



Oral Hearing

Day 72 – Thursday, 16th November 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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CHAIR: Good morning, everyone. Mr. Wolfe.

ROGER KIRBY, HAVING PREVIOUSLY BEEN SWORN, CONTINUED TO
BE EXAMINED BY MR. WOLFE KC:

MR. WOLFE KC: Good morning, Prof. Kirby. You are hearing us loud and clear?

A. Loud and clear.

1 Q. Perfect.

Speaking to Mr. Boyle, senior counsel instructed by Tughans, who you will know well, he tells me you have both a hard copy of the bundle and a computer by your side so that you can navigate to the document pages that I'm going to refer to you. When I bring a page up here, I will also give you a reference for your bundle so that you can find it, whether in the hard copy or electronically.

This morning we're going to look at some of the themes of concern that emerged from the nine Serious Adverse Incident reviews that you examined. I'm conscious that you told us yesterday when you looked at those nine SAIs and you wrote your reports, you were seeking to try to get an understanding of how Mr. O'Brien was working and, as it appears from your reports, very few criticisms of his approach. Generally, your finding is his approach was, you use a phrase "not inappropriate" or "not unreasonable by the standards of a reasonable

1 competent doctor or clinician".

2
3 when you wrote your reports, you probably would have
4 been unaware of a broader context. What I mean by that
5 is that in more recent times, the Inquiry will have 10:03
6 introduced you to a lot of background material which
7 showed that Mr. O'Brien and his clinical practice and
8 his relationship with the Trust, his employer, was in
9 some degrees of difficulty going back a number of
10 years. Did you pick up on that from your reading? 10:03

11 A. I did. Yes, I did.

12 2 Q. Before we descend into some of the finer detail of the
13 themes, did you reach, if you like, a general
14 conclusion or overview of the man, the clinician, that
15 you were, I suppose, writing about in your medical 10:04
16 reports?

17 A. Well, yes, I did. With the benefit of all the extra
18 information, it was clear that Mr. O'Brien has never
19 been what you could describe as a "mainstream"
20 urologist. He has an unusual approach to urology in 10:04
21 some ways, "idiosyncratic" might be a better word to
22 describe that. Also I was able, having read nearly
23 2,000 pages of evidence over a period of time, he was
24 working in an extremely difficult situation. You know,
25 I think he's one of -- I described to you when we spoke 10:05
26 a few days ago that he's a slightly old-fashioned
27 urologist, of the ilk of some of my own teachers way
28 back when, very famous urologists who were also
29 somewhat idiosyncratic in their approach. Very

1 distinguished in their own way but they like to do
2 things in their own way, and perhaps not as
3 collaborative with their colleagues, and certainly not
4 with managers as perhaps nowadays is expected.

10:05

6 In addition to that, I would say that obviously urology
7 in Northern Ireland is under tremendous pressure. The
8 waiting list is expanding and you could go right back
9 to the years of austerity, George Osborne and David
10 Cameron - our new foreign secretary (reestablished) -
11 have lead to increasing pressures on the health
12 service, especially in Northern Ireland perhaps, where
13 you have a large number of quite small hospitals
14 serving a population. There are arguments for
15 rationalisation of the whole set-up there.

10:06

10:06

16
17 Plus, I think, more specifically to Aidan O'Brien's
18 position, the absence of colleagues specialising in
19 oncology, radiology and pathology in the MDT meetings
20 made some of the decisions he made more difficult. It
21 would have been very helpful to have had that extra
22 expertise. When managing some of these elderly, frail,
23 highly symptomatic patients, they are not easy to
24 manage and there isn't one way that is clear that they
25 should be managed.

10:06

10:07

26
27 I would add in one extra point about MDTs. The
28 disadvantage I always found about MDTs -- and they were
29 established in Aidan's practice in 2010, I think -- the

1 problem with them is they don't have any input from the
 2 patient or from the patient's family. So an MDT can
 3 say, well, listen, I think this patient should be
 4 treated with hormones and radiotherapy, but you might
 5 say that to the clinician then who carries the 10:07
 6 responsibility, legal responsibility, for the
 7 management of that case, who might say to the patient,
 8 "This is what the MDT recommends and that means going
 9 into Belfast every day for six weeks to have -- every
 10 weekday for six weeks to get your treatment", and the 10:07
 11 patient says, "I don't want to do that. That's not
 12 what I want and that's not what my family want".

13
 14 So I don't think that MDT recommendations should be
 15 regarded as mandatory. They are -- 10:08

16 3 Q. Sorry to cut across you, Prof. Kirby, we'll come to
 17 that as a theme in a moment. What I want to perhaps
 18 focus on, and I'm not sure you intend it entirely as
 19 a criticism, but when you describe Mr. O'Brien as
 20 idiosyncratic and likening him to your old respected 10:08
 21 teachers growing up in the profession, how did you see
 22 that reflected in the practices that you read about?

23 A. I think that obviously one of the key points is the use
 24 of Bicalutamide or Casodex as a hormonal therapy, that
 25 is a little bit idiosyncratic but I think justifiable; 10:08
 26 it does have activity in prostate cancer. I think you
 27 can see that ideally a urologist should have a good
 28 relationship with a radiotherapist because quite a lot
 29 of these patients need shared care, partly urology to

1 deal with the surgical aspects, and radiotherapy,
2 especially in prostate cancer, which is one of my
3 special interests. So, a good collaborative
4 arrangement with a radiotherapist in the MDT so the
5 patient can be passed seamlessly from one to the other 10:09
6 would have been a good advantage. Obviously, that
7 wasn't happening in Aidan's case.

8
9 I would say that then, you know, increasingly we're
10 using oncology, medical oncology, as in one of the 10:09
11 cases that we looked at, the patient with the seminoma.
12 So, you would ideally like a medical oncologist, a
13 radiation oncologist in that MDT so there can be a sort
14 of seamless passing of patient from one specialty to
15 the other, rather than -- 10:10

16 4 Q. Sticking -- sorry, Prof. Kirby -- with what you
17 described as idiosyncrasy. One is his Bicalutamide
18 use, and we'll look at that in some detail this
19 morning. You described it as "justifiable" so we'll
20 look at why it is justifiable. 10:10

21 A. Yes.

22 5 Q. You point out that he was perhaps shorn of good
23 relationships within the MDT, which are important for,
24 if you like, building the quality of the response for
25 the patient. What about nursing; did you pick up on 10:10
26 that?

27 A. Yes, I did. In an ideal situation, you would like not
28 only a relationship with the clinicians I've already
29 mentioned, of the specialities I mentioned, but also

1 a good relationship with the senior nurse
 2 practitioners, the nurse specialists, who can be very
 3 helpful in the ongoing management of patients with
 4 cancer particularly, and with stones. I think
 5 Mr. O'Brien obviously preferred to work, you know, more 10:11
 6 in isolation than perhaps was ideal and he didn't
 7 employ the help of the specialist nurses quite as well
 8 as he might have done. I think it would have helped
 9 the patients. It would have helped him, actually.

10 6 Q. It is no doubt very difficult, to coin a phrase, to 10:11
 11 teach an old dog new tricks, if that's the sense of
 12 what you're communicating --

13 A. Yes.

14 7 Q. -- about him in terms of the use of the word
 15 "idiosyncratic". Is there a responsibility on the part 10:11
 16 of clinicians to move with the times to try to embrace
 17 new practices and new ways of doing things?

18 A. I think, yes, ideally that's what should happen. I
 19 think the key relationship in urological surgery is the
 20 consultant surgeon and the patient. I think that there 10:12
 21 is a sort of tryst between the patient and the
 22 urologist. When things go wrong, it is the urologist
 23 that gets criticised. I think over the passage of time
 24 we've seen more and more people deployed into the team
 25 who facilitate - the nurses, the radiologists, the 10:12
 26 radiotherapists, medical oncologists, etcetera - but
 27 the key relationship is that urologist with the
 28 patient. Some more senior urologists have been
 29 understandably reluctant to let go of their own special

1 management of the patient; they feel uneasy about
2 delegating their care to nurses who may have a slightly
3 different view. You know, there's a sense of wanting
4 to keep the patient to yourself because you're the one
5 who carries the can, really. So I do understand where 10:13
6 Aidan is coming from, but I don't think it helped his
7 practice.

8 8 Q. Yes. I mean that sense that you've picked up on of
9 keeping ownership of the patient, would you regard
10 that, certainly in 21st Century urological medicine, as 10:13
11 a bit of a blind spot?

12 A. It probably is, yes. I think what we've seen is the
13 development of all sorts of individual specialties
14 within urology - stones, cancer. I mean, in my case
15 I only looked at prostate cancer patients in the last 10:14
16 five/10 years in my practice. You do need the
17 assistance of other people because you no longer have
18 the necessary knowledge. You can understand why some
19 people feel reluctant to delegate or to hand over the
20 ownership of the patient. I think that's what happened 10:14
21 in Aidan's case.

22 9 Q. Yes. You will also have picked up on the conflict
23 between him and his employer, which is, I suppose,
24 manifested in a number of processes, including the MHPS
25 investigation from 2017. I think we briefed you with 10:14
26 Dr. Chada's report, and you may have seen his response
27 to that?

28 A. Yes.

29 10 Q. You yourself were a medical director in the private

1 facility we briefly mentioned yesterday obviously
2 Mr. O'Brien was working in a public district general
3 hospital. Have you anything to offer us in terms of
4 your experience of dealing with matters, perhaps of
5 clinicians in difficulty or problems with clinicians,
6 wearing your medical director's hat? 10:15

7 A. Yes. Well, we had about 26 employees in the prostate
8 centre, so nothing like the number of employees in
9 a district general hospital. I was Medical Director.
10 Yes, we did have some disagreements there but, you 10:15
11 know, the personal relationships between all of us that
12 worked there, of all the different disciplines required
13 to treat patients with prostate cancer predominantly
14 but also benign enlargement of the prostate, yes,
15 I have experience of that and I can see that 10:16
16 Mr. O'Brien did get into conflict with the management
17 of the Trust. I think a lot of his energies were
18 devoted to those sort of struggles with them and
19 probably that was, you know, of emotional detriment to
20 him and possibly affected the way that he managed his 10:16
21 practice.

22 11 Q. We'll come this afternoon perhaps to look at, for
23 example, triage and some of those other issues. We'll
24 maybe ask you to expand on your thoughts at that point.

25
26 Let's spend some time now looking at the whole concept
27 of multidisciplinary working and the principles and
28 practices that you think are apt to apply to that
29 approach to medicine. You've said already Mr. O'Brien 10:17

1 was something of an individualist, liked to own his
2 cases, but it should be put in the balance that he was
3 an active participant in the multidisciplinary urology
4 meeting at the Southern Trust. He was its long-time
5 chairperson until the chairing role began to be
6 rotated.

10:17

7
8 Let's perhaps start. If I can ask you to find within
9 your bundle page 1389, and if we can have up on the
10 screen here WIT-84532. What you should find,
11 Prof. Kirby, at 1389 is the urology cancer MDT
12 operational policy.

