



**Oral Hearing**

**Day 67 – Thursday, 19<sup>th</sup> October 2023**

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

**Held at: Bradford Court, Belfast**

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

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**Gwen Malone Stenography Services**

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

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

09:59

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

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

09:59

09:59

10:00

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

10:00

1 screen, please, AOB-82838. And you will remember that  
2 really it was just on the eve of you coming to give  
3 evidence that we drew your attention to this case. It  
4 was a case, so far as we understand it, where the  
5 patient was in the care of Mr. O'Brien in 2010, and he 10:01  
6 prescribed Bicalutamide 50mg, and he was -- the patient  
7 was on that dose when he came along to see you at  
8 review in 2016.

9 A. Yes.

10 1 Q. You kept him on that dose. He came along to see you 10:01  
11 again in May 2020, and you kept him on that dose, and  
12 you told us in your evidence -- the reference is  
13 TRA-08282 -- that regrettably you didn't change the  
14 treatment, although in fairness to you, you wanted to  
15 have the opportunity to consider whatever notes, paper 10:02  
16 notes that there might have been available to you which  
17 you hadn't had an opportunity to consider when you last  
18 gave evidence.

19  
20 Is there anything in your researches since then that 10:02  
21 you wish to add to the evidence that you have given us?

22 A. So I've now had the opportunity to review the paper  
23 notes. There are two handwritten entries by  
24 Mr. O'Brien in 2010. One of those entries describes  
25 the prescription of Bicalutamide 50 and Tamoxifen 10. 10:02  
26 There are no letters, typed letters, in the chart  
27 reflecting those two clinic appointments. Subsequently  
28 then my own handwritten notes are available in the  
29 chart. They don't lend anything extra to what I have

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

2 2 Q. Yes. I think you were, I suppose to some extent  
3 anxious to better understand your own thinking around  
4 why you continued the regime of 50mg, both in 2016 and  
5 2020. 10:03

6 A. Yes.

7 3 Q. Your notes don't add anything to your thinking around  
8 that?

9 A. They don't. They do not.

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

19

20 So as I explained on the last occasion, Mr. Haynes is 10:04  
21 writing to a number of patients following the  
22 Bicalutamide audit and lookback review, and if we go  
23 into the - if we go to the last of the three pages at  
24 66 in the sequence and to the -- sorry 26 in the  
25 sequence -- and to the last paragraph. So his 10:04  
26 recommendation for the patient is that he discontinues  
27 the hormone treatment and move on to surveillance. In  
28 ordinary cases you do, was that the appropriate  
29 recommendation and one that upon reflection you should

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

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

21 5 Q. Yes. So your differences is my -- you would have -- my  
22 recommendation is to discontinue the hormone treatment  
23 and move to watchful waiting?

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

25 6 Q. Yes. Could I just go back up to the previous page? 10:06  
26 So, bearing in mind that Mr. Haynes, the thrust of his  
27 advice is to stop the hormone treatment?

28 A. Yep.

29 7 Q. And move to surveillance. You would prefer watchful

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

4  
 5 "If you do not wish to stop hormone treatment and wish 10:07  
 6 to continue hormone treatment as a long term treatment,  
 7 recognising that evidence shows that this treatment  
 8 will not increase your life expectancy and that  
 9 continued hormone treatment does continue to give side  
 10 effects, then the recommended hormone treatment would 10:07  
 11 be an injection treatment which is given every three  
 12 months."

13  
 14 So that appears to be a prescription of or suggestion  
 15 that the prescription would be LHRH agonist. Is that 10:07  
 16 your reading of that?

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

19 8 Q. Of course. We can go back to the first page.

20 A. Yes. 10:08

21 9 Q. So it is -- I think it's low risk organ confined --  
 22 yeah.

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

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

9 10 Q. So, just to go back to that paragraph, because it does  
10 introduce, if you like, just to remind ourselves 10:09  
11 Mr. Haynes is saying:

12  
13 "Dear patient,  
14 Surveillance is the route for you and come off  
15 hormones. " 10:09

16  
17 And if you go back to that page then, down to the  
18 bottom of -- yeah.

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

22 11 Q. Yeah.

23 A. And he is giving the patient options.

24 12 Q. Yes.

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

26 13 Q. Yes. It is the case, you've made the point yourself, I  
27 wouldn't in this case on the face of it move him to  
28 LHRH. That is associated with adverse toxicity  
29 compared to Bicalutamide, is it, or the risk of adverse



1           --

2           A.   Both therapies can have side effects for the patient.

3           The side effects are somewhat different in profile, but

4           watchful waiting would have no side effects.

5   14   Q.   Yes. And the third of the options here, and as you say 10:10

6           we can maybe ask Mr. Haynes about this letter, and

7           maybe it's an attempt, as you say, to set out all the

8           options and then engage in a conversation with the

9           patient. The suggestion of moving to a daily 150

10          Bicalutamide as a monotherapy, is that drug licensed 10:10

11          for the treatment of localised organ confined prostate

12          cancer?

13          A.   I don't think it's licensed for localised, but I think

14          it might be licensed for locally advanced. I'd have to

15          check that. 10:11

16   15   Q.   Could I move to Patient 137? We again looked at this

17          on our last occasion. You'll recall that this was a

18          case where Mr. Young had been told to refer the patient

19          to an endocrinologist arising out of a

20          multi-disciplinary meeting, and that didn't happen, and 10:11

21          it was, in essence, lost until the general practitioner

22          wrote in. We looked at that on the last occasion. I

23          think you told us that you had no discussions around

24          this, it hadn't been brought to your attention. I just

25          want to look at that again with you. If we go to 10:12

26          WIT-100394, and this is -- if we just go to the top of

27          the page. Sorry, further up. Yep. And it appears to

28          be an incident check list. It sets out a series of

29          events in the processing of this incident report, the

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

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

And just on down the page, 9th January:

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

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

"Not an SEA processes.

2. Regarding MDM to be reviewed with Mr. Glackin meeting being organised by governance team."

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

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

4 A. Yes.

5 16 Q. And these entries suggest at least that the direction 10:14  
6 of travel would be to discuss the malfunction in the  
7 procedure with you?

8 A. Mm-hmm.

9 17 Q. Do you remember the issue being discussed with you?

10 A. No. 10:15

11 18 Q. Should it have been discussed with you?

12 A. Yes.

13 19 Q. why should it have been discussed with you, given that  
14 you were the lead?

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

19 20 Q. We know that Mr. Young received a letter signed off by  
20 Mr. Glackin asking him to give assurance? 10:15

21 A. Perhaps it was Mr. Haynes.

22 21 Q. Sorry, of course. Mr. Haynes, of course. Asking  
23 Mr. Young to give assurance that he had in place  
24 processes to ensure that this doesn't happen again. I  
25 suspect that Mr. Young will say that he gave verbal 10:15  
26 assurance around this. Again, that's not something  
27 that was drawn to your attention?

28 A. So I have no knowledge of that.

29 22 Q. Yep.

1 A. So I think my first -- I may have been at the MDT where  
2 this was discussed, but I have no recollection of the  
3 original discussion, as documented in that timeline. I  
4 have no recollection of it ever being discussed at a  
5 later date as a result of this process. And my first 10:16  
6 reading of this, as far as I am aware, was when I  
7 received the evidence bundle.

8 23 Q. Yep. In light of the nature of the error and the break  
9 down in the safety nets, which you referred us to the  
10 last time, onus on the consultant I think you explained 10:16  
11 --

12 A. Yes.

13 24 Q. -- to get on with the referral.

14 A. The primary responsibility is that of the consultant.

15 25 Q. Yes. The tracker or coordinator nevertheless knows 10:17  
16 about it and should, in the normal case, have emailed  
17 the consultant's secretary?

18 A. Yep.

19 26 Q. To provide a further layer of protection.

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

22 27 Q. Yeah. Yeah. How is the Inquiry to view, in governance  
23 terms, a situation where that can happen? It's  
24 reviewed through an incident report process leading to  
25 a letter to the consultant involved, and it doesn't 10:17  
26 reach your desk as MDT lead so that you can satisfy  
27 yourself that everything that can be done to prevent  
28 this happening again has been done?

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

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

5 28 Q. Of course. That's one way of monitoring the robustness 10:18  
6 of the system. But is there -- looking at the  
7 situation as it was in 2018 when Mr. Young, two years  
8 after the event, finally gets his letter from  
9 Mr. Haynes, is there not some shortcoming in a system  
10 where you as the MDT lead is not even brought in, to 10:18  
11 the best of your recollection, to a discussion in  
12 relation to it?

13 A. Yes, that is a shortcoming.

14 29 Q. Now, I want to move to another issue that emerged from  
15 the SAI process that was reviewed by Dr. Hughes and 10:19  
16 Mr. Gilbert in 2020. It's the case of, in their  
17 language, a failure to refer on a timely basis a case  
18 of penile cancer.

19 A. Okay.

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

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

28 31 Q. Just maybe we'll start with some of the facts around  
29 this. If we can go briefly to DOH-00092, and if you

1 just glance at the Executive Summary. So:

2  
3 "The patient was referred to Urology Services 20th  
4 February 2019 in view of a growth on his foreskin. He  
5 was referred for urgent circumcision which was 10:21  
6 performed on 10th April. Histology confirmed squamous  
7 cell carcinoma. There was both lymphovascular invasion  
8 and perineural infiltration, both of which were  
9 associated with an increased risk of metastatic disease  
10 at presentation or subsequently. 10:21

11  
12 At the MDM, which was a virtual meeting conducted by a  
13 single urologist, recommendation was that Dr. 1 would  
14 review the patient and arrange for a CT scan of chest,  
15 abdomen and pelvis to complete staging. He was 10:21  
16 referred to the Regional Penile Cancer Service in  
17 February 2020. The patient passed away in January  
18 2021. "

19  
20 It is the case that this patient's case passed through 10:21  
21 MDM on a couple of occasions in 2019?

22 A. Yeah, that's correct.

23 32 Q. And as it's made plain here, there was no referral to  
24 -- there was no referral made to the Regional Penile  
25 Cancer Service until February 2020? 10:22

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

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

5 33 Q. Yes. Could I just bring you to the recommendations, or 10:22  
6 the findings of this SAI. If we go to DOH-00097. So  
7 if you just actually go back to the bottom of 96. So  
8 it's saying that:

9  
10 "The MDM should have recommended urgent staging and 10:23  
11 simultaneous referral either to a regional or  
12 supraregional penile cancer specialist group. . ."

13  
14 - you of course correctly say it didn't exist:

15 10:23  
16 "...or to a surgeon with appropriate expertise for all  
17 subsequent management."

18  
19 So I suppose in the absence of supraregional group the  
20 other option is to place this in the hands of a 10:24  
21 specialist rather than retaining it amongst apparently  
22 non-specialists in Southern Trust. Is that a  
23 reasonable point to make?

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

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

11  
12 I think you come to recognise though that it is a -- it  
13 forms a very small part of our workload and certainly  
14 in the west Midlands it was centralised, so the move to  
15 centralise the service in Northern Ireland was a 10:25  
16 sensible move, and, you know, the numbers of cases are  
17 small every year, they're probably fewer than 30. So I  
18 think if this had of been a year later it would have  
19 been referred, you know. So that's just the  
20 difference. 10:25

21 34 Q. The NICA<sup>n</sup> position on this, I think it's set out at  
22 WIT-85345. And this is the NICA<sup>n</sup> guidance from 2016,  
23 and it provides that:

24  
25 "Patients with penile cancer should be managed by 10:26  
26 specialist penile cancer teams working at the supra  
27 network level."

28  
29 So, again, that wasn't a feature of life in Northern



- 1 Ireland in 2020?
- 2 A. There are lots of things that are written in the NICaN  
3 guidelines that were aspirational and they weren't in  
4 place.
- 5 35 Q. Nevertheless, given the unpredictability of penile 10:26  
6 cancers...
- 7 A. I'm not sure that I would agree with that.
- 8 36 Q. Okay. Would you agree that they are, they have the  
9 potential to be high risk cancers?
- 10 A. Yes, I would, but it's not unpredictable. It is very 10:27  
11 well established how the lymph nodes are involved and  
12 how the disease spreads. But it can be an aggressive  
13 disease, I think that's the word I would use, not  
14 unpredictable.
- 15 37 Q. The thrust of the guidelines and the direction of 10:27  
16 travel which your MDT would have been aware of was that  
17 these, this particular species of cancer should be  
18 dealt with by specialists, those who have regular  
19 exposure to the disease, rather than, for whatever  
20 reason, holding them in a small local centre that isn't 10:28  
21 regularly exposed to the disease?
- 22 A. Yep, I think that's the correct way that it should be  
23 managed, but as I made the point to you earlier, these  
24 cases prior to the establishment of that team in 2020  
25 were being managed in all of the urology units in the 10:28  
26 region. So the volumes in all of the units would have  
27 been small at that time.
- 28 38 Q. Is there general learning to be extracted from a case  
29 like this in terms of whether the centre at Craigavon

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

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

6 39 Q. No, no, I am asking you.

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

23 40 Q. As an MDT, when cases come along that the guidance  
24 suggests should go to a specialist such as this, is  
25 there a discussion about the capacity and the expertise 10:30  
26 to retain the case?

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

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

12  
 13 So, you know, you're faced with a situation of on the  
 14 face of it you've got these guidelines which are  
 15 basically mirroring what has happened in IOG in 10:31  
 16 England. We're working with a much smaller population.  
 17 We have to deliver the care for the people who live  
 18 here. And sometimes you're faced with a decision that  
 19 you have to do the best with the resource that you've  
 20 got available. 10:31

21 41 Q. So that's, I suppose, a broad expression of principle  
 22 to reflect the kind of difficulties you might face?

23 A. Yeah.

24 42 Q. As a small local unit.

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

26 43 Q. Yes. To be clear, because of your exposure to the  
 27 treatment of penile cancer from where you came in  
 28 training, did you ever see the need to refer out of  
 29 Craigavon, whether as MDT lead or wearing your

- 1 consultant hat?
- 2 A. So prior to the establishment of the regional or the  
3 specialist MDT for penile cancer, I would have dealt  
4 with penile cancer cases myself in Craigavon. I would  
5 have had the skills do so, and I would have felt 10:32  
6 comfortable doing so. But I recognised that the  
7 development of the specialist MDT was appropriate, and  
8 once we had the staffing in place all of the cases go  
9 to the specialist MDT.
- 10 44 Q. As an MDT in, to take this particular case, it was -- 10:33  
11 the patient was being managed by Mr. O'Brien?
- 12 A. Yes.
- 13 45 Q. The referral didn't take place until a year after the  
14 patient had come to Southern Trust's attention?
- 15 A. The referral couldn't take place any sooner than 10:33  
16 January 2020.
- 17 46 Q. Well the -- and that is of course right. As an MDT, is  
18 there any interrogation or questioning of the expertise  
19 of the clinician in whose hands the patient is being  
20 taken forward? 10:34
- 21 A. Yeah. So I had knowledge of Mr. O'Brien's capability  
22 to do an inguinal lymphadenectomy, and in my view he  
23 could do an inguinal lymphadenectomy to the appropriate  
24 standard.
- 25 47 Q. And the management thereafter? 10:34
- 26 A. Yes, and I had the experience of sharing ward rounds  
27 with him, looking after the patients who had had such  
28 surgery over the previous, by that stage four years as  
29 a consultant colleague.

- 1     48    Q.     So, as an MDT you were each satisfied that this case  
2                    should remain in Craigavon?
- 3             A.     No, I don't think "satisfied" is the word I'd use. I  
4                    mean if there had of been a specialist MDT established  
5                    in Northern Ireland for this disease, then all of the     10:35  
6                    patients should have been going to that. We were  
7                    working in a situation where that was not the case and,  
8                    therefore, we had to deliver care for the patient,  
9                    albeit it without the framework of a specialist MDT.
- 10    49    Q.     And in the absence of a specialist MDT, other     10:35  
11                   alternatives that are available to your unit in terms  
12                   of seeking advice?
- 13             A.     So on occasion, and it would be a very occasional  
14                   thing, patients may have been referred to MDTs in  
15                   England. I had one penile, not penile cancer, I had     10:35  
16                   one testicular cancer case shortly after I joined  
17                   Craigavon, we discussed at the local MDT, there was no  
18                   provision for that patient in Northern Ireland in terms  
19                   of specialist MDT, and I referred that case to  
20                   Birmingham. So that kind of thing happened very     10:35  
21                   occasionally.
- 22    50    Q.     Knowing the features of this case, is this one that  
23                   should have been referred externally, or short of that,  
24                   is this a case where advice from a clinician with more  
25                   regular experience and expertise of managing these     10:36  
26                   cancers?
- 27             A.     I'm not sure I would characterise it that way.  
28                   Mr. O'Brien at this stage of his career probably had 25  
29                   years experience of delivering cancer care. So, you

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

9  
10 I also differ from Mr. Gilbert's assessment. When the 10:36  
11 patient had had the CT scan there was obvious  
12 lymphadenopathy on one side. If you read the EAU  
13 guidelines which pertained at the time of this, then it  
14 did not describe doing a bilateral procedure, it  
15 described a lymphadenectomy singular, that means doing 10:37  
16 one side. So that's the evidence on which we would  
17 have made the decision at the MDT, and that's how we  
18 proceeded.

19  
20 The fact that the patient had disease in his lymph 10:37  
21 nodes means that it was aggressive disease, and when  
22 you're faced with that situation those patients do not  
23 do well.

24 51 Q. Yes. My interest in particular is not the instant  
25 case, it is the process around a situation where at the 10:37  
26 point of staging the SAI reports says "refer"?

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

28 52 Q. There was no one to refer to in the region. But that  
29 doesn't - broadening this out - it can be any cancer

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

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

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

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

15 54 Q. And you can't pick up the phone and seek advice? 10:39

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

19 55 Q. Let me move on now to briefly examine where the MDT is  
 20 now at in terms of it's governance and in terms of the 10:39  
 21 superintendence of its procedure, so that some of the  
 22 issues that have been identified as amounting to safety  
 23 issues, so that we can begin to chart whether those  
 24 shortcomings have been addressed.

25 10:40  
 26 The recommendations of the SAI, or the series of SAIs  
 27 in 2020, spoke across a number of the issues to the  
 28 need for audit. Let me bring just bring that up.  
 29 DOH-00129. If you just scroll to the bottom of the

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

4  
5 "The Trust must provide high quality urological cancer 10:41  
6 care for all patients."

7  
8 And there's an expression as to how that will be  
9 achieved. And the assurance to ensure that this is  
10 achieved is described as: 10:41

11  
12 "...a comprehensive pathway audit of all patients care  
13 and experience."

14  
15 And as I say, the need for an audit, or various audits, 10:41  
16 is expressed across a number of the recommendations.  
17 Move down to (2). Again, a high level expression of  
18 the recommendation that:

19  
20 "The patients should be appropriately supported and 10:41  
21 informed about their cancer care."

22  
23 And if we scroll on down, the assurance is a  
24 comprehensive cancer pathway audit and patient  
25 experience. 10:42

26  
27 At (5), moving down, the recommendation is that the MDM  
28 - a little more specific:  
29



1 "...would be resourced to provide appropriate tracking  
2 of patients and to confirm that the recommendations and  
3 actions are completed."  
4

5 And scrolling down, the assurance is audit.

10:42

6  
7 Help us with this, Mr. Glackin. We've heard I think  
8 already from you that the MDT is better resourced with  
9 the appointment of a Mr. Mark Quinn as a clinical audit  
10 and information manager, Mrs. Muldrew as a specific MDT 10:43  
11 focused admin support. In terms of the audit of the  
12 kinds of things discussed in the SAI report, is that  
13 being done? I think we've heard from you already that  
14 audit is now much improved in the Trust. Is it  
15 specific within MDT structures? 10:43

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

- 1 56 Q. And do you feel -- we've been through some of the  
2 issues and we've seen where tracking has gone wrong in  
3 the past, we've seen through the SAIs where referrals  
4 haven't happened despite the recommendation of the MDM,  
5 and there has been no report back to the MDT to alert 10:45  
6 the members to that. Is that -- are those the kinds of  
7 things that the audit processes are now designed to  
8 hone in on?
- 9 A. Yeah, I think certainly missed referrals would be  
10 picked up by that audit process, but it also means that 10:45  
11 the level of communication between cancer services and  
12 our MDT is much better than it would have been in the  
13 past, and that's a definite improvement. It also means  
14 that if we have ideas about how we would like to do  
15 things, that we've somebody to approach and speak to 10:45  
16 them and say "we'd like to do this audit", for  
17 instance. The whole pathway wracking is still not in  
18 place, is not funded.
- 19 57 Q. Yeah. Recommendation -- I think it's Recommendation 5,  
20 if we scroll back up. So it's talking about -- yeah, 10:46  
21 it's talking:  
22  
23 "This will be achieved by appropriate resourcing of the  
24 MDM tracking team to encompass a new role comprising  
25 whole pathway tracking, pathway audit and pathway 10:46  
26 assurance."  
27  
28 Is that what's not in place?
- 29 A. I think we're still only funded to first treatment.

