



Oral Hearing

Day 45 – Tuesday, 23rd May 2023

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

Held at: Bradford Court, Belfast

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

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THE INQUIRY RESUMED AS FOLLOWS at 10:00 A.M. ON
TUESDAY, 23RD MAY 2023

CHAIR: Morning everyone. Ms. McMahon.

MS. McMAHON: The first witness is Fiona Reddick, who
 is the head of Cancer Services, and she's going to take
 the oath. 10:01

MS FIONA REDDICK, HAVING BEEN SWORN, WAS EXAMINED BY
MS. McMAHON AS FOLLOWS: 10:01

1 Q. MS. McMAHON: Ms. Reddick, thank you for coming to the
 Inquiry to give evidence. You have already provided
 evidence in written form, a Section 21 response. If we
 just go to that at WIT-91001. It's notice number 99 of
 2022. That's the first page of that. Then if we go to
 the signature at the bottom of WIT-91023, you have
 signed the notice dated 8th December 2022. If we just
 look at your signature, do you recognise that as your
 signature? 10:02

A. Yes, I do.

2 Q. And that's your statement to the Inquiry?

A. Yes.

3 Q. And you wish to adopt that as your evidence?

A. Yes. 10:02

4 Q. Thank you. For the Panel's note, the enclosures with
 that statement are from WIT-91024 to WIT-91048.

Ms. Reddick, I just want to discuss briefly with you

1 your employment history to date, which you set out at
2 your statement. We do not need to go to it but it's at
3 WIT-91003. From 1999 to 2003 you were a staff nurse in
4 the Mandeville Unit of the legacy Trust?

5 A. That's correct, yes. 10:03

6 5 Q. Then in 2003 you were appointed the clinical sister in
7 the same department?

8 A. Yes.

9 6 Q. From January 2010 to July 2012, you were an acute
10 oncology nurse specialist? 10:03

11 A. Yes.

12 7 Q. Is that now what would be called a cancer nurse
13 specialist?

14 A. It's different; it's site specific. Acute oncology is
15 an area in its own entity. But it ties in as a cancer 10:03
16 nurse specialist, it has various aspects which are
17 consistent across the board.

18 8 Q. So it's specific to that unit at that time?

19 A. Yeah.

20 9 Q. July 2012 was when you were appointed the Head of 10:03
21 Cancer Services in the Trust?

22 A. That's right.

23 10 Q. And that's your current role?

24 A. Yes.

25 11 Q. Now, as regards what your role involves, you have set 10:04
26 out at WIT-91001 of your statement -- and we'll just
27 bring that one up, 91001. You have said in the third
28 line down:
29

1 "I have indicated in my responses that I was
2 responsible for ensuring that cancer access ministerial
3 targets were adhered to, and that any issues or delays
4 were escalated as appropriate. This would have been
5 carried out using the Trust's escalation process and 10:04
6 completing breach reports, which would have been shared
7 locally and at HC and Health and Social Care Board
8 level."

9
10 Just in relation to that aspect of your role, how did 10:04
11 you go about ensuring that ministerial targets were
12 adhered to?

13 A. So, within the Trust we had regular cancer performance
14 meetings. On a day and daily basis, we would have been
15 monitoring patients along their pathway, and I worked 10:05
16 very closely with the cancer tracking team and
17 operation support lead. We worked very closely in
18 monitoring those, where the patients were in their
19 pathway. We had regular performance meetings within
20 Cancer Services, and then once per month we had a 10:05
21 monthly cancer performance meeting, where we worked
22 with the other heads of services and assistants to
23 directors for each of the specialties, and we looked at
24 areas where there were issues and highlighted those; we
25 worked our way through individual patients and shared 10:05
26 breach reports. If patients breached their 62-day
27 cancer performance target, then we went through the
28 detail of where the delays were.

1 we also were accountable to the Health and Social Care
2 Board. We had regular performance meetings with the
3 Board where we were held to account for our cancer
4 access targets, and we reported back to those as well.

5 12 Q. The breach reports are what they sound like, 10:06
6 highlighting any breach in expected targets?

7 A. That's correct.

8 13 Q. Would they be completed on an ad hoc basis or would you
9 have done that weekly or monthly anyway?

10 A. No, that was part and parcel of the role of the cancer 10:06
11 tracking team. So any patient that breached, there
12 were breach reports, and those were visible for
13 everyone.

14 14 Q. Now, we'll go on to talk about the Trust's escalation 10:06
15 processes shortly. You have mentioned there the Health
16 and Social Care Board. How often did you provide them
17 with the reports detailing the information you've just
18 set out?

19 A. So, we would have sent that through. We would have 10:07
20 either met on a monthly basis or bimonthly basis, and
21 they would have requested information from the Trust
22 prior to the meeting. Each month, they would have
23 focused -- potentially they would have told us where
24 they were going to focus for that ensuing meeting that
25 was going to happen. So, we would have shared that 10:07
26 information ahead of the meeting and then they would
27 have went through the detail at those meetings.

28 15 Q. Now, the Inquiry have heard from a cancer tracker as
29 well so there's information available to the Inquiry.

1 In relation to your particular role as Head of Cancer
 2 Services, if you identified information that was fed up
 3 to you to inform you whether targets were met or not,
 4 did you have any responsibility around dealing with
 5 issues that were causing problems?

10:07

6 A. Yes. Collectively as a cancer team, the trackers, the
 7 operational support leads, myself and my Assistant
 8 Director would have shared that information with the
 9 head of service if there was issues across a particular
 10 tumour site. That would have been shared through the
 11 escalation process. If someone was delayed, if the
 12 first appointment was delayed, or if they were waiting
 13 on an investigative test, that would have been flagged
 14 up through e-mail.

10:08

15 16 Q. So was the limit - and I do not mean any disrespect,
 16 just so we know the contours of your responsibility -
 17 the limit of what you could do when a problem was
 18 highlighted was let someone know to deal with it?

10:08

19 A. Yeah. You escalated it to the service because there
 20 was things within -- out of our control that we could
 21 not do. It was up, you know, to the service. If it
 22 was theatre access, that was out of our control, it had
 23 to be flagged up to the service.

10:08

24 17 Q. Was there any sanction or feedback from the HSCB when
 25 targets were not met or performance was not as
 26 expected?

10:08

27 A. HSCB, you know, we went through issues at our meetings.
 28 There also was the Northern Ireland Cancer Network
 29 Clinical Reference Group, site specific. A lot of

1 their focus would have been around performance as well.
 2 They would have looked -- they would have picked a
 3 particular meeting to look at performance across Trusts
 4 and shared that at meetings to see if there were any
 5 other ways that they could work to achieve the targets 10:09
 6 in a more timely manner. So, there would have been
 7 focus from HSCB on our performance as well.

8 18 Q. Just in relation to the issue of sanction or any
 9 feedback from a commissioning perspective, was there
 10 any response from the HSCB if targets or performance 10:09
 11 were consistently not met?

12 A. They would have tried to look at other -- you know,
 13 there would have been site specific groups set up. For
 14 example, in urology there was an implementation group.
 15 But I would not have been at that, I would not have had 10:10
 16 sight of the discussions that would have taken place at
 17 those meetings. Across tumour sites, there would have
 18 been meetings with boards to see how they could, you
 19 know, look at performance and improve it.

20 19 Q. In relation to clinical nurse specialists or cancer 10:10
 21 nurse specialists -- and just before I ask the
 22 question, you have set out in your statement that there
 23 is a difference between those; they're not
 24 interchangeable, the names, cancer nurse specialists
 25 are specific for Cancer Services. That is something 10:10
 26 that welcome on to discuss, about you seeking funding
 27 for --

28 A. Hmm-mm.

29 20 Q. -- to ensure that Cancer Services were properly

1 resourced. In your role, did you have any oversight or
2 management in relation to cancer nurses or clinical
3 nurses?

4 A. Yes. In my role I was responsible for some tumour site
5 specific cancer nurse specialists. However, in the 10:10
6 context of this Inquiry, within urology I didn't. I
7 suppose when I took up post in 2012, there weren't that
8 many cancer nurse specialists across tumour sites.
9 Some tumour sites didn't have any at all; some were
10 single-handed. So within the NICA cancer lead nurses 10:11
11 forum, we tried to drive that forward. We actually
12 were part of a cancer patient experience survey in
13 2015. As a result of that, patients were saying it was
14 very clear that they had a better experience if they
15 had a key worker and a clinical nurse specialist at the 10:11
16 point of diagnosis. So, on the back of the cancer
17 patient experience survey in 2015, we highlighted to
18 the Health and Social Care Board that we were keen to
19 try and recruit, and we championed that we wanted more
20 clinical nurse specialists for cancer patients going 10:11
21 forward. So, we approached Macmillan as well for some
22 funding and were able to develop a bid for additional
23 cancer nurse specialists. We scoped out across the
24 region in various Trusts -- in all of the Trusts. We
25 done a scoping table to see where we were, where our 10:12
26 baseline was and where we needed to go. That,
27 thankfully, was taken on board by the Health and Social
28 Care Board and we expanded that over a five-year plan,
29 starting from 2016. It was a tapered funding model,

1 and that was the first type of funding of its kind.
2 we did roll it out. I worked with heads of services
3 across various specialties to scope out what their
4 baseline was and where they felt they needed to go over
5 the next five years.

10:12

6 21 Q. well, you have given us a lot of information in that
7 answer. If I could just break it down slightly so we
8 can highlight the stops along the way chronologically.

9
10 So, the 2015 patient survey highlighted the importance
11 of the role of the cancer nurse specialists in the
12 patient's pathway. That triggered then the 2016
13 request, I think to Macmillan, for co-funding for
14 cancer nurse specialists. I think you said that you
15 were also responsible for mapping out within the
16 service the particular need for cancer nurse
17 specialists throughout Cancer Services so you could
18 identify where those posts may most helpfully be
19 placed.

10:13

10:13

20
21 As part of that, that was something that was worked on
22 with the board -- sorry, the Health and Social Care
23 Board, and the Public Health Agency?

24 A. That's correct, yeah.

25 22 Q. And they were on board with that.

10:13

26
27 You said something about funding in relation to that.
28 Was this going to be a recurrent funding post or was
29 this going to be time-limited at that time?

1 A. No. So, the funding was a tapered funding model where
2 Macmillan done the initial pick-up and then, over the
3 years, it rolled into pick-up by the Health and Social
4 Care Board. Those were recurrently funded beyond that
5 point. So, they were all recurrently funded; that was 10:14
6 the agreed model.

7 23 Q. So, the Board's commitment was to pick up when the
8 Macmillan funding ended?

9 A. Yeah.

10 24 Q. And this was around 2016? 10:14

11 A. That's correct.

12 25 Q. Now, there were nurses employed around that time within
13 Urology Services. I do not know whether you've heard
14 the evidence of any of the nurses who gave evidence,
15 Leanne McCourt at Kate O'Neill? Were you able to hear 10:15
16 that evidence? You were?

17 A. I was, yeah.

18 26 Q. And Leanne McCourt explained that she had applied for a
19 clinical nurse specialist post as then, in 2016, which,
20 as was explained to her because of, I think, a missing 10:15
21 aspect or an element of the job description, was
22 incorrect; it became a clinical sister's post and a
23 charge nurse post. Now, those seem to be the same sort
24 of jobs that you're speaking about, the funding for
25 that came from Macmillan. Were you involved at all in 10:15
26 that process?

27 A. No. I shared job descriptions as part of -- you know,
28 within the Cancer Manager Lead Nurse Forum, the NICaN
29 Lead Nurse Forum, we worked up job descriptions in that

1 forum and agreed them and signed them off. Obviously
 2 because Northern Ireland's a small place, nurses moved
 3 across Trusts; they moved, you know, to similar posts,
 4 so we wanted consistency. Those job descriptions were
 5 worked up and signed off at that forum. I shared those 10:16
 6 with the head of service to go ahead and appoint and
 7 recruit into the... But I wasn't aware of the
 8 interview process or what happened until I heard it in
 9 the evidence.

10 27 Q. So, just so the Panel is clear, the funding that you 10:16
 11 have secured or assisted in securing through Macmillan,
 12 the match funding that was ultimately going to be paid
 13 by the Board, is the same posts that were advertised
 14 for urology in 2016?

15 A. I would believe that would be the case, yeah. 10:16

16 28 Q. I just want to give you the opportunity to comment on
 17 Mrs. Corrigan's explanation for that to see if it is in
 18 any way familiar to you. If we could go to WIT-26197,
 19 this is Mrs. Corrigan's Section 21 reply on the nurse
 20 specialist issue. This is paragraph 16.3B. So I'll 10:17
 21 just read these points. It's B1 to 5. This is one of
 22 the aims that Mrs. Corrigan had in relation to urology
 23 in order to increase the workforce.

24
 25 The clinical nurse specialist was to increase from two 10:17
 26 to four clinical nurse specialists. She says:

27
 28 "In 2009 there were two clinical nurse specialists in
 29 post, Kate O'Neill and Jenny McMahon. The plan from

1 the review, which was the initial 2009 review, was to
2 recruit a further two nurses who were to be aligned to
3 cancer as per the review. It was also stated in the
4 review that this would be taken forward by NICaN during
5 January-March 2011, which meant that the Trust couldn't 10:18
6 move to recruit for those two posts until this had
7 finished."

8
9 Now, this is before your time, you came in in 2012.
10 She then says: 10:18

11
12 "As head of service, I was not involved in this process
13 and this was under the remit of Head of Cancer
14 Services, Alison Porter and then Fiona Reddick, who
15 both reported to Ronan Carroll, Assistant Director, 10:18
16 from 2009 to 2016, and then to Heather Trouton from
17 2016 to 2018, and then to Barry Conway from 2018 to
18 now. So, for this process I had no influence to speed
19 it up, which, from a personal perspective, I felt did
20 cause issues for the operational aspect of the service 10:18
21 in that whilst I operationally managed the clinical
22 nurse specialists, I had no influence over how and when
23 they would be appointed.

24
25 In October 2014, whilst still waiting on the decision 10:19
26 on the cancer clinical nurse specialists, I prepared
27 and presented a paper to Mrs. Burns, Interim Director
28 of Acute Services, in which I requested that we would
29 appoint two Band 6 nurses so that we could start to

1 train them up to become specialist nurses. There were
2 no Band 6 qualified or with the experience to become
3 Band 7s. Funding for this proposal was going to go at
4 risk, but I presented that these were needed to assist
5 in tackling the increasing waiting times for outpatient 10:19
6 appointments. Mrs. Burns agreed to go at risk with
7 these posts and we temporarily appointed two members of
8 staff, who were substantive Band 5s, to these and then
9 we backfilled their posts into the unit. To note, both
10 of these Band 6s have taken in Band 7 clinical nurse 10:19
11 specialist roles, Leanne McCourt and Jason Young.

12
13 Furthermore, in 2020, the clinical specialist nurses
14 have increased to five members of staff. However, the
15 key issue here is that it took from 2009, when the 10:20
16 recommendation was made, until 2020 when there were
17 finally five clinical nurse specialists in post."

18
19 I just want to go back up to paragraph 4, I think it
20 is. Paragraph 3. Now, you're mentioned in there 10:20
21 obviously as the Head of Cancer Services, we know, from
22 2012. We can see from Mrs. Corrigan's statement that
23 she expresses that she had no influence to speed up the
24 process. Now, from your perspective in 2016, from the
25 2015 patient survey in 2016, did you feel that the 10:20
26 process was unduly slow in achieving the funding from
27 Macmillan and the buy-in from the Board and the PHA?

28 A. It is. When we're seeking funding, it can be a very
29 slow process. We submit bids all the time, and it

1 can -- from the time you actually submit that bid to
 2 you actually get recurrent funding agreed, it can be a
 3 very slow process. In recent years we tend to get
 4 nonrecurrent funding for time-limited. You know, we
 5 get time-limited funding, which is very difficult to
 6 recruit into. You know, people want permanent posts.
 7 From experience, it can be a slow process.

10:21

8
 9 But this is one route. The Macmillan funding was one
 10 route to seek funding to expand the cancer nurse
 11 specialist nursing workforce. So, you know, there are
 12 various routes that funding can be sought through, but
 13 this was one route that we, as cancer managers, took
 14 forward on the back of the cancer patient experience
 15 survey.

10:21

16 29 Q. Was that for one post, the Macmillan post?

17 A. No, that was in -- sorry, in Urology?

18 30 Q. Yes. Was it for two or one?

19 A. One post.

20 31 Q. One post?

21 A. Yes. It was one Band 7 post that was agreed.

10:22

22 32 Q. So when Mrs. Corrigan is speaking about October 2014,
 23 preparing a paper for Mrs. Burns, this was in advance
 24 of your seeking funding?

25 A. Yes.

10:22

26 33 Q. Did this all dovetail at one stage, because it sounds
 27 like two different processes?

28 A. I would not have been aware of the 2014 process with
 29 Ms. Burns. I wasn't aware of that happening.

- 1 34 Q. But it was your expectation that when the funding was
2 received for that post, a cancer nurse specialist would
3 be appointed?
- 4 A. Yes, that's right.
- 5 35 Q. Now, before we got into the issue of the funding for 10:22
6 the post, we were talking about the management of the
7 CNS within Cancer Services. Urology sits within the
8 surgical management rather than in Cancer Services?
- 9 A. That's correct.
- 10 36 Q. Has that historically been the case, that urology and I 10:23
11 think lung as well sits within the surgical
12 Directorate, does it?
- 13 A. Urology sits, and head and neck sits within the
14 Surgical Services. Breast used to sit under my remit,
15 I did manage the breast symptomatic service at a point 10:23
16 in time. But that was moved in, I think it was 2016.
17 At that time the breast care nurses then went under the
18 surgical remit as well. So, for most other cancer
19 nurse specialists, they sit under my remit, for
20 example, haematology, acute oncology, lung, gynae. 10:23
- 21 37 Q. From a governance perspective, what's the difference
22 between services that sit under your remit and those
23 that do not, from your perspective?
- 24 A. I suppose from a governance perspective, I can monitor
25 what the nurses are doing, what their activity's like. 10:24
26 We monitor their key performance indicators; that
27 obviously patients that are on a cancer pathway have
28 access to a key worker, that they have holistic needs
29 assessments carried out. Some of the nurses would do

1 independent clinics, and some have progressed on to
2 more advanced roles where they would free up
3 consultants to see more complex cases.
4

5 So, you know, I suppose I have more ownership of those 10:24
6 nurses and I can see what their performance is like
7 and, you know, see how they're developing through their
8 career. Some have progressed on. We actually were the
9 first Trust to actually progress on with advanced nurse
10 practitioners. So, they are working at a very 10:24
11 independent level now. I think that has been very
12 beneficial because we know that there's lots of waiting
13 lists, and it has made great inroads to tackle waiting
14 lists. I think that's something that we, you know,
15 really want to move forward with and develop nurses to 10:25
16 more expanded roles in the future.

17 38 Q. Obviously one of the issues for the Panel is to look at
18 the allocation of key worker to patients on the
19 pathway. When you speak of monitoring the ones under
20 your remit, you know, the nurses and whether they're 10:25
21 allocated or who the key worker is, is that something
22 you've always done or is that a relatively new audit
23 that's carried out now as a result of what's happened?

24 A. For the nurse that I'm responsible for, that would be a
25 fairly new concept in line with the cancer nurse 10:25
26 specialist workforce expansion plan that was agreed
27 when nurses came into post, because bearing in mind
28 some specialties didn't have any cancer nurse
29 specialists at all, and some had, some were

1 single-handed. The key performance indicators were
 2 signed off at the NICaN Nurse Leaders Forum that that's
 3 something that we would want to monitor going forward,
 4 and on the back of the cancer patient experience
 5 survey, that patients did have access and were seen by 10:26
 6 a key worker.

7 39 Q. What year was that?

8 A. So, the start of the expansion was 2016.

9 40 Q. So it's something that has already been done for the
 10 past seven years? 10:26

11 A. Well, I would say probably more like five years.

12 41 Q. Five years?

13 A. By the time we got recruitment done and nurses trained
 14 up. Because a lot of the nurses were coming from Band
 15 5 posts that would not have been doing some elements of 10:26
 16 the -- so, by the time they were trained up, it's more
 17 like 2018.

18 42 Q. From 2018 then, the KPI for the allocation of key
 19 workers has been something that's been monitored within
 20 services under your remit? 10:27

21 A. Yeah.

22 43 Q. Do you think that that is a flaw in where Urology and
 23 others sit, that there's not a standardised approach to
 24 issues such as KPIs for key workers?

25 A. I think the Trust is trying to move forward with that 10:27
 26 across tumour sites and have a Cancer Nurse Specialist
 27 Forum, you know, that we are consistent across the
 28 Board, no matter where nurses sit operationally. I
 29 think it's something that we -- there's more work to be

1 done with.

2 44 Q. I'll ask you it in a slightly different way then. Do
3 you think if Urology had sat within your remit from
4 2018, you would have been able to identify that key
5 workers had not been allocated?

10:27

6 A. Potentially.

7 45 Q. Do you miss any at the moment in the services under
8 your remit? Have you identified any key workers not
9 being allocated under any of the services you're
10 responsible for as being an issue?

10:28

11 A. Not at the moment but that is an ongoing, you know,
12 measure. I suppose, you know, there's always the risk
13 that staff go off for one reason or another. It may
14 not always be 100% but we try to make it that way.

15 46 Q. So any you've seen have been more blips in the system
16 rather than systemic?

10:28

17 A. Yes.

18 47 Q. Just while we're on the issue of standardisation in
19 approach, within your remit, the areas that you cover,
20 is there a standard way in which clinical nurse
21 specialists or cancer nurse specialists operate when
22 they need to attend to a patient? For example, is there
23 any priority given to people with first diagnosis that
24 there must be a nurse around? Is there any priority
25 given to patients if it's known that they're going to
26 have complicated treatment pathways explained?

10:28

10:29

27
28 Does any of that currently exist to ensure that the
29 patient does have someone there, no matter what?

1 A. It depends. I suppose now, you know, patients are
 2 given diagnosis at various places. Very often cancer
 3 patients are given a diagnosis in the Emergency
 4 Department. Some -- you know, obviously we have now
 5 the rapid diagnostic centres; we have outpatients. 10:29
 6 Patients do not always get, you know, their diagnosis
 7 given at an outpatient clinic where there's a clinical
 8 nurse specialist present. However, we've done a lot of
 9 work working with Outpatient Departments, Emergency
 10 Departments, where there's some information, and then a 10:29
 11 note is taken to give to the cancer nurse specialists.
 12 At that point then, the cancer nurse specialist would
 13 try and pick up with the patient and give them some
 14 more information and see them, you know, further along
 15 their journey. 10:30

16
 17 we also have a health and wellbeing information centre
 18 at the front of the hospital. That's also been funded
 19 by Macmillan. We would find a lot of patients would
 20 call in there and get basic information. We try and -- 10:30
 21 you know, obviously the cancer nurse specialists are
 22 there as close to the point of diagnosis as possible to
 23 give core information about their treatment plan and
 24 their management plan. Then obviously the softer
 25 things like financial worries or fatigue or side-effect 10:30
 26 information is given by others.

27 48 Q. Now, the change in profile in how people get
 28 information about their health care and cancer
 29 diagnosis, does that present a challenge for you in

1 delivering the service; that you can't be everywhere
 2 all at once, as you say, but the information comes in
 3 to a central point that you then know if people have
 4 been allocated key workers. That puts the emphasis
 5 then on the admin support that you have, the data that 10:31
 6 you receive. Is there a greater emphasis on other
 7 systems to allow you to know what's happening?

8 A. Yes. We have a function on our cancer pathway system,
 9 CaPPS - I'm sure you've heard that across the
 10 evidence - and there is a field on that to record that 10:31
 11 the patient has a key worker. So, there's a field
 12 there that we can monitor as well, that patients have
 13 been identified a key worker.

