Urology Services Inquiry

Oral Hearing

Day 12 – Tuesday, 29th November 2022

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON TUESDAY, 29TH DAY OF NOVEMBER, 2022 AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Hughes, Mr. Gilbert, good morning, welcome. It's very unusual for us to have two witnesses giving evidence at the one time. Can I just remind you both we only have the one microphone and we need to pick up what each of you say. If you wouldn't mind putting it between you, that's a good idea. Thank you. 10:08

MR. HUGH GILBERT, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

DR DERMOT HUGHES, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS: 10:08

MR. WOLFE KC: Good morning. For the record, the first witness who took the oath this morning was Mr. Hugh Gilbert and the second witness who took the oath was Dr. Dermot Hughes. 10:09

Good morning, Panel, as you say, a slightly unusual but not wholly unconventional arrangement this morning. Lawyers sometimes call it hot-tubbing, but we have two witnesses and the road map, if you like, this morning, just to explain. As you know from your papers, Dr. Hughes and Mr. Gilbert were commissioned by the Southern Health and Social Care Trust to form part of 10:09

a Serious Adverse Incident Review team, or panel, which examined nine cancer cases; five of us were prostate, two renal, one testicular, and one penile. They carried out their work in late 2020 and into 2021. Their evidence this morning, the rest of the day and into tomorrow, will, hopefully, assist the Inquiry, particularly in relation to Term of Reference Part C. Their evidence should enable the Inquiry to develop a better understanding of the clinical aspects of the cases which reached the threshold for an SAI, and the kinds of deficiencies in governance which they, in their various reports, identified. 10:10 10:10

Before getting into some of the issues arising out of all of that, let me just ask the witnesses about their Section 21s. 10:11

First of all, Mr. Gilbert, if I could have up on the screen for you your Section 21 response to the Inquiry. It can be found at WIT-85886. Do you recognise that, Mr. Gilbert? 10:11

A. MR. GILBERT: Yes.

1 Q. If we can scroll down, I think there's a signature on the last page at line 1, 85891, yes, it's electronically signed, dated 9th November 2022. Do you wish, Mr. Gilbert, to adopt that statement as part of your evidence to the Inquiry? 10:11

A. MR. GILBERT: Yes.

2 Q. Thank you. And similarly, Dr. Hughes, you provided

a Section 21 response, we will call it a statement, on 17th October 2022, it can be found, let's go to the first page, WIT-84148. Again, Dr. Hughes, that should be familiar to you?

A. DR. HUGHES: Yes.

3 Q. Let's scroll to the last page, WIT-84176. There you go, your signature. That's your signature?

A. DR. HUGHES: Yes.

4 Q. Any amendments or revisions that you wish to indicate?

A. DR. HUGHES: No.

5 Q. I might, and perhaps should have done this in advance. My apologies. Can I just bring you to something I spotted, WIT-84152, and see if you can resolve this for me? Paragraph 10(i), here you are talking about the circumstances in which you were briefed about the SAIs, and you talk about the involvement of the PHA, the Public Health Agency. The last sentence, the classification of the SAI process would be agreed between the Trust and, it says SAI, I assume it should say PHA?

A. DR. HUGHES: It should have said PHA. I beg your pardon.

6 Q. No problem. I should have spoken to you in advance. If we can delete SAI and insert the word PHA?

A. DR. HUGHES: Yes, please. Apologies for that.

7 Q. Not at all. The final piece of housekeeping before we begin, gentlemen, is you should have in front of you a cipher list. When you wish to refer to the name of a patient, you should use that cipher list.

I trust the Panel have a copy of it?
CHAIR: Yes.
MR. WOLFE KC: What should be immediately obvious is that the cipher list that we have been using to date, has had to be tweaked slightly because, within the SAI reports, the patient designations are letters, so patient A, to read across into the patient ciphers that the Inquiry has been using in respect of patient A, should be Patient 1. I will hope to be consistent in using the Inquiry's ciphers, but we have that designation list for clarification. Of course, as I said before, everybody should be conscious of the restriction order which applies in these hearings and refrain from identifying any patient or family member by name. 10:14 10:15 10:15

Mr. Gilbert, you are a Consultant Urologist?
A. MR. GILBERT: Yes, I have been a Consultant Urologist for 24, 25 years, the first 23 in Gloucestershire. 10:15
8 Q. If I just stop you there. It's just for the ease of the Panel's note and your own eye. Let's bring up your statement to guide us through this, WIT-85890. College medical degree, and then various Royal Colleges. Scrolling down to your employment, first employed as a Consultant in 1996 at Gloucester, and 19 years there or so, maybe longer than that? 10:16
A. MR. GILBERT: 23 altogether.
9 Q. 23.

A. Yeah.

10 Q. Then a short hop over to Bristol in 2019?

A. MR. GILBERT: Yes.

11 Q. You have been there to date. You tell us, just below that, in positions, in terms of the positions that you have held that are perhaps most relevant to the work that you were asked to do for the Southern Trust, can you highlight some of that for us, please? 10:16

A. MR. GILBERT: Yeah. As a Consultant Urologist I have been involved in case reviews for my own Department, initially. I was responsible for setting up the MDT when Improving Outcomes Guidance was first published just over 20 years ago. I then became the Clinical Director for General Surgery and Urology Services, and established a formalised Clinical Governance structure with regular reviews of performance in terms of publishing audits, and so on and so forth. 10:17 10:17

I subsequently volunteered to become a GMC Performance Assessor, which essentially was a review of notes to ascertain the effectiveness of someone's practice and subsequently their ability to put that into effect, because there were questions about the individuals concerned. I then became part of the Invited Review Mechanism, which is a body under the auspices of the Royal College of Surgeons in London. This is a surgical group subdivided into specialties and is a resource for Chief Executives and Medical Directors to obtain independent and systematic advice regarding any concern they might have about a Service or an 10:18 10:18

individual. In 2019, at competitive application, I was appointed as its lead for Urology.

12 Q. Yes. Thank you. That's very helpful.

Dr. Hughes, likewise, if we could have up on the screen WIT-84149. At paragraph 4, yes -- so you are a pathologist by trade, by profession? 10:19

A. DR. HUGHES: Yes, I am a histopathologist by trade. I trained in Northern Ireland and I also trained in Washington D.C. Following that, I was appointed as a Consultant Histopathologist in the Western Trust in, goodness, in 1990. I managed Pathology Services in that, and I was a senior lecturer in Queen's University Belfast. In my time there, I became the Lead Clinician for Cancer Services and Diagnostics from 2003 to 2008. 10:19 10:20

After that I became the Medical Director for the Northern Ireland Cancer Network between 2008 and 2011. At that time, we were setting up MDT services across Northern Ireland, and I led and brought in the first round of peer review of Cancer Services in Northern Ireland, and that was facilitated by the London team. At that time the initial work was with breast cancer, lung cancer and colorectal cancer. 10:20

Following that appointment, I returned back to the Western Trust and was Clinical Director of Diagnostics in Cancer Services. At that time we developed a cross-border Radiotherapy Centre and a cancer Service, which is shared between the Republic of 10:20

Ireland and Northern Ireland. I then became the Associate Medical Director and eventually became the Medical Director of the Trust for four years. I am a visiting professor of the Ulster University, at the newly established graduate entry medical school, and I currently am an Associate with the Leadership Centre. Some of my work that I currently do, I spend one day a week at the Independent Medical Examiner's Office, I have supported RQIA in the review of deceased patients who were previously seen by Dr. Watt, and I am the senior responsible owner for the Encompass Project for Northern Ireland, which is an Epic implementation to completely review the IT infrastructure on an Epic platform for Health and Social Care and providing a portal for patients. 10:21

13 Q. In terms, Dr. Hughes, of your SAI experience and know how, if I can put it in those terms, could I draw your attention to what you have said at WIT-84149. Just scroll down the page to paragraph 5. You have explained that you have formal training in SAI, that you have chaired SAIs and that, as Medical Director, you had a review and quality assurance role. You suggest that your experience, between 2015 and '19, shortly before doing this work for the Southern Trust, that quality assurance role brought 350 cases across your desk? 10:22

A. DR. HUGHES: Yes, all SAIs in the Trust would have been reviews at Director level, and I chaired that process, and that was to assure immediate learning to quality

assure and make sure that the learning was embedded within the system. Subsequently to that, after leaving that role, I have done a range of SAIs, one -- as well as the Southern Trust, one I have done work for the Belfast Trust reviewing nine cancer-related cases in Thoracic Surgery. I have also done two nosocomial covid SAIs relating to outbreaks of Covid, both within the Western Trust. These would have involved patient engagement and chairing SAIs processes. I think it was about 22 patients in total. 10:23

14 Q. We will come on, in just a few moments, to look at the circumstances in which you became to be appointed to the role for the Southern Trust. Your role specifically, Dr. Hughes, was to be the external Independent Chair; isn't that correct? 10:24

A. DR. HUGHES: Yes, that's correct.

15 Q. Mr. Gilbert, again, external independent subject matter expert, I suppose, with responsibility for reviewing the clinical aspects, benchmarking, and providing an analysis of any deviation from benchmark? 10:24

A. MR. GILBERT: Exactly, yes.

16 Q. Dr. Hughes, in the last paragraph of your statement, I'm going to bring it up in front of you just to orientate you, it's WIT-84175, paragraph 24. You draw the Inquiry's attention to the General Medical Council's guidance called Leadership and Management For All Doctors, which was published in January 2012, and you go on to say: 10:25

"I have used this guidance to benchmark how doctors with additional responsibilities perform in the management of governance of care delivered by teams they manage."

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You say:

"The principles set out in this document have informed my clinical and managerial practice and informed the approach to the ten Serious Adverse Incident review reports"

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which you prepared for the Southern Trust.

Just on that, why is that an important document from your perspective?

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A. DR. HUGHES: I think it's a very important document because it describes how professionals work in teams. It describes how professionals work with other professionals. It describes the responsibilities that people should know they are adopting when they take on roles of Leadership. It details the expectations of these professionals. Sometimes I have found in the past that people take on Leadership roles thinking it's a seniority, thinking it's a vague role to do, without actually seeking detailed information about what the expectations are, what the goals are, and what they should do when there are problems. That could be interpersonal problems, that could be resource problems, that could be many. This document is set out

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in a very helpful, straightforward manner to explicitly state how people should approach their roles. It's divided into expectations of all doctors who work in teams, and then it has doctors with additional responsibilities. I think often when you talk to people who have taken on additional responsibilities, A, they are not aware of the document, and B, they are not aware of the expectations that roles often are required of them [sic]. 10:27

17 Q. Yes. I'm going to touch on some of the principles, maybe principles is perhaps the wrong word in the context, certainly the guidance within that document, in just a moment, and you can help me with some of the points that you think were particularly important in guiding your work. Just as a general issue on this whole area of medical management, obviously the Inquiry is at a very early stage of hearing evidence, but last week, or was it the week before, we heard from Mr. Haynes, who took up the role of Associate Medical Director within the Surgery and Elective Care side of the Southern Trust. He had specific responsibility for Urology and he took up that position from October 2017. Just asking, not necessarily specifically in relation to him, but I will set it out in his context; he reflected to the Inquiry that, as a very busy Clinician, holding down a practice in the Southern Trust but also providing nephron sparing services to Belfast, I think, one day a week, he was also Chair of NICaN, that he had great difficulty in carrying out all 10:27 10:28 10:28 10:29

of the duties necessary to comply with the job description of Associate Medical Director. In general terms, is that a problem perhaps in Northern Ireland, or in Trusts within Northern Ireland, that you have come across, that doctors take on these managerial roles but the resources aren't there necessarily to support them to do it properly?

A. DR. HUGHES: I suspect it's a problem across the UK and I expect it's a problem throughout the NHS. Often people who seek these senior roles are highly functional, high achievers, very busy people, and often if you want something done you ask a busy person, but sometimes they may not have enough insight into the roles they are taking on, and sometimes people need to be protected from their own willingness and people should step back, make sure they understand the roles and responsibilities of an Associate Medical Director before, you know, assenting to that role. I often think people are not mentored, not guided, not supported, so people end up dealing with quite complex issues and there's nothing more complex than dealing with your immediate colleagues, because that's an incredibly difficult psychological space to be in, without training, without support, and without expertise. I have seen that frequently in Northern Ireland. People are offered training episodically, but often it's not necessarily focused on the skills they need.

18 Q. Yes. Mr. Gilbert, could I ask you have you any

reflections on that broad area? You have been a Medical Manager, I suppose, and you point in your CV to Director's role and I think Clinical Director's role as well. Is there a difficulty, perhaps a fundamental difficulty, in busy Clinicians also taking on managerial roles and being able to deal with them effectively?

A. MR. GILBERT: Undoubtedly, there is. Very often, people don't volunteer to do these jobs, it's a question of everybody else stepping backwards, and very often it's a baton which is passed from one Clinician to another after a fairly short time, simply because it's an untenable position in many respects, and largely because hitherto there's been very little support and training for what is, in fact, a very specialised job. That is being addressed by Leadership courses up and down the country, and certainly in the southwest anyone aspiring to this sort of role will now go through the appropriate training, but that hasn't been the case across the country.

19 Q. Thank you for that. Dr. Hughes, I promised I was going to bring you to the Leadership Management GMC document, so if I can have that up on the screen, please. It's INQ-30227. I wonder is there an earlier page to it. I want to get the front page up. Yes, that's the document. I'm sure you are familiar with it, Dr. Hughes. Is there any particular principles or guidance that you'd like to draw the Inquiry's attention to?

A. DR. HUGHES: If you scroll down.

20 Q. I was going to bring you to INQ-231. This is the section which tells you what the guidance is about. It explains that being a good doctor means more than simply being a good clinician. 10:34

"Doctors can provide leadership to their colleagues and vision for their organisations. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are 10:34 wrong, patient care is likely to suffer".

Is that something that I suppose you went into this task for the Trust worrying that that's the kind of thing that you might find? 10:34

A. DR. HUGHES: Possibily. I think that opening statement is to emphasise to everybody, all doctors, that the first and foremost responsibility is to patient care and patient safety, and that the culture that Leadership must bring to it is an open culture, and 10:35 a culture where people can put their hand up and say, I am concerned about things, and that there is a process for that to be escalated and to be heard.

21 Q. If you scroll down a little. Back up again, please, sorry. I think it may not be on that page but there's 10:35 a reference to speaking up when things go wrong. Is that something that --

A. DR. HUGHES: Yes.

22 Q. -- is relevant in this context?

A. DR. HUGHES: Yes.

23 Q. There's a section within the guidance on multidisciplinary working. If we go to INQ-30235. Of course your work for the Southern Trust was to bring you face-to-face with the multidisciplinary team in Urology, Cancer, and you were, I suppose, asked to run your rule over the efficacy of those arrangements. What, within this guidance, was informing you about multidisciplinary working? 10:36

A. DR. HUGHES: This guidance shows that everybody within the team has a responsibility to Patient Safety and good patient outcomes. While it's shared with the whole team, there's a further guidance for those with additional responsibility, which clearly sets out their roles and responsibilities, and they have to have systems in place to know about issues, systems in place to deal with issues. If you take on a leadership role, be it Chair of the Multidisciplinary Team Meeting, you have to have systems to know about problems and systems to escalate problems. 10:36 10:37 10:37

24 Q. If we could go back to 30327 in this sequence. Sorry, it's maybe 30337. I beg your pardon. Scroll up, please. It appears the communications are of significance with multidisciplinary teams?

A. DR. HUGHES: I think it's the core of what they do. If you don't have clear communication, and clear communication between professionals and with patients you'll end up with poor results. That requires a highly functional team. That requires a space where 10:38

people feel comfortable to work, to discuss, to have differences. It requires people to know that the patient is at the centre of what they are doing and first and foremost, of what their outcome should be focused on. That doesn't always exist in multidisciplinary teams. That takes work. That takes effort. That takes insight. Without that, you will not get the positive goals and the additional benefit that the teams are set up to deliver for patient care. I think when it says: 10:39

"You must communicate relevant information clearly to your colleagues, to those who work within Services and to patients". 10:39

I think that's critical to what we are dealing with today. Patients and professionals should know when they are working in a multidisciplinary team that, when treating a patient, they have to feed back information about changes in plans. They have to make sure the team is informed, that they have oversight and governance of the care that the team is delivering, and also other colleagues who work within other services, so if there are issues they must escalate it to their line managers, their Clinical Managers and their Service Managers. 10:40

The other issue here is we talk about patients. Healthcare can be very complex. It can be very full of

jargon, but you need to have mechanisms so that patients can fully understand the care they are receiving and fully understand the options they have around treatment, and that should be done in a highly supportive way with a multidisciplinary professional input. 10:40

25 Q. Jumping slightly ahead to the findings of your reviews that I will explore with you later, you found communication problems right throughout these arrangements; isn't that right? For example, the Cancer Services Management, I think it was your conclusion, didn't appear to be well-connected to the multidisciplinary team or well-connected to Urology Services. Can you explain that just briefly to give us a taster of what lies ahead in this communication context? 10:41 10:41

A. DR. HUGHES: Yes. Initially talking to the Senior Clinical and Managerial Cancer team I would have expected them to have oversight, knowledge and experience of what was happening in each MDT. I would have expected them to have a corporate view of the patch. I would have expected them to have joint meetings with all the different Leads, taking best practice from the more mature MDTs. Classically in Northern Ireland the more mature are the better resourced ones, such as breast and colorectal and lungs because they have been formed the longest. I didn't see that. I found it virtually an adversarial relationship between the team and the Urology Services. 10:41 10:42

I found a disconnect. Governance was stated to be through their professional lines. While I can understand that in terms of what a professional delivers, the overarching team needs to know about issues and needs to know how to escalate them because, ultimately, they are responsible for the outcomes from Cancer Care, so if they don't know about issues they won't know about the deficits or the problems and how they can resolve it. Especially when there are problems within teams, it is very difficult for a team to resolve their own issues, and that often needs to have a senior person, or a critical friend, or somebody in management to have an ear to the ground to address problems and help resolve issues. 10:42 10:42

26 Q. Yes. Thank you for that. We will descend into some of the finer details and specifics of that presently. Just working through this, can I jump to the issue of systems at INQ-30240? 10:43

Paragraph 19 talks about doctors with extra responsibilities:
"You should contribute to setting up and maintaining systems to identify and manage risks in the team's area of responsibility". 10:43

Again, is that something that was germane to, I suppose, the review that you were going to conduct for the Southern Trust?

A. DR. HUGHES: Yes, I think Cancer Services have evolved

over the last 25, 30 years, I come from a laboratory background so I am very used to standard operating procedures, variance from best practice, you know, minor variance, major variances, quality assurance, manage the improvement, and that's core to any good Clinical Governance. They had tracking systems but the tracking systems were very focused on the ministerial targets of 31 and 62 days. I would have expected an empowered enabled tracking team to almost augment the audit processes, so you knew that the recommendations from MDT were actually actioned. There was feedback groups so that you knew were there issues within patient accessing scans, patients' pathways that there would be information and knowledge to feed that back so there could be early intervention and early action. I didn't see that. I found limited assurance audits, focused on patient experience by Clinical Nurse Specialists, very good audits on what the Clinical Nurse Specialists did in their Trust biopsy procedures, but not assurance audits on, say, how did we manage the last 15 prostate cancers? How did we manage the bladder cancers? I didn't see work that is usually done by maybe training staff, just to have an annual, not annual, twice yearly business meeting that focused on what are the problems, what are the deficits, what's the evidence, and how do we improve that? I think it was not as structured as it could have been.

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27 Q. Yes. Mr. Gilbert, I know that your focus was more on the Clinical aspects, but these issues of deficiency in

monitoring, audit, manage the assurance, tracking these kinds of things where you were being exposed to these at the team meetings; did the absence of these jar with you in terms of your own experience in a Urology Service?

A. MR. GILBERT: Yes, there were clearly deficiencies that I wouldn't have expected to have occurred in an MDT that I was a member of. I think it's important to state that ultimately the Consultant Clinician is responsible for his or her patient. That's where the buck stops. However, owing to the increasing complexity of Pathways, owing to the volume of work coming across an individual's desk, no one individual can manage the organisation of that workload, and is absolutely reliant upon team working, whether that's Clinical Colleagues, Cancer Nurse Specialists, and, most importantly, data trackers or patients trackers who will actually flag up when something or someone has gone wrong or fallen out of the system. The MDT has been one of the most important positive initiatives within the Health Service as a whole in providing that universal support and safety net for patients, and assuring that the manage the of care is given, but that is contingent on effective standing orders and regular review within the Department itself to identify specific problems and deal with them.