1 58 Q. And is there agitation or advocacy around this?  
2 A. Yep.  
3 59 Q. As far as you know?  
4 A. This has been spoken about for a long time. It is  
5 known to the people who lead our cancer services that 10:46  
6 this is appropriate.  
7 60 Q. What would be the utility of it from your perspective?  
8 Can you paint for us some examples of where you see the  
9 potential for patient safety or patient risk if this  
10 isn't in place? 10:47  
11 A. It's hard to think of examples straight off the top of  
12 my head, but there are some cancers that we survey or  
13 monitor for very long periods of time, bladder cancer  
14 would be one example. Some of the prostate cancers,  
15 fall into that category. So those would be the 10:47  
16 patients I think who would benefit from that process.  
17 It would be very resource intensive. You know, the  
18 trackers are currently tracking perhaps 700 live cases.  
19 So that's a lot of people to keep an eye on. If we  
20 went to the whole of pathway tracking, that number 10:47  
21 would invariably increase, and if we had some form of  
22 tracking mechanism for all those patients who were on  
23 forms of monitoring and surveillance, my own personal  
24 workload of cancer patients probably comes into the  
25 range of three or 400, minimum. So you multiply that 10:48  
26 out across the team, you can have an idea of how many  
27 patients we're talking about.  
28 61 Q. In terms of -- you mentioned a moment ago that there's  
29 now I suppose better accessibility to the cancer side

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

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

14  
 15 Secondly, we have a new cancer service's CD. He's a 10:49  
 16 medical oncologist. He happens to attend our MDT,  
 17 which from my perspective is great because I have a  
 18 direct line of communication, and that has given a new  
 19 impetus to improving the governance and oversight of  
 20 all of the MDTs. 10:49

21  
 22 So you'll be aware that there was a piece of work  
 23 following this report from Dr. Hughes that was  
 24 undertaken by Dr. Tarek, who was the AMD for this  
 25 service, and out of that then there has been lots of 10:50  
 26 new changes, and I would say certainly in my experience  
 27 with the Urology MDT, improved support for us.

28 62 Q. In terms of the MDT membership itself, we know that  
 29 there was -- there is built into the operating

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

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

23 63 Q. In terms of, let me take a particular example, its  
24 Recommendation 8, if we scroll down through this. It  
25 talks about: 10:52  
26

27 "All patients should receive cancer care based on  
28 accepted best care guidelines."  
29

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

8  
 9 "Exception reporting and escalation would only apply to  
 10 cases without appropriate peer discussion." 10:53

11  
 12 So is that something that's capable of being captured  
 13 by audit, and is it being captured by the current  
 14 audit?

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

26 64 Q. And that's the understanding of the clinician, but  
 27 where's the check to ensure that that...

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

1 discussion and that then happens.

2 65 Q. So, just in nuts and bolts terms, if the recommendation  
3 of MDT is to refer to oncology, but --

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

15 66 Q. Yes. And how would the audit capture the change of 10:55  
16 approach? Say --

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

18 67 Q. No doubt an exceptional case, but the clinician has had  
19 the meeting, had the consultation with the patient,  
20 they're thinking of going down another route, they 10:55  
21 don't wish to share that with the MDT, and I recognise  
22 that's against the norm that you're seeking to promote  
23 as an MDT, but how would the audit capture that change  
24 of direction?

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

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

4 68 Q. You've said in your -- just scrolling up to  
5 "Recommendation", you've said in your witness statement 10:56  
6 at paragraph 1.5, that you are working with Dr. Tarek,  
7 is that right, to formulate a job description for the  
8 Chair and --

9 A. So that has been completed.

10 69 Q. Yes. 10:56

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

13 70 Q. Yes. Have you taken that role on?

14 A. No, I was assisting Dr. Tarek.

15 71 Q. Yeah. 10:56

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

19 72 Q. And so that's a global job description, where one  
20 didn't exist in the past? 10:57

21 A. Correct.

22 73 Q. -- applying to all MDTs. So we'll no doubt seek a copy  
23 of that job description from the Trust, but if you  
24 could give us a brief heads up on that? Are there  
25 activities within the job description that surprise you 10:57  
26 in the sense that they were never there before, or is  
27 it simply a putting on paper stuff that was routine for  
28 you?

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



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

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

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

You work closely with all of them.

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

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

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

5   75   Q.    A further one appointed in 2019, and two, that is           11:00  
6           Messrs Young and Thompson?

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

22   76   Q.    In terms of the cancer work and what you have described  
23           here in terms of the integration of the cancer  
24           specialist nurses within the work that you do, having  
25           them present at consultations, for example, as maybe a           11:01  
26           strong illustration of how central they are.  Obviously  
27           there's a lot of work beyond that.  Is that the  
28           approach that you have adopted with them and them with  
29           you throughout your period in post or has that improved

1 with resource?

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

9  
10 In other places, the CNSSs would have been available 11:02  
11 within the unit to see patients after they had been  
12 consulted with by the doctor.

13  
14 So when I joined Craigavon, we had the system whereby  
15 we didn't have enough staff that they could be in the 11:02  
16 room for every consultation, but the CNSSs were  
17 available to patients after the consultation, either  
18 immediately after or by providing the contact details  
19 for the CNS and the details of the patient to the CNS,  
20 so that the patient could be contacted. 11:03

21  
22 Over time as our team expanded it became possible for a  
23 CNS - it wasn't always the same person - to attend my  
24 Monday afternoon clinic. That clinic is only for  
25 Uro-oncology patients, the majority of which are post 11:03  
26 MDT discussion patients, and a smaller number of  
27 oncology review patients who may need to be seen  
28 urgently, for whatever reason.

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

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

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

1 the contact details for the CNS." If they were  
2 available they'll see them after the clinic. If they  
3 weren't, they would make contact with them thereafter.  
4 Some patients didn't want that information, and that  
5 was their choice, and if they didn't want it I'd 11:05  
6 document that they had declined the offer to meet with  
7 the CNS. Perhaps it would be right to say that that  
8 was a tiny minority of patients.

9 78 Q. The patients that were the subject of the SAI review,  
10 all nine of them, at least in accordance with the 11:05  
11 findings, did not receive the benefit of a CNS. Does  
12 that surprise you?

13 A. It did surprise me.

14 79 Q. Out of that small group of nine, there were a range of  
15 cancers, and no doubt Mr. O'Brien would have met with 11:06  
16 those patients in different settings, including the  
17 Southwest Acute Hospital, where, as I understand it, a  
18 CNS wouldn't routinely be stationed?

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

27 80 Q. Yes. And thinking about your own practice, and those  
28 of your other colleagues, with the exception of  
29 Mr. O'Brien, by 2019 you're up to a third CNS

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

11:07

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

9 81 Q. Could I ask you about the approach to the, if you like  
10 the appointment of a CNS, and you can correct me if you 11:08  
11 don't feel that the word "appointment" is appropriate,  
12 but before you perhaps do, can we look at the MDT  
13 operational policy? We can find it at WIT -- I'll just  
14 show you -- well, we probably don't need to show you  
15 the front page, you're familiar with it, but WIT-84726. 11:08  
16 Sorry, if we actually could go back? If we go back to  
17 WIT-84545, and it is hear talking about the key worker,  
18 which as I understand it, is used interchangeably with  
19 CNS, and it talks about the identification of the key  
20 worker being the responsibility of the designated MDT 11:09  
21 core nurse member. It says:

22  
23 "It is the joint responsibility of the MDT clinical  
24 lead and of the MDT core nurse member to ensure that  
25 each urology cancer patient has an identified key 11:09  
26 worker and that this is documented in the agreed record  
27 of patient management."

28  
29 Can you help us understand whether that is the approach

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

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

19 82 Q. So if it's right that in the nine cases that we've been  
20 referred to pursuant to the SAI process, that none of 11:11  
21 those patients had a key worker, where, in terms of  
22 your lead responsibility, does that omission come to?

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

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

4  
5 I think there's an equal responsibility on the core 11:11  
6 nurse member to undertake that kind of questioning  
7 activity.

8  
9 I know from how custom and practice has been described  
10 to me by the core nurse member in the past that they 11:12  
11 would have a list of patients seen at MDT and that they  
12 would go through that list and ensure that patients had  
13 been allocated a key worker. Quite when that activity  
14 began and how detailed it was, I don't know. But  
15 that's my understanding. 11:12

16 83 Q. So, in terms of what we have in front of us, are you  
17 describing a situation where the MDT discusses a  
18 patient, the next step is for the consultant urologist  
19 to bring the patient to a review meeting, and it is at  
20 that review meeting where the introduction, if the 11:12  
21 nurse is available, is made? Or in the alternative,  
22 the patient is sign posted to the nurse?

23 A. Yes, I would agree with that.

24 84 Q. Yes. But if that doesn't happen for any reason, you  
25 would expect, whether it's a resource issue or whether 11:13  
26 it's some other issue, you would expect that to be  
27 drawn to your attention in your role as clinical lead,  
28 and at that point --

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



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

5  
6 It's also I think perhaps important to note, and this  
7 isn't really reflected appropriately in these  
8 documents, that the key worker would be assigned at the  
9 MDT. That doesn't happen in practice at the time of  
10 the meeting, it happens afterwards.

11:13

11:14

11 85 Q. Mmm.

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

11:14

20 86 Q. We are aware historically, because of the resource  
21 issue, of the shortfall in terms of patients being  
22 allocated a CNS. So, for example, if we can have up on  
23 the screen, please, WIT-81489. This is a Northern  
24 Ireland Cancer Patient Survey 2015, and we can see for  
25 Urology 48% of patients have given the name of the CNS  
26 in charge of their care, comparing with 53% in the  
27 region, and that I think, if we just see the whole of  
28 the table, it looks as if urology, at least at that  
29 time, was working at comparative shortfall with other

11:14

11:15

1 cancers.

2 A. I would observe that we were grossly underserved by CNS  
3 capacity at that time, and if you look at other  
4 specialties, in particular breast cancer and  
5 haematology, two specialities which have long had 11:16  
6 better resources than we have had.

7 87 Q. Yes. If we go to your statement WIT-42304. You say at  
8 26.2 that you understand that not all of your  
9 colleagues worked in the same manner with urology  
10 cancer CNSs. Kate O'Neill and Leanne McCourt told you 11:16  
11 that they found the communication was difficult with  
12 some consultants and that they were not invited to be  
13 present at uro-oncology consultations. You've said  
14 earlier that obviously you don't have the benefit of  
15 being in the room with your colleagues as they consult 11:17  
16 with their patients, so you can't know precisely what's  
17 going on. What is contained within this paragraph  
18 seems to be a reference to more than one consultant not  
19 behaving in the same manner as you do in terms of their  
20 use of CNSs? 11:17

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

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

11:18

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

11:18

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

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

11:19

11:19

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

11:19

Kate also relayed to me at another time that when we

1 established the prostate biopsy service under the  
 2 nurses, that some of our consultant colleagues would  
 3 refer the biopsies to be done by the radiologist and  
 4 not by the CNS. Now whether that was a willful process  
 5 or whether it was just what they had always done, I'm 11:20  
 6 not sure, but it felt to her, as she described it to  
 7 me, that the consultant was not utilising the CNS  
 8 resource, for whatever reason.

9 89 Q. And I'm going to ask you about your interactions with  
 10 Dr. Hughes presently, the first of which took place in 11:20  
 11 November 2020, late November?

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

17 90 Q. Yes. Did the engagement with these nurses take place  
 18 then after that telephone conversation?

19 A. Yes, they did.

20 91 Q. But before your subsequent meeting with Dr. Hughes? 11:21

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

23 92 Q. 18th of February?

24 A. Yeah.

25 93 Q. Just in terms of the language that is used there in 11:21  
 26 26.2, you're reporting more generally that it was being  
 27 said to you Mr. O'Brien is not using our resource. You  
 28 make the point more specifically that some consultants,  
 29 it was being reported to you, were not inviting them to

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

11:22

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

10 94 Q. Yes. That's what -- I wasn't intending to disassemble  
11 the language. What I'm asking you really is that.

11:22

12 A. Yeah.

13 95 Q. You have an appointment with Mr. Smith following the  
14 MDM - again not his real name - how does the CNS become  
15 aware of that, and do they, in your practice, simply  
16 arrive in the room at half past two, the date of the  
17 appointment, without requirement for invitation?

11:23

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

20 96 Q. Right.

11:23

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

11:23

28 97 Q. So was this conversation, or conversations, the first  
29 time in your role as clinical lead of the MDT, the

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

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

7 98 Q. Now we are getting to English language and grammar  
8 perhaps. You had said "was difficult with some  
9 consultants", plural. Was it more than Mr. O'Brien  
10 that the finger was being pointed at? 11:25

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

20 99 Q. Yes. Yes. But the developments around key workers and 11:26  
21 the use of CNS, or the subject of education and  
22 information, just if you could articulate to us in  
23 patient safety, or beyond that in whatever terms, why  
24 are these cadre of qualified professional staff viewed  
25 as important, perhaps vital to the patient's process? 11:26

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

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

8 100 Q. Do you see a role as well for the nurses in terms of,  
9 if you like, superintending the process to ensure that  
10 the care that perhaps was suggested or recommended by 11:27  
11 the MDT isn't forgotten about or isn't taken off in a  
12 different direction?

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

19 101 Q. Just finally in terms of Mr. Young, were the comments  
20 that were being made to you in the context of his stone 11:28  
21 clinics or was it cancer care?

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

23 102 Q. I'm talking in terms of what the nurses were saying  
24 about his use of them?

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

1 Unit he may not have had the CNS in the room for all of  
 2 the consultations. He may have, and I am presuming  
 3 this, he may have used them at other times, he may have  
 4 asked the CNS to see the patient, I just don't know,  
 5 you will have to ask Mr. Young how he practised that. 11:28  
 6 But it is my understanding that the nurses would not  
 7 have been in the room for the whole clinic in the way  
 8 that they would have been for mine.

9 103 Q. In terms of what has come after these revelations, has  
 10 work been done to reinforce amongst your colleagues the 11:29  
 11 primacy or the importance of the key worker role in  
 12 both cancer and benign care, where the patient wishes  
 13 to have them?

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

19 104 Q. I ask you that question because it would appear on the  
 20 conclusions of the SAIs that Mr. O'Brien, for example, 11:30  
 21 was an outlier in that respect, and that's why I ask  
 22 has there any -- has there perceived to be an --

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

27 105 Q. I suppose what I'm asking is whether the MDT as a unit,  
 28 and in your role as clinical lead supported by  
 29 management, has the message gone out that some of these



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

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

7 106 Q. Yes. In terms of your conversations with Mr. Hughes,  
8 let me deal with those then. As you say, 30th November  
9 telephone conversation with him, and if we could bring  
10 it up, please? TRU-162250. And you have had, I hope, 11:31  
11 an opportunity to review this note. It was a telephone  
12 conversation, no doubt not a verbatim note. Are you  
13 content with the broad sense of it, the broad meaning  
14 of it?

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

21 107 Q. We'll perhaps come back to these notes for other  
22 purposes later, but if we just scroll about a third of  
23 the way down. Yeah, just here. Talking about the use  
24 of the clinical specialist nurses, and Dr. Hughes is  
25 telling you: 11:32

26  
27 "SAI review panel has met with the families and they  
28 each said that they had not been involved with a CNS."  
29

1 And he's asking was this unusual for one consultant?

2 And you said:

3  
4 "That there were only two urology clinical specialist  
5 nurses in the Trust to support urology cancer parents. 11:33

6 Recently the Trust have appointed a new clinical  
7 specialist nurse from the South Eastern Trust..."

8  
9 - that would have been Leanne McCourt, I think?

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

14 108 Q. Very well. Thank you. And you say:

15  
16 "The nurses are available for clinics held in the acute  
17 setting. However, there had been no nurse available to  
18 attend any clinics held off site..."

19  
20 - either, as you've said earlier, South Tyrone, 11:33  
21 Banbridge, that's Armagh, is it?

22 A. It is, yes

23 109 Q. Or SWAH. So as I understand it, you're explaining  
24 there to Dr. Hughes perhaps the reason why patients are  
25 not seeing nurses is because of a resource issue, 11:34  
26 they're not --

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

1 that these patients had not had the benefit of a CNS.  
 2 So first of all I was surprised by that. Secondly, I  
 3 was thinking on the hoof, so to speak, at the time  
 4 "Well, why is it that these patients haven't had the  
 5 benefit of a CNS?", and the first obvious reason that 11:34  
 6 came to me was that, well, if they were seen at a  
 7 clinic outside Craigavon that was very possible.

8 110 Q. And then if we turn to what you say on the 18th  
 9 February of the next year. WIT-94347. And this is  
 10 where Dr. Hughes came along and met with the MDM. AS I 11:35  
 11 understand it nurses were present. That is a rogue  
 12 reference. 84347. Thank you, Michael. WIT-84347. I  
 13 am obliged. So we can see the attendees: Jenny  
 14 McMahon, nurse; Kate O'Neill, nurse, in attendance. If  
 15 we go to the bottom of the page, please. 11:35

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

18 111 Q. Thank you. And you've been talking about the nurses -  
 19 penultimate paragraph - explaining that you were Chair  
 20 of the Urology MDM, took over from Mr. O'Brien, and the 11:36  
 21 language of this note "are confirming that nurses were  
 22 excluded from Mr. O'Brien's practice". He doesn't  
 23 believe there's an issue with other doctors. Is that  
 24 -- whether you're happy with the precise language you  
 25 can tell us, but is that the broad message that you 11:36  
 26 were communicating at this meeting?

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

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

3    112    Q.    Yes. And obviously we've looked at what was recorded  
4            at the November telephone conversation?

5            A.    Yep. 11:37

6    113    Q.    Is it between those dates, November and February, that  
7            you've had the meeting then with the two nurses?

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

10   114    Q.    So the source -- 11:37

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

13   115    Q.    Yes. If we go to TRA-05376, and this is the evidence  
14            we received from Kate O'Neill when she came to this  
15            room. If we just scroll down a little. And she's 11:38  
16            being asked by counsel -- the starting point for this  
17            is that:

18

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

21

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

24

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

28

29            There was, in the evidence before us, the information

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

4  
5 "Did you ever speak to Martina Corrigan to the effect 11:38  
6 that Mr. O'Brien doesn't allow us access, or it's  
7 difficult, or he's obstructive in any way?"

8  
9 And she denies that. In terms of -- if we just go to  
10 the bottom of the -- yeah, that completes it. That 11:39  
11 evidence, although specific to Mrs. Corrigan perhaps,  
12 brings out, I suppose, a general point being made by  
13 that nurse in her evidence before us, which appears to  
14 be inconsistent with what you have been told, on the  
15 face of it? 11:39

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

19 116 Q. Don't worry. It wasn't me.

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

1 117 Q. well, we can certainly follow up using the language  
2 that you have used to describe your interaction with  
3 the nurses and see what response we obtain from them.  
4 I mean the reality would appear to be that nine  
5 patients, for whatever reason, suffered what might be 11:40  
6 regarded as a care deficit, in not having the services  
7 of the CNS during their care pathway, and you would  
8 agree that however that may have come about, it is  
9 certainly not a welcome development within the context  
10 of your MDT? 11:41

11 A. I agree.

12 118 Q. And it's not something that was drawn to your attention  
13 until after Mr. O'Brien had retired?

