Urology Services Inquiry

# Oral Hearing

## Day 88 – Thursday, 22nd February 2024

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| **Being heard before:** | **Ms Christine Smith KC (Chair)** |
| | **Dr Sonia Swart (Panel Member)** |
| | **Mr Damian Hanbury (Assessor)** |
| **Held at:** | **Bradford Court, Belfast** |

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1 THE INQUIRY COMMENCED AT 10:00 A.M. ON THURSDAY 22ND
2 FEBRUARY 2024 AS FOLLOWS:
3
4 CHAIR: Good morning, everyone.
5 MR. WOLFE KC: Your witness this morning, Chair, is 09:59
6 Mr. Mark Haynes. I think technically he should be
7 resworn. I'm not sure it was explicitly said he was
8 released from his oath on the last occasion but
9 certainly I've consulted with him, and no doubt other
10 people have consulted with him in the interim.
11 CHAIR: Very well, then. If you don't mind taking the
12 oath again then, Mr. Hayes.
13
14 MARK HAYNES, HAVING BEEN RESWORN, WAS EXAMINED BY
15 MR. WOLFE KC AS FOLLOWS:
16
17 MR. WOLFE KC: For the record, Chair, Mr. Haynes was
18 last with us in November 2022. I should say
19 December 2022. His evidence was taken over three days.
20 16 November, you can find the transcript reference. 10:00
21 CHAIR: December '23?
22 MR. WOLFE KC: '22, in fact.
23 CHAIR: It was '22?
24 MR. WOLFE KC: It was '22. All of us are aging.
25 CHAIR: Some of us more rapidly than others, Mr. Wolfe. 10:00
26 MR. WOLFE KC: Yes, it was '22. It was in the early
27 weeks of the Inquiry. Just for your note, the
28 transcript for 16 November is to be found at TRA-00818;
29 for 17 November at 00883, and for 1 December 2022

1 01282, the prefix, of course, being TRA for each of
2 those references.
3 CHAIR: Thank you.
4 MR. WOLFE KC: Also in the interim, Chair, Mr. Haynes
5 furnished us, at the Inquiry's request, with a second 10:01
6 Section 21 response, which I'm going to invite him to
7 formally adopt now. The first page is to be found at
8 WIT-103804. You will recognise that, Mr. Haynes. It
9 is number 20/2023.
10 10:01
11 You'll recall, Chair, that at some point in the
12 evidence an issue arose about the use of monopolar as
13 opposed to bipolar in TURP process, and the use of
14 glycine or the use of saline. That response or
15 statement is specifically focusing on that issue. 10:02
16
17 Then if we go to the last page, Mr. Haynes, we can find
18 that at WIT-103820. 819 to be precise. That's your
19 signature, is it?
20 A. Yes. 10:02
21 1 Q. It is dated 2 November 2023. Can I ask you do you wish
22 to adopt that statement as part of your evidence to the
23 Inquiry?
24 A. Yes.
25 2 Q. I'm obliged. 10:02
26
27 Just to reorient ourselves, you, Mr. Haynes, are
28 a consultant urologist and you remain primarily
29 deployed in the Southern Trust?

1 A. Yes. I am employed by the Southern Trust and I do
2 clinician activity in Belfast Trust as well.
3 3 Q. You have held the consultant urologist post since
4 12 May 2014, and we heard in more detail the last
5 occasion about that. 10:03
6
7 You also told us the last time that since
8 December 2021, you've held the role of Divisional
9 Medical Director within Urology and for Urology
10 Improvement, according to the job title? 10:03
11 A. Yes.
12 4 Q. Now, in the course of your evidence today, I want to
13 first of all look back and recap on some issues that
14 were raised with you previously. I want to look at
15 those in light of or to take account of some of the 10:04
16 evidence that we've received since you were last with
17 us. Then, I suppose in the second part of your
18 evidence, we will wish to look at what improvements you
19 have observed and perhaps participated in, given the
20 shortcomings that were exposed primarily as a result of 10:04
21 the SAIs that were initiated in 2020. But broader than
22 that, we will want to look at the whole area of urology
23 improvement, taking into account some of the evidence
24 you gave the last time about the demand capacity issue
25 and how that has been addressed in the interim. 10:05
26
27 If I could start this morning by looking at the issue
28 of private patients which you raised with us in your
29 evidence in November 2022. It will be recalled that

1 in May 2015 and again in November of 2015, you wrote to
2 Mr. Young to express concerns that you considered that
3 Mr. O'Brien was advantaging patients who he had seen in
4 a private capacity; isn't that right?
5 A. Yes. 10:06
6 5 Q. In your evidence you explained that you considered the
7 approach that was being adopted by Mr. O'Brien to be
8 immoral. That was the word that you used.
9
10 Now, as you explained, you raised those issues with 10:06
11 Mr. Young first in May 2015, and then you saw the same
12 problem again in November 2015. The problem, it
13 appeared to you, had not been fixed; is that fair?
14 A. Yes.
15 6 Q. In your evidence in that context of the problem not 10:06
16 being fixed, I asked you about the governance around
17 this issue and you said that it was, at best,
18 ineffective. You might remember saying that.
19
20 Can I bring you to this? If we bring up Mr. Young's 10:07
21 witness statement; we can find it at WIT-104216. If
22 we just take the bottom half of that from (b)
23 downwards. He is recalling that:
24
25 "I believe that I spoke briefly to Mr. Haynes at some 10:07
26 point after the first email". That was the email that
27 you delivered in May of 2015. "I have a recollection
28 it was after a ward round at the nurses's station, and
29 asked him if there was any clinical reason for the

1 patient being seen in the time scales in question.
2 I cannot recall if he responded then or later, nor can
3 I recall if I made any attempt to follow up the issue
4 (although, for the avoidance of doubt, I accept that
5 I should have done)". 10:08
6
7 I just wanted to ask you about that because I got the
8 sense from your evidence on the last occasion, correct
9 me if I'm wrong, that you felt that the issue raised by
10 you in May 2015, and again in November 2015, had not 10:08
11 elicited any response from Mr. Young?
12 A. It had not elicited an effective response; it hadn't
13 changed the behaviour as I saw it. That's what
14 I've highlighted in the later, in the second email,
15 that it continued to happen. 10:08
16 7 Q. You say continued to happen. It is perhaps not a point
17 lost on the Inquiry that, if we go to TRU-01069, this
18 is the list of patients that were seen privately by
19 Mr. O'Brien which then raised a question for the MHPS
20 investigation. One can see that all of those patients 10:09
21 which were the subject of Mr. Young's analysis for the
22 purposes of Dr. Chada's investigation were seen and
23 operated upon in the period immediately after - the
24 12 months or so - immediately after you raised your
25 concerns with Mr. Young. That might prompt the 10:10
26 conclusion, would it, that the issue had not been
27 effectively tackled?
28 A. Yes. I mean, it continued happening.
29 8 Q. Yes. I suppose this issue might be considered

1 important for the purposes of the Inquiry because it
2 raises a compliance issue. There are rules associated
3 with the management of private patients into the NHS,
4 just as there are rules about triage, there are rules
5 about whether you retain records at home, there are 10:10
6 rules about dictation. You are bringing your concerns
7 to a medical manager in the form of Mr. Young and it's
8 your view that the matter was not effectively handled.
9 Mr. Young, just in fairness, I should say, has accepted
10 candidly in his evidence that he dropped the ball, to 10:11
11 use his expression, around this, that he should have
12 taken steps; he should have, perhaps, escalated it to
13 more senior management.
14
15 Can I ask you this: Has anything changed within the 10:11
16 Southern Trust Urology Service? If a senior clinician,
17 one of your colleagues, was today being seen to be
18 breaking any of those rules or potentially breaking any
19 of those rules - it might be private patients, it might
20 be any of the other practice areas that I've referred 10:12
21 to - have you confidence that it would be better
22 addressed?
23 A. So if you look at this private patient issue here, yes,
24 there is a procedure that was supposed to be followed.
25 If a patient transfers into NHS care, a patient 10:12
26 transfer form was supposed to be filled and I don't
27 believe any were filled in at this point by
28 Mr. O'Brien. We know that that procedure has been
29 tightened up within the Trust. There is a -- I know

1 that my colleagues who undertake private practice, when
2 they transfer the patients in for NHS care, are
3 completing that form. That form is collated through
4 a central -- I think it is linked to the Medical
5 Director's office. There are audits that are 10:13
6 undertaken to check that they have gone through the
7 right steps. In terms of the expediting or bringing
8 people ahead of patients who have been waiting longer
9 for the same procedure, if we look within Urology, we,
10 as a team, function from a pooled waiting list. While 10:13
11 someone may be added to the list under my name, that
12 doesn't mean that they are getting their operation
13 under me. They will get their operation when they come
14 to the top of the waiting list by an appropriately
15 trained clinician on the next available list. We have 10:13
16 a scheduler who plans and schedules our list rather
17 than us having a direct point. So the ability for
18 a consultant to transfer a patient from their private
19 practice into NHS care and then on to their next
20 operating list is much more limited. 10:14
21 9 Q. Okay, that's helpful. That's a response centrally to
22 the private patients points. But a little more
23 broadly, as was the focus of my question, the mischief
24 here I'm identifying is -- and, as I say, it is not
25 just private patients, the evidence seems to suggest 10:14
26 that it's divergence or compliance issues across
27 a number of practice areas; management, whether
28 operational or professional, knew about them but the
29 private patients example, in your own words, is an

1 ineffective response, an ineffective governance
2 response. It is that point that I'm focused on. Has
3 the responsiveness or the culture changed around that?
4 If there is an outlier in terms of one of your
5 colleagues, what is the appetite for addressing that at 10:15
6 the coal face? Is there a better approach to
7 escalating these matters, or where does your confidence
8 lie in all of that?
9 A. So it's only -- fortunately, I haven't had to escalate
10 a noncompliance thing, but we do have monitoring that 10:15
11 is ongoing of the entire team on a number of issues
12 directly related to some of the failings that have been
13 identified. I've mentioned there that private practice
14 is -- as I say, I know that this is monitored but
15 I haven't had to escalate it. If we look at management 10:16
16 of results, we have a monitoring process, we have an
17 escalation process within that, but I haven't had to go
18 beyond the first step of that escalation at any point.
19 That first step of the escalation is me contacting the
20 clinician. Typically that is that they've fallen 10:16
21 behind because they've had a period of leave and they
22 are just over two weeks in terms of actioning their
23 results.
24
25 If we look at triage, we have a monitoring process in 10:16
26 place, we have an escalation process in place.
27 I haven't had to trigger the higher steps of that
28 escalation process because they haven't happened. So
29 I'm confident that we have processes surrounding

1 a number of the failings that have procedures linked to
2 when there is a failing identified that escalate it
3 through the system and the medical management structure
4 that will identify the problem and enable it to be
5 tackled. 10:17
6
7 The very first point, though, is that actually lots of
8 it is self-policing, certainly I found with many
9 things. If you are telling your team of consultants
10 this is how well you are doing at this particular thing 10:17
11 and you've effectively got a league table, although you
12 may not portray it as a league table, they make sure
13 that they are not the outlier. So it is self-policing.
14 So before anyone needs to escalate, someone will spot
15 that I'm a bit behind, I better pick myself up. 10:17
16 10 Q. Perhaps later we'll look at some, if you like, of the
17 devices or tools that have been constructed to ensure
18 that outlying behaviours are more quickly picked up.
19 Is it not fair to say to while there have been
20 improvements in the development of those kinds of alarm 10:18
21 bells or devices, during the whole triage problem,
22 during the whole notes at home era - put it in these
23 terms - the system knew that the rules were being
24 broken. The problem, perhaps, which I'm pointing to
25 was where was the appetite, where was the culture in 10:18
26 terms of properly addressing what was known, in other
27 words, the first line manager speaking to, in this case
28 Mr. O'Brien, or escalating as the case might be. It's
29 that, I suppose, I'm asking you to comment upon.

1 Perhaps it is unfair to do so a little because the
2 problem hasn't come across your desk, you haven't had
3 to deal with an outlier in the years that follow. But
4 is there anything you can say to assist the Inquiry in
5 terms of whether there had been conversations, whether 10:19
6 there had been attempts to build a culture whereby
7 talking to the outlier is likely to happen and
8 addressing it effectively is likely to happen if the
9 problem arises?
10 A. As I say, with the current team I have not had to do 10:20
11 anything beyond that first step, which is talking to,
12 which I have done. As I've said, for most of that
13 that's been delays that are very easily and readily
14 explainable. In terms of taking it further, I think
15 within my first Section 21 I mention clinical concerns 10:20
16 about a locum consultant in post that I did address
17 through initial conversations and then took beyond
18 that. So, I know I have done that. I've since had
19 concerns raised with me about a middle grade locum,
20 which I also addressed through conversation initially 10:20
21 and then subsequently had to take further. I can
22 assure you that I am happy to have them conversations,
23 which aren't always easy. I haven't had to take them
24 further.
25 11 Q. Thank you. Let me move on. 10:21
26
27 The second issue I want to raise with you, which was
28 raised with you perhaps at some length on the last
29 occasion, is the process leading to Mr. O'Brien's

1 retirement and the decision that, despite his wishes
2 and his intentions, he was not to be permitted to
3 return on a part-time basis. If I could bring up on
4 the screen just to remind ourselves of your thinking
5 TRU-258960. If we scroll down, Ronan Carroll is 10:21
6 asking -- this is 15 April 2020. "We're taking Aidan
7 back -- yes?" You respond a couple of minutes later to
8 say:
9
10 "Needs more discussion than can be had at present. In 10:22
11 short, yes, but with strings attached and these strings
12 need to be clear and accepted before he is offered
13 anything".
14
15 In terms of your thinking, that's fairly clear. You 10:22
16 were of the view that he would or could come back.
17 There hadn't been a big developed discussion at that
18 point but, in principle, he could come back, albeit
19 with strings attached. You proceeded in your evidence
20 on the last occasion to explain what you meant by 10:22
21 strings, and that was that there needed to be a very
22 clear way of managing his performance and what those
23 expectations were, and he needed to agree to them;
24 isn't that right?
25 A. Yes. 10:23
26 12 Q. You went on to say in your evidence that thereafter
27 there were discussions and a view was taken that he
28 couldn't come back. I want just to refocus on aspects
29 of that briefly this morning.

1
2 First of all, could I ask you, Mr. O'Brien certainly
3 had formed the impression before your conversation with
4 him on 8 June that he would be coming back. Did
5 you ever discuss with him - and if not, why not - your 10:23
6 view that he could return with strings attached?
7 A. I don't have a direct recollection of ever having that
8 conversation. I think we have to remember where in
9 time this was. This was early COVID, there was a lot
10 happening that this, rightly or wrongly, will have been 10:24
11 within a long list of things that I needed to do.
12 13 Q. But plainly there were conversations with others, as
13 you've referenced, just not with Mr. O'Brien?
14 A. Yes. So I've said "Needs more discussion than can be
15 had at present", so I've implied that it needs a lot 10:24
16 more discussion and thought through but I've said what
17 my initial thoughts are. Them thoughts are really in
18 line with knowing that there was the return to work
19 requirements, that monitoring thing. So we needed
20 absolute clarity at minimum that them things were going 10:25
21 to be adhered to.
22
23 From memory, what would have happened over the
24 intervening period is my thoughts and consideration of
25 the issue and the risks posed would have evolved, and 10:25
26 they would have evolved through conversation with
27 others to a point where I came to a view that the risk
28 was too great, that it was not an acceptable risk to
29 take on and, therefore, came to a view not to proceed.

1 14 Q. Yes. If we look again briefly at your conversation
2 with Mr. O'Brien on 8 June. If we bring up AOB-56498.
3 Just at C, you've explained that you've taken the
4 issue, I suppose, forward with a number of
5 conversations within the Trust, with HR, and at Medical 10:26
6 Director level. "Unfortunately, the practice of the
7 Trust would be they don't re-engage with people while
8 there's an ongoing HR process". I think you've
9 explained in your evidence that the persons mentioned
10 there were, in terms of HR that would have been Zoë 10:26
11 Parks, and at Medical Director level it would have been
12 Dr. O'Kane; is that correct?
13 A. Yes.
14 15 Q. Just again on the last occasion when I was asking you
15 about this phrase, "don't re-engage people while 10:27
16 there's an ongoing HR process", it was the sense of
17 your evidence on the last occasion that that was, in
18 a sense, just a convenient phrase whereas the real
19 reason was that you had no confidence in Mr. O'Brien to
20 deliver? 10:27
21 A. If he came back into work, I needed confidence that the
22 failings that had been identified before would be
23 addressed, and I didn't have that confidence. I didn't
24 say in that telephone conversation that I had discussed
25 with his colleagues but I had, albeit informally, my 10:27
26 concerns that there were risks attached if he were to
27 come back. I would have discussed it, as I've said
28 there, with the Medical Director, my concerns that if
29 he did come back, it came with risks. We'd had

1 a period of time from that first set of SAIs, so 2017
2 into '18, with a Return to Work Plan, a monitoring
3 process, and we had found during that monitoring that
4 there had been exceptions. I didn't have evidence that
5 there had been practice change, acceptance that there 10:28
6 were failings that needed change and, therefore, as
7 I've said, my view evolved to a point where I felt that
8 risk was too great.
9 16 Q. In terms of your discussions with HR and with
10 Dr. O'Kane and the Medical Director's office, can you 10:28
11 help us with that? Is that you giving your view and
12 seeking their advice on it or was it, in essence,
13 a tripartite decision?
14 A. It will have been me expressing my view and seeking
15 support, for instance, with the Medical Director, which 10:29
16 the Medical Director did agree with my view. With HR
17 it will have been more 'do we have an obligation to
18 re-engage? Is there any reason why I can't say no?'
19 17 Q. We know, and we'll look again briefly in a moment, that
20 you had concerns about how Mr. O'Brien had handled two 10:29
21 particular patients and a concern as to whether they
22 were on the PAS, on the waiting list, and we'll come to
23 that in a moment. Are you confident that your
24 conversations with Mrs. O'Kane, Dr. O'Kane, around
25 whether he can come back, did they take place before 10:30
26 you were aware or before you were concerned about those
27 two patients?
28 A. From memory - I haven't got the dates in front of me -
29 but from memory the plan for the -- the time for this

1 planned phone call was set before that email had been
2 sent.
3 18 Q. Now, we can see from the record of your discussion with
4 Mr. O'Brien that he asked you to commit the rationale
5 for the decision that he wouldn't come back, to commit 10:30
6 that to writing. If we look at TRU-163341. Zoë Parks,
7 Human Resources, wrote to you what I think on the last
8 occasion I called something of a script for you to send
9 on to Mr. O'Brien. Could I just ask for your thoughts
10 on one aspect of it. It says in the last sentence: 10:31
11
12 "I have discussed this with the Director of
13 Acute Services and we decided that we are not in
14 a position to re-engage given the outstanding MHPS/GMC
15 processes that have still to be concluded". 10:32
16
17 It is noticeable perhaps that this script isn't
18 directing attention to your conversations with
19 Dr. O'Kane or with Human Resources, which we saw in the
20 transcript of your meeting with Mr. O'Brien had been 10:32
21 your advisers or your confidants on that issue. Just
22 to be clear, did you seek HR and Medical Director input
23 into the decision?
24 A. I will have spoken to them. They will have been aware
25 that I was speaking to Mr. O'Brien, and I've obviously 10:32
26 communicated with them afterwards.
27 19 Q. Yes. Did you seek the input of the Director of
28 Acute Services?
29 A. I would anticipate I would have spoken to the Director

1 of Acute Services at that time as well.
2 20 Q. That's what Zoë Parks has recorded here but she hasn't
3 recorded, for whatever reason, your involvement with
4 the Medical Director and herself leading to this
5 decision. Can you explain why that wasn't mentioned? 10:33
6 A. No. That's what I was advised to put in the script.
7 21 Q. Is it the case that this wasn't sent to Mr. O'Brien by
8 you?
9 A. I don't know exactly -- I haven't got... I haven't
10 looked to see what happened beyond there, but I think 10:33
11 then there was a letter received by the Trust from
12 Mr. O'Brien which --
13 22 Q. There was, in fact, a letter sent that day, 9 June, by
14 Mr. O'Brien that prompted a response on 18 June, nine
15 days later, from Mrs. Toal. Can you recall a conscious 10:34
16 decision not to respond to Mr. O'Brien as you had
17 promised to do in your discussion the day before?
18 A. As I say, I think my memory -- I haven't looked at the
19 timeline. My memory is that letter from Mr. O'Brien to
20 Mrs. Toal altered the plan for how to communicate. So 10:34
21 that then went through that communication with
22 Mr. O'Brien and my letter didn't go.
23 23 Q. We spent some time on the last occasion looking at
24 Patients 104 and 105. I think you know the names, but
25 they're in the designation list before you. You 10:34
26 explain in your statement -- I don't need to bring it
27 up on the screen but just for reference purposes, it is
28 WIT-53938 at paragraph 62.11. You explained in your
29 statement, and indeed in your evidence on the last

1 occasion, how, in your role superintending the movement
2 of patients into the post-COVID operation lists at
3 Daisy Hill using the services of the independent
4 sector, you became concerned when Mr. O'Brien emailed
5 you with a list of ten patients, you became concerned 10:35
6 that two of those patients, 104 and 105, did not appear
7 on the Trust's waiting list. Isn't that right?
8 A. Yes. So the process at the time in terms of me acting
9 as the gatekeeper for the limited operating available
10 that was across both the Trust and the independent 10:36
11 sector providers that were being used regionally during
12 COVID, each specialty had their specialty lead who was
13 supposed to collate those patients who required surgery
14 in the coming two weeks and send me a list. As
15 individual consultants there was a process that was 10:36
16 supposed to be gone through before this that got
17 collated by the specialty lead and then sent on to me.
18 So I would have received a weekly email from specific
19 individuals of the specialities, if you like, demand
20 for surgery that needed to be undertaken during that 10:36
21 period of COVID.
22
23 What I didn't receive from anyone else was any green
24 form waiting list forms. We have to remember that this
25 is in the context of an individual who we already have 10:36
26 concerns is not undertaking administrative aspects of
27 his job. In receiving them that I didn't receive from
28 anyone else, and I've checked in my email archive over
29 periods of that time and I didn't receive green forms

1 from anyone else, I received a list from specialty
2 leads as to the patients to go on to the urgent
3 bookable list. I then looked at a copy of the waiting
4 list I had at that time which, as we've covered in
5 previous, I have not been able to identify that precise 10:37
6 file, and my belief at that time was that them two
7 patients were not on that waiting list on my check of
8 that file.
9
10 As I've accepted previously, as it comes to light 10:37
11 subsequently, them two patients were on the list. But
12 my concern was that they weren't and that concern was
13 heightened in the fact that this was an individual who
14 we had concerns that they weren't doing administrative
15 parts of their job, who was also about to leave the 10:38
16 Trust. So I had another concern, is there a group of
17 patients who we don't know about who need surgery,
18 should be on a waiting list but aren't currently on
19 that waiting list? So that was, if you like, the
20 thought process, the thinking behind my concern. 10:38
21
22 What that concern triggered was a look into a number of
23 other patients. Very rapidly, I think within ten days
24 of that -- within a short number of days of that
25 concern, Martina Corrigan had undertaken a review of a 10:38
26 number of patients who'd had procedures similar to them
27 two patients, and had identified I think it was the 13
28 patients who appeared to only have been added to the
29 waiting list at the time planned surgery was given

1 a date, not at the point that they had their first
2 surgery, and a further patient who appeared to have
3 never been added to the waiting list but had come in as
4 an emergency and had had their problem dealt with as an
5 emergency. That then led on to a practice review in 10:39
6 a number of factors. I think it is the 6 July email
7 from me where I've gone through some individual cases
8 that have been highlighted by Martina Corrigan.
9 I've highlighted a number of my concerns with regards
10 to things this brought to light and I suggested what 10:39
11 needed to be done. A further patient review looking at
12 cohorts of patients from MDT discussions, radiology
13 results, pathology and cytology results was undertaken,
14 and that identified I think it was seven of the nine
15 patients within the Hughes SAI. 10:39
16
17 Now, as I've acknowledged, my concern about them two
18 patients was wrong, but it doesn't mean that we didn't
19 find other problems.
20 24 Q. Yes. You wrote to Mr. O'Brien - I think it was 11 July 10:39
21 but I'm struggling to find the reference - to set out,
22 if you like, the outworkings of those further
23 investigations that had been prompted by your, as
24 you've said this morning, misplaced or incorrect
25 concern about those two patients. Just to be clear, 10:40
26 unambiguously you accept that you had made a mistake in
27 asserting a suspicion that those two patients weren't
28 on the waiting list?
29 A. Yes, but my belief at the time was that they weren't.