14 49 Q. And that's irrespective of what route they come into
 15 the Cancer Services from? 10:31

16 A. Yes.

17 50 Q. Now, from your own role in governance systems for
 18 reporting and escalating concerns, you had weekly
 19 one-to-one meetings with the assistant director?

20 A. That's correct. 10:32

21 51 Q. At the moment that's Mr. Conway?

22 A. Yes.

23 52 Q. Prior to that it was Heather Trouton?

24 A. Yes.

25 53 Q. I think she was 2016 to 2018? 10:32

26 A. That's right.

27 54 Q. Before that, it was Ronan Carroll?

28 A. Yes.

29 55 Q. At these one-to-one meetings, were these more high

1 level meetings about performance, staffing, or was it
 2 getting beneath the data and speaking about issues that
 3 might have been impacting on meeting targets? Give us a
 4 flavour of your one-to-one meetings with Mr. Conway or
 5 Mrs. Trouton or Mr. Carroll.

10:32

6 A. At those one-to-one meetings, we would look at services
 7 that I'm responsible for. We would touch on
 8 performance but the main area for discussing
 9 performance would be at our -- we would have weekly
 10 head of service meetings with our assistant director
 11 and, over a four-week period, we would focus on one
 12 week would be performance, next week would be
 13 governance, next week would be finance, and then the
 14 other week would be ad hoc.

10:33

15
 16 we would, you know, spend -- those head of service
 17 meetings would have lasted on average an hour and a
 18 half to two hours, so we would focus quite a bit of
 19 time on performance. Also governance. You know, if it
 20 was a governance week, we would look at our complaints,
 21 our IRIs, our Datixes, and we would work through those
 22 and pick out key themes and, you know, update our risk
 23 registers, see what was on our risk registers. There
 24 would have been a lot of focus from Cancer Services,
 25 you know, we would look at our divisional risk
 26 registers and our complaints.

10:33

10:33

10:33

27 56 Q. When you say weekly head of service meetings with the
 28 assistant director, would that have been with
 29 Mrs. Corrigan, yourself? No?

1 A. No. No, it would have been the heads of service within
 2 the cancer division. So, that would not have
 3 interfaced across with surgical.

4 57 Q. When did you interface with surgical? How did that
 5 happen?

10:34

6 A. That would have been at our monthly performance
 7 meeting. We would have went through our - and I think
 8 I did include one of the dashboard, the cancer
 9 dashboard, an example of that. That would have been a
 10 report that would have been shared and discussed and
 11 went through in great detail at the monthly performance
 12 meetings. We would have went through the breach
 13 reports and cancer access targets across all
 14 specialties. All heads of services and assistant
 15 directors would have been at that forum.

10:34

16 58 Q. Was it your view that the weekly head of service
 17 meetings with those within your remit provided better
 18 communication and allowed a better flow of information?

19 A. Yes.

20 59 Q. You've said about communication in your Section 21 at
 21 WIT-91011. At 18.1, you say -- the question asked of
 22 you was "Did you feel supported by staff within urology
 23 in carrying out your role"? You have said:

10:35

24
 25 "Communication from the service was not always
 26 forthcoming. I felt there could have been better
 27 communication with me when recruiting and appointing
 28 cancer nurse specialists". We'll talk about that.
 29 "There were delays in the appointment of nurses even

10:35

1 though I had secured funding. Feedback from the
2 Urology Professional Implementation Group was limited."

3
4 There's a couple of examples in that paragraph of what
5 you think are poor communication. why do you think the 10:36
6 communication was poor?

7 A. I honestly can't answer. I just felt that in those
8 couple of situations, it probably could have been
9 better so that there was openness and transparency
10 interlinked between, you know, the specialty and Cancer 10:36
11 Services.

12 60 Q. Was it a case of you trying to contact people and them
13 not getting back to you, or them trying to contact you
14 and you not getting back; or was no one trying to
15 contact anyone else? 10:36

16 A. I think in those couple of instances, it just -- you
17 know, I had secured the funding and it just felt like a
18 long time -- you know, I'd shared the job descriptions,
19 and it felt quite a long time from the funding was
20 available to the actual nurses were in post. There was 10:37
21 poor communication as to why the reasons were for that.

22 61 Q. And was that a source of frustration to you?

23 A. It was, yes.

24 62 Q. Did you consider the failure to properly appoint cancer
25 nurse specialists when the funding was available 10:37
26 something that had an impact on patient care and
27 safety?

28 A. Yes, it potentially could have.

29 63 Q. If we go to WIT-91020, this is a reference to the key

1 performance indicator. Paragraph 36.1, just halfway
2 down, the sentence begins "level" and then the sentence
3 I want is "At those cancer performance meetings". Can
4 you see it?

5
6 "At those cancer performance meetings, I had also
7 highlighted to Martina Corrigan that urology patients
8 should have a key worker urology cancer nurse
9 specialists as part of a key performance indicator. I
10 would have highlighted this in other services whose
11 patients required a CNS."

12
13 Then you talk about the funding that you'd been
14 successful in securing. You say:

15
16 "I was disappointed that this took so long to appoint.
17 Indeed, I was surprised that I was not communicated
18 with or involved in the recruitment of cancer nurse
19 specialists for urology. This was kept within the
20 surgical directorate."

21
22 Again, you have said communication with Cancer Services
23 was not always forthcoming.

24
25 Do you think that the poor communication allowed
26 problems to exist and persist, such as the ones that
27 the Inquiry are looking at? Do you think the poor
28 communication from Urology towards Cancer Services
29 assisted in creating an environment where problems were

1 not dealt with?

2 A. I suppose I have used a couple of examples here that I
3 was aware of.

4 64 Q. Well, you were aware of the issues around Mr. O'Brien
5 and triage from 2015, I think? Do you recall that? 10:39

6 A. Yes. In regard to red flag triage, yes.

7 65 Q. I know that's not one of the examples that you've
8 referred to but if I go back to my initial question.
9 When you saw those emails -- and I'll give the Panel
10 the note for the emails. 2015-2016, referring to 10:39
11 Mr. O'Brien, referring to triage, referring to
12 referral, referring to the build-up of patients who
13 were not coming through the system and representing a
14 blockage to get through the care pathway. Did you
15 think that the failure for that information to be 10:40
16 properly communicated to you allowed problems to
17 persist in Urology?

18 A. Probably, in hindsight, if it had have been more joined
19 up communication, that everything was together, it
20 probably would have dealt with things at a much earlier 10:40
21 time.

22 66 Q. Well, if those problems were arising in one of the
23 areas which falls within your remit, what would you
24 have done? If you were getting emails saying patients
25 aren't being triaged, there's delay; if that was under 10:40
26 one of the other services that you cover, what would
27 your role have allowed you to do about that?

28 A. Our escalation process. So, you know, we would have
29 been escalating that back to the service where there

were delays. So, those escalations were happening.

67 Q. We'll just go to some of the emails now so the Panel has the note. WIT-14651. This is an email from Wendy Clayton on 28th January 2015 to Ronan Carroll and you, copying in Vicki Graham. It says:

10:41

"Hi, I have met with Vicki re: Urology escalations. We are going to continue e-mailing the Urology PTLs twice weekly highlighting action required and risks. Vicki is going to attend the beginning of the Urology MDM to ensure the trackers are highlighting escalations, patients requiring dates for surgery."

10:41

Then under "Outstanding Issues", it says:

"AOB issues with triage. However, Debbie has given Martina to the end of day to revolve. Longest waiter, 23 days. Vicki or I will continue to escalate individual risks to consultants. Martina will copy you in. Regards, Wendy."

10:42

10:42

Do you recall these emails? Do you recall seeing them at the time?

A. Yes, I do. Yes.

68 Q. Then WIT-14660. This is an email from Martina Corrigan on 1st February 2015. It's to Wendy Clayton and you're copied in, as is Mr. Carroll. The subject: Red flag triage.

10:42

1 "Hi Wendy, I am conscious we have had an issue with
2 Mr. O'Brien and the delay in returning his triage. I
3 am aware that he is the only consultant that there is a
4 delay in getting the triage returned. I have had
5 numerous conversations with some of the Urology team 10:43
6 and we are going to raise this at our meeting next
7 Thursday. In order to present the problem, I have been
8 asked to have some information available for the
9 meeting in that they want to find out what the
10 turnaround time is for all the consultants. That is so 10:43
11 we can show Mr. O'Brien that he is the only problem.
12 Can you provide me with this information, even from the
13 beginning of November which is when we moved to
14 Consultant of the Week".

15
16 Then she's on leave until Wednesday. So, this
17 information was going to you and Mr. Carroll?

18 A. Yes, that's right.

19 69 Q. You're saying that, so we understand the governance
20 routes, because Martina Corrigan was the Head of 10:44
21 Service within Urology, there was no one for you to
22 escalate it to because she was actually dealing with
23 the issue?

24 A. Yes. She wanted, you know -- my perception of that
25 email is, you know, she was dealing with it at 10:44
26 specialty level; she was having a meeting. I note
27 there that her assistant director wasn't copied into
28 that email. But, you know, she was wanting the
29 information from Cancer Services to take back to the

1 meeting.

2 70 Q. When you say you note the assistant director wasn't
3 copied in, why do you say that?

4 A. From an escalation point of view, that would be our
5 process, that, you know, your assistant director is
6 copied into that as well. 10:44

7 71 Q. A further email at WIT-14680. These are further emails
8 back and forth. I think we'll go down just to the
9 bottom. Vicki Graham to Martina Corrigan. You're not
10 CC-ed into this one but you are CC-ed into the 10:45
11 subsequent replies. "Missing urology RF referrals from
12 triage". Vicki Graham says:

13
14 "Hi Martina. Please see below list of patients whose
15 referrals have not still been triaged. The date of 10:45
16 these referrals date back to last Wednesday and
17 Thursday."

18
19 You will see just at the top of that page the reply
20 that you and Mr. Carroll are subsequently copied into? 10:45

21 A. Yes.

22 72 Q. Then January 2016, WIT-14684. At the bottom of the
23 page, it says from Angela Muldrew to Martina Corrigan
24 and copies then to Wendy Clayton. Again, you're going
25 to be copied into the reply. It says: 10:46

26
27 "Hi. See below referrals that we have not received
28 back from triage. Could you please chase this up for
29 us?"

1
2 The email just above that on 6th January 2016 copies
3 you and Mr. Carroll in. Wendy Clayton says:

4
5 "Who is on triage? If nothing back tomorrow, can you 10:46
6 ask one of the other consultants to triage, please."

7
8 Then Ronan Carroll says "Martina, can we leave with you
9 to resolve, please?"

10
11 Did you ever speak to Mr. Carroll about this issue?

12 A. Yes, we were well aware of it. You know, this would
13 have been discussed at cancer performance meetings.
14 It's difficult, because you escalate back to the
15 specialty and it's not our remit to work directly with 10:46
16 the clinicians. There is a process, you know, to work
17 directly with them if there is an issue highlighted.
18 So, the issue was highlighted from Cancer Services but
19 it was out of our control to actually deal with it.

20 73 Q. Those emails, a snapshot over a period over January 10:47
21 2015 for a year through to January 2016, and it's a
22 significant period of time and the same issue is coming
23 up again and again. Was that something that you ever
24 brought to the HSCB or to any other source to inform
25 them that there was an underlying problem as to why 10:47
26 targets weren't being met in some cases?

27 A. No, I personally didn't take it to the HSCB. I'm not
28 sure if -- I can't answer you if the Urology Service
29 took it in any way or gave an early alert. I am not

1 aware of that.

2 74 Q. Or Mr. Carroll?

3 A. Or Mr. Carroll. I'm not aware of that.

4 75 Q. Do you think it might have been something that they

5 should have been informed about, that there was an

6 issue underneath the figures that was rumbling on and

7 had not been dealt with?

8 A. Yes. Potentially, yeah.

9 76 Q. well, when you say potentially, do you mean that it may

10 have been, they may have been told or they may not, or 10:48

11 do you think they should have been told?

12 A. I think they should have been told but I'm not aware if

13 they were or weren't, in my role.

14 77 Q. Now, there seems to have been, if I can say, quite a

15 few opportunities to communicate with others. You have 10:48

16 mentioned some of the meetings, the weekly meetings,

17 head of service weekly meetings with your AD. There

18 was a Trust monthly cancer performance meeting that you

19 have referred to at your statement at WIT-19010. This

20 was a meeting where all specialties were invited and 10:49

21 minutes, agenda and dashboard were shared. At

22 paragraph 15.1, you say:

23

24 "From a cancer perspective we held a Trust monthly

25 cancer performance meeting where all specialties were

26 invited and minutes, agenda and a dashboard were

27 shared. Martina Corrigan, Head of Service For Urology,

28 attended these meetings and would have always received

29 the documents. The Urology MDT was also peer reviewed

1 and the findings of this were shared with Martina
2 Corrigan, Ronan Carroll, Heather Trouton and myself via
3 the Chief Executive and also to the HSCB."

4
5 Just before we look at the peer review, when you say 10:49
6 that Martina Corrigan attended these meetings and would
7 have always received the documents, are you saying that
8 she would have known exactly what the performance
9 figures were for her specialty?

10 A. Yes. 10:50

11 78 Q. The peer review of Urology MDT, is that the review that
12 was carried out in 2015?

13 A. I think it was 2017.

14 79 Q. 2017. You reference a peer review in a paragraph in
15 your statement I would like to go to as well, when you 10:50
16 talk about risk to patients. It's at WIT-91011,
17 paragraph 17.1. You say this:

18
19 "I highlighted on many occasions at cancer performance
20 meetings the risk to patients who had a suspect cancer 10:51
21 and who were delayed in getting an appointment to be
22 seen and commenced on a first definitive treatment
23 within 62 days. I worked with the Urology MDT in order
24 to prepare and be peer reviewed in October 2017. The
25 serious concerns raised during this assessment were 10:51
26 escalated by myself for including on the Acute
27 Directorate Risk Register."

28
29 Then you say you secured the funding via Macmillan and

1 the HSCB Cancer Nurse Specialist Workforce Expansion
 2 Plan for an additional urology nurse specialist, and
 3 there were delays in getting this appointed.

4
 5 Just a couple of things in that paragraph. When you 10:51
 6 say "I highlighted on many occasions the risk to
 7 patients", over what period of time and roughly how
 8 often did you highlight it?

9 A. The risks would have been noted on our dashboard on a
 10 monthly basis, you know, risks like first appointments, 10:52
 11 if we had delays in various investigations along the
 12 pathway. You know, we would have examined the breach
 13 reports, so the reasons why patients were delayed were
 14 clearly on the breach reports and they were all, you
 15 know, those were shared widely. 10:52

16 80 Q. So the data was there --

17 A. Yes.

18 81 Q. -- that supported that. Did you feel a sense of
 19 professional frustration that because Urology sat
 20 outside your boundaries, you couldn't get to the bottom 10:52
 21 of some of the reasons why performance targets weren't
 22 being met?

23 A. Yes, it is frustrating. Yes.

24 82 Q. Now, the peer review in October 2017, you have said
 25 that the concerns raised in that, you put in the acute 10:52
 26 directorate. We can have a look at a couple of
 27 documents that highlight that you did escalate the
 28 issue. Now, the peer review was in October 2017, and
 29 the serious concerns you've set out in your updated

1 information of May 2018. We can look at that at
2 WIT-91043. This is a document -- is this a document
3 you completed?

4 A. Yes. This was an action plan completed on the back of
5 the serious concerns that were raised. 10:53

6 83 Q. This was updated in May 2018. Can I just ask before we
7 go to May 2018, do you have any knowledge of what
8 happened after the peer review when these serious
9 concerns were highlighted in October 2017? Was there
10 any action taken at that point? 10:53

11 A. Yes. From a point of view of the oncologist gaps and
12 the radiologist, unfortunately at that time we did have
13 deficits in Oncology. The Oncology Services obviously,
14 it's like a hub and spoke model, the Cancer Centre was
15 in Belfast and the oncologist came out from the Cancer 10:54
16 Centre to the units. At that time, 2015, there was a
17 regional roll-out of acute oncology consultants. We
18 also were preparing to open the Northwest Cancer
19 Centre, and there just wasn't enough oncologists to
20 meet all of those needs. That was highlighted various 10:54
21 times to Health and Social Care Board. Indeed, there
22 was oncology pressures meetings regularly to see how we
23 could cover the demand for services, and there just
24 wasn't enough cover to meet all of the demands from a
25 clinic provision, acute oncology, to MDT cover. There 10:55
26 were gaps. Those were well recognised at department
27 level.

28
29 we did have then a piece of work started in 2018 led by

1 the Health and Social Care Board, looking at oncology
 2 transformation and how we could try to bridge some of
 3 the gaps. That was a huge piece of work and there were
 4 lots of deficits. There was also a paper shared by the
 5 Health and Social Care Board where Cancer Research UK 10:55
 6 done a scoping exercise looking at how we could
 7 actually make our MDTs more effective. There were a
 8 few workshops here where there was suggestions looking
 9 at protocolised discussions, and we were talking about
 10 piloting some of that. However, that never really was 10:56
 11 taken forward; it didn't really go anywhere.

12
 13 we were trying and we were escalating and we were
 14 trying to actually see how we could improve the quoracy
 15 within MDT. So, there were lots of regional 10:56
 16 discussions to try and address some of the gaps.

17 84 Q. If we just look at this plan again that's completed
 18 just seven months after the peer review. There's four
 19 serious concerns on it; three are of interest for our
 20 purposes. The first one is "No cover in place for the 10:56
 21 clinical oncologists and the consultant radiologist."

22
 23 The update of May 2018:

24
 25 "Clinical oncology representation core and cover 10:57
 26 provided through the regional oncology centre when
 27 possible but it is not the same person each time and is
 28 still not consistent. For consultant radiology
 29 representation, no cover for the radiologists, though

1 an expression of interest is being developed to recruit
2 an additional radiologist with urology interests and
3 expertise."

4
5 The Inquiry will hear this afternoon from Marc
6 williams, a radiologist, on the particular issues he
7 experienced.

10:57

8
9 The second point is the quoracy is low due to low
10 clinical oncology and radiology attendance. It had
11 been, in October 2017, 25% attendance and it was now
12 11% by May 2018. You say that only five meetings were
13 quorate throughout 2017 and it is perceived that this
14 has decreased even further.

10:57

15
16 "Therefore, more patients are not benefiting from the
17 knowledge and expertise of a full multidisciplinary
18 team when decisions are being made about diagnosis and
19 care. This could lead to delays in the decision-making
20 process and treatment.

10:58

21
22 3. Long waits for routine referrals. Due to
23 increasing number of referrals, services concentrating
24 resource on meeting red flags and urgent demand.
25 Routine referral waiting times have increased from 52
26 weeks to 128 weeks, present day. Referrals are triaged
27 by consultants so there is the opportunity for routine
28 referrals to be upgraded."

10:58

1 The Inquiry has heard evidence that routine referrals,
2 sitting back, not getting priority because of the red
3 flag in urgent referrals, posed a risk to patient
4 safety. I presume that's something that you would
5 agree with?

10:58

6 A. Yes.

7 85 Q. In relation to the quoracy, you have identified there
8 delays in decision-making processes in treatment. So,
9 the level of oversight that perhaps is anticipated by
10 full attendance at MDT for Cancer Services is absent if
11 quoracy is not met and the right people aren't round
12 the table?

10:59

13 A. That's right.

14 86 Q. Now, you had a role in MDT in terms of linking in with
15 the specialties and their heads of service and their
16 ADs. In that role, did Urology sit outside that
17 because it wasn't in your remit, or did you also cover
18 that within Urology MDTs?

10:59

19 A. No. There was interface. You know, we had interface.
20 This action plan would have been shared because
21 obviously there were things that were the
22 responsibility of Cancer and Clinical Services, for
23 example the oncologists and radiologists cover.
24 However, you know, the waits was back to service, it
25 was back to the Urology Service. That was out with our
26 control, how we would deal with that. That's why the
27 action plan was collated, you know, and all the serious
28 concerns were brought together to see how they could be
29 addressed collectively.

10:59

11:00

1 87 Q. You've also said:

2

3

4

5

6

7

A. That's correct.

8

88 Q. So, were the Board aware that it was on the risk register or is that two separate things?

9

10

A. The Board would have been aware. In fact, it was the

11:00

11

Board that funded the peer review process from 2014.

12

So, any of the serious concerns actually would come

13

back down through the Board to the Trust Chief

14

Executive. That's, you know, any of the reports coming

15

and arising out of peer review process would have gone

11:00

16

directly to the Board before coming out to Trusts.

17

89 Q. The Health and Social Care Board?

18

A. Yes.

19

90 Q. Not the Trust Board?

20

A. No, the Health and Social Care Board.

11:01

21

91 Q. You have updated the risk assessment. We'll just see

22

that. Just two pages on, I think, from that one, 45.

23

This is an email from you on 16th December 2019 to

24

Vivienne Toal and Barry Conway. You say:

25

11:01

26

"Hi Vivienne, please find attached updated risk

27

assessment for Urology MDT to replace risks 3728.

28

Regards, Fiona."

29

1 So, that was done in 2019. Had there been an updated
2 risk assessment reflected on the Acute Directorate
3 Register in 2017 or 2018 when the peer review findings
4 were made?

5 A. No, because the action plan -- the process would have 11:02
6 been to look at the action plan first to see what we
7 could do before raising those risks on the risk
8 register.

9 92 Q. The delay between the May 2018 action plan and updating
10 the risk register in December 2019, a year and a half, 11:02
11 would that be a normal lead-in time before you would
12 mark something up as a risk?

13 A. No, it probably should have been reviewed.

14 Unfortunately, I had a period off at that point, so
15 there probably was a gap in having that reviewed. 11:02

16 93 Q. My question was just to try and understand the system,
17 if the Trust do things periodically. I'm assuming if
18 something is identified as a risk, best practice would
19 mean that someone reports it as a risk on the register.
20 would that be a fair enough assumption on my part? 11:02

21 A. Yes.

22 94 Q. There are some figures. I just want to give the
23 Inquiry Panel a note of some peer reviews rather than
24 go to them. There was a peer review visit report from
25 2015 indicating a self-assessment of 70% for MDT and 11:03
26 the peer review came in at 35%. That can be found at
27 AOB-78513. Then subsequent to that, there was a 2017
28 self-assessment of 55%, which was upheld on peer
29 review. That is AOB-78607.

1
2 I would like to go to AOB-78606. This is an email of
3 6th January 2017 - I'm hoping - from you to Ronan
4 Carroll, Wendy Clayton, Martina Corrigan, Anthony
5 Glackin, Mark Haynes, and Mr. O'Brien. Heather Trouton 11:04
6 is copied in. Subject, Urology MDT Peer Review.

7
8 "Dear all, please find attached the external validation
9 report from the recent validation process required for
10 Urology peer review for circulation amongst all members 11:04
11 of the Urology MDT. This year Urology MDT were
12 required to undertake a self-assessment which was then
13 externally validated by the National Peer Review Team.
14 We have been advised by HSCB that when MDTs are
15 self-assessing, that the feedback from National Peer 11:05
16 Review Team will be directly uploaded onto CQUINS
17 rather than a formal feedback report coming into Trust
18 via the Chief Executive. As you can see, the overall
19 self-assessment score achieved 55%, and this score of
20 55% was maintained by the external team. The National 11:05
21 Peer Review Team have indicated that the Urology MDT
22 will have to undertake a self-assessment again in
23 September 2017, and Mary Haughey will continue to work
24 with the Urology MDT to prepare for this process."

25
26 Just stopping there for a moment, is there a reason why
27 Urology had to undertake the self-assessment again at
28 that point?

29 A. The National Peer Review Team, depending on what

1 concerns were raised, they were the ones who indicated
2 whether we needed to have a formal visit or a
3 self-assessment. They indicated that on the back of
4 what the previous report highlighted.