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

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

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

19

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

22

23 CHAIR: Thank you everyone. Mr. wolfe.

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

1       shortcoming in the approach of an individual colleague.  
2       And I want to start by looking briefly at the, I think  
3       it's possibly the first Serious Adverse Incident Review  
4       that you led on, or co-led on. It concerned Patient  
5       128, and if we have up on the screen, please, 12:02  
6       TRU-278671. The draft report was made available for  
7       the Interim Director of Acute Services, Mrs. Burns, in  
8       or about March 2015.

9  
10       Just briefly on this case, the facts, the clinical 12:03  
11       facts are maybe not terribly important for our  
12       purposes, but this was a patient who, following a right  
13       radical nephrectomy, was the beneficiary of a CT scan  
14       in May 2013. Wasn't reviewed as planned in June 2013.  
15       The GP re-referred the patient in August 2014, 12:03  
16       concerned about a risk of recurrent disease, and it was  
17       found that there was metastatic disease when a CT scan  
18       was produced.

19  
20       One of the problems in the case was that the clinician 12:03  
21       with carriage of the care, I think it was Dr. Connolly,  
22       having referred for a scan, left for pastures new and  
23       there was no handover at the time, so the patient was  
24       in a sense lost to follow-up.

25 12:04  
26       But let me bring your attention to the recommendations,  
27       because they were the subject of commentary from  
28       Mrs. Burns, and she said something about that, those  
29       recommendations and how she found them, when she came

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

3  
4 So, first of all the Recommendations and Conclusions.  
5 If we go to TRU-278679, just a few pages on. Just 12:04  
6 taking up on the bottom of the page she's saying, or  
7 you're saying, sorry, onto the next page. So these are  
8 the recommendations that:

9  
10 "The Review Team recommends a robust system for 12:05  
11 managing overdue uro-oncology review is established.  
12 A handover of patient caseload is required before a  
13 consultant leaves the Trust.

14 All Radiology reports must be actioned if required and  
15 signed off by an appropriate person. 12:05

16 A timely discharge letter should be dictated for every  
17 urology patient.

18 The Review Team recommends a communication record is  
19 designed and instigated for use with uro-oncology  
20 patients and named key worker." 12:05

21  
22 So bearing in mind those recommendations, let's see  
23 what Mrs. Burns had to say about it. TRU-2786699, and  
24 at the bottom of the page, sorry, Mrs. Burns writing to  
25 Dr. Tracey Boyce and Paula Fearon. She says: 12:06

26  
27 "I'm not happy with this review on a number of counts."  
28

29 She says:



1  
2 "These comments are not for sharing but, Tracey, can  
3 you review please and see what you think and then take  
4 forward in my absence. . . "

12:06

5  
6 - as she's going on leave. She says:

7  
8 "This review feels like the urology team had no part to  
9 play in this at all. None bar one minor issue of the  
10 recommendations falls to them."

12:06

11  
12 She says:

13  
14 "The CT scan results are not included in the review.  
15 What did they say? They're not signed off. What did  
16 they say? The handover within a team of senior  
17 clinicians needs addressed, but this is not a corporate  
18 issue surely? Surely that is a team issue?"

12:06

19  
20 And:

12:07

21  
22 "The Urology Oncology reviews, I've not heard before  
23 now that they're well out of time. I had been told the  
24 waiting lists had been separately made, but the backlog  
25 is another issue. Again, Urology have not  
26 highlighted."

12:07

27  
28 Just in fairness, scrolling back and sharing a variety  
29 of views on this, Ms. Fearon comments and says that:

1  
2 "I personally don't feel that there was any attempt to  
3 deflect Urology Service re their part to play. The  
4 Chair was most receptive to get to the root cause of  
5 the problem and to try to reduce the likelihood of a 12:07  
6 similar problem happening again."

7  
8 And then up the page to what Dr. Boyce has to say. Go  
9 on up, please. She has a range of comments to make,  
10 but she says: 12:08

11  
12 "I had a read through the report, it's a good report,  
13 but I can see what Debbie is getting at..."

14  
15 - in terms of Mrs. Burns' perception that you, as the I 12:08  
16 suppose key author of the report is passing the buck to  
17 management as opposed to recognising that there were  
18 urology team inputs required to get these things right.

19  
20 Just before I invite you to comment, we asked 12:08  
21 Mrs. Burns when she came along to give evidence to  
22 better explain or to unpack what she was getting at  
23 here, and so she says, if we go to TRA-07064. And just  
24 about half way, yeah. So:

25 12:09  
26 "Mr. Glackin would have been involved in this patient's  
27 journey. He was a very skilled urologist. He  
28 understood the context in which the team was operating  
29 and he could peer review how that had went. But it

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

10  
11 -- and she goes on, just scrolling down, to say, that  
12 she is saying:

13  
14 "...they were trying but they had no capacity to see  
15 that person in that timeframe." 12:10  
16

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

24 A. Is that your question there?

25 119 Q. well, I suppose it comes to this: Is she right to say 12:10  
26 that as a team, judged by reference to the issues that  
27 she's talking about, there was a lack of ownership?

28 A. She's missed the point.

29 120 Q. okay.

1           A.    So, I've a lot of respect of Debbie Burns and we worked  
2                well together, but this back channel communication  
3                that's going on, I don't think it was appropriate.  If  
4                we go back to the five recommendations of the SAI, if  
5                you wouldn't mind showing them on the screen, please?  12:11

6  121   Q.    Sure.  TRU-278679.  And just over the page.  I beg your  
7                pardon.

8           A.    So, we as a team instigated uro-oncology review clinics  
9                on the back of this.  So clinic codes were generated,  
10              and that meant that patients on the waiting lists were  12:11  
11              easily identifiable as a uro-oncology patient so that  
12              they would be prioritised in terms of getting their  
13              review.  So we as a team did that.  So, you know, that  
14              is -- we didn't ask anybody else to sort that out, we  
15              sorted that out.  12:12

16

17                The second bit is a point that I think goes well  
18                outside our own department, and I disagree with Debbie  
19                Burns when she describes how we should have been  
20                sorting this out, because if any consultant leaves any  12:12  
21                department there is going to be work left behind, and  
22                if the Trust does not have a policy in place as to how  
23                that will be managed, then that's the Trust's fault,  
24                that is a problem with the governance within the Trust.  
25                So I was making the point that, yes, the urologists had  12:12  
26                had a consultant leave, there was no formal or robust  
27                process in place to manage that consultant's workload,  
28                but that point was equally applicable to any consultant  
29                leaving any post within the Trust, and I think that's

1 where she has missed the point on that.

2  
3 The fact that Radiology reports, at that point in time  
4 they were coming in paper format, there was no facility  
5 to sign them off electronically. There is now a, there 12:13  
6 was a note came from the Medical Director's office some  
7 years after this, advising all members of medical staff  
8 about the actioning of results and the signing off of  
9 results. That came after this recommendation.

10 12:13  
11 In Urology now we have a process whereby we use  
12 electronic sign off, and that's audited, and in  
13 particular we receive a report for Radiology sign off,  
14 it is coded red, green and orange, and that is provided  
15 by our Head of Service to us so that we can see that we 12:13  
16 are on track for all of this activity.

17  
18 The discharge letter issue is largely pointed at the  
19 fact that Mr. O'Brien wasn't dictating letters on time  
20 and it was to lay that out that that was an 12:13  
21 expectation, a reasonable clinic expectation.

22  
23 And we have -- and point 5, we have subsequently put in  
24 place a written communication record for uro-oncology  
25 patients following their consultation. 12:14  
26

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

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

12:14

6  
 7 The second point in her evidence then, if you have --  
 8 and if we perhaps go back to her evidence where she  
 9 quotes the number of outstanding reviews, if you  
 10 wouldn't mind showing that?

12:14

11 122 Q. Yes, it's in the transcript of her evidence. It's at  
 12 TRA-07064, towards the bottom of this page. If we go  
 13 down just there. Yep.

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

12:15

12:15

12:15

28 123 Q. Just on that point. Is her issue that it's being  
 29 raised as a result of this MDT, but where was the

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

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

6 124   Q.    What was happening to, if you like, take the step that  
7           you've outlined after the SAIs review, rather than take  
8           it - given the knowledge that you had before.

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

18 125   Q.    We'll come back, for example, to look at perhaps a  
19          standalone issue, the issue of sign off, if we have  
20          time this afternoon. Obviously there's the issue you 12:17  
21          point out in relation to, and here a specific example  
22          of Mr. O'Brien's dictation practices, and we'll come to  
23          that very shortly.

24          A.    Yeah.

25 126   Q.    In terms of the handover, we've obviously got a picture 12:17  
26          of turnover amongst the consultant staff, particularly  
27          during those years until perhaps relatively recently  
28          when things may have settled down to a degree. To what  
29          extent is the handover problem well addressed at this

1 time?

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

8  
9 So, for instance, from the cancer perspective, those  
10 patients who are coming to MDT where it is clear that 12:18  
11 that person has retired or left the Department, those  
12 cases are shared out formally and they're handed over  
13 to a new named consultant. From a results perspective,  
14 when somebody has left employment of the Trust, we have  
15 agreed to share out the results of those people and 12:18  
16 divide the workload between the existing consultants.

17  
18 Now, that brings me to another point that I've made I  
19 think in my witness statement. There is a quantum of  
20 work that it is safe to deliver, and if you are funded 12:18  
21 for a team of seven consultants, and you've had various  
22 locums coming in filling posts and then they leave, and  
23 you're then back down to a team of less than that,  
24 perhaps four and a bit as we are at present, the Trust  
25 is expecting four and a bit to deliver the workload 12:19  
26 that was previously delivered by more people. That's  
27 not safe.

28 127 Q. Thank you for that. Obviously we have your response to  
29 what Mrs. Burns has said. Let me broaden this out a



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

9  
10 "... therefore unless advised by the clinical or Medical 12:20  
11 Director I would not necessarily be aware of concerns  
12 regarding the practice of my colleagues. "

13  
14 You go on at paragraph 52, if we bring up or go forward  
15 to WIT-42322. So you go on to explain that you're 12:20  
16 aware, and we don't need to name these people in this  
17 context, we'll go on to specifically address  
18 Mr. Suresh's issues at a high level, he gave evidence  
19 yesterday. You go on to explain that you:

20 12:21  
21 "... became aware of concerns raised by nursing staff  
22 about the clinical practice of several locum  
23 consultants. "

24  
25 This was dealt with by Mr. Young. Scrolling down. 12:21

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

28 128 Q. very well. I'll take that correction. The issue --  
29 you became aware that the issue was dealt with, the

1 issue hadn't been brought up by nurses. And then at  
 2 52.2, you explain that again other concerns were raised  
 3 about other colleagues. Mr. Haynes addressed that  
 4 issue. And then at 52.3, concerns regarding the scope  
 5 of -- I think this was discussed openly yesterday, 12:22  
 6 wasn't it? Concerns about the scope of Mr. Suresh's  
 7 practice were discussed.

8  
 9 So what I am wanting to explore with you, Mr. Glackin,  
 10 is the -- notwithstanding the absence of managerial 12:22  
 11 responsibilities on your part and other of your  
 12 colleagues, what is the expectation resting with you  
 13 where you become aware that a colleague, or if you  
 14 become aware of a colleague delivering his practice in  
 15 a way that is adverse to patient safety or potentially 12:23  
 16 adverse to patient safety?

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

28 129 Q. With regards to Mr. Suresh, you explain there, his  
 29 practice was discussed by the urology team, including

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

8  
9           So this is March 2016, and we don't need to get into  
10          the minutia of what was happening to Mr. Suresh around 12:25  
11          that time, but it is the case that the team, albeit  
12          with some management support, took ownership of this  
13          issue and helped to develop a remediation package, if I  
14          can call it that, perhaps not in the formal sense  
15          remediation, but a package of support for Mr. Suresh? 12:25

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

18   130   Q.    Is that because, as you described it earlier, the  
19          fundamental here is patient safety, and where you see  
20          issues you, if you see them and you feel nobody else is 12:25  
21          aware of them, you report them to management, and  
22          perhaps speak to the colleague concerned in a  
23          supportive way, if appropriate?

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

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

16 131 Q. Can I ask you to reflect, in light of the support that  
17 Mr. Suresh appears to have received, in terms of  
18 Mr. O'Brien's practice - and we're going to look at a  
19 number of issues, and perhaps you can only address the  
20 issue generally at this point, because much depends on 12:27  
21 the gravity with which the issue is understood from a  
22 patient safety perspective, there's obviously whether  
23 there's full knowledge around the issue - but in terms  
24 of looking back on Mr. O'Brien, he came through an MEPS  
25 process and then there was a return to work plan, and I 12:27  
26 know from what you've said that that was largely hidden  
27 from his colleagues. Do you think, from a team  
28 perspective, Mr. O'Brien could have been better  
29 supported with the practice difficulties that he faced?

- 1 A. Yes, and I've said so in my statement. I think it  
 2 would have been much better if those issues, and I  
 3 realise there are sensitivities around some of them,  
 4 but certainly I think if the medical managers had of  
 5 discussed with us as a team of consultants the 12:28  
 6 particular issues, and allowed us to understand the  
 7 breadth of issues, but then also to formulate a support  
 8 plan, a network, if you like, as to how Mr. O'Brien  
 9 could return to the team and practice safely. It would  
 10 also have given us greater oversight going forward as 12:28  
 11 to when, if there were any dips in performance, or  
 12 non-adherence to agreed behaviours, then we would have  
 13 been able to identify that at an earlier stage.
- 14 132 Q. We'll maybe unpack some of that as we go along. What  
 15 do you identify as being the, if you like, the block or 12:29  
 16 the obstacle that was in place that prevented the  
 17 development of that kind of approach?
- 18 A. So, I had no knowledge or part to play in the return to  
 19 work plan. That was developed without input from the  
 20 whole team. It was developed, as far as I understand, 12:29  
 21 from the medical management side and with some input  
 22 from the Head of Service, from what I've read  
 23 subsequently. So those people held that information.  
 24 It wasn't shared with us. I think if we had of been  
 25 aware of what they were monitoring and how they were 12:30  
 26 addressing any shortcomings, then we would have been in  
 27 a position to assist.
- 28 133 Q. I'm now going to work through what had been described  
 29 as those shortcomings, and take your view on when you

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

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

14  
15 I don't recall having concerns about his operative 12:31  
16 capacity. I don't recall having concerns about his  
17 manner of working with colleagues and interpersonal  
18 difficulties. Certainly I didn't have any  
19 interpersonal difficulties with him.

20 12:31  
21 I think it's important to reflect though that, you  
22 know, there was a definite chilling process that  
23 happened around the time of this late 2016 and  
24 returning to work in 2017. That was difficult for  
25 everybody. 12:31

26 134 Q. Yes.

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

1 135 Q. We know, or at least we've been told by Mr. Suresh,  
 2 that he raised some issues. He raised an issue about  
 3 the use of intravenous antibiotics, and he explained in  
 4 his witness statement that he placed this on, if you  
 5 like, the agenda at a departmental meeting, it was 12:32  
 6 discussed and assumedly resolved.

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

8 136 Q. Yes.

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

11 137 Q. I haven't seen. So. But I suppose what prompts that  
 12 question is the, at least until the MHPS process kicked  
 13 in, what I want to suggest to you is that there was a  
 14 level of knowledge, perhaps not to the degree and  
 15 extent as it was to be unveiled to you later... 12:33

16 A. Yeah.

17 138 Q. But things, as we'll see with each of these issues,  
 18 were addressed at the level of informality rather than  
 19 the erection or the pursuit of a formal expression of  
 20 concern with Mr. O'Brien. Is that your appreciation, 12:33  
 21 regardless of where the responsibility for that lies?

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

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

3   139   Q.    Yes.  Yes.  You say that -- I just will bring it up on  
4           the screen briefly.  WIT-42319, and at paragraph 50.8  
5           you allude to that conversation.  It's perhaps 12:34  
6           mentioned by you because it forms some significance in  
7           the sense of it being --

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

12   140   Q.    Yes.  I suppose that's what I was about to say to you.

13          A.    Yes.

14   141   Q.    That its significance perhaps is that to the best of  
15          your recollection, and I'm not sure you put a date on 12:34  
16          it, but --

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

18   142   Q.    Yeah.  But it precedes the January 2017 meeting.  And  
19          what you, I think what you say about this interaction  
20          with Mrs. Trouton is that it reflected, you understood 12:35  
21          it as reflecting a degree of exasperation on her part  
22          about backlogs, but she didn't descend into any detail.  
23          You said in your witness statement, and we just go down  
24          to WIT-42326, that in terms of at 56.1 you say:  
25 12:35

26                "From 2012 Mr. O'Brien had a long review backlog for  
27                out-patients and in-patient operating, but he was not  
28                unique in that regard."  
29



1           A.    Yes.

2   143   Q.    So that wasn't a concern particular to him is I suppose  
3                   your position?

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

7   144   Q.    But something perhaps specific to Mr. O'Brien?  You  
8                   were also aware that he had a backlog of completing  
9                   correspondence, which was your experience as a trainee  
10                  back in, or a research fellow in 2002 and 2005, but it 12:36  
11                  had been largely unchanged when you came back in in  
12                  2012?

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

15   145   Q.    Yes. 12:37

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

18   146   Q.    Yes.  Just on that, in terms of what you expect of  
19                  yourself as a practitioner, and your understanding of  
20                  your obligations.  It's right to say, I suppose, that 12:37  
21                  the job plan - to take what document - doesn't descend  
22                  into that kind of detail about the expectations around  
23                  dictation?

24          A.    It doesn't.

25   147   Q.    But -- 12:37

26          A.    -- nor does the job description.

27   148   Q.    Yes.  But presumably you agree that it's the duty of a  
28                  doctor to make a record consultation and to communicate  
29                  that record in a timely fashion?

- 1 A. So my practice is that I will make a written note on  
2 nearly all occasions, nowadays we have the facility to  
3 make a contemporaneous electronic note on ECR, and I  
4 will also dictate a letter for every patient at the end  
5 of clinic. There is a very rare occasion when I need 12:38  
6 to check something and I may delay writing that letter  
7 for that reason.
- 8 149 Q. And why, just to get it out on the table, why is that  
9 important? why is that documentation --
- 10 A. So there's a couple of reasons why it is important. 12:38  
11 First of all, you're working at such pace that if you  
12 don't do it there and then you will never catch up. So  
13 that's the first thing. It's about keeping on top of  
14 your workload.  
15 12:38
- 16 The second thing is, I think it's important that the GP  
17 and others providing care to the patient have ready  
18 access to the outcome of the consultation.
- 19 150 Q. And in terms of your colleagues, again you --
- 20 A. I understand that they practice similarly. 12:38
- 21 151 Q. Yes. And was it known -- well you knew because you had  
22 exposure in 2002 to 2005 about Mr. O'Brien, and in  
23 2012. How did your knowledge of his continuing deficit  
24 in this respect come about?
- 25 A. So, I think my knowledge came about largely because 12:39  
26 there was a backlog review, and we undertook extra  
27 clinics to see patients, and when we saw those patients  
28 who might have been Mr. O'Brien's, there wasn't a  
29 clinic letter in the chart. So that meant one of two

1 things: either it hadn't been dictated or it hadn't  
2 been typed. So you could at that time, in the early  
3 2010s, you could check on our system called Patient  
4 Centre, because that's where the letters would have  
5 went to. So you would open Patient Centre and you 12:39  
6 would check was there was any correspondence. And if  
7 there wasn't any correspondence on Patient Centre, then  
8 it was quite clear that it hadn't been dictated or  
9 typed, one of those two things.

10 152 Q. And is that something you ever spoke to him about? 12:40

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

20 12:40  
21 It was also raised with Mr. O'Brien in the departmental  
22 meetings, and when, I think was Mr. Haynes raised the  
23 particular issue on the particular day, the necessity  
24 to have a clinic letter dictated and available in the  
25 chart for every patient, and Mr. O'Brien perversely 12:40  
26 expressed the view, perversely from my perspective, the  
27 view that it wasn't necessary to dictate on every  
28 patient, that he knew what was going on and he didn't  
29 have to write to the GP. I just couldn't get my head

1           around that.