1 25 Q. Yes.
2 A. I can't tell you when that got -- that came to light.
3 To me, that really -- that came to me last time I was
4 here.
5 26 Q. Yes. Can I just -- we'll come to the timing of your 10:40
6 realisation in a moment.
7
8 In terms of your error in this respect, we spent some
9 time on the last occasion reflecting the fact that you
10 had access to an Excel sheet as opposed to the full 10:41
11 patient waiting list, and there was some discussion
12 about whether filters had been applied that, for
13 whatever reason, had removed those two patients from
14 the document that you were looking at. Have you been
15 able to work out since you were last here, in the 10:41
16 period since you were last here, how the mistake on
17 your part came about?
18 A. Because I haven't been able to identify that Excel
19 sheet, I can't say definitively. As I did last time,
20 I gave potential explanations but I can't say 10:41
21 definitively because I have not been able to find that
22 file.
23 27 Q. We know, and we'll come to it perhaps in a moment, that
24 this triggering event, the discovery -- your concern
25 about the two patients, the concern you held at the 10:42
26 time - I hope it is not unfair to call it a triggering
27 event - but it's written into, for example, the report
28 that went to the Department in the autumn of that year
29 that, as I say, the explanation is given that because

1 of a suspicion around those two patients,
2 investigations followed into other patients. Then,
3 that is read into the record of the Northern Ireland
4 Assembly when the Minister spoke about the issue.
5 10:43
6 Since realising that there was, in fact, an error in
7 your analysis around this, has that been formally drawn
8 to the attention of either the Trust Board or the
9 Department?
10 A. I don't know. 10:43
11 28 Q. You don't know.
12
13 You wrote to Dr. O'Kane about the issue on
14 11 June 2020. I just want to bring that up on the
15 screen; it is to be found at TRU-252799. Your email is 10:43
16 just below. You explain your concern. Behind that
17 email are the green forms and the patients that we're
18 talking about, 104 and 105. We don't need to go to
19 that. "This is a really concerning email", Dr. O'Kane
20 reflects, and she sets out a series of questions. What 10:44
21 I want to ask you about is what follows from this.
22
23 If we go to Mr. Devlin's witness statement; Mr. Devlin
24 was the then Chief Executive of the Southern Trust. If
25 we bring up WIT-00096, and just at the bottom of the 10:45
26 page, please. He says:
27
28 "In the middle of June 2020 (I do not have a note in
29 the diary of the exact date) Maria O'Kane, Medical

1 Director, approached me in my office to raise serious
2 concerns about an issue that had come to her attention.
3 She had been made aware by Mark Haynes, Associate
4 Medical Director, that an email had been sent to
5 Mr. O'Brien to request that his patients that had not 10:45
6 been added to the waiting list were to be considered
7 for an urgent bookable list. When Mr. Haynes reviewed
8 this further, it was clear that there were other
9 patients that required to be investigated.
10 10:46
11 "At that point Dr. O'Kane had already commenced an
12 administrative review and suggested that the offer for
13 Mr. O'Brien to return to work following his retirement
14 should be withdrawn. I supported this proposal".
15 10:46
16 Just over the page to see if there's anything else
17 relevant. Okay.
18
19 Mr. Devlin's recollection in that statement, and I go
20 on to test him on that in his evidence, appears to be 10:46
21 that after word emerged about your concerns in relation
22 to those two patients, he had a conversation with
23 Dr. O'Kane and it led to a discussion about whether
24 Mr. O'Brien could return to work, and the decision
25 between the two of them was that he couldn't. So let's 10:47
26 try to unpick that a little.
27
28 You had, as everyone agrees, your conversation with
29 Mr. O'Brien on 8 June, telling him he couldn't return;

1 isn't that right?
2 A. Yes.
3 29 Q. And that conversation took place at a time when you had
4 not identified a concern about those two patients?
5 A. Yes. 10:48
6 30 Q. I suggested in my questioning of Mr. Devlin that his
7 recollection around this could be faulty. I suppose
8 where his evidence rested was that perhaps he had got
9 it wrong and perhaps Mrs. O'Kane was simply asking his
10 support for a decision that had already been made. 10:48
11
12 Can I ask you this, emerging from that: You said
13 already that - it's on the record of your discussion
14 with Mr. O'Brien on 8 June - you've said already that
15 Mrs. O'Kane and the Human Resources officer had been 10:49
16 the subject of a conversation with you in advance of
17 8 June about whether Mr. O'Brien could return. Can
18 I ask you again, are you confident that Dr. O'Kane and
19 you discussed this issue before 8 June?
20 A. Yes. I wouldn't have gone into that conversation with 10:49
21 a decision either way, given that we had -- we were
22 having discussions and meetings about Mr. O'Brien and
23 the issues regarding the 2018, the Hughes SAI, and the
24 outworkings of the return to work and the concerns
25 there. Given that we were having meetings about that 10:50
26 and we were discussing things about that and he had
27 been referred to the GMC, I wouldn't have made
28 a decision without having that conversation beforehand
29 so that she was aware that that's the decision I had

1 come to.
2 31 Q. Why would it have been important to seek out the
3 Medical Director's view in advance of 8 June before
4 reaching a decision?
5 A. To ensure that my line management structure were happy 10:50
6 with the decision that we'd come to.
7 32 Q. Could I bring you to something Dr. O'Kane said in
8 evidence and seek your input on it. It is to be found
9 at TRA-01467. Just pick up at line 11, which is my
10 question to -- sorry, Ms. McMahon's question to 10:51
11 Dr. O'Kane. She asks:
12
13 "At that stage did you think it might be best to take
14 some action or to do something around clinical practice
15 of Mr. O'Brien at that point"? The answer is: 10:51
16 "Mr. O'Brien retired from the Trust on 17th July. When
17 we had discovered difficulties after -- I think I was
18 informed on 11 June and the clinical team, principally
19 Mr. Haynes and Mrs. Corrigan, had been working on an
20 email that they had received that suggested that there 10:52
21 was a discrepancy in two waiting lists and that caused
22 them a bit of concern. When they worked their way
23 through that, they realised there wasn't a discrepancy,
24 but what they also discovered on the back of those
25 explorations were the concerns then around the cancer 10:52
26 multidisciplinary team meeting".
27
28 To be clear, the point I'm going to ask you to address
29 is at line 20-21. "When they worked their way through

1 that, they realised there wasn't a discrepancy...".
2 Can you help us in terms of what Dr. O'Kane is saying
3 there? She is suggesting that at some point - perhaps
4 in the summer of 2020, she's not putting a specific
5 date on it - that you and Mrs. Corrigan realised that 10:53
6 there wasn't a discrepancy in association with those
7 two patients. Can you put a date on when you realised
8 there wasn't a discrepancy?
9 A. So in preparation, and having seen this, I've been
10 looking through all of our communication that we had 10:53
11 around that time as we'd undertook this investigation,
12 and I haven't found anything that's been able to jog my
13 memory as to whether we actually specifically addressed
14 the question as to whether them two patients -- whether
15 that concern was right or wrong. I know that when 10:53
16 I was here last time, it was highlighted to me and
17 I accepted it. What we very rapidly became focused on
18 was not them two patients, it was the other findings,
19 and that overtook everything that we were doing. So
20 I don't ever actually have a recollection of going back 10:54
21 and answering the question were them two patients
22 actually on the waiting list or not until I was here
23 last time.
24 33 Q. Okay. We will have opportunity to ask Dr. O'Kane
25 questions that perhaps flow from that in terms of what 10:54
26 is she saying precisely about the timing of the
27 realisation that there wasn't, in fact, a discrepancy.
28 On one reading of it, she might be pointing to the time
29 when you were going on to look at other aspects of

1 Mr. O'Brien's practice, which was the summer of 2020,
2 or she may mean something else entirely. I thought, in
3 fairness, you should have an opportunity to deal with
4 it.
5 10:55
6 Certainly you would accept if there had been
7 a realisation that you got it wrong in the summer of
8 2020, would you accept that that should have been
9 communicated and, in fact, the communications that went
10 from the Trust's solicitor on these and the 10:55
11 communications to the Department should have corrected
12 the record?
13 A. Yes. As I've accepted previously, they were on the
14 waiting list, but it doesn't -- as I say, the
15 outworkings of that concern found other concerns that 10:56
16 were relevant and required further action.
17 34 Q. Just something you said a moment or two ago. Is it
18 your evidence, doing the best you can about this, that
19 you didn't appreciate the error of your suspicion in
20 the summer of 2020, you only realised it closer to the 10:56
21 point when you came to give evidence in 2022? Is that
22 your position?
23 A. Certainly that's when it's definitely I can recognise
24 that I know. It's only as I've gone back and having
25 known that and seen it within the Minister's statement, 10:56
26 that I've seen how that's been portrayed. I accept, as
27 I've said, they were on the waiting list, but the rest
28 of the concerns that stemmed from that piece of work
29 stand.

1 35 Q. Can I ask you some questions about the Bicalutamide
2 audit. A submission was made to the GMC on behalf of
3 the Trust at the request of the GMC, and you
4 contributed to that by describing the background to the
5 audit, how it was conducted and its findings. If we 10:57
6 can just bring you to that document, TRU-346161. Just
7 at the bottom of the page, please. That's the starting
8 point, I'm going to just bring you to the substance of
9 something you said. If we go forward three pages to 63
10 in the sequence. 10:58
11
12 You're explaining, in the middle of the page, something
13 of the methodology of the audit. You're saying in
14 terms that you obtained from the Health and Social Care
15 Board a list of all patients across the Northern 10:58
16 Ireland Trusts who had received a prescription of
17 Bicalutamide at any dose in the preceding months.
18 I think it was the preceding three or four months;
19 isn't that right? That list was obtained from the
20 Board. But although you obtained information in 10:59
21 respect of patients of all the Northern Ireland Trusts,
22 your focus, is it right to say, was only on the lists
23 relating to the Southern Trust, the Western Trust and
24 the Northern Trust; is that fair?
25 A. Yes. So at the time, patients living in them Trust 10:59
26 areas could potentially have been managed within
27 Southern Trust. The purpose of this piece of work was
28 to identify patients who needed to be seen,
29 potentially, to have their treatment changed. So my

1 focus was those who potentially may have needed seeing,
2 and therefore it was those who would have been seen in
3 the Southern Trust Urology Service, and that Urology
4 Service would have seen patients as a standard from
5 them Trust areas. 11:00
6 36 Q. You also made the remark, if we scroll back to 62 in
7 the series. You've explained to the GMC (middle of the
8 page):
9
10 "I have not subsequently reviewed these patients' 11:00
11 records and not all of these patients' care has been
12 subject to a Lookback Review as many were under the
13 care of both urology and oncology teams/consultants
14 across multiple Trusts while lookback reviews have been
15 done only on patients managed by Mr. O'Brien". 11:01
16
17 You explained why you took out of your audit patients
18 associated with other Trusts. Is it fair to suggest to
19 you that in the conduct of the audit, your restriction
20 of your analysis to patients managed by Mr. O'Brien 11:01
21 might compound a belief that he alone was responsible
22 for inappropriate prescribing?
23 A. No, no, because that's not what I've said there. What
24 I've said is that the subsequent lookback review only
25 looked at Mr. O'Brien's patients. What I've done is 11:02
26 look at all 764 patients in them Trust areas which
27 included all consultants in the Southern Trust and also
28 included patients who were under the care of urologists
29 in the Western Trust, so the Altnagelvin team; also

1 included patients in the Northern Trust which covered
2 some of the Altnagelvin team. So there were patients
3 who were under the care of all Southern Trust
4 consultants, under a number of consultants from other
5 Trusts, and patients who were under the care of 11:02
6 oncology teams. So that piece of work was not limited
7 to Aidan O'Brien, but that was not the Lookback Review.
8 That piece of work to identify patients who needed
9 a change in their treatment.
10 37 Q. Okay. Just so that we understand better the 11:02
11 distinction you're making, the Lookback Review was
12 focused on patients managed by Mr. O'Brien?
13 A. Yes. So the Lookback Review which came after this was
14 focused on patients who had been managed by Mr. O'Brien
15 during a time period -- I can't remember that time 11:03
16 period but there's a time window.
17 38 Q. January '19 to June 2020 in the first stage.
18
19 Your audit did identify a small number of patients who
20 hadn't been treated by Mr. O'Brien. If you can recall, 11:03
21 whose prescription of Bicalutamide did give cause for
22 some concern?
23 A. So from memory, there were three patients who I raised
24 in an e-mail with Darren Mitchell, and there were two
25 other patients, one who's been covered in the evidence 11:03
26 with Mr. Glackin. There was a second patient who had
27 been managed by -- who had been treated by Mr. Jacob,
28 and when we looked at that issue, this was a patient
29 that the MDT had recommended that his androgen

1 deprivation therapy be stopped. Mr. Jacob had seen the
2 patient and stopped his LHRH analogue injection, which
3 was one of his treatments, but has overlooked the
4 patient was actually on combined androgen blockade and
5 was also on Bicalutamide so had overlooked stopping it, 11:04
6 so it wasn't he initiated this treatment.
7
8 Mr. Glackin, as I say, has mentioned his. There were
9 three --
10 39 Q. We'll come to Mr. Glackin's in a moment but can I raise 11:04
11 the more general point, and I suppose it's this: Was
12 the real focus of both the audit exercise and the
13 lookback exercise, the entirely separate lookback
14 exercise, was the focus of those primarily
15 Mr. O'Brien's patients? 11:05
16 A. No. The focus was to identify patients who needed to
17 be brought back to clinic, who needed their treatment
18 changed. In identifying them patients, it was clear
19 that this practice was limited to Mr. O'Brien. So
20 that's where I was going to come on to with the 11:05
21 oncology patients. There were three patients I raised
22 with oncology. When I look at them --
23 40 Q. Yes. Just before, let's just bring that on the screen.
24 It is TRU-280977. This is correspondence between
25 yourself and Dr. Mitchell at the Belfast Trust, which 11:05
26 the Inquiry has heard about. You're explaining that
27 below is a list of what appears to be 12 patients under
28 regular oncology review you've picked up on as users of
29 Bicalutamide. You say some are biochemical failure

1 post radiotherapy. You say "From a text message over
2 the weekend, we think this is standard practice and
3 okay". You've highlighted three patients on low dose
4 Bicalutamide, and you are asking him to have a look at
5 them to see if there needs to be treatment changes and 11:06
6 arrangements for a review.
7
8 Help us to understand your thinking. If we can see the
9 three patients referred to. These three are on 50mg,
10 the other nine on high dose Bicalutamide. What was 11:06
11 your interest in these patients?
12 A. So, as I've said, the focus of this piece of work was
13 to identify patients who may need their treatment
14 changing. When I look at these three patients, what
15 I see for two of them patients is letters in 11:07
16 oncology -- from the oncologist that acknowledged that
17 the patient is on a low dose of Bicalutamide. One of
18 them patients I actually -- I can't identify
19 electronically who initiated that treatment. The other
20 patient, I think from memory, had been initiated 11:07
21 actually by Mr. O'Brien and had declined to change to
22 the higher dose as recommended by the oncologist who
23 had seen him at that time; subsequently switched to an
24 injection treatment around 18 months later.
25 11:07
26 The third patient I have in error included him in this
27 list. He was a patient who was on 50mg for biochemical
28 failure post radiotherapy; he is Patient 206, I think
29 it is. He had only been seen since that treatment, as

1 far as I can see, by Mr. O'Brien. He had been started
2 on that treatment by Mr. O'Brien. Unfortunately,
3 because I included him in this list, he wasn't included
4 in the list to come back for a review with me; he'd
5 actually been discharged from review by Mr. O'Brien to 11:08
6 his GP.
7
8 To compound that, he wasn't caught in the first backlog
9 review because the last recorded contact fell outside
10 of that 2019 to 2020 window. He's been picked up in 11:08
11 the second Lookback Review and has had his care
12 reviewed by Professor Sethia and arrangements for
13 follow-up have been put in place now with them concerns
14 that he is on a low dose of Bicalutamide.
15 41 Q. Yes, that's the patient, I think we've called him -- 11:09
16 A. 206.
17 42 Q. -- 206. I wanted to ask you this question: Of those
18 three patients, from what the Inquiry can discern at
19 least two of them had been treated by Mr. O'Brien at
20 some point? 11:09
21 A. I think all three had been treated by Mr. O'Brien.
22 43 Q. It's the Inquiry's understanding that, if you're right
23 all three of them have been commenced on Bicalutamide
24 by Mr. O'Brien, only one of them, that is Patient 25 as
25 we have called him, only one of them was screened in 11:09
26 for the purposes of an SAI, or should I say an SCRR
27 exercise. Do you have any familiarity with the reasons
28 for why the other two were not subject to an SCRR?
29 A. So the SCRR comes about as part of the lookback

1 process. Patients who have their care reviewed within
2 lookback window, so that first lookback of 2019 to
3 2020, they had their care reviewed. Where concerns
4 were identified at that review, they were escalated to
5 at SCRR. These patients' care under Mr. O'Brien fell 11:10
6 outside of that window and therefore they weren't part
7 of that Lookback Review process. Patient 206 is within
8 the second lookback window; his care has been reviewed
9 as part of that and that process is ongoing, so we have
10 the initial review form completed for him. 11:10
11 44 Q. I don't need to bring up the form but, as I understand
12 it, Professor Sethia has reached the view that it
13 doesn't reach the threshold for an SAI.
14
15 Can I ask you this: In terms of the focus of the SCRR 11:11
16 process, is it the case that, unapologetically perhaps,
17 the focus is on pushing Mr. O'Brien's cases into that
18 process to the exclusion of any other practitioner who
19 may have had management input in respect of these
20 patients? 11:11
21 A. The SCRR process is part of the Lookback Review process
22 that is focused on Mr. O'Brien's patients. I think in
23 the -- it is even referenced within the Minister's
24 statement that, with a number of SAIs, there needs to
25 be another process developed because we can't continue 11:12
26 doing SAIs; or the inference is. So the SCRR process
27 is part of the Lookback Review process, and the
28 Lookback Review applies to Mr. O'Brien's patients in
29 the windows of time as per each Lookback Review.

1 45 Q. You've refer to Mr. Glackin's handling of a patient who
2 had initially been under the care of Mr. O'Brien who
3 started him on a low dose Bicalutamide, and that
4 patient is 139. We can see, if we bring on to the
5 screen AOB-83826, that Mr. Glackin reviews Patient 139 11:12
6 in February 2016. We can see under "Current
7 Management" Bicalutamide 50mg once daily, tamoxifen
8 10mg once daily. He records that he is tolerating his
9 Bicalutamide and tamoxifen very well, and he directs
10 a PSA. He says that this result is stable, that he 11:13
11 remains suitable for continued Bicalutamide
12 monotherapy.
13
14 Let me bring Mr. Glackin's two reviews together before
15 I ask the question. If we go to the record for 11:14
16 May 2020, it is AOB-82838. Yes, it is 5 May 2020,
17 Patient 139. Again, current management remains
18 Bicalutamide 50. While it may not be explicit in that,
19 the regime doesn't change.
20 11:14
21 You get to look at this case later in 2020. If we look
22 at WIT-04624, you write to the patient and, to
23 summarise, just scrolling down a little, you're
24 explaining to the patient that the treatment he's
25 currently on is not licensed, and you tell him - and 11:15
26 I'm summarising here - that the recommended approach is
27 surveillance.
28
29

1 If you just scroll over the page and go to the bottom
2 of that page, you're saying:
3
4 "If you don't wish to stop the hormone treatment and if
5 you wish to continue hormone treatment as a long term", 11:15
6 you're recommending one of two alternative courses.
7 One is an injection treatment and the other -- if he
8 doesn't want that, the alternative is to go to high
9 dose Bicalutamide.
10 11:16
11 A couple of questions arising out of all of that.
12 Mr. Glackin has maintained the patient on an unlicensed
13 dose of Bicalutamide, the regime having been started
14 sometime earlier by Mr. O'Brien. Should that have
15 prompted something equivalent to an SCRR? 11:16
16 A. I haven't got the records going in front of me and
17 I haven't got them in mind in terms of when he was
18 diagnosed with his cancer, what the MDT recommendations
19 were so it's difficult for me to answer at this point.
20 Knowing what I know now, yes, it should have. But as 11:17
21 an isolated case, Mr. Glackin may have - and let's just
22 say Mr. Glackin has spoken to this - he may have made
23 an assumption that there had been a thorough discussion
24 of treatment options, that the reality that starting
25 a low dose of Bicalutamide doesn't provide the patient 11:17
26 with any benefit in terms of survival or outcome from
27 the prostate cancer. The fact it is off licence, he
28 may have assumed that that had happened.
29

1 when he saw the patient, the patient had been
2 established on a treatment for a period of time. I've
3 done lots of these discussions. They are difficult
4 discussions, where patients' confidence in the
5 healthcare system can be shaken. In a patient who was 11:17
6 happy and tolerating their treatment with minimum side
7 effects, he may have decided a decision to not shake
8 that individual's confidence in the system and tell
9 them, as I have done on a number of occasions, that you
10 don't need the treatment that you believe you needed 11:18
11 for the last X years.
12 46 Q. Is it reasonable to suggest that if Mr. O'Brien had
13 continued to be the managing clinician of Patient 139,
14 it would have automatically have gone down the SCRR
15 route? 11:18
16 A. Had the patient been pulled into the lookback time
17 window, I would imagine it would have gone down an SCRR
18 route. As we've covered, Mr. O'Brien had initiated
19 this treatment.
20 47 Q. Does that in any sense suggest an unfairness or bias 11:18
21 against Mr. O'Brien in terms of how the management of
22 patients on low dose Bicalutamide is being viewed by
23 the Trust?
24 A. Again, I would have to -- so this patient has obviously
25 come back to a clinic where I have changed their 11:19
26 treatment. I had been - and I haven't looked for
27 definite - I had been filling in the ten-question
28 reviews at that time. Given that I've changed this
29 patient's treatment, I would have anticipated I would

1 have or should have filled in a ten-question review
2 highlighting that this patient required their treatment
3 changing and that would have pulled them into that
4 process. Whether they had been screened in or out,
5 I can't comment on because I'm not sure whether I did 11:19
6 that. It may be that I, actually not intentionally,
7 haven't filled in that ten-question review at that time
8 on an assumption that this patient was going to have
9 their ten-question reviewed completed by
10 Professor Sethia. There was -- I think we covered 11:19
11 before, I was keen that, as much of this was done not
12 by me, the assessment of care was done by someone else.
13 48 Q. Thank you for that.
14
15 It is 11:20; a convenient point for a short break? 11:20
16 CHAIR: Yes, I think we'll rise now and come back at 25
17 to 12.
18
19 THE INQUIRY ADJOURNED AND RESUMED AS FOLLOWS:
20 11:20
21 [Technical pause]
22
23 49 Q. MR. WOLFE KC: I'm going to assume that the
24 record didn't catch any of that and just, in any event,
25 repeat the point. I want to look at the area, 11:44
26 Mr. Haynes, of missed opportunities we touched upon the
27 last occasion?
28
29 You said at TRA-01370 that the nature of your concerns

