland we provide essentially
19 an advice note to the GP to prescribe these medicines.
20 So, that goes out to the GP, the GP issues the 14:44
21 equivalent of an FP10, and that goes to the local
22 pharmacy and it's dispensed. I am aware that GPs in
23 Northern Ireland get very detailed reports of their
24 pharmacy prescribing, almost down to the tablet. So,
25 the information about how these medicines are 14:44
26 prescribed in Northern Ireland and dispensed was
27 available. It was just never looked for until that
28 audit.
29 307 Q. Are you suggesting - and I didn't hear

1 Prof. O'Sullivan's evidence, and that's my fault?
2 A. Sorry.
3 308 Q. But are you suggesting that the information was in the
4 hands of --
5 A. Yeah, so -- 14:45
6 309 Q. -- the actual prescribers, the GPs?
7 A. Well, first of all the GPs would know, because many of
8 them have very sophisticated prescribing systems. But,
9 secondly, it would have been known to the regional
10 pharmacy service how many patients - if they looked for 14:45
11 this information - how many patients were on
12 Bicalutamide as a monotherapy. All it would have taken
13 was for them to search their systems and filter
14 patients who were on an LHRH analogue and patients who
15 were on Bicalutamide 50mg. That information would have 14:45
16 been easily found. And, indeed, that's how it was
17 found when Mr. Haynes ran the audit.
18 310 Q. Yes. I hope I don't misunderstand you, but when you
19 said earlier the 50mg dose of itself is something of a
20 red herring, the bigger picture, the bigger issue being 14:46
21 the absence of timely referral --
22 A. Referral, yeah.
23 311 Q. -- or sometimes absence of referral at all.
24 A. Yeah. Yeah.
25 312 Q. You're not suggesting that -- 14:46
26 A. I'm not apportioning blame to the regional pharmacy and
27 I'm not apportioning blame to the GPs.
28 313 Q. No.
29 A. I'm just pointing out that the information is there.

1 314 Q. Yes. And I'm not to mistake your point as suggesting
2 that the 50mg dose should not have been identified and
3 addressed at an earlier point?
4 A. Well, there was potential for it to be identified.
5 Because if the information is there, there's potential 14:46
6 to see it.
7 315 Q. Yes.
8 A. I suppose the other point is this: Many other
9 medicines that are used in oncology within secondary
10 care are prescribed and dispensed within secondary 14:46
11 care. That's not true for these medicines. They're
12 not on what's known as a red or amber list. There
13 isn't a shared care protocol for these medicines
14 between primary and secondary care. There are for lots
15 of other medicines that would fall into these 14:47
16 categories. So, you know, if these medicines had of
17 been dispensed from secondary care and controlled from
18 secondary care, our pharmacy departments in the Trust
19 would have had oversight of that.
20 316 Q. It is the case, as you will have heard from 14:47
21 Prof. O'Sullivan's evidence, Dr. Mitchell's evidence
22 perhaps, if you heard it, and indeed what Mr. Suresh
23 has said, and we're going to turn to that now, that
24 this issue of inappropriate unlicensed prescribing,
25 leaving aside the referral point, was known both 14:47
26 internally and externally prior to any consideration of
27 an audit in 2020.
28 A. Yeah. So, my only knowledge of this issue being
29 discussed in our department was at one MDT meeting, and

1 the particular patient's details I cannot recall, but
2 the discussion was finishing on "This patient needs to
3 start ADT", and my recollection of it was that
4 Mr. O'Brien nonchalantly said "50mg?", and the rest of
5 us in the meeting said "I wouldn't do that, I would 14:48
6 give him an LHRH analogue." And it was a short, brief
7 interaction.
8
9 When I mentioned this to Dr. Hughes - and he didn't
10 really explore it further with me when we spoke - I 14:48
11 mentioned that it was discussed, "challenged" have
12 might be the word I used, but not minuted. And what I
13 mean by not minuted is that the outcome of the MDT for
14 that patient would have stated "to initiate ADT", it
15 wouldn't have stated we had a discussion about using 50 14:49
16 or not using 50, etc.. So, you know -- and it wouldn't
17 have been recorded verbatim in the minutes of the MDT,
18 which are a separate document from the outcome
19 summaries that are generated on CaPPS.
20 14:49
21 So it was a very brief interaction about the dose of a
22 medicine.
23
24 Now, the point that I would take away from that is, if
25 you're in a meeting with your colleagues and they 14:49
26 challenge you about the use of a particular medicine
27 and they say that they would do something different,
28 then I think you have to accept that perhaps what
29 they're saying might be right, you have to reflect on

1 what they've said to you, and you would then, you know,
2 if it was me and it was a learning point, I'd go off
3 and I'd read the documents and I'd reassure myself that
4 what I was doing was correct or otherwise and I'd act
5 accordingly. 14:50
6
7 So, that's where -- that's the only time I recall that
8 issue being discussed. In reading the evidence
9 bundles, I now see that Mr. Suresh has a recollection
10 of an event where it was discussed. I do not know for 14:50
11 sure whether it is the same event.
12 317 Q. Yes. Let me sketch in some other details around the
13 points you've just made. Let's start with Mr. Suresh.
14 His statement, if I go to that, please, at WIT-50363.
15 And he says at 49.3 at the bottom of the page that he 14:50
16 can recall:
17
18 "...a patient under the care of Mr. O'Brien being on
19 unconventional treatment for prostate cancer, being
20 treated with low dose tablet Bicalutamide over a few 14:50
21 years. I noticed it when patient turned up in my clinic
22 for the follow-up. I do not recall the exact date."
23
24 So he saw it coming through a clinic. And then he
25 copied his clinic letter to Mr. O'Brien with his 14:51
26 concern that it was unconventional treatment, and he
27 added it in the agenda of the next urology multi
28 disciplinary team meeting. Just pausing there. Is
29 that essentially doable? Is that a conventional thing

1 to do if an issue arises?
2 A. I think that sounds entirely appropriate.
3 318 Q. And he goes on to say that:
4
5 "The consensus was that treatment with long-term low 14:51
6 dose Bicalutamide was unconventional and that
7 Mr. O'Brien was to review the patient in the clinic and
8 to discuss the appropriate options with the patient."
9
10 He remembers the presence of Mr. O'Brien in the meeting 14:52
11 but cannot recall the entire attendance. And then he
12 goes on to deal with an antibiotic issue, which we'll
13 come to later.
14
15 That doesn't appear to resemble the episode that you 14:52
16 can recall?
17 A. Yeah. I mean he's got a lot more detail about it than,
18 you know, the episode that I recall. But I suppose
19 what I might consider there is that he was the person
20 who identified this issue and he correctly brought it 14:52
21 to the MDT. So his recollection of it may be a lot
22 more detailed than mine.
23 319 Q. Yes.
24 A. If it is the same event.
25 320 Q. Yes. And I just want to take a look at this through a 14:52
26 governance lens.
27 A. Yeah.
28 321 Q. You have a multi disciplinary team, hopefully, if it
29 was quorate, but you certainly have urologists who

1 should know that 50mg is an unconventional, unlicensed
2 dose. It's entirely appropriate that Mr. O'Brien would
3 be challenged if that was his way of proceeding?
4 A. That that practice was challenged is correct.
5 322 Q. Yes. 14:53
6 A. And, secondarily, from my perspective this was an
7 isolated incident and I was not aware of the previous
8 discussion that had went on by e-mail from the
9 oncologist to Mr. O'Brien about other patients. So, if
10 you're looking at it from the perspective - and 14:53
11 Mr. Suresh hasn't dated this, so I'm not sure who was
12 leading the MDT at that time - but if you're looking at
13 it from my perspective if I was the lead clinician, I
14 would have looked at this as this is a one-off, I'd no
15 evidence to suggest otherwise, I'd no particular reason 14:53
16 to go digging around to find out if it was a repeat
17 behaviour. I just wouldn't have known that.
18 323 Q. Can I try to better understand that? I don't have a
19 reference for this, and it's reasonably hot off the
20 press from the Trust. They've been conducting a 14:54
21 lookback --
22 A. Okay.
23 324 Q. -- exercise. I don't have a Bates number for it. But
24 as part of their update, they've explained that change
25 of medication was required in association with 14:54
26 Mr. O'Brien's patients in 140 cases, going through what
27 they call a lookback recall clinic, and for 48 patients
28 with cancer the medication issue focused entirely on
29 Bicalutamide. I'm just wondering, given the scale of