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28 Q. Yes. Thank you. Just working our way through this document, if we go to INQ-30244. This highlights the importance of the doctor with extra responsibilities

having in place systems to give early warning of any failure. Again, Dr. Hughes, is that another piece of guidance or principle that you had in mind to inform your review at the Southern Trust?

A. DR. HUGHES: Yes. It states in black and white the requirements of a person who takes on Leadership, and I think doctors often go into Leadership roles not fully understanding the requirements placed on them, both by their employer but also by their professional body. If you take on Leadership you have a vicarious responsibility for all the care that's delivered in that MDT and, therefore, you have to have feedback loops that will warn you of deficits in the services, be it timeliness of care, be it appropriateness of care and you have to act upon it. I think what we found was that an under-resourced team which struggles, which was not quorate, and one of these issues were their fault, but it wasn't being escalated appropriately and when it was escalated it wasn't being heard, and I think at that point action should have been taken. 10:48 10:48 10:49 10:49

29 Q. We will maybe go on and look at this in a bit more detail. Just before leaving this particular point. An MDT is organised around a Chair, and in the Southern Trust we know that the role of Chair rotated from meeting to meeting, perhaps, or maybe you are Chair for a month and then it rotates, but also more importantly perhaps the Clinical Lead, and then you had a series of core members across various disciplines. The guidance here talks about you must make sure. Are you putting 10:50

the obligation to ensure that these kind of systems are in place, are you putting that obligation on anyone in particular, or is it a case of having the insight and then the energy to raise it with Service Management if you are not being supported? 10:50

A. DR. HUGHES: Yeah. Unfortunately this is a GMC document, and when they say you must, it means you personally as a professional. That's quite an onerous task because people need to understand that they need to deliver on what's being asked of them. I think 10:51 people often go into roles and responsibilities without that resource present, you know, doing it in a very professional way, doing it in the best way possible, but not understanding their actual professional body is holding them to account for delivering that to a very 10:51 high standard. This may put people off taking on these roles in the future, which I really don't want to happen because they are essential for patient care, but I think a discussion with an employing body needs to be had to say look, that is what's being asked of me, how 10:51 can you deliver that?

30 Q. The paragraph just below that, paragraph 29, introduces the concepts of auditing and benchmarking. I know from what you have said and in your report that while there was some evidence of auditing, and you refer, for 10:52 example, to the good auditing of a particular kind on the nursing side, you are to reflect -- and we will look at it later -- that the auditing of the whole Patient Care Pathway and outcomes was just not

something they did?

A. DR. HUGHES: Yeah. I think you can only give assurance if you feel you have assured the whole pathway and the totality of the work. While you can have business meetings about experience, audits you have done, very focused pieces of work, that is not assurance. You need to have whole system assurance and identify the areas of greatest variance or the greatest problems, and they are areas that you have to focus your energy on. Time and resource is limited and I think that wasn't done. I don't think they had the infrastructure to do that. 10:52 10:52

31 Q. Yes. You said at the top of this when we looked at your statement, that the guidance here was used by you to inform you of the proper approaches to see if there was alignment between the principles set out here and the practice. Is it fair to say that you found a lack of alignment in various areas of the Southern Trust's Urology Multidisciplinary Team working? 10:53

A. DR. HUGHES: Yeah. I think that would be fair. But it's also in light of the peer review processes, the cyclical review of Services that happens on a regular basis, which is very much this document in practice in terms of Cancer Services. People are expected to review all aspects of their care, focus on the areas that are known problems and address them, or attempt to address them. 10:53 10:54

32 Q. Yes. Let's move away from that document now and talk about Serious Adverse Incidents. There is a procedure

governing Serious Adverse Incidents. It's gone through several iterations, I think, since you conducted this process, or at least one anyway. The document that was in place at that time is a 2016 version. It's WIT-84180. Is that something you are familiar with, Dr. Hughes?

A. DR. HUGHES: Yes.

33 Q. Let's look at a number of aspects of it, and if you can help us walk through it. If we go down to 84187 and this tells us something about the purpose or the aims of an SAI. The process aims to. Talk us through the aims of a Serious Adverse Incident, and, if you can, can you reflect upon the value of an SAI to those who ultimately are to receive it, whether that's patients, the healthcare organisation or individual practitioners?

A. DR. HUGHES: Yeah. SAIs have a troubled history in Northern Ireland, in that they are meant to be learning tools, but often they are put in place after a significant deficit has occurred. Sometimes it's very difficult to learn from such a process when staff have maybe a heart sink moment and take issues on board. I think it has to be done in a neutral way, benchmarking best practice against the outcomes for patients, and it has to be about what happened and what should have happened. The HSC in Northern Ireland have reviewed this document subsequent to that. It is a patient-focused process, so it's really about patients and families, and making sure that you engage

with them appropriately so they go through the journey with the professionals, and that can be very challenging and difficult at times. Ultimately, it's not a blame process, it's about resolving problems and coming up with recommendations for the Service. 10:56

34 Q. We will come on presently to look at Mr. O'Brien's input, or the request for him to have input into this process and how that was managed and dealt with. In terms of, if you like, the requirement to conduct a Serious Adverse Incident Review, to what extent 10:57 should those conducting it be expected to take on board the opinions of those that they are investigating?

A. DR. HUGHES: I think it depends on the level of SAI. A Level 3 SAI, as the one we are discussing at the moment, or the series of SAIs that we are discussing at 10:58 the moment, had an external input from myself as Chair and from Mr. Hugh Gilbert. The process there was that we had an independent expert opinion on the Clinical Care, and that was supported by engagement with the families on multiple occasions. From that process, 10:58 over a period of time, stepping through the timelines, so deciding on variants from best practice we themed out issues. These would have been shared with the families. Then we asked of other professionals the outcomes and their views on it. That was then resolved 10:58 into recommendations and an action plan. It's a learning tool. It's a learning document. It's not specifically about individual professional practice. It's about what happened? What can we do next?

35 Q. My question was focused on, perhaps, to what extent is it important to hear from the Clinician or Clinicians that you are reviewing, the actions that you are reviewing?

A. DR. HUGHES: Yes, it is important to hear from them. I don't think they should be involved in the review of the actual cases, because it's about harm and potential harm, and there would be an inbuilt potential subconscious bias. I think it's important that when you see the outcomes that you give them an opportunity to respond to that. In this case, we did ask those team outcomes to be described in the nine patients. 10:59 10:59

36 Q. Yes. We will come to look at that in some detail later. Let's just look at what is meant by an Adverse Incident. If we could have WIT-84192. The definition of an adverse incident set out here: 11:00

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation". 11:00

That's a working definition with which you are familiar?

A. DR. HUGHES: Yes.

37 Q. For it to qualify as a Serious Adverse Incident, there are a series of criteria that are set out. In this situation, 4.2.1: "Serious injury to or the unexpected death of a service user". That appears to have been germane? 11:00

A. DR. HUGHES: Yes.

38 Q. Equally, 4.2.2 "unexpected serious risk to a service user"?

A. DR. HUGHES: Yes.

39 Q. One thing we have been looking at so far, and we will probably go on to look at it a little further, is, it would appear, and I will put it as neutrally as I can, that sometimes when screening incidents, professionals adopt the view that, if there was no actual harm, then it should not qualify as an SAI; in other words, it would be screened out. I hope that's not unfair on some of the decisions that we are aware of, and we can explore that with witnesses in due course, but do you see the problem I'm pointing to? In your experience, is there sometimes a tendency to look for actual harm before screening a case in? And, in your view, would that be the wrong approach? 11:01 11:01 11:02

A. DR. HUGHES: Yeah. There is a subconscious bias that people look for actual harm and do screen cases out. I have experience in other settings where people, that we were concerned about issues, so instead of simply doing an SAI, we did a lookback exercise, which triggers another process which you have to go to the Department of Health. It's not a Cancer setting, but it meant you got much better assurance because you are looking at much bigger numbers of cases, and that can be done through maybe an Electronic Care Record, and a smaller setting on files and a smaller setting looking at patients, but that triggers a much, much 11:02 11:03

wider approach to risk management and looking at cases. I think, if we were responding to the matter at hand, the initial trigger for some of this work was the prescribing of Bicalutamide, but in essence when we looked at the cases we found multiple other things that would not necessarily have been triggered if that was the only sole thing looked at. 11:03

40 Q. Yes. You have indicated that this was a Level 3 SAI. Just again looking at the document, WIT-84193, and it says: 11:04

"SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAI incidents it's important the level of review focuses on the complexity of the incident and not solely on the significance of the event." 11:04

Over at WIT-84195, we get an explanation of when a Level 3 will be appropriate. Level 3 reviews will be considered where SAIs that are particularly complex involving multiple organisations: 11:04

"Have a degree of technical complexity that requires independent expert advice; 11:05
are very high profile and attracting a high level of both public and media attention."

As I understand it, and you could help us with this,

Dr. Hughes, the levelling, or the choice of the level, is not a matter for you?

A. DR. HUGHES: No. That was a discussion I believe between the Southern Trust and the PHA.

41 Q. Yes. Do you have an understanding of why this was identified as a Level 3? 11:05

A. DR. HUGHES: Yeah. I think this was a particularly complex issue, covering multiple organisations. I think it had a complexity across a range of services, and certainly was a high profile issue. There was a certain number of cases identified but a concern about a range of other cases which then triggered a separate event, I think that was the reason why it was made a Level 3. 11:06

42 Q. Yes. It goes on to explain in just this section that the format for a Level 3 review shall be the same as for Level 3 reviews, and it provides some guidance at appendix 7. 11:06

In essence, what a Level 2 and a Level 3 engage is a Root Cause analysis; isn't that right? 11:06

A. DR. HUGHES: Yes.

43 Q. Again, could you help the Inquiry understand what that means in this context, if you were to be the author of a Root Cause analysis? 11:07

A. DR. HUGHES: Yes. In this context, I would have chaired the process. Mr. Gilbert would have given the expert clinical input. We had an in-house Cancer manager to help us with contextualised issues. We had

a Clinical Nurse Specialist who, although was employed by the Southern Trust, had just recently joined the Southern Trust and had experience from elsewhere, and we had support and input from Clinical Governance from the Southern Trust. The process was based on patients' timelines and it was based on the care they received against the expected care. It's a process of benchmarking, and then a Root Cause analysis where there is a variance to look into what caused that variance and what were the underlying factors, so you'd have contributing factors. Then you would identify the variance from best practice. You could quantify it in terms of minor variance or major variance, and you summate it per patients. I think that process was relatively straightforward. The theming and then taking the information back to the wider Cancer teams and actually trying to tease out the why things had happened, was more complex, because it's quite easy to say what the issue is. The next thing is why and how, and that resulted in the multiple conversations with a wide range of professionals who were not part of the core team but contributed to the discussions. 11:07 11:07 11:08 11:08

44 Q. Yes. That was, in essence, your fieldwork, as we will see as we develop this morning. Mr. Gilbert's clinical timeline and benchmarking was, I suppose, substantially concluded prior to Christmas. I know that there was subsequent iterations of your report, isn't that right, in chronological terms? 11:09

A. MR. GILBERT: Yes, exactly so.

45 Q. Then, Dr. Hughes, if I could use the word fieldwork. Armed with that knowledge of the deviation from benchmark, you went into the field and spoke to a range of different staff members and groups, including the MDT and the specialist nursing group, to try to work out what had happened here in governance terms primarily? 11:09

A. DR. HUGHES: Yes. I also spoke to the families at the start of the process, and I spoke to them at the midpoint to say this is early learning, early experience. Then we spoke to most of them at the end, not all. Some of them found it a bit troubling and preferred not to, which was fully understandable. At that stage, when we went to speak to the staff, this Inquiry had been called, so there was understandable anxiety within the staff group. 11:10 11:10

46 Q. Yes. We will come to that just presently. What you are describing are the key ingredients that go to make up a Root Cause analysis?

A. DR. HUGHES: Yes. 11:10

47 Q. The key evidential ingredients, I suppose?

A. DR. HUGHES: Yes.

48 Q. If we just take a look at appendix 7, which is at WIT-84229. This just helps us to understand the format that you were generally expected to work through. This is, I suppose, a precedent for the structure of a report. Just slowly take us through the pages. An introduction section. That's the cover page generally? 11:10

A. DR. HUGHES: Mm-hmm.

49 Q. Go forward. Then you start off with an Executive summary. As you can see this is a precedent, it isn't filled in. The Review Team's explained and introduced. You set out a Terms of Reference. Over the page. Into your methodology, description of the incident, findings, conclusions, lessons learned and recommendations and action plan, and then there's a distribution list. That's the basic precedent that was followed, and was followed in this case. You did that for nine cases? 11:11 11:12

A. DR. HUGHES: Yes.

50 Q. And then provided an overarching report?

A. DR. HUGHES: Yes.

51 Q. In terms of timescales for completion of a Level 3, I want to draw your attention to WIT-84197: 11:12

"Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA, DRO as soon as it is determined that the SAI requires a Level 3 review." 11:12

We will come to look at some of the reports presently, but written into the procedure for the review is a four month deadline, I suppose, for completion of the review? 11:13

A. DR. HUGHES: Yes.

52 Q. That's correct, is it?

A. DR. HUGHES: Yes.

53 Q. Can you help us in terms of where that came from; who imposed that deadline?

A. DR. HUGHES: I'm not sure if you could use the term imposed. It was largely from the Southern Trust and the Oversight Group at the Department of Health, along with the PHA. I think because there were concerns about future work to be done, they were very keen that they had early learning, early outcomes from this piece of work, so there was pressure to have it completed. 11:13

54 Q. Was that, in your experience, for something of this nature, an extremely tight deadline or something that was workable? 11:13

A. DR. HUGHES: I think the benchmarking and review process was relatively straightforward. Meeting with all the staff took longer. We attempted to get feedback from Mr. O'Brien but he wasn't able to do so. The other pressure that we have to discuss in this process is two of the patients had died before the start of the review, another two died during the review, so as we met the families going through there was a pressure from the families to get the reports. So we had to make a judgment, do we push ahead or do we wait. I made the judgment, rightly or wrongly, that the family should get the reports. 11:14 11:14

55 Q. Yes. We are going to look at that in the context of Mr. O'Brien's inability to meet with the deadline, shortly. The document provides for Service user or family involvement, and we don't need to go specifically to that. In this series of cases you 11:14

considered that particularly important, and I think you have told us in your statement that you engaged with families at three different stages, broadly?

A. DR. HUGHES: Yeah. As part of my role as Medical Director I would have met families when things go wrong. Since I have moved on from that post I have done work with the Belfast Trust, with the Neurology Inquiry families, and this piece of work. This piece of work is quite difficult, I think, for families because not many of them had any idea that there was something wrong. Some of them had some concerns but it was announced, I think, in the press and then moving on from that, I met three families initially, and then met all nine at the first to explain what the initial concerns were and how that impacted on their loved ones' care. I met the family of Patient 1 -- 11:15 11:16 11:16

56 Q. We will come to the specifics of that in a moment.

A. DR. HUGHES: Sorry.

57 Q. Just in terms of the concept of an SAI and what it's seeking to achieve, in other words it's seeking to achieve learning, I think, as you have explained, and to, I suppose, find remedies, perhaps, for things that have gone wrong in terms of systems and that kind of thing. Where is the role for the patient or the Service user and their family in that? How do they contribute? 11:16 11:17

A. DR. HUGHES: First and foremost, it's about being open and transparent when things go wrong, and that's a pre-eminent responsibility from the GMC. It's the

responsibility on the Service. When the Service calls an SAI, things have reached a certain threshold for discussion, at least, and that's the first part. It's to inform them of the concerns of the healthcare provider and to explain to them the next steps that will be taken, and it's to assure them that their views, their stories, will form part of the process. I think it depends on the SAI you are doing. As we step through this process, it was quite clear from an early stage that normal support mechanisms had not been put in place for patients. So the classic example of having a Clinical Nurse Specialist to support patients, to inform patients, to provide ongoing coordinated care, wasn't there. Our first meeting was quite bizarre. I really couldn't understand the story they were telling me because they were seeking access to the GP and seeking access through ED for services that would normally be supplied by a comprehensive CNS Service. It was at that stage we then went further and asked. From their stories we started to pick up information that wasn't immediately obvious to us. 11:17 11:17 11:18 11:18

58 Q. In more general terms, the role of the patient is, it seems, quite important in giving you, as the lead reviewer, information that might not otherwise be available on the clinical note, for example? 11:18

A. DR. HUGHES: Yes.

59 Q. Just broadening the issue of SAI out just a little while we have you here. The Inquiry has heard some evidence to date that the conduct of SAIs, at least in

the number of examples that we have looked at, have, in a number of cases, been extremely slow to work their way through the system. You touch upon an SAI that was drawn to your attention when you were conducting these reviews concerning the care that Mr. O'Brien provided in the context of referrals in triage; that was an SAI that was initiated in 2017 concerning care provided in 2016 and wasn't reported until 2020, the early months of 2020; in other words, a period of between three and perhaps four years from the incidents giving rise to the review. Is that something, that kind of delay, is that something that is commonplace and which bedevils SAIs? 11:19 11:20

A. DR. HUGHES: Unfortunately, yes, a small proportion of cases do have a very long lifespan and before you receive an outcome, I heard of that SAI when talking to other professional Urologist, I wasn't aware of it but asked to get the information and then when I saw it was about problems with the start of the Cancer Pathway, about administration and other issues of the Cancer Pathway I was quite alarmed because we had been picked up other administration and missed reports and things elsewhere in the Pathway. I was concerned because obviously this was about triage and red flag referrals, and perhaps only 15% of people who are referred in actually turn out to have a cancer, yet we were dealing with a pathway where everybody had cancer, so I was concerned about that. 11:20 11:21 11:21

60 Q. Yes. One of the factors cited for a delay of this

order, and I'm trying to broaden it out in general terms, just because the Inquiry, I understand, is interested in SAI as a process more generally, and particularly in the context of Mr. O'Brien's practice and the failure to expedite learning, given the gap of three years in that example. There's at least one other example that I could cite. One of the factors here appears to be that the clinicians who stepped up to be on the SAI Review Panel haven't necessarily got the time to be available all as a group to devote to the task in hand. That obviously didn't affect your panel because you were coming at it as independents. Is that something you've any thoughts about? Have you any thought as to how that could be remedied more generally? 11:22 11:22

A. DR. HUGHES: Yes. Traditionally SAIs are done by senior Clinician, Senior Nurse, who do it episodically and perhaps not on a regular basis. They always have other duties and other responsibilities. I think there is an argument to say that you should form an expert team within a Trust, who are professionally qualified in dealing with SAIs, and support them with nurses and doctors so that the process is driven by them and the clinical information is fed in by the professionals. The current system really doesn't work. It really doesn't work on a timely basis. You can circumvent it. If you see things arriving in an SAI, you can go for early learning, early action, but that doesn't necessarily have the full weight of a completed SAI. 11:23 11:23

There has been a process to review SAIs in Northern Ireland because it's not as effectual as it should be.

61 Q. Is that an experience, Mr. Gilbert, of delayed outcomes from SAIs that you are familiar with?

A. MR. GILBERT: It's an occasional problem. Most of the equivalent to SAIs would be dealt with in a timely way, simply by making sure that the Clinical Governance process or timetable is scheduled into consultants' job planning. It shouldn't be an additional overtime activity, it should be included within the three-monthly meeting, Clinical Governance meetings that most Departments will have. 11:24 11:24

62 Q. Yes. Presumably, Dr. Hughes, there is an importance from a learning perspective, and perhaps from a Patient Safety perspective as well, in producing timely outcomes? 11:24

A. DR. HUGHES: Yeah. I mean learning decays with time and important information then becomes yesterday's news. It really, it needs to be comprehensive to address all the issues, but it needs to be, you know, of an acceptable time frame that people can say, yeah, that happened, I remember it, I will now move on with the actions. I think it's very process-heavy in places. 11:25

63 Q. Yes, yes. Another concern that has come our way, as a result of SAIs, is in terms of recommendations, and the point seems to be twofold: First of all, recommendations are, often times, at least that's been suggested, not specific enough to focus on the deficits 11:25

either in the system or in the individual practitioner's conduct and, secondly, a delay in implementing recommendations through an action plan. Are they, again, issues that bedevil this process?