2   153   Q.    But that was, from his perspective a full stop, end of  
3           conversation, he wasn't changing his practice. Is that  
4           your understanding of his stance?

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

6   154   Q.    And was the problem, at least in terms of your  
7           experience, more than just a communication issue, a  
8           record of what has been done, was it more than that?  
9           Was it also a failure to action by a dictation a next  
10          step on occasions, a next clinical step? 12:42

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

18   155   Q.    Did you view it, or did your colleagues view it as  
19          potentially a patient safety issue?

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

22   156   Q.    Plainly you didn't have line management responsibility  
23          for him. You drew it to the attention of Mrs. Corrigan  
24          you've said, so that the system was well aware of it.

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

1 157 Q. There was also an issue of charts, patient charts not  
 2 being available when colleagues needed them. The  
 3 patient perhaps came in from Accident and Emergency, or  
 4 there was a clinic arranged and...

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

6 158 Q. Yes.

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

15 159 Q. Was it recognised that Mr. O'Brien was retaining 12:44  
 16 patient notes at his home or in places that were  
 17 inaccessible to you and his colleagues?

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

21 160 Q. You properly allude to Mr. Haynes raising this issue.  
 22 He says in his witness statement at WIT-53932 that  
 23 concerns were regularly raised, regularly voiced, I  
 24 should say:  
 25  
 26 "...by all members of the consultant team regarding the  
 27 frequent lack of clinical information in the form of  
 28 letters following outpatient consultations, as this had  
 29 the potential to impact on us when patients had 12:45

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

12:45

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

8 A. Yeah, that tallies with my recollection.

9 161 Q. Yeah. Different issue with Mr. Suresh, but these  
 10 issues concerning practice come in all shapes and  
 11 sizes. Do you think it was enough for yourselves as a  
 12 urology team to deal with the matter informally, as you  
 13 did, or when you think about it now should another  
 14 track have been pursued?

12:45

15 A. Some of the people who would have been present at those 12:46  
 16 meetings would have had knowledge of what was going on  
 17 in the background, and I'm referring largely to Martina  
 18 Corrigan, and I think Mr. Young would have had some  
 19 knowledge of how the management had tried to manage  
 20 Mr. O'Brien over a number of years. I didn't have that 12:46  
 21 knowledge. Do I think that it should have, this  
 22 particular issue of dictation, letters not being  
 23 available and notes being taken off site, do I think  
 24 that should have been managed formally? Yeah, I think  
 25 it should have been managed formally. 12:46

26 162 Q. Let's move to triage. Again, just in terms of your  
 27 practice and what you understand are the obligations in  
 28 respect of triage, using both the period before the  
 29 urologist of the week model and the introduction of

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

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

6   163   Q.    Just on that, sorry to interrupt your flow.

7           A.    Yes.

8   164   Q.    Is that unhelpful and is it by contrast with other  
 9           settings?

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

15 12:48

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

22

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

1 ways of delivering this activity.

2  
3 when I arrived it was a paper based activity and it was  
4 shared out among the consultants. There was an  
5 expectation that the red flags would be turned around 12:48  
6 within a timeframe, I think it might have been 24  
7 hours, and that the others would be turned around  
8 thereafter. I think there was an IAEP policy. I had  
9 no knowledge of that policy, I wasn't provided with it,  
10 but I now understand that that policy would have been 12:49  
11 in place at that time.

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

18  
19 The triage activity was largely in two parts. It was  
20 the red flag cancer referrals which were provided to 12:49  
21 the team from the red flag office, as it's termed in  
22 the Trust, and we expected to do those on a daily basis  
23 and return them. The second bundle would have been the  
24 urgents and routines, and they would have been returned  
25 I think at that time via our secretaries, and then as 12:49  
26 e-triage became available we shifted to doing that.

27 165 Q. And you point out the absence of a policy that would,  
28 or a process that would allow you to better understand  
29 the expectation. Dealing with the urologist of the



1 week model and triage within, the triage work within  
 2 that, absent the availability of a policy was it  
 3 nevertheless understood that by the completion of your  
 4 period as urologist of the week you would nevertheless  
 5 be expected to have delivered back to the source all of 12:50  
 6 the referrals that have come your way?

7 A. Yes, I think that was a fair expectation. It was  
 8 certainly what I understood by the process. And my  
 9 experience was that there were weeks where you would,  
 10 where I could easily accomplish the triage within the 12:50  
 11 time. There were other weeks when you were busy and  
 12 perhaps you might have been in at night, and on those  
 13 occasions it might have been more difficult, but it was  
 14 always my practice to clear the desk, so to speak, as  
 15 soon as I could, and not leave work for my colleagues. 12:51

16  
 17 Now since the E-triage process has come in, there are  
 18 times when, on a Wednesday evening you'll check the  
 19 electronic care record triage system and you will find  
 20 that everything is done at 5:00 o'clock, and you'll 12:51  
 21 come in the next morning on a Thursday and find that a  
 22 load of stuff has arrived overnight. Now your  
 23 colleague who has taken over on a Thursday might look  
 24 at you and say "What have you been doing?" but, you  
 25 know, it's just the way the system works. 12:51

26  
 27 So I think there's an acceptance amongst us that we  
 28 would check last thing on a Wednesday evening that  
 29 everything had been tidied up, and whatever comes in on

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

3 166 Q. In terms of your own practice and comment on what you  
4 understand to be the approach of others, if you can, is  
5 there a difference of approach depending on whether it 12:52  
6 is a red flag referral, in terms of the steps that you  
7 might initiate when sending the referral back, as  
8 contrasted or compared with the other categories of  
9 referral?

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

12 167 Q. Okay.

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

1           that would have been requested ahead of time.

2  
3           The model has changed somewhat more recently in that we  
4           don't have the same setup, and it has been complicated  
5           by the fact that a large number of referrals are going 12:53  
6           out to the independent sector, including some red  
7           flags. Therefore, up until the independent sector  
8           provider came on, we were largely requesting scans  
9           ahead of time to try and expedite and facilitate care  
10          for patients. Since the IS provider has come along, we 12:54  
11          have stopped doing that because it has been causing  
12          problems between us and the IS provider and, therefore,  
13          those scans are not requested until the patient is  
14          allocated to one or other, the Trust or the IS. So  
15          that has muddied the waters a little. 12:54

16  
17          There is some -- there are, I suppose, a variety of  
18          views amongst the consultant body as to how we do this  
19          activity. Some people use the term "advanced triage",  
20          and I know that Mr. O'Brien used that term. Some 12:54  
21          people used advanced triage and meant different things  
22          by it, and that's all a confounder.

23  
24          So on more than one occasion we, Mr. O'Brien described  
25          in great detail how he did advanced triage. Well, it 12:54  
26          essentially amounted to a virtual consultation. Both  
27          myself and Mr. Haynes at meetings said to him "We don't  
28          think that's a good use of your time, you're not set up  
29          to be doing virtual consultations for all the new

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

12:55

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

12:55

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

12:56

12:56

12:56

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

1 triage was frequently discussed. Mr. O'Brien would  
2 frequently express the view that he did not have enough  
3 time to complete triage of new referrals during his  
4 week on-call, or his week as urologist of the week, and  
5 that the response from some of you at the meetings, and 12:57  
6 perhaps you've just outlined a moment or two ago, was  
7 that the style of working and organisation on the part  
8 of Mr. O'Brien was generating the problem.

9 A. Yes.

10 170 Q. And what was his response to that in the round, if you 12:57  
11 can remember?

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

15 171 Q. His description, or I suppose your description of what 12:57  
16 he said was, ehm, expressing the view that he did not  
17 have enough time. Did you realise that when he used  
18 words to that effect that he wasn't actually performing  
19 triage, he wasn't doing it across a number of cases or,  
20 as we know, largely -- as we know now, he largely 12:58  
21 wasn't doing it for routine and urgent referrals?

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

28 172 Q. Yes. Mr. Young engaged with management in --  
29 Mrs. Burns in particular I think in February 2014, and

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

12:59

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

13:00

13:00

13:00

13:01

26 173 Q. We'll come after lunch just to look at what has been  
27 described as a default mechanism for dealing with  
28 triage and what that meant in practice and what you  
29 knew about it, if anything. But just to finish for

1 now, it is your evidence that while Mr. O'Brien is  
2 talking of the difficulties, and you as colleagues  
3 responded in saying "well, this is matter of style and  
4 approach, and you don't need to do that", at no stage  
5 were you advised that he wasn't doing triage for a raft 13:01  
6 of cases?

7 A. That's correct.

8 174 Q. Okay. You now know that there was a mechanism by which  
9 management side at least would have been aware that he  
10 wasn't triaging? 13:02

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

13 175 Q. Yes.

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

18 176 Q. And we'll come to that after lunch, perhaps?

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

21  
22 THE HEARING ADJOURNED FOR LUNCH

1           THE HEARING RESUMED, AS FOLLOWS, AFTER THE LUNCHEON  
 2           ADJOURNMENT

3  
 4           CHAIR:   Good afternoon everyone.

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

18          A.   Yes.

19   177   Q.   On what basis?

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

28   178   Q.   And it's an issue I think you took up directly in the  
 29          SAI review that you participated in in respect of



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

5  
6 If we go AOB-01245. This is a letter that was written  
7 to Dr. Boyce. It was signed off by Connie Connolly.  
8 As I say, it is dated 15th December 2016, and it is  
9 taking up on the investigation of that SAI, and it  
10 makes the point that:

11  
12 "Part of the work included a lookback exercise for  
13 seven urology patients who had been managed in the same  
14 manner at or around the same time as Patient 10 in  
15 October 2014."

16  
17 The Panel has looked at that. Six of the patients, it  
18 could be seen, had been discharged or management plans  
19 in place, one of the patient's chart couldn't be found  
20 and it eventually came back into the system. So, just  
21 scrolling down. So I think this was designed as a  
22 message to management. It says:

23  
24 "The review team agree that there are a number of  
25 relevant and related issues and themes causing concern  
26 for the Panel which have been exposed during the  
27 investigation."

28  
29 And they need looked at. Were you party to this letter

1           being sent?

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

4   179   Q.    So although it refers to the Review Team agreeing that  
5                there are a number of relevant and related issues or   14:08  
6                themes, you weren't consulted in terms of the drafting  
7                of the letter?

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

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

17           A.    Yeah.

18   181   Q.    A prominent member of the Review Team?

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

21   182   Q.    In any event, does the detail of the letter speak to  
22                concerns that you had and were subsequently to be  
23                reflected in the SAI review?

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

26   183   Q.    If we just touch briefly, this is well trampled ground  
27                I think at this stage, but if we just go to your SAI  
28                report, and I am conscious that you were part of a  
29                team, and a significant aspect of the analysis of the

1 review concerned the radiography aspects.

2 A. Yes.

3 184 Q. And it wasn't, lest anybody suggest otherwise, it  
4 wasn't simply a focus on the shortcomings of triage?

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

9 185 Q. Yes.

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

12 186 Q. Yes. And if we can, I quite take that point that you  
13 viewed them as that the radiography aspects were  
14 significant, more significant. I do, however, for our  
15 purposes, need to focus on triage. So just touching 14:10  
16 upon the recommendations. PAT-000008. And the  
17 recommendations spoke to the increased risk of harm and  
18 the opportunity when early intervention and triage is  
19 omitted.

20 14:11

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

25 14:11

26 And you say in particular:

27

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

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

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

14:11

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

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

14:12

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

14:12

14:13

1  
2 And, secondarily, the imaging is freely available. You  
3 could have reviewed the imaging yourself.

4 188 Q. Yes.

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

11 189 Q. And I just want to touch on that very point and try to  
12 assess through your evidence whether these issues  
13 remain of some concern to you as a urology team. Just  
14 picking up on what you've said in relation to  
15 Mr. O'Brien and his views. As I say, he responds to 14:14  
16 the draft SAI. If we can pick that up at AOB-01393.  
17 Sorry, just over the page. I beg your pardon. No,  
18 back the way we came. Back up a wee bit higher. Yeah.  
19 "Comments Regarding Triage", if we just come to that  
20 subheading. Yep. 14:15

21  
22 So, yes, he makes the point that he would -- bottom of  
23 the page as we see it:

24  
25 "I would not have considered upgrading it to red flag 14:15  
26 status."  
27

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

1  
2 "I have believed and expressed the view that the  
3 inclusion of the triage of all letters of referral in  
4 duties and responsibilities of the urologist of the  
5 week was inappropriate." 14:15

6  
7 And he goes on to explain what he meant, what he means  
8 by that.

9  
10 If we go to the top of the next page, he talks about: 14:15

11  
12 "The purpose and priorities of the urologist of the  
13 week are for the consultant to deliver hands-on  
14 clinical and operative management of all urological  
15 patients, all other in-patients in the hospital whose 14:16  
16 assessment and management was sought..."

17  
18 - it is a long sentence, but in essence it comes to  
19 triages getting in the way of the original purpose and  
20 objectives of urologist of the week, and that leads to 14:16  
21 a, if you like, a deficit in the time available to him  
22 to address the triage requirements. Is that a  
23 challenge that you too recognise?

24 A. No.

25 190 Q. That's a very stark position. It's a no because you 14:16  
26 take a different approach to triage and management?

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

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

13 191 Q. Let me just put two other pieces of information into  
 14 the mix and we can have your observations on this. Out  
 15 of chronological order perhaps, but you are aware that 14:17  
 16 there was a further SAI review conducted in relation to  
 17 the triage issue in association with five patients who  
 18 emerged from the out-workings of early 2017?

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

21 192 Q. Precisely, yeah. I was trying to find a group word to  
 22 describe it, but you're familiar with that?

23 A. I am now.

24 193 Q. Yep.

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

29 194 Q. Yep. It was, as you say, reported on the 22nd of May

1 2020, and what I want to bring you to is its  
2 recommendations, or at least some of them.

3  
4 If we go to TRU-161196? And I'm reminded as I bring  
5 you to this of your evidence just before lunch, where 14:19  
6 you spoke about the absence of a triage policy, well  
7 perhaps not alone for urology but perhaps a more  
8 widespread problem than simply urology.

9  
10 If we go to Recommendation 6, scrolling down, please? 14:19  
11 It is explained this SAI Review Team, which included  
12 Dr. Johnston from outside of the Trust, Mr. Haynes was  
13 part of the team that led on this review, and it  
14 recommends that:

15 14:19  
16 "The Trust should re-examine or reassure itself that it  
17 is feasible for the consultant of the week to perform  
18 both triage of non-red flag referrals and the duties of  
19 the consultant of the week."

20 14:20  
21 It says that:

22  
23 "The Trust will develop written policy and guidance for  
24 clinicians on the expectations and requirements of the  
25 triage process. This guidance will outline the systems 14:20  
26 and processes required to ensure that all referrals are  
27 triaged in an appropriate and timely manner."

28  
29 Writing in 2020, I'm not sure if it continued to be



1 relevant, they're saying:

2  
3 "The current informal default triage process should be  
4 abandoned. If replaced, this must be with an  
5 escalation process that performs within the triage  
6 guidance and it does not allowed red flag patients to  
7 wait on a routine waiting list."

14:20

8  
9 So just we'll remember I've read that out, but I also  
10 wanted to take you to something that you wrote in  
11 November 2018. If we go to WIT-81609. I say you wrote  
12 it, but in fact I think you may have circulated it.  
13 It's the minutes of Urology Service Development Day,  
14 attended by you and some colleagues. It says in terms  
15 of triage, if we scroll down, that:

14:21

14:21

16  
17 "The Trust needs to provide a plan detailing what  
18 exactly it expects the consultants to do in terms of  
19 triage. This must include recognition of the time  
20 constraints and time commitment required to complete  
21 triage, including time spent speaking to patients,  
22 booking scans, reviewing results and mitigating risk  
23 for patients on the current long outpatient waiting  
24 list. Consideration was given..."

14:21

25  
26 - presumably by the meeting:

14:22

27  
28 "...to decoupling the triage activity from that of the  
29 urologist of the week."

1  
2 And I think the preface to that discussion might well  
3 have included a paper prepared by Mr. O'Brien in  
4 September of that year. So having put all of that  
5 information in front of you, what it seems to speak of 14:22  
6 in 2018 and then again in an SAI review published in  
7 the summer of 2020, is that the team, the Urology  
8 Service, is crying out for guidance by way of a policy  
9 or whatever, in terms of how triage is to be done,  
10 what's expected. And, secondly, a need to assess 14:23  
11 whether it's feasible to continue doing urologist of  
12 the week with triage within those responsibilities. Is  
13 that still the position? Is it still a concern?

14 A. It is still a concern. So I think I did write this  
15 document. It's not dated, and that's my fault that it 14:23  
16 is not dated. There are also handwritten notes which I  
17 think the Inquiry have access to. They're in my  
18 handwriting. And in this, as in all the sections of  
19 this document, what I'm trying to reflect is the nature  
20 of the discussion and the views expressed by the 14:23  
21 members of the team. They're not my personal views.  
22 As best as I could capture them, they are the views of  
23 the team.

24  
25 So there was a variance of opinion as to how we should 14:23  
26 be dealing with is this. Mr. Haynes had one particular  
27 view, that we were responsible for sorting this out  
28 ourselves and that "we were the Trust", I think was the  
29 phrase he used. I think that that might have been

1 captured in a recording, which you may have the  
 2 transcript to. Mr. O'Brien, Mr. Young and I didn't  
 3 share Mr. Haynes view. We felt that it was incumbent  
 4 on the Trust to provide a policy to clearly outline how  
 5 this activity would be delivered, and we were therefore 14:24  
 6 at variance with Mr. Haynes in that regard.

7 195 Q. So, I don't want to spend an awful lot of time on this,  
 8 for obvious reasons, but just drilling down a little  
 9 deeper. We have the debate as to whose responsibility  
 10 it is to sort it out, but in terms of the team members, 14:24  
 11 was there a divergence of view in terms of the  
 12 doability of triage during the urologist of the week  
 13 period?

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

20 196 Q. And is that, as I think you've alluded to already, is 14:25  
 21 that divergence of views a reflection of a deeper  
 22 divergence in terms of the approach to be taken to  
 23 triage? In other words the time to be spent and the  
 24 activity. You described it as a quasi clinic approach  
 25 or words to that effect? 14:25

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

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

14:26

7 197 Q. Now, in terms of what has been put on paper, whether it  
8 is the SAI review that I've read, or your minutes here,  
9 which assumedly went in the direction of management  
10 perhaps, or the messages from the minutes went in the  
11 direction of management, has there been any attempt on  
12 the part of management to wrestle with either an  
13 assessment of whether triage is doable during urologist  
14 of the week, or an attempt to wrestle with the policy,  
15 or engage with you as a team on either of those issues?

14:26

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

14:27

21 198 Q. Yes. I take that answer in the sense that, okay, to  
22 some extent water under the bridge. Mr. O'Brien, who  
23 was, let's put it in neutral terms, was having a  
24 difficulty with triage and it created difficulties for  
25 patients, but the Trust could potentially have, you  
26 know, another clinician come in and struggle with  
27 triage, and difficulties of the past could, in another  
28 shape or form, be repeated. Do you see --

14:27

29 A. It could also be happening in other departments within

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

14:28

6 199 Q. Yes. I do take it that, if you like, on the other side  
7 of the equation the ability to check that something is  
8 being done, whether there's certainty as to what the  
9 actual obligation is, but the ability to check and  
10 monitor the doing of it?

14:28

11 A. To check that triage has happened.

12 200 Q. Yep.

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

14:28

18 201 Q. Thank you. Now, when you spoke to Dr. Chada about, I  
19 suppose your experiences in working with Mr. O'Brien,  
20 and your participation in what might be called the  
21 clean up operation that was triggered from the  
22 revelations in January 2017, you said the following,  
23 and I'll bring you to the extract. It is TRU-00774,  
24 and at paragraph 25 you're reflecting in terms of  
25 working arrangements, and Mr. O'Brien you say:

14:29

26  
27 "...frequently expressed the view at consultant  
28 meetings that his most pressing commitment was to  
29 patient care and operative waiting list."

14:29

1  
2 This was a workload issue for him.