1 this --
2 A. Yeah.
3 325 Q. How -- and all of those patients must inevitably, if
4 they were cancer patients, have come through your MDT?
5 A. Yes, they should have. 14:55
6 326 Q. How is it that the rotating Chairpersons, whoever they
7 might have been, including yourself --
8 A. Yeah.
9 327 Q. -- can miss his approach to hormone prescription?
10 Because in some cases, perhaps many cases, that 14:55
11 prescription is starting in advance of the MDT
12 recommendation.
13 A. It probably wasn't starting in advance of the MDT, for
14 the reason that most patients with prostate cancer come
15 to the MDT when their histology is available, and then 14:55
16 further after that when their staging scans are
17 available, and it's usually at the point where their
18 staging scans are available that the decision about
19 treatment is made.
20 14:55
21 So, following that, the patient would then be seen in
22 an outpatient clinic, and it's at that point that the
23 patient would receive the advice note for the GP to
24 initiate the treatment.
25 14:55
26 So, for my practice, that's how it works. The patient
27 takes that note away and they get the GP to issue a
28 prescription.
29

1 So, the MDT wouldn't necessarily have had sight of the
2 advice note to the GP, and unless that patient was
3 coming back to the MDT for some particular reason - and
4 many of them wouldn't be - then we wouldn't be aware
5 that they were on 50mg. 14:56
6 328 Q. So, what you're saying is that but for Mr. O'Brien's
7 remark "50mg then?" you wouldn't have known about it at
8 all?
9 A. I don't think I would have.
10 329 Q. And -- 14:56
11 A. Because...
12 330 Q. Obviously we have the Suresh case.
13 A. For the reasons that I've outlined, you know, we
14 weren't responsible for reissuing the prescriptions,
15 that was done in primary care. So we wouldn't have had 14:57
16 oversight of that.
17 331 Q. You make the point that if it had been you on the
18 receiving end of a correction of your approach, even a
19 mild mannered one, as appears to have been the spirit
20 of the intervention on the day you mention, you would 14:57
21 have taken it upon yourself to review your own practice
22 and taken advice?
23 A. We've all been on the receiving end of our colleagues
24 correcting us at an MDT, whether we've overlooked
25 something or we haven't addressed something quite 14:57
26 correctly. It's never a pleasant experience. You feel
27 that you've in some regards failed. So, my natural
28 response to that would be "Well, I'm going to do better
29 the next time and I'm going to go and find out why I

1 didn't know that and I'm going to, you know, check the
2 information." That's the kind of learning that I think
3 you have -- you have to be reflective about what you're
4 doing.
5 332 Q. Mr. O'Brien disputes that. He was challenged, and I 14:58
6 think that's the word that has been used. Maybe that's
7 --
8 A. Challenged sounds like a very strong term in this, you
9 know.
10 333 Q. Yes. 14:58
11 A. It was discussed. You know, unfortunately listening to
12 this Inquiry and reading the transcripts, there's an
13 awful lot of challenge. Well, you know, actually it's
14 about discussing care most of the time. We're not at
15 each others' throats. 14:58
16 334 Q. Yes. Yes. Well, let's use a different verb which
17 seems to be more consonant with the tone of the
18 meeting. He was politely advised that 50mg really
19 wasn't appropriate?
20 A. Yes. That's my recollection. 14:58
21 335 Q. Yeah. And we'll ask him whether challenge read in that
22 way was a feature of his memory. It would appear on
23 the face of it that he might say, no, this issue was
24 not raised with him at all, in the sense that he simply
25 is telling us that nobody ever spoke to him within the 14:59
26 Southern Trust, as I understand his position, about
27 Bicalutamide.
28 A. Okay. Well, you have my evidence now and you have
29 Mr. Suresh's evidence. It's up to the Inquiry to make

1 what they will.
2 336 Q. Yes. And in terms of the documentation around an MDM,
3 would it not be the case that if the recommendation of
4 the team is for a certain approach, and the managing
5 clinician, in this case Mr. O'Brien, thinks it should 15:00
6 be another approach, that that would be minuted, or at
7 least reflected in the MDM record in some shape or
8 form?
9 A. Yes, you would expect that the MDM summary for that
10 patient would reflect the views of the MDT. And I 15:00
11 would have expected in this case that Mr. Suresh is
12 referring to. Unfortunately he doesn't have the
13 details of the patient for us to go back and check.
14 337 Q. You took it to be a one-off, it appears to be --
15 A. Yeah, that's the only time I recall this being 15:00
16 discussed.
17 338 Q. It does strike me, and maybe you can comment on this,
18 that for him to say 50mg, is so off beam, so out there,
19 so unconventional, that it should have caused a pause
20 of surprise, and should it not have prompted an 15:01
21 interrogation - there we go again - a challenge as to
22 "Is this something you do routinely?"
23 A. I don't know, Mr. Wolfe, sometimes we all misspeak, you
24 know? And maybe that's the context that I interpreted
25 that within, that he misspoke. But that's, that's all 15:01
26 I can recall of that event.
27 339 Q. We have obviously observed Belfast's input into this.
28 Mr. Mitchell, Dr. Mitchell wrote to Mr. O'Brien. We
29 can see that his evidence was that, although he set out

1 in painstaking terms where he thought Mr. O'Brien
2 should be going with the management of patients, that
3 letter/e-mail, didn't receive a response. Mr. O'Brien,
4 just to be clear, never drew this external correction
5 of him or criticism of him to the attention of the MDT 15:02
6 at any point.
7 A. I don't recall him ever raising this issue with me or
8 at the MDT. And I would say this about the
9 oncologists: They are extremely precise about their
10 prescribing practice. 15:03
11 340 Q. Let's just briefly look at the e-mail, AOB-71990. He
12 reflected in his evidence this week that he personally
13 would have been quite shocked if he had received a
14 letter like this, and he was quite shocked that he had
15 written it to such a senior clinician as Mr. O'Brien. 15:03
16 A. Dr. Mitchell is a gentleman, a mild mannered
17 individual. So, you know...
18 341 Q. Yes. But have you had an opportunity to look at this
19 letter?
20 A. I have, yeah. And it's constructed with great detail 15:03
21 and precision, and it's exactly the kind of approach
22 I'd expect from Dr. Mitchell.
23 342 Q. What --
24 A. Perhaps not in the tone. I think he reflected that
25 himself. But, yeah, the precision of it. 15:04
26 343 Q. Yes. Yes. If you were standing in the shoes of the
27 recipient?
28 A. I'd be left in no doubt as to where...
29 344 Q. What would you have done with a letter like this?

1 A. I'd have modified my practice.
2 345 Q. Could I bring you to Patient 139? WIT-04624. And this
3 is a letter from Mr. Haynes to Patient 139, late
4 December 2020, and it forms part of the work associated
5 with the lookback and the Bicalutamide audit. 15:05
6 A. Yeah.
7 346 Q. And Patient 139, just to fill in a bit of the history,
8 had been placed on low dose 50mg of Bicalutamide daily
9 with Tamoxifen 10mg daily by Mr. O'Brien back in 2010.
10 A. So, my reading of this, and I've read the letters, is 15:05
11 that this patient was diagnosed with small volume
12 Gleason 3+4 prostate cancer at some point in late 2009.
13 347 Q. Yeah.
14 A. The patient went through the biopsy process. They had
15 a -- there's no MDT record that I can find on the 15:05
16 system. And the patient was seen by a number of
17 registrars in the period from 2010 through to 2016.
18 There is no clinic letter from Mr. O'Brien relating to
19 this patient that I can find on the clinical record.
20 So, it's not clear to me who initiated the treatment, 15:06
21 but if a registrar initiated this treatment, I would
22 make the assumption that it was on the direction of the
23 consultant in charge of the case.
24 348 Q. Just to put this letter in context. Just scroll down.
25 Essentially there's been some discussions, you can see 15:06
26 there "Diagnosis of prostate cancer was given in
27 2009/2010", and the last line of that paragraph:
28 "Commenced on the treatment of low dose Bicalutamide",
29 as I've outlined. So, there was then a discussion on