1 about Mr. O'Brien changed in late June into July 2020
2 when you saw Patient 1. To paraphrase, your concerns
3 were no longer of an administrative type nature but, as
4 you said later in your evidence, the bar was raised.
5 11:45
6 Additionally, Mr. Haynes, you offered a personal
7 expression of regret within your first witness
8 statement, WIT-53957 at paragraph 77.1, a regret that
9 there was a failure to recognise in late '17-late '18
10 that in addition to the factors that gave rise to the 11:45
11 MHPS investigation, there was a likelihood of
12 additional issues that would have required
13 investigation. So, that's the kind of points that
14 we looked at on the last occasion.
15 11:46
16 Since you were last here, we have heard from some
17 witnesses from the Belfast Trust, notably
18 Professor O'Sullivan and Dr. Mitchell, and we've also
19 obtained witness statement evidence and haven't yet
20 taken oral evidence from, for example, Professor Jain. 11:46
21 I want to turn to aspects of that Belfast evidence,
22 Belfast Trust evidence, and seek your views on it.
23
24 Could I start with WIT-96680? This is an e-mail which
25 Dr. Mitchell sent to you on 28 March 2019. Just to put 11:46
26 it in context, this is, I suppose, six months or so
27 before Patient 1 comes into the system. What he is
28 relating to you is a concern raised with him by Suneil,
29 and that is Professor Jain. He says:

1
2 "Mark, this is one of the cases we chatted about" -- in
3 full that appears to be Bicalutamide 50 -- then
4 escalated to Bicalutamide 150 and we would probably
5 like to have been involved in the decision-making 11:47
6 process a bit earlier. Suneil's history February 2019
7 is on ECR, gives the full detail. I don't think this
8 is an isolated occurrence".
9
10 Do you remember getting that e-mail? 11:48
11 A. So I do recall receiving that e-mail and that
12 conversation, having been prompted by Dr. Mitchell's
13 evidence that he gave. I don't think when we'd done my
14 e-mail search for discovery actually had managed to
15 identify this e-mail within the archive. 11:48
16 50 Q. Certainly we have no evidence of you responding to it
17 in writing. Have you been able to find any written
18 response?
19 A. No. I have looked at the patient in question and
20 considered what my thought process would have been at 11:48
21 this time.
22 51 Q. Yes. Before I maybe delve into that, I think it would
23 be helpful to put on the screen Professor Jain's
24 analysis of what the impact was, just to unpack and
25 detail to that e-mail. He has in relevantly recent 11:49
26 times, I think within the last four to eight weeks,
27 placed before us his statement. If we go to
28 WIT-106808, it is underneath (i). I think it is fair
29 to say, and maybe the representatives of

1 Professor Jain, I think his timeline is a little askew
2 in that he mixes up 2019 with 2020, because his preface
3 here is:
4
5 "From memory Dr. Mitchell had been in discussion with 11:49
6 Mr. Mark Haynes, who had indicated there was an
7 investigation ongoing into Mr. O'Brien's practice at
8 Craigavon Southern Trust. We therefore agreed that any
9 cases of Bicalutamide 50mg monotherapy prescribing
10 would be highlighted and that Dr. Mitchell would send 11:50
11 the details to Mr. Haynes".
12
13 Just on that, had you initiated any investigation into
14 Bicalutamide 50 in 2019?
15 A. No. 11:50
16 52 Q. He then goes on to speak about this patient who is the
17 subject of the e-mail which I put up on the screen.
18 What he has said is this:
19
20 "I met this patient for the first time as a new patient 11:50
21 on 1 February 2019 at a waiting list initiative clinic.
22 He had been treated with Bicalutamide 50mg monotherapy
23 for a short period of time from January 2013 to
24 May 2013 before this was increased to Bicalutamide 150.
25 He had required a coronary artery bypass graft in 2013 11:51
26 and a TURP in April 2014 for lower urinary tract
27 symptoms and his PSA was very low at 0.11 in June 2014.
28 This would have been a good time to refer him for
29 radiotherapy but this did not happen and the patient

1 continued on Bicalutamide 150. His PSA began to climb
2 and eventually reached 3.35 in December 2018. Around
3 this time, an MRI showed his prostate cancer was
4 locally advanced with extracapsular extension and
5 invasion into the seminal vesicals. He was then 11:52
6 referred for consideration of radiotherapy".
7
8 The mischief he is identifying within that paragraph is
9 rather than referring to radiotherapy at the most
10 optimum point, which is back in 2013/2014, the patient 11:52
11 was maintained on a high dose Bicalutamide monotherapy.
12 He then explains what he did in 2019 upon discovering
13 this series of facts. He says:
14
15 "I emailed Dr. Mitchell to make him aware of this case 11:52
16 on 1 February 2019. He indicated that he would discuss
17 with me and Jonathan" - Jonathan McAleese -
18 "Dr. Mitchell then emailed Mr. Haynes, as we've seen,
19 on 28 March 2019".
20 11:53
21 That's the context as explained by him in his
22 statement. Just before I come to the questions, let me
23 just bring you to some emails that are internal to the
24 Belfast Trust which you wouldn't have seen at that
25 time. WIT-106813. Just at the bottom of the page, 11:53
26 please. You might be able to help me with some of
27 these abbreviations. It seems to be saying on
28 one February, Jain to Mitchell:
29

1 "New patient today from Aidan O'Brien. Will get a bone
2 scan but would have been much better if he had been
3 seen by us in 2014. MRI, and on examination locally
4 very advanced now. PSA has go to 3.35. On
5 Bicalutamide." 11:54
6
7 Up the page then, Dr. Mitchell is saying:
8
9 "Bicalutamide 50 initially? I said the next step would
10 be through the clinical director route at Craigavon 11:54
11 area Hospital".
12
13 Then Professor Jain clarifies for Dr. Mitchell the
14 clinical history. "Short AS period"?
15 A. Probably "active surveillance". 11:54
16 53 Q. Okay.
17
18 Then "50mg." Is that for one month?
19 A. No, that's January 2103. 150mg 2013.
20 54 Q. We have seen the rest of that clinical history set out 11:55
21 in his statement.
22
23 Could I ask you this: When you received this
24 information, can you recall what steps you took?
25 A. So I haven't got a written report of what steps I took. 11:55
26 What I would have done, and what I've done subsequently
27 as well, is I would have looked at this patient's
28 detail on the electronic care record to look through.
29 When I do that, what I see is a letter from Mr. O'Brien

1 that seemingly explains a reason why he did not refer
2 at that point, and states within the letter that the
3 patient didn't -- I think he uses the term "reticent"
4 to pursue radical treatment and therefore elected to
5 remain on monotherapy. 11:56
6
7 Seeing that, I assumed there had been an informed
8 patient discussion and decision to not proceed to
9 radiotherapy at that time and to remain on the
10 treatment that he was on. So my view - which 11:56
11 subsequently, I would say, was wrong - was there was
12 a reason why this patient wasn't referred. While I can
13 understand the oncology opinion with a documented
14 reason within a patient correspondence for why he
15 wouldn't have done that, there wasn't anything to 11:56
16 trigger me to look further into this practice. I'd got
17 one patient. In criticism of myself, if I actually
18 look at the timing of that, the timing -- the date that
19 that letter was actually dictated and done was a number
20 of years after that decision would have been made, and 11:57
21 I obviously didn't pick up on that and that didn't
22 trigger an alert for me.
23 55 Q. The letter you were looking at was proximate to the
24 referral back to -- the referral for the first time in
25 to Professor Jain? 11:57
26 A. Yes. It wasn't a contemporaneous letter at that time
27 that treatment had been done. I've drawn my conclusion
28 based on that, not on contemporaneous notes.
29 56 Q. Yes. To summarise, you received the e-mail from

1 Dr. Mitchell, you conscientiously went and looked at it
2 and you reached the view on the basis of the
3 information contained in the documents you had to hand
4 that there was a plausible, acceptable explanation for
5 not referring to oncology in 2014? 11:58
6 A. Yes. So there was an explanation that the patient did
7 not want to pursue that route of treatment.
8 57 Q. The wider context which I extract from the evidence
9 received by the Inquiry is this: Dr. Mitchell,
10 Professor Jain and perhaps some others, several years 11:58
11 before this, before 2019, had become concerned about
12 Mr. O'Brien's prescribing practices in relation to
13 Bicalutamide, which I think in earlier evidence you
14 have indicated, this Bicalutamide practice, is perhaps
15 a hallmark of a more significant issue, which is 11:58
16 delayed referred in to oncology. But their awareness
17 of this problem, that is the Belfast Trust's awareness
18 of this problem in 2013/2014, leading in 2016 to the
19 preparation by Dr. Mitchell of regional hormone
20 guidelines, their awareness of this problem was, if you 11:59
21 like, not circulated to the Southern Trust. It was
22 drawn to the attention of Mr. O'Brien in a notable
23 e-mail sent by Dr. Mitchell, and Professor Jain has
24 explained and I think Professor O'Sullivan has
25 explained that on occasion they changed the 11:59
26 Bicalutamide regime, recognising that it was improper
27 or a shortcoming.
28
29

1 But this e-mail to you in March 2019, I hope I'm
2 correct in saying, was the first, if you like,
3 externalisation of the problem. It was coming to you,
4 wearing what would have been your Associate Medical
5 Director's hat or your clinical director's hat; clearly 12:00
6 wearing your management hat at that time. When
7 you think about it now, should have done more? Should
8 have asked more questions, perhaps, of your colleagues
9 in Belfast as to the nature of their concern?
10 A. I think if I look back now, you'd started with 12:00
11 a preamble around missed opportunities, this is another
12 missed opportunity. I can explain my thought process
13 but in the context, as you highlighted, of issues
14 raised before directly with Mr. O'Brien that I wouldn't
15 have been aware of, in the context of the sort of wider 12:01
16 concerns you've mentioned, the oncologist -- they may
17 have been aware of additional patients that they just
18 corrected or changed the treatment when they saw them.
19 I should or could have initiated a wider investigation
20 but I didn't have all of that information to hand at 12:01
21 that point and so I didn't know that. So I guess my
22 review and my decision that actually I couldn't see
23 anything to spark a deeper investigation was one that
24 I formed out of an attempt to be fair to the
25 individual. I'd got a letter that said -- that gave 12:01
26 a plausible reasoning for why that decision had been
27 made.
28 58 Q. Yes.
29 A. If we were to spark an investigation into people's

1 practice on the back of one concern raised, where that
2 concern actually, on the face of it, doesn't look to be
3 substantiated, we would have very unhealthy practices.
4 59 Q. Just in terms of what Dr. Mitchell has said about the
5 communication due to him, if we just bring it up on the 12:02
6 screen, WIT-96668. Just scrolling down. He says that
7 he spoke to you informally as you attended the regional
8 urology MDM in 2019, and then subsequently emailed you
9 about the off licence prescribing of what he says is
10 Bicalutamide 50 in 2019 and 2020. When you spoke to 12:03
11 him -- can you remember speaking to him as well as
12 getting the e-mail?
13 A. So one of the changes that happened, as I've reflected
14 in terms of my working practices but also as a first,
15 if you like, or a new thing in Northern Ireland, was 12:03
16 I was no longer just Southern Trust MDT, I was
17 attending the Belfast Trust MDT in my role working
18 across the two sites. So them relationships became,
19 rather than a telelink relationship, they became
20 closer, personal relationships where I was meeting them 12:03
21 in person and perhaps we would be present before an MDT
22 started, perhaps we'd have a conversation after an MDT
23 started. So myself and Dr. Mitchell would have had
24 many discussions at many points before and after MDTs
25 about difficult patients, about difficult things. 12:04
26 I recall having a conversation with Dr. Mitchell about
27 Bicalutamide. I can't remember the specifics of the
28 date but it's recorded in Darren's e-mail that we
29 discussed on that date, and he followed that up with an

1 e-mail.
2 60 Q. What you seem to be clear about is that this seems to
3 have come to you as an isolated concern and you weren't
4 provided with the history of concerns that were raised
5 with Mr. O'Brien, prescriptions changed in 2014/'15 12:05
6 leading to the regional guidelines; that whole context
7 which Dr. Mitchell has given to this Inquiry wasn't
8 shared with you?
9 A. Well, it may have been in the discussion but we've got
10 -- when we look at that patient, his management, the 12:05
11 point in time he was initially treated was at that
12 period in time. It wasn't a practice that was
13 happening in 2019, this was a patient who was raised in
14 2019 as a possible problem but whose management by
15 Mr. O'Brien and decision to not refer was back in 2014. 12:05
16 61 Q. This is coming to you as an issue in March 2019. By
17 this stage, you had perhaps formed a view of
18 Mr. O'Brien's practice. You were certainly aware of
19 the MHPS issues. Dr. O'Kane had become Medical
20 Director shortly after MHPS had reported. She brought 12:06
21 you into conversations about the fact that this doctor
22 was to be referred to GMC. The February/March period
23 brought other concerns to your attention.
24
25 If we bring up on the screen WIT-55862, please. This 12:06
26 is in the context of the DARO issue. Just scroll down.
27 Mr. O'Brien has written to Colette McCall to express
28 his concerns -- I don't know if you want to see the
29 whole of his expression, I assume you are familiar with

1 it. Just down the next page. He's raising concerns
2 about the need to use the DARO system, or for his
3 secretary to use the DARO system, and you come back on
4 that. If we scroll back in the direction we came.
5 12:07
6 When you saw that, Mr. Haynes, is it fair to say that
7 you were concerned that DARO was not being used?
8 A. So those concerns are in keeping with the other, if you
9 like the administrative concerns, the concerns that had
10 been identified with regard to triage, with regard to 12:08
11 not actioning results. The DARO process is a process
12 to ensure that results are looked at and necessary
13 action undertaken. What I had there was someone
14 seemingly not wanting to participate in that process,
15 which is to act, as I think I've described it, as 12:08
16 a failsafe. You should have procedures beforehand that
17 ensure that you get your results, with DARO as our
18 backstop so we know all results are being actioned.
19 But Mr. O'Brien is seemingly saying I won't participate
20 in that process because the patient should come to 12:08
21 a clinic in the face of, in the knowledge of backlog
22 review extending to many years, so them patients not
23 engaging in that process to make sure results are
24 looked at, but accepting they won't get looked at for
25 many years. 12:09
26 62 Q. Also, this is February into March of that year. You
27 had occasion to raise an incident report in respect of
28 Mr. O'Brien's management of Patient 92. If we bring up
29 on the screen TRU-162123. The incident date was the

1 year before and, as we can see, you're the reporter on
2 this incident, 12 March '19. You are explaining, in
3 essence, that there had been -- it doesn't say it
4 explicitly there but -- yes, there had been a failure,
5 as the subsequent SAI report acknowledged, a failure on 12:10
6 the part of Mr. O'Brien to action a set of results
7 leading to delay in treatment, the treatment
8 fortuitously coming back into the system via her
9 general practitioner.
10 12:11
11 I put those strands together and there are others
12 around in that immediate period, including
13 Mr. O'Brien's deviation from the action plan which you
14 discussed in the context of triage with Dr. O'Kane.
15 That was in late March of 2019, I needn't bring it up 12:11
16 on the screen. But I suppose I'm assembling those
17 points and putting them beside what Dr. Mitchell has
18 sent to you in relation to that patient.
19
20 Now, you've explained the steps you've taken in 12:11
21 relation to that patient, and you saw a plausible
22 explanation for it. But when you see all of this
23 together, all that was going on at the same time, you
24 were clearly concerned about Mr. O'Brien's practice in
25 various areas. Can you help us understand why, when 12:11
26 you see it all together, even allowing for what was, in
27 writing, a plausible explanation about the Dr. Mitchell
28 patient, why at that time the thinking on your part, or
29 on the part of yourself and other management, doesn't

1 go towards a deeper investigation?
2 A. As I think I reflected about the 2017 concerns,
3 I failed to recognise, broadly grouped together, the
4 administrative concerns, the concerns that he wasn't
5 actioning results, the concerns that he wasn't 12:12
6 triaging; these issues. I failed to recognise that
7 underneath these there was also an individual who
8 wasn't managing patients in the way that they were
9 supposed to be. I didn't have a high degree of
10 suspicion at this time, and that's a failing on my 12:13
11 part, that he was doing things in a different way.
12 I wouldn't have imagined that an individual who had
13 acted in the role I fill now as a Clinical Reference
14 Group Chair for our cancer network group, who in
15 sitting in that role had been instrumental in the 12:13
16 development of guidelines in how to manage prostate
17 cancer for Northern Ireland, had reviewed the NICE
18 guidance as part of that; as part of that, as we've
19 heard, that group had developed hormone treatment
20 guidelines. I wouldn't have -- it didn't cross my mind 12:13
21 as a suspicion that this individual, who seemingly has
22 held positions that direct how things should be
23 managed, is then in his own practice doing something
24 completely differently.
25 12:13
26 As I've said, I accept this is another -- I could
27 probably map out a number of points where I feel
28 I personally could and should have identified things
29 sooner knowing what I know now, but hindsight makes

1 things very easy. Had we not found the other things
2 later or them not existing, I could have initiated an
3 investigation that was unwarranted as well.
4 63 Q. Yes. It brings to the surface, I suppose, a key
5 question which the Panel will have to wrestle with. 12:14
6 You have these multiple issues of concern, many of
7 which are -- people have characterised them as
8 administrative in nature, albeit in some cases touching
9 upon the management of patients and therefore of such
10 substance that they could cause risk to patients. But 12:15
11 where is the threshold for intervention? You've gone
12 through this process, the Trust has gone through this
13 process and we have, obviously, the advantage of
14 hindsight. We can see now these various limbs or
15 straws which weren't brought together in one place, and 12:15
16 we now recognise, because of what we now know, that
17 they ought to have been more deeply investigated. Have
18 you worked out or can you assist the Panel in trying to
19 work out where is the threshold for intervention?
20 A. I think it is difficult. I think when you receive, as 12:16
21 in that case, one e-mail of concern, it is difficult to
22 say that that renders -- does that create a flag.
23 I think when you have an individual who has gone
24 through an MHPS investigation that has addressed issues
25 of concern, that has raised some issues, I think, in 12:16
26 Dr. Chada's report to discuss his insight and other
27 issues, I think at that point where you have a process
28 that has identified yes, there are issues of concern
29 with an individual's practice, then that should trigger

1 a wider review of their practice. Unfortunately, we
2 were -- that process limited itself, if you like, to
3 the known-known and didn't look for the unknowns. So
4 it addressed the problems but didn't look for the other
5 problems. To me, that is the point where, if you have 12:17
6 an individual where you have identified problems, where
7 you have identified concerns, then you have to address
8 their wider practice at that point.
9 64 Q. Yes. It won't have gone without comment that, if you
10 like, the deeper dive here, the broader dive, was 12:17
11 performed at the point when, from a Trust perspective,
12 Mr. O'Brien was not going to cause any further risk to
13 patients because he was retiring. So you would readily
14 accept perhaps that the threshold question and the
15 intervention point has to be at some earlier point. 12:18
16 There has to be within the employer's armoury some way
17 of trying to grapple with the problem when it still
18 matters.
19 A. As I've said, I think when you've got a process that
20 has confirmed issues with an individual's practice, 12:18
21 their wider practice needs to be considered within that
22 process. That process can't narrow itself to the
23 problems that you found.
24 65 Q. What, if any, in your experience are the downsides of,
25 if you like, a premature intervention or a premature 12:18
26 challenge to a colleague who may be giving indications
27 of concern but might otherwise be simply practising in
28 a way that is unusual but doesn't give rise to risk?
29 A. To be put through an investigation for any clinician is

1 challenging and difficulty. I have personally
2 triggered an investigation into an individual's
3 practice within a different specialty based on a number
4 of concerns brought to me by a colleague at that time
5 regarding their practice. I witnessed the impact on 12:19
6 that individual of what subsequently, after that
7 practice had been looked into, didn't have any concerns
8 about his -- the practice of the individual. It has
9 a huge negative effect on that individual's practice,
10 both during the time of the investigation and 12:20
11 afterwards. So, triggering an investigation too early
12 or too often would have a huge negative effect on the
13 way people practise, and could almost be at risk of
14 paralysing their ability to practise.
15 66 Q. Can I ask you about the relationship with Belfast Trust 12:20
16 Southern Trust clinicians such as yourself,
17 Mr. O'Brien, regularly refer to the Oncology Unit at
18 the Cancer Centre. So, as we have seen, the
19 oncologists in the Belfast setting have opportunity,
20 which they've taken, to correct what they see as 12:21
21 shortcomings in, in this instance, the administration
22 or the prescription of Bicalutamide. But until they
23 wrote to you in March 2019 - and I'm specifically
24 dealing with the Bicalutamide issue here, I know that
25 there was other correspondence on other issues between 12:21
26 the two medical directors in or about 2010 or '11 - do
27 you think there are lessons to be learned in terms of
28 the communication between Belfast to Southern Trust
29 when they saw problems with Mr. O'Brien's practice in

1 respect of Bicalutamide?
2 A. I think, as I acknowledged in the oncologists'
3 evidence, they said -- other people, you may have said,
4 people would have changed the treatment. At various
5 points in time multiple different individuals have 12:22
6 recognised and changed the treatment but not done
7 anything else. I don't know whether there's a barrier
8 that they're two different Trusts so they know how to
9 raise that concern within Trust; how do you raise it
10 without Trust, outside to the other Trust, whether 12:22
11 that's an issue. Whether, actually as you've
12 intimated, the history goes back beyond and whether
13 it's happened so often that people have almost given up
14 because they've seen nothing happen.
15 12:23
16 There were other issues as you suggested there in 2010,
17 2011. As myself and Mr. Hanbury have lived through the
18 Improving Outcomes Guidance, centralisation of cancer
19 surgery across all of the cancer networks did lead to
20 strained relationships between teams, where some teams 12:23
21 were essentially to stop doing certain procedures,
22 whether them strained relationships fed into that.
23 Certainly I feel that the in-reach practice which
24 I have, the outreach practice which has been developed
25 by a colleague of mine from Belfast to Craigavon from 12:24
26 a renal cancer perspective, relationships have improved
27 across the region as all of these relationships become
28 closer working relationships, so the ability to raise
29 a concern is much easier. As we've said, Dr. Mitchell

1 raised it with me informally at the MDT. Had I not
2 been there at the MDT because I wasn't in-reaching, how
3 would that case have been raised? Would it have been
4 raised? Who would it have been raised to? We had
5 a relationship; we'd built that relationship up because 12:24
6 we worked together.
7
8 I think that it does create challenges. I think there
9 is a role for the network group. I remember sketching
10 out, when Professor Jain asked me to give a talk at 12:24
11 a prostate cancer meeting he gave on the role of the
12 network, what the network in Northern Ireland was
13 doing. I separated out a number of the -- a number of
14 where I saw the role of the network. Performance and
15 outcomes, I felt, were a critical part actually of that 12:25
16 CRG network group. A good-functioning network group,
17 you would hope, with representation from across teams
18 with good relationships would enable people to say
19 during that network group we've a concern about this,
20 we're getting late referrals from this team, can 12:25
21 we work with you, we're seeing this problem with this
22 individual.
23
24 I think a well-functioning network group can add to and
25 deliver that. I've tried to structure that network 12:25
26 group up to include these things, but we aren't --
27 I would say we're not at that point yet but we do have
28 the relationships and we do have the ability to talk
29 to. Not the ability, of course we have the ability.