10:18

13 A. Yes.

14 12 Q. Okay. It's the policy that, if you like, governed the
15 operations of that MDT. That's the covering page.

10:18

16
17 If we can scroll through it to the third page in the
18 document; 1392 for you, 84535 for us. You can see that
19 the purpose of the MDT is there set out. Just perhaps
20 familiarise yourself with that. It probably provides
21 some uncontroversial descriptors of what an MDT
22 generally is directed towards. There's a list of
23 bullet points at the bottom of the page.

10:19

24 A. Yes.

25 13 Q. You can probably see within that that the emphasis is
26 very much towards the team, towards multidisciplinary
27 discussion and decision-making with multidisciplinary
28 input. You'll be familiar with those principles. You
29 had an MDT within your NHS sector practice as well as

10:19

1 your private sector practice; is that right?

2 A. Yes, at St George's. Yes, MDTs were established about
3 2010, towards the end of the Tony Blair era of
4 government where he encouraged that. They also
5 introduced a number of targets, which were slightly 10:20
6 resented by some of the profession; not everyone agreed
7 with the MDT. I think they have been very successful,
8 but they do depend on the interpersonal relations of
9 the people in the MDT, which is a lot easier to control
10 in a private set-up in the prostate centre where you 10:20
11 can choose who you work with, who is included and who
12 isn't included. In an NHS system, people are
13 parachuted in there.

14
15 I think in Northern Ireland it is especially difficult 10:20
16 because there are so many different units that people
17 have to travel from one to another to get together.
18 Back in the days where some of these cases that we're
19 looking at, you know, we didn't have Zoom. Things have
20 been a whole lot easier since COVID and the development 10:21
21 of virtual MDTs. In 2018/2019 they weren't possible,
22 they all had to be in person.

23 14 Q. If we just look to the top of that page. I'm trying to
24 get, I suppose, the essence of the purpose of an MDT.
25 It says that the primary aim of the MDT is to ensure 10:21
26 equal access to diagnosis and treatment for all
27 patients in the agreed catchment area. It goes on to
28 say:

1 "We aim to provide a high standard of care for all
 2 patients, efficient and accurate diagnosis, treatment,
 3 and ensuring continuity of care. It ensures a" -- I
 4 think this is important, perhaps -- "a formal mechanism
 5 for multidisciplinary input into treatment, planning 10:22
 6 and ongoing management and care of patients".

7
 8 It is very much focused, is it not, on bringing experts
 9 together who are from different fields? You mentioned
 10 oncology, medical and clinical; obviously the 10:22
 11 diagnostic people, the urologists themselves and the
 12 nurses. In terms of the role of the MDT, it's to look
 13 after the patient throughout the process, isn't it, the
 14 process of treatment?

15 A. Well, that would be ideal but the reality is that most 10:23
 16 MDTs are deployed at the initiation of treatment
 17 because most cases are brought to the MDT at time of
 18 diagnosis. The ongoing treatment, because you have so
 19 many patients who have ongoing treatment and whose
 20 treatment will vary according to the progression of 10:23
 21 their disease, that, you know, the MDT would be
 22 absolutely overloaded with cases if it tried to -- in
 23 an ideal world, that's what you'd like, you want every
 24 patient to be monitored at every phase of their
 25 treatment. The reality is that MDTs focus on the 10:23
 26 initial diagnosis and the initial management, the
 27 decision between using radiotherapy or surgery, for
 28 example in prostate cancer; do you remove the prostate
 29 or do you irradiate the prostate or do you give

1 chemotherapy to the patient, etcetera, etcetera,
 2 etcetera. Once that decision is made, then the patient
 3 tends to go down that route without necessarily being
 4 referred to the MDT, unless a specific problem arises.
 5 If a specific problem arises and there's debate about 10:24
 6 the right thing to do, then they will be brought back.
 7 But you just couldn't manage. You couldn't have any
 8 one time -- even at the Prostate Centre, which is not
 9 as busy as NHS clinics, we'd have thousands of patients
 10 undergoing ongoing management at any one time; you 10:24
 11 couldn't possibly bring them all back.

12 15 Q. I suppose this provides a more specific definition of
 13 the circumstances in which a case should come back. If
 14 you go to 1395 in your bundle and we'll go to
 15 WIT-84538. It's asking the question -- if we just 10:25
 16 scroll down towards the middle of the page. It's the
 17 middle of the page for you, Prof. Kirby, roughly.

18 A. Right.

19 16 Q. "All new cases of urological cancer and those following
 20 urological biopsy will be discussed. Patients with 10:25
 21 disease progression or treatment-related complications
 22 will also be discussed and a treatment plan agreed.
 23 Patient's holistic needs will be taken into account as
 24 part of the multidisciplinary discussion."

25
 26 I needn't read on. It is identifying, I suppose, two
 27 broad areas where the patient should come back or the
 28 case should come back to MDM - if there's disease
 29 progression or if there are treatment-related

1 complications. Is that the norm, in your experience?

2 A. Yes, although it wouldn't include every patient.

3 I think you have to use your common sense in this
4 respect. You know, there's a spectrum of cancers, some
5 of which are more serious and life-threatening than 10:26

6 others. Bladder cancer is a good example of tiny
7 little papillary tumours within the bladder which can
8 be removed safely without any other treatment. You
9 might see that patient again several times with more
10 little tumours being there but you wouldn't necessarily 10:26

11 need to discuss those. But, I mean, a good example of
12 a patient coming back to the MDT would be a patient who
13 had his prostate removed, the PSA remains undetectable
14 for a number of years and suddenly it spikes up and
15 those patients then usually go on to a course of 10:26
16 secondary radiotherapy to the prostate bed, that would
17 be the standard, with hormone manipulation as well. So
18 that patient would be brought back to the MDT.

19
20 Take another example, a patient with kidney cancer. 10:27

21 The kidney is removed, the patient seems to be doing
22 well for a number of years and suddenly, on the chest
23 Xray or CTs, you see a number of metastases appearing,
24 you would have to bring the patient back to the MDT
25 with a view to getting a medical oncologist involved 10:27
26 because now there are new treatments that can help
27 patients with recurrent kidney cancer, a situation that
28 wasn't the case only a few years ago. Now we have new
29 treatments coming on board.

17 Q. I see. Can I add another piece into the mix? It is the evidence of Dr. Hughes, who oversaw the nine SAIs that you were concerned to look at. He, in partnership with Hugh Gilbert, Mr. Hugh Gilbert -- Gilbert being the urologist, of course -- were responsible for the SAIs that you commented upon. Dr. Hughes, page 683 of your bundle, if we go to TRA-01060.

10:28

A. Yes, right. Getting there.

18 Q. Just at the bottom of the page. He's saying there is a requirement, if you don't implement an MDT recommendation, that you would bring it back to your colleagues and discuss it, and agree how that would be achieved. That's not terrible well expressed, but how treatment would be achieved, I suppose.

10:28

Do you agree with that, that if you leave the MDT with a recommendation under your arm, you review that with the patient and you discover something about the patient that might make the recommendation unimplementable or the patient disagrees with the MDT approach, that comes back to the MDT, does it?

10:28

A. well, in an ideal world. I think you have to remember that MDTs are already terribly busy. If minor fluctuations or variations on what the clinician decides to do with that particular patient and what the MDTs recommended, if you brought them all back, you'd just would be -- the whole system would be overloaded. I think if there's a major change, then it probably should be brought back, but I don't think it is

10:29

10:29

1 a necessary stipulation that happens in every case.

2 19 Q. Yes. I suppose if we approach the problem in this way:
3 The essence of the MDT is to get the multidisciplinary
4 input up and running?

5 A. Yes. 10:30

6 20 Q. And to have that, I suppose best-available quality care
7 from different perspectives, perhaps different
8 perspectives even within the domain of urology, even
9 leaving aside the other disciplines that come to the
10 meeting. That's why it's important to bring the case 10:30
11 back, isn't it?

12 A. Yes, I think I would agree with that. I imagine,
13 I don't know, but in my position as President of the
14 Royal Society of Medicine, I have to deal now with 55
15 different sections, 55 different specialities. There 10:31
16 are some specialities where there would be more debate
17 about individual cases; you know, where they would be
18 sometimes quite heated debates about what should be
19 done. I know this firsthand because I've just had my
20 knee operated on, and the orthopaedic surgeons fight 10:31
21 like billy-o whether somebody should have a partial
22 knee replacement or a total knee replacement. They are
23 at war with each other about this. So, you can imagine
24 an MDT of orthopaedic surgeons having a huge battle
25 about an individual case, which is the best way to do 10:31
26 it.

27

28 It isn't always entirely clear which is the best way to
29 manage a specific condition, and then you add in all

1 the added uncertainty of the patient and the patient's
2 family who says, well, the MDT is telling me I ought to
3 have this done but I don't want to have it done;
4 I don't want to travel, I don't like the idea of
5 chemotherapy, I'm too old. Many of these patients that 10:32
6 we looked at with Aidan where in their late 80s. It's
7 quite justifiable. In fact, Christopher Witty wrote in
8 the BMJ only a couple of weeks ago that we should be
9 looking at quality of a patient's life, not necessarily
10 their longevity. I think the drawback of an MDT is it 10:32
11 looks at how can we keep the patient alive for longer,
12 but it's a perfectly legitimate point of view of the
13 patient to say I don't want to be kept alive longer,
14 I've got a catheter in, I've got all these symptoms,
15 I'm in my late 80s, just leave me in peace and I don't 10:32
16 want -- I'm not going to have what the MDT is
17 recommended, I just don't want it.

18
19 That's not an uncommon scenario in urology where a lot
20 of our patients are elderly and quality of life, you 10:33
21 know, rather than length of life can be more important
22 to them.

23 21 Q. I want to look briefly at a couple of the cases that
24 you have helpfully scrutinised from the SAIs.
25 I wonder, in thinking about the cases again as we go 10:33
26 through them, whether you would recognise that there
27 was any omission to properly refer these cases back to
28 the MDM.

1 Let me start with Service User A or Patient 1. You'll
2 perhaps remember that case, it was perhaps alluded to
3 it earlier. This is a patient who wanted to travel,
4 wanted to go on holiday. That was, I suppose,
5 a factual feature of it according to Mr. O'Brien's
6 account of the case. 10:33

7 A. Yes.

8 22 Q. Now, just to orientate you -- you may be very happy in
9 your memory of the facts -- but if we go to your
10 page 4, and we'll going to page DOH-00004. 10:34

11
12 In essence, if I can summarise it in this way: This
13 was a prostate cancer case?

14 A. Yes.

15 23 Q. Intermediate, confined, Gleason 7. The recommendation 10:34
16 that came out of the monthly disciplinary meeting on
17 31st October was it's described there as
18 a recommendation for ADT and referral for external beam
19 radiation therapy?

20 A. Yes. 10:35

21 24 Q. Mr. O'Brien has explained that was ultimately difficult
22 to implement. He points to the fact this was a patient
23 who didn't want disturbed in terms of his health while
24 he went on holiday. Then, he felt the need to start
25 him on 50mg of Bicalutamide because the patient had run 10:35
26 into difficulty when on 150, the larger dose, some
27 months earlier. So, it is only by March 2020 that the
28 patient is put on to the higher dose of 150.