3  
4 "Most of the other consultants are not dealing with the  
5 same volumes in terms of our waiting lists. There is 14:30  
6 certainly a bit of wanting to hold on to things. Every  
7 consultant makes different decisions about how to  
8 manage things. His approach is different to that of  
9 his colleagues, and I am not saying it isn't good work  
10 or safe, but Mr. O'Brien does fall behind with things. 14:30  
11 Mr. O'Brien sees significantly fewer patients in clinic  
12 per year than most of his colleagues. This issue has,  
13 to the best of my knowledge, not been explored,  
14 challenged or addressed."

15 14:30  
16 I look at that paragraph and I look at your statement  
17 to Dr. Chada in the round, and other of your remarks,  
18 including your Section 21 response to this Inquiry, and  
19 you make the point that you're not saying that  
20 Mr. O'Brien's work isn't good work, or it isn't safe 14:31  
21 work. Was his work safe when you look from a standing  
22 position after you came into the job in 2012, or in  
23 light of what you were told in 2017?

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

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

12  
13 what I am saying about it not being good work. I'm not  
14 saying it isn't good work or safe. Mr. O'Brien was a  
15 very safe operator in my opinion. I did not see 14:32  
16 patients coming to harm because he had operated on  
17 them. That was my experience when I gave that  
18 statement. When patients were seen in clinic they got  
19 a thorough assessment, in my view, when they saw him,  
20 and when he handed over patients to me on the post, on 14:33  
21 the handover ward round, they had had a very thorough  
22 assessment from him, and he was able to tell you in  
23 great detail what had happened to all of those  
24 patients. So that is where I am coming from with that  
25 statement. 14:33

26  
27 Now, what I don't say there, and perhaps what I should  
28 have said, was that -- there was something about the --  
29 yeah, about the correspondence. I don't think I've

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

14:33

6 202 Q. I suppose what you say is he does fall behind with  
7 things?

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

10 203 Q. Yeah. Yeah. Yeah.

14:33

11 A. Yeah.

12 204 Q. I just wonder, I want to give you an opportunity to  
13 comment on this, but I wonder whether there was some  
14 hesitation on your part, or on the part of your  
15 colleagues in calling a spade a spade, that you took  
16 the view that Mr. O'Brien had areas of practice that  
17 gave rise to patient safety risk? And we've looked  
18 before lunch and we've looked since lunch at this sort  
19 of informality of the challenge to him from colleagues.

14:34

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

14:34

26 205 Q. When you had completed the draft of your, the SAI, with  
27 your colleagues for Patient 10, Dr. Boyce invited you  
28 to send that to Mr. O'Brien, and if we just pick up on  
29 that email correspondence. TRU-257720. And we don't



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

A. Actually the fine detail is important.

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

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

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

A. I did.

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

A. Yes.

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

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

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

5  
6 So here I'm receiving an email from somebody who I have  
7 no knowledge of what their role is, on behalf of the  
8 Medical Director, and I am sitting there reading it  
9 fuming, thinking "why hasn't the Medical Director  
10 written to me?", because I'd want to have a  
11 conversation with the Medical Director about this.

12  
13 The Medical Director had chosen to exclude Mr. O'Brien  
14 from work. I didn't feel it was appropriate for me to  
15 send any correspondence to Mr. O'Brien if he had been  
16 excluded from work by the Medical Director. If the  
17 Medical Director wanted to send correspondence to  
18 Mr. O'Brien, he was quite free to do so.

19 209 Q. Did you feel conflicted?

20 A. No.

21 210 Q. He was a colleague who had a responsibility as one of  
22 the senior authors of the SAI review.

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

29 211 Q. I see. I'm not sure I understand? Perhaps you could

1 spell it out to assist the Inquiry?

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

6 212 Q. I'm not sure I follow. How is it an interruption from  
7 his exclusion from work to pass on the --

8 A. He is not --

9 213 Q. Let me finish, please. To pass on an SAI review for  
10 his observations? 14:39

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

17 214 Q. Could I bring you to Dr. Boyce's observations in terms  
18 of your response to this. TRA-05951. And she says --  
19 just scrolling down. Yes. I'm asking her about the  
20 normalcy of the responsibility of passing on the SAI 14:40  
21 Review Report, and she says this is one for you to  
22 address.

23

24 "I understand he was very conflicted..."

25 14:40

26 - as you say:

27

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

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

3  
4           Bit jerky there, the text, but --

5           A.    I'm not sure, you know, I've never had a conversation       14:41  
6           with Dr. Boyce.

7   215   Q.    Yeah.

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

10   216   Q.   Yeah. Yeah. Well let's just think about it, think       14:41  
11           through it one more time. Did you see it as a  
12           responsibility in general as a --

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

19   217   Q.    I'm asking you these questions because on the face of  
20           it there was no formal challenge by you to any of the       14:42  
21           identified deficits or shortcomings in Mr. O'Brien's  
22           practice, and I wonder whether there was -- was there a  
23           closeness there in terms of your relationship with him  
24           as a colleague, and to use Dr. Boyce's language, as a  
25           mentor, which would have made it uncomfortable for you       14:42  
26           to engage in a more decisive or aggressive manner in  
27           challenging his conduct, or perhaps in the alternative  
28           you didn't see it as your role at all?

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

1 Mr. O'Brien a previous SAI relating to Patient 128. I  
2 had no issue about doing that. I had no issue with  
3 discussing these things with Mr. O'Brien. This solely  
4 came down to the fact that the Medical Director sought  
5 and excluded Mr. O'Brien from work. I batted this 14:43  
6 back, Tracey Boyce clearly had a conversation with  
7 Esther Gishkori and Richard Wright, and none of them  
8 came back to me.

9 218 Q. And broadening the issue out in terms of my question --

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

12 219 Q. Yes.

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

22 220 Q. Yes. And my broader question is: How do we explain any  
23 failure on your part to more rigorously challenge what  
24 might be regarded as patient safety issues on the part  
25 of Mr. O'Brien? Is that explained on the basis that 14:44  
26 you didn't see it as your responsibility to go beyond  
27 an informal challenge as part of a team meeting, or was  
28 there an uncomfortable closeness with him which made it  
29 difficult for you to pursue issues with him, or is

1           there some other explanation?

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

3   221   Q.    Well, I think we've got to the place where you accept  
4           that you've never raised, for example, an incident  
5           report in respect of Mr. O'Brien, and across the issues 14:45  
6           we've looked at so far it has been of a flavour of  
7           raising issues with him in a team meeting format,  
8           informal approaches.

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

20   222   Q.    Could I bring you to something that Mr. Hughes, 14:45  
21          Dr. Hughes said? We were at the note this morning and,  
22          again, I should give you an opportunity to deal with  
23          it. It's the telephone conversation 30th November  
24          2020. If you just bring up the record for that again,  
25          please? It's TRU-162250. I think towards the bottom 14:46  
26          of the page. Yeah. So the note at the very last line,  
27          if you can just bring it up slightly so we can see it?  
28          Yeah. So Dr. Hughes indicates that you were describing  
29          Mr. O'Brien as a holistic physician or clinician, and

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

17  
18 "In this day and age to describe somebody as a holistic  
19 clinician is really suggesting somebody is working  
20 outside their fields of competence. You can't deliver 14:48  
21 the roles of clinical nurse specialist, you can't  
22 deliver the roles of a palliative care physician, you  
23 can't meet patient needs working in isolation, and  
24 that's something that people need to be protected  
25 from." 14:49

26  
27 So he, I suppose most directly sees a misplaced  
28 collegiate friendship in how you are portraying  
29 Mr. O'Brien in your discussions with him?

1           A.    So I think he has misconstrued this.

2   223   Q.    Did he, when he was speaking to you, ask you what you  
3                    meant about --

4           A.    No.

5   224   Q.    -- holistic physician? 14:49

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

8   225   Q.    Very well.

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

28

29                   In the interests of openness, I explained to



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

5 226 Q. Do you wish me to give you a reference? 14:51

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

8 227 Q. I can't help you unless -- I'm happy that you're --

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

11 228 Q. Sorry, I thought you were referring to your Section 21  
12 statement. So, yes, we can go to Dr. Hughes' telephone  
13 conversation, 30th November, at TRU-166249. It's the  
14 start of it, and then the -- sorry, I beg your pardon.  
15 There it is there. 50 is the proper reference. The 14:51  
16 extract that we were focusing on is at the bottom of  
17 the page. Do you wish to go to that?

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

20 14:52

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

23

24 we would refer medical issues to a medical colleague.  
25 we wouldn't necessarily tackle them ourselves. 14:52

26 Mr. O'Brien's approach was a little different in that  
27 regard. So that's what I was getting at. Is there  
28 another page to that or not?

29 229 Q. Of course, yes, over the page.

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

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

25 230 Q. Is this a reference over the page? 14:54

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

27  
28 "The current investigation should be evenhanded and  
29 proportionate in manner."

1  
2 And I think that's the very least that any of us would  
3 expect, and I was getting a sense that -- my sense of  
4 this was that everything was being stacked up against  
5 one person at that point in time. Now, I was not in 14:54  
6 possession of all of the facts, and I admit that, but  
7 working in the Department, that was the sense that I  
8 had.

9 231 Q. Yes. I think just over the page, it continues that.

10  
11 "... the Minister had taken disproportionate view and  
12 this was prejudicial."

13  
14 A. Yeah. And perhaps I am not, as I told you earlier, I  
15 am not a scholar of English and maybe "prejudicial" 14:54  
16 wasn't the correct word, but I felt it was detrimental  
17 maybe as an alternative adjective.

18 232 Q. Yes. Looking at what Dr. Hughes was saying, and  
19 bearing in mind the facts that he was establishing, it  
20 perhaps seemed to him that Mr. O'Brien was in essence 14:55  
21 regarding himself as in charge of many matters, or  
22 capable of discharging many matters as this holistic  
23 physician, when in fact what in the view of Dr. Hughes  
24 was that Mr. O'Brien was silo working, he's not  
25 delegating, he's not using nurses, he's not taking on 14:55  
26 view the recommendations of the MDT, or reporting back  
27 to the MDT, those kinds of things. And in that context  
28 could you be surprised that he has taken the view that  
29 you appeared overly defensive of Mr. O'Brien, in light

1 of what he knew?

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

14 233 Q. Thank you. Now, we have heard from you already in  
15 relation to the meeting that took place in January 14:56  
16 2017, and you've said in your witness statement that it  
17 left you all feeling awkward and difficult because  
18 Mr. O'Brien was a colleague, you knew that there were  
19 real issues that needed to be addressed, but  
20 nevertheless it was an awkward situation. Is that 14:57  
21 fair?

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

23 234 Q. Yeah. And did you doubt the importance or the  
24 significance of the issues that were being revealed to  
25 you perhaps for the first time in terms of their 14:57  
26 extensiveness?

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

29 235 Q. Did it surprise you in terms of that is the description

1 of a colleague you had known for years?

2 A. Yeah, it did surprise me.

3 236 Q. You were with the Trust for a period of about five  
4 years at that point?

5 A. Yep.

14:58

6 237 Q. The description of what Mr. O'Brien was and wasn't  
7 doing was being revealed to you. You had, I suppose,  
8 something of further information because of your work  
9 on the SAI, albeit limited to the triage issue.

10 A. Yeah.

14:58

11 238 Q. In terms of the governance arrangements that should be  
12 capturing such shortcomings and dealing with them, had  
13 you, by 2017, observed any frailties or vulnerabilities  
14 in those arrangements that would have left you thinking  
15 "well, that doesn't really come as a surprise." It may 14:59  
16 come as a surprise that it's Mr. O'Brien, but given the  
17 state of the arrangements, one can quite see how a  
18 practitioner might get away with it for so long?

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

26

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

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

8 239 Q. And precise numbers are maybe not terribly important.  
9 But you didn't have a sense that your activity around  
10 that was, or indeed any of your colleague's activity 15:00  
11 around dictation of clinical encounters was being  
12 monitored?

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

26 240 Q. You would probably have appreciated as well that things  
27 like sign off were not particularly well monitored at  
28 that time?

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

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

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

15:01

A. Yeah.

15:02

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

A. She was carrying too big a workload.

15:02

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

15:03

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

15:03

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

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

3 A. I have a suspicious mind.

4 244 Q. Yes. (Laughs).

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

16 245 Q. And was the full story, as you surmised it might be, or  
17 were suspicious about, was it ultimately revealed to  
18 you in any better way than you have currently described  
19 it to us?

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

22 246 Q. And those concerns, just to be clear, were primarily  
23 triage and dictation.

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



- 1 247 Q. Could I ask you about the work that you undertook with  
2 colleagues as part of - and it's my phrase and if you  
3 can use a better phrase feel free - as part of this  
4 clean up. What was your focus in terms of activity?
- 5 A. So, my recollection is that Martina Corrigan obtained 15:05  
6 lists of clinics, and there was an exercise undertaken  
7 to check whether or not letters had been dictated from  
8 those clinics and actions undertaken, and where it was  
9 identified that they hadn't been done, those charts  
10 were then obtained and passed to us as consultants in 15:06  
11 bundles. So I participated in that activity I think in  
12 the later part of January 2017, perhaps February 2017,  
13 and I went through bundles of charts, returned them  
14 back to Martina, together with an outcome sheet as to  
15 what action I had taken, and there were various 15:06  
16 actions. So I might have requested scans for somebody,  
17 I might have indicated that that patient needs to come  
18 to clinic, et cetera.
- 19 248 Q. I think we might have an example, perhaps, of the work  
20 you did. WIT-292300. WIT-292300. Let's try TRU. I 15:06  
21 beg your pardon. Yes, so your handwriting?
- 22 A. It is.
- 23 249 Q. Yes. So it is 27th April. You've worked for, on the  
24 face of it, just under two hours on this. So each of  
25 those represents a chart that's handed to you to 15:07  
26 consider. Is that fair?
- 27 A. Yeah, I think so. I think that's how it was done.
- 28 250 Q. Yes. Yes. And obviously if you were seeing these  
29 patients in clinic you would be dictating an outcome

1 generally. Is that fair?

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

3 251 Q. Yes.

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

5 252 Q. Yes. 15:08

6 A. So the outcome sheet would be completed, that's

7 returned to the secretaries so that they know what

8 actions need to be taken.

9 253 Q. So you weren't expected to dictate on these patients,

10 is that fair? You were sending messages back in this 15:08

11 form?

12 A. So I was -- this was being returned to Martina, and the

13 actions were -- if you take the one at the bottom, the

14 patient has been seen by me on that date and

15 discharged. 15:08

16 254 Q. Right.

17 A. Where there was no -- the one above that, where there

18 is no urology entry in the chart, no urology entry on

19 Patient Centre, that patient clearly needed a review,

20 so that would have been organised. 15:08

21 255 Q. Yes. Dr. Chada describes this as an extensive review

22 exercise undertaken at significant cost, her words.

23 Perhaps you don't know about the cost, and I'll not ask

24 you to comment unless you do know.

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

26 256 Q. Yes.

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

28 257 Q. Yes.

29 A. Yeah.

- 1 258 Q. But in terms of its impact on the resources available  
2 within a small urology team, was it a significant  
3 exercise?
- 4 A. It was, and it wasn't deliverable during our normal  
5 working time, and that's why you can see that this was 15:09  
6 done in the evening.
- 7 259 Q. In terms of the thoroughness of the process. We can  
8 see that Mrs. Corrigan told the Oversight Committee - I  
9 don't need to bring it up on the screen unless  
10 necessary. It's TRU, for the Panel's reference, 15:09  
11 TRU-257708. As a group of consultants you were  
12 advising her and perhaps Mr. Carroll, that you would  
13 prefer to go with Mr. O'Brien's outcome, as it would be  
14 very difficult for you as consultants, never having  
15 seen the patient, to make a determination. But are 15:10  
16 happy, you're happy if anything comes from the  
17 administrative exercise to see the patient, if  
18 required. So, for some patients were you working of an  
19 outcomes sheet that might have been available from  
20 Mr. O'Brien? 15:10
- 21 A. No, I think it was perhaps more the case that if there  
22 was an entry in the chart, or if there happened to be a  
23 letter, then we were working from that.
- 24 260 Q. And in terms of what was found. We can see, for  
25 example, if we go to TRU-278933, your writing. Sorry, 15:10  
26 it may be further down the page. Scroll up again,  
27 sorry. Yes. Sorry. I had a note of you writing to  
28 Mr. Haynes. It's the other way round. So, early  
29 stages of the process of looking at Mr. O'Brien's work.

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

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

7 261 Q. Yes.

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

17 262 Q. Yes.

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

20 263 Q. Okay. So this is Mr. O'Brien communicating well that 15:12  
21 there were concerns around particular patients that  
22 needed to be seen with a degree of urgency?

23 A. Yes.

24 264 Q. I am obliged. Thank you. Mrs. Corrigan on 7th June  
25 2017, provides an update on the cleanup review. If you 15:12  
26 go to that? TRU-268814. And she is updating Siobhan  
27 Hynds and Ronan Carroll on the findings from the  
28 updated, sorry, the undictated clinics, and some  
29 standout figures. There are 110 patients being added

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

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

17 265 Q. And then the next paragraph 35:

18  
 19 "Patients needed to be added to theatre waiting lists."

20 15:14  
 21 They're all classed as Category 4 or routine. Again,  
 22 due to the backlog, they wouldn't get to be due to be  
 23 seen, but they're not on the waiting list, which is at  
 24 least an administrative problem?

25 A. Yes, it is. 15:15

26 266 Q. Just scrolling down. She explains that:

27  
 28 "There were three patients whom consultants have  
 29 concerns on and urgent appointments made. One has

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

3  
4 Did you have a sense, or what was your sense in terms  
5 of the cases that you were dealing with in terms of 15:15  
6 whether these were merely administrative difficulties  
7 in nature or whether alternatively some came with a  
8 degree of clinical seriousness or concern for patient  
9 safety?

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

11 267 Q. Very well. You have said, if we go to your witness  
12 statement, WIT-42329, at paragraph 60.1, that in terms  
13 of -- just scroll back and we'll see the question  
14 precisely. Just up a wee bit:

15 15:16  
16 "Did you consider that any concerns raised regarding  
17 Mr. O'Brien may have impacted on patient care and  
18 safety? And, if so..."

19  
20 - a series of questions, including:

21  
22 "In what way, may concerns have impacted on patient  
23 care and safety?"

24  
25 And you explain going down over to the next page that: 15:16

26  
27 "The impact was in patient care and safety terms  
28 relating to delayed time to assessment and treatment,  
29 the risk of failing to appropriately escalate routine

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

4  
5 That being your view, perhaps in light of the passage 15:17  
6 of time more appropriate to set it in those terms  
7 rather than any specifics, but were you left with a  
8 changed impression of Mr. O'Brien in terms of how he  
9 practised?

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

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

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

24 269 Q. But in terms of his safety as a practitioner in light  
25 of what was revealed in 2017 and what was to be 15:18  
26 discovered when reviewing the cases, was that the  
27 subject of conversation with your immediate colleagues  
28 in terms of we now have to be more cautious in terms  
29 of, for example, in terms of how we deal with

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

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

12 270 Q. Equally where you see shortcomings here, it might be  
13 suggestive of at least the need to look for  
14 shortcomings here?

15 A. Yeah. 15:20

16 271 Q. Dr. Boyce, when she came to give evidence, and  
17 reflecting about what we now know arising out of 2020  
18 SAIs and all of that, she says that she's left with an  
19 unanswered question as to why the MHPS process, the  
20 MHPS investigation, did not uncover any of the further 15:20  
21 patient safety concerns which subsequently came to  
22 light. Is that a fair question to pose?

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



1 that when this came to light a whole practice review  
2 should have taken place. Now that's easy to say in  
3 hindsight. My experience of dealing with trainees in  
4 difficulty is that that's really what you need to do.  
5 We're not talking here about a trainee, we're talking 15:21  
6 about a senior consultant. But, nonetheless, the  
7 senior management responsible for the person, in my  
8 view now, in hindsight, should have undertaken that  
9 kind of activity.

