Urology Services Inquiry

Oral Hearing

Day 67 – Thursday, 19th October 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON THURSDAY, 19TH OCTOBER 2023 AS FOLLOWS:

CHAIR: Good morning everyone. Mr. Glackin. Mr. Wolfe. 09:59

MR. ANTHONY GLACKIN, PREVIOUSLY SWORN, WAS QUESTIONED BY MR. WOLFE AS FOLLOWS

MR. WOLFE: Good morning, Chair. Good morning, 09:59
Mr. Glackin. You were last with us on the 21st of September, and I was exploring with you on the afternoon of that day a number of issues arising out of the multi-disciplinary meeting, and I suppose at the heart of my exploration with you was an attempt to 09:59
understand the culture and the norms of the multi-disciplinary meeting, and we examined that through a number of issues, finishing with consideration of a case that you had some direct knowledge of, that was the case of Patient 138, and 10:00
the, I suppose the tracking error which led to that case being closed on CaaPS rather than being discussed after pathology was available.

I want to recap, just before moving on to new ground 10:00
this morning on a couple of issues that were left, well one at least was left slightly hanging, and that concerned -- the first of those concerned Patient 139. And you will recall -- if we maybe just have up on the

screen, please, AOB-82838. And you will remember that really it was just on the eve of you coming to give evidence that we drew your attention to this case. It was a case, so far as we understand it, where the patient was in the care of Mr. O'Brien in 2010, and he prescribed Bicalutamide 50mg, and he was -- the patient was on that dose when he came along to see you at review in 2016.

A. Yes.

Q. You kept him on that dose. He came along to see you again in May 2020, and you kept him on that dose, and you told us in your evidence -- the reference is TRA-08282 -- that regrettably you didn't change the treatment, although in fairness to you, you wanted to have the opportunity to consider whatever notes, paper notes that there might have been available to you which you hadn't had an opportunity to consider when you last gave evidence.

Is there anything in your researches since then that you wish to add to the evidence that you have given us?

A. So I've now had the opportunity to review the paper notes. There are two handwritten entries by Mr. O'Brien in 2010. One of those entries describes the prescription of Bicalutamide 50 and Tamoxifen 10. There are no letters, typed letters, in the chart reflecting those two clinic appointments. Subsequently then my own handwritten notes are available in the chart. They don't lend anything extra to what I have

already said, so I can't shed any further light on it.

2 Q. Yes. I think you were, I suppose to some extent anxious to better understand your own thinking around why you continued the regime of 50mg, both in 2016 and 2020. 10:03

A. Yes.

3 Q. Your notes don't add anything to your thinking around that?

A. They don't. They do not.

4 Q. Yes. Could I just -- and maybe I didn't tidy this up as well as I should have on the last occasion. After you saw or reviewed the patient in May 2020, as reflected in the letter we have in front of us, Mr. Haynes, seven or so months later wrote to him. If we could have that letter up on the screen, please? We touched on it briefly on the last occasion. It's WIT-04625. Sorry, just drop down a page so we can see the front of it, 04624. 10:03 10:04

So as I explained on the last occasion, Mr. Haynes is writing to a number of patients following the Bicalutamide audit and lookback review, and if we go into the - if we go to the last of the three pages at 66 in the sequence and to the -- sorry 26 in the sequence -- and to the last paragraph. So his recommendation for the patient is that he discontinues the hormone treatment and move on to surveillance. In ordinary cases you do, was that the appropriate recommendation and one that upon reflection you should 10:04 10:04

have pushed for in 2016 when you first saw the patient?

A. So, I wouldn't chose to use the word "surveillance". I think that indicates in the context of prostate cancer that the patient may be at some point suitable for a treatment with curative intent. That wasn't the case for this patient. So I would chose to use the term "watchful waiting". And Mr. Haynes and I have differed on this in the past at MDT, but that's the way that I would chose to express that. So I think it is -- as I gave in evidence previously, it is entirely valid that this patient could have been offered watchful waiting, and that was something that I would have considered when I met him in 2016. He was already established on Bicalutamide therapy for some six years at that point, and as I have told you before, I made the decision to continue his therapy, to maintain the status quo, rather than to change his treatment plan. I can't shed any further light on why I made that decision at this point because my handwritten notes don't lend any extra evidence and the letters are as you've seen. 10:05 10:05 10:06 10:06

5 Q. Yes. So your differences is my -- you would have -- my recommendation is to discontinue the hormone treatment and move to watchful waiting?

A. Yeah, I think both of those options were reasonable.

6 Q. Yes. Could I just go back up to the previous page? So, bearing in mind that Mr. Haynes, the thrust of his advice is to stop the hormone treatment? 10:06

A. Yep.

7 Q. And move to surveillance. You would prefer watchful

waiting, and we see the difference in your approach there. Let me ask you about this last paragraph, if you can help us with this. He says to the patient:

"If you do not wish to stop hormone treatment and wish to continue hormone treatment as a long term treatment, recognising that evidence shows that this treatment will not increase your life expectancy and that continued hormone treatment does continue to give side effects, then the recommended hormone treatment would be an injection treatment which is given every three months." 10:07 10:07

So that appears to be a prescription of or suggestion that the prescription would be LHRH agonist. Is that your reading of that? 10:07

A. Would you mind just drawing the document back down to the top so I can see the diagnosis?

8 Q. Of course. We can go back to the first page.

A. Yes. 10:08

9 Q. So it is -- I think it's low risk organ confined -- yeah.

A. Yeah, maybe a little bit further. Okay. So this patient doesn't have metastatic prostate cancer diagnosed at this point in time. So I personally wouldn't, you know, if this was a new patient to me I wouldn't be initiating LHRH analogue therapy for this patient. What we have is a situation whereby the patient is a non-standard dose of Bicalutamide, and I 10:08

think Mr. Haynes is attempting to draw the patient into standard therapy by giving them either, or offering them the opportunity of either an LHRH analogue or Bicalutamide 150mg. But I think on balance, if the patient doesn't have metastatic disease, they may well have locally advanced disease, and that might be a reason for considering therapy, but I think on balance the better option here would be watchful waiting. 10:08

10 Q. So, just to go back to that paragraph, because it does introduce, if you like, just to remind ourselves Mr. Haynes is saying: 10:09

"Dear patient,
Surveillance is the route for you and come off hormones." 10:09

And if you go back to that page then, down to the bottom of -- yeah.

A. I think you could also take the view, reading this letter, that perhaps Mr. Haynes is recognising that the patient may be resistant to changing therapy. 10:09

11 Q. Yeah.

A. And he is giving the patient options.

12 Q. Yes.

A. Which is a reasonable thing to do. 10:09

13 Q. Yes. It is the case, you've made the point yourself, I wouldn't in this case on the face of it move him to LHRH. That is associated with adverse toxicity compared to Bicalutamide, is it, or the risk of adverse

--

A. Both therapies can have side effects for the patient. The side effects are somewhat different in profile, but watchful waiting would have no side effects.

14 Q. Yes. And the third of the options here, and as you say we can maybe ask Mr. Haynes about this letter, and maybe it's an attempt, as you say, to set out all the options and then engage in a conversation with the patient. The suggestion of moving to a daily 150 Bicalutamide as a monotherapy, is that drug licensed for the treatment of localised organ confined prostate cancer? 10:10 10:10

A. I don't think it's licensed for localised, but I think it might be licensed for locally advanced. I'd have to check that.

15 Q. Could I move to Patient 137? We again looked at this on our last occasion. You'll recall that this was a case where Mr. Young had been told to refer the patient to an endocrinologist arising out of a multi-disciplinary meeting, and that didn't happen, and it was, in essence, lost until the general practitioner wrote in. We looked at that on the last occasion. I think you told us that you had no discussions around this, it hadn't been brought to your attention. I just want to look at that again with you. If we go to WIT-100394, and this is -- if we just go to the top of the page. Sorry, further up. Yep. And it appears to be an incident check list. It sets out a series of events in the processing of this incident report, the 10:11 10:11 10:12

IR1, and if we just scroll down the page to the 21st of September, and we can see that it says that:

"The patient has been reviewed by the endocrine team and is for discussion with Radiology, but the likely outcome will be ongoing surveillance. Discussions concluded that while this is not an SAI there is learning regarding the processes in MDM. The incident is to be shared with Mr. Glackin, Chair of the MDM, for discussion regarding current processes." 10:13

And just on down the page, 9th January:

"Send information to Mr. Haynes to see if a letter is required. Not an SAI. Meeting being organised with the Chair of the MDM. Discussed outcome of findings. Does this case need included in a letter to Michael Young." 10:13

And then there's a box marked "Decision on level review", et cetera: 10:13

"Not an SEA processes.
2. Regarding MDM to be reviewed with Mr. Glackin meeting being organised by governance team." 10:14

So I didn't draw your attention to those entries on the last occasion. Your evidence on the last occasion, however, was I suppose inter alia, that was not a case

you had any awareness or knowledge about, and I was suggesting to you that's perhaps surprising in circumstances where you were the MDT lead at the time.

A. Yes.

16 Q. And these entries suggest at least that the direction of travel would be to discuss the malfunction in the procedure with you? 10:14

A. Mm-hmm.

17 Q. Do you remember the issue being discussed with you?

A. No. 10:15

18 Q. Should it have been discussed with you?

A. Yes.

19 Q. Why should it have been discussed with you, given that you were the lead?

A. Because there's a significant delay in appropriate referral to another speciality resulting from an outcome from our own MDT. So that should have been brought to my attention. 10:15

20 Q. We know that Mr. Young received a letter signed off by Mr. Glackin asking him to give assurance? 10:15

A. Perhaps it was Mr. Haynes.

21 Q. Sorry, of course. Mr. Haynes, of course. Asking Mr. Young to give assurance that he had in place processes to ensure that this doesn't happen again. I suspect that Mr. Young will say that he gave verbal assurance around this. Again, that's not something that was drawn to your attention? 10:15

A. So I have no knowledge of that.

22 Q. Yep.

A. So I think my first -- I may have been at the MDT where this was discussed, but I have no recollection of the original discussion, as documented in that timeline. I have no recollection of it ever being discussed at a later date as a result of this process. And my first reading of this, as far as I am aware, was when I received the evidence bundle.

23 Q. Yep. In light of the nature of the error and the break down in the safety nets, which you referred us to the last time, onus on the consultant I think you explained -- 10:16

A. Yes.

24 Q. -- to get on with the referral.

A. The primary responsibility is that of the consultant.

25 Q. Yes. The tracker or coordinator nevertheless knows about it and should, in the normal case, have emailed the consultant's secretary? 10:17

A. Yep.

26 Q. To provide a further layer of protection.

A. Yes. That was custom and practice. Whether that's written down in an SOP, I'm not sure. 10:17

27 Q. Yeah. Yeah. How is the Inquiry to view, in governance terms, a situation where that can happen? It's reviewed through an incident report process leading to a letter to the consultant involved, and it doesn't reach your desk as MDT lead so that you can satisfy yourself that everything that can be done to prevent this happening again has been done? 10:17

A. Yeah. So in many ways this opens a can of worms

because you then naturally I think would ask the question: Are there other cases that have not been actioned? So the only way that you would know that is if you did some form of audit.

28 Q. Of course. That's one way of monitoring the robustness of the system. But is there -- looking at the situation as it was in 2018 when Mr. Young, two years after the event, finally gets his letter from Mr. Haynes, is there not some shortcoming in a system where you as the MDT lead is not even brought in, to the best of your recollection, to a discussion in relation to it? 10:18 10:18

A. Yes, that is a shortcoming.

29 Q. Now, I want to move to another issue that emerged from the SAI process that was reviewed by Dr. Hughes and Mr. Gilbert in 2020. It's the case of, in their language, a failure to refer on a timely basis a case of penile cancer. 10:19

A. Okay.

30 Q. To a supraregional forum or, in the alternative, a specialist in the field. It is the case, is it not, that at that time a supraregional MDT wasn't established and functioning? And by "at that time" I should of course say that the case came in to the MDM in the Southern Trust in April 2019. 10:19 10:20

A. That is correct. There was no specialist MDT and there was no supraregional MDT link.

31 Q. Just maybe we'll start with some of the facts around this. If we can go briefly to DOH-00092, and if you

just glance at the Executive Summary. So:

"The patient was referred to Urology Services 20th February 2019 in view of a growth on his foreskin. He was referred for urgent circumcision which was performed on 10th April. Histology confirmed squamous cell carcinoma. There was both lymphovascular invasion and perineural infiltration, both of which were associated with an increased risk of metastatic disease at presentation or subsequently. 10:21

At the MDM, which was a virtual meeting conducted by a single urologist, recommendation was that Dr. 1 would review the patient and arrange for a CT scan of chest, abdomen and pelvis to complete staging. He was referred to the Regional Penile Cancer Service in February 2020. The patient passed away in January 2021." 10:21

It is the case that this patient's case passed through MDM on a couple of occasions in 2019? 10:21

A. Yeah, that's correct.

32 Q. And as it's made plain here, there was no referral to -- there was no referral made to the Regional Penile Cancer Service until February 2020? 10:22

A. Yeah. So there wasn't a Regional Penile Cancer Service established until January 2020. So two units within the region had made bids to be the host service. That process was ongoing in 2019. Towards the end of 2019

it was established that the host service would be based at the Western Trust and that two surgeons, two urologists at the Western Trust would be providing that service. That came into being in January 2020.

33 Q. Yes. Could I just bring you to the recommendations, or the findings of this SAI. If we go to DOH-00097. So if you just actually go back to the bottom of 96. So it's saying that: 10:22

"The MDM should have recommended urgent staging and simultaneous referral either to a regional or supraregional penile cancer specialist group..." 10:23

- you of course correctly say it didn't exist:

"...or to a surgeon with appropriate expertise for all subsequent management." 10:23

So I suppose in the absence of supraregional group the other option is to place this in the hands of a specialist rather than retaining it amongst apparently non-specialists in Southern Trust. Is that a reasonable point to make? 10:24

A. I think looking at it through the lens of 2023 perhaps it is, but I would counter that in Northern Ireland historically penile cancer surgery would have been conducted in all of the units. Most penile cancer surgery is relatively straightforward. The capability to do an inguinal lymphadenopathy or lymphadenectomy 10:24

would have been certainly part of the competency of most of the surgeons who undertook major cancer work. So it's perhaps a question you should ask Mr. O'Brien about whether he felt competent to do an inguinal lymphadenectomy. Personally I've had training in this. I spent a full year working in a regional penile cancer service in the West Midlands. So I, at that point in my career I would have felt very confident about doing an inguinal lymphadenectomy, and I certainly could have done the penile cancer surgery myself. 10:25

I think you come to recognise though that it is a -- it forms a very small part of our workload and certainly in the West Midlands it was centralised, so the move to centralise the service in Northern Ireland was a sensible move, and, you know, the numbers of cases are small every year, they're probably fewer than 30. So I think if this had of been a year later it would have been referred, you know. So that's just the difference. 10:25

34 Q. The NICaN position on this, I think it's set out at WIT-85345. And this is the NICaN guidance from 2016, and it provides that:

"Patients with penile cancer should be managed by specialist penile cancer teams working at the supra network level." 10:26

So, again, that wasn't a feature of life in Northern

Ireland in 2020?

A. There are lots of things that are written in the NICaN guidelines that were aspirational and they weren't in place.

35 Q. Nevertheless, given the unpredicability of penile cancers... 10:26

A. I'm not sure that I would agree with that.

36 Q. Okay. Would you agree that they are, they have the potential to be high risk cancers?

A. Yes, I would, but it's not unpredictable. It is very well established how the lymph nodes are involved and how the disease spreads. But it can be an aggressive disease, I think that's the word I would use, not unpredictable. 10:27

37 Q. The thrust of the guidelines and the direction of travel which your MDT would have been aware of was that these, this particular species of cancer should be dealt with by specialists, those who have regular exposure to the disease, rather than, for whatever reason, holding them in a small local centre that isn't regularly exposed to the disease? 10:27 10:28

A. Yep, I think that's the correct way that it should be managed, but as I made the point to you earlier, these cases prior to the establishment of that team in 2020 were being managed in all of the urology units in the region. So the volumes in all of the units would have been small at that time. 10:28

38 Q. Is there general learning to be extracted from a case like this in terms of whether the centre at Craigavon

should retain to itself cases that are better treated by specialists, or do you maintain the view that really in 2019 it was entirely appropriate to hold on to a case like this?

A. No, I didn't say it was entirely appropriate. 10:29

39 Q. No, no, I am asking you.

A. Yeah. I had already had experience of working in a regional centre delivering this kind of a service, so I knew what should be happening. It's just the fact that it wasn't established here. So to give you a little 10:29 bit of background. One of the trainees who finished our training programme left and did two years of andrology, and that person then came back and was appointed in the Western Trust. That then led us to the situation where we had a specialist in the region 10:29 trained and able to deliver this. That person was accompanied by one of their other colleagues, who was a long established consultant in the Western Trust, and between the two of them they were then able to deliver this service as a regional service. Prior to that 10:29 there was no specialist trained andrologist appointed in Northern Ireland.

40 Q. As an MDT, when cases come along that the guidance suggests should go to a specialist such as this, is there a discussion about the capacity and the expertise 10:30 to retain the case?

A. So this has also affected other things in Northern Ireland. There was a period when the person providing the bulk of the renal surgery in Belfast City Hospital

left, and they went on sabbatical for a long period of time, and that meant that there was nobody to provide that specialist service in Belfast. So we then had the situation of consultant surgeons in other units, such as myself, Mr. Haynes, and another surgeon at Altnagelvin, being faced with the possibility that we couldn't refer to Belfast and we had to take on things ourselves. We were all adequately trained to do that work, but if you looked at the guidelines we would have been treating those patients outside of what NICaN guidance said. 10:31 10:31

So, you know, you're faced with a situation of on the face of it you've got these guidelines which are basically mirroring what has happened in IOG in England. We're working with a much smaller population. We have to deliver the care for the people who live here. And sometimes you're faced with a decision that you have to do the best with the resource that you've got available. 10:31

41 Q. So that's, I suppose, a broad expression of principle to reflect the kind of difficulties you might face?

A. Yeah.

42 Q. As a small local unit.

A. Not even a small local unit, a small region. 10:32

43 Q. Yes. To be clear, because of your exposure to the treatment of penile cancer from where you came in training, did you ever see the need to refer out of Craigavon, whether as MDT lead or wearing your

consultant hat?

A. So prior to the establishment of the regional or the specialist MDT for penile cancer, I would have dealt with penile cancer cases myself in Craigavon. I would have had the skills do so, and I would have felt comfortable doing so. But I recognised that the development of the specialist MDT was appropriate, and once we had the staffing in place all of the cases go to the specialist MDT. 10:32

44 Q. As an MDT in, to take this particular case, it was -- the patient was being managed by Mr. O'Brien? 10:33

A. Yes.

45 Q. The referral didn't take place until a year after the patient had come to Southern Trust's attention?

A. The referral couldn't take place any sooner than January 2020. 10:33

46 Q. Well the -- and that is of course right. As an MDT, is there any interrogation or questioning of the expertise of the clinician in whose hands the patient is being taken forward? 10:34

A. Yeah. So I had knowledge of Mr. O'Brien's capability to do an inguinal lymphadenectomy, and in my view he could do an inguinal lymphadenectomy to the appropriate standard.

47 Q. And the management thereafter? 10:34

A. Yes, and I had the experience of sharing ward rounds with him, looking after the patients who had had such surgery over the previous, by that stage four years as a consultant colleague.

48 Q. So, as an MDT you were each satisfied that this case should remain in Craigavon?

A. No, I don't think "satisfied" is the word I'd use. I mean if there had of been a specialist MDT established in Northern Ireland for this disease, then all of the patients should have been going to that. We were working in a situation where that was not the case and, therefore, we had to deliver care for the patient, albeit it without the framework of a specialist MDT. 10:35

49 Q. And in the absence of a specialist MDT, other alternatives that are available to your unit in terms of seeking advice? 10:35

A. So on occasion, and it would be a very occasional thing, patients may have been referred to MDTs in England. I had one penile, not penile cancer, I had one testicular cancer case shortly after I joined Craigavon, we discussed at the local MDT, there was no provision for that patient in Northern Ireland in terms of specialist MDT, and I referred that case to Birmingham. So that kind of thing happened very occasionally. 10:35

50 Q. Knowing the features of this case, is this one that should have been referred externally, or short of that, is this a case where advice from a clinician with more regular experience and expertise of managing these cancers? 10:36

A. I'm not sure I would characterise it that way. Mr. O'Brien at this stage of his career probably had 25 years experience of delivering cancer care. So, you

might want to check the timelines, but it would have been about that amount of experience. You know, the surgery in this case I don't think was at all the issue, it's the absence of the specialist MDT. You can read the histology report of the lymphadenectomy, it was a very adequate lymphadenectomy. He described the anatomical boundaries of it, you know, it was correct surgery. 10:36

I also differ from Mr. Gilbert's assessment. When the patient had had the CT scan there was obvious lymphadenopathy on one side. If you read the EAU guidelines which pertained at the time of this, then it did not describe doing a bilateral procedure, it described a lymphadenectomy singular, that means doing one side. So that's the evidence on which we would have made the decision at the MDT, and that's how we proceeded. 10:36 10:37

The fact that the patient had disease in his lymph nodes means that it was aggressive disease, and when you're faced with that situation those patients do not do well. 10:37

51 Q. Yes. My interest in particular is not the instant case, it is the process around a situation where at the point of staging the SAI reports says "refer"? 10:37

A. Yeah. There was nobody to refer to within the region.

52 Q. There was no one to refer to in the region. But that doesn't - broadening this out - it can be any cancer

that comes along at any time for which your MDT doesn't have the specialism. If you don't have the specialism in the unit, and you don't have it in the region, is it good enough to keep it in-house rather than refer it outside of the region to another MDT, or at least a specialist in the field? 10:38

A. So, as I have already told you, I think that in terms of delivering the surgical care that this patient needed, the care was appropriate.

53 Q. That's not the issue. The issue is what is done after the surgery when you know the staging? 10:38

A. There were no formal links for any of the units in Northern Ireland for penile cancer outside the region at that point in time. They were not established.

54 Q. And you can't pick up the phone and seek advice? 10:39

A. I don't think I would have needed to, because I've managed this situation myself before. I think Mr. O'Brien wouldn't have needed to either.

55 Q. Let me move on now to briefly examine where the MDT is now at in terms of it's governance and in terms of the superintendence of its procedure, so that some of the issues that have been identified as amounting to safety issues, so that we can begin to chart whether those shortcomings have been addressed. 10:39

10:40

The recommendations of the SAI, or the series of SAIs in 2020, spoke across a number of the issues to the need for audit. Let me bring just bring that up. DOH-00129. If you just scroll to the bottom of the

page, please? So we can see that the recommendations of the SAIs are quite often expressed in high level language, and here's a typical example.

"The Trust must provide high quality urological cancer care for all patients." 10:41

And there's an expression as to how that will be achieved. And the assurance to ensure that this is achieved is described as: 10:41

"...a comprehensive pathway audit of all patients care and experience."

And as I say, the need for an audit, or various audits, is expressed across a number of the recommendations. Move down to (2). Again, a high level expression of the recommendation that: 10:41

"The patients should be appropriately supported and informed about their cancer care." 10:41

And if we scroll on down, the assurance is a comprehensive cancer pathway audit and patient experience. 10:42

At (5), moving down, the recommendation is that the MDM - a little more specific:

"...would be resourced to provide appropriate tracking of patients and to confirm that the recommendations and actions are completed."

