



# **Urology Services Inquiry**

## **Oral Hearing**

**Day 62 – Wednesday, 20<sup>th</sup> September 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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1           THE INQUIRY RESUMED AS FOLLOWS ON WEDNESDAY,  
2           20TH SEPTEMBER 2023

3  
4           CHAIR:    Good morning everyone.

5           MS. McMAHON:  Chair, panel, the witness this morning is 10:04  
6           Prof. O'Sullivan, a consultant urologist with the  
7           Belfast Trust, and he wishes to affirm.

8           CHAIR:    Just before that, Ms. McMahon, I think is there  
9           a new representative in the chamber?

10          MS. McMAHON:  Yes, I was going to do that after, but 10:04  
11          maybe I'll do that now.  Yes, Laura King on behalf of  
12          Prof. O'Sullivan.

13          MS. KING:  Madam, Chairman, panel.  My name is Laura  
14          King.  I represent Prof. O'Sullivan, instructed by  
15          Sarah Loughran from DLS. 10:04

16          CHAIR:    Thank you, Ms. King.

17  
18          PROFESSOR JOSEPH O' SULLIVAN, HAVING AFFIRMED, WAS  
19          EXAMINED BY MS. McMAHON AS FOLLOWS:

20 10:04  
21          MS. McMAHON:  Good morning, Prof. O'Sullivan.  Thank  
22          you for coming along to give evidence to the Inquiry.  
23          My name is Laura McMahon, I'm junior counsel to the  
24          Inquiry.  We've already met, but just for the record  
25          I'll formally introduce myself.  You have already 10:05  
26          provided us with a section 21 notice setting out your  
27          answers to some of the queries we have raised and, on  
28          foot of that, we thought that we should bring you along  
29          just to explore some of the issues in your statement a

1           little bit more fully.

2           A.    Okay.

3       1   Q.    We'll just go to your section 21 first of all. You can  
4           find that at WIT-96648. Do see your name at the top of  
5           that, it's Notice 25 of 2023. And if we go to 10:06  
6           WIT-96651, just go to the bottom of that page and we'll  
7           see a signature there. Is that your signature?

8           A.    It is, yes.

9       2   Q.    And it's dated 17th May 2023?

10          A.    Yeah. 10:06

11       3   Q.    Do you wish to adopt that as your evidence to the  
12           Inquiry?

13          A.    Yes.

14       4   Q.    Are there any amendments or corrections at this point  
15           before we just go through your evidence? 10:06

16          A.    No.

17       5   Q.    Thank you. Now, the context of your evidence and why  
18           you're here is that you were interviewed by Dr. Hughes  
19           on 4th January 2021 in relation to a number of SAIs  
20           concerning former patients of Mr. Aidan O'Brien. 10:06

21          A.    Yes.

22       6   Q.    And you provided us with this evidence. And the  
23           purpose of today is to ask you about that in more  
24           detail and to allow the panel to raise any issues or  
25           queries they may have with you. 10:06

26          A.    Okay.

27       7   Q.    So, we have a limited time, we have this morning to  
28           work through that, and hopefully that will be all  
29           that's needed. We'll just start off with your

1 background and your current role.

2 A. Yeah.

3 8 Q. Then I want to move on to your engagement with  
4 consultants from the Southern Trust, and generally the  
5 way in which communications operated between them and 10:07  
6 the Belfast Trust where you were based.

7 A. Okay.

8 9 Q. And then we'll move on to address some of the issues  
9 arising from your section 21, in particular look at the  
10 interview with Dr. Hughes, then the prescribing 10:07  
11 generally around Bicalutamide 50mg as a monotherapy,  
12 I'll just ask your views on that.

13 A. Yeah.

14 10 Q. Then some of the concerns you raised around Mr. O'Brien  
15 and your interaction with others in relation to those 10:07  
16 concerns. And then I want to ask you some questions  
17 about the e-mail sent by Darren Mitchell, Dr. Mitchell,  
18 in 2014, to Mr. O'Brien.

19 A. Yeah.

20 11 Q. And then just some mop up points that you've referred 10:08  
21 to in your statement.

22 A. Okay.

23 12 Q. I don't know whether you got the chance to listen in to  
24 Darren Mitchell and Chris Hagan's evidence yesterday?

25 A. Not yesterday, no. 10:08

26 13 Q. Well, just by way of background, we did cover their  
27 involvement around their concerns. Obviously some of  
28 that interacts with your...

29 A. Yes.

1 14 Q. Experience. So, I'm not going to repeat, unless it's  
2 necessary for your evidence, the issues. So I'll try  
3 and stay nice and focused on what you can bring as  
4 regards your own personal experience and, of course,  
5 your expertise? 10:08

6 A. Okay.

7 15 Q. I wonder if you could just then set out for the panel  
8 the background of your clinical experience and your -  
9 how you got to Prof. O'Sullivan and your current role?

10 A. Yeah. So medical school within University College 10:08  
11 Dublin from 1987 to 1993, after which I did some  
12 general medical jobs and then joined a radiotherapy  
13 training scheme in Dublin, completing that in 2000,  
14 when I moved to Royal Marsden Hospital London to do a  
15 fellowship in prostate cancer, where I also did a 10:09  
16 doctorate thesis, and I left there, joining the staff  
17 at Queens University Belfast on 1st January 2004 as a  
18 joint appointment between Queens as a senior lecturer  
19 in oncology and Belfast City Hospital, as it was then,  
20 as a consultant clinical oncologist. And I've worked 10:09  
21 in the same role for the last 20 years almost. I  
22 became a professor in 2011, following an advertised  
23 post which I applied for and was successful with, and  
24 over the last 20 years I have continued to work as a  
25 clinical oncologist. For the last ten years or so 10:09  
26 purely in prostate cancer, prior to that I would have  
27 also covered bladder cancer along with prostate cancer.  
28 I currently have a busy academic prostate cancer  
29 practice based at Belfast Trust at the Northern Ireland

1 Cancer Centre, looking after men with prostate cancer  
 2 as part of a wider oncological team.

3 16 Q. And in relation to the split of your work, clinical and  
 4 academic, how does that operate?

5 A. Well, officially it's meant to be roughly 50/50, but a 10:10  
 6 lot of my research is done with patients, so in  
 7 clinical trials. So in my standard clinic, maybe half  
 8 the patients are taking part in some form of clinical  
 9 trial. And then I also spend time supervising, for  
 10 example, other researchers like PhD students, 10:10  
 11 organising grants and that type of thing. So it's  
 12 roughly a 50/50 split between academic and clinical  
 13 work.

14 17 Q. Thank you. For the purposes of today, we'll need to go  
 15 back and forward in time slightly, because the starting 10:10  
 16 point for some of your knowledge is 2004.

17 A. Yes.

18 18 Q. When you started in the Belfast Trust.

19 A. Yes.

20 19 Q. You were consultant at that point? 10:10

21 A. That's correct, yeah.

22 20 Q. And so we'll move back and forwards. We're very  
 23 conscious that you sit now with much more experience  
 24 than you did at the timeframe that we're referring to?

25 A. Yes. 10:11

26 21 Q. And the panel is mindful of that.

27 A. Yes.

28 22 Q. But we would like to explore some of the issues and  
 29 ask, if you can, to bring yourself back to various

1 times?

2 A. Sure.

3 23 Q. So we can try and unpick any governance learning that  
4 might be useful for the panel.

5 A. Yes. 10:11

6 24 Q. I just want to ask you about your engagement with the  
7 Southern Trust, the way in which it operated. We'll  
8 come on to look at your, some of the issues you raise  
9 in your statement around referrals and how you  
10 identified perhaps some issues? 10:11

11 A. Yeah.

12 25 Q. That you thought needed rectified.

13 A. Yeah.

14 26 Q. But just for the purposes of understanding referrals,  
15 how did that operate at that time in 2004? 10:11

16 A. At that time, well, most of the referrals coming to  
17 myself as a Belfast Trust oncologist were coming from  
18 the Belfast City Hospital urologists, so the team  
19 there. We also would have covered some of Antrim and  
20 the Ulster Hospital area as well. Whereas patients who 10:11  
21 were diagnosed in the Southern Trust would have come  
22 through the visiting oncologists. So at that time when  
23 I started first, Dr. David Stewart was the clinical  
24 oncologist who would visit from Belfast to Craigavon,  
25 do a weekly clinic, see patients on treatment, and also 10:12  
26 identify new patients for radiotherapy in Belfast, for  
27 example. So the vast majority of diagnosis from  
28 Southern Trust would come via the visiting oncologist.  
29 And it was quite uncommon that referrals came directly



1 from Southern Trust to myself in Belfast.

2 27 Q. So, Dr. Stewart would have travelled then to the

3 Southern Trust and dealt with referrals on-site, as

4 such?

5 A. Yes, he would have done a clinic once, I think on a 10:12

6 Wednesday, I think an all day Wednesday clinic. So it

7 would have a mixture of new referrals and patients in

8 follow-up.

9 28 Q. And did that also happen in other Trusts?

10 A. Yes. 10:12

11 29 Q. That there was, I won't call it outreach, but that

12 there was a travelling by a specialist to the area?

13 A. Yes, this was very much the model of hub and spoke

14 practice where there were four cancer units, there was

15 Craigavon, Ulster Hospital, Antrim and Altnagelvin, and 10:13

16 each of those then had visiting oncologists for the

17 different tumour sites, so urology obviously was the

18 one relevant here, but there was also GI cancer, lung

19 cancer, etc.

20 30 Q. And was it as a result of the review in 2009/2010 that 10:13

21 it centralised referrals to Belfast or did it happen

22 before that?

23 A. I think it happened before that. I think that the unit

24 system had been established from the Campbell Report

25 some years previously. So that system of visiting 10:13

26 oncologists to the local units was well established

27 when I arrived here in 2004.

28 31 Q. And you said just a moment ago that it was, I think you

29 used the word "rare" or perhaps not frequent?

1 A. Uncommon I think, yeah.

2 32 Q. Uncommon. That you would have had referrals directly  
3 to you from...

4 A. Yes.

5 33 Q. And when would those referrals, what sort of scenario 10:13  
6 would that take place?

7 A. Well, it might have been a patient, for example, who  
8 had been looked after - who knew me already or had a  
9 family member who had been looked after by me, perhaps  
10 had requested that specifically they come to Belfast, 10:14  
11 or perhaps it was in relation to a clinical trial that  
12 might have been open at the time that a patient might  
13 have enquired from their urologist "Oh, maybe I'd like  
14 to take part in that trial", in which case I would be  
15 the person to refer to. 10:14

16 34 Q. Just to put in context at this stage questions that I'm  
17 going to ask you in a moment around the referrals.

18 A. Yeah.

19 35 Q. The ones that you remembered, and I think you numbered  
20 them around three... 10:14

21 A. Yes.

22 36 Q. Between a period of 2004 and 2008, in which you had  
23 concerns around the prescription of Bicalutamide 50mg  
24 as a monotherapy?

25 A. Yes. Yes. 10:14

26 37 Q. Do you recall if those referrals came to you directly  
27 from Craigavon?

28 A. I think they probably came to the central team and I  
29 picked them up. You know, depending on the setup,

1           there may be two or three of us oncologists in Belfast  
2           who would take those referrals, and depending on who  
3           had new patient slots available. I don't recall  
4           specifically if they were directly referred to me  
5           personally or to the wider team.

10:14

6   38   Q.   And was it possible that either you could have been the  
7           named referred to consultant or --

8           A.   It's entirely possible that I was the named.

9   39   Q.   Or randomly allocated that patient based on the  
10          workload of the other consultants at that point?

10:15

11          A.   Yes. Yeah.

12   40   Q.   There were three of you?

13          A.   That's right. At that time, so centrally Dr. Stewart,  
14               who also covered Craigavon, would have also done some  
15               central urology practice, Dr. Stephan Stranick did the  
16               same as well, and then laterally, I think about 2005,  
17               another colleague, Dr. Lin Shum came on board as a  
18               central oncologist.

10:15

19   41   Q.   And at this point when you started in 2004 did you know  
20          any of the consultants from Craigavon?

10:15

21          A.   No, I didn't know anybody here at all.

22   42   Q.   Now, Mr. Hagan, who is the Medical Director, as I'm  
23          sure you know in Belfast Trust?

24          A.   I do.

25   43   Q.   Yesterday was referring to a period of time around  
26          2010, and his evidence to the Inquiry was at that time  
27          all of the other urology units in the region were  
28          dialling in to the Regional MDT, apart from Craigavon.  
29          And that's in the context of the possibility to discuss

10:16

1 cases that might have been, or could have been or  
2 should have been referred.

3 A. Yeah.

4 44 Q. And may have been delay in referred. Do you have any  
5 recollection of there being, at least from Dr. Hagan's 10:16  
6 perspective, a disconnect with Craigavon at that point?

7 A. I don't remember specifically there being a disconnect,  
8 but I do know that they were not involved in the  
9 Regional MDT at the time, because I was Chairperson of  
10 that MDT at the time. So we had links from - well it 10:16  
11 was a bit sporadic - from the Ulster hospital, we had  
12 links from Antrim and also, depending on the case, from  
13 Altnagelvin as well.

14 45 Q. When did you take up Chairship of the MDT?

15 A. I think pretty much as soon as I arrived in Belfast I 10:16  
16 was handed that lovely job. It was not as organised as  
17 MDTs have now become. In those days it was prior to  
18 the sort of national reorganisation and I suppose  
19 restructuring of MDTs. It was a little bit more ad hoc  
20 at that time, and as the new boy in the door I was 10:17  
21 given the job of Chair very quickly.

22 46 Q. And you stayed in that job until 2014?

23 A. Correct. Just before I became clinical director.

24 47 Q. Is ten years as Chair of MDT unusual?

25 A. Well, it's definitely a long time. I felt it! Again, 10:17  
26 in the early years it was quite, I wouldn't say ad hoc,  
27 but it certainly was not as structured and we didn't  
28 have a quorum of people who had to be there, etc. That  
29 became much more formalised in subsequent years. So I

1           guess it wasn't that much of a burden. And, again, as  
2           a new person in, I hadn't got so busy yet. And then  
3           all of a sudden I was the only person doing it and...

4    48   Q.    Perhaps you couldn't say no?

5           A.    Probably at that stage. But then luckily, when I 10:17  
6           became Clinical Director, it became obvious I couldn't  
7           do both of those roles.

8    49   Q.    And we'll speak about that as well. But that was 2014  
9           you became Clinical Director?

10          A.    Correct. 10:18

11   50   Q.    And Darren Mitchell took over then as Chair of MDT?

12          A.    Yes, he did. Yes.

13   51   Q.    And that's where you have that connection at that point  
14           in time?

15          A.    Yes. 10:18

16   52   Q.    And we'll look at the e-mail around that time.

17          A.    Yes.

18   53   Q.    Now, just for the completeness of the record, Mr. Hagan  
19           did mention that after some events in 2010, which  
20           you're not part of and I don't need to go into, that 10:18  
21           Craigavon started to tele-link into the Belfast MDM,  
22           and that was for the purpose of presenting patients who  
23           had muscle invasive bladder cancer that might require  
24           radical prostatectomy. Now, do you recall that  
25           development of the tele-link involvement? 10:18

26          A.    Yes, I remember it changed where surgery became, major  
27           pelvic surgery became centralised and, therefore,  
28           patients who needed a major operation, for example a  
29           cystectomy, or a cystoprostatectomy, or even a

1 prostatectomy, would be discussed by the Regional MDT  
 2 team where the pelvic surgeons were present, and they  
 3 could between them make a decision whether it was  
 4 appropriate or not for a patient to be considered for  
 5 major pelvic surgery.

10:19

6 54 Q. Now, did you consider, as Chair of the MDM meetings at  
 7 the time, did you consider that that involvement  
 8 collectively in relation to expertise and knowledge was  
 9 beneficial?

10 A. Well, I thought it was absolutely essential. If you're  
 11 going to recommend a major operation you should have  
 12 the people who are expert in doing those operations and  
 13 who are actually doing those operations to give the  
 14 opinions. So absolutely necessary, yes.

10:19

15 55 Q. I just want to look at the interview with Dr. Hughes.  
 16 And if we could go to the typed note at TRU-162262.  
 17 That's TRU-162262. Oncologist. I just want to read  
 18 this into the record. So, this was a meeting with you  
 19 on Monday, 4th January 2021, via Zoom at 11:15. The  
 20 attendees were Dr. Dermot Hughes and Mrs. Patricia  
 21 Kingsnorth, who we have -- we have heard from both of  
 22 those witnesses. So, "DH" obviously is Dr. Hughes and  
 23 "JOS" is your initials, so I'll just read from the  
 24 note:

10:19

25  
 26 "DH thanks JOS for meeting with him and explained the  
 27 process to date regarding the SAI review involving 9  
 28 patients (one with penile cancer, 1 testicular cancer,  
 29 5 prostate cancers and 2 renal cancers.)

10:20

10:20

1  
2 He asked if JOS was aware of any issues regarding the  
3 practice of Mr. AOB. JOS advised that when he came  
4 into post initially about 17 years ago, he had concerns  
5 in relation to the use of Bicalutamide and that they 10:21  
6 had frequently challenged him about the treatment. He  
7 made recommendations in clinic letters questioning the  
8 use of Bicalutamide 50mg instead of the standard 150mg  
9 or LHRH agonist therapy. In the cases he had seen, the  
10 dose of Bicalutamide would not have resulted in a major 10:21  
11 detriment to the patient's therapy/outcome and  
12 therefore was not escalated further. JOS said that he  
13 was aware that his colleague DM (as MDT Chair) had  
14 raised our concerns about AOB's Bicalutamide  
15 prescribing with the then CD for oncology, SMcA, 10:21  
16 probably in 2011.

17  
18 JOS said that the MDT improved with the attendance of  
19 two of the newer consultants about 7 years ago.

20 10:21  
21 DH advised that there were a number of delays of people  
22 being referred for oncology/palliative care.

23  
24 DH said that there were issues regarding lack of  
25 oncologists attending MDM as it was on the same time as 10:22  
26 Lung MDM and that there was inadequate cover for CAH  
27 MDM.

28  
29 JOS agreed he did want it recognised that there was a

1 lot of good work from urologist in CAH and good  
2 involvement in MDT, in particular he named two  
3 consultants, Mr. MH and Mr. AG.  
4

5 DH wanted to assure JOS that the SAI review will also 10:22  
6 recognise the good work that the MDT are doing and  
7 recognised that the concerns relate to one person's  
8 practice. It would seem he worked in isolation despite  
9 being involved in a multi disciplinary team. JOS said  
10 that that was his impression of Mr. AOB." 10:22  
11

12 And it ends at that point. Do you recall the  
13 interview?

14 A. Yes.

15 56 Q. Over Zoom. And when you -- the first contact you had 10:23  
16 with Dr. Hughes was him informing you that he needed to  
17 speak to you?

18 A. Yes.

19 57 Q. Did he say why you had come on to his radar at all?

20 A. Because I think probably Darren Mitchell had mentioned 10:23  
21 that I had remembered some cases of Bicalutamide 50mg  
22 monotherapy, I think. I think that was the reason.

23 58 Q. Now, you had been given this note and asked to comment  
24 on it and correct it, and you did indicate some tracked  
25 changes. We'll just go to that at TRU-162366. If we 10:23  
26 just move down. So, where you have made the  
27 corrections, you'll see on the - it's highlighted  
28 clearly on the screen.

29 A. Yeah.



1 59 Q. And you have made comments on the right. The first one  
 2 I'd like to bring you to is the second paragraph down,  
 3 where the comment is made - this is the initial note,  
 4 subsequently changed into what we have just read:

5  
 6 "He advised that he had raised concerns to AOB in  
 7 writing but Mr. AOB produced evidence to support his  
 8 practice. JOS advised that as the drug did not  
 9 apparently cause harm, they didn't escalate further."

10  
 11 In the comment for that, you say:

12  
 13 "I would have made recommendations in clinic letters  
 14 questioning the use of Bicalutamide 500D instead of  
 15 standard 150mg OD dose or LHRH agonist therapy. I  
 16 didn't write any formal letter of concern."

17  
 18 In the cases I had seen the dose of Bicalutamide would  
 19 not have resulted in a major detriment to the patient's  
 20 therapy outcome and therefore was not escalated  
 21 further."

22  
 23 Now, your comment is reflected in what we've just read.

24 A. Yes.

25 60 Q. But this initial version, I just want to ask you, where  
 26 you've said "Mr. O'Brien produced evidence to support  
 27 his practice"?

28 A. Yeah, I don't recall that at all.

29 61 Q. Do you recall saying that?

1 A. No.

2 62 Q. Do you recall if Mr. O'Brien ever did produce evidence  
3 to you?

4 A. Not that I can recall.

5 63 Q. Or anyone else, and they told you? 10:25

6 A. Not that I can recall.

7 64 Q. Do you have any explanation as to why that particular  
8 sentence -- I ask you because it does tend to support a  
9 view that Mr. O'Brien had engaged at some level with  
10 you or others and had supported the prescribing of 10:25  
11 Bicalutamide 50 as a monotherapy with evidence?

12 A. Certainly never directly to me.

13 65 Q. But do you have knowledge of it with anyone?

14 A. I mean, I have vague recollections of there being some  
15 evidence produced about 50mg of Bicalutamide, but it 10:25  
16 wasn't directly to me and I don't recall it in detail.

17 66 Q. Do you recall who it was with?

18 A. No.

19 67 Q. And when you say you have vague recollection, is that  
20 in the context of that evidence being supportive of the 10:25  
21 appropriateness of prescribing Bicalutamide 50mg as a  
22 monotherapy?

23 A. Yeah, I think it probably was when I was having  
24 discussions with colleagues about this practice and  
25 somebody said - oh - it might have been mentioned 10:26  
26 somewhere that Mr. O'Brien had some evidence of 50mg  
27 daily. But I mean, I'm very well aware of the field of  
28 prostate cancer and there are no evidence supporting  
29 that.

1 68 Q. Now, the other issue that's commented there was:

2  
3 "JOS said that the MDT improved with the attendance of  
4 two of the newer consultants 7 years ago. AOB was seen  
5 as an outlier." 10:26

6  
7 A. Yes. I mean the comment about the MDT, that's the  
8 Southern Trust MDT, and what I mean by "improved" was  
9 that consultants, clinical oncologists from Belfast  
10 were as job planned to attend that MDT, where there had 10:26  
11 been some gaps in oncology cover for the Southern Trust  
12 MDT. That was that comment.

13  
14 Again, I don't remember saying that Mr. O'Brien was  
15 seen as an outlier. I don't recall saying that. 10:27

16 69 Q. And just the next sentence after that:

17  
18 "JOS said that Mr. AOB was an objector to  
19 recommendations and did not engage with or respect the  
20 MDM process." 10:27

21  
22 A. I definitely didn't say that, those words exactly. I  
23 think what I meant was that with the prescribing of  
24 50mg of Bicalutamide that seemed to be outside of  
25 standard MDT recommendations. 10:27

26 70 Q. Just for completeness, if we could look at the  
27 handwritten note. Patricia Kingsnorth, who we have  
28 heard from, she took the notes from the call.

29 A. Yeah.

1 71 Q. TRU-165299. And this is the handwritten note from  
2 Mrs. Kingsnorth. You'll see the fifth line down that  
3 has writing on it, at the last part on the right-hand  
4 side it says:  
5  
6 "Aidan produced evidence base for 50mg use."  
7  
8 And that's the formal note as, as much as a handwritten  
9 note can be formal by Zoom?  
10 A. Yeah. Yeah. 10:28  
11 72 Q. But that's the note, the recollection?  
12 A. Yeah.  
13 73 Q. So you may have mentioned at the interview with  
14 Dr. Hughes what you've told us, you have a vague  
15 recollection? 10:28  
16 A. Yes.  
17 74 Q. And that there was something produced.  
18 A. Yes.  
19 75 Q. And I think you've said, and we'll go on to look at  
20 your understanding or your expertise in Bicalutamide 10:28  
21 50mg as a monotherapy, that there is no evidence base  
22 for that?  
23 A. Correct.  
24 76 Q. You also, in your section 21, took the opportunity to  
25 correct another aspect of Dr. Hughes' note. If we go 10:28  
26 to WIT-96648, at paragraph 1(i). So, we give you an  
27 extract from the note that I've just read out and then  
28 at point (i) we ask:  
29

1 "Confirm whether the above is an accurate record of the  
2 discussion during interview. To the extent that it is  
3 not, please identify any alleged inaccuracies and offer  
4 clarification of same."

10:29

5  
6 And you say:

7  
8 "The above statement is accurate except I don't recall  
9 saying "frequently challenged" in relation to  
10 Mr. O'Brien around the Bicalutamide 50 monotherapy  
11 prescription.

10:29

12  
13 My intended phrase was challenged on a number of  
14 occasions."

10:29

15  
16 A. Yes.

17 77 Q. And then you take the opportunity to also correct the  
18 date. Your reference to Darren Mitchell having spoken  
19 to Dr. McAleer?

20 A. Yeah.

10:29

21 78 Q. And you say at paragraph 1(i)(b):

22  
23 "I was incorrect about the date Dr. Mitchell discussed  
24 with Dr. McAleer. It was 2019 and not 2011. The  
25 discussion was about a proposed regional protocol  
26 concerning the use of hormone therapy in prostate  
27 cancer, rather than specifically about Mr. O'Brien's  
28 prescribing. I did have a discussion with Dr. Mitchell  
29 in 2014 regarding my recollection of a few cases

10:30

1 (involving prescription of Bicalutamide 50mg daily as  
2 monotherapy in prostate cancer) that I had encountered  
3 early in my consultant career."  
4

5 And those are the totality of your corrections around 10:30  
6 what you say represents your evidence to Dr. Hughes...

7 A. Yeah. Yes.

8 79 Q. When he spoke to you. You had said in response to what  
9 Dr. Hughes had said in the reference that we've looked  
10 at, TRU-162262, where Dr. Hughes said a comment to the 10:31  
11 effect that it would seem Mr. O'Brien worked in  
12 isolation, despite being involved in a multi  
13 disciplinary team, and you said that was your  
14 impression of Mr. O'Brien. How did you form that  
15 impression and what was it based on? 10:31

16 A. I think I may have - I correct that statement further  
17 down in that document as well.

18 80 Q. Yeah.

19 A. I thought that was a bit of a leading question really.  
20 So I don't think I would have phrased it like that. I 10:31  
21 think my impression, if it was in that vicinity, was in  
22 relation purely to the prescribing of Bicalutamide 50mg  
23 daily and that being outside of standard guidelines.

24 81 Q. We'll just go to paragraph (iii), where you answer  
25 that, just to remind you what you said. Sorry, it's 10:31  
26 WIT-96650. So, we'll see there at paragraph (iii):

27  
28 "During the interview referred to above..."  
29

1                   -- we've just read that:  
2  
3                   "...in response to a comment by Dr. Hughes to the  
4                   effect that it would seem he, Mr. O'Brien, worked in  
5                   isolation, despite being involved in a multi 10:32  
6                   disciplinary team, it is recorded it JOS said that was  
7                   his impression of Mr. AOB."  
8  
9                   And we've asked you what led you to have this  
10                  impression. And you say: 10:32  
11  
12                  "This impression was based on my experience with the  
13                  cases that had been prescribed Bicalutamide 50mg as  
14                  monotherapy. My view was that an MDT would be unlikely  
15                  to recommend this therapy and that it was probably the 10:32  
16                  decision of Mr. O'Brien alone."  
17  
18                  A. Yeah.  
19       82       Q. So your impression of, your view of Mr. O'Brien in that  
20                  context was that had the prescribing of 50mg as a 10:32  
21                  monotherapy once daily been subjected to MDT oversight  
22                  then it may not have passed muster?  
23                  A. That would be my view, yes.  
24       83       Q. But you didn't have any direct connection or contact --  
25                  A. No. 10:33  
26       84       Q. -- with Mr. O'Brien in order to form that view for any  
27                  other basis?  
28                  A. I did not, no.  
29       85       Q. I just want to ask you some questions generally so that

1 the panel has a baseline based on your area of  
 2 expertise, but also your clinical experience.