A. DR. HUGHES: Yeah, I think action plans should have a timescale and an expectation. I would be careful, I don't think SAIs can be used to alter a professional's conduct. I think that's a separate issue, but certainly action plans have to be realistic, doable and achievable, or else it just becomes a wish list sitting on a shelf. 11:26 11:26

64 Q. Thank you for that. Just on the concern you have maybe just expressed that the SAI -- if I picked you uprightly -- shouldn't be used to focus on the individual practitioner because you may recall that the SAI review that you looked at concerning triage, some time ago now, went the opposite way and was quite specific about Mr. O'Brien and his triage practice and really suggested to him politely that he should get in line, if that's not to butcher the conclusions. Those who authored that, including Mr. Haynes has given evidence to the Inquiry that specific recommendations focused on the Clinician in the context of what has gone wrong, are not only helpful but necessary to point people in the right direction? 11:26 11:27 11:27

A. DR. HUGHES: Yes. An SAI is a learning tool and I think if you are going to focus on a professional and what a professional does, that's a Maintaining High Professional Standards issue, and that's just the

dichotomy of medical practice and it's probably a false division. I think if you are going to focus on a professional's practice behaviours, et cetera, there's a clear framework to do that.

65 Q. That brings us on to another point: Should there be, I suppose, a closer relationship between those processes? What I mean by that is that those who hold the levers on the MHPS side of the house should be in conversation, or vice versa, with those on the SAI, because an SAI review can reveal deficits in clinical practice that perhaps ought to be, in particular circumstances, the subject of whether an informal or a formal MHPS arrangement? 11:28 11:28

A. DR. HUGHES: Yes. Outcomes from SAI reviews can inform Maintain High Professional Standards but Maintaining High Professional Standards framework is quite old, from 2006, I believe. I think it probably needs to be reviewed. It's very focused on incidents, you know, specific incidents of deficits over short periods of time. It's an investigation that has to be completed in six weeks and it doesn't address real problems. I think there is an issue about how you deal with this dichotomy. I mean, Serious Adverse Incidents are about patient deficits and learning from that. Maintaining High Professional Standards is a HR framework which needs to be dealt with in a separate way. 11:29 11:29

66 Q. MHPS is to be reviewed in the early months of next year and the Inquiry is keeping an eye on that.

Chair, could I suggest a quick break, for ten minutes or so?

CHAIR: Yes. If you hadn't done so, I was about to, Mr. Wolfe. So, let's give everyone until quarter to 12. 11:30

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe.

MR. WOLFE KC: Mr. Gilbert, in terms of your engagement in this exercise, you've told us in your witness statement that you'd no prior knowledge of Mr. O'Brien, or indeed I think of the Southern Trust? 11:46

A. MR. GILBERT: No, neither. No prior knowledge in either case. 11:46

67 Q. Yes. Your selection or commissioning for this task, that came through your work with the --

A. MR. GILBERT: With the IRM. It was a slightly more complicated process in that I think the Southern Trust initially approached the IRM for help with a notes review to be done by the incumbent Urologists. That's not the sort of work that the IRM does. It sends in a team to look specifically at a specific problem. I was asked in that role did I know somebody who would do the work, and I spent quite a lot of time 11:47 11:47 phone-calling, and to say that it's not popular work is something of an understatement. Okay.

68 Q. That was the work associated with the Lookback Review?

A. MR. GILBERT: That's the lookback review, as

I understand it, and Professor Krishna Sethia undertook the work, and I know nothing about -- I deliberately have siloed all this.

69 Q. Yes.

A. MR. GILBERT: The IRM was approached again to perform a notes review. Because I had been involved, my involvement with that approach was stopped and it was handed over to somebody else. My only role in that was to appoint my equivalent for that process as a substitute to me because I was tainted. 11:48

70 Q. Yes.

A. MR. GILBERT: I understand that that work is still outstanding, and I suspect is not going to happen, but I don't know, again, that's siloed. I was then approached again by the Southern Trust to say do you know who would do these serious adverse events? Having gone through two iterations of trying to recruit people I thought I'm not going through this again so I put my own hand up. 11:48

71 Q. Yes. I just want to pick up on a word you use in your statement. If we can bring up WIT-85891. If we scroll back to 887. Sorry. Thank you. 11:49

If we look at what you say at 1(d). Here you describe what you understood your role would be to review the clinical records of nine cases that had been deemed by the Southern Health and Social Care Trust to have reached to threshold to trigger SAI reviews. You say: 11:49

"As a general Urologist with 23 years' Consultant experience in diagnosis and management of urological cancers at a district general hospital I felt that I was in a position to perform disinterested and contextually realistic case reports to inform the governance process at HSCT". 11:50

Just that last line "disinterested" in this context. That means that you had no skin in the game, you didn't know anybody, and you came at this independent? 11:50

A. MR. GILBERT: Independently and from an equivalent position to the urologists at the Southern Trust. I make no bones about it, I am a general Urologist. I am not a professor of Urology, and I think as such, this was my pitch to get the job with the IRM was that I could identify with the pressures and concerns of other general urologists in district general hospitals. 11:50

72 Q. Yes. Your working life, your professional life, Gloucester and then North Bristol, I am not sure it's not like for like Craigavon or Southern Trust, but district general hospital providing a range of typical urological services in your case, and broadly similar to what you think was going on in Southern Trust at Craigavon? 11:51

A. MR. GILBERT: Yes. Yes, indeed. 11:51

73 Q. How many urological Consultant colleagues would you have had at either of your home places?

A. MR. GILBERT: When I started in 1996, there were two of us. By the time I left there were 12.

74 Q. That was Gloucester?
A. MR. GILBERT: Gloucester. In Bristol, it's a teaching hospital environment, and there are 23 and counting.
75 Q. Yes.

In terms, Dr. Hughes, of your knowledge of both the Southern Trust and Mr. O'Brien, I suppose Mr. O'Brien, first of all, any particular knowledge or dealings with him prior to this engagement? 11:52
A. DR. HUGHES: Yes, I would have had some engagement with Mr. O'Brien between 2008 and 2011 when I was the Medical Director of the Northern Ireland Cancer Network I would have engaged with the Urology team in discussions about Urology Services. As part of the role as the Medical Director the Northern Ireland Cancer Network there are discussions about centralising types of care, centralising at that time prostatectomy care. I do remember visiting and discussing that with Mr. O'Brien, but no other particular engagements. At that time our main focus was on breast cancer, lung cancer and colorectal cancer, because they were the first tumour types to undergo peer review. 11:52 11:53
76 Q. Yes. Of course, as a Medical Director in the neighbouring Trust of the Western Trust, some of your patients, some of your population, I should probably say, in the Fermanagh area, I think you touch on this in your statement, would have been recipients of the Urology Services of the Southern Trust? 11:53
A. DR. HUGHES: Yes. The Urology Services had been

reviewed in 2009 by the HSCB, and the structure of Urology Services had been changed. My Trust took the north part of the Northern Trust and the southern part of the Northern Trust went to the Belfast Trust, and the Southern Trust took on the population of Fermanagh, which features quite a bit in some of the discussions. I think it was quite a stretch, an extension of their geographical area, and I think, in some of the evidence you would have received, that people felt it was putting the Service under further pressure and they couldn't address. I must admit, I would have some sympathy with that. I believe after I left the Western Trust, the Western Trust took back the Fermanagh population because while the Service was outreached to Fermanagh, it sort of fractured the normal pathways of patient flow. So the nursing flows, the radiology flows, the laboratory flows would have stayed within the Western Trust, and while it looked good on a map it probably didn't address patient need. 11:54 11:54 11:54

77 Q. I think you again say in your statement, you had no knowledge of the particular problems that had developed around Mr. O'Brien prior to coming into this engagement? There had been an MHPS process between 2017 into late '18. No knowledge of any of that until you came into this process? 11:55 11:55

A. DR. HUGHES: The first time I heard of that was when discussing the findings of the SAIs with professionals in the Southern Trust.

78 Q. Yes. You would perhaps have been aware, and maybe you

just subtly touched on it a moment ago, of the demand pressures faced by the Southern Trust in the delivery of Urology Services. We have heard evidence, a good deal of evidence has been received about the demand capacity mismatch as it's framed, creating all sorts of backlogs particularly amongst non-cancer patients, and even some of the cancer patients were facing difficulties in getting seen within the -- what you referred earlier as the ministerial deadlines or time limits. Were you aware of that kind of pressured context coming into this? 11:56 11:56

A. DR. HUGHES: Yes, I would have been aware of that both within my own Trust where they had adjoined two legacy systems together to form a new Trust, or form a new team. They moved to three teams in Northern Ireland. I would not have been aware of the detail within the Southern Trust until I went to do this process when it became very obvious that people explained the pressure they had and the difficulty they had with delivering a Service to an extended population. 11:56 11:57

79 Q. One of the issues we will maybe come on to explore in some detail is, I suppose, the explanation, or some might call it the excuse, of resources. We haven't been commissioned to govern in this way or to do governance in this way and, therefore, there's a resources impediment to us providing the kind of safe service that you, I suppose, demand through your SAI conclusions. I mean, in general terms, is that familiar to you as an explanation that was put to you? 11:57

A. DR. HUGHES: I think it's a fair explanation. I think it's not familiar to me.

80 Q. Sorry, it's familiar to you from what you were told during this investigation?

A. DR. HUGHES: Yes, yes, yes. 11:58

81 Q. Yes.

A. DR. HUGHES: From my own Trust background, it wasn't familiar to me because I believe we were quite well-resourced in terms of cancer services, and perhaps differentially so compared to the Southern Trust. We'd 11:58 gone through a process of agreeing to build a Radiotherapy Cancer Centre in the Northwest, on a cross-border basis. It meant we had in-house Oncology. It meant we had a range of services. It meant that perhaps we were in a better position to 11:58 deliver on the targets.

82 Q. Yes. We will go on and look at the whole resource issue maybe in some detail. If I could have up on the screen, please, WIT-84153. At paragraph 5 you say:

11:58

"I was initially unaware of the professional involved", that's Mr. O'Brien, you've called him Dr. 1: "Was unaware of the concerns within the Urology Services. This however changed when meeting with professionals who referred to a previous serious adverse review 11:59 involving the named professional, I believe this could be of importance to the ongoing nine SAI reviews and to the learning and action plan resulting from that process."

I didn't really understand what you were saying there so I want to ask you some questions about it. When you were asked to do these reviews were you told the name Mr. O'Brien?

A. DR. HUGHES: Not initially. I was told that they had a range of SAIs in Cancer Services and would I consider doing this. I presumed they asked me because I had a background in Cancer Services and a background as a Medical Director. I agreed at that stage, I think that was appropriate. I don't think the name should be important.

83 Q. Yes,

A. DR. HUGHES: When I started the process and in talking to professionals, some professionals mentioned previous actions that had been ongoing within the Trust and a previous Maintaining High Professional Standard Process. I had not been briefed on those but I was informed of them by other professionals.

84 Q. Yes. Was it the intention -- I mean, this paragraph maybe suggests it was the intention that you would process through this not knowing the name but you stumbled across it because an SAI was mentioned to you, or is that not the meaning I'm to take from this?

A. DR. HUGHES: No, the meaning is that I was asked to do an SAI about a Service as opposed about a professional, and the name in essence doesn't matter, it's about the nine patients. I think the issue about hearing about other investigations, I think that that was just human

nature, people were declaring that to me.

85 Q. Yes.

CHAIR: Mr Wolfe, just I might ask a supplemental question, while it's in my head then. Would it be the norm that if you were asked to carry out an SAI, you've indicated that you think it's preferable that you don't know the individuals involved because it's about learning for the organisation essentially. But is it the norm, given that Northern Ireland is such a small place, that you would eventually find out who might be involved in it? 12:01 12:01

A. DR. HUGHES: It's not the norm to find out a name, and I think it's unhelpful. A Serious Adverse Incident is about a Serious Adverse Incident on a patient and I think it should be approached that way. In some of my evidence you will see when I am talking to professionals within the Trust, I said this is rather professional focused rather than patient focused. I think it was unhelpful that something becomes professional focused because it can cloud the issue. 12:02 12:02

CHAIR: Yes. Thank you.

MR. WOLFE KC: Albeit that the characteristics of the professional and how they could go about their job, can be important and where it proved to quite important in terms of the cases that you were examining? 12:02

A. DR. HUGHES: Yeah. I mean, this is where you have to focus on a patient and when you do your Root Cause analysis these things will unfold in due course. If it's about a range of patients you have to see the

variance from expected best practice and then ask yourself why and, you know, that would be self-evident. I just think it's unhelpful to start off with a name.

86 Q. Yes. Thank you. Just in terms of your role. We have touched on it briefly, but drilling down a little bit more. If we go to WIT-84154, and if we look at paragraph 11, just zone in on that. You explain your role was the Independent Chair of the process, and you set out your responsibilities for the review, for the Root Cause analysis, for patient timelines, and leading on family engagement. Then sitting alongside you is the expert clinical advisor, that's obviously Mr. Gilbert, and his role is different. If you can help us to fully understand the distinction between your roles. Mr. Gilbert, you can obviously join us in that? 12:03 12:03 12:04

A. MR. GILBERT: I saw my role specifically to review the case record and write down what has happened. Nothing more than that.

87 Q. Did you have at your side, if you like, the benchmarks in terms of the various national and regional guidance? 12:04

A. MR. GILBERT: Yes. I mean, I used the guidelines that I've used to from both my previous or my current MDT work. There's no rocket science behind guidelines. They come straight from the European Association of Urology, and anyone setting up an MDT, the easiest part of it is to fill in the guidelines because you just say we follow the European or the national guidelines. 12:05

88 Q. Yes.

A. MR. GILBERT: Those should be in most urologists' head. On occasions you might need to refer to them for unusual cases, but for what might be termed the more straightforward pathways, then those should be in each Urologist's mind. 12:05

89 Q. Yes. We will just come and look at some of those in just a moment. But in terms of your role, Dr. Hughes, did you do all of the writing when we look at these reports, or was the clinical aspect written by Mr. Gilbert? 12:06

A. DR. HUGHES: It would have been an iterative approach. I would have done some of the writing with the Governance Lead Patricia Kingsnorth, and we would have shared documents and amended them, and agreed an outcome. 12:06

90 Q. In terms of Mr. Gilbert's role, you go on to explain in your statement that it was important that he worked in a district general hospital, a similar environment, and that he was familiar with national best practice, in both of those, one a personal characteristic or an occupational characteristic, and the other his expertise, that was important? 12:06

A. DR. HUGHES: Yeah. I think it's important if you're assessing a Serious Adverse Incident that you do it in its context, benchmarking both experience and processes. 12:07

91 Q. In terms of benchmarking, if we go to your statement at WIT-84157, and down to the bottom of the page, please, paragraph 5. You are asked here to outline how the

Review Team assessed the performance of the MDT pathway for Cancer management and who took the Lead for this aspect of the Review Team's work, and provided the description of what steps they took. Here you do what you have just explained, you've explained Mr. Gilbert's role as the external expert, Clinical Advisor, and you say that the work of the team was to discuss at weekly and bi-weekly meetings, benchmarked against care as defined by, and you set out a number of specific guidelines - NICaN, Urology, Cancer guidelines, NICE guidance, cancer-improving outcomes. You say: 12:07 12:08

"This review also included the local Urology Cancer MDT recommendations".

Over the page: "Findings were compiled into reports." 12:08

Here, just on the bullet point there. Sorry, I shouldn't forget that you refer to the family input as well. You refer then: 12:08

"The patient pathways and outcomes were also benchmarked against the stated standards of care declared by the Southern Trust to the external cancer peer review." 12:08

Can we just have that document up, please. The external cancer peer review is at AOB-79828. While we are waiting on that coming up, a peer review of the

Southern Trust's Urology cancer MDT was conducted in 2017; isn't that right? AOB-79828. This is the self-assessment report pro forma which Mr. Glackin is the Clinical Lead for the MDT put into the peer review. If we just scroll down it. There's a number of general remarks about how the MDT functions. Then over the page, if you would, at 79829. There's two particular points I would like you to pick up on in reverse order. The point about nursing is dealt with here, and I will ask you to explain why this is germane to the work that you did. Mr. Glackin says here to the peer review: 12:09 12:10

"Progress is ongoing in relation to the full implementation of the key worker holistic needs assessments communication, ensuring all patients are offered a permanent record of patient management. With the appointment of two more nurses to the Thorndale Unit and clerical staff, all newly diagnosed patients have a key worker appointed a holistic needs assessment conducted adequate communication and information advice and support given". Et cetera. 12:10 12:11

That is, as I understand it, a reference to the Cancer Nurse Specialist and I think the frequent refrain in your report says that while this was asserted to the peer review, it wasn't the reality? 12:11

A. DR. HUGHES: Yes, sadly. I think we need to unpick this a bit --

92 Q. Okay.

A. DR. HUGHES: -- and explain what a Cancer Nurse Specialist does for patients. A Cancer Nurse Specialist is responsible for a baseline holistic needs assessment and reassessment as a patient's pathway changes. They are responsible for the well-being of patients, and they are responsible for ensuring patients fully understand the MDT discussions and fully understand their treatment options. Their role is essential in care. This statement implied, and it was in 2017, when we were looking at patients largely from 2019, implied all patients had access to that care. When I first met the family I couldn't understand how disjointed and/or difficult their care was in the community. I really struggled with it, but then I discovered that they didn't have access to a Cancer Nurse Specialist. I then tried to unpick this, and it was established that Mr. O'Brien did not include the Cancer Nurse Specialist at his Oncology clinics, and that meant either being present in the clinic or even giving a telephone number. We had a cohort of patients who were not receiving that essential care. 12:12 12:12 12:12 12:13

93 Q. I am going to look just a little later about the evidence around that and the implications of that, but for present purposes what I am going to do for the next few minutes is setting out the kind of benchmark evidence that you received. That was one indicator, as I understand it, that the Trust set themselves the standard of being in a position to resource a key worker or specialist nurse to all newly diagnosed 12:13

patients, cancer patients, and that was the standard you were essentially applying?

A. DR. HUGHES: Mm-hmm.

94 Q. Yes. Let me see if we can scroll back up the page, if I can find it. Yes. Just at the bottom of the page then, this is Mr. Glackin declaring to the peer review that the Urology Cancer MDT adheres to the Regional Urological Clinical Reference Group guidelines and patient pathways, and these have been agreed at an MDT meeting. Unpacking that for us, that is a reference to our local Northern Ireland Cancer Advisory Network process, is the NICaN process, is it? 12:14 12:14

A. DR. HUGHES: Yeah, that's a reference to the NICaN Northern Ireland Cancer Network Urology Regional Reference Group. Their number one Terms of Reference is to agree best practice guidelines and ensure consistent implementation across Northern Ireland. 12:15

95 Q. What Mr. Glackin is signalling here is that the MDT in the Southern Trust was embracing and applying the NICaN standard? 12:15

A. DR. HUGHES: Yes.

96 Q. Mrs. Kingsnorth then sent you, as I understand from your statement, a series of documents which are relevant to the benchmarking exercise. That's plainly one of them, that's signalling what the MDT does. 12:16 Could I look at WIT-84439? This is one of the documents you cite in your statement. This is a cancer research UK document Improving the Effectiveness of Multidisciplinary Team Meetings in Cancer Services.

Why was that relevant from a benchmarking perspective?

A. DR. HUGHES: It's really to show the principles of how a functional MDT should work and how they should deliver care for patients.

97 Q. Yes. In terms of the dual work that you were carrying out, that's more relevant for the governance side, for your side of the house, Dr. Hughes? 12:17

A. DR. HUGHES: Yes.

98 Q. Is there anything in particular in that document that you wish to refer us to? I know that, within your reports, you talk about difficulties within the MDT, cases not being referred back, failure to escalate, deficits in care, these kinds of things? 12:17

A. DR. HUGHES: I think the overarching findings were that absence of Clinical Nurse Specialists meant that there was no overarching view of MDT recommendations being implemented. 12:17

99 Q. Yes.

A. DR. HUGHES: There is a requirement, if you don't implement an MDT recommendation, that you would bring it back to your colleagues and discuss it, and agree how that would be achieved. I think the other issues are that, because the team focused on first diagnosis and first treatment, patients weren't being brought back to the MDT for discussion as their care needs changed, and because a cohort of patients were not also being cared for by a nurse specialist, it meant that they had a major deficit in their care. 12:18 12:18

100 Q. There's a series of documents cited by you as having

been provided by Patricia Kingsnorth, I just want to highlight each of them to the Inquiry, and you can offer any relevant comments, or indeed yourself, Mr. Gilbert. WIT-84448. Publication of the British Uro Oncology group concerning multidisciplinary team guidance for managing prostate cancer. Again, for you, Dr. Hughes, the relevance of this document?