And scrolling down, the assurance is audit. 10:42

Help us with this, Mr. Glackin. We've heard I think already from you that the MDT is better resourced with the appointment of a Mr. Mark Quinn as a clinical audit and information manager, Mrs. Muldrew as a specific MDT 10:43 focused admin support. In terms of the audit of the kinds of things discussed in the SAI report, is that being done? I think we've heard from you already that audit is now much improved in the Trust. Is it specific within MDT structures? 10:43

A. So following the appointment of Mark Quinn, and under the direction of Angela Muldrew, we have a monthly audit process of outcomes from MDT to ensure that the outcomes are followed up and actioned. That report is provided to me, and it's also provided to the whole of 10:43 the MDT, so that if there are any shortcomings or points that have not yet been actioned, they can be brought back to the meeting and discussed and actioned. So, that's been in place for almost a year. So that is working. We have a report from the Pathology 10:44 Department that's run I think on a weekly basis to ensure that all pathology is brought to the meeting that should be. So they're at least two of the reports that are being supported by cancer services.

56 Q. And do you feel -- we've been through some of the issues and we've seen where tracking has gone wrong in the past, we've seen through the SAIs where referrals haven't happened despite the recommendation of the MDM, and there has been no report back to the MDT to alert the members to that. Is that -- are those the kinds of things that the audit processes are now designed to hone in on? 10:45

A. Yeah, I think certainly missed referrals would be picked up by that audit process, but it also means that the level of communication between cancer services and our MDT is much better than it would have been in the past, and that's a definite improvement. It also means that if we have ideas about how we would like to do things, that we've somebody to approach and speak to them and say "We'd like to do this audit", for instance. The whole pathway wracking is still not in place, is not funded. 10:45

57 Q. Yeah. Recommendation -- I think it's Recommendation 5, if we scroll back up. So it's talking about -- yeah, it's talking: 10:46

"This will be achieved by appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance." 10:46

Is that what's not in place?

A. I think we're still only funded to first treatment.

58 Q. And is there agitation or advocacy around this?
A. Yep.
59 Q. As far as you know?
A. This has been spoken about for a long time. It is known to the people who lead our cancer services that this is appropriate. 10:46
60 Q. What would be the utility of it from your perspective? Can you paint for us some examples of where you see the potential for patient safety or patient risk if this isn't in place? 10:47
A. It's hard to think of examples straight off the top of my head, but there are some cancers that we survey or monitor for very long periods of time, bladder cancer would be one example. Some of the prostate cancers, fall into that category. So those would be the patients I think who would benefit from that process. It would be very resource intensive. You know, the trackers are currently tracking perhaps 700 live cases. So that's a lot of people to keep an eye on. If we went to the whole of pathway tracking, that number would invariably increase, and if we had some form of tracking mechanism for all those patients who were on forms of monitoring and surveillance, my own personal workload of cancer patients probably comes into the range of three or 400, minimum. So you multiply that out across the team, you can have an idea of how many patients we're talking about. 10:47 10:48
61 Q. In terms of -- you mentioned a moment ago that there's now I suppose better accessibility to the cancer side

of management, whereas it was painted in fairly bleak terms within the SAI reports. There was talk of a disconnect between the MDT and cancer side, and I think you've echoed that in your Section 21 statement. In what ways has that connection been "enhanced" probably isn't the right word if there was not much there to start with? 10:49

A. I think the key appointments have been those of Angela Muldrew and Mark Quinn, because they are then able to work with the MDTs across all the different specialities to provide the kind of audit support and back office support, if you like, for the activities that we undertake. 10:49

Secondarily, we have a new cancer service's CD. He's a medical oncologist. He happens to attend our MDT, which from my perspective is great because I have a direct line of communication, and that has given a new impetus to improving the governance and oversight of all of the MDTs. 10:49

So you'll be aware that there was a piece of work following this report from Dr. Hughes that was undertaken by Dr. Tarek, who was the AMD for this service, and out of that then there has been lots of new changes, and I would say certainly in my experience with the Urology MDT, improved support for us. 10:50

62 Q. In terms of the MDT membership itself, we know that there was -- there is built into the operating

procedures the need for an annual business meeting as such. Is that something that has been, while it may have taken place in the past, has that being reinvigorated as a process? Is there, if you like, a more robust review of performance within the MDT and, for that matter, a more I suppose considered view of what the MDT needs in terms of reaching out to others for assistance and support? 10:50

A. So the business meeting does take place. The last one I think was in September. I think it was maybe a week or two before I appeared at this Inquiry. The performance data is presented. All of the core membership attended. It's an open meeting in terms of members are very welcome to critique, or question, or ask questions of the data and of myself. I Chair the meeting. I am supported by Mary Haughey, who is the Operational Support Lead. I might have that term not quite right, but that's her role is to support the MDT. So, yeah, I think the business meeting has been working well, but it only happens once a year because that's really the all the resource and time that I've got to devote to it. 10:51 10:51 10:51

63 Q. In terms of, let me take a particular example, its Recommendation 8, if we scroll down through this. It talks about: 10:52

"All patients should receive cancer care based on accepted best care guidelines."

Again, fairly high level. But it's focus is the clinician who might see fit, perhaps for good reason, to defer from the, or divert from I suppose is the right word, the outcome reached at MDT. So it's said as part of the assurance variance from accepted fair guidelines and MDM recommendations should form part of the cancer pathway audit. 10:52

"Exception reporting and escalation would only apply to cases without appropriate peer discussion." 10:53

So is that something that's capable of being captured by audit, and is it being captured by the current audit?

A. So the first thing to say is that the vast majority of cases that have been audited have had the outcome checked that was given at MDT, and that has been found to be delivered. A very small number of cases are at variance, and a small number of cases where things have not happened that should have happened. So I think it's all very well understood now by our team, and as I expressed to you the last time I was here, that where a clinician makes a decision at clinic that is at variance with the MDT recommendation, that we bring that back to the MDT. 10:53 10:53 10:53

64 Q. And that's the understanding of the clinician, but where's the check to ensure that that...

A. Because the audit takes place. I am aware of it, the whole team is aware of it. The case is listed for

discussion and that then happens.

65 Q. So, just in nuts and bolts terms, if the recommendation of MDT is to refer to oncology, but --

A. It's not usually something like that that would cause a variance. What would cause a variance is whereby we have recommended a treatment plan, and the patient comes to clinic and for whatever reason that treatment plan isn't appropriate, whether it's patient choice, whether it's fitness, whatever it happens to be, and so that would then be brought back to the meeting by the clinician to say "I've met with this patient. We can't proceed with this plan for this reason", the MDT reviews that and it's signed off, if that's appropriate to do so. 10:54 10:54

66 Q. Yes. And how would the audit capture the change of approach? Say -- 10:55

A. Yeah. So the audit is based on --

67 Q. No doubt an exceptional case, but the clinician has had the meeting, had the consultation with the patient, they're thinking of going down another route, they don't wish to share that with the MDT, and I recognise that's against the norm that you're seeking to promote as an MDT, but how would the audit capture that change of direction? 10:55

A. Yes. So, the audit is reading the letters that have been provided, provided there's letters there, which invariably now there are, and so they would read through the letter and they would determine from that whether or not the outcome had been appropriate. And 10:55

if it's not appropriate, it comes back to the meeting, and if it is appropriate it's recorded that it's appropriate and that information is also provided.

68 Q. You've said in your -- just scrolling up to "Recommendation", you've said in your witness statement at paragraph 1.5, that you are working with Dr. Tarek, is that right, to formulate a job description for the Chair and -- 10:56

A. So that has been completed.

69 Q. Yes. 10:56

A. But it's not just for me, it's for all the Chairs of MDT throughout the Trust. The cancer MDTs.

70 Q. Yes. Have you taken that role on?

A. No, I was assisting Dr. Tarek.

71 Q. Yeah. 10:56

A. I suppose primarily because urology was under most focus. But it was his responsibility and he has delivered that.

72 Q. And so that's a global job description, where one didn't exist in the past? 10:57

A. Correct.

73 Q. -- applying to all MDTs. So we'll no doubt seek a copy of that job description from the Trust, but if you could give us a brief heads up on that? Are there activities within the job description that surprise you in the sense that they were never there before, or is it simply a putting on paper stuff that was routine for you? 10:57

A. I think it is capturing in a document the activity

that's expected correctly of the lead clinician of an MDT. It is also setting out the responsibilities, it sets out the chain of management, things like that.

74 Q. Could I move now to the area of key workers and the CNS. You've explained in your witness statement the extent to which clinical or cancer nurse specialists are in essence embraced by your practice and in terms of how you work. If we go to WIT-42303. Just, sorry, if we skip back to the bottom of the previous page, and you say that: 10:58 10:59

"The nursing staff in Urology Outpatient Department are excellent. The team has expanded over the years to include five clinical nurse specialists."

10:59

You work closely with all of them.

"I have been involved in providing membership and training to four of them. The urology cancer CMSs are all integral part of the cancer MDT. They attend my uro-oncology clinic each week to support patients and provide advocacy. They are in the room for all face to face consultations. Lines of communication are open and effective. We engage on a daily basis. I value them and I know from formal feed-back that this is reciprocated. I consider that five CNSs is sufficient to provide for the needs of our department to ensure patient safety." 10:59 10:59

So historically, of course, you didn't always have five, it was sitting at two, as I understand it?

A. Yes. So when I joined the Department in 2012 there were two CNSs in post.

75 Q. A further one appointed in 2019, and two, that is Messrs Young and Thompson? 11:00

A. So I think -- yeah. I think you heard the evidence of my CNS colleagues. Two people were appointed to what were a charge nurse role and ward sister role, when they really should have been appointed to CNS roles. 11:00 That seemed to be some kind of mess up on behalf of the Trust. But essentially they were functioning at CNS activity, although they did have managerial activity to deliver, which was preventing them from being full-time CNS. So we now have five. They are three people 11:01 delivering primarily oncology, and two people delivering benign, and many of the members of the team have advanced skills. So they're actually working beyond the level of a CNS, they're working at what in other jurisdictions might be considered an advanced 11:01 nurse practitioner role.

76 Q. In terms of the cancer work and what you have described here in terms of the integration of the cancer specialist nurses within the work that you do, having them present at consultations, for example, as maybe a 11:01 strong illustration of how central they are. Obviously there's a lot of work beyond that. Is that the approach that you have adopted with them and them with you throughout your period in post or has that improved

with resource?

A. Yeah, it's improve with resource. So if I look back at my training, I worked in different places where there were different systems. In some places they were very well resourced with CNSs, and you would have had specialist CNSs for each disease type, and we would have had CNSs in the room, because there were enough staff to provide that for the clinics. 11:02

In other places, the CNSs would have been available within the unit to see patients after they had been consulted with by the doctor. 11:02

So when I joined Craigavon, we had the system whereby we didn't have enough staff that they could be in the room for every consultation, but the CNSs were available to patients after the consultation, either immediately after or by providing the contact details for the CNS and the details of the patient to the CNS, so that the patient could be contacted. 11:02 11:03

Over time as our team expanded it became possible for a CNS - it wasn't always the same person - to attend my Monday afternoon clinic. That clinic is only for Uro-oncology patients, the majority of which are post MDT discussion patients, and a smaller number of oncology review patients who may need to be seen urgently, for whatever reason. 11:03

So, you know, it's very valuable to me that they're in the room, because they hear the whole conversation. It's valuable to the patient because they've got an immediate person to contact, and frequently the way I deliver the care is that the patient actually uses the CNS as their first point of contact. So if they make a decision for treatment, perhaps for prostate cancer, they phone the CNS and they say "This is the route I want to go", the CNS keeps me informed and we make sure the referral happens. 11:03 11:04

77 Q. During that period when the resource wasn't as good as it was now, and therefore you didn't always have the opportunity to have the nurse attend the consultation with you, and it was maybe a bit disjointed, the connection with the patient and the nurse happened afterwards, or maybe it happened after a phone call, was that something you felt in terms of your style of working you needed to push on the patient, or was that, if you like, an easy sell? 11:04

A. So, every patient would have been offered the contact details for the CNS, they would have been offered written information regarding the support services within the Trust, and they would have been offered written information regarding their particular disease process. So that information was stored in a locked filing cabinet in, or it's a cupboard actually in each consulting room, and that cupboard was open every clinic so that you could take that information out of the cupboard, hand it to the patient and say "This is 11:04

the contact details for the CNS." If they were available they'll see them after the clinic. If they weren't, they would make contact with them thereafter. Some patients didn't want that information, and that was their choice, and if they didn't want it I'd document that they had declined the offer to meet with the CNS. Perhaps it would be right to say that that was a tiny minority of patients.

78 Q. The patients that were the subject of the SAI review, all nine of them, at least in accordance with the findings, did not receive the benefit of a CNS. Does that surprise you? 11:05

A. It did surprise me.

79 Q. Out of that small group of nine, there were a range of cancers, and no doubt Mr. O'Brien would have met with those patients in different settings, including the Southwest Acute Hospital, where, as I understand it, a CNS wouldn't routinely be stationed? 11:06

A. Yeah, that's correct. So there wasn't any facility for us to bring our CNS team to Southwest Acute, largely because of staffing issues. Secondarily, until very recently the CNS activity was all delivered in Craigavon. It wouldn't have followed consultants to Banbridge, for instance, or to Armagh, or South Tyrone for that matter. So, you know, we really only had CNS capability in Craigavon until very very recently. 11:06

80 Q. Yes. And thinking about your own practice, and those of your other colleagues, with the exception of Mr. O'Brien, by 2019 you're up to a third CNS 11:06

appointment, two more follow in 2020, albeit they're not all focusing on cancer cases. But what is your understanding of the practice of your colleagues in terms of their utilization of the CNS for cancer work, or indeed for benign work? 11:07

A. So I'm not present at their clinics, but my understanding is that they have CNS input at their clinics.

81 Q. Could I ask you about the approach to the, if you like the appointment of a CNS, and you can correct me if you 11:08 don't feel that the word "appointment" is appropriate, but before you perhaps do, can we look at the MDT operational policy? We can find it at WIT -- I'll just show you -- well, we probably don't need to show you the front page, you're familiar with it, but WIT-84726. 11:08 Sorry, if we actually could go back? If we go back to WIT-84545, and it is hear talking about the key worker, which as I understand it, is used interchangeably with CNS, and it talks about the identification of the key worker being the responsibility of the designated MDT 11:09 core nurse member. It says:

"It is the joint responsibility of the MDT clinical lead and of the MDT core nurse member to ensure that each urology cancer patient has an identified key 11:09 worker and that this is documented in the agreed record of patient management."

Can you help us understand whether that is the approach

in practice that there is an obligation resting with you as the MDT clinical lead to ensure that each urology cancer patient has an identified key worker?

A. So I think this document was certainly live in 2016, it would have been reviewed by me in 2017, and largely the sentiment of this still pertains to today. The statement is there really to reinforce the fact that all the patients should have access to a cancer nurse specialist, and in order to have some oversight of that, that should be the responsibility of the MDT lead and the core nurse member. I think they're the two appropriate people for that responsibility. As the MDT clinical lead currently I have the overall responsibility, and clearly the core nurse member themselves being a CNS, would have, if you like, not line management responsibility, but a responsibility to ensure that the other CNSs are available to do this kind of work for the patients. 11:09 11:10 11:10

82 Q. So if it's right that in the nine cases that we've been referred to pursuant to the SAI process, that none of those patients had a key worker, where, in terms of your lead responsibility, does that omission come to? 11:11

A. So I had no awareness first of all that they didn't have a CNS, but if I had have had an awareness then it would have been up to me to address that with the CNSs and the core nurse member to say, to ask them, you know, were they aware that these patients hadn't been offered the opportunity of CNS input, and if they hadn't been offered it, why not, and you know, to dig 11:11

into that a little bit and understand why it hadn't happened. So, you know, that's I think where my responsibility lies.

I think there's an equal responsibility on the core nurse member to undertake that kind of questioning activity. 11:11

I know from how custom and practice has been described to me by the core nurse member in the past that they would have a list of patients seen at MDT and that they would go through that list and ensure that patients had been allocated a key worker. Quite when that activity began and how detailed it was, I don't know. But that's my understanding. 11:12

83 Q. So, in terms of what we have in front of us, are you describing a situation where the MDT discusses a patient, the next step is for the consultant urologist to bring the patient to a review meeting, and it is at that review meeting where the introduction, if the nurse is available, is made? Or in the alternative, the patient is sign posted to the nurse? 11:12

A. Yes, I would agree with that.

84 Q. Yes. But if that doesn't happen for any reason, you would expect, whether it's a resource issue or whether it's some other issue, you would expect that to be drawn to your attention in your role as clinical lead, and at that point -- 11:13

A. So I think the first step would be that the CNSs should

be aware of who has been seen and who has not been seen, from their perspective, and if there are patients who are not being seen, I would expect that to be drawn to my attention.

11:13

It's also I think perhaps important to note, and this isn't really reflected appropriately in these documents, that the key worker would be assigned at the MDT. That doesn't happen in practice at the time of the meeting, it happens afterwards.

11:14

85 Q. Mmm.

A. And I think you heard evidence from our nurse colleagues as to why that is, because essentially in the job, or rather their time-tabling or scheduling of their own work, they wouldn't be certain who would be at a particular clinic, but nonetheless they make sure the clinics are covered to the best of their capacity and, therefore, at that time it would be established by them who is going to be present to see which patients.

11:14

86 Q. We are aware historically, because of the resource issue, of the shortfall in terms of patients being allocated a CNS. So, for example, if we can have up on the screen, please, WIT-81489. This is a Northern Ireland Cancer Patient Survey 2015, and we can see for Urology 48% of patients have given the name of the CNS in charge of their care, comparing with 53% in the region, and that I think, if we just see the whole of the table, it looks as if urology, at least at that time, was working at comparative shortfall with other

11:14

11:15

cancers.

A. I would observe that we were grossly underserved by CNS capacity at that time, and if you look at other specialties, in particular breast cancer and haematology, two specialities which have long had better resources than we have had.

87 Q. Yes. If we go to your statement WIT-42304. You say at 26.2 that you understand that not all of your colleagues worked in the same manner with urology cancer CNSs. Kate O'Neill and Leanne McCourt told you that they found the communication was difficult with some consultants and that they were not invited to be present at uro-oncology consultations. You've said earlier that obviously you don't have the benefit of being in the room with your colleagues as they consult with their patients, so you can't know precisely what's going on. What is contained within this paragraph seems to be a reference to more than one consultant not behaving in the same manner as you do in terms of their use of CNSs? 11:16 11:16 11:17 11:17

A. So it came as more than a surprise to me that all of these patients in Dr. Hughes' SAIs had not had a cancer nurse specialist involved in their care. Around that time I was aware that this Inquiry was going to be announced, and I was also aware that we were being interviewed by Dr. Hughes. So I was careful in the discussions that I had with my CNS colleagues, because I didn't want to colour their view or try and influence how they perceived the situation. So I spoke 11:17

informally to both Kate and Leanne and asked them what their experience was. Mr. O'Brien would not have had the CNS in the room at his clinics on every occasion, he may have invited them in for selected patients, and that was what I understood from those conversations.

I also -- Leanne also relayed to me the encounter that she had with Mr. O'Brien regarding the key worker discussion, and she outlined that discussion which took place -- from my recollection she described it taking place in the small kitchen in the Thorndale Unit. So that stuck in my mind as to a kind of important interaction that they had had on the key worker role.

88 Q. Just outline that account for the benefit of...

A. So Leanne McCourt described to me that she had advised Mr. O'Brien that she was available to be the key worker for his clinic, and he in turn spoke to her, and I'm relaying what she told me, that he didn't understand what the key worker was. "What is the key worker?", is the kind of substance of it. She was -- she described feeling a little bit taken aback and shocked by his language, and she relayed that story to me, and I think she's relayed it to you here as well.

So that to me kind of laid out that perhaps he wasn't as open to involving the CNSs as I was, that there was a difference in his approach.

Kate also relayed to me at another time that when we

established the prostate biopsy service under the nurses, that some of our consultant colleagues would refer the biopsies to be done by the radiologist and not by the CNS. Now whether that was a willful process or whether it was just what they had always done, I'm not sure, but it felt to her, as she described it to me, that the consultant was not utilising the CNS resource, for whatever reason.

89 Q. And I'm going to ask you about your interactions with Dr. Hughes presently, the first of which took place in November 2020, late November? 11:20

A. Yeah. So, sorry, just to be clear about that. The discussions that I had with Leanne and Kate regarding this CNS absence from the SAIs took place after I had had the telephone conversation with Dr. Hughes and Patricia Kingsnorth. 11:21

90 Q. Yes. Did the engagement with these nurses take place then after that telephone conversation?

A. Yes, they did.

91 Q. But before your subsequent meeting with Dr. Hughes? 11:21

A. Before the subsequent meeting in person, which took place perhaps in February.

92 Q. 18th of February?

A. Yeah.

93 Q. Just in terms of the language that is used there in 26.2, you're reporting more generally that it was being said to you Mr. O'Brien is not using our resource. You make the point more specifically that some consultants, it was being reported to you, were not inviting them to 11:21

be present at uro-oncology consultations, is that the correct dynamic, as you understand it, that their attendance at such a consultation, where they're available, depends upon an invitation from the consultant? Is that the way it works? 11:22

A. I'm not an English scholar. I've tried to express it as best I can. In my view it isn't that I'm not inviting them, it is absolutely their role to be present to advocate for the patients.

94 Q. Yes. That's what -- I wasn't intending to disassemble the language. What I'm asking you really is that. 11:22

A. Yeah.

95 Q. You have an appointment with Mr. Smith following the MDM - again not his real name - how does the CNS become aware of that, and do they, in your practice, simply arrive in the room at half past two, the date of the appointment, without requirement for invitation? 11:23

A. So the current situation for me is that one of the CNSs will be allocated to my Monday afternoon clinic.

96 Q. Right. 11:23

A. That clinic begins at 1:30 and runs to 5:30. The CNS is available for the entirety of the clinic. Generally speaking, when I arrive, I'll arrive a little bit early, I'll go through the cases, and then I'll -- their room happens to be next door to where I consult, so I'll knock their door and say "We're ready to start", and the two of us will start. 11:23

97 Q. So was this conversation, or conversations, the first time in your role as clinical lead of the MDT, the

first time that you became aware of a problem in terms of a consultant giving out the, I suppose the message that the nurses weren't automatically to be welcomed to these consultations?

A. It's the first time that I became aware that there was an issue that they weren't there by right. 11:24

98 Q. Now we are getting to English language and grammar perhaps. You had said "was difficult with some consultants", plural. Was it more than Mr. O'Brien that the finger was being pointed at? 11:25

A. Yeah. My recollection is that Mr. Young wouldn't have always used the nurses in the same manner that I used them, and I think that was reflected in the discussion. Whether or not he -- I wasn't present at his clinic, so I don't know this other than what I've been told, but, you know, perhaps there's just a difference in approach. I mean, I'm a younger person than they are, perhaps they had a different upbringing surgically speaking. That's all that I can reflect on that. 11:25

99 Q. Yes. Yes. But the developments around key workers and the use of CNS, or the subject of education and information, just if you could articulate to us in patient safety, or beyond that in whatever terms, why are these cadre of qualified professional staff viewed as important, perhaps vital to the patient's process? 11:26

A. I think the best person to answer that is actually probably a patient. But my take on it would be this; that perhaps consultants, doctors, are very focused on the medical nuts and bolts of care, and perhaps not so 11:26

focused on the holistic aspects, and that's perhaps a generalisation, because there are indeed, I'm sure, doctors who are very focussed on those issues. But, you know, you're talking to a surgeon here, we like operating, that's our focus. Perhaps we're not as good at some of the other stuff, and the nurses might be a whole lot better at it than we are. 11:27

100 Q. Do you see a role as well for the nurses in terms of, if you like, superintending the process to ensure that the care that perhaps was suggested or recommended by the MDT isn't forgotten about or isn't taken off in a different direction? 11:27

A. So I don't think they have a specific role in being the watchman, but they have definitely a role, as all the members of the MDT have, in ensuring that appropriate care is delivered to the patient, and they have clearly a role in advocating for the best interests for their patients as well. 11:27

101 Q. Just finally in terms of Mr. Young, were the comments that were being made to you in the context of his stone clinics or was it cancer care? 11:28

A. I've no knowledge of his stone clinics.

102 Q. I'm talking in terms of what the nurses were saying about his use of them?

A. So Mr. Young, when I first arrived, would have had a cancer practice alongside other aspects of his practice. In later years he has withdrawn from the cancer practice. So, I think what I am reflecting is when he was doing an Outpatient clinic in the Thorndale 11:28

Unit he may not have had the CNS in the room for all of the consultations. He may have, and I am presuming this, he may have used them at other times, he may have asked the CNS to see the patient, I just don't know, you will have to ask Mr. Young how he practised that. But it is my understanding that the nurses would not have been in the room for the whole clinic in the way that they would have been for mine.