29 A. Yes.

1 25 Q. There has been no referral to oncology for EBRT. In
 2 the month of March, the patient runs into difficulty.
 3 There is an increased PSA and there is urinary
 4 retention requiring catheterisation.

5 A. Yes.

10:36

6 26 Q. That is the kind of case classically, is it not, that
 7 should go back to the MDT for either/or both of those
 8 reasons. Either because Mr. O'Brien couldn't implement
 9 the MDT recommendation and/or the patient's disease had
 10 clearly progressed?

10:37

11 A. Yes, not only his disease had progressed but his
 12 symptoms. Memorably, his holiday was in Lake Garda, if
 13 I remember the case, an extremely nice place and so you
 14 can remember why he didn't want to start treatment that
 15 would have interrupted that, having paid for it all and
 16 looking forward to it.

10:37

17
 18 Secondly, the urinary symptoms is a big, big problem
 19 with elderly patients with prostate disease. Ideally
 20 you would want them to have the chance of cure with
 21 a six-week course of radiotherapy. Radiotherapy makes
 22 urinary symptoms worse. The radiotherapists, at least
 23 the radiotherapists that I work with in London,
 24 excellent radiotherapists and wonderful people, they
 25 really do not like treating patients who already have
 26 persisting severe urinary symptoms as the radiotherapy
 27 makes it worse. If the patient does, as in this case,
 28 develop retention of urine and requiring coming in as
 29 an emergency and having a catheter in, then the

10:37

10:38

1 radiotherapist thinks oh my goodness, I'm going to be
 2 blamed for this. They're going to think it is the
 3 radiotherapy rather than the prostate disease causing
 4 the retention. In our case, we used to operate to
 5 relieve the obstruction before they'd even consider the 10:38
 6 radiotherapy. So, I think even if Mr. O'Brien had
 7 referred this patient to Belfast for radiotherapy, the
 8 radiotherapist probably would have said, well, we can't
 9 treat this patient at the moment, he is passing urine
 10 so frequently and we can tell he's going to go into 10:39
 11 urinary retention soon.

12 27 Q. Sorry, we'll come to referral issues as perhaps a
 13 separate theme later. What I'm focused on here is
 14 there are, Mr. O'Brien says, good reasons why I can't
 15 implement the MDT recommendation; what I'm able to 10:39
 16 offer the patient is not ADT, it is 50mg Bicalutamide,
 17 and that's clearly not what the MDT intended. Surely
 18 that kind of case has to go back?

19 A. Well, in an ideal world, yes, I would agree with you,
 20 but we don't live in an ideal world and the MDTs are 10:39
 21 already so busy that every variation on what's been
 22 advised by the MDT compared with what actually happens
 23 to the patient, if you brought them all back, the MDT
 24 would be overwhelmed. I think in this specific case,
 25 as you say, it is quite a major departure from the 10:40
 26 recommendation. So yes, another urologist probably
 27 would have brought that back. Mr. O'Brien, I think,
 28 likes to do things his own way so he chose not to.

29 28 Q. Yes. Equally, come March, when plainly localised

1 disease is getting worse and there's perhaps
2 a suspicion, or perhaps ought to have been a suspicion
3 of metastatic disease at that point, he is having to be
4 catheterised, again that needs, rather than
5 uni-disciplinary approach, "well, I'll just manage 10:40
6 this" -- which appears to be Mr. O'Brien's thinking --
7 that should go back to his colleagues to say, right,
8 what have we got here, what are the alternatives,
9 we see he hasn't gone to radiotherapy, we see that you
10 haven't started him on ADT or it's been a slow burn to 10:41
11 reach 150mg; again, classically a case that should go
12 back?

13 A. Yes, I would agree. Ideally this case should have been
14 brought back, yes.

15 29 Q. As I proceed through today, I'm not going to bring you 10:41
16 to every case where there's perhaps an argument that
17 the case could go back. I think the issues may be
18 important on a general level. It reflects, perhaps, an
19 approach to medicine that, I think as you indicated at
20 the start, is not ideal and perhaps now frowned upon in 10:42
21 terms of particularly urology; that's our focus, but
22 perhaps more generally. Clinicians, in order to offer
23 their patient the best quality of treatment, need to
24 relinquish ownership of the cases and follow, if you
25 like, the rules of the MDT? 10:42

26 A. Yes. I'm not sure "rules" is quite -- I think "advice"
27 is a better word for MDTs. But yes, collaborative
28 working clearly is preferable to working in isolation,
29 especially these days where the complexity of the

1 treatments that we can offer patients is increasing.
 2 But, on the other hand, you know, a sort of counter
 3 view is that the patients, especially in urology that
 4 we look after, are getting older and more frail. It is
 5 not unusual now to look after patients over the age of 10:43
 6 100 years. You will often find that what the MDT, in
 7 the absence of the patient or the patient's family,
 8 will offer standard therapy when, in reality, you need
 9 to tailor that treatment to what this patient,
 10 individual patient, needs, and the individual clinician 10:43
 11 who takes overall responsibility for that patient, the
 12 urologist who is going to be sued when the patient puts
 13 in a claim of negligence, it wouldn't be the nurse and
 14 it wouldn't usually be or the radiotherapist, the
 15 radiologist or the pathologist, it is the consultant 10:44
 16 surgeon, urologist.

17
 18 So you have to have flexibility between MDT advice,
 19 which is often regarded as best practice, and then you
 20 need clinical freedom to make the right decision for 10:44
 21 the right patient and then take medicolegal
 22 responsibility for that. So, you have to defend what
 23 you've done. If what you've done is counter to what
 24 the MDTs has advised, then you are taking an individual
 25 risk for yourself if you do that. There are plenty of 10:44
 26 situations where the sensible thing to do is not do
 27 what the MDT says but to do what the patient would
 28 like.

29 30 Q. Yes. Just at a tangent to that, you will have seen in

1 the cases, and beyond that the nine cases -- and we'll
2 come back and look at Bicalutamide in more specificity
3 later but just this discrete point -- you will have
4 observed the tendency of Mr. Mr. O'Brien to use 50mg as
5 a preferred dose?

10:45

6 A. Yes.

7 31 Q. Quite often we have will have seen that that may have
8 been the approach, notwithstanding the recommendation
9 of the MDT for either expressed as LHRHa or sometimes
10 expressed in their recommendation as ADT. If
11 Mr. O'Brien at the MDT realises he's dealing with
12 a frail patient, an elderly patient, and he is going to
13 leave the room, go to that patient and prescribe 50mg
14 of Bicalutamide, that should be on the table at the MDT
15 and open for discussion, should it?

10:45

16 A. Yes, it should. I think in one of the cases -- I can't
17 remember which one -- it was discussed and nobody
18 raised any objections to it. I forgot which case it
19 was now.

10:46

20 32 Q. I think you make that point in relation to this case,
21 Service User A where -- let me remind you, and I think
22 I've got this right -- patient starts on 150?

10:46

23 A. Yes.

24 33 Q. I think after MRI but before the bone scan. Then runs
25 into difficulty, hot flushes impacting on his drive and
26 Mr. O'Brien takes him off the Bicalutamide and plans to
27 start him on 1st November 2019 at 50. The MDT happens
28 on 31st October, the day before he planned to restart
29 him on 50. You're right to say that there doesn't

10:47

1 appear to be any adverse comment about the plan to
2 start him on the 50 the next day. But the
3 recommendation from that MDT was to commence on ADT?

4 A. Yes.

5 34 Q. So it may well not have been, I suppose, terribly 10:47
6 important to say to Mr. O'Brien why do you plan to
7 start him on 50 the next day when, in fact, the plan
8 coming out of the MDT was essentially, I suppose, he
9 had the option, he had the option of LHRHa or starting
10 the dose at 150 to comply with the recommendation? 10:48

11 A. Yes. I mean, I'm sure we're going to come on to this
12 when we talk about Bicalutamide and its dosage.
13 Remember, ADT really is castration therapy. In the old
14 days when I first started urology, castration therapy
15 meant literally removing both testicles. So you'd say 10:48
16 to a patient, listen, I think your prostate cancer is
17 advancing, we're going to have to remove both your
18 testicles. Now, that's not an easy discussion to have.
19 Then, the LHRH analogues came along; Zoladex was the
20 first one produced by AstraZeneca. That is just 10:49
21 a chemical way of castrating patients. I remember the
22 conference that I went to when they were introduced, it
23 is much easier to say we're going to give you this
24 treatment on a monthly or three-monthly basis, and you
25 kind of avoid the word "castration". Then, 10:49
26 Bicalutamide came along, which was just a gentler form
27 of castration, it blocks the receptors rather than
28 removing all the testosterone. So it had a different
29 side-effect profile which was more favourable for the

1 patients, less hot flushes. Sometimes you have severe
2 psychological issues surrounding castration therapy,
3 the patient's life is changed, the masculinity is gone,
4 hot flushes; they sometimes get a change in their whole
5 body, a feminising effect. These are not easy
6 decisions to make.

10:49

7
8 I think Mr. O'Brien, from reading these cases and the
9 rest of it, was clearly in favour of using a gentler
10 form of ADT, a gentler form of castration therapy, if
11 you like. That clouded his judgment in certain cases
12 but that influenced his decision, is a better way of
13 putting it. He was trying to help the patients. This
14 was not a deliberate act of sort of medical sabotage;
15 it was the opposite. He was trying to be kind to his
16 patients and use a gentler form of therapy. I think
17 there's a good rationale in some of the cases we looked
18 at.

10:50

10:50

19 35 Q. I'll not cross swords with you on that at this point.
20 We'll come back to that. We have digressed slightly.

10:50

21
22 Let me go to the point, and I think you've made it
23 a couple of times, MDT is a recommendation. It usually
24 is, as you say, best practice, but it may not suit the
25 patient --

10:50

26 A. Yes.

27 36 Q. -- or at the review the clinician, in this case
28 Mr. O'Brien, might say, well, I've heard from the
29 patient, I think I'll explain the advice in a different

1 way or take a different approach.

2
3 Can you tell me this: when there is a departure, for
4 whatever reason, from the MDT recommendation, should
5 that be recorded? 10:51

6 A. Ideally, yes, along with a plan. Ideally what you'd
7 like to do is to record the plan of management. The
8 MDT advice/recommendation would be not mandatory in my
9 view but it would be another piece of the jigsaw.
10 You'd say, well, this is the jigsaw, we have the MD 10:51
11 advice for radiotherapy and ADT, the patient has severe
12 urinary symptoms, wants to go off to Lake Garda for his
13 holiday; his wife says, you're kidding, you want to not
14 only castrate my husband but you want to give him six
15 weeks of radiotherapy, which he has to travel to 10:52
16 Belfast through the traffic to get there for six weeks,
17 when he's already having to get out of the car every
18 25 minutes to pass urine, on the verge of retention.
19 Then what I would have done is I would have said,
20 listen, we have A, B, C, and D; MDT advice is taken, 10:52
21 I accept that that's the advice but I'm going to
22 deviate because this is the best way, in my view, that
23 the patient should be managed. I'd record that in the
24 notes and then I'd be prepared to stand up in court and
25 defend that on the basis of all the information. 10:52

26
27 The MDT is part of the overall scene but it's not
28 everything and it's certainly not mandatory.