1 We do talk to each other, we do raise questions, we do
2 raise concerns, we do ask each other questions about
3 treatment that seems -- or things that have happened
4 that seem a little bit strange.
5 67 Q. That's helpful. If we think back to that period 2014 12:26
6 to '16, Dr. Mitchell is driven, it seems, to develop
7 regional guidelines, I think his evidence was with
8 specifically Mr. O'Brien in mind, and yet that's
9 unspoken. I mean, at the very least that should have
10 warranted a communication from one Trust to the other 12:26
11 at a management level to ensure that the issue was
12 tackled. I think you reflected earlier, well, there
13 has to be an element of trust here; Mr. O'Brien was
14 central to the NICaN process, he was Chair or clinical
15 lead - or whatever he was precisely - and you would 12:27
16 have expected him to comply. In fact, we've seen
17 arguably, at least from the Trust perspective,
18 non-compliance, unlicensed approach to Bicalutamide,
19 and delayed referrals. Patient 1's case is an exemplar
20 and there are other examples. 12:27
21
22 Is it enough to leave it to good relations which you
23 seem to have promoted more recently, or is there a need
24 almost for it to be written into the rule book as such
25 that there must be communication between medical 12:28
26 directors where you see a problem, a persisting problem
27 that can't be resolved?
28 A. I think obviously things need to be escalated where it
29 is not being resolved and the line management

1 structures are the appropriate measures. But if I go
2 back to the 2014, if I place myself in the position of
3 the recipient of an e-mail from Dr. Mitchell saying
4 effectively that I'm not treating patients
5 appropriately, that would trigger a significant amount 12:28
6 of thought of myself, of my own practice. It would
7 trigger an immediate change, a conversation maybe with
8 Darren, say what am I doing wrong? What do I need to
9 change? What do I need to do? Yet that didn't trigger
10 any change; that actually just carried on. 12:29
11 Unfortunately, that insight, that self-awareness to
12 accept that actually Darren is a well-respected
13 oncologist, we, all of us, will seek Darren's opinion
14 on difficult patients and Darren will seek our opinion
15 as surgeons on difficult situations. But to have 12:29
16 Dr. Mitchell say to you you are not managing patients
17 appropriately - and I appreciate I'm paraphrasing it
18 because I haven't got that e-mail here in front of me -
19 I'd be horrified. That would trigger an immediate
20 change in the way I function. 12:29
21
22 The alarm there is notable. To then -- I think the
23 fact that the guidelines are created with the intent
24 but without the voiced intent demonstrates there was
25 a relationship issue, that that was one issue. But 12:30
26 absolutely, where that practice had been recognised as
27 continuing, that should have been escalated through to
28 medical director level and through across Trusts.
29 68 Q. I'm asking this question in the context of Patient 4,

1 and maybe rather inelegantly joining it to what
2 Dr. Mitchell was raising with you about that patient in
3 March 2018. Patient 4, just to elaborate, was
4 a patient who you saw when you were Urologist of the
5 Week, I think, in January or February 2020. He had 12:31
6 ought to have been started on LHRH in the previous year
7 but that hasn't started; Mr. O'Brien was the managing
8 clinician and he hasn't started him on that. When the
9 patient came in several months later as an emergency,
10 you saw the patient and commenced him on Degarelix; 12:31
11 isn't that right? We can see that you, as you've
12 explained in your witness statement, didn't realise
13 that there was a problem here when you saw the patient,
14 you thought it was simply an oversight whereas you now
15 consider that that was a failure on Mr. O'Brien's part 12:32
16 to treat the patient properly. Have I summarised that
17 adequately?
18 A. Yes. So I saw him in extremis essentially as an
19 emergency. I treated him surgically. I operated on
20 him as an emergency because of complications of local 12:32
21 progression of his prostate cancer, and started him on
22 Degarelix, which is a fast-acting hormone treatment
23 that works in a slightly different way. I just hadn't
24 twigged at that time that this is a pattern of
25 treatment. But remember, at this time still a pattern 12:33
26 of treatment of someone with high-risk disease who has
27 been started on 50mg of Bicalutamide, I wouldn't even
28 anticipate that this would be a pattern of standard
29 treatment. We would all start people on 50mg of

1 Bicalutamide for a temporary period before they have
2 their first LHRH analogue injection. I can only
3 presume I have assumed there has been an oversight
4 rather than this representing his standard practice.
5 Again, my degree of suspicion was too low. 12:33
6 69 Q. Yes. If we can see the steps that you took then later
7 that year in November of 2020, you raised a Datix at
8 that point or an incident report. We can see that at
9 TRU-162168. This, more comprehensively than I achieved
10 a moment ago, sets out the factual background to this 12:34
11 case, the case of Patient 4. As we can see, it's you
12 raising the Datix in November '20. The history is
13 described in the "Description", where the patient was
14 diagnosed with high grade prostate cancer In July '19,
15 and then the outcome was to commence LHRHa, arrange a 12:34
16 CT chest and bone scan and subsequent MDM. Where you
17 came into it was in January 2020 where, as you say, the
18 patient came in *in extremis*, requiring transurethral
19 resection and ureter extent with nephrostomy, and
20 during the in-patient administration it was not 12:35
21 recognised that he had not been started on the hormone
22 treatment despite that being indicated at MDM some six
23 months or so earlier. As you've explained, you started
24 him on standard treatment in the form of Degarelix.
25 12:35
26 In trying to understand these missed opportunities,
27 because I think we'd probably accepted here was another
28 one, you didn't recognise that Mr. O'Brien may have -
29 and I use these words advisedly - deliberately avoided

1 the MDM recommendation for whatever reason, but you
2 hadn't realised that, you just saw it as an oversight.
3 Is part of the explanation for the missed opportunity,
4 linking it back, as I said I would earlier, with
5 Dr. Mitchell's intervention with you just the year 12:36
6 before, is there a sense among colleagues, you and
7 Mr. O'Brien, you and other colleagues and perhaps in
8 other circumstances, that there's a benefit of doubt
9 given, there's a tendency to be restrained from making
10 an allegation of shortcoming for fear that you could be 12:37
11 wrong and that you could cause damage by making the
12 allegation?
13 A. I think the first thing to recognise on this patient is
14 he came in as an emergency and I have managed him as an
15 emergency. What I have not done at that time is 12:37
16 a forensic look through as to what has happened
17 previously. We've recognised that he needs treatment.
18 I think that it might be a typo within that IR1,
19 I think he was started on his treatment during that
20 in-patient administration. I think it was the day of 12:37
21 discharge he had his first Degarelix. But when
22 we looked at it more forensically, because we are
23 managing his emergency admission problem, when
24 I've looked at it more forensically what I've seen is
25 (A) there's the pattern of treatment but there's also 12:37
26 delays here which are just difficult to comprehend to
27 me. He's come to clinic in August, on 20 August, he is
28 supposed to be getting some staging scans organised;
29 they have not been requested for six and a half weeks

1 from when that patient has come. So again that's
2 another factor within the concerns that have been
3 identified.
4
5 It goes back to, as we've said earlier, we kind of knew 12:38
6 that there were issues, these administrative issues,
7 the delay in doing things, but actually underlying the
8 delays in doing things there were other factors, and
9 that's what we failed to recognise previously.
10 12:38
11 In terms of that, if you like, reluctance to trigger
12 investigation early, I think you have to recognise it
13 is the first thing. I don't spend my emergency
14 admission ward round conducting an analysis and
15 critique of every patient's historic management. I've 12:39
16 recognised there's an issue. I have not even --
17 I've managed him acutely, it is only later
18 I've recognised that this fitted a pattern of
19 behaviour. I've figured that it was an oversight,
20 incorrectly. But as I've said, all patients who are 12:39
21 going to start an LHRH analogue started on 50mg of
22 Bicalutamide. I wouldn't be continuing it so I've
23 assumed that there's an oversight; incorrectly.
24 70 Q. Yes. The Panel will be aware that this case was then
25 the subject of review through the SAI process with 12:39
26 Dr. Hughes, and it takes its place amongst that
27 collection of cases.
28
29

1 One of the points I think you made on the last occasion
2 was, I suppose, the impact of the demand capacity
3 problem. You were explaining that really in the way
4 that you and your colleagues had to work and still have
5 to work, as you maybe just expressed a moment or two 12:40
6 ago, you don't have that opportunity necessarily to
7 know in detail what your colleagues are doing, or to
8 read back through the file to get to grips forensically
9 with the history. You gave a sense on the last
10 occasion of momentum on to the next case because there 12:40
11 really wasn't the time to engage in that kind of
12 scrutiny. Is that perhaps another factor that explains
13 the opportunities that were lost here?
14 A. I think so. I think if you are busy and are keeping
15 your head above water, but only just, you don't have 12:41
16 the capacity to be analysing every aspect of another
17 individual's practice. Indeed, you don't get the
18 opportunity necessarily to do that. There are some
19 things even within the busyness that you can change
20 which sort of enable it. I've mentioned the - or I may 12:41
21 have mentioned - pooled waiting lists, operating on
22 each other's patients. You get an opportunity in doing
23 that to see how other people are practising because you
24 are coming across their patients as standard, and
25 you develop shared standard practices because you are 12:42
26 all operating on the same patients. But that pooling
27 of patients didn't happen at this time. The only times
28 we would have come across Mr. O'Brien's patients would
29 have been during a week, as Urologist of the Week,

1 which is the busiest week in our cycle when we are
2 covering the emergencies.
3 71 Q. If you were to identify the key or the singular
4 governance failure that led to the circumstances which
5 triggered this Inquiry, upon reflection what is that or 12:42
6 how would you describe it if it's not a singular
7 identifiable failure?
8 A. I think as I said before, it is a failure to recognise
9 that an individual who has a series of concerns being
10 raised needs a wider practice look at. There's the 12:43
11 longitudinal argument as well. I don't know what sight
12 of the previous concerns from '2010/11 the 2017-2018
13 MHPS investigation process had. We know that -- you
14 mentioned just recently Dr. Mitchell's e-mail to
15 Mr. O'Brien in 2014, we know that that only went to 12:43
16 Mr. O'Brien so they wouldn't have had sight of that.
17 So, there were a number of things that we don't know
18 whether they had sight of. But there were, I would
19 suggest, enough concerns from an MHPS investigation
20 point, to me, to flag a need to look a bit deeper at an 12:44
21 individual's practice.
22 72 Q. I suppose the big question is how can you cure that for
23 the present or for the future as a Trust and as
24 a senior clinician within the Trust. You're seeing
25 what's happened in the past. Is it about changing 12:44
26 behaviours so there's increased sensitivity to what can
27 go wrong, or is it about writing a more effective rule
28 book to specify when intervention should take place?
29 A. I think it's both. You need to have an environment

1 where individuals at the very base level raise concerns
2 with each other. You need to have an environment where
3 people feel that they can raise concerns about other
4 individuals' practice or behaviours which are not going
5 to be detrimental to themselves or the other person if 12:45
6 they are wrong. And coupled with that, sort of that
7 reporting, you need to have something that mandates
8 that when you have concerns that reach a threshold
9 about an individual, that them concerns automatically
10 move on to a wider look at an individual's practice 12:45
11 outside of them specific areas of concern. If that's
12 accepted and recognised as standard practice, then it
13 isn't considered unusual to trigger a wider
14 investigation.
15 73 Q. Thank you for that. I want to move on to look at, as 12:46
16 I described this morning, the second part of your
17 evidence, the area of improvement and what specific
18 measures have been taken to address some of the
19 concerns that were exposed in 2020, '21, and later this
20 afternoon into look at some of, if you like, the 12:46
21 practice development areas - or the service development
22 areas I should more properly say - in the context of
23 the well-known demand capacity problem.
24
25 As I explained this morning, you were appointed 12:46
26 Divisional Medical Director of Urology Improvement in
27 2001. Just pull up the job description for that, it is
28 to be found at WIT-54012. We'll look at aspects of
29 that in a moment.

1

2 We observed on the last occasion, Mr. Haynes, that in
3 September of 2001 you had been appointed Divisional
4 Medical Director for Surgery and Elective Care, but in
5 December 2021 you took on this role, the Urology 12:47
6 Improvement role. Can I safely assume that the earlier
7 role, the wider role which was responsible for the SEC,
8 it was handed over to somebody else; is that right?
9 A. Yes. Mr. McNaboe took on the Divisional Medical
10 Director for SEC as of December 2021. 12:48
11 74 Q. Is it fair to say that to have a Divisional Medical
12 Director, yourself, appointed to take care of - I hope
13 I'm not wrong in saying this - a modestly sized service
14 within a bigger service, the SEC, is this an unusual or
15 novel step in your experience? 12:48
16 A. Yes. If you like, as you say a modestly sized service,
17 but with some big challenges.
18 75 Q. Of course. Undoubtedly.
19
20 Is it fair to say in your understanding that the 12:48
21 development of this post with a focus specifically on
22 urology and nothing else was as a response to the
23 problems that had been identified and that were
24 bringing the Trust into a public inquiry?
25 A. Yes. So it was in response to the issues identified, 12:49
26 the public inquiry, and the requirements to make
27 changes within the service, the department, to look to
28 improve things.
29 76 Q. The improvement element that's added on to the job

1 title, can you help us with that? If we look at
2 WIT-54013, if we scroll down the next page, one can see
3 - just that last bullet point on the page - that two
4 specific tasks are carved out for you: Chairing the
5 Urology Quality Improvement Group, and co-Chairing 12:50
6 Urology SAI Task and Finish Group responsible for
7 ensuring compliance with SAI recommendations made in
8 the period 2016 to 2021. One can immediately see how
9 improvement in the job title links to those kind of
10 tasks. Were you Chair of the Urology Quality 12:50
11 Improvement Group?
12 A. No. So early on in the meeting of that -- sorry, I'm
13 talking about the Task and Finish Group.
14 77 Q. Let's take the first one. I am not sure what the
15 Quality Improvement Group is as distinct from the Task 12:51
16 and Finish Group?
17 A. You share my unsureness. As far as I'm aware, the
18 Urology Quality Improvement Group has never existed.
19 Quality improvement within Urology is something that is
20 dealt with within our regular departmental meetings, 12:51
21 and it is dealt with regionally through the PIG
22 meetings. So there is Quality Improvement; I do play
23 a role in Urology in Southern Trust and I do sit on the
24 regional PIG Group, which also are looking at quality
25 improvement projects. I'm sure we will come on to some 12:52
26 of them as we go through.
27 78 Q. Just so I understand and the Panel understands, you've
28 referred to PIG, that's the Programme Improvement
29 Group, which is a regional committee chaired by the

1 SPPG which brings together Trust urology providers from
2 throughout Northern Ireland?
3 A. Yes.
4 79 Q. We'll look at its role in a moment.
5 12:52
6 In terms of locally within the Trust, there's no group
7 called the Quality Improvement Group --
8 A. There is no urology quality improvement group.
9 80 Q. But improvement initiatives are, nevertheless, on the
10 Urology Service agendas but they are pursued not 12:52
11 through this standalone group, which doesn't exist, but
12 through your normal process of service meetings?
13 A. Yes.
14 81 Q. Secondly, in terms of co-chairing the Task and Finish
15 Group, which has a specific responsibility or did have 12:53
16 a specific responsibility for dealing with the SAI
17 recollections, were you co-Chair of that?
18 A. No. That's where I started my answer previously.
19 Early on in that group's initial meetings, it was
20 recognised that the recommendations from them SAIs were 12:53
21 much broader than just urology. With my remit being
22 urology only, it was felt that the co-Chairing
23 responsibilities needed to have a broader reach. So
24 the initial co-Chairs of that meeting were the
25 Divisional Medical Director from Cancer Services, which 12:53
26 is Shahid Tariq, and Ronan Carroll as AD for Surgery
27 and Elective Care.
28 82 Q. Yes. Help us with this then: In terms of improvement,
29 the improvement element of your job title, how would

1 you define that in practice? What is it improving and
2 what are the structures through which the need for
3 improvement is identified and then pursued?
4 A. So there are two facets to the improvement.
5 Improvement in relation to the deficiencies and 12:54
6 failings that have been identified through the SAIs, as
7 I've said, the Task and Finish Group was looking
8 broader at the Trust. But within Urology Services,
9 I've been ensuring that we ensure that they are
10 delivered within our services. Then there's 12:54
11 improvement which is beyond that; that's improving our
12 patient pathways, improving patient access, looking at
13 ways of working differently, changing who, when or
14 where services are delivered to improve the care that
15 patients receive. 12:55
16
17 If I take the first one in terms of the improvements
18 from the failings that have been recognised, broadly we
19 could group them into, if you like, performance. You
20 could have an MDT aspect, we could have a patient 12:55
21 information and support, and a culture section. If
22 we look at our performance, it's touched upon there in
23 the job description. Quantitative performance, so how
24 many patients we can see, how close we are to meeting
25 cancer targets are clearly going to be hampered by how 12:55
26 much capacity we have. We have engaged with SPPG, and
27 there has been significant investment in independent
28 sector outsourcing, while we have been carrying --
29 83 Q. I'm pausing here because that is an area I want to

1 perhaps open up in a bit more detail this afternoon.
2 Each of the elements of the improvement work will also
3 be touched upon so I'm not intending to treat you
4 unfairly by stopping you. I just want to get the
5 building blocks in place before we go to the substance. 12:56
6
7 I brought you down the road of helping to explain the
8 improvement elements, but your role is broader than the
9 improvement focus. You carry, I suppose, the entirety
10 of the responsibility typically associated with an 12:56
11 Associate Medical Director, as we used to call them,
12 but you are not doing that with the support of
13 a clinical director; is that right?
14 A. No. So Mr. McNaboe, who is now the Divisional Medical
15 Director of Surgery and Elective Care was the clinical 12:57
16 director. When I moved into this role, Mr. McNaboe
17 replaced me in that role for Surgery and Elective Care
18 and we don't have a clinical director in Urology across
19 ENT services.
20 84 Q. You do have some support, I see from your witness 12:57
21 statement. For example, Mr. Tyson was described as
22 Quality Lead and also Standards and Guidelines Lead.
23 We obviously have heard that Mr. O'Donoghue runs the
24 Patient Safety meeting. But in terms of your role,
25 you're, in essence, the senior clinical manager with 12:58
26 responsibility for Urology; is that an apt description?
27 A. Yes.
28 85 Q. It comes with three PAs. One recalls you described the
29 pressures of medical management on the last occasion.

1 This seems to be a significant role, so how do
2 you manage that in the context of your clinical
3 responsibilities?
4 A. So, my job plan is essentially written so that I have
5 Mondays set aside purely as my Divisional Medical 12:58
6 Director role. I have some additional short periods of
7 time elsewhere in the job plan, which are normally
8 detailed as time for me to keep up with emails and the
9 like. The reality is also on Tuesday, I have other
10 nonclinical roles within my job plan, including my 12:59
11 educational supervision sometimes as the NICaN CRG, and
12 my own CPD SPA. The reality is that Mondays and
13 Tuesdays, my Divisional Medical Director activity moves
14 across both of them days. Indeed, where I can fit
15 things in, where there's a meeting on a Thursday and 12:59
16 I'm able to get to it in between clinical activities,
17 I will do that as well.
18
19 Certainly, I know I have -- the virtual working and
20 Teams and Zoom, as we all know through COVID, have 12:59
21 facilitated or enhanced the ability to actually attend
22 a meeting in between two clinical sessions. I might be
23 doing a clinic and, over lunchtime, link into
24 a meeting.
25 86 Q. Thank you for that. That's the building blocks in 12:59
26 place. Take a break now?
27 CHAIR: Two o'clock, everyone.
28
29

1 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

2

3 87 Q. MR. WOLFE KC: Good afternoon, Mr. Haynes.

4

5 Before I explore with you the changes and the extent of 13:58
6 the changes in Urology Service over the past several
7 years, I suppose it bears reflection that a service and
8 a Trust that's cast into the storm of a very public
9 inquiry must suffer some form of trauma, or I suppose
10 upset or unsettlement, as a result of the experience. 13:59

11

12 Could you comment from the perspective of a working
13 urologist, as well as a medical leader within urology,
14 just how are things within your service and amongst
15 your colleagues? I think you reflected on the last 13:59
16 occasion it has been a difficult period. Have things
17 evened out in the interim?
18 A. As I said before, it's obviously difficult. As a team
19 go through an experience like this, they will go
20 through a wide range of emotions individually and 14:00
21 functionally as a team. That does affect, inevitably,
22 their working and how they work. Time does allow
23 people to work through them emotions and change -- you
24 know, we all learned at medical school about the stages
25 of grief. I'd say actually them stages are very 14:00
26 similar in response to many external stimuli, and this
27 is no different.

28

29

1 We've covered vacancies within the consultant body.
2 We know on at least one occasion we've had withdrawal
3 of an applicant from their application for a consultant
4 post citing advice of colleagues given the spotlight
5 the service is currently under. So, we know it's 14:01
6 impacted people outside.
7
8 I think there has been an inevitable impact on how
9 people practice as well. I think that there's been --
10 that we have, understandably, developed somewhat of 14:01
11 a defensive practice in some things and maybe, where
12 previously we might managed a patient, for instance, on
13 surveillance for a small kidney mass with an unchanged
14 scan ourselves and continuing a standard follow-up
15 protocol, there is a much greater tendency to bring 14:01
16 that patient to the multidisciplinary team meeting
17 repeatedly without any change in what would have been
18 the management, so there has been an inevitable impact
19 from that perspective.
20 14:01
21 However, as a team I think we are in a healthy place.
22 We all get on well; we have good working relationships;
23 we are happy to pick up the phone, and that's across
24 the consultants and across our more junior team and
25 across the nursing team. We have been able to, 14:02
26 possibly on the back of part of the improvements,
27 improve our specialist team, and that's taken us to
28 a much better place from a nurse specialist support.
29 We have been able to expand some of our junior team.

1 These things have improved the environment that we work
2 in, but we're still facing challenges with vacant
3 spaces on the rota. Hopefully sorted, as we'll
4 probably touch on later, with recent international
5 medical recruitment. 14:02
6 88 Q. Yes. Just on one of the points you make there about
7 working well as a team, good relations, ability to pick
8 up the phone, is that by contrast with pre-Inquiry or
9 pre-summer of 2000? Because Mr. O'Brien, not to put
10 a fine point on it, is no longer there? Is that what 14:03
11 you are saying, or is it more a recognition that in
12 order to work as a collegiate body, these kinds of
13 conversations, this kind of informality, pick up the
14 phone, share views, is a necessary component?
15 A. Share views, disagree, accept disagreement. We don't 14:03
16 have the elephant in the room.
17 89 Q. That's what I wanted to extract, to test with you. Is
18 that because Mr. O'Brien is gone and are you saying
19 that was a problem, or are you saying a different
20 reason, that it's actually a recognition that we need 14:04
21 to behave in a different way, more collegiately, even
22 on an informal level? From your perspective, and it
23 may not be everybody's perspective.
24 A. I think that's very difficult. I think I've always
25 practised in that way. If I reflect on my practice 14:04
26 before I came to Northern Ireland, I would have had
27 them working relationships in the previous consultant
28 team that I worked in. I mentioned "elephant in the
29 room". We know that -- or it's been covered in others'

1 evidence as well as my own, that Mr. O'Brien was
2 difficult to challenge. He didn't respond well to
3 challenge, he didn't accept other perspectives and
4 change his view. To a degree we touched on it this
5 morning with the 2014 Dr. Mitchell e-mail. If that was 14:05
6 received by any of the rest of the team, that would
7 have led to practice change, but it didn't seem to lead
8 to any change.
9 90 Q. Before we move to the 2020 SAIs and what has been the
10 response to those, I want to ask you about a number of 14:05
11 discrete areas. Just before lunchtime we were talking
12 about your medical leadership rose and you explained
13 how you were able to carry that out. There's an
14 element of sort of using available time during the week
15 and sort of squeezing things in between sessions to get 14:05
16 the job done. I think more particularly when you were
17 here with us on the last occasion, you reflected quite
18 often just you weren't able to get to meetings and
19 there was an almost - and you can correct me if I'm
20 wrong about this - but there was a sense from your 14:06
21 evidence that you weren't doing medical management in
22 the way you would like to because simply there wasn't
23 enough space in the working week to do that. Correct
24 me if I'm wrong about any of that, but I wanted to ask
25 you the question and you can tie all of that into your 14:06
26 answer, have there been changes, noticeable changes in
27 support for medical management in the last two or three
28 years within the Trust?
29 A. In the preamble, you touched on not being able to get

1 to meetings. That can still be an issue. We have
2 management processes that work over five days, but no
3 medical manager has five days' availability. So
4 a meeting that's always scheduled for a Friday, for
5 instance, I don't get to because I operate in Belfast 14:07
6 Trust on Friday. I have to accept that I just can't
7 get to them.
8
9 I don't think there's a good solution to that sort of
10 issue because, inevitably, if all medical managers have 14:07
11 between two and three PAs, then having them tie up all
12 at the same time to get all of the things that are
13 required just won't happen.
14
15 I think, from my perspective, things have been 14:07
16 simplified because I'm managing one specialty, one team
17 of doctors, one team of nurses, with one head of
18 service and with one AD. Things have been simplified
19 from that perspective, which makes it easier from my
20 perspective. The head of service has planned in the 14:08
21 week things that tie in with when I'm available, and
22 does things that don't require me the other times in
23 the week. Similarly with the AD, we do that. But
24 there are still things, as I say, outside that do
25 happen on days that don't suit me and I just have to 14:08
26 accept that.
27 91 Q. I think I'm right in saying that you were clinical
28 director within SEC in 2016, assuming the reins of the
29 Associate Medical Director in late 2017, taking on this