103 Q. In terms of what has come after these revelations, has work been done to reinforce amongst your colleagues the primacy or the importance of the key worker role in both cancer and benign care, where the patient wishes to have them? 11:28 11:29

A. I think as consultants we all accept the importance of the CNS role, and we try to involve the CNSs in - I think they're in nearly every aspect of what we do in an Outpatient setting, both benign and malignant, or cancer. 11:29

104 Q. I ask you that question because it would appear on the conclusions of the SAIs that Mr. O'Brien, for example, was an outlier in that respect, and that's why I ask has there any -- has there perceived to be an -- 11:30

A. To put it this way, I don't think my practice has changed. My practice already included the CNSs. You may have to ask the others to what extent their practice has changed or not. 11:30

105 Q. I suppose what I'm asking is whether the MDT as a unit, and in your role as clinical lead supported by management, has the message gone out that some of these

practices of the past, whether they were exceptional, whether they only involved Mr. Young and Mr. O'Brien, they had to change, and if your practice is not where it should be, you should change?

A. I think the incumbents behave in a similar manner to me. 11:30

106 Q. Yes. In terms of your conversations with Mr. Hughes, let me deal with those then. As you say, 30th November telephone conversation with him, and if we could bring it up, please? TRU-162250. And you have had, I hope, an opportunity to review this note. It was a telephone conversation, no doubt not a verbatim note. Are you content with the broad sense of it, the broad meaning of it? 11:31

A. Yeah, I was provided with a draft by Patricia Kingsnorth. I didn't take notes myself at the time, and I didn't record the conversation, but I felt that the note taken by Patricia Kingsnorth accurately reflected the conversation that we had, and I replied to her by email to that effect. 11:32

107 Q. We'll perhaps come back to these notes for other purposes later, but if we just scroll about a third of the way down. Yeah, just here. Talking about the use of the clinical specialist nurses, and Dr. Hughes is telling you: 11:32

"SAI review panel has met with the families and they each said that they had not been involved with a CNS."

And he's asking was this unusual for one consultant? And you said:

"That there were only two urology clinical specialist nurses in the Trust to support urology cancer parents. Recently the Trust have appointed a new clinical specialist nurse from the South Eastern Trust..." 11:33

- that would have been Leanne McCourt, I think?

A. No. So at that time two nurse specialists were working on the cancer side; that was Kate O'Neill and Leanne McCourt, and the person who was appointed from SET was Patricia Thompson. 11:33

108 Q. Very well. Thank you. And you say:

"The nurses are available for clinics held in the acute setting. However, there had been no nurse available to attend any clinics held off site..." 11:33

- either, as you've said earlier, South Tyrone, Banbridge, that's Armagh, is it? 11:33

A. It is, yes

109 Q. Or SWAH. So as I understand it, you're explaining there to Dr. Hughes perhaps the reason why patients are not seeing nurses is because of a resource issue, they're not -- 11:34

A. Yeah. So Dr. Hughes didn't explain to me, first of all, where these patients had been seen. So this information at this phone call was brand new to me,

that these patients had not had the benefit of a CNS. So first of all I was surprised by that. Secondly, I was thinking on the hoof, so to speak, at the time "Well, why is it that these patients haven't had the benefit of a CNS?", and the first obvious reason that came to me was that, well, if they were seen at a clinic outside Craigavon that was very possible.

110 Q. And then if we turn to what you say on the 18th February of the next year. WIT-94347. And this is where Dr. Hughes came along and met with the MDM. As I understand it nurses were present. That is a rogue reference. 84347. Thank you, Michael. WIT-84347. I am obliged. So we can see the attendees: Jenny McMahon, nurse; Kate O'Neill, nurse, in attendance. If we go to the bottom of the page, please. 11:34 11:35 11:35

A. Jason Young is also there and he is a CNS on the benign side.

111 Q. Thank you. And you've been talking about the nurses - penultimate paragraph - explaining that you were Chair of the Urology MDM, took over from Mr. O'Brien, and the language of this note "are confirming that nurses were excluded from Mr. O'Brien's practice". He doesn't believe there's an issue with other doctors. Is that -- whether you're happy with the precise language you can tell us, but is that the broad message that you were communicating at this meeting? 11:36 11:36

A. So I'm not sure who used the word "excluded" first, whether it was him or me, but I think broadly knowing what we knew at that point in time in February, that it

appeared that Mr. O'Brien was the only person who hadn't been using CNSs in a routine manner.

112 Q. Yes. And obviously we've looked at what was recorded at the November telephone conversation?

A. Yep. 11:37

113 Q. Is it between those dates, November and February, that you've had the meeting then with the two nurses?

A. Yes, I spoke to both Leanne McCourt and Kate O'Neill to get a sense from them as to what was happening.

114 Q. So the source -- 11:37

A. Yes, the source for that answer that I provided was the discussions that I had had with both of them.

115 Q. Yes. If we go to TRA-05376, and this is the evidence we received from Kate O'Neill when she came to this room. If we just scroll down a little. And she's 11:38 being asked by counsel -- the starting point for this is that:

"You never experienced Mr. O'Brien preventing the assistance of CNS or a key worker?" 11:38

"That was our understanding. That was my understanding. That was my experience, yes."

She's asked -- she's not asked about a conversation 11:38 with you, because we possibly didn't pick up on that, or maybe weren't aware of it directly at the time.

There was, in the evidence before us, the information

before us, evidence from Martina Corrigan that the nurses had made their concerns known to her, and she's asked:

"Did you ever speak to Martina Corrigan to the effect that Mr. O'Brien doesn't allow us access, or it's difficult, or he's obstructive in any way?" 11:38

And she denies that. In terms of -- if we just go to the bottom of the -- yeah, that completes it. That evidence, although specific to Mrs. Corrigan perhaps, brings out, I suppose, a general point being made by that nurse in her evidence before us, which appears to be inconsistent with what you have been told, on the face of it? 11:39 11:39

A. Yeah, I recognise that. What I would say is the way the questions were asked there is, you know, and this isn't a reflection on you, but you know --

116 Q. Don't worry. It wasn't me.

A. (Laughs). Very good. So, you know, is, were they obstructed? I think that would be a very strong term to use, you know. "Did he stand in the doorway and not allow you to walk in?", type of scenario. That never would have happened. The question rather should be: "Were you present? Were you in the room? Were you asked every single time to partake in the care of a patient?". That's the question that should have been asked, and I think if you ask that question you might get a different answer. 11:39 11:40

117 Q. Well, we can certainly follow up using the language that you have used to describe your interaction with the nurses and see what response we obtain from them. I mean the reality would appear to be that nine patients, for whatever reason, suffered what might be regarded as a care deficit, in not having the services of the CNS during their care pathway, and you would agree that however that may have come about, it is certainly not a welcome development within the context of your MDT? 11:40 11:41

A. I agree.

118 Q. And it's not something that was drawn to your attention until after Mr. O'Brien had retired?

A. Yes, it was drawn to my attention by Dr. Hughes for the first time. 11:41

MR. WOLFE: Could we perhaps now take a break?

CHAIR: Yes, it's -- we'll come back again then at noon then, ladies and gentlemen.

THE INQUIRY ADJOURNED FOR A SHORT PERIOD AND RESUMED AS FOLLOWS 11:41

CHAIR: Thank you everyone. Mr. Wolfe.

MR. WOLFE: Mr. Glackin, I want to spend the next period of time exploring with you the role, as you see it, for the team of consultants in urology, whether as a team or as individuals, to take steps to address issues of patient safety when you've become aware of them, whether as a shortcoming in a practice or a 12:01

shortcoming in the approach of an individual colleague. And I want to start by looking briefly at the, I think it's possibly the first Serious Adverse Incident Review that you led on, or co-led on. It concerned Patient 128, and if we have up on the screen, please, TRU-278671. The draft report was made available for the Interim Director of Acute Services, Mrs. Burns, in or about March 2015. 12:02

Just briefly on this case, the facts, the clinical facts are maybe not terribly important for our purposes, but this was a patient who, following a right radical nephrectomy, was the beneficiary of a CT scan in May 2013. Wasn't reviewed as planned in June 2013. The GP re-referred the patient in August 2014, concerned about a risk of recurrent disease, and it was found that there was metastatic disease when a CT scan was produced. 12:03 12:03

One of the problems in the case was that the clinician with carriage of the care, I think it was Dr. Connolly, having referred for a scan, left for pastures new and there was no handover at the time, so the patient was in a sense lost to follow-up. 12:03

But let me bring your attention to the recommendations, because they were the subject of commentary from Mrs. Burns, and she said something about that, those recommendations and how she found them, when she came 12:04

to give evidence here and, in fairness, you should have the opportunity to respond.

So, first of all the Recommendations and Conclusions. If we go to TRU-278679, just a few pages on. Just taking up on the bottom of the page she's saying, or you're saying, sorry, onto the next page. So these are the recommendations that: 12:04

"The Review Team recommends a robust system for managing overdue uro-oncology review is established. A handover of patient caseload is required before a consultant leaves the Trust. 12:05
All Radiology reports must be actioned if required and signed off by an appropriate person. 12:05
A timely discharge letter should be dictated for every urology patient.
The Review Team recommends a communication record is designed and instigated for use with uro-oncology patients and named key worker." 12:05

So bearing in mind those recommendations, let's see what Mrs. Burns had to say about it. TRU-2786699, and at the bottom of the page, sorry, Mrs. Burns writing to Dr. Tracey Boyce and Paula Fearon. She says: 12:06

"I'm not happy with this review on a number of counts."

She says:

"These comments are not for sharing but, Tracey, can you review please and see what you think and then take forward in my absence..."

12:06

- as she's going on leave. She says:

"This review feels like the urology team had no part to play in this at all. None bar one minor issue of the recommendations falls to them." 12:06

She says:

"The CT scan results are not included in the review. What did they say? They're not signed off. What did 12:06 they say? The handover within a team of senior clinicians needs addressed, but this is not a corporate issue surely? Surely that is a team issue?"

And: 12:07

"The Urology Oncology reviews, I've not heard before now that they're well out of time. I had been told the waiting lists had been separately made, but the backlog is another issue. Again, Urology have not 12:07 highlighted."

Just in fairness, scrolling back and sharing a variety of views on this, Ms. Fearon comments and says that:

"I personally don't feel that there was any attempt to deflect Urology Service re their part to play. The Chair was most receptive to get to the root cause of the problem and to try to reduce the likelihood of a similar problem happening again."

And then up the page to what Dr. Boyce has to say. Go on up, please. She has a range of comments to make, but she says: 12:07 12:08

"I had a read through the report, it's a good report, but I can see what Debbie is getting at..."

- in terms of Mrs. Burns' perception that you, as the I suppose key author of the report is passing the buck to management as opposed to recognising that there were urology team inputs required to get these things right. 12:08

Just before I invite you to comment, we asked Mrs. Burns when she came along to give evidence to better explain or to unpack what she was getting at here, and so she says, if we go to TRA-07064. And just about half way, yeah. So: 12:08 12:09

"Mr. Glackin would have been involved in this patient's journey. He was a very skilled urologist. He understood the context in which the team was operating and he could peer review how that had went. But it

demonstrates very well I think the discussion that we had earlier, which is, governance means that you can have all the systems and processes but you have to accept a responsibility of actioning them individually and the urology team, I didn't feel, took those responsibilities. They tried to and they were correct, and I'm not saying they were wrong. There was 20,000 people from a performance report that I read on a review backlog..." 12:09

-- and she goes on, just scrolling down, to say, that she is saying: 12:09

"...they were trying but they had no capacity to see that person in that timeframe." 12:10

And she accepts that. But she goes on to, I suppose the thrust of her point is that you, as a team, need to be taking care of some of these issues. Take, for example, the handover. You, as a team, would have recognised that David Connolly, had gone elsewhere and yet there was no facility in place to pick up on his work. 12:10

A. Is that your question there?

119 Q. Well, I suppose it comes to this: Is she right to say that as a team, judged by reference to the issues that she's talking about, there was a lack of ownership? 12:10

A. She's missed the point.

120 Q. Okay.

A. So, I've a lot of respect of Debbie Burns and we worked well together, but this back channel communication that's going on, I don't think it was appropriate. If we go back to the five recommendations of the SAI, if you wouldn't mind showing them on the screen, please?

121 Q. Sure. TRU-278679. And just over the page. I beg your pardon.

A. So, we as a team instigated uro-oncology review clinics on the back of this. So clinic codes were generated, and that meant that patients on the waiting lists were easily identifiable as a uro-oncology patient so that they would be prioritised in terms of getting their review. So we as a team did that. So, you know, that is -- we didn't ask anybody else to sort that out, we sorted that out.

The second bit is a point that I think goes well outside our own department, and I disagree with Debbie Burns when she describes how we should have been sorting this out, because if any consultant leaves any department there is going to be work left behind, and if the Trust does not have a policy in place as to how that will be managed, then that's the Trust's fault, that is a problem with the governance within the Trust. So I was making the point that, yes, the urologists had had a consultant leave, there was no formal or robust process in place to manage that consultant's workload, but that point was equally applicable to any consultant leaving any post within the Trust, and I think that's

where she has missed the point on that.

The fact that Radiology reports, at that point in time they were coming in paper format, there was no facility to sign them off electronically. There is now a, there was a note came from the Medical Director's office some years after this, advising all members of medical staff about the actioning of results and the signing off of results. That came after this recommendation. 12:13

In Urology now we have a process whereby we use electronic sign off, and that's audited, and in particular we receive a report for Radiology sign off, it is coded red, green and orange, and that is provided by our Head of Service to us so that we can see that we are on track for all of this activity. 12:13

The discharge letter issue is largely pointed at the fact that Mr. O'Brien wasn't dictating letters on time and it was to lay that out that that was an expectation, a reasonable clinic expectation. 12:13

And we have -- and point 5, we have subsequently put in place a written communication record for uro-oncology patients following their consultation. 12:14

So I think, you know, for Mrs. Burns to give evidence and in the email statements to say that we were passing the buck, is clearly wrong, it's not in keeping with

the activity that went on after this, and I think I was making the point to her, because the SAIs are not just about what happens in Urology, they're about what happens in the wider organisation, and that's why we structured the recommendation in that manner. 12:14

The second point in her evidence then, if you have -- and if we perhaps go back to her evidence where she quotes the number of outstanding reviews, if you wouldn't mind showing that? 12:14

122 Q. Yes, it's in the transcript of her evidence. It's at TRA-07064, towards the bottom of this page. If we go down just there. Yep.

A. Okay. So I would ask the question: If you are receiving a performance report with 20,000 people on it 12:15 overdue their review, would you not be digging into that a little bit further to understand who those patients are? What their clinical priority is? Would you not be asking your ADs and your heads of service to give you a clear understanding of the clinical risk 12:15 involved in this situation? It's not good enough to say that you've got 20,000 people waiting, you need to know what's happening. We knew what was happening in Urology, that's why we did the uro-oncology review list, that's why we created various categories for the 12:15 Outpatient reviews, so that we could in some way try to manage and mitigate the risk.

123 Q. Just on that point. Is her issue that it's being raised as a result of this MDT, but where was the

proactivity on the part of the consultant body who know about this problem in terms of --

A. She might have been better served asking me what was happening, rather than having a back channel conversation with Paula Fearon and Dr. Boyce. 12:16

124 Q. What was happening to, if you like, take the step that you've outlined after the SAIs review, rather than take it - given the knowledge that you had before.

A. So we established the codes so that uro-oncology patients would not be -- would be easily identifiable from the backlog. That meant that they could be pulled forward into clinics in a more timely manner. There were other patients who were routine or urgent, and they were coded appropriately, so that it was easy for the staff booking the clinics to know that this patient needs to be prioritised over another. So that activity took place very quickly after this SAI. 12:16 12:16

125 Q. We'll come back, for example, to look at perhaps a standalone issue, the issue of sign off, if we have time this afternoon. Obviously there's the issue you point out in relation to, and here a specific example of Mr. O'Brien's dictation practices, and we'll come to that very shortly. 12:17

A. Yeah.

126 Q. In terms of the handover, we've obviously got a picture of turnover amongst the consultant staff, particularly during those years until perhaps relatively recently when things may have settled down to a degree. To what extent is the handover problem well addressed at this 12:17

time?

A. There is still no policy in place, to the best of my knowledge in the Trust, describing how this process should be managed. Within our own department what we have been doing, we've had a number of locums in the last few years and we've had other members of staff retire. 12:18

So, for instance, from the cancer perspective, those patients who are coming to MDT where it is clear that that person has retired or left the Department, those cases are shared out formally and they're handed over to a new named consultant. From a results perspective, when somebody has left employment of the Trust, we have agreed to share out the results of those people and divide the workload between the existing consultants. 12:18 12:18

Now, that brings me to another point that I've made I think in my witness statement. There is a quantum of work that it is safe to deliver, and if you are funded for a team of seven consultants, and you've had various locums coming in filling posts and then they leave, and you're then back down to a team of less than that, perhaps four and a bit as we are at present, the Trust is expecting four and a bit to deliver the workload that was previously delivered by more people. That's not safe. 12:18 12:19

127 Q. Thank you for that. Obviously we have your response to what Mrs. Burns has said. Let me broaden this out a

little more. I want to ask you about your understanding of the role of the team, if I can call it that, in terms of the performance of individuals. You've explained in your witness statement, if we bring it up, WIT-42311, that -- 42311. Thank you. At paragraph 38.2, that you've said, self-evidently you don't have line management responsibility for your consultant colleagues: 12:19

"...therefore unless advised by the clinical or Medical Director I would not necessarily be aware of concerns regarding the practice of my colleagues." 12:20

You go on at paragraph 52, if we bring up or go forward to WIT-42322. So you go on to explain that you're aware, and we don't need to name these people in this context, we'll go on to specifically address Mr. Suresh's issues at a high level, he gave evidence yesterday. You go on to explain that you: 12:20

"...became aware of concerns raised by nursing staff about the clinical practice of several locum consultants." 12:21

This was dealt with by Mr. Young. Scrolling down. 12:21

A. Sorry, Mr. Wolfe, that issue was not about locum consultant. That was about a speciality doctor.

128 Q. Very well. I'll take that correction. The issue -- you became aware that the issue was dealt with, the

issue hadn't been brought up by nurses. And then at 52.2, you explain that again other concerns were raised about other colleagues. Mr. Haynes addressed that issue. And then at 52.3, concerns regarding the scope of -- I think this was discussed openly yesterday, wasn't it? Concerns about the scope of Mr. Suresh's practice were discussed. 12:22

So what I am wanting to explore with you, Mr. Glackin, is the -- notwithstanding the absence of managerial responsibilities on your part and other of your colleagues, what is the expectation resting with you where you become aware that a colleague, or if you become aware of a colleague delivering his practice in a way that is adverse to patient safety or potentially adverse to patient safety? 12:22 12:23

A. So your first responsibility is to make sure the patients are safe. Your second responsibility then is to address the issues with the person who has got management responsibility for that clinician. You may have a discussion with the individual clinician as well, because there may be other very valid reasons as to why care has not been appropriate, or their performance has not been appropriate, there may be personal issues, there may be health issues. So I think you need do that in a sensitive manner. You don't do it otherwise. 12:23 12:23

129 Q. With regards to Mr. Suresh, you explain there, his practice was discussed by the urology team, including

yourself, Mr. O'Brien, Mr. Young, Mr. O'Donoghue, and Mr. Haynes, and this identified support that was, that it was felt was needed for him, and that then led to the development of a package that was put in place. If we can see Mrs. Corrigan outlines this in her statement at WIT-11946. Sorry, a document she appends to her first statement. 12:24

So this is March 2016, and we don't need to get into the minutia of what was happening to Mr. Suresh around that time, but it is the case that the team, albeit with some management support, took ownership of this issue and helped to develop a remediation package, if I can call it that, perhaps not in the formal sense remediation, but a package of support for Mr. Suresh? 12:25

A. Yeah, I think support is the correct term, and I think it was appropriate that the team did that.

130 Q. Is that because, as you described it earlier, the fundamental here is patient safety, and where you see issues you, if you see them and you feel nobody else is aware of them, you report them to management, and perhaps speak to the colleague concerned in a supportive way, if appropriate? 12:25

A. Yeah. I think when we became -- when we started working as urologists of the team model, that gave us a greater insight as to how our colleagues were practicing, because you would receive handover from somebody about the in-patients, and you would then have the opportunity over the coming days to review all of 12:26

the in-patients and to review their results and to see how things had been done and what decisions had been made, and if decisions hadn't been taken in a timely manner, or decisions that you perhaps didn't agree with, then you had the opportunity to discuss that with your colleagues and say "Well, you know, I perhaps would have done something different" or "Why didn't X happen?" So that's all to the benefit of the patient, and when it becomes a pattern whereby you recognise that there are "deficits" is perhaps too strong a word, but areas that need support, then it is your responsibility to discuss that openly with the relevant people and then to put in place a safe plan to manage the situation. And I think that's what we did in that circumstance. 12:26 12:26 12:27

131 Q. Can I ask you to reflect, in light of the support that Mr. Suresh appears to have received, in terms of Mr. O'Brien's practice - and we're going to look at a number of issues, and perhaps you can only address the issue generally at this point, because much depends on the gravity with which the issue is understood from a patient safety perspective, there's obviously whether there's full knowledge around the issue - but in terms of looking back on Mr. O'Brien, he came through an MEPS process and then there was a return to work plan, and I know from what you've said that that was largely hidden from his colleagues. Do you think, from a team perspective, Mr. O'Brien could have been better supported with the practice difficulties that he faced? 12:27 12:27

A. Yes, and I've said so in my statement. I think it would have been much better if those issues, and I realise there are sensitivities around some of them, but certainly I think if the medical managers had of discussed with us as a team of consultants the particular issues, and allowed us to understand the breadth of issues, but then also to formulate a support plan, a network, if you like, as to how Mr. O'Brien could return to the team and practice safely. It would also have given us greater oversight going forward as to when, if there were any dips in performance, or non-adherence to agreed behaviours, then we would have been able to identify that at an earlier stage. 12:28 12:28

132 Q. We'll maybe unpack some of that as we go along. What do you identify as being the, if you like, the block or the obstacle that was in place that prevented the development of that kind of approach? 12:29

A. So, I had no knowledge or part to play in the return to work plan. That was developed without input from the whole team. It was developed, as far as I understand, from the medical management side and with some input from the Head of Service, from what I've read subsequently. So those people held that information. It wasn't shared with us. I think if we had of been aware of what they were monitoring and how they were addressing any shortcomings, then we would have been in a position to assist. 12:29 12:30

133 Q. I'm now going to work through what had been described as those shortcomings, and take your view on when you

knew something about them, or when your colleagues knew something about them. Can I take it that at no point did you, whether formally or informally, raise any concern about the practice of Mr. O'Brien?

A. I certainly never did an IR1, as far as I know. Whether we had informal discussions about the timeliness of correspondence, I'm sure we did. That would have been the kind of thing that would have been, and it was discussed at departmental meetings, the need for letter writing and notes to be in the chart. So those things were discussed in an open forum amongst the team. So other than those things, I don't think there was anything else. 12:30 12:31

I don't recall having concerns about his operative capacity. I don't recall having concerns about his manner of working with colleagues and interpersonal difficulties. Certainly I didn't have any interpersonal difficulties with him. 12:31

I think it's important to reflect though that, you know, there was a definite chilling process that happened around the time of this late 2016 and returning to work in 2017. That was difficult for everybody. 12:31

134 Q. Yes.

A. It was difficult for me, it was difficult for my colleagues, and it was particularly, I'm sure, difficult for Mr. O'Brien.