5 95 Q. What is then indicating that Urology have to undertake 11:06
6 a self-assessment again; what is the reason for that?

7 A. I would imagine it's probably because our overall
8 assessment score achieved 55, they wanted to review
9 that again to see if things had improved or went the
10 other way. 11:06

11 96 Q. Okay. The last paragraph:

12
13 "I'm conscious that at a business meeting prior to
14 Christmas leave that concerns were expressed by members
15 re inadequate quoracy of the MDT, particularly for 11:06
16 radiology and oncology. I have escalated the concerns
17 to Professor O'Sullivan, Clinical Director Cancer
18 Centre, and we are due to meet Tuesday, 10th January to
19 agree improved representation for oncology input.
20 Dr. Gracey is aware of concerns re radiology. We will 11:07
21 continue to attend Urology business meetings as
22 requested."

23
24 Now, it's clear there that there are two avenues of
25 trying to sort out the quoracy issue for oncology and 11:07
26 radiology. One of them was to meet with Professor
27 O'Sullivan. Did you have that meeting with Professor
28 O'Sullivan, do you recall?

29 A. Yeah. Can you just scroll down to see the date of that

1 email, sorry? Yes, that was 2017. Subsequently, yes,
 2 the meeting happened but then subsequently, you know,
 3 there were other ongoing challenges within the Oncology
 4 Service across the region so that, on the back of that,
 5 there were pressures -- oncology pressures meetings 11:07
 6 established. Then, it was a regional forum where all
 7 Trusts were brought together to highlight where the
 8 gaps were. There was a scoping exercise to see where
 9 the gaps were across the board. On the back of that
 10 then, the Health and Social Care Board instigated the 11:08
 11 oncology transformation piece of work.

12 97 Q. And the result of that was?

13 A. Oncology transformation? So we looked at -- we had
 14 some -- from an MDT point of view, we did have an
 15 improvement where some of the oncologists tried to link 11:08
 16 in from the centre to our MDTs. Then, we appointed an
 17 acute oncology consultant with an interest in lung and
 18 urology. So, he has been in the Trust - sorry, I don't
 19 have the exact date. But that did highlight
 20 improvement. So, from an oncology perspective, there 11:08
 21 were pieces of work happening to try and improve
 22 oncology representation at MDT.

23 98 Q. It was a matter of people working together to try and
 24 find workarounds to cover oncology for MDTs?

25 A. Yeah. 11:09

26 99 Q. "And Dr. Gracey is aware of the concerns re
 27 radiology."

28
 29 Do you recall what was done in 2017 around that?

1 A. I'm not close to radiology, and perhaps Marc will be
2 able to explain that in the afternoon. I know that
3 David did, at times, do workarounds and link in, you
4 know, from leave and that. I'm not close, but you'll
5 probably get more detail from Marc around that. 11:09

6 100 Q. There's just another email at WIT-57926. This is from
7 Anthony Glackin to Ronan Carroll, Wendy Clayton,
8 Martina Corrigan, Mark Haynes, Mr. O'Brien. It's on
9 16th January 2017. He writes:

10

11 "Dear Fiona, can I meet with you to discuss ongoing
12 problems with quoracy at the urology cancer MDM, the
13 urologists are coming to the view that this meeting is
14 no longer sustainable in view of the pressures on our
15 single-handed radiologists and the infrequent oncology 11:10
16 attendance. Kind regards, Tony."

17

18 So, that email illustrates the clinical impact and
19 potential patient risk from the absence of quoracy.

20 11:10

21 I think your reply is just above that. You reply to
22 everyone saying:

23

24 "Tony, yes, I understand that there has been, and are,
25 ongoing challenges with quoracy at the Urology MDM. 11:10
26 This has been escalated at HSCB level, particularly
27 from an oncology perspective as the lung and GU Service
28 is currently facing staffing issues. The Northwest
29 Cancer Centre opened recently and recruitment of

1 oncologists there has depleted the service within
2 Belfast Cancer Centre, and there currently is not the
3 same in number of oncology registrars available to
4 provide cover within clinics. Rory and I attended a
5 meeting last week with colleagues within Belfast Trust 11:11
6 and commissioners to explore options to address the
7 current difficulties. I have highlighted that there is
8 a risk that the Urology MDM here in Southern Health
9 Trust is at a point where full quoracy is making it
10 extremely difficult to function. We are due to meet 11:11
11 again next Friday and hope to have potential solutions
12 agreed by then. I am happy to meet with you in the
13 meantime to discuss further."

14
15 You've mentioned in that email that the Northwest 11:11
16 Cancer Service is now opened; you'd referred to it
17 earlier in your evidence. At this point in January
18 2017, it had opened?

19 A. Yes, that's right.

20 101 Q. When had that opened, can you recall? Was it just 11:12
21 before this?

22 A. Yes. It was just in or around - sorry, I don't have
23 the specific date, but I know that it opened and in
24 tandem with that there was an agreement to roll out an
25 acute oncology consultant led service across Trusts, 11:12
26 which further depleted oncology resource. I do recall
27 at a meeting, the late Stephen Hall, who was my
28 Associate Medical Director in Cancer Services in the
29 Trust, and also a radiologist, he raised his concerns

1 back in 2015, you know, the difficulty that that would
 2 bring, trying to roll out an acute oncology
 3 consultant-led service in tandem with another cancer
 4 centre opening in the northwest, because there simply
 5 wasn't enough oncologists to deal with all aspects of
 6 the service. 11:13

7 102 Q. within the context of a significant evidence base from
 8 2015 of quoracy --

9 A. Yes.

10 103 Q. -- at MDTs. By your email, it seems clear that those 11:13
 11 expansions of services had a negative impact on the
 12 existing ones?

13 A. Yes.

14 104 Q. I wonder if we could take a break just at the moment,
 15 if that's okay? 11:13

16 CHAIR: Yes. We'll come back again then at 11:30.

17
 18 THE INQUIRY THEN ADJOURNED BRIEFLY AND RESUMED AS
 19 FOLLOWS:

20
 21 CHAIR: Thank you, everyone. 11:14

22 MS. McMAHON: Ms. Reddick, just before we move onto the
 23 last two sections I want to ask you about, I had asked
 24 you about the funding secured through Macmillan that
 25 was going to be match-funded by the Board. I asked you 11:31
 26 were they paid for by the -- were they the posts that
 27 were advertised for urology in 2016 and you said: "I
 28 would believe that would be the case at that point."
 29

1 I just want, for the Panel's note and for everyone
2 else, to identify three documents. We do not need to
3 bring them up but I need to put them on record, and
4 I'll speak to Mrs. Corrigan about them. I just want to
5 note them at this point. For the Panel's note, it's 11:31
6 WIT-94649, which is the HSCB and PHA funding document
7 dated April 2016. Then WIT-94653, where it indicates
8 that the additional Urology CNS will be in Phase 3.
9 Then WIT-94651, where it's referenced that Phase 3 is
10 2018-2019. That's really just for our exploration, 11:32
11 we've got your answer to the question.

12
13 You were initially involved in the SAI process, in the
14 nine SAIs?

15 A. That's correct, yes. 11:32

16 105 Q. How did you come to be involved in that?

17 A. Well, it was during the Covid pandemic, and I literally
18 got an invite into a virtual meeting from governance,
19 the governance team in the Trust. And I wasn't -- it
20 was put in my calendar and I wasn't aware of what 11:33
21 actually the context of what the meeting was about.
22 So, I linked in and then I discovered that I was being
23 invited in as Head of Cancer Services to look at --
24 initially it was a few and then the numbers were
25 growing as the meetings went on. 11:33

26
27 The context of me being there was, from a Cancer
28 Services point of view, to look at MDTs and tracking
29 and things like that. So, that was my understanding

1 but I wasn't given a clear explanation as to what the
 2 meeting was about or anything, so I went along with the
 3 process. It was quite difficult because at that time
 4 it was a big commitment and I already was working over
 5 my hours, trying to run Cancer Services and keep things 11:33
 6 flowing in the midst of a pandemic. Our chemotherapy
 7 service outpatient setting was very, very busy; it was
 8 busier than pre-pandemic because we were trying to give
 9 patients additional chemotherapy because of delays in
 10 access to theatre and surgery. There was an on-call 11:34
 11 commitment as well as part of my remit, which was very
 12 busy. So, it was an added pressure to my already busy
 13 workload.

14 106 Q. So, there was no preamble for you as to what the
 15 context was, you were copied into an email and you 11:34
 16 attended the meeting and that's when you found out?

17 A. Yes.

18 107 Q. Was that the meeting of 4th January 2021, or were you
 19 involved earlier than that?

20 A. No, it was earlier. I think it was late summer of 2020 11:34
 21 whenever the process started.

22 108 Q. Had you had a few meetings by the time it came round to
 23 January 2021?

24 A. Yes. Yes.

25 109 Q. When you've described your role in that process, was 11:34
 26 there an expectation that with your experience, you
 27 would go and speak to individuals to find out the
 28 evidence base or get facts from them about what the
 29 situation was on the ground?

1 A. No. The only time I was asked to find out information
2 was in regard to where the patients - those patients in
3 the SAI process - were on their pathway at that moment
4 of time. That was really the only time that I was
5 asked to go away and discover additional information. 11:35

6 110 Q. So, was it the understanding from the outset of your
7 involvement that Dr. Hughes would be the only person
8 who spoke to others; had meetings with interested
9 parties?

10 A. No, I wasn't -- that wasn't made clear to me but I 11:35
11 discovered it then subsequently in the report. I felt
12 that I didn't have the opportunity to -- as part of
13 that SAI Panel, I was denied that opportunity to speak
14 to others in tandem with Dr. Hughes.

15 111 Q. Do you know why that was? 11:36

16 A. I've no idea.

17 112 Q. Did you ever raise it with Dr. Hughes?

18 A. No.

19 113 Q. Did you know who he was going to speak to at any given
20 time? Did he share that information with you? 11:36

21 A. It wasn't very clear who the individuals were that he
22 was. It wasn't made clear.

23 114 Q. You have seen the findings of the SAI, the
24 recommendations?

25 A. Yes. 11:36

26 115 Q. Do you think that your particular role may have
27 contributed more to the investigation if you'd have
28 been allowed to speak to people and undertake some of
29 the investigatory work?

- 1 A. Yes. I think it would have been good to be involved in
 2 that discussion with others across, you know,
 3 specialties across the MDT. I think it would have been
 4 good to be part of that. If I was involved in the SAI
 5 Panel, it would have been good to actually fulfil that 11:37
 6 role.
- 7 116 Q. Had you ever attended MDTs with Mr. O'Brien being
 8 present at them?
- 9 A. Yes, I would have went to various MDTs. Indeed,
 10 Mr. O'Brien held the position as Chair for a period of 11:37
 11 time. As part of the peer review process, at times I
 12 would have went, you know, ad hoc. It wasn't, you
 13 know, planned, I just would have went if my diary
 14 allowed me to go.
- 15 117 Q. Did you have a particular experience of Mr. O'Brien at 11:37
 16 those MDTs, the way in which he interacted? Did you
 17 form a view or share that view?
- 18 A. I always found Mr. O'Brien to be very professional
 19 towards me and very courteous. When he held the
 20 position as Chair of the MDT, we worked together on 11:37
 21 peer review documents, along with Mary Haughey, my
 22 Service Improvement Lead, and he was always found to be
 23 very willing to work to get those documents ready and
 24 in preparation for peer review.
- 25 118 Q. I wonder if we could go to WIT-84769? I just want to 11:38
 26 get the introduction page so that the Panel knows the
 27 context. This is a note of a meeting held on Monday,
 28 4th January 2021 to discuss the complaint regarding
 29 Mr. O'Brien. Present are Patricia Kingsnorth, you,

1 Patricia Thompson, Hugh Gilbert and Dermot Hughes.
2 Then in attendance, Peter Rogers. Do you recall this
3 meeting, first of all?

4 A. Yes.

5 119 Q. This was a meeting in which the individuals, their 11:39
6 context was set out and there was sharing of
7 information gathered or gleaned to date about each
8 individual scenario. I do want to go to WIT-84769
9 again, please. Just at the bottom of the screen, you
10 can see FR, just on the left, the sentence beginning 11:40
11 "FR". Can you see that?

12 A. Yes.

13 120 Q. "FR voices how it is imperative to have good
14 communication amongst MDT, which Mr. O'Brien
15 neglected." 11:40
16

17 Now, FR, I presume, is the initials for you. Have you
18 seen these notes at all before?

19 A. I've just seen them as part of this process in my
20 evidence bundle. 11:40

21 121 Q. Just in the context of what you've said about
22 Mr. O'Brien, is that a view you formed about
23 Mr. O'Brien or do you agree that that note reflects
24 your contribution?

25 A. I totally refute the word "neglected". I would not 11:40
26 have used that. I know that's not part of my language,
27 and particularly in health care that's quite a strong
28 word. So, I would totally refute that I used the word
29 "neglected". I probably made that comment, how it's

1 imperative to have good communication amongst MDT, but
 2 definitely I do not recall using the word "neglected".

3 122 Q. Is your recollection then that, in your mind, there's a
 4 full stop after the word "MDT", or do you recall going
 5 on to say anything at all after that? 11:41

6 A. I don't honestly recall what would have been said after
 7 that. It's probably -- I couldn't, you know, say
 8 that... I couldn't, you know -- I just don't recall
 9 what was said after that. But "neglected" wouldn't be
 10 a word that I would use in regard to a peer colleague. 11:41

11 123 Q. Is it your recollection that it was Mrs. Kingsnorth who
 12 took the notes to the meeting; do you recall that?

13 A. Sorry?

14 124 Q. Patricia Kingsnorth took the notes to the meeting. Do
 15 you recall she was the note-taker at this meeting? 11:41

16 A. Yes. Generally Patricia Kingsnorth took the notes at
 17 those meetings, yeah.

18 125 Q. And I think her process was she wrote everything down
 19 and then and typed it up subsequently. But you didn't
 20 get a copy to confirm that you were content with these 11:42
 21 notes at all at any point?

22 A. No.

23 126 Q. Now, in his evidence Dr. Hughes has commented on your
 24 involvement in the SAI process, because you ultimately
 25 moved away from that role. Do you recall when you 11:42
 26 stopped being involved?

27 A. I actually went off ill on, I think it was mid
 28 February, 14th or 15th February. I unfortunately went
 29 off for a period of time ill. So, at that point this

1 process wasn't completed.

2 127 Q. And did anyone take over your role from Cancer Services
3 in this process?

4 A. I'm not sure of that.

5 128 Q. When you came back, things had moved on and the report 11:42
6 was ultimately completed --

7 A. Yes.

8 129 Q. -- not long after? I just want to --

9 A. Sorry, just coming back to your point. Did you ask did
10 someone cover generally my role or in this process? 11:43

11 130 Q. Sorry, in this process.

12 A. I'm not aware how in the SAI if that was replaced or
13 not.

14 131 Q. Sorry. I should have made that question clearer,
15 sorry. 11:43

16

17 Dr. Hughes, in evidence, referenced your involvement.
18 We do not need to go to this, just for the Panel's
19 note, because I'll just read the relevant extracts.
20 TRA-81786 from line 10. He said this: 11:43

21

22 "Fiona Reddick, I felt, had probably the biggest
23 conflict of interest and I think she was placed in an
24 invidious position and in retrospect perhaps it wasn't
25 best. I think she was in a place where the service 11:43
26 that she was managing was being implicitly criticised.
27 I think she probably found it stressful."

28

29 Do you agree with Dr. Hughes' view in that regard? was

1 there a conflict of interest, and was your involvement
2 stressful?

3 A. No, I don't think. In the context of the understanding
4 of Cancer Services and how it works, I think it was
5 useful to have me sit on the Panel. I don't believe 11:44
6 there was a conflict. You know, I managed the MDT
7 processes; peer review was there, the reports were
8 there; you know, the issues have been highlighted and
9 escalated on the back of that. So, I felt contextually
10 that was useful for me to be on the Panel. 11:44

11 132 Q. Did Dr. Hughes ask you your experience of attending
12 MDTs when Mr. O'Brien was present?

13 A. No.

14 133 Q. Did you ever offer your view on any of that?

15 A. No. 11:44

16 134 Q. Now, in relation to one potential issue of relevance
17 for the Inquiry, there was some movement around jobs
18 restructuring in March 2016. The Inquiry has heard
19 evidence of individuals moving posts. There was some
20 movement in Cancer Services. I want to just read the 11:45
21 following paragraph in Barry Conway's Section 21. It's
22 at WIT-23915. This is just to give a context of the
23 way in which directorates moved under different, other
24 headings. Whether that had any governance impact might
25 be a matter of interest for the Panel. 11:45

26
27 At 70.3, Mr. Conway states:

28
29 "The integrated Maternity and Women's Health Division

1 was a standalone division from April 2007 up to March
2 2016, when the acute directorate was restructured by
3 the Director of Acute Services at that time,
4 Mrs. Esther Gishkori, and then Integrated Maternity and
5 Women's Health was coupled with Cancer and Clinical 11:46
6 Services in April 2016, creating the large division
7 that I took over on 1st June 2018. Early in 2021, I
8 escalated work pressures to the Director of Acute
9 Services, Mrs. Melanie McClements, and she agreed with
10 me that the division needed split in two. Mrs. 11:46
11 McClements was supportive and she secured approval from
12 the Chief Executive, Mr. Shane Devlin, to adjust the
13 structure, and from 1st June 2021 Integrated Maternity
14 and Women's Health reverted to being a standalone
15 division, with Cancer and Clinical Services division 11:46
16 becoming a smaller but still a busy division. In my
17 view, the decision taken by Esther Gishkori in April
18 2016 to couple Cancer and Clinical Services with
19 Integrated Maternity and Women's Health as a large
20 acute division was a mistake." 11:47

21
22 Now, you were there at the time, you were obviously
23 there from 2012 and, four years into your tenure, this
24 restructuring occurred. Do you agree with Mr. Conway
25 that that restructuring was a mistake? 11:47

26 A. Yes. I think that was a huge remit for an assistant
27 director to carry. Integrated Maternity and women's
28 Health on its own is a very, very busy service, with
29 lots of governance. You know, there's lots of --

1 there's enough there for probably two assistant
2 directors, never mind one in its own right. So I
3 think, yeah, I would agree with that statement.

4 135 Q. Mr. Conway took over that on 1st June 2018 but you were
5 already in the midst of that change, did you see any 11:47
6 change or impact, either positive or negative, in
7 governance terms when that change took place --

8 A. I think --

9 136 Q. -- in your role, from your perspective?

10 A. -- it was a very busy role and Barry Conway was doing 11:48
11 his best to manage all aspects of that, but to take on
12 those historic two divisions was quite a remit.

13
14 But from my point of view, our one-to-one meetings
15 continued, our performance continued, Barry done his 11:48
16 best and kept the momentum up that I was used to, and
17 the meetings. So, I feel he done his best with very
18 busy services.

19 137 Q. His increased role didn't have any impact on his
20 accessibility to you? 11:48

21 A. No.

22 138 Q. We've heard of - this is the last section - on
23 improvements and things that have changed, because
24 obviously the Panel are interested, if they want to
25 make recommendations on areas, in making ones that are 11:48
26 helpful. You've talked about the quoracy issue and
27 tracking, and the Panel have heard evidence on that.
28 Mr. Conway, in his statement, updates us specifically
29 in some of the developments. I just want to take you

1 through them because at the time of the statement it
2 wasn't clear whether they had actually taken place, so
3 you might be able to provide further information on
4 that.

5
6 One of the things he does mention is that he now
7 receives monthly reports showing how cancer MDTs are
8 working. Is that something that you feed to him?

9 A. Yeah, so that's done. I suppose we always had really
10 highlighted the need, and through the Cancer Peer
11 Review Process we were highlighting to the Health and
12 Social Care Board, the need for data managers within
13 Trusts, and that's something that we've been
14 highlighting for a number of years. Unfortunately,
15 there was no funding to do that. I think obviously
16 Cancer Services has grown, the demand has grown, the
17 numbers are going rapidly upwards, there's now one in
18 two people diagnosed with cancer. So, I don't believe
19 the funding has went in tandem with that to bring in
20 the additional resources to meet the needs of that.

21
22 We did highlight the need for data managers to monitor
23 more of our MDTs and to pull the figures and to audit
24 and to make that really meaningful information. On the
25 back of the USI work, we have now recruited an audit
26 person who runs reports randomly from each of the MDTs
27 to look at how outcomes are taken forward and if they
28 are. I think that's a very positive step forward.

1 we also have an MDT administrator, who helps -- works
2 very closely with the trackers and coordinates those
3 reports as well. Mary Haughey is our Service
4 Improvement Lead, and she continues to work with all of
5 the MDTs to standardise protocols and how patients are 11:51
6 presented to them. So, that work is ongoing. So
7 that's all beneficial.

8 139 Q. Well, just so I can tick off what Mr. Conway has said
9 was going to happen and marry it with what you said has
10 happened, the first thing he talks about in his 11:51
11 statement - and for the Panel's note, WIT-23917, at
12 71.3. He says.

13
14 "The current Director, Mrs. Melanie McClements,
15 appointed two additional Band 7 staff in August 2021 to 11:51
16 support the assistant directors in matters relating to
17 governance. More recently, Mrs. McClements has also
18 approved the appointment of four Band 5 governance
19 staff to provide additional governance support to the
20 Acute divisions with an expected start date of October 11:51
21 2022."

22
23 Do you have familiarity if those posts have been
24 filled?

25 A. Yes. 11:52

26 140 Q. They all have. Then he speaks about - and this is at
27 the next paragraph, 71.4, for the Panel's note:

28
29 "Concerns about the lack of clinical audit and support

1 to the Cancer MDTs has been noted in the MDT annual
2 reports, including for the Urology MDT. I raised this
3 issue with the Director of Acute Services in May 2022
4 and approval was given to appoint a new post to provide
5 clinical audit support to the Cancer MDTs. The
6 recruitment process is under way and I hope the post
7 holder will be in place by September 2022."

11:52

8
9 So it's a clinical audit support for cancer MDTs,
10 that's what you --

11:52

11 A. That's what I was referring to, yes.

12 141 Q. Just different names. Then he also says at paragraph
13 71.5:

14
15 "More generally, there continues to be a deficit in
16 clinical audit capacity in the Trust. It is my
17 understanding that work is ongoing to expand the Trust
18 clinical audit team, which sits within the Medical
19 Director's office. The Medical Director are best
20 placed to provide more detail on this."

11:53

21
22 would you be aware of those posts having been filled at
23 all? They're more ancillary to Cancer Services, I
24 think.

25 A. I'm not aware of those.

11:53

26 142 Q. Then at paragraph 71.7, he says:

27
28 "I believe the previous governance arrangements
29 relating to the Cancer MDTs were not sufficiently

1 robust to identify the issues in Urology." "A cancer
2 MDT administrator was appointed in January 2022. They
3 are now leading on establishing robust governance
4 arrangements around the cancer MDTs."

11:54

5
6 A. Yes.

7 143 Q. And that's in place. How effective are all of those
8 posts, those additional posts, how effective are they
9 in bolstering or reassuring you around governance?

10 A. Those are very effective, you know. They can run
11 reports to give us an assurance that when decisions are
12 made at MDT, that, you know, we can now monitor the
13 outcomes and assure ourselves that those outcomes are
14 actually happening.

11:54

15 144 Q. He does mention that the peer review process was stood
16 down during Covid and, at the time of his statement,
17 had not recommenced. Has that recommenced, do you
18 know?

11:54

19 A. Not a formal commissioning of peer review or peer
20 review visits; that isn't happening. However, in the
21 absence of that, I think it's good practice to continue
22 to monitor our MDTs against the measures that are
23 there. So, you know, our service improvement will
24 continue to monitor our quoracy, monitor key worker
25 role. That work will continue to happen, even though
26 it's not properly commissioned or we do not have formal
27 site visits.