1 the phone in 2020. Mr. Haynes, fresh out of the audit,
2 identifying patients who he thought was on the wrong
3 medication. So this is discussed on the phone.
4
5 Scrolling down. He's telling the patient it's not 15:07
6 licensed for use and the evidence shows it's an
7 inferior treatment. And he goes on to outline the
8 appropriate options --
9 A. Yes.
10 349 Q. -- for this patient: Active surveillance. Scrolling 15:07
11 down. I think he goes through other options, which may
12 or may not be appropriate, depending on how this case
13 might then be investigated. It's kind of a global
14 letter setting out --
15 A. Yeah, I think it's a global letter indeed, yeah. 15:07
16 350 Q. Yeah. Yeah.
17 A. It's maybe not taking into account the specifics of
18 this individual patient in all of that.
19 351 Q. And can we take it back to your involvement --
20 A. Yeah. 15:07
21 352 Q. -- with the case? You saw this patient on review on
22 22nd February 2016. If we pull up AOB-82836. So
23 you're writing to his general practitioner following a
24 clinic in February 2016, as I say. His current
25 management of Bicalutamide daily, low dose Bicalutamide 15:08
26 daily is outlined, and you tell the general
27 practitioner that he's going to be the subject - the
28 patient can be the subject of U&E and alkaline
29 phosphatase. They were normal on 2nd February.

1 A. Yeah.
2 353 Q. And you say:
3
4 "I will write to the patient with the result in due
5 course." 15:08
6
7 A. Yeah.
8 354 Q.
9 "If the result is stable then he remains suitable for
10 continued Bicalutamide monotherapy." 15:08
11
12 A. Yeah.
13 355 Q. So, help us understand your approach. Here's a patient
14 diagnosed in 2009/10?
15 A. So I think this gentleman is 79 at this point? If we 15:09
16 can just scroll to his date of birth? Or that's
17 probably redacted, is it? It is redacted. But my
18 calculation was that he was 79. So, I'm seeing a
19 patient six years post diagnosis. He'd been initiated
20 on this treatment six years previously. There were 15:09
21 also notes relating to this patient that he had
22 comorbidity, and there was a remark in one of the
23 letters about this patient's anxiety being a factor in
24 managing him.
25 356 Q. I should just say, we - and for the purposes of the 15:09
26 panel - we alerted you to this case.
27 A. You did.
28 357 Q. On Monday, as recently as Monday of this week.
29 A. Yeah.

1 358 Q. And you've --
2 A. So I haven't had recourse to his paper notes, but I've
3 had recourse to his electronic care record. So, I
4 don't recall meeting this person. And I reviewed, I
5 presume, as would be my practice, I would have reviewed 15:10
6 the previous letters. I would have reviewed his chart,
7 if it was available at the time of the clinic, and I
8 took the view that this 79-year-old gentleman with
9 small volume Gleason 7 was not going to be a candidate
10 for curative treatment at six years down the line. His 15:10
11 comorbidity would have precluded that. And, therefore,
12 in my mind, in these patients my thinking would be,
13 "Well, he's either for watchful waiting", which would
14 have been my typical approach in this setting, or if
15 the patient develops metastatic disease, they should be 15:10
16 for an LHRH analogue.
17
18 This patient was already established on treatment.
19 Regretfully, I didn't stop that treatment. Possibly -
20 in fact, not possibly, I should have. I may have had 15:10
21 reason for not stopping his treatment; the patient may
22 have expressed to me at the time a desire to remain on
23 treatment. It's my experience that many prostate
24 cancer patients experience an anxiety surrounding their
25 diagnosis and that anxiety is compounded by the 15:11
26 periodic testing that we put them through to see is
27 their disease progressing. And I have had it expressed
28 to me by patients: "Can you give me something for my
29 disease?" Now, that's not a reason, in my view, to

1 initiate unnecessary treatment. It's a reason to have
2 as best to your ability the discussion with the patient
3 as to why the treatment's not necessary.
4
5 So, reflecting on this now, I think that's a possible 15:11
6 reason why I didn't stop his treatment. But on
7 balance, I probably should have tried to stop his
8 treatment. And if it came along again, knowing what I
9 know now, that's the approach I'd take.
10 359 Q. Could I invite you, through the Chair, when you do have 15:12
11 opportunity, if opportunity avails you, to see the
12 written notes, if you made any, to come back to us with
13 an addendum to your statement in that respect?
14 A. Yeah. (Witness Nods).
15 360 Q. I think the justification for what I think you accept 15:12
16 is an unlicensed prescription is important. But at the
17 moment, the best you can do without the notes is to
18 say, "Well, this gentleman had been on this course or
19 this regime for six years, didn't appear to be doing
20 him any harm and, regretfully, I didn't counsel him off 15:12
21 the drug, which I should have done, but it was really
22 perhaps", and you're speculating a little bit, an act
23 of kindness, given his potential anxiety?
24 A. So, I don't know what counselling I gave him, because
25 it's not recorded here, you know? So that's difficult 15:13
26 to answer. And I just don't recall the case. But I
27 have had this discussion with other patients about the
28 appropriateness of being on watchful waiting versus
29 hormonal therapy.

1 361 Q. The other view of this might be that you didn't
2 recognise the inappropriateness of the prescription,
3 you were --
4 A. I don't subscribe to that.
5 362 Q. What you're saying plainly to the Inquiry is that it 15:13
6 was a clinically inappropriate prescription, in the
7 sense that it was of no material benefit to his
8 disease?
9 A. It was clinically not the appropriate treatment for his
10 disease. Whether or not it was relieving him of some 15:14
11 of his anxiety related to being diagnosed with prostate
12 cancer, I can't answer at this point in time.
13 363 Q. Can I move on from Bicalutamide, please, to looking at
14 one of the issues that emerged from the 2020 SAIs? And
15 one of the themes -- 15:14
16 CHAIR: Mr. Wolfe, if is this going to take some time
17 it might be appropriate to take a short break before we
18 do that?
19 MR. WOLFE KC: Yeah, it's a new area. That's helpful,
20 yeah. 15:15
21 CHAIR: Okay. So we'll come back then at half past
22 three.
23
24 SHORT ADJOURNMENT
25 15:21
26 CHAIR: Thank you everyone. The last session of the
27 afternoon, and week, hopefully.
28 MR. WOLFE KC: Just one further point arising out of
29 the Bicalutamide issue. When you think upon it now,

1 there was the one case, potentially two, and
2 Mr. Suresh's case isn't the same one as the one you
3 recall. When you add those one or two to your
4 supervision on review of Patient 139, I suppose that's
5 at least two examples of linking it back to 15:29
6 Mr. O'Brien's off licence inappropriate prescribing.
7 A. Yeah.
8 364 Q. And perhaps you didn't join them together in your head,
9 but when you reflect now, there was, with two
10 instances, and perhaps three, an opportunity to say 15:30
11 "What's going on here?"
12 A. Yeah. I mean, as you've reflected, you know, I don't
13 know what the temporal relationship was between these
14 events, so clearly it didn't trigger anything at the
15 time, because if it did, we would have at least 15:30
16 discussed it. So, that's all I can really say about
17 it. It didn't trigger anything for me at the time.
18 365 Q. Should even the one event, the patient that you had
19 sight of, did you not - maybe it's difficult to bring
20 you back to 2016. You saw the patient again in 2020 15:30
21 and you continued him on the same regime, as you know
22 from the correspondence. Should that not of itself
23 have been a "What's going on here moment?"?
24 A. Well, it's the same patient, and I've only, as I've
25 given in evidence, I've only one other recollection of 15:31
26 this ever being discussed in another case. So, no, I
27 don't think there was a big enough trigger for me to
28 recognise a pattern.
29 366 Q. The next issue I want to look at, I put the label on it