29 37 Q. Assumedly there's an obligation to do your best to

1 explain the MDT's thinking to your patient?

2 A. Yes.

3 38 Q. In other words, in that case they're recommending ADT
4 and referral for radical radiotherapy with curative
5 intent, and any delay to progressing that 10:53
6 recommendation places you at risk?

7 A. Yes, I think you should say that. Then the patient
8 might say, well, not only do I not want to go because
9 of the travel, because of my holiday, because of the
10 castration, but I actually put my trust in you, 10:53
11 Mr. O'Brien, you're my doctor, now you're telling me
12 I have to go all the way into Belfast and another
13 doctor is going to look after me? I don't want that,
14 I trust you.

15 10:53

16 One does form, particularly with these elderly
17 patients, a sort of bond. That is sometimes hard to
18 break and sometimes the patient does not want to break
19 that bond.

20 39 Q. We'll move on. 10:54

21

22 The issue of quorum looms large in not only these cases
23 but in the history of this MDM; regularly inquorate,
24 struggling to get oncology to attend, even remotely;
25 less of a problem but a regular problem with 10:54
26 radiography attendance. Could you help us generally
27 understand the significance of having that kind of gap
28 at your MDT? Is it something you've experienced?

29 A. No. I think at the Prostate Centre we have a weekly

MDT and we would always would manage to be quorate.
Private medicine is different; less caseload and the
doctors are more incentivised to attend for financial
reasons. Also, we were a close-knit group of friends
so MDTs were fun; fascinating discussions with nice
people we all got on with. Also nice in patients to
look after as well, I should say.

10:55

So not having the radiologist who has detected the
metastases in the spine, for example, and can highlight
that, the pathologist who looked at the Gleason score
of the biopsy, and a radiologist might also help on
whether or not it is feasible to biopsy a kidney
tumour; then surgeons to discuss, you know radical
prostatectomy or nephrectomy; radiotherapists who say
no, no, this patient is not suitable for surgery so I
think radiotherapy is the best way. Then a medical
oncologist who would advise about Carboplatin in the
case of seminoma, or other very innovative oncological
treatments that are changing week by week almost these
days with immunotherapies coming on board. So you can
see ideally that's the ideal set-up. This was not the
case in Aidan's hospital.

10:55

10:56

10:56

40 Q. One of the cases that you pick out -- or one of the
points you make, I should say, when reviewing the
cases -- was that, I suppose, the gap in oncology
attendance sometimes affected decision-making or
weakened decision-making. One case in particular maybe
can have your comments on. It was the testicular

10:56

1 disease case. It was Patient 2 or Service User E.

2
3 If you go to your bundle at page 65 and we go to
4 DOH-00086. If you go to 65, we get a bit of the
5 description of the events as a reminder. Mr. O'Brien 10:57
6 is Dr. 1. He planned to have the case discussed at
7 urology MDM on 18th July but there was a histology
8 delay, I think, so it was discussed on 25th July, with
9 the recommendation that Mr. O'Brien would review in
10 Outpatients and then refer to the regional testicular 10:58
11 cancer oncology service. The review with the
12 patient didn't take place until 23rd August, and the
13 referral to the specialist testicular service didn't
14 happen until 25th September. So, a delay of something
15 approaching eight weeks before the referral is made. 10:58
16

17 I suppose the suggestion through the SAI report is with
18 all cancers, of course, it is important, but with
19 testicular cancer there is an underscoring or an added
20 emphasis to the importance of prompt referral. Is that 10:59
21 a fair description?

22 A. I think it is. I mean, some testicular tumours are
23 more dangerous than others. This, actually, was
24 a small lesion with a very favourable prognosis,
25 although it sounds rather dramatic that the patient 10:59
26 required the chemotherapy within a very short
27 timeframe. I'm not sure most urologists would be aware
28 of that timeframe limit, and it is based on just one
29 bit of evidence, a trial that was done sometime ago

1 which showed Carboplatin reduced the risk of
2 recurrence. But even if they recur, seminomas are
3 100 percent curable. A lot of people argue now that
4 actually giving that dose of Carboplatin, which is not
5 a nice medicine to receive, quite a lot of side-effects 11:00
6 with it, can be avoided in many cases because
7 80 percent never recur. This patient had at least an
8 80 percent chance of it never recurring. Even if it
9 did recur, he could have received curative
10 chemotherapy. 11:00

11
12 I don't think in this case it was dramatic.
13 Mr. O'Brien would have been aided by the presence of
14 a medical oncologist at that MDT who would have pointed
15 out to him the need -- the ideal scenario of an 11:00
16 eight-week referral to the medical oncologist.

17 41 Q. Just to interpose -- sorry to cut across you -- you
18 make that point at page 513 of your bundle. Just for
19 the Panel's note, AOB-42632. You make the point that
20 in the absence of a medical oncologist at the MDT where 11:01
21 the histopathology was available, it is understandable
22 that a general urologist would not necessarily be aware
23 of the view of some oncologists that the timing of
24 postoperative chemotherapy was especially important?

25 A. Yes. 11:01

26 42 Q. That's your point.

27
28 Does it really require the presence of a specialist
29 oncologist to have informed those at the meeting that

1 this should be a prompt referral?

2 A. well, no, it doesn't. I think, again from looking more
3 widely, it is clear that Mr. O'Brien's practice of
4 dictating after clinics was less than ideal. Most
5 urologists do dictate immediately, either at the time 11:02
6 of the clinic -- although that slows the clinic down
7 considerably -- but at least within 24 hours or so. It
8 is hard to remember all the details of the case and you
9 want to have recorded everything. If you dictate
10 immediately after a clinic or the following day, then 11:02
11 you can remember the facets of the case. If you leave
12 it, as Mr. O'Brien has tended to do, for sometimes
13 weeks, even months, then you're entirely relying on
14 what you've written down and you can run into problems
15 and delays. 11:02

16
17 I think in this particular case there were extenuating
18 circumstances because Mr. O'Brien's mother-in-law was
19 very poorly. But I think his practice was deficient in
20 the speed, the celerity with which he dictated after 11:03
21 seeing patients in the clinic and this is an example of
22 that.

23 43 Q. It really should have been handled more urgently, even
24 without specialist knowledge of testicular cancer
25 treatment? 11:03

26 A. It should have been. In quite a few of these cases
27 I've looked through, which reflects the sort of
28 practice of lookback, rather than waiting for patients
29 to actually complain, where you've obviously got

1 a problem because the patient is unhappy, the problem
2 with lookback is you are kind of looking for mistakes,
3 and some of those mistakes are important in some of the
4 cases, but in other cases the mistakes are actually
5 unimportant.

11:03

6
7 This unfortunate delay would not, I believe, have any
8 impact on the patient at all. It might have been
9 better not to have told the patient because now he
10 realises there was a drawback, but actually it is not
11 going to affect his prognosis.

11:04

12 44 Q. Happily this Inquiry is not dealing with causation;
13 we'll leave that to the civil court.

14
15 Could I go to the issue of key worker and remind
16 ourselves what the MDT operating policy says about
17 that. If you go to page 1402 and we'll pick up at
18 WIT-84545. I preface my consideration of this area to
19 say that there are evidential and factual controversies
20 around the finding of the SAI that all nine patients
21 were without the input of a key worker or cancer nurse
22 specialist. So there's a range of different
23 perspectives, perhaps, on the evidence. I suppose the
24 key factor is that, for whatever reason, none of the
25 nine patients that you will have considered in your
26 reports had the benefit of key worker cancer nurse
27 specialist input.

11:04

11:05

11:05

1 The importance of that input is perhaps summarised in
 2 this document. Scrolling down, it says:

3
 4 "Clinical nurse specialists or practitioners should be
 5 present at all patient consultations where the patient 11:06
 6 is informed of a diagnosis of cancer and should be
 7 available for the patient to have a further period of
 8 discussion and support following consultation with the
 9 clinician, if required or requested. They may also be
 10 present and should be available when patients attend 11:06
 11 for further consultations along their pathway".

12
 13 Then there's a number of key responsibilities for the
 14 key worker set out at the bottom of that page that you
 15 can briefly glance at, perhaps. 11:06

16
 17 One responsibility is to ensure continuity of care
 18 along the patient's pathway. Let me see if I can spot
 19 that. The fourth one.

20 11:07
 21 "Ensure continuity of care along the patient's pathway
 22 and that all relevant plans are communicated to all
 23 members of the MDT involved in the patient's care."

24
 25 Your experience, Prof. Kirby, I suppose during the 11:07
 26 latter part of your practice maybe, is the greater use
 27 and reliance upon key workers in your practice?

28 A. Yes. I mean, obviously having a key worker, a nurse
 29 specialist with good knowledge of urology is a useful

1 adjunct. I don't think it is absolutely necessary. In
2 private medicine, often I would find that often the
3 sort of high net worth patients we were looking after
4 in Harley Street wouldn't agree to speak to their nurse
5 specialist; they'd say "I want to speak to" -- "I need 11:08
6 this from the horse's mouth". "I'm going to ring Roger
7 up at two o'clock in the morning and ask him
8 personally".
9

10 There is the ownership of the patient. I think 11:08
11 Mr. O'Brien is obviously reluctant to, as we discussed
12 earlier, relinquish that to nurses. I think there are
13 some areas --

14 45 Q. Sorry to cut across you. That makes the mistake,
15 doesn't it, that the nurses are there to provide the 11:08
16 same function in consultation as the clinician?
17 They're there to provide a range of different services
18 that are complementary to and essential to the work of
19 the clinician.

20 A. Yes. I think they're a point of contact, which is very 11:09
21 important. I mean, another sort of basic tenet of
22 cancer medicine is often the patients, you give them
23 the bad news that they've got a form of cancer,
24 prostate or whatever, their mind goes blank and they'd
25 would like to -- this idea that they can talk to 11:09
26 somebody, a nurse specialist, immediately after to have
27 the same information relayed perhaps in a less
28 technical way to reinforce the decision that the
29 clinician has made. Then, you know, especially with

1 ongoing treatment.

2
3 A good example, my sister-in-law at the moment is
4 actually undergoing breast cancer chemotherapy. That
5 means weekly doses of really strong chemotherapy and 11:10
6 all the side-effects associated with that. Then a key
7 nurse working there is absolutely crucial because
8 things are changing day to day.

9
10 With urology, with the exception of the urinary 11:10
11 symptoms requiring retention of urine, the whole
12 process is a lot slower, so maybe the clinical nurse
13 specialist is not as integral or vital as it is in
14 breast cancer. But you could argue about that, it does
15 vary from case to case. 11:10

16
17 Certainly I think they had five nurse specialists
18 working there, so I would accept that Mr. O'Brien sort
19 of missed the opportunity of utilising that facility.
20 He must have had his own reasons for that. 11:10

21 46 Q. Could I seek your comment on the following. If you go
22 to page 103 of your bundle and if we go to DOH-00124.