135 Q. We know, or at least we've been told by Mr. Suresh, that he raised some issues. He raised an issue about the use of intravenous antibiotics, and he explained in his witness statement that he placed this on, if you like, the agenda at a departmental meeting, it was discussed and assumedly resolved. 12:32

A. I don't recall that ever being discussed.

136 Q. Yes.

A. And you might correct me, but I don't recall seeing any minutes of any meeting where it was discussed. 12:32

137 Q. I haven't seen. So. But I suppose what prompts that question is the, at least until the MHPS process kicked in, what I want to suggest to you is that there was a level of knowledge, perhaps not to the degree and extent as it was to be unveiled to you later... 12:33

A. Yeah.

138 Q. But things, as we'll see with each of these issues, were addressed at the level of informality rather than the erection or the pursuit of a formal expression of concern with Mr. O'Brien. Is that your appreciation, regardless of where the responsibility for that lies? 12:33

A. Yeah. I wasn't aware of any formal process prior to the meeting of January 3rd, 2017. Now, I have in my witness statement alluded to a brief conversation that I had with Heather Trouton, who was AD for surgery at the time, and that conversation happened on the corridor in the administration area of the hospital, whereby she expressed some concern about Mr. O'Brien's practice. I took it from what she said, and it's a 12:33

vague recollection, that she was concerned about his backlog and him keeping up with his workload.

139 Q. Yes. Yes. You say that -- I just will bring it up on the screen briefly. WIT-42319, and at paragraph 50.8 you allude to that conversation. It's perhaps mentioned by you because it forms some significance in the sense of it being -- 12:34

A. Well I have to say, I racked my brains to think about any time when any senior member of the Trust had raised an issue with me, and this was the only one that I could recall. 12:34

140 Q. Yes. I suppose that's what I was about to say to you.

A. Yes.

141 Q. That its significance perhaps is that to the best of your recollection, and I'm not sure you put a date on it, but -- 12:34

A. I can't put a date on it. Yeah.

142 Q. Yeah. But it precedes the January 2017 meeting. And what you, I think what you say about this interaction with Mrs. Trouton is that it reflected, you understood it as reflecting a degree of exasperation on her part about backlogs, but she didn't descend into any detail. You said in your witness statement, and we just go down to WIT-42326, that in terms of at 56.1 you say: 12:35

"From 2012 Mr. O'Brien had a long review backlog for out-patients and in-patient operating, but he was not unique in that regard." 12:35

A. Yes.

143 Q. So that wasn't a concern particular to him is I suppose your position?

A. No, not particular to him. It applied to Mr. Young, it applied to Mr. Akhtar, who had been there until perhaps maybe late 2011/early 2012. 12:36

144 Q. But something perhaps specific to Mr. O'Brien? You were also aware that he had a backlog of completing correspondence, which was your experience as a trainee back in, or a research fellow in 2002 and 2005, but it had been largely unchanged when you came back in in 2012? 12:36

A. Yeah, and I think part of that's due to how he chose to practice.

145 Q. Yes. 12:37

A. He would have explained on occasion that he wanted all of the results back before he would write a letter.

146 Q. Yes. Just on that, in terms of what you expect of yourself as a practitioner, and your understanding of your obligations. It's right to say, I suppose, that the job plan - to take what document - doesn't descend into that kind of detail about the expectations around dictation? 12:37

A. It doesn't.

147 Q. But -- 12:37

A. -- nor does the job description.

148 Q. Yes. But presumably you agree that it's the duty of a doctor to make a record consultation and to communicate that record in a timely fashion?

A. So my practice is that I will make a written note on nearly all occasions, nowadays we have the facility to make a contemporaneous electronic note on ECR, and I will also dictate a letter for every patient at the end of clinic. There is a very rare occasion when I need to check something and I may delay writing that letter for that reason. 12:38

149 Q. And why, just to get it out on the table, why is that important? Why is that documentation --

A. So there's a couple of reasons why it is important. First of all, you're working at such pace that if you don't do it there and then you will never catch up. So that's the first thing. It's about keeping on top of your workload. 12:38

12:38

The second thing is, I think it's important that the GP and others providing care to the patient have ready access to the outcome of the consultation.

150 Q. And in terms of your colleagues, again you --

A. I understand that they practice similarly. 12:38

151 Q. Yes. And was it known -- well you knew because you had exposure in 2002 to 2005 about Mr. O'Brien, and in 2012. How did your knowledge of his continuing deficit in this respect come about?

A. So, I think my knowledge came about largely because there was a backlog review, and we undertook extra clinics to see patients, and when we saw those patients who might have been Mr. O'Brien's, there wasn't a clinic letter in the chart. So that meant one of two 12:39

things: either it hadn't been dictated or it hadn't been typed. So you could at that time, in the early 2010s, you could check on our system called Patient Centre, because that's where the letters would have went to. So you would open Patient Centre and you would check was there was any correspondence. And if there wasn't any correspondence on Patient Centre, then it was quite clear that it hadn't been dictated or typed, one of those two things. 12:39

152 Q. And is that something you ever spoke to him about? 12:40

A. So, first of all myself, Mr. Haynes and Mr. O'Donoghue would have partaken in that activity, and we all recognised that that was a problem and we raised that with Martina Corrigan, because it meant that when you saw these patients that you were essentially starting from scratch. So that meant that the time that you required in clinic to see that patient was greater than perhaps a straightforward review. So that was raised with Martina. 12:40

12:40

It was also raised with Mr. O'Brien in the departmental meetings, and when, I think was Mr. Haynes raised the particular issue on the particular day, the necessity to have a clinic letter dictated and available in the chart for every patient, and Mr. O'Brien perversely expressed the view, perversely from my perspective, the view that it wasn't necessary to dictate on every patient, that he knew what was going on and he didn't have to write to the GP. I just couldn't get my head 12:40

around that.

153 Q. But that was, from his perspective a full stop, end of conversation, he wasn't changing his practice. Is that your understanding of his stance?

A. Yeah. Yeah, I think he would be digging his heels in. 12:41

154 Q. And was the problem, at least in terms of your experience, more than just a communication issue, a record of what has been done, was it more than that? Was it also a failure to action by a dictation a next step on occasions, a next clinical step? 12:42

A. So I don't know that for sure. But if you're leaving it weeks to months after you've seen somebody - first of all I don't have perfect recall, so I would wonder how anybody else would have perfect recall. So that would leave - if it was me, it would leave me open to 12:42 forgetting to do things. So I just didn't understand the rationale of what he was describing.

155 Q. Did you view it, or did your colleagues view it as potentially a patient safety issue?

A. Well, Mark raised it because he was concerned. Yeah, 12:42 it was an issue.

156 Q. Plainly you didn't have line management responsibility for him. You drew it to the attention of Mrs. Corrigan you've said, so that the system was well aware of it.

A. Yeah. So Mrs. Corrigan knew that we had concerns that 12:43 there weren't letters in the charts relating to Mr. O'Brien's patients. Whether she was there on the day that Mr. Haynes raised that specific issue, I can't recall.

157 Q. There was also an issue of charts, patient charts not being available when colleagues needed them. The patient perhaps came in from Accident and Emergency, or there was a clinic arranged and...

A. It was more generally clinic activity. 12:43

158 Q. Yes.

A. And I suppose in the period of maybe 2012 to whenever NIECR was introduced that was a live issue, because if you didn't have the chart it was a real struggle to work out what was going on with somebody. When NIECR 12:44 became available, all the information was in one web portal, if you like, and it made it much easier, you could almost conduct clinics without recourse to paper notes.

159 Q. Was it recognised that Mr. O'Brien was retaining 12:44 patient notes at his home or in places that were inaccessible to you and his colleagues?

A. Yeah. Yes, it was recognised and it was common knowledge that Mr. O'Brien would be taking patient charts to his home. 12:44

160 Q. You properly allude to Mr. Haynes raising this issue. He says in his witness statement at WIT-53932 that concerns were regularly raised, regularly voiced, I should say:

12:45

"...by all members of the consultant team regarding the frequent lack of clinical information in the form of letters following outpatient consultations, as this had the potential to impact on us when patients had

unplanned emergency admissions. This voicing of concerns would have occurred during informal conversations and within departmental meetings, including with the Head of Service."

12:45

So I suppose that's confirmatory of what you've just said?

A. Yeah, that tallies with my recollection.

161 Q. Yeah. Different issue with Mr. Suresh, but these issues concerning practice come in all shapes and sizes. Do you think it was enough for yourselves as a urology team to deal with the matter informally, as you did, or when you think about it now should another track have been pursued?

12:45

A. Some of the people who would have been present at those meetings would have had knowledge of what was going on in the background, and I'm referring largely to Martina Corrigan, and I think Mr. Young would have had some knowledge of how the management had tried to manage Mr. O'Brien over a number of years. I didn't have that knowledge. Do I think that it should have, this particular issue of dictation, letters not being available and notes being taken off site, do I think that should have been managed formally? Yeah, I think it should have been managed formally.

12:46

12:46

162 Q. Let's move to triage. Again, just in terms of your practice and what you understand are the obligations in respect of triage, using both the period before the urologist of the week model and the introduction of

that model in late 2014, what were the obligations and how did you practice?

A. So I think it's important to understand that there is no written policy as to how this was to be delivered when I arrived in 2012. 12:47

163 Q. Just on that, sorry to interrupt your flow.

A. Yes.

164 Q. Is that unhelpful and is it by contrast with other settings?

A. So I've no knowledge of how it operated in other Trusts. I was a trainee in other Trusts. I wouldn't have necessarily been involved in the triage process for referrals, except I think I did do a few in Wolverhampton when I was nearly finished. 12:47

12:48

So what I would say, if the Trust developed a policy then it would be very clear to everybody what their responsibilities were, and what the timeframes for delivering that activity would be, and how that activity was to be delivered, and it could be clearly set out. 12:48

Not every department operates their triage in the same way that we do. So I've been involved in other projects within the Trust, and I understand that, for instance, my rheumatology colleagues concentrate the triage in the hands of a couple of consultants rather than the whole team and they are given protected time to do that activity. Okay. So there are different 12:48

ways of delivering this activity.

When I arrived it was a paper based activity and it was shared out among the consultants. There was an expectation that the red flags would be turned around within a timeframe, I think it might have been 24 hours, and that the others would be turned around thereafter. I think there was an IAEP policy. I had no knowledge of that policy, I wasn't provided with it, but I now understand that that policy would have been in place at that time. 12:48 12:49

We then moved to the urologist of the week, and in discussions for setting up the urologist of the week, in which we all participated, we agreed that the urologist of the week would undertake the triage activity. 12:49

The triage activity was largely in two parts. It was the red flag cancer referrals which were provided to the team from the red flag office, as it's termed in the Trust, and we expected to do those on a daily basis and return them. The second bundle would have been the urgents and routines, and they would have been returned I think at that time via our secretaries, and then as e-triage became available we shifted to doing that. 12:49 12:49

165 Q. And you point out the absence of a policy that would, or a process that would allow you to better understand the expectation. Dealing with the urologist of the

week model and triage within, the triage work within that, absent the availability of a policy was it nevertheless understood that by the completion of your period as urologist of the week you would nevertheless be expected to have delivered back to the source all of the referrals that have come your way?

A. Yes, I think that was a fair expectation. It was certainly what I understood by the process. And my experience was that there were weeks where you would, where I could easily accomplish the triage within the time. There were other weeks when you were busy and perhaps you might have been in at night, and on those occasions it might have been more difficult, but it was always my practice to clear the desk, so to speak, as soon as I could, and not leave work for my colleagues.

Now since the E-triage process has come in, there are times when, on a Wednesday evening you'll check the electronic care record triage system and you will find that everything is done at 5:00 o'clock, and you'll come in the next morning on a Thursday and find that a load of stuff has arrived overnight. Now your colleague who has taken over on a Thursday might look at you and say "What have you been doing?" but, you know, it's just the way the system works.

So I think there's an acceptance amongst us that we would check last thing on a Wednesday evening that everything had been tidied up, and whatever comes in on

a Wednesday night is dealt with by the person coming on on Thursday, and that's a quid pro quo.

166 Q. In terms of your own practice and comment on what you understand to be the approach of others, if you can, is there a difference of approach depending on whether it is a red flag referral, in terms of the steps that you might initiate when sending the referral back, as contrasted or compared with the other categories of referral? 12:52

A. So that answer is a little bit difficult for the reason that services have changed over time. 12:52

167 Q. Okay.

A. Okay. So we established essentially a one-stop clinic service in the Thorndale Unit, and that clinic, each consultant had one of those clinics and within that clinic there were slots set aside for things like haematuria, red flag prostate cancer referrals and other red flags, and then there was a smaller tranche of slots set aside for urgent patients and routines. So it was the expectation that the patients coming to those clinics would, as far as possible, have all of their investigations completed on the day. So we had ultrasound available, we had, at the time when we had Trust biopsy, we had that available, and we would have things like flow rates and bladder scans and all of that kind of activity. So that could have been delivered on the day. So there wasn't so much a necessity to order investigations beforehand, except for those patients who might need a CT urogram, and 12:52 12:53 12:53

that would have been requested ahead of time.

The model has changed somewhat more recently in that we don't have the same setup, and it has been complicated by the fact that a large number of referrals are going out to the independent sector, including some red flags. Therefore, up until the independent sector provider came on, we were largely requesting scans ahead of time to try and expedite and facilitate care for patients. Since the IS provider has come along, we have stopped doing that because it has been causing problems between us and the IS provider and, therefore, those scans are not requested until the patient is allocated to one or other, the Trust or the IS. So that has muddied the waters a little. 12:53 12:54 12:54

There is some -- there are, I suppose, a variety of views amongst the consultant body as to how we do this activity. Some people use the term "advanced triage", and I know that Mr. O'Brien used that term. Some people used advanced triage and meant different things by it, and that's all a confounder. 12:54

So on more than one occasion we, Mr. O'Brien described in great detail how he did advanced triage. Well, it essentially amounted to a virtual consultation. Both myself and Mr. Haynes at meetings said to him "We don't think that's a good use of your time, you're not set up to be doing virtual consultations for all the new 12:54

referrals, you simply need to triage the referral. If you want to request a scan, request the scan, and let the patient know that you've done so by writing them a letter. You don't need to phone everybody and do it in that manner". So we'd a difference of opinion as to how things should be done. 12:55

168 Q. And the thinking, as you understood it behind Mr. O'Brien's approach to advanced triage, to use that label, was what? Was he recognising that patients falling into routine and urgent categories were unlikely to be seen given the waiting list conditions for some time and, therefore, it was, from his perspective, necessary to engage in this in-depth approach to avoid morbidity or risk? 12:55

A. I can't tell you precisely what his thought process was, but it would be my view that we didn't have the time or the resource to be doing virtual consultations for the number of referrals that were coming in to the department, and the patients who needed tests expedited were those patients that you thought had a significant clinical issue, either it was a potential cancer or it was a concerning benign urological complaint that needed to be seen promptly. So those are the kind of patients that I would have addressed with advanced triage in the way of requesting imaging or expediting their appointment, but I would not have been phoning them. 12:56 12:56

169 Q. Yes. You have preferred both in your response to us and in your evidence to Dr. Chada, that the issue of

triage was frequently discussed. Mr. O'Brien would frequently express the view that he did not have enough time to complete triage of new referrals during his week on-call, or his week as urologist of the week, and that the response from some of you at the meetings, and perhaps you've just outlined a moment or two ago, was that the style of working and organisation on the part of Mr. O'Brien was generating the problem.

A. Yes.

170 Q. And what was his response to that in the round, if you can remember? 12:57

A. I think his response was that what he was doing he thought was right, and he was difficult to dissuade. I felt he was difficult to dissuade.

171 Q. His description, or I suppose your description of what he said was, ehm, expressing the view that he did not have enough time. Did you realise that when he used words to that effect that he wasn't actually performing triage, he wasn't doing it across a number of cases or, as we know, largely -- as we know now, he largely wasn't doing it for routine and urgent referrals? 12:57 12:58

A. So I didn't know that he wasn't doing it. I became aware of that later, and I was shocked by the extent of it. And I also became aware later that for a period Mr. Young did some of Mr. O'Brien's triage and I didn't do any of Mr. O'Brien's triage, nor was I -- I don't think I was ever asked to. 12:58

172 Q. Yes. Mr. Young engaged with management in -- Mrs. Burns in particular I think in February 2014, and

it was agreed that no new referrals would come Mr. O'Brien's way, and it would appear from the email correspondence that Mr. Young was asked to speak to the consultant team with a view to filling in that shortfall? 12:59

A. Well, I don't have a clear recollection of that being discussed. It may well have been, and I'm not wishing to say that it wasn't. I do recall a certain unhappiness that I had about what I saw as unilateral withdrawal from providing elements of the core service, 13:00 and this speaks to the same issue that I have been talking about, about the lack of transparency across the team as to what was happening, the lack of open discussion as to how things were being managed, small numbers of the team being aware of things and others 13:00 not. So, you know, when I looked at that and I became aware that there was a proposal that Mr. O'Brien would not participate in new patient clinics, which I recall being mentioned, I was deeply unhappy with that. I thought that this is not the right approach for us to 13:00 be taking, this has not been discussed as a team as to how we're going to work, and I, you know, for all the reasons I've outlined as to Mr. O'Brien's style of working, they were the root cause of these problems. So, you know, that needed to be addressed properly. 13:01

173 Q. We'll come after lunch just to look at what has been described as a default mechanism for dealing with triage and what that meant in practice and what you knew about it, if anything. But just to finish for

now, it is your evidence that while Mr. O'Brien is talking of the difficulties, and you as colleagues responded in saying "Well, this is matter of style and approach, and you don't need to do that", at no stage were you advised that he wasn't doing triage for a raft of cases?

A. That's correct.

174 Q. Okay. You now know that there was a mechanism by which management side at least would have been aware that he wasn't triaging? 13:01 13:02

A. So through the SAI process, I think it was Patient 10 that I Chaired.

175 Q. Yes.

A. I became aware of this default mechanism. I had no knowledge of that default mechanism prior to the SAI process. I profoundly disagreed with the default mechanism. 13:02

176 Q. And we'll come to that after lunch, perhaps?

CHAIR: Okay. Five past two, ladies and gentlemen then. 13:02

THE HEARING ADJOURNED FOR LUNCH

THE HEARING RESUMED, AS FOLLOWS, AFTER THE LUNCHEON ADJOURNMENT

CHAIR: Good afternoon everyone.

MR. WOLFE: So just before lunch, Mr. Glackin, we touched on the issue of the default triage mechanism, and I think you were telling us that, or at least your evidence to Dr. Chada tells us that you established through the Serious Adverse Incident Review that you conducted in respect of Patient 10, that such a mechanism was in place and it had been placed without discussion with the consultant urologists, although you understood that it was done with the knowledge of the clinical service, but you didn't know the names of the individuals who had agreed to it. If you had been asked about the mechanism that was put in place, would you have had objections to it? 14:04 14:04 14:04

A. Yes.

177 Q. On what basis?

A. So my understanding of the process was that if a referral had not been triaged, that the referral and booking centre team were to apply the triage standard that had been requested by the GP. So that for me raises an immediate concern that if the GP is wrong, then a patient could wait unnecessarily long to be seen or have investigations organised where it would be appropriate. 14:05 14:05

178 Q. And it's an issue I think you took up directly in the SAI review that you participated in in respect of

Patient 10. I suppose it's also an issue that was touched upon indirectly in a letter that was written to Tracey Boyce in December 2016, and I'd just ask for your observations in relation to that.

14:06

If we go AOB-01245. This is a letter that was written to Dr. Boyce. It was signed off by Connie Connolly. As I say, it is dated 15th December 2016, and it is taking up on the investigation of that SAI, and it makes the point that: 14:06

"Part of the work included a lookback exercise for seven urology patients who had been managed in the same manner at or around the same time as Patient 10 in October 2014." 14:06

The Panel has looked at that. Six of the patients, it could be seen, had been discharged or management plans in place, one of the patient's chart couldn't be found and it eventually came back into the system. So, just 14:07 scrolling down. So I think this was designed as a message to management. It says:

"The review team agree that there are a number of relevant and related issues and themes causing concern 14:07 for the Panel which have been exposed during the investigation."

And they need looked at. Were you party to this letter

being sent?

A. No, and I had no knowledge of this letter until it was raised in evidence at this Inquiry.

179 Q. So although it refers to the Review Team agreeing that there are a number of relevant and related issues or themes, you weren't consulted in terms of the drafting of the letter? 14:08

A. I was not consulted and I had no knowledge of this letter. And as you may recall, it was attributed to me initially in evidence at this Inquiry, and when I heard that and I read it in the transcript, I was shocked, and as you quite correctly now point out, this letter was written by Connie Connolly. 14:08

180 Q. And I take it from your answer that no doubt you feel you should have been consulted upon it before it was written, because you were a member of the Review Team? 14:08

A. Yeah.

181 Q. A prominent member of the Review Team?

A. This is another example of back channel communication going on. 14:09

182 Q. In any event, does the detail of the letter speak to concerns that you had and were subsequently to be reflected in the SAI review?

A. No, I think it does reflect the concerns that the team doing the SAI had. 14:09

183 Q. If we just touch briefly, this is well trampled ground I think at this stage, but if we just go to your SAI report, and I am conscious that you were part of a team, and a significant aspect of the analysis of the

review concerned the radiography aspects.

A. Yes.

184 Q. And it wasn't, lest anybody suggest otherwise, it wasn't simply a focus on the shortcomings of triage?

A. No, the radiology aspects were very important and the incorrect reporting of a scan and the failure to recognise the importance of the information contained in the report. 14:09

185 Q. Yes.

A. So they were, to my mind in fact, probably the most pertinent issues in this SAI. 14:10

186 Q. Yes. And if we can, I quite take that point that you viewed them as that the radiography aspects were significant, more significant. I do, however, for our purposes, need to focus on triage. So just touching upon the recommendations. PAT-000008. And the recommendations spoke to the increased risk of harm and the opportunity when early intervention and triage is omitted. 14:10

14:11

"The review panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the IEAP."

14:11

And you say in particular:

"The fundamental issue of triaging GP referral letters remains a challenge within urology. The urology

operational and medical management teams immediately need to address the issue of untriaged referrals not being processed in accordance with the IEAP."

So that was pointing a finger at the default arrangement, at least in part?

A. Yeah. I didn't think the default arrangement was a safe arrangement, and that's what I was trying to get at.

187 Q. Yes. Mr. O'Brien saw this report in draft and had an opportunity to comment on it. Again, I suppose one of the points he makes is, and I am anxious for your views on it to the extent that the panel think it's relevant, he makes the point that it would have taken a deeper form of triage than would have been customary at the time to unpick the error in the scan report and, therefore, if he had his time again he would have triaged -- if he had triaged Patient 10 he would have kept it as a routine?

A. I don't agree with that. I think reading that referral I think would spark an interest from a consultant urologist as to what's going on in this referral? I think it would also lead one to read the report of a CT that's remarking on an abnormality in a kidney, because as urologists we would understand that there is a spectrum of abnormalities, some of which are benign, others of which are potentially cancer, and others which are clearly cancer, and reading the report would have allowed you to understand that.

And, secondarily, the imaging is freely available. You could have reviewed the imaging yourself.