11:54

11:55

28 145 Q. Are there any other changes or improvements that I have
29 not mentioned that you wish to tell the Panel about?

1 A. well, obviously we've got additional tracking resource.
2 we have highlighted the gaps in tracking for a number
3 of years, again to the Health and Social Care Board.
4 we put in bids for additional resource because our
5 numbers had significantly increased from when cancer 11:55
6 trackers were first appointed. So, we now have got
7 recurrent funding, and the numbers have expanded of
8 trackers, which is good, and tracking is more often
9 up-to-date than not, which is positive.

10 146 Q. Is there anything else you'd like to add at this point 11:56
11 to your evidence that perhaps I have not covered, I
12 have not taken you to, or is there a point you'd like
13 to make or any evidence you've heard that you do not
14 agree with?

15 A. well, I suppose we did do a lot of work across the 11:56
16 region and developed a cancer strategy for the first
17 time in many years, and the report came out in 2022.
18 That does highlight a lot of the inefficiencies and
19 things that we've talked about throughout this process,
20 and obviously a lot of the improvements that we need to 11:56
21 make across Cancer Services in the future, right from,
22 you know, sending out health promotion messages right
23 through when patients are diagnosed, their treatment
24 and life after cancer. I think there's a lot of need
25 for resources -- you know, for services to be properly 11:56
26 resourced to fully meet the needs of cancer patients
27 going forward.

28 147 Q. Just finally, does Urology still sit outside your
29 remit?

1 A. It does.

2 148 Q. It still sits under the Surgical Directorate?

3 A. That's correct.

4 149 Q. The issues around communication that you report, and
5 the evidence would suggest are substantiated, do they 11:57
6 still exist, the problems with communication?

7 A. No. I feel this process has improved things
8 significantly.

9 MS. McMAHON: Chair, I've no further questions.

10 CHAIR: Thank you, Ms. McMahon. I'm sorry, we can't 11:57
11 release you just yet. There will be some more
12 questions for you, Ms. Reddick. Mr. Hanbury.

13

14 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
15 FOLLOWS: 11:57

16

17 MR. HANBURY: Thank you for your evidence so far. I
18 just have a couple of other clinical things. The peer
19 review was originally 2015, and then your main comments
20 seem to sort of come in 2017/2018 when you added that 11:57
21 to the risk register. Just a question: The red and the
22 green categorisation, how did you categorise it red,
23 and what information did you use to come to that?

24 A. So the red, you know, those would have been where I
25 graded from the peer review team, that would have been 11:58
26 their rag rating, and then we brought that into Trust.
27 They would have, actually it was their -- you know, if
28 it was immediate risk or serious concern, they were rag
29 rated accordingly from the National Cancer Peer Review

1 team.

2 150 Q. So that was them, not you?

3 A. Yes, that's correct.

4 151 Q. In the same document, the compliance rate was 67%.

5 Could you expand on that? What would it have been to 11:58

6 get into the green category on the peer review?

7 A. So what was the percentage, sorry?

8 152 Q. 67%.

9 A. Of quoracy?

10 153 Q. No, it was the compliance from the peer review. 11:58

11 A. The overall compliance?

12 154 Q. Yes.

13 A. Generally, you know, that wouldn't be bad for an MDT.

14 You know, a compliance report, that ideally wouldn't be

15 a low report. I suppose we always aim to be over the 11:59

16 70 mark in compliance.

17 155 Q. So, the fact that it was in red was more the quoracy

18 problems in your view, was it?

19 A. Yes.

20 156 Q. Okay. Sticking with that in a way, when you did 11:59

21 escalate it to Professor O'Sullivan, the regional, and

22 there seemed to be some movement in your recruitment

23 with the lung and urology appointment, I remember that

24 there was a problem with that person who was then busy

25 on a Thursday afternoon with lung responsibilities? 11:59

26 A. Yes, that's correct.

27 157 Q. What happened next? There was a person in but a

28 Thursday afternoons is only one of ten sessions in a

29 week. Did someone go and say is there a different

1 session we could do?

2 A. From an oncology perspective, you know, they would be
3 job planned in Belfast Trust. So, you know, that
4 person would have moved things around to make the MDT
5 attendance more doable. 12:00

6 158 Q. Then you've gone to all this trouble, a new person came
7 and they were doing lung, not urology. That must have
8 been --

9 A. Yeah.

10 159 Q. -- a huge frustration to you? 12:00

11 A. Yes.

12 160 Q. Did anything happen? Did anyone go and say can we move
13 the MDT, can we move the clinic to make this happen in
14 any circumstance?

15 A. Yes, we tried to resolve that. It's quite difficult 12:00
16 because we then have another MDT; you know, we had the
17 MDT on a Thursday afternoon. So that was difficult to
18 jig things around because we have an earlier MDT on a
19 Thursday. So, we did try options to make it work.

20 161 Q. But it never really happened? 12:00

21 A. No.

22 162 Q. Okay. Thank you.

23

24 There was Mr. Glackin's email saying that, in his
25 opinion, holding an MDT really wasn't always very 12:01
26 difficult, to quote him. Was there any guidance from
27 the National Peer Review Team at a point to say
28 actually, this is not working, we should stop? Did they
29 come back to you with a --

1 A. No, there was no guidance. To be honest, a lot of
 2 clinicians, not just in urology, felt sometimes that
 3 peer review was a tick box exercise because there were
 4 things out with our control that required commissioning
 5 that just wasn't forthcoming. So, there wasn't really 12:01
 6 any control from peer review to say no, don't do this
 7 any longer or, you know, stop it, it's not viable.
 8 There was no direction.

9 163 Q. Do you think, looking back, that might have been
 10 something that they should have done? 12:01

11 A. Yes, I think that would have been helpful. You know,
 12 we did explore working with the Cancer Centre to see,
 13 you know, if they could have taken on more of our
 14 urology. But all MDTs are, you know, they're just --
 15 the numbers are so large and there's so many 12:02
 16 discussions. I think over recent years there's a lot
 17 more complex discussions, you know. What would have
 18 been a five-minute conversation before can now be 15/20
 19 minutes. That hasn't really been taken into
 20 consideration as time has went on and as the years went 12:02
 21 on. There are a lot of patients with other
 22 comorbidities and other quite complex cases.

23

24 We did try to explore, you know, the Cancer Centre
 25 taking some of our MDT discussions, but it wasn't -- 12:02
 26 they were already fully filled to capacity with
 27 discussions in the centre as well.

28 164 Q. Okay. Just one last thing. You said on the CaPPS
 29 system, there was a field there that you can say a key

1 worker allocated yes or no. Is that a recent thing or
 2 was that in existence back in 2016?

3 A. It was in early existence but I think it's been
 4 utilised more now. The key workers would click that,
 5 and if they have had involvement, they have the -- you 12:03
 6 know, they have access to do that. I think that's
 7 useful.

8 165 Q. But that's not something you necessarily looked at --
 9 A. No.

10 166 Q. -- at that time? 12:03
 11 A. I suppose we were, you know -- in 2016 we were really
 12 just on a journey to expand our nursing workforce.
 13 Some tumour sites didn't have a cancer nurse
 14 specialist. It's been a work in progress and
 15 development as more cancer nurse specialists come on 12:03
 16 board.

17 167 Q. I share your frustration, having gone through all the
 18 effort of raising the money through Macmillan, and a
 19 lot of departments did this. Did you feel fit to sort
 20 of go around and shout a bit? You say you were 12:03
 21 frustrated. Did you...

22 A. You just keep chipping away and raising the message as
 23 much as you can at every forum.

24 168 Q. Again, looking back, do you think you could have been a
 25 bit more assertive in your view then, your actions? 12:04
 26 A. Probably, yes.

27 MR. HANBURY: Okay. Thank you.

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

29 DR. SWART: You mentioned the patient experience survey

1 back in 2015; has that been done on an annual basis
2 since? I have not seen it in the documents. How do you
3 get your information about patient experience from the
4 cancer patients?

5 A. So, we do -- certainly within Cancer Services, that 12:04
6 would be -- patient and public involvement is very much
7 high on our agenda. However, you know, that can be
8 limited when I don't manage specialties.

9 169 Q. But that national survey that was done?
10 A. So, the national survey was repeated in 2018 again. 12:04

11 170 Q. But it's not done every year?
12 A. No, it's not because it is a commissioned service and
13 not --

14 171 Q. The barrier is money to that then, is it?
15 A. Yeah. There's a whole data protection process as well 12:05
16 around that, you know, where lists have to be cleansed
17 in case people have passed away. So, there is a lot of
18 work behind that before it's sent out on a regional
19 basis. And it is a commissioned service.

20 172 Q. So, you haven't been able to do that big one. Within 12:05
21 specialties, are they doing their own cancer patient
22 experience surveys?

23 A. Yes.

24 173 Q. Is that reported back to you or where does that go?
25 A. So, that would be reported back to the specialty, 12:05
26 generally. The cancer nurse specialists would very
27 much take a lead on that because they obviously know
28 their patients well, and they would send out, you
29 know -- from time to time they would, in tandem with

1 our cancer service improvement lead, they would send
2 out 20, 30 random patient experience surveys, and then
3 pull a report from that to see what the key issues or
4 themes are.

5 174 Q. Is that one of the KPIs that you would follow for 12:05
6 cancer nurse specialists?

7 A. Yes. Yes.

8 175 Q. You mentioned a range of KPIs. Do you ever see those
9 KPIs for the cancer nurse specialists or does that go
10 as well as? 12:06

11 A. For the nurses in my area of responsibility, yes.

12 176 Q. What are the recurring themes from that, if you had to
13 summarise it for us? You know, they are doing a lot of
14 very important work; are there some recurrent issues
15 coming up from their KPIs that you have had to take on 12:06
16 board in terms of making improvements, for example?

17 A. I think one of the KPIs is regularly doing a holistic
18 needs assessment with patients. You know, yes, when
19 patients have a diagnosis, they want to know what's
20 happening to me, what's my treatment planned, how long 12:06
21 can I expect this to last, and then obviously, you
22 know, when patients get to the end of their treatment,
23 we, at that point, try to do another holistic needs to
24 see, do an end of treatment summary to see what the key
25 issues are moving forward and how we can support those 12:06
26 patients living with and beyond their cancer diagnosis.

27 177 Q. Does that go to a Trust committee on patient
28 experience, or how do you --

29 A. Yes.

1 178 Q. -- report upwards on that?

2 A. So, that would go to our PPI Panel within the Trust.

3 179 Q. You've mentioned a lot about the Health and Social Care
4 Board, you have not said much about the Trust Board.
5 Do you feel for cancer it more or less goes directly to 12:07
6 the Health and Social Care Board for action? How does
7 that feel to you?

8 A. We had a NICaN Trust Board, of which our, you know,
9 senior managers would have linked into. That, in
10 recent times, has been changed. I felt that was a 12:07
11 route as well for raising any issues.

12 180 Q. What about the Southern Health Care Trust Board itself;
13 did you have any reporting structure through to that as
14 far as you're aware?

15 A. That would have been higher than myself. I never would 12:07
16 have been invited --

17 181 Q. So, you had a direct relationship externally but not
18 internally; would that be fair?

19 A. Well, my senior managers would have had that.

20 182 Q. But not for you? 12:08

21 A. Not for me personally.

22 183 Q. The peer review process. There was a formal peer
23 review process in 2015, wasn't there?

24 A. Yes.

25 184 Q. Is it right that since then it's been largely 12:08
26 self-assessment with some sort of external validation?
27 I'm just trying to get an understanding of this.

28 A. That's correct, yeah.

29 185 Q. The external validation is done by who, exactly? Is it

1 a paper exercise by a central team or...

2 A. Yes, that's right, the National Peer Review Team. We

3 would submit our papers and then they externally look

4 at that and agree that our assessment is correct and

5 that it marries up with what their assessment has been. 12:08

6 186 Q. Is there then a Trust-wide meeting to discuss how the

7 peer review processes have gone for all the tumour

8 sites? Is there an opportunity to bring that together

9 with some senior Trust challenge of any sort?

10 A. Yes. So all our reports would go up right up to Chief 12:09

11 Executive in the Trust.

12 187 Q. But is there a meeting where you can all sit around and

13 discuss the challenges from peer review for this year?

14 A. Not as -- no, that generally would have been discussed

15 at our cancer performance meetings. It would have tied 12:09

16 into the agenda with that.

17 188 Q. Okay. In the cancer performance meetings, do you

18 specifically focus on all the peer review problems?

19 A. Yes. Yes.

20 189 Q. And discuss how to solve those, or just escalate them? 12:09

21 A. We try to, you know, solve what we can.

22 190 Q. Hmm-mm.

23 A. However, if it's commissioning and resource, that can

24 be difficult.

25 191 Q. Yes. You've talked a lot about escalation but I get a 12:09

26 sense that most of the actions you feel are outside

27 your own control. Would that be fair?

28 A. Yes. Some of them, yes.

29 192 Q. Can you think of any examples where you've had to

1 escalate something and you've been able to fix the
2 problem yourself through your escalation and through
3 finding the source of the problem?

4 A. I can't just think offhand, you know, now, of... but
5 yes, yes. That, I suppose in my role, is very 12:10
6 rewarding when you actually see something that you have

7 escalated, that you get to an end point and you get --
8 193 Q. Because it must be very hard to always be pointing out
9 the problems and not be able to fix them?

10 A. Yes. I suppose, to be fair, the cancer nurse 12:10
11 specialist workforce expansion was beneficial. I did
12 see, you know, the outcome of that was really good for
13 patients.

14 194 Q. Now, you've got a background as a cancer nurse yourself
15 in chemotherapy and all sorts of specialism. It must 12:10
16 be quite difficult to be producing all of these breach
17 reports with large numbers of patients waiting a long
18 time and not understand the impact on patients. You
19 must be aware of that. Have the Health and Social Care
20 Board asked you to assess the harm to patients at any 12:10
21 stage of these long waits? Has there been any emphasis
22 on that?

23 A. No.

24 DR. SWART: Thank you.

25 CHAIR: Can I just be clear because it's perhaps my 12:11
26 misunderstanding of the language used here, but it
27 seemed to me that you talked a lot about escalation.
28 To my mind, escalation is where you move something up
29 to somebody more senior so that they can do something

1 about it. Sending it back to the head of service, to
2 my mind, is really not escalation. Is that not just
3 sort of, well, you know, this is your problem, you need
4 to deal with it?

5 A. Do you mean the head of service within the specialty? 12:11

6 195 Q. Within Urology, yes.

7 A. Generally, whenever I was escalating any issue, that
8 would have gone through to the operational support
9 lead, to the head of service and the assistant director
10 within that area. 12:11

11 196 Q. Of Surgery and Elective Care?

12 A. Yeah.

13 197 Q. So, when you say escalation, it wasn't just the head of
14 service who was expected to sort it out; by escalation
15 you mean, in this case it would have been Martina 12:12
16 Corrigan and her line managers?

17 A. Yes.

18 CHAIR: Okay. Thank you. I was obviously not clear in
19 understanding what you meant by escalation.

20 A. Sorry. They have been schooled to be courteous as well 12:12
21 and to give people their place, you know, if they are
22 head of service and go up the chain of service as such.

23 198 Q. You don't go over their heads, you include them in it?

24 A. Absolutely.

25 199 Q. I understand. 12:12

26 A. That has always been ingrained into me, to give people
27 their place and where they are in the chain of command.

28 CHAIR: Okay. Thank you very much, Ms. Reddick. I
29 don't think we have any other questions.

Then I think our next witness is due at two o'clock.

MS. McMAHON: Mr. wolfe has suggested 1:45, if that's possible, because the witness is available.

CHAIR: Yes. I have no difficulty with that. I take it, gentlemen, ladies? No? Thank you.

12:12

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon everyone. Mr. wolfe.

13:48

MR. WOLFE KC: Good afternoon, Chair, good afternoon, Panel. Your witness this afternoon is Dr. Marc Williams. Are you taking the oath or are you affirming?

THE WITNESS: Affirming.

13:48

MR. WOLFE KC: Our secretary will administer the affirmation.

DR. MARC WILLIAMS, HAVING AFFIRMED, WAS EXAMINED AS FOLLOWS BY MR. WOLFE:

13:48

MR. WOLFE KC: The first thing we're going to do, Dr. Williams, is bring your witness statement up onto the screen in front of you. The first page of that is WIT-60278. You'll recognise that as the first page of your statement. It runs to approximately 20 pages. If we go up to WIT-60298, that's your signature?

13:49

A. Yes.

200 Q. You recognise that, dated 6th October 2022. would you

1 wish to adopt that statement as part of your evidence
2 to the Inquiry?

3 A. Yes.

4 201 Q. So far as I understand it, you've no corrections or
5 amendments -- 13:50

6 A. No.

7 202 Q. -- to make to your statement. Thank you.

8

9 You are currently employed with the Southern Trust as a
10 consultant radiologist? 13:50

11 A. Yes.

12 203 Q. You commenced work with the Trust in 2009; is that
13 correct?

14 A. Yeah, yes.

15 204 Q. That's the only post you have held in the Trust? 13:50

16 A. Yes.

17 205 Q. You have a particular interest or specialism in
18 uroradiology?

19 A. Yes.

20 206 Q. Briefly, could you help us with that? what does that 13:50
21 mean, that you have a special interest or an expertise
22 in that area?

23 A. Well, as it says, it's a small, I suppose you'd call it
24 a district general; it's a smaller hospital than a
25 tertiary referral centre. So, we all do general 13:50
26 radiology with a specialist interest. So. Mine is
27 uroradiology. So I would do the majority of the
28 specialist urology examinations, such as prostate MR
29 would be the biggest group of those, but also a variety

of other examinations; it's usually MRI.

I go to the Urology MDT. I am the lead radiologist for the Urology MDT. I'm often the first point of call for questions from the urologists about cases. I have done other meetings in the past, which we don't do at the moment. I would deal with any sort of urological imaging issues or queries about the service that need to be worked out.

I think that's the crux of it. In addition to other, you know, a lot of general radiology, a variety of other things, and general (inaudible). I provide opinions to my colleagues on urology, urology imaging. I think that's most of it.

207 Q. That's helpful. I wonder is there a sound issue, a slight sound issue this afternoon? I'm struggling a little bit.

CHAIR: I think we're...

MR. WOLFE KC: You're okay?

CHAIR: we're okay, yes.

MR. WOLFE KC: we'll persevere.

THE WITNESS: I can come in a little bit closer.

208 Q. MR. WOLFE KC: You are also the lead radiologist to the Urology MDT. Does that remain the case; yes?

A. Yes.

209 Q. Until relatively recently, you were the only radiologist with an interest, special interest, in urology; is that right?

1 A. Yes.

2 210 Q. You've recently been joined by an additional
3 radiologist with a specialism in that field?

4 A. Yes. I think he has interests in other things as well
5 but he does do some urological imaging. 13:52

6 211 Q. Yes. I suppose hidden within that question is part of
7 the reason for having you along to give evidence this
8 afternoon. As the Inquiry has heard, for a long period
9 of time, you were what's described in the papers as the
10 single-handed radiologist with this specialism? 13:53

11 A. Yes.

12 212 Q. That created issues around the quoracy of the Urology
13 MDT.

14 A. Yes.

15 213 Q. That will be the main stay of some of my questions this 13:53
16 afternoon. But before we get to that, the Department
17 of Radiology, it sits within the Cancer Services
18 Directorate; is that right?

19 A. Cancer and Clinical Services, yeah.

20 214 Q. Within that, you are responsible or report to the 13:53
21 clinical Director of Radiology; is that correct?

22 A. Yes.

23 215 Q. And that's currently Dr. Yousaf?

24 A. Yes.

25 216 Q. Before that it was Dr. Gracey? 13:54

26 A. Yes.

27 217 Q. I think within your statement - we don't need to bring
28 it up -- for example at WIT-60286, you make it clear
29 that while you report and provide reports to urologists

1 for the purposes of the MDT, you're not employed in
2 urology departments, self-evidently?

3 A. Yes, that's correct. Yeah.

4 218 Q. And you have no input into the operation governance or
5 clinical aspects of urology as such? 13:54

6 A. That's correct.

7 219 Q. For the purposes of the Urology MDT, however, you do
8 report to the Chair of that body?

9 A. Yes.

10 220 Q. Currently it's Mr... 13:55

11 A. Glackin.

12 221 Q. Glackin, thank you. Now, let's just put some figures
13 around the MDT quoracy issue. If we could have up on
14 the screen, please, TRU-84685. This is an extract from
15 the report of the peer review visit to the Trust which 13:55
16 took place on 16th June 2015. If we just scroll down,
17 please, to that fifth paragraph. This is reporting in
18 respect of the visit in June 2015. It says:

19

20 "Radiology attendance is problematic and more so due to 13:56
21 long-term absence, which now leaves a single-handed
22 radiologist to provide the clinical services, as well
23 as MDT cover. The MDT recognises this is a problem and
24 is in discussions with the senior management team on
25 how to resolve this problem." 13:56

26

27 So that was you, you were the single-handed
28 radiologist?

29 A. Yes.

1 222 Q. Can you help us with when approximately your colleague,
2 the new radiologist who can attend the MDT, when was he
3 appointed?
4 A. I can't give you the exact date but I think it's within
5 the last year. 13:57

6 223 Q. Yes. Can you remember for how long the problem
7 presented in this narrative; for how long that was an
8 issue? How long had you been the single-handed?
9 A. Again, I would find it very difficult to give you exact
10 dates but it's going to be for a few years, I think. 13:57

11 224 Q. And so for five, six, seven years perhaps?
12 A. It doesn't seem as long as that; maybe going on the
13 shorter side. But to be clear, I really would have to
14 check the dates.

15 225 Q. Yes. No doubt the Trust's representatives are hearing 13:57
16 the questions and they can take it that the Inquiry
17 would like to know the precise dates.
18 A. Yeah.

19 226 Q. The question being how long were you the single-handed
20 urologist. 13:58
21 A. Yes.

22 227 Q. If we scroll down this page to the penultimate
23 paragraph. It says:
24
25 "Due to low clinical oncology and radiology attendance 13:58
26 at the MDT meetings in the reported period, only 25% of
27 meetings were quorate."
28
29 That probably comes as no surprise to you, does it?

1 A. No, not really. Obviously, you know, it says there we
 2 had issues with both radiology and oncology attendance.
 3 Sometimes we had no oncologist for prolonged periods of
 4 time, which obviously still made us non-quorate despite
 5 me attending the meeting. Then there was my attendance 13:58
 6 as well; it was variable.

7 228 Q. Yes. We'll come on just to look at some of the reasons
 8 for that and what was done about it and the
 9 implications of it in a short period of time.

10
 11 There's an external verification report from the next
 12 year, if we can just bring that up on the screen,
 13 please. TRU-98213. This is an external verification
 14 report and the reply at NICA in 2016. If we just
 15 scroll down, please, onto the next page. It describes 13:59
 16 only 42 MDT meetings were held in 2015, 43% of those
 17 meetings had no radiologist presence and 19% no
 18 oncologist. So, just short of 50% of those meetings
 19 did not have you in attendance. Plainly at that time,
 20 if you couldn't attend, there was no alternative, apart 14:00
 21 from perhaps on some occasions a general radiologist;
 22 is that fair?

23 A. Yes. I don't think any of my colleagues really felt
 24 they wanted to take it on. You know, they didn't feel
 25 they had the experience to do it. So there really 14:00
 26 wasn't anybody.

27 229 Q. Yes. So, let's look at some of the reasons why the
 28 issue of quoracy wasn't resolved. In circumstances
 29 where you were the only urologist, you, of course,

1 had to take leave on occasions, and if you were on
2 leave and leave happened to be on a Thursday, it's fair
3 to say that there was no substitute for you?

4 A. That's correct.

5 230 Q. Preparation time for attendance at MDTs is obviously 14:01
6 important, isn't it?