23 A. Yes.

24 47 Q. This document is the overarching report of the SAIs.
25 It brings together all of the nine cases together in 11:11
26 a composite form. Just scroll up so I can see the
27 final bullet point there.

1 "Safe cancer patient care and pathway tracking is
2 usually delivered by a three-pronged approach of MDT
3 tracking, consultants and their secretaries, and
4 urology specialist nurses."

11:11

5
6 So, it is portraying, at least in public sector NHS
7 medicine, the use of the nurses as part of
8 a three-pronged approach to Patient Safety, ensuring
9 that the appropriate steps along the care pathway are
10 being taken. The last sentence of the paragraph there
11 is the important one. If we go over to DOH-00126 and
12 if you go to page 105, Prof. Kirby. It's saying that
13 the use of a CNS is common for all other urologists in
14 the Trust. I'm struggling to find it. The sentence
15 I want is in my note so I'll just read. It is on that
16 page:

11:12

11:13

17
18 "The absence of a specialist nurse from care presented
19 a clinical risk".

11:13

20
21 what is meant by that is the absence of the nurse meant
22 that there wasn't that -- absent from the equation was
23 that additional level of security to ensure that things
24 got done. We've looked at an example with Patient 1 or
25 Service User A. You've agreed with me that that was
26 a case that should have made its way back to the MDM
27 for two reasons. It didn't make its way back to the
28 MDM. If a nurse had been present in that patient's
29 care, he or she would have seen that deficit,

11:13

1 potentially, and ensured that the patient's case was
2 discussed in that way, perhaps with Mr. O'Brien, and
3 then arranged for the case to go back.
4

5 Is that a fair understanding of how a nurse might
6 assist in the avoidance of patient risk?

11:14

7 A. Yes. I think I would have to agree with that.
8

9 The key point, really, is the nurse should provide
10 a point of contact. Often it's extremely difficult for
11 a patient to speak to his overarching clinician on the
12 telephone, or send an email. They can sometimes speak
13 to their secretary. But if you have a Clinical Nurse
14 Specialist, then usually you have a mobile telephone
15 number that you can ring them directly and say either
16 this side-effect has occurred, or I'm having more and
17 more difficulty passing urine, I think I'm going to
18 need a catheter put in because I can't empty my
19 bladder, or I should have had a scan but I don't seem
20 to have had it so can you help me with it.
21

11:14

11:15

11:15

22 I'm not sure why Mr. O'Brien didn't avail himself of
23 the help of one of those -- of all five Clinical Nurse
24 Specialists. I think it's his practice, he decided not
25 to. I don't think he actively stopped them but
26 he didn't actively encourage them either. You would
27 have to ask him that question, I suppose.

11:15

28 48 Q. Of course.
29

1 Just to take another example to reinforce the point,
2 perhaps. You'll recall the case of Patient 5 or
3 Service User C. That was a case where a CT report was
4 organised by Mr. O'Brien in December 2019?

5 A. Yes.

11:16

6 49 Q. It was after, earlier that year, a very complicated,
7 I think, partial nephrectomy. I think you are
8 complimentary of the skills deployed for that difficult
9 operation with this elderly man. Come the other end of
10 the year, December '19, Mr. O'Brien arranges for
11 a CT scan. That's available to be read and actioned on
12 11th January, but, on Mr. O'Brien's account, he doesn't
13 read it for maybe six weeks or so. The scan, if he had
14 read it at that time, he would have noticed that it was
15 demonstrating a suspicion of sclerotic metastatic
16 disease, and obviously further investigations were
17 required. Again, a case where arguably significant
18 delay in actioning the report. But a nurse interposed
19 into that transaction, a specialist nurse, would have
20 expected to be aware of what was going on in that
21 patient's care pathway and would have been expected to
22 intervene and say, listen, this is something we need to
23 move on?

11:16

11:17

11:18

24 A. Yes, they might have been. I mean, it is quite
25 a difficult scenario where you have a radiological
26 finding. This is a good example, actually. It was one
27 metastasis in the spine that appeared on that CT scan.
28 Remember, this patient had had a -- it wasn't a partial
29 nephrectomy, as you said, it was a total nephrectomy;

11:18

1 there was a big 14cm tumour in a patient in his late
2 80s. So Mr. O'Brien clearly -- this is a good
3 example -- he is clearly a very proficient urological
4 surgeon with open surgery, which actually, as we are
5 seeing now, open surgery is on the wane because there
6 are so many robots and minimally invasive surgeons
7 around that people are forgetting to do this
8 traditional open surgery. He clearly is an excellent
9 surgeon.

11:18

10
11 But this patient had this abnormal scan. The result
12 should have been really highlighted and red-flagged
13 from the Radiology Department. The radiologist ideally
14 would have got on the phone and said we've picked up
15 this metastasis. The patient did have known cancer, so
16 maybe it wasn't that surprising. What was surprising
17 was it was a second cancer; not the original kidney, it
18 was a prostate cancer. A nurse specialist might have
19 picked that up.

11:19

20
21 But what tends to happen to these reports is they get
22 sent back to the clinician amongst a pile of maybe
23 hundreds of other reports. So, picking out the
24 important red flag report from the 100 or so other
25 irrelevant blood results that are piling up on your
26 desk sometimes is difficult. Maybe a nurse wouldn't
27 have picked it up. It's quite a subtle abnormality
28 here. Then, ideally the patient should be seen in the
29 clinic with the result of the scan. The clinic

11:19

11:19

11:19

1 appointment -- this happened during the COVID crisis,
 2 of course, in 2020, so the clinic appointment was
 3 delayed and that was one of the reasons why --

4 50 Q. We'll set the issue of Mr. O'Brien's approach to
 5 addressing results from diagnostic investigations in 11:20
 6 a fuller context maybe later today. You make the point
 7 a big pile of reports, difficult through on top of
 8 everything else. Doesn't that, in essence, make the
 9 point that if you have a nurse specialist fully briefed
 10 and aware of what's going on in that patient's care 11:20
 11 pathway, he or she would -- I'm not saying it would be
 12 guaranteed, I'm not saying it is an absolute failsafe,
 13 it is a word that has been used, but I'm suggesting to
 14 you that it at least enhances the prospect, if you have
 15 a nurse involved with the care, that the cases that 11:21
 16 slip through the cracks will be better able to be
 17 spotted?

18 A. Yes, yes, I would have to agree with that. It does
 19 depend on how good the specialist nurses are. This was
 20 a subtle finding, not that easy to spot. I'm not sure 11:21
 21 that a nurse specialist necessarily would have picked
 22 it up.

23 51 Q. I'm not even making that point. The point I'm making,
 24 just to be clear, is you sent that man for a scan in
 25 December, it is now late February, or whatever the date 11:21
 26 was. In fact, this wasn't picked up until July.
 27 what's happened; it's that question? I'm not
 28 suggesting that she would interpret the scan -- or
 29 he -- it is a question of where is the scan? what has

1 been done about it?

2 A. Yes.

3 52 Q. Just before we take a break, I want to draw your
4 attention and seek your comments on the following
5 remarks in the overarching SAI report. You go to
6 page 103 and we'll go to DOH-00124.

11:22

7 A. Right. Got it.

8 53 Q. It is the third bullet point. Let me just read it:

9

10 "The urology MDM was under-resourced for appropriate
11 patient pathway tracking. The review team found that
12 patient tracking related only to diagnosis and first
13 treatment. That is the statutory targets of 31 and
14 62 days. It did not function as a whole system and
15 whole pathway tracking process. This resulted in
16 preventable delays and deficits in care."

11:23

11:23

17

18 The point that's being made there is that this MDT, in
19 terms of its governance, did not have a facility that
20 scrutinised the progress of the patient along the care
21 pathways. So if delays in referral happened, for
22 example, it wasn't spotted. If referral didn't happen,
23 it wasn't spotted.

11:23

24

25 Can you help us with your own experience, particularly
26 in the public sector in the NHS. Was there good
27 governance, and was that governance around ensuring
28 that patients got what they were expected to get in
29 terms of treatment?

11:24

1 A. Well, in general they did but I think you have to
 2 recognise that the system is overburdened, it's
 3 swamped. I think I read that Mr. O'Brien's hospital
 4 was getting 160 referrals a week, urology referrals
 5 a week, and we'll come on to talk about triage, I'm 11:25
 6 sure. Of those 160 patients referred in urology, at
 7 least half would have cancer. That's 80 patients that
 8 need to be discussed every week, and you have a waiting
 9 list that's getting longer and longer and longer.
 10 Inevitably, delays will come because patients are not 11:25
 11 coming in to be treated, and you have emergencies
 12 pouring in through the Accident & Emergency Department.
 13 Inevitably in such an overloaded system, you are going
 14 to get delays. It is really hard for individual
 15 clinicians to look after their individual patients, or 11:25
 16 build in systems in a hospital whereby these sort of
 17 errors that we're seeing in these cases are bound to
 18 occur. I'm afraid COVID had compounded that
 19 enormously. It is a system right across the NHS, not
 20 just in Northern Ireland, where we're seeing the system 11:26
 21 is overloaded.

22
 23 Clinical Nurse Specialists will help; a really active
 24 MDT with a full complement of different specialists
 25 will help, but inevitably some cases are going to get 11:26
 26 delayed and lost in the system because there's too many
 27 patients.

28 54 Q. Yes. In your experience would an active, job-specific
 29 tracker assist in the process of ensuring that care was

delivered appropriately and on time?

A. Yes. You could call a tracker an MDT coordinator, because it's so difficult for the individual clinicians when they have to operate and do Outpatients and dictate on their clinics, and so on and so forth. To try and to keep track of all your own patients is almost impossible. 11:26

I think one or two of the cases illustrate maybe Mr. O'Brien didn't prioritise some of the really urgent cases as well as he could have done. The patient with the penile cancer, for example, was rather slow; methodical but too slow in the way it was dealt with. An MDT coordinator with a specialist nurse badgering and liaising directly with the patient would definitely have improved the situation. 11:27

55 Q. Thanks for now. It is 11.30. I think it is probably a convenient time to take a short break. CHAIR: we'll come back again, ladies and gentlemen, at a quarter to 12. 11:27

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

MR. WOLFE KC: 11:46

56 Q. Just before the break, Prof. Kirby, we were discussing how the absence of tracking of patients along the care pathway may have contributed to issues around delayed referrals and sometimes no referrals at all. I want to

1 come back and look at that theme by reference to the
2 penile cancer case that you introduced yourself just
3 before the break.