3 A. Yes. Yes.

4 86 Q. In relation to cancer guidelines, what guidelines do  
 5 you follow? 10:33

6 A. Well, it really depends on the situation. With regards  
 7 drugs that are reimbursed it would be the NICE  
 8 Guidelines would be a big guide within the UK system as  
 9 to what both the protocols for diagnosis and treatment,  
 10 as well as what drugs are available, are funded within 10:33  
 11 the UK. So that would be one core. The ESMO  
 12 Guidelines would be another guideline in oncology  
 13 generally, that's the European Society of Medical  
 14 Oncology. To a certain extent the EAU, that's European  
 15 Association of Urology. But I would say for 10:34  
 16 oncologists in practice in the UK it would be the NICE  
 17 Guidelines and ESMO Guidelines would be the dominant  
 18 guidelines we would adhere to.

19 87 Q. And those guidelines, are they updated and reviewed?

20 A. Yes. 10:34

21 88 Q. Dependant on advances in technology.

22 A. Exactly.

23 89 Q. And medical research?

24 A. Yes, I think most of them get a standard revamp every  
 25 two to three years, but if a new piece of evidence, a 10:34  
 26 new strong piece of evidence comes out then it would be  
 27 incorporated fairly quickly within that guidelines.

28 90 Q. We've heard evidence around the NICE Guidelines and  
 29 they seem to overarch a lot of the clinical practice



1           generally...

2           A.    Yes.

3    91   Q.    In the UK.

4           A.    Yes.

5    92   Q.    Are those guidelines informed by these other 10:34

6           guidelines? Do they work in collaboration in any way?

7           A.    I would say they're informed by the same evidence base

8           that informs all the guidelines. Each guideline

9           committee has a slightly different agenda or different

10          emphasis, I suppose. But essentially they would be 10:34

11          influenced by each other but mostly because they are

12          based on the same sets of evidence, large clinical

13          trials mostly.

14    93   Q.    Are there ever examples of tension between guidelines

15          that allow people to exercise discretion about their 10:35

16          prescribing?

17          A.    Yeah, sure, there would be some differences. Because -

18          especially the European guidelines have to cover a lot

19          of different jurisdictions where practices are

20          organised differently and health services are organised 10:35

21          differently. So, yes, there will be some gaps between

22          them. And there also are some areas where there are

23          evidenced gaps. You don't have a clinical trial to

24          tell you how to do everything, so there are sometimes

25          when you need consensus opinion type thing and there 10:35

26          can be disagreements on those type of consensus views.

27    94   Q.    And in the same context, the guidelines are guidelines,

28          and clinicians clearly have to exercise their own

29          professional judgment.

- 1 A. Yes.
- 2 95 Q. Depending on the clinical presentation of any  
3 particular patient?
- 4 A. Exactly. So each individual patient, especially  
5 relevant in cancer, where the differences between 10:35  
6 patients can, you know, their lifestyle, their  
7 priorities mightn't fit exactly with what the  
8 guidelines were written for. So, yes, you have to have  
9 some flexibility in applying those to an individual  
10 person. 10:36
- 11 96 Q. So keeping in mind that potential flexibility and the  
12 discretion that's exercisable by the clinicians...
- 13 A. Yeah.
- 14 97 Q. Are there circumstances in which you would use  
15 Bicalutamide 50mg once daily as a monotherapy? 10:36
- 16 A. No. Apart from the few weeks around. So what it's  
17 normally - it's used in two broad categories. It is  
18 used for, one, is to prevent testosterone flare in  
19 patients commencing treatment with LHRH agonists or  
20 castration therapy. So usually a week or two prior to 10:36  
21 the first injection patients are on Bicalutamide 50mg  
22 daily, and that's to prevent something called  
23 testosterone flare. So I use that frequently. And the  
24 second circumstance is used in combination with LHRH  
25 agonist therapy. And a patient who is on that type of 10:36  
26 therapy, but their cancer is starting to progress,  
27 sometimes we add Bicalutamide 50mg daily to the hormone  
28 injection. But it's not as a monotherapy.
- 29 98 Q. And what are the risks of Bicalutamide 50mg as a

- 1 monotherapy?
- 2 A. I don't think there are any particular toxicity risks.
- 3 I think the risk, biggest risk I guess in this context
- 4 would be a patient not having adequate therapy for
- 5 their cancer, perhaps starting definitive therapy for 10:37
- 6 their cancer later than they should have done or -- it
- 7 would depend on how long the patient was on the
- 8 monotherapy for. If they were on it for a very
- 9 extended period of time, like years, that would
- 10 certainly compromise their chance of being cured by 10:37
- 11 other surgery or radiotherapy, depending on which was
- 12 the curative treatment being suggested.
- 13 99 Q. So in those circumstances would you consider it to be a
- 14 suboptimal treatment?
- 15 A. I would definitely consider - if it was being used a 10:37
- 16 cancer therapy, then certainly 50mg daily is
- 17 suboptimal, yes.
- 18 100 Q. The panel heard evidence yesterday around the hormone
- 19 resistance --
- 20 A. Yes. 10:38
- 21 101 Q. -- building up if someone is on this for a long period
- 22 of time, and the body naturally becomes resistant to
- 23 that.
- 24 A. Yeah.
- 25 102 Q. If there is a need then to, as you say, use it in 10:38
- 26 combination with another form of treatment, that they
- 27 may actually, it may prove ineffective because of that.
- 28 Is that --
- 29 A. Yeah, I mean any patient exposed to hormone therapy

1 will eventually become resistant if they're continually  
2 exposed to it. I think my bigger concern about the  
3 lower dose of Bicalutamide is that it would have  
4 inadequate control of the cancer. And while it might  
5 control certain aspects, I suspect the cancer would  
6 progress sooner compared to a patient on full dose  
7 Bicalutamide. 10:38

8 103 Q. Would it be common in your practice to change dosage of  
9 Bicalutamide in response to side effects?

10 A. No, no, not really. I mean when Bicalutamide 150 is 10:39  
11 used there are a number of side effects that patients  
12 can experience. We try to mitigate those, but patients  
13 can experience fatigue, hot flushes, mood swings, and  
14 breast growth and breast pain, which we normally treat  
15 with a drug called Tamoxifen. 10:39

16 104 Q. And what are the circumstances, the clinical  
17 circumstances under which you would prescribe  
18 Bicalutamide 150?

19 A. Yeah. That's commonly used in patients with  
20 intermediate risk prostate cancer who are intended to 10:39  
21 have curative treatment with radiation therapy. And  
22 normally - it depends on the risk group of the patient,  
23 in other words how bad their cancer is, that will  
24 dictate the duration of hormone therapy. But the  
25 minimum will be six months of Bicalutamide 150, and 10:39  
26 normally that's three months therapy before the  
27 radiation treatment, a month during the radiation, and  
28 then six or eight weeks following the radiation  
29 therapy, and that's in conjunction with the radiation.

- 1 105 Q. And that treatment regime involving Bicalutamide 150,  
2 has that been a longstanding regime?
- 3 A. Very much so. I've been doing that for 25 years or so.  
4 It's well established. It's in the NICE Guidelines.
- 5 106 Q. As well as being well established, is that a reflection 10:40  
6 that it is an efficient and effective form of  
7 treatment?
- 8 A. It is an evidence based form of treatment, yes. It's  
9 been proven to be effective. It improves the outcomes  
10 from radiation therapy in those patients. 10:40
- 11 107 Q. When would you expect to see a referral to you as an  
12 oncologist with someone who fits some of the patient  
13 profiles that you've just described?
- 14 A. These days generally it's at the point they've just  
15 been officially confirmed as having prostate cancer and 10:40  
16 that they would be potentially suitable for an opinion  
17 from oncology. So that would be anything from very low  
18 risk early prostate cancer, which might be suitable for  
19 active surveillance, right through to patients with  
20 very advanced metastatic disease. So we would see all 10:41  
21 of those patients. But from my perspective as an  
22 oncologist, we really only hear about the patients once  
23 they have been officially diagnosed with prostate  
24 cancer, and that's when they're discussed at the MDT.  
25 Sometimes a patient might have what we call a clinical 10:41  
26 diagnosis of prostate cancer where they haven't had a  
27 biopsy because they're maybe unfit for other reasons,  
28 and in those patients we have to make a sort of  
29 clinical decision that they have prostate cancer. And,

again, that would be at the MDT, and that would be the first point of involvement for oncology.

108 Q. And what are the risks of late referral to oncology?

A. Again, that would depend on the patient category. It would depend on the aggressiveness of the cancer. Many different factors in relation to the patient. So for some patients it might make no difference at all, some patients with very low risk prostate cancer probably are better off not being diagnosed in the first place, and for those patients a delay is not going to make much difference. Other patients at the more advanced disease ending might either miss a chance, the window of opportunity for cure by radiation or surgery or brachytherapy, or a later stage patient might become more symptomatic by the time they were seen by us, for example, developing pain or symptoms of advanced cancer progression.

109 Q. And given your area of expertise and your academic research profile as well, are there times when you would prescribe a non standard protocol based on your own experience or for research purposes, rather than on the published evidence?

A. Well, in a research trial there would be an ethically approved, you know, very carefully controlled experiment. So if a patient's going into there, it would be very much that we look at the ethical as well as the scientific rationale for that study. So that would be a very controlled environment. In a sort of non clinical trial standard clinical practice setting,

1 yes, of course we have to make decisions that are maybe  
 2 outside the guidelines at times. I think proudly in  
 3 Belfast we do this as a group. So if we're going to do  
 4 something that's well outside the guidelines, or  
 5 something that's, you know, that could be questioned 10:43  
 6 later, then we tend to have a peer group discussion  
 7 about that beforehand.

8 110 Q. And when you referred to outside the guidelines, is  
 9 that the same as saying that the use would be  
 10 unlicensed? 10:43

11 A. Yeah. No, not necessarily, no. It might be using a  
 12 licensed drug but maybe in a different circumstance  
 13 than the guideline. The guidelines and the licence are  
 14 different things really. The licence has more to do  
 15 with the pharmaceutical, is it a proven pharmaceutical? 10:43  
 16 Is it safe? Are the production appropriate, etc.?  
 17 Whereas the guidelines is telling you where you should  
 18 use that or where the evidence base supports using that  
 19 therapy or drug.

20 111 Q. So you can use a licensed drug but in an non evidence 10:43  
 21 based way?

22 A. Or in a non guideline way. Yes. You know, there may  
 23 be an evidence -- usually it would be a situation where  
 24 there is an evidence gap, where there is no specific  
 25 evidence to guide a particular clinical scenario. And 10:43  
 26 that could be a patient who has a big comorbidity, for  
 27 example a heart disease, or a lung disease, or liver  
 28 disease, something which makes it difficult to give  
 29 them standard therapy and you have to be a little bit

1 more flexible.

2 112 Q. And if you were to step to the side of the guidelines,  
3 or outside the guidelines, as you say with how the  
4 patient presents...

5 A. Yes. 10:44

6 113 Q. What would you tell the patient about that? What way  
7 would you inform them and how would you record that?

8 A. Yeah, generally we'd be very straight with patients,  
9 saying that "In your particular situation this would be  
10 the standard treatment, but for whatever reason in your 10:44  
11 situation we can't do that", and we would have a  
12 discussion about it, "and here's what we've decided to  
13 do based on our best opinion." As I say, we would make  
14 them aware.

15 114 Q. And would you record that in the notes or is that not 10:44  
16 normal practice?

17 A. I would say generally if something is very much outside  
18 the guidelines I would dictate in the notes that I've  
19 discussed with my colleague, and probably name them so  
20 that they're in there too. 10:44

21 115 Q. At what point, if you were -- at what point would you  
22 consider experimental therapy for patients with  
23 prostate cancer?

24 A. I consider that for every single patient I see, because  
25 that's my job is to be experimental with designing new 10:45  
26 treatments. So I really try to think about - in our  
27 clinical practice in Belfast we try to have a clinical  
28 trial for each, as much as possible, each different  
29 clinical scenario. So I think of research for most



1 patients. However, thankfully things have improved a  
 2 lot in prostate cancer care, so we know a lot more.  
 3 Compared to when I started 20 years ago, we're a lot  
 4 better at managing, especially high risk and advanced  
 5 prostate cancer.

10:45

6 116 Q. And in practical terms how do you go about arranging  
 7 that sort of therapy?

8 A. Experimental therapy?

9 117 Q. Yes.

10 A. That's a long journey. So it depends on the type of  
 11 clinical trial. Let's say a clinical trial that I've  
 12 designed myself, which we've had a few of those, you  
 13 start with an idea, then you build a team of scientists  
 14 and clinicians around that. It usually takes three or  
 15 four years to go from an idea to a clinical trial

10:45

10:45

16 opening, and what's done in that time is you make sure  
 17 that you have the ethical approval, you've a protocol  
 18 that's acceptable to everybody, and you have to meet  
 19 the regulations, for example the NHRA, the various  
 20 different national guidelines have to be met. And then  
 21 once it's been approved for opening, and that's usually  
 22 by a sponsor, so in trials that I would run, Belfast  
 23 Trust would be the sponsor for a number of trials, and  
 24 they do the overall I suppose governance of the trial  
 25 to make sure it's reason properly, and then we have  
 26 clinical research nurses, as well as my colleagues, who  
 27 would tell the patient about the trial, would give them  
 28 information and then they take part. But it's usually  
 29 a two or three-year gestation to get a trial from idea

10:46

10:46

1 to opening.

2 118 Q. Now we've talked about outside guidelines in  
3 prescribing and I've just asked you a question about  
4 experimental therapy.

5 A. Yeah. 10:46

6 119 Q. What would be the definition of experimental therapy in  
7 the context that you've just described? That sounds  
8 like a research project that has obviously a great deal  
9 of oversight.

10 A. Well, to me experimental therapy, in the context of how 10:46  
11 I work, is therapy that's being offered as part of a  
12 clinical trial, that it's something which has not yet  
13 been proven to be of use or in a particular clinical  
14 scenario, and you're either testing to see how safe or  
15 how toxic it is, or you're deciding - you're comparing 10:47  
16 that to a current standard therapy. So there are  
17 different -- it depends on the phase of clinical trial.  
18 If it's one where it's almost to the patient, we cause  
19 that a Phase 3 trial, and you're basically comparing  
20 the experimental or the unproven treatment to the 10:47  
21 current standard guideline treatment and you see is it  
22 better or worse or whatever. So that's how I would  
23 design experimental.

24 120 Q. And that's a way of trying to establish if there's a  
25 new evidence base for new treatment? 10:47

26 A. Yes. So you would be based on some sort of scientific  
27 or clinical hypothesis that you think, well, I think  
28 this therapy might work in these patients because of X,  
29 Y and Z reason. Then in order to get a trial open you

1 have to, other people have to agree with you that that  
 2 is a reasonable experiment or a reasonable question to  
 3 ask, and then, depending on the type of trial, it might  
 4 be comparing that idea, or that new treatment, or that  
 5 new way of doing the treatment to a current standard of 10:47  
 6 care.

7 121 Q. And from what you've said, it would appear to be the  
 8 case that that's the pathway for a drug to become  
 9 licensed?

10 A. In general terms, yes, especially pharmaceutical. So 10:48  
 11 if the pharmaceutical company has a new product in  
 12 development, they will tend to do the large Phase 3  
 13 trial, and exactly that, the purpose of that trial,  
 14 it's called a registration trial, would be to get the  
 15 drug licensed or available for a particular disease 10:48  
 16 situation.

17 122 Q. So everyone could look back and say "We got to this  
 18 point with this licensed drug based on that research,  
 19 this evidence base, and we know about the efficacy of  
 20 the drug"? 10:48

21 A. Yes. Yeah, efficacy and safety as well, yes.

22 123 Q. In relation to standards and guidelines that are  
 23 adopted in your practice...

24 A. Yeah.

25 124 Q. Are they analysed or reviewed by departments within 10:48  
 26 hospital, or within the Trusts, or what way does that  
 27 work from your clinical experience?

28 A. Yeah, well, certainly when the NICE, when NICE come up  
 29 with a new therapy, or they've approved a new therapy,

1 for example, I will normally get an e-mail from  
 2 somebody in the pharmacy department in the Trust saying  
 3 "NICE have just approved this. We have three or six  
 4 months to implement. What are the plans?", and you  
 5 know, whenever I've been in positions where I've been 10:49  
 6 the lead for a particular drug coming in, then I would  
 7 liaise with pharmacy to make sure the drug is available  
 8 for our patients, according to NICE Guidelines. We  
 9 have a certain amount of time to implement that.

10 125 Q. And if you wanted to deviate from those guidelines, 10:49  
 11 NICE Guidelines, if you would at all, how would that  
 12 happen?

13 A. Yeah. I mean I would say it's not that common that we  
 14 deviate, because essentially NICE Guidelines  
 15 particularly covers drug therapies, and if NICE haven't 10:49  
 16 approved it then we can't afford the drug. So. Or we  
 17 can't offer the patients the drug.

18 126 Q. What about a deviation from the MDT or the MDM opinion  
 19 or view?

20 A. Yeah. 10:49

21 127 Q. I know it's only a recommendation and, of course,  
 22 things may change, it's a point of contact post MDM...

23 A. Yes.

24 128 Q. But if you wanted to deviate from a recommendation, how  
 25 would you go about that? 10:49

26 A. Again, I think that would be fairly uncommon in my  
 27 situation. But a lot of MDT recommendations are quite  
 28 general. For example, it might say something like  
 29 "Patient should have, should be offered curative

1 therapy", and in that case then they go and discuss  
 2 surgery with one of the urologists, they discuss  
 3 radiation therapy or brachytherapy with ourselves, and  
 4 then we have a shared decision. So the MDT is not  
 5 saying this patient should have surgery or should have 10:50  
 6 -- or even, it won't even say what type of hormone  
 7 therapy they should have, for example, it just says  
 8 "This patient should be considered for curative  
 9 treatment". That's one example. So even though -- in  
 10 my view that's quite a broad group of recommendations. 10:50  
 11 If you were to say, if the MDT was to recommend that a  
 12 patient should have curative, or should be considered  
 13 for curative therapy and you decided, no, they  
 14 shouldn't be considered for curative therapy, that  
 15 would be a very big deviation from the MDT, in my view. 10:50  
 16 So if I saw the patient and I go "No, I don't agree  
 17 with the MDT, this patient is palliative or not for  
 18 treatment."

19 129 Q. And what would you do about that?

20 A. I mean I would definitely discuss that with other 10:51  
 21 colleagues and say -- well, I would ideally have it  
 22 rediscussed at the MDT and say "well, actually, we've  
 23 got further information now." For example, "This  
 24 patient has very severe dementia and they're probably  
 25 not suitable for radical treatment", something that may 10:51  
 26 have been missed in the diagnostic pathway.

27 130 Q. And what are the ways in which you might be aware that  
 28 a colleague or practitioner has deviated from  
 29 guidelines or recommendations?

- 1 A. It might be difficult to know that for sure. In our  
 2 practice in Belfast it's very much a group practice, so  
 3 I think it would be unusual, because we tend to, as a  
 4 group, we see the patients as a group of doctors, we  
 5 don't have individual patients allocated to ourselves. 10:51  
 6 So I think it would be unusual that that would happen  
 7 in any kind of frequent basis without us having  
 8 discussed with each other.
- 9 131 Q. So you don't always see the same patients if they come  
 10 back? You share patients? 10:51
- 11 A. Correct. Yes.
- 12 132 Q. And is that a way of having some peer oversight?
- 13 A. It's a mixture -- I think that's one, definitely one  
 14 benefit of that practice. It also means that  
 15 individuals don't have to be there every clinic, so we 10:51  
 16 can share the practice. But definitely one benefit of  
 17 that is maybe identifying if there's somebody sort of  
 18 going on a solo run of some description.
- 19 133 Q. And if you saw a solo run, how would you deal with  
 20 that? 10:52
- 21 A. I would say that would be a conversation we would have  
 22 together quite informally as colleagues. I can't  
 23 imagine that happening in our current setup, but if it  
 24 did, it would be very easy to have a conversation with  
 25 each other as a group of doctors. 10:52
- 26 134 Q. And when -- the setup that you've just described, how  
 27 long has that been in place in the Belfast Trust in  
 28 your particular team where that --
- 29 A. Pretty much since I started. This was a practice I

1 brought from Royal Marsden, where I had spent four  
 2 years, and the way we do it is, before each clinic - so  
 3 we have two big clinics in the week, Tuesday and  
 4 Thursday mornings - and for the one hour before each  
 5 clinic we sit down as a group of doctors, we talk 10:52  
 6 through all the patients who are coming to clinic, what  
 7 the purpose of the clinic visit is, is it the results  
 8 of scans, or is it a decision on treatment, or is it  
 9 just a follow-up visit, and as a group we decide, "Yes,  
 10 this gentleman needs to start chemotherapy", or this 10:53  
 11 gentleman needs to stop something or change to  
 12 something else. So we will have a group discussion  
 13 about each and every patient coming. And I have been  
 14 doing that since I arrived back in Belfast. Initially  
 15 it was just myself and one of the nurses, but now it's 10:53  
 16 about 30 people in the room.

17 135 Q. And since 2004?

18 A. 2004 was myself and maybe one nurse, and then we built  
 19 it up over time as the team built, yes.

20 136 Q. I just want to go back to your statement and turn to 10:53  
 21 some of the concerns around Mr. O'Brien's referral to  
 22 you, or referrals that you picked up.

23 A. Yeah.

24 137 Q. And if we go to WIT-96649, paragraph 1(iii). So  
 25 question: 10:53  
 26

27 "When did you first become concerned about the use of  
 28 Bi cal utami de?"  
 29

1 And you say:

2  
3 "I can't recall the exact time I became aware of the  
4 issue, but it was during my initial few years as a  
5 consultant in Belfast (2004 to 2008). The vast 10:54  
6 majority of my referrals were from the Belfast City  
7 Hospital urology team, however I also received  
8 occasional referrals from Mr. O'Brien or other members  
9 of the Southern Trust urology team.

10  
11 (iv) What was the cause of your initial concern? 10:54  
12

13 My concern was about the use of the oral antiandrogen  
14 Bicalutamide 50mg as monotherapy for the treatment of  
15 localised prostate cancer. The correct monotherapy 10:54  
16 dose of Bicalutamide is 150mg or alternatively LHRH  
17 agonist therapy. I noticed several cases where  
18 patients had been on Bicalutamide 50mg as a  
19 monotherapy, prescribed by Mr. O'Brien. My concern was  
20 that Bicalutamide 50mg was a suboptimal dose of hormone 10:54  
21 therapy when used as a monotherapy."  
22

23 Then you're asked at (v):  
24

25 "Please indicate at that time your specific concerns in 10:55  
26 relation to the use of Bicalutamide were?"  
27

28 And your answer is:  
29



1 "My specific concern was that patients were receiving a  
2 non evidenced based hormone therapy dose which might be  
3 suboptimal therapy for patients with prostate cancer."

4  
5 we'll just stop there and discuss the detail of your  
6 issues at that point.

10:55

7 A. Yes.

8 138 Q. So, as set out, you start in 2004, referrals either  
9 came in through a named route or as a general referral  
10 and you may have picked up one?

10:55

11 A. Yeah.

12 139 Q. You've mentioned in your statement that you had a few  
13 concerns. Do you recall the number, the number of  
14 patients that raised concerns with you?

15 A. In thinking about this, it was three is the number that  
16 comes to me.

10:55

17 140 Q. And you don't -- do you have any specific recollection  
18 of those patients?

19 A. I do not, no. No.

20 141 Q. Now, when you first noticed this, was it when you spoke  
21 to the patient or based on the referral letter? When  
22 did you first recognise that Bicalutamide 50mg as a  
23 monotherapy had been prescribed?

10:56

24 A. In taking a history from the patient.

25 142 Q. Would the referral letter have included that  
26 information?

10:56

27 A. Possibly. But I don't recall that specifically. But I  
28 would have, you know, part of the assessment of a  
29 patient is going through, "Okay, what treatment have

1           you had so far? when did you start that?"

2   143   Q.   And in 2004, when a patient was being referred to an  
3           oncologist, was a letter sent to the GP?

4           A.   I would think that would be pretty standard practice.  
5           But I don't recall specifically if these had copied a   10:56  
6           GP. But, yes, usually the GP is aware, yes, or is made  
7           aware.

8   144   Q.   And the GP would be responsible for issuing the  
9           prescription for treatment, or would that have been  
10          picked up at the hospital do you know?   10:57

11          A.   Yeah. Usually in Northern Ireland the way it works is  
12          you write an outpatient prescription form that you  
13          either give to the patient or sent to the GP practice,  
14          and then the GP practice then puts that on to a script  
15          that's brought to a chemist. Generally in hospital   10:57  
16          medicine here you don't prescribe directly to  
17          pharmacies.

18   145   Q.   And we have spoken about the longstanding nature of  
19          Bicalutamide prescribing.

20          A.   Yeah.   10:57

21   146   Q.   Would that have been information that one might have  
22          expected a GP to know, that standardised dose of 150?

23          A.   I don't think so, no.

24   147   Q.   Is that because of the area of specialty, that if they  
25          hadn't of experienced a patient on that, they may not   10:57  
26          necessarily have that brought to their attention?

27          A.   Yeah. I think it's quite niche area of expertise,  
28          especially with regards different doses of  
29          Bicalutamide. GPs would be well aware of Bicalutamide,

1 but they may not be as aware of the subtleties and  
2 difference in dose.

3 148 Q. Do you recall the clinical presentation of the three  
4 patients at all?

5 A. I don't. But my assumption, based on the fact that it 10:57  
6 was 50mg, was that they were patients with potentially  
7 curable prostate cancer, but I can't recall their  
8 particular risk groups.

9 149 Q. Now, you've given us scenarios, I think earlier you  
10 gave us two scenarios in which Bicalutamide 50mg may be 10:58  
11 used in combination with another as part of a regime.

12 A. Yes. Yes.

13 150 Q. Given the concerns that you identified with three  
14 patients, is it fair to say that those patients didn't  
15 fit that profile? They weren't on a combined regime in 10:58  
16 any way?

17 A. Correct. So, they would have been ones where they were  
18 solely, the sole treatment for, at least for the  
19 cancer, was Bicalutamide 50mg daily. And that would  
20 have stood out as being outside standard practice to 10:58  
21 me.

22 151 Q. So, the way they presented didn't justify in any way,  
23 in your view, them being on Bicalutamide 50mg as a  
24 monotherapy?

25 A. No. 10:58

26 152 Q. Now, just you've mentioned the time period that you  
27 were aware of this from 2004 to 2008.

28 A. Yes.

29 153 Q. And the Inquiry has seen an e-mail then from Darren

1 Mitchell, which you obviously had sight of in 2014?

2 A. Yeah.

3 154 Q. Which is obviously a decade later.

4 A. Yes.

5 155 Q. When the issue was continuing to be raised. 10:59

6 A. Yeah.

7 156 Q. When you first -- if I can ask you, and I appreciate

8 that you can't recall particular details.

9 A. Yes.

10 157 Q. When you saw the first patient, was there any sense 10:59

11 from you that this was an error, that you just didn't

12 understand it, or did it alert you right away that

13 there was a concern?

14 A. I can't remember specifically the order of patients,

15 but it certainly jumped out as something which was not 10:59

16 standard care, standard of care. But it didn't raise

17 any major alarm bells, you know. It could have been an

18 error. There's a number of explanations why -- you

19 know perhaps the patient had been planned to receive

20 the hormone injection, in which case being on 10:59

21 Bicalutamide monotherapy for a few weeks would be okay.

22 But clearly these cases it was longer than a few weeks.

23 I can't remember exactly, but certainly it stood out as

24 being not being prescribed in preparation for an

25 injection of hormone therapy. 11:00

26 158 Q. And that applies to all three patients that you recall?

27 A. Yes.

28 159 Q. Now, I know that you've said in your evidence, and

29 we'll go on to that, that you corrected the

1 prescription to 150mg, but did you say anything to the  
2 patient at the time?