1 that there has been failure to comply with MDT
2 recommendations, some perhaps by inadvertent error -
3 and I'm going to refer you to a couple of cases that
4 weren't considered by Messrs. Hughes and Gilbert, and
5 then we'll move into some of the cases that they did 15:32
6 look at.
7
8 Could I start with a case that you're probably familiar
9 with, or at least you were probably part of the MDM
10 which considered the case, and you will have had an 15:32
11 opportunity to look at it on the papers. It's Patient
12 137. And this is a case where the recommendation was
13 to refer the patient for an endocrinology opinion or
14 review?
15 A. Yeah. 15:32
16 367 Q. And the patient was in the hands of Mr. Young. And if
17 we can pull up the incident report or the Datix for
18 that? It's WIT-100386. And it's helpful that there's
19 a short summary of the incident, or description:
20 15:33
21 "Patient discussed at MDM 12th January. Outcome to be
22 referred to endocrine MDM. Unfortunately this did not
23 happen. Further GP referral - five months later, 12th
24 May 2017 - brought this to my attention..."
25 15:33
26 - this is Mr. Haynes:
27
28 "...and the referral has now been done."
29

1 Did you know this case before --
2 A. No, I didn't know this case before the evidence bundle.
3 368 Q. Yes. Thank you.
4 A. And I had no - well I had no recollection of this case
5 before the evidence bundle. 15:33
6 369 Q. Yes. You can see the problem succinctly described
7 there. You are at this stage, 2017, the lead of the
8 MDT?
9 A. Yes.
10 370 Q. And that carries with it the kinds of sort of 15:34
11 problem-shooting managerial oversight issues --
12 A. Yeah.
13 371 Q. -- that you described this morning, quoracy being one
14 of them that you addressed. Was it not part of the way
15 of working to draw incidents like this to your 15:34
16 attention so that you could get cross about it or
17 direct some kind of constructive action?
18 A. So, I think where there has been a failure to make the
19 referral in a timely manner, I would have expected that
20 to have been tracked. So the fact that it hadn't been 15:34
21 caught by the tracker is of concern. Clearly, it's
22 brought back to the attention of ourselves by the GP.
23 So, it is a concern that this has happened and we
24 haven't identified it through our own mechanisms,
25 rather it has taken the GP to point it out to us. 15:35
26 372 Q. I'll come back to the tracker probably on several times
27 this afternoon, or what remains of the afternoon. If
28 we go to WIT-100383.
29 A. I might just add one thing to that as well? It is the

1 practice of the tracker to send an e-mail to the
2 secretaries of each of the consultants after the MDT
3 listing the cases that need action. So, therefore, I
4 would have expected that an e-mail would have been sent
5 to Mr. Young's secretary by the tracker, following the 15:35
6 MDT, outlining that this case needed referral to the
7 endocrine MDM.
8 373 Q. So what you're helpfully building into your answer is
9 there were at that time, and assumedly now, and perhaps
10 enhanced now, and I want to look at whether they had 15:36
11 been enhanced, safety nets?
12 A. Yes.
13 374 Q. Or potential safety nets.
14 A. Yes.
15 375 Q. Didn't appear to work in this case. But the safety net 15:36
16 is the tracker who attends the MDT?
17 A. Yes, or tracker coordinates, in my view -- well, we
18 would use the terminology interchangeably.
19 376 Q. Yeah. So it's a broad enough and heavy enough job
20 description for that person. So, he or she is, I think 15:36
21 it was Mrs. McVeigh at that point?
22 A. It was probably Ms. McVeigh at that point, yes.
23 377 Q. Yes. And she's receiving all the to-dos or
24 recommendations at the MDM. Mr. Young's supposed to go
25 away and action it, but as an aid to remembering to 15:36
26 action it, an e-mail from Mrs. McVeigh should go to
27 consultant secretary?
28 A. It would be the normal practice for that to happen.
29 378 Q. Yeah. And I suppose just building on that, if the

1 referral hasn't happened, was it a shortcoming of the
2 system, at least at that time, that the
3 tracker/coordinator wouldn't be necessarily following
4 that up?
5 A. My understanding is that case should have been tracked 15:37
6 and it shouldn't be closed on CaPPS until we're sure
7 that the referral has been made.
8 379 Q. Right. So, just technically help us with how that
9 should be done? So if the letter goes out from
10 Mr. Young's office: "Dear endocrinologist, please take 15:37
11 this patient", that should trigger something to close
12 the case on CaPPS?
13 A. Yeah. So the tracker would have access to the letters
14 to know whether or not the letters have been done, and
15 the tracker could then close the episode on CaPPS, 15:37
16 which is the cancer patient management system.
17 380 Q. Yes. And, so, what happens is that - without going
18 exhaustively through the table tennis match - 14th
19 August 2018, a year and a half after the incident came
20 to light, rather than take this through a serious 15:38
21 adverse incident review, it seems, which might have
22 been one approach, risk to patient.
23 A. Yeah.
24 381 Q. There's a "Dear Michael" letter, and the "Dear Michael"
25 letter or "Dear Mr. Young" letter, is concluded with: 15:38
26
27 "The review team concluded that following MDM any
28 actions must be progressed by the consultants nominated
29 as responsible for the action required as per the MDM

1 outcome report. Referrals for specialist care need to
2 be sent from consultant to consultant."
3
4 And finally:
5 15:39
6 "Can you provide reassurance that you have a process in
7 place to ensure that MDT outcomes for patients under
8 your care are actioned in a timely and appropriate
9 manner?"
10 15:39
11 So, the ball is now on Mr. Young's side of the Court.
12
13 Mrs. Reid, who spoke to this incident, because she was
14 the facilitator on the consideration of the incident
15 report, said no record of Mr. Young answering this or 15:39
16 addressing the need for assurance.
17 A. Yeah.
18 382 Q. We'll bottom that out with Mr. Young. Undoubtedly you
19 would have expected him to have provided assurance,
20 whether in writing, hopefully in writing, but at least 15:39
21 orally?
22 A. Yeah, I would have expected that. I'd no knowledge of
23 this particular process happening, but I would have
24 expected him to have responded positively to this
25 letter. 15:40
26 383 Q. I mean it does seem, on your analysis of the issue,
27 that there was also a lesson to be learned by the
28 coordinator or tracker. If Mr. Young, as it appeared,
29 hasn't made the referral, where was the safety net?

1 A. I think -- yeah, I think the primary responsibility is
2 that of the consultant. The safety net is the tracker,
3 the coordinator. There's also the aspect of, you know,
4 the e-mail may have been shared with - I would have
5 thought it actually went to Mr. Young's secretary, 15:40
6 perhaps copied to Mr. Young, I'm not sure. We don't
7 have e-mail evidence to support that here.
8 384 Q. Can you help us with another case of, I suppose similar
9 in nature but factually distinct? It's Patient 102.
10 This is going back in time. If we look at WIT-100357? 15:41
11 An incident reported on 21st October... No, it couldn't
12 have been the 21st. Yeah, it was.
13
14 So, the incident happened on 20th November 2014, and
15 it's explained as follows: 15:41
16
17 "The patient was discussed at urology MDM on 20th
18 November 2014. The recorded outcome was a restaging
19 MRI scan has shown organ confined prostate cancer and
20 the case is for direct referral to Dr. H..." 15:41
21
22 Is that Dr. Houghton?
23 A. Yes, Dr. Houghton was a clinical oncologist who was
24 attending our meeting at the time.
25 385 Q. Yes. So it's for direct referral for radical 15:41
26 radiotherapy:
27
28 "For outpatient review with Mr. O'Brien."
29

1 And the incident is recorded as saying:
2
3 "Was reviewed by Mr. O'Brien in Outpatients on 28th
4 November..."
5 15:42
6 - so that's eight days after the MDM:
7
8 "No correspondence created from this appointment. The
9 referral letter from the GP received 16th October
10 2015." 15:42
11
12 - so, a year on from the MDM.
13
14 "Stating that the patient had not received any
15 appointments from oncology." 15:42
16
17 So we've been interested in that case because of the
18 shortcoming.
19 A. Yes.
20 386 Q. But we've also been interested in it because, 15:42
21 notwithstanding the risk to the patient, there was
22 never an -- no screening was performed to decide
23 whether it should be an SAI or otherwise. So, can you
24 help us with this? We've heard that in the case of a
25 direct referral - and that appears to have been the 15:43
26 recommendation - that that should generate a CaPPS
27 output. But I'm not saying it's a complicating factor,
28 but the essence of the incident as described here is
29 that Mr. O'Brien, after reviewing the patient, didn't

1 put pen to paper or hand to his dictating machine to
2 action the referral. Can you help us understand how
3 that sits technically? What is the process in the
4 event of a direct referral, or what should it be?
5 A. So, this afternoon I've already outlined to you how I 15:43
6 manage this situation. So, even though there may be a
7 direct referral made at the MDT and accepted by the
8 clinician on the other side, it is my practice when I
9 see the patient at clinic to dictate a letter to that
10 clinician at the time of seeing the patient. 15:44
11 387 Q. So, just help me understand the concept of a direct
12 referral. Is that -- and in fairness to you, you did
13 explain it earlier.
14 A. Yeah.
15 388 Q. But let me unpack it a little more. Is that the Chair 15:44
16 of the MDT for that day going back after the meeting
17 and sending something off, or is it the use of this
18 CaPPS system?
19 A. No, it's actually more than that.
20 389 Q. Okay. 15:44
21 A. So at the meeting there's a clinical discussion about
22 the care of the patient. The urologist would seek a
23 direct referral, in this instance to the clinical
24 oncologist, it could be to the medical oncologist, and
25 that person is present at the meeting, whether it's in 15:44
26 person or by videolink, and that person would accept
27 the referral at the time. We would use the terminology
28 "direct referral". Everybody understands that that
29 means that "I am now asking you to see this patient."