A. DR. HUGHES: It's just to show the abundance of standard guidelines and the abundance of standard evidence that people should adhere to, and clearly that wasn't the case in all patients. 12:19

101 Q. You refer also amongst the list of material received, or going backwards and forwards between you and Patricia Kingsnorth, to an e-mail, WIT-84526, and it appears that this concerns the issue in respect of one patient who had a diagnosis of penile cancer. This e-mail suggests that there was a bit of debate, perhaps, between you and her, and perhaps you and the rest of your Review Team about the applicable standard or the applicable benchmarking criteria? 12:20

A. DR. HUGHES: Yeah. Penile cancer is quite a rare cancer, and the NICaN guidance signed up in 2016 indicated that all cases should go to a regional penile cancer Service which was local in Northern Ireland but linked, I believe, to Manchester, as a supra-regional Service. While that guidance came out in '16, it took them several years to actually get a functional system up and running. The Northwest Penile Cancer Service, which is the Service for Northern Ireland, only became 12:21

operational in 2019.

102 Q. You refer to the 2016 guidelines, the NICaN guidelines. If we could open those, please, at WIT-84611. Is it fair to say, Mr. Gilbert, that in terms of a benchmarking exercise that you had to perform, that this was something approaching the core text? 12:22

A. MR. GILBERT: Yes.

103 Q. For local purposes?

A. MR. GILBERT: Yes.

104 Q. Is it your understanding that this document borrows on the learning and research from a national level, from a GB level? 12:22

A. MR. GILBERT: Yes.

105 Q. It incorporates, for example, the NICE learning, NICE guidance? 12:22

A. MR. GILBERT: Yes, this is a condensation of a number of sources, and that process of condensation would have been reiterated around the countries in order to bring up their local guidelines, but they will all be based upon national and international advice and guidance. 12:22

106 Q. Yes. Just touching upon some aspects with this. All of the major tumour sites are covered obviously within this. We have prostate dealt with at WIT-84651. If we look at, for example, WIT-84665 on this sequence, the fourth bullet point from the bottom is something we will maybe get into in a little detail later. So it says: 12:24

"Men with intermediate and high risk localised prostate

cancer should be offered a combination of radical radiotherapy and ADT androgen deprivation therapy rather than radical radiotherapy and androgen deprivation therapy alone."

12:24

We are going to explore later with you what that means, but that is something of the standard that you were considering; is that right?

A. MR. GILBERT: Exactly so. I think it's important to point out these are guidelines, and what the clinician responsible for patient's care brings to the MDT is the context; that is the patient's existing or pre-existing disease, their expectations, their express desires in terms of their treatment, but any deviation from these points of guidance should be documented within the MDT discussion. For example, if somebody feels they don't want to have radiotherapy because it's too arduous to go to 50 miles up to the road to the nearest facility, that should have been made clear within the MDT minutes, either at the time of discussion, because of prior knowledge, or after the options have been discussed with the individual.

12:24 12:25 12:25

107 Q. Yes,

A. MR. GILBERT: That closes that particular loop of variation.

12:25

108 Q. Yes. We will look at that, perhaps later, in the context of a specific case or cases. Just pointing out the standard for present purposes. Looking at another type of cancer that was relevant to your consideration,

was penile, as I have just mentioned. Looking at WIT-84674 and moving through to 84679, this deals with treatment and that was one of the issues, I think, that concerned you in respect of patient H or Patient 3's case, if I've got that name right. I have got right, have I? I have.

A. MR. GILBERT: Yes.

109 Q. Yes. We will maybe go and again look at this in a bit more detail later. The concern for you in that case was the retention of the care locally and the delay in referring to the supra-regional hub of specialists?

A. MR. GILBERT: Yes, certainly that's true. This particular aspect of the guidelines, which relate to the rarer cancers, were brought about in order to ensure that particular centres had enough experience to provide the best possible standard of care, and that the occasional practice of, say, doing one or two cases a year was to be eradicated, on the basis that the more you do, the better you become at things. The population for penile cancer was 4 million. It's actually been quite a difficult thing to establish because of political differences around but it has been. But any Clinician, before the arrangements were made to divide up the various parts of the countries into these subspeciality MDTs, before that was formalised, any Clinician would have understood that, actually, the writing was absolutely clear and that individual arrangements had been made by the clinician. So, from, probably, 2008, I would refer penile cancers

to a specialist provider.

110 Q. Yes. We don't need to bring up all of the pages, but these guidelines also deal with renal cancers, testicular cancer. There is a section on nursing which I will open briefly. WIT-84725 highlights, I think as you were referring to earlier, Dr. Hughes, it highlights the importance of the nursing aspect in the management of urological cancers. For example, halfway down the page, NICE 2014, it emphasises that the CNS can ensure that patients have information that is tailored to their individual needs, therefore enhancing shared decision-making, also in an excellent position to provide individualised care following treatment which promotes cancer survivorship, and it goes on to cite Anne McMillan on the study of the importance of nursing expertise. 12:29 12:29 12:29

Again, some of the lines there were to resonate with your work on these nine reviews?

A. DR. Hughes: Yeah, the role of the Urological Cancer Nurse Specialist is really essential for care. It's supportive, it's informative, and patients receive better experience. I think the families found it quite difficult to know that the majority of people received that care, but their cohort didn't. Looking at the recent cancer patient audit you can see the care delivered from the nurses from the Southern Trust is exemplary and I think that's a particular problem. By the luck of the draw because they were allocated 12:30 12:30

a professional they didn't get this Service.

111 Q. Another benchmark document that your attention was drawn to, as I understand, was the MDT operational policy for the Southern Trust Urology Cancer MDT. We can find that at WIT-84532. It's the cover page, signed off by the Director of Acute at the time, Esther Gishkori, 1st September 2017. The Clinical Director of cancer services, then Dr. Convery and Mr. Anthony Glackin as the MDT lead. Again, a document that you would have familiarised yourself with prior to or during your work. Just a couple of aspects I want to seek your comments on. 12:31 12:31

If we turn to WIT-84538, "disease progress" says:

12:32

"All new cases of urological cancer and those following urological biopsy will be discussed. Patients with disease progression or treatment related complications will also be discussed and a treatment plan agreed. Patients' holistic needs will be taken into account as part of the multidisciplinary discussion. When a clinician has dealt with the patient will represent the patient and family concerns and ensure this discussion is patient-centred." 12:33

12:33

The focus of my attention here is this principle that a case should come back if there's disease progression or complication.

A. MR. Gilbert: Yes, that would be a standard part of any

MDT's operational policy. Any substantial change in the circumstances of the patient and their disease should be brought back to the MDT for discussion, because it might mean the need for another or different professional to become involved, so that the MDT is the focus for managing the patient. 12:34

112 Q. Yes. Could I present you with a slightly different scenario? The MDT has thoroughly discussed the case and made a recommendation, which is then brought to the patient by the treating clinician, and either can't be sold to the patient, if I can use that term, or it becomes a treatment that is inappropriate, for whatever reason; the disease has moved on or there's another factor that the clinician becomes aware of, or whatever. What is to be done in that scenario in terms of the single clinician and his relationship with the MDT? 12:34 12:34

A. MR. GILBERT: The case should be brought back to the MDT to appraise the team of the reasons for any change. They should be obviously recorded in the notes and in the MDT record. Yes, simple as that, really. Again, a patient declining treatment or being unsuitable for treatment is a significant change in management, and any significant change in management should be discussed at the MDT. 12:35 12:35

113 Q. Presumably the Clinician should record it and the reasons relevant to the process within the individual patient's notes?

A. MR. GILBERT: Yes, that would be the first action. The

next action would be to request that the patient was discussed at the MDT so that people were aware of that as a decision.

114 Q. Yes. What you have just described there, obviously we have here a description of cases that should go to the MDT, what you have described patient not taking the medicine that's recommended, or circumstances changing, so that the recommendations perhaps no longer are appropriate, should go back to the MDT. Is that something that is committed to writing anywhere in any of these guidelines? Is that something you need to go and have a think about, or is it just a good practice that most MDTs would insist upon even if it's not written down? 12:36 12:36

A. MR. GILBERT: I think a good MDT would insist upon it, and I think it is written down in the sense that any significant change in management from that dictated or -- not dictated, that's too strong a word -- that recommended by the MDT should be brought back to the MDT. Yes. 12:36 12:37

115 Q. Yes.

A. DR. HUGHES: Sorry, effective MDT National Cancer Action team from 2010 and it makes -- under the section of governance, it's probably 5.3, it clearly says that if there's a change in MDT plan, the information has to be brought back to the MDT so (a), they know about it, they may want to discuss it or act upon it. That's a document that is signed off by Mr. Mike Richards a very long time ago, and it's just good practice. 12:37

116 Q. It appears, from just our review of some of those documents, that -- I don't say this disparagingly at all, but there are a range of, I suppose, stakeholders in this area who have something important to say about these issues. We've seen cancer charities contribute. Northern Ireland has the good fortune of having NICaN. Different contributors say something about the benchmark or the standard they would like to see implemented, but to what extent does a local MDT like the Southern Trust have to take all of that on board? Here I am thinking about the specific example we are working with of a patient, having listened to his individual clinician, deciding that the recommendation isn't for him. You say that should go back? You cite the -- 12:38 12:38 12:39

A. DR. HUGHES: Yeah, I think it should. There will be a record on the cancer patient pathway that states plan A is there but he is receiving plan B, that's an issue. I think if the care is truly multidisciplinary, I think the other members of the team should know. In terms of significant changes, I think that would be a significant change in the patient's pathway, so there would be a duty on the professional to inform the team. 12:39

117 Q. Yes.

A. DR. HUGHES: I can understand that this could be bureaucratic and troublesome, but it should not happen on a regular basis. 12:39

118 Q. Just finally on this document, key worker and nursing issues, they are dealt with in this multidisciplinary

operational policy at WIT-84545. Just at the top there, it says:

"It is the joint responsibility of the MDT Clinical Lead and the MDT core nurse member to ensure that each Urology cancer patient has an identified key worker, and that this is documented in the agreed record of patient management."

We will look at the cases in some detail maybe later this afternoon and into tomorrow, but it was to be your finding that none of the nine cases that you looked at had access to a Cancer Nurse Specialist, and this document puts the onus on the Clinical Lead and the core nurse member to ensure that the patient has an identified nurse? 12:40 12:40 12:41

A. MR. GILBERT: The key worker and Cancer Nurse Specialist are not interchangeable. A key worker could be a doctor. It is a person who is willing to be an access point for the patient throughout their journey and To remember that they may change hospitals, they may change consultants, but the key worker is there continuously to allow the patient access to information and support. It just so happens that the best-placed person for that is a Cancer Nurse Specialist. They have the expertise not just in the medical aspects of care but also within the nursing aspects of care, which are fundamental to a patient's wellbeing. In my experience, at the time of discussion, the key worker 12:41 12:42

is appointed, and that is almost inevitably a Cancer Nurse Specialist. They are named, and their name is printed on the MDT pro forma so that everybody knows who is responsible.

119 Q. Yes. We can look at some of the detail, and you have gathered evidence from a range of people on this issue. The cancer nurse specialists themselves, Mrs. Corrigan stands out as someone who gave you particular evidence. Can you help us with this, just as a taster before we get to the detail of those cases. This appears to give a duty to allocate the key worker, who is usually the nurse, if I understand Mr. Gilbert's evidence correctly. In terms of the reports that you wrote up on each of the nine patients, the focus wasn't on these two people, it wasn't on the Clinical Lead and it wasn't on the core nurse member, but it was on Mr. O'Brien as the Clinician with responsibility for the care of the patient and the onus, correct me if I am wrong, in your reports seemed to suggest that the buck rested with him to sort out that allocation? 12:42 12:43 12:43 12:43

A. DR. HUGHES: Yes. Normal practice, in my experience, would be that care is shared, so when a patient comes, they come to the breaking bad news clinic, the Oncology clinic either with the Consultant or the Consultant gives the name. In that way there is a seamless care so there is a Clinical Nurse Specialist to support the patient and inform the patient of their illness. This document clearly says something different, but, in my experience, the professional giving care should be the 12:44

care should be the person who -- clinical nurse specialist. The issue with that there was clearly an issue in the Southern Trust where Mr. O'Brien did not work with Clinical Nurse Specialists in his Oncology Clinics. There is an issue he asked them to do transactional issues and nursing issues, but he did not involve them in terms of the classic roles of a Clinical Nurse Specialist, a Cancer Nurse Specialist in terms of holistically baseline assessment, ongoing baseline assessment informing them of their disease and discussing the options. 12:44 12:45

120 Q. Yes. Are you saying that it's your understanding of the process -- and I'm probably getting here in a little more deeply than I intended to at this stage but we have gone down the road too far to come back now. Are you saying that, notwithstanding the written word of the local MDT operational policy, that the practice of that MDT was that it was a matter for the treating Clinician to put the patient in touch, whether that was simply handing a phone number or a leaflet, or actually making a formal physical introduction. The role is there and it's not as stated on this page? 12:45 12:45

A. DR. HUGHES: The question arose when we had nine patients, none of whom had a Clinical Nurse Specialist so part of the Root Cause analysis we go back and ask how this happened and the response from Martina Corrigan, who was the Urology Services Manager for eleven years, explained that they were not included in the outpatients of Mr. O'Brien that had been challenged 12:46

on two occasions by two nurses without success. She says in her evidence, and it's included, that that was escalated but without result.

121 Q. Did you ask the question, or were you able to establish, why aren't you complying with your operational policy which takes the matter out of Mr. O'Brien's hands and puts it in the hands of these two people specifically named? 12:46

A. DR. HUGHES: I did ask the question of a range of professionals but I didn't get a satisfactory answer. 12:47

122 Q. Did you reach the conclusion that, notwithstanding what is on this written page, the practice in the Southern Trust was for the treating clinician to make the introduction or bring the contact information to the patient? 12:47

A. DR. HUGHES: The practice in the Southern Trust was that all other patients received this care in tandem with their caring Consultant, but a separate cohort did not.

123 Q. Yes. 12:47

A. DR. HUGHES: That issue was known but not dealt with.

124 Q. We will maybe come back to that issue. Just one other document by way of benchmarking, which I want to open at this stage. It came your way following a conversation with a Dr. Mitchell who, as I understand it, is a Clinical Oncologist in the Belfast Trust. 12:48 I don't want to go into the detail of that conversation just at this point but I want to open the document with you and just ask you to what extent it was relevant to

the exercise that you were performing, perhaps Mr. Gilbert. The document, just to give it its opening page, is WIT-84426. It's entitled Regional Hormone Therapy Guideline. I think the pages have 'draft' which are marked across. This was a document sent to you by Dr. Mitchell; is that right?

A. DR. HUGHES: Yes, I had spoken to Dr. Mitchell, who is a Urology Radiation Oncologist in the Northern Ireland Cancer Centre after speaking with Professor Joe O'Sullivan. Dr. Mitchell had previous interactions with Mr. O'Brien and was concerned about his therapeutic prescribing, and had challenged him on several occasions. Dr. Mitchell was the regional Chair of the Urology Regional Cancer Guidance group and, at that stage, he also indicated that he challenged Mr. O'Brien about his prescribing of --

125 Q. I am going to come to that bit in a minute. Just in terms of this document. Dr. Mitchell sent you this?

A. DR. HUGHES: Yes.

126 Q. Just in terms of the origin of the document, how did the document come to be created? Were you told about that?

A. DR. HUGHES: Yes, Dr. Mitchell explained it was Regional Hormone Therapy guidelines and it was drafted to address concerns around Bicalutamide prescribing, and it was signed off by Mr. O'Brien when Mr. O'Brien was the Chair of the Regional Clinical Guidance group.

127 Q. Was the concern about Bicalutamide prescribing that was the trigger for this document?

A. DR. HUGHES: Yes.

128 Q. Were you given to understand that was a general issue, or was he saying it was a Mr. O'Brien issue that caused this to be drafted?

A. DR. HUGHES: He was implying it was a Mr. O'Brien issue. Professor O'Sullivan had concerns for 17 years. In the document I have shared, Dr. Mitchell had concerns for ten years. 12:50

129 Q. Yes. Are you clear about that, that Dr. Mitchell formulated this document in response to -- 12:51

A. DR. HUGHES: Yes.

130 Q. -- issues of Bicalutamide prescribing, specifically directed from Mr. O'Brien?

A. DR. HUGHES: Yes. That's covered in the minutes of our meeting. 12:51

131 Q. Yes. We will come to that. Just in terms of a specific feature of the document, it deals with Bicalutamide. If we can turn to WIT-84427. This is setting out information for the region in relation to prescribing in circumstances of prostate cancer in the main. If we scroll down the page, it deals with the circumstances of intermediate high risk prostate cancer: 12:52

"Men with intermediate risk prostate cancer should receive a total of six months of hormone therapy before, during and after their radiotherapy." 12:52

It specifically provides the hormone therapy options

with radical radiotherapy, and he sets out the LHRH agonists.

Scrolling down the page, it says:

"In order to prevent testosterone flare, anti-androgen cover with Bicalutamide 50 milligrams is given for 3 weeks in total with the first LHRHa given 1 week after the start of the Bicalutamide." 12:53

It goes on to say: "Bicalutamide 150mg monotherapy can be used as neo-adjuvant hormone therapy especially in men where preservation of physical capacity or sexual function is important or in those who may not tolerate hot flushes." 12:53

It goes on to say:

"The cardiovascular and metabolic toxicities of LHRHA should be discussed and the patient advised to address cardiovascular risk factors with their GP." 12:53

Mr. Gilbert, can you help us with this? For a patient who emerges from MDT with a recommendation for radiotherapy -- 12:54

A. MR. GILBERT: Yes.

132 Q. -- is it conventional to provide for hormone treatment in advance of the radiotherapy?

A. MR. GILBERT: Yes, neo-adjuvant treatment is code for

treatment prior to the definitive radical therapy, which in this case would be radiotherapy and the neo-adjuvant treatment would be hormone treatment.

133 Q. Yes.

A. MR. GILBERT: The studies that were done were based on the use of an LHRH analogue in two big studies which showed that this was advantageous in terms of disease control. So all men would start hormone therapy and that would be with an LHRH analogue in most instances. The use of Bicalutamide 150 milligrams is an alternative when the LHRH analogue is, for whatever reason, not tolerated or not indicated. There are some concerns around so-called metabolic syndrome which is, essentially, that these drugs may give a predisposition to some cardiac events and may contribute towards the development of diabetes, and those need to be considered as part of the holistic approach. 12:54 12:55 12:55

134 Q. If there was a known cardiovascular risk, it might be an option to use Bicalutamide as an anti-androgen?

A. MR. GILBERT: I have never done so in my own practice, even with patients with significant cardiac risk, I think, the benefits of LHRH analogue over Bicalutamide I, in sticking to the protocol of the studies outweighs any risk, in my view. The use of Bicalutamide in my own practice would be limited to those men who are worried about loss of sexual function, which is not many in this age group, who might wish to preserve some sort of libido because Bicalutamide is associated with a lower risk of effects 12:56 12:56

on sexual function, and possibly in general energy as well.

135 Q. Just help us with the science. The hormone therapy prior to radiotherapy is with what objective or with what purpose in mind? 12:57

A. MR. GILBERT: The way I view it is what you are doing is shrinking the gland and the cancer more particularly, and the smaller the cancer the more effective the radiotherapy is going to be. That's in simplistic terms. What tends to happen is a recommendation is 12:57 made from the MDT. The patient will be started on an anti-androgen which is Bicalutamide, usually at a dose of 50 milligrams and that practice, why we do it is slightly lost in the mists of time, but the rationale is said that if you start an LHRH analogue, which is 12:57 the definitive hormone treatment, you may exacerbate the cancer because what happens at the initial injection of the drug is that you get a surge of testosterone, and that, in itself, may be problematic. My problem with that if it's hormone -- if it is 12:58 localised disease it's not going to cause any problems, it's going to make your prostate a bit bigger. The usual practice is to use Bicalutamide 50 milligrams and that's never questioned. That blocks the flare of testosterone and the patient can safely start their 12:58 LHRH analogue, and that would continue for anything between 4 and 6 months.