3 A. I can't recall. But I certainly would have explained  
4 that I'm putting you on to a higher dose of  
5 Bicalutamide. I'm not sure if I would have discussed 11:00  
6 any detail as to whether I thought that was right or  
7 wrong or -- I can't remember.

8 160 Q. And you recall that this patient was referred to you,  
9 or was the referring clinician Mr. O'Brien?

10 A. Yes. 11:00

11 161 Q. Now, the second time that it happened and the same  
12 issue arose, you can't help us with what timeframe  
13 there may have been between that?

14 A. I can't. They may be quite close together. I really  
15 can't recall the timeframe. I know it was -- all I 11:01  
16 know is it was early in my consultant years here. I  
17 was quite a junior consultant at the time. So I can't  
18 remember the exact sequence of - they may have been  
19 reasonably close together, I can't recall.

20 162 Q. And did that engender any concerns within you that 11:01  
21 "here we go again"?

22 A. Not particularly, no. I don't recall thinking like  
23 that. I guess it was still relatively early days,  
24 getting to know Northern Ireland and the health service  
25 here as well, so... 11:01

26 163 Q. But you do recall that the referring clinician was  
27 Mr. O'Brien?

28 A. I do, yeah.

29 164 Q. And then on the third occasion when this happened and

1           you noticed it, was this a potential trigger point for  
 2           there being an issue here?

3           A.   Possibly so. But I don't recall it being that, and I  
 4           certainly didn't escalate it at the time. I probably  
 5           dealt with it in the same way, which was just writing 11:01  
 6           back saying "I've now switched him to the full dose of  
 7           Bicalutamide."

8   165   Q.   Was the commonality of all of the patients were that  
 9           they were referred from the same clinician on a drug  
 10          regime that was suboptimal and not prescribed? 11:02

11          A.   Yes.

12   166   Q.   -- for licensed use?

13          A.   Yeah. And I had never encountered Bicalutamide 50mg as  
 14          a monotherapy before from any other doctor.

15   167   Q.   I suppose the point I'm asking you to comment on: Was 11:02  
 16          the commonality of those issues sufficient for you to  
 17          identify that there was something going on?

18          A.   In retrospect, that seems to be the case. But at the  
 19          time, I don't think it occurred to me, no.

20   168   Q.   Now, you described earlier that you could be a named 11:02  
 21          referral or random, I think you used the word  
 22          "randomly" --

23          A.   Yeah, it would be "Dear Oncologist".

24   169   Q.   "Dear Oncologist" or "Dear" --

25          A.   Or "Dear" -- if there was -- I think the only reason it 11:02  
 26          would be specifically to my name might have been  
 27          perhaps a patient who I'd looked after a friend or a  
 28          relative of theirs already and...

29   170   Q.   Or if Mr. O'Brien knew of your reputation perhaps and

1 wanted to refer to you specifically?

2 A. Perhaps. I don't think he knew much about me in those

3 days though. I was fairly new on the scene, so.

4 171 Q. But the referral nature and the way in which

5 allocations were made... 11:03

6 A. Yes.

7 172 Q. Did that increase the possibility that other people may

8 have been also receiving referrals from Mr. O'Brien?

9 A. Well I'd say most of Mr. O'Brien's referrals would have

10 gone, at that point, to Dr. Stewart, who was the 11:03

11 visiting oncologist from Belfast Trust.

12 173 Q. And how did they get around him to get to you then?

13 A. I don't know. I mean it didn't really occur to me at

14 the time. But, you know, generally the radiotherapy,

15 which is I guess what a lot of patients were referred 11:03

16 for, only takes place in Belfast. So I guess it didn't

17 really matter where the patients were seen initially at

18 that point. The treatment would be in Belfast

19 ultimately anyway.

20 174 Q. So there was a route to get into Belfast and it was 11:03

21 either through Dr. Stewart or yourself?

22 A. Yes. I mean, by far and away the most common was

23 through Dr. Stewart, who was attending the unit.

24 175 Q. Did you have any concerns about the risk that the

25 patients were being exposed to by not being on the 11:04

26 correct clinical regime, given that earlier in your

27 evidence you said that the patients not having adequate

28 therapy for their cancer was the risk of this

29 suboptimal regime?

1 A. Yeah. I think at the time I probably made an  
2 assessment that these particular patients I saw, once I  
3 switched them on to the correct dose and lined them up  
4 for radiotherapy, that they were going to be okay, I  
5 think was my assumption. I think if any of those 11:04  
6 patients, if I had felt they were at a major deficit in  
7 terms of their likely long-term outcome, I probably  
8 would have raised more concerns about it at the time.

9 176 Q. And if you had of considered that there was a greater  
10 risk or that there was harm - and we'll look at that in 11:04  
11 a moment...

12 A. Yeah.

13 177 Q. What would you have done at that time?

14 A. I think if I was convinced that there was definite harm  
15 to patients, I would have raised it with my Clinical 11:04  
16 Director. That would have been the usual route at that  
17 stage of my career.

18 178 Q. And I know you were a consultant at this point?

19 A. Yes.

20 179 Q. Would you have any expectation of the steps that a 11:04  
21 Clinical Director may take when presented with that  
22 sort of information?

23 A. I would assume they would talk to their equal number in  
24 the Southern Trust and see if there is a wider concern, or  
25 probably have a conversation with the individual 11:05  
26 consultant involved.

27 180 Q. So, as we mentioned earlier, the informal approach to  
28 try and see if this is perhaps a misunderstanding, lack  
29 of --



1 A. Yes.

2 181 Q. -- proper information, or if there was something else  
3 going on.

4 A. Yes.

5 182 Q. And if that wasn't then resolved, would it be your view 11:05  
6 that, or expectation, that formal governance processes  
7 would be triggered?

8 A. Yes, I think if somebody - if somebody was identified  
9 as practising outside the guidelines without good  
10 reason then I think that would be a governance issue, 11:05  
11 yes.

12 183 Q. If you were to see letters like this, containing  
13 information where clinical regimes are not evidence  
14 based and acting outside guidelines currently, what  
15 would you do? what would you do now today about this? 11:05

16 A. Yeah. I think - first of all, I think the easiest  
17 thing would be talking to my colleagues and see is this  
18 just an error or is this a one-off or what? You know,  
19 try and understand the situation. If it was a pattern  
20 of behaviour then I think Clinical Director is the 11:06  
21 first route in the sense of my line management to let  
22 them know. So that would be my first port of call.

23 184 Q. So, the modes of dealing with this issue are  
24 effectively the same as they were in 2004?

25 A. I think so, yeah. Yeah. Where it goes from there may 11:06  
26 have changed, but as a clinician operating, or working  
27 in Belfast Trust, my line manager would be Clinical  
28 Director, and that be would the first person I would  
29 notify.

1 185 Q. And from your earlier evidence it would seem that your  
2 view is that something like this could happen again,  
3 couldn't happen again, because there is greater  
4 collective vision on documents and patient pathways?

5 A. Well, I can only speak for the practice we have in 11:06  
6 Belfast. It would certainly be very unlikely to happen  
7 in our practice the way it is right now in Belfast with  
8 peer oversight.

9 186 Q. And I think from your statement, you didn't actually  
10 speak to anyone about this at the time? 11:07

11 A. No.

12 187 Q. Was the first time that you mentioned it in 2014, when  
13 Darren Mitchell brought up the issue that he had  
14 identified, and indicated that he was going to send an  
15 e-mail? 11:07

16 A. Yeah, that certainly -- when he brought up a case, that  
17 refreshed my memory that I had encountered some cases  
18 earlier in my career, yes.

19 188 Q. Just on the law of averages, you have seen, you think  
20 you recall three cases between 2004 and 2008? 11:07

21 A. (Witness Nods).

22 189 Q. Darren Mitchell then from 2008 to 2014 thinks he saw  
23 three cases.

24 A. Right.

25 190 Q. Do you think that there's a possibility that other 11:07  
26 clinicians had cases like this?

27 A. It's possible, yeah.

28 191 Q. What sort of team numbers, what sort of numbers are we  
29 talking about potentially who could have got referrals

1 or had knowledge of this?

2 A. So, oncologists who would have -- over the course of  
3 the last 20 years you mean? Probably eight to ten  
4 oncologists, something like that. Yeah. There were  
5 some oncologists who spent a short time as locums 11:08  
6 servicing the Southern Trust, they would have had some  
7 --

8 192 Q. Moving around, staff moving around?

9 A. Yes. Yes. So there would have been some people sort  
10 of filling in for a while and then more substantive 11:08  
11 posts. There were a few people who stayed for a while  
12 and then moved on. So probably about ten people  
13 altogether.

14 193 Q. And you don't remember anyone discussing this issue  
15 with you? 11:08

16 A. Not particularly, no. No.

17 194 Q. When you say "not particularly", I suppose I need to  
18 try and get a firmer answer, if possible.

19 A. Well, I don't recall specific conversations about this  
20 prescribing pattern. I probably had forgotten about it 11:08  
21 by the time Dr. Mitchell raised it again in 2014.

22 195 Q. Have you ever seen anything like that at all in your  
23 career, where you're getting more than a couple of  
24 referrals with inappropriate clinical treatment on your  
25 view? 11:09

26 A. I can't recall any specific - no, I can't recall any  
27 specific episodes of that, no.

28 196 Q. Did you have any sense, whenever Darren Mitchell spoke  
29 to you in 2014, did you have any sense of ten years

1 later this problem is still here?

2 A. Yeah, probably to a certain extent, yeah. Probably

3 surprised, yeah.

4 197 Q. Did it cause you any concern?

5 A. Not specifically. But, you know, I suppose on 11:09

6 reflection, with all this going on, yes, I suppose

7 perhaps I sort of felt maybe I should have made more of

8 it back in the early days.

9 198 Q. And given what you've said at the start of your

10 evidence around the risks, do you see that there was at 11:09

11 least a potential for an existing patient risk?

12 A. Yes. Yeah.

13 199 Q. Now, you've said that you changed the patient regime.

14 I'll just finish up just on this topic, if that's

15 convenient for the Chair. You said you changed the 11:10

16 patient regime to Bicalutamide 150mg.

17 A. Yeah.

18 200 Q. In doing so, you would have written a letter to the GP,

19 or the referring consultant or both?

20 A. Both. Usually you would write to the referring 11:10

21 consultant saying "Thank you for the referral", but

22 you'd also copy that same letter to the GP so that the

23 GP had the plan of action for the patient in their

24 notes.

25 201 Q. And do you recall how you might have addressed in that 11:10

26 correspondence the fact, first of all, that you had

27 changed the treatment regime and, secondly, that the

28 first treatment regime was in your professional view

29 inappropriate?

1 A. I may not have commented on the appropriateness of it,  
2 but I would have just said that I've now switched to  
3 the standard dose of Bicalutamide and the plan is for  
4 radiotherapy after a period of months, or something  
5 like that. 11:11

6 202 Q. would there be a reluctance to have put something on  
7 paper that might have suggested that you were  
8 challenging the initial treatment?

9 A. Probably, yes, as a junior consultant, yeah, I would  
10 say so, yeah. 11:11

11 203 Q. Do you recall if you ever saw any of those patients  
12 again?

13 A. Not specifically. I'm certain we would have done,  
14 because if they were -- I assume they were radiotherapy  
15 patients, so we tend to follow those men up for five 11:11  
16 years or so after their treatment. So, probably, yes.

17 204 Q. So it wasn't in your mind, or you weren't sufficiently  
18 concerned to look at their notes when you saw them  
19 again to make sure that the 150mg prescription regime  
20 had been adhered to? 11:11

21 A. Well, I would have assumed that the 150 had been  
22 adhered to, yes.

23 MS. McMAHON: Chair, I wonder if this is a convenient  
24 time?

25 CHAIR: Yes, we'll come back at half past eleven. 11:12

26 MS. McMAHON: Thank you.

27

28 SHORT ADJOURNMENT

29

1 CHAIR: Thank you everyone.

2 MS. McMAHON: Prof. O'Sullivan, before the break we

3 were discussing the dosage of Bicalutamide and the

4 150/50 issue generally. When Darren Mitchell gave

5 evidence yesterday, Dr. Mitchell, he had referred to 11:29

6 the fact in his evidence, written evidence as well as

7 oral evidence, that patients not given the correct

8 information or on incorrect treatment regimes can be

9 viewed as having been misled. Would you agree with

10 that? 11:30

11 A. Sorry, could you rephrase that question? Sorry, I

12 didn't quite get...

13 205 Q. Well, Dr. Mitchell was being asked about a variety of

14 patients in relation to bladder cancer in particular...

15 A. Yeah. 11:30

16 206 Q. But the general point to him was, concerned whether

17 patients, if they were on the incorrect treatment

18 pathway, or have been treated in a way that would not

19 be the norm, then there's a possibility, in his view,

20 that they have been misled. 11:30

21 A. Yeah. Yes, that's true, yes. Yeah.

22 207 Q. I appreciate it's easy in hindsight for us to use

23 phrases such as that when you are talking about

24 isolated cases in your mind of three over a four-year

25 period. 11:30

26 A. Yes.

27 208 Q. Can I take it from your evidence so far this morning

28 that the idea that a patient had been misled didn't

29 enter your head back then, or would you just not have

1 framed it that way?

2 A. I was probably more focused on making sure the patient  
3 got the right treatment henceforth, and that was  
4 probably my major focus, to make sure they were  
5 hopefully offered the best advice with regards treating 11:31  
6 their cancer and getting them on to the correct dose of  
7 Bicalutamide and then organising their radiotherapy,  
8 was probably my major focus, rather than worrying  
9 whether they were misled or not.

10 209 Q. And I had asked you if you had spoken to anyone about 11:31  
11 it and you said "not particularly"?

12 A. Yeah. Yeah.

13 210 Q. Did you speak to David Stewart about it?

14 A. I don't recall specifically. I mean if I was talking  
15 to anybody, it would have been him, but I don't recall 11:31  
16 specifically talking to him about it.

17 211 Q. Did he ever raise this issue with you?

18 A. Not that I can recall.

19 212 Q. Do you think it might have been a useful approach at  
20 that time to gauge the experience of your colleagues to 11:31  
21 see if this was a wider problem?

22 A. Yes, I think with more experienced years behind me,  
23 that's certainly what I would do now. But those days I  
24 guess I was still finding my feet as a consultant, so I  
25 probably wasn't as well able to do that type of move. 11:32

26 213 Q. So, if I refer to it as inaction, but I'm not saying  
27 that in a critical way, just in a factual way.

28 A. Sure.

29 214 Q. If I can phrase my question in that way?

1 A. Sure.

2 215 Q. You're saying it was based on your lack of experience  
3 rather than the absence of any governance processes  
4 that would have allowed you to address it?

5 A. Yeah. I mean, looking back, probably I wasn't so aware 11:32  
6 of the governance processes at that stage of my career.  
7 And also I probably had, yeah, not seen it as serious  
8 enough to merit escalation at that time.

9 216 Q. And how do you become aware of governance processes as  
10 you progress through your career? Is it trial and 11:32  
11 error literally, or is it training, updating? How does  
12 that work?

13 A. It's all of the above. But for me, also it was gaining  
14 experience in roles not -- outside the standard  
15 consultant looking after patient role. So in medical 11:33  
16 management. So various roles over the years, MDT  
17 Chair, Lead for Radiotherapy, and then Clinical  
18 Director, you pick up a lot of skills and you meet a  
19 lot of people who have knowledge of these systems and  
20 you learn from them. 11:33

21 217 Q. And do you think that the culture within an  
22 organisation and within departments, and even within  
23 clinics, has a part to play on whether people feel  
24 comfortable raising governance issues?

25 A. I do. Yeah, I do. And I think looking back, you know, 11:33  
26 when I think when I arrived here from London I didn't  
27 know anybody here, I was very, you know, not quite  
28 isolated, but certainly didn't know how things worked.  
29 So that takes a while to get - not just to understand



1 the governance structures, but also to understand  
2 exactly, as you say, the culture. Just coming in from  
3 it cold, it takes a while to understand the culture.

4 218 Q. And the two parts of that maybe are the confidence of  
5 the person who needs to speak about something and also 11:33  
6 a listening ear or a willing recipient of that  
7 information?

8 A. Yes, both of those things, exactly, yeah.

9 219 Q. What would make it easier, in your view, for junior  
10 colleagues, or indeed any colleagues, to raise concerns 11:34  
11 such as this?

12 A. Yeah, I think first of all, it is a culture where  
13 everything gets discussed in a friendly,  
14 non-confrontational manner, and essentially just  
15 leading from the front as a more senior consultant now, 11:34  
16 I certainly would encourage open discussion in our peer  
17 chats when we're discussing patients, and we try not to  
18 have a hierarchical approach to that, but we do bring  
19 -- I have a lot of experience now, so I bring that to  
20 the table. But we really try and create a culture 11:34  
21 where junior members of staff feel empowered, and  
22 that's really just by having a friendly attitude to how  
23 we operate.

24 220 Q. And have you had to talk to colleagues over the years  
25 informally about issues maybe just that you needed 11:34  
26 clarity on or were concerned about? Have you had  
27 experience of that?

28 A. Sure. Certainly as Clinical Director that would be a  
29 weekly occurrence, yeah.

1 221 Q. And as Clinical Director, is that something that, in  
2 your experience, has brought about the necessary  
3 change, or have you had to then instigate formal  
4 governance processes?

5 A. There have been occasions where formal governance 11:35  
6 processes were required. But as I say, for the most  
7 part a more informal discussion solved a lot of things.

8 222 Q. And again from your experience as Clinical Director,  
9 when the governance processes are instigated, whichever  
10 pathway that involves... 11:35

11 A. Yeah.

12 223 Q. Is it your experience that the learning from the  
13 outcome of those processes is fed back?

14 A. Yeah. well, I can only really talk about Belfast  
15 Trust, but that was certainly my experience when I was 11:35  
16 Clinical Director, that whenever incidents happened or  
17 learnings were found, that it was fed back in a pretty  
18 good way, I think.

19 224 Q. When were you Clinical Director? Do you remember the  
20 -- 11:35

21 A. Yes, I do, very well. September 2014 to September  
22 2017. For three years.

23 225 Q. Until September, sorry?

24 A. So it was probably the end of August 2017.

25 226 Q. So you'll know, I'm coming onto the e-mail in November 11:36  
26 2014.

27 A. Yes.

28 227 Q. And if we could just have that e-mail? The panel  
29 looked at this yesterday in detail, but I just want to

1 bring it up again. AOB-71990.

2 A. Yeah.

3 228 Q. Now, we've looked at this, and that's the content of  
4 the e-mail for the purposes of the transcript.

5 A. Yes. 11:36

6 229 Q. And then if we go to WIT-96678? This is the e-mail  
7 forwarded to you with this e-mail attached to it or in  
8 the train of it.

9 A. Yeah.

10 230 Q. So you'll see at the top of the page, the date on this 11:37  
11 e-mail is 20th November. So you were just a couple of  
12 months in...

13 A. Yeah.

14 231 Q. -- in post. 20th November 2014 from Darren Mitchell to  
15 Lucy Jellet, Joe O'Sullivan and... 11:37

16 A. Suneil Jain.

17 232 Q. Sorry, I couldn't see the name. Suneil Jain. And this  
18 is from Darren Mitchell, and he says:  
19

20 "I've e-mailed Aidan to open discussion on this case. 11:37  
21 Copy below for your information only."  
22

23 Now, Dr. Mitchell indicated yesterday when I asked him,  
24 that he didn't discuss the contents of the e-mail with  
25 anyone before sending it. He was surprised, having 11:37  
26 read it again, by his tone. I asked him had anyone  
27 helped him draft it to see if there was a collective  
28 view as to the level of robustness perhaps that should  
29 be reflected in the e-mail, and he said that it was his

1 e-mail alone. Did you have any discussions with  
2 Dr. Mitchell in the lead up to this?

3 A. Just as we discussed earlier, just my recollection that  
4 there had been cases earlier in my consultant career.

5 233 Q. And how did that conversation come about? 11:38

6 A. I can't remember precisely how it came about, but it  
7 probably would have been in our pre clinic meetings on  
8 a Tuesday or Thursday, something around "Oh, I have  
9 this case. Here's the story. What do you think?"

10 234 Q. And you said that or -- 11:38

11 A. No, that would have been probably Darren telling me  
12 about this particular case that is referenced in this  
13 e-mail.

14 235 Q. And it was at that point that that triggered your  
15 recollection? 11:38

16 A. Yes.

17 236 Q. And do you recall then the extent of your conversation  
18 with him?

19 A. No, just that I had recalled early in my career that  
20 there had been some cases. I wasn't very specific, 11:38  
21 because I still can't be very specific about that, I  
22 can't recall the individual cases, but I told him that  
23 I had recalled an issue with Bicalutamide 50mg  
24 monotherapy in my early days as consultant.

25 237 Q. Now, you have seen the e-mail that he sent? 11:39

26 A. Yeah.

27 238 Q. And he has set out the clinical presentation of the  
28 patient?

29 A. Yeah.

1 239 Q. In order to provide, in his mind, his evidence base for  
2 his effectively a challenge...  
3 A. Yes.  
4 240 Q. To Dr. O'Brien's prescription regime.  
5 A. Yes. 11:39  
6 241 Q. Did you talk about that specific case with him?  
7 A. I don't recall precise details, except that this seemed  
8 to be a two year period that this patient was on  
9 Bicalutamide, and that was a lot longer than I would  
10 have recalled from my cases. Two years is a very long 11:39  
11 time for monotherapy.  
12 242 Q. And that two-year period, does that result, by the  
13 nature of its duration, in an increase in risk?  
14 A. It would depend on the exact type of prostate cancer  
15 being dealt with here, whether it was high risk, low 11:39  
16 risk, etc. But I think the assumption is that it was a  
17 detriment to this patient.  
18 243 Q. That there was a risk and a patient safety issue  
19 arising?  
20 A. Yes. Yes. Yes. 11:40  
21 244 Q. Now, you were the Clinical Director at this point?  
22 A. Yes.  
23 245 Q. If we just step away from the process of the e-mail and  
24 the expectation around it.  
25 A. Yeah. 11:40  
26 246 Q. And your conversation with Darren Mitchell, and then  
27 your view of the clinical detail that he provided in  
28 his e-mail...  
29 A. Yes.

1 247 Q. Did you consider that, having now said that it was a  
2 risk and a patient safety issue, that that might have  
3 been something that you should have explored further?  
4 A. Perhaps. In retrospect, I guess the e-mail was very  
5 much to me as a colleague rather than as a Clinical 11:40  
6 Director.  
7 248 Q. And how do we know that from the e-mail?  
8 A. Well, just looking, the fact that my other uro-oncology  
9 colleagues were copied, it wasn't specifically to me as  
10 Clinical Director, it was me being copied in as a 11:40  
11 uro-oncology colleague.  
12 249 Q. Is it your view, when working as a Clinical Director,  
13 that unless someone directs it to you as a Clinical  
14 Director, that there are no governance concerns  
15 arising? 11:41  
16 A. I mean, probably if this had been two or three years  
17 into my clinical directorship I may have handled it  
18 differently. But at this stage my impression was very  
19 much that this was including me as a colleague in  
20 prostate cancer oncology, rather than as Clinical 11:41  
21 Director.  
22 250 Q. I just want to be clear on your evidence. You've said  
23 that you perhaps might have done something and you may  
24 have handled it differently.  
25 A. Yeah. 11:41  
26 251 Q. If you're presented with information that someone is at  
27 risk and patient harm is in existence, given a two-year  
28 delay...  
29 A. Yes.

1 252 Q. I'm just keen to explore what your baseline is for  
2 triggering the use of governance processes. Is that  
3 not enough?

4 A. In retrospect, it does look like that. And probably  
5 with a bit more experience as Clinical Director I 11:41  
6 probably would have escalated this.

7 253 Q. So we're still equivocal?

8 A. Yeah, I mean, it's hard to know. Because this was one  
9 case. The way the e-mail was sent, certainly the way I  
10 read it now is I was being copied in for information 11:42  
11 rather than for action directly. So looking at -- my  
12 impression was that certainly my receipt of the e-mail  
13 at the time was very much as a colleague rather than as  
14 Clinical Director.

15 254 Q. If we just, I just want to be absolutely clear. Your 11:42  
16 receipt of the e-mail, your evidence is that you were  
17 -- this was for information purposes only rather than  
18 any expectation?

19 A. Yes.

20 255 Q. And the panel have your evidence on that? 11:42

21 A. Yes.

22 256 Q. As Clinical Director at that time.

23 A. Yes.

24 257 Q. But I just want to make sure we're clear on your  
25 evidence on the clinical issue arising. 11:42

26 A. Yeah.

27 258 Q. Where it's clearly articulated clinical evidenced  
28 patient harm issue has been put in writing. And I  
29 asked you earlier on is there a reluctance to put

1 things in writing and you agreed. And here we have  
2 Darren Mitchell taking the bull by the horns in one  
3 respect and putting this in writing.

4 A. Yeah.

5 259 Q. And at this stage you're in post ten years. 11:43

6 A. Yes.

7 260 Q. So, what others might not have done previously in  
8 formal language, he has committed to.

9 A. Yes.

10 261 Q. And he also, in this e-mail, attaches the MDU 11:43  
11 guidelines around the safety and the prescribing of  
12 Bicalutamide. You recall that from the e-mail?

13 A. Yeah, yeah.

14 262 Q. So, in many respects, it's quite a robust approach?

15 A. Yes. 11:43

16 263 Q. And specifically in relation to the patient, did that  
17 not trigger in you any expectation, either as a fellow  
18 clinician or as most particularly the Clinical  
19 Director, that that patient issue needed to be  
20 considered, even if we consider an informal route first 11:43  
21 of all?

22 A. Yes. Yes. Well, I mean, my assumption was that that  
23 was happening by virtue of this e-mail. And I guess I  
24 handled this e-mail as a colleague rather than as  
25 Clinical Director. Perhaps I would have approached 11:44  
26 that differently with a bit more time in the Clinical  
27 Director role.

28 264 Q. Would you handle it differently now?

29 A. Yes.



1 265 Q. I mean you were -- you would?  
2 A. Yes.  
3 266 Q. You're sure about that?  
4 A. I am, yeah.  
5 267 Q. When I asked you earlier about what you would do in 11:44  
6 2004 if the scenario arose where you had been recurrent  
7 prescribing off licences, as you experienced then.  
8 A. Yeah.  
9 268 Q. You said you would speak to your Clinical Director...  
10 A. Yes. 11:44  
11 269 Q. And expect them to speak to their counterpart.  
12 A. Yes.  
13 270 Q. Informally in the other Trust --  
14 A. Yeah.  
15 271 Q. Is this an opportunity that you might have taken at the 11:44  
16 time to do that?  
17 A. Yeah, probably, yes. Yeah.  
18 272 Q. Now, Dr. Mitchell has told us that there was no reply  
19 to the e-mail, there was no discussion, the expectation  
20 obviously from his wording of the e-mail is that it 11:44  
21 would instigate perhaps a response.  
22 A. Yeah.  
23 273 Q. His evidence, in summary form, just in general terms,  
24 was that he anticipated that it would start a  
25 conversation that would allow some clarification. 11:45  
26 A. Yeah.  
27 274 Q. And that didn't happen. Did you follow this up with  
28 Dr. Mitchell and say "what happened with the e-mail?  
29 Did anyone get back to you?"

1 A. I don't recall. But the e-mail, as it's written there,  
2 didn't really ask for action specifically.

3 275 Q. It didn't ask for action from you, but --

4 A. No.

5 276 Q. And I don't want to labour the point, but as Clinical 11:45  
6 Director, on notification of a patient safety issue, it  
7 didn't really have to, did it?

8 A. I guess you could say that, yeah.

9 277 Q. Now, one of the other things that Dr. Mitchell thought  
10 he might utilise to address this concern was the 11:45  
11 guidelines.

12 A. Yeah.

13 278 Q. I'm not sure if you were involved in the drafting or...

14 A. Not specifically, no.

15 279 Q. Any input into them? 11:46

16 A. No.

17 280 Q. Were you involved in them at all?