1 So that's one part of the process, it's verbalised.
2 390 Q. So that's verbalised at the meeting in realtime?
3 A. At the meeting. The second part of the process is that
4 that wording is captured in the outcome for the MDT for
5 that patient. And the third part of the process is 15:45
6 that there is an ITT generated. And that is where the
7 patient is transferred from one Trust to another.
8 Because for the vast majority of these cases we're
9 transferring them from our Trust to the Belfast Trust.
10 391 Q. And the further step that you say you would take would 15:45
11 be to dictate your --
12 A. Yeah, it is my practice to dictate a letter after I see
13 every patient in clinic.
14 392 Q. Yes. So in a situation -- well, this case, for
15 whatever reason, and it wasn't investigated, so I'm not 15:46
16 in a position to say to you what precisely happened,
17 but I'm looking at it nevertheless from a governance
18 perspective in asking, well, what are the safety nets
19 here again, and is it back to what we have described
20 with Mr. Young's case earlier and Patient 137? 15:46
21 A. Yeah. Yeah.
22 393 Q. The coordinator ought to have tracked this through?
23 A. So, I don't know if that's the case. The coordinator
24 might have actually done their job correctly. We don't
25 have evidence to say otherwise here. I don't know if 15:46
26 there's a software issue. I don't know if it was
27 received in Belfast and not actioned. We just don't
28 know. I don't have enough evidence to make an
29 assumption about any of those things.

1 394 Q. Okay. But, theoretically, what is the safety net?
2 A. So the safety net should be that it would be accurately
3 recorded in the outcome of the MDT. That's shared with
4 everybody in the team so it's very clear as to what's
5 happening. The coordinator should make an ITT, so that 15:47
6 should be going from one Trust to the other, that
7 should be received and actioned at the receiving Trust.
8 And then there's also the issue that the clinicians
9 involved have a responsibility to look through the
10 minutes of the meeting and check that, "Yeah, I've seen 15:47
11 all the patients that I need to see and I've actioned
12 the action points."
13 395 Q. Yes. But it shouldn't come out of the - the case
14 shouldn't be closed in the system until there's some
15 signal that the referral has been perfected? 15:47
16 A. And I don't know if it was closed in the system.
17 396 Q. No, no, I'm back on theory, I suppose.
18 A. Yeah.
19 397 Q. Is what I've just said correct, that it shouldn't close
20 on the system until there's some indication that the 15:47
21 referral has been perfected?
22 A. I suppose one of the vagaries of treating prostate
23 cancer with hormones and radiotherapy is that in the
24 guidelines that we have, the first definitive treatment
25 for these patients is actually the initiation of the 15:48
26 hormones. And that's a problem. We recognise that
27 it's a problem. So, CaPPS could have been closed on
28 that basis. I don't know, this is a speculation, but
29 it's a problem because the patients aren't receiving

1 their definitive treatment, in my view, at that point
2 in time. They're receiving the prelude to their
3 definitive treatment.
4 398 Q. Yes. I think that's a point we've received before. I
5 think others have expressed sympathy with it, that 15:48
6 really it's, as you say, it's the prelude to the proper
7 definitive treatment. But the definition in the book,
8 whatever the book is, is once you get the hormones
9 started, that's it, you're through the door.
10 15:49
11 Could I move to some other failure or delay referral
12 cases? Could I ask you, I suppose generally, where you
13 are the treating clinician, you receive the
14 recommendation from your MDM as to what your patient
15 should receive by next steps treatment? 15:49
16 A. Yeah.
17 399 Q. What are the steps that you take after that?
18 A. So, the coordinator would share the outcomes by e-mail
19 with all of the consultants. The secretaries would
20 receive that list from the coordinator of patients who 15:49
21 required a review appointment or an action. So, as you
22 know the MDT took place on a Thursday afternoon,
23 typically I was operating on a Friday, that e-mail
24 would generally land in my inbox some time on Friday,
25 and in between cases on a Friday afternoon I would look 15:50
26 at the e-mail. I would make sure that my secretary had
27 allocated clinic slots on my Monday uro-oncology
28 clinic, and she was very pro-active about sorting that
29 out. And if there were letters to be written to

1 patients, I would endeavour to try to do that before I
2 left work on a Friday evening, because often we were
3 writing to patients rather than necessarily seeing
4 them. And if there were scans or whatever to be
5 organised, I'd similarly try to do that before I left 15:50
6 work on a Friday evening.
7
8 It wasn't always possible, because when you're
9 operating, and perhaps you're single-handed operating
10 that day, you don't really have much downtime. But as 15:50
11 far as I could do, that's what I would try to do. I
12 had an administrative session on a Monday morning and
13 if I needed to mop things up, that's when they got
14 mopped up.
15 400 Q. And the patient, let's talk about a situation where the 15:51
16 patient is coming in to you then to receive the word on
17 the MDM.
18 A. Yeah.
19 401 Q. Do you typically deliver the MDM's recommendation to
20 the patient and explain that that's the way you would 15:51
21 like the patient to go?
22 A. So, in my clinic, I would see the patient and often a
23 relative, they'd often bring a family member with them.
24 We now have the facility whereby I would have a CNS in
25 the room. That wasn't always the case. And I would 15:51
26 often have a trainee with me, and I may have, as well
27 as the trainee, there may be another nurse present at
28 times. So, it's my practice to, first of all, gauge
29 what the patient understands as to what's going on and

1 then fill in the gaps and explain to them, these are
2 the findings, this is what's been discussed at the MDT
3 and this is the recommendation of the team.
4
5 Now, on a small number of occasions, the recommendation 15:52
6 doesn't actually fit the patient, and it may not fit
7 the patient appropriately because of comorbidity or
8 perhaps the MDT wasn't aware of a particular piece of
9 information before the MDT or something that the
10 patient tells me at the time of the clinic, and in 15:52
11 those circumstances, I think in the past, I wouldn't
12 necessarily have put that back through the MDT,
13 depending on the importance of that information.
14 However, I think now, and in more recent times, we
15 would put that back through the MDT, largely for fear 15:53
16 of criticism. Okay? Because, you know, I think you
17 have to take -- the MDT outcome happens somewhat in
18 isolation to the patient, and I think it's a point that
19 Mr. Gilbert made, you know; the patient isn't present,
20 so really you're basing the information on what the 15:53
21 clinicians are telling you in the brief summary and
22 what is entailed on the electronic care record. And,
23 so, there will be times when a recommended plan from
24 the MDT isn't actually the best course of action for
25 that patient, or the patient doesn't want to follow it. 15:53
26 402 Q. Yes. And I suppose it's more common that the
27 information to support the proposition that this is the
28 wrong plan, or could be the wrong plan, it's more
29 likely that that comes at the meeting with the patient?