7 A. It's vital, yeah.

8 231 Q. Is it your position that you can't attend an MDT unless
9 you've done the preparation because without the
10 preparation, you cannot safely and effectively 14:02
11 participate?

12 A. That's true. I mean, obviously you can attend but you
13 can have no input into the cases, unless the questions
14 are just very generic.

15 232 Q. Were there situations, and how regular were these 14:02
16 situations, where, instead of prepping for an MDT, you
17 had to instead carry out acute work, clinical work?

18 A. I don't think those -- it wasn't a frequent thing, but
19 it did happen. You know, that, in combination with the
20 other things you've mentioned, plus study leave, you 14:03
21 know, obviously were the reasons why my attendance was
22 as it is. They usually kept me available for the
23 meeting but I don't think those who made the rota
24 really understood the prep aspect. So what would
25 happen is they would usually take my prep session for 14:03
26 acute work and then I would have no role at the
27 meeting.

28 233 Q. Hmm-mm. Can you give us an example of that? What could
29 crop up that would require somebody, your manager, to

1 prioritise the acute work and your attendance on the
2 acute work rather than attendance at an MDT?

3 A. Well, it would usually be one of two things. It would
4 usually be an acute CT list, so inpatients who needed a
5 scan, needed a radiologist for that list. The other 14:04
6 was we have a thing called general inquiries, which is
7 a radiologist available basically for inquiries, so
8 doctors to come and speak to a radiologist. Also, just
9 to come and mop up any emergency work that is falling
10 outside of the CT work, so urgent cases that needed to 14:04
11 be done. So we always have an acute CT radiologist for
12 every session, and some sessions usually -- I think in
13 the afternoons now we have a radiologist for the
14 inquiries session.

15 234 Q. The fact that on occasions you had to fill in on the 14:04
16 clinical side rather than be granted time to get on
17 with prep for MDT, is that a reflection of the fact
18 that the Trust had been unable to recruit sufficient
19 radiologists or a urologist to divide the labour?

20 A. I think it's a combination of things. As the MDT was 14:05
21 kind of in its infancy in the first few years, I think
22 the Trust was probably still prioritising the acute
23 work. It probably didn't, as I said, didn't really
24 appreciate the need to keep both my Wednesday afternoon
25 and the Thursday afternoon sessions free so as not to 14:05
26 take my prep time. They maybe didn't appreciate that.
27 In addition, I was the sole person available. I will
28 just summarise the other things so I can tell you
29 there. So, if I took leave on a Wednesday afternoon or

1 a Thursday afternoon or study leave on either of those
2 days. So, all of those things were the reason why I
3 wouldn't be at an MDT.

4 235 Q. Yes. Could I seek your views on something Dr. Hughes
5 has told the Inquiry? Dr. Hughes, you may know, was the 14:06
6 senior reviewer on a series of serious adverse
7 incidents which were reviewed in 2020 in the Trust and
8 into 2021. He addressed the issue of quoracy in his
9 evidence. If we go to TRA-02027. Just halfway down
10 the page, the Chair asks a question in relation to 14:06
11 quoracy. I think upon reading Dr. Hughes' answer, the
12 question incorrectly refers to radiology as opposed to
13 oncology. So, oncologists were expected to attend the
14 MDT; isn't that right?

15 A. Yes. 14:07

16 236 Q. The answer that Dr. Hughes gives in relation to this
17 issue was that the urology service is a very large
18 service. And, again, I think that should be oncology.
19 It's a bit confused.

20 14:07
21 "The oncology service is a very large service and they
22 did the lung cancer service in the afternoon, which is
23 very large and complex as well and they simply didn't
24 have the time. As well as that, it was staffed by
25 rotating locums so there was no continuity. Even 14:07
26 though it may have been quorate one or two times, it
27 may not have been the same professional. In essence,
28 you didn't have embedded oncology within the team on a
29 stable basis."

1
2 I think the sense of that is made clear by the last
3 sentence, despite a number of false starts. The answer
4 is in relation to oncology attendance at the MDT.

14:08

6
7 Were you aware that oncologists found it difficult to
8 attend on occasions because there was a competing lung
9 cancer service MDT arranged for the same time?

10 A. No, I wasn't aware of that.

14:08

11 237 Q. Were you aware of the fact that when oncologists did
12 attend, they were locums, and there wasn't, as
13 Dr. Hughes describes here, the presence of an embedded
14 oncology within the team on a stable basis?

15 A. I mean, I never had any knowledge of anyone being a
16 locum. I think there were periods of time where we did
17 have an oncologist and it seemed to be the same person.
18 Then my recollection is there were periods of time
19 where we had no oncologist at all. That's how I
20 remember it.

14:09

21 238 Q. I assume you did have appreciation that both oncology
22 difficulties as well as radiology difficulties were
23 contributing to the quorum issue?

24 A. I think oncology was -- I'm not sure of the reasons why
25 the oncologists obviously didn't attend but I would
26 think they probably had staffing issues of their own.
27 I assume so.

14:09

28 239 Q. Yes. Now, in terms of the efforts that were made to
29 try to resolve the issues affecting radiology, you've

1 said in your statement -- if I can pull it up,
2 WIT-60287. 20.3 towards the bottom, please. You're
3 describing the situation when, if you were on leave -
4 the single radiologist - then there would not be a
5 radiologist present. The issue with a lack of
6 attendance by a radiologist was an issue for a
7 prolonged period, as you've described, and this was
8 mentioned at the MDT on a number of occasions but you
9 don't know by whom, or you're unsure by whom, but most
10 likely Mr. O'Brien and Mr. Glackin.

14:10

14:10

11
12 "But this was not solvable in the absence of an
13 appointment of an additional radiologist, which was the
14 Trust's responsibility, and I cannot comment as to how
15 much effort the Trust made to achieve this. But I am
16 of the opinion that the Trust did not do all it could
17 do to appoint an additional radiologist by making an
18 attractive job, particularly when in competition with
19 other Trusts both within Northern Ireland and the UK.
20 I think, but I cannot be sure, that the MDT Chair may
21 have raised the issue of radiology cover with the
22 relevant clinical radiological clinical director, but I
23 have no detailed knowledge of this, nor the response
24 which was received."

14:10

14:11

25
26 The impression is that the Trust had been making
27 efforts to recruit but your evidence is that they
28 needed to do something more to make the post, to make
29 the offering, more appealing; is that fair?

14:11

1 A. Yes, and I think that's true. The problem is that
 2 radiology is -- there's a shortage, a big shortage of
 3 radiologists and a lot of places don't even advertise
 4 any more because they just can't fill their posts. So,
 5 newly qualified radiologists can almost pick and choose 14:12
 6 where they want to work. The departments have to make
 7 themselves as attractive as possible to those people
 8 who are coming, which, it's difficult, you know, in
 9 Northern Ireland, because they're relying, you know,
 10 mostly to the extent on northern Irish trainees coming 14:12
 11 through the programme who generally don't have much of
 12 an interest in uro-radiology as opposed to the UK -- to
 13 England, sorry, where there are a lot of
 14 uro-radiologists. But here there seem to be quite few,
 15 you know, if any really. So they're perhaps not 14:12
 16 exposed to that specialty and, therefore, not really
 17 enthused to do it. I think, you know, there is a sort
 18 of combination of factors.

19
 20 So, to be in competition with other Trusts within 14:12
 21 Northern Ireland and the rest of the UK, you have to do
 22 something extra to make your job appealing, whether it
 23 be an attractive job plan, the on-call is good.
 24 Because the on-call is always a problem and it's
 25 something, you know, applicants will look at, whether 14:13
 26 there's ability to work at home; any financial
 27 remuneration, things like that. You know, a good job
 28 advert, for example.

29 240 Q. We can see from some of the materials that have been

1 provided that you took this issue up with Sam Porter, I
2 think, or mentioned it to Simon Porter. If you just
3 look at WIT-89846. If we just scroll down, please.
4 Just scroll down a little further. Thank you. You're
5 writing to Simon Porter and you're saying you hear on 14:14
6 the grapevine that you might be interested in reporting
7 across the MRI, and you've explained to him the various
8 requirements that go with that, including, as per the
9 standards set by the European Society of Uroradiology,
10 a requirement or at least a strong suggestion that such 14:14
11 a person should attend the Urology MDT regularly.

12
13 You go on to explain the obligations that go with that.
14 Just if we scroll down. Urology MDT, within that
15 paragraph, you explain how arduous that is. Then you 14:14
16 say:

17
18 "What we really need in the Trust is the recruitment of
19 a radiologist with an interest in general urology,
20 someone that can partake in the GU Service and attend 14:15
21 and take the MDT. The only way to achieve this is to
22 make a real attempt to recruit by putting out
23 interesting job plans that offer more than the bare
24 minimum, mentions of flexibility, offsite SPA, more
25 than 1.5 SPAs, recruitment and retention premia. I 14:15
26 remain unclear why the Trust does exactly the opposite
27 and how it expects to recruit in the circumstances,
28 which leaves me, as a sole practitioner, which is not
29 safe and not recommended by the College."

1
2 So you're explaining yourself in fairly strident terms
3 to -- who is Mr. Porter?
4 A. He is a colleague, another radiologist.
5 241 Q. Yes. If we just scroll up to the top of that email, 14:16
6 please. You're copying in the Assistant Director for
7 Cancer Clinical Services, Mrs. Trouton, and Barry
8 James. Who is he?
9 A. Another colleague.
10 242 Q. Yes. 14:16
11 A. Not working now, but...
12 243 Q. Did you ever get direct feedback yourself on this point
13 that you're making, that we need to, as an
14 organisation, make the role more attractive, to be more
15 proactive in our recruiting strategy? 14:16
16 A. No, I don't think so. I think this was something that
17 I suggested a number of times over the years and I
18 didn't get any feedback.
19 244 Q. Another theme that emerges from the materials that
20 we've assembled is your job plan, and how, in terms of 14:17
21 your ability to contribute as regularly and as
22 comprehensively as you would have liked to have done to
23 the MDT, you believed or you felt that you were being,
24 if I can use the expression, shortchanged in terms of
25 the amount of time extended to you within the job plan 14:17
26 to enable you to complete the work. Wasn't that an
27 issue?
28 A. I don't think there's any doubt about that. I think
29 initially - and I am trying to remember - I think I had

1 two hours of prep time for two meetings. One was the
2 Urology MDT, which lasted a variable amount of time,
3 but towards the start it often ran until after five
4 o'clock, so for three to four hours, with basically
5 unlimited number of cases; they were not capped. The 14:18
6 other was a benign sort of Urology MDT, sort of for
7 stones and cysts and things like that, which was wholly
8 inadequate, two hours' preparation for those two
9 meetings.

10 245 Q. Yes. We can see how this is raised in the 14:18
11 correspondence, if we just briefly work through some of
12 that. If we go to WIT-89943. Scroll down the page,
13 please. This is 2nd May 2016. This comes, I think,
14 close to the end of a number of pieces of
15 correspondence and, as we'll see, Mr. O'Brien becomes 14:18
16 engaged in the debate on your behalf as well.

17
18 The essence of the point you're making is in the second
19 paragraph. You're saying to David - that's David
20 Gracey, your line manager - 14:19

21
22 "I will, from now on, be working to my job plan. I
23 have two hours of prep time to wait in the job plan.
24 The first hour is supposed to be for the Urology
25 Thursday morning meeting. This leaves approximately 14:19
26 one hour prepare for the MDT for a meeting that lasts
27 up to three hours. Once this hour ends, I won't be
28 spending any more time preparing nor providing
29 radiology input into cases that I have not prepared

1 for. I will ensure that the MDT Chair knows which
2 cases won't have any input that week."

3
4 You say: "I have been asking for extra preparation for
5 Urology MDT but there is no indication whatsoever that 14:19
6 this will be provided, and I have been asking for
7 perhaps nine months. An email I sent last week was
8 unanswered, which is most unfortunate. A new general
9 urologist job has been advertised which has two hours
10 of prep time for the MDT in it and I don't get this." 14:20
11

12 You say: "I remain unclear and confused as to why I
13 should have to fight to get the time to do the job I am
14 asked to do. I have been trying, by giving up my free
15 time, to provide radiology input to the whole of the 14:20
16 MDT but, as I have said, this will not continue
17 indefinitely. I have also started looking for
18 alternative employment and am considering taking locum
19 work to bridge the gap."

20 14:20
21 We can sense your frustration in that communication.
22 Did you, in essence, feel that you were being
23 undervalued by the Trust, or is it more than that? Is
24 there a suggestion there that they weren't taking -- in
25 your view, were they not taking the preparation 14:21
26 requirements for MDT as seriously as they should have
27 been?

28 A. I mean, again my memory on this sort of thing is a
29 little bit sketchy because it's quite some years back,

1 but I think I'd been asking for a long time to have
 2 extra time for the meetings, which were getting more
 3 and more arduous, and I wasn't being engaged with
 4 whatsoever. So this was probably one of the last
 5 emails that I sent, trying to get more time for the 14:21
 6 meeting. And, you know, it was very frustrating. As
 7 you've said, I'm only asking for time to do the job
 8 they're asking me to do, nothing more, and I couldn't
 9 get that.

10 246 Q. We can see that a couple of weeks before you sent that 14:21
 11 email, Mr. O'Brien wrote, sharing elements of the
 12 concern that you've articulated. If we can bring up
 13 AOB-77295. If we just scroll up slightly - sorry, the
 14 other way - so we can see the top of the email.
 15 Further up. Okay. It's Mr. O'Brien writing on 20th 14:22
 16 March, directing his correspondence to David Gracey
 17 again and copying in a range of both clinicians, such
 18 as Mr. Glackin, Mr. O'Donoghue, Mr. Suresh, Mr. Haynes,
 19 as well as relevant managers, including Ronan Carroll
 20 and Fiona Reddick, who the Inquiry heard from this 14:23
 21 morning.

22
 23 To take up what he's saying substantively, he is
 24 writing to make the point that we have had a properly
 25 constituted Urology MDM since April 2010. During the 14:23
 26 earlier years, the greater problem had been to have the
 27 input of an oncologist. This has been resolved, he
 28 suggests, in that we have had clinical oncologists
 29 videoing in from Belfast and a medical oncologist

1 present onsite these past two years. However, the
2 issue of radiological input remains unresolved.

3
4 "Having considered this issue at length and having
5 experience and participated in repeated attempts over 14:23
6 the years to have the issue resolved, I believe that
7 the core issue is that the Department of Radiology has
8 never acknowledged or accepted that radiological
9 membership from MDT and presence at MDM are both
10 compulsory." 14:24

11
12 He draws a contrast to the Department of Pathology,
13 which has ensured that the pathologist is present at
14 almost all MDMS.

15 14:24
16 "We urologists have to suspend all other elective
17 activities to accommodate MDM."

18
19 Just before I conclude this email, do you recognise
20 that criticism which Mr. O'Brien makes to the effect 14:24
21 that within the Department of Radiology, there is a
22 failure to acknowledge the compulsory nature of
23 attendance by radiologists at the MDM, or do you think
24 that overstates it?

25 A. I think it's difficult. I don't know, and I have no 14:25
26 knowledge of what the manager's attitudes to the
27 urology MDM were and whether they felt it was important
28 for radiologists to be there. I think the problem is
29 likely due to the fact that we were just very

short-staffed many times and they were just having this battle between getting everything staffed. If we had enough staff, then having a radiologist at MDT would never have been a problem.

247 Q. He goes on to say that he greatly - that is, on behalf of the MDT - 14:25

"Greatly appreciates the expertise and experience of the only radiologist who does attend. However, we find the lack of commitment to ensure attendance at the majority of meetings unacceptable. If not resolved with immediacy, this issue poses an existential threat to our MDM, which we may be forced to terminate." 14:25

He goes on to say that he would like to have this discussed, and he attaches the quoracy timesheet. 14:26

we know that, shortly thereafter, there was some improvement to the time allocated to you for preparation. Mr. O'Brien, in an email from June 2016, suggests that you were granted an increased preparation time allocation of three hours; is that fair? 14:26

A. Yes.

248 Q. So it took some time and there was a degree of frustration, but you got fair. Did the allocation of three hours make life easier for you professionally in terms of your preparation? 14:26

A. Yes, because it meant that I wasn't having to spend my free time preparing. It meant it could be done in work

1 hours.

2 249 Q. But was it sufficient?

3 A. It's often not sufficient but I kind of put up with it
4 at the moment.

5 250 Q. You touched, in an email in 2017, on a particular case 14:27
6 which had not, judging by the emails, been reported on
7 terribly satisfactorily from your perspective. Let me
8 bring this up and see if you can help us with a little
9 bit of context to this. It's AOB-79923. At the top of
10 the page we have obliterated the name of the patient, 14:28
11 perhaps a little unhelpfully for you, but we can go
12 back over some of the emails if you need it for
13 context. But what you're saying here is that:

14
15 "In this particular case, I think we could have done 14:28
16 better in radiology and I am in part to blame as my
17 review of the case for MDT was not complete enough, and
18 I think this is unusual for me. At least the relatives
19 were accepting of things after your conversation. As a
20 slight aside, despite having three hours of prep time 14:28
21 for the MDT, I find I am having to rush and work at a
22 speed I am not comfortable with just to get through the
23 cases in this time. I will be taking this under
24 review."

25 14:29
26 The fine detail of the case that was in discussion
27 between various clinicians and yourself was, is it fair
28 to call it an inaccurate diagnosis or inaccurate
29 description of the precise location of the malignancy?

1 A. I think actually, as far as -- I remember the case now,
2 having looked at it. As far as the MDT summary, it was
3 absolutely correct and there was actually no error in
4 the MDT summary, because I think it said something like
5 we do not think this patient has metastases from 14:29
6 prostate or bladder cancer, which was factually right.
7 The error was that it wasn't clear on my part, or I
8 didn't make it clear as to where the primary actually
9 was, which was lung. The reason for that was because I
10 had not looked at the chest part of his CT scan, which 14:29
11 is a single event in twelve years, I think. It happens
12 occasionally.

13 251 Q. Hmm.

14 A. And I don't know the reason for that, I don't know
15 whether it was because I was rushing. I mean, I rush 14:30
16 now, I have to rush to get through my MDT prep in three
17 hours. I work at huge speeds. And I am also keeping
18 it under review. I don't know whether rushing was the
19 cause - it probably did play a part of the reason for
20 it - or just something I forgot. 14:30

21 252 Q. Yes. And essentially that's what perhaps the Inquiry,
22 in terms of your evidence, wishes perhaps to know
23 something more about. Is it very much a radiology
24 department, even today with an extra radiologist coming
25 in to work alongside you in recent years, is it a 14:30
26 department that has, for a long time, been under a high
27 degree of strain?

28 A. I think you could say that as an understatement.

29 253 Q. Yes. Now, Dr. Gracey, in his statement, has put a

1 number of factors together to try to explain the
2 pressures on the MDT and its quoracy, and I would
3 invite your comments in relation to them. If we can
4 bring up on the screen, please, WIT-89464. Just
5 towards the bottom of the page, please, at 17.9. I 14:32
6 think we've covered some aspects of this in what you've
7 said already in your evidence this afternoon but let me
8 read it and then invite your comments.

9
10 "Urology MDM radiology cover was problematic throughout 14:32
11 my tenure. Dr. Williams was the sole consultant
12 radiologist appointed to the MDM, as he was the only
13 one with urology expertise. He found a number of
14 cases at the meeting and the length of the MDM notes
15 arduous. His MDM preparation time was increased to 14:32
16 facilitate the meeting in May 2016", and we've seen
17 that.

18
19 "Initial clashes with other acute clinical duties
20 conflicting either with preparation time or the actual 14:33
21 meeting were addressed to optimise attendance in
22 September 2017. Dr. Williams' leave also frequently
23 coincided with the MDM. It was not possible to move
24 the MDM or to discuss individual cases at another day
25 or time to accommodate Dr. Williams and facilitate 14:33
26 patient flow, and Dr. Williams was similarly not able
27 to move his preparation time."

28
29 Is that a commentary with which you can agree?

1 A. Some of it I agree with. I agree that my leave tended
2 to occur towards the end of the week, because my job
3 plan is such that I don't have any formal commitments
4 on a Friday, although when I'm not on leave, I usually
5 work anyway. But if I'm away, I usually would take the 14:33
6 Thursday then. So, Thursday for the MDT was never
7 really a great time and it was always my preference to
8 have it at another time of the week, but it was on
9 Thursday anyway. So I did try to work around that as
10 much as I could, but that's potentially why my 14:34
11 attendance may have been not as good as I might have
12 hoped for, though actually it is not far below what the
13 recommended or the acceptable attendances should be.
14 But I find now it's actually higher than it was before.
15
16 In terms of -- I'm just looking at the other things it
17 says on there. Moving the prep time wouldn't have made
18 a difference because often the prep time wasn't the
19 issue. It wasn't possible to discuss a case at another
20 time? Well, that's not true because we would 14:34
21 regularly -- I would regularly take emails about cases.
22 We had a sort of recognised, I won't say pathway, but
23 urologists knew they could e-mail if there was
24 something urgent that needed to be discussed in the
25 absence of a radiologist being at the MDT. 14:34
26 254 Q. Yes.
27 A. And that would happen.
28 255 Q. Yes. I think we can show you an example just a little
29 later in relation to that. But there was a workaround

1 whereby you could be contacted beyond or outside of the
2 MDT to look at particular aspects of a case, if it was
3 necessary?

4 A. Oh, yes. Yeah.

5 256 Q. We'll look at that. Now, was there also a situation 14:35
6 where, on occasions, non-urological colleagues
7 would, perhaps with some reluctance, attend the MDT to
8 try to progress cases if you weren't available?

9 A. That happened but not very often. It's probably on
10 less than five occasions, I would estimate. 14:35

11 257 Q. So, again it comes back to the need to recruit a person
12 with interest in the area was the big answer to this
13 question, or the most complete answer to this question
14 of addressing quoracy?

15 A. I think that was probably the answer to solving the 14:36
16 problem.

17 258 Q. Yes. We have observed from your statement and some of
18 the papers provided that the department made use of an
19 independent sector supplier for the purposes of
20 providing additional reporting capacity in some 14:36
21 subspecialty urology studies. Was that of any
22 assistance to you in freeing up time within your
23 practice and perhaps within the practices of others
24 within the radiological team?

25 A. No, that was the reverse. 14:37

26 259 Q. It was the reverse. In what sense?

27 A. Well, the cases that were reported by the independent
28 sector or outsourcing companies, they would come up,
29 they would still come to the Urology MDT but,

1 unfortunately, they are associated with a higher
2 discrepancy rate. It would take me longer to review
3 those cases rather than me having reported them in the
4 first -- I mean, I had to review the whole case. There
5 could be anything on them, right, wrong or miss, false 14:37
6 positive, false negative, anything. So, it took me a
7 lot longer when that was happening.

8
9 I don't think the urologists trusted the reports
10 either. So, I think there were issues with the reports 14:37
11 that were done outside of the hospital.

12 260 Q. Yes. The question, if I can go back to the question I
13 asked, which was do you think it was the intention of
14 the Trust in asking the independent sector to become
15 involved, was that with a view to trying to free up 14:38
16 your time, and the time of others perhaps, to address
17 this demand issue, even if the consequence was, as
18 you've described, leaving you to deal with poor quality
19 reporting and costing you more time in the long run?
20 The question is focused on what was the intention in 14:38
21 going to the independent sector.

22 A. I'm not sure why they did that. I think it certainly
23 wouldn't have any impact on the Urology MDT. The two
24 are completely independent. Obviously, if you send
25 work out, then it gets rid of your backlog. That's the 14:38
26 only reason really you would send it out.