10 272 Q. You make a number of points in or around this area. 15:22  
11 You make a point, for example, if we can bring up your  
12 statement at WIT-42331 and paragraph 65.3, that:

13  
14 "From 2017 onwards medical managers were involved but  
15 communication to me from them was minimal." 15:22  
16

17 You say:

18  
19 "I don't recall a single meeting to discuss governance  
20 issues or patient safety concerns related to 15:22  
21 Mr. O'Brien or the Urology Department with any of the  
22 following post holders who held tenure in the period  
23 following the meeting in January 2017 up until June  
24 2020."

25 15:23  
26 And then you name medical directors, assistant medical  
27 directors, and scrolling over the page, clinical  
28 directors.  
29

1 Is that to suggest that looking back on, from a  
2 position of where we are now, that you consider that  
3 really the Trust and Senior Trust management on the  
4 professional side could have done a lot better by way  
5 of attempting to uncover all of the problems and 15:23  
6 support the urology team to assist Mr. O'Brien, or at  
7 least protect patients in a better way?

8 A. Yeah, I think it could have been done better. I'm not  
9 -- by naming these people I am not pointing the finger  
10 at them. They were the post holders, you know. There 15:23  
11 was little, in fact, minimal is the right word,  
12 communication back to us as a team as to what was  
13 happening. And I made the point to you earlier today,  
14 and if we didn't know what was happening how were we to  
15 look out for problems, and who were we to report them 15:24  
16 to when they came along? So, you know, I do think it's  
17 a failing.

18 273 Q. Well as you say, you've made that point that  
19 Mr. O'Brien's return to work was in a sense with a  
20 vacuum of information in terms of his relationship or 15:24  
21 management relationship with you, his colleagues.  
22 Would there have been value, and what would have been  
23 the value in advising you, his colleagues, of more  
24 precisely about what was going on, both in terms of his  
25 perceived shortcomings and what was being done to 15:24  
26 address them, or at least superintend them?

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

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

17 274 Q. I suppose potentially one of the difficulties here is  
18 that this case of Mr. O'Brien was shunted down the  
19 formal MHPS route, and if we look at that route which  
20 has layers of employment law around that, and 15:26  
21 contractual issues, and confidentiality and all of  
22 that, as compared with the route that as a team I  
23 suspect you chose in respect of Dr. or Mr. Suresh,  
24 where it was all round the table. Different issues of  
25 course. 15:26

26 A. Yeah.

27 275 Q. But is there something to be taken from that contrast?

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

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

15:27

6 276 Q. Just finally before we move on to a new topic, if we  
 7 can go to WIT- the next page, in fact. You're asked,  
 8 having had the opportunity to reflect:

9  
 10 "Do you have an explanation as to what went wrong  
 11 within Urology Services and why?"

15:27

12  
 13 And I suppose the -- I think it's a series of strands  
 14 to your thinking, and there is a failure to deliver  
 15 timely care set against a failure to monitor the  
 16 performance of individual consultant's activity.  
 17 workload pressures obviously predominate. Keeping your  
 18 head above water, balancing the competing interests in  
 19 an inadequately resourced department. Going down to  
 20 69.3, yeah -- no, that deals more specifically with the  
 21 Bicalutamide issue I think.

15:28

15:28

22  
 23 You say just before 69.3, and I take your answer as  
 24 this has to be viewed in the context of the capacity  
 25 issues, but behaviours of individuals, you say:

15:29

26  
 27 "...custom and practice went unchallenged with respect  
 28 to the timeliness of correspondence, triage, monitoring  
 29 of volumes of activity and chronological listing of

1 cases for theatre."

2  
3 So is part of your concern here in terms of what we  
4 learn from all of this is that, as I think we discussed  
5 on the last day, performance management, more focused 15:29  
6 performance management is key to getting at the  
7 problems at the earliest possible stage?

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

19  
20 I think, you know, timeliness of correspondence and 15:30  
21 completing triage in a timely manner, all of that stuff  
22 should be formally agreed, it should be, you know,  
23 recorded in a job plan, and it should be recorded in a  
24 policy for the Trust.

25 277 Q. very well. would it be convenient to take a short 15:30  
26 break and then back...

27 CHAIR: A quarter to four then everyone.

28  
29 A SHORT ADJOURNMENT

THE HEARING RESUMED, AS FOLLOWS, AFTER A SHORT  
ADJOURNMENT

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

15:47

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

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

15:47

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

15:47

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

15:48

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

15:48

1  
2 And I think it ultimately leads to the surgery having  
3 to be pulled.  
4

5 Another example of a pre-op issue. If we go to the 15:49  
6 case of Patient 90, I think you're familiar with that  
7 case and we've touched upon it in other contexts I  
8 think before now, but briefly, that was a case where  
9 the patient died following surgery, didn't have an  
10 appropriate preoperative assessment in the context of 15:49  
11 significant co-morbidities, and in the context of a  
12 need, albeit unrecognised by the surgeon, Mr. O'Brien,  
13 and the anaesthetist it would appear, for an  
14 echocardiogram that had been written up and indicated  
15 some couple of years, at least 18 months prior to that. 15:49  
16

17 So, again, by way of example. If we go to the  
18 recommendations arising out of that Serious Adverse  
19 Incident Review. TRU-161146. Scrolling down. So  
20 Recommendation 2: 15:50  
21

22 "All patients undergoing elective surgery must have a  
23 formal preoperative assessment completed prior to  
24 surgery, including liaison with other specialities to  
25 ensure maximum optimisation of patients prior to 15:50  
26 procedure."  
27

28 And you can see the rest of that recommendation.  
29

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

15:51

6  
7 Again, the setting is one of complex co-morbidities,  
8 but it's clear that he didn't have a preoperative  
9 assessment and didn't have a midstream urinary  
10 microbiology output prior to surgery, or at least the  
11 results hadn't come back prior to surgery, I think  
12 that's the correct sequence.

15:51

13  
14 So, again, WIT-33320. Recommendation 2:

15:51

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

15:52

24  
25 So different settings, different cases, different  
26 clinical issues. Common denominator was a failure to  
27 provide for or to conduct preoperative assessment.

15:52

28  
29 The Inquiry is interested in this issue generally from



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

7 A. Yes.

8 278 Q. To the best of your knowledge has the situation  
 9 improved in governance terms since any of the cases  
 10 that I've touched on here? 15:53

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

22 279 Q. Yes. Well, I was going to ask to what extent are you  
 23 aware of a culture where risk taking is tolerated?  
 24 Clearly it might be suggested that the cases that I've,  
 25 the examples I've referred to shouldn't have proceeded? 15:54

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

28 280 Q. 91, yeah?

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

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

12  
13 when we joined to use the regional facility at Lagan  
14 valley, their Trust had a different standard, and that  
15 raised concerns for us because we had had this very 15:55  
16 recent experience of this patient, and we were doing  
17 MSUs, they were dipstick testing urine, so they were  
18 doing a bedside test and accepting the result of that  
19 to go ahead. That left us very uneasy because we  
20 didn't feel that that was secure enough, and we've 15:55  
21 insisted that our patients would have an MSU.

22  
23 So there are different standards being applied in  
24 different Trusts in Northern Ireland with respect to  
25 this. Our standard is as a consequence of learning 15:55  
26 from this episode.

27 281 Q. Yes. I think - I didn't read it out loud, so my memory  
28 may be weak on this, but I think it was Patient 90's  
29 recommendation that there would be audit of compliance

- 1 with pre-assessment regimes. Is it your understanding  
2 that this is an area that is the subject of audit?
- 3 A. I do not know.
- 4 282 Q. Again, getting to the nuts and bolts of it, say  
5 hypothetical example, that you or a colleague have 15:56  
6 listed a patient for theatre, and the date for  
7 operation is fast approaching and you have not  
8 conducted a preoperative assessment, or the team  
9 responsible for that hasn't. Who is responsible for  
10 arresting the process into theatre and preventing it 15:57  
11 from taking place?
- 12 A. Yes. So the way that that works at present is that the  
13 preoperative assessment team nurses would communicate  
14 directly with the consultant responsible for the list.  
15 My recollection is that in my case, my secretary would 15:57  
16 be copied into that correspondence, and they would say  
17 in that note "This patient hasn't completed X, we  
18 therefore think they should be waiting list suspended",  
19 and from my perspective I would agree with that, you  
20 know. There's a safety reason to do it. You know, I 15:57  
21 take their point on board. The patient is suspended on  
22 the waiting list, offered another date when the  
23 particular investigation has been completed.
- 24 283 Q. Is there an override button where you decide "well, you  
25 know, that's all well and good, but I feel we should 15:58  
26 get on with it. This patient is in need and I think  
27 it's a risk worth taking", how is that debated out?
- 28 A. I suppose the MSU is a relatively straightforward  
29 thing, okay.

1 284 Q. Yeah.

2 A. And that's kind of black and white and there's no  
3 debate. We deal with a very comorbid population of  
4 patients. So not all of them have their preoperative  
5 assessment with a nurse, some of them have a consultant 15:58  
6 led preoperative assessment by an anaesthetist, and the  
7 purpose of that for those patients is to get a very  
8 clear handle on their comorbidity and what the expected  
9 complication rates would be, mortality, predicated  
10 mortality rates. So that's all documented very 15:59  
11 thoroughly in a clinical letter by the consultant  
12 anaesthetist, and that would then be a two-way  
13 conversation between the consultant anaesthetist from  
14 the pre-op clinic and the operating surgeon. So that  
15 happens a lot. And as you can imagine, there are times 15:59  
16 when between you, the anaesthetist and the patient, you  
17 have to come to an agreement as to what you're going to  
18 do, because not every patient is optimally fit.

19 285 Q. Can I move to remaining item two on my agenda, and  
20 we've touched upon it sporadically throughout your 15:59  
21 evidence, and that's sign off and actioning of  
22 diagnostic results or diagnostic tests.

23  
24 Again, let me start with a number of examples. There  
25 was a never event in 2011, before your time, retention 16:00  
26 of a swab in the cavity, which was the subject of the  
27 procedure. Subsequent to the procedure, scans seemed  
28 to show a presence of a foreign body, and it would  
29 appear that Mr. O'Brien didn't look at the scan report

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

13  
14 You, as we saw this morning, had custody of Patient  
15 128, or you had carriage of Patient 128, SAI review, 16:02  
16 which in part, for reasons of a want of a handover  
17 procedure, was a situation again where in 2014 there  
18 was a failure to deal with the results, again in a  
19 timely fashion.

20 16:02  
21 2016, if we go to TRU-277936, and this may well have  
22 been -- scroll down, please. This is being issued by  
23 Heather Trouton, Assistant Director within Acute  
24 Services. This may well be -- this is five months  
25 after your outcome in the Patient 128 SAI, so I don't 16:03  
26 know if there's a linkage there. But essentially  
27 following the outcome of several SAI she is saying:

28  
29 "We are writing to remind all consultants that it is

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

4  
5 And so we go on. There's examples, Patient 90, as we 16:03  
6 saw earlier. Patient 92 was a case of renal cell  
7 carcinoma, and there was a failure to attend at a CT  
8 scan, the reportage of a CT scan, until the GP spotted  
9 the problem.

10 16:04  
11 So a number of cases pointing to clinicians, including  
12 Mr. O'Brien, failing to action, to read and action  
13 investigation reports as soon as they might be  
14 available. What's your practice and has it changed  
15 over time? 16:04

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

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

16:05

6  
7 Secondly, ECR became available, pathology, radiology  
8 and the other laboratory speciality results were all  
9 available on ECR. So it's my practice daily to review  
10 results and to sign them off.

16:05

11  
12 In our department we've been doing that for a few  
13 years, and I mentioned earlier that there is a report  
14 regarding the radiology that is provided to us rag  
15 rating our timeliness.

16:06

16 286 Q. So in terms of the safety nets that are in place in  
17 your practice, you use your secretary as a  
18 communication tool, do you, when...

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

16:06

16:06

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

6 287 Q. Yes. And those safety nets are I suppose personal to  
7 your practice. DARO was a system, I suppose, supplied  
8 by the Trust and you use it.

9 A. Yes.

10 288 Q. When results or reports of results are generated, 16:07  
11 whether in pathology or on the film side as a result of  
12 CT scans or whatever, is there action at this date in  
13 time, is there action on their part to highlight  
14 unexpected results?

15 A. Ehm... 16:08

16 289 Q. Or maybe not unexpected but untoward results.

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

25 290 Q. Yes. I think we've heard word, or we are to hear word 16:08  
26 from Mr. O'Donoghue, I know what he will say on this,  
27 but there is a system, and I think you've alluded to it  
28 already, where if there is a backlog in terms of you  
29 processing electronic sign off, you will get your



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

3 A. Yeah.

4 291 Q. It is automated, in other words?

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

10 292 Q. Yes. 16:09

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

13 293 Q. We can point to cases, and we will hear from  
14 Mr. O'Brien in relation to his explanation for this,  
15 where he has delayed on actioning results. We know 16:09  
16 that he seemed to be philosophically opposed to using  
17 DARO, and as we understand it didn't use it. Was his  
18 approach to the actioning of investigation and results  
19 something known to you?

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

22 294 Q. No, of course not.

23 A. So, ehm...

24 295 Q. It's not -- don't worry, it's not a trick question.

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

1 dictation. So what I took from that was that he might  
2 have seen somebody in clinic, he might have organised  
3 investigations, and he wouldn't have dictated the  
4 clinic letter or the result of the investigations until  
5 everything returned to him. So that was his practice. 16:10  
6 It's certainly never been practice to do that, you  
7 know. If I have to do a few small extra letters to  
8 keep people apprised, that's what I'll do.

9 296 Q. It does raise the question that if there are outliers  
10 or people who depart from the expected norm, what is 16:11  
11 the governance arrangement doing about it? Are there  
12 governance arrangements, first of all? And, if so, why  
13 aren't they being applied?

14 A. I don't think there are robust governance arrangements  
15 around this issue. Nobody ever said to me "You've got 16:11  
16 to do these results within this timeframe or there's a  
17 consequence."

18 297 Q. Do you feel the situation is, if not perfect, it's much  
19 safer now?

20 A. Ehm... 16:11

21 298 Q. Or where are there residual gaps?

22 A. Okay. Because of this Inquiry there has been a focus  
23 on our department. Our department is perhaps behaving  
24 now in a manner which is different from other  
25 departments throughout the Trust. I would suspect that 16:12  
26 if you looked at a broader array of specialities, you  
27 may find that their house is less well in order than  
28 ours is now.

29 299 Q. In terms - and thank you for that. In terms of the

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

5 A. Yeah.

16:12

6 300 Q. Are there any residual gaps that you would be concerned  
7 about, where a practitioner who is less than  
8 enthusiastic about complying with this could still get  
9 away with it?

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

16:13

14  
15 The second thing is that I'm aware, I think it is from  
16 the evidence bundle, that surgical secretaries across  
17 the Trust were asked how their consultants dealt with  
18 correspondence, and you saw in that answer a plethora  
19 of answers as to how people manage the system. So  
20 clearly not everybody is doing the same thing. Now  
21 that may be a little bit historic, I can't put a date  
22 on that, but it's there in the evidence bundle. And  
23 there was a third thought that came to me. It's  
24 escaped, I'm sorry.

16:13

25 301 Q. Okay. Now, let me move to my third remaining issue,  
26 and that's the whole area of private patients and how  
27 they were managed by practitioners within Urology  
28 Services. If they had a private practice the question  
29 raised, at least in the MHPS investigation as regards

16:13

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

16:14

5  
6 If we go to TRU-274504, and bottom of the page, please.  
7 This is May '15. I needn't read all of this, but he  
8 says -- he's telling Mr. Young and Mrs. Corrigan that  
9 he's:

16:14

10  
11 "... feeling increasingly uncomfortable discussing the  
12 urgent waiting list problem while we turn a blind eye  
13 to a colleague listing patients for surgery out of date  
14 order, usually having been reviewed in a Saturday  
15 non-NHS clinic.

16:15

16  
17 On the attached total urgent waiting list there are 89  
18 patients listed for an urgent TURP the majority of whom  
19 will have catheters in situ. They have been waiting  
20 for up to 92 weeks."

16:15

21  
22 And then he gives an example of a patient who was seen  
23 in a private clinic on a Saturday, 18th April, and his  
24 admission is arranged for just over a month later.

25 "The immorality of this is astounding", he exclaims.

16:15

26  
27 If we then just scroll up the page, we have Mr. Young's  
28 response. He agrees with the sentiment, and he says he  
29 fully appreciates the questions raised and he feels the

1 need in November of that year to write again. So if we  
2 go to WIT-54106. And so six months further on -- he  
3 references an email on the 2nd June, and I'm not sure  
4 if that's a mistake, certainly we've looked at the May  
5 2015 email just now, and he says that he has:

16:16

6  
7 "...once again come across examples of this behaviour  
8 continuing."

9  
10 He says he has:

16:17

11  
12 "...expressed my view on many occasions, immoral and  
13 unacceptable."

14  
15 And I needn't go any further. Were you aware of  
16 Mr. Haynes' concern, or did you have your own concern  
17 about how Mr. O'Brien apparently was advantaging his  
18 private patients, or at least that's the allegation?

16:17

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

16:17

16:18

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

9 302 Q. Yes. Yes. I'll just come back to that process bit in  
10 a moment. 16:19

11 A. Yeah.

12 303 Q. You've said to Dr. Chada, just bring it up, TRU-00776,  
13 and paragraph 39. So you recount that you were asked  
14 about Mr. O'Brien's private patients and if any had  
15 been seen faster than is in keeping with waiting list 16:19  
16 times? And the way this is written, you advised that  
17 the question presumably, and that:

18  
19 "I have no evidence of this. However, with the  
20 lookback exercise it does appear that some patients 16:19  
21 have been seen sooner than anticipated given the  
22 Trust's waiting lists."  
23

24 A. Yeah.

25 304 Q. would you just help us understand what you're referring 16:20  
26 to there?

27 A. So that was in 2017, and we had been asked - you called  
28 it the "clean up", but lookback exercise is what I've  
29 termed it there.

1 305 Q. Yes.

2 A. We had been asked to review cases, and I was aware from

3 that process, I'm not sure if they were any of the

4 cases that I reviewed, maybe my colleagues, that they

5 felt that some of the patients who they had reviewed 16:20

6 the notes for, there was evidence, or there was a --

7 "evidence" perhaps is a strong word, because I've never

8 seen the evidence, but there was information that led

9 them to believe that those patients had been seen

10 initially privately and then subsequently in the NHS, 16:20

11 and I can't put it any more stronger than that, because

12 I've never seen the evidence to support it.

13 306 Q. Yes. Can I just put a few things in front of you and

14 if you can comment that would be helpful, if you can't

15 so be it. The MHPS process was triggered by a meeting 16:21

16 of the Oversight Committee, as it was called on the,

17 top of my head, 22nd December 2016. At its triggering,

18 in the sense of that meeting, there was no interest or

19 no expressed interest in private patient issue. That

20 came several days later then when Mr. Haynes intervened 16:21

21 and drew the Oversight Committee's attention to one or

22 other of the emails that I've just outlined to you. So

23 we also know that for the purposes of the investigation

24 conducted by Dr. Chada, Mr. Young, on the face of it,

25 prepared a report setting out the treatment of a number 16:21

26 of patients, I think it's nine off the top of my head,

27 who had been private patients but were then treated

28 within the Trust, all Mr. O'Brien's. So I want to ask

29 you this: When you got your instructions to do the

1 lookback, we've talked already about dictation cases  
 2 and triage cases, was it part of the work of you and  
 3 your colleagues to look out for cases that appeared to  
 4 have been advantaged by dint of their private origin?  
 5 A. Not that I recall. I don't recall being given that 16:22  
 6 instruction and I don't recall that being a feature  
 7 that we were to look out for.  
 8 307 Q. Yes. But it does appear to be your evidence, in the  
 9 light of what you've said there, that as part of that  
 10 lookback exercise, it did emerge from your... 16:22  
 11 A. Yeah.  
 12 308 Q. And you've added to it this afternoon, through your  
 13 colleague, and not necessarily through you?  
 14 A. Yeah, that's my recollection of it. I don't recall  
 15 finding evidence of this. 16:23  
 16 309 Q. Yea. And what you're also saying is that although  
 17 Mr. Haynes is raising these issues with Mr. Young by  
 18 email, you don't have any recollection of that issue  
 19 being taken out and put on the agenda to be discussed  
 20 with Mr. O'Brien as part of your weekly or monthly team 16:23  
 21 meetings?  
 22 A. I don't recall it ever being discussed at a team  
 23 meeting, a departmental meeting. Whether Mr. Haynes  
 24 and I had an informal discussion at some point, we may  
 25 have had. I don't recall it. 16:23  
 26 310 Q. And it's not something, self-evidently it's not  
 27 something you took up with Mr. O'Brien?  
 28 A. No.  
 29 311 Q. Just in terms of the process. Obviously you've a



- 1 private practice. You've told us that you've started a  
2 private practice about a year in to...
- 3 A. No, it was probably two to three years after I  
4 commenced as a consultant.
- 5 312 Q. Yes. And initially it was at least in part bringing 16:24  
6 private patients into Craigavon for convenience. Or  
7 Newry?
- 8 A. Yeah. So, yeah, there would have been the occasional  
9 TURP, straightforward things like circumcisions, but it  
10 was within about a year of that that, I think it was 16:24  
11 Dr. Simpson largely made the decision that the Trust  
12 wouldn't be delivering private care at all, so that  
13 meant that everything went elsewhere.
- 14 313 Q. Yes. There was in place, there remains in place a 16:24  
15 Trust transfer form. I think it's origin was in the  
16 first decade of the millennium, somewhere around  
17 2008/2009, at least in terms of the Department writing  
18 one up. We can look briefly at the 2016 version, which  
19 may or may not be the current iteration. It's  
20 TRU-267692. Help us with this. Are there 16:25  
21 circumstances in your current or recent practice where  
22 you would see the need to complete one of these forms?
- 23 A. Every time a patient wants to transfer from my private  
24 practice to the NHS, I complete one of these forms.  
25 The form is emailed to the Trust. It goes to the 16:25  
26 paying patient's office. I copy it to my secretary. I  
27 think in very recent times there has been another  
28 address that I've had to add to that, actually it's the  
29 referral and booking centre, and if the patient

1 happened to be a suspected cancer, I would copy in the  
2 red flag booking team.