1 most recent role, the particular focus in urology, in
2 December 2021. It must be a very obvious reduction in,
3 I suppose, the stretch that you have to apply to
4 yourself if you're only required to focus on urology.
5 Have you formed the view that, really, for an associate 14:09
6 medical director to do his job effectively, he or she
7 can't be stretched across all the SEC; the role needs
8 to apply to smaller services or divided up so that it
9 applies only to one or two services?
10 A. I think it has been useful, me being able to apply 14:09
11 myself just to urology. I think that does enable
12 a much greater handle and focus on the issues that
13 require a divisional medical director. In terms of
14 recognition of the breadth of SEC, there are now two
15 ADs for Surgery across what used to be Surgery & 14:09
16 Elective Care where there used to one, so there has
17 been additional recognition of that. Even one step
18 above that, what used to be Acute Services is now
19 Surgery and Clinical Services with one director and --
20 I've forgotten the name of the other group but there's 14:10
21 a second director at that same level. Where there used
22 to be one director across all acute services, there are
23 now two, and within that surgical and clinical services
24 group, there are two ADs, assistant directors.
25 92 Q. I suppose that greater focus or lessening of that 14:10
26 burden, what has been the impact of that or the
27 advantages of that in terms of the tasks that you're
28 expected to carry out as Divisional Medical Director?
29 A. It inevitably improves your ability to maintain a focus

1 on one thing. When, for want of a better description,
2 when you have multiple fires to put out, you put out
3 the one that is nearest to you. When you have lots of
4 problems and you haven't enough time to address them
5 all, you, unfortunately, inevitably, address the one 14:11
6 that's shouting the loudest. That's what happens when
7 you've got too much activity to do.
8 93 Q. Yes. I want to ask you briefly about relationships
9 upwards to the Medical Director's office. I think you
10 reflected the last time, or perhaps it was put in your 14:11
11 statement, that whenever Dr. O'Kane came in as Medical
12 Director in January or so '19, that triggered,
13 I suppose, a more direct engagement between you at that
14 time as Associate Medical Director and that office.
15 I think you were reflecting that was a positive change 14:11
16 compared to what you had experienced before that.
17 There are now, I understand, a number of deputy medical
18 directors; is that right? How is that relationship,
19 that looking-up relationship - or maybe you don't think
20 of it in terms of looking-up. How do you find that? 14:12
21 Has there been any positive improvement or initiatives?
22 A. Over time, as I said, there was a change in approach
23 when Dr. O'Kane came in. That approach has been
24 continued with Dr. Austin. We have regular senior
25 medical leaders meeting which, in an attempt to manage 14:12
26 the fact that we don't all have our time at the same
27 time, we switch from a Monday one week to a Wednesday
28 on another week. They happen regularly. The presence
29 or the existence of deputy medical directors means that

1 there is a much easier line into that senior
2 management. It is not a question of only one person to
3 contact; I can contact one of a number of people
4 depending on the specific issues.
5 94 Q. I think one of the issues historically was that 14:13
6 concerns around Mr. O'Brien weren't leaving the
7 service, they were staying within the service, possibly
8 reaching back in the time of Mr. Mackle, the level of
9 Associate Medical Director but not going beyond that,
10 not being escalated, effectively, to the Medical 14:13
11 Director's office until Dr. Wright was, perhaps, told
12 about concerns at the tail end of 2015 into 2016.
13
14 In terms of the ability to escalate issues, if there
15 were issues to escalate, is that something you feel 14:14
16 structurally is more readily available to you as
17 a leader?
18 A. I think so, both formally and informally. So, as I've
19 said, with the team as it is, there is a much greater
20 opportunity. The regularity of them interactions as 14:14
21 a group mean that the Medical Director isn't someone
22 who feels distant from you, nor are the deputy medical
23 directors.
24 95 Q. How often would you see them?
25 A. The Medical Director? 14:14
26 96 Q. Or his deputies.
27 A. So there's the weekly senior leaders' meeting, so
28 that's a regular occurrence in the diary. Now, if I'm
29 doing a clinical activity on a Wednesday and I can't

1 meet it, I'll make it on the Monday because that fits
2 with me.
3
4 I've mentioned previously that relationships between
5 people actually make things easier. Regularly seeing 14:15
6 and being in contact with people make things much
7 easier to pick up the phone. But there's also the
8 formal process and, again, I think that started to be
9 instigated by Dr. O'Kane and has continued on with
10 Dr. Austin in terms of the revalidation process. Now, 14:15
11 whenever a doctor comes up for revalidation, all of
12 their appraisals are reviewed and discussed by the
13 divisional medical directors with the Medical Director
14 at a formal meeting where any of them concerns are
15 raised. I would hope, had that been the case in 14:15
16 Mr. Mackle's time, that he would have had an
17 opportunity there through that formal process, perhaps,
18 to say actually there have been some issues raised
19 here.
20 97 Q. That's an example of the kind of thing that might be 14:16
21 discussed formally. What about informally? Can you
22 share? Is the structure, or indeed the relationships,
23 there to discuss, if necessary, and it may not have
24 arisen as yet, but maybe concerns that are in the back
25 of your mind about practice issues, about behaviour of 14:16
26 colleagues?
27 A. I would have no hesitation because the relationships
28 are there.
29 98 Q. In terms of, if you like, the bottom up to you, you

1 don't have a clinical director in place. If the
2 situation was to arise, how do you ensure that
3 information comes to you? Is that by having more
4 improved meeting space with your clinical colleagues?
5 You mentioned earlier picking up the phone to each 14:17
6 other, that kind of thing. How does that information
7 come to you generally?
8 A. Yes, so there's the simple informal relationships.
9 There's relationships wider than just clinical
10 colleagues. I will and do make a habit of always 14:17
11 seeking out and speaking to nursing colleagues on the
12 ward, actively seeking and looking for feedback on how
13 things are going. Again, I think it's that
14 relationship. People need to feel comfortable in
15 speaking to you. I hope I'm not -- not got a false 14:17
16 impression but I think people are happy to raise things
17 with me. I think part of that comes from people
18 feeling confident that you might actually look into
19 what their concern is.
20 99 Q. In terms of the Board level, there might be a sense in 14:18
21 the evidence that the Board members, particularly the
22 non-executive directors, may not historically have been
23 well-connected initially into urology; that's what
24 we're focused on. Has there been opportunity for you
25 to meet with the Board, communicate with the Board, any 14:18
26 individual Board members, or does that come through the
27 structure of you speaking to the Medical Director and
28 any views that you might have being shared through that
29 process?

1 A. So I have been invited and spoken and met the Board
2 Governance Committee. I have met them on the one
3 occasion. Eileen Mullan has made contact with me
4 personally and spoken to me. Dr. O'Kane, obviously
5 being the chief exec, we had a working relationship 14:19
6 before when she was Medical Director, and that working
7 relationship has continued. Again, just like I do with
8 the Medical Director, I feel quite happy to drop her
9 a text and ask her to give me a call if there's
10 anything I would like to speak to her about. 14:19
11 100 Q. The Inquiry has heard evidence from Board members that
12 whereas, perhaps, in recent years there has been
13 a focus in terms of Board interests on promoting
14 compliance with performance targets, there has been
15 a shift from that more recently, it has been suggested, 14:20
16 and that the primary focus is now patient safety,
17 quality. That's much more central, perhaps, than it
18 was allowed to be previously. I'm hoping I'm
19 describing it correctly. That's the sense of some of
20 the evidence that we have received. 14:20
21
22 In how I've described it, have you observed a change in
23 focus?
24 A. I couldn't consciously say I've witnessed a change in
25 focus but I wasn't ever really consciously aware of 14:20
26 a focus on times -- however you referred to it.
27 101 Q. It seemed to be that these are the targets, the
28 ministerial or statutory targets.
29 A. I wouldn't have consciously aware that there was

1 a focus on targets over other things previously either,
2 so I wouldn't have noticed a change.
3 102 Q. You mention some engagement with the Board through one
4 of its committees. Obviously with Urology in the eye
5 of the storm, have those conversations looked at or 14:21
6 focused upon patient safety issues within Urology or
7 what has been the focus of them?
8 A. So, the Trust Board governance meeting was around the
9 outworkings of the Lookback Review, so was around the
10 outworkings of that and discussed things, the sort of 14:22
11 measures we've taken in light of them findings. That
12 was the purpose of that meeting.
13 103 Q. That's an understandable starting point but has there
14 been further contact, building upon that?
15 A. No. 14:22
16 104 Q. Do you think there ought to be greater connectivity
17 particularly between your service because of recent
18 history and the Board?
19 A. I don't know. We reflected at the start of this
20 session on the difficult time we've been through. 14:22
21 Allied to this process, we've also had a GIRFT review,
22 we've had an RQIA review. The team have felt under the
23 spotlight anyway. Having the Board come and talking to
24 the team more regularly might make them feel like
25 there's another spotlight on them. I think at the end 14:23
26 of the RQIA review, I think we were asked if there was
27 anything that could be done, and the request from the
28 team was leave us alone to get on with what we want to
29 do. Allowing us that freedom to develop our services,

1 with an assurance that we are focused on delivering in
2 the patients' interests, delivering safe, high-quality
3 care but not having to be questioned about it every
4 couple of weeks, every month, there's a significant
5 value in that. 14:24
6 105 Q. In terms of the Trust having a long-term vision, would
7 you as a senior clinician know what that was? In other
8 words, it's an indirect way of asking you do you feel
9 and do your colleagues feel that you have a share in
10 shaping the vision and outlook of the Trust? 14:24
11 A. I think everyone involved in healthcare wants to
12 deliver a safe, high-quality service that meets the
13 needs of the population, but the constraints are such
14 that what might be what everyone's intent or golden
15 view is can't be delivered. We know, and it's covered 14:25
16 elsewhere outside of here, about the infrastructure
17 surrounding many of our hospitals. We know that
18 we don't -- we commission differently in Northern
19 Ireland to, say, in England where Trusts are
20 commissioned by what they deliver, so encouraged to 14:25
21 meet the demands of the population, where we're
22 commissioned to deliver a set volume of service which
23 doesn't meet the needs of the population. I think that
24 automatically leads to, perhaps, a bit of a tug because
25 if I, as a clinician, want to see patients every day 14:25
26 who are taking longer to get treatment than I feel they
27 should, then I want to be able to deliver that, but the
28 constraints on the Trust and the service are such that
29 they can't physically do that. So you can get this

1 feeling of a disconnect between the aims of them two
2 groups of people but actually there's no disconnect, it
3 is just an inability to do it.
4 106 Q. Yes. Notwithstanding that inability, the disconnect
5 that you speak of, is there ways that you think that 14:26
6 could be eliminated so that even if there are these
7 hurdles in terms of delivery, at least your voice and
8 the voice of your experienced colleagues might be
9 better heard in devising mitigations if not solutions?
10 A. I think clinicians, and so clinical input, into the 14:27
11 design and delivery of every service is required and
12 has to be encouraged. I think without that, you do
13 lose that voice and that ability to guide. As I say, I
14 think the picture at the moment is very difficult
15 because we all know that the focus really is that our 14:27
16 hospitals are full and there's emergency departments
17 with ambulances waiting outside and patients waiting
18 too long, and naturally the focus has to be on
19 resolving the emergent problem.
20 107 Q. Let me bring you back to, if you like, the fall-out of 14:27
21 the 2020 SAIs which were reflected in a series of
22 recommendations. Bring the recommendations up on the
23 screen. They can be found at DOH-00129. The role of
24 doing something with those recommendations was handed
25 to a Task and Finish Group, WIT-11509. There it is 14:28
26 described, and its terms of reference being
27 implementing all the recommendations and providing
28 assurance and evidence externally to the Urology
29 Oversight Group and its significant membership. As

1 we can see there, your name is the third down on the
2 left-hand side. You've explained earlier that as
3 things transpired, you were not a co-Chair.
4
5 We've looked at some minutes in relation to the 14:29
6 meetings of this group. You aren't often in
7 attendance; is that fair?
8 A. Yes. The meetings, just like we've covered earlier,
9 were not always at a time where I could attend.
10 108 Q. Yes. Clearly, as this group went about its work, it 14:29
11 was focused not just on urology, as it happened,
12 because it was recognised, following a baseline audit,
13 that the kinds of issues that had emerged from these
14 urology SAIs were of wider import. They affected,
15 essentially, the suite of Urology Services within the 14:30
16 Trust; isn't that right?
17 A. Yes.
18 109 Q. Perhaps for those reasons the ownership of the Task and
19 Finish Group in terms of its Chairpersonship was handed
20 to Dr. Tariq. Is that your understanding? 14:30
21 A. As I said earlier, my memory is it was co-Chaired by
22 Dr. Tariq and Ronan Carroll.
23 110 Q. We can see, if we can turn to TRU-30588... I wonder
24 did I leave a digit out? I should have said
25 TRU-303588. Thank you. 14:31
26
27 This is a summary of the improvements visited upon or
28 intended to be visited upon cancer MDT workings as of
29 December 2022. I just want to scroll down through it

1 just so that the Panel can familiarise itself with it.
2 It set out some of the contextual issues that the Trust
3 became aware of in light of the SAIs. For example, MDT
4 meetings had broadly remained unchanged for more than
5 a decade; no commission post to oversee the 14:32
6 effectiveness of each MDT; an absence of monthly
7 reports to deal with some of the key issues, including
8 on quoracy. Familiar problems for those of us who have
9 read the SAIs emerging from Urology, these are the
10 kinds of themes - and you can see others listed there, 14:32
11 cancer nurse specialist - that Dr. Hughes and his team
12 picked up as part of the SAI reviews.
13
14 Just scrolling over the page. We're going to just come
15 back to that in a moment, we'll come back to some of 14:33
16 the specific actions. This implementation stage of
17 recommendations flowing from the SAIs was taken forward
18 as part of a task and finish approach. I think the
19 last time when we were asking you about Serious Adverse
20 Incidents more generally, you were reflecting - and 14:33
21 we can see it, we don't need to bring it up - but
22 we can see at TRA-0964 you were reflecting your
23 concerns that SAI action plans do not get implemented
24 quickly enough. That was perhaps in the context of
25 a number of cases that you were participating in, 14:33
26 including the five triage-related SAIs that were taken
27 forward together.
28
29

1 Before we look at some of these actions taken as a
2 result of the Task and Finish Group's work, have
3 you noticed any change in how SAIs are approached in
4 the past 14 or 15 months since you were last with us?
5 A. In terms of the primary SAI processes, it is very 14:34
6 similar in terms of the decision to proceed to an SAI.
7 There is a much greater focus on getting those SAI
8 reports completed and improved and through the acute
9 clinical governance meeting so they are at a point to
10 be implemented. There has also been expansion of the 14:35
11 team supporting that process whereby them
12 recommendations can be tracked live through the Datix
13 system, where they couldn't have been previously.
14
15 There's a retrospective element to that in terms of 14:35
16 getting the older recommendations on to the system so
17 they can be tracked as well, as well as the prospective
18 elements. So, there is work undertaken to improve
19 that. The position in terms of SAIs waiting doing, as
20 far as I'm aware, is much better than it was. 14:35
21 111 Q. What has been, if you like, the practical remedy that's
22 enabled some speeding up or expedition of reviews in
23 terms of -- does it relate to the personnel or the
24 ability to deploy personnel more readily?
25 A. Support staff, more than anything. There's still 14:36
26 a challenge where you require clinician input,
27 particularly where, say, someone were to come in for
28 Urology, with only three of us in substantive post at
29 the moment we haven't got a huge capacity to be

1 managing many SAIs at any time.
2 112 Q. One of, I suppose, the complaints we've heard said
3 through a number of witnesses is almost there is a
4 disincentive sometimes to raising an incident report,
5 or a Datix as it is sometimes called, because the sense 14:36
6 of it was you might raise something you feel quite
7 concerned about and earnest about and you go through
8 the process, and you never hear back or you sometimes
9 don't hear back in terms of how your concern has been
10 viewed by others and how it has been dealt with. I'm 14:37
11 not sure I asked you about that on the last occasion;
12 is that something you recognise, and what can be done
13 about it?
14 A. It is certainly something I do recognise. It is like
15 a development of apathy. If you raise a concern and 14:37
16 then keep raising a concern but never hear anything
17 back, you ask the question why should I continue
18 raising a concern? One of the challenges with that is
19 how much feedback and when to fee back to individuals
20 through that process. Certainly as a department, SAI 14:37
21 reports and recommendations are fed back through our
22 patient safety meeting, so that comes back in to us.
23 What you perhaps don't hear about is the IR1 that's
24 completed that's been screened out as not requiring
25 investigation. 14:38
26 113 Q. Perhaps it seems an obvious point to make, why wouldn't
27 you treat the person who raises the IR1 in the way that
28 you would treat any other complainant? A patient
29 complains; if the Trust is following its normal

1 protocols, it will regularly update that patient in
2 terms of their complaint - this is what we're doing
3 now, this is why there's the delay, or this is the
4 decision we reached. Would it be very unusual or
5 dramatic to treat a staff member raising an IR1 as you 14:38
6 would treat a complainant?
7 A. No, I think that's a reasonable question but what you
8 require is the support staff to enable that, rather
9 than it be another task that needs to be done by people
10 who are struggling to meet the demands of what they've 14:39
11 already got to do.
12 114 Q. The actions taken as a result of the Task and Finish
13 Group's work - and I emphasise this - are only
14 summarised here. What sits behind this report is
15 a spreadsheet that's much more elaborate and sets out, 14:39
16 using the red, amber, green system, what has been
17 achieved and what is a work in process. I emphasise
18 that this document affords us a helpful summary but no
19 more than that.
20 14:39
21 It describes a number of new support staff being
22 brought into the MDT arena, including someone whose
23 responsibility is to provide monitoring by way of
24 assurance and -- sorry, a Cancer MDT Administrator and
25 Project Officer, and then a Cancer Information and 14:40
26 Audit Officer and, in addition to that, an Interim Lead
27 Nurse For Cancer Services. Are those posts that
28 you have an interaction with in your participation in
29 the MDT?

1 A. So in terms of interaction with, yes. In terms of the
2 Thursday afternoon MDT, they're not MDT members, so no.
3 Their roles are very much part of the assurance
4 processes that surround the MDT. If you take the
5 Cancer Information and Audit Officer, that's the 14:41
6 individual that does a monthly audit of the outcomes
7 recommended from MDT and are addressing the question
8 are they being actioned, and I get a report from that
9 individual. So yes, I have interaction with them.
10 Their role is that assurance process around MDT. 14:41
11 115 Q. I want to, in a moment, look more particularly at how
12 some of those actions work. Just scrolling down,
13 we can see under the next heading that in addition to
14 bringing new personnel and embedding them within the
15 MDT arrangements, there's now a suite of new monthly 14:42
16 reports that superintend the MDT process, including one
17 focusing on attendance and quoracy; one relating to, as
18 you mentioned a moment ago, audits to confirm that
19 actions agreed by MDT are implemented. There are three
20 reports dealing with the role of a key worker, 14:42
21 confirmation that a key worker has been identified and
22 documented, and then an assurance that a key worker has
23 been identified and contact made with the patient, and
24 then confirmation that the CNS or key worker was
25 involved with patients with a confirmed cancer. Then 14:43
26 the last of the reports mentioned -- the last of the
27 arrangements mentioned in this list is the connectivity
28 between the labs, the pathology lab and the MDT where
29 there is a case of confirmed cancer.

1
2 You explained earlier that this initiative to bring
3 improvement to the cancer arena broadly, as
4 I understood your evidence, is the subject of
5 a separate piece of work within Urology itself, and 14:43
6 that's where your improvement role kicks in. Explain
7 to me the mechanism. Do you know - assumedly you do
8 know - what's going on with the Task and Finish Group,
9 and then it's your responsibility or your team's
10 responsibility to ensure that those kinds of 14:44
11 initiatives are implemented for Urology?
12 A. So if you go back to the Task and Finish Group
13 membership, included in that membership is the Urology
14 MDT Chair Mr. Glackin and three specialist nurse
15 specialists. So there is Urology input in there in 14:44
16 addition to my being a member. So although I wasn't
17 able to attend, there was Urology input into that.
18
19 My role, as you say, is very much to make sure that
20 these things are implemented in Urology. In Urology, 14:44
21 as is highlighted there in the second point, Urology
22 was very much used as the first rollout for these
23 things. That audit of outcomes was done for us first
24 and then has been rolled out across others. There's
25 a dashboard that is produced on a monthly basis which 14:45
26 gives us our cancer dashboard in terms of waiting
27 times, treatment times.
28
29

1 We have, relatively recently, been liaising with a team
2 in the Cancer Services about the third point, because
3 what we found is a list of patients waiting the longest
4 for diagnosis, all that tends to reveal is patients
5 with very complex pathways which, actually, aren't very 14:45
6 easily fixable. What we need to know actually isn't
7 that small number of extremely long pathways, what
8 we need to know is the ways we can fix what are
9 affecting the majority of patients and bring the
10 majority of patients' wait times down. We have asked 14:46
11 for a slight change in how we get that sort of problem
12 patients or waiting time problem information escalated
13 or brought to us.
14
15 The key worker information is well described there. In 14:46
16 Urology in order to do that, we appointed two
17 additional posts, which were on temporary funding
18 initially but will be morphed into permanent funding to
19 provide that key working input, so that every clinic
20 that happens in the Urology team, where cancer 14:46
21 diagnoses or post multidisciplinary team meeting
22 discussions are happening, we have a clinical nurse
23 specialist present at with the consultant; not called
24 in but present with the consultant.
25 14:46
26 We know from the information provided by this audit
27 report, but also from patient feedback - and it is
28 commented on in the initial feedback from RQIA - that
29 our patients, all of them, recognise that yes, they had

1 met their key worker, they did know who they were and
2 how to contact them. Them things we have been able to
3 implement within the Urology team.
4 116 Q. Let me ask you about some specifics of how these,
5 I suppose, governance tools work in practice. One of 14:47
6 the matters that's not particularly touched upon here
7 is the whole area of actioning results. So whether
8 it's a pathology result arriving back at you or an
9 images result coming back to you, I think you agreed on
10 the last occasion that it is imperative that they are 14:47
11 read and actioned promptly. We won't go over this
12 afternoon the history of difficulties which surrounded
13 that but it is reflected in a number of cases,
14 including two of the 2020 SAIs that we've looked at.
15 14:48
16 We have been sent this week the administrative and
17 clerical standard operating procedure, which is
18 a policy or procedure that was developed or implemented
19 in April 2023. We can bring that up on the screen. It
20 is TRU-320269. I want to check with you that I'm on 14:48
21 the right page with this. Is this the most recent,
22 I suppose, iteration of the way a secretary is expected
23 to conduct him or herself in the arena of working with
24 a clinician with results, whether it's results for
25 a new patient or whether it is subsequent diagnostic 14:49
26 results?
27 A. Yes. This was developed by us specifically around the
28 management of results. This is how the secretarial
29 support staff address or manage this, and it includes

1 escalation. Separate to this, there is how we as
2 consultants manage our results. I can't remember
3 whether it's in there but there is an element of the
4 monitoring for results which comes to myself and Wendy
5 Clayton as a first-line weekly thing that we do through 14:49
6 the Splunk report.
7 117 Q. I'll move to that in a moment. In terms of this
8 process, if we go over on to the next page and the
9 context is "New Patients". If we scroll down just
10 towards the bottom of this page, I think there's very 14:50
11 much an emphasis on trying to get staff to act
12 electronically or use electronic means because it's
13 safer and provides, I suppose, an audit trail to prove
14 things are being done when it is said they are expected
15 to be done. 14:50
16
17 Moving down the page a little bit further, is it fair
18 to say that a particular onus or particular
19 responsibility is placed on the secretary in this
20 regime? In other words, it's the secretary who must 14:51
21 keep an eye on things and escalate if his or her
22 consultant is not dealing with the result within the
23 expected timeframe?
24 A. As I said, the first step of the monitoring process is
25 undertaken by myself and Wendy Clayton. All of the 14:51
26 consultant -- indeed all of the team, so nurse
27 specialists as well within Urology use electronic
28 sign-off for their results management. That's our
29 primary mechanism for managing results. Myself and

1 Wendy Clayton, every Wednesday morning, we receive a -
2 for want of a better word - a dump, an Excel file,
3 which contains the details of all radiology results
4 requested by a urology consultant. It goes back six
5 weeks from reporting date. We've written -- I've 14:52
6 written a number of formulae within Excel which then
7 take that data and tabulate it for us and covert that
8 into a red/amber/green table for each consultant of
9 their reporting.
10 118 Q. I think we can look at an example of that just to 14:52
11 illustrate the point. Sorry to cut across you. If
12 we go to TRU-301760. Mr. O'Donoghue will think I'm
13 picking on him but I think there are other examples.
14 Is that what you mean?
15 A. Yes. So this is early -- as we were developing this 14:52
16 process. Early on, as we were moving to electronic
17 sign-off, I started receiving the Splunk report and
18 monitoring. So this is, as you say, the SOP showed
19 earlier was a 2023 date on it as a starting.
20 14:53
21 I generate this red/amber/green printout for each
22 consultant, and it tells me how long a result has been
23 outstanding and awaiting action. This time in
24 particular for Mr. O'Donoghue, I know, is as we were
25 just switching to electronic sign-off for him, so he 14:53
26 was just moving to 100% electronic sign-off, and I can
27 say that I know that now Mr. O'Donoghue is in green
28 every week. We have an escalation process behind that
29 for myself and Wendy. The first thing we do is an

1 escalation letter or e-mail similar to this where
2 we just raise the attention of the consultant that they
3 have fallen into amber. Then if they fall into red,
4 we arrange a formal meeting with them and establish
5 a way we are going to get back to the green. 14:54
6 119 Q. Are you suggesting that, if you like, the mere
7 availability of an overview like this has helped to
8 change the culture?
9 A. Yes. The full table for all consultants we regularly
10 e-mail around so we all know how each other is doing, 14:54
11 and no one wants to be bottom of the table. You don't
12 want to be bottom of the class so it generates
13 a culture whereby everyone keeps on top of things. If
14 you get an e-mail that shows you as an outlier, it
15 changes the way you behave. 14:54
16 120 Q. I just want to better understand the relationship
17 between this process and the policy that I had up on
18 the screen. If you just go back to that. It's
19 TRU-320270. This is setting out, in essence, the
20 relationship between secretary and consultant. Just 14:55
21 over the page, I just draw your attention to this.
22 There's various steps in this process. If a consultant
23 doesn't respond, the secretary does; the next step and
24 the next step and several weeks might pass by. Then,
25 as we can see in the -- and I'm pressing here in the 14:55
26 interests of time, but after a further week of no
27 action, secretary informs the service administrator,
28 the head of service for admin and the head of service
29 for the specialty.