18 A. Not specifically, no. I wasn't involved in NICaN at  
19 that point.

20 281 Q. Were you aware of the guidelines being drafted? 11:46

21 A. Yes.

22 282 Q. And were you aware that Dr. Mitchell was hoping to use  
23 the guidelines as a route to address?

24 A. Yes.

25 283 Q. And how did that, your knowledge about the intended use 11:46  
26 of the guidelines by Dr. Mitchell arise? Did you have  
27 a conversation with him?

28 A. Yes, he would have spoken to me and my other colleagues  
29 at our weekly meetings.

- 1 284 Q. So would it have been collectively known that the  
2 guidelines were being drafted to address what had been  
3 identified as a potential patient risk issue?
- 4 A. I'm not sure if it was widely known, but certainly part  
5 of the reason for the guidelines was to formalise a 11:46  
6 description of what the correct doses of hormone  
7 therapies were.
- 8 285 Q. Well, was it not a little bit more than that? That it  
9 wasn't just about standardising, it was about  
10 highlighting and indicating that there could be no 11:47  
11 doubt, given that there appeared to be doubt?
- 12 A. I would call that standardising.
- 13 286 Q. In the absence of the issues that arose in relation to  
14 the referrals by Mr. O'Brien, do you think the  
15 guidelines would have been drafted anyway? 11:47
- 16 A. Yeah, I think eventually, yes. I think we have  
17 guidelines for most things, so...
- 18 287 Q. In relation to Bicalutamide dosage, the evidence has  
19 been that that was so widely known that that was the  
20 licensed dosage, 150. 11:47
- 21 A. I think in most guidelines they tend to specify doses,  
22 I would think, yeah.
- 23 288 Q. Did you generally just feel this wasn't an issue?
- 24 A. Not generally -- that what wasn't an issue  
25 specifically? 11:47
- 26 289 Q. The Bicalutamide 50mg monotherapy being prescribed for  
27 people who clinically presented as needing other  
28 clinical regimes.
- 29 A. Okay. I guess this e-mail highlighted that it was

1 still an issue, yes.

2 290 Q. I did generalise my question earlier and said it was  
3 "widely known". What I meant was that it was known  
4 among the colleagues with who whom you worked?

5 A. Yes. 11:48

6 291 Q. Who would have been aware. They would have been aware  
7 that Bicalutamide 50mg monotherapy was being prescribed  
8 or had been prescribed?

9 A. I'm not sure how many of my colleagues were aware, but  
10 certainly myself and Dr. Mitchell would have discussed 11:48  
11 it for sure, yeah.

12 292 Q. Was there any reflection among you or any others who  
13 you may have spoken to, who you can't recall, that  
14 given this had lasted over a ten-year period that maybe  
15 someone needed to have a look at this and perhaps see 11:48  
16 if this was a wider issue?

17 A. I think with regard to the 50mg, I thought this e-mail  
18 discussion was going to hopefully solve things and then  
19 the rewriting of the guidelines or the clarification of  
20 the guidelines. 11:48

21 293 Q. Well, I'll just ask it again just before we move on.

22 A. Yeah.

23 294 Q. This was ten years later.

24 A. Yes.

25 295 Q. Was there any concern in your mind that for the past 11:49  
26 decade this could have been happening? This is a clear  
27 patient risk. You've identified that e-mail does  
28 establish harm, two years. 5?

29 A. Yes.

1 296 Q. Was there any triggering in your mind, "Oh, that has  
2 been going on for ten years at this point"?  
3 A. Not particularly. But in retrospect, yes. At the time  
4 probably not. But in retrospect, yes.

5 297 Q. I just want to bring you to an e-mail, AOB-78095. I 11:49  
6 just need to find the start. Some of the sequencing  
7 can be slightly backwards in the e-mails. So this is  
8 an e-mail chain, the content is largely irrelevant.  
9 It's contact at the time at which you were Clinical  
10 Director. 11:50

11 A. Yeah.

12 298 Q. So this is the start of an e-mail chain from Fiona  
13 Reddick to you, 8th September 2016. I just want to  
14 read it out to give you the opportunity.

15 A. Yeah. 11:50

16 299 Q. It's e-mails you've sent, I know you'll be familiar  
17 with them, and it's just a general point.

18 A. Yeah.

19 300 Q. But for the record. An e-mail was sent to you, Debbie  
20 Whiteman, Gillian Traub, copied in to Aidan O'Brien and 11:51  
21 Rory Convery, and the subject is "Urology MDT each  
22 Thursday", and it says:  
23  
24 "Joe,  
25 On behalf of the urology MDT at Craigavon Area Hospital 11:51  
26 I wish to highlight our concerns at the inadequacy of  
27 attendance by videolink of an oncologist at the  
28 Southern Trust weekly urology MDT. This was  
29 highlighted as a serious concern following last year

1 year's cancer peer review visit and unfortunately the  
2 attendance is actually worse this year to date.

3  
4 We are happy to meet at your earliest convenient to try  
5 to resolve this situation as the urology MDT is not 11:51  
6 quorate."

7  
8 So, the panel has heard quite a bit of information  
9 about the quoracy and staffing issues, and this is  
10 another example in 2016. 11:51

11  
12 You reply and say -- sorry, Dr. O'Brien replies on the  
13 9th, or Mr. O'Brien replies on 9th September to you and  
14 Fiona Reddick, and says:

15 11:52  
16 "Dear Joe,  
17 I would like to echo the concern expressed by Fiona.

18  
19 For some time we did have an improved input from  
20 oncology when Fionnuala Houghton linked in and Judith 11:52  
21 Carser attended (even though neither were available for  
22 a whole meeting). Since their deployment elsewhere,  
23 the input from oncology has deteriorated to the extent  
24 that it has become nonexistent. The last time we had a  
25 link in from oncology was in July. 11:52

26  
27 I have had the view expressed to my colleagues that it  
28 is no longer tenable for us to continue as a MDT unless  
29 this issue is resolved satisfactorily.

I do believe that this does need to be addressed so that it can be determined whether we can continue as an MDT.

Thank you,  
Aidan. "

So Mr. O'Brien is articulating and putting in writing his concerns about the viability of the MDT, given the absence of an oncologist. I presume this is all familiar territory around staffing for you?

A. Oh, yeah.

301 Q. And then you reply on 9th September 2016:

"Dear Aidan and Fiona,  
I agree that cover for the SHSCT Urology MDT has been less than ideal in recent months. As you know this has resulted largely from an SHSCT vacancy which remains unfilled since Dr. Carcer's departure last year. This gap has placed significant strain on the GU/Lung clinic.

I am delighted to inform you that we in BHSCT have appointed an excellent locum consultant, Dr. Ciara Lyons to join Dr. O'Hare in covering the GU/Lung clinic.

Dr. Lyons will link with the URO MTD from next week

onwards. She has outstanding uro-oncology credentials, having just completed a three year PhD fellowship in prostate cancer here at QUB/BHSCT.

We clearly need a more sustainable long-term solution in due course and discussions are in train in this regard.

11:53

Kind regard,  
Joe. "

11:54

So this was - the absence of cover in oncology and the potential for a consultant to come back and say the viability's actually threatened --

A. Yes.

11:54

302 Q. Is a governance concern?

A. Absolutely.

303 Q. And this is, it's almost an informal/formal way of trying to deal with it. I presume they're contacting you as Clinical Director?

11:54

A. Correct.

304 Q. And action was taken to try and fill the gap to allow the quoracy to be maintained?

A. Yes.

305 Q. And then Mr. O'Brien writes back on 9th September and copies in his colleagues; Michael Young, Anthony Glackin, Ram Suresh, Mark Haynes, John O'Donoghue, Gareth McClean, Mark Williams, and Shauna McVeigh, and says:

11:54



1  
2 "Dear all ,  
3 Pleased to share with you some posi tive news regarding  
4 oncology at MDM.

5  
6 Hope that this proves sati sfactory. "  
7

8 Then Tony Glackin replies saying:  
9

10 "Very good news. I have always found Dr. Lyons'  
11 patients' letters to be of a very high standard.  
12 Tony. "  
13

14 So that's an example, perhaps from this remove, at  
15 least for our purposes, of a problem being raised,  
16 cross Trust communication taking place to try and  
17 remedy it.

18 A. Yeah.

19 306 Q. And there being an effective solution. It does lead me  
20 slightly back to what we have discussed; given that you  
21 were in contact with Mr. O'Brien by e-mail at this  
22 point, might it have been appropriate for you to take  
23 the opportunity to raise any concern or issue with him  
24 about Bicalutamide?

25 A. I think at that point the problems were much larger  
26 than Bicalutamide in terms of what we were trying to  
27 sort out, which was inadequate oncology coverage of a  
28 major MDT. So I think those kind of issues would have  
29 been well down my agenda, in dealing with Mr. O'Brien

1 at this point.

2 307 Q. Yes, but I suppose the point in relation to that is, if  
3 you're e-mailing in 2016 about issues and are able to  
4 go back and forth to find solutions, was that an option  
5 available in 2014?

11:56

6 A. It was certainly an option to e-mail Mr. O'Brien, but  
7 obviously I didn't. But this issue of coverage of the  
8 MDT was a completely separate issue. I didn't feel  
9 like just because the lines of communication were open  
10 on that, I could then go back and talk about something  
11 from...

11:56

12 308 Q. Yeah, the suggestion is really that the route of  
13 contact has been used in informal ways and been  
14 successful. That's really just the suggestion that's  
15 being made.

11:56

16 A. Okay.

17 309 Q. Not that you should PS on the end of a 2016 e-mail,  
18 more that as a method of communication, that that was  
19 an option open?

20 A. Sure.

11:56

21 310 Q. That was the direction, I think, behind that question.

22 A. Okay.

23 311 Q. I know we have run around the houses slightly in order  
24 to try and figure out what the landscape was like, and  
25 really the context of the questioning is for learning,  
26 it's for governance learning, to identify flaws that  
27 existed that might help explain why things happen, but  
28 also to identify areas of continued vulnerability that  
29 the panel may turn their minds to for recommendations

11:57

1 and to understand how things have changed. So, really  
 2 it's, that's the global context of the questioning, and  
 3 I hope that came across in my - in the way in which I  
 4 phrased my questions. But now, at the end of my  
 5 questions, I just wanted to ask you around governance 11:57  
 6 generally, improvements that you might have seen, given  
 7 the breadth of your involvement, both in prescribing as  
 8 a clinician, but also as an academic coming and having  
 9 to introduce new ways of thinking and, not sell, but  
 10 certainly develop thinking so that you're leading with 11:58  
 11 best practice.

12 A. Yeah.

13 312 Q. I mean what's your sense of how governance has  
 14 developed since 2004?

15 A. I think there have been a lot of improvements. I think 11:58  
 16 nationally within the UK reorganisation of cancer  
 17 services has made a big difference, and that was the  
 18 standardisation of the MDTs so that decision-making,  
 19 that each patient has really got access to expert multi  
 20 disciplinary opinion. So that was a big change 11:58  
 21 nationally within the UK.

22  
 23 I think within Northern Ireland specifically, or  
 24 Belfast Trust specifically where I have been working, I  
 25 think that certainly during my time as Clinical 11:58  
 26 Director I saw improvements in how incidents were  
 27 handled, the openness of approach in dealing with those  
 28 incidents, and the attempt at finding learnings from if  
 29 something happened, assessing it, what happened, but

1 very importantly, trying to have new learning from  
 2 that. So I certainly saw that improve in my time as  
 3 Clinical Director and beyond that.

4  
 5 I think the MDTs have also improved, but we have a lot 11:59  
 6 of challenges. I think the coverage of the Southern  
 7 Trust with oncology is one example. That's a mixture  
 8 of inadequate funding, which I think the cancer  
 9 services probably are inadequately funded, and I think  
 10 also we're practising based on the Campbell Report, 11:59  
 11 which is well over 20 years old now. So I think that  
 12 while things have improved, I do think we need a new  
 13 assessment of how oncology is organised, particularly  
 14 with regard to the hub and spoke model. I think that  
 15 governance would be improved a lot more if we were a 11:59  
 16 more, a more coherent and better funded service.

17 313 Q. well, it's a combination of both the funding, but also  
 18 the willingness to engage with new ways of thinking  
 19 around governance?

20 A. I think organisation around that could be improved. 11:59  
 21 But certainly in my 20 years here in Belfast I've seen  
 22 big improvements in both identifying incidents and then  
 23 learning from them.

24 314 Q. Just in relation to anything I've asked or anything  
 25 we've covered, is there anything else you want to say 12:00  
 26 at this point before the panel may have some questions  
 27 for you?

28 A. No.

29 MS. McMAHON: Thank you very much. I'll just hand you

1 over to the Chair.

2  
3  
4 QUESTIONS BY THE PANEL

5  
6 CHAIR: Thank you. Professor, I'm going to ask  
7 Mr. Hanbury to ask you some questions first of all.

8 MR. HANBURY: Thank you very much for your evidence,  
9 you've answered a lot of my questions so far. I've  
10 just got a few little things. 12:00

11 A. Okay.

12 315 Q. You say in the early days when you picked up the  
13 Bicalutamide 50 question it was really in the context  
14 of low grade localised disease. Were you aware of any  
15 patients that came with high grade disease that you  
16 saw? 12:00

17 A. I can't specifically recall, but I know that they were  
18 likely to be patients who were in the curable bracket  
19 in that they were localised. But the actual risk  
20 group, I'm not sure exactly. 12:00

21 316 Q. Okay.

22 A. But the fact that they were being referred for  
23 radiotherapy makes me think they're probably  
24 intermediate, most likely intermediate to high risk  
25 patients. 12:00

26 317 Q. The Inquiry are aware certainly in this of nine SAIs we  
27 saw later of two patients particularly who had high  
28 grade disease but were given Bicalutamide 50 and it  
29 progressed actually very rapidly.

1 A. Yes. Yes.

2 318 Q. From what you say, that wouldn't surprise you --

3 A. Well, I mean, certainly if a high risk patient is

4 receiving Bicalutamide, one would expect they would

5 progress, yeah. 12:01

6 319 Q. Mr. O'Brien had a particular style where he would

7 monitor the PSA and refer on to oncology when he was

8 happy there was a response. Is that something that

9 you've come across from other clinicians or something

10 you'd recommend? 12:01

11 A. Certainly not something I recommend. I think that the

12 evidence base for the duration of hormone therapy is

13 very strong, we have level one evidence from several

14 randomised trials showing that the hormone therapy,

15 what, what the duration should be; for example, three 12:01

16 months before the radiotherapy and then, depending on

17 the risk group, continuing for two to three years. So

18 that's pretty clear what the evidence base for that is.

19 And the idea of just trying a hormone therapy and

20 seeing how it goes, does not fit any evidence base that 12:02

21 I'm aware of.

22 320 Q. In fact the opposite might be true; if you didn't have

23 a response to hormones, it might be more important --

24 A. Yes.

25 321 Q. That oncologists see -- 12:02

26 A. Agreed. Yes.

27 322 Q. So bouncing on from that, there's one clinical scenario

28 which faced colleagues at Southern Trust, and this was

29 really with relation to a triage issue.

1 A. Yeah.

2 323 Q. Where a patient was sent in with a PSA of 34 and pain -  
3 I'm not exactly sure where the pain was.

4 A. Okay.

5 324 Q. And subsequently shown to have high grade prostate 12:02  
6 cancer with lymph node mets, and was actually seen by a  
7 different type of surgeon, a vascular surgeon, and when  
8 it was being decided whether or not to flag this up as  
9 an SAI, a comment was made, "well, it was probably a  
10 three month delay in diagnosis, but that wouldn't have 12:02  
11 affected survival."

12 A. Yeah.

13 325 Q. Which is a slightly curious response.

14 A. Yes.

15 326 Q. It didn't seem right to me. But anyway. What was your 12:03  
16 view on that, just off the top of your head?

17 A. Yeah. I mean it's certainly difficult to estimate what  
18 effect that would have on survival, but one would  
19 assume if a patient with node positive prostate cancer,  
20 any delay will result in more likely chance of 12:03  
21 spreading or becoming less curable, I would have  
22 thought. But it's hard to quantify that though.

23 327 Q. Yes. There was a study back in the '90s, a sort of  
24 randomised study with metastatic disease, between early  
25 and delayed hormone therapy? 12:03

26 A. Yes, the MRC trial, yes.

27 328 Q. The MRC trial. But do you think that comment may have  
28 come from that study or...

29 A. Possibly so. But I mean, I think to me, a patient who

has developed lymph node metastases is somebody who is going to die from prostate cancer if they're not treated properly. So the longer you the wait, the more likely the cancer has to spread. I think the difficulty is that even with a patient who is classically high risk or has developed lymph node metastases, the trajectory of that disease is still hard to assess just from the fact you've outlined. If you saw a couple of years of PSAs or you had some idea of the rate of growth, then you could have a better estimate of the impact on that particular patient.

12:04

12:04

329 Q. Thank you. Just lastly really on this sort of quoracy issue. I mean from your evidence, it was actually quite impressive how well Southern Trust were served when Dr. Stewart was there and there were really no problems.

12:04

A. Yes.

330 Q. And we've just seen in e-mail correspondence you did find a colleague to come in. I'm not sure did Dr. Lyons come in and, if so, for how long was that for?

12:04

A. She certainly did come in. But how long she was there, I'm not quite sure. She then subsequently moved on. The difficulty is filling these sort of locum positions, that people will tend to move on if they get a substantive post somewhere. So I think she got a substantive post in the south of Ireland and moved on. But I'm not sure how long she was in that particular role.

12:04

331 Q. So, going back to the sort of colleagues at the



1 Southern Trust who were, as to quote you, the sort of  
 2 cover was patchy?

3 A. At best.

4 332 Q. So they were then back and unsupported again. I  
 5 suppose my question is really: How do you see the 12:05  
 6 responsibility of the host cancer centre to say  
 7 "Listen, colleagues are really struggling in this  
 8 particular place. Who can do this? Are there any  
 9 sessions? Can we back up?"

10 A. Yeah. 12:05

11 333 Q. I mean as Clinical Director, pretty much at that time.

12 A. Yeah.

13 334 Q. Did you feel a responsibility for that? There was just  
 14 no solution? How did you handle that?

15 A. Yeah. It was a very frustrating period, and I mean one 12:05  
 16 of the challenges as Clinical Director of Oncology in  
 17 Belfast Trust, you sort of assume running the whole of  
 18 the cancer service, which is not within the role and  
 19 certainly not within the timeframe allocated within  
 20 that. But we'd an excellent team in Belfast Trust. 12:05  
 21 And, again, the regional cancer service tended to  
 22 default to Belfast Trust, I think, both formally and  
 23 informally. So we did, as the Belfast Trust team, we  
 24 did feel responsible for the regional cancer service  
 25 and for gaps within that. 12:06  
 26

27 The consultants who were attending, oncology  
 28 consultants attending the various unit clinics were  
 29 employed by Belfast Trust, so we had that

1 responsibility, except for one, which was Dr. Carser,  
2 who was a direct Southern Trust employee. So, yes, we  
3 did feel responsible. There were no easy solutions, so  
4 I think we were quite pleased with that innovative  
5 solution at that time. Dr. Lyons was just finishing a 12:06  
6 PhD with myself, she was expert in GU cancer, but there  
7 were no easy solutions. And, also, we also looked at  
8 hiring locums. And, again, that was done at different  
9 times. But it was very challenging to find people.  
10 There are not that many oncologists who can take on a 12:06  
11 GU practice like that who are locums.  
12 MR. HANBURY: Okay. Thank you very much. That's all  
13 I've got.  
14 CHAIR: Thank you, Mr. Hanbury. Dr. Swart?  
15 DR. SWART: Thank you. Just earlier on you said 12:06  
16 something which I think is fairly clear, I just wanted  
17 to clarify that.  
18 A. Okay.  
19 335 Q. It was when you were being asked about experimental  
20 treatments. And from my reading the tenor of your 12:07  
21 evidence was that if you're going to use something  
22 that's not absolutely standard, that should be done  
23 within the auspices of a clinical trial. And that is  
24 the preferred route. But -- unless there are  
25 exceptional circumstances. So I think that's what you 12:07  
26 were saying?  
27 A. I think I was saying -- well I think the question was  
28 around experimental therapy.  
29 336 Q. It was.

1           A.    And my understanding of experimental therapy is that  
2                   that should be within a clinical trial. There are  
3                   circumstances where one might use a non guideline  
4                   therapy, or even an off label therapy, outside of an  
5                   experiment and outside of standard clinical practice, 12:07  
6                   but that would be rare.

7   337   Q.    And that would be a discussion, a documented discussion  
8                   with colleagues and so on?

9           A.    Correct. Yes.

10   338   Q.   But not the systematic use of something that's not in a 12:07  
11                   trial and not evidence based?

12           A.    Correct. Yes.

13   339   Q.    Okay. Yeah. Is it your view that compliance with NICE  
14                   Guidelines should be audited regularly? Is it audited  
15                   regularly? 12:08

16           A.    Yes, and yes. I think especially when new guidance  
17                   comes out about a new therapeutic intervention, yeah,  
18                   we tend to have an implementation plan, part of which  
19                   is auditing a year later, two years later to see are we  
20                   -- 12:08

21   340   Q.    I think they have an audit tool quite often, don't  
22                   they?

23           A.    Yes, yeah. It's part of the implementation process.

24   341   Q.    Yeah. And do you audit compliance with MDM decisions  
25                   at all? 12:08

26           A.    Personally, no. But, yes, there is an audit of MDT.

27   342   Q.    So that is a part of the culture, shall I say?

28           A.    Yeah, very much so, yeah.

29   343   Q.    Yeah. Okay. Patient information. We've heard varying

1 sort of bits of evidence on this. Overall it does not  
2 seem that historically patients were copied in to all  
3 their letters.

4 A. Yeah.

5 344 Q. And patients were not necessarily given full 12:08  
6 information about the different choices, certainly not  
7 about things like doses of drugs.

8 A. Right.

9 345 Q. If you saw these patients today who were on 50, and you 12:09  
10 had to change the dose, would you deal with that any  
11 differently in terms of telling the patient about the  
12 implications of this?

13 A. I suppose it would depend on the scenario, how long  
14 they were on. But say, for example, it was that two  
15 year patient. 12:09

16 346 Q. Yes. Say it's two years.

17 A. Yes, I think -- I guess I would say to the patient that  
18 that's been non standard therapy.

19 347 Q. Because we have heard from some patients as part of  
20 this Inquiry... 12:09

21 A. Yes.

22 348 Q. And it appears that in many cases they had not been  
23 fully informed.

24 A. Sure.

25 349 Q. Do you think it should be mandatory that patients are 12:09  
26 copied in to all letters?

27 A. I think that's becoming the culture now. I have some  
28 issues regarding certain circumstances, especially  
29 where the patient has got very short survival who don't

1 want to know about that.

2 350 Q. Yes.

3 A. So there are some challenges. But overall, yes, I

4 think patients, and patients, with the new IT systems

5 coming, will have full access to their health records. 12:09

6 So I strongly support that.

7 351 Q. What do you think the barriers to that have been?

8 A. I think cultural and paternalistic approach to medicine

9 over the years. "Doctor knows right".

10 352 Q. And going back to the 2014 e-mail, it's quite an 12:10

11 important e-mail in the sense that it's quite clear,

12 it's strongly worded.

13 A. Yes.

14 353 Q. And it sort of sat there.

15 A. Yeah. 12:10

16 354 Q. It wasn't acted on by either Trust, for a variety of

17 reasons.

18 A. Yeah.

19 355 Q. It seems evident that there was a widespread practice

20 outside of licence and evidence base. How do you think 12:10

21 that should have been dealt with in its entirety? If

22 that sort of thing happened today, what do you think

23 would be different?

24 A. Yeah. I think a formal letter to the Clinical Director

25 saying "I have these concerns" I think would have a 12:10

26 different response nowadays. So I think that would

27 escalate things quite well these days.

28 356 Q. And then going back to the cancer unit, cancer centre

29 thing. Effectively you can't really have an effective

1 MDT in urology without an oncology presence, can you?

2 A. Correct. That's correct.

3 357 Q. I mean it's -- and yet there was a limping along going  
4 for quite a long time, the difficulty with recruitment  
5 and so on. What should the Southern Trust have done 12:11  
6 about that, do you think? What would have galvanised  
7 people more effectively or what would have helped with  
8 the solution?

9 A. I'm not sure, because one of the challenges was the  
10 lack of -- there was funding available for consultant 12:11  
11 posts, we had both funding in the Southern Trust for an  
12 acute oncologist, we also had funding in the Belfast  
13 Trust. We actually advertised and couldn't find  
14 people. So one of the big challenges was, although we  
15 know what the solution was, we had the funding to fix 12:11  
16 that, there were not the available oncologists. So I  
17 don't think Southern Trust could have effected that.  
18 Whether there would have been more willingness to put  
19 money forward for a longer term locum or something like  
20 that? But those monies weren't on the table at the 12:11  
21 time.

22 358 Q. No, but this is, you know, extremely serious for  
23 patients, isn't it?

24 A. Yes.

25 359 Q. And it's the sort of thing that would normally come - 12:12  
26 in England it would come to the Chief Executive of the  
27 Trust?

28 A. Yes.

29 360 Q. And there would be big discussions. And it takes you

1 back to: Is the organisation of cancer services in  
 2 Northern Ireland in need of an overhaul in order to  
 3 make the jobs more sustainable, more attractive?

4 A. Absolutely, yes.

5 361 Q. More research based? Because we have people who don't 12:12  
 6 get oncology, their access to clinical trials is  
 7 limited.

8 A. Yeah.

9 362 Q. And most people would say that full access to clinical 12:12  
 10 trials is part of a standard of cancer care these days.  
 11 So what efforts are being made to push for that for the  
 12 patients for Northern Ireland, do you know?

13 A. Yeah. I'm not aware of any specific efforts right at  
 14 this very present time, but I know the Bengoa Report  
 15 included cancer services and the reorganisation of 12:12  
 16 hospital services, and I think that's, in my view,  
 17 certainly required. But also I think cancer care has  
 18 really dramatically changed since the Campbell Report,  
 19 which is over 20 years ago. The numbers of patients  
 20 have increased, the complexity of treatment has 12:13  
 21 increased, the expectation of patients has increased,  
 22 and the way oncologists are trained has changed as  
 23 well, as well as urologists. So I think we absolutely  
 24 need a revamp. And looking back at those e-mails when  
 25 I was Clinical Director, it was a little ridiculous to 12:13  
 26 be expected to be sort of the Chief Executive of cancer  
 27 services in Northern Ireland with one day a week  
 28 allocation to be Clinical Director looking after 50  
 29 consultants and...

- 1 363 Q. Yeah. So there's a recurring team of where does  
2 responsibility sit?
- 3 A. Yeah.
- 4 364 Q. And I think what I'm trying to get out of you is what  
5 is the appetite really for people really contributing 12:13  
6 to - taking the various reports that we already have,  
7 taking the evidence, taking the situation we have today  
8 and looking at things differently - do you think that  
9 appetite is there?
- 10 A. Yeah. Very much so. 12:13
- 11 365 Q. From a clinical perspective?
- 12 A. Absolutely. And really because of the problems  
13 described there, and there are other pressures and gaps  
14 within the regional oncology service delivery, and for  
15 sure a reorganisation, it is not just more money, it is 12:14  
16 reorganisation and restructuring.
- 17 366 Q. Yeah.
- 18 A. And I think among my oncology colleagues there would be  
19 a very big appetite for that. We have engaged with  
20 whatever, you know, the redesign of cancer services, I 12:14  
21 think it's been in stagnation a bit recently I think in  
22 the last few years, to say the least. But within the  
23 oncology community we are certainly very keen to engage  
24 with that and we want to do better for our patients.
- 25 367 Q. And, finally, what do you think is the thing that most 12:14  
26 attracts oncologists to jobs? What is the thing that  
27 really, you know, this is the thing that brings people  
28 in?
- 29 A. I don't know. I can't answer that for other



1 oncologists.

2 368 Q. well, you must have some idea. There are jobs that  
3 nobody can recruit to and there are jobs that everybody  
4 wants. So what makes the difference?