136 Q. Then you are into the radiotherapy?

A. MR. GILBERT: Radiotherapy.

137 Q. The purpose then, as you say, is to shrink the disease and the organ --

A. MR. GILBERT: Yes.

138 Q. -- and the conventional approach is LHRH?

A. MR. GILBERT: Yes. 12:58

139 Q. 150 milligrams of Bicalutamide, not as effective, in your view, and has some side effects but will achieve for you the same broad purpose as the LHRH; is that correct?

A. MR. GILBERT: Theoretically, yes, but we don't know 12:59 that. It's an experimental fact. But yes, it's blocking the testosterone and should therefore have the same effect.

140 Q. The 50 milligram dose of Bicalutamide, walk us through that, if you would? You have described its function as 12:59 an anti-flare agent, which is a phenomenon that would be experienced if you didn't have that intervention, or you could theoretically have it?

A. MR. GILBERT: Yes.

141 Q. Is the 50 milligram dose effective, or, put it another 13:00 way, is it licensed for the task of shrinking the cancer or the --

A. MR. GILBERT: No. I mean if you were going to use an alternative it would be the 150 milligram dose. Bicalutamide, to my own knowledge, is licensed in two 13:00 indications, the first is for the anti-flare, which we have discussed at 50 milligrams. The second is for men who have locally advanced prostate cancer which is going to need hormone therapy and who may be elderly

and frail as the side effects may be more tolerable on the -- on the Bicalutamide 150 milligrams, not 50 milligrams, 150 milligrams, than --

142 Q. Just sticking at the 50, to avoid any confusion. It really only has one function, is that what you are saying, as an anti-flare agent? 13:01

A. MR. GILBERT: Certainly in my practice and in general practice I would suggest, yes, it is an anti-flare agent. It can be used in another scenario, which is called maximum androgen blockade. Essentially the LHRH analogue will suppress between 90 and 95% of testosterone production because it suppresses the testicular production of testosterone. Testosterone is also produced in the adrenal glands, so although conventionally we would just treat prostrate cancer with an LHRH analogue getting 90 to 95% coverage, there is some evidence to suggest that once the disease has escaped that control, which on average would happen at around 15 to 18 months after the first injection, then the addition of 50 milligrams of the anti-androgen will in, I think it's 27% of patients, something like that, will actually produce a second response. 13:01 13:01 13:02

143 Q. Thank you for that. I know that analysis is relevant to some of the prostate management that you came across in the cases, but I think now would be a suitable time to park for lunch. 13:02

CHAIR: Thank you, Mr. Wolfe. We will see everyone again at 2 o'clock.

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon. Are you ready, Mr. Wolfe?

MR. WOLFE KC: Yes, good afternoon. Good afternoon, gentlemen. 14:05

144 Q. I just want to check a point, Dr. Hughes. Just before lunch we were looking at the multidisciplinary team's operational policy, and I can see, if you could pull up WIT-84158, you can see that you said, top of the page: 14:05

"The patient pathways and outcomes were benchmarked against the stated standards of care declared by the Southern Trust".

Then you attach, for our assistance, those documents. 14:06

A. DR. HUGHES: Yes.

145 Q. Document 34, take it from me, is that multidisciplinary team operational policy. I want to ask you, because I assumed knowledge on your part in the way I asked the question just before lunch and that might have been 14:06 unfair. Had you seen that document and used that document as part of your work?

A. DR. HUGHES: Yes.

146 Q. Thank you. The Review Team, Dr. Hughes, was not just yourselves; it comprised of three other people; isn't 14:06 that right?

A. DR. HUGHES: Yes, yes.

147 Q. You set out their roles at WIT-84151. Patricia Kingsnorth -- let me take them in order as they appear

on that page. Mrs. Reddick was the Cancer Services Manager?

A. DR. HUGHES: Yes, Cancer Services Manager with the Southern Trust.

148 Q. Yes. You have recorded here that she provided local contextual information on how services were operated, supported and resourced within the Cancer Unit. You had, maybe skirmish is the wrong word but you had a number of conversations with Cancer Services, Dr. Tariq, Dr. McCaul and Mr. Conway? 14:07

A. DR. HUGHES: Yes.

149 Q. What was her relationship into that part of the Service?

A. DR. HUGHES: She would sit beneath them and manage the day-to-day processes within the MDTs. 14:08

150 Q. Okay. They were more on the Governance side?

A. DR. HUGHES: Dr. Sadiq was an Assistant Medical Director within his remit. Mr. McCaul was the Clinical Lead for Cancer Services. Sorry, I have forgotten the name of the other gentleman, was a manager. 14:08

151 Q. Mr. Conway?

A. DR. HUGHES: Conway.

152 Q. I will come back to that in a moment, just let me work through the rest of the team members. Patricia Thompson was a recently appointed Nurse Specialist; isn't that right? 14:08

A. DR. HUGHES: She was a recently appointed Nurse Specialist to the Southern Trust but had many years experience previously within the South-Eastern Trust,

so she was new to the Service and independent of the ongoing Service delivery within the Southern Trust.

153 Q. Patricia Kingsnorth then. She is described here as Governance Lead. Was that her role within the Trust?

A. DR. HUGHES: She was an assistant, I think she was an Assistant Director but she was Governance Lead aligned to this review process. 14:09

154 Q. Yes. One can see from your meetings that, from time to time, other people appeared to join you. For example, I see a Fiona Sloan attended a meeting? 14:09

A. DR. HUGHES: Fiona Sloan was a family appointed liaison officer. It became very clear there were specific and extensive family engagement needs, so the Trust appointed her. I think she came from a Children's Services background. 14:10

155 Q. I want to ask you some questions now about the independence of the process because, as we can see from the three female members of the Review Team, they all belong to services or areas of management which were, I hope you agree with me, subject to scrutiny within the reviews. Is that a fair way of putting it? 14:10

A. DR. HUGHES: Yes, that's self-evident, yes.

156 Q. Yes. The advantage, I suppose, is that they provided the review with accessibility in terms of both knowledge of how things are done and who people are, and access to those people, I suppose, in terms of setting up meetings and that kind of thing? 14:10

A. DR. HUGHES: Yeah.

157 Q. Can you help us with that; why would they have been

selected and did you have any role in their selection?

A. DR. HUGHES: Patricia Kingsnorth was aligned to the programme when I came. She was the Governance Lead. We were commissioned by the Southern Trust to do this work and, you are quite right, there is a potential inherent conflict of interest in that. Patricia Thompson was selected by myself because although she was employed by the Southern Trust she was new to the Southern Trust and brought experience from a Clinical Nurse Specialist working elsewhere. Fiona Reddick I felt had probably the biggest conflict of interest, and I think she was placed in an invidious position and, in retrospect, perhaps, it wasn't best. I think she was in a place where the Service that she was managing was being implicitly criticised. I think she probably found it stressful but I think that's -- yeah. 14:11 14:11 14:11

158 Q. That's a learning from it?

A. DR. HUGHES: Yes. Part of the problem is if you just bring a complete outside team in, how do you get ownership and buy-in and ongoing actions if the local team aren't there to own it? I think that's a reflection. I think we have to accept that it probably was tough on some of the members of the team who were invested in their own Service for a very long period of time and it was being implicitly criticised. 14:12 14:12

159 Q. Lawyers tend to get very excited when somebody says that person has a conflict of interest. The next step is to ask then, does somebody act on that conflict of interest in a way that destroys the integrity of the

process; are you saying that?

A. DR. HUGHES: No.

160 Q. You are not?

A. DR. HUGHES: Her role facilitated and helped in the process, but she did not interfere with the output from the process in any form. 14:13

161 Q. Yes. The HSCB procedure, which we looked at earlier for other purposes, deals with the issue of independence and membership of a Review Team. Let's just look briefly at that. If we could bring up appendix 12 of that process. That's at WIT-84242. Yours was a Level 3 review? 14:13

A. DR. HUGHES: Mm-hmm.

162 Q. This is guidance on membership of a Level 3 review. And it says: 14:13

"The level of review shall be proportionate to the significance of the incident, the same principles shall apply as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of incident. Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB, PHA and designated Review Officer prior to the Level 3 review commencing." 14:14

Let's just look at Appendix 11, because this sends us back to Appendix 11 to look at the Level 2 review. If we go to WIT-84241. If the process has to be the same

as a Level 2 this is what it should be:

"The core Review Team should comprise a minimum of three people of appropriate seniority and objectivity, Review Team should be multidisciplinary or involve experts' opinion" -- well, hard to read that:

""Or involve experts/expert opinion/independent advice or specialist reviewers. The team shall have no conflicts of interest in the incident concerned and should have Independent Chair."

You were the Independent Chair. It was multidisciplinary, but your concern, looking back on it, that perhaps Mrs. Reddick was too close to the issues and was made to feel perhaps uncomfortable

A. DR. HUGHES: Yeah. I don't think she discharged her duties in anything other than a professional way, but I think the role was a role of conflict for her because, in essence, she was reviewing her own Service and reviewing, you know -- it proved difficult, I think.

163 Q. You say, just on that, at WIT-84174, at paragraph 23, that:

"The SAI Review Team had an essential external component and did include professionals from the Southern Trust who discharged their duties in an exemplary manner, despite a potential perceived

conflict of interest by some."

Is that where you are thinking about Mrs. Reddick?

A. DR. HUGHES: I was actually thinking about the Governance team from the Southern Trust who managed the family engagement to a very high standard, in my view, and their commitment to the process of doing the Root Cause analysis and developing the SAIs, and that was my objective opinion. 14:16

164 Q. You say at WIT-84165, that a particular issue arose and I want to ask you about that. It's the second bullet point on the page. You say there: 14:17

"I became aware that the Trust was receiving feedback through the Governance Lead within the SAI review via the Director responsible for the Urology Cancer Services." 14:17

The Trust was receiving feedback from Patricia Kingsnorth 14:18

A. DR. HUGHES: I just wasn't aware of it, but it was feedback about the progress of the reports and they were doing a progress report to the Board to know where they were. I believe it was in order to fully inform the oversight body within the Department of Health. 14:18

165 Q. But that wasn't something you had been made aware of in advance?

A. DR. HUGHES: No.

166 Q. Not something you had authorised?

A. I didn't authorise it but became aware of it.
167 Q. There shouldn't have been any particular need for that, should there, because you were regularly having meetings with senior management in the Trust? Maybe not regular but certainly occasional meetings with 14:18
senior management within the Trust, including Mrs. O'Kane, the Medical Director at the time?
A. DR. HUGHES: Yeah, yeah. But I probably would not have been given structured progress report, and I think it was a structured progress report. 14:19
168 Q. Yes. One such meeting with Dr. O'Kane, if we could have up on the screen, please, TRU-161110. This is an e-mail which Mr. Stephen Wallace sends to himself, I think, for record purposes. As you can see from the subject, it's notes following a meeting with you on 14:20
23rd October. If you just scroll down, it seems to be a progress update on what you'd discovered by that point. You can see reference to -- I'm not sure if I can quickly pick up on it but I believe Mrs. O'Kane was at that meeting and Mrs. McClemments. What was the 14:20
function of that kind of meeting?
A. DR. HUGHES: That was very early stages. That is what you'd call early learning, early action, and it was in the progress, was there any immediate actions needed to be taken. It's pretty standard within an SAI that if 14:20
you discover some calamity that needs immediate action so that was very early feedback, and you can see from the date it's 26th --
169 Q. 23rd October?

A. DR. HUGHES: Of October. But even at that stage, we had a reasonable view of some of the issues that were arising.

170 Q. In terms of how you would score the independence of your process, you'd some concerns about a perception of a conflict on the part of some of your members, but overall, were you able to get on with your work without fear or favour? 14:21

A. DR. HUGHES: We were able to get on with our work without fear or favour in its totality, and I do not recall any amendments or the Southern Trust accepted the report in full without any amendments. The issue about feeding back at an early stage was in terms of Patient Safety, and it's about what you know and making sure that the services are safe, and they would have the requirement to do that. 14:21 14:22

171 Q. Yes.

A. DR. HUGHES: I think being aware of the potential for conflict of interest is the first step and to have that in the forefront of all the discussions. 14:22

172 Q. Yes. I mean the Inquiry will judge for itself. There are some criticisms of the Trust process and governance arrangements, but equally, and perhaps not intended in a learning document, but certainly Mr. O'Brien would interpret the remarks directed to his practice as being critical of his performance. Was the Trust pushing any particular agenda towards you and your team in terms of Mr. O'Brien? 14:22

A. DR. HUGHES: No, no. We had feedback on the basis of

patient concerns and Patient Safety. I don't believe they were pushing any agenda.

173 Q. Within your statement -- I don't need to bring this up -- you talk about how the team worked. You talk about meetings that happened weekly or perhaps bi-weekly, depending on progress. You say that the process was very much one of consensus? 14:23

A. DR. HUGHES: Yes.

174 Q. That Mr. Gilbert would provide his reports through several drafts, they would be circulated for comment and discussion, and it was an iterative process before you eventually reached a final view, bringing together both the Clinical and the Governance. 14:23

A. DR. HUGHES: I think that's a fair description. It would be an iterative approach benchmarked against expected best practice. 14:24

175 Q. You say at WIT-84159, if we can look at the second observed bullet point just further down the page. You were asked whether you recall any disagreement arising with regard to any finding and/or conclusion and what you say by way of response is: 14:24

"The SAI process was relatively straightforward in terms of the identified clinical variation from expected best practice." 14:25

You explain how Mr. Gilbert led that part identified variation from declared standards and you say, just going down into the second bullet point, that the

report has evolved. Yes, I thought there was an additional point to make there.

Mr. Gilbert, perhaps could I have your view on it? Was this variance that's talked about here and evident from the SAI reports, was it -- 14:25

A. MR. GILBERT: The variance.

176 Q. The variance?

A. MR. GILBERT: Do you mean the different drafts or the variation -- 14:26

177 Q. Sorry, the variance in the delivery of clinical care from the expected standards?

A. MR. GILBERT: Yes.

178 Q. It's recorded by, just scroll down again, please, so it's said here: 14:26

"The process was relatively straightforward in terms of the identified clinical variation from expected best practice."

A. MR. GILBERT: Yes. All I did was to go through the timeline for each patient, describe the pathway, and point out any particular area which may have varied from what would be a reasonably expected standard of practice. 14:26

179 Q. Did the conclusions on that, the findings of variation from expected standard of practice, did that come relatively easily in most cases, or were there complications that had to be worked through? 14:27

A. MR. GILBERT: No, it was a straightforward process and

much of the reiteration was more about style rather than substance, so that there was a uniform way of presenting the information. There was also reiteration in the light of some corrections or observations by family, which I was happy to include, but the main body of each report essentially state the same, from my initial draft through to the final report.

180 Q. Yes. You set out in your statement, Mr. Gilbert, something of a chronology, and I don't intend to delve too deeply into each of the stages for the purposes of your evidence, but it might be just helpful to show the Inquiry that, at WIT-85887, paragraph 1(e). The initial meeting took place, and I am going to bring you to that meeting shortly, on 12th October. Then you describe the people present there, we will go to the record of that shortly, but scrolling down to paragraph 1(j), you say that you submitted your first draft of your piece to the Review on 5th November. By 30th November, this is paragraph 1(l), the team was meeting to discuss the first draft reports. Then 4th January, just scrolling down, maybe not -- wrong date. Yes, paragraph 1(o), you proofread your first drafts which had been annotated by the members of the review group and return the revised documents on 4th January. This is this iterative process you have referred to, Dr. Hughes. Then the Review Group met on 24th January to consider the second drafts that emerged from that, paragraph 1(p0. Some points from the discussions with the families is being fed back to you. You didn't have

14:27 14:28 14:28 14:29 14:29

any direct involvement with the families, Mr. Gilbert, but you responded to these points as they arose, and then, as we can see in paragraph 1(q), you submitted a third draft compliant with the format which had been agreed at the 24th January meeting. Then I think I'm right in saying that a draft report was circulated to families, patients and Trust staff members, or at least was available to Trust staff members, by 16th March. Does that ring true for you, Dr. Hughes? 14:30

A. DR. HUGHES: I think so, yes. 14:31

181 Q. Yes. Then you say at paragraph 1(s), Mr. Gilbert, that a final version submitted on 19th April 2021. Over that period of drafting and redrafting, is much changing from the starter version or is it mainly matters of formatting and sign detail? 14:31

A. MR. GILBERT: It's matters of grammar, clarity in that I may have pitched the explanations at a level which would not be understood by the families and so the language needed to be modified. For that I needed the Review Team to point out where I was being a little bit too technical. But, to answer your question specifically, there was no real change in the substance of the recorded events, or the events as I interpreted them from the clinical records. 14:32

182 Q. Yes, 14:32

A. MR. GILBERT: No one said you can't write that or that's not true. The final report essentially is the same as the first draft.

183 Q. Yes. The process of the team working together,

Dr. Hughes, got moving before Mr. Gilbert was on board; isn't that right?

A. DR. HUGHES: Yes.

184 Q. We will pull up a meeting on 10th September 2020, TRU-163347. As we can see from the top of the page, everyone is there. Mr. Gilbert hasn't been appointed. Just scrolling down the page slightly. At that stage it records that six cases, with one more to follow, had been identified. We will come on to how it became nine shortly, but the situation was, Dr. Hughes, that the Trust's governance arrangements were in control of screening cases for SAI purposes. Those cases that met the threshold was a decision for that process and then handed to you? 14:33 14:34

A. DR. HUGHES: That's correct, and these notes were summaries that were handed to us as a result of that triage or screening process. 14:34

185 Q. Just scrolling down through those, I think it says six but I think my note tells me that five, over the page, please, there's three, four, and it seems that five have been highlighted, I'm not sure if the note is entirely good. If we just scroll down so we can see. 14:34

"Dr. Hughes advises that the team would conduct a systematic review of what is expected in the pathway, what has occurred in the patient's journey and might say are the variants." 14:35

You had a clear view of how the work would be done at

that point?

A. DR. HUGHES: Yes. It would have been a simple pathway timeline followed by expected timeline, followed by an assessment of variants.

186 Q. There's then discussion of a draft Terms of Reference and the following were agreed. Just scrolling down. I think I'm right in saying that those terms don't, although they are in draft, don't significantly change, albeit that they weren't agreed by the Health and Social Care Board until a process of family engagement; is that right? 14:35 14:36

A. DR. HUGHES: That's standard practice. The first thing you should do is tell the family about the process and ask for their input into the Terms of Reference, otherwise you are presenting them with a fait accompli and it's not appropriate. 14:36

187 Q. Just scrolling down the page further, just looking at that page, Patricia Kingsnorth advises that a Urologist is being commissioned and they hope to be available for the next meeting. That was obviously you, Mr. Gilbert, and you have explained the various machinations around that? 14:37

A. MR. GILBERT: Yes.

188 Q. Just moving then. The full team then got together on 12th October, and you attended that meeting, Mr. Gilbert. The reference for that meeting is TRU-162286. We can just see, at the bottom of the screen there, that you advised that there are now eight cases? 14:37

A. MR. GILBERT: Mm-hmm.

189 Q. You emphasise the importance of everyone having the same information and that was going to be accessible via the electronic system egress. Just scrolling down the page, just stopping there. There's a reference to the principles that you would apply, Dr. Hughes. You have said: 14:38

"Everything that will be done will be scrutinised". You advised it's important that you take the same approach to all cases. Was that simply emphasising the importance of procedural consistency in how you went about your work? 14:38

A. DR. HUGHES: I think it's advising people of having a structured approach, and an approach which is consistent, but it's also a approach which is based on evidence. 14:39

190 Q. Reference to medical opinion:

"District general hospital consultants should be able to give peer opinion." 14:39

That seems obvious but what were you getting at there, assuming it was you?