27
28 I think the problem was that whilst work was being sent
29 out, what the Trust did at that time was they stopped

1 the waiting lists in combination with the outsourcing
2 of the urology work. There was actually no problem
3 really in us reporting it, because we did it as sort of
4 extra work. So, when I couldn't do -- when the
5 (inaudible) became too much, we took it on as the extra 14:39
6 work and reported it to the same high standard that I
7 would have done however or, you know, on whatever basis
8 I reported it at. When it was outsourced, I think the
9 additional work we were able to do was then stopped, so
10 it was kind of an alternative to that. 14:39

11
12 I don't think there's any doubt that, you know, the
13 outsourcing of work helps clear the backlog of work.
14 There's no doubt about that. It just depends on what
15 quality of work you want. 14:39

16 261 Q. We can see WIT-89905. This is 22nd November 2017 and
17 you're writing to David Gracey again. You're referring
18 to an email below with your comments contained in red.
19 I don't think we need to go down to the detail of that
20 for present purpose. But what you're saying, in a 14:40
21 nutshell, is that:

22
23 "We should be in no doubt that the outsourcing of these
24 examinations has caused significant quality issues and
25 prevents the further improvement of our service to the 14:40
26 best it can be. We are already ahead of any Trust in
27 Northern Ireland and we could have done better. I have
28 worked hard to get us to this position and I can do
29 nothing more now. Ask any urologist if they are happy

1 with the service. Managers need to rethink what is
 2 happening here. The Trust could always try and
 3 recruit."

4
 5 So, a number of issues are brought together there. 14:41
 6 You're unhappy with the quality of the reporting on the
 7 part of the independent sector provider, it's something
 8 that could be done better in-house, and things would be
 9 much assisted with the recruitment of an additional
 10 urologist. Is that the thrust of your response? 14:41

11 A. I think the way I recall is that since I came to the
 12 Southern Trust, you know, we have spent a lot of time
 13 trying to get the prostate MR service the best it could
 14 be, you know, with the assistance of the urologists; to
 15 try and make the service the best it could be for 14:41
 16 patients. Which, you know, the way that things were a
 17 changing from kind of Trust first, then MRIs later, to
 18 pre-biopsy MRI is what we'd achieved, and we were
 19 trying to move further ahead of that by progressing
 20 with fusion techniques to try and locate tumours and 14:42
 21 doing reduced numbers of biopsies in targeting tumours,
 22 and all of that fell apart as a result of the
 23 outsource, basically. That's the way I kind of saw it.

24 262 Q. Yes.

25 A. You know, I felt quite frustrated that all the work had 14:42
 26 been put in, to sort of lose that quality.

27 263 Q. If we go to WIT-89464. If we just scroll down to 17.4,
 28 please. Or 17.8. Thank you. Dr. Gracey, addressing
 29 this, says:

1 "The independent sector provider withdrew their
 2 services following criticism of some of the reports by
 3 Dr. Williams with the subsequent impact on report
 4 turnaround times."

14:43

6 First of all, did the independent sector withdraw as a
 7 result of criticism directed by you or suggested by
 8 you?

9 A. You see, I wasn't aware of that actually until I read
 10 the bundle.

14:43

11 264 Q. Yes.

12 A. I've no doubt that I was, you know, critical of their
 13 reporting because there were errors, and we feed back,
 14 and, you know, I've fed back the errors. Some of the
 15 errors I regarded as, you know, fairly basic. You
 16 know, they're not just a matter of because radiology is
 17 an opinion. It's not just a matter of opinion, it's
 18 basic fundamental mistakes. I think they obviously
 19 weren't -- they didn't want to be criticised.

14:43

20 265 Q. You've reflected in your statement - I needn't bring it
 21 up on the screen but it's WIT-60286 - that you received
 22 support from urologists in relation to your expressions
 23 of concern around the standard of the independent
 24 sector work.

14:44

25 A. Yes, I think that's true. My memory is not very clear
 26 on that but I do remember some of the urologists not
 27 being too happy about the reports, yes.

14:44

28 266 Q. Now, if we go back to your statement, please, at
 29 WIT-60286, at 17.1. Scroll up a little so that I can

1 get the full question.

2
3 "Do you feel you are able to provide the requisite
4 services to support Urology Service which your role
5 required? If not, why not? Did you ever bring this to 14:45
6 the attention of management?"
7

8 You've said:
9

10 "I felt and do feel able to support urological service 14:45
11 in my role as a radiologist. I did not raise any
12 issues in this regard."
13

14 The expression of satisfaction in terms of your ability
15 to provide radiological services to urology, does that 14:45
16 not rather fly in the face of what we have just worked
17 through in terms of --

18 A. Yeah.

19 267 Q. -- your ability to contribute, for example, to MDT?

20 A. In some ways, but I still think I'm able to do my job. 14:45

21 268 Q. Yes.

22 A. And I think that statement is correct.

23 269 Q. Yes.

24 A. Yeah, I stick with it.

25 270 Q. Yes. Let me ask why you stick with it. Have you 14:46
26 interpreted that question as a question directed to you
27 personally, in the sense of to the extent that you had
28 control over matters, you felt able to support Urology
29 Service, but you're not seeking to deny, with that

1 answer, that there were a raft of pressures and
2 problems out with your control?

3 A. Yes, I think that's exactly right. I interpret that as
4 it was asking me if I felt to support the service? I do
5 feel fully able to do my job. If other things are 14:46
6 happening around me that I have no control over, that's
7 something entirely different.

8 271 Q. Now, just briefly on the consequences of these
9 radiology pressures and inability on what were regular
10 occasions to attend the MDT. If we scroll just four 14:47
11 pages down to 26.1, please. Thank you. Here, you're
12 asked did you have any concerns arising from any of the
13 issues set out, and some of the issues you've set out
14 were around quoracy. You say:

15 14:47
16 "I didn't have any concerns in regard to any of the
17 issues set out and I have not raised any. To clarify,
18 the issue in regards radiological attendance at the
19 Urology MDT was not a concern I personally held, but
20 one I simply had noted. This was an issue for the MDT 14:48
21 Chairman and the Trust. The lack of radiology cover by
22 a radiologist with the subspecialist interest in
23 uroradiology at the MDT was an issue in some individual
24 cases, as radiology reports made by non-specialist
25 radiologists were not reviewed by the radiologist at 14:48
26 the MDT with an interest in uroradiology, and in some
27 instances resulted in inappropriate outcomes. For
28 example, the follow-up of abnormalities that did not
29 require any" - and here you refer to an incidental

1 testicular lesion for which follow-up was suggested and
2 none was required, and a patient given a nephrectomy
3 for a benign lesion.

4
5 "In regard to the latter, the case was rediscussed at 14:49
6 the Urology MDT with histology, where I reviewed the
7 kidney lesion for which the nephrectomy was performed
8 and I considered it unlikely to be malignant."

9
10 To pick up with issues arising from that paragraph. 14:49
11 where you say you didn't have a personal concern about
12 the quoracy issue, can you explain what you meant by
13 that?

14 A. Yeah, I think I probably haven't phrased that in the
15 right way necessarily, it appears rather blunt. What I 14:49
16 mean is it kind of -- I mean it wasn't sort of my
17 responsibility to solve the problem. Obviously it was
18 a concern that, you know, I was the sole person and the
19 Trust could do better than it was doing. I mean that I
20 had raised the issue and it wasn't my issue, it wasn't 14:49
21 my problem to sort, it was someone else's problem.

22 272 Q. Yes.

23 A. In fact, there was nothing I could actually do to solve
24 it anyway.

25 273 Q. We can see that you brought issues to the table and 14:50
26 raised concerns. From your perspective, you weren't
27 able to achieve change around that?

28 A. It wasn't within -- I had no ability to make any
29 change. You know, I actually didn't really need to do

1 anything anyway. The lack of another radiologist was
2 well known without me having to comment on it.

3 274 Q. Your answer there suggests that, I think you said in an
4 earlier answer, maybe four or five occasions when
5 general radiologists would have attended if you weren't 14:50
6 available. You point there to a number of examples,
7 two examples, of misdiagnosis or inappropriate outcomes
8 arising from their consideration of cases when, is it
9 fair to say, they weren't sufficiently expert to give
10 the opinion? 14:51

11 A. Yes, I think that's true. I mean, I do recall both of
12 those cases actually. You know, these are infrequent
13 but they're just an example of why, if you have a
14 specialist MDT, you need a specialist radiologist at
15 that MDT. I fully appreciate, you know, my colleagues' 14:51
16 attempts to cover the MDT and why they would do it for
17 the service but it's not always helpful. I think just
18 having the knowledge and the expertise and breadth of
19 the cases, you know, helps you make decision-making.

20
21 In regard to the nephrectomy, I think it was again
22 probably because there was a review of imaging without
23 a radiologist present, and I think maybe the report was
24 maybe sort of taken as fact. But, you know, again
25 opinions vary. 14:52

26 275 Q. well, is it your firm view upon consideration of this
27 in the presence of pathology that a nephrectomy was
28 unnecessary?

29 A. well, I mean, that would be a very easy assumption to

1 make if you had the pathology. But no, I saw the
2 imaging first and thought I don't think this is going
3 to be malignant.

4 276 Q. Yes.

5 A. But, you know, again I'm not the definitive opinion. 14:52
6 Other radiologists may hold a different view.

7 277 Q. But I suppose in an appropriately resourced MDT, you
8 would have two radiologists present, hopefully both
9 with some expertise in uro-radiology or some interest in
10 uro-radiology, and that would be talked through and the 14:52
11 right answer arrived at, whereas what you're pointing
12 to here was a situation where a general radiologist was
13 present, no doubt doing their best to assist to
14 progress the case in these resource-challenged
15 circumstances, but the right answer not being arrived 14:53
16 at?

17 A. Well, I mean, I don't think there was any radiologist
18 there for the nephrectomy case. I think, you know, the
19 answer is, I mean, the gold standard would be having
20 two to three radiologists at every MDT, with each one 14:53
21 having prepped all the cases and come to an opinion on
22 each one and then those cases discussed. But I'm not
23 aware of anywhere that that happens.

24 278 Q. Hmm.

25 A. I don't know if any radiology department could manage 14:53
26 that.

27 279 Q. If you could help the Inquiry with this: Is that
28 situation, or both those situations but maybe focusing
29 on the major surgical intervention that a nephrectomy

1 involves, is that kind of thing very uncommon where a
2 urologist is present at the MDT, that kind of
3 mistake?

4 A. I don't think these cases would be common. They
5 wouldn't be a common occurrence. I mean, we review a 14:54
6 lot of cystic lesions in MDTs and we suggest whether we
7 should continue with follow-up or whether something
8 more needs to be thought about. I think we hardly ever
9 would see patients with nephrectomy for a benign
10 lesion; it does happen. The most common example would 14:54
11 be on a cytoma, for example. I think that would be
12 acceptable. But I don't think I ever see cysts that
13 are benign; hardly ever see that.

14 280 Q. Yes. A case or cases like this - and you can only
15 think of two examples where a general radiologist may 14:55
16 have expressed a view on it - would they have gone, the
17 latter, into the governance system to be queried and
18 questioned whether an incident report or leading to an
19 SAI, or how would issues like that have been handled?
20 Because they are reflective, are they not, of an MDT 14:55
21 and of a process that's not well-resourced leading to
22 harm to patients?

23 A. Yes. I mean, I think if there was -- yeah, if there
24 was a radiological discrepancy that resulted in harm,
25 then there would be an incident report. We do fill in 14:56
26 Datix for the odd occasions that something happens like
27 that.

28
29 For a surgical one, I would never do that one myself,

1 I'd leave that to the urologist if they wanted to
2 complete an incident form, an incident report for that.

3 281 Q. Can you remember, in relation to this specific case,
4 whether there was any response or challenge to what had
5 happened? 14:56

6 A. No, I'm not sure. I don't know.

7 282 Q. Another consequence, I suppose, of an underresourced
8 radiological input into MDT is delay, a delay in
9 considering cases. I think we've seen in the peer
10 review -- if we can bring up TRU-84685. If we just 14:57
11 scroll down. The penultimate paragraph, please. It
12 records that:

13

14 "The quorate issues mean that a large proportion of
15 patients are not benefiting from the knowledge and 14:57
16 expertise of a full multidisciplinary team when
17 decisions are being made about their diagnosis and
18 care. As a result, this could lead to delays in the
19 decision-making process and treatment."

20 14:58

21 The operational policy of the MDT was that if a case on
22 the agenda for the meeting definitively does not
23 require the input of the absence member, then every
24 effort should be made to discuss the case; isn't that
25 right? 14:58

26 A. Yes, I think that's right.

27 283 Q. Otherwise, the discussion will be deferred. If we look
28 at the case I mentioned in passing earlier, WIT-89947.
29 Just scroll down a little, please. Sharon Glenny,

1 writing to David Gracey in respect of a patient we call
2 113. The name isn't important, it's the fact that her
3 discussion, or the discussion of her case at MDM has
4 been deferred on three occasions due to requirement for
5 radiology opinion, and Sharon Glenny, who is the Cancer 14:59
6 Services Manager, is asking for any suggestions.

7
8 First of all, would that be, in your experience, not
9 untypical of a number of cases, that they have to be
10 deferred over several meetings before radiological 15:00
11 input is available?

12 A. I'm not sure that there were many occasions where
13 someone would have to be deferred three times. That's
14 probably unusual. It would usually be a week at most,
15 maybe two at most. You know, three would be quite 15:00
16 unusual.

17 284 Q. Yes. If we just scroll up to see David Gracey's
18 response. He is saying: "Discuss with radiology
19 outside of the meeting."

20 15:01
21 I was asking you earlier about a workaround if you
22 weren't available for the MDM. Is that what he's
23 hinting at here, that you could be contacted outside of
24 the meeting to give an opinion?

25 A. It's difficult to know whether he's suggesting me 15:01
26 specifically or any radiologist; I can't really tell.
27 But the urologists knew that they could ask me any time
28 for...
29

(LOSS OF AUDIO AND VISUAL FEED)

CHAIR: Hopefully we'll not have any more technological problems. Today is Tuesday, so I suppose we shouldn't be surprised.

15:24

285 Q. MR. WOLFE KC: Just before we come to what the reviewers in the context of the SAI said about what was needed around quorum issues, could you bring together what you've said in evidence so far, doctor, and give us your observations overall on the impact of the quoracy issue within radiology and the MDT on yourself, for the service you worked in, and for patients? What were the real impacts of that over several years?

15:24

A. I suppose it's probably mainly the issues were just patient delays. But I mean, they're probably, you know, in a week, or the days of a week in discussion, because there won't have been that many instances where I was absence, for example, or there was no radiologist for multiple consecutive weeks, although it did happen on occasion. You know, whether those cases did have any particular impact, I can't imagine they really had much of an impact on the patient with a delay of a week more than a psychological, the anxiety of having to wait, which is never a -- you know, that's quite unpleasant, I suppose.

15:24

15:25

15:25

The impact on the outcome is probably okay for, you know, a week or so. It's not going to make any difference in the outcome.

- 1 286 Q. Yes.
- 2 A. The other things - we've kind of hinted at them
- 3 already - are decision-making. If decisions are made
- 4 about cases which are primarily based on imaging, then
- 5 there's a potential for error if there's no radiologist 15:25
- 6 to provide a second opinion on those cases. I think
- 7 they're the main issues.
- 8 287 Q. Yes. The SAI reviewers picked up on this issue of
- 9 imaging and whether there were implications for the
- 10 quality of the process, given the absence of a second 15:26
- 11 urologist. If we could have up on the screen,
- 12 please, TRU-163316. Just if we go to the second
- 13 bullet, please. After setting out the quorate rates
- 14 for the years 2017/'18/'19 and '20, they say of
- 15 radiology that: 15:26
- 16
- 17 "Radiology had only one urology cancer specialist
- 18 radiologist, impacting on attendance, but critically
- 19 meaning there was no independent quality assurance of
- 20 images by a second radiologist prior to MDM." 15:27
- 21
- 22 Have you noted that observation prior to today?
- 23 A. I have. I mean, I think I probably touched on that
- 24 earlier. It's an interesting thing that because, I
- 25 mean, that would suggest that a second radiologist 15:27
- 26 reviews the images prior to the MDT as well, because I
- 27 don't really think you can give a proper opinion based
- 28 on what's presented at an MDT by one radiologist who
- 29 has reviewed the images, because they're just going to

1 show you selected images. It hasn't enabled you to
2 review the whole case, as you would need to if you
3 wanted to give a proper opinion on a case. That would
4 mean that two radiologists would need to be present at
5 every MDT and need to have prepared -- each radiologist 15:28
6 would have to prepare the whole meeting, and I don't
7 know whether any hospital does that.

8
9 My impression is that usually if there's more than one
10 radiologist attending an MDT, which is mostly the case, 15:28
11 then they're usually on a sort of rota system where one
12 radiologist could prepare the meeting and do the
13 meeting and another may just attend to give. Usually
14 they don't say a lot, that's my experience, you know,
15 of someone who hasn't prepared the meeting attending. 15:28
16 You often say nothing at all for the whole meeting,
17 sometimes a little bit; depending on their seniority
18 versus the presenter.

19 288 Q. Yes.

20 A. If the second radiologist is more junior than the 15:28
21 presenting radiologist, who's more senior, the junior
22 may not say anything at all. So, I do think that, as I
23 said, the gold standard would be for both radiologists
24 to prepare the whole meeting and, if there is any
25 disagreement, to discuss. There should be, you know, 15:29
26 two people agreeing that the images show this and, you
27 know, maybe this is what should happen. But as I said,
28 I'm not sure that any hospital actually does this.

29 289 Q. Yes. Let me go to the more specific recommendation and

1 perhaps the more general recommendation. It's to be
2 found at TRU-163322. We'll look at this and then I'll
3 ask you about the current situation as it applies on
4 the ground in the Southern Trust now that you have a
5 second radiologist with an interest in uro.

15:29

6
7 Recommendation 3. It says:

8
9 "The Trust must promote and encourage a culture" --
10 sorry, recommendation 4, I beg your pardon. Yes.

15:29

11
12 "The Trust must ensure that patients are discussed
13 appropriately at MDM and by the appropriate
14 professionals. This will be achieved by all MDMs being
15 quorate with professionals having appropriate time in
16 job plans. This is not solely related to first
17 diagnosis and treatment targets. Real discussion of
18 patients as disease progresses is essential to
19 facilitate best multidisciplinary decisions and onward
20 referral."

15:30

21
22 The assurance that is sought is that you have quorate
23 meetings, sufficient radiology input to facilitate free
24 MDM, quality assurance of images, answer patient
25 pathway audit, and audit of recurrent MDM discussion
26 and of onward referral.

15:30

27
28 Now, can we try to unpack some of that in the context
29 of what currently happens in the Southern Trust? You

1 can't remember the date of appointment but you now have
 2 a colleague who has an interest or specialised interest
 3 in, amongst other things, urology?

4 A. Yes.

5 290 Q. You, however, are the lead to the MDT and he is your 15:31
 6 substitute, is that right, if you can't attend, or does
 7 he attend with you?

8 A. No, if we both -- we both would attend. I think what
 9 happens from week to week is very variable. So,
 10 usually I tend to find that my two sessions - the prep 15:31
 11 time and the Urology MDT time - is kind of safeguarded
 12 so that I always get it, so that I can prepare and do
 13 the meeting. If he's there, then he's always scheduled
 14 to attend but he may not have any prep time, in which
 15 case I do the whole prep, I do the whole meeting. 15:32

16
 17 Sometimes he's given prep time, in which case we
 18 usually would split some variation of the meeting,
 19 equally or either I do a bit more and he does a bit
 20 less; something like that. We're never really in a 15:32
 21 position where we can both prepare the whole meeting.
 22 I tend to find that when I'm preparing the whole
 23 meeting myself, I go well over my allocated time, or
 24 it's a big rush to try to get it done within the time
 25 that I'm given. You know, I think that's kind of what 15:32
 26 tends to happen.

27 291 Q. Yes. In terms of quoracy, are the meetings of the
 28 Urology MDT, from a radiological perspective or from a
 29 radiological input, are they now more often quorate

1 than not?

2 A. Yes. Yes, they're usually quorate now. It's quite
3 unusual for us both to be away, for example.

4 292 Q. Yes. Stepping back into the prep time, we have heard 15:33
5 in your evidence this afternoon that you sometimes lost
6 prep time because of a requirement for you to come and
7 do clinical work where there was nobody else available.
8 Is that prep time now much more regularly protected, if
9 not sacrosanct?

10 A. Yes, I think it is, yeah. I very rarely would ever 15:33
11 lose that time now.

12 293 Q. Yes.

13 A. Although I have made changes to my job plan so that if,
14 for example, it usually would be the case I'm on leave
15 on a Wednesday afternoon, I would prepare the meeting 15:34
16 on a Thursday instead. So, there are some other sort
17 of safeguards that I can use if need be.

18 294 Q. If you just glance at the screen, under the heading of
19 "Assurance" just before recommendation 5, it's back to
20 that what you described as perhaps a gold standard, 15:34
21 where it says here that there should be sufficient
22 radiology input to facilitate pre-MDM quality assurance
23 of images.

24

25 Is that available or is it potentially available 15:34
26 through your colleague to you if it was required? For
27 example, a particularly tricky case, imaging maybe not
28 entirely clear, or whatever the problem might be; does
29 that quality assurance option become available to you

- 1 because there's now two, even if you don't need to use
2 it in every case?
- 3 A. Oh, yes. There would be no issue with that. If we
4 wanted to ask a colleague a question or, in terms of
5 the urology, the two of us wanted to go through a case 15:35
6 together, that would be, fine, you know, that's easily
7 done.
- 8 295 Q. The other issue raised here is in terms of you being
9 available or your colleague being available for
10 radiological input beyond first diagnosis, so if 15:35
11 there's a need for re-discussion of a patient as
12 disease progresses, for example. Again, is that
13 something that you are available to contribute to?
- 14 A. Oh, yes. These patients just are put back onto the MDT
15 so they're dealt with just in the same way. 15:35
- 16 296 Q. By contrast with how things were for howsoever many
17 years - and we're going to have that checked - but
18 let's say for the five or six years when you were
19 single-handed, how would you characterise the
20 improvements in terms of the capacity for radiological 15:36
21 input to the MDT at Southern Trust?
- 22 A. I think things have significantly improved. I'm sure
23 there is, you know, always more improvement possible.
- 24 297 Q. Where do you think there are some difficulties that are
25 yet to be resolved? 15:36
- 26 A. Well, I think -- I actually think that the MDT's
27 probably a three-person, three-radiologist job, I
28 think, to ensure 100% quoracy. I still am a bit
29 quizzical about even the recommendation there, does it

- 1 mean that you should have two radiologists prepping the
2 whole meeting? I still think that's the way to provide
3 a really good service.
- 4 298 Q. But it's not currently available to you with existing
5 resources? 15:37
- 6 A. No, and I don't know whether it would be. I mean, it
7 would need more time in job plans, particularly for my
8 colleague more than me, because I have time to -- well,
9 roughly time to prepare the meeting.
- 10 299 Q. Now, I prefaced your evidence this afternoon by 15:37
11 reflecting the fact that you work within a different
12 and a wholly separate division to urology. Urology
13 sits within Acute, you sit within?
- 14 A. Cancer and Clinical Services, yes.
- 15 300 Q. Yes. You've made it clear, in answer to a long list of 15:38
16 questions, for example at 27, question 27.1, that you
17 do not and nor have you had any concerns with regard to
18 the practice of any practitioner in urology. Is that
19 still your position?
- 20 A. Yes. 15:38
- 21 301 Q. We can see from some of the emails that you would have
22 had particular dealings with Mr. O'Brien. For example,
23 he intervened on the issue of your prep time for MDT.
24 He was obviously the Chair of the MDT for a number of
25 years and then it became a rotational post or task. 15:39
26 Had you close dealings with Mr. O'Brien?
- 27 A. I'm not sure I would say close but we certainly would
28 talk about, you know, have normal conversations in
29 addition to the work conversations. Friendly, you

1 know, relationship as work colleagues, you know, in
2 different specialties.

3 302 Q. In terms of his input into the MDT, how would you
4 describe it?