4
5 Before I do so, just picking up on one of the points 11:47
6 I wished to deliberately draw your attention when we
7 were looking at the whole area of nursing and key
8 worker a while ago. If I could just bring you to 1402
9 on your documents, and WIT-84545. You were making the
10 point that it was for Mr. O'Brien to explain why 11:47
11 he didn't actively seek out the nurses when he had
12 cancer patients recently diagnosed come through his
13 review clinic. I draw your attention to the second
14 paragraph on that page. It says:

15
16 "It is the joint responsibility of the MDT clinical 11:48
17 lead and of the MDT core nurse member to ensure that
18 each urology cancer patient has an identified key
19 worker and that this is documented in the agreed record
20 of patient management." 11:48

21
22 It may not do entire justice to Mr. O'Brien's position
23 to say that he thought it was somebody else's or he
24 considered it was somebody else's responsibility to
25 ensure allocation or identification of the key worker 11:48
26 in the way that it is explained there and it wasn't for
27 him to actively seek out the nurse. Do you understand
28 the point?

29 A. Yes, I do. I think what would be ideal would be that

1 the MDT allocate a nurse and that that nurse then
2 liaises with the consultant responsible for the care.
3 Just emphasising, the responsibility for the patient is
4 with the individual consultant. You need a leader of
5 the team. You can have a team but you have to have 11:49
6 a leader and that leader has to take legal
7 responsibility for the care. But the assistance of
8 a Clinical Nurse Specialist would have been
9 advantageous in quite a few of these cases. How that
10 nurse specialist is allocated, ideally the MDT would 11:49
11 have allocated the case to a nurse, the nurse would
12 have liaised with Mr. O'Brien, and there would have
13 been seamless ongoing care for that patient. But
14 that didn't happen.

15 57 Q. Yes. As I say, I prefaced my remarks earlier by saying 11:50
16 that there were lots of evidence around this and
17 different approaches, different views, and that
18 reflects one of them, Mr. O'Brien's view of this.

19
20 Having dealt with that, let's look at the following. 11:50
21 If you go to the overarching SAI report at page 103 in
22 your bundle, and we'll pick it up at DOH-00124.

23 A. I've got that.

24 58 Q. Just at the bottom of the page, it makes the point that
25 "The review team noted repeated failure to 11:50
26 appropriately refer patients". The word
27 "appropriately" seems to be intended to cover delayed
28 referral as in, for example, the testicular case that
29 we talked about. That is the case of Service User E

1 that you can see in a bullet point there, and you have
2 given your evidence and we have your report around
3 that, as well as the penile cancer case. We can see
4 reference there to Service User H at the bottom of the
5 page, and I want to pick up on that one in a moment. 11:51

6
7 Service User A, to use another example, we've looked at
8 this morning, with which we're familiar.

9
10 Maybe just using Service User A's case as an example on 11:51
11 the prostate cancer side. I've outlined, and I think
12 you can recall, the recommendation that came out of
13 MDT. It was for adjuvant deprivation therapy and
14 referral to EBRT. The referral didn't happen,
15 it didn't happen at least until the summer, and I think 11:52
16 by that stage Mr. O'Brien was on his way to retirement.
17 The referral happened in the summer about eight months
18 or so after the MDT decision when the patient was
19 really in a very bad way, and I think the prospects at
20 that stage were recognised as being bleak for him. 11:52
21 I think he died in October 2020.

22
23 But just on that recommendation at the end of October,
24 ADT and referred to EBRT, at what point are you
25 expected to make the referral? 11:53

26 A. Well, I think you're expected to see the patient,
27 convey to them the advice of the MDT, then have
28 a discussion with the patient whose views are
29 preeminent about what they would like to do, and also

1 to ask that patient has there been any change in the
2 situation that would influence that MDT decision.
3 I think in this specific case, his urinary symptoms
4 were deteriorating, which would have made the journey
5 backwards and forwards to Belfast for the radiotherapy 11:53
6 more difficult. He might have been referred to
7 a radiotherapist who rejected him saying I can't
8 possibly irradiate this patient's prostate because
9 we're going to cause a lot more urinary problems, he's
10 already got them. Then there's the Lake Garda holiday 11:54
11 issue as well. Although it is not recorded, there may
12 have been issues about whether the patient was able to
13 accept castration ahead of radiotherapy as a treatment
14 option. Some men -- he was in his early 70s, wasn't
15 he? I forget his age now. 74. Sexual function may 11:54
16 still be an important consideration in his case and,
17 remember, Bicalutamide is potency preserving compared
18 with ADT, which is castration therapy which completely
19 neglects the sex life.

20 11:54
21 This wasn't recorded in Mr. O'Brien's notes but this
22 conversation could easily have taken place and that
23 would have been the stimulus for him saying, well, I'm
24 not going to refer this patient now, I'm going to sort
25 out his urinary problems, let him go to Lake Garda and 11:55
26 preserve his sex life for a few more months at least,
27 because he's asked for that.

28 59 Q. Leaving some of those -- and I quite take your point
29 that every case will depend upon what the patient's

1 view of the process is, and that's fundamental -- is
 2 there room for the clinician to, if you like, try to
 3 achieve optimum biochemical response by moving through
 4 the gears with of Bicalutamide, as in that case, before
 5 making the referral?

11:56

6 A. Yes, I think that would be justifiable. We know
 7 radiotherapy works better when the patient's prostate
 8 has shrunk to some extent, and the tumour indeed
 9 shrinks so there's less cancer to treat. The results,
 10 it's quite clear that ADT preceding radiotherapy has
 11 better results than radiotherapy alone.

11:56

12
 13 How you define ADT, most people would use the stronger
 14 LHRH analogue agonist, which is Degarelix. Some people
 15 prefer Casodex and you'd have to individualise the
 16 patient. Those who want to keep their sexual potency,
 17 very important to them. Maybe married to a much
 18 younger woman, for example, that might be an
 19 influential factor.

11:56

20 60 Q. But the MDT is saying commence the patient with a form
 21 of ADT and refer. It's surely not the business of, if
 22 you like, the local clinician to delay the referral
 23 while seeing whether the Bicalutamide in this incidence
 24 at 50mg is going to have a effective response?

11:57

25 A. I think maybe you might be putting too big an emphasis
 26 on the MDT recommendation. This is not, you know, the
 27 law says you have to do this; it is a recommendation.
 28 You might easily have a conversation with the patient
 29 saying the MDT is recommending this, and they'll say

11:57

1 who the hell are the MDT, I've never met the MDT, they
2 are just a bunch of doctors out there; they are
3 ordaining that I should issued have this but I don't
4 want that; you're my doctor, I want to take your
5 advice; I couldn't give a tinker's cuss about the MDT. 11:58
6 And I've had conversations like that with my patients;
7 it's not unusual.

8 61 Q. For it to be a sensible and intelligent conversation,
9 all of the thinking of the MDT must be reflected. In
10 a case like that, they're referring to oncology with 11:58
11 curative intent. I think as we agreed earlier,
12 delaying on that, if that's the patient wish, so be it.
13 I think that's probably controversial in this
14 particular case and I want to steer clear of the
15 personal traits of the case. 11:58

16 A. Yes.

17 62 Q. But you've got to -- maybe this is where we can leave
18 it -- you've got to fully explain to the patient that
19 delay may not be in the patient's best interests and if
20 the patient says, well, so be it, then that's the 11:59
21 answer.

22 A. There are risks and benefits. There are risks and
23 benefits of both approaches, and that should be not
24 only explained to the patient but documented in the
25 notes ideally. 11:59

26 63 Q. Let's turn to, as I say, this summary. We have it up
27 on the screen in front of you and in the bullet points
28 at the bottom of the page. I think you will have
29 observed in your reports that there has been delays in

1 the patient pathway and failures of referral or delays
2 in referral for a range of reasons, some of which are
3 systemic and some of which Mr. O'Brien has contributed
4 to the delay; is that fair?

5 A. Yes, that's fair. 12:00

6 64 Q. Just before our break, you drew attention to the penile
7 cancer case. If I could refer you to -- if we can pull
8 up DOH-00093. I am not sure of the page reference
9 for you but if you go to page 70, we'll try and marry
10 it up. 12:00

11 A. Yes, I've got that.

12 65 Q. I think we're starting at page 93 in the series.
13 DOH-00093 should be at the top of your page. Page 72
14 for you, I believe.

15 A. Yes, got it. 12:01

16 66 Q. It provides a description of the case. I don't need to
17 worry too much about all of the facts. What it appears
18 to come down to is that this patient was referred to
19 the Urology Service on 20th February with a mass under
20 the foreskin. Various procedures and investigations 12:01
21 throughout much of that year, including latterly a left
22 inguinal lymphadenectomy; is that how you pronounce it?
23 Excising the nodule in the groin?

24 A. Lymphadenectomy. It's the removal all the lymph nodes
25 in the groin. 12:02

26 67 Q. It wasn't until 17th February 2020 when this patient
27 was referred to a penile cancer MDT. In the findings
28 of the SAI, if you go to page 74. Perhaps page 75 and
29 it's our 96. DOH-00096 for us and it's your page 95,

1 I believe. Your page 75, I beg your pardon.

2 A. Got it.

3 68 Q. Just scrolling down, please. It says:

4

5 "Although there was a five-week delay between the 12:03
6 revert and initial appointment, the management of this
7 case was appropriate up to the MDM on 18th April 2019.
8 At this point the MDM should have recommended an urgent
9 staging CT scan and simultaneous referral onward to the
10 regional or supraregional penile cancer specialist 12:03
11 group, or to a surgeon with the appropriate expertise
12 for all subsequent management."

13

14 This is a situation where the region, that is Northern
15 Ireland, didn't have an operable specialist MDT until 12:04
16 2020. The point remains, according to this SAI, that
17 given, I suppose, the rarity of this disease, it was
18 one that required specialist input at a much earlier
19 stage than February of 2000, in other words almost
20 a year after referral. Is that something you would 12:04
21 agree with?

22 A. Yes. I think it's unfortunate that Northern
23 Ireland didn't have a supraregional cancer set-up until
24 I think it was December 2020, wasn't it, when it came
25 into play. So, I think Mr. O'Brien can be defended 12:05
26 along those lines. He couldn't refer him to Manchester
27 where now the supraregional penile cancer expertise
28 lies, because that hadn't been set up. But he could
29 have taken things into his own hands and referred that

1 patient himself. It's quite a big step to refer
2 somebody from Northern Ireland to Manchester, to fly
3 across there, in the absence of a network having been
4 set up.

5
6 You know, I think the steps that Mr. O'Brien took in
7 this particular case were defensible and applicable.
8 It was just that the process was too slow. But, you
9 know, that has to be seen against the background of
10 overloaded clinics, waiting lists spiraling out of
11 control, and all the other issues that Mr. O'Brien was
12 facing at the time, including ongoing battles with
13 hospital administration and so on.

14
15 In all the nine cases I'm defending Mr. O'Brien because
16 I think he did his best. His best might not have been
17 the best available in the world for these patients but
18 he was doing his utmost best. There's nothing I could
19 pick up that indicated that he deliberately delayed
20 things or made any deliberate mistakes. Any mistakes
21 he made reflected his training, the way he practised
22 medicine. I would have to agree that this patient in
23 particular's case was not ideal.