A. DR. HUGHES: Yeah, I think we have to benchmark like with like, so if the practice that we were looking at is in equivalent to an English district general hospital, that's where we would seek our expert from. 14:39

191 Q. At the bottom of this page you talk about family

expectation and the need to involve them with the Terms of Reference, a point we have already made. Then the top of the next page, please. Here Mr. Gilbert advised that if it's to be a multidisciplinary review, I think it says, that's maybe a question, should there be an oncologist on the Review Panel? And Patricia Kingsnorth advised there's two ways of doing this, having somebody on the Panel or ask for an Oncology opinion which wouldn't delay the process. Mr. Gilbert adds his view that you need to have an Oncologist for reviewing a case. Mr. Gilbert would do the primary case review, what a Urologist or Oncologist would do better". Maybe that's a bit of a difficult note, but you seem to be emphasising, Mr. Gilbert, the importance of having support from an Oncologist in the process? 14:40 14:41 14:41

A. MR. GILBERT: My view was that this was a review of a multidisciplinary team and, therefore, the body doing the review should reflect an MDT.

192 Q. Yes.

A. MR. GILBERT: There were some of the skills that we would expect to see, Cancer Nurse Specialist, for example, but I felt that an Oncologist would be reasonable. However, timelines overtook, and what I did was I essentially went through each case and, to be frank, I think it's fairly clear that an Oncologist won't add anything to what I've written already. 14:41 14:41

193 Q. It appears that the option was being made available to you, to perhaps seek an opinion if that was, in your view, necessary?

A. MR. GILBERT: Yes. I mean, I didn't find a need to actually clarify any of the points around the management, and I think that's obvious because the concentration on this was around the decisions being made by a Urologist and not necessarily within the MDT itself, so I simply put myself in the position of saying what I would have done, not what an oncologist would have done. 14:42

194 Q. Yes. You go on to say, just a little bit further down the page, that you had gone through the cases. Do you see that? It's sort of the penultimate paragraph on the screen. 14:42

"Q has advised he has gone through cases and knows what they are about. Not entirely black and white, happy to provide questions for oncologist to consider." 14:43

Just on that, you've explained that when you went through the timeline perhaps in more detail, you ruled out the need for an oncologist. Can you recall what it was about Mr. O'Brien's work that wasn't, at least at first blush, black and white for you? 14:43

A. MR. GILBERT: I think I hadn't been given enough time to come to a definitive review so I was maintaining a position of open-mindedness. As I went through in more detail matters clarified and, in fact, I didn't really need the opinion of an oncologist because, within this gentleman's practice, there didn't seem to be a need for an oncologist, so I was really just 14:43

commenting on what he had done. If he had consulted with an oncologist and there had been some sort of discussion, then I would have said what would that discussion look like for me and an oncologist but, in fact, Mr. O'Brien rarely, if at all, spoke to oncologists so there was no point in making any consideration of that.

195 Q. One way of viewing the descriptor black and white is to say, I was looking at some of these cases and I was unsure whether that was good practice or practice that wasn't possibly so good or varied from the guidelines. Is that what you are getting at there at all? 14:44

A. MR. GILBERT: What I'm getting at is that Mr. O'Brien seemed to be practising in an isolated way with very little interaction with other people. Therefore, the decisions are those specifically of a Urologist, and my judgments became more concrete, that the more I read, then the more I reflected on what I might have done under those circumstances. 14:45

196 Q. Scrolling on down, one can see that you have said that you have been given huge files and have gone through them, all apart from, and we have the initials for a patient there who appears to be Patient 5, or Patient C in your language. We needn't go into the detail of your summaries there, but it seems that within a short few weeks of your appointment, you were able to make some clear view about the cases? 14:45 14:46

A. MR. GILBERT: I think that's testament to the manage the of the information given to me by Southern Trust.

I mean, the records were complete, legible, properly redacted and relatively easy to go through. It was as if I had the volume in front of me.

197 Q. Yes.

A. MR. GILBERT: It was a straightforward process. 14:46

198 Q. Yes. I think, Dr. Hughes, I didn't pick it up on the screen for you, but there was maybe something of a complaint from you in the notes that, at this stage, you had been involved since August, I think you said, possibly September, and yet the number of cases coming 14:47 in the direction of this process hadn't been settled. Maybe that doesn't ring a bell. I can bring you to the record if you wish.

A. DR. HUGHES: I can't actually recall that but it may be something I might have said. 14:47

199 Q. We can pass over that. I suppose the question I wanted to ask you was, you've explained that the process of identifying cases for SAI purposes, or screening them in, was none of your business; it was done by the screening governance process. The cases that did come 14:47 your way, were you satisfied that they all met the threshold for SAI or was that something you didn't give any consideration to?

A. DR. HUGHES: No, it was something I gave consideration to. I think they all met the threshold for 14:48 consideration for an SAI. I don't think they all met the consideration for a Level 3 SAI. Patient 8 was a TURP where the diagnosis of cancer was missed due to a late notification or a late awareness of a pathology

report and that might be a level 1, but as it was part of a combined group, I didn't have any problem with the range of SAIs. The reason I didn't really want to get into the triage process was because I knew there would be ongoing further cases coming on and possibly going into another process, and I didn't really want to -- I wanted to put a Chinese wall between that work and the work we were doing with the SAIs.

200 Q. You make that point in your statement. Maybe we will just bring it up and explore it a little. WIT-84153. 14:49
You say at (iv) that you were:

"... aware of an ongoing process to perform a lookback exercise and ongoing triage of cases as potential SAIs". 14:49

You go on to say: "As chair of the SAI process I did not seek nor was I given any further details regarding outcomes of triage to SAI thresholds where subject [quotes] believing this would be inappropriate." 14:49

You wanted to maintain the independence of your SAI process.

You were aware in the background that there was this 14:50
other process, but you wanted to keep out of it?

A. DR. HUGHES: Yes, that's correct.

201 Q. You may now know, and we have asked you a question about this, that because of an agreement reached at

what has become known as the Urology Assurance Group, which is an amalgam of officials from the Trust, the Department, PHA and HSCB, there would have been no more SAIs brought through as a result of Mr. O'Brien's practice, that other cases were going to go this SCRR route. I just want to ask you some questions about that. If we go to your witness statement at WIT-84174. Just scroll up to the bottom of 173, if you would, please. The question was: 14:50

"What, if any, view did you express to the Trust in writing or orally on the merits of this decision?" The decision being that there would be an SCRR process. And you say, politely, not answering the question directly, you say that: 14:51

"I believe that this approach would be constructive provided patient and family engagement was adequately addressed". 14:52

You say you have experience of this. I think it was called structured judgment review, which has been variously described and the Trust ultimately calls it an SCRR. Back to the question you were asked, you were asked did you advise the Trust in relation to the SCRR process? 14:52

A. DR. HUGHES: I discussed the process with Dr. Miriam O'Kane and I had said that I had some experience of it and that it could work to deal with high volume in

a constructive, timely way. I did made the point that irrespective of what you do you have to do the same family engagement because you can't produce a result without engagement because that doesn't meet need. So my experience is that it can be timely but it often isn't, and it depends how it is structured, if it's multiple professionals reviewing a case twice and with or without family stories. If you do the family engagement before and after, it can be almost as -- I don't like to use the word time-consuming -- it can take as much time as an SAI process. But, you have to find a meaningful way to address the clinical deficit and address concerns and assure you have got appropriate information, and also address family and patient need. 14:52 14:53 14:53

202 Q. Yes. Your view about the need for family engagement chimes with the recommendations contained in a recent RQIA, manage the assurance exercise, which has focused on the Trust's SCRR, and indeed its lookback process?

A. DR. HUGHES: Yeah. 14:54

203 Q. They make exactly that point, that the deficit, or one of the deficits, in the Trust's SCRR process, which is still ongoing, is that there's only family engagement at the back end, as the report is finished and signed off; there isn't family engagement at the commencement. That seems to be what you saying here? 14:54

A. DR. HUGHES: Yeah, it's likely that the SCRR -- I will get the words right -- structured judgment reviews will have the same underlying background of absent Clinical

Nurse Specialists, and it's likely that the communication and the understanding is similar to what we found in the nine SAIs. So I think you have to address that deficit in any structure judgment review because it will be the same as what we found in the nine. If the care isn't supported by Clinical Nurse Specialists it's invariably less informed and patients are often not fully knowledgeable of the pathways and of various illness. 14:54

204 Q. Yes. As I understand it, the structured judgment review derives from a model formulated by the Royal College of Physicians. Just to take your observations and perhaps, Mr. Gilbert's observations on this. The RQIA has said of the Trust's process, SCRR process, that another deficit is that it's not gathering information on governance issues, whereas the Royal College's model would be more geared towards that. Again, is that something that you think ought to form part of an SCRR arrangement? 14:55 14:55

A. DR. HUGHES: I'm not sure I agree with the RQIA on that. I think if you do a proper structured judgment review, you will pick out the same variance in care and you will be able to make the same inferences. I think the thing that probably is missing from the Southern Trust process is coming to families afterwards and saying this is what we found, without asking them in advance 14:56 14:56

what do you know?

205 Q. Yes. Mr. Gilbert, have you experience -- well, you

clearly have experience of this structured judgment.

A. MR. GILBERT: Yes. I mean, this structured judgment review was introduced around about 2019, I think, and is now used across surgical departments in order to look at adverse incidents. My experience with it has been that we allocate a Registrar to go through the case and then present it so that the group, as a whole, can identify learning points and any gaps in governance issues. To me there are an awful lot of algorithms about this, but essentially the same process applies across, which is, you want to know what happened and why it happened, and from that you can learn. It doesn't matter what you label it as. The importance of family involvement is essentially to allow them to understand the processes that we go through. I'm not entirely certain they contribute other than to give us an important perspective on what we are doing to our patients. 14:56 14:57 14:57

206 Q. Yes. I want to move now, for the next while, to look at while Mr. Gilbert was completing his thoughts leading to draft 1 and then draft 2, you were beginning the process, Dr. Hughes, having learned what had gone wrong here in terms of departures from or variations from the standard guidelines. You were wanting to go out to speak to staff to understand the why has that happened, and something of the governance arrangements. You refer in your statement, if we can bring up 814455, your initial meetings were with core members of the MDT to understand the context of care. Then, after 14:58 14:58

identifying the care deficits, you had -- it doesn't look like the reference I want. 84154. I think we can get by without the reference. The context is this: That you initially wanted to speak with some of the core members of the MDT, and I think for that reason, 14:59
perhaps, you started your series of meetings, so far as I can work out from the documents available, with Mr. Glackin?

A. DR. HUGHES: Yes.

207 Q. Who was the then Clinical Lead. You have reflected, 15:00
I think, that, just as a general point, not specifically Mr. Glackin, but you have reflected that the conversations with staff were difficult, but you obtained significant learning for your purposes. What was difficult about the meetings from staff 15:00
perspective?

A. DR. HUGHES: I think there was a concern that the question had moved from what happened to how it happened, and I think they were probably reflecting on what role they had in this and what were their 15:00
responsibilities. I think the meetings, when I say difficult, I think it was difficult for the staff, it was stressful. I think particularly for the Clinical Nurse Specialists who felt this deficit would be seen to be their deficit, and I think they are incredibly 15:01
anxious about that. Part of the process was to reassure them that this was a learning tool and an improvement tool, but they were very anxious about oncoming and upcoming Urology Services Inquiry.

Perhaps some of the findings, I found almost inexplicable. When you have the resource for a Clinical Nurse Specialist and everybody understands the benefit of it, I couldn't understand why patients didn't receive that care. The other thing I was very aware of, because it was an independent review, the staff weren't actually engaging with the families and the experience and so myself and Patricia Kingsnorth and Carly from - we would meet with the families and hear these stories of people being unable to access basic care, continence care, trying to access GPs at time of Covid, having to go to ED when you are suffering from cancer because there was nowhere else to go, and I think these were difficult conversations. 15:01 15:02

208 Q. Did it come across, and we will look at the specifics in a moment, I'm just trying to put some of the headlines out on to the table. There was this sense of difficulty. Did it come across as defensiveness on the part of some staff? 15:02

A. DR. HUGHES: Some staff. Others were quite shocked and because cases were not being brought back to the MDT, nobody had full knowledge of the deficits patients suffered. If a patient was being dealt with in isolation without the supporting environment and didn't have a holistic baseline assessment or was not being brought back to the MDT, the other team members would not know about it. 15:02 15:02

209 Q. But some of the things, just again unpacking some of this, the headlines. What was clearly known, I think

you were able to establish, and we will go to the evidence for this in a moment, it was clearly known that nurses, specialist nurses weren't involved with these patients?

A. DR. HUGHES: Yes. 15:03

210 Q. Not just these patients, but it had gone back some time. The second thing that seemed to be known was that Mr. O'Brien had a particular practice in respect of the use of Bicalutamide?

A. DR. HUGHES: Yes. 15:03

211 Q. Which, in the opinion of some, to put it neutrally, was at variance with the guidelines. Those two factors were known?

A. DR. HUGHES: Those two factors and Mr. Glackin referred to that. The Nurse Specialist bit was known but was 15:04 seen to be like a long term problem that nobody could address, and it was just there but not dealt with. I think variance from MDT recommendations was not known.

212 Q. One of the others, and we will look at that and how 15:04 that could have happened and what that said to you in terms of culture and governance in a moment but another sort of looking at this at a high level, another feature of what you discovered through these meetings was, not to put too fine a point on it, the disconnect 15:04 between Cancer Services on the one part, MDT on the other, so that the former seemed to exist in a bit of a vacuum from the latter?

A. DR. HUGHES: Yes. The senior cancer management team

seemed to have little insight and knowledge about the difficulties of the Urology team and, in terms of quorate numbers in terms of the actions that were required to meet appropriate standards of care, it was an intense source of frustration for the Urology MDT because they felt they were handling an increased workload, maybe up to 400,000 with a newly configuration of services. Some services, dysfunctionality between Consultants and nobody external to support them, to achieve a better outcome. When I discussed it with Dr. Tariq and Mr. McCaul, I was kind of shocked at their lack of understanding. 15:05 15:05

213 Q. Yes. We will come to that just now. We will start with Mr. Glackin and run through them in some kind of chronological order. You saw Mr. Glackin, I think it was a telephone conversation, for the first time on 30th November. You were subsequently to meet him as part of the multidisciplinary team a little later in your process? 15:06

A. DR. HUGHES: Yes. 15:06

214 Q. WIT-162250. Okay. So a telephone conversation with Mr. Glackin, you attend with Mrs. Kingsnorth. You start the meeting, Dr. Hughes, by introducing the Clinical Nurse issue?

A. DR. HUGHES: Mm-hmm. 15:08

215 Q. You told Mr. Glackin that the families had had no involvement with the Clinical Nurse Specialists, and you are asking was that unusual. Mr. Glackin's answer appears on the screen here, seems to be one based on

resources. His explanation is about the resource to provide Nurse Specialists in this context. He didn't seem to indicate at this meeting that this was an issue which was other than resources?

A. DR. HUGHES: Yeah. At that stage I was unsure if it was a funding issue, was it a locality issue, because they'd expanded their areas, and Mr. Glackin reflected that, I think. It was only later when I found out that, you know, even if you didn't have a nurse at the clinic did you give the number, and it turned out that all other Consultants did use Nurse Clinical Specialists. It was just the exception of Mr. O'Brien who didn't. 15:08 15:09

216 Q. Yes. Mr. Glackin, of course, signed off on the 2017 Peer Review document, which I opened earlier. His contribution to that was to recognise that, in 2016/'17, this Service had been granted additional resources to bring further nurse specialists into the system? 15:09

A. DR. HUGHES: Yes. They had increased their number of nurse specialists to five, and they had stated that all patients had access to a Clinical Nurse Specialist, which wasn't factually correct. 15:10

217 Q. In light of what you were to hear subsequently about Mr. O'Brien's exclusion of Cancer Nurse Specialists, this can't have been a candid answer that you were receiving from Mr. Glackin? 15:10

A. DR. HUGHES: My views at that time were forming. I didn't know for a fact, and it was only later that

I fully understood that (a) was there the resource, and (b), that selectively, one professional did not use that resource, and certainly Mr. Glackin didn't put it in those terms.

218 Q. I know that you'll recall, and we will come to this later, that the three employees from the Cancer Service wrote when your draft report was ready and put changes into the report? 15:10

A. DR. HUGHES: Yes.

219 Q. They raised the issue about, we would like you to specify in your report who knew and who didn't know about this nursing issue. Your response to that, I can bring it up later, if necessary, was that you were appreciative of those who were candid with you in the process of investigating how this had come to be. Did that reflect the view that there were some staff who weren't entirely candid with you? 15:11 15:11

A. DR. HUGHES: Yes. I think I respond that way because I regarded the comment as verging on bullying in trying to seek out who knew and who didn't know. It was very clear that the nurses and the Urology Services Manager was very clear and honest and open about not being able to assure that all patients got access. It was SAI learning outcome and I thought it was verging on blame culture, I thought that was unhelpful. 15:12 15:12

220 Q. Yes, yes. We will come to that piece in a moment or later, perhaps. Moving just down to this now to the Bicalutamide issue, if we can just find that. You DH advised that AOB prescribed off guidance which didn't

adhere to NICaN guidelines. He appeared to ignore the recommendations from MDT in relation to the prescription of Bicalutamide without patient informed consent. Then Mr. Glackin indicated that he was aware of this. 15:13

A. DR. HUGHES: Yes.

221 Q. He advised you that this would have been challenged at MDT. He advised the practice for prescribing to MDT had changed in the last six years, the cases are discussed, each case reviewed in advance by a Consultant Urologist, the chairing is rotated, this was done to share the workloads as opposed to monitor the practice of colleagues. The question around Bicalutamide 50 milligrams use would have been challenged but not minuted. 15:13

You went on to say:

"Once a patient's care was discussed in MDT this was named to the named Consultant to continue the patient's care. No one was looking over the shoulders of others to check that the work was done". 15:13

Mr. Gilbert, in light of what you said this morning about the usage of 50 milligrams, if that was known to Consultant Urologists, and indeed if Oncologists were there, which appears to be rarely, that is something that an MDT would be expected to challenge? 15:14

A. MR. GILBERT: Yes.

222 Q. Because if somebody is using 50 milligrams outside of the anti-flare scenario, I think you pointed to one other potential use for it, if it was being used in the way that is being suggested here, that would, in your opinion, I know Mr. O'Brien wishes to have me explore with you some issues around that, but, in your opinion, that is something that an MDT would challenge, should challenge? 15:14

A. MR. GILBERT: Would and should challenge, yes.

223 Q. Yes. 15:15

A. MR. GILBERT: The indications we have already discussed.

224 Q. Yes.

A. MR. GILBERT: Licensing we have already discussed. The rationale for giving 50 milligrams on one level is not made clear, and the decision is to modify the MDT decisions or the MDT recommendation is not annotated in the notes, or not alluded to in the notes, and certainly doesn't include the MDT either. 15:15

225 Q. Is it surprising, in your view, that if this is challenged, and perhaps challenged on a number of occasions, that it (a) isn't minuted, and (b), not escalated? 15:15

A. MR. GILBERT: It's difficult to comment because it's a very unusual series of events. There aren't many MDTs up and down the country in which someone insists on giving a particular type of treatment out with the guidelines and recommendations. It's a rare event. I can only think of one instance where one of the senior Oncologists was quite keen on giving a very 15:16

large dose of Bicalutamide and for pharmacological reasons he said, but we all rounded on him and he immediately stopped doing it. That was just a misunderstanding. It wasn't done in an aggressive manner. It was done in a collegiate manner, and that's what the MDT should be about; everybody informing each other and supporting each other, and being open and honest about what they are doing and why they want to do it. 15:16

226 Q. For the record, Mr. O'Brien says he had never been challenged and it's never been escalated because he has never been challenged and, therefore, not at all surprising that it's not minuted if it hasn't been challenged. Assuming Mr. Glackin is right, Dr. Hughes, that he was challenged but not minuted, and he says he was just allowed to get on it, nobody was looking over his shoulder, what does that say in plain Governance terms for you? 15:17 15:17

A. DR. HUGHES: Well, it's a laissez-faire attitude to Governance. Governance only works if everybody takes their role and responsibility seriously and that means, as it says in the guidance that you read from this morning, everybody has a responsibility for patient care. If you are a member of a team, you have to act upon issues. I think an MDT would have been an ideal situation to do it by getting a collegiate group to do this, that was difficult thing to do. I also think they should escalate it to line management above them, their clinical leads, their Associate Medical Director 15:18 15:18

because it is very difficult sometimes to manage within a dysfunctional group of professionals and we have to recognise that. But there were options to address this. You could either address it as a collegiate group or they could escalate it to those with line management responsibilities.