3  
4 Now, this form has in the past few months been replaced  
5 with an on-line version, which is a lot more detailed 16:26  
6 and captures a lot more governance type information,  
7 and has been met with a lot of resistance from my  
8 colleagues because of the amount of time that it takes  
9 to complete.

10 314 Q. Very well. So to what extent, and maybe this is an 16:26  
11 unknowable, but to what extent do you think the process  
12 that goes with moving a private patient into the NHS is  
13 well understood by your colleagues, and enforced by the  
14 powers that be?

15 A. So I can't answer their understanding. Some of my 16:26  
16 colleagues don't do any private practice, so I would  
17 suggest they probably have little or no understanding  
18 of this. The enforcement, again I don't know. All I  
19 can tell you is that I adhere to this process.

20 315 Q. Okay. If you're complying you're not going to get a 16:27  
21 knock on the door.

22 A. Yeah.

23 316 Q. Yeah. Now, just finally, this is the final point. 16:27  
24 Mr. O'Brien retired reluctantly in July 2020, his plan  
25 having been to retire and to return on a part-time  
26 locum basis, as I understand it, or perhaps there is  
27 some contractual expectation on his part. In any  
28 event, the short form is he intended to retire and  
29 return?

1 A. Less than full-time, yeah.

2 317 Q. Yes. He was told by a combination of Mr. Haynes and  
3 Mr. Carroll in the early days of June 2020 that that  
4 would not be possible, and in explaining how he had  
5 reached this view or how this decision had been 16:28  
6 reached, Mr. Haynes explained to the Inquiry that he  
7 had sought the views of colleagues, including his  
8 consultant colleagues, as to - I used the word  
9 "wisdom", he may have used other words in relation to  
10 Mr. O'Brien coming back. Is that an area or a subject 16:28  
11 that was discussed with you, whether through Mr. Haynes  
12 or through anyone else?

13 A. So it was only discussed with Mr. Haynes. Perhaps the  
14 way I would describe it is a sounding out, and he  
15 informally sought my view. I didn't have any 16:29  
16 managerial responsibility. I made that very clear. I  
17 wasn't going to be a decision-maker in that process,  
18 and he sought my opinion as to what I thought.

19 318 Q. Yes. And that was at what time, can you recall?

20 A. I think it would have been the spring of 2020. 16:29

21 319 Q. And what view did you express to him?

22 A. Well clearly by that time a lot of what we now know had  
23 transpired, and I had concerns that if Mr. O'Brien  
24 returned to work that he would continue to practise in  
25 the way that he had been practising, and I felt that 16:29  
26 that for us as a team was going to be a risk going  
27 forward, and my blunt view was that it would be better  
28 if he didn't come back to work because we would then  
29 have, you know, a clean slate, and we could move

forward.

MR. WOLFE: Okay. Thank you for that. And thank you for your evidence over the past two and a half, three days, and I'll leave you to the Panel's questions.

CHAIR: Unfortunately, Mr. Glackin, we can't release you just yet. There's some questions from each of us. So, first of all Mr. Hanbury will have some questions for you.

16:30

QUESTIONED BY MR. HANBURY

16:30

MR. HANBURY: Thanks very much for your evidence. I'm just going to bounce around a bit, mainly clinical things, so hopefully not too taxing.

16:30

A couple of things on MDT. First of all the quoracy. When sitting up MDTs/MDMs it is quite difficult, and often you have to go around the availabilities of people who are not always available. You had particular problems with the radiology and the oncology, especially -- did you or did any of your colleagues ask Dr. Williams or the radiologists whether there were better sessions that they could do and be prepared to maybe be flexible in terms of scheduling?

16:31

A. I don't recall that ever being discussed, changing the date, for a couple of reasons. Everybody else's timetable matched up. The regional urology meeting also took place at the same time in Belfast, and that allowed us as a team to be sure that we could link in

16:31

- 1 with the specialist MDTs that took place. So I don't  
2 recall it ever being proposed in our own department  
3 that we would change from Thursday afternoon.
- 4 320 Q. Okay. Thank you. Just moving onto the adrenal case,  
5 the one that should have had a referral and didn't. 16:31  
6 I'm just trying to get under the skin of that a bit.  
7 Was there -- I mean obviously the patient was discussed  
8 and usually there was a results clinic or arrangement  
9 that you or the responsible urologist would see the  
10 patient within a couple of weeks. I mean why was that 16:32  
11 not proposed in that situation, to explain to the  
12 patient?
- 13 A. I'm not sure. You know your expectation after the MDM  
14 would be that the consultants would review all of the  
15 outcomes and see -- and organise to see all the 16:32  
16 patients that needed to be seen. So I'm not sure why  
17 that didn't happen.
- 18 321 Q. But the outcome there was just a referral letter to the  
19 endocrinologist.
- 20 A. Yeah. 16:32
- 21 322 Q. Which is slightly unusual. I mean we see, as  
22 urologists we see a lot of adrenal lesions, I guess.
- 23 A. Yeah.
- 24 323 Q. And just on a broader subject, do you have an adrenal  
25 MDM with the endocrinologists? 16:32
- 26 A. Yeah.
- 27 324 Q. How do you deal with that?
- 28 A. There is a specialist endocrine surgery based in the  
29 Belfast Trust, and there is an endocrine MDT in the

1 Belfast Trust. So those patients are referred to that  
 2 surgeon for discussion at the specialist MDT. Well, it  
 3 may not be termed specialist MDT, it is endocrine MDT  
 4 in Belfast Trust.

5 325 Q. And that was where?

16:33

6 A. That's where the patient was sent to.

7 326 Q. They were referred.

8 A. Yes.

9 327 Q. And is the expectation they'll have their biochemical  
 10 investigations done upfront by you?

16:33

11 A. So often in parallel we will involve the local  
 12 endocrinologist in our own Trust to do the biochemical  
 13 workup, but nonetheless they would be referred to  
 14 Dr. Eatock who is specialist endocrine surgery.

15 328 Q. Okay. Thank you. So moving on to urologist of the  
 16 week, sort of interested in sort of work practices  
 17 there. I think it was Mr. O'Donoghue who said that you  
 18 regularly did a one in seven, but he seemed -- and  
 19 recruitment has obviously been a problem with varying  
 20 numbers. Is that the case - maybe I should ask him -  
 21 but if there were say six of you in town, would you not  
 22 do a prospective cover?

16:33

23 A. So we're funded for one in seven, and on that basis we  
 24 run a one in seven rota, but what that means is when  
 25 we're short of staff that we have to run what we call  
 26 locum weeks, and that means one or more of us stepping  
 27 out of our elective activity to cover that week. So  
 28 that, if you like, there may be two blank weeks in the  
 29 seven week span, and between us we have to cross cover

16:34

- 1           those.
- 2   329   Q.    So that means actually you lose more elective activity  
3           because of that?
- 4           A.    Exactly. Exactly.
- 5   330   Q.    Which obviously -- and is there cross-filling of           16:34  
6           operating lists in that scenario?
- 7           A.    So as you know, we don't have enough operating lists.  
8           So there's always a willing party to take your  
9           operating list.
- 10  331   Q.    Okay. Thank you. A lot of comments about how busy           16:34  
11          urologists of the week are, and obviously there are  
12          different models which are used all over England and  
13          Northern Ireland. I was interested that despite that  
14          you saw the elective cases on the ward as well?
- 15          A.    Yeah.   16:35
- 16  332   Q.    Might it have been reasonable to say maybe drop those  
17          and just do the emergencies?
- 18          A.    So there are variances of opinion as to how we should  
19          do that, and one of the reasons that we have persisted  
20          with a single urologist of the week looking after the           16:35  
21          post-operative elective cases plus the emergency cases,  
22          is that not everybody is on site everyday. So there  
23          are times, for instance, when I may not be on the  
24          Craigavon site for three, four, or five days at a time,  
25          and in that circumstance I cannot see my post-operative           16:35  
26          patients. So it wasn't felt to be safe to leave things  
27          to the vagaries of the SPR unsupervised, particularly  
28          when some of the SPRs are quite junior.
- 29  333   Q.    So is that a particular feature of your work balance?

- 1 A. Yeah. Yeah.
- 2 334 Q. Average lists. On the same line, and maybe you've  
3 partly answered this already, I was interested that the  
4 -- on your job plans -- the urologist of the week just  
5 went on from 9:00 to 5:00. But it's true, is it, that 16:36  
6 you always did the nights on-call seven nights in a  
7 row, is that right?
- 8 A. So we haven't always done seven nights in a row. There  
9 was a period when Mark Haynes and I shared our weeks,  
10 week nights. So, for instance, if I started on the 16:36  
11 Thursday, I would have done Thursday, Friday, Saturday,  
12 Sunday. He would have done Monday and Tuesday, I would  
13 have had a break, and I would have done Wednesday to  
14 finish the week, and the reciprocal is true then on his  
15 week. So we did that to try and give ourselves a bit 16:36  
16 of a break, that you weren't on seven nights in a row.  
17 Unfortunately we've drifted back to seven nights in a  
18 row, largely because, the same reason, we don't all  
19 work on the same site. As I'm sure you're aware,  
20 Mr. Haynes is employed for part of the week by the 16:36  
21 Belfast Trust, and for other reasons he hasn't been  
22 able to deliver that, so it has slipped back.
- 23 335 Q. But if you did a day each like a rota, that might be a  
24 good deal less onerous?
- 25 A. Yeah, it might be, but then there's the continuity 16:37  
26 issue and, you know, the other thing is, it is not that  
27 frequent that we're in late night, and after midnight  
28 is a rarity. So, you know, swings and roundabouts.
- 29 336 Q. It works for you. Okay. Just one last thing on the



1 urologist of the week. Weekend ward rounds, you  
2 commented once that there was variable takeup. Any  
3 comment on that?

4 A. Yeah. I mean I can't really account for what my  
5 consultant colleagues do at the weekend. I come in on 16:37  
6 a Saturday morning invariably and go round with the  
7 registrar. Depending on the experience of that  
8 registrar I may or may not come in on a Sunday morning.  
9 We have a person who is working with us at the moment  
10 who is post FRCS, he is about to become a consultant, 16:38  
11 he's very capable of doing a ward round.

12 337 Q. So, adaptable. Just one question on waiting lists.  
13 With your attachments you produced, I think it was from  
14 back in 2013, so obviously ten years ago, where I think  
15 you were sent an Excel spreadsheet of all the patients 16:38  
16 waiting to come in, all the way from endoscopy, day  
17 surgery, with the varying consultants, all the lists of  
18 various urgency. I mean that is a huge thing, and I  
19 presume you'd have to look at that every -- I mean your  
20 -- that's quite an unusual thing. Has that changed now 16:38  
21 completely?

22 A. What's unusual?

23 338 Q. Being sent 800 patients a week to look at on an Excel  
24 spreadsheet to chose your patients, which is what you  
25 said you do? 16:38

26 A. So I sought access to business objects so that I could  
27 understand how many people were on the waiting list,  
28 and that allows me to download the entirety of the  
29 waiting lists, both planned and elective. Then that,

1 you know, I've got very adept at filtering it and  
2 working out what's what on the waiting list. I am  
3 probably the only person in our department who does  
4 that. The others will rely on their secretary or  
5 somebody else to provide them with their waiting lists, 16:39  
6 their individual waiting lists. But I find it a  
7 helpful exercise because, particularly as a team when  
8 we're trying to deliver timely cancer care, I can pick  
9 out from the entire waiting list where cancer patients  
10 haven't been offered a date, and when you've had a lot 16:39  
11 of locums coming through the Department things get  
12 missed if you don't do that. So it means that I can  
13 colour code everything on the list and easily pick out  
14 who needs to be called and arrange a date for them. So  
15 I find that useful. 16:39

16 339 Q. You've clearly got good IT skills. I mean not all  
17 urologists would have. I mean is there not an argument  
18 to have someone, an expert in waiting list management  
19 to help?

20 A. So we've employed a scheduler in the last few months. 16:40  
21 This is something we've been agitating for for a long  
22 time, and it will be the role of the scheduler to do  
23 exactly what I've described. That person will need  
24 some support and training, and I'm more than happy to  
25 help and provide that, and I've met with the scheduler 16:40  
26 in the past two weeks to sketch that out.

27 340 Q. Okay. Thank you. So that's moving. Okay. I've just  
28 got a few questions on the subject of small renal  
29 masses and partial nephrectomy particularly.

- 1 A. Yeah.
- 2 341 Q. You have a laparoscopic interest, so you do  
3 laparoscopic partials as well as radical --
- 4 A. So I did in the past. There was -- I mentioned earlier  
5 that there was a period in Belfast where one of their 16:40  
6 surgeons left and went on sabbatical, and that  
7 sabbatical lasted five years. That person was the main  
8 person providing partial nephrectomy service. In  
9 keeping with IOG, as you know, those services should be  
10 centralised to a specialist unit. But when that person 16:41  
11 left, we were then in the position where there was  
12 nobody in Belfast to provide that service. Mark Haynes  
13 and I are both trained in that procedure, as was  
14 another surgery in Altnagelvin, so it meant that those  
15 patients had to have that surgery in those units during 16:41  
16 that period of time.
- 17
- 18 More recently, one of our trainees finished training  
19 and he went and did a fellowship in renal surgery at  
20 the Royal Free, and when he returned and was appointed 16:41  
21 in Belfast, all that work has returned to Belfast, in  
22 keeping with guidance.
- 23 342 Q. Thank you. When did your colleague go on a five year  
24 sabbatical?
- 25 A. I'm not quite sure of the dates. 16:41
- 26 343 Q. It is just interesting --
- 27 A. It would have been the mid 2015 type period.
- 28 344 Q. Right. So he or she was there pre-2015?
- 29 A. Yes. They're a similar vintage to me and they would

1 have been a consultant in Belfast for perhaps two to  
2 three years before they went on sabbatical.

3 345 Q. Right. So the only thing I've picked up on was the  
4 peer review team picked up around about 2015 that the  
5 centralization wasn't happening? 16:42

6 A. Yeah, and that's the explanation.

7 346 Q. And NICAN sort of hadn't agreed, and I just wanted your  
8 comments about that?

9 A. Yeah, that's the explanation.

10 347 Q. It was a personnel problem? 16:42

11 A. That person left the employment of Belfast Trust on a  
12 sabbatical.

13 348 Q. Okay. So currently no partial nephrectomies are  
14 happening in Craigavon anymore?

15 A. They all go to Belfast. They are discussed at what's 16:42  
16 known as the small renal mass meeting. It's a kind of  
17 a side-shoot of the specialist MDT in Belfast.

18 349 Q. And they offer ablation treatment as well?

19 A. They offer ablation, they offer surgery robotically  
20 now, and if they feel that the patient needs radical 16:42  
21 nephrectomy rather than a partial, they come back to  
22 me.

23 350 Q. Okay. So you're now effectively compliant with the  
24 original IOG?

25 A. I suppose we are. 16:43

26 351 Q. But it has taken a while to get there.

27 A. The only other fly in the ointment, Mr. Hanbury, is the  
28 fact that Belfast Trust does not have capacity to  
29 deliver these things in a timely manner, and the number

- 1 of patients for several years have been going to the  
2 Mater Private in Dublin, funded by the Health Service  
3 here.
- 4 352 Q. Okay. Done by specialists?
- 5 A. My colleagues in Dublin are excellent. I'm not going 16:43  
6 to say otherwise!
- 7 353 Q. I suppose the last thing. We saw Mr. Suresh yesterday  
8 and there was the question about -- and obviously this  
9 was 2016, and you've explained why things have changed,  
10 and that's good. I mean modern urology, people 16:43  
11 specialised in endourology or open surgery, and it is  
12 quite common for people to be on-call and not have open  
13 nephrectomy skills. I mean it seemed as though there  
14 was some awkwardness there, and if you're doing partial  
15 nephrectomies did you have backup, I guess, is my 16:44  
16 question really?
- 17 A. Yeah. So, at the time that we were delivering partial  
18 nephrectomies in Craigavon, both Mark Haynes and I had  
19 the skills to do that. We also had the support of  
20 Mr. O'Brien and Mr. Young, both experienced consultants 16:44  
21 with a long experience of doing open complex urology.  
22 So, that being said, we recognised that there were  
23 difficulties with us delivering that service in  
24 Craigavon, and one of the key difficulties that we all  
25 had concern about was the absence of 24/7 16:44  
26 interventional radiology on the Craigavon site. That's  
27 fixed now because they go to the Belfast Trust and they  
28 have a 24/7 service.
- 29 354 Q. Okay. But when Mr. Suresh got into that difficulty, I

1 mean there was presumably an arrangement between the  
2 nephrectomy competent colleagues of yours to cover that  
3 --

4 A. Yes. There was a second tier on-call.

5 MR. HANBURY: Okay. Thank you very much.

16:45

6 CHAIR: Dr. Swart. Thank you.

7  
8 QUESTIONED BY DR. SWART

9  
10 DR. SWART: So you've had a lot of detailed questions  
11 about things that have happened. I'm quite interested  
12 in your observation of what you actually thought of the  
13 medical management and leadership structure at the  
14 time, if we talk to '16/'17 this was all a big issue.  
15 How well did that work? How well did it not work? Do  
16 you have any thoughts as to what the problems were  
17 there in terms of how it interacted with you as a  
18 practicing clinician or any other thoughts, because you  
19 haven't had a formal medical management role, and  
20 you've referred to that a few times? So what do you  
21 think about it all?

16:45

16:45

16:45

22 A. So, Mr. McNaboe approached me on the corridor one day,  
23 and he had recently been elevated to AMD, and he said  
24 to me "Do you want to be CD of Urology?" It was a  
25 short conversation.

16:46

26 355 Q. Yes.

27 A. No, thank you.

28 356 Q. why?

29 A. Because I don't feel that the people who are taking up

1           those roles are adequately supported and resourced to  
2           deliver them, and you'd be set up to fail.

3   357   Q.   Do you think that's the main problem, that they don't  
4           have the time, the expertise, the training, the support  
5           to do it, or is there something else behind this? I   16:46  
6           mean you talk about back channel communication. We've  
7           heard it from other people about various things:  
8           hierarchy, silos, secrecy, fear, mistrust. These are  
9           not good words, and nobody in these roles would set out  
10          to be like that, I'm quite sure. So what do you think   16:46  
11         the problem was? And while you're answering that, have  
12         there been attempts to improve on it, do you think, or  
13         how does it feel from a practising clinician point of  
14         view?