24
25 I do argue at the end of my report that some of these
26 cases of penile cancer, a very aggressive cancer, are
27 extremely difficult to treat because the cancer spreads
28 so fast. Trying to remove a cancer before it spreads
29 is actually a bit of a no-hope situation, you are

1 playing catch up. By the time you get it out, the
 2 lymph node has already spread out further away and you
 3 end up having to chop out all sorts of bits for no good
 4 outcome in the end.

5 69 Q. That rather underscores the point, does it, that 12:07
 6 a cancer of this nature really ought to be placed in
 7 specialist hands, even for advice, if not referral, at
 8 the earliest opportunity? Because as we can see here,
 9 as time went on, they almost lost control of it. Maybe
 10 that's an issue for the MDT in general, that you've got 12:07
 11 to recognise -- this is perhaps the key learning --
 12 you've got to recognise when cases need to leave the
 13 locale and go into the hands of those who have the
 14 specialism?

15 A. Yes, I would agree with that. I counted to some extent 12:08
 16 that the original lesion was a small lesion and only on
 17 the foreskin. Mr. O'Brien thought he completely
 18 removed it, he thought he cured it. He was surprised
 19 when the CT scan showed recurrence in the groin. We
 20 all know that that can occur. Then there was delay 12:08
 21 after that. It begs the question of what a patient
 22 like this with a relatively rare but serious condition
 23 comes through. Is it the responsibility of the MDT in
 24 general to provide the care of that patient, or is it
 25 the individual clinician to whom he's designated? In 12:08
 26 terms of the legal responsibility, as I've mentioned
 27 before, it still lies with the clinician. You can't
 28 sue an MDT, it is quite difficult to do that, but you
 29 can sue an individual clinician. So there's a bit of

1 a tension there, which we've talked about.

2 70 Q. Your report usefully sets out a chronology of this
3 case. If you would kindly go to 556, 557. We'll open
4 at AOB-42638. Scroll down. Maybe it's the next page,
5 is it? There we are. It is at the bottom. Back up 12:09
6 again. Thank you. It should be a page with AOB-42639
7 at the top, continuing into AOB-42640.

8 A. Yes.

9 71 Q. You set out the chronology of the diagnosis for that
10 case. I think you go on to highlight that at Item 7 12:10
11 and then Item 12. As regards those items, you say:

12
13 "During the 12 month interval between the original
14 referral by the GP and Mr. O'Brien's onward referral to
15 a specialist in penile cancer, only steps 7 and 12 can 12:10
16 be legitimately considered to be directly under
17 Mr. O'Brien's control."

18
19 In time terms, they were fairly significant, were they?
20 A. Well, overall, you know, cumulative delays were 12:11
21 obviously too many. But waiting for Outpatient slots
22 and waiting for CT scans to be performed in an NHS
23 under extreme stress, inevitably these delays are built
24 in. Each time Mr. O'Brien saw him and then had to do
25 a surgical intervention, circumcision in the first 12:11
26 place, lymph node section secondarily, that was done in
27 quite a short time space. But waiting for the scans,
28 then waiting to see the patient with the result of the
29 scans, that's where the main delays came in.

1 72 Q. I suppose the glib point in response to that is that
2 this case should never have stayed at this hospital.
3 There was a responsibility on somebody's shoulders, and
4 there was obviously a governance issue given that the
5 case stayed there and nobody appears to have had the 12:12
6 understanding to action it over to a specialist, even
7 for advice. As we know, the specialist MDT had not yet
8 been established. Is that a fair analysis?

9 A. Yes. I suppose in an ideal situation, the time when
10 they knew there was a problem was when the lymph nodes 12:12
11 from the lymphadenectomy from the groin came back
12 positive. That was a surprise; the disease had spread.
13 At that stage, you could have anticipated that if it
14 had already spread to the lymph nodes, it would have
15 been elsewhere in the body too. Then radiotherapy and 12:13
16 chemotherapy -- oncology rather surgery -- is going to
17 be the way ahead. Having said that, squamous cell
18 carcinomas of the penis are notoriously resistant to
19 either chemotherapy or radiotherapy. What tends to
20 happen when the patient is like this, unfortunately, is 12:13
21 they get all this extra treatment but it doesn't make
22 any difference. He would have had to be flown across
23 to Manchester for quite a lot of that treatment.

24
25 You know, the patient might have said, had it been 12:13
26 explained to him, listen, you are going to have to go
27 to Manchester for your treatment, he might have said
28 I don't want to do that. I think this man had
29 a history of alcoholism, diabetes, lots of

1 co-morbidities. It's not entirely clear who is going
2 to pay for him to fly across to Manchester to have
3 therapy.

4 73 Q. As I say, across a range of these cases there are
5 referral issues. As I say sometimes delay, sometimes, 12:14
6 in Patient 1 SUA's case, no referral at all.

7 I suppose, again, there's a governance issue to be
8 explored in terms of a responsibility on those who
9 support the MDT to drive these things forward, to
10 recognise where there is avoidable slowdown and get 12:14
11 cases appropriately on track?

12 A. Yes. A red flag system aided and abetted by the
13 specialist nurses, and probably some better IT working
14 in the MDT, rather than relying on the patient's notes
15 and all these bits of paper flying all over the place 12:15
16 which, unfortunately, was a characteristic of the NHS
17 then and probably still is now.

18 74 Q. Could I bring you to the next question of the
19 management of prostate cancer patients with
20 Bicalutamide? 12:15

21 A. Yes.

22 75 Q. We have, amongst the nine cases that you've looked at,
23 several where the dosage of Bicalutamide introduced at
24 an early stage is said, by the SAI reports, to be
25 unlicensed and suboptimal, the dosage being 50mg 12:15
26 typically. There is, I suppose you know now having had
27 a chance to look at the documentation, a longer history
28 to this problem than simply the cases that emerged in
29 2019 and 2020.

1
2 Could I start our discussion around this by introducing
3 to you some of the various evidential strands that the
4 Inquiry has had to look at and generally get your
5 comment as we work through some of them. I'll start 12:16
6 with a gentlemen called Dr. Darren Mitchell who gave
7 evidence to the Inquiry relatively recently. He
8 practises in The Cancer Centre in Belfast, to whom many
9 of Mr. O'Brien's patients would have been referred. In
10 his witness statement to the Inquiry, which you can see 12:17
11 at 2229, we can pick it up at WIT-96667.

12 A. I've got that.

13 76 Q. You're ahead of me. We're waiting for it to come up on
14 the screen.

15
16 I'm just trying to find the reference. Do you have
17 that? "Prescribing Outside Guidelines" is at the top
18 of the page?

19 A. Yes.

20 77 Q. Here he is explaining the licensed doses for 12:18
21 Bicalutamide. He explains that they are either 100mg
22 once daily as a monotherapy, or 50 once daily when used
23 in combination with hormone therapy injections, known
24 as lutenising hormone releasing hormone agonists.
25 There are no licensed indications that I am aware of 12:19
26 for Bicalutamide 50mg once daily as a monotherapy. As
27 such, he says:

28
29 "I viewed the use of the Bicalutamide 50mg once daily

1 as a monotherapy as being outside the licensed
2 indications. "

3
4 Is there anything in that paragraph with which you
5 disagree?

12:19

6 A. No.

7 78 Q. He, as I've said, has a long history, relatively long
8 history of working with Mr. O'Brien. In 2014 he wrote
9 to Mr. O'Brien on this subject. You'll see the email
10 at page 2203 of your pack, and we'll go to AOB-71990.
11 So it's 2014, six years before these SAIs with which
12 you have been interested in occurred.

12:19

13
14 Mr. Mitchell is the regional MDT Chair for urological
15 cancers. He is reporting back to Mr. O'Brien in
16 respect of a patient of Mr. O'Brien's. You can see the
17 history of the prostatic disease set out there. It is
18 a high grade organ-confined disease dating from 2012.
19 Just a couple of lines down, he is explaining:

12:20

20
21 "A hormone therapy in this case that we would use is
22 the LHRHa or occasionally Bicalutamide 150 once daily
23 as a monotherapy".

12:21

24
25 That's a description of what he set out earlier in his
26 statement; that's the licensed and recognised approach
27 for a cancer of this type?

12:21

28 A. Yes.

29 79 Q. He's saying:

1
2 "I'm told he has only just been referred for
3 radiotherapy at two years after initial presentation."

4
5 He goes on, if we can scroll down, to say:

12:22

6
7 "I'm also told that he was on Bicalutamide 50mg once
8 daily for the first year of his management."

9
10 Now, we don't know what the conversation was between
11 Mr. O'Brien and that patient. We don't know what the
12 patient's desires or intentions were. Ideally, that
13 patient should have been started on 50mg as an
14 anti-flare, moving on to one of the LHRHa preparations
15 with a view to referral for radical radiotherapy. Is
16 that how you would read it?

12:22

17 A. Yes, but there may have been circumstances that would
18 account for his decision not to do that.

19 80 Q. This was, if you like, by way of correction to
20 Mr. O'Brien's approach. Dr. Mitchell, in the last
21 line, as you can see at the bottom, is referring
22 Mr. O'Brien to the relevant website providing
23 information in relation to a clinician's
24 responsibilities when prescribing off-label.

12:22

25
26 Mr. O'Brien has no recollection of replying to this,
27 but the message that is being sent here by Dr. Mitchell
28 is then to be reflected in some guidelines which he
29 developed at a time when Mr. O'Brien was Chair of the

12:23

1 regional urology network in Northern Ireland called
2 NICA n. Let me bring you to the regional hormone
3 therapy guidelines. You will find them at page 1378.

4 A. Yes.

5 81 Q. We can find them at WIT-84426.

12:24

6 A. Yes.

7 82 Q. That's the first page. I think the relevant page
8 I want to turn to is the next page. It's saying that
9 men with intermediate or high risk prostate cancer
10 should be offered neoadjuvant hormone therapy for at
11 least three months before the commencement of radical
12 radiotherapy. It goes on to say:

12:25

13
14 "Men with intermediate or high risk prostate cancer
15 should continue their hormone therapy through the
16 course of radiotherapy. Men with intermediate risk
17 prostate cancer should receive a total of six months of
18 hormone therapy before, during, and after the
19 radiotherapy is complete. Up to three years of
20 adjuvant hormone therapy after radical radiotherapy
21 should be considered for men with high risk prostate
22 cancer".

12:25

12:25

23
24 Then it sets out the recognised therapies, and there
25 they are set out.

12:26

26
27 Just scroll down, so we can see the rest of that.
28 Referring to Bicalutamide in particular:
29

1 "In order to prevent testosterone flare, anti -adjuvant
 2 cover with Bicalutamide 50mg is given for three weeks
 3 in total, with the first LHRHa given one week after the
 4 start of Bicalutamide".

12:26

6 Then it goes on to describe the usage for 150mg. You
 7 can read that.

9 That is one strand of the evidence that the Inquiry has
 10 received. As I understand your answers to my question,
 11 you're agreeing that that is an appropriate and
 12 accurate description of the licensed indication for
 13 hormone therapy with patients of this type?