227 Q. One of the difficulties, I suppose, was the Associate Medical Director, certainly from 2017, Mr. Haynes was a member of the MDT. I think perhaps it's what you have alluded to, Mr. Gilbert. It is perhaps difficult and colleagues have to be, I suppose, brave and step outside the zone to raise complaints, escalate complaints about colleagues? 15:18 15:19

A. MR. GILBERT: It's absolutely necessary. It's a duty. We are very privileged to practice, but that comes with a series of roles and responsibilities, and one responsibility is to ensure Patient Safety, not just for your own patients but those around you. If you see anything that isn't as it should be, or you think it isn't as it should be, then if your peers don't take notice, then you escalate, and you escalate until you get a satisfactory answer. That has to be the truth, the rule that you adhere to. 15:19 15:19

228 Q. Sometimes, a note, Dr. Hughes, doesn't do justice to the nuances of a conversation. Obviously this is conversations down the phone. In light of your expectations from a Governance perspective about how this laissez-faire approach was allowed to predominate, did you respond saying are you serious, it wasn't even 15:19

recorded, let alone escalated or was your role not to be, I suppose, judgmental in that context?

A. DR. HUGHES: Yeah. I try to make sure I'm not judgmental, because I want to get as much information as possible and to address it. I'm sure he understood that I couldn't understand the actions, but unfortunately, there were similar actions out with the Trust from Oncologists, which you will probably come to, who also knew of the practice, wrote directly, but didn't escalate. So it's not unique to the Southern Trust, I have to say. 15:20 15:21

229 Q. The next issue you cover just below this, before we have a short break, just to finish this, you talk about disease progression with him. You ask -- sorry, you say, just at the top of the screen, halfway down now: 15:21

"Advised that often the patients involved in the review were not represented to MDT when their conditions deteriorated."

15:21

I'm not sure what particular patients you might have had in mind. I know from the facts, for example, of patient A or Patient 1, that he went into retention in March 2020, having been before the MDT at the end of October. The recommendation was to start ADT and to refer to Oncology for EBRT, none of which had happened, according to your report. Seemingly a deterioration in March with retention. We are in the middle of Covid at that time, March 2020. Was that the kind of case that 15:22

should come back?

A. DR. HUGHES: Yeah. I mean, I think we are focusing on Bicalutamide here, but we must remember the three patients who were referred in and ended up on Bicalutamide also didn't have referral to Oncology, which is probably a much more major issue, and certainly not referral to Oncology in a timely fashion. Patient 1 developed complications because he hadn't been referred to Oncology in a timely fashion. I just want to get the numbers right here. Patient 6 wasn't referred to Oncology at all. Patient 9 had a very delayed diagnostic pathway and presented as a quite complex, unfortunate complication, and the MDT recommendation wasn't acted upon. He wasn't referred to Oncology and he didn't get a Clinical Nurse Specialist, despite having particularly complex personal needs. 15:23 15:23 15:23

One of the first things we did when we did the family engagement, we met that gentleman and Patricia Kingsnorth organised -- 15:24

230 Q. Which particular patient?

A. DR. HUGHES: Patient 9. Patricia Kingsnorth organised clinical care, community nursing to support this gentleman. So we went out to an engagement piece, where we did end up doing direct care. 15:24

231 Q. Yes. I suppose when you look at the two issues that we have just touched on, the Bicalutamide and then the issue of not bringing patients back for review,

Mr. Glackin is saying, we simply wouldn't know whether a patient has disease progression or whether he has been brought back to fit or whatever. What is the solution for that? Is the solution different types of tracking or different types of monitoring in Governance terms? 15:25

A. DR. HUGHES: The first solution would be to have a Clinical Nurse Specialist who does a holistic baseline assessment and does another assessment as your needs change. There is little point in having a palliative care team sitting at an MDT if you can only access the first presentation. It makes no sense. The reason you bring more complex patients back to an MDT is to get the benefit for all these multi-professionals and that's about doing the right thing for the patient at the right time, and that's about having the right support. Unfortunately, this cohort of patients didn't have that right support in terms of Clinical Nurse Specialists, but that would not stop anybody else re-referring them to get access to this care. 15:25

232 Q. Just finally, just going to the bottom of the page, Mr. Glackin comes back to deal with the nursing issue. It says that his patients have access to the CNS and are referred to palliative colleagues for support. He described Mr. O'Brien as a holistic physician clinician. Can you contextualise that for us? Was that by way of an excuse or explanation or is that a compliment? 15:26

A. DR. HUGHES: I think Mr. Glackin has a misplaced collegiate friendship with Mr. O'Brien and I think is misjudged. In this day and age, to describe somebody as a holistic clinician is really suggesting somebody is working outside their fields of competence. You can't deliver the roles of Clinical Nurse Specialist, you can't deliver the roles of a Palliative Care Physician, you can't meet patient need working in isolation, and that's something that people need to be protected from. I think the theme we are seeing here is a professional, and maybe in his own best will, but working in isolation from all other resources, and patients not being able to access the resources that others could, and resources that they should have. 15:26 15:27

233 Q. Just on the top of the next page, he goes on to describe Mr. O'Brien's work at one of the satellite facilities at Enniskillen where there's no nurse available. You, as the conversation continues, talk about the absence or the limited audit reports. Mr. Glackin responds that he and Mr. Haynes were involved in National Audit. 15:27 15:28

Scrolling down. You advised that you appear to accept that the MDT was under-resourced and under-provided within Oncology. You asked a specific question was there any oncology concern about Mr. O'Brien, Mr. Glackin wasn't aware. He is of the view that it was a functional MDT. That's something you agreed with? 15:28

A. DR. HUGHES: If you look at the quorate levels, 11% to very, very low levels, and it could not have been functional. There was particularly poor representation of medical Oncology, and especially clinical Oncology. Radiology didn't have double reading. People weren't referring cases back to the MDT. There's lots of known and there's lots of unknown unknowns, but the reason they were unknown is because there wasn't process audit, there wasn't manage the assurance, there wasn't checks and balances in place. 15:29

234 Q. Just scroll down. There's discussion about Mr. O'Brien's return to work after sick leave, and about relationships and how they were strained for some time, which may relate back to the MHPS. But in terms of Mr. Glackin, he says: 15:30

"I have known him since before I was a medical student. It's fair to say Mr. O'Brien is very helpful and supportive of me in my role as Consultant. The current investigation should be evenhanded and proportionate in manner. You should be aware of the good things he has done." 15:30

Is that really where Mr. Glackin was coming from; he saw the good in Mr. O'Brien as a human being and as a person, and he had been kindly to him, but he was allowing that, to some extent, to cloud his proper judgment of important clinical and governance issues? 15:30

A. DR. HUGHES: I would believe so. I think Mr. Glackin

was in his remit as a student, under Mr. O'Brien and that's why he became a doctor, so I'd say he has a lot of personal investment in Mr. O'Brien as a person, totally understandable but as a doctor he has to take a step back, as somebody who is the lead for the MDT has to step back and maybe would have been in a good position to have discussions with Mr. O'Brien but I think the power of differential was such that those discussions weren't happening. 15:31

235 Q. I am struggling to find the reference on the screen. If we could go to the middle paragraph, there's just a point I want to raise with you, Mr. Hughes. That's the very paragraph, thank you. Mr. Gilbert, Mr. Glackin explains that one of the flaws of the MDM process is that clinicians who are present may be making a decision on patient care with incomplete information, a decision is reached indicating a course of action, but until you meet the patient in clinic and then have to revise the management. Is that something that's familiar to you, Mr. Gilbert? 15:31 15:32 15:32

A. MR. GILBERT: Yes, indeed. As I think I alluded to it before, which is that these decisions in the MDT are slightly made in isolation. It would be great if the patient could be there as well but they are not. When the decision is taken back to discuss with the patient sometimes they may add some input, which means the MDT decision is untenable or unworkable. Under those circumstances, that discussion needs to be recorded in the notes and it's perfectly reasonable to come to 15:32

a decision then but that decision needs to be relayed back to the MDT so that it can be understood as a learning point, but also as a definitive record of that patient's care, so that the whole of the team can be involved rather than it just being a decision between an individual and the patient themselves.

236 Q. So absolutely no difficulty in carrying a recommendation back to the patient and being unable to implement it, for whatever reason, as long as it's done in a procedurally proper way that you describe? 15:33

A. MR. GILBERT: Precisely, yes. There's no restriction. One of the big problems for the Urology MDT, to be frank, is that we deal with five cancer sites. Most other only deal with one. The pathways are all complex, sometimes they are intertwined. We deal with a large number of patients within those contexts, the Urology MDT probably sees as many as the Breast Cancer MDT does, for example, so busy, busy time. 15:34

237 Q. Yes.

A. MR. GILBERT: Nevertheless, the important cases for discussions are those that vary from what might be called standard practice. Very often what happens in a meeting is you get a description of a patient and the options are clear. Say, for example, a man with localised prostate cancer, he can either go on to active surveillance or consider radiotherapy and he needs to go and have those options explained to him. 15:34

238 Q. Yes.

A. MR. GILBERT: Very often by a Cancer Nurse Specialist

because they are well-placed. There is a reluctance to bring cases back because of the busyness, but it's those very cases which illustrates how we need to modify our practice within the context of dealing with real people rather than the almost theoretical aspects of the MDT, and that's an important discussion and an important learning point for people, and it's an incredibly important process to make sure that the patient is, in fact, getting the right treatment.

239 Q. Just finally on this document, if we can go to the top of the next page. There's a further indication perhaps of Mr. Glackin's defensiveness. He felt that the Minister had taken a disproportionate view, and this was prejudicial, appears to be a reference to the ordering of this Inquiry. 15:35 15:36

A. DR. HUGHES: Yes, yes.

240 Q. Leaving that meeting or that telephone discussion, what was your overall impression then of the culture? Here you have a significant figure in Urology Services, Mr. Glackin, Clinical Lead, quite an experienced Consultant Urologist within the Service, and he's standing over an MDT which he thinks is functioning well but rarely achieves a quorate, and he has a key member within it who he knows, it's his view, Mr. O'Brien might have a different view. He, that is Mr. Glackin, knows that a key prescribing issue isn't being handled well? 15:36 15:37

A. DR. HUGHES: Yes, I think it's something he has a personal connection with Mr. O'Brien for a very long

period of time and has allowed that to cloud his judgment. That said, his judgment is based on opinion and not facts and figures, because you could not be happy with an MDT with a quorate levels, they certainly kept those facts and figures and that will alone will tell you (a) we are not supported. They had very few attendances from Oncology, so that alone you would say it's not a functional MDT and would not pass any sort of Peer Review process. I think there's a culture of acceptance, I think, you know, you take one step by one step over a period of years and you end up in a bad place. I don't think this was a deliberate attempt to hide over things. I just think they slid down to a bad place and had not really addressed the issues. 15:37 15:38

241 Q. I suppose the wider context, in fairness to Mr. Glackin, is that they are running to stand still wan Service that's under-resourced and doesn't appear, and we will look at this in some detail, doesn't appear to have the resources for proper tracking, proper audit, proper monitoring? 15:38 15:38

A. DR. HUGHES: Yes, but they didn't seek them in terms, and when this was pointed out their tracking was insufficient they were quite defensive about it and said that's what we are paid for it. You are paid to keep patients safe, not to keep Minister's numbers right. I think I suppose I have to be tempered in this because people probably were genuinely trying to do their best but very often made wrong judgments and did wrong things. I think that's why we are here. 15:39

242 Q. Yes.

Chair, I have over shot by probably ten minutes in terms of when I wanted to take a break. Do people need a break? 15:39

CHAIR: Let me check if our witnesses are willing to sit on until half past four today? Okay. If we take five minutes and get back and finish at half past four.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 15:39

CHAIR: Thank you.

243 Q. Dr. Hughes, after your meeting with Mr. Glackin about a month later, you sat down with the three managers, both Clinical and Operational, in Cancer Services? 15:47

A. DR. HUGHES: Yes.

244 Q. You met with Barry Conway, who is the Assistant Director of Cancer Services, on 29th December, Dr. Tariq -- I think I may have been calling him Sadiq earlier and apologies for that, and we will correct the 15:47 record if I have -- who was the Associate Medical Director for Cancer Services and Dr. McCaul, who is the Clinical Director for Cancer Services, meeting with Tariq on 29th December and McCaul on 4th January. Just before we explore what happened in those meetings, can 15:47 you help us in terms of the, I suppose the relationship between Urology Services Cancer multidisciplinary meeting or team, which is staffed with a number of Consultant Urologists, albeit multidisciplinary

obviously by definition; how does that relate to Cancer Services?

A. DR. HUGHES: Yeah. The Urology Services was part of a different Directorate and their Governance went up that pathway. Cancer Services was an overarching structure which linked into all the Cancer Services, but did not necessarily have governance responsibility for that, and I think that was a critical weakness because while the problems are in a cancer structure, they didn't really have a good escalation structure to get help, get support, and the Cancer Lead, I think was probably reasonably new into post, had no understanding of the issues within the MDT and Urology, and Dr. Tariq had limited knowledge of the issues within the Urology Service, because it was really very much seen as a Service within a Service, and the collegiate benefit you get from bringing all MDT leads together and having a commonality of purpose, hadn't been put in place. I think they might have had one meeting of such a structure at that time. This is quite a long way into the development of Cancer Service. You would have expected at least a Cancer Services nominal Directorate with the Leads meeting all the time, the equivalents in the MDT sort of admin leads meeting so they can share best practice so that you learn from where it's working well and understanding that maybe your normal is not normal, and that there may be better ways of doing things and actually seeking collegiate support. It seemed to be a very just dysfunctional and discrete

15:48 15:48 15:49 15:49 15:49

process.

245 Q. Yes. I'm not going to open each of the three meetings; I am going to give the Inquiry the reference. Barry Conway's meeting with you was 29th December and it's referred to at WIT-84413. Dr. McCaul, the reference is WIT-84420. I'm going to focus on Dr. Tariq, but before I do so, is it fair to say that, broadly speaking, the same themes emerge from speaking to the three of these employees? Essentially you seem to reflect a disconnect between that Service and the Urology MDT so that, by and large, they did not know about the issues impacting on that MDT in terms of clinician performance. They didn't know about the nursing issue, that's what they have told you. They didn't know about the Bicalutamide issue. They didn't know about any of those issues. The one issue that emerged I think was their awareness of the oncological -- sorry, a Radiology issue had been raised, I think, with Dr. McCaul, for him to address the question of attendance of Radiology. In terms of issues pertaining to the MDT, they weren't engaged? 15:50 15:50 15:51 15:51

A. DR. HUGHES: No, they weren't engaged and they weren't actually even over the Peer Review reports which, while there would be matrices of information to be passed on and shared externally by a manage the assurance process, the Associate Medical Director was not aware of any of the ongoing processes for Mr. O'Brien, although he may have had need to know, seeing as Mr. O'Brien was working in the Service that he was 15:52

professionally responsible for but that had not been shared with him and I suppose maybe there's a judgment on that.

246 Q. Let's pull up Dr. Tariq's meeting with you. Just in the interests of time and because the issues are relatively common between the three of them, we will use his as a vehicle to explore that. It's WIT-84418. Scrolling down, please. You introduce yourself obviously, and the issues that you are exploring. You mention the access to the nurse, and that that is an issue. ST, just at the bottom, says to you he was not: 15:52 15:53

"... aware of any concerns mentioned, any clinical concerns would go through the speciality management structure route." 15:53

Can I suggest that the routing of any issues through the Service, through the Urology Services, is probably as good a structure as any, but should there not be some form of system to enable the overarching Cancer Service to be aware of issues, whether professional or operational, affecting that MDT? 15:53

A. DR. HUGHES: Yes. Irrespective of the fact he may not have had professional line management or staff within that area, he would have been responsible for the safety and manage the of patients within that area. You can't deliver on that unless you have information and knowledge about the manage the of Service. I was 15:54

under whelmed by the meeting and felt that while he had a very significant role in the Trust, I don't think it was being delivered in any meaningful way. Whether that's because Urology MDT was a hot potato and a difficult thing to deal with, I'm not sure. I didn't see any collegiate approach where they would be grouping together all the MDT processes, sharing best practice, working together and, if there are difficulties, you know, reflecting how other MDTs have dealt with their resourcing difficulties. 15:54 15:55

247 Q. Yes. If we go over the page to 84419. It talks about the question of PA for the MDT lead. That's a matter for Urology. He says:

"The Cancer Services responsible for performance targets, tracking of patients on cancer pathways and to provide help and operational support to the tumour site teams if it is needed." 15:55

Just on that, one of your concerns reflected in your statement was that the tracking was limited to the 31, 62 day targets, and simply limited to that? 15:55

A. DR. HUGHES: Yeah. Tracking is a great resource if it's used to its full extent. If you empower the tracking team they will be able to expedite scans, tests, they will act as a safety net, they will ensure patients get timely care and also meet their targets. But if you start from the point of counting the targets and forgetting the other aspects of patient pathways 15:56

and patient care, you are putting the cart before the horse. Your primary responsibility is to the safety and manage the of care and good tracking does that, but tracking focused only on targets forgets the vast enormity of the things they could be doing, and that may be a resource issue, and that's something the Trust may have to reflect on. The culture was very focused on 31 and 62 days as opposed to ensuring nobody was missed out, people were re-referred, people got scans at the right time and you can see from a lot of the patients that we have looked at, the time limits of their care was quite poor. 15:56 15:57

248 Q. Yes. He says here that his Service, the Service that he has a responsibility for, encompasses a responsibility for tracking of patients. But then presumably you would agree with me that the tracking of patients is a function of Governance? 15:57

A. DR. HUGHES: Yes.

249 Q. It's a tool of Governance, perhaps?

A. DR. HUGHES: Yes. 15:57

250 Q. Is there an inconsistency here because he says "governance arrangements", and perhaps he means the management of practitioners lay with the primary team management structure. In other words, the Clinical Director and the Associate Medical Director? 15:58

A. DR. HUGHES: Tracking itself can be a useful governance tool if you do an exception report and review the things that would have missed it, and you would have picked up lots of cases had very long periods of time

and examined why that happened. That analysis was not being done. It was did they achieve a target or not. Although 31 and 62 day targets can be a blunt instrument they are sort of something patients understand, one month, two months, they can't be used as a tool to see why did that patient take so long, and I think you would have learned a lot from doing that quite simple piece of work.

251 Q. Yes. As this develops, you say in the two line paragraphs that sits by itself in the middle there: 15:58

"People didn't realise the deficits of care was the absence of a key worker impacted on the patient's care."

15:58

Dr. Tariq comes back and says, they, that is his Service "were removed from that process because the primary team' leadership is responsible for governance arrangements."

15:59

Is that what left you with a sense that this is not satisfactory, that although it's his Service and, as you say, he has responsibility for the patients coming through this Service, he doesn't seem, on the basis of this, to be embracing any particular governance responsibility? 15:59

A. DR. HUGHES: I think when people start telling you what their responsibility is in a response, that's not a good place to be because they are actually saying

what they are not responsible for. Irrespective of a role in the Health Service, everybody is responsible for the care and safety of patients, and these were major deficits. I didn't get the understanding that he really understood some of the deficits and the absence of a key worker, absence of what they actually did, and the fact that, as long as the governance lay elsewhere, I think when you have got services split across different line management, and this is not unusual, you need to have good collegiate ways of working, good communication, good organisation, or else you will have patients fall between gaps and stools, and I think that's what happened. 15:59 16:00

252 Q. Yes. The three employees who are dealing with it just in this scenes of the evidence, they were the three employees who were to write to track changes into your report? 16:00

A. DR. HUGHES: Yes.

253 Q. We will look at the circumstances in which that occurred. It may be that they thought that this was at the invitation of Patricia Kingsnorth, who invited them to comment on the factual accuracy of the report, but we will look at that in the round. Is it fair to say, and I think it's reflected in your statement, and we will look at that tomorrow, that the response from the three of these employees left you feeling that there was a lack of insight into the importance of strong clinical and social care governance in this area of delivery? 16:00 16:01

A. DR. HUGHES: Yes.

254 Q. The next meeting you conducted was with Ronan Carroll, and you met with him on 18th January. The reference for the meeting is WIT-84342. Again, the usual format, you explain your role, Dr. Hughes. Just scrolling down. You ask a question of Mr. Carroll about the way in which Mr. O'Brien practices. Mr. Carroll, we know, has worked in the Trust for some years and has worked closely with Mr. O'Brien over those years, and he provides quite a personalised response to it. He says that he "believed that everyone made excuses for Mr. O'Brien, the consensus was that he was a very strong personality who could be spiteful and even vindictive, many of the Cancer Nurse Specialists were afraid of him, but Ronan Carroll was unaware that the Cancer Nurse Specialists were excluded from seeing Mr. O'Brien's patients." 16:02 16:02 16:03

Was that credible, in your view, the latter part?