1
2 I suppose the concern I'm putting to you through this
3 policy is that you have the secretary, perhaps it has
4 to have a close working relationship and a cooperative
5 working relationship with the consultant. The onus 14:56
6 seems to be placed on her or him to blow the whistle
7 and escalate, which may not necessarily be an easy task
8 to perform given the need for good working
9 relationships with the consultant. Is that a fair
10 concern to raise? 14:56
11 A. I don't think so because that initial concern, if you
12 like, may simply be that that consultant has been on
13 holiday for two weeks. So, you return from holiday and
14 get told there's these paper results. This is the
15 second stage, if you like, the second monitoring 14:57
16 process. The first line monitoring process is that
17 monitoring of electronic results. If a consultant is
18 signing off all their results electronically, the
19 number of results that are coming through on paper is
20 very few, it is only those that haven't been assigned 14:57
21 to the consultant at the requesting stage. It should
22 be very few results coming through on paper.
23
24 So as I say, this is a second stage, and that working
25 relationship, I think it is maintained there, because 14:57
26 the consultant knows the secretary has to keep an eye
27 on it, but they also know the secretary will come to
28 them first.
29 121 Q. If we look back several years, Mr. O'Brien practised in

1 a way where it would appear to be the case that
2 he didn't always action his results in a timely fashion
3 and was in the habit, perhaps - at least in some cases
4 it is suggested by the evidence - that he would wait
5 until the patient came in on review to look at the 14:58
6 result, and he wasn't a user of the electronic sign-off
7 system. So how do present arrangements guard against
8 that problem?
9 A. So one of the problems we had previously was we didn't
10 know what had been handed to a consultant in paper 14:58
11 form. I think one of the 2015 SAI groups that
12 Dr. Johnson chaired, I think there were a number of
13 letters from an oncology team that had been written to
14 Mr. O'Brien but we had no record as to whether they had
15 ever been received. Part of this is actually recording 14:59
16 when we've got something and when it has been handed
17 over for action and the process behind that, so that
18 we know that action has been undertaken.
19 122 Q. I think if we go to the last page of this document.
20 Yes, it's 73 in the series, the last two digits. 14:59
21 Scroll down, I think. Just scroll down. It's recorded
22 here:
23
24 "Results are not signed off electronically but arrive
25 in paper form. The secretary must scan to the 14:59
26 consultant. Handing a folder over has been proven to
27 be ineffective and increases the risk of a patient
28 being missed for follow-up. By scanning there is proof
29 the results have been sent".

1
2 Is that the point you are making?
3 A. Yes, that's the point I'm making. We need to know what
4 has been given to someone and when it has been given
5 and when we have received it back. This is what this 15:00
6 is aiming to have as a process.
7 123 Q. Let me move through a number of the other specifics
8 that arise out of those SAIs. The key worker or the
9 nurse specialist, we didn't ask you on the previous
10 occasion about your engagement with key workers and how 15:00
11 well you used them within your practice prior to the
12 2020 SAIs. You know the problem as presented by the
13 SAI reviews was that Mr. O'Brien did not, across the
14 nine cases, use a key worker or apply a key worker to
15 those patients. The point he has made is that 15:01
16 he didn't exclude key workers. He points to the
17 operational policy for the MDT which suggests it is
18 somebody else's responsibility to allocate the key
19 worker.
20 15:01
21 Had you any experience, directly or indirectly, of
22 those key workers not being used by Mr. O'Brien within
23 his practice?
24 A. Had I experienced him?
25 124 Q. Had you observed that as a problem? 15:02
26 A. I don't know because I know what I know now; I can't
27 recall what I didn't know then. I know from my own
28 practice, I don't recognise that view that it's someone
29 else's job to assign a key worker. I know when I did

1 clinics, even though we didn't have someone able to sit
2 in clinic with us, I would, either before I started
3 clinic, go through my clinic list and identify to the
4 nurses in clinic which patients were going to require
5 a key worker or, as often has been touched on, I get up 15:02
6 early, I would e-mail in the morning the patient list
7 to the nursing team with the likely requirements of
8 that patient group, not only key workers but also if
9 they were likely to need additional tests while they
10 were in clinic. 15:02
11 125 Q. One of the more recent features, I think you've
12 mentioned it earlier, is that there's been further
13 recruitment and a greater number of key workers
14 available to the service than there was historically.
15 Might the shortfall, if it was a shortfall, in the 15:03
16 number of key workers available in 2018, 2019, 2020,
17 might that explain any difficulty which Mr. O'Brien
18 might have experienced in linking a key worker to
19 a patient?
20 A. That same shortage would have applied to me and my 15:03
21 colleagues. It didn't stop me from letting the team
22 know whether a patient required a key worker input.
23 126 Q. What did you see was the value or the benefit for the
24 patient, or perhaps indeed yourself as a practitioner,
25 in bringing a key worker or providing the circumstances 15:03
26 in which a key worker could link with a patient?
27 A. For me, one of the most important things is we know
28 that patients don't retain all information given to
29 them at the time of a consultation. It's why I've

1 always copied my letters to the patient, so that they
2 have that information as well. But we know that
3 patients get home, they have other relatives, other
4 family members who they speak to and questions always
5 arise. I'm not available on the phone to answer them 15:04
6 questions. That's what a key -- you know, a major part
7 of the key worker is that role. It's also the
8 navigator through their care.
9
10 Inevitably, and my dad told me this once, the worst bit 15:04
11 of being a patient is waiting. In between visits, you
12 are waiting for the next thing. Inevitably after
13 a period of time, patients will develop some anxiety
14 and they need to be able to contact someone to see
15 where things are at. The key worker can do that. 15:05
16
17 Additionally, there's a safety net aspect for
18 ourselves, for me as a practising clinician.
19 Practising clinicians are busy; there will always be
20 occasions where you overlook something. Say on an 15:05
21 electronic requesting of a scan, you don't allow it to
22 go through and it doesn't register. With a key worker,
23 they can actually come back to you and say this patient
24 asked about their scan and actually I've had a look and
25 it doesn't seem to have gone through, can you do it 15:05
26 again. So, you do. So there is a safety net aspect
27 for me as well.
28
29

1 That safety net aspect extends to the MDT outcome as
2 well. If I've done something different to the MDT
3 outcome, the key worker might raise -- say the MDT
4 outcome says to request a CT and a bone scan and
5 I've neglected to request a bone scan, the key worker 15:06
6 can highlight that to me. There's a better chance of
7 it being recognised.
8 127 Q. Let me take you back to the summary of the
9 improvements, the report from December 2022 which we
10 were on a few moments ago. TRU-303589. Just at the 15:06
11 bottom of the second half of the page, I should say, as
12 I highlighted earlier there are now a series of reports
13 directed to the role of the key worker, essentially
14 providing for assurance that those key workers have
15 been identified and, if appropriate, appointed and 15:06
16 contact made with the patient, and then involved with
17 every confirmed cancer case. Is that something that is
18 now implemented within Urology to the best of your
19 knowledge?
20 A. Yes, to the best of my knowledge that is all 15:07
21 implemented. I think there is an aspect to it that was
22 required for the monitoring, for ease of monitoring,
23 that required some regional input on the CAPP system,
24 the cancer -- the computer system that's used for
25 recording the cancer patients. The actual, the 15:07
26 physically doing it and auditing it and recording it is
27 all being done.
28 128 Q. Yes. Just some of the other aspects of reportage and
29 auditing of the processes. Attendance and quoracy is

1 recorded on a weekly and monthly basis. I'm not sure
2 if that's any different from the historical position
3 because we have statistics available to us showing
4 shortcomings of quoracy over many years. It is the
5 quoracy issue itself I wish to ask you about. The 15:08
6 problem historically has been oncological and
7 radiological attendance leading to situations where
8 MDTs have to be -- or consideration of particular
9 patients at MDTs have had to be postponed, or
10 workarounds have had to be developed. 15:09
11
12 Has the quoracy situation improved at all?
13 A. Significantly. The issue previously, as you highlight,
14 was down to oncology and radiology were our biggest --
15 most difficult areas, with a single radiologist and 15:09
16 a single oncologist. From a radiology perspective, we
17 are in a position where we have three radiologists
18 attending currently, so I don't recall over recent
19 times not having a radiologist present. Pathology
20 cross-cover is always provided. From a urologist 15:09
21 perspective, if there aren't two of us available -
22 which is the quoracy number - we don't proceed with an
23 MDT that week. From an oncology perspective, it's
24 dramatically different. We have two medical
25 oncologists who attend regularly. One of them is the 15:10
26 Clinical Director For Cancer Services in Southern Trust
27 as well. Our only remaining area of weakness is
28 we have a single clinical oncologist and so we don't
29 have cover when our colleague is off on annual leave or

1 sick leave. But we're in a much, much better position
2 than we were historically.
3 129 Q. The next issue on this list is now - again we touched
4 on it briefly earlier - audits performed to confirm
5 that actions agreed by MDT were implemented. Is that 15:10
6 something that is now embedded within Urology?
7 A. Yes.
8 130 Q. I suppose the mischief that this audit was intended to
9 correct was the situation that we saw with some of the
10 2020 SAIs; Patient 1, for example, where the 15:11
11 recommendation from the MDT was hormones and referral.
12 I simplify that, of course. That wasn't implemented
13 and there was no report back to the MDT to say it
14 wasn't implemented. Despite disease progression,
15 urinary retention in March of the previous year, the 15:11
16 case still didn't come back to the MDT and, of course,
17 there wasn't in place a key worker so there was no
18 safety net.
19
20 Tell me about how the audit works in practice and how 15:12
21 quickly does the MDT Chair, or whoever the responsible
22 person is, become aware of any disconnect between the
23 MDT recommendation and the clinician's action?
24 A. So the audit is done on a monthly basis. Where there
25 are, if you like, discrepancies, where there's an 15:12
26 outcome or a query regarding the outcome, it is raised
27 first-off with the clinician themselves. As I
28 mentioned earlier, there may be a simple oversight or
29 failure of the requesting process that means something

1 hasn't been requested, or it may be that the clinician
2 has forgotten to bring the patient back to MDT when
3 they've changed it, so it allows for the clinician to
4 actually look at it and bring it back if required. But
5 if there's no action, then my understanding is that 15:13
6 that is then escalated to the MDT Chair to bring it
7 back to the MDT.
8 131 Q. It may be an unusual situation or an exceptional
9 situation but is there a way of, I suppose, challenging
10 the correctness or the merits of the reasoning that 15:13
11 might be articulated by a clinician who is saying that
12 he does not wish, or the patient does not wish, to
13 follow the recommendation?
14 A. So the commonest situation we've had - and from memory
15 it has not been this process that brought the patient 15:14
16 back to MDT, it has been the clinician who has brought
17 the patient back to MDT - has been where the patient's
18 wishes are different to those that have been put or
19 recommended by the MDT. Where you have that
20 consultation taking place with the clinician and the 15:14
21 Clinical Nurse Specialist, and you have in that
22 well-counselled patient they are making an effective
23 decision to go with a different plan, it is very
24 difficult to change a patient's decision when they've
25 made a reasoned judgement themselves. We haven't had 15:14
26 to challenge a clinician, saying I think we should do
27 something different.
28 132 Q. The final point on this list I wish to deal with is the
29 concern that was exhibited, I think, in one of the nine

1 SAIs about a result known to the pathology lab that
2 there was a confirmed cancer, but not then known to the
3 MDT, but was known to the clinician, that is
4 Mr. O'Brien, but not actioned, so that the case sat
5 with a positive cancer result and there was delay in 15:15
6 follow-up. Is that the mischief that this arrangement,
7 a cross-check mechanism with the laboratory, is
8 designed to address?
9 A. Yes. So the MDT process requires someone to initiate
10 the addition of the patient to the MDT. For Urology, 15:16
11 there's an electronic form for that MDT addition. That
12 cross-check is so that if there is a patient with
13 a cancer on biopsy who has not been added to the MDT by
14 the clinician, that patient will be brought to the MDT.
15 133 Q. Thank you for that. 15:16
16
17 Overall, taking into account your experience of working
18 within this MDT before 2020 and knowing the environment
19 now in light of these changes, how would you
20 characterise the improvements? Has there been 15:17
21 meaningful progress and is it a safer environment for
22 your patients?
23 A. I think there has been significant progress. It's
24 a safer environment for patients. It's also an
25 environment where we as clinicians feel safe. We know 15:17
26 that there are processes to make sure that everything
27 is happening as it should be.
28 134 Q. Can I turn to some other clinical aspects that captured
29 the attention of the Panel through the evidence. There

1 have been a number of cases where, in the context of
2 inadequacies in the preoperative assessment to process
3 where it might be said the consent of the patient
4 wasn't adequate -- I'll pull up one example. It
5 experience Patient 90, which was - if you recognise the 15:18
6 name, perhaps -- a case where Mr. O'Brien was the
7 presiding surgeon, the patient died shortly after
8 theatre. We can see the recommendation of the SAI,
9 which can be found at TRU-161146. Actually, if we just
10 scroll back before we get to... Scroll back to the 15:18
11 page before that, if you would. Thank you.
12
13 Under the heading "Consent", the review panel was
14 unable to find documentation of detailed discussion of
15 individual risks based on his comorbidities in the 15:19
16 medical notes. Just scrolling to the last paragraph in
17 that section:
18
19 "He did not have a full outpatient preoperative
20 assessment which would have identified all his 15:19
21 individual anaesthetic risks to be assessed and
22 discussed with the patient to ensure informed consent".
23
24 We have seen another example, I don't need to go to it,
25 the case of Patient 91, which I think you're familiar 15:20
26 with. It wasn't one of Mr. O'Brien's cases but it was
27 a stent replacement operation where the patient died
28 because there hasn't been an adequate preoperative
29 assessment to assess the need for a midstream urine

1 test or toxicology test. We can see at recommendation
2 2:
3
4 "All patients undergoing elective surgery must have
5 a formal preoperative assessment completed prior to 15:20
6 surgery".
7
8 It goes on in recommendation 3:
9
10 "Discussions regarding the risks and benefits of 15:20
11 surgery must be clearly documented in the record and
12 reflected on the patient consent form to ensure
13 informed consent".
14
15 So, the two issues link. 15:21
16
17 Help us with this, Mr. Haynes. Would you, in your
18 experience, appreciate that there are problems in the
19 area of preoperative assessment and consent within the
20 service that you work, or do you consider these kind of 15:21
21 cases to be fairly isolated?
22 A. In terms of preoperative assessment, obviously these
23 two cases highlight patients where that preoperative
24 assessment hadn't taken place. Certainly, in my
25 practice, I would never intentionally operate on 15:22
26 someone who hasn't undergone preoperative assessment.
27 Indeed, the position where we are now with a scheduler
28 planning the lists is such that those patients have to
29 have been passed preop fit before they can go on to

1 a list.
2
3 Like any other service, the preoperative assessment
4 service is challenged for capacity. From memory, the
5 second patient you mentioned, Patient 91, did have 15:22
6 appointments for preoperative assessments but missed
7 them because they were an in-patient, and that hadn't
8 been recognised when the patient was sent for theatre.
9 There was an oversight, if you like, because the
10 patient had an appointment but just hasn't been. 15:22
11
12 In terms of this Patient 90, he was having major
13 surgery. Certainly in my own practice, I would never
14 take someone to major surgery without them having
15 a preoperative assessment. Even in an emergency 15:23
16 situation, patients get assessed by an anaesthetist
17 prior to attending the emergency theatre, and there's
18 a discussion where that patient carries a high risk and
19 the anaesthetist will ask the question does it need to
20 go now or can we optimise in whatever way possible? 15:23
21
22 With regard to consent, it would be naive to say any
23 service or any individual can't improve their
24 consenting process and documentation of consent.
25 Indeed, if we were to look at the medico-legal input 15:23
26 into any Trust, we'd find that consent is probably the
27 single biggest factor that arises to claims.
28
29

1 In terms of how we all practice, we would all give
2 patients standardised information sheets at the time of
3 adding to the waiting list for surgery. We would all
4 document that decision in terms of why they've gone for
5 that operation and the risks that have been discussed 15:24
6 and the alternatives that have been discussed. We
7 would look to document that on the consent form as
8 well. We have had an audit of consent done within our
9 audit programme --
10 135 Q. We can see that. The Panel may not be familiar with 15:24
11 it. It is to be found at TRU-320280. This was an
12 audit performed. It is described as a two-stem audit,
13 so it's looking at, as it says there, consent in those
14 two particular procedures.
15 15:25
16 As we can see at TRU-320925, I think you would accept
17 it is probably a fairly narrow audit, looking at two
18 procedures. If we go to TRU-320295, it gave the
19 clinicians taking consent from patients a relatively
20 good score, if you like. The standard being applied 15:25
21 was the Royal College of Surgeons STARR checklist, the
22 BAUCS guidance, and the other measurement used was the
23 Trust's consent form. It's saying:
24
25 "Most parameters are excellent but significant room for 15:26
26 improvement can be achieved in writing down the
27 intended benefits of consent forms".
28
29 I suppose the question comes to this: This is useful

1 evidence but has there been any initiative, in light of
2 some of the cases that we are aware of, two
3 particularly catastrophic cases, where consent was an
4 issue, preoperative assessment was an issue; has there
5 been any particular initiative within the Trust to try 15:26
6 to remove these risks and improve performance or at
7 least improve awareness around the risks of proceeding
8 in circumstances that are less than optimal?
9 A. First of all, just on the audit, as you say it is
10 limited. It's an audit of the completion of the 15:27
11 consent form at the time of the signing of the consent
12 form, not the whole consent process.
13
14 In terms sort of that consent piece, there is a piece
15 of work that I am engaged with along with a colleague 15:27
16 who's working alongside the litigation team with the
17 Medical Director's office, and that's around improving
18 our documentation across teams of that consent process.
19 Also looking at improving some of the communication
20 strands that have come back in terms of -- I can't 15:27
21 remember, I think it was a piece of work for the
22 Department of Health or somewhere, where it looked at
23 patients' awareness of waiting times and communication
24 from Trusts that was done in Northern Ireland. Looking
25 at how, when we add someone to a waiting list, we can 15:28
26 provide patients with detail about what they have been
27 added to the waiting list for, detail of all of their
28 risks, but also information about current waiting times
29 and things. I know, because I seen it over lunchtime,

1 that a draft is there of a standard aspect of a letter
2 for that purpose. That piece of work is ongoing.
3
4 The preoperative assessment team are engaged and
5 clinically led to try to improve that position. As 15:28
6 I've said, within our service our theatre scheduling is
7 done by our scheduler, so where patients haven't been
8 through preoperative assessment, they are not added, or
9 an active decision needs to be made and is made in
10 communication between an anaesthetic team and 15:29
11 a surgical team as to whether it is reasonable to
12 proceed without it. Invariably the answer to that is
13 no.
14
15 I think the position is there. There is ready access 15:29
16 to additional, if you like, enhanced anaesthetic
17 assessments with physiological testing, so CPX testing
18 where we can give, for patients who are having more
19 major surgery, and they do get, a very personalised
20 assessment of their risks of undergoing that major 15:29
21 surgery.
22 136 Q. Can you ask you briefly, just finishing on this aspect
23 of clinical aspect shortcomings, triage and the area of
24 dictation following reviews or clinical episodes.
25 Taking them together, what work has been done to better 15:30
26 keeping a check on those and escalating those issues if
27 there are shortcomings?
28 A. So triage is part of that dashboard that I mentioned
29 earlier that we get. So we get along or within that

1 dashboard detail of triage and time scales for triage.
2 There is a data limitation within how that's obtained,
3 which means that the time scales applied can be
4 complicated by factors like a patient needing
5 registration or the referral going to another Trust 15:30
6 first before being redirected, because the time scale
7 is from the point at which the GP presses refer, not
8 the point at which it is passed to the consultant for
9 triage. So there is a limitation in that but it is
10 monitored and there is an escalation process. 15:31
11
12 I neglected to mention earlier when we talked about
13 results but it applies to the dictation and the triage
14 as well. We also have an in-person interface meeting
15 where myself, the head of service, our manager for our 15:31
16 admin and support team, and our Cancer Services manager
17 meet on a monthly basis and run through the performance
18 across the team looking at triage, looking at
19 dictations, looking at results management, and if any
20 other things need to be brought up. You mentioned 15:31
21 earlier is it fair for a secretary to be the one who
22 contacts the consultant first. It is not only the
23 secretary that does it, it would come to that meeting
24 as well.
25 137 Q. You spoke on the last occasion, and indeed in real time 15:31
26 you were speaking to Dr. O'Kane about the shortcomings
27 of the backlog reports that were being utilised to
28 monitor Mr. O'Brien. In general, I think you expressed
29 the view that they would perhaps give the uneducated

1 a false impression of what was outstanding. In
2 a nutshell, you might get a report through the
3 secretary that there's no dictation pending but, in
4 fact, that's only because the dictation hadn't been
5 performed. I think that was the problem you were 15:32
6 pointing to. Has that concern around backlog reports
7 been addressed?
8 A. That forms part of that monthly meeting, the discussion
9 of the backlog report. At the outset, as
10 we established that meeting, one aspect -- to me the 15:33
11 most important aspect is understanding for everyone
12 involved what data is being collected and how it is
13 being collected so that we get consistency in how it is
14 reported, so we can see that. That guidance to the
15 secretarial team in terms of how they collate that data 15:33
16 and what the purpose of that is for has been
17 communicated to them. I'm much happier that not only
18 is the data produced reliably but also the way it is
19 produced, and the limitations - because everything
20 we collect has limitations - are recognised by the team 15:33
21 as we analyse it and understand it.
22 MR. WOLFE KC: Thank you. Chair, I would be
23 particularly keen to finish, I'm sure Mr. Haynes would
24 be particularly keen that I finish his evidence today.
25 I probably have another hour, looking at my speaking 15:34
26 note. I'm sure you have questions. I'm conscious of
27 the stenographer as well. Should we take a short break
28 now?
29 CHAIR: We will take a break. I take it that everybody