5 A. Yeah, I think it's more the negatives probably are 12:14  
6 things that put people off, and that would be workload,  
7 needing to do sort of -- if a job is felt to be a  
8 patchwork of various things. For example, my job is  
9 very clear, it's prostate cancer. But some of the jobs  
10 advertised will be a bit of lung cancer, a bit of 12:15  
11 prostate cancer. "Oh, no, by the way this MDT hasn't  
12 had a urologist or it hasn't had an oncologist a few  
13 years. How would you come like to come in and solve  
14 all those problems?" That mightn't suit everybody's  
15 personality. Yeah. 12:15

16 DR. SWART: No. Okay. Thank you.

17 CHAIR: Just following on, Professor, from what  
18 Dr. Swart was saying, you were saying about the  
19 appetite for change within the cancer --

20 A. Yes. 12:15

21 369 Q. what do you want to see happen?

22 A. well, I mean, I don't have the answers to what it  
23 should look like, but certainly we need some sort of  
24 system that reorganises the way patients come through  
25 the system. Personally I am in favour of, you know, 12:15  
26 expert centralisation. That already happens in terms  
27 of radiotherapy. So the Northwest Cancer Centre and  
28 the Northern Ireland Cancer Centre deliver the  
29 radiotherapy and that acts as sort of a hub for cancer

1 expertise.

2 I think it's good that patients can visit their local  
3 hospital and meet an oncologist, but I really think  
4 that the majority of therapies should be delivered  
5 centrally. 12:16

6 370 Q. Okay.

7 A. Then with regards -- a lot of things can be devolved to  
8 units as well. But that's a huge project of  
9 reorganisation and looking at the way different cancers  
10 are treated. Compared to 20 years ago it's totally 12:16  
11 different how most cancers are managed. They have all  
12 become more complex. Thankfully there are more life  
13 extending therapies. But the decisions are much more  
14 nuanced and much more expert now than they were before.  
15 So I think that, I personally don't have the exact 12:16  
16 solution, but I just know the current setup is not fit  
17 for purpose, in my view.

18 CHAIR: Thank you very much. You'll be glad to know  
19 that that is us finished with your evidence.

20 A. Great. 12:16

21 CHAIR: Two o'clock then, Ms. McMahon?

22 MS. McMAHON: Two o'clock. Anthony Glackin will be  
23 giving evidence.

24 CHAIR: Yes, you got a short lunch yesterday, ladies  
25 and gentlemen, you get a longer one today. 12:16

26  
27 LUNCHEON ADJOURNMENT

THE INQUIRY RESUMED AS FOLLOWS AFTER THE LUNCHEON  
ADJOURNMENT

CHAIR: Good afternoon everyone. Mr. Wolfe.

MR. WOLFE KC: Good afternoon. Your witness this afternoon is Mr. Anthony Glackin, and he proposes to affirm.

14:02

MR. ANTHONY GLACKIN, HAVING AFFIRMED, WAS EXAMINED BY  
MR. WOLFE AS FOLLOWS:

14:02

MR. WOLFE KC: Good afternoon, Mr. Glackin.

A. Good afternoon, Mr. Wolfe.

371 Q. Welcome to the Urology Services Inquiry. Thank you for coming along. The first thing I should do with you is put your witness statements on the screen and have you formally adopt them as part of your evidence. So, the first document is your primary response to our section 21 Notice. If we go to WIT-42279. And you can see that the date of the Notice was 31st May of last year, 2022, number 57. And just scrolling down, you'll recognise that as the first page of your response. Just scrolling up, we've annotated the top of it to reflect the fact that you have recently submitted an addendum statement.

14:03

14:03

14:04

So, just to the last page then of this document, which we find at 42336. And you'll recognise your signature, I hope.

1 A. I do.

2 372 Q. And would you wish to adopt that statement, subject to  
3 some addendum corrections, subject to those do you wish  
4 to adopt that?

5 A. Yes. 14:04

6 373 Q. Thank you. And then the short addendum which corrects  
7 two small factual inaccuracies, WIT-100352. And,  
8 again, you'll recognise the front page. As I say, two  
9 small corrections. One relates to whether or not -  
10 scrolling down - if I remember his name, yes, whether 14:05  
11 or not Mr. Mackle was at a meeting in January 2013  
12 which you attended. Your first statement said he was,  
13 this corrects it --

14 A. That's correct.

15 374 Q. -- to tell us that he wasn't. And the second 14:05  
16 correction relates to the period of time in which you  
17 held the role of lead for the M&M?

18 A. That's correct.

19 375 Q. So, straightforward matters. And if we go to the last  
20 page then, it's at 5.3 in this series, a couple of 14:05  
21 pages down, if we scroll down. There we have your  
22 signature. And again --

23 A. Yes.

24 376 Q. Do you wish to adopt that?

25 A. I do. 14:06

26 377 Q. One further source of evidence is your statement to  
27 Dr. Chada. The Inquiry has heard generally about the  
28 process which was undertaken for gathering those  
29 statements. You went along, I assume like others, and

1 spoke to Dr. Chada and?

2 A. Siobhan Hynes.

3 378 Q. Siobhan Hynes. Thank you. And that conversation was

4 sculpted into a statement for your approval?

5 A. It was drafted by Mrs. Hynes and I approved her draft. 14:06

6 379 Q. Yeah. And so just if we put that on the screen, just

7 to remind ourselves. TRU-00771. And it goes through

8 to 00777. And I assume that you've had an opportunity

9 maybe to review that ahead of today?

10 A. Yes, I have reviewed it. 14:07

11 380 Q. You're content with its accuracy?

12 A. Yes.

13 381 Q. I'm obliged. Now, as I say, thank you for coming to

14 speak to us today. I'll take a moment just to outline

15 really a bit of a road map to assist you and to assist 14:07

16 the panel and those out there who may be watching or

17 listening to us. So, as was said yesterday in our

18 opening, calling clinicians to give evidence as part of

19 this phase of the Inquiry's work provides the Inquiry

20 with an opportunity to engage with clinicians and for 14:07

21 you to engage with us. I know that you will be able to

22 describe the practices of the urology specialty in the

23 Southern Trust, its culture and behaviours, how it

24 functioned, how it was led and supported, and the

25 difficulties which it faced. I want to explore with 14:08

26 you the context in which you worked. It appears to

27 have been a specialty or an environment under constant

28 capacity pressures, and you can tell us about that, how

29 it impinged on your work and the health of your

1 patients.

2  
3 You performed a number of roles which appear to be at  
4 the heart of the governance arrangements. We will hear  
5 that you had duties with the mortality and morbidity - 14:08  
6 have I got that the right way around?

7 A. (Witness Nods).

8 382 Q. Otherwise known as the Patient Safety Committee, with  
9 -- you had responsibilities with the multi disciplinary  
10 team, which you can tell us about, and in the conduct 14:09  
11 of some SAIs. So, we want to hear from you about how  
12 those arrangements operated, whether they were  
13 effective in supporting the objective of safe patient  
14 care.

15 14:09  
16 Then there's a number of specific issues which will be  
17 examined. For example, the management of stent  
18 patients has been a feature of the evidence before the  
19 Inquiry so far. We want to try to unpack some of the  
20 issues around that from your perspective. 14:09

21  
22 I want to look at a particular issue that's maybe just  
23 arisen relatively recently in terms of the sight of it,  
24 of this Inquiry, and that's TUR syndrome, and what you  
25 can say about that. 14:09

26  
27 we will also want to know about the use that was made  
28 of some of the key ingredients which support or inform  
29 good governance, and you've said something in your

1 witness statement already about some of these,  
2 including appraisal, job planning, the use of data,  
3 audit and incident reporting.

4  
5 It will be important to establish how you and your  
6 fellow consultants practised in a range of important  
7 matters. Inevitably, we will be interested to examine  
8 your knowledge of the practice of Mr. O'Brien. I will  
9 explore with you issues including triage, dictation,  
10 preoperative assessment, sign off and actioning of  
11 diagnostic results, prescribing in the cancer context,  
12 conduct in association with the operation of the MDM,  
13 including the use of nurse specialists or key workers.  
14 I'll also maybe touch upon the issue of private  
15 patients.

14:10

14:10

14:11

16  
17 As was said yesterday, the Inquiry will wish to  
18 understand the extent to which there were variations in  
19 practice and whether adherence to best practice was  
20 viewed as necessary, and whether the pressures we're  
21 about to look at in urology services had any impact on  
22 compliance with best standards.

14:11

23  
24 So, that's a bit of a road map. Hopefully we'll get  
25 through the majority of that across today and tomorrow,  
26 although I understand that a spillover slot has been  
27 booked with your diary, if that becomes necessary.

14:11

28  
29 So, let's start with your career history, Mr. Glackin.

1 We can see -- perhaps put it up on the screen, please,  
 2 at WIT-42279, and you outline - just scrolling down -  
 3 your academic background, graduating from University  
 4 College Dublin in June 1998.

5  
 6 The first matter of note perhaps is your first  
 7 encounter with, professionally at least, with the  
 8 Craigavon Hospital, and you did a round as a senior  
 9 house officer in general surgery in August 2001 through  
 10 to July 2002. Did that bring you into contact with  
 11 urology or was that a broader experience?

12 A. So, I was attached to the general surgery department.  
 13 You may have met Mr. Mackle at this Inquiry, I'm not  
 14 sure if you have. So, Mr. Mackle would have been one  
 15 of the supervising consultants in that department,  
 16 amongst others. So I was working for them at that  
 17 time. But I would have cross-covered urology in the  
 18 evening for on-call, I would have known Mr. O'Brien  
 19 prior to this anyway, but it would have been my first  
 20 opportunity to meet Mr. Young.

21 383 Q. And perhaps you had it already, but did that spark an  
 22 interest in urology, or was that always your direction?

23 A. So essentially I took this job because I was waiting  
 24 for a slot to become available to undertake urology  
 25 research. I'd already established during my basic  
 26 surgical training that I wanted to pursue a urological  
 27 career, and I was waiting basically for the opportunity  
 28 to start research and undertake a higher degree, which  
 29 you'll see later I did.



1 384 Q. Yes. And that research, we can see it at the bottom of  
 2 the page in front of us, that research post became  
 3 available and commenced in August 2002, split between  
 4 Craigavon and the University?

5 A. Yes. So, I had a clinical commitment in Craigavon 14:14  
 6 which amounted to two to three clinical sessions per  
 7 week, except in the case where the higher surgical  
 8 trainee was on leave, in which case there were two  
 9 clinical fellows, myself and another. We would have  
 10 substituted completely for that person when they were 14:14  
 11 on leave. So that meant that during that period of  
 12 time I had a fair bit of clinical experience, both in  
 13 terms of outpatient work, in terms of doing flexible  
 14 cystoscopy diagnostics, alongside my research at  
 15 Queens. 14:15

16 385 Q. Yes. And who was your clinical supervisor during --

17 A. So during the research project that was primarily  
 18 Mr. Young, from a clinical perspective. From Queens'  
 19 perspective I was supervised by Dr. Kate Williamson,  
 20 who was a, I think at that time she was a lecturer, I'm 14:15  
 21 not sure if she was a senior lecturer.

22 386 Q. Yes. And your attendance at Craigavon was how many  
 23 hours or how many days per week?

24 A. So, it varied. It could be as little as two sessions,  
 25 which is one full day's work, up to some weeks it could 14:15  
 26 be two and a half days a week. And at other times if  
 27 the SPR was on leave, it could be a full week's work.

28 387 Q. And at that time the urology service was just staffed  
 29 by two consultants, is that correct?

1 A. Two consultants; Mr. Young and Mr. O'Brien. There was  
2 a single SPR, there was an SHO, and there were house  
3 officers assigned to the Urology Department.

4 388 Q. And you knew Mr. O'Brien from I suppose the area where  
5 you grew up? 14:16

6 A. Yeah, that's right. Family connections. And it's no  
7 secret, before I entered medical school I sought  
8 Mr. O'Brien's advice.

9 389 Q. And you spoke to him about?

10 A. A career in medicine. 14:16

11 390 Q. A career pathway?

12 A. Yeah.

13 391 Q. Perhaps spoke to him about a practice in urology?

14 A. Not so much a practice in urology, more at that point  
15 it was a career in medicine. I think my interest in 14:16  
16 urology grew when I became a clinical medical student  
17 in perhaps the third or fourth year at UCD. I spent a  
18 whole month in the Urology Department as that was, I  
19 was assigned to that, it wasn't a choice, but I  
20 actually loved it, so that's why my interest grew from 14:16  
21 that point.

22 392 Q. And we may have formed the impression that even as  
23 early as that time - and here we're talking about the  
24 summer of 2002 - you stayed in Craigavon as part of  
25 this research fellowship for how long? 14:17

26 A. A little over three years.

27 393 Q. Yes. The impression could be formed that, even at that  
28 time, that it was a service under strain?

29 A. Yeah.

1 394 Q. But perhaps by comparison with now, it was?

2 A. I suppose what I would say there is I wouldn't have had  
3 a comparator at that time. This was my first  
4 experience to the specialty.

5 395 Q. Yeah.

14:17

6 A. But we were a service under pressure. There's no  
7 doubt.

8 396 Q. Yeah. And in terms of the work that you carry out, or  
9 the work that you were able to see being performed by  
10 others, such as Mr. Young and Mr. O'Brien, did you get 14:18  
11 to see the range of urological care and procedures that  
12 were available?

13 A. So, at that point in my career I'd completed three  
14 years of surgical training. So, I was quite competent  
15 to do many smaller procedures independently, as was 14:18  
16 kind of the norm at the time. It wouldn't perhaps be  
17 the norm now for SHOs. So, I was able to undertake  
18 things like flexible cystoscopy, with limited  
19 supervision. I could run that clinic without any  
20 immediate help on hand, and the consultants were freely 14:18  
21 available by telephone to support me should I need  
22 help.

23

24 Similarly, I had experience of running - working in  
25 outpatient clinics, so I could work alongside the 14:19  
26 consultants relatively independently. Now, clearly the  
27 case mix would mean that I would have to discuss some  
28 cases with the consultant, and that's normal. But that  
29 help was on hand.

1  
2 During my clinical research fellowship, my exposure to  
3 inpatient operating would have been very limited,  
4 because that was really the prerogative of the SPR, the  
5 higher surgical trainee, and so my opportunity to do 14:19  
6 that kind of work would have been limited perhaps to  
7 out of hours or weekends, when emergencies needed to be  
8 dealt with. So, things like putting in a stent or  
9 taking a torsion to theatre. And I would have been  
10 quite competent at doing those things, with limited 14:19  
11 supervision, but I can recall evenings where I would be  
12 in theatre and I might need some help, and I would  
13 phone either Mr. Young or Mr. O'Brien, and there was no  
14 issue, they'd either come in, or they'd tell me what to  
15 do, and I'd get on and do it. And, you know, the 14:19  
16 support was good.

17 397 Q. And in terms of your ability to observe their  
18 practices, was that available to you for learning  
19 purposes?

20 A. Yeah. So, I would have worked in their clinics. So I 14:20  
21 would have had sight of how they ran their outpatient  
22 clinics. I would have had support and, I suppose,  
23 training, for want of a better term, in the clinical  
24 environment. I would have participated on ward rounds,  
25 particularly at weekends. And because I was relatively 14:20  
26 junior, they would often be present for the ward round,  
27 because, you know, you wouldn't leave an inexperienced  
28 person to do the ward round unsupervised, so they would  
29 come in. So I would observe how they interacted with

1 patients, how they interacted with the staff, how they  
2 interacted with the likes of me, other consultants,  
3 etc.

4 398 Q. I know that you probably had an opportunity to review  
5 aspects of the statement prepared for the Inquiry by  
6 Mr. Chris Hagan. He outlined his experience as a  
7 surgical trainee just before this period.

14:20

8 A. Yes.

9 399 Q. In or about 2000. And he set out in his statement, I  
10 suppose, what might be described as a catalogue of  
11 concerns about the practice of Mr. O'Brien in  
12 particular at that time. Did you observe any issues of  
13 concern during your period of three months?

14:21

14 A. Three years.

15 400 Q. Three years, of course. Between 2002 and 2005.

14:21

16 A. Yeah. I found the department on the whole to be very  
17 supportive of me as a trainee learning. I observed  
18 that same supportive attitude displayed to other  
19 trainees coming through the department. I never once  
20 felt belittled or dismissed by Mr. Young or  
21 Mr. O'Brien. And, similarly, the nursing staff behaved  
22 in a very professional manner towards us as well. So,  
23 you know, I had very good relationships with everybody  
24 in that department.

14:21

25  
26 To perhaps mention some of the issues that Mr. Hagan  
27 brought up. I am aware of patients admitted for  
28 intravenous fluids and antibiotics. At the time I was  
29 relatively junior in the specialty and I wouldn't

14:22

1 necessarily have had the knowledge-base to question  
2 that. And I also, when I've read the list of patients  
3 that were in the bundle who were affected by that  
4 particular issue, I recognised lots of those names.  
5 But I also recall looking after lots of those patients 14:22  
6 when they were profoundly unwell. I recall some of  
7 them coming in with sepsis, requiring intravenous  
8 antibiotics and fluids, requiring the input of the ITU.  
9 I recall some of those -- I now, looking at those  
10 names, know some of those patients who are deceased. 14:23

11 401 Q. Yes.

12 A. And, you know -- so my experience of that particular  
13 issue was that my recollection is that some of these  
14 patients, in my experience, I met them when they were  
15 at their sickest. 14:23

16  
17 There were other patients admitted at the weekends at  
18 the same time and they were patients who were admitted  
19 for chemotherapy for kidney cancer. Now, the  
20 chemotherapy that was available for kidney cancer at 14:23  
21 the time was pretty toxic, and these patients had a  
22 propensity to get sick at the weekend, which, me being  
23 the registrar who would typically be doing the weekends  
24 and maybe not seeing people during the week, you were  
25 looking after these folk who were having two particular 14:23  
26 drugs that I can recall that made them very unwell.

27  
28 So, you know, that was my experience of that.  
29

1 I said to you before I didn't really have that much  
2 experience of operating during the week in theatre, and  
3 at the level of seniority that I had, I have to say to  
4 you that a lot of the big operations would have been  
5 beyond my skill set, and the understanding of them as a 14:24  
6 junior trainee wouldn't have been there. That  
7 understanding developed as I developed as a trainee.

8 402 Q. Yes. So, to summarise, to the extent that you were  
9 able to observe the practices of both Mr. O'Brien and  
10 Mr. Young, given your, I suppose, relative inexperience 14:24  
11 in urology discipline, you didn't pick up on anything  
12 of particular note to concern you?

13 A. No. And I'm only now aware of the issues relating to  
14 the intravenous therapies because of the evidence  
15 bundle. I'm only aware of the discussions that 14:24  
16 happened with other more senior members of the Trust,  
17 such as the Medical Director, as a result of reading  
18 the evidence bundle.

19 403 Q. So, those, when you saw --

20 A. They were not live issues for me in 2003 to 2005. 14:25

21 404 Q. Yes. Yes.

22 A. Yeah, I think that was the period.

23 405 Q. To focus on that perhaps as an example, you've said  
24 some of the names of the people who were the subject of  
25 intravenous antibiotic fluid management are familiar to 14:25  
26 you?

27 A. Yes.

28 406 Q. You saw them at their sickest. What you seem to be  
29 suggesting is that you had no reason to suspect that

1 patients were being brought into hospital for days at a  
2 time to receive IV antibiotic management...

3 A. Yeah.

4 407 Q. When there was no good cause to do so?

5 A. So, I'll bring you back to what I said earlier. I had 14:25  
6 no comparator. I had no knowledge of another unit  
7 doing something different or not doing this.

8 408 Q. Yes. Can you -- is it useful to think back on it now  
9 and reflect that the treatment that you were seeing had  
10 no scientific base? 14:26

11 A. So, as you will come to, I'm sure, I entered higher  
12 surgical training in 2006, and on the basis of that, my  
13 experience and knowledge base increased, such that by  
14 2012 I was ready to take up a consultant appointment.  
15 So I'm now aware that there was no evidence base for 14:26  
16 that. It's not part of my practice then in 2012, it's  
17 not part of my practice now.

18

19 Lots of things have changed in urology, you know. I  
20 reflect on a conversation that I had with a very senior 14:26  
21 consultant in Birmingham, and he had spent his life  
22 doing reconstructive surgery, and he had come to the  
23 realisation that a lot of this reconstructive surgery  
24 doesn't actually benefit the patient in the long-term.  
25 14:26

26 So, you know, when you hear things like that, you  
27 reflect on what went before, and you think, were we  
28 actually serving the patients well by doing these major  
29 operations or was there an alternative way?



1 409 Q. So, one issue you do pick up on during that time, as I  
2 understand it - and we'll come and look at it in a  
3 little bit more detail in a broader context later - was  
4 a sense that Mr. O'Brien was behind with his  
5 administration? 14:27

6 A. (Witness Nods).

7 410 Q. That there were obvious backlogs --

8 A. Yeah.

9 411 Q. In his correspondence.

10 A. Yeah, that's correct. I would have noted that it took 14:27  
11 time for letters to be typed and appear in the chart.  
12 Back in the early two thousands I'm not sure that we  
13 would have had access to letters electronically in the  
14 same way that we have now. I'm fairly certain that I  
15 would not have had access to Patient Centre, which is 14:27  
16 the software on which the letters are generated, as a  
17 trainee. So, you know, we were reliant on letters  
18 being printed and placed into a paper chart.

19 412 Q. Now, you decided upon the conclusion and the award of  
20 your doctor of medicine, following that research 14:28  
21 period, to commence higher urological training in the  
22 West Midlands, is that correct?

23 A. Yeah. So as was customary at the time, you needed a  
24 higher degree to even get yourself in the door for the  
25 interview. I trotted around all the regions, as we did 14:28  
26 at the time, interviewing, and I was appointed in  
27 Birmingham, and I grabbed it with both hands.

28 413 Q. Yes. And that, upon completion of that, I suppose you  
29 were brought full circle then and an opportunity arose

1 to take up a consultant's post in Craigavon?

2 A. Yes.

3 414 Q. The Southern Trust, in 2012?

4 A. Yes.

5 415 Q. And as we can see from - if we scroll down, please, to 14:29

6 paragraph 1.3, you outline your duties, and it goes

7 over on to the other pages as well. Those duties - and

8 we'll come to this in a moment - those primary duties

9 were added to or supplemented to - and I think you see,

10 yes, it's set out at (g) - your participation in the 14:29

11 MDT and morbidity and mortality meetings. In fact as

12 we will see, it was more than mere participation; you

13 were, from April 2015, lead clinician for the M&M, if I

14 can call it that?

15 A. Yes. 14:30

16 416 Q. And from November '16, lead clinician for the urology

17 cancer MDT?

18 A. Yes.

19 417 Q. You remain in that latter post?

20 A. Regrettably, yes. 14:30

21 418 Q. And you've handed over the reins, as of 2021, of the

22 M&M post.

23 A. I have.

24 419 Q. To Mr. O'Donoghue?

25 A. Yes. 14:30

26 420 Q. So, we can see what appears to be a heavy load. One

27 other post I think I should mention is, you're Urology

28 Training Programme Director at NIMDT?

29 A. I am.

1 421 Q. That's the Medical and Dental Training Agency. And  
2 you've been in that role for four years, since February  
3 2019?

4 A. Yes.

5 422 Q. Do you also have a private practice? 14:31

6 A. I do.

7 423 Q. And is that a practice that consults as well as treats?  
8 A. So, my private practice takes place outside of the  
9 Southern Trust. I consult at two clinics and I operate  
10 at a third private hospital. 14:31

11 424 Q. And how many hours per week currently do you --

12 A. It varies between four and eight.

13 425 Q. And your duties set out here are, I suppose, set within  
14 the framework of the urologist of the week model?

15 A. Yes. 14:31

16 426 Q. Take us briefly through a typical week for you in  
17 Southern Trust, in terms of your activities,  
18 embroidering in, if you can, the times when you were  
19 both lead in the M&M and the MDT.

20 A. So, I suppose there are three ways that my weeks work. 14:32  
21 So, there's the elective weeks. And typically I would  
22 have a uro-oncology clinic on a Monday afternoon. That  
23 is largely seeing post MDT discussion patients and  
24 other cancer patients who need review. There's  
25 typically six to ten patients to that clinic in person. 14:32  
26 If there's only six, then there will be at least four  
27 virtual consultations for patients who don't wish to  
28 travel to have an appointment.  
29

1           Tuesdays then, often I will have day case surgery and  
2           an out-patient clinic in Dungannon. That happens -  
3           currently it happens twice a month. And on the  
4           alternate Tuesdays I may be doing private work.

14:33

6           Then on Wednesdays I would have a new patient clinic.  
7           Wednesday afternoon most weeks I would be doing private  
8           work.

10          Then Thursday is taken up with departmental activities,  
11          primarily in the morning and at lunchtime, and then the  
12          cancer MDT in the afternoon. I Chair the cancer MDT on  
13          a rotational basis, until recently it was with three  
14          other consultants, but as of August it has become two  
15          others, so it's me plus two others.

14:33

14:33

17          Then on Friday I've typically operated, ever since as I  
18          arrived at Craigavon, it's an all day inpatient  
19          operating list.

14:33

21          So that would be my normal week, if you like.

23          You'll note in my statement recently that I've reduced  
24          my hours in the Trust, okay? So on the third -- on the  
25          week where the third Tuesday falls, I have reduced my  
26          clinical commitments. And the reason I did that was  
27          because, first of all, I enjoy my private practice and  
28          it allows me to deliver the private practice safely in  
29          a time that I am not conflicted with clinical activity

14:34

1 from the Trust. So, that's safe for me, it's safe for  
 2 the patients, and it's clearly discussed with my  
 3 managers.

4 427 Q. Yes.

5 A. So, on the week that I'm urologist of the week, so that 14:34  
 6 begins on a Thursday morning. There's a handover  
 7 between the consultant finishing and the consultant  
 8 starting. There is a ward round conducted with the  
 9 middle grade staff. The patients are all seen in  
 10 person. That usually takes most of a morning. And 14:34  
 11 then in the afternoon, whatever other activity is  
 12 required. So, we would undertake the triage. If  
 13 there's patients who need to go to the emergency  
 14 theatre, we would deal with those. If there are  
 15 consults to be seen, the consults would be seen, any 14:34  
 16 correspondence would be dealt with, that kind of thing.  
 17 And the same on the Friday.

18  
 19 On the weekends I tend to do a ward round, if I'm the  
 20 urologist of the week, I'll do a ward round on a 14:35  
 21 Saturday morning. I will come in, go round with the  
 22 registrar, we'll see everybody, troubleshoot any  
 23 problems, see any consults, etc.

24  
 25 Then depending on the experience of the registrar, I 14:35  
 26 may or may not come in on a Sunday morning. At the  
 27 moment we have one registrar who is post exams, so, you  
 28 know, he's more than able to do a ward round with  
 29 limited supervision, whereas at other times we have a

1 very junior trainee who needs a lot more supervision  
2 and can't do things independently.

3  
4 So the urologist of the week then would extend Monday,  
5 Tuesday and Wednesday, and we would complete the triage 14:35  
6 activity during that time. We would, you know,  
7 interact with other specialties as necessary, take  
8 patients to theatre on the emergency list, all of that  
9 kind of activity.

10 428 Q. I'm going to resist asking you questions about triage 14:35  
11 at this stage?

12 A. Yeah, sure.

13 429 Q. No doubt in the clinics on a Monday you would have had  
14 the support of the nurse specialists?

15 A. Yeah. 14:36

16 430 Q. I may ask you about that in due course. But just a  
17 couple of things arising out of that. We're going, in  
18 a short period of time, to look at the capacity issues.

19 A. Yeah.

20 431 Q. And it's notable, and I of course mean no criticism by 14:36  
21 this question, but your decision to devote more time to  
22 a private practice on a Tuesday, reducing your hours,  
23 you've had conversations with your Southern Trust  
24 employer --

25 A. Yeah. I think it's really important for you to 14:36  
26 understand that I was over-delivering, okay?

27 432 Q. Yeah.