15         A.   I don't think the people who are asked to take on those   16:46  
16         roles are provided with adequate training and support.  
17         I don't think they have enough time in their week to  
18         deliver that workload. It's not really something that  
19         I have ever aspired to be.

20   358   Q.   I can see that.   16:47  
21         A.   Yeah.

22   359   Q.   You must have a feeling that it's not working well, or  
23           that it's not rewarded well enough, or it's not worth  
24           it, in terms of the value you can add. If you don't  
25           know...   16:47  
26         A.   I don't have anything further to add on that.

27   360   Q.   So when you met at the beginning of January 2017 as a  
28           team, and you were told about the exclusion of Aidan  
29           O'Brien, and you describe the shock you had at that

1 meeting, and I can well understand that. What were you  
2 told as a team about who you could talk to about it and  
3 where you could get support with the Department and so  
4 on? Who dealt with that with you?

5 A. Nobody.

16:48

6 361 Q. Who do you think should have, apart from you wanted a  
7 senior medical presence there, which I understand, but  
8 you know, who did you regard as your first medical  
9 manager go-to person for something like this? Because  
10 this is a huge deal for a department.

16:48

11 A. Yes, I agree. I think the first port of call should  
12 have been the CD.

13 362 Q. So did you feel you could go to your CD?

14 A. No, the CD was in the middle of the issue, and that  
15 wasn't offered? It wasn't. Neither were any other  
16 support services within the Trust offered. I've had a  
17 subsequent experience, not a pleasant experience, where  
18 I was sign posted by Dr. O'Kane, as it happened, to  
19 psychology. It was an unrelated thing to what's going  
20 on in this Inquiry. And that was useful, probably  
21 would have been useful back in 2017. But there wasn't  
22 any support put in place for us as a team.

16:48

23 363 Q. Did you feel you could talk to the other members of the  
24 team about it or did you feel it was all totally  
25 secret?

16:49

26 A. We would have had chats informally amongst ourselves as  
27 to how we were going to organise things and get on with  
28 sorting things out. There wasn't really any safe space  
29 created for us to vent, because I think some of us



- 1           probably needed to vent.
- 2   364   Q.   As it went through, I mean this unfolded and, as you  
3           know, it all took a very long time to sort out. Did  
4           anybody update you as a team? Did they bring you back  
5           together and say "This is what's happening now", or did 16:49  
6           they bring you together with Aidan O'Brien in any way?
- 7           A.   No.
- 8   365   Q.   No. Did you feel you could go and talk to him about  
9           it?
- 10          A.   No, I felt that was very difficult. The period of 2017 16:49  
11          was extremely difficult, and perhaps a few years later  
12          he would have come to me to talk about clinical matters  
13          and he would have sought my opinion about cases. But,  
14          again, I felt there was a really big barrier to us  
15          discussing other things. 16:50
- 16   366   Q.   Related is the issue of, you start to look at his, the  
17          list of patients and you find all this problem with  
18          dictation. That wasn't -- you tell Martina Corrigan.  
19          Why didn't you go to your clinical director about that  
20          or maybe even the medical director? I mean it is a big 16:50  
21          basic duty of a doctor, isn't it? Did that not occur  
22          to you, or did you think that Martina would deal with  
23          it? What was in your head?
- 24          A.   So what's in my head was that they were basically  
25          absent, the clinical managers. We had no day-to-day 16:50  
26          contact with them whatsoever. So I had no inkling that  
27          they were even there to be spoken to.
- 28   367   Q.   So they didn't seek you out regularly to say "So,  
29          urology, how are you doing? What are your strategic

1 plans for the future? Shall we have a planning  
2 session?" They didn't do things like that with you?

3 A. Never.

4 368 Q. Right. So on the subject of serious incidents. This  
5 is something where I think often medical management and 16:51  
6 operational management and clinical governance sort of  
7 get quite well. How clear was that whole structure to  
8 you before you started doing these investigations, and  
9 even when you were doing it, were you clear who was  
10 overseeing it? Were you clear what the role of the 16:51  
11 Board was? Did you know exactly what was going to  
12 happen when the report was issued?

13 A. I had no clarity at the beginning. I read the document  
14 that the Trust had created for how to conduct the  
15 process, and that is the limit of my understanding when 16:51  
16 I began them.

17 369 Q. Just last small thing. We heard from Mr. Suresh about  
18 antibiotic audits, and there was a table produced which  
19 on the face of it seemed to indicate that I think the  
20 pharmacy must have done an audit and the indications 16:52  
21 for the treatment weren't clear, and the antibiotics  
22 weren't the right one, roughly. Did somebody -- did  
23 you have an ongoing conversation with microbiology  
24 about this? He wasn't quite sure where it was  
25 discussed. Did someone come to you and explain why 16:52  
26 they had made those judgments? Did you have anything  
27 like that?

28 A. So my recollection of those graphs being provided was  
29 that that information was collected by a ward based

1 pharmacist on review of in-patient drug Kardexes.

2 370 Q. okay.

3 A. And as you can see from the graphs, there were very few  
4 numbers of patients included in the sample. So,  
5 therefore, you know, you might have two patients under 16:53  
6 your care and if one of them doesn't meet you're 50% in  
7 the wrong. Now, subsequently that information would  
8 have come to the patient safety meeting in a slightly  
9 different format. But I think at that time the whole  
10 antibiotic stewardship thing was just getting off the 16:53  
11 ground and this was an attempt by the pharmacy  
12 department to improve day-to-day prescribing on the  
13 wards.

14 371 Q. Has the Trust made -- I mean you will have had a lot of  
15 attention on urology as a result of this Inquiry, and I 16:53  
16 am sure that's been extraordinarily difficult. Has the  
17 Trust changed anything fundamentally in terms of  
18 medical management generally or anything else that has  
19 really hit you as this indicates a new approach?

20 A. I don't think so, really. 16:53

21 DR. SWART: That's all from me.

22

23 QUESTIONED BY THE CHAIR

24

25 CHAIR: Thank you, Dr. Swart. I've several questions, 16:54  
26 some of which I had written down and I think it is more  
27 for clarification for me, rather than anything.

28

29 One of your comments was about team meetings, that they

1           weren't achieving anything, people didn't turn up. why  
2           did you not give up?

3           A.    Right. So Mr. Young was the lead clinician and he was  
4           the person Chairing most of the meetings, and I have a  
5           great regard for Mr. Young. I also thought it was 16:54  
6           important that we continued this activity. I felt it  
7           was necessary for the good running of the Department.  
8           So, invariably, if I was at work on a Thursday, I'd go  
9           to the meeting.

10   372   Q.    And given that you did feel that they were important, 16:54  
11           I'm just wondering then did you do anything to  
12           encourage the others to attend?

13           A.    Yeah. "why aren't you here?", by phone, by text, in  
14           person.

15   373   Q.    And what kind of response did you get? 16:55  
16           A.    "I'm doing this", or "I'm doing that", or "I'm off site  
17           today."

18   374   Q.    So it was really that they were busy doing other things  
19           rather than going to these important meetings, or do  
20           you think there was a lack of enthusiasm? 16:55  
21           A.    I suppose you can ask them, but from my perspective I  
22           think they chose to do other activity. They  
23           prioritised other activity.

24   375   Q.    Okay. I get the impression from the totality of your  
25           evidence that, well, you did actually say that there 16:55  
26           wasn't a collegiate way of working. Has that improved?

27           A.    Yes, I think it has, and I think in particular at the  
28           MDT it has improved, but I think it's also improved  
29           within the consultant body, the junior doctor body, and

1 the nurse specialists that we work with. I think the  
2 atmosphere in the Department is better than it was  
3 before. So, I think we're in a better place as a team  
4 now than we were two years ago.

5 376 Q. And if you had to say why that was, I mean obviously 16:56  
6 this Inquiry being set up, all of the attendant SAIs  
7 and everything, I'm sure, as Dr. Swart has said, was  
8 very traumatic for the team. Is that sort of out of  
9 adversity comes improvement, or what would you say?

10 A. I think, you know, many of the things that have been 16:56  
11 identified correctly by others, to give them their  
12 credit, Dr. Hughes, others, we've taken that on board  
13 and we've implemented the changes and we realise, as a  
14 team, that we're in a safer, better environment than we  
15 were before. So that gives us all a sense of 16:56  
16 achievement in terms of we've turned things around.  
17 But also we realise that we're all in it together,  
18 we're all pulling in the same direction. And I think  
19 that's what has allowed us to move on.

20 377 Q. Just coming back to the SAIs, you were involved in some 16:57  
21 yourself, and one of the things that has been discussed  
22 when we have been discussing SAIs in the Inquiry, was  
23 whether or not it is appropriate to have external teams  
24 to come in. They're obviously a time intensive  
25 procedure. I'm just curious to know what your own view 16:57  
26 is, having been involved in them yourself?

27 A. So I don't think you necessarily need people from  
28 outside the Trust. I think that if the Trust staffed  
29 SAIs with people who had adequate time in their job

1 plan to deliver that, then it could be delivered from  
2 within the Trust. But if the Trust hasn't got that  
3 resource, or cannot develop that resource, then they  
4 may well have to go outside the Trust.

5 378 Q. And one of the things that Mr. Suresh talked about 16:57  
6 yesterday, and I think he had emailed you and you said  
7 "bring this up at the meeting", was about having a  
8 stent registry, and he said that he recalls it being  
9 discussed and you recall that there was a lack of  
10 consensus about stent removal. Can you explain a bit 16:58  
11 more about why that was?

12 A. Yeah. To be quite straight about it, everybody was  
13 doing their own thing. There was no system within the  
14 Trust that the Trust had supplied or recommended that  
15 we should be using. So each person was keeping their 16:58  
16 own record, however that was done, whether that was  
17 paper based, electronic, or whatever, and applying  
18 their own standard to management of that. That has  
19 changed more recently, but it is still regrettably  
20 always going to be an issue in urology. We had a 16:58  
21 patient safety meeting yesterday and this same issue  
22 came up.

23 379 Q. Just checking my notes here, if you bear with me. I  
24 mean following on from that, you're talking about  
25 differences in practice. Do you think that that was, 16:59  
26 that that has changed much? I mean you're saying the  
27 stent issue maybe less so, but I'm just wondering, as a  
28 result of all of this do you feel now that people are  
29 looking, are more open to listening to other people's

1 viewpoint, if I can put it that way, about what is best  
2 for patients?

3 A. I think most of us in what we do every day try to do  
4 the best for the patients in front of us, I think  
5 that's why we're in the job. But as a consultant, 16:59  
6 you're trained to think independently and to manage all  
7 of the information that comes your way and to make, you  
8 know, a rational balanced decision on care for a  
9 patient, together with the patient. So there will  
10 always be differences in style and differences in 16:59  
11 opinion. But I think if you're talking about do we all  
12 try to adhere to preoperative assessment and things  
13 like that, yeah, I think we do.

14 380 Q. Well I'm thinking more of the movement towards, I mean  
15 certainly in cancer care the movement has really been 17:00  
16 towards multi-disciplinary practice rather than  
17 individual practice, and I'm wondering is there now  
18 more of that across the in board in the Department or  
19 not?

20 A. I don't quite share the view that was expressed by 17:00  
21 Dr. Hughes that it is a team who is responsible for the  
22 patient. That's not true. That doesn't fly in  
23 reality. There's a named consultant. So whilst we all  
24 participate in the meeting for the benefit of the  
25 patients, there is somebody's name over the bed, there 17:00  
26 is somebody's name over the clinic, you take  
27 responsibility. So I think we work together to ensure  
28 that that's as safe for the patients as it can be, but  
29 at the end of the day the patient is meeting with an

1 individual consultant and they will have that  
 2 discussion on a one-to-one basis.

3 381 Q. Just say, for example, there's a patient who you're not  
 4 quite certain as to how you might treat this patient.

5 A. Yes. 17:01

6 382 Q. Do I take it you pick up the phone and you speak to  
 7 somebody?

8 A. It's entirely appropriate to bring that to an MDT type  
 9 scenario. It is just a pity on the benign side there  
 10 really isn't that kind of forum, because those patients 17:01  
 11 can be just as difficult to manage as the cancer  
 12 patients, and in many respects will are fewer  
 13 guidelines for those patients that there are for the  
 14 cancer patients.

15 383 Q. But I'm just wondering, are those the kind of cases 17:01  
 16 that you might discuss at the departmental meeting, for  
 17 example, or is that not really --

18 A. The departmental meeting, no, it wouldn't be  
 19 appropriate for that agenda, but it would be something  
 20 that we could certainly discuss as consultants, and I 17:01  
 21 would not infrequently refer patients, for instance, to  
 22 Mr. O'Donoghue, who has an interest in functional  
 23 urology, and has expertise, and I would seek his  
 24 opinion. I have referred several patients to a  
 25 colleague in Altnagelvin who has a similar interest, 17:02  
 26 for neurological conditions, for SNS. So, you know,  
 27 there's no difficulty in referring and seeking expert  
 28 opinion for patients.

29 384 Q. So I suppose the corollary of that is that you



described Mr. O'Brien holding on to his patients. Was he the only one to do that or was that a common practice in the past that has now changed?

A. We grew up in a different era, a different training. I think many urologists who were trained in a previous era would have delivered the entirety of urology in their practice, and that has changed over time. The sub-specialisation that Mr. Hanbury referred to has become increasingly common, but there are downsides to that too.

17:02

17:02

385 Q. If -- what you have described, you described the meeting where you discussed triage and you thought that that had been recorded, but we certainly have not seen a transcript of that meeting. But it was clear that Mr. O'Brien, from what you've told us, had no intention of changing his working practices. Is that your view?

17:03

A. Mr. O'Brien was very difficult to dissuade from his position on many issues, and that would have been an experience that I think many of us would have observed. If you were going to argue the toss with Mr. O'Brien about something, he would be well fit to have that discussion with you for a long period of time.

17:03

386 Q. And is that part of what Mr. Haynes described as a challenge to challenge then?

A. That's the way Mr. Haynes termed it, but I would recognise that aspect of his personality.

17:03

387 Q. So recognising that aspect of his personality, would it be fair then to say that if someone has challenged him and had to be well fit to get a lengthy discussion

1           about the issue, that after a while they might just  
2           give up?

3           A.    You might be exhausted by it.

4   388   Q.    Just checking.  Yes.  The 2015 figures that we saw I  
5           think earlier today about the 48% of the clinical nurse 17:04  
6           specialists, I just wondered, urology being so much  
7           less having so many fewer clinical nurse specialists or  
8           key workers assigned to their patients, I just wondered  
9           what did the Department do when that figure was  
10          presented to them to seek to improve the situation? 17:04

11          A.    I don't know in 2015 because I wasn't --

12   389   Q.    You weren't --

13          A.    I wasn't a clinical lead at that point in time.  So I  
14          can't answer.

15   390   Q.    Do you remember any discussion at the departmental 17:04  
16          meeting about it?

17          A.    I think there was a very clear understanding in our  
18          department around that time, and before, that we  
19          couldn't deliver what was expected of us with two  
20          clinical nurse specialists. 17:05

21   391   Q.    Okay.  Coming back to the clinical nurse specialist,  
22          and you talked about after the telephone call from  
23          Dr. Hughes and before you met with Dr. Hughes, you  
24          informally sounded out Kate O'Neill and Leanne McCourt  
25          to see what their experience was, and I wonder just 17:05  
26          what the tone of that was, that conversation from them?

27          A.    So, as you heard, I gave evidence earlier today about  
28          my sensitivity to the fact that we were all going to be  
29          asked difficult questions, not only by Dr. Hughes but

1           also by this Inquiry, and I went into the meeting not  
2           trying to provoke a response from anybody, but just  
3           trying to understand what their experienced had been.  
4           So the questions I asked them were quite open. I  
5           wasn't trying to narrow it down to any particular 17:06  
6           person's practice. And I just wanted to get a sense of  
7           where they were and what their experience had been,  
8           because I was taken aback when Dr. Hughes told me over  
9           the phone that all nine of those patients had not had a  
10          CNS involved in their care. That was quite -- I was 17:06  
11          alarmed, and I wanted to...  
12   392   Q.    You wanted to try to get to the bottom of it, was it?  
13          A.    I just wanted to know what had been happening.  
14   393   Q.    And what was the tenor of their conversation with you?  
15          A.    I think we were all in quite a fragile state at that 17:06  
16          point in time. I think we were all quite upset. I  
17          think we were - I suppose anger was a natural enough  
18          response from us at that time too. We were coming to  
19          terms with what was unfolding. So, you know, Leanne  
20          relayed the story of how she had spoken to Mr. O'Brien 17:07  
21          in the kitchen, and I didn't want to push them into  
22          saying things that they weren't going to volunteer,  
23          because I knew that they'd have to be giving their  
24          version of events anyway.  
25   394   Q.    Well the conversation that she, or what she related to 17:07  
26          you about that conversation in the kitchen, what  
27          impression were you left with?  
28          A.    My impression of the way that she relayed it was, first  
29          of all I couldn't understand why he didn't, why there

1 was any issue about the key worker, because this had  
2 been a feature of MDT working for a long, long time.  
3 It was part of the operational policy. He had drafted  
4 the operational policy that we were working to at that  
5 time. I don't see why it would have been - to me it 17:07  
6 shouldn't have even been anything that would have  
7 required any conversation or questioning. So I was  
8 kind of taken aback that she had received that  
9 response.

10 395 Q. She has told this Inquiry that despite what was 17:08  
11 recorded in the minutes of the meeting with the MDT,  
12 and what was -- or, sorry, with the nurses, I should  
13 say -- and what she put in her statement to this  
14 Inquiry, she said that "Oh, it was Mr. O'Brien joking  
15 with her." Is that the imposition she gave you? 17:08

16 A. No, that's not the way it came across to me, and I  
17 didn't probe her at the time about that, and I think I  
18 was upset about what was going on. It was quite clear  
19 to me that Leanne and Kate were upset about what was  
20 going on, and I didn't want to add to their degree of 17:08  
21 upset, but it didn't come to me across as a joke.

22 396 Q. Thank you. Just one other thing about, I mean there  
23 has been talk about the contrast of the support that  
24 was put in place for Mr. Suresh compared to how  
25 Mr. O'Brien did not receive similar type of support. I 17:09  
26 suppose one of the -- would you say that one of the  
27 main issues for that was because of the MHPS process  
28 and the whole issue of confidentiality around that and  
29 not really understanding in the team just what the

1 issues were?

2 A. I don't, I don't see any reason why support couldn't  
3 have been provided to Mr. O'Brien in parallel to the  
4 MHPS process happening. Now, I'm not by any means an  
5 expert in MHPS, I have never participated in the 17:09  
6 process, but I have read in preparation for this  
7 documents relating to it. So I see no reason why the  
8 Trusts couldn't have put supports in place. I also  
9 think that the kind of shrouded approach that was  
10 adopted didn't serve us well. 17:10

11 397 Q. And, finally, just one other thing. Did Mr. O'Brien  
12 ever ask you, or to your knowledge, any of your  
13 colleagues for help? Did he ever say to you -- apart  
14 from these meetings where he said it is impossible to  
15 do this as urologist of the week, for example, in 17:10  
16 relation to triage, did he ever say "Look, can any of  
17 you help me here?"

18 A. He never expressed those, that kind of request to me.  
19 Did I sit at times thinking how is he? How is he  
20 coping? Yes, it did cross my mind. I regret that I 17:10  
21 didn't have that conversation.

22 CHAIR: Okay. Thank you. That's been really helpful,  
23 Mr. Glackin, and I am pleased to say that we have  
24 concluded your evidence, so you're free to go. Unless  
25 there's anything further, Mr. Wolfe? 17:11

26 MR. WOLFE: Not from me.  
27  
28  
29

1 CHAIR: No. Okay. Thank you very much. Ladies and  
2 gentlemen then I think we're back on - I have forgotten  
3 the date, but Tuesday the week after next.

4  
5 THE INQUIRY WAS ADJOURNED TO TUESDAY, 31ST OCTOBER 2023 17:11  
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