1 Because at the MDM itself, you should be in a position
2 to argue --
3 A. The scenario is an infrequent one, but it happens.
4 403 Q. Yeah. Yeah. Without more, would it be inappropriate
5 to go straight in to the patient and say "I disagree 15:54
6 with the MDM recommendation"?
7 A. (Witness laughs). I've been in the unhappy position of
8 MDT recommendations coming down from Belfast that I
9 don't agree with, and I've had to say to the patient "I
10 don't agree with what they've said here and I'm going 15:54
11 to take it back to them and we're going to re-discuss
12 it for these reasons." And you know...
13 404 Q. Isn't that the important caveat?
14 A. Of course it is, yeah.
15 405 Q. Yeah. 15:54
16 A. But, you know, you've got to explain to the patient on
17 what grounds you're perhaps disagreeing, and you've got
18 to realise that your colleagues making that decision
19 may have made it in good faith, but they may not have
20 had all of the information available to them. 15:55
21 406 Q. We - and I assume some knowledge on your part in
22 respect of the 2020/2021 SAIs - we've seen, for
23 example, Patient 1, which is a useful illustration of a
24 number of the issues, and I will have a tendency to use
25 that scenario, the scenario springing that, as a 15:55
26 framework. But that was a case, if I can remind you,
27 where the recommendation of the MDM on 31st October
28 2019 was to commence ADT and refer for EBRT. That's -
29 is it electro beam?

1 A. External Beam Radiotherapy.
2 407 Q. I'm obliged. The patient had been started on
3 Bicalutamide high dose to 150 prior to the MDM, ran
4 into side effects and was reduced to 50mg, and then up
5 to 100. There was - I use these words advisedly - 15:56
6 there was a bit of play with the Bicalutamide.
7 A. Titration might be the term I would use.
8 408 Q. The upshot was that the patient was not referred --
9 A. Yeah.
10 409 Q. -- to radiotherapy until the summer of 2020, when he 15:56
11 had disease progression?
12 A. Yes.
13 410 Q. And the prospects were bleak, and was referred at that
14 point by Mr. Haynes, I think in June or July 2020...
15 A. Okay. 15:57
16 411 Q. -- eight months after the MDM.
17 A. Yeah.
18 412 Q. Can I ask you this: Do you support the recommendation
19 or the conclusion of the MDM - sorry, the SAI, I should
20 say - that in cases like that, to use that as a 15:57
21 scenario, any deferment or variation from the MDM
22 decision should, first of all, be recorded in the
23 clinical notes?
24 A. Yeah, if you're going to vary from a recommendation,
25 you'd need very good grounds to do it, and you need to 15:57
26 record that, you need the consent of the patient. And
27 I think as we've said, you would bring it back to the
28 meeting if there's a significant variation.
29 413 Q. Yes. I know you've explained that that would not

1 always have been your practice --
2 A. I think when there were minor variations.
3 414 Q. Yes, that's what --
4 A. Patients unfit for treatment, you know, you're clearly
5 not suitable, then I would record that in the notes. 15:58
6 It would be very clear to anybody coming behind me that
7 this is the reason I've made this decision.
8 415 Q. Was there - I think you've described your practice now
9 as "any variation" and invariably bring it back --
10 A. More or less, yes. 15:58
11 416 Q. To avoid criticism, and maybe implied within that is
12 that you don't always think it's necessary because it's
13 a minor turn in the road as opposed to a fundamental
14 turn in the road. Can you --
15 A. Yeah, it's removal somewhat of our clinical judgment, 15:58
16 but there you go.
17 417 Q. Yes. Can you outline for us perhaps the test that you
18 would have applied, before your more universal approach
19 now, in determining whether I need to go back for
20 revalidation of the approach? 15:59
21 A. Yeah, I think now it's pretty much everything,
22 Mr. Wolfe.
23 418 Q. Yes. I get that point. But what was it before that?
24 What was the fundamental?
25 A. Take, for instance, a case where it was quite clear 15:59
26 that a patient was - had an advanced cancer that was
27 going to require palliative care, rather than referring
28 them for the likes of external beam radiotherapy for
29 bladder cancer or something like that. So my practice

1 would have been there's very little point in the rest
2 of the MDT having to give second opinion on that, this
3 patient is clearly palliative, they need the input of
4 the palliative care specialists, they would get
5 involved from my clinic, you'd called the palliative 15:59
6 care nurse, she'd come down and she'd see the patient,
7 you'd agreed with the patient and the family a plan of
8 action. If they needed referral on to oncology for
9 palliative radiotherapy rather than treatment with
10 curative intent, you'd arrange for that to happen. 15:59
11 You'd liaise with the GP, make sure that the patient
12 had appropriate analgesia, appropriate support in the
13 community, all of that kind of thing.
14 419 Q. We're also aware of delays in referral to, for example,
15 the Cancer Centre in Belfast. I suppose the headline 16:00
16 from the 2020 SAIs was that five out of the nine cases
17 under consideration experienced significant delay in
18 diagnosis, which is perhaps a different point. But
19 focusing on the delay in referral issue, I want to seek
20 your views on an issue that Mr. Hagan raised on 16:00
21 Tuesday. If we go to WIT-98864. He recalls at
22 paragraph 50 that he became aware in 2016 of delays in
23 association with muscle invasive bladder cancer cases.
24 And just scrolling down on to the next page. He
25 explains that - just scroll down, please - that by 16:01
26 comparison with other cases that were coming from other
27 centres, he was becoming aware of delays in cases
28 coming out of Craigavon, and they struck upon this
29 particular case, which was the subject of

1 correspondence between Dr. Mitchell and Mr. O'Brien,
2 who was possibly just about to conclude his
3 Chairmanship - or, sorry, lead of the MDM. You took it
4 on in...
5 A. October maybe 2016. 16:02
6 420 Q. Yeah, I think you've told us 16th November 2016.
7 A. Okay. Yeah. Whatever.
8 421 Q. So just a little before you stepped in to the Chair.
9 A. Yeah.
10 422 Q. Let me bring up the e-mail that was sent to Mr. O'Brien 16:02
11 and Mrs. McVeigh. If we go to WIT-98869. I think from
12 recalling Dr. Mitchell's evidence earlier this week,
13 that the delay in this case was in part caused by - his
14 words - "an inappropriate bone scan", it wasn't
15 necessary to perform a bone scan before making the 16:03
16 referral, maybe it wasn't appropriate to bone scan at
17 all. But the point is one of delay in --
18 A. Yeah.
19 423 Q. -- muscle invasive bladder cases. And Darren Mitchell
20 writes in August 2016: 16:04
21
22 "Aidan,
23 This was one of the bladder cases flagged up from the
24 review of timelines for muscle invasive bladder cancer
25 - I think she has been seen by Chris Hagan and was 16:04
26 deemed unfit for surgery.
27
28 We'll review it here and I suspect you'll want to do a
29 case note review there and see if there is any shared

1 learning from it either regionally or locally?"
2
3 A. Yeah.
4 424 Q. We'll get to asking Mr. O'Brien about that in due
5 course. Mrs. McVeigh was copied into that e-mail, and 16:04
6 we've sought her view on it through the Trust's
7 lawyers, and she cannot recall being asked to take any
8 action in association with the case.
9 A. Yeah.
10 425 Q. In particular she couldn't recall being asked to bring 16:04
11 it back to the MDM, for example. Is that an -- I
12 mean...
13 A. I wouldn't expect Ms. McVeigh to take any action here.
14 She's the coordinator. You know, this is a clinical
15 issue, it should be dealt with by the clinicians. 16:05
16 426 Q. Yes. Yes. On the face of it, for others to judge, at
17 least a potentially reasonable response from the
18 regional centre pointing up a problem. Obviously
19 there's a spectrum of options available to
20 Dr. Mitchell: Could he have gone higher? Could he 16:05
21 have gone less aggressive? He pitched the matter back
22 to Mr. O'Brien. Can you recall whether this was an
23 issue that was then discussed by yourselves as a team?
24 A. So, management of muscle invasive bladder cancer that
25 is not metastatic is a time sensitive issue. That 16:05
26 would be very well understood by all urologists. And
27 the evidence, in terms of getting these patients to
28 treatment within the 90-day period, would be
29 understood. We would have faced significant challenges