28 A. So, my contract was more than twelve and a half PAs.  
29 So I have no contractual obligation to continue with

1           that.

2   433   Q.    Yeah.

3           A.    So, over time I've reduced that, such that my contract

4                as from October will be 11 PAs.

5   434   Q.    Yes. And I was simply going to ask you this: No 14:37

6                doubt, for the good reasons you outline, no contractual

7                obligation to do more than what you're doing, but your

8                decision in that respect takes place within, as you've

9                described in your statement, an environment where there

10               is currently, and for some years gone by, pressure in 14:37

11               terms of the consultant resource.

12          A.    Yeah.

13   435   Q.    It's a seven consultant setup, but you've never - that

14                is the Trust - has never been in a position to deliver

15                seven permanent full-time consultants. 14:37

16          A.    Yeah.

17   436   Q.    That kind of conversation that you were having, is

18                there a pressure on consultants to do more than their,

19                I suppose, strictly contracted hours? Is that one way

20                round, or one attempt to mitigate the difficulties in 14:38

21                recruitment?

22          A.    So, you're continually asked to do more and more.

23                Okay? And, you know, one of the out workings of the

24                2017 meeting was that we were asked to do more. One of

25                the out workings of locums leaving is that you're asked 14:38

26                to pick up after them. So, you know, working in our

27                department, with so few people on the ground, there's

28                always somebody coming to you asking can you do this,

29                can you do that, can you do an extra clinic? So, you

1 know, over time that builds up, and over time it means  
2 that you're actually looking after more than you should  
3 be looking after, because there is potential for you to  
4 be missing things because you're snowed under with  
5 work, there's the potential that you're not able to do 14:39  
6 things properly. So, I recognise that potential, I  
7 recognise that risk, and I've had an open conversation  
8 with the head of service and with the AMD, and I said,  
9 you know, "I'm doing this for me, because I feel it's  
10 safer for me to practise in this manner, and I can't 14:39  
11 continually be asked to do more and more."

12 437 Q. Yes.

13 A. I was very clear about that.

14 438 Q. And in fairness, I should have drawn your attention to  
15 -- you've as much as said that in your witness 14:39  
16 statement; you've reduced your contracted hours to  
17 avoid risks to both yourself...

18 A. Yeah.

19 439 Q. And your patients and remain capable of delivering a  
20 safe service. 14:39

21 A. Yeah. I have reduced it, but I'm actually delivering  
22 more than full-time at 11 PAs.

23 440 Q. Yeah. The urologist of the week model.

24 A. Yeah.

25 441 Q. Introduced around 2014? 14:40

26 A. So...

27 442 Q. Or thereabouts.

28 A. It was.

29 443 Q. I was going to make the point to you in terms of your



1 career consultant urologist level, you've known very  
2 little else apart from that model --

3 A. So I was familiar with this model as a trainee. It had  
4 been adopted in a few of the units that I had worked  
5 in. And when I came to the department, there were just 14:40  
6 three of us, I was quickly joined by two other  
7 colleagues, and we stayed at a stable five for only a  
8 short period of time and then those two people left and  
9 two further colleagues joined. So, we were at the  
10 point where at one point we got up to six people. 14:40

11  
12 And it became quite clear that the inpatients were  
13 getting a raw deal. They needed more input from a  
14 senior person every day, and there were too many  
15 inpatients for us just to be dipping in and dipping 14:40  
16 out, as would have been the practice in the past. So  
17 we agreed that by doing a consultant led ward round  
18 every day, the patients would all be seen, that they'd  
19 be safe, there'd be a senior decision maker, and we all  
20 felt that that was a good thing to do. 14:41

21 444 Q. I want to briefly put to you, I suppose, by contrast  
22 with what I take to be your relatively positive view of  
23 the framework as a way of doing the business of  
24 delivering urology, I want to set aside that, or set  
25 beside that, I suppose, Mr. O'Brien's view of it. If 14:41  
26 we pull up AOB-01904. And I'm not going to do justice  
27 perhaps to the time and thought that he has put into  
28 this document, which was to be, I think it was  
29 submitted with a view to meeting management on that day

1 and I think the meeting was cancelled - and we'll come  
 2 back to this for other reasons later. But I suppose,  
 3 just scrolling down, he -- I'm not sure if you're  
 4 familiar with this document, but...

5 A. I am familiar with it. 14:42

6 445 Q. Yeah. I suppose to summarise, within the document he,  
 7 I suppose he speaks, and it's clear in front of us,  
 8 that he found the discussions around the UOW to be  
 9 frustrating and incomprehensible, and as he goes into  
 10 the substance of what he's trying to get across, I 14:43  
 11 think at the heart of it seems to be a concern that the  
 12 ward round in particular has been sacrificed on the  
 13 altar of having to run to standstill to deliver  
 14 surgery, an over reliance on inexperienced registrars  
 15 who - my words, not his - are receiving tasks that 14:43  
 16 they're not necessarily able to deliver on and are  
 17 ending up having to refer back in to the system for him  
 18 to, him or you, or your colleagues, to eventually catch  
 19 up on.

20 14:43  
 21 So, it's not a model, it appears, that works for him.  
 22 Is there -- you've talked about the fundamentals of the  
 23 model just a moment or two ago. Is that the best way  
 24 of doing business, so far as you can see,  
 25 notwithstanding the resource pressures and all of that? 14:44

26 A. I can only tell you how I operated the model. I was  
 27 present on time every day to do the ward round. I  
 28 supervised the trainees doing the operating, if they  
 29 needed supervision. So, you know, from my perspective,

1           this model did work well. It was better than what went  
2           before it.

3  
4           Mr. O'Brien, in this document, expresses concerns about  
5           how some of our colleagues operated the model. That's 14:44  
6           for them to address. But from my perspective, it was  
7           working well.

8   446   Q.   In terms of the model then, it's --

9           A.   In terms of the model and in terms of enhancing  
10          inpatient care. 14:44

11   447   Q.   Yes.

12          A.   In terms of having senior input on the ward round on a  
13          daily basis.

14   448   Q.   Now, let me move to what you describe as your  
15          overarching concern since taking up the post. If we go 14:45  
16          back to Mr. Glackin's statement at WIT-42281, and  
17          scroll down to 1.7, please. So, I suppose this is one  
18          of your statements of faith contained within this  
19          statement. Since 2012 you have had patient safety  
20          concerns, and you explain that they are due to 14:45  
21          inadequate numbers of consultants in the department to  
22          deliver a timely service.

23  
24          Scrolling down. Since 2002, or you acquired knowledge  
25          in 2002, and upon your return in 2012, it was clear to 14:46  
26          you that there was, and remains, a persisting problem  
27          with waits.

28  
29          Just, I suppose, to help people understand this in

1 context, we'll bring up some figures. If we go to  
2 TRU-98238. And if we can just highlight those, please.

3  
4 So, this table relates to the period in 2016. It's  
5 taken from 2016 and it illustrates, as the heading 14:46  
6 indicates, the number of patients waiting on a  
7 consultant led first outpatient appointment for  
8 regional urology specialty, and we can see it's split -  
9 it's allocated along consultant lines.

10  
11 But let me just bring us across to the far right and 14:47  
12 the headline figure is 2,743 patients, of which 420, I  
13 think - yes - we can see are waiting more than 52  
14 weeks.

15  
16 If we then go to a table, keeping those figures in 14:47  
17 mind, if we go to the similar exercise for September  
18 2021 at TRU-98244. And we can see that the 52 week  
19 measurement has increased from 420 in 2016 to more than  
20 three and a half thousand people, 3683, and the total 14:48  
21 waits, the total of those waiting to see a consultant  
22 for a first outpatient appointment has risen by just  
23 under 100% to 5237. Those figures, no doubt, don't  
24 surprise you?

25 A. They're not surprising to me in the least. I'm very 14:48  
26 familiar with the data. I would have reviewed the  
27 data. This is not a surprise to me.

28 449 Q. Yes. Maybe if we put another set of figures up, those  
29 awaiting inpatient or day cases, TRU-98245. These are

1 the figures for May 2016. And we can see that there's  
2 a total of 1047 patients on that waiting list, with 240  
3 waiting for more than 52 weeks.

4  
5 Then if we go to figures for September 2021, TRU-98251, 14:49  
6 and we can see that the 52 week wait is now showing at  
7 1321, increasing from, as I've said, the previous  
8 figure of 241, five or six years earlier. Again, part  
9 of your daily awareness, I suspect, Mr. Glackin?

10 A. Yeah, very aware of this as an issue. It's a live 14:50  
11 issue for me, it's a live issue for all of the  
12 consultants, it's a live issue for the secretarial  
13 staff who have to deal with all the enquiries from  
14 these patients and their families, who are waiting  
15 excessively for treatment and appointments. 14:50

16 450 Q. Yes.

17 A. So...

18 451 Q. I'm going to go on and maybe drill down into some of  
19 the implications or consequences that lie behind those  
20 figures. 14:50

21  
22 Just one final set of figures, I'll not bring them up  
23 on the screen, in ease of our time, but if the panel  
24 wish to consult TRU-98356, they will see an outpatient  
25 review backlog in 2016 of just over 2,000 patients, 14:51  
26 that's 2041. And the position is a little worse in  
27 2021. If you go to TRU-98361, there is a total number  
28 on the outpatient backlog of 2386.

1 Now, you were a trainee in West Midlands?

2 A. Yes.

3 452 Q. Do you retain contact with practitioners in other  
4 jurisdictions?

5 A. Yes, I do. I had recent reason to go to Birmingham for 14:52  
6 a benign prostate meeting and I met up with many of the  
7 people that I'd worked with, and we were discussing how  
8 to recover services after Covid, and my colleagues in  
9 Birmingham and Wolverhampton in particular were  
10 bemoaning the fact that they had some patients waiting 14:52  
11 for BPH surgery more than a year. I didn't really want  
12 to tell them that we had patients waiting six and seven  
13 years, but I did. It's appalling!

14 453 Q. Is it, to diagnose the problem, all about money?  
15 Birmingham gets more resources. Or is it part of this 14:52  
16 bigger NI problem that we oft see reported in the media  
17 of systemic issues in the structuring?

18 A. So, to take the benign prostate scenario as an example,  
19 there are now a plethora of options available to treat  
20 these patients, and one of the good things that's 14:53  
21 happened in the last couple of years is the development  
22 of the regional day case centre at Lagan Valley  
23 Hospital. That has allowed us to take those patients  
24 who are fit to that environment to have their prostate  
25 surgery done. So that has allowed us to have an impact 14:53  
26 for those patients. But one of the problems with that  
27 approach is that Lagan Valley is a standalone small  
28 unit, they can't take patients who are ASA3 or more.  
29 And, unfortunately, that affects a lot of the men who

1 are waiting on prostate surgery.

2  
3 So what you're left with is a tail of patients who are  
4 not fit to go to this day case environment, who need  
5 care in an inpatient environment and who aren't getting 14:53  
6 any care because they've been displaced by all the  
7 other things that are going on in the acute hospital  
8 sector.

9  
10 You can quite clearly see by the number of names who 14:54  
11 are on the screen there that we've had loads of  
12 consultants coming through our departments, small  
13 periods of time these locums have stayed and generated  
14 work which has been largely left undone. We have never  
15 really had a full complement of people in the 12, 14:54  
16 nearly 12 years that I'm there now, and you do need a  
17 full complement of people.

18 454 Q. Could I just pause, pause that thought?

19 A. Yeah.

20 455 Q. And we can bring up on the screen, just to illustrate 14:54  
21 the point you're beginning to make, that the Urology  
22 Department has been, I suppose, forever inadequately  
23 staffed since you arrived. If we go to WIT-42298, and  
24 at paragraph 16.1. Just continue, I think you're  
25 making the point -- 14:55

26 A. Yeah, so.

27 456 Q. -- about the current complement.

28 A. So the current complement means that if we run a one in  
29 six or one in seven urologist of the week rota, one or

1 more of us has to step out during our elective time to  
2 deliver that emergency care. Now, the emergency care  
3 is really important, so it has to happen. But it means  
4 that the elective care isn't happening as a  
5 consequence. So that's a negative impact.

14:55

6  
7 You know, the Trust and the wider health service here,  
8 have identified that we need seven consultants to  
9 deliver the service. So, if we haven't got seven  
10 consultants, it is quite clear to me that you can't  
11 deliver the services required.

14:55

12  
13 And the same goes for the nurses; you know, we had the  
14 situation of too few clinical nurse specialists. You  
15 know, you need middle grade staff. We found that very  
16 hard to recruit to.

14:55

17  
18 So if you don't have enough people on the ground,  
19 you're not going to be able to deliver the volume of  
20 service that you need to do for the population.

14:55

21 457 Q. I think you've -- yes, sorry, I can't see it just in  
22 front of me, but what you've described in your  
23 statement is a, I suppose a constant cycle I think is  
24 the phrase you used --

25 A. Yeah.

14:56

26 458 Q. -- of recruitment.

27 A. Yeah.

28 459 Q. Quite often you go to recruitment and you're finding,  
29 you've expressed this, that you aren't able to recruit



1 because candidates are not appointable as a safe day  
2 one NHS consultant?

3 A. That's correct. I mean, I recall two particular  
4 instances. One is where the Chair of the Trust was  
5 Chairing our appointments panel, and she made it very 14:56  
6 clear that the person that we had interviewed was not  
7 suitable for appointment and she did not want that  
8 person working in the Trust.

9  
10 And on another occasion, a very senior urologist from 14:56  
11 the East Midlands was our external, and he was scathing  
12 of the quality of the candidates that were presenting  
13 for interview.

14  
15 So, you know, when you're interviewing people for what 14:57  
16 are very important roles, where they have to be able to  
17 perform at a safe level, you want to be appointing  
18 people who are appropriate, and to bring people into  
19 those roles who are not appropriate generates problems  
20 for the patients, it generates problems for us. It's 14:57  
21 just a disaster.

22 460 Q. You've also, just a moment or two ago, said it's not  
23 just a clinician or consultant issue, it's also a  
24 nursing issue. And if we go down through your  
25 statement to paragraph 25.3 at WIT-42303, you make the 14:57  
26 point that:

27  
28 "The ward situation has been difficult over the last  
29 ten years, with a heavy reliance on agency staff and a

1 lack of consistent senior management."

2  
3 I can see there you also bemoan the loss of a dedicated  
4 ward.

5 A. Yes.

14:58

6 461 Q. That was more recently reinstated, am I correct to say  
7 that?

8 A. Yeah. So everything that I've said here is correct.  
9 We now have a situation where we have a dedicated ward.

10 And that's very, very recent. We have a ward manager 14:58

11 who, in my view, is doing an excellent job. It has  
12 really turned the thing around. And we have a very  
13 good elective admissions ward, which is separate from  
14 our inpatient ward. So, in recent times things have  
15 improved, but for a long time we struggled with this. 14:58

16 We had a merry-go-round of different senior nurses  
17 leading the ward who didn't stay, because of the  
18 challenges they faced. We've had agency staff who know  
19 nothing about looking after urology patients. That,  
20 for me, was scary. That gave me sleepless nights. You 14:58  
21 do major operations, particularly on a Friday, and you  
22 think, "Well, who's going to be seeing my patients over  
23 the weekend?" So even though I wasn't on-call, I'd  
24 come in and see them myself.

25 462 Q. You also, in terms of the contributory factors towards 14:59  
26 this inability to deliver to the demand, refer to  
27 theatre provision in Craigavon Hospital as being  
28 inadequate for the demands of modern urology service.  
29 This is, just for the panel's note, at paragraphs 15.5

1 to 15.7 of Mr. Glackin's statement.

2  
3 You point to the limited number of sessions that have  
4 been available historically for the urology team, and  
5 you point to the shortage of trained theatre staff?

15:00

6 A. Yes.

7 463 Q. As all being contributors to --

8 A. Yeah.

9 464 Q. To this broader difficulty. Has there been any  
10 improvement across those indices recently or not?

15:00

11 A. So, one really good example of this problem is that  
12 Theatre 4 in Craigavon was the urology theatre since I  
13 arrived in 2012. Since just before Covid, Theatre 4  
14 has been a storeroom. We have not got back into  
15 Theatre 4. As a consequence, when things opened up  
16 again a little after Covid, I have been operating in  
17 Theatre 6. And those nurses, their specialism is  
18 actually ENT. Okay?

15:00

19  
20 So, the nursing shortage is real, it's a problem. I've  
21 no issue with the theatre staff in 6, they're  
22 excellent. But they're not urology staff. We had a  
23 urology team before Covid who knew all the kit, who  
24 anticipate your next move, all of that stuff that makes  
25 your day operating much safer and easier.

15:01

26  
27 So, you know, when you walk into a theatre, Mr. Wolfe,  
28 and you look around you and you think "I've never seen  
29 you assist me do this operation ever", and you say to

1 the nurse, "Have you ever seen this operation? Have  
2 you ever helped anybody do it?", and they tell you it's  
3 their first time, it doesn't really build a lot of  
4 confidence.

5 465 Q. Does that impact on efficiency as well in terms of -- 15:01  
6 A. Absolutely.

7 466 Q. Does it mean you get five cases done instead of six, or  
8 is it not as bad as that?  
9 A. No, it probably is as bad as that. Yeah.

10 467 Q. We've seen the data, I think you've explained in your 15:01  
11 witness statement in various parts the limited extent  
12 to which data is used within the Trust - and we'll go  
13 on to look at audit and quality improvement in just a  
14 little while. But the messages around performance, the  
15 data around performance, you explain in terms of cancer 15:02  
16 wait times, new referral numbers, waiting times for  
17 routine and urgent, all of the stuff we've seen on the  
18 screen as well, that was readily available and  
19 regularly discussed?  
20 A. Yes. 15:02

21 468 Q. And I think as you say in your statement, it  
22 demonstrated a self-evident risk to patients. You  
23 also, if we go back to 17.1 of your statement,  
24 WIT-42298, you point at the bottom of the page to, I  
25 suppose, something of a vicious circle as being the 15:03  
26 impact of all of this. So --  
27 A. Yeah.

28 469 Q. Patients on waiting lists. These are typically benign  
29 patients?

1 A. That's correct, benign patients have probably suffered  
2 more, because they're not prioritised in the same way  
3 that the cancer patients are, for perhaps  
4 understandable reasons. But that's, nonetheless, it  
5 doesn't negate their suffering, coming in with a stent 15:03  
6 related problem, coming in with a catheter related  
7 problem. You know, the patients who are waiting the  
8 longest on our list are those with the benign  
9 conditions, and they're probably the ones who have  
10 suffered the most out of this. 15:03

11 470 Q. I'll take you in a moment just to some, I suppose,  
12 staff agitation around this, a number of interventions  
13 by your colleagues on that very point. But as I think  
14 you paint eloquently in that paragraph, these patients  
15 are coming back, being seen more often as their -- 15:04

16 A. Yeah.

17 471 Q. -- morbidity increases.

18 A. It would be clearly in the patient's best interests to  
19 have their issue dealt with definitively on their first  
20 attendance or in a planned manner electively. 15:04

21 472 Q. Yeah. Yeah.

22 A. But if you're waiting five or six years with a catheter  
23 in, you're going to have multiple attendances with  
24 problems.

25 473 Q. And there's obviously resource implications associated 15:04  
26 with that.

27 A. Which cancer patient do I displace from the theatre  
28 list to deal with this man who needs a TURP?

29 474 Q. Yes. And you go on just over the page then to, I

1           suppose, describe the impact on staffing. If you're, I  
2           suppose, being sucked in to trying to resolve these  
3           problems, whether you, your secretary or management  
4           staff, it's obviously inefficient?

5           A. Yes. I've huge empathy for the patients and their 15:05  
6           families. You know, the service that they're being  
7           offered is not acceptable. And I understand that. But  
8           it does have a negative impact on our working, in terms  
9           of our secretaries being verbally abused down the  
10          telephone, that happens, you know. You know, the 15:05  
11          patients and their families are frustrated by the poor  
12          level of service that we're able to offer, and we spend  
13          inordinate amounts of time answering their queries,  
14          when we'd all be better served if we'd a better service  
15          and we could just get on with doing the job when it 15:05  
16          should be done, in a timely manner.

17   475   Q. And it would appear that staff are not silent about  
18           these concerns. They are regularly articulated?

19          A. They are, openly discussed, yes.

20   476   Q. You say in your witness statement you met regularly 15:06  
21           with Debbie Burns, although I think you point out and  
22           maybe comment on this, but not with either Mrs. Rankin,  
23           I think Dr. Rankin, or with Mrs. Gishkori. But you met  
24           with Debbie Burns on a regular basis to discuss service  
25           improvement and management of waiting lists, and with 15:06  
26           Mrs. McClements more recently?

27          A. Yeah.

28   477   Q. Insisting with her that these issues are placed, if  
29           they weren't already placed, on the risk register. And

1 I think they are on the risk register and have been for  
2 some time?

3 A. Yeah. So my recollection is that around the period  
4 that Mrs. Burns was in post, there was quite a bit of  
5 work going on with the Health and Social Care Board and 15:07  
6 we would have had meetings with the Health and Social  
7 Care Board about urology in the region, and it's  
8 really, I think, on the basis of that that she would  
9 have been meeting with us and we would have -- I recall  
10 going to meetings on the administration floor and she 15:07  
11 was present, along with the consultant urologist, and  
12 I'm fairly sure Martina Corrigan was present, and we  
13 would have discussed all of these issues. She was  
14 receptive to the discussion. I'm afraid the others  
15 didn't engage, didn't engage with me anyway I suppose 15:07  
16 is probably the more correct way to put that. And my  
17 engagement with Mrs. McClements only began after the  
18 announcement of this Inquiry.

19 478 Q. Let me pick up on a couple of examples just to, I  
20 suppose, illustrate the concern of staff and the energy 15:07  
21 with which they appear to have pursued the points on  
22 behalf of, I suppose, the service and their patients.  
23 So, we've already referred to the concern that you  
24 observed about the nursing complement and their skills  
25 or otherwise in urology. Could I bring up on the 15:08  
26 screen, please, AOB-75761? And this is, Mr. Glackin, a  
27 short report penned by Catherine Hunter.

28 A. Yes.

29 479 Q. With whom I'm sure you're familiar?

1 A. I am. And I'm familiar with the report.

2 480 Q. She's copied you in to this e-mail, and a list of  
3 others, on 12th November 2015. I think the panel will  
4 have seen this e-mail when hearing from Mrs. Gishkori,  
5 and I think off the top of my head Mrs. Trouton as 15:09  
6 well. But we don't need to go to the report which sits  
7 behind this e-mail. The e-mail, in essence,  
8 encapsulates the point very well. She is saying that  
9 she has a lack of staff and, I suppose, a deficient  
10 skills mix at present. She, just to be clear, managed 15:09  
11 the urology ward, is that right?

12 A. I think at this point in time she was relatively new to  
13 the post. She'd come in from another position, I'm not  
14 quite sure where, and she'd identified all of these  
15 issues, quite correctly. She'd discussed them 15:09  
16 informally with us as consultants when we were doing  
17 ward rounds and, to her credit, she brought that to the  
18 attention of her management.

19 481 Q. And I suppose the headline is that:  
20  
21 "Currently the standard of care being given to patients  
22 is being compromised and I would consider the ward to  
23 be clinically unsafe at times."  
24  
25 were you in a position to see or know what the, I 15:10  
26 suppose the governance response through management to  
27 that was? She does refer here to what might be  
28 described as a couple of short-term fixes which she  
29 considered inadequate, which was the getting staff to



1 cover unfilled shifts.

2 A. Yeah.

3 482 Q. But would you --

4 A. So I'm not aware of what governance or what management  
5 response there was from the Director of Nursing side of 15:10  
6 things. Neither am I aware of what response there was  
7 from the assistant director or the head of service  
8 responsible for urology, you know. So I'm not sure  
9 what their response to Catherine Hunter was at this  
10 point in time. These were not new issues. Catherine 15:11  
11 was not the first person to raise these issues. And  
12 some of these issues persist.

13 483 Q. Going back to, I suppose, the point in relation to  
14 benign patients. If we go to AOB-01811. And this is a  
15 note penned by Mr. Haynes to Mrs. Gishkori. Again, you 15:11  
16 and your fellow consultants copied in. And it's May  
17 2018. And what he is saying, to summarise this note,  
18 is that:

19

20 "There are serious patient safety concerns within the 15:11  
21 Urology Department regarding the current status of our  
22 inpatient theatre waiting list and the significant risk  
23 that this poses to patients."

24

25 If we just scroll down a little bit. The impact, as he 15:12  
26 sees it, is on the, primarily the clinically urgent  
27 cases, and he makes the point that only limited numbers  
28 of non-cancer cases are being seen. They belong within  
29 the urgent classification. And no routine patients, or

1 very few, classified as routine are being seen.

2  
3 Just in the last paragraph. "Tragically", he refers,  
4 without naming Patient 91, you'll see on your list, or  
5 at least I take that to be Patient 91, who was a 15:13  
6 patient who came in with some comorbidities, but for a  
7 stent replacement or removal, I can't quite --

8 A. So I'm very familiar with that patient. Yeah.

9 484 Q. Yeah. And we'll come to it in some detail. But I  
10 think we can -- I suppose the thrust of the point is 15:13  
11 delays with the management of, for example, stent  
12 patients, risks, infection, sepsis, and in this case  
13 there may have been other contributory factors, but  
14 "This is what we're up against, this is the risk we  
15 face." 15:13

16 A. Yeah, he was laying it out in very clear terms to  
17 Mrs. Gishkori. And, you know, this was about the  
18 inpatient operating capacity and the clear disconnect  
19 that we had between the volume of patients that we had  
20 to deal with versus the capacity that we had to deliver 15:14  
21 care for them. And, you know, we didn't have anywhere  
22 else to send these people. Our colleagues in other  
23 units were under similar pressures. It's not that we  
24 could pick up the phone and ask the Ulster or the City  
25 or somebody else to take these people. On occasions 15:14  
26 that kind of thing did happen. But, you know, we just  
27 had no capacity to sort these people out, which is  
28 shocking.

29 485 Q. If we scroll just down three pages to AOB-01814, a

couple of weeks later, it seems, following a meeting, as we can pick up from the first line of this e-mail, Mr. Haynes writing to Mrs. Gishkori again, says that:

"The meeting was to resolve the issues of the impact of the loss of the extended day operating." 15:15

A. (Witness Nods).

486 Q. And we'll come to some of these initiatives in a short moment. "But the meeting did not result", it says: 15:15

"...in urology having its full number of weekly theatres, nor was it intended to address any increase in urology operating to address the waiting list backlog." 15:15

So --

A. So, my point there would be that, first of all, 11 half day slots for a team that's supposed to be six or seven consultants is not enough. But that's what we had. 15:15

487 Q. Yeah.

A. We weren't able to get back to that position. So, we were never going to be able to play catchup.

Secondly, there's a disparity in the waiting times across the specialties, and that was something that was discussed. You can see that some of the larger specialties like orthopedics and general surgery have huge waiting lists as well. We have terrible waiting 15:15

1 lists. But there are other specialties that didn't  
 2 have such bad waiting lists. So there was a discussion  
 3 as to whether or not the Trust should be applying some  
 4 form of quantitative metric as to who gets what  
 5 proportion of the available theatre time.

15:16

6  
 7 It's also - I think this was written in May, is that  
 8 correct?

9 488 Q. It's into June with this one.

10 A. Okay. Yeah. June. So this is the summer. You know,  
 11 this is just an example of how there are year-round  
 12 pressures. You know, we can't even operate at full  
 13 capacity in the summer months. That's -- and that has  
 14 been my experience now for I would say probably six to  
 15 seven years. Now, you know, I have a recent example.

15:16

16 I went on to the ward on a Friday morning to be greeted  
 17 by the ward manager, whom I have known for 20 years,  
 18 and she said "We've got outliers in our elective beds.  
 19 They promised me they wouldn't put outliers in the  
 20 elective beds. We're going to have to cancel some  
 21 surgery." This was August.