1 is happy to go on beyond five o'clock? Very well, come
2 back then at 3:50.
3
4 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
5 15:34
6 CHAIR: Thank you, everyone.
7 138 Q. MR. WOLFE KC: I want to finish this afternoon,
8 Mr. Haynes, by looking at the area of developments
9 within the service and performance against the
10 background of the demand capacity shortfall that you 15:47
11 described at your last attendance.
12
13 Just before we get to that, and briefly, just a final
14 thing in the whole area of patient safety and
15 improvement. I want to ask you about clinical audit 15:47
16 and whether the Trust has been able to extend to the
17 Urology Service better support and is there a greater
18 appetite for audit than perhaps there was during a
19 financially straitened era at the tail end of the last
20 decade.
21
22 Can I start by perhaps looking at TRU-320279. This is
23 the Urology Division Annual Clincal Audit Programme for
24 the current year. It's a midyear update from a few
25 months ago. It sets out a number of National Audits
26 which are bracketed in green at the top and then other
27 forms of internal audit and divisional audit.
28
29 In broad terms, have you detected increased support for

1 audit in recent times or has there not been any
2 identifiable change?
3 A. It's a huge change. So we have a member of staff from
4 the audit team assigned to urology for audit purposes.
5 She attends our Patient Safety meetings with us. She's
6 constantly in communication with us with regard to the
7 ongoing audit projects and, indeed, just yesterday was
8 in contact with me about -- I think it's one of them on
9 there or it's one that's on the current one. It's one
10 of the ones through BAUS. It is there. It's the top
11 one.
12
13 So it's a much greater engagement and it's led to a
14 massive improvement through the audit programme that we
15 undertake in the team. As you say, what we have there
16 is multiple levels of priority in terms of the
17 department for audit, and they go down from "external
18 must dos", down to "for interest", if you like, audit.
19 The findings are presented at our Patient Safety
20 meeting by our trainees. They have presented at our
21 regional audit meeting for urology as well, and I know
22 the trainees are looking at -- where appropriate,
23 they're looking to put their projects in for
24 presentation at national meetings as well.
25
26 [Technical pause].
27
28 CHAIR: I think it might be better if we just sit on --
29 hopefully you can do it quickly -- rather than rise

1 again.
2
3 MR WOLFE KC: It's called technology Tuesday for
4 a reason.
5 CHAIR: It used to be Tuesdays but it's obviously 15:55
6 getting tired, moving to Thursdays!
7 139 Q. So, you were presenting roundly a fairly positive,
8 certainly a picture of progress in terms of the
9 appetite and the support for clinical audit. In terms
10 of, I suppose it may not have happened yet, but if an 15:55
11 audit produces evidence of shortcomings in practise,
12 whether it's risk, patient risk or whether it's
13 shortcomings in the way that things are being
14 performed, are you confident that there is a process
15 within the Trust that listens to that and embraces that 15:55
16 with a view to facilitating service improvement?
17 A. Yes. But I'd add the caveat; where it's able to be
18 delivered. And as an example of that I'd give one of
19 the standards within one of the audits there which is
20 the NICE bladder cancer management. So, within there 15:56
21 is an audit standard which has a specific timeframe for
22 a surgical procedure. I know from that audit that most
23 of those patient day cases, for which that standard was
24 relevant for, failed to meet that six-week standard
25 because we don't have capacity to deliver that 15:56
26 standard. So, where there's that sort of challenge,
27 well, it's very difficult to rectify it. Where the
28 standard is achievable and deliverable then, yes, there
29 is support to deliver that change and re-audit to

1 demonstrate delivery of that change.
2 140 Q. Can you think of any example of where that has
3 manifested itself?
4 A. We haven't got into that point through these audit
5 cycles to be able to give you an exact example. 15:57
6 141 Q. Let me turn to that other aspect of your improvement
7 role that you listed for us just before lunchtime.
8 I think you used the term "performance". I think
9 elsewhere you talk about development of services and
10 we know from your evidence on the last occasion that 15:57
11 you were particularly concerned about the demand,
12 capacity, shortfall. We've seen and we've been over
13 the detail of the paper that you put together for
14 purposes of the HSCB in 2014 concerning resources and,
15 in particular, the need to improve nursing recruitment, 15:58
16 theatre provision and that kind of thing.
17
18 We can observe from the papers that were on your
19 disclosure bundle that in terms of resource
20 improvements, there have been some in recent times, so 15:58
21 two new cancer specialist nurses appointed, three new
22 consultants recruited internationally, one I think
23 about to take up his position, isn't that right?
24 A. Yes.
25 142 Q. And two to come in in the course of this year. 15:58
26 Additional trainee numbers is something that's being
27 discussed through PIG. A recent appointment of
28 a radiographer to the ESWL service. So, there have
29 been some resource improvements on the ground, is that

1 fair?
2 A. Yeah, all those you highlighted, and outreach delivery
3 of surgery. So, one of my colleagues who does renal
4 cancer surgery in Belfast comes out to Southern Trust
5 and does two half-day theatre lists and two half-day 15:59
6 clinics a month.
7 143 Q. That's Mr. Connolly?
8 A. No, that's Mr. Evans.
9 144 Q. Mr. Evans.
10 A. Mr. Connolly also outreaches, that's part of the 15:59
11 regional complex stone surgery service, which is also
12 being delivered in Southern Trust.
13 145 Q. Okay. In addition to that in the context of meeting,
14 I suppose, both a local and a regional waiting list
15 problem, we've seen developments both at Daisy Hill and 16:00
16 Lagan Valley Hospital in order to try to improve
17 capacity. Is that fair as well?
18 A. Yeah. So, for urology across Northern Ireland,
19 Lagan Valley and Omagh Hospital, regional day procedure
20 units have been developed and the breadth of procedures 16:00
21 delivered as day cases has been enthusiastically
22 expanded by the urologists. So, procedures that maybe
23 ten years ago would have been done as in-patients are
24 being delivered as day cases on patients who are fit
25 for. Similarly, Daisy Hill offers us the additional 16:00
26 option of an overnight stay. So that allows for,
27 perhaps, slightly more complex surgery or slightly less
28 fit patients to undergo surgery. And them surgical
29 centres are ringfenced. There's no issue of emergency

1 admissions coming in and taking up the beds for them
2 patients. It does leave the problem of the patients
3 whose either not fit for them environments or procedure
4 isn't suitable for them environments, we still have
5 that challenge in having to deliver in-patient care. 16:01
6 But it has taken a large amount of patients away from
7 the in-patient site and able to have their surgery
8 safely delivered in these high volume, I think high
9 volume, low complexity centres, I think they're
10 determined. 16:01
11 146 Q. The Panel may have detected from your evidence on the
12 last occasion, as I say, 15/16 months ago, perhaps an
13 air of despondency on your part about the state of the
14 urology services in Northern Ireland, particularly in
15 the context of these burdensome waiting lists. Are 16:02
16 you, because of recent developments, slightly more
17 optimistic that things are being tackled in a strategic
18 way and, if so, what is that strategy and what grounds
19 do you have for optimism, if I've detected your mood
20 change accurately? 16:02
21 A. So, the development of the elective centres is a
22 significant development and Daisy Hill, The Mater as
23 well in Belfast has also been developed as a 23-hour
24 overnight stay centre as well. So, that has increased
25 the capacity for the teams. The approach through the 16:02
26 PIG team, through the PIG meeting in terms of looking
27 at things regionally I think is a very positive thing.
28 We are, effectively, using Lagan Valley as a region.
29 So patients, although presently I suspect most patients

1 have their operation by a consultant from their
2 host trust, it is a single list that patients are added
3 to in Lagan Valley. So, that's beneficial.
4
5 The approach of specialist services being delivered 16:03
6 outside of Belfast is a very positive one as an
7 attractant for consultant urologists. So, having the
8 complex stone service in Southern Trust means that
9 people who are interested in wanting to deliver that
10 surgery will be able to be attracted to Southern Trust. 16:03
11 And similarly, with the penile cancer service up in
12 Altnagelvin attracting up there. The approach we've
13 taken with Belfast Trust, with Mr. Evans supporting the
14 service in Southern Trust also strengthens the team and
15 that in and outreach, or that single renal cancer team 16:04
16 approach for Northern Ireland is recommended in the
17 Northern Ireland GIRFT report, but it was already
18 developed at the time of that. It's something
19 we proactively sought to deliver within Northern
20 Ireland. Indeed, our colleague who works in 16:04
21 Altnagelvin comes into Belfast and works with us as
22 well. So, that cross-Northern Ireland approach is much
23 better. We're still faced with the same challenges of
24 a long waiting list, and that is going to still be
25 a challenge, particularly for those patients requiring 16:04
26 in-patient surgery. If you like, there's still
27 a mountain ahead of us before we can get to a point
28 where things are at a stable position.
29 147 Q. So, in terms of waiting lists, where are we seeing the

1 movement? Where is the progress?
2 A. So, one of the impacts there or one of the things that
3 has impacted there has been a proactive investment by
4 SPPG in independent sector outsourcing of new patient
5 referrals. So, if you like, it's slightly turned off 16:05
6 the tap. So, if a number of new patient referrals into
7 urology are being managed in the independent sector, it
8 reduces the number of new additions to our waiting list
9 and enables us to be able to tackle some of the
10 backlog. There has also been investment in procedural 16:05
11 independent sector outsourcing. So, for instance,
12 patients with catheters in awaiting a TURP had some
13 outsourcing to independent outsourcing providers in the
14 Republic of Ireland which enabled us to bring down our
15 waits for them patients. There have been initiatives 16:06
16 which have helped from that perspective.
17 148 Q. Is what you've described part of a recognisable
18 strategy or is it a series of clever initiatives,
19 perhaps initiated locally within each Trust and then
20 brought regionally for approval? Is there a sense that 16:06
21 you're working within a more global strategy that has
22 clear aims and objectives?
23 A. So, they're not individual plans that are kind of
24 piecemeal together, they do all come through the same
25 group, through the PIG meeting and have all of that 16:06
26 sort of regional collaborative approach. Inevitably,
27 there are going to still remain challenges and we know
28 where the financial position with Northern Ireland has
29 been and my understanding is that independent sector

1 outsourcing was stopped in December, so we're in a bit
2 of a hiatus at the minute. And that's been stopped but
3 we're not in a position, yet, where we can provide for
4 everything that's coming in.
5 16:07
6 Additionally to that, there have been some things which
7 have had the opposite effect of what I've just
8 described. One example I would give of that is
9 a decision that was made to -- I think it was
10 temporarily stop funding primary care provision of 16:07
11 vasectomy services. And that meant that patients now,
12 who would have been referred to primary care to have
13 a vasectomy are now being referred into secondary care
14 because there isn't an option anywhere else. So,
15 that's adding to our demand, so that creates 16:08
16 a challenge for us.
17 149 Q. We've looked at some of the resourcing improvements
18 that no doubt help to address the capacity issues or
19 the demand issues, I should say, but it's not just
20 about resources, is it? Has there been discussion, 16:08
21 whether within your Trust or regionally about working
22 differently, working more efficiently, using scarce
23 resources in other ways?
24 A. Yeah. As you say, that's all -- capacity is only one
25 end of it. If we look at an outpatient resource, we 16:08
26 have to change the way we deliver care and move away
27 from, if we like, historic practices where patients
28 were followed up in person ad infinitum. Active
29 encouragement of virtual follow-up pathways rather than

1 in-person pathways; active encouragement of early
2 discharge; and patient initiated follow-up initiates,
3 patient initiated follow up, there is a regional task
4 and finish group that's started that I'm sitting on
5 from that perspective. 16:09
6
7 Then there's looking at who's delivering care. So does
8 every patient need to be seen by a consultant?
9 Ultimately, the answer is no. And within
10 Southern Trust we have developed the skill set of our 16:09
11 nurse specialists to deliver a large amount of new
12 patient consultations, the biggest group being men with
13 urinary systems, also for hematuria services,hematuria
14 referrals. We've also developed our nurse specialist
15 skills beyond that. So, our prostate biopsies are all 16:10
16 delivered by our nurse specialists. Our Botox
17 treatments, our urodynamics, they're all delivered by
18 nurse specialists. We have follow-up pathways for
19 renal cancer follow-up and for prostate cancer
20 follow-up that are delivered by our nurse specialists. 16:10
21 If we look at the Northern Ireland GIRFT report for
22 Southern Trust and compare it to the other trusts in
23 terms of what's delivered by our nurse specialists, our
24 nurse specialists are delivering more services than
25 elsewhere and the GIRFT report has encouraged that 16:10
26 expansion of delivery.
27 150 Q. I think we can see that, just maybe if we can
28 illustrate that point, if we bring up DOH-72326. Down
29 on the next page perhaps. That's the raw numbers at

1 the bottom of the page, the raw numbers of nursing
2 staff that are employed across the Trusts.
3
4 Then if we go over the page, is this what you're
5 referring to? 16:11
6 A. Yeah.
7 151 Q. We can see along itself left-hand column, the roles or
8 the services. Then the Southern Trust is providing
9 many of those services. A no against flexible
10 cystoscopy. 16:12
11 A. That's a no against TULA, so that's transurethral laser
12 ablation that nowhere in Northern Ireland have, but
13 there has been investment in that, the device required
14 to deliver that. And we have a training plan for nurse
15 specialists to deliver that. 16:12
16 152 Q. Yes. Your point being that more can be done if you
17 think beyond the scarce resource of the consultant, if
18 you up-skill your workforce by the deployment of
19 specialists nurses.
20 A. Yeah. 16:12
21 153 Q. That's a useful way to proceed.
22 A. And the physician associates. We have a physician
23 associate who's worked with us for the last couple of
24 years, and we're looking to develop her role with in
25 the delivery of this. We've also recently interviewed 16:12
26 for a second physician's associate. So, expanding
27 beyond, if you like, traditional roles to use staff
28 groups to deliver care.
29 154 Q. To what extent has consideration been given to using

1 data to more accurately or perhaps more intelligibly
2 understand how you and your colleagues practise to see
3 if, if you like, savings or improvements can be made
4 there?
5 A. I would love to be able to have update live, if you 16:13
6 like, live performance data for the team but,
7 unfortunately, the data collection coding time scales
8 for Northern Ireland are not sufficient to give me that
9 information.
10 155 Q. You talked on the last occasion, albeit briefly -- 16:13
11 perhaps it's -- sorry, I think it is perhaps just in
12 your statement and we haven't picked up on it with you
13 yet. You explain - and this is at WIT-53899 - that
14 quantitative data has not historically been used in the
15 performance management. This is at 31.3. You see it 16:14
16 there. You're now working to incorporate some
17 quantitative performance management reports into the
18 job planning process in your role as AMD. Has that
19 come to fruition since you were last with us?
20 A. I think that's qualitative. 16:14
21 156 Q. I hoped you were going to say that.
22 A. So that's really looking at outcomes. If we look
23 across the water and we look at NHS England, what was
24 done previously through BAUS looking at major procedure
25 outcomes, and that data was collected by self-entry by 16:15
26 the clinicians, that has been taken over and is now
27 collated centrally through the coding and what becomes
28 the hospital episode statistics. We don't have that
29 ability to collect that data at present. So

1 historically we were put in a position where
2 we couldn't input our data into that, say the
3 nephrectomy audit to monitor outcomes. We're now in
4 a position where the HES data is being used in England
5 and we don't have an equivalent option that can collect 16:15
6 and risk balance our patient cohorts.
7
8 What I mean by that is if we look at my kidney cancer
9 surgical practice in Belfast Trust, if you took a crude
10 look at my length of stay and my complication rate, you 16:16
11 would see me as a dramatic outlier to my two colleagues
12 in Belfast Trust. If you looked at the case type,
13 you'd see that they do almost solely laparoscopic and
14 robotic procedures which are on a lower risk end, and
15 most of mine are open procedures for much higher risk 16:16
16 cases. So we haven't got the data to allow us to
17 outcome monitor our surgical practice.
18 157 Q. Is that an aspiration as set out that hasn't been
19 fulfilled to date?
20 A. Yes. 16:16
21 158 Q. I suppose in the way that you described it earlier,
22 greater communication within the team, a greater sense
23 of respectful challenge which is, as you portrayed it,
24 now an accepted way of working and doing business, is
25 there an argument that peer-to-peer challenge can help 16:17
26 to drive improvements in the way that you work so that,
27 again, that might have some positive effect on how
28 patients are managed and possibly some positive effect
29 on waiting list efficiency?

1 A. Of course. Peer-to-peer challenge, peer-to-peer
2 discussion, we all want to improve what we're doing and
3 we're always looking to improve how we deliver care.
4 159 Q. If these discussions are happening, do you find
5 a supportive environment within the Trust to drive 16:17
6 service improvement?
7 A. If we look at service improvements in our stone
8 service, for example, we've been very supported both by
9 the Trust and SPPG as we look to deliver the
10 lithotripsy service, so the outpatient treatment, as we 16:18
11 look to develop the virtual service with the regular
12 stone meeting, and as we look to bring that regional
13 way of working for patients. So the in-reach of.
14 Mr. Connolly, Mr. Thompson is in-reached as well.
15 We have been very supported in delivering that by both 16:18
16 the Trust and the regional groups.
17 160 Q. I want to finally touch upon the GIRFT Report. It
18 published in November of last year a series of,
19 I think, totalling 40 national recollections is the
20 phrase that's particular to the Department. So far as 16:19
21 the Southern Trust is concerned, we can see, just to
22 bring it up on the screen, DOH-072344. While we're
23 waiting with that, I'll say it sets out 18
24 recommendations for the Southern Trust. Those
25 recommendations, Mr. Haynes, break down into workforce 16:20
26 issues, facilities issues, outpatients and diagnostics,
27 oncology, urgent and emergency care, and specialist
28 services and outpatient care.
29

1 It appears we're not able to bring these
2 recommendations up. We have a spreadsheet which shows
3 the progress being made using a RAG status approach,
4 TRU-320313. A number of the recommendations are
5 already in play and some will be implemented in the 16:21
6 course of this year. Could you help us, Mr. Haynes, in
7 terms of what's emerged from the Getting It Right First
8 Time analysis, do the kinds of recommendations coming
9 through that present challenges to the Trust or are
10 they broadly to be welcomed by you and your colleagues 16:21
11 working within Urology Services?
12 A. Broadly welcomed. The clinicians, through the PIG
13 Group, were all in support of the Northern Ireland --
14 the GIRFT assessment across Northern Ireland. Many of
15 us, and recent actions are in green for some of them, 16:22
16 or well underway, because prior to the inspection GIRFT
17 have issued over the last number of years a number of
18 reports into individual aspects of urological care,
19 which we'd already set about delivering care alongside.
20 There was a GIRFT report in delivering care for stone 16:22
21 patients which we'd already set about delivering care
22 according to. Indeed, one of the audits on the
23 previous document was against the standards or the
24 recommends within that document.
25 16:22
26 There's one for bladder outflow obstruction.
27 Similarly, we'd already taken aspects of that and
28 instigated them into part of our service. And our
29 kidney cancer one. So in many respects --

1 161 Q. Are you saying it is almost giving the --
2 A. It is supporting the direction of travel we wanted to
3 go.
4 162 Q. -- what you are seeking to do.
5 A. Yes. 16:23
6 163 Q. Sorry. We can work through some of these. Perhaps if
7 we scroll up, I think the recommendations are
8 summarised onto this sheet from the report, and we can
9 see some of them. We don't have the time, perhaps, to
10 work through the fine details, but could you attempt to 16:23
11 characterise for us what the ambition of these
12 recommendations indicates and where will this bring
13 Urology Service, both locally in your Trust and
14 regionally, if the Department and the commissioner can
15 resource them effectively? 16:24
16 A. I think effectively the aim of the GIRFT document is
17 about what things outside of more resource can be done
18 to deliver care more effectively. It encourages, as
19 you see within that recommendation that is in front,
20 the use of advance nurse practitioners and physicians' 16:24
21 associates to deliver care which would have previously
22 been delivered by doctors. It encourages the
23 developments of high-volume, low complexity surgical
24 centres. It encourages network working for a service
25 to support and maintain the service; in the case of 16:24
26 kidney cancer services in the recommendations in here.
27 It encourages the development of specialist centres, so
28 you make, if you like, the nonspecialist centres
29 attractive to recruitment. It aims to address all the

1 things outside of more resource being put in that can
2 improve the service for patients but also for the staff
3 delivering that care.
4 164 Q. We can see, you touched earlier, you touched several
5 times on the role of the region, which is manifest 16:25
6 through the operation of PIG, as I described it
7 earlier, the Programme Improvement Group. I think you
8 reflected positively about that group. Can you help us
9 better understand what that group is, how often it
10 meets, what its objectives are, and how does it work? 16:25
11 A. So I haven't reread but there is a terms of reference
12 that was updated, I think, earlier this year and sent
13 round. Essentially the group is made up of
14 representatives from SPPG, who chair it, there's
15 Department of Health representatives. From each Trust 16:26
16 that provide urological services, there are clinical
17 representatives and there's managerial representatives.
18 It is a proactive group at all levels, with good
19 relationships, and relationships that do challenge how
20 things are being done. So we have had discussions that 16:26
21 you could describe as lively or challenging, but there
22 is no issue with having them discussions and them
23 challenging conversations. But everyone in that group
24 is working towards a positive outcome in the delivery
25 of care, and the GIRFT report has provided a framework 16:27
26 going forwards for many of the work streams that will
27 come out from that PIG Group.
28 165 Q. I think it is fair to say that the GIRFT Report wasn't
29 long off the press when it was discussed at the PIG

1 meeting in November. We can touch on that briefly,
2 TRU-320308. We can see that the attendees at that
3 meeting, including yourself and your colleague
4 Mr. Tyson, Mr. Glackin. As you say, chaired by David
5 McCormack of the SPPG and attended by various 16:28
6 stakeholders, including representatives of the Belfast
7 and Southeastern Trust, Southwestern Trust and the
8 Department of Health. If we scroll down, you can see
9 that GIRFT has just been reported and it's on the
10 agenda, summarised by Mr. McCormack. Over the page, he 16:28
11 sets out, I suppose, the action that's going to be
12 required, which involves some prioritisation of the
13 recommendations, Task and Finish Groups to be set up
14 within each urology unit but a clear understanding that
15 there would need to be a regional focus. The Inquiry 16:28
16 can see from documents supplied that this was the
17 subject of further discussion at the January meeting
18 and no doubt so on.
19
20 In terms of the benefits that the implementation of 16:29
21 GIRFT might bring, where do you see those benefits
22 being most obvious for the Southern Trust?
23 A. As I say, the drive supported the direction of travel
24 we wanted to go. The establishment of a specialist
25 service in Southern Trust provides, I think, some 16:29
26 confidence that we will be able to recruit and attract
27 people into a specialist post. The support for the
28 network for kidney cancer service is really important
29 because there has been a change in how kidney cancer is

1 managed surgically, which has inevitably meant the
2 number of kidney removals, whole kidney removals, in
3 each Trust has dropped dramatically. The number of
4 open operations for big cancers has dropped
5 dramatically. Left in isolation, there was always 16:30
6 a risk of the kidney cancer surgeons finding themselves
7 unable to continue in the districts where support,
8 outreach and cross-network working will hopefully
9 prevent that from happening.
10 16:30
11 It's very clinically led so the goals are driven by
12 GIRFT, which is body coming with -- which is clinicians
13 lead the final -- do the inspections and write the
14 report. It is supported by us as clinicians. That
15 clinical leadership in delivery of this will hopefully 16:31
16 mean that we will have a service that is not only safe
17 for patients but what we want and what we see as the
18 best way of delivering care.
19
20 I think the name of the group, Getting It Right First 16:31
21 Time, gives it away. If someone is referred with
22 suspected kidney cancer, they should see a kidney
23 cancer surgeon, and that's this goal but split across
24 all of the services.
25 166 Q. I suppose to bring it back to a slightly more sober 16:31
26 place, perhaps, the GIRFT report - I'm not going to try
27 to bring it up on the screen because I think I've lost
28 that battle already - the GIRFT report reflects in its
29 executive summary that Northern Ireland has witnessed