1 in getting patients, number one, seen at clinic in an
2 appropriate timeframe; number two, operated on to get a
3 tissue diagnosis; and then number three there would
4 have been issues with the timeliness of staging and MDT
5 discussion and referral to the specialist MDT. 16:06
6
7 That being said, it was around this period when
8 Dr. Mitchell was the - I think he was lead clinician of
9 the Belfast MDT by this point - that he, you know,
10 reminded other MDTs, ourselves included, that at the 16:06
11 first point that we had knowledge of a case of muscle
12 invasive bladder cancer, that we should be flagging
13 that directly to the specialist MDT, so that those
14 patients could be appropriately escalated, staged, and
15 seen in Belfast by the appropriate specialists. 16:07
16
17 So, I think over the past number of years we've worked
18 very hard to ensure that that happens as far as we can.
19
20 So, patients, it is our practice now as soon as we have 16:07
21 evidence of muscle invasive disease, that is most
22 commonly tissue diagnosis, histology, but on occasions
23 the histology may be non muscle invasive but the
24 imaging is reporting that there's a high likelihood
25 that it's muscle invasive. Those cases would be 16:07
26 escalated to the specialist MDT.
27
28 So that's how we practice now. Things happen in
29 parallel. The staging happens in parallel to that

1 process happening so that the patients are expedited.
2
3 I think it's very important to say that since the
4 centralisation of pelvic oncology in Belfast there have
5 been ongoing issues with the timeliness of treatment 16:08
6 provided by the Belfast Trust. That is not necessarily
7 the fault of the clinicians in the Belfast Trust, but
8 patients are still waiting too long to have radical
9 cystectomy in the Belfast Trust.
10 16:08
11 It's also the case that they do not have adequate
12 capacity to provide timely radical prostatectomy in the
13 Belfast Trust, and for a number of years patients have
14 been outsourced to independent sector providers,
15 largely in Dublin, but prior to that it was in 16:08
16 Cambridge.
17
18 So there is - not alone do we have capacity issues in
19 delivering the diagnostic element of this pathway, but
20 there are clearly issues in the Belfast Trust for 16:08
21 delivering the definitive care.
22 427 Q. Thank you for that. My, I suppose narrower interest in
23 addition to that was to explore how this governance
24 relationship worked, and maybe take it beyond this case
25 as well. But in the first instance, did that trigger a 16:09
26 response from Mr. O'Brien: "My attention has been
27 drawn to this. I think we should all know about this.
28 We need to find ways of improving because Belfast has
29 pointed this out", or can you not recall?

1 A. I don't recall this specific patient's care being
2 discussed in that manner. But it was - I think we all
3 had a focus on trying to make sure the muscle invasive
4 bladder cancer patients got through the system as
5 quickly as we could process them, because we recognised 16:09
6 that it was important they got their definitive
7 treatment and that you had a window of opportunity to
8 deliver that.
9 428 Q. I'm sure the Inquiry is interested in, I suppose, the
10 nature of the governance relationship between these two 16:10
11 centres. In essence it's one patient, and while
12 they're going to different facilities, they probably
13 think, right, globally this is my care package, so they
14 will want, I suspect, to be assured that if things go
15 wrong on either side of those centres that it's being 16:10
16 well managed so that you are alerted in Craigavon if
17 Belfast thinks things are not as they should be and
18 vice versa. Is that a relationship - is the
19 relationship one that works in that way?
20 A. I don't think that there is enough sharing of 16:10
21 information across the cancer network here. I think
22 that -- I can't recall what's been provided on a unit
23 basis from the centre data demonstrating timelines and
24 pathways. I can't recall that for either bladder
25 cancer or prostate cancer. We've had a recent exercise 16:11
26 whereby all of those units providing kidney surgery
27 have participated in a project. So I have participated
28 in that at Craigavon on behalf of our Trust, and my
29 colleagues in Belfast and Altnagelvin have participated

1 as well, and I think the Ulster. So that's the kind of
2 work that we need to do.
3
4 So, I think it's somewhat frustrating to hear things
5 being thrown back at the units when, indeed, the 16:11
6 communication coming the other way from the centre
7 could be better.
8 429 Q. Can I bring you to two scenarios where the argument is,
9 I suppose, that the case should come back for
10 re-discussion, or fresh discussion, with the MDM? And 16:12
11 the first scenario, I suppose, is where the decision is
12 to pursue a different treatment. We've covered this to
13 some extent already. Upon reflection, we probably
14 don't need to repeat the exercise on that point.
15 16:13
16 The second point is in the event of disease
17 progression.
18 A. Mm-hmm.
19 430 Q. Let me refer you to the MDT operating procedures.
20 WIT-84538. And if we go to... Yeah. So the direction 16:13
21 from the operating procedures for your MDT is that all
22 new cases - middle of the page:
23
24 "...of urological cancer and those following urological
25 biopsy will be discussed." 16:13
26
27 That's straightforward.
28
29 "Patients with disease progression or treatment related

1 complications will also be discussed and a treatment
2 plan agreed."
3
4 Is that again self-evident and routine in terms of your
5 practice and the practice of your colleagues? 16:14
6 A. So, I think it's probably nuanced. There are patients
7 who are coming to the end of their life and who may
8 present acutely to the hospital and be admitted, and
9 it's quite clear that they require end of life care,
10 and that end of life care will be delivered by the team 16:14
11 looking after them in the ward, but it will also
12 involve input from the palliative care team within the
13 hospital, and perhaps the palliative care team in the
14 patient's community. So there may be little benefit to
15 discussing that kind of patient at the MDT because of 16:14
16 the, you know, we're on an end of life pathway with
17 that patient, and there may not be anything to add from
18 the MDT perspective. So I can understand how that kind
19 of patient doesn't need to come back through the
20 meeting. 16:15
21
22 But there are other patients whose disease is
23 progressing who may benefit from therapies such as
24 palliative radiotherapy or changes in chemotherapy, and
25 quite clearly it is appropriate to discuss those 16:15
26 patients at the MDT for the specialist input of those
27 clinicians.
28 431 Q. Yes. Back to, I suppose, the Patient 1 case again,
29 which, as I said earlier, is respectfully a useful

1 vehicle to explore some of these themes. And that was
2 a case where the SAI found that the case was not
3 re-discussed at MDM, despite clear progression of
4 disease. So, he was, pursuant to the MDM
5 recommendation at the end of October 2019, due to be 16:16
6 referred with curative intent --
7 A. Yes.
8 432 Q. As I understand the position. That referral, in
9 Mr. O'Brien's hands, for witness that we will explore
10 with him, was not made. Come March or April of 2020 - 16:16
11 of course we were in the middle of the pandemic, but
12 that's mere background, I suspect - the patient
13 presented at Emergency Department with urinary
14 retention and his PSA had notably increased. The
15 thinking of the SAI people, to take that scenario, but 16:16
16 you can think about it in other factual circumstances
17 as well, that was clearly a case that ought to have
18 come back for re-discussion, even if it was a virtual
19 meeting, as you were probably having at that time at
20 the height of the pandemic? 16:17
21 A. Yeah, just be careful with the word "virtual", because
22 in the past we would have had virtual meetings as a
23 sole practitioner. But virtual meetings during the
24 pandemic would have been more than one practitioner by
25 video conference. 16:17
26 433 Q. Yes.
27 A. So, yeah, I think that was clearly an opportunity to
28 identify disease progression and for that patient's
29 care to come back to the MDT.

1 434 Q. Why is that important? Just help us better understand
2 that?
3 A. Because that patient, first of all they had a clear
4 urological issue, retention of urine. As I understand
5 it they had prostate cancer, is that correct? 16:17
6 435 Q. That's correct.
7 A. Yeah. So, you know, whatever treatment the patient was
8 on, their disease had progressed to cause them to have
9 urinary retention despite their treatment. So that's a
10 clear reason to intervene. So that might have required 16:18
11 surgical intervention, it might have required
12 chemotherapeutic type intention, and it might have also
13 necessitated restaging the patient to find out was
14 there other evidence of disease progression.
15 436 Q. It was also a case, and I think this is probably one of 16:18
16 the standout cases, maybe other cases not so much, but
17 this was a case where you could see the very practical
18 advantages, as this gentleman's disease progressed, of
19 having a key worker deployed in the case?
20 A. Yeah. 16:18
21 437 Q. Because the family, who the Inquiry has heard directly
22 from - and this is maybe a slightly different point
23 from the re-referral for re-discussion - they were very
24 "angry" is probably the word, at how they had to meet
25 the challenges of providing for catheter care and then 16:19
26 into palliative care in the absence of assistance from
27 a key worker?
28 A. Yeah. The whole package of care was absent there.
29 Because, you know, all of those things that you've just