188 Q. Yes.

A. So, you know, this also occurred at a period when we were having discussions within the Department about the nature of triage and how it was being done, and Mr. O'Brien had clearly expressed the view that he was undertaking advanced triage, and the activity that I've just outlined would clearly fall within that remit. 14:13

189 Q. And I just want to touch on that very point and try to assess through your evidence whether these issues remain of some concern to you as a urology team. Just picking up on what you've said in relation to Mr. O'Brien and his views. As I say, he responds to the draft SAI. If we can pick that up at AOB-01393. Sorry, just over the page. I beg your pardon. No, back the way we came. Back up a wee bit higher. Yeah. "Comments Regarding Triage", if we just come to that subheading. Yep. 14:14 14:15

So, yes, he makes the point that he would -- bottom of the page as we see it:

"I would not have considered upgrading it to red flag status." 14:15

But more generally he goes on to say that - if you scroll down. Yes. He says:

"I have believed and expressed the view that the inclusion of the triage of all letters of referral in duties and responsibilities of the urologist of the week was inappropriate." 14:15

And he goes on to explain what he meant, what he means by that.

If we go to the top of the next page, he talks about: 14:15

"The purpose and priorities of the urologist of the week are for the consultant to deliver hands-on clinical and operative management of all urological patients, all other in-patients in the hospital whose 14:16
assessment and management was sought..."

- it is a long sentence, but in essence it comes to triages getting in the way of the original purpose and objectives of urologist of the week, and that leads to 14:16
a, if you like, a deficit in the time available to him to address the triage requirements. Is that a challenge that you too recognise?

A. No.

190 Q. That's a very stark position. It's a no because you 14:16
take a different approach to triage and management?

A. So let's take a little step back. At the outset of instituting this urologist of the week activity, we, as a team, agreed what was important. That was the

in-patient care that he is referring to, but it was also an agreement that we would do the triage. So at the outset that was agreed. I found that I was able to deliver all of that activity within the week, with the caveat that I gave earlier, that occasionally there was a small number of triages that I wasn't able to complete, but they would be completed by the end of the calendar week. So I didn't have a problem in undertaking this activity for all triage, whether it be red flag, urgent or routine, and to the best of my knowledge my other colleagues also completed it in a contemporaneous manner. 14:17 14:17

191 Q. Let me just put two other pieces of information into the mix and we can have your observations on this. Out of chronological order perhaps, but you are aware that there was a further SAI review conducted in relation to the triage issue in association with five patients who emerged from the out-workings of early 2017? 14:17

A. Are they the Dr. Johnston patients? Is that what you're referring to? 14:18

192 Q. Precisely, yeah. I was trying to find a group word to describe it, but you're familiar with that?

A. I am now.

193 Q. Yep.

A. You know that process took place from I think 2017, as you've described, but the report for that process wasn't delivered to us as a group of consultants to my knowledge until some time in the summer of 2020. 14:18

194 Q. Yep. It was, as you say, reported on the 22nd of May

2020, and what I want to bring you to is its recommendations, or at least some of them.

If we go to TRU-161196? And I'm reminded as I bring you to this of your evidence just before lunch, where you spoke about the absence of a triage policy, well perhaps not alone for urology but perhaps a more widespread problem than simply urology. 14:19

If we go to Recommendation 6, scrolling down, please? It is explained this SAI Review Team, which included Dr. Johnston from outside of the Trust, Mr. Haynes was part of the team that led on this review, and it recommends that: 14:19

14:19

"The Trust should re-examine or reassure itself that it is feasible for the consultant of the week to perform both triage of non-red flag referrals and the duties of the consultant of the week."

14:20

It says that:

"The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner." 14:20

Writing in 2020, I'm not sure if it continued to be

relevant, they're saying:

"The current informal default triage process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and it does not allowed red flag patients to wait on a routine waiting list." 14:20

So just we'll remember I've read that out, but I also wanted to take you to something that you wrote in November 2018. If we go to WIT-81609. I say you wrote it, but in fact I think you may have circulated it. It's the minutes of Urology Service Development Day, attended by you and some colleagues. It says in terms of triage, if we scroll down, that: 14:21

"The Trust needs to provide a plan detailing what exactly it expects the consultants to do in terms of triage. This must include recognition of the time constraints and time commitment required to complete triage, including time spent speaking to patients, booking scans, reviewing results and mitigating risk for patients on the current long outpatient waiting list. Consideration was given..." 14:21

14:22

- presumably by the meeting:

"...to decoupling the triage activity from that of the urologist of the week."

And I think the preface to that discussion might well have included a paper prepared by Mr. O'Brien in September of that year. So having put all of that information in front of you, what it seems to speak of in 2018 and then again in an SAI review published in the summer of 2020, is that the team, the Urology Service, is crying out for guidance by way of a policy or whatever, in terms of how triage is to be done, what's expected. And, secondly, a need to assess whether it's feasible to continue doing urologist of the week with triage within those responsibilities. Is that still the position? Is it still a concern?

14:22

14:23

A. It is still a concern. So I think I did write this document. It's not dated, and that's my fault that it is not dated. There are also handwritten notes which I think the Inquiry have access to. They're in my handwriting. And in this, as in all the sections of this document, what I'm trying to reflect is the nature of the discussion and the views expressed by the members of the team. They're not my personal views. As best as I could capture them, they are the views of the team.

14:23

14:23

So there was a variance of opinion as to how we should be dealing with is this. Mr. Haynes had one particular view, that we were responsible for sorting this out ourselves and that "we were the Trust", I think was the phrase he used. I think that that might have been

14:23

captured in a recording, which you may have the transcript to. Mr. O'Brien, Mr. Young and I didn't share Mr. Haynes view. We felt that it was incumbent on the Trust to provide a policy to clearly outline how this activity would be delivered, and we were therefore at variance with Mr. Haynes in that regard.

195 Q. So, I don't want to spend an awful lot of time on this, for obvious reasons, but just drilling down a little deeper. We have the debate as to whose responsibility it is to sort it out, but in terms of the team members, was there a divergence of view in terms of the doability of triage during the urologist of the week period? 14:24

A. Yes. Mr. O'Brien expressed the view at this meeting, and at other meetings, that he was struggling to do this activity in the time given. He also described how he was doing this activity in his own time. Whereas others, myself included, were able to deliver this activity within the allotted time. 14:24

196 Q. And is that, as I think you've alluded to already, is that divergence of views a reflection of a deeper divergence in terms of the approach to be taken to triage? In other words the time to be spent and the activity. You described it as a quasi clinic approach or words to that effect? 14:25

A. Yeah. So certainly I was not taking the approach that each patient needed a telephone consultation to work out what we were going to do. Mr. O'Brien expressed the view that he did that, that he spoke to lots of

patients and organised things on their behalf. As I've told you earlier I didn't share that view, and that was expressed at meetings, and so Mr. Haynes didn't share that view either. So there were different ways of working, and I think that the way that Mr. O'Brien chose to work was exacerbating this issue for him. 14:26

197 Q. Now, in terms of what has been put on paper, whether it is the SAI review that I've read, or your minutes here, which assumedly went in the direction of management perhaps, or the messages from the minutes went in the direction of management, has there been any attempt on the part of management to wrestle with either an assessment of whether triage is doable during urologist of the week, or an attempt to wrestle with the policy, or engage with you as a team on either of those issues? 14:26

A. Well, Mr. O'Brien left the employment of the Trust at the end of June or early July 2020. I don't think it has been really an issue of concern since that time. But, to the best of my knowledge, there is no policy yet in place as to how triage should be done. 14:27

198 Q. Yes. I take that answer in the sense that, okay, to some extent water under the bridge. Mr. O'Brien, who was, let's put it in neutral terms, was having a difficulty with triage and it created difficulties for patients, but the Trust could potentially have, you know, another clinician come in and struggle with triage, and difficulties of the past could, in another shape or form, be repeated. Do you see -- 14:27

A. It could also be happening in other departments within

the Trust. So, you know, I think it's very obvious to me that there should be a policy, that it should have been implemented, and that consultants should have been appraised of what the policy was, so that we were meeting the standards that were required. 14:28

199 Q. Yes. I do take it that, if you like, on the other side of the equation the ability to check that something is being done, whether there's certainty as to what the actual obligation is, but the ability to check and monitor the doing of it? 14:28

A. To check that triage has happened.

200 Q. Yep.

A. The vast majority of triage is now done electronically, so that's very easy to audit, and that triage that is paper based goes through the referral and booking 14:28 centre, and they can easily check if triage has been completed and returned.

201 Q. Thank you. Now, when you spoke to Dr. Chada about, I suppose your experiences in working with Mr. O'Brien, and your participation in what might be called the 14:29 clean up operation that was triggered from the revelations in January 2017, you said the following, and I'll bring you to the extract. It is TRU-00774, and at paragraph 25 you're reflecting in terms of working arrangements, and Mr. O'Brien you say: 14:29

"...frequently expressed the view at consultant meetings that his most pressing commitment was to patient care and operative waiting list."

This was a workload issue for him.

"Most of the other consultants are not dealing with the same volumes in terms of our waiting lists. There is certainly a bit of wanting to hold on to things. Every consultant makes different decisions about how to manage things. His approach is different to that of his colleagues, and I am not saying it isn't good work or safe, but Mr. O'Brien does fall behind with things. Mr. O'Brien sees significantly fewer patients in clinic per year than most of his colleagues. This issue has, to the best of my knowledge, not been explored, challenged or addressed." 14:30 14:30

I look at that paragraph and I look at your statement to Dr. Chada in the round, and other of your remarks, including your Section 21 response to this Inquiry, and you make the point that you're not saying that Mr. O'Brien's work isn't good work, or it isn't safe work. Was his work safe when you look from a standing position after you came into the job in 2012, or in light of what you were told in 2017? 14:31

A. So, looking at this statement now, this obviously was a statement taken when I was interviewed by Dr. Chada, and I think Siobhan Hynds was the note taker, and what I'm reflecting is that both Mr. Young and Mr. O'Brien did have a very work heavy workload. Me coming in as a third consultant inherited a workload from a colleague 14:31

who had left, and then there were others who joined who essentially had no backlog because they were new consultants. And, you know, he, as I've said, Mr. O'Brien did express these views about his most important commitments were to in-patient care and the operating that needed to be done. And I know from the data, because I had access to business objects, when you run the data you can see exactly how many patients people see under their name every year, and he was significantly below that of others. So he was seeing fewer people, and I can back that up with the data. 14:32 14:32

What I am saying about it not being good work. I'm not saying it isn't good work or safe. Mr. O'Brien was a very safe operator in my opinion. I did not see patients coming to harm because he had operated on them. That was my experience when I gave that statement. When patients were seen in clinic they got a thorough assessment, in my view, when they saw him, and when he handed over patients to me on the post, on the handover ward round, they had had a very thorough assessment from him, and he was able to tell you in great detail what had happened to all of those patients. So that is where I am coming from with that statement. 14:32 14:33 14:33

Now, what I don't say there, and perhaps what I should have said, was that -- there was something about the -- yeah, about the correspondence. I don't think I've

expressed anything about correspondence there, but clearly there was an issue with correspondence not being done in a timely manner, you know. It hasn't been stated in that section. I don't know if it is stated in another section of that? 14:33

202 Q. I suppose what you say is he does fall behind with things?

A. Yeah. So I mean that's what I'm referring to I think there.

203 Q. Yeah. Yeah. Yeah. 14:33

A. Yeah.

204 Q. I just wonder, I want to give you an opportunity to comment on this, but I wonder whether there was some hesitation on your part, or on the part of your colleagues in calling a spade a spade, that you took 14:34 the view that Mr. O'Brien had areas of practice that gave rise to patient safety risk? And we've looked before lunch and we've looked since lunch at this sort of informality of the challenge to him from colleagues.

A. Did I recognise the full extent of the patient safety 14:34 risk at the time that I was interviewed for this? I probably didn't. Was I aware of the extent of it? I certainly wasn't. So I think that's reflected in what I've said, you know. There are things I haven't said that now in hindsight I would say. 14:34

205 Q. When you had completed the draft of your, the SAI, with your colleagues for Patient 10, Dr. Boyce invited you to send that to Mr. O'Brien, and if we just pick up on that email correspondence. TRU-257720. And we don't

need to look at the fine detail of it. 10th January, she's asking you to pass the SAI on to Mr. O'Brien.

A. Actually the fine detail is important.

206 Q. Okay. Happy to go there. So, if you just want to - I'll not read it aloud. And scrolling up the page, and you're telling her: 14:35

"I will not be sending the report to Mr. O'Brien. I am his colleague and not his manager." 14:36

You had previously, when you were dealing with the SAI in respect of Patient 128 in 2015, shared the report.

A. I did.

207 Q. Yeah. And that prompted a response from Mr. O'Brien "Congratulations"? 14:36

A. Yes.

208 Q. "An excellent report." What was it about your role that caused you to be reluctant, or caused you to refuse to send the Patient 10 report to him?

A. So the timing of this is very important. First thing to say is I had no knowledge of Dr. Boyce's role in governance. I had no idea that she was involved in any way in the governance structure. So I received this email from somebody who I knew to be a senior member of the Pharmacy Department. I didn't understand why she was writing to me. Secondly, her email arrived exactly one week after we had all sat in a room with Ronan Carroll and others, being told that the Trust was excluding Mr. O'Brien from work. I had told you at the 14:37 14:37

Inquiry the last time I was here that I was annoyed at how that had been managed and that I felt that the Medical Director should have addressed us as a group of consultants.

So here I'm receiving an email from somebody who I have no knowledge of what their role is, on behalf of the Medical Director, and I am sitting there reading it fuming, thinking "Why hasn't the Medical Director written to me?", because I'd want to have a conversation with the Medical Director about this. 14:38

The Medical Director had chosen to exclude Mr. O'Brien from work. I didn't feel it was appropriate for me to send any correspondence to Mr. O'Brien if he had been excluded from work by the Medical Director. If the Medical Director wanted to send correspondence to Mr. O'Brien, he was quite free to do so. 14:38

209 Q. Did you feel conflicted?

A. No. 14:38

210 Q. He was a colleague who had a responsibility as one of the senior authors of the SAI review.

A. If the Medical Director had chosen to exclude my colleague from work, I was not going to be having correspondence with an excluded colleague. That was the prerogative. That, in my view, fell at the feet of the Medical Director. And the medical never came back to me on this issue. 14:39

211 Q. I see. I'm not sure I understand? Perhaps you could

spell it out to assist the Inquiry?

A. So if somebody is not at work, if they're sick or whatever, then I don't have a role in interrupting that person's sick leave or otherwise, and I didn't believe I had a role in interrupting his exclusion from work. 14:39

212 Q. I'm not sure I follow. How is it an interruption from his exclusion from work to pass on the --

A. He is not --

213 Q. Let me finish, please. To pass on an SAI review for his observations? 14:39

A. This is a work related issue. He's not at work. He has been excluded. In my view, that was something for the Medical Director to deal with. The Medical Director never came back to me on this issue. If he had come back to me and said "You have to do this", I think I'd have still refused. 14:40

214 Q. Could I bring you to Dr. Boyce's observations in terms of your response to this. TRA-05951. And she says -- just scrolling down. Yes. I'm asking her about the normalcy of the responsibility of passing on the SAI Review Report, and she says this is one for you to address. 14:40

"I understand he was very conflicted..."

14:40

- as you say:

"...being a colleague, and I understand now that he saw Mr. O'Brien almost like a mentor. When I had been

asked to do that and it came back, obviously I went back to Ester and Richard and it was taken."

Bit jerky there, the text, but --

A. I'm not sure, you know, I've never had a conversation with Dr. Boyce.

215 Q. Yeah.

A. I've only had email correspondence. So I'm not sure how she understood I was conflicted.

216 Q. Yeah. Yeah. Well let's just think about it, think through it one more time. Did you see it as a responsibility in general as a -- 14:41

A. Yeah, I would have no issue in delivering an SAI report to a colleague. But the circumstances here were very different. My colleague had been excluded from work. It was not my responsibility, in my view, to start communicating with somebody who had been excluded from work. 14:41

217 Q. I'm asking you these questions because on the face of it there was no formal challenge by you to any of the identified deficits or shortcomings in Mr. O'Brien's practice, and I wonder whether there was -- was there a closeness there in terms of your relationship with him as a colleague, and to use Dr. Boyce's language, as a mentor, which would have made it uncomfortable for you to engage in a more decisive or aggressive manner in challenging his conduct, or perhaps in the alternative you didn't see it as your role at all? 14:42 14:42

A. So, you correctly pointed out earlier that I had sent

Mr. O'Brien a previous SAI relating to Patient 128. I had no issue about doing that. I had no issue with discussing these things with Mr. O'Brien. This solely came down to the fact that the Medical Director sought and excluded Mr. O'Brien from work. I batted this back, Tracey Boyce clearly had a conversation with Esther Gishkori and Richard Wright, and none of them came back to me.

218 Q. And broadening the issue out in terms of my question --

A. In terms of mentorship. Mr. O'Brien and Mr. Young fulfilled that role for me when I was a junior trainee. 14:43

219 Q. Yes.

A. When I was a clinical fellow in their department. When I became a consultant colleague, I was a consultant colleague, albeit a junior colleague, and over time your relationship matures, it develops. You come to a different position than you were when you were a trainee, you know. As I've said in my statement to the Inquiry, I completed these SAIs in good faith and to the best of my ability, and I did not offer undue favour to anybody in any of the SAIs. 14:43 14:44

220 Q. Yes. And my broader question is: How do we explain any failure on your part to more rigorously challenge what might be regarded as patient safety issues on the part of Mr. O'Brien? Is that explained on the basis that you didn't see it as your responsibility to go beyond an informal challenge as part of a team meeting, or was there an uncomfortable closeness with him which made it difficult for you to pursue issues with him, or is 14:44

there some other explanation?

A. Are you referring to the specifics, Mr. Wolfe?

221 Q. Well, I think we've got to the place where you accept that you've never raised, for example, an incident report in respect of Mr. O'Brien, and across the issues we've looked at so far it has been of a flavour of raising issues with him in a team meeting format, informal approaches. 14:45

A. Yeah, I mean, in what other formats do you think I should be raising things? I mean if we discuss them as a team, we're discussing them as a team, and I think that's the right forum to discuss these things. You know, I didn't have reason to be sending in IR1s. If I'd of thought there was a reason, I would have done one. You know. I was asked to Chair SAIs. They happened to be about his patients. I didn't select them, they were given to me. I did them faithfully. So, you know, I reject the assertion that I in some way turned a blind eye to his shortcomings. 14:45

222 Q. Could I bring you to something that Mr. Hughes, Dr. Hughes said? We were at the note this morning and, again, I should give you an opportunity to deal with it. It's the telephone conversation 30th November 2020. If you just bring up the record for that again, please? It's TRU-162250. I think towards the bottom of the page. Yeah. So the note at the very last line, if you can just bring it up slightly so we can see it? Yeah. So Dr. Hughes indicates that you were describing Mr. O'Brien as a holistic physician or clinician, and 14:45 14:46

this is, it seems that the lead into this in a note that we all accept isn't verbatim, the lead into this is the absence of CNS input into Mr. O'Brien's patients. And I went on when he came to give evidence to ask him about that description, which he has in parenthesis "(holistic physician clinician)", and if we go to what Dr. Hughes said in expanding upon that in evidence, it's at TRA-01120, and just to the bottom of the page, please. And you can see my question to him. And I'm asking him whether that description which he says that you used of Mr. O'Brien a being a "holistic physician clinician" was by way of an excuse or explanation or is it a compliment? And he goes on over the page then to say that he thought that you had a misplaced collegiate friendship with Mr. O'Brien and he thinks that that is misjudged. 14:47 14:48 14:48

"In this day and age to describe somebody as a holistic clinician is really suggesting somebody is working outside their fields of competence. You can't deliver the roles of clinical nurse specialist, you can't deliver the roles of a palliative care physician, you can't meet patient needs working in isolation, and that's something that people need to be protected from." 14:48 14:49

So he, I suppose most directly sees a misplaced collegiate friendship in how you are portraying Mr. O'Brien in your discussions with him?

A. So I think he has misconstrued this.

223 Q. Did he, when he was speaking to you, ask you what you meant about --

A. No.

224 Q. -- holistic physician? 14:49

A. No. Can we go back to my statement, please, and I will explain to you what I was trying to say?

225 Q. Very well.

A. So the conversation that I had with him over the telephone, you can see that the transcript amounts to 14:49 less than two pages. This was a rather stilted conversation. And what I was getting at wasn't necessarily about Mr. O'Brien believing that he could be the CNS, he could be everybody. Mr. O'Brien had a clinical practice whereby, for instance, if a patient 14:50 had a medical problem on the surgical ward, he would quite frequently take it upon himself to initiate the treatment for that, such as hypertension, et cetera. So he saw himself as being a doctor first and a surgeon second, and he frequently expressed that kind of view 14:50 when we would do ward rounds. And that's part of who he was and that's the way that he practised. So that is what I was referring to. I was not referring to that he saw himself in place of the CNS or their role, that's what I was referring to. Dr. Hughes did not 14:50 explore that further during that telephone conversation.

In the interests of openness, I explained to

Dr. Hughes, and I think if I had my statement in front of me I could tell you exactly what I said, but it was essentially that I had known Mr. O'Brien for a very long time.

226 Q. Do you wish me to give you a reference? 14:51

A. Yes, I think that would be helpful. I don't have the reference, I'm afraid.

227 Q. I can't help you unless -- I'm happy that you're --

A. It's the transcript of Dr. Hughes' conversation with me that you showed a few moments ago. 14:51

228 Q. Sorry, I thought you were referring to your Section 21 statement. So, yes, we can go to Dr. Hughes' telephone conversation, 30th November, at TRU-166249. It's the start of it, and then the -- sorry, I beg your pardon. There it is there. 50 is the proper reference. The 14:51 extract that we were focusing on is at the bottom of the page. Do you wish to go to that?

A. Yes, please. So, I say as has been recorded by Patricia Kingsnorth:

14:52

"We would work in multi-disciplinary teams and we would deal with the surgical management."

We would refer medical issues to a medical colleague. We wouldn't necessarily tackle them ourselves. 14:52 Mr. O'Brien's approach was a little different in that regard. So that's what I was getting at. Is there another page to that or not?

229 Q. Of course, yes, over the page.

A. Yeah. Can you go down towards the very bottom of the statement I think it is? So they asked me about our relationships, and 2016 was difficult, and after Mr. O'Brien returned to work in 2017 it remained difficult. I had -- and I told them about, you know, how long I had had an experience of knowing both Mr. Young and Mr. O'Brien, and so that he wasn't blindsided to this, I told him I had known Mr. O'Brien since I was a medical student, before I was a medical student. I did not want Dr. Hughes or any of the investigating team to come back to me to say "Well, you haven't declared that you've known this person for 30 years", so I put that out there upfront. 14:52 14:53

I was also, you know, this was 2020, November 2020, around the time that this was going through the assembly, the announcement of this Inquiry, I was a little bit miffed at how the Department or the Minister of Health had decided to do things, and Dr. Hughes had not completed his SAIs, they were still in hand, and yet events had moved on in the assembly, and I really felt that there was a risk that Mr. O'Brien would not be treated in an evenhanded and proportionate manner, and that's why I said that. And, you know, I think -- 14:53 14:53

230 Q. Is this a reference over the page? 14:54

A. No, it's on that same page at the last - I said:

"The current investigation should be evenhanded and proportionate in manner."

And I think that's the very least that any of us would expect, and I was getting a sense that -- my sense of this was that everything was being stacked up against one person at that point in time. Now, I was not in possession of all of the facts, and I admit that, but working in the Department, that was the sense that I had.

231 Q. Yes. I think just over the page, it continues that. 14:54

"...the Minister had taken disproportionate view and this was prejudicial."