1 a 10-year, a decade long, deterioration in its Urology
2 Services. It reflects that in terms of specialist
3 urologists, we in Northern Ireland are underrepresented
4 by reference to our population compared to other
5 regions in this island. There are structures that are 16:32
6 not set up to deliver care at its most efficient.
7
8 The implementation of the GIRFT recommendations is not
9 going to correct the waiting lists as they stand; isn't
10 that right? 16:33
11 A. As we said, the GIRFT recommendations are part of the
12 picture of the not adding in resource. You touched on
13 there that the number of consultant neurologists per
14 head of population in Northern Ireland is lower than
15 elsewhere across the NHS, and that's been the case 16:33
16 since I've been here. There's a challenge across the
17 NHS as a whole, and I think it is touched on in the
18 GIRFT report, that there are vacant posts everywhere.
19
20 We have a unique challenge in Northern Ireland. 16:33
21 We have a border with another country where the
22 consultant pay package is different to here and so
23 there is a disincentive to people moving across the
24 island. There's a disincentive to people who don't
25 already have a base in Northern Ireland moving from 16:33
26 England, Scotland or Wales. They have to uproot and
27 move across the sea and they get paid less, and they
28 are moving into a service which is challenged for
29 waiting times, it is much more stressful when you have

1 constant -- you know, every consultation is difficult
2 when the patient asks the inevitable, "and how long
3 will I wait". So there are many disincentives that we
4 can't fix, but we can fix trying to deliver care in the
5 best way. 16:34
6 167 Q. Thank you for your evidence. I have no further
7 questions for you. I leave you to the Panel.
8 CHAIR: Thank you, Mr. Wolfe. I know Mr. Hanbury will
9 have some technical questions for you.
10 16:34
11 THE WITNESS WAS EXAMINED BY THE INQUIRY PANEL AS
12 FOLLOWS:
13
14 168 Q. MR. HANBURY: Mr. Wolfe has asked most of my questions
15 but I just have a few outstanding ones. I'll try to 16:35
16 keep it narrowed down.
17
18 Looking at preop assessment, we have talked about
19 Patient 90 and 91, there was still an opportunity to
20 avoid the problems that ensued with the WHO checklist. 16:35
21 I wonder what your thoughts are on perhaps why those
22 cases slipped through the net there, and are you
23 confident that that's working better now?
24 A. Yeah. I mean, of course there are opportunities for
25 them cases to not proceed. Both patients were seen on 16:35
26 the morning by an anaesthetist and a surgeon. There
27 was an opportunity at the time of the checklist to
28 discuss whether the patient was optimally assessed.
29

1 I know from my own practice that I have had them
2 discussions where myself and the anaesthetist have come
3 to an agreement that a patient isn't optimally worked
4 up, and cancelled the case or change the case to
5 a different procedure for a diagnostic rather than what 16:36
6 was intended. It comes down to the individual's
7 switching and changing and recognising that, and that's
8 got to be in a discussion because there is always the
9 potential that a case who hasn't been through
10 preoperative assessment maybe is a very low risk 16:36
11 25-year old athlete who actually doesn't require any
12 additional preoperative assessment and could
13 potentially proceed without.
14
15 On the other side, if we take Patient 91 who hadn't had 16:36
16 a preoperative urine tested, my colleagues who do stone
17 surgery would be fairly rigid now on the requirements
18 of pre-operative urines and how they manage patients
19 who haven't had a urine specimen sent, particularly
20 those who have stents and stones in that they know 16:37
21 about.
22 169 Q. Just on the issue of regional referrals, which is less
23 of a problem now, I think, that there's a lot more
24 subspecification happening. Certainly the time the
25 Inquiry was looking at, there was not much capacity for 16:37
26 HoLEP, that is laser surgery for the very large
27 prostates, and surgery for penile cancer in the region
28 as well. Those issues seem to have been fixed. Are
29 you sort of happy with the way that's going now in

1 general in the region?
2 A. If we look at the specialist surgical procedures,
3 robotic surgery and penile cancer were two of the
4 issues. The penile cancer service is in Altnagelvin in
5 the Western Trust, delivered by a specially trained 16:37
6 consultant supported by a colleague who is recently
7 retired but is back still supporting that service. The
8 robotic surgery, we have the robot in Belfast. For
9 renal cancer, we have two robotically-trained renal
10 cancer surgeons, and we have three trained robotic 16:38
11 prostatectomists. We are still challenged
12 with capacity, and still - certainly up until very
13 recently - there's been outsourcing of patient care,
14 but to Dublin rather than across to England, which is
15 different to previously. 16:38
16
17 HoLEP service is something that is still being
18 developed; it has not been developed yet. It had been
19 earmarked to be developed by Southeastern Trust, and
20 perhaps some of the heated or challenging discussions 16:38
21 we've had at PIG meetings have been concerning the
22 developments of the HoLEP service.
23
24 There are additional areas of practice which we still
25 don't have in place. We don't have a urethral 16:38
26 sphincter service; we don't have a penile implant
27 service. We have surgeons who have been trained to
28 deliver them but we haven't got, if you like, that
29 benign andrology. The GIRFT Report discusses that

1 female and reconstructive urology element that needs
2 some thought regionally. There's still some way to go
3 on delivering, if you like, a full urology service.
4 170 Q. We have heard from the Director of Commissioning that
5 referrals out of province are still funded if the 16:39
6 consultant asks for them.
7 A. Yes.
8 171 Q. Thank you. National audits or audits in general, I was
9 very impressed with your presentation there, also the
10 subregional ones. I noticed the National Prostate 16:39
11 Cancer Audit wasn't represented. That is something
12 that has been quite well-established in England, I'm
13 sure you know. Is that one of the ones you're thinking
14 of?
15 A. We can't contribute to it. 16:39
16 172 Q. That's part of the...
17 A. Yes. Professor Clarke was over at -- I touched on
18 a meeting I talked on that Suneil Jain had organised.
19 Mr. Clarke was over presenting the National Prostate
20 Cancer Audit at that, but essentially we can't 16:40
21 contribute currently.
22 173 Q. That's a feature of the litigation that you mention in
23 your statement, because there are other departments who
24 have done national audits.
25 A. Yes, I can't remember it is the means in which the data 16:40
26 is collected.
27 174 Q. But you are doing some other BAUS studies which --
28 A. Yes. They are collected through different means so
29 there's no patient-identifiable aspect to the data that

1 is transferred.
2 175 Q. But where it is possible, you are obviously looking for
3 things you can do?
4 A. Yes.
5 176 Q. Thank you. Moving on. Just maybe about the long 16:40
6 waiters and we heard a lot about the challenges there.
7 Probably still got a lot of people waiting over a year.
8 Are you doing harm reviews on them? Are people
9 contacting patients who have been on the list a long
10 time? 16:41
11 A. That's always a -- that is a challenge. There are
12 patients waiting many years for surgery still on
13 routine waiting lists. One of the things certainly
14 we encourage is certainly if you have been waiting five
15 years, you shouldn't come just straight to an operating 16:41
16 list, you need another review before you come because
17 your situation could and may well have changed. But
18 there is a challenge in going out of the blue and
19 providing a review to all them patients. First of all,
20 what do we stop doing to deliver them reviews? There's 16:41
21 also a patient expectation thing. If they get called
22 to a review when they have been waiting four years for
23 an operation and you say you're going to wait another
24 few years as yet and we'll probably see you again
25 beforehand, it can set patient expectations up to 16:41
26 a difficult position.
27 177 Q. Hopefully your surgical hubs might help there.
28 I suppose the other end of -- my question is about low
29 priority things. You mentioned vasectomies, and I saw

1 on your waiting list there was someone waiting a long
2 time for a vasectomy reversal, and I was amazed in
3 a way that in this sort of atmosphere, you were
4 offering vasectomy and vasectomy reversals?
5 A. You all know, I think it was called the procedures of 16:42
6 limited therapeutic benefits list, had been generated
7 many, many years ago. Indeed, I can remember, even as
8 an SHO in Cardiff in the early 2000s, vasectomy
9 reversal wasn't offered on the NHS, and yet I moved
10 here in 2014 and vasectomy reversal is still offered on 16:42
11 the NHS. That procedure that aren't offered has now
12 been signed off. Those are not being added to but
13 we still have this legacy problem of patients who were
14 added to the waiting list a long time ago. The irony
15 obviously being that, as we know, the longer they wait, 16:43
16 the less likely it is to be successful anyway.
17 178 Q. Thank you. Just one thing on GIRFT. It was a sort of
18 structural review, obviously a very helpful one, it
19 seems, that the urologists in Northern Ireland have
20 looked at almost excitedly. The next phase when GIRFT 16:43
21 comes back is the sort of deep dive into what you
22 actually do and the helpful peer-to-peer comparisons.
23 Will that be possible or is that a problem without the
24 HES? Hospital Episode Statistics, I should say.
25 A. So there was a deep dive element to the visits where 16:43
26 they ran through data, but it was limited by the data
27 that could be collected and how that could be compared
28 across Trusts, and even whether it was felt reliable
29 within Trusts. I know there were concerns that it

1 under-represented the case volume. I think if you look
2 in the report, it talks about cystectomy volumes, and
3 I think it talks of a volume of around 40 to 50.
4 We don't recognise that as cystectomists; we recognise
5 a volume of 80 to 90 a year. At the initial draft 16:44
6 phase, I fed back in because I had a monthly tally of
7 patients who have had cystectomies, and we were at that
8 annual volume which had been provided in the data at
9 six months into the year. So...
10 179 Q. Okay. But I guess with time, that may... 16:44
11 A. We hope it will improve. I think it will lead to some
12 improvement in that coding and outcome of data.
13 180 Q. Thanks. Final question. Clinical directors, over
14 a lot of time that you were there and previous, the
15 Urology Department had CDs that were essentially 16:44
16 general surgeons, obviously looking after big
17 departments of their own and lots of hungry mouths to
18 feed wanting surgical lists, and there's a disincentive
19 to give theatres to the annoying urologists with the
20 very long waiting time. Do you think, looking back, 16:45
21 that was a major factor? Do you regret that the
22 urologists weren't given the opportunity to have a CD
23 of their own from amongst your ranks?
24 A. So, I think that ideally you need a medical management
25 representative from each specialty. Certainly during 16:45
26 my time in Southern Trust, even I wasn't CD for
27 urology, I feel I have banged the drum regarding
28 theatre allocation when there has been downturns and
29 looking at proportionality of demand as a driver not,

1 if you like, an equal reduction. You know, if you've
2 got a service like, unfortunately, urology in Northern
3 Ireland, where almost all of their surgery that's being
4 delivered is urgent and red flag, why should they have
5 their capacity reduced by the same percentage as 16:46
6 a service which is able to deliver a significant volume
7 of routine surgery? I think somewhere within my
8 evidence there are example emails where I've raised
9 that.
10 181 Q. But if you'd been CD it might have -- 16:46
11 A. Well, I was AMD when I was raising it, so...
12 MR. HANBURY: Okay. No more questions. Thank you very
13 much.
14 CHAIR: Dr. Swart?
15 182 Q. DR. SWART: I just want to ask you a few things about 16:46
16 your improvement director role to start with, clearly
17 this important senior titled role. Who sets your
18 framework for you, if you like, in a practical way? Do
19 you have a work programme that you've set out yourself
20 that somebody's helped you design? Do you report to 16:46
21 a Medical Director to someone senior in a kind of
22 mentoring way? How does that all work?
23 A. So, obviously I report to the Medical Director. In
24 terms of a framework for much of what we've been
25 delivering, it's been based on the findings that have 16:47
26 come through the various reports/recommendations.
27 183 Q. But is it set out for you? Have you kind of sat down
28 and said: 'Right, this is my plan, this is what I need
29 to deliver the plan.' I'm really coming to the support

1 to delivery?
2 A. So, in terms of setting out that, I've tried to do that
3 as a team-based approach rather than me saying this is
4 what I want to do. This is what the team want to do.
5 And that's why it's all being delivered through our 16:47
6 departmental meetings, through our consulted meetings,
7 in that format, rather than me saying: 'This is what
8 we're doing.'
9 184 Q. And have you got a RAG-rated thing or have you got
10 metrics? What have you got to assist you in terms of 16:47
11 reporting? I mean I'm conscious that you made the
12 comment everybody's on your case. You know, RQIA did
13 a review and there's GIRFT, and there's the Inquiry,
14 and there's everything else, and I can imagine that's
15 quite onerous. Have you been given any support to 16:48
16 create some kind of updating reporting mechanism to
17 make it a bit easier for you?
18 A. No, I haven't. And essentially we've moved from
19 managing each thing we're looking to work and then
20 we move on as we get through them. 16:48
21 185 Q. Do you think you've been got enough managerial support
22 to take on the totality of that work? I'm talking
23 about people working to you rather than --
24 A. Yeah. So, our Head of Service covers Urology and ENT,
25 and I think outpatients as well. So she is split three 16:48
26 ways, which I would imagine, if you asked, does create
27 some challenge in terms of workload. But that's what
28 we're faced with. We do have support to us as well in
29 terms of creating, or data to support what we're doing

1 from what within the limitations that we can provide.
2 And some of that support is doing things like our
3 monitoring in terms of stented patients on the waiting
4 list, how many there are, how long they've been
5 waiting; looking at delivery of our ESWL service and 16:49
6 the efficiency of that. So, we've got that support
7 aligned to us.
8 186 Q. But you don't have a project manager working to you,for
9 example, specifically for this?
10 A. No. 16:49
11 187 Q. And the data support, is that helping you to produce
12 some things that can be put into regular reports in the
13 way that you've done for triage? So far I'm thinking
14 for the stents for example, the time from first
15 procedure to stent and surgical removal, or whatever? 16:49
16 A. I haven't got round to looking at how to take the data
17 that we've got collected and put it into that same
18 report. I mean I touched on, if you like, the triage
19 dashboard's been developed by the Cancer Services Team.
20 The results thing, I developed that and I did the 16:50
21 background coding within Excel for that. I've
22 mentioned a couple of times online forms. The Java
23 script coding I've done. We haven't got anyone who can
24 do that.
25 188 Q. So, would it help you if you had specific project 16:50
26 management support for this sort of thing?
27 A. Absolutely. If they have the skills that we need. I'm
28 not alone in having written that Java script and I know
29 for online forms I know my colleagues in Belfast Trust

1 have done exactly the same. It's been developed by
2 them.
3 189 Q. Because although everybody's on your case and this must
4 have been a very difficult experience, you could look
5 at it the other way and see it as an opportunity to 16:50
6 really showcase the work of Urology, take the GIRFT
7 recommendations and change the dialogue considerably.
8 So, what conversations have you had about the Trust
9 about that, about what you've learnt from taking on
10 this specific role and how that could be used to 16:51
11 benefit in the rest of the Trust?
12 A. I haven't had any specific conversation because I don't
13 consider that I've finished my role as yet.
14 190 Q. I'm not suggesting that you have.
15 A. I'm still developing things as we do. It's the -- as 16:51
16 I've touched on, I've had support in how we develop
17 things along the lines of GIRFT. I've not been having
18 to push doors down, they've been open in front of me.
19 191 Q. What thing that you've achieved are you most proud of
20 so far - bearing in mind I'll ask you next about what 16:51
21 you still have to do. But if you think now, actually,
22 I'm so glad I sorted that out, and you can see that
23 it's a benefit to the service and to patients?
24 A. Probably, for me, it's the -- so we touched on that
25 I've worked across Trust for a number of years. For 16:52
26 me, or widening that out so it's not just me, so there
27 are a number of individuals now working across Trusts,
28 demonstrating that can work has been to me -- that will
29 be the thing that enables us as services to drive

1 subspecification and still maintain our services in the
2 local hospitals.
3
4 In terms of the biggest bit for me to still do I think
5 is finishing off that single renal cancer service, 16:52
6 which needs -- we need to get to a point where we have
7 a single MDT that every renal cancer surgeon is part of
8 so that the whole of that process is embedded as
9 a single Northern Ireland service. And I think if or
10 when we get to that point, that will be a major change 16:53
11 for me and that will be the first, if you like, whole
12 of Northern Ireland service that's not based in one
13 hospital.
14 192 Q. So, do you think the PIG, as it's set up, has the
15 potential to effectively become the regional planning 16:53
16 group for Urology as a single service? How do you see
17 that going?
18 A. Most of us have the goal or the vision that that's what
19 we should see be functioning as in Urology. We're not
20 a big specialty. We should be looking to deliver the 16:53
21 services across Northern Ireland as one service. And
22 indeed, it's been asked by many of us at veracious
23 points, why are we not a single employer, why are
24 we not a single service?
25 193 Q. And if you look at the demand capacity issue, for 16:54
26 example, and you've described and we've heard about
27 lots of the initiatives, there's the independent sector
28 work which clearly is only temporary from what you've
29 described, you've got some surgical sites and so on,

1 could you say at the moment that there is a regional
2 plan for demand and capacity for the future set out in
3 steps. Does that exist as such?
4 A. I don't think so, because as I touched on earlier, when
5 we -- unfortunately I don't think -- well, I think the 16:54
6 SPPG representatives, when they came, touched on,
7 we aren't in a position to commission for demand for at
8 present, we're so far behind. It is unfortunate that
9 some things that, as touched on by Mr. Hanbury, like
10 vasectomy reversal took so long to be withdrawn from 16:54
11 the offer. And it's unfortunate that decisions have
12 been made which have, if you like, added to the demand
13 on secondary care. I touched on the vasectomy example
14 where certainly my understanding in England is it's
15 commissioned in primary trust, and that model was in 16:55
16 place and that funding is no longer in place and then
17 patients are now coming to secondary care. So, they're
18 very unfortunate decisions which will have a direct
19 impact on the demand within the Urology Service.
20 194 Q. Does the group see as part of its role to develop such 16:55
21 plans with the help of SPPG and others? Because
22 without that you can't really --
23 A. Absolutely. And have been supported in delivering
24 alternative treatments. So we touched upon HoLEP, but
25 Rezum steam treatment for prostates, that has been 16:55
26 supported and is delivered in Lagan Valley as a day
27 case procedure. If that takes a volume of patients
28 away from needing traditional TURPs, then that gets us
29 to a point with a much quicker procedure that's

1 deliverable as a day case deliverable through an
2 elective care centre where you can meet demand more
3 efficiently.
4 195 Q. Just going back to slightly more mundane things. If,
5 at this stage, that you had a urologist who was using 16:56
6 medicines indication contrary to guidelines and outside
7 of licence, how would that be picked up in your current
8 systems? And if you thought it might be a problem, how
9 would you deal with it now bearing in mind you will
10 have learnt a few things from hindsight, experience, 16:56
11 and so on?
12 A. So, if we look at the starting point, so, the starting
13 point for that patient would be a recommendation from
14 MDT for specific treatment. As was touched upon
15 earlier, the concern about Bicalutamide wasn't 16:57
16 Bicalutamide per se, the concern was the patient not
17 receiving the appropriate prostate cancer treatment.
18 The audit process that we've touched upon of the MDT
19 outcomes would highlight that patient who has not had
20 that treatment, and that would bring that back both to 16:57
21 the consultant and to the MDT. So, that would allow
22 for peer challenge.
23
24 Where that peer challenge failed I would expect - and
25 it's difficult because I'm talking about something 16:57
26 where I'm a member of the MDT as well as, if you like,
27 the line manager as well - I would expect the MDT chair
28 to bring that then to the medical line management of
29 'this has been identified, we've attempted to address

1 it through the MDT and have failed, can you take this
2 on.'
3 196 Q. So you would escalate it?
4 A. Yeah.
5 197 Q. Quicker? 16:57
6 A. Yeah. And it would be identified quicker.
7 198 Q. What tools do you have now? I mean you've more audit
8 which hopefully would pick these things up better.
9 What else has changed in terms of the atmosphere of the
10 department or the atmosphere of the Trust that would 16:58
11 assist you in exploring these issues?
12 A. I think, from my perspective, I've more experience in
13 challenging these things so I would be -- I think I'd
14 be better at challenging directly. As a team I've
15 touched on we are much happier to raise these problems 16:58
16 before they become a problem, if that makes sense.
17
18 The audit processes will identify where there are
19 issues. So, I would anticipate that would all work
20 much better. 16:58
21
22 In terms of support and input, I did mention earlier in
23 terms of contact directly through our Deputy Medical
24 Directors and our Medical Director that those
25 relationships and the regularity of meetings are there 16:59
26 such that it would be able to be raised. Then
27 I mentioned the revalidation group where it's a further
28 opportunity where the question is asked: 'Are there
29 any issues that you're aware of that may not be here

1 that we need to talk about?'
2 DR. SWART: Thank you. That's all from me.
3 199 Q. CHAIR: You'll be glad to know I don't have very much
4 to ask you. I just wondered, certainly just in
5 response to Dr. Swart, what you're saying is that there 16:59
6 seems to be -- the impression that you're giving us
7 anyway is there's now more visibility around
8 a consultant's practice in the Urology Service that
9 would mean that the problems that have been identified
10 in the nine SAIs and through the work of this Inquiry 16:59
11 would be less likely to happen; is that your opinion?
12 A. Yeah. Absolutely. There's more visibility both in
13 terms of how we work. We don't work -- I mentioned
14 pooled waiting lists and the like. The CNS
15 availability, the numbers of CNS' means that there's 17:00
16 always other people present in these consultations and
17 the audit facilities mean that it's always checked on
18 as well.
19 200 Q. So, would I be right in my belief then there's less
20 working in silos more working in a multidisciplinary 17:00
21 way, generally, never mind in cancers?
22 A. Yeah.
23 201 Q. Just finally, we have to make recommendations at the
24 end of all of this. Obviously we can't have a pot of
25 money and a magic wand that will give you the people 17:00
26 that you need and the resources that you need, but what
27 would you like to see? What one recommendation would
28 you like to see us make?
29 A. This is like where you have a job interview and you're

1 asked --
2 202 Q. Yes, it is. I appreciate it's difficult, but we want
3 to make recommendations that will be of benefit
4 generally to Southern Trust, to the Urology Service and
5 the service across the region. 17:01
6 A. I think you probably touched on the most important
7 aspect and that is that visibility. Whatever we do, we
8 have to remove the opportunity of people just
9 delivering their own practice in isolation without ever
10 being -- well, with the opportunity to never have other 17:01
11 people looking in on that practice. I think that's
12 dangerous for the individual as much as it is for the
13 patient. Because you can find yourself, if you like,
14 heading down a road of what you think is right and
15 never having an opportunity to be pulled back. So, 17:01
16 that way of working where you function as a team, where
17 there is pooling of patients, where there is
18 multidisciplinary input, where there is allied health
19 professional input and delivery of care rather than all
20 within a consultant's practice, is what I'd see as the 17:02
21 biggest thing that can, if you like, reduce the risk of
22 this happening. Many of the other things that I've
23 done are all about proving that it's not happening,
24 whereas removing the opportunity is the most important
25 thing. 17:02
26 CHAIR: Thank you very much, Mr. Haynes. You'll be
27 delighted to know that we probably will not have to
28 hear from you again and you're free to go.
29

1 But just before I release everybody else, I just wanted
2 to reiterate a couple of dates. We're getting to the
3 end of our hearings now and I think I've indicated that
4 31st May is when I will expect written submissions from
5 all Core Participants, and I want to emphasise again 17:02
6 that those should be directed to the Terms of Reference
7 as far as possible. I'm not hamstringing you in saying
8 if there's certain points you want to make beyond that,
9 then please do, but please try and focus on the Terms
10 of Reference. 17:03
11
12 Secondly, on 13th June you will be invited to deliver
13 oral submissions to the Inquiry. That will give us
14 some time to read the written submissions between
15 31st May and 13th June. We are hopeful that that will 17:03
16 be the last public sitting of the Inquiry before I do
17 all my work and deliver a report. That's just to give
18 you the heads up as to the timetable, ladies and
19 gentlemen, so you know what to look forward to.
20 17:03
21 Thank you very much everyone. See you in two weeks'
22 time.
23
24 THE INQUIRY THEN ADJOURNED TO TUESDAY, 12TH MARCH 2024
25
26
27
28
29