15:16

22 489 Q. I suppose I can detect perhaps an end of tether moment  
 23 on the part of Mr. O'Brien a year later, when perhaps  
 24 his tether is longer than that. But in 2019 he wrote  
 25 to you and colleagues. If you just bring up on the  
 26 screen, please, WIT-55757?

15:17

27 A. It feels like I'm telling you tales of woe.

28 490 Q. Well, I think it's important to put this context in  
 29 place before we get on to some of the other substance

1 we have to explore.

2 A. Yeah.

3 491 Q. So, Mr. Haynes is again pointing up the risks of  
4 urosepsis, and he's saying: Going forward can we  
5 document this? Can we, I suppose, better put it on the 15:18  
6 in-tray of those who need to know by filing incident  
7 reports where there has been unreasonable waits? I see  
8 you smiling. I don't know how you responded to that?  
9 Was that --

10 A. I... 15:18

11 492 Q. Is it correct, I suppose, to describe it as a "where do  
12 we go?", end of tether moment?

13 A. I think Mr. Haynes here is very clearly outlining how  
14 we have to flag to the Trust that there's a significant  
15 problem. However, I would say that the Trust should 15:19  
16 very well know that there's a significant problem by  
17 the volume of the waiting lists. All the procedures  
18 that go on the waiting list are coded. All you have to  
19 do is run a coding and you can understand very clearly  
20 what's waiting on the waiting list. 15:19

21 493 Q. I don't need to bring you to it, but we'll perhaps come  
22 to it later.

23 A. Yeah.

24 494 Q. In terms of the dissemination of these key messages, we  
25 know, for example, in Patient 91's case, and in other 15:19  
26 cases, his SEA report or review pointed up the need for  
27 the Trust to deal with capacity issues. It was one of  
28 the...

29 A. Yeah.

1 495 Q. The recommendations.

2 A. I suppose a little bit of good news on that front,

3 Mr. Wolfe, would be that Lagan Valley has actually

4 given us quite a good outlet for the stented patients.

5 A lot of them are fit enough to go there. And that has 15:20

6 meant that to a large extent that has improved in

7 recent times.

8 496 Q. I focused some attention on Mr. Haynes' energy in

9 lifting this issue on to the agenda; you reflect in

10 your witness statement that Mr. O'Brien raised concerns 15:20

11 on many occasions about the needs of urology service,

12 whether that was at departmental meetings with the

13 assistant directors and with commissioners from the --

14 A. Yes.

15 497 Q. -- Health and Social Care Board. I don't wish to 15:20

16 disrespect his input, but was similar messages to what

17 we have seen already...

18 A. So, I referred earlier to the meetings that we had with

19 Mrs. Burns. So, around that time there was engagement

20 with the Health and Social Care Board about how 15:21

21 services should be, you know, progressing. And

22 Mr. O'Brien would have raised, very clearly, these

23 exact concerns at those meetings.

24 498 Q. And you're at those meetings as well?

25 A. Yeah, I was at some of them, yes. 15:21

26 499 Q. Yeah. The Commissioner -- I mean --

27 A. I'm telling you it happened first hand. I heard it

28 happening.

29 500 Q. Yeah.

1 A. Yeah.

2 501 Q. The Trust is clearly, Trust management, hopefully --

3 A. Present.

4 502 Q. -- senior management and Board are aware of these

5 issues. It has the -- 15:21

6 A. I can't speak about the Board.

7 503 Q. well...

8 A. But Trust management, in terms of the Acute Services

9 Director, would have been aware.

10 504 Q. Yeah. And certainly the Acute Directorate Risk 15:22

11 Register has, if you like, had this issue stamped upon

12 it from, I think, in or around 2012, possibly 2014?

13 A. I've never had sight of the Risk Register, but I did,

14 on one occasion, on a video conference meeting, ask

15 Mrs. McClements were these issues on the Risk Register, 15:22

16 and she assured me that they were.

17 505 Q. Yeah. So, we can see through various sources that the

18 issues aren't hiding behind the trolley.

19 A. No, they were fully out in the open.

20 506 Q. Yes. What is the Health and Social Care Board saying 15:22

21 at these meetings that you've attended? Noting the

22 issue and taking it away?

23 A. I can't honestly recall what Mr. Sullivan's responses

24 were. It didn't come to very much, Mr. Wolfe. Nothing

25 has really changed. 15:23

26 507 Q. So, in terms of progress, you've highlighted the

27 assistance that the Lagan Valley has brought to the

28 stent issue?

29 A. Yeah.

- 1 508 Q. But more broadly, looking at the range of new patient  
 2 capacity issues, follow-up capacity, surgical --
- 3 A. Yeah. In fairness, I should add that during the Covid  
 4 pandemic, services in Craigavon were severely  
 5 restricted. So, we took the opportunity to establish a 15:23  
 6 small amount of surgery for urology at Daisy Hill  
 7 Hospital. That was entirely new. It had never been  
 8 done before. We, as a team, were flexible, we worked  
 9 together to identify the patients who could go there.  
 10 We were very warmly received by the theatre and ward 15:24  
 11 teams in Daisy Hill, we found them to be excellent.  
 12 And we had a long held -- prior to Covid, we had a long  
 13 held wish to establish services in Daisy Hill, and we  
 14 would hope to build on that going forward. So that  
 15 remains in place. We have theatre lists in Daisy Hill 15:24  
 16 that we never had before, patients are largely having  
 17 day case surgery, the occasional 23-hour stay, and  
 18 that's working well. We need more of it.
- 19 509 Q. Can I ask you some questions about the extent to which,  
 20 as well as very properly complaining about the issues 15:24  
 21 and seeking improvement, to what extent the urology  
 22 team, supported by management, were able to engage in  
 23 discussion or reflection about how things, I suppose,  
 24 might be done better, more efficiently, to try to  
 25 improve the lot, or are you telling me clearly that 15:25  
 26 there's no blue sky thinking here, or there's appetite  
 27 for blue sky thinking, but it is difficult to improve  
 28 without resource?
- 29 A. So, you don't have to reinvent the wheel. Okay? Lots



1 of these things are being done in other places very  
 2 well. You may be familiar with GIRFT. It's a project  
 3 that I think began in an orthopedic setting but has  
 4 been extended to other specialties. We've had a recent  
 5 GIRFT visit. I think on the whole GIRFT were impressed 15:25  
 6 with many of the things that we were doing within the  
 7 department, but they recognised the shortcomings that  
 8 we have in terms of resource.

9  
 10 We are very open to moving towards, as far as possible, 15:25  
 11 day case operating for all the patients who are fit for  
 12 it. We've tried to deliver that, as far as we can  
 13 within the resource that we've got at the moment. We  
 14 have shifted things out of theatre that used to be done  
 15 in theatre, we've moved them to Outpatient Department 15:26  
 16 activity. So, all of that, you know, that's not that  
 17 we've suddenly seen the light, we've been doing this  
 18 for the last ten years. It's just you need the  
 19 resource to deliver these good ideas. And if you  
 20 haven't got the resource, you're going to struggle to 15:26  
 21 do it.

22 510 Q. In outpatients, I think you've reflected in your  
 23 statement that Thorndale, at least physically, is a  
 24 good setting, you have good staff, well managed, a  
 25 cohesive team. 15:26

26 A. (Witness Nods).

27 511 Q. But nevertheless, there is a time lag in terms of  
 28 outpatients being seen. Is there effective use of the  
 29 nursing resource? Are things managed efficiently?

1       A.    So the nursing resource has evolved over time.  When I  
2            joined the department there were two people who were  
3            working as CNSs, and we now have a CNS team of five  
4            staff, plus two people who have been appointed in the  
5            last few months on what's known as "expression of       15:27  
6            interest", and I've had that clarified for me, because  
7            I wasn't quite clear what that meant, but basically  
8            it's nonrecurrent funding.

9  
10           So we would be hopeful that these two new appointees,       15:27  
11           who are both known to us, they both worked as urology  
12           staff nurses in the past, would be appointable in the  
13           future as permanent members of the team, because it's  
14           no secret but some of the members of our CNS team are  
15           coming towards the end of their clinical careers and we       15:27  
16           need to do a bit of succession planning.

17  
18           So, our nurses perform, many of them perform at  
19           advanced nurse practitioner level, a lot of the  
20           activity that they undertake, it's beyond just what       15:28  
21           would be considered CNS activity.  And we have  
22           supported that as a group of consultants, we've  
23           mentored the nurses in various aspects.  I've  
24           personally mentored them in prescribing, administration  
25           of flexi and Botox.  I've mentored two of the nurses to       15:28  
26           undertake perhaps transperineal biopsy of the prostate.  
27           So we have a very supportive cohesive team.  You will  
28           have heard from Patricia Thompson, when she gave  
29           evidence a few days ago, about nurse led clinical

1 activity, and as the team has expanded, we have been  
2 able to expand that.

3  
4 So, you know, you need - it's coming back to my point -  
5 you need enough resource to allow you to deliver these 15:28  
6 things.

7  
8 The nurses that we have are extremely capable, they're  
9 pro-active, and they're well regarded by us. And I  
10 think in reverse they regard our support well. 15:29

11 512 Q. Could I ask you about, I suppose, theatre, surgical?  
12 We'll come on to look at performance management more  
13 specifically in a moment, but are efforts made to  
14 measure comparable efficiency within theatre across the  
15 team? 15:29

16 A. So, we all have slightly differing interests. Okay?  
17 So if I take, for example, Mr. Young is primarily a  
18 stone surgeon now, okay? His practice was perhaps  
19 wider than that in the past. So he does operations  
20 that I don't do. So, to compare his practice with 15:29  
21 mine, you wouldn't be comparing apples with apples.  
22 But there are things that we all do in terms of a  
23 commonality. We would all do things like TURBT, we  
24 would all do things like simple ureteroscopy, many of  
25 us would do bladder outlet surgery, although some of us 15:30  
26 don't do any. So the theatre utilisation, the theatre  
27 management team would go through a utilisation and they  
28 present data on that. I've never found it to be that  
29 helpful or meaningful.

1  
2 Mark Haynes went through an exercise at one time where  
3 he looked, kind of on a coding basis, as to how long  
4 each procedure should take, roughly, and then used that  
5 as a way of gauging what capacity we had to deliver 15:30  
6 what was on our waiting list.

7  
8 We have come to the view more recently that we needed a  
9 scheduler. Okay? And we came to that view for a  
10 couple of reasons. Firstly, it would mean that certain 15:30  
11 procedures would essentially be pooled - and they have  
12 been for a while now. So, for instance, anybody  
13 needing a transurethral resection of a bladder tumour,  
14 we would just pick that up. We wouldn't necessarily -  
15 that wouldn't go under a named person, we would just 15:31  
16 get them the first possible date. So that's where a  
17 scheduler comes in, because they're very - they can  
18 very easily pick that off the waiting list, make sure  
19 the patient is pre-oped and put them on the first  
20 available list. So that person has only just joined 15:31  
21 the team this past maybe two weeks, and that will be a  
22 change for our department. It's something we've been  
23 asking for for a long time, and I think that will be a  
24 positive benefit. It will also mean that as far as we  
25 can, we will draw patients from the waiting list in 15:31  
26 chronological order, based on their clinical urgency.

27  
28 Now, you may or may not be aware of a document issued  
29 by the FSSA, which was about prioritising surgery

1 during Covid. We have largely maintained that  
2 prioritisation process. And when patients go on our  
3 waiting list, they are coded according to that process.  
4 So this is a way that we have of reassuring ourselves  
5 that we are using the resource that we're provided with 15:31  
6 most appropriately.

7 513 Q. The importance of a scheduler, does that point to  
8 perhaps recent historic weaknesses in terms of giving  
9 consultants too much autonomy in terms of the  
10 management and allocation of patients to waiting lists, 15:32  
11 perhaps allowing their preferences to take priority  
12 ahead of the wider needs of the service?

13 A. So, I think the scheduler will work in concert with the  
14 consultants, because clearly the scheduler doesn't have  
15 the clinical insight that the consultants have. But it 15:32  
16 will level the playing field for patients of a similar  
17 clinical urgency being called in chronological order.

18  
19 We haven't yet, but I think we will have, work up an  
20 SOP so that it's a very clear for the scheduler how we 15:33  
21 wish to organise things. And naturally, you know, I  
22 alluded to Mr. Young earlier doing stone cases, he's  
23 now semi-retired, but my other colleague does stone  
24 work, so there will be things that only will go on his  
25 list that won't go on my list and vice versa. And that 15:33  
26 applies across the team, because we have different  
27 skill sets across the team.

28 514 Q. I perhaps should have come to this a little earlier in  
29 the piece, but you do, in your witness statement,

1 describe certain initiatives to try, in particular, to  
2 remove -- sorry, to move surgery along. You talk about  
3 --

4 A. Yeah.

5 515 Q. -- working Saturdays for a period, a couple of years 15:33  
6 maybe, and then it ran into the brick wall of bed  
7 issues.

8 A. (Witness Nods).

9 516 Q. You talk about the three session week. Again, it ran  
10 into difficulty. So, in fairness to the Trust, is it 15:34  
11 appropriate to say that they have looked at trying to  
12 address these issues, but they have been faced with --

13 A. I think it's in fairness to the Trust, yes, I agree.  
14 It's also in fairness to the clinicians. You know, the  
15 urologists and the anaesthetists and the nurses agreed 15:34  
16 to do the extra lists.

17  
18 The Saturdays, as you pointed out, became untenable  
19 because of essentially nursing shortages and bed  
20 pressures. And the extended days, it was a three 15:34  
21 session day on a Tuesday and a Wednesday. I didn't  
22 operate on those particular days, I operated on a  
23 Friday. So, the productivity wasn't as good as we had  
24 hoped. The final session of the day was never quite as  
25 productive as the first two. And then there became an 15:34  
26 issue with, I think it was primarily anaesthetic  
27 staffing of those lists.

28  
29 So, you know, that fell by the wayside for that reason.

1

2

But I come back to what I said about the 11 sessions;  
it's just not enough.

3

4

517 Q. Yes. I think, I suppose the solution, as you see it,

5

and hopefully that's not unfair to put it in those

15:35

6

terms, is set out in your witness statement at

7

WIT-42297, and that is, I suppose, at paragraph 15.5.

8

Your, I suppose, proposal - if you had the keys to the

9

kingdom - would be for three to four sessions per

10

consultant per week, giving you 21 to 28, instead of

15:35

11

the current, is it 11?

12

A. Yes.

13

518 Q. At the time of the writing that statement.

14

A. Yeah, I think consultants in the NHS operate too

15

little. Surgical consultants. If you go to other

15:36

16

health care systems, they spend three or four days a

17

week operating. We are not using the resource that we

18

have appropriately. You know, you have trainees who --

19

I'm a TPD, so I hear this from the trainees' side.

20

They go off and do a fellowship in another country and

15:36

21

they tell you that they're in theatre five days a week.

22

Now maybe that's not the right balance - it isn't the

23

right balance. But, you know, we are lucky if we get

24

two days in theatre a week, you know, and it shouldn't

25

be that way. And if we were able to offer more timely

15:36

26

surgery, the patients are the people who would benefit.

27

519 Q. Can I just pick up on two points that you make in your

28

statement which, if I interpret you correctly, you are

29

putting them forward as perhaps impediments to progress

on capacity, which are, I suppose, a separate issue to the bigger resources issue? So you see resources as being the primary issue, but you make a point about job planning.

A. Yes.

15:37

520 Q. which I would be grateful if you could expand for me. If we go to WIT-42315, and if we scroll down to 46.1. You make the case that:

"Performance objectives are not utilised for consultant medical staff. A consultant job plan sets out sections of direct clinical care and SPA. It records the frequency of clinics, theatre lists, on-call activity. In my case it also captures the time allocated to..."

15:37

-- your roles as:

"...educational supervisor, TPD, Chair of Urology MDT, preparation time for the MDT.

15:38

My job plan does not..."

And this is your point:

"...specify how many patients I am expected to see per clinic or theatre list."

15:38

Although it does specify how many clinic and theatre/procedural sessions you're expected to deliver



1 over the course of a year.

2  
3 Just scrolling down, so we can take both related points  
4 together, you say that:

5  
6 "Job planning happens in isolation from the whole team.  
7 There is no discussion with the team about the  
8 overarching view of the needs of the service. I am not  
9 aware of any standard setting for productivity across  
10 the team." 15:38

11  
12 So, would I be right in saying that you think that the  
13 resource, the human resource in terms of consultants,  
14 could be used better, could be used more efficiently if  
15 greater emphasis was given to performance managing and 15:39  
16 directing the staff towards their area, the areas  
17 needed by the service?

18 A. Yeah, I do agree with that. And, you know, in my view  
19 what should be happening is that we, as a consultant  
20 team, should be sitting down with the management, 15:40  
21 having the data available to us to see what it is that  
22 we can deliver within the resource that we've got, and  
23 agreeing how we're going to do that, benchmarking  
24 practice in terms of numbers of patients coming to  
25 certain types of clinics. I appreciate that, you know, 15:40  
26 perhaps if you're breaking bad news you might need more  
27 time than whether you're counseling somebody for a  
28 circumcision. So that all could be factored in.

29 521 Q. Yes.

1           A.    You know.  So these discussions haven't taken place  
2                   until very recently in our team.  We've had a couple of  
3                   away days where this kind of, I've raised this kind of  
4                   topic, and we would like -- I personally would like to  
5                   travel in this direction. 15:40

6 522   Q.    Yes.  And was that - I think you told me when we spoke  
7                   before you gave evidence - was that experience, that  
8                   kind of bringing the data into a monthly meeting and  
9                   crunching through it as a team, was that your  
10                  experience elsewhere? 15:40

11          A.    Yeah.  So, towards the end of my training I worked in  
12                  two units, one was in Birmingham and the other was a  
13                  Wolverhampton.  I was a post-exam trainee in both  
14                  units.  And you're in a much different position as a  
15                  post-exam trainee to understand what's going on. 15:41  
16                  You're -- also it was the practice of those units to  
17                  invite the post-exam trainees in to the business  
18                  meetings that the consultants attended.  And that was a  
19                  useful experience, because you got to see how they  
20                  interacted with their management. 15:41

21  
22                  So, the data, in terms of the numbers of patients  
23                  presenting to their departments, the workload, all of  
24                  that was presented at these meetings.  It was openly  
25                  discussed.  You know, strategies were discussed as to 15:41  
26                  how we're going to manage this, that and the other, you  
27                  know, and we haven't had that.  We have had elements of  
28                  it at times --

29 523   Q.    Sorry to cut across you, and just as part of this

1           answer. why is that?

2           A.    Yeah.

3   524   Q.    It seems relatively obvious that this should be done,  
4               but maybe I'm missing something.

5           A.    So, it has begun. Last week perhaps we had our first   15:42  
6               meeting where this kind of data was presented. Okay?  
7               And I congratulated the person who did it and I said -  
8               because this is exactly what we need to see, this is  
9               what we need to hear, okay, we need to be aware of  
10              this. It hadn't happened I think in our department   15:42  
11              before this, because for one, Martina Corrigan had far  
12              too much on her plate. She was being pulled from  
13              pillar to post looking after ourselves, ENT,  
14              ophthalmology, and outpatients. Everything was  
15              reactive. She didn't have the time to have this   15:42  
16              prepared and bring it to us in a structured manner on a  
17              monthly basis.

18

19           when we had departmental meetings, Martina would often  
20           not be able to be present for the meeting because she   15:42  
21           had a conflicting meeting with ENT, and we were  
22           therefore not getting, to my mind, the full benefit of  
23           having the head of service present at the meeting.

24   525   Q.    I know that you're not saying that as a criticism of  
25               Mrs. Corrigan?   15:43

26           A.    It's not a criticism of her, because in my experience  
27               she was extremely hard-working, she worked often  
28               18-hour days. It was -- she was -- there was just  
29               simply too much being asked of one person. The

consequence of that is that you don't have the structures in place to have these regular discussions about how you're doing, where you're going, what you need to do to address shortcomings, things that are coming on the horizon, plan for the future, etc..

15:43

526 Q. You say in your statement, I think I've got the right reference, hopefully I've got the right reference. It's WIT-42294, 13.2, if I can see it. Yeah. Yeah.

You make the point towards the very bottom that to the most extent, to a large extent, the waiting lists are a function of inadequate resource. But I think you add this other point as a contributing factor to --

15:43

A. Yeah.

527 Q. -- inefficiency, that there is also an aspect of individual working styles and differing case mix. So:

15:44

"If a surgeon chooses to take cases out of chronological order or gives no resource to the longest routine waiters, then inevitably the waiting list will grow more quickly than that of a colleague who lists chronologically."

15:44

A. Yes.

528 Q. Was that a problem?

A. It's still a problem. Because, you know, if you look at our current waiting list, the patients who are waiting longest are waiting for bladder outlet obstruction surgery, there is the occasional Nesbit's that's waiting. So clearly other cases have been

15:44

1 picked ahead of them.

2  
3 I didn't make the comment when you put up the data of  
4 the waiting lists, by the way, but if you look at that  
5 in great detail you'll see that there are differences 15:45  
6 across the team.

7 529 Q. Yes.

8 A. Okay? There are people, I think in the 2016 data that  
9 you presented, who don't have patients waiting more  
10 than a year. 15:45

11 530 Q. Yes.

12 A. So, there is an element as to how you choose to run  
13 your practice.

14 531 Q. Yes. And the kind of forum or approach that had its  
15 first meeting last week, is that the kind of structure 15:45  
16 that could potentially bring discipline - and I don't  
17 mean discipline in the nastier sense, but organisation  
18 or build a common approach towards --

19 A. I think consensus is important. We need to build  
20 consensus as to how we move forward. I notice from 15:45  
21 reading Mr. Young's contributions that he shared that  
22 view. But you need the data to demonstrate to people  
23 where we are. Without it, you're just talking  
24 anecdotes.

25 532 Q. Within your statement you speak about your ability to 15:46  
26 progress matters, I think with hard work, I suppose,  
27 and targeting. You say, if we go to WIT-42293, 12.2 at  
28 the bottom, that you were given access - and maybe  
29 you'll unpack this for us - to business objects through

1 Mrs. Corrigan and using, I suppose, the data available  
2 to you through that, you were able to better target  
3 long waiters and over time reduce your backlog. I  
4 don't understand that as you suggesting this is the  
5 magic solution that will alleviate waiting lists in 15:47  
6 toto, but what are you alluding to there?

7 A. Yeah. So, waiting lists are held on the patient  
8 administration system. Business objects is a suite of  
9 software that allows you to generate reports and to  
10 query things on the waiting list. And from that, you 15:47  
11 can then download Excel files, or pdfs or whatever you  
12 want to download, and have a full view of what the  
13 waiting list contains. It also allows you to download  
14 activity. So, I could quite clearly see from the  
15 activity how many outpatients we were seeing every 15:47  
16 month, it was coded by both clinic code, it was also  
17 coded by consultant, nurse, registrar, whatever it  
18 happened to be. So, I had a very clear view of what  
19 the activity was. I had also a very clear view of what  
20 the waiting lists were. 15:48

21  
22 So I inherited a waiting list when I came to the Trust  
23 of another consultant who had left, and at that stage I  
24 took on his work, and I wasn't familiar, clearly, with  
25 his patient workload, so I had to go through his 15:48  
26 waiting lists and see what was there. So, I requested  
27 access to this, because it was the only way that I was  
28 going to be able to understand the data and understand  
29 how many patients were waiting to see me. And, you

1 know, the review backlog was substantial, I cleared it.  
2 My practice meant that you don't get a review in my  
3 clinic unless you need one. I discharge people who  
4 don't need to be coming back. You know, patients who  
5 get results, they'll come, if it's a post-MDT, they'll 15:48  
6 have a face to face discussion, if that's what they  
7 want, and after that then, if they're having follow-up  
8 by imaging, they will receive a letter with the  
9 results, with an open invitation that if they want to  
10 come back to my clinic, please contact me, please 15:49  
11 contact my secretary, there's no problem about seeing  
12 you.

13  
14 So, by working in that manner it means you don't have a  
15 review backlog, you have capacity to bring people in 15:49  
16 who need to be seen when they need to be seen, and you  
17 can do it in a timely way.

18  
19 So that's the reason I wanted business objects, so that  
20 I could get a firm handle on my practice and understand 15:49  
21 where I was.

22 CHAIR: Mr. Wolfe, it's now ten to four. I think we  
23 all need a break.

24 MR. WOLFE KC: I was going to suggest that and I think  
25 everybody could benefit from one. 15:49

26 CHAIR: Yes. So five past four.

27 MR. WOLFE KC: Very well. Thank you.

28  
29 SHORT ADJOURNMENT

1  
2 CHAIR: Thank you everyone. I think we have had the  
3 temperature adjusted to try and make it a little cooler  
4 in here, because it has been quite hot this afternoon.  
5 And that's not a reflection on you, Mr. Glackin.

16:06

6 MR. WOLFE KC: I propose to stop about a quarter to  
7 five and then pick up again tomorrow.

8 CHAIR: Okay.

9 533 Q. MR. WOLFE KC: So we were talking just before the  
10 break, Mr. Glackin, about the initiative commenced last  
11 week - no doubt it had been in planning for some time -  
12 to bring data to a meeting, to number crunch and decide  
13 on, I suppose, better ways of attacking service related  
14 problems.

16:06

15  
16 You were a participant with your colleagues in the  
17 Thursday lunchtime departmental meeting.

16:06

18 A. Yes.

19 534 Q. That was, I suppose, a standard or regular date in the  
20 diary, and the diary of every member of the team, or it  
21 should have been?

16:07

22 A. Correct.

23 535 Q. And you say within your statement, I'll just read it  
24 out, 34.2, that this meeting, it lasted 45 to 60  
25 minutes. Chaired by Mr. Young. Attended by urology  
26 consultants and Mrs. Corrigan.

16:07

27  
28 "The purpose of the meeting was to provide an update on  
29 matters concerning the running of the department, such



1 as waiting times, referral data, reports from theatre  
 2 user groups, equipment issues, and plans to purchase  
 3 new equipment, etc. . "

4  
 5 So, it's a fairly broad agenda, but essentially 16:07  
 6 anything could go on the agenda if it related to the  
 7 running of this service?

8 A. Yeah. All items relevant to the running of the  
 9 department.

10 536 Q. Yeah. In terms of the functioning of the team, does it 16:08  
 11 occur to you upon reflection that the kind of  
 12 purposeful meeting that you refer to as having taken  
 13 place for the first time last week, should have been a  
 14 feature of a properly functioning team well before now,  
 15 given the range of problems that were being faced by 16:08  
 16 the service?

17 A. Okay. To be fair, on occasions Martina Corrigan or  
 18 Sharon Glenny would have brought data to the meeting,  
 19 but that was - I wouldn't describe that as frequent or  
 20 routine, that happened on occasions. And to my mind, 16:08  
 21 that should have been frequent and routine.

22  
 23 The meetings often lacked structure, often there wasn't  
 24 an agenda, attendance was poor. I reflect in the  
 25 statement that too often I'd be sitting across the 16:09  
 26 table looking at Michael Young and the two of us would  
 27 ask each other "Where are the others?" They were doing  
 28 other things. They had prioritised other activity.  
 29 They were in the building, they just weren't in the

1 meeting.

2 537 Q. Yes. I'll allow you to pick the descriptor, but was  
3 this a dysfunctional team or, to put it at a slightly,  
4 on a slightly softer surface, did it not coalesce or  
5 gel sufficiently to have conversations around problems 16:09  
6 that were, if not soluble, were at least capable of  
7 mitigation?

8 A. I suppose there's always degrees of dysfunction. I  
9 don't think we had interpersonal problems. I think we  
10 could all have a civil conversation with each other in 16:10  
11 a room. So I don't think that was the problem. I  
12 think, you know, our workloads were very heavy and I  
13 think that was a challenge for people to give up time  
14 to come to a meeting when they had other competing  
15 interests. I'm not making excuses for my colleagues, 16:10  
16 because I went to the meetings every week and I thought  
17 they were important, but I'm just trying to see it from  
18 their perspective.