A. Yeah. And perhaps I am not, as I told you earlier, I am not a scholar of English and maybe "prejudicial" wasn't the correct word, but I felt it was detrimental maybe as an alternative adjective. 14:54

232 Q. Yes. Looking at what Dr. Hughes was saying, and bearing in mind the facts that he was establishing, it perhaps seemed to him that Mr. O'Brien was in essence regarding himself as in charge of many matters, or capable of discharging many matters as this holistic physician, when in fact what in the view of Dr. Hughes was that Mr. O'Brien was silo working, he's not delegating, he's not using nurses, he's not taking on view the recommendations of the MDT, or reporting back to the MDT, those kinds of things. And in that context could you be surprised that he has taken the view that you appeared overly defensive of Mr. O'Brien, in light 14:55 14:55

of what he knew?

A. So he and I were at two different points in that discussion. He was party to information that I was not party to. That information was not shared with me. He was coming with a background knowledge of what was going on that was greater than was available to me. I was also conscious of the fact that he was, whilst it might come across on the phone as a very informal chat, this isn't an informal chat. This is a formal documented meeting about, you know, shortcomings alleged of a colleague. So I wasn't going to say things in that meeting that I wasn't certain about and that I couldn't later defend. 14:56

233 Q. Thank you. Now, we have heard from you already in relation to the meeting that took place in January 2017, and you've said in your witness statement that it left you all feeling awkward and difficult because Mr. O'Brien was a colleague, you knew that there were real issues that needed to be addressed, but nevertheless it was an awkward situation. Is that fair? 14:56 14:57

A. Yes, it's very fair. It's how I felt.

234 Q. Yeah. And did you doubt the importance or the significance of the issues that were being revealed to you perhaps for the first time in terms of their extensiveness? 14:57

A. I think it's difficult to get your head around the breadth and extent when you're first told about it.

235 Q. Did it surprise you in terms of that is the description

of a colleague you had known for years?

A. Yeah, it did surprise me.

236 Q. You were with the Trust for a period of about five years at that point?

A. Yep. 14:58

237 Q. The description of what Mr. O'Brien was and wasn't doing was being revealed to you. You had, I suppose, something of further information because of your work on the SAI, albeit limited to the triage issue.

A. Yeah. 14:58

238 Q. In terms of the governance arrangements that should be capturing such shortcomings and dealing with them, had you, by 2017, observed any frailties or vulnerabilities in those arrangements that would have left you thinking "Well, that doesn't really come as a surprise." It may 14:59 come as a surprise that it's Mr. O'Brien, but given the state of the arrangements, one can quite see how a practitioner might get away with it for so long?

A. So I didn't hold a management role so I wasn't aware of discussions perhaps at CD level or Head of Service 14:59 level as to how things were monitored. So, for instance, I wasn't aware of how close an eye the Trust kept on triage being returned and in timeframes and things like that. So I had absolutely no concept that there was such a large number of triage undone. 14:59

I wasn't aware that they actually closely monitored dictation of clinic letters and things like that. So when it came to light that there were lots and lots of

clinic letters not done, I was shocked by that. Our previous experience of when we had done clinics and there hadn't been a letter present, you're talking small numbers of patients that we saw. So you can't, I wouldn't have gauged from that, that there were necessarily perhaps hundreds of letters undone. I'm not sure of the numbers. I haven't got them to quote. 15:00

239 Q. And precise numbers are maybe not terribly important. But you didn't have a sense that your activity around that was, or indeed any of your colleague's activity around dictation of clinical encounters was being monitored? 15:00

A. No. No. At a later point I became aware that the Trust developed a monitoring exercise, which was done from an administrative point of view. It was -- and then provided to us on an Excel sheet. But I think as Mr. Haynes correctly pointed out to you here in evidence, that was an inaccurate reflection of what was happening, because it was only if the secretaries were recording things accurately on the system that that would be up-to-date. And he reflected, and I would share the view, that my secretary and his secretary had things up-to-date and things were recorded properly, and I don't think that that was necessarily the case across the whole team. 15:00 15:01

240 Q. You would probably have appreciated as well that things like sign off were not particularly well monitored at that time? 15:01

A. Yeah. There was no electronic sign-off available at

that time. So that was not easy to check. Paper results came through to consultants to be signed, and I am certain that that was not checked. So, you know, there were lots of holes.

241 Q. Yes. And I think you've reflected already that in terms of the people, the boots on the ground who are supposed to work those systems and I suppose enforce them or improve them, such as Martina Corrigan and other people -- 15:01

A. Yeah. 15:02

242 Q. I'm just picking on her name as an example, but you've already said that it appeared to you that she lacked the time or the capacity because of the other demands on her...

A. She was carrying too big a workload. 15:02

243 Q. Yes. In terms of what you were told at the meeting. You say, if we go back to your statement at WIT-42320 at 50.9, top of the page. So you're talking about interaction with Mr. Carroll and the shock that visited you when told of Mr. O'Brien's shortcomings in 2017. 15:03 You say:

"It was impression at the meeting that Mr. Carroll and other managers present were party to information about Mr. O'Brien's practice that was not shared with the urology consultants at the meeting." 15:03

It's an unusual sentence, and I obviously have to probe it. Is that just a suspicion that you weren't being

told the whole story, or can you vouch it any better today?

A. I have a suspicious mind.

244 Q. Yes. (Laughs).

A. I think if you're in a meeting and you're being told information like this, naturally you're going to question where this has come from, what's the extent of it, you know, and I now understand, and I didn't know at the time, that an MHPS process had commenced. So I appreciate that they may not wish to share all of the details of that with the whole entirety of the team, and that's perhaps a reason why they wouldn't have shared information in its entirety with us, but I left the meeting with the impression that we haven't got the full sorry here. 15:03 15:04 15:04

245 Q. And was the full story, as you surmised it might be, or were suspicious about, was it ultimately revealed to you in any better way than you have currently described it to us?

A. So we weren't given figures or facts at this meeting, we were just told about items of concern. 15:04

246 Q. And those concerns, just to be clear, were primarily triage and dictation.

A. Triage and dictation, and letters not being present in charts, and whether or not actions had been taken at clinic related to consultations. So, you know, I wasn't sure if that was the sum total of it or what else could there be? Were there other issues that where as yet not disclosed? 15:04

247 Q. Could I ask you about the work that you undertook with colleagues as part of - and it's my phrase and if you can use a better praise feel free - as part of this clean up. What was your focus in terms of activity?

A. So, my recollection is that Martina Corrigan obtained lists of clinics, and there was an exercise undertaken to check whether or not letters had been dictated from those clinics and actions undertaken, and where it was identified that they hadn't been done, those charts were then obtained and passed to us as consultants in bundles. So I participated in that activity I think in the later part of January 2017, perhaps February 2017, and I went through bundles of charts, returned them back to Martina, together with an outcome sheet as to what action I had taken, and there were various actions. So I might have requested scans for somebody, I might have indicated that that patient needs to come to clinic, et cetera. 15:05 15:06 15:06

248 Q. I think we might have an example, perhaps, of the work you did. WIT-292300. WIT-292300. Let's try TRU. I beg your pardon. Yes, so your handwriting? 15:06

A. It is.

249 Q. Yes. So it is 27th April. You've worked for, on the face of it, just under two hours on this. So each of those represents a chart that's handed to you to consider. Is that fair? 15:07

A. Yeah, I think so. I think that's how it was done.

250 Q. Yes. Yes. And obviously if you were seeing these patients in clinic you would be dictating an outcome

generally. Is that fair?

A. If I saw the patient I'd dictate a letter.

251 Q. Yes.

A. And in addition to that, we use outcome sheets.

252 Q. Yes. 15:08

A. So the outcome sheet would be completed, that's returned to the secretaries so that they know what actions need to be taken.

253 Q. So you weren't expected to dictate on these patients, is that fair? You were sending messages back in this 15:08 form?

A. So I was -- this was being returned to Martina, and the actions were -- if you take the one at the bottom, the patient has been seen by me on that date and discharged. 15:08

254 Q. Right.

A. Where there was no -- the one above that, where there is no urology entry in the chart, no urology entry on Patient Centre, that patient clearly needed a review, so that would have been organised. 15:08

255 Q. Yes. Dr. Chada describes this as an extensive review exercise undertaken at significant cost, her words. Perhaps you don't know about the cost, and I'll not ask you to comment unless you do know.

A. Okay. Well, I'll be honest, I was paid for doing it. 15:09

256 Q. Yes.

A. That's why the times are at the top of the thing.

257 Q. Yes.

A. Yeah.

258 Q. But in terms of its impact on the resources available within a small urology team, was it a significant exercise?

A. It was, and it wasn't deliverable during our normal working time, and that's why you can see that this was done in the evening. 15:09

259 Q. In terms of the thoroughness of the process. We can see that Mrs. Corrigan told the Oversight Committee - I don't need to bring it up on the screen unless necessary. It's TRU, for the Panel's reference, TRU-257708. As a group of consultants you were advising her and perhaps Mr. Carroll, that you would prefer to go with Mr. O'Brien's outcome, as it would be very difficult for you as consultants, never having seen the patient, to make a determination. But are happy, you're happy if anything comes from the administrative exercise to see the patient, if required. So, for some patients were you working of an outcomes sheet that might have been available from Mr. O'Brien? 15:09 15:10 15:10

A. No, I think it was perhaps more the case that if there was an entry in the chart, or if there happened to be a letter, then we were working from that.

260 Q. And in terms of what was found. We can see, for example, if we go to TRU-278933, your writing. Sorry, it may be further down the page. Scroll up again, sorry. Yes. Sorry. I had a note of you writing to Mr. Haynes. It's the other way round. So, early stages of the process of looking at Mr. O'Brien's work. 15:10

Can you just help us in terms of this as an example?

A. No, I don't think that's the case here. So you can see from the email just below that, that Mr. O'Brien had written to all of the consultants on 7th November. That was shortly before he went off for sick leave or maybe during the period of sick leave. 15:11

261 Q. Yes.

A. I don't know the exact dates. And what he was alerting the team to were a number of cases of high clinical priority, in his opinion, which, if you go down the list, I think when you look at them, that's very likely to be the case. So this is now Mark Haynes writing to me in late January 2017, with respect to the list that Mr. O'Brien had provided, and clearly there were patients within that list that we needed to get sorted out. 15:12 15:12

262 Q. Yes.

A. Because it was clear at that point that Mr. O'Brien wouldn't be available to sort them out himself.

263 Q. Okay. So this is Mr. O'Brien communicating well that there were concerns around particular patients that needed to be seen with a degree of urgency? 15:12

A. Yes.

264 Q. I am obliged. Thank you. Mrs. Corrigan on 7th June 2017, provides an update on the cleanup review. If you go to that? TRU-268814. And she is updating Siobhan Hynds and Ronan Carroll on the findings from the updated, sorry, the undictated clinics, and some standout figures. There are 110 patients being added 15:12

to a Review Outpatient Waiting List, a number of these should have had an appointment before now, but she would add that Mr. O'Brien has a review backlog issue already. So the patients, even if they had been added timely, may still not have been seen. So is that simply saying that done appropriately these patients should have been added to the Review Outpatient Waiting List at the point of clinical encounter rather than waiting until now? So it's a delay issue? 15:13

A. Yeah, I think that's correct, because if the letter hasn't been dictated at the time of the clinic, and if an outcome sheet has not been provided to the consultant's secretary to, for instance, book a clinic appointment in six months, then that's not going to be recorded by the secretary on PAS, so there will be a delay. 15:14

265 Q. And then the next paragraph 35:

"Patients needed to be added to theatre waiting lists." 15:14

They're all classed as Category 4 or routine. Again, due to the backlog, they wouldn't get to be due to be seen, but they're not on the waiting list, which is at least an administrative problem?

A. Yes, it is. 15:15

266 Q. Just scrolling down. She explains that:

"There were three patients whom consultants have concerns on and urgent appointments made. One has

since been sorted and two others have cancelled appointments and these have to be rearranged."

Did you have a sense, or what was your sense in terms of the cases that you were dealing with in terms of whether these were merely administrative difficulties in nature or whether alternatively some came with a degree of clinical seriousness or concern for patient safety? 15:15

A. Six years down the line I can't remember. 15:16

267 Q. Very well. You have said, if we go to your witness statement, WIT-42329, at paragraph 60.1, that in terms of -- just scroll back and we'll see the question precisely. Just up a wee bit:

15:16

"Did you consider that any concerns raised regarding Mr. O'Brien may have impacted on patient care and safety? And, if so..."

- a series of questions, including:

"In what way, may concerns have impacted on patient care and safety?"

And you explain going down over to the next page that: 15:16

"The impact was in patient care and safety terms relating to delayed time to assessment and treatment, the risk of failing to appropriately escalate routine

referrals to urgent or red flag at triage and delays to treatment caused by the absence of or late correspondence to GPs and others."

That being your view, perhaps in light of the passage of time more appropriate to set it in those terms rather than any specifics, but were you left with a changed impression of Mr. O'Brien in terms of how he practised? 15:17

A. So, following the events of January 2017, clearly my view changed, and that's reflected in what I told Dr. Chada. It's reflected in what I've written in this statement. So the scope and extent of the problem became clear from that point forward, to me. 15:17

268 Q. The view as set out there, was that a view you shared with colleagues or colleagues shared with you about Mr. O'Brien and... 15:18

A. Others may have held this view before I held it, they may have been in possession of information to support that view, but I know that since this all came to light others would have shared similar concerns about delayed correspondence, delayed referral, and the absence of triage. 15:18

269 Q. But in terms of his safety as a practitioner in light of what was revealed in 2017 and what was to be discovered when reviewing the cases, was that the subject of conversation with your immediate colleagues in terms of we now have to be more cautious in terms of, for example, in terms of how we deal with 15:18

Mr. O'Brien or in terms of our working relationship with him?

A. I think our working relationship was damaged by this process and this information coming to light, and I'm sure that was a two-way street. You know, it did make relationships at work more difficult. There are many aspects of his practice that I think, you know, that were safe, but when you take it in the round and you look at all of the issues, these aspects clearly weren't. So I suppose people are more complex than just one issue paints them. 15:19 15:19

270 Q. Equally where you see shortcomings here, it might be suggestive of at least the need to look for shortcomings here?

A. Yeah. 15:20

271 Q. Dr. Boyce, when she came to give evidence, and reflecting about what we now know arising out of 2020 SAIs and all of that, she says that she's left with an unanswered question as to why the MHPS process, the MHPS investigation, did not uncover any of the further patient safety concerns which subsequently came to light. Is that a fair question to pose? 15:20

A. I think it's a fair observation on her part. So what I would say about this is that I'm responsible for trainees, okay, and when I have a trainee in difficulty then there is usually more than one issue at play, and so when you have that situation you need to look at more than just the one facet that's come to light, and I think it would be a very fair observation to suggest 15:21

that when this came to light a whole practice review should have taken place. Now that's easy to say in hindsight. My experience of dealing with trainees in difficulty is that that's really what you need to do. We're not talking here about a trainee, we're talking about a senior consultant. But, nonetheless, the senior management responsible for the person, in my view now, in hindsight, should have undertaken that kind of activity.

272 Q. You make a number of points in or around this area. You make a point, for example, if we can bring up your statement at WIT-42331 and paragraph 65.3, that: 15:21 15:22

"From 2017 onwards medical managers were involved but communication to me from them was minimal." 15:22

You say:

"I don't recall a single meeting to discuss governance issues or patient safety concerns related to Mr. O'Brien or the Urology Department with any of the following post holders who held tenure in the period following the meeting in January 2017 up until June 2020." 15:22 15:23

And then you name medical directors, assistant medical directors, and scrolling over the page, clinical directors.

Is that to suggest that looking back on, from a position of where we are now, that you consider that really the Trust and Senior Trust management on the professional side could have done a lot better by way of attempting to uncover all of the problems and support the urology team to assist Mr. O'Brien, or at least protect patients in a better way?

A. Yeah, I think it could have been done better. I'm not -- by naming these people I am not pointing the finger at them. They were the post holders, you know. There was little, in fact, minimal is the right word, communication back to us as a team as to what was happening. And I made the point to you earlier today, and if we didn't know what was happening how were we to look out for problems, and who were we to report them to when they came along? So, you know, I do think it's a failing.

273 Q. Well as you say, you've made that point that Mr. O'Brien's return to work was in a sense with a vacuum of information in terms of his relationship or management relationship with you, his colleagues. Would there have been value, and what would have been the value in advising you, his colleagues, of more precisely about what was going on, both in terms of his perceived shortcomings and what was being done to address them, or at least superintend them?

A. So I'll again reflect on how we would manage a trainee in difficulty. We would have a meeting with that trainee and agree a return to work strategy. We would

document that. We would set goals and targets. We would ensure that that person has appropriate support. So, you know -- and that's outside of the management structure. So we have a professional support unit at NIMDA, they would be involved. We would make sure that the person is supported in their returning to work. They may have a phased return to work. They may be undertaking certain activities and not others. That would all be clearly documented. That's the kind of approach that I think should have been shared with us, that should have been open. Because if you don't do that, then you have this vacuum of information, people are wondering "Well, what's so and so supposed to be doing anyway? Are they doing it? We don't know." It creates mistrust. So that's why I think it was important that that activity was shared with us. 15:25 15:25 15:25

274 Q. I suppose potentially one of the difficulties here is that this case of Mr. O'Brien was shunted down the formal MHPS route, and if we look at that route which has layers of employment law around that, and contractual issues, and confidentiality and all of that, as compared with the route that as a team I suspect you chose in respect of Dr. or Mr. Suresh, where it was all round the table. Different issues of course. 15:26 15:26

A. Yeah.

275 Q. But is there something to be taken from that contrast?

A. Yeah. Mr. Wolfe, I do not know the niceties of the contractual situation of the MHPS, and that may have a

very important bearing on how this was managed, but I think the collegiate response that we had to the issues that Mr. Suresh had, and the team being involved and that supportive environment, to me that seemed absent when Mr. O'Brien returned to work.

276 Q. Just finally before we move on to a new topic, if we can go to WIT- the next page, in fact. You're asked, having had the opportunity to reflect:

"Do you have an explanation as to what went wrong within Urology Services and why?" 15:27

And I suppose the -- I think it's a series of strands to your thinking, and there is a failure to deliver timely care set against a failure to monitor the performance of individual consultant's activity. Workload pressures obviously predominate. Keeping your head above water, balancing the competing interests in an inadequately resourced department. Going down to 69.3, yeah -- no, that deals more specifically with the Bicalutamide issue I think. 15:28

You say just before 69.3, and I take your answer as this has to be viewed in the context of the capacity issues, but behaviours of individuals, you say: 15:29

"...custom and practice went unchallenged with respect to the timeliness of correspondence, triage, monitoring of volumes of activity and chronological listing of

cases for theatre."

So is part of your concern here in terms of what we learn from all of this is that, as I think we discussed on the last day, performance management, more focused performance management is key to getting at the problems at the earliest possible stage? 15:29

A. I think we need performance management. I think we also need openness and transparency in terms of job planning and what people are delivering and what they're expected to deliver. You know, practice. Even amongst a small team like ours, we all have sub-specialist interests and, you know, it may not be possible for us all to see equal numbers of patients, but we should be expected to deliver a reasonable volume of work, and that should be agreed, and we should be monitored to ensure that that's happening, you know. 15:29 15:30

I think, you know, timeliness of correspondence and completing triage in a timely manner, all of that stuff should be formally agreed, it should be, you know, recorded in a job plan, and it should be recorded in a policy for the Trust. 15:30

277 Q. Very well. Would it be convenient to take a short break and then back... 15:30

CHAIR: A quarter to four then everyone.

A SHORT ADJOURNMENT

THE HEARING RESUMED, AS FOLLOWS, AFTER A SHORT ADJOURNMENT

CHAIR: Thank you everyone. Sorry we're slightly later than I suggested we'd be back.

MR. WOLFE: Thank you. Mr. Glackin. Three, three and a half more issues to go through with you before we finish.

I want to explore with you the issue of surgical safety, preoperative assessment, that kind of area. Let me start by I suppose referring to several examples of issues that have come up in that domain.

Let's start with an email that was sent to Mrs. Corrigan back in 2015. I don't pretend that you would have any knowledge of it, but just to illustrate the point. TRU-277928, and Mary McGeough writing to Martina Corrigan and others, 2nd November 2015. Scrolling down, please, and she says:

"Please see below regarding Mr. O'Brien's patients for his day surgery list tomorrow.

As you will see, three out of the five patients have not been to pre-op. Could you please investigate and advise why these patients were never sent to pre-op as to get this level of notification of their surgery is, as I am sure you will agree, unacceptable."

And I think it ultimately leads to the surgery having to be pulled.

Another example of a pre-op issue. If we go to the case of Patient 90, I think you're familiar with that case and we've touched upon it in other contexts I think before now, but briefly, that was a case where the patient died following surgery, didn't have an appropriate preoperative assessment in the context of significant co-morbidities, and in the context of a need, albeit unrecognised by the surgeon, Mr. O'Brien, and the anaesthetist it would appear, for an echocardiogram that had been written up and indicated some couple of years, at least 18 months prior to that. 15:49

So, again, by way of example. If we go to the recommendations arising out of that Serious Adverse Incident Review. TRU-161146. Scrolling down. So Recommendation 2: 15:50

"All patients undergoing elective surgery must have a formal preoperative assessment completed prior to surgery, including liaison with other specialities to ensure maximum optimisation of patients prior to procedure." 15:50

And you can see the rest of that recommendation.

Then, thirdly, just by way of illustration. You're familiar with the case of Patient 91, and that was a case where there was some delay in bringing the patient in for stent, or at least objectively some delay, and his surgery was performed and he died thereafter. 15:51

Again, the setting is one of complex co-morbidities, but it's clear that he didn't have a preoperative assessment and didn't have a midstream urinary microbiology output prior to surgery, or at least the 15:51 results hadn't come back prior to surgery, I think that's the correct sequence.

So, again, WIT-33320. Recommendation 2:

15:51

"All patients undergoing elective and planned procedures where the urinary tract will be entered and the mucosa breached, including endoscopic urological surgery, must have a preoperative assessment with microbiological testing of urine within 7 days of the 15:52 planned procedure, and any confirmed bacteria urea treated with appropriate antibiotics prior to the planned procedure."

So different settings, different cases, different 15:52 clinical issues. Common denominator was a failure to provide for or to conduct preoperative assessment.

The Inquiry is interested in this issue generally from

a governance perspective. In terms of your own practice first of all, I mean where you're encountering a case for theatre, whether with or without significant co-morbidities, is it the practice of you and your colleagues, to the best of your knowledge, to use a preoperative assessment format? 15:52

A. Yes.

278 Q. To the best of your knowledge has the situation improved in governance terms since any of the cases that I've touched on here? 15:53

A. So the capacity of the preoperative assessment service has improved over time. Certainly back in 2015 they wouldn't have had the same capacity that they have now. But my recent experience is that the capacity is still some way short of what it needs to be. Even if lists are provided in a timely manner, the pre-op team are still struggling to get people through the pre-op process ahead of surgery. So that still leads to problems because it may mean patients being cancelled because they haven't completed that process, and that's what would happen, they would be cancelled. 15:53 15:54

279 Q. Yes. Well, I was going to ask to what extent are you aware of a culture where risk taking is tolerated? Clearly it might be suggested that the cases that I've, the examples I've referred to shouldn't have proceeded? 15:54

A. So I think, you know, particularly with - and I'll just refer to the number. The learning from Patient 91.

280 Q. 91, yeah?

A. Right. That obviously had a profound effect on how we

operate in the Southern Trust. So every patient who is having an endourological procedure, that means a telescope into the urinary tract, is having an MSU beforehand, and the results acted upon. So there are still patients where that is not happening ahead of time quickly enough, and those patients are getting cancelled as a consequence. Now, that has implications because it may be a number of weeks before you can get them back in, and as you know from that particular case, that gentleman waited 10 weeks for his definitive stone procedure. 15:54 15:55

When we joined to use the regional facility at Lagan Valley, their Trust had a different standard, and that raised concerns for us because we had had this very recent experience of this patient, and we were doing MSUs, they were dipstick testing urine, so they were doing a bedside test and accepting the result of that to go ahead. That left us very uneasy because we didn't feel that that was secure enough, and we've insisted that our patients would have an MSU. 15:55 15:55

So there are different standards being applied in different Trusts in Northern Ireland with respect to this. Our standard is as a consequence of learning from this episode. 15:55

281 Q. Yes. I think - I didn't read it out loud, so my memory may be weak on this, but I think it was Patient 90's recommendation that there would be audit of compliance

with pre-assessment regimes. Is it your understanding that this is an area that is the subject of audit?