5 A. I mean, I think he seemed to be doing a good job and 15:39
6 trying to improve the MDT. From what I've read -
7 because I wouldn't probably, sort of in normal work, go
8 through the MDT annual reports, I probably wouldn't
9 have time. Having a look here, there seems to have
10 been a lot of work he's done to help improve the MDT. 15:40
11 I think my impression of him as Chairman was that he
12 was trying to make improvements, make things better.

13 303 Q. It's a different question to whether or not you had any
14 concerns about any practitioner in urology; that's the
15 question we've asked you in your Section 21. Apart 15:40
16 from the quorum issue, did you have any concerns about
17 the quality and standards of the operation of the MDT
18 during your time on it from its inception until now?

19 A. I think it was more -- my issues really were more sort
20 of organisational things rather than the quality of the 15:40
21 service provided. More to do with questions about
22 whether, for example, radiologists needed to attend the
23 whole meeting. The detail of information provided in
24 clinical summaries was often immense. More those sort
25 of things rather than the actual quality of care that 15:41
26 was being given, which I thought was excellent.

27 304 Q. For example, the two examples you've given, having to
28 stay the entirety of the meeting and the denseness of
29 the clinical information provided to you, that, staying

1 the whole meeting, reading all that material, obviously
2 impacted on time required from you when perhaps you had
3 other competing duties to perform?

4 A. well, maybe I also didn't mention the fact that it's
5 not always clear for each patient what's to be
6 discussed, so I prepare every patient and sometimes it
7 can take 20 minutes to look through a case, sometimes
8 longer, and then the radiology is not needed. I think
9 that's still the case, it's not always clear what needs
10 to be -- who needs to do what for each case.

15:42

15:42

11
12 In terms of, you know, if a radiological opinion is not
13 needed for a case that needs just clinical discussion,
14 and as the Trust is under pressure, why have a
15 radiologist sit doing nothing? why not give them
16 something else to do and try to cluster the cases that
17 need radiological opinion elsewhere? I mean, I admit
18 there is always a chance that a case could need a
19 radiology opinion even though it may not be a reason
20 for discussion, so there is that chance.

15:42

15:42

21 305 Q. The Serious Adverse Incident Review across the nine
22 cases that you have looked at raised a number of
23 concerns, and some of the criticisms were that there
24 was no mechanism to check whether the actions
25 recommended by the meeting were implemented; the MDM
26 was underresourced for full pathway tracking; there was
27 a focus on delivery of the access targets such as the
28 31/62-day targets, and limited capacity to benchmark
29 quality to cite just some of the concerns that were

15:43

expressed. Those kinds of matters, did they ever come across your desk? Did you appreciate those were issues in realtime or did those issues only emerge for you when you read the report?

A. Yeah, just from reading the report. I think those are clinical. I would have no knowledge of that at all. 15:44

306 Q. Is that because of your particular role, which was distinct and limited to radiological input?

A. I mean, my input at MDT is quite limited. It's really about the radiology and suggestions about imaging, and sometimes a little suggestion on management but that's primarily the urologists. All of that follow-up of outcomes is really well out of, you know, my area. It's nothing I would have really had anything to do with. 15:44

307 Q. Yes. The SAI made some recommendations about how things could be done better. I suppose if you didn't appreciate that things weren't entirely optimal, then you perhaps didn't appreciate the need for improvements but I'll ask the question anyway. Have you noticed any change in the MDM environment since these issues emerged in 2020/'21? Have you noticed things being done differently? For example, is the team -- is the membership of the meeting better supported in any way, is it better organised, is the discussion any different? 15:45

A. A lot of it's similar but there seems to be more emphasis on particularly making sure the patient has a key worker. That's one thing, or a nurse who's kind of

1 looking after that patient. That's something that I
2 have noticed, there's been more emphasis on that.
3 Maybe some other things but I can't really put my
4 finger on them particularly. But there just seems to
5 be maybe more structure and...

15:46

6 308 Q. Yes. The Trust have carved out a new role for the
7 person on the management side, if you like, who
8 attends. So it's now an Angela Muldrew who is the MDT
9 coordinator. It is said of her that her time, she's
10 now better enabled to give more focus and more support
11 to the needs of the MDT. Is that something you've
12 observed from your role or do you think that's more
13 recognisable in the hands of a urologist?

15:46

14 A. Yes. I think the urologists would know more.

15 309 Q. One of the cases that the SAI review looked at was the
16 case of Service User C. I want to just have your views
17 on this issue generally. The issue which emerges from
18 the case of Service User C is the question of how
19 clinicians respond to the reports that emerge from your
20 department. In other words, the clinician, the
21 urologist, refers a case to you or one of your
22 colleagues for CT scan and you report and send it back.
23 So, I want to explore that with you briefly.

15:46

15:47

24
25 If we look at TRU-163308 and at the bottom of the page,
26 please, which is the case of Service User C. You can
27 observe his history. The case comes in in December
28 2018 via the Emergency Department, seen by Mr. O'Brien,
29 investigations arranged, and ultimately he's managed

15:47

1 through.

2
3 Just going over the page to where we really want to be.
4 In late 2019, Mr. O'Brien arranged for a repeat CT scan
5 to be performed, and this took place on 17th December 15:49
6 and there was a plan to review the patient in January
7 2020. The review didn't happen. The CT scan report
8 was available on 11th January 2020 and it showed a
9 possible sclerotic metastases in a vertebral body which
10 had not been present on the previous scan, but the 15:49
11 report was not actioned until July 2020. Mr. O'Brien,
12 when asked about this, has said at AOB-82733 that while
13 he doesn't have a record of the date, he believes that
14 it was either in late February 2020 or early March 2020
15 when he reviewed the report of the CT scan and its 15:50
16 recommendation that there should be a radioisotope bone
17 scan.

18
19 To summarise, report from the CT scan coming out of
20 your department available as of 11th January but, on 15:50
21 Mr. O'Brien's best recollection, not looking at the
22 report until either late February or March.

23
24 Now, I don't wish to have your views on the specific
25 case but, having that background in mind, could you 15:51
26 talk us through the procedure that happens when a CT
27 scan report is prepared by yourself or one of your
28 colleagues and it reveals a concern about the
29 possibility of a drug or disease?

1 A. Yes. I think there's been sort of -- there's quite a
2 lot of flux about this at the moment, so what we may do
3 now may not necessarily have been what would have
4 happened in 2020. So, like, I'll try and outline that
5 for you.

15:51

6
7 If we report a scan and then once we've reported it and
8 are happy with the report, we verify the report. Once
9 that's done, it's finalised and it's available on the
10 electronic care record, and the referrer will get a
11 notification that they have reports to look at.

15:52

12 310 Q. Is that an electronic notification?

13 A. Yes. I mean, I don't think -- there's not an alert or
14 anything that comes up. I think it just shows in a bar
15 maybe that there's, you know, a number will show or
16 something appears in red. There's not a box that comes
17 up when you log in, I don't think. You have to check,
18 you know, that there are reports there. It notifies
19 you of the reports and you check them.

15:52

20
21 I think what you're maybe getting at is informing
22 refers back unexpected findings. I mean, it's always
23 been an option through PACS, to make an alert on PACS
24 with an urgent -- you basically highlight an urgent
25 finding, and then the secretaries or admin staff will
26 pick that up and I think they e-mail the referrer.
27 There's a protocol that they should probably refer to
28 but they e-mail the referrer to tell them that there's
29 an urgent finding. So, that kind of works for things

15:53

1 that are not critical. So, you know, things that are
2 not going to make the patient deteriorate immediately;
3 that would require a telephone call. So, that's done
4 for the urgent ones.

5
6 Then I suppose it's up to the radiologist what they
7 feel is a significant unexpected finding. We all, I
8 suppose, have different thresholds for using the
9 system. I suppose we do make some assumption that the
10 reports are going to be read. Ultimately in 2020, I
11 think the opinion would be that it is the referrer's
12 responsibility to read their reports. So, actually,
13 you shouldn't really have to flag urgent or, you know,
14 significant or urgent findings other than those which
15 were life and death sort of critical ones.

16 311 Q. Is there a standard or an assumption, even if it's not
17 written down, that clinicians who have referred the
18 patient in for a CT scan will read the product of that
19 scan in the form of a report within a period of time,
20 or is it really at the discretion of the clinician,
21 having regard perhaps to factors such as his own
22 availability, risk to the patient, comorbidities or
23 what have you?

24 A. Obviously I can't speak for other colleges but the
25 Royal College of Radiologists has had certain
26 recommendations, but it really, I think, would only
27 comment - this is in and around 2020 - that it would be
28 the referrer's responsibility to check their reports.
29 It doesn't specify under what timeframe. I think we

1 would kind of hope, kind of give a discretion to the
2 consultants that they would do that and not need to be
3 told when and how to do that work.

4 312 Q. These reports that come from CT scans, are they
5 difficult to read in terms of finding the key message? 15:55

6 A. So they're going to be very variable because obviously
7 we all work in a slightly different way. However
8 difficult they are, usually -- I mean, okay, sorry,
9 I'll start again. Some people have very concise
10 reports, some people's are like an encyclopedia, so 15:55
11 it's very variable. But there always should be some
12 conclusion to look at which will give you the main
13 salient findings. Even if you don't read the whole
14 report, you should be able to pick out whether there's
15 anything important. Most scan reports are somewhere in 15:56
16 between those two, from very short to very long. It
17 shouldn't take more than a minute or two to read a CT
18 report, in full actually.

19 313 Q. Have you heard of a practice whereby clinicians won't
20 read the report until they have a review of the patient 15:56
21 set up or established, an appointment fixed, and at
22 that point now's the time to read the report, but until
23 that review appointment happens, I'm not going to read
24 the report or there's less need to read the report?

25 A. Yes. I mean, that's what we used to do when I was a 15:56
26 houseman. We would have the patient back in clinic and
27 the report would be in the notes. We didn't make any
28 effort to read the report before then. I think things
29 have moved on. You know, you have electronic reports

1 now that you can check, and you should do that before
2 you see a patient in clinic because you don't know when
3 you are going to see that patient.

4 314 Q. Yes.

5 A. In the past I think if we asked to see a patient with a 15:57
6 CT report, that often did happen. You know, you would
7 see them almost within a few days, it was quite
8 organised. But now I don't think you can; you can't
9 rely on really anything happening.

10 315 Q. You were outlining some of the steps that are now 15:57
11 available to you that mightn't have been available in
12 2020. I think you were probably drawing from a
13 particular protocol which came in effect from April
14 2021. If I could just bring that up on the screen,
15 please. You could maybe help us with some of the keys 15:58
16 aspects of how things are now done, if this protocol
17 remains the appropriate base for that. WIT-60281.
18 Sorry, let's not go there, that's where you mention it
19 in your statement. If we go to the protocol itself,
20 it's at TRU-103348. Is this what you had in mind when 15:58
21 you were...

22 A. Well, yeah, sort of. I mean, this is a protocol, but
23 it was kind of similar to what we may have been doing
24 before that. I was more referring to more recent
25 changes which are going to be more dramatic. 15:58

26 316 Q. Okay.

27 A. But they're more in process; it's only very recent.

28 317 Q. Yes. Well, this protocol speaks about categorisations
29 of cases that emerge after radiological investigation.

1 If we just go down to the next page, please - 49 in the
2 series - it discusses critical findings, urgent
3 findings and significant unexpected findings. Are you
4 working to that kind of categorisation?

5 A. Yes. I mean, we don't -- even though there is a sort 15:59
6 of split, there's only one option for us to use within
7 PACS, which is to kind of put an urgent report,
8 communicate an urgent report. Whatever is the urgency,
9 it's just one category. The critical findings, you
10 would have to deal with those yourself. 16:00

11 318 Q. Yes. I suppose what I'm focusing on here is is there
12 now a way of specifically drawing a clinician's
13 attention or a cancer tracker's attention to an
14 unexpected finding that wasn't in place in 2020?

15 A. No, I don't think so. I think this sort of pathway 16:00
16 protocol, it's just going to outline things that were
17 already in place in 2020. So, in 2020 you could still
18 flag reports for urgent communication and you could
19 flag reports for the cancer tracker. I think they've
20 become a bit more robust. Sometimes the secretaries 16:00
21 maybe didn't check the lists as often as they should
22 do, and now it's much more, as I say, much more robust
23 than it used to be. But the sort of process is still
24 much the same.

25 319 Q. If the imaging showed the possibility of a sclerotic 16:01
26 metastatic disease or some finding that wasn't
27 available on a previous scan, is that something that
28 would or should be highlighted over and above the
29 description of the finding?

- 1 A. Yes. I mean, I think most of us now would probably
2 highlight it. Being honest, I think most of us now
3 would probably highlight it. In the past, I think
4 there'd be a mixture, probably. Because I think, you
5 know, in the past, as I said, there's more of an 16:01
6 assumption that the referrer's going to read the
7 report. But I think now we're beginning to change our
8 practices a bit and assume that they are not
9 necessarily going to do that, so we need to kind of do
10 our bit to identify things that maybe do need action, 16:02
11 as a safety.
- 12 320 Q. You said that there's a recognition of the need for
13 radiologists to do your bit, to do more than simply
14 provide a description. Does that suggest that within
15 the Trust, or perhaps more generally, within health 16:02
16 care provision more generally, there is a problem with
17 clinicians failing to read the output from such
18 investigations in a timely fashion?
- 19 A. I think that may be the case, but I think also you have
20 to consider that clinicians can be on leave as well. 16:02
21 They can be off for a fortnight and there can be things
22 that need to be dealt with. Having mechanisms to deal
23 with that is, you know, it's important. I mean, I
24 certainly don't think the system that we have in place
25 is adequate in any way at the moment; e-mailing someone 16:03
26 who could potentially not check their emails every week
27 or who may be on week is not going to be adequate.
- 28 321 Q. Is there anything within the current system that allows
29 you, the radiologist, or the tracker or any other

1 responsible person to know that the clinician hasn't
2 yet actioned the report?

3 A. Yes. So, this is what I mean by more recent changes.
4 These are things that are being worked on. As we
5 currently are, there is no way of knowing what's
6 happened. 16:03

7 322 Q. So, there is a mechanism by which you can check to see
8 administratively whether your report has gone out, you
9 do the dictation and it's checked. Then does an
10 administrator, a clerical person, issue that for you? 16:04

11 A. No. So, if the report goes automatically
12 electronically, it just goes out, straight onto
13 automatic, straight onto the electronic care record.
14 There is a paper report sent as well at some point. It
15 will be a little bit slower, obviously. That's done by 16:04
16 the administration staff. If there's a flag put on,
17 then that's when the administration staff would be
18 involved as well. They would send the email to the
19 referrer.

20 323 Q. So, as we stand in 2023, where do you think the gaps 16:04
21 and the improvements are necessary?

22 A. Well, there's lots of improvements that -- I mean,
23 there really is a lot of improvements that are
24 possible, from using, you know, mobile devices to be
25 able to alert consultants; you have to be sure who's 16:05
26 covering and you have to make sure that the report goes
27 back to someone who's actually available, not someone
28 who's on leave; or there is a safe mechanism for
29 someone else to check if someone else is away. There

1 he has to be an acknowledgment of reports; when you
2 receive them that you have to acknowledge that you've
3 received them. If there's recommendations, then
4 someone has to check that those recommendations have
5 been followed, or if they have not been followed, why 16:05
6 they have not been followed. Lots of back-up, admin
7 staff to do all these tasks of reporting and checking.
8 So there's quite a lot of change.

9 324 Q. Is there a need for a standard read time by the
10 referrer? 16:06

11 A. Well, there probably -- I mean, there probably should
12 be. I suppose it's the only way of picking up things
13 which you may want to know about. Although, I mean, we
14 are using this flagging a lot more than we're used to,
15 which will identify anything that may need action. I 16:06
16 think referrers should check their reports, ideally
17 daily but at least every few days, I suppose. I'm not
18 sure, there's no agreed recommendation.

19 325 Q. The document that I have up on the screen also
20 refers -- if we go down to page 53 in the series, 16:06
21 TRU-13353. I know that you say that this protocol, to
22 some extent, is almost being bypassed by the pace of
23 change, but it refers to communicating with the
24 referrer or the cancer tracker. My questions so far
25 have focussed on the referrer by and large. The 16:07
26 Inquiry has heard evidence about the work of the cancer
27 tracker. I'm not sure that this particular aspect of a
28 communication from radiology to a cancer tracker has
29 emerged in the evidence so far. Is this a tool or a

1 mode of communication that is used in the Southern
2 Trust, in other words, telling the cancer tracker if a
3 particular problem is identifiable on investigation, or
4 is the tendency still to focus on sending the
5 information to the referrer?

16:08

6 A. No. I think when we use the alert system, if you alert
7 the cancer tracker, which we can do, then you would
8 automatically alert the referrer as well. So, you
9 either do that or you just alert the referrer. I think
10 if we have an unexpected cancer maybe on the scan, then
11 we would alert both to the cancer tracker and the
12 referrer in those instances, yes.

16:08

13 326 Q. So it's a severity issue? If it's...

14 A. I mean, the vast majority of -- I mean, we do a lot of
15 scanning and a lot of them for very concerning symptoms
16 but the vast majority of those scans are going to be
17 normal. It's trying to pick up the ones that aren't to
18 try and give the clinician, to sort of focus their mind
19 on those cases. So, if you have a patient referred
20 with red flag symptoms and the scan's abnormal, it
21 shows a cancer, then you would flag those to the cancer
22 tracker and also to the unexpected findings. That's
23 what we would -- it's not really necessary. Well, I
24 suppose it is severity, you know, you've found
25 something important so you would flag that.

16:09

26 327 Q. Yes. Is there a particular reason or particular
27 thinking behind bringing the tracker into the equation?

28 A. I suppose it's just another, it's another safety. You
29 know, as we've said, the flagging to the referrer, you

16:09

1 know, in my view, is not really optimal; the referrer
2 could be away; they may not check their emails as often
3 as they might, for whatever reason, could be busy.
4 whereas the cancer trackers are normally there all the
5 time and they're quite good at the admin. So, you 16:10
6 know, they're checking lots of things and can make sure
7 that someone takes that patient on.

8 328 Q. Yes. Thank you. Moving to a different issue now, if
9 we go to AOB-77753. This is an email that you sent to
10 Mr. O'Brien in August 2016 when he was, I understand, 16:10
11 Chair of the MDM. You're raising a question about the
12 discussion of private patients at the Urology MDT. You
13 say:

14
15 "I understand that the Trust does not indemnify us for 16:11
16 discussing these cases so if an error is made, we are
17 personally liable. This is notwithstanding the fact
18 that private patients should be paying for the services
19 of all staff at the MDT. I have asked for
20 clarification from the Medical Director and am awaiting 16:11
21 discussion. I will not be providing any radiology
22 input into these cases until I receive clarification
23 and I suggest that this is discussed at the MDT AGM or
24 such like."

25 16:11
26 An email sent, obviously, seven years ago. Can you
27 recall what the issue was beyond what's plain on the
28 email there? Was there a traffic jam of private
29 patients coming through the MDT or what was the context

1 for this?

2 A. No, I don't think there was. There weren't many of
3 these patients coming through. I think I just felt
4 maybe a bit disgruntled by it, because you would find
5 patients crop up in the MDT who clearly have not been 16:12
6 seen in the NHS, and I didn't know whether these
7 patients would have had their care transferred to the
8 NHS or whether they were private patients who were sort
9 of dipping into the MDT and then out again. I just
10 felt a bit uneasy about that. I wasn't sure if we were 16:12
11 supposed to be providing opinion, whether the Trust
12 allowed us to provide an opinion, because my
13 understanding was that the Trust didn't allow that to
14 happen. I didn't know if we were indemnified by the
15 Trust for providing an opinion, if anything happened. 16:12
16 Just I felt uneasy and I wanted clarification as to
17 what we should be doing, what the Trust expected of us.
18 I never really, I never really got anywhere with that.
19 I still remain unclear as to the situation.

20 329 Q. Hmm-mm. 16:13

21 A. So I think that was it, really.

22 330 Q. Was that a new issue at that time for you or was it
23 something that had been annoying you for some time and
24 you decided to raise it?

25 A. I think there were a few cases that had come into the 16:13
26 MDT, but also, you know, there was the odd other
27 patient who used to sometimes come for a radiological
28 investigation and then, you know, were clearly not NHS
29 patients.

1 331 Q. what was the reason for writing to Mr. O'Brien? Was it
2 his patients? Was it other clinicians' patients? Or can
3 you not be sure?

4 A. I cannot remember whose patients they were. I think it
5 was just because he was the Chairman, so that's why I 16:13
6 wrote to him.

7 332 Q. Does the Chairman have any controlling role in terms of
8 what patients can be discussed at the MDT?

9 A. Well, I think they would maybe be more knowledgeable of
10 the policies that the Trust would have for MDT 16:14
11 discussion, or if they weren't, they should write a
12 policy so that we're all clear. Because as far as I
13 was aware, you know, what was happening was not what
14 the Trust wanted. It didn't want patients coming into
15 the Trust and going out of the Trust for either being 16:14
16 MDT discussion or a radiological procedure or
17 investigation.

18 333 Q. We can't locate any response from Mr. O'Brien to your
19 email. Do you recall getting a response from him?

20 A. It is a long time ago. I do not recall getting a 16:14
21 response. I don't think I received a response from
22 Mr. O'Brien or the Medical Director.

23 334 Q. Yes. You say you are awaiting clarification from the
24 Medical Director, and you also suggest discussing it at
25 the AGM for the MDT. Again, did the issue receive any 16:15
26 further consideration?

27 A. I don't recall but, you know, I'm not going to be able
28 to remember whether I was at an AGM. It may have been
29 discussed in my absence, for example. So I can't

1 remember.

2 335 Q. Is it an issue that continued to trouble you? In other
3 words, were you seeing cases after that where you were
4 suspicious that they may have had a private sector
5 origin?

16:15

6 A. I think there have been some other cases. They're not
7 very many. It's often -- you know, you still see
8 patients, I still see patients, you know, even now
9 where they do have a private sector origin but it's
10 often not always clear to me where their destination
11 is. I'm still really sort of a bit unsure about this
12 sort of thing.

16:16

13 336 Q. Is it an issue you've subsequently raised with anybody
14 beyond this email?

15 A. No. I don't think I've -- I don't think I've ever
16 mentioned it again.

16:16

17 337 Q. Just finally, doctor, just in terms of some of your
18 reflections that we could pick out from your statement
19 to us. One thing perhaps arises in this context that
20 we've just been looking at is that you say that
21 management, in certain circumstances, have been
22 unresponsive to issues that you raised. This is
23 perhaps one example; you've raised this with
24 Mr. O'Brien and with the Medical Director. Let's just
25 pull up your statement to see the context in which you
26 make this point. WIT-60293. At paragraph 35 you're
27 asked:

16:16

16:17

28
29 "What could improve the ways in which concerns are

1 dealt with to enhance patient safety and experience and
2 increase your effectiveness in carrying out your role?"

3
4 And you say: "I do not think that management take
5 concerns seriously within the Trust and often fail to
6 act or do not communicate that they have done so. I
7 have previously raised, for example, in regard to the
8 duplicity" - is that duplication --

16:17

9 A. Yeah.

10 338 Q. - "of investigations and that hasn't been acted upon.
11 When one raises an issue, usually a response is not
12 received.

16:18

13
14 "35.2. Many issues I raised in regard to radiological
15 practice through the Radiology Clinical Director and
16 the Radiology Service Manager which are not
17 specifically neurological are not addressed by managers
18 and opportunities for the improvement of patient care
19 and efficiency are lost."

16:18

20
21 You give examples of SPA entitlement for service
22 improvements, and teaching.

16:18

23
24 "Such issues are raised infrequently as I do not think
25 time raising them is not well spent."