19 538 Q. As a team member with, say, experience of the  
20 Wolverhampton approach, did you reflect that maybe I 16:10  
21 could have done a bit more to agitate for reform in  
22 terms of how we make these decisions, suggesting that  
23 really there's no excuse for not bringing this data  
24 every week and having this kind of conversation?

25 A. Yeah. These things were discussed, Mr. Wolfe. You 16:11  
26 know, on more than one occasion I said we need the  
27 data. On more than one occasion I said we need an  
28 agenda at this meeting, we need proper minutes taken at  
29 this meeting, you know? So there comes a point when

1           you've said these things so many times that you're just  
2           hearing yourself repeatedly saying the same thing, the  
3           same mantra.

4   539   Q.    You refer in your witness statement to, I suppose, a  
5           lack of leadership or a lack of direction from  
6           management, or at least that is implied. You say - if  
7           we can bring up on the screen, please, WIT-42307, just  
8           at 31.1 there, you say that in your opinion:

16:11

9  
10          "... the senior managers did not work well with  
11          urology. "

16:12

12  
13          And you point out that:

14  
15          "... engagement with the department by the clinical  
16          directors, medical directors, assistant directors for  
17          surgery and directors for acute services was very  
18          limited and infrequent in my experience. "

16:12

19  
20          And I think elsewhere you say that the connection  
21          between cancer services, and the management structure  
22          within cancer services and urology was, I'm not sure if  
23          you used the word nonexistent, but there was a  
24          disconnect there?

16:12

25          A.   I think nonexistent is probably correct. Can I just  
26          say that, you know, there was a short period where  
27          Mrs. Burns did interact with us, but she was the only  
28          person in that role who did. As for the AN or the  
29          assistant director for surgery, very infrequent

16:12

1 attendance at any meetings regarding our department,  
2 from my recollection. Didn't meet the Medical Director  
3 at any meetings for our department, which I think is  
4 very relevant for 2017, and we'll come to that I'm  
5 sure. And the Clinical Directors were never at our 16:13  
6 meetings.

7 540 Q. And we have your evidence on Mrs. Corrigan running to  
8 standstill, and you compliment her on her work ethic,  
9 but she was being pulled in too many directions?

10 A. Yeah. 16:13

11 541 Q. To offer strategic leadership?

12 A. And I think that may also apply to some of the other  
13 managers that we're speaking about here. You know, I'm  
14 fairly certain that Ronan Carol was pulled in multiple  
15 directions as well. The whole aspect of the acute or 16:13  
16 unscheduled care delivered by the Trust versus the  
17 elective aspect - and urology is largely an elective  
18 specialty - they were overwhelmed with the unscheduled  
19 or emergency care aspect, in the emergency department,  
20 on the wards, and that had a negative consequence then 16:14  
21 for elective care. They were firefighting every day.

22 542 Q. Yes. I'm thinking about the other important  
23 roles/responsibilities you had, quite apart from, I  
24 suppose, the basic consultancy. You had responsibility  
25 for the Patient Safety Committee? 16:14

26 A. Yeah.

27 543 Q. You had responsibility from 2016, '15, for the multi  
28 disciplinary team.

29 A. Yeah.

1 544 Q. You were the clinical lead?

2 A. (Witness Nods).

3 545 Q. Is it surprising, or are you expressing your surprise  
4 that notwithstanding your involvement in those roles,  
5 you had no contact with any of the people you've just  
6 listed, or little contact?

16:15

7 A. So, little contact. But what I would say is this: The  
8 patient safety meeting, that terminology actually came  
9 from Dr. John Simpson. He had been the Medical  
10 Director. And he had taken a view that the M&M  
11 structure within the Trust wasn't really delivering and  
12 he wanted to change that. He wanted to bring that  
13 activity closer to each department, which I think was a  
14 good move, and he supported that.

16:15

15  
16 So, I borrowed that term from him, it's not that I  
17 generated that term. And what had gone before it in  
18 terms of M&M was all of surgery and all of anaesthetics  
19 sitting in a room, not much smaller than this, and it  
20 was a bun fight, it was adversarial, there was no  
21 learning, it was juniors standing up presenting cases  
22 and then get taken apart by senior consultants. It was  
23 not a pleasant place to be. So, Dr. Simpson was very  
24 right in suggesting what he did. So he then, he sought  
25 volunteers, basically, to run the M&M or patient safety  
26 meetings in each department.

16:15

16:15

16:16

27  
28 I was relatively new through the door at that stage, I  
29 had seen how it had worked well in other places, I

1 thought we can do something with this, we can develop  
2 this, we can bring in more than just the doctors -  
3 because up until that stage it had just been the  
4 doctors.

5  
6 So at the outset I spoke to my consultant colleagues  
7 and I said "we need to include the whole team here. We  
8 need to ask the nurses from the Outpatient Department",  
9 which was the Thorndale, "We need to ask the nursing,  
10 the senior nursing staff from the ward. We need to  
11 seek input from the management team." So that's what  
12 we did. And we started drafting agendas that would  
13 allow us to discuss both the mortality and morbidity  
14 aspects, but also the other things like the SAIs, the  
15 complements, the complaints, the learning letters, the  
16 coroner's reports, all of the things that cascades  
17 down from the management to the departments. It  
18 included audit.

19 546 Q. Could I --

20 A. You're going to pause.

21 547 Q. Those items then, and audit, are on my agenda.

22 A. Yeah. Good.

23 548 Q. In a short period of time, or perhaps in the morning.

24 But it's the, it's, I suppose, what could have been  
25 done with better management support across any of your  
26 interests, which I suppose I'm interested in at this  
27 point.

28 A. Yeah. So --

29 549 Q. If you - and this is, I suppose, largely leaving aside

1 your traineeship, the only place that you have worked,  
 2 and you have, I suppose, on your account, experienced  
 3 largely a default in proper leadership and proper  
 4 management, for perhaps understandable reasons if  
 5 people are not resourced and are pulled in other 16:18  
 6 directions, but do you have a sense of the implications  
 7 of this deficit for the urology service?

8 A. Yeah, I have --

9 550 Q. Is it possible to articulate that knowing --

10 A. I had a very strong sense of the deficits. And in 16:18  
 11 drafting the agendas, as I've outlined, we were trying  
 12 to bring out all of those things that needed to be  
 13 discussed. And, you know, audit was not well supported  
 14 within the Trust at that point in time. I'm pleased to  
 15 say that's actually changed quite substantially in the 16:18  
 16 last year, you know? There was no support to me as a  
 17 lead clinician for this meeting, so I had to draft the  
 18 agenda, I had to then write - type the minutes - and as  
 19 you can imagine, I'm a surgeon, I'm not very good at  
 20 typing minutes, you know, so there was a delay in 16:18  
 21 getting the minutes out. You know. It just -  
 22 everything was done on a shoestring.

23 551 Q. Who did you go to then if you had issues?

24 A. These issues were known by our team. You know,  
 25 Mr. Young was lead clinician, Mrs. Corrigan was aware 16:19  
 26 of this. We would feedback the minutes of the meetings  
 27 up through the governance chain. They were shared both  
 28 with the governance team, but also the Medical  
 29 Director's team. They were also shared with the other

1 chair, or the other lead clinicians of the other M&Ms.  
2 So I would receive, for instance, minutes of the  
3 orthopedic meeting, so I would have a read through of  
4 those to see were there any issues in the orthopedic  
5 meeting that would have read across our specialty. 16:19

6 552 Q. I think you reflect within your statement that things  
7 changed in terms of management interest in urology  
8 after the announcement of this Inquiry?

9 A. Yeah, they did change. We now, both -- in the audit  
10 setting we have a much better support, we have several 16:20  
11 members of the governance team who interact with us,  
12 we've set a firm audit plan, it's agreed as a team,  
13 it's monitored, the work is presented, and as it's  
14 presented it's ticked off and we move on to the next  
15 thing. So these things have improved a lot. 16:20

16 553 Q. Can I move on? We'll look at aspects of management in  
17 a short moment when we move on to look more closely at  
18 governance issues, but let me ask you about appraisal,  
19 briefly.

20 16:20  
21 You set out in your statement, if we could go just over  
22 the page, I think, to 32.2 - on down the page a little.  
23 So, you make the point that you're the subject of  
24 appraisal for the purposes of validation, and it's said  
25 on a number of occasions, so I get the impression that 16:21  
26 you think it important to say it repeatedly that this  
27 is not a performance related review, and in answer to  
28 other questions you make the point that consultants are  
29 outside of the performance management loop.



1  
2 Tell me about your thinking on that. Are you  
3 suggesting in those answers that you think it would be  
4 a good idea, in light of experiences within urology  
5 services at the Southern Trust, and perhaps elsewhere, 16:22  
6 for you and your colleagues to be subject to some form  
7 of performance management?

8 A. Yeah, I think it's very important that there is a  
9 degree of performance management for all members of the  
10 staff, not just consultants. And, you know, you can 16:22  
11 quite easily go through the whole appraisal process  
12 without anybody raising any questions as to what kind  
13 of work you've done and to what standard.

14 554 Q. You refer to it as, I don't think I need to bring that  
15 up on the screen, it's paragraph 47.2. You seem to 16:22  
16 value the opportunity, if it had stayed like this, for  
17 a confidential reflective exercise in professional  
18 development; you see advantages or benefits in that.  
19 But what you say is that the process has now morphed  
20 into something akin to bean counting - my words - it's 16:22  
21 a formulaic capture of documents - your words?

22 A. Yes. I think bean counting is equally good as a  
23 descriptor.

24 555 Q. So, moving from the positive side of that spectrum to  
25 the negative, why was this opportunity for reflective 16:23  
26 discussion around professional development, why was  
27 that useful and what has it now become?

28 A. So, when I first became a consultant, the appraisal  
29 process was between two peers and was largely a

1 discussion, and you felt that you could have a  
2 confidential discussion about the challenges that you  
3 faced, the difficulties that there were, perhaps share  
4 the successes that you'd had, all of that kind of  
5 thing. Now nobody's really interested in that. They 16:23  
6 just want to make sure that you meet all the domains  
7 that the GMC have set out, that all of those -- in our  
8 Trust they use an electronic method for capturing all  
9 of that, I think it's common across Northern Ireland,  
10 and, you know, as long as you've got a tick in every 16:24  
11 domain, that's really what it's about.

12  
13 You know, you can see from the spread of specialties  
14 that have been my appraiser, many of them don't have  
15 that much insight into my specialty. Maybe I don't 16:24  
16 have that much insight into theirs. So, you know,  
17 there's something of questioning the value of that  
18 conversation.

19  
20 They don't have the performance data, they can't 16:24  
21 possibly meaningfully interpret the performance data in  
22 the different specialty, you know. How would, for  
23 instance, an emergency medicine consultant interpret  
24 the data of a surgeon? It's difficult for them, I  
25 would think. It would be difficult for me to interpret 16:24  
26 the outcomes of their work. I don't do their job.

27 556 Q. So, if, as you imply, it is, to use another metaphor, a  
28 box ticking exercise, are there implications of that  
29 if, for example, the practitioner has some frailties or

1 --

2 A. So, a point that was made to me by Robin Brown, who was  
 3 at one time CD for urology quite some years ago, and  
 4 more laterally has been one of the senior members of  
 5 the revalidation team, he said to me "I'm not looking 16:25  
 6 for all the good points in your appraisals. What I'm  
 7 looking for are the little indicators that there are  
 8 problems", and I think that's largely what it has  
 9 become, and it may be very difficult through this  
 10 appraisal process for the Trust to actually pick up 16:26  
 11 where there are problems. Not too many people present  
 12 warts and all in their appraisal, I would suggest.

13 557 Q. And your seeming endorsement of some form of  
 14 performance management, whether integrated within the  
 15 appraisal process or standing separately from that -- 16:26

16 A. I actually think that should be taking place on a team  
 17 basis. I think that should be out in the open. I  
 18 think we should all be able to discuss openly with our  
 19 colleagues how we're performing as a team, what our  
 20 outcomes are, you know, is somebody doing a lot more 16:26  
 21 work than somebody else and what are the reasons for  
 22 that? There may be good reasons for it.

23 558 Q. And safety of practice?

24 A. Absolutely.

25 559 Q. Knowing what we know, and there may be a bit of a 16:27  
 26 debate about what precisely we know has emerged out of  
 27 urology services in the last few years, particularly  
 28 arising out of the processes relating to Mr. O'Brien,  
 29 do you see in that particular context a specific merit

1 around performance management or --

2 A. Yes, I do. Because I think if you identify these  
3 things at an early point and they're out in the open,  
4 then it allows the team to, first of all, identify and  
5 name the issue and, secondly, then to think of ways 16:27  
6 that the team can address the issue together. It means  
7 a more consensual collegiate way of working, you know.  
8 So I think there are merits to that.

9 560 Q. You have said in your witness statement that you can't  
10 recall any discussion - if I could pick up my note... 16:28  
11 Yes. If we go to paragraph 65.3 at WIT-42331. So, in  
12 terms of patient safety and governance then, if we just  
13 focus on what you say in that paragraph, if we scroll  
14 down. So, the second aspect of that paragraph:

15 16:28  
16 "I do not recall a single meeting to discuss governance  
17 issues or patient safety concerns related to  
18 Mr. O'Brien or the Urology Department with any of the  
19 following post holders who held tenure in the period  
20 following the meeting in January 2017 up until June 16:29  
21 2020."

22  
23 So, the problem, or aspects of the problem as viewed  
24 from the Trust's perspective, emerged in January 2017,  
25 and you were told about it in some form, and we'll look 16:29  
26 maybe at it in a bit more detail. And then you draw  
27 the other temporal parameter, June 2020. So, you have  
28 this meeting with -- in January 2017, to tell you about  
29 aspects of the problem, and what you're saying is that

1           thereafter no further discussion?

2           A.    Yeah. There was a vacuum of information. The meeting  
3           on 3rd January came as a shock. Okay? And the number  
4           of issues that were raised and explained to us by Ronan  
5           Carol primarily, and I think also Colin Weir, came as a 16:30  
6           shock to me, and obviously then Mr. O'Brien wasn't  
7           coming back to work immediately after that meeting.  
8           You know, for a consultant to be excluded I think is a  
9           rare event. I was, I was annoyed that the Medical  
10          Director didn't see fit to come and speak to us, you 16:30  
11          know. He excludes one of our colleagues. We are going  
12          to be struggling as a consequence, and yet he doesn't  
13          deem that it's important enough to come and speak to  
14          us. Now, I don't know what else was on his plate, I'm  
15          sure medical directors have lots to do, but excluding 16:30  
16          somebody from a work is a big deal as far as I'm  
17          concerned.

18  
19          So that's the first thing.

20  
21          Then, you know, throughout whatever process took place  
22          after that, I was completely unaware of what was going  
23          on behind the scenes. Nobody came to explain that to  
24          us. We were not told about any measures that had been  
25          put in place for Mr. O'Brien when he came back to work, 16:31  
26          we weren't told about any supports that were put in  
27          place. You know, there was an absence of  
28          communication.

29   561   Q.    You say, just focusing on the Mr. O'Brien scenario and

1 communication and discussions that evolved around that,  
2 if any, you say - if we go to WIT-42320, you say just  
3 at the bottom of the page you had frequent discussions  
4 with Mr. Young.

5 A. Yeah.

16:31

6 562 Q. In his role as lead clinician, discussing matters  
7 concerning the running of the department informally,  
8 and you discussed concerns regarding the performance of  
9 medical staff. And you then refer us to the paragraphs  
10 where particular medical staff are named.

16:32

11 A. Yes.

12 563 Q. And we don't need to go into the details around that,  
13 but I may pick up on an issue around Mr. Suresh as we  
14 go along. But you don't name Mr. O'Brien in the - in  
15 those paragraphs. I'm wondering to what extent there  
16 were conversations between you as a team about the  
17 shortfall caused by Mr. O'Brien's exclusion on the one  
18 part.

16:32

19 A. Yeah.

20 564 Q. And, I suppose perhaps more importantly, the patient  
21 safety implications of what you were being told?

16:32

22 A. So, in the period prior to 3rd January 2017, the issues  
23 that concerned me relating to Mr. O'Brien's practice,  
24 or the issues that I had concern about, were things  
25 like late dictation of letters, or letters not being  
26 present in the chart when I was seeing a patient. I  
27 was concerned about the review backlog. I was  
28 concerned about the waiting lists. I did not have  
29 sight or knowledge of the other issues that were then

16:33

1 outlaid to us in terms of -- I had a concern about  
2 triage -- but I wasn't, I wasn't aware of the volume of  
3 these things. So it came to me as a shock when we were  
4 told these things on 3rd January.

5  
6 You will be aware that I chaired an SAI related to  
7 Patient 10. So in the course of that SAI, it became  
8 apparent that that patient's letter hadn't been triaged  
9 on that particular week, and a lookback was conducted  
10 to find out had any other letters not been triaged and 16:33  
11 I think seven other patients were identified as not  
12 being triaged.

13  
14 So that SAI was coming to its final version in December  
15 of 2016, and on the basis of that, I got a couple of 16:34  
16 prompts - one from Connie Connolly "Have you got this  
17 nearly ready?" I got the draft finalised. And then  
18 before the draft was sent up I think to the Medical  
19 Director, we then had the meeting of 3rd December.

20 565 Q. Yes. 16:34

21 A. Or 3rd January.

22 566 Q. Yeah. And I suppose what I'm - and we'll maybe go into  
23 some depth on those just in the fullness of time - but  
24 broadly speaking maybe just on this simple point, are  
25 you pointing to a failure on the part of management of 16:34  
26 whatever hue to engage with consultant staff about the  
27 implications in their entirety of Mr. O'Brien's coming  
28 into difficulty?

29 A. Yeah. So, you know, from my perspective, I knew that

1 he was having a difficulty dictating his letters on  
2 time. That was widely known. When I went to a meeting  
3 on the admin floor, in some period before 2016, I had a  
4 very brief conversation with Heather Trouton as we left  
5 the meeting and she expressed to me concerns about how 16:35  
6 Mr. O'Brien was managing his workload. Now, you know,  
7 she was the AD, she clearly had those concerns, she  
8 mentioned them. I would have shared the concerns,  
9 because we were all working hard and we were all  
10 struggling to deliver. 16:35

11  
12 was he an outlier in terms of having his dictation  
13 done? I'd say he was an outlier relative to me. You  
14 know.

15 16:36  
16 So these issues were known by others, they were not  
17 hidden, but the quantity of that dimension of it was  
18 not clear to me at that time.

19 567 Q. And nor, it seems - and this is the focus of my  
20 question - nor, it seems, was it particularly discussed 16:36  
21 with you, even as the problems were put out on the  
22 table in January of 2017.

23 A. No, the January meeting was quite short. And it was  
24 also, you know, Ronan Carol reiterated "You're not to  
25 discuss this outside the room." Now, what's the first 16:36  
26 thing that we're all going to do as soon as we leave?  
27 we all say, "well, what's going on here?" You know. I  
28 just found the whole approach, I found it really  
29 disconcerting. You know, we've clearly got a problem,



1 yet you're not to talk about it. You know, this is --  
 2 who's going to fix the problem? It's not going to be  
 3 the managers on their own.

4 568 Q. Yes. And I suppose that is the point I'm looking to  
 5 focus upon before I broaden it out into wider  
 6 governance leadership issues.

16:37

7  
 8 Were you ever, as a team or as an individual, engaged  
 9 by management of whatever hue between that 2017 and  
 10 2020 date, to discuss with them, I suppose, the patient  
 11 safety and/or governance implications for you as a team  
 12 working with a colleague who, at least from the Trust's  
 13 perspective, had difficulties?

16:37

14 A. No, I don't think there were those discussions.

15 569 Q. Yes. And you say, as I say, broadening it out a  
 16 little, if we go down, or back up to WIT-42310, perhaps  
 17 illustrative of just what you said, during your tenure:

16:38

18  
 19 "...no one person held responsibility for quality  
 20 assurance of urology services. In a broad sense, each  
 21 clinician was responsible for their own practice, and  
 22 the degree to which individuals engaged with quality  
 23 improvement or audit was variable. There was no  
 24 mandatory element or structure to this activity."

16:38

25  
 26 And that's where I suppose I wish to stop with that  
 27 aspect of the quote. You go on elsewhere in your  
 28 statement to say that as busy clinicians you needed  
 29 support, "robust support", to use your language, for

16:38

1 data collection, in order to support sound clinical  
2 governance, and you found that that wasn't there?

3 A. Correct.

4 570 Q. So, moving into some of these specific instruments or  
5 ingredients of governance, let's briefly deal with the 16:39  
6 use of data before we finish this afternoon. You say  
7 in your statement that - this is 14.2 - that the Trust  
8 used, can we say "CHKS"? C-H-K-S

9 A. C-H-K-S would be the terminology I'm familiar with,  
10 yeah. 16:39

11 571 Q. CHKS.

12 A. Yeah.

13 572 Q. And that was used to provide comparative data in the  
14 annual clipboard -- Clip Report, sorry?

15 A. Yes. 16:40

16 573 Q. So there were some useful metrics in that around age --  
17 sorry, length of stay, mortality, new to review ratios,  
18 that kind of thing. But some of the data was  
19 misleading, because it --

20 A. Yeah, it's just it's not sophisticated enough. 16:40

21 574 Q. It allocated your name to patients you maybe weren't  
22 operating on that day and vice versa?

23 A. I don't think it's that. I think it's -- the urology  
24 of the week model meant that, you know, individual  
25 clinicians would hand over care to another oncoming 16:40  
26 consultant and, therefore, complications that might  
27 arise - you might have been the admitting consultant,  
28 but they might have been in for a few weeks and they  
29 have a complication that arises down the line. So, the

1 data wasn't sophisticated enough to pick out who was  
2 actually delivering the care, and the care for the  
3 inpatients was largely delivered as a team, so that  
4 wasn't really reflected well in the Clip Report.

5 575 Q. The bigger point I think that you make around data 16:41  
6 concerns the absence of any data collection mechanism  
7 to support key performance indicators, and here you  
8 emphasise data around patient safety, and this is 37.1  
9 of your statement. So, data, at least until relatively  
10 recently, I think you're telling us, was not gathered 16:41  
11 around, for example, positive surgical margin rates  
12 during partial nephrectomy?

13 A. Yeah.

14 576 Q. Transfusion rates during cross date.

15 A. Yeah. 16:41

16 577 Q. Those kinds of valuable patient outcomes data that will  
17 speak to morbidity, but perhaps more particularly will  
18 speak to performance issues around the members of the  
19 clinical team?

20 A. Yeah. And, you know, there's a lot to be learned from 16:42  
21 morbidity. Probably in our specialty there's more to  
22 be learned from morbidity and understanding those  
23 aspects than there is from mortality. Because most of  
24 the mortalities in our specialty are expected. It is  
25 the exception that is unexpected. Obviously that's 16:42  
26 worthy of investigation in that circumstance.

27 578 Q. You have said, at 37.3 of your statement, these patient  
28 related -- bring it up, would you please? WIT-42311.  
29 This is a straightforward point. These measures are

1 now coming in to the currency of the Trust?

2 A. Yeah, you need support to collect these important bits  
3 of data. You need somebody to collect them. You need,  
4 obviously, somebody to analyse them and then present  
5 them to the team. You know? So, it's well recognised 16:43  
6 in surgery that if you ask surgeons to collect their  
7 own data you get a very skewed view of what's  
8 happening, and that probably applies to other  
9 disciplines, but it certainly applies to surgery.

10 579 Q. what do you think the implications are of not 16:43  
11 collecting the data and presenting it?

12 A. So if you don't know what your outcomes are like you  
13 don't really know if you're doing a good job, and if  
14 you don't ask the patients what their experience is  
15 then you're not going to know whether or not the 16:43  
16 patients thought you were doing a good job. So you  
17 have to collect the data to know that.

18 580 Q. You say that within the world you were operating in,  
19 and notwithstanding the health warning you put against  
20 it a second or two ago, you did feel it appropriate to 16:44  
21 carry out your own personal outcome related audits?

22 A. Yeah. So BAUS, which is the British Association of  
23 Urological Surgeons, ran a number of audit projects in  
24 the past. Certainly I did nephrectomy, I continue to  
25 do nephrectomy surgery and I would have contributed to 16:44  
26 the national audit, so did Mark Haynes, and we would  
27 have been able to compare our data to that of peers  
28 across the UK and Ireland, and we would have been able  
29 to compare our unit to comparator units in the same

1 jurisdiction. So, you know, that gave us a good feel  
2 for where we were. But I caveat it with the thing that  
3 I said a moment ago; you know, we were collecting the  
4 data. So, I mean, I was pretty scrupulous about mine,  
5 I have to tell you, but, you know, it's well recognised 16:44  
6 that surgeon reported data is not as reliable as  
7 independently collected data.

8 581 Q. And again, just briefly, you say several times in your  
9 statement that audit was poorly supported within the  
10 Trust. We see some audits coming up through your 16:45  
11 patient safety meeting.

12 A. Yeah.

13 582 Q. Maybe some were better than others. You do say that  
14 some - and this is at paragraph 7.5 of your statement -  
15 some audits that came up were not fit for purpose, they 16:45  
16 didn't complete the full circle, the audit loop. Just  
17 explain what you mean by that?

18 A. So, I suppose in many departments audit would have been  
19 delegated to trainees, and trainees may have little  
20 insight into what they're actually auditing, because 16:46  
21 they're trainees and they haven't enough experience to  
22 know otherwise. So you could have a trainee  
23 undertaking an audit and not really understanding what  
24 they were doing, and there is some value in that,  
25 because if the trainee has support from an experienced 16:46  
26 practitioner then it's a learning experience for the  
27 trainee. However, the situation that we're in now is  
28 much better. We have support from the audit  
29 department, we agreed a programme of audit, we

1 participate in audits across four domains, the first of  
 2 which would be national audits, and they go all the way  
 3 down to, like, local audits is number four. So, we now  
 4 have a structured programme. We've been pushing for  
 5 that for a long time. But without the support of the 16:46  
 6 audit department, or the governance team, we wouldn't  
 7 have been able to deliver on that. So that has been  
 8 really helpful. We've had the first of those audits  
 9 being presented in the past year. And on a similar  
 10 vein, in the cancer services domain, we have support 16:47  
 11 for audit within cancer services, which is very  
 12 welcome, and it allows us to demonstrate patient  
 13 safety. Because that's really what the audits are  
 14 about.

15 583 Q. Yes, and we'll come to that in the context of the SAI 16:47  
 16 recommendations perhaps tomorrow. But we have heard,  
 17 and I think your evidence around the lack of support  
 18 for audits echoes evidence that the Inquiry has  
 19 received from several of the governance co-ordinators  
 20 within the acute directorate who have, I suppose, said 16:47  
 21 that resources simply weren't available to do audit,  
 22 which I suppose viewed from another perspective, it  
 23 could be articulated as them not being seen as  
 24 important or as important as other things that the  
 25 Trust -- 16:48

26 A. I think my point on that would be that audit is  
 27 important and quality improvement is important. But  
 28 when you're in a service that is struggling, and you  
 29 have too few people to deliver that service, then it is

1 often those type of activities that are sacrificed  
2 rather than direct clinical care.

3 584 Q. And is that, in your view, the explanation for why  
4 audit wasn't done, as opposed to something like a lack  
5 of appetite, or a lack of interest, or a lack of  
6 appreciation of its fundamental importance?

16:48

7 A. I've expressed my view. I think you'd have to ask  
8 others what their view is. You know, you've seen from  
9 my statement I participated in audit to the best of my  
10 capability, even though we weren't supported. I value  
11 its importance. You'll have to ask others what their  
12 view is.

16:49

13 MR. WOLFE KC: Yeah. Okay. Thank you for your  
14 evidence this afternoon. Subject to the Chair, we'll  
15 stop now and pick up again at ten o'clock.

16:49

16 CHAIR: Yeah. Ten o'clock tomorrow morning. Thank  
17 you, Mr. Glackin. See you again tomorrow.

18  
19 THE INQUIRY WAS THEN ADJOURNED UNTIL THURSDAY,  
20 21ST SEPTEMBER 2023 AT 10:00 A.M.

16:50