A. I do not know.

282 Q. Again, getting to the nuts and bolts of it, say hypothetical example, that you or a colleague have listed a patient for theatre, and the date for operation is fast approaching and you have not conducted a preoperative assessment, or the team responsible for that hasn't. Who is responsible for arresting the process into theatre and preventing it from taking place? 15:56 15:57

A. Yes. So the way that that works at present is that the preoperative assessment team nurses would communicate directly with the consultant responsible for the list. My recollection is that in my case, my secretary would be copied into that correspondence, and they would say in that note "This patient hasn't completed X, we therefore think they should be waiting list suspended", and from my perspective I would agree with that, you know. There's a safety reason to do it. You know, I take their point on board. The patient is suspended on the waiting list, offered another date when the particular investigation has been completed. 15:57 15:57

283 Q. Is there an override button where you decide "Well, you know, that's all well and good, but I feel we should get on with it. This patient is in need and I think it's a risk worth taking", how is that debated out? 15:58

A. I suppose the MSU is a relatively straightforward thing, okay.

284 Q. Yeah.
A. And that's kind of black and white and there's no debate. We deal with a very comorbid population of patients. So not all of them have their preoperative assessment with a nurse, some of them have a consultant led preoperative assessment by an anaesthetist, and the purpose of that for those patients is to get a very clear handle on their comorbidity and what the expected complication rates would be, mortality, predicated mortality rates. So that's all documented very thoroughly in a clinical letter by the consultant anaesthetist, and that would then be a two-way conversation between the consultant anaesthetist from the pre-op clinic and the operating surgeon. So that happens a lot. And as you can imagine, there are times when between you, the anaesthetist and the patient, you have to come to an agreement as to what you're going to do, because not every patient is optimally fit. 15:58 15:59 15:59
285 Q. Can I move to remaining item two on my agenda, and we've touched upon it sporadically throughout your evidence, and that's sign off and actioning of diagnostic results or diagnostic tests. 15:59

Again, let me start with a number of examples. There was a never event in 2011, before your time, retention of a swab in the cavity, which was the subject of the procedure. Subsequent to the procedure, scans seemed to show a presence of a foreign body, and it would appear that Mr. O'Brien didn't look at the scan report 16:00

as quickly as others thought he should, and that prompted some correspondence, and if I could just draw your attention to that. TRU-276805. And in response to the correspondence telling Mr. O'Brien and indeed others in the consultant body at that point about the importance of timely consideration of the results of reports of investigations, he writes to Mrs. Corrigan indicating that he has several concerns about what is expected of him, and there are a series of questions set out there, and I needn't read it out. Let's have the full email up on the screen, please. You can get the flavour of it from there. 16:01 16:01

You, as we saw this morning, had custody of Patient 128, or you had carriage of Patient 128, SAI review, which in part, for reasons of a want of a handover procedure, was a situation again where in 2014 there was a failure to deal with the results, again in a timely fashion. 16:02

2016, if we go to TRU-277936, and this may well have been -- scroll down, please. This is being issued by Heather Trouton, Assistant Director within Acute Services. This may well be -- this is five months after your outcome in the Patient 128 SAI, so I don't know if there's a linkage there. But essentially following the outcome of several SAI she is saying: 16:02 16:03

"We are writing to remind all consultants that it is

their personal responsibility to have checked and signed all radiology and pathology reports to assure that no serious results are missed."

And so we go on. There's examples, Patient 90, as we saw earlier. Patient 92 was a case of renal cell carcinoma, and there was a failure to attend at a CT scan, the reportage of a CT scan, until the GP spotted the problem. 16:03

16:04

So a number of cases pointing to clinicians, including Mr. O'Brien, failing to action, to read and action investigation reports as soon as they might be available. What's your practice and has it changed over time? 16:04

A. So, in 2016 results came in paper format from the laboratories for haematology and clinical chemistry, and perhaps for some other things that came from other labs where they were sent out. Radiology and pathology came in paper format. So those things would have been 16:04 provided to me by my secretary in a folder, and I would have went through the results. Normal results I would have signed and usually dated and returned to my secretary. Results that needed further action, I'd have either looked them up on the computer system to 16:05 see what needed to be done and organised it, and made a small note on the, you know, "CT requested", et cetera, on a note. But they would have all been signed as contemporaneously as I could have managed. There was

an issue where things might have taken a short number of weeks to come to your attention because they were coming from Radiology or pathology, so there could potentially be a delay in terms of that, but my practice was to sign them off.

Secondarily, ECR became available, pathology, radiology and the other laboratory speciality results were all available on ECR. So it's my practice daily to review results and to sign them off.

In our department we've been doing that for a few years, and I mentioned earlier that there is a report regarding the radiology that is provided to us rag rating our timeliness.

286 Q. So in terms of the safety nets that are in place in your practice, you use your secretary as a communication tool, do you, when...

A. So when it was paper format, yes, my secretary was key. Now that everything is electronic, they get signed off electronically, and there are very few paper results come through anymore. My secretary though uses the DARO system. So that's a Discharge Awaiting Results Outcome. So any time I request a particular investigation from clinic, my secretary, when she's typing the letter, or the audio typist, will record that as a DARO. So, CT six months, whatever, that will go on, and then we run a monthly DARO report. The DARO report is provided to me on a monthly basis of

outstanding results, and I go through the DARO report each month, check what has and hasn't been done. Sometimes there'll be things that'll have already been actioned. That's fine. If there are things that haven't been actioned, I will take action on them. 16:07

287 Q. Yes. And those safety nets are I suppose personal to your practice. DARO was a system, I suppose, supplied by the Trust and you use it.

A. Yes.

288 Q. When results or reports of results are generated, whether in pathology or on the film side as a result of CT scans or whatever, is there action at this date in time, is there action on their part to highlight unexpected results? 16:07

A. Ehm... 16:08

289 Q. Or maybe not unexpected but untoward results.

A. So the Radiology Department will send an email to the consultant, I think the secretaries are copied into it, and I have received these emails this week saying "This patient has had a scan. There is a significant finding. Can you please review?" So I will log on. Now, to be honest, their email arrives after I've already actioned this. So I'll just write back to them and say "Thanks for letting me know. I've sorted it." 16:08

290 Q. Yes. I think we've heard word, or we are to hear word from Mr. O'Donoghue, I know what he will say on this, but there is a system, and I think you've alluded to it already, where if there is a backlog in terms of you processing electronic sign off, you will get your 16:08

monthly total and a polite "catch up please", is that right?

A. Yeah.

291 Q. It is automated, in other words?

A. It is. It is managed by our Head of Service. But, truthfully, we've been on top of things, so there really isn't a big issue here. There may be an issue occasionally when people have taken leave and you return to a mountain of work to clear. 16:09

292 Q. Yes. 16:09

A. And that will take you some time, naturally, but it isn't an issue for us.

293 Q. We can point to cases, and we will hear from Mr. O'Brien in relation to his explanation for this, where he has delayed on actioning results. We know that he seemed to be philosophically opposed to using DARO, and as we understand it didn't use it. Was his approach to the actioning of investigation and results something known to you? 16:09

A. The email that you put up a few minutes ago from 2011, I had no knowledge of that email. 16:10

294 Q. No, of course not.

A. So, ehm...

295 Q. It's not -- don't worry, it's not a trick question.

A. No, no, I know you're not trying to trick me, but what I am trying to recall is whether or not I had knowledge, and I think I said to you earlier today that I recall Mr. O'Brien saying that he would wait until results returned before he would do the episode of 16:10

dictation. So what I took from that was that he might have seen somebody in clinic, he might have organised investigations, and he wouldn't have dictated the clinic letter or the result of the investigations until everything returned to him. So that was his practice. It's certainly never been practice to do that, you know. If I have to do a few small extra letters to keep people appraised, that's what I'll do.

296 Q. It does raise the question that if there are outliers or people who depart from the expected norm, what is the governance arrangement doing about it? Are there governance arrangements, first of all? And, if so, why aren't they being applied?

A. I don't think there are robust governance arrangements around this issue. Nobody ever said to me "You've got to do these results within this timeframe or there's a consequence."

297 Q. Do you feel the situation is, if not perfect, it's much safer now?

A. Ehm...

298 Q. Or where are there residual gaps?

A. Okay. Because of this Inquiry there has been a focus on our department. Our department is perhaps behaving now in a manner which is different from other departments throughout the Trust. I would suspect that if you looked at a broader array of specialities, you may find that their house is less well in order than ours is now.

299 Q. In terms - and thank you for that. In terms of the

systems that are now available, whether your personal approach to it, but supplemented by the apparatus supplied by the Trust, whether that's electronic sign off and followed up by an audit.

A. Yeah. 16:12

300 Q. Are there any residual gaps that you would be concerned about, where a practitioner who is less than enthusiastic about complying with this could still get away with it?

A. There's a couple of supported bits of evidence for this, Mr. Wolfe. First of all, just taking something off NIECR doesn't mean that you've actually taken appropriate action. That's the first thing. 16:13

The second thing is that I'm aware, I think it is from the evidence bundle, that surgical secretaries across the Trust were asked how their consultants dealt with correspondence, and you saw in that answer a plethora of answers as to how people manage the system. So clearly not everybody is doing the same thing. Now that may be a little bit historic, I can't put a date on that, but it's there in the evidence bundle. And there was a third thought that came to me. It's escaped, I'm sorry. 16:13

301 Q. Okay. Now, let me move to my third remaining issue, and that's the whole area of private patients and how they were managed by practitioners within Urology Services. If they had a private practice the question raised, at least in the MHPS investigation as regards 16:13

Mr. O'Brien was, was that private patient coming into the public health system, the Trust system, in an appropriate way? Let me start by putting on the screen some interventions raised by Mr. Haynes.

16:14

If we go to TRU-274504, and bottom of the page, please. This is May '15. I needn't read all of this, but he says -- he's telling Mr. Young and Mrs. Corrigan that he's:

16:14

"...feeling increasingly uncomfortable discussing the urgent waiting list problem while we turn a blind eye to a colleague listing patients for surgery out of date order, usually having been reviewed in a Saturday non-NHS clinic.

16:15

On the attached total urgent waiting list there are 89 patients listed for an urgent TURP the majority of whom will have catheters in situ. They have been waiting for up to 92 weeks."

16:15

And then he gives an example of a patient who was seen in a private clinic on a Saturday, 18th April, and his admission is arranged for just over a month later. "The immorality of this is astounding", he exclaims.

16:15

If we then just scroll up the page, we have Mr. Young's response. He agrees with the sentiment, and he says he fully appreciates the questions raised and he feels the

need in November of that year to write again. So if we go to WIT-54106. And so six months further on -- he references an email on the 2nd June, and I'm not sure if that's a mistake, certainly we've looked at the May 2015 email just now, and he says that he has: 16:16

"...once again come across examples of this behaviour continuing."

He says he has: 16:17

"...expressed my view on many occasions, immoral and unacceptable."

And I needn't go any further. Were you aware of 16:17
Mr. Haynes' concern, or did you have your own concern about how Mr. O'Brien apparently was advantaging his private patients, or at least that's the allegation?

A. So, I didn't have this concern and I wasn't party to this discussion. So I don't recall meeting any of 16:17
these patients. I was aware of what was expected of us from the Trust in terms of listing private patients for care in the NHS, and when I started private practice in the Trust, which was a couple of years after I was appointed as a consultant, we were permitted at that 16:18
time to admit private patients to the hospital, that was part of the contract. That situation changed probably within a year or so of me starting private practice, and the Trust took the position that they

would not have any private practice of any sort, including laboratory investigations, radiology, within the Trust. So that led me personally to treat my private patients in a private hospital here in Belfast, and my private patients don't touch the Trust unless the patient wishes to be referred back to NHS care, in which case I complete the necessary paperwork and they are listed accordingly. 16:18

302 Q. Yes. Yes. I'll just come back to that process bit in a moment. 16:19

A. Yeah.

303 Q. You've said to Dr. Chada, just bring it up, TRU-00776, and paragraph 39. So you recount that you were asked about Mr. O'Brien's private patients and if any had been seen faster than is in keeping with waiting list times? And the way this is written, you advised that the question presumably, and that: 16:19

"I have no evidence of this. However, with the lookback exercise it does appear that some patients have been seen sooner than anticipated given the Trust's waiting lists." 16:19

A. Yeah.

304 Q. Would you just help us understand what you're referring to there? 16:20

A. So that was in 2017, and we had been asked - you called it the "clean up", but lookback exercise is what I've termed it there.

305 Q. Yes.
A. We had been asked to review cases, and I was aware from that process, I'm not sure if they were any of the cases that I reviewed, maybe my colleagues, that they felt that some of the patients who they had reviewed the notes for, there was evidence, or there was a -- "evidence" perhaps is a strong word, because I've never seen the evidence, but there was information that led them to believe that those patients had been seen initially privately and then subsequently in the NHS, and I can't put it any more stronger than that, because I've never seen the evidence to support it. 16:20 16:20
306 Q. Yes. Can I just put a few things in front of you and if you can comment that would be helpful, if you can't so be it. The MHPS process was triggered by a meeting of the Oversight Committee, as it was called on the, top of my head, 22nd December 2016. At its triggering, in the sense of that meeting, there was no interest or no expressed interest in private patient issue. That came several days later then when Mr. Haynes intervened and drew the Oversight Committee's attention to one or other of the emails that I've just outlined to you. So we also know that for the purposes of the investigation conducted by Dr. Chada, Mr. Young, on the face of it, prepared a report setting out the treatment of a number of patients, I think it's nine off the top of my head, who had been private patients but were then treated within the Trust, all Mr. O'Brien's. So I want to ask you this: When you got your instructions to do the 16:21 16:21 16:21

lookback, we've talked already about dictation cases and triage cases, was it part of the work of you and your colleagues to look out for cases that appeared to have been advantaged by dint of their private origin?

A. Not that I recall. I don't recall being given that instruction and I don't recall that being a feature that we were to look out for. 16:22

307 Q. Yes. But it does appear to be your evidence, in the light of what you've said there, that as part of that lookback exercise, it did emerge from your... 16:22

A. Yeah.

308 Q. And you've added to it this afternoon, through your colleague, and not necessarily through you?

A. Yeah, that's my recollection of it. I don't recall finding evidence of this. 16:23

309 Q. Yea. And what you're also saying is that although Mr. Haynes is raising these issues with Mr. Young by email, you don't have any recollection of that issue being taken out and put on the agenda to be discussed with Mr. O'Brien as part of your weekly or monthly team meetings? 16:23

A. I don't recall it ever being discussed at a team meeting, a departmental meeting. Whether Mr. Haynes and I had an informal discussion at some point, we may have had. I don't recall it. 16:23

310 Q. And it's not something, self-evidently it's not something you took up with Mr. O'Brien?

A. No.

311 Q. Just in terms of the process. Obviously you've a

private practice. You've told us that you've started a private practice about a year in to...

A. No, it was probably two to three years after I commenced as a consultant.

312 Q. Yes. And initially it was at least in part bringing private patients into Craigavon for convenience. Or Newry? 16:24

A. Yeah. So, yeah, there would have been the occasional TURP, straightforward things like circumcisions, but it was within about a year of that that, I think it was Dr. Simpson largely made the decision that the Trust wouldn't be delivering private care at all, so that meant that everything went elsewhere. 16:24

313 Q. Yes. There was in place, there remains in place a Trust transfer from. I think it's origin was in the first decade of the millennium, somewhere around 2008/2009, at least in terms of the Department writing one up. We can look briefly at the 2016 version, which may or may not be the current iteration. It's TRU-267692. Help us with this. Are there circumstances in your current or recent practice where you would see the need to complete one of these forms? 16:24 16:25

A. Every time a patient wants to transfer from my private practice to the NHS, I complete one of these forms. The form is emailed to the Trust. It goes to the paying patient's office. I copy it to my secretary. I think in very recent times there has been another address that I've had to add to that, actually it's the referral and booking centre, and if the patient 16:25

happened to be a suspected cancer, I would copy in the red flag booking team.

Now, this form has in the past few months been replaced with an on-line version, which is a lot more detailed and captures a lot more governance type information, and has been met with a lot of resistance from my colleagues because of the amount of time that it takes to complete.

314 Q. Very well. So to what extent, and maybe this is an unknowable, but to what extent do you think the process that goes with moving a private patient into the NHS is well understood by your colleagues, and enforced by the powers that be? 16:26

A. So I can't answer their understanding. Some of my colleagues don't do any private practice, so I would suggest they probably have little or no understanding of this. The enforcement, again I don't know. All I can tell you is that I adhere to this process. 16:26

315 Q. Okay. If you're complying you're not going to get a knock on the door. 16:27

A. Yeah.

316 Q. Yeah. Now, just finally, this is the final point. Mr. O'Brien retired reluctantly in July 2020, his plan having been to retire and to return on a part-time locum basis, as I understand it, or perhaps there is some contractual expectation on his part. In any event, the short form is he intended to retire and return? 16:27

A. Less than full-time, yeah.

317 Q. Yes. He was told by a combination of Mr. Haynes and Mr. Carroll in the early days of June 2020 that that would not be possible, and in explaining how he had reached this view or how this decision had been reached, Mr. Haynes explained to the Inquiry that he had sought the views of colleagues, including his consultant colleagues, as to - I used the word "wisdom", he may have used other words in relation to Mr. O'Brien coming back. Is that an area or a subject that was discussed with you, whether through Mr. Haynes or through anyone else? 16:28 16:28

A. So it was only discussed with Mr. Haynes. Perhaps the way I would describe it is a sounding out, and he informally sought my view. I didn't have any managerial responsibility. I made that very clear. I wasn't going to be a decision-maker in that process, and he sought my opinion as to what I thought. 16:29

318 Q. Yes. And that was at what time, can you recall?

A. I think it would have been the spring of 2020. 16:29

319 Q. And what view did you express to him?

A. Well clearly by that time a lot of what we now know had transpired, and I had concerns that if Mr. O'Brien returned to work that he would continue to practise in the way that he had been practising, and I felt that that for us as a team was going to be a risk going forward, and my blunt view was that it would be better if he didn't come back to work because we would then have, you know, a clean slate, and we could move 16:29

forward.

MR. WOLFE: Okay. Thank you for that. And thank you for your evidence over the past two and a half, three days, and I'll leave you to the Panel's questions.

CHAIR: Unfortunately, Mr. Glackin, we can't release you just yet. There's some questions from each of us. So, first of all Mr. Hanbury will have some questions for you. 16:30

QUESTIONED BY MR. HANBURY 16:30

MR. HANBURY: Thanks very much for your evidence. I'm just going to bounce around a bit, mainly clinical things, so hopefully not too taxing. 16:30

A couple of things on MDT. First of all the quoracy. When sitting up MDTs/MDMs it is quite difficult, and often you have to go around the availabilities of people who are not always available. You had particular problems with the radiology and the oncology, especially -- did you or did any of your colleagues ask Dr. Williams or the radiologists whether there were better sessions that they could do and be prepared to maybe be flexible in terms of scheduling? 16:31

A. I don't recall that ever being discussed, changing the date, for a couple of reasons. Everybody else's timetable matched up. The regional urology meeting also took place at the same time in Belfast, and that allowed us as a team to be sure that we could link in 16:31

with the specialist MDTs that took place. So I don't recall it ever being proposed in our own department that we would change from Thursday afternoon.

320 Q. Okay. Thank you. Just moving onto the adrenal case, the one that should have had a referral and didn't. I'm just trying to get under the skin of that a bit. Was there -- I mean obviously the patient was discussed and usually there was a results clinic or arrangement that you or the responsible urologist would see the patient within a couple of weeks. I mean why was that not proposed in that situation, to explain to the patient? 16:31 16:32

A. I'm not sure. You know your expectation after the MDM would be that the consultants would review all of the outcomes and see -- and organise to see all the patients that needed to be seen. So I'm not sure why that didn't happen. 16:32

321 Q. But the outcome there was just a referral letter to the endocrinologist.

A. Yeah. 16:32

322 Q. Which is slightly unusual. I mean we see, as urologists we see a lot of adrenal lesions, I guess.

A. Yeah.

323 Q. And just on a broader subject, do you have an adrenal MDM with the endocrinologists? 16:32

A. Yeah.

324 Q. How do you deal with that?

A. There is a specialist endocrine surgery based in the Belfast Trust, and there is an endocrine MDT in the

Belfast Trust. So those patients are referred to that surgeon for discussion at the specialist MDT. Well, it may not be termed specialist MDT, it is endocrine MDT in Belfast Trust.

325 Q. And that was where? 16:33

A. That's where the patient was sent to.

326 Q. They were referred.

A. Yes.

327 Q. And is the expectation they'll have their biochemical investigations done upfront by you? 16:33

A. So often in parallel we will involve the local endocrinologist in our own Trust to do the biochemical workup, but nonetheless they would be referred to Dr. Eatock who is specialist endocrine surgery.

328 Q. Okay. Thank you. So moving on to urologist of the week, sort of interested in sort of work practices there. I think it was Mr. O'Donoghue who said that you regularly did a one in seven, but he seemed -- and recruitment has obviously been a problem with varying numbers. Is that the case - maybe I should ask him - 16:33 but if there were say six of you in town, would you not do a prospective cover?

A. So we're funded for one in seven, and on that basis we run a one in seven rota, but what that means is when we're short of staff that we have to run what we call 16:34 locum weeks, and that means one or more of us stepping out of our elective activity to cover that week. So that, if you like, there may be two blank weeks in the seven week span, and between us we have to cross cover

those.

329 Q. So that means actually you lose more elective activity because of that?

A. Exactly. Exactly.

330 Q. Which obviously -- and is there cross-filling of operating lists in that scenario? 16:34

A. So as you know, we don't have enough operating lists. So there's always a willing party to take your operating list.

331 Q. Okay. Thank you. A lot of comments about how busy urologists of the week are, and obviously there are different models which are used all over England and Northern Ireland. I was interested that despite that you saw the elective cases on the ward as well? 16:34

A. Yeah. 16:35

332 Q. Might it have been reasonable to say maybe drop those and just do the emergencies?

A. So there are variances of opinion as to how we should do that, and one of the reasons that we have persisted with a single urologist of the week looking after the post-operative elective cases plus the emergency cases, is that not everybody is on site everyday. So there are times, for instance, when I may not be on the Craigavon site for three, four, or five days at a time, and in that circumstance I cannot see my post-operative patients. So it wasn't felt to be safe to leave things to the vagaries of the SPR unsupervised, particularly when some of the SPRs are quite junior. 16:35 16:35

333 Q. So is that a particular feature of your work balance?

A. Yeah. Yeah.

334 Q. Average lists. On the same line, and maybe you've partly answered this already, I was interested that the -- on your job plans -- the urologist of the week just went on from 9:00 to 5:00. But it's true, is it, that you always did the nights on-call seven nights in a row, is that right? 16:36

A. So we haven't always done seven nights in a row. There was a period when Mark Haynes and I shared our weeks, week nights. So, for instance, if I started on the Thursday, I would have done Thursday, Friday, Saturday, Sunday. He would have done Monday and Tuesday, I would have had a break, and I would have done Wednesday to finish the week, and the reciprocal is true then on his week. So we did that to try and give ourselves a bit of a break, that you weren't on seven nights in a row. Unfortunately we've drifted back to seven nights in a row, largely because, the same reason, we don't all work on the same site. As I'm sure you're aware, Mr. Haynes is employed for part of the week by the Belfast Trust, and for other reasons he hasn't been able to deliver that, so it has slipped back. 16:36 16:36

335 Q. But if you did a day each like a rota, that might be a good deal less onerous?

A. Yeah, it might be, but then there's the continuity issue and, you know, the other thing is, it is not that frequent that we're in late night, and after midnight is a rarity. So, you know, swings and roundabouts. 16:37

336 Q. It works for you. Okay. Just one last thing on the

urologist of the week. Weekend ward rounds, you commented once that there was variable takeup. Any comment on that?