16:18

26
27 Then at 35.3 you say:

28
29 "There is scope for improvement in radiological

1 practice. Managers need to acknowledge each and every
2 issue raised with them and state how best the issue
3 could be dealt with, rather than appearing not to
4 engage at all."

5
6 You finish by saying, "Areas of improvement should be
7 discussed with clinical and nonclinical managers and a
8 plan made to make improvements to the service."

9
10 Does that reflect your experience over 15 or so years,
11 doctor, that you are articulate in raising concerns
12 from time to time about issues affecting your own
13 practice, your service and its impact potentially on
14 patients, but you seem a little despondent that the
15 culture generally doesn't seem to direct responses by
16 to you?

17 A. I think that's summarised it really, yes. I mean, I'm
18 kind of at the point for the last few years where I
19 don't really raise issues any more because I don't feel
20 it's a good use of time. I feel that I am not -- if I
21 raise an issue, either for something that could be
22 improved or something that's gone wrong, there's often
23 no response to that email. That may, of course, mean
24 that it's being dealt with in the background, and I'm
25 sure sometimes that it is the case. But communicating
26 with the person who has e-mailed the manager, I would
27 have thought, is quite important for staff morale, just
28 to know that you've been listened to.

1 I tend to find that, in the Southern Trust, I think
2 there are so many big issues, major issues, that
3 managers are probably dealing with many of these in
4 their limited time, particular clinical managers, the
5 limited time for managers are dealing with these 16:21
6 things. So, things that I raise that are comparatively
7 minor are probably just ignored, because there's no
8 time to deal with them. I think that's probably what
9 happens.

10 339 Q. Apart from giving you responses, can you think of any 16:21
11 ways, any vehicles, any structures that aren't
12 currently in place that might, with little effort and
13 little resources, be put in place to improve things?

14 A. I think the problem is that we have -- the supporting 16:21
15 professional activities, which as you probably know, is
16 part of the job plan or things other than clinical
17 work, of which it's kind of recognised that 1.5 is the
18 minimum, and that's really for personal revalidation
19 and, more recently, is supposed to include some
20 teaching, but it doesn't include service improvement. 16:22
21 I think the Trust is very unwilling to give individual
22 consultants additional SPA time for managing a service.
23 So, any improvements that you wanted to do a service
24 you would do in our own time. I don't think there's
25 been -- there hasn't been much encouragement to give 16:22
26 consultants additional time, certainly in radiology
27 anyway.

28 MR. WOLFE KC: Okay. Thank you for your attendance
29 this afternoon and the answers to my questions. The

1 Panel may have some further questions for you.

2
3 THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:

4
5 CHAIR: Thank you, Mr. Wolfe. Thank you, doctor I'm 16:22
6 going to hand over to my colleague, Mr. Hanbury, first.

7 MR. HANBURY: Thank you very much for your evidence. I
8 think I speak for most urologists to say we depend very
9 heavily on our uro-radiological colleagues, so it is
10 from that context that I am going to run through a few 16:22
11 clinical things.

12
13 You mentioned about recruitment and we've heard about
14 this certainly from a northern Irish perspective. What
15 brought you to the Southern Trust? Was it the ability 16:23
16 to perhaps develop uro-radiology as a subspecialist
17 interest, or other reasons?

18 A. Other reasons. They're usually the same reason, which
19 is a wife from Northern Ireland.

20 340 Q. Okay. Thank you. If that hadn't have been the case... 16:23
21 Perhaps I'll move on.

22 A. I know what you're going to ask now but maybe don't ask
23 it.

24 341 Q. Okay. Thank you. We've heard a lot about MDM quorums
25 and radiological attendance, and I would say that 16:23
26 radiological attendance at these are even more
27 important than perhaps your evidence would support.
28 Just specifically, when you were there and specialist,
29 you moved onto the specialist MDT with Belfast

1 colleagues, discussing, for example, things like small
2 kidney masses --

3 A. Yeah.

4 342 Q. -- advanced pelvic cancer, there was presumably a
5 Belfast radiologist who linked in, was there, or how 16:24
6 did you interact with the other radiologists in the
7 centre, shall we say?

8 A. That's been quite difficult because since Covid came,
9 we're able to do the meeting virtually, which I have
10 been doing quite a lot. I've never been able to -- 16:24
11 there's always been a technical problem trying to log
12 into the Belfast Trust really from anywhere unless
13 you're actually in the Urology MDT room. So what's
14 happened we're not really -- we're not actually doing
15 that. So what tends to happen is we provide an opinion 16:24
16 on the imaging first and then that case would then
17 be -- once we've reviewed it locally, the case then
18 would go to, say, the small renal mass, for them to
19 look at. I think, you know, their radiologists would
20 kind of present the case to the local, to the Belfast 16:25
21 surgeons for a decision on the management.

22

23 Prior to that, so when I more physically attended the
24 meeting, then what we tended to do is because I was in
25 the room, it was possible to present the cases and we 16:25
26 would present the cases to the meeting at Belfast. And
27 their radiologists didn't usually, they didn't do
28 anything and didn't say very much because I think most
29 of the time it was okay, what we presented.

1 343 Q. But was there not an opinion coming back to say biopsy
2 ablation for small --

3 A. Yes, the management. So, the management is decided by
4 the urologists in Belfast.

5 344 Q. It was primarily the urologists? 16:25

6 A. Yes.

7 345 Q. Okay. Thank you. Moving on. Certainly Mr. Glackin, I
8 think we heard, felt quite strongly that when you
9 weren't there, then that put a big query over the
10 quality of the MDM/MDT. Do you think they should have 16:26
11 dug their heels in and cancelled it?

12 A. I don't think it necessarily needs to be cancelled
13 because I think there are quite a number of cases where
14 there probably isn't -- they're not asking for a
15 radiological opinion. There are a lot of cases where 16:26
16 they're just, you know, superficial bladders cancers,
17 for example, or some questions about prostate cancer
18 management in a patient whose PSA is... You know,
19 those cases could be discussed.

20 16:26

21 Yes, the ones that need radiology to help determine the
22 management, whether there's anything at all, even if
23 it's just a renal cancer staging, anything like that,
24 yes, those cases would have to be deferred.

25 346 Q. Okay. Thank you. Just moving away from cancer, which 16:26
26 you'll probably be quite relieved about, I was
27 interested to hear that in the past there was a
28 uroradiology meeting, I think on a Thursday morning?

29 A. Yes.

1 347 Q. That seemed to have stopped?
2 A. Yes.
3 348 Q. I mean, there's lots of urology that's nothing to do
4 with cancer.
5 A. Yes. 16:27
6 349 Q. Stones, upper tracts --
7 A. Yes.
8 350 Q. -- hydrology; lots of stuff.
9 A. Yeah.
10 351 Q. why did that happen? 16:27
11 A. That meeting, as you say, it was mostly stones, the odd
12 other thing, and a lot of cysts, a lot of complex
13 cysts. Those cysts have actually, a lot of them have
14 now moved over to the MDT because I suppose they are
15 potential cancers, although very rarely the case. So 16:27
16 we deal with those there. It's really just left to
17 stones and the odd other thing. I get emails about
18 those other cases and sometimes about the stone ones.
19 There is a stone meeting, but it's not an MDT. There
20 is no radiologist, which is an oversight, I think. 16:27
21
22 But in answer to your question why did it stop, it
23 stopped because I used to find that I was there at half
24 past eight or whatever to start the meeting and no one
25 came. Or Mr. Glackin would come and that was it. Or 16:27
26 when Mr. Glackin wasn't there, no one else was there.
27 I looked at the cases and I just got a bit -- I'd sort
28 of had enough of it, really. So, I just didn't
29 continue.

1 352 Q. A lack of interest from the clinicians?

2 A. I think so. I don't think -- Mr. Glackin certainly

3 wasn't surprised about that because I think he said

4 we've got a meeting, why is no one turning up?

5 353 Q. On that, you've made a comment about substandard 16:28

6 imaging of patients with stone. Is that something you

7 still --

8 A. Yes. I mean, what I mentioned was that more recently,

9 within the last maybe year or two, we're doing a lot of

10 CTs now for patients with stone disease. I think in 16:28

11 the past there was probably sort of an over-utilisation

12 of ultrasound for inpatients with stone disease, and

13 then no one was really sure what was happening with the

14 ultrasounded patients. So they're using, I think -

15 because I think CT obviously is the standard for 16:28

16 knowing, you know, whether a patient has a stone or

17 not. I think they're using CT a lot more than they

18 used to do, for sure. I think there's more of an

19 overall reliance on ultrasound.

20 354 Q. Okay. Thank you. Moving on to sort of interventions. 16:29

21 Nephrostomy, that's putting a needle into, say, an

22 abstracted kidney?

23 A. Yeah.

24 355 Q. Were you the only urologist who would do that, or

25 would your other colleagues do -- 16:29

26 A. No.

27 356 Q. -- needle abscesses and do other interventions?

28 A. It's a bit complicated to answer that because when I

29 first started, I was kind of able to do, you know, a

1 fair bit of interventional things, basic
2 interventional. I could do a nephrostomy; I could do
3 sometimes do ureteric stents. But I think we have an
4 interventional urologist in our department who is
5 keen to do that work, so I kind of let it fall by the 16:29
6 wayside and he took most of it up. I think our
7 department is quite unusual, in that there's a lot of
8 -- what I found was quite unusual, because there are a
9 lot of radiologists who are happy to do a lot of
10 interventional work, albeit basic drainages, so the 16:30
11 work is quite spread basically, so sometimes it's
12 difficult to get any cases. So I do less and less than
13 I actually probably had hoped for.

14 357 Q. That's a good service to the patients who need it?

15 A. Yes, because there's a lot of people. We are never 16:30
16 struggling to find someone who is happy to drain
17 something.

18 358 Q. Okay. Thank you. You mentioned the outsourcing. I
19 don't want to talk about the governance issue, but was
20 part of the push for that this sort of surgeon demand 16:30
21 for prostate MRI pre-biopsy?

22 A. I'm not really sure why that happened because we were
23 covering -- I think we were covering that work, albeit
24 on, you know, waiting lists if need be. So, it was
25 additional work. Then it seemed to switch to 16:30
26 additional work for the outsourcing companies and the
27 waiting lists were stopped. There was a sort of an
28 alternative. I never understood the rationale of why
29 that happened.

- 1 359 Q. But it's come back again now?
- 2 A. Yeah. Yeah because, I mean, the outsourcing companies
3 stopped providing the service, I think, as we
4 mentioned, because I was critical of what they were
5 doing and there was no choice but to bring back the 16:31
6 waiting lists for that. I think again we're in quite a
7 good position now where they're getting reported quite
8 quickly and everything's happening as it should.
- 9 360 Q. Okay. Thank you. Just a couple of other quick ones.
10 Discrepancy meetings, just describe what that is. 16:31
- 11 A. So it's meant to be -- it was meant to be -- they
12 changed the name to something called REALM, which I
13 think is more of a learning meeting rather than an
14 errors meeting. You are meant to be learning from
15 cases rather than pointing fingers. So it's called 16:31
16 REALM. It's a monthly meeting which happens every
17 month. Whoever is there will attend. We do it
18 virtually now because it kind of continued on from
19 Covid, where the cases of discrepancies are presented
20 by the consultant who basically chairs the discrepancy 16:31
21 meeting. He shows examples of errors and we kind of
22 talk about those and try to learn from them and feed
23 back to the original report.
- 24 361 Q. An internal audit type?
- 25 A. Yeah, and educational as well. Sometimes we present 16:32
26 cases where there is a discrepancy but it's not meant
27 to be critical, but maybe something to learn from.
- 28 362 Q. Okay. Thank you. You mentioned a nephrectomy for a
29 benign lesion on one case that popped up. I mean, I

1 would never imagine doing a nephrectomy in a case that
2 I had not discussed with a radiologist. Are you aware
3 of any other cases in your time there that --

4 A. No, I think that would be very rare. I mean, there may
5 well have been other cases where - I'm sure there were 16:32
6 other cases - the management was progressed without a
7 radiologist being at MDT. In the most part, most
8 reports are going to be correct, so, by luck, all will
9 have been well. I suppose there's always going to be
10 that chance that either the report's wrong or you just 16:33
11 get unlucky, and that was that instance.

12
13 That certainly doesn't happen any more. Any case where
14 it hinges on the imaging needs a radiologist to give
15 the second opinion on it. 16:33

16 363 Q. So, just pushing a bit more. If you had had someone
17 with a symptomatic but simple kidney cyst, would you...

18 A. Sorry, what's...

19 364 Q. Someone with flank pain, a simple watery cyst in the
20 kidney -- 16:33

21 A. Yes.

22 365 Q. -- seemingly needing intervention, would you expect
23 that would be discussed?

24 A. I don't think that would get to MDT. Probably not.

25 366 Q. But it would come to perhaps a benign meeting if you 16:33
26 did have?

27 A. Yes. I mean, I think it's going to be very variable as
28 to who looks at that case. If it's reported by a
29 radiologist that the urologists are happy with, they

1 would probably just take that, I mean as a benign case,
2 simple cyst. A lot of the urologists are happy to look
3 at the images and sort of double-check them. I know
4 they're not radiologists but they're good at it. So,
5 they do that. If there's any queries, they'll come 16:34
6 back, often to me. They might e-mail me and say could
7 you have a look at this? Sorry, is that what you are
8 asking?

9 367 Q. I think so. Particularly going towards intervention, I
10 guess that's what I was hinting at. 16:34

11 A. Yeah. Often they ask us to drain these cysts to see it
12 if it gives symptomatic relief, so we're often involved
13 any way. Yeah, because they're very rare. I mean,
14 obviously you know better than I but I'm not sure they
15 would do the surgery immediately. They often like for 16:34
16 us to drain it first to see if there's symptomatic
17 relief, and then they have got a radiology opinion
18 basically.

19 368 Q. That's what I was getting at, its a two-way
20 conversation? 16:34

21 A. Yes. Yes.

22 369 Q. One final one, if I'm allowed. You mentioned your
23 frustration about developing new things as a
24 department. Did you have departmental meetings, say
25 once a month and present a collegiate view to your 16:34
26 management or your clinical director? was that the sort
27 of culture, or you say you e-mailed the lot?

28 A. I used to e-mail a lot but I don't tend to do that now.
29 I think in my initial frustrations which you've seen in

1 those e-mails, I don't have those so much now, I just
2 don't think it's too important.

3
4 we do have a management meeting. It goes hand in hand
5 with the discrepancy meeting that's every month, so we 16:35
6 could discuss really any aspect of radiology. Some
7 things are taken on as a group; other things the
8 clinical director might impress himself even without
9 general agreement. It's variable.

10 370 Q. So, at least you have an opportunity? 16:35

11 A. Yeah, you can. You can always go and speak to someone
12 if you want to about something. I find that's more
13 useful now than writing an email, which generally
14 doesn't achieve a lot.

15 MR. HANBURY: Thank you very much. 16:35

16 CHAIR: Dr. Swart.

17 DR. SWART: Another opinion, not writing emails and
18 having discussions with management, there is clearly a
19 problem from your perspective in terms of the culture
20 of management. I just wanted to ask you a bit about 16:36
21 that. Is that, do you think, a general feature because
22 of the busyness and pressures at the Southern Health
23 Care Trust? Is it specific in your department? Was it
24 particularly your clinical director that you'd had some
25 sort of conflict with, or was it a more just a general 16:36
26 disillusionment of not being involved?

27 A. Yeah, I don't think I've had really anything I would
28 say is a confrontation. I think I just generally get
29 the impression sometimes that -- well, quite a lot of

1 the time, that if you raise an issue, particularly by
2 email, it often doesn't get -- nothing really happens
3 with it, or that's the impression. I think you can
4 raise it with non-clinical managers and clinical
5 managers to the same sort of general outcome.

16:36

6
7 I think our clinical director, he is more responsive
8 certainly than maybe the nonclinical managers, and he
9 will reply.

10 371 Q. Do you have an opportunity not to have necessarily
11 regular management meetings but, say, once a year sit
12 down and say this is how we're taking our radiology
13 department, this is how we think things should go
14 forward, these are the things we want to make better
15 this year, and have some sort of a sense of where
16 you're going? Is that atmosphere there or is it getting
17 to be there, or what's your view on that?

16:37

18 A. We tend to discuss more of that at the monthly
19 meetings. There is usually a section about equipment
20 or recruitment. So, it's kind of discussed more on a
21 monthly basis.

16:37

22 372 Q. If I said to you do you know what the plans are for
23 five years for radiology in the Southern Health Care
24 Trust, would you know?

25 A. No, I don't.

16:37

26 373 Q. I'm really thinking of, you know, you're a
27 urologist, have you had thoughts about how that
28 service should go forward, and has anybody asked you to
29 develop those thoughts?

1 A. No, I don't get asked to do anything like that. It
2 would be -- we've just done things over the years
3 ourselves really rather than anyone kind of asking us
4 to develop a service. The only thing, I suppose, as I
5 alluded to, is the SPA time. We are not really given 16:38
6 any service development time. We know things about
7 what may happen in radiology, where they're trying to
8 get another MRI scanner and...

9 374 Q. I'm trying to get at do you feel there is a role for
10 you in designing your own destiny? You know, if you 16:38
11 want change to happen, do you see that as part of your
12 role or do you see it as not part of your role?

13 A. I don't see it much as part of my role now. I used to
14 see it much more. But I've found - a bit candid here -
15 I've found, coming from England then to Northern 16:38
16 Ireland, there was a big discrepancy in what we did and
17 the services that were well kind of entrained in
18 England were not even being used at all. I found that
19 changing some of this was a really -- very, very
20 difficult, and I used to get a lot of resistance, you 16:38
21 know, things which were clearly things that shouldn't
22 be done. Just often I kind of gave up really.

23 375 Q. You gave up. If you take the issue of the independent
24 service provider, for example, did somebody sit there,
25 sit the radiologist down and say we've got too much 16:39
26 work to do and we think we should outsource some of it,
27 what should we outsource, what do you think? Did you
28 have that chance to input before it started? I know
29 you've fed back afterwards, but were they saying we

1 don't want to pay you waiting list initiatives any more
2 or anything of that nature?

3 A. I don't think it was really discussed. I think I have
4 made -- you know, I have said to them, please don't
5 outsource any urology. 16:39

6 376 Q. But they didn't ask you?

7 A. I don't think they did. I don't think I was asked
8 whether it should be done or not.

9 377 Q. Was there a tension around the waiting list initiative
10 payments; was that causing trouble? 16:39

11 A. It did cause some trouble for me, not necessarily
12 because of financial things, but more, as I say,
13 because I used to get two things from those: I used to
14 be able to report them and it saved me time for the
15 MDT, because I relied on, you know, I looked at my 16:39
16 report and I was happy with it, obviously. Whereas if
17 it was someone else's and someone I didn't know, that I
18 knew the service was associated with a discrepancy, it
19 cost me time.

20 378 Q. I meant before the independent service provider. I 16:40
21 mean, was it an issue that there were lots of waiting
22 list initiatives that were regarded as a bad thing from
23 the point of view of job planning, for example?

24 A. No, I don't think so.

25 379 Q. That wasn't part of the tension around how you did your 16:40
26 job plan or anything like that?

27 A. No, because the waiting lists were always separate,
28 completely separate from the job plan. I mean, I would
29 never put the two together. Waiting lists are

1 completely -- they're something you do in your own
2 time. They're not really...

3 380 Q. But the Trust have done that. The reason I ask,
4 they've said we're paying too many of that, we're going
5 to send it to Australia overnight? 16:40

6 A. Yeah. It's very difficult to work out what -- because
7 we've had issues with waiting lists in the Trusts that
8 you probably know about. Why they wanted to stop
9 waiting lists at that time, I really don't know. I'm
10 not sure whether it actually saves them any money to 16:40
11 send them anywhere else.

12 381 Q. The job planning, was that a source of confrontation
13 with you personally and the whole job planning and
14 leave and all of that? I'm thinking now of the MDT
15 quoracy and the fact that you were missing for a quite 16:41
16 a few Thursdays.

17 A. Yeah, I mean, I take some of the blame for that anyway
18 in terms of my own priorities and leave and study
19 leave. You know, I'm not blaming the Trust for that.
20 I would... 16:41

21 382 Q. But did you try and change it to another day. If you
22 were kind of tagging it on to your Friday, I can kind
23 of see how that would happen?

24 A. Yeah. Well, I think I did mention the Urology MDT
25 changing to another day. I suggested a Tuesday or a 16:41
26 Wednesday and my quoracy rates were probably high for
27 those days, but I don't think it was something that was
28 --

29 383 Q. So you didn't have a conflict about people telling you

1 couldn't take your leave those days or anything like
2 that?

3 A. I don't think so. Well, leave is always a request and
4 it was signed off.

5 384 Q. Yeah. 16:41

6 A. I don't think anyone ever came and said you can't have
7 this leave. No, they never did that.

8 385 Q. So that wasn't a source of it, you just didn't know why
9 the decision was made about the waiting list initiative
10 versus independent sector? 16:41

11 A. Yes. I still don't know why.

12 386 Q. Another issue is, you mentioned the issue of MDT and
13 sitting there all afternoon and radiology input, which
14 is something that I certainly recognise. Have you had
15 any discussions with people about streamlining the 16:42
16 radiology input into MDTs to make that better, either
17 within the Trust or within Northern Ireland?

18 A. No. I think from what I've -- the emails I've kind of
19 read in the past - I think maybe some were contained in
20 the bundle - the expectation is they want all core 16:42
21 members there, they made it very clear, for the whole
22 meeting.

23 387 Q. But there are the various initiatives about how
24 radiology input can be made a bit easier because it's a
25 general problem, I think? 16:42

26 A. Yeah.

27 388 Q. It's not unique to the Southern Health Care Trust.
28 You're not aware of anything that's coming on that?

29 A. I think Mr. Glackin has expressed interest in trying to

1 make it clear which cases need radiological input. He
2 does keep mentioning that. Certainly, even if I had to
3 stay for the whole meeting, it would at least
4 substantially help the prep time, which is very
5 valuable, because I find I'm at the limit of it a lot 16:43
6 of the time.

7 389 Q. You mentioned the Belfast Trust and some of the working
8 during Covid. Have there been any discussions about
9 sharing imaging formally through networked PACS images?

10 A. Yes. 16:43

11 390 Q. Because that's a way of getting a bit more expertise
12 together, isn't there, over a wider geographical area?
13 Where have you been able to take that, or is that --

14 A. I can't give you have much information, unfortunately.
15 I know it has been discussed before. 16:43

16 391 Q. Is that the sort of thing that you feel you could take
17 forward as a consultant if you were given a bit of
18 support for development?

19 A. I think people have tried to take that forward already
20 and I don't think it's worked. So, probably wouldn't 16:43
21 be something I would --

22 392 Q. Similarly on the recruitment, have there been any
23 discussions with the whole consultant body as to what
24 are we going to do to make this more attractive? Have
25 the senior management team in the Trust, HR and Medical 16:43
26 Director got you all together to talk about that?

27 A. No. No. I think they tend to discuss along the
28 traditional lines with, you know, with the clinical
29 director. I do --

1 393 Q. would you welcome that? Do you think people would feel
2 engaged and listened to?
3 A. I think -- yes, I think I have provided opinions before
4 on what could be done to improve.
5 394 Q. That is different from people actually asking you. 16:44
6 A. Yes, yes. I mean, I've never been asked. I rarely
7 would get asked anything really, unfortunately.
8 DR. SWART: Okay. Thank you. That's all from me
9 CHAIR: You'll be glad to know I have no further
10 questions -- 16:44
11 THE WITNESS: Great.
12 CHAIR: -- for you, Dr. Williams. Thank you very much
13 for coming along.
14 THE WITNESS: Thank you
15 CHAIR: It's now a quarter to five and we'll see 16:44
16 everyone again in the morning.
17
18 THE INQUIRY WAS THEN ADJOURNED UNTIL WEDNESDAY, 24TH
19 MAY 2023 AT 10:00 A.M.
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