1 outlined could have been addressed if the patient was
2 put back in contact with the team.
3 438 Q. Would a key worker - and some of the cancer nurse
4 specialists who we're now familiar with have some
5 considerable experience -- 16:19
6 A. Yeah.
7 439 Q. -- under their belts. Would they know, would they have
8 an instinct, even if the consultant wasn't doing it, to
9 say "Well, this case really ought to go back to MDM",
10 would you expect of that them? 16:19
11 A. So the people who are fulfilling that role in our
12 department now would all have that experience and would
13 all have the understanding that they are key members of
14 the team and are more than welcome to bring back any
15 case that they think is necessary to the MDT. Now 16:20
16 perhaps a point that I think has come up before in
17 discussion is whether or not our key workers were
18 redeployed at that point in time? I don't know if that
19 was the case or not at that particular time. But our
20 key workers were redeployed for a period during the 16:20
21 pandemic. It wasn't a decision that the consultant
22 urologists were party to.
23 440 Q. And I'm --
24 A. And in fact, in fact --
25 441 Q. -- in each of these situations I'm inviting not just 16:20
26 the specific case, but even broadening it out into a
27 scenario.
28 A. Yes.
29 442 Q. So in strict theory there should be a key worker there

1 and they could perform that role?
2 A. Yeah. So, you know, there were periods during the
3 pandemic where we were operating, if you like, without
4 the support of our clinical nurse specialists because
5 they had been redeployed. 16:21
6 443 Q. Yes. It's probably a challenging enough issue to
7 perfect, but in light of the lessons to be drawn from
8 these SAIs, has there been any attempt to try to ensure
9 that cases always come back when there has been
10 relevant disease progression, or how do you square that 16:21
11 circle?
12 A. So, the team are very aware that any patient whose
13 disease progresses and a member of the team, be that
14 medical staff, nursing staff, or if the tracker gets
15 knowledge of that to bring it back to the meeting, we 16:22
16 are open to that happening. You are reliant on people
17 alerting you to the fact that something has -- where a
18 patient's disease has progressed. I don't see how else
19 we would know that. Unless, for instance, there was an
20 imaging study that had alerted that there was obvious 16:22
21 evidence of disease progression. And in those
22 circumstances, then the person requesting the imaging
23 study is responsible for actioning the study and they
24 should take the appropriate action.
25 444 Q. Do you have any sense of whether the problem of not 16:22
26 referring back was widespread, or do you really have no
27 way of knowing? Could it be isolated to this one
28 practitioner in several cases, or do you not know?
29 A. I do not think it was widespread. But I don't have

1 evidence to back that up. I don't have an audit, for
2 instance, or I don't have a 2,000 case series review of
3 patients.
4 445 Q. Yeah. Can I bring you to Patient 138? This was, I
5 think, one of your patients? 16:23
6 A. Yeah. And remains so.
7 446 Q. And this was not a case that, just so that the panel --
8 this is not a case that went through the 2020
9 Dr. Hughes' SAIs. It, I suppose, illustrates, I think
10 you might agree, another issue in terms of the 16:23
11 performance of the tracker safety net mechanism, and
12 let's just unpack it we'll end with this one today.
13
14 So, let's just pull up TRU-178380. So this was a case
15 that was discussed - so it was a case that was 16:24
16 discussed at...
17 A. I think it was 28th December 2017.
18 447 Q. Yeah. This is, I think it's the one the facts are not
19 -- the minutiae is not terribly important. The problem
20 was this: The case came up for discussion at the MDM, 16:25
21 but it was decided to defer that discussion because
22 pathology wasn't available for that meeting.
23 A. Yes.
24 448 Q. And the expectation was, or the note was: Bring it back
25 when pathology was available, and it was anticipated 16:25
26 that that would be, I suppose, relatively quick.
27 A. I think the pathology was available the following day,
28 so the anticipation would have been it would have been
29 listed the following week.

1 449 Q. Yeah. And if we -- so the case didn't come back. It
2 was closed on CaPPS, isn't that right?
3 A. Yes.
4 450 Q. And you were reminded of the system and you personally
5 were reminded of the fact that the patient hadn't been 16:26
6 discussed, because the general practitioner wrote in in
7 October. And let me just pull that up. It's
8 TRU-178393. And you are -- just down the bottom of the
9 page, please? So, you're being advised - is that your
10 secretary? 16:26
11 A. That's my secretary. So I think she'd received a
12 telephone call from the GP.
13 451 Q. Yeah. Yeah. And so she has checked with Shauna,
14 that's Shauna McVeigh?
15 A. Yes, correct. 16:26
16 452 Q. The coordinator?
17 A. Yes.
18 453 Q. And:
19
20 "There has been a mistake made and this patient has 16:26
21 never been discussed. He was listed for discussion on
22 28th December 2017 and he was deferred for pathology.
23 Their tracking was closed off as he had a low grade
24 bladder cancer."
25 16:27
26 And so arrangements were made for him to be discussed
27 the following week.
28
29 The patient was re-discussed at MDM. He, your current

1 ongoing patient, received the appropriate treatment. A
2 Datix was raised, or an incident report was raised. It
3 didn't go into the SAI format, it appears. The issue,
4 it appears, was addressed informally by the development
5 of some form of standard operating procedure to try to 16:27
6 avoid this happening again?
7 A. Yeah. Yeah, that's correct. So, Shauna McVeigh's
8 manager is a lady called Vicky Graham and Vicky had
9 actually fulfilled Shauna's role prior to that. So,
10 clearly they investigated why this had happened on 16:28
11 CaPPS, and they then worked up an SOP, quite
12 reasonably, to ensure that this wouldn't happen again,
13 because obviously it has broader implications than just
14 urology MDT. And I think sensibly, Vicky Graham sought
15 advice, a sense check of what they had done with her 16:28
16 colleagues in Belfast, and they had, I think, based on
17 the discussions I've seen, agreed that they also
18 recognised that this was a potential issue and had been
19 working on a similar SOP.
20 16:28
21 So, I wasn't involved at all in the screening of the
22 IR1, but I think this is a good example of, once an
23 issue has been identified by the tracking team of
24 working up a solution to try and keep patients safe.
25 454 Q. Plainly, simple human error? 16:29
26 A. Yeah, I think it boils down to that.
27 455 Q. But plainly, one with potentially significant
28 consequence?
29 A. Yeah.

1 456 Q. It's not on all fours, but it has similarities to the
2 cases that we looked at at the start of this sequence
3 where referrals are not actioned and it's not spotted.
4 I mean, do you have a sense, as the lead of the MDM,
5 that while systems are always vulnerable to human 16:29
6 error, that safety nets, if I can describe them as
7 that, are as robust as they need be, or do you have any
8 lingering concerns that keep you awake at night in this
9 context?
10 A. At this period of time in 2018, we didn't have resource 16:30
11 to properly audit and quality assure what was
12 happening, and we had flagged that up as a concern. We
13 now do have that resource. So as I spoke about earlier
14 today, we run a check on random cases every month to
15 ensure that outcomes are actioned. 16:30
16 MR. WOLFE KC: I'm going to leave until the next
17 occasion then just, I suppose, the final issue arising
18 out of the MDT, apart from the nursing issue. So
19 there's a couple more issues arising out of the MDT
20 which I think we'll safely leave until the next 16:30
21 occasion. So, we'll work with your lawyers to try and
22 arrange a suitable date. So thank you for your
23 evidence today and yesterday.
24 CHAIR: Thank you, Mr. Glackin. I appreciate you've
25 been here a day and a half, and I'm sorry that we can't 16:31
26 conclude your evidence today, but it is important
27 evidence and we do need to hear from you whenever we
28 can arrange a date again.
29

1 Ladies and gentlemen, that concludes this session, and
2 we should be back, I think it is 10th October is our
3 next date. Am I right on that? 10th October at ten
4 o'clock.
5 THE WITNESS: Chair, do I remain on oath? 16:31
6 CHAIR: You do remain on oath, but if you require to
7 consult with your lawyers I will certainly release you.
8 You won't need to be sworn again, but I'm content for
9 Mr. Lunny to speak to you in the interim on issues that
10 arise. 16:32
11 MR. LUNNY: Thank you, Chair.
12
13 THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY,
14 10TH OCTOBER 2023 AT 10:00 A.M.
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