A. DR. HUGHES: Yeah. I struggle with it, and it's something that I think, if that was my environment, would I know, would I hear? Yes. 16:03

255 Q. He was Assistant Director within -- I will have to just get this.

A. DR. HUGHES: Surgery, I think. 16:03

256 Q. I am minded to say Surgery and Elective Care, but I will have that checked. Certainly in a subsequent meeting with the Head of Service for Urology, Mrs. Corrigan, she was very plain in admitting or

accepting her knowledge of this situation vis-à-vis the nurses?

A. DR. HUGHES: Yes, I think it's really hard to get into conjecture thinking what people know because that's not really a good place to be. I think it's appropriate to say they should have mechanisms in place to know, and understand what the deficits for patients were, and if they didn't know, people at that level should have known. 16:04

257 Q. That, perhaps, says something about communication, firstly, and the culture of failing to escalate? 16:04

A. DR. HUGHES: Yeah. I think that is a theme you will see, where there's issues that some knew but it wasn't escalated, not restricted to the Southern Trust, but everybody, maybe assuming the small piece of information they have was of not great significance, possibly because they don't understand the patient deficits. 16:05

258 Q. Scrolling down the page again. More reflections, I suppose, on his perception of Mr. O'Brien? 16:05

A. DR. HUGHES: Yes.

259 Q. To what extent was that helpful to you, or was it unhelpful?

A. DR. HUGHES: I thought it was totally unhelpful because, again, it brings the Governance round to the named person as opposed to what actually was going on with the patients. What was the care they were receiving? What were the deficits? How do we address it? If it becomes focused on one person, you don't see 16:05

the problems for patients and I believe that's what happened.

260 Q. From your perspective, perhaps the focus was also on the management, such as Mr. Carroll, who had presumably duties to get the governance arrangements right. If he is telling you, as he says, that he wasn't aware of the issues identified by the SAI review and was quite shocked when the issues were identified during the update of early learning provided by Mrs. Kingsnorth, then that is telling you something about the health of the governance arrangements? 16:06 16:06

A. DR. HUGHES: Yeah. I think you should have a culture that allows people to identify things at an early stage. Identifying things at an SAI is far, far too late in the game. This should have been identified as a non-conformity or patient experience audit to note that 10 or 15% of our patients are not receiving the care everybody else does. It needs to be escalated. It needs to have a process that allows people to do that without fear or favour. 16:07 16:07

261 Q. If we go to the top of the next page, please. He talks about an SAI of a man who had a bladder tumour who was a red-flag referral. I think that's slightly garbled. Perhaps that should have been a routine referral that ought to have been red-flagged. Passing over the fine detail of that, he talks about the perception of Mr. O'Brien being clinically sound so that any issues that were raised were regarding system and administration processes. 16:07

This analysis that Mr. O'Brien, good surgeon, but Mr. O'Brien poor administrator, is a theme that I suspect the Inquiry will grow wearingly familiar with. In your experience, where a doctor is exhibiting shortcomings in an aspect of his care, and let's call it the administration of clinical decision-making. He should be dictating letters, he should be actioning reports that he has initiated through Radiology or Histopathology or whatever. That was the kind of information that was in the system following MHPS and formally through other SAIs, but there was a failure to get to grips with the stuff that you were asked to get to grips with through the SAI process; these issues that were going on in MDM. Is there an area of reflection here for the Trust in terms of, if they know that some things are going poorly, they should be looking beyond that? 16:08 16:09 16:09

A. DR. HUGHES: Yeah.

262 Q. Investigating beyond that? 16:10

A. DR. HUGHES: Yeah. Well, a couple of points. If somebody has deficits in their clinical administration up to and including the level of an SAI, that's quite a serious issue. Also if somebody, and I don't know the details of it, ends in an MHPS process, you are required to give assurance to the GMC, you are required to assess that that person is safe in every other way. In the MHPH framework clearly says the list of places where things can arise, so you have to go down that 16:10

list and get assurances. You cannot just assume. We have a history of this. I mean, poor clinical administration may be a function of somebody struggling in many ways; somebody who needs support, somebody who needs to be mentored, supported. You can't just assume that the problem lies within perceived sort of clinical administration. It can be a symptom.

263 Q. Yes. Mr. Carroll is asked about the issue of the need for assurances -- just four or five lines from the bottom -- through regular audits for all clinicians. His answer to that is: 16:11

"The system is not resourced for re-referral to MDT."

Does that read like an accurate note? You are asking him, it seems, about audits, and he is answering by talking about re-referral. Is that the same issue? 16:12

A. DR. HUGHES: Yeah, well it would be one of the critical issues that you'd like to audit, you would like to ensure that re-referrals to MDT for somebody whose care has moved on or because MDT guidance has been changed is reviewed, but the stock answer was we are not resourced for that. 16:12

264 Q. Yes. Just so I'm clear, is he telling you that they are not resourced for any rereferral to MDT? 16:12

A. DR. HUGHES: No, I think he is not resourced to do the audit.

265 Q. The audit. Okay. I beg your pardon. Right, okay. Again, that's, as we see from your statement, where you

see a fairly fundamental shortcoming of the governance process. If they are not in a position to track, audit, monitor, then they can't assure themselves that care is being provided safely?

A. DR. HUGHES: Yeah. Quite perplexing because most functioning MDTs that I know would do this work automatically, because they want to capture all the complexity they are dealing with. They want to share so their line managers know the volumes of work and understand the pressures they are under and look for additional resource whereas what was said, we can't do that. So there was lots of unknown unknowns sitting out there, both clinical Service pressures, and it was a culture that I didn't recognise. 16:13 16:13

266 Q. The next person you saw was Martina Corrigan. You saw Martina Corrigan and Mr. Haynes and Urology MDT all on the same day. If we start with Martina Corrigan. She was the Head of Urology Service and had been for some time by that date. Could we go to WIT-84355. Just scrolling down. She explains that she had worked in the Trust for 11 years and confirmed during that time Mr. O'Brien never recognised the role of Clinical Nurse Specialists. She confirmed that he never involved them in his Oncology clinics. He is aware that some of the Clinical Nurse Specialists would have asked to be at the clinics but Mr. O'Brien never included them. 16:13 16:14 16:15

We know from some of the evidence that you gathered that Mr. O'Brien worked mostly with nurses in other

fields, the management of benign disease, because you described this morning other operational and administrative duties, but was this the -- is this the clearest account that you were receiving in terms of a manager plainly telling you that nurses weren't involved in his cancer management? 16:15

A. DR. HUGHES: Yeah, this was the direct line manager of Urology Services saying the nurses weren't involved in cancer specialist care.

267 Q. Mm-hmm. And, for you, that appears to corroborate, does it, the accounts that you were receiving from patients and families? 16:16

A. DR. HUGHES: Yeah.

268 Q. I mean, no doubt you appreciated her candour, but it doesn't say much, does it, for the management of the issue? 16:16

A. DR. HUGHES: No, I think -- I'm not quite sure what people think. They certainly didn't have an understanding of the role of a Clinical Nurse Specialist and what it brings to a patient and a patient's experience of their care and understanding of their care. I think Ms. Corrigan was pretty frustrated by the processes and maybe had been unable to change things, and certainly that probably comes out in her language. Whether there should have been a way of escalating this and having it dealt with, I think is probably -- I should have explored that more, but it certainly wasn't addressed. 16:16 16:17

269 Q. She refers, I think, on down the page, to two nurses.

Yes.

"The two Clinical Nurse Specialists did report that they did regularly challenge Mr. O'Brien and asked him if he needed them to be in the clinic to assist with the follow-up of the patients, but it got to the stage where staff were getting worn down by no action and they gave up asking as they knew that he wouldn't change." 16:17 16:18

Did you take a note of who she was referring to or did you ask her to name them?

A. DR. HUGHES: No, I didn't, I didn't.

270 Q. And I think there were two nurses, possibly a third, in place for quite a long time before the recent recruits of, I think, 2017? 16:18

A. DR. HUGHES: Yes.

271 Q. It could be 2016 --

A. DR. HUGHES: 2017, and the quorate went up to five.

272 Q. Was it your impression that she was perhaps talking about the nurses who had been there for some time or can you simply not say? 16:18

A. DR. HUGHES: It could only have been, it could only have been.

273 Q. Right. Okay. Did you perhaps inform her that nurses are so important to the patients' journey -- do you suspect that sense of importance and value that attaches to the CNS role wasn't appreciated by management and that may be a factor in terms of why it 16:18

wasn't escalated?

A. DR. HUGHES: I think that's correct. I certainly -- they didn't have the understanding that I would have of a Clinical Nurse Specialist, but I suspect the consultants would have been aware of the role and value and probably some of them did speak about it. The question is absence of a Clinical Nurse Specialist, apart from the right of patient supporting and holistic basis, there is the information piece and supporting informed decision-making, especially in a situation where MDT recommendations are being changed, and this -- this is the major concern. 16:19 16:20

274 Q. You go on, I think, towards the bottom of this page, to say that - just over the page, perhaps - that the Associate Medical Director and the -- 16:20

"... Mrs. Corrigan advised that, during MDT, on occasions there were issues raised about Mr. O'Brien and, at times, these were escalated to the AD and AMD, but as with other concerns regarding Mr. O'Brien, these never got anywhere as he either promised that he would sort or else he gave a reason why he couldn't follow through and the ethos among many other staff was 'well, sure, that's just Aidan'," a sense of resignedness that they couldn't challenge or escalate. Did she elaborate on what those issues might have been if they were emerging from MDT, can you remember? 16:21 16:21

A. DR. HUGHES: No, no.

275 Q. You can't.

A. DR. HUGHES: But again, it's this process of naming the individual instead of naming the deficit the patients were suffering, and I genuinely don't think people fully understood.

276 Q. You saw Mr. Haynes on that day as well, and his meeting with you is recorded at WIT-84353, and you ask Mr. Haynes: 16:21

"Were there concerns raised about Mr. O'Brien's practice?" 16:22

And he explains that he was the person who raised the concerns, and he describes, I suppose, the distinction, as he sees it, between his practice and Mr. O'Brien's practice: 16:22

"He" -- that is Mr. Haynes -- "works in a more team-based approach with three Consultants and five Specialist Nurses, whereas Mr. O'Brien worked as more an individual and non-involvement with any others members of the team, which meant that his practice was not scrutinised." 16:22

So that's, I suppose, the set-up of -- or the culture, to some extent, that he is explaining. 16:23

A. DR. HUGHES: Mm-hmm.

277 Q. In terms of what he knew specifically, he told you that he was not -- let's see if I can see it here:

"He was not acutely aware of his failure to comply with standard treatments."

Just at the bottom of the page:

"He advised there are a number of concerns about how Mr. O'Brien practised, but he was not acutely aware about his lack of conformities to standard treatments."

But he goes on to say that, if you go further down the page, please: 16:23

"Mr. Haynes advised that the MDT did disagree with Mr. O'Brien's decision-making regarding ADT."

That strikes me -- I ask for your comments; is that inconsistent? 16:24

A. DR. HUGHES: Yeah --

278 Q. He said, on the one part, he's not aware of Mr. O'Brien's failure to comply with standard treatments, and, by the next sentence, almost, he is explaining that: 16:24

"The MDT had knowledge of Mr. O'Brien's decision-making around ADT. There was disagreement in relation to his use of ADT for a patient, but Mr. O'Brien became entrenched in his decision-making and he never accepted the challenges". 16:24

Is that the issue of Bicalutamide that's being raised here?

A. DR. HUGHES: Yes, I think so.

279 Q. You met the Urology MDT then at some point on that day, the 18th February. We will just finish with that. WIT-84347. And the first issue discussed -- well, first of all, let's just orientate ourselves to who is there. So the whole of the MDT, certainly the Urologists and the nurses are present? 16:25

A. DR. HUGHES: Mm-hmm. 16:25

280 Q. Kate O'Neill and Jenny McMahon, being the nurses. And the Senior Urological Clinicians, including Mr. Young, Mr. Glackin, Mr. Haynes. Mr. O'Meara was he a radiologist?

A. DR. HUGHES: He was a locum. 16:26

281 Q. Locum. And scrolling down, the first issue you touch upon is the Nurse Specialist. Just scrolling down a little further. And he confirms that "Nurses were excluded from Mr. O'Brien's practice". He doesn't believe there is an issue with other doctors. So is that Mr. Glackin's language, the use of the word "excluded", or can you not be so specific? 16:26

A. DR. HUGHES: I'm not sure, I'm not sure.

282 Q. But he's clearly telling you that Mr. O'Brien doesn't use the nurses in -- 16:27

A. DR. HUGHES: Yeah, I think it is Mr. Glackin because he is giving assurance that that's not an issue with other doctors.

283 Q. Yes, yes.

A. DR. HUGHES: Yeah.

284 Q. And we will have to ask him about this, but you will recall when you spoke to him in November, he seemed to be putting the blame on, if you like, on a lack of resources? 16:27

A. DR. HUGHES: Yeah.

285 Q. Whereas now there appears, at least on the face of this note, to refer to his knowledge of an exclusion?

A. DR. HUGHES: That may be -- and in response to -- at that stage, I presumed it was because of geographical 16:27 reasons or resource reasons that nurses weren't made available, and he may have responded in that way, but I later became aware that it was because they weren't included in the care.

286 Q. And just scrolling down a little bit, please, on down 16:28 to the next page, please. Again, he is talking about the improvement of nurses, in terms of resources, in the past couple of years. I think at some point he goes on to say that management were aware of the issue, but nurses weren't deployed by Mr. O'Brien. We will 16:28 maybe come across that reference. Yeah, I think it's a couple of pages down, but we will come to it eventually.

A. DR. HUGHES: Yeah, I think it's the third line down.

287 Q. Yes, thank you. And you -- going back to the previous 16:29 page, you discuss, in the middle of the page, the issue of tracking:

"Mr. Glackin recalled his time in the West Midlands

when the MDM was better resourced, follow-up and tracking was more robust, more a priority and had admin support."

And you agreed with him, but questions if the issue was systematic and a problem for more than nine cases and, if so, this would need to be addressed, but Mr. Glackin referred back to the audits, and his view, again, is no time and no resources, a theme that seems to come through. 16:29 16:30

A. DR. HUGHES: Yeah.

288 Q. And what's your reflections on that? It may well be the case that resources were tight or were not forthcoming, but as a Clinical Lead in his case or looking across the way at Cancer Services, who are saying things aren't resourced, what is to be the approach here for people working in the system; do they have to ask or should they be provided with the resource without having to ask? 16:30

A. DR. HUGHES: Well -- 16:31

289 Q. It's a complex issue, presumably?

A. DR. HUGHES: Well, Cancer Services are organised in quite a structured way, in that you are supposed to have two business meetings each year and that you reflect on areas of problems, so you have to have some sort of mechanism to collect data, be it trainees doing it under supervision from a Consultant, but to focus on areas of concern or deficit. And if you take the role as a Clinical Lead, you have to make sure that you get 16:31

the resource, and that might be a difficult question, but I think it would be interesting to see if this issue is replicated across their MDMs and -- or if it's just a Urology issue. I'm not saying they are not busy, they had obviously expanded their Service, but you can't expand a Service at the consequences of safety and governance.

290 Q. There is then at the bottom of the page a discussion about Bicalutamide-prescribing and Mr. Glackin specifically focuses on the dose of 150 milligrams. If you can maybe look at that as well, Mr. Gilbert. And I'm not sure how this was introduced to the conversation, but he referred to a specific dose of 150 milligrams and suggested that the evidence was weak in the criticism of the use of this treatment and said the scientific evidence was not so robust.

I think we heard this morning, Mr. Gilbert, that 150 milligrams of Bicalutamide, in some circumstances, for some classes of patients, would be the appropriate hormonal approach, not something you have particularly used --

A. MR. GILBERT: I would regard it as an alternative in particular circumstances when hormones should or must be given in locally advanced disease. If, for example, the disease is clearly becoming very active, PSA is rising rapidly or the presenting PSA is particularly high, and that's the blood test which gives the risk of the presence of prostate cancer, under those circumstances it might be reasonable to try and control

the disease using Bicalutamide 150.

291 Q. Mm-hmm.

A. MR. GILBERT: An alternative, it is also an alternative to patients who don't particularly want to be on the LHRH analogue and particularly concerned about maintaining sexual function -- 16:34

292 Q. Yes.

A. MR. GILBERT: It doesn't particularly do that. And the third instance would be if a patient had intolerable side effects from the LHRH, needed hormones and it was used as an alternative. So it needs to be regarded as an alternative. The only licensed indication for 150 is for locally advanced disease where hormone treatment is appropriate. 16:34

293 Q. Yes. And so, Dr. Hughes, do you know why this issue came in at this point? I mean, assumedly, Mr. Glackin didn't -- you hadn't given Mr. Glackin a read-out of the prostate Bicalutamide cases that you were looking at, in any great detail anyway? 16:34

A. DR. HUGHES: No, we were given a feedback just to what the problems were, and there's a line about -- what is a misspell, and it says "calutamide", and it should be "Bicalutamide", and then Mr. Glackin came out with this comment, and I was a bit concerned about it and I just said I will -- am just taking advice from Mr. Gilbert. I didn't want to close it down. 16:35 16:35

294 Q. Yes, because the clear message you were getting from Mr. Haynes, Mr. Glackin during your one-to-one with him the year before, there was an understanding of a clear

problem, an understanding within the MDT of a clear problem with Mr. O'Brien's use of Bicalutamide at a low dosage?

A. DR. HUGHES: Yeah.

295 Q. And just finishing with this, going over the page, there is discussion of the enormous disconnection -- just going down to Mr. Haynes' entry at the very bottom: 16:35

"An enormous disconnection between services and feels Consultants are blamed when they fail, but, at the same, time --" 16:36

Is that "Clinical Cancer Services"? What's the "C"?

A. DR. HUGHES: Yes. 16:36

296 Q. "... will take credit when they succeed."

So is that the disconnect that you sensed when speaking to Dr. Tariq, Mr. McCaul and Mr. Conway?

A. DR. HUGHES: I mean, very much so. I think Cancer Services tend to be quite collegiate and quite cohesive, and I was quite taken aback by the disconnect between those responsible at the highest level and those delivering at the MDT level, and clearly, as well as the problems we are talking about today, they were struggling with a range of other major issues in terms of getting the meetings to be quorate and having appropriate Radiology support and just actually having enough infrastructure to deliver what they would regard as a good Service. Mr. Haynes, Mr. Glackin, maybe 16:36 16:37

another Consultant, had come from practices in the UK and had known different methods of working and better methods of working and there was a sense of frustration.

297 Q. Yes. And just if we can go to the last page of the meeting, no doubt skipping over some other issues, but I just want to get to this one, WIT-84351. Just further down the page, please -- over the page. I have missed the reference. I will find it and start with it tomorrow. There was a suggestion in your statement that the professionals within this meeting were somewhat defensive in their approach with you, in the sense that they thought that the focus should be on the -- I suppose the shortcomings of one individual professional and that the teams shouldn't be getting dragged into it, and does -- you recall that? 16:37 16:38 16:39

A. DR. HUGHES: Yes. Yeah, I mean --

MR. WOLFE KC: It's something maybe we will take up first thing in the morning.

CHAIR: Very good. 16:39

MR. WOLFE KC: Thank you.

CHAIR: 10 o'clock tomorrow, Mr. Wolfe?

MR. WOLFE KC: Yes, thank you.

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 30TH NOVEMBER 2022 AT 10 A.M. 16:39