A. Yeah. I mean I can't really account for what my consultant colleagues do at the weekend. I come in on a Saturday morning invariably and go round with the registrar. Depending on the experience of that registrar I may or may not come in on a Sunday morning. We have a person who is working with us at the moment who is post FRCS, he is about to become a consultant, he's very capable of doing a ward round. 16:37 16:38

337 Q. So, adaptable. Just one question on waiting lists. With your attachments you produced, I think it was from back in 2013, so obviously ten years ago, where I think you were sent an Excel spreadsheet of all the patients waiting to come in, all the way from endoscopy, day surgery, with the varying consultants, all the lists of various urgency. I mean that is a huge thing, and I presume you'd have to look at that every -- I mean your -- that's quite an unusual thing. Has that changed now completely? 16:38 16:38

A. What's unusual?

338 Q. Being sent 800 patients a week to look at on an Excel spreadsheet to chose your patients, which is what you said you do? 16:38

A. So I sought access to business objects so that I could understand how many people were on the waiting list, and that allows me to download the entirety of the waiting lists, both planned and elective. Then that,

you know, I've got very adept at filtering it and working out what's what on the waiting list. I am probably the only person in our department who does that. The others will rely on their secretary or somebody else to provide them with their waiting lists, 16:39
their individual waiting lists. But I find it a helpful exercise because, particularly as a team when we're trying to deliver timely cancer care, I can pick out from the entire waiting list where cancer patients haven't been offered a date, and when you've had a lot 16:39
of locums coming through the Department things get missed if you don't do that. So it means that I can colour code everything on the list and easily pick out who needs to be called and arrange a date for them. So I find that useful. 16:39

339 Q. You've clearly got good IT skills. I mean not all urologists would have. I mean is there not an argument to have someone, an expert in waiting list management to help?

A. So we've employed a scheduler in the last few months. 16:40
This is something we've been agitating for for a long time, and it will be the role of the scheduler to do exactly what I've described. That person will need some support and training, and I'm more than happy to help and provide that, and I've met with the scheduler 16:40
in the past two weeks to sketch that out.

340 Q. Okay. Thank you. So that's moving. Okay. I've just got a few questions on the subject of small renal masses and partial nephrectomy particularly.

A. Yeah.

341 Q. You have a laparoscopic interest, so you do laparoscopic partials as well as radical --

A. So I did in the past. There was -- I mentioned earlier that there was a period in Belfast where one of their surgeons left and went on sabbatical, and that sabbatical lasted five years. That person was the main person providing partial nephrectomy service. In keeping with IOG, as you know, those services should be centralised to a specialist unit. But when that person left, we were then in the position where there was nobody in Belfast to provide that service. Mark Haynes and I are both trained in that procedure, as was another surgery in Altnagelvin, so it meant that those patients had to have that surgery in those units during that period of time. 16:40 16:41 16:41

More recently, one of our trainees finished training and he went and did a fellowship in renal surgery at the Royal Free, and when he returned and was appointed in Belfast, all that work has returned to Belfast, in keeping with guidance. 16:41

342 Q. Thank you. When did your colleague go on a five year sabbatical?

A. I'm not quite sure of the dates. 16:41

343 Q. It is just interesting --

A. It would have been the mid 2015 type period.

344 Q. Right. So he or she was there pre-2015?

A. Yes. They're a similar vintage to me and they would

have been a consultant in Belfast for perhaps two to three years before they went on sabbatical.

345 Q. Right. So the only thing I've picked up on was the peer review team picked up around about 2015 that the centralization wasn't happening? 16:42

A. Yeah, and that's the explanation.

346 Q. And NICAN sort of hadn't agreed, and I just wanted your comments about that?

A. Yeah, that's the explanation.

347 Q. It was a personnel problem? 16:42

A. That person left the employment of Belfast Trust on a sabbatical.

348 Q. Okay. So currently no partial nephrectomies are happening in Craigavon anymore?

A. They all go to Belfast. They are discussed at what's known as the small renal mass meeting. It's a kind of a side-shoot of the specialist MDT in Belfast. 16:42

349 Q. And they offer ablation treatment as well?

A. They offer ablation, they offer surgery robotically now, and if they feel that the patient needs radical nephrectomy rather than a partial, they come back to me. 16:42

350 Q. Okay. So you're now effectively compliant with the original IOG?

A. I suppose we are. 16:43

351 Q. But it has taken a while to get there.

A. The only other fly in the ointment, Mr. Hanbury, is the fact that Belfast Trust does not have capacity to deliver these things in a timely manner, and the number

of patients for several years have been going to the Mater Private in Dublin, funded by the Health Service here.

352 Q. Okay. Done by specialists?

A. My colleagues in Dublin are excellent. I'm not going to say otherwise! 16:43

353 Q. I suppose the last thing. We saw Mr. Suresh yesterday and there was the question about -- and obviously this was 2016, and you've explained why things have changed, and that's good. I mean modern urology, people specialised in endourology or open surgery, and it is quite common for people to be on-call and not have open nephrectomy skills. I mean it seemed as though there was some awkwardness there, and if you're doing partial nephrectomies did you have backup, I guess, is my question really? 16:43 16:44

A. Yeah. So, at the time that we were delivering partial nephrectomies in Craigavon, both Mark Haynes and I had the skills to do that. We also had the support of Mr. O'Brien and Mr. Young, both experienced consultants with a long experience of doing open complex urology. So, that being said, we recognised that there were difficulties with us delivering that service in Craigavon, and one of the key difficulties that we all had concern about was the absence of 24/7 interventional radiology on the Craigavon site. That's fixed now because they go to the Belfast Trust and they have a 24/7 service. 16:44 16:44

354 Q. Okay. But when Mr. Suresh got into that difficulty, I

mean there was presumably an arrangement between the nephrectomy competent colleagues of yours to cover that --

A. Yes. There was a second tier on-call.

MR. HANBURY: Okay. Thank you very much. 16:45

CHAIR: Dr. Swart. Thank you.

QUESTIONED BY DR. SWART

DR. SWART: So you've had a lot of detailed questions about things that have happened. I'm quite interested in your observation of what you actually thought of the medical management and leadership structure at the time, if we talk to '16/'17 this was all a big issue. How well did that work? How well did it not work? Do you have any thoughts as to what the problems were there in terms of how it interacted with you as a practicing clinician or any other thoughts, because you haven't had a formal medical management role, and you've referred to that a few times? So what do you think about it all? 16:45

A. So, Mr. McNaboe approached me on the corridor one day, and he had recently been elevated to AMD, and he said to me "Do you want to be CD of Urology?" It was a short conversation. 16:46

355 Q. Yes.

A. No, thank you.

356 Q. Why?

A. Because I don't feel that the people who are taking up

those roles are adequately supported and resourced to deliver them, and you'd be set up to fail.

357 Q. Do you think that's the main problem, that they don't have the time, the expertise, the training, the support to do it, or is there something else behind this? I mean you talk about back channel communication. We've heard it from other people about various things: hierarchy, silos, secrecy, fear, mistrust. These are not good words, and nobody in these roles would set out to be like that, I'm quite sure. So what do you think the problem was? And while you're answering that, have there been attempts to improve on it, do you think, or how does it feel from a practising clinician point of view? 16:46 16:46

A. I don't think the people who are asked to take on those roles are provided with adequate training and support. I don't think they have enough time in their week to deliver that workload. It's not really something that I have ever aspired to be. 16:46

358 Q. I can see that. 16:47

A. Yeah.

359 Q. You must have a feeling that it's not working well, or that it's not rewarded well enough, or it's not worth it, in terms of the value you can add. If you don't know... 16:47

A. I don't have anything further to add on that.

360 Q. So when you met at the beginning of January 2017 as a team, and you were told about the exclusion of Aidan O'Brien, and you describe the shock you had at that

meeting, and I can well understand that. What were you told as a team about who you could talk to about it and where you could get support with the Department and so on? Who dealt with that with you?

A. Nobody. 16:48

361 Q. Who do you think should have, apart from you wanted a senior medical presence there, which I understand, but you know, who did you regard as your first medical manager go-to person for something like this? Because this is a huge deal for a department. 16:48

A. Yes, I agree. I think the first port of call should have been the CD.

362 Q. So did you feel you could go to your CD?

A. No, the CD was in the middle of the issue, and that wasn't offered? It wasn't. Neither were any other 16:48 support services within the Trust offered. I've had a subsequent experience, not a pleasant experience, where I was sign posted by Dr. O'Kane, as it happened, to psychology. It was an unrelated thing to what's going on in this Inquiry. And that was useful, probably 16:48 would have been useful back in 2017. But there wasn't any support put in place for us as a team.

363 Q. Did you feel you could talk to the other members of the team about it or did you feel it was all totally secret? 16:49

A. We would have had chats informally amongst ourselves as to how we were going to organise things and get on with sorting things out. There wasn't really any safe space created for us to vent, because I think some of us

probably needed to vent.

364 Q. As it went through, I mean this unfolded and, as you know, it all took a very long time to sort out. Did anybody update you as a team? Did they bring you back together and say "This is what's happening now", or did they bring you together with Aidan O'Brien in any way? 16:49

A. No.

365 Q. No. Did you feel you could go and talk to him about it?

A. No, I felt that was very difficult. The period of 2017 was extremely difficult, and perhaps a few years later he would have come to me to talk about clinical matters and he would have sought my opinion about cases. But, again, I felt there was a really big barrier to us discussing other things. 16:49 16:50

366 Q. Related is the issue of, you start to look at his, the list of patients and you find all this problem with dictation. That wasn't -- you tell Martina Corrigan. Why didn't you go to your clinical director about that or maybe even the medical director? I mean it is a big basic duty of a doctor, isn't it? Did that not occur to you, or did you think that Martina would deal with it? What was in your head? 16:50 16:50

A. So what's in my head was that they were basically absent, the clinical managers. We had no day-to-day contact with them whatsoever. So I had no inkling that they were even there to be spoken to. 16:50

367 Q. So they didn't seek you out regularly to say "So, Urology, how are you doing? What are your strategic

plans for the future? Shall we have a planning session?" They didn't do things like that with you?

A. Never.

368 Q. Right. So on the subject of serious incidents. This is something where I think often medical management and operational management and clinical governance sort of gel quite well. How clear was that whole structure to you before you started doing these investigations, and even when you were doing it, were you clear who was overseeing it? Were you clear what the role of the Board was? Did you know exactly what was going to happen when the report was issued? 16:51 16:51

A. I had no clarity at the beginning. I read the document that the Trust had created for how to conduct the process, and that is the limit of my understanding when I began them. 16:51

369 Q. Just last small thing. We heard from Mr. Suresh about antibiotic audits, and there was a table produced which on the face of it seemed to indicate that I think the pharmacy must have done an audit and the indications for the treatment weren't clear, and the antibiotics weren't the right one, roughly. Did somebody -- did you have an ongoing conversation with microbiology about this? He wasn't quite sure where it was discussed. Did someone come to you and explain why they had made those judgments? Did you have anything like that? 16:52 16:52

A. So my recollection of those graphs being provided was that that information was collected by a ward based

pharmacist on review of in-patient drug Kardexes.

370 Q. Okay.

A. And as you can see from the graphs, there were very few numbers of patients included in the sample. So, therefore, you know, you might have two patients under your care and if one of them doesn't meet you're 50% in the wrong. Now, subsequently that information would have come to the patient safety meeting in a slightly different format. But I think at that time the whole antibiotic stewardship thing was just getting off the ground and this was an attempt by the pharmacy department to improve day-to-day prescribing on the wards. 16:53 16:53

371 Q. Has the Trust made -- I mean you will have had a lot of attention on urology as a result of this Inquiry, and I am sure that's been extraordinarily difficult. Has the Trust changed anything fundamentally in terms of medical management generally or anything else that has really hit you as this indicates a new approach? 16:53

A. I don't think so, really. 16:53

DR. SWART: That's all from me.

QUESTIONED BY THE CHAIR

CHAIR: Thank you, Dr. Swart. I've several questions, some of which I had written down and I think it is more for clarification for me, rather than anything. 16:54

One of your comments was about team meetings, that they

weren't achieving anything, people didn't turn up. Why did you not give up?

A. Right. So Mr. Young was the lead clinician and he was the person Chairing most of the meetings, and I have a great regard for Mr. Young. I also thought it was important that we continued this activity. I felt it was necessary for the good running of the Department. So, invariably, if I was at work on a Thursday, I'd go to the meeting. 16:54

372 Q. And given that you did feel that they were important, I'm just wondering then did you do anything to encourage the others to attend? 16:54

A. Yeah. "Why aren't you here?", by phone, by text, in person.

373 Q. And what kind of response did you get? 16:55

A. "I'm doing this", or "I'm doing that", or "I'm off site today."

374 Q. So it was really that they were busy doing other things rather than going to these important meetings, or do you think there was a lack of enthusiasm? 16:55

A. I suppose you can ask them, but from my perspective I think they chose to do other activity. They prioritised other activity.

375 Q. Okay. I get the impression from the totality of your evidence that, well, you did actually say that there wasn't a collegiate way of working. Has that improved? 16:55

A. Yes, I think it has, and I think in particular at the MDT it has improved, but I think it's also improved within the consultant body, the junior doctor body, and

the nurse specialists that we work with. I think the atmosphere in the Department is better than it was before. So, I think we're in a better place as a team now than we were two years ago.

376 Q. And if you had to say why that was, I mean obviously this Inquiry being set up, all of the attendant SAIs and everything, I'm sure, as Dr. Swart has said, was very traumatic for the team. Is that sort of out of adversity comes improvement, or what would you say? 16:56

A. I think, you know, many of the things that have been identified correctly by others, to give them their credit, Dr. Hughes, others, we've taken that on board and we've implemented the changes and we realise, as a team, that we're in a safer, better environment than we were before. So that gives us all a sense of achievement in terms of we've turned things around. But also we realise that we're all in it together, we're all pulling in the same direction. And I think that's what has allowed us to move on. 16:56

377 Q. Just coming back to the SAIs, you were involved in some yourself, and one of the things that has been discussed when we have been discussing SAIs in the Inquiry, was whether or not it is appropriate to have external teams to come in. They're obviously a time intensive procedure. I'm just curious to know what your own view is, having been involved in them yourself? 16:57 16:57

A. So I don't think you necessarily need people from outside the Trust. I think that if the Trust staffed SAIs with people who had adequate time in their job

plan to deliver that, then it could be delivered from within the Trust. But if the Trust hasn't got that resource, or cannot develop that resource, then they may well have to go outside the Trust.

378 Q. And one of the things that Mr. Suresh talked about yesterday, and I think he had emailed you and you said "bring this up at the meeting", was about having a stent registry, and he said that he recalls it being discussed and you recall that there was a lack of consensus about stent removal. Can you explain a bit more about why that was? 16:57 16:58

A. Yeah. To be quite straight about it, everybody was doing their own thing. There was no system within the Trust that the Trust had supplied or recommended that we should be using. So each person was keeping their own record, however that was done, whether that was paper based, electronic, or whatever, and applying their own standard to management of that. That has changed more recently, but it is still regrettably always going to be an issue in urology. We had a patient safety meeting yesterday and this same issue came up. 16:58 16:58

379 Q. Just checking my notes here, if you bear with me. I mean following on from that, you're talking about differences in practice. Do you think that that was, that that has changed much? I mean you're saying the stent issue maybe less so, but I'm just wondering, as a result of all of this do you feel now that people are looking, are more open to listening to other people's 16:59

viewpoint, if I can put it that way, about what is best for patients?

A. I think most of us in what we do every day try to do the best for the patients in front of us, I think that's why we're in the job. But as a consultant, you're trained to think independently and to manage all of the information that comes your way and to make, you know, a rational balanced decision on care for a patient, together with the patient. So there will always be differences in style and differences in opinion. But I think if you're talking about do we all try to adhere to preoperative assessment and things like that, yeah, I think we do. 16:59 16:59

380 Q. Well I'm thinking more of the movement towards, I mean certainly in cancer care the movement has really been towards multi-disciplinary practice rather than individual practice, and I'm wondering is there now more of that across the in board in the Department or not? 17:00

A. I don't quite share the view that was expressed by Dr. Hughes that it is a team who is responsible for the patient. That's not true. That doesn't fly in reality. There's a named consultant. So whilst we all participate in the meeting for the benefit of the patients, there is somebody's name over the bed, there is somebody's name over the clinic, you take responsibility. So I think we work together to ensure that that's as safe for the patients as it can be, but at the end of the day the patient is meeting with an 17:00 17:00

individual consultant and they will have that discussion on a one-to-one basis.

381 Q. Just say, for example, there's a patient who you're not quite certain as to how you might treat this patient.

A. Yes. 17:01

382 Q. Do I take it you pick up the phone and you speak to somebody?

A. It's entirely appropriate to bring that to an MDT type scenario. It is just a pity on the benign side there really isn't that kind of forum, because those patients 17:01 can be just as difficult to manage as the cancer patients, and in many respects will are fewer guidelines for those patients that there are for the cancer patients.

383 Q. But I'm just wondering, are those the kind of cases 17:01 that you might discuss at the departmental meeting, for example, or is that not really --

A. The departmental meeting, no, it wouldn't be appropriate for that agenda, but it would be something that we could certainly discuss as consultants, and I 17:01 would not infrequently refer patients, for instance, to Mr. O'Donoghue, who has an interest in functional urology, and has expertise, and I would seek his opinion. I have referred several patients to a colleague in Altnagelvin who has a similar interest, 17:02 for neurological conditions, for SNS. So, you know, there's no difficulty in referring and seeking expert opinion for patients.

384 Q. So I suppose the corollary of that is that you

described Mr. O'Brien holding on to his patients. Was he the only one to do that or was that a common practice in the past that has mow changed?

A. We grew up in a different era, a different training. I think many urologists who were trained in a previous era would have delivered the entirety of urology in their practice, and that has changed over time. The sub-specialisation that Mr. Hanbury referred to has become increasingly common, but there are downsides to that too. 17:02

385 Q. If -- what you have described, you described the meeting where you discussed triage and you thought that that had been recorded, but we certainly have not seen a transcript of that meeting. But it was clear that Mr. O'Brien, from what you've told us, had no intention of changing his working practices. Is that your view? 17:03

A. Mr. O'Brien was very difficult to dissuade from his position on many issues, and that would have been an experience that I think many of us would have observed. If you were going to argue the toss with Mr. O'Brien about something, he would be well fit to have that discussion with you for a long period of time. 17:03

386 Q. And is that part of what Mr. Haynes described as a challenge to challenge then?

A. That's the way Mr. Haynes termed it, but I would recognise that aspect of his personality. 17:03

387 Q. So recognising that aspect of his personality, would it be fair then to say that if someone has challenged him and had to be well fit to get a lengthy discussion

about the issue, that after a while they might just give up?

A. You might be exhausted by it.

388 Q. Just checking. Yes. The 2015 figures that we saw I think earlier today about the 48% of the clinical nurse specialists, I just wondered, urology being so much less having so many fewer clinical nurse specialists or key workers assigned to their patients, I just wondered what did the Department do when that figure was presented to them to seek to improve the situation? 17:04

A. I don't know in 2015 because I wasn't --

389 Q. You weren't --

A. I wasn't a clinical lead at that point in time. So I can't answer.

390 Q. Do you remember any discussion at the departmental meeting about it? 17:04

A. I think there was a very clear understanding in our department around that time, and before, that we couldn't deliver what was expected of us with two clinical nurse specialists. 17:05

391 Q. Okay. Coming back to the clinical nurse specialist, and you talked about after the telephone call from Dr. Hughes and before you met with Dr. Hughes, you informally sounded out Kate O'Neill and Leanne McCourt to see what their experience was, and I wonder just what the tone of that was, that conversation from them? 17:05

A. So, as you heard, I gave evidence earlier today about my sensitivity to the fact that we were all going to be asked difficult questions, not only by Dr. Hughes but

also by this Inquiry, and I went into the meeting not trying to provoke a response from anybody, but just trying to understand what their experienced had been. So the questions I asked them were quite open. I wasn't trying to narrow it down to any particular person's practice. And I just wanted to get a sense of where they were and what their experience had been, because I was taken aback when Dr. Hughes told me over the phone that all nine of those patients had not had a CNS involved in their care. That was quite -- I was alarmed, and I wanted to... 17:06 17:06

392 Q. You wanted to try to get to the bottom of it, was it?

A. I just wanted to know what had been happening.

393 Q. And what was the tenor of their conversation with you?

A. I think we were all in quite a fragile state at that point in time. I think we were all quite upset. I think we were - I suppose anger was a natural enough response from us at that time too. We were coming to terms with what was unfolding. So, you know, Leanne relayed the story of how she had spoken to Mr. O'Brien in the kitchen, and I didn't want to push them into saying things that they weren't going to volunteer, because I knew that they'd have to be giving their version of events anyway. 17:06 17:07

394 Q. Well the conversation that she, or what she related to you about that conversation in the kitchen, what impression were you left with? 17:07

A. My impression of the way that she relayed it was, first of all I couldn't understand why he didn't, why there

was any issue about the key worker, because this had been a feature of MDT working for a long, long time. It was part of the operational policy. He had drafted the operational policy that we were working to at that time. I don't see why it would have been - to me it shouldn't have even been anything that would have required any conversation or questioning. So I was kind of taken aback that she had received that response. 17:07

395 Q. She has told this Inquiry that despite what was recorded in the minutes of the meeting with the MDT, and what was -- or, sorry, with the nurses, I should say -- and what she put in her statement to this Inquiry, she said that "Oh, it was Mr. O'Brien joking with her." Is that the imposition she gave you? 17:08

A. No, that's not the way it came across to me, and I didn't probe her at the time about that, and I think I was upset about what was going on. It was quite clear to me that Leanne and Kate were upset about what was going on, and I didn't want to add to their degree of upset, but it didn't come to me across as a joke. 17:08

396 Q. Thank you. Just one other thing about, I mean there has been talk about the contrast of the support that was put in place for Mr. Suresh compared to how Mr. O'Brien did not receive similar type of support. I suppose one of the -- would you say that one of the main issues for that was because of the MHPS process and the whole issue of confidentiality around that and not really understanding in the team just what the 17:09

issues were?

A. I don't, I don't see any reason why support couldn't have been provided to Mr. O'Brien in parallel to the MHPS process happening. Now, I'm not by any means an expert in MHPS, I have never participated in the process, but I have read in preparation for this documents relating to it. So I see no reason why the Trusts couldn't have put supports in place. I also think that the kind of shrouded approach that was adopted didn't serve us well. 17:09 17:10

397 Q. And, finally, just one other thing. Did Mr. O'Brien ever ask you, or to your knowledge, any of your colleagues for help? Did he ever say to you -- apart from these meetings where he said it is impossible to do this as urologist of the week, for example, in relation to triage, did he ever say "Look, can any of you help me here?" 17:10

A. He never expressed those, that kind of request to me. Did I sit at times thinking how is he? How is he coping? Yes, it did cross my mind. I regret that I didn't have that conversation. 17:10

CHAIR: Okay. Thank you. That's been really helpful, Mr. Glackin, and I am pleased to say that we have concluded your evidence, so you're free to go. Unless there's anything further, Mr. Wolfe? 17:11

MR. WOLFE: Not from me.

CHAIR: No. Okay. Thank you very much. Ladies and gentlemen then I think we're back on - I have forgotten the date, but Tuesday the week after next.

THE INQUIRY WAS ADJOURNED TO TUESDAY, 31ST OCTOBER 2023 17:11