12:26

14 A. Yes.

15 83 Q. Another strand, a similar strand of evidence has come
 16 from Prof. Joe O'Sullivan, again Belfast Cancer Centre.
 17 To summarise, he has explained in his evidence that he
 18 was seeing cases coming to him from Mr. O'Brien before
 19 2010 on 50mg of monotherapy Bicalutamide, and he would
 20 have corrected that and Mr. O'Brien should have seen
 21 that it was being corrected. His concern, much like
 22 Mr. Mitchell's concern, or Dr. Mitchell's concern, was
 23 that on 50mg, the patient was receiving suboptimal
 24 treatment; it wasn't as effectively as LHRHa or the
 25 150mg dose, and for that reason it should not have been
 26 given.

12:27

12:28

12:28

28 You have looked at a number of cases, and it doesn't
 29 appear on the face of it that you have criticised the

1 approach of using 50mg in the treatment of intermediate
2 or high risk prostatic cancer?

3 A. Right. Well, I'll give you a slightly roundabout
4 answer. By chance, I happen to be the lead clinician
5 in the launch of Bicalutamide Casodex in the UK 12:29
6 manufactured by AstraZeneca. The original dose that
7 was advocated and received a licence for the treatment
8 of prostate cancer was 50mg. That was back in the
9 1990s. I remember it because I put the programme
10 together and we held it in the Intercontinental Hotel 12:29
11 at the bottom of Park Lane. There was subsequent data
12 that showed 150mg was more effective. There's a lot of
13 evidence that 50mg works, maybe 150mg works better.
14 There's a lot of evidence that it's equivalent to LHRH
15 analogues in locally advanced prostate cancer but not 12:30
16 in metastatic prostate cancer, which is already spread
17 outside the prostate. I think there are 25
18 publications on the use of Bicalutamide, some of which
19 in the early days the use of 50mg, and then updated,
20 more recent ones, to 150mg. 12:30

21
22 You would have to ask Mr. O'Brien himself why he was so
23 beloved of the 50mg dosage. That seems to be his
24 preference. There is some effect at 50mg, it is not
25 a treatment that has no value and no impact. Just 12:30
26 150mg would work better and has a licence for it, but
27 doctors often use medications outside their licence; it
28 is not at all unusual for doctors to do that. The
29 150mg dosage does have more side-effects than the 50mg,

1 particularly breast enlargement, hot flushes; those two
2 things.

3
4 The use of Casodex, as I mentioned before, is potency
5 preserving and doesn't give some of the other quite 12:31
6 dramatic side-effects of castration therapy using LHRH
7 analogue. So I think Mr. O'Brien certainly could be
8 criticised for the use of that drug. I can't explain
9 why that's -- why that was his choice, but I don't
10 think you could say he was negligent in using that. 12:31
11 It's not the wrong treatment, it's a less than ideal
12 treatment. Remember, the background of prostate cancer
13 is highly controversial because you can go from active
14 surveillance to radical prostatectomy with robots and
15 so on. Open prostatectomy, radiotherapy with hormones 12:32
16 and now high intensity focused ultrasound and all sorts
17 of new treatments coming in, many of which don't have
18 licences for that either but patients are getting them.
19 Prostate cancer is one of the most controversial
20 treatment areas out there clinically, and Mr. O'Brien 12:32
21 had his own idiosyncratic way of dealing with it.

22
23 But I can see that would bring him into conflict --
24 well, into disagreement, not conflict maybe -- with
25 radiation therapists in Belfast, which probably 12:32
26 explains why Mr. O'Brien seemed quite reluctant to
27 refer his patients into Belfast for radiotherapy. That
28 reflects his desire to keep his own patients under his
29 own care, even if it is a bit idiosyncratic.

1
2 Again, reading from what I have, it seems to me the
3 patients seem to buy into this with Mr. O'Brien. They
4 trusted him. He must have been a good communicator
5 with them. I'm not sure he would have explained 12:33
6 absolutely the pros and cons of all the things he did,
7 but he seems to care for his patients to a great
8 extent. But he was using idiosyncratic ways of
9 treating them that he may or may not have explained to
10 them. 12:33

11 84 Q. Idiosyncratic ways of treating them is maybe a polite
12 way of explaining to us that it is not something you
13 would endorse for your own patients?

14 A. Yes. I wouldn't have used 50mg unless I was forced
15 into that position by a patient saying I want to 12:33
16 preserve my potency, I'm getting bad side-effects from
17 150mg so give me a lower dose. I think in a couple of
18 cases that was the situation here amongst the nine
19 cases.

20 85 Q. Let's go back to brass tax a little. You recognise 12:34
21 that by the date on which Mr. O'Brien is prescribing
22 this treatment that the days of 50mg being regarded as
23 an effective treatment had gone, the licence was for
24 150 monotherapy, or, in the alternative, as an
25 anti-flare agent. So it was off licence? 12:34

26 A. Yes.

27 86 Q. If you are prescribing off licence, you have an
28 obligation to explain to your patient and record why
29 you are doing so?

1 A. Yes.

2 87 Q. The efficacy of the approach must also come into
3 question in terms of its optimisation. A patient
4 receiving 50mg as a monotherapy may be receiving some
5 benefit but it's not the optimal benefit, and that's
6 why 150mg is realised as the appropriate approach?

12:35

7 A. Yes. I would agree with that, yes.

8 88 Q. You have suggested that perhaps one thought around
9 this -- we'll have to ask Mr. O'Brien -- a patient
10 struggling with 150 or he suspects he might struggle
11 with 150, there are side-effects so we'll use 50, that
12 view is not uncontroversial, is it? The dosage may not
13 be terribly relevant to the question of side-effects?

12:36

14 A. Well, a good question, really. I don't think anybody
15 has actually studied the incidence of side-effects of
16 50 verses 150. There are no trials so we don't know
17 for certain. But I suppose empirically you could argue
18 that giving three times the dose is likely to produce
19 more side-effects. The dominant side-effect is
20 gastrointestinal side effects, which I think one of
21 them, Patient A, got, and gynaecomastic breast
22 enlargement that is quite troublesome with patients
23 with Casodex. I don't know if anybody knows whether
24 that's more likely to occur with 150 than 50. The
25 effects on PSA is stronger with 150.

12:36

12:36

12:37

26
27 Again I think it was in Patient A, the PSA did come
28 down on 50mg quite dramatically so it shows it has an
29 effect. If it didn't have an effect, it wouldn't be

1 used as an anti-flare therapy. It blocks the
2 receptors, the androgen receptors, but doesn't block it
3 as effectively as 150mg.

4 89 Q. We know in Patient A's case that Mr. O'Brien was, for
5 whatever reason -- and he can maybe best it explain the 12:37
6 science -- endeavouring to step it up 50mg in November,
7 up to 100 at the end of January, finally into 150 in
8 March. Maybe it was some kind of titration approach?

9 A. Yes.

10 90 Q. Then ultimately in June, eight months after the MDT had 12:38
11 made the recommendation, finally a move into LHRHa as
12 the approach.

13
14 You say he wasn't doing anything wrong but if the
15 recommendation inevitably in these kinds of cases is 12:38
16 ADT; the patient isn't getting ADT if he's not on the
17 150mg dose?

18 A. He's not getting maximal ADT. He's getting -- it is
19 ADT, it's a treatment to block testosterone stimulation
20 on the prostate but it's perhaps not at the optimum 12:39
21 level. In other situations, you take a patient with
22 hypertension, you want to get their blood pressure down
23 so you give them an anti-hypertensive therapy but they
24 get terrible side-effects, so you have to titrate the
25 dose of the treatment against the response that you 12:39
26 see. It is not quite as clear in prostate cancer
27 because PSA is not a reliable marker, not as a reliable
28 marker as blood pressure measurement.

1 He was, I think, trying to titrate the dose against the
2 side-effects and also looking at the PSA reduction.

3 We did see some good PSA reductions with 150mg dosage.

4 91 Q. You will have seen from your readings that the Royal
5 College have looked at Mr. O'Brien's practice across
6 100 cases and expressed some concerns in a number of
7 cases about Bicalutamide. The Trust itself has done an
8 audit and then a lookback exercise. Can I just have
9 your views on a couple of points that emerge from the
10 lookback.

12:40

12:40

11
12 Patient 18. I know you'll be unfamiliar with the
13 patient but you have a sheet, I think, beside you. His
14 name doesn't much matter?

15 A. Yes.

12:40

16 92 Q. If you can turn to 2037 and we'll turn to PAT-001804.
17 This is Mr. Haynes, a consultant urologist in the
18 Southern Trust, writing to a patient -- and we'll not
19 use his name, we'll use Patient 18 -- writing to the
20 patient in November 2020. If we scroll down, we can
21 see that this patient came to see Mr. Haynes in the
22 Outpatient Department following review of his notes.
23 He is being treated with a low dose of Bicalutamide
24 since diagnosis with a localised intermediate risk
25 prostate cancer back in 2010. From memory, [Patient
26 18] and his daughter could not recall having any
27 discussion -- I want to check an issue that has been
28 drawn to my attention. It should be Patient 82, not
29 Patient 18.

12:41

12:41

1 "The patient and his daughter could not recall having
2 any discussion regarding alternative radical treatment
3 options such as radiotherapy or any discussions
4 concerning active surveillance or watchful waiting".

12:43

6 I don't wish to get into the facts of this with you,
7 Prof. Kirby, Mr. O'Brien may have something to say
8 about these examples which I use in due course.

9 I suppose the question I have for you is do
10 you recognise in any guidance an indication for the use 12:44
11 of 50mg of Bicalutamide over a ten-year period in
12 a case like this?

13 A. Well, yes, there's good clinical evidence that 150mg is
14 effective treatment in patients with locally advanced
15 prostate cancer. The definition of what is localised 12:44
16 and what is locally advanced is actually a bit
17 indistinct because it is quite difficult to tell
18 whether the capsule of the prostate is or is not
19 actively infiltrated. Even with state-of-the-art MRI
20 scanning, you can't tell whether the tumour is locally 12:45
21 advanced, i.e. extending a little bit outside the
22 prostate. I can imagine a scenario that Mr. O'Brien
23 felt this was a tumour likely to progress if left
24 untreated entirely with active surveillance, but the
25 patient may not have been keen, or suitable even, for 12:45
26 radiotherapy, or surgery. You could do radical surgery
27 and remove the whole prostate in this case; that would
28 be another approach. Perhaps he discussed the use of
29 this medication with his relatively favourable

1 side-effect profile, especially in terms of sexual
2 function, and scaled back the dose to perhaps reduce
3 the impact of breast enlargement or hot flushes or
4 gastrointestinal disturbance. I can imagine a scenario
5 where it would be more justifiable; we'd need more
6 information about that individual patient.

12:45

7
8 In an ideal world, that conversation with those options
9 would have been had with the patient but, in the end,
10 you must allow the patient to make his own decision.
11 I think you pointed out the daughter couldn't remember
12 that conversation, but I have two daughters and they
13 don't always remember the conversations I've had with
14 them either.

12:46

15 93 Q. I think we are all familiar with that, perhaps. My
16 question was in terms of the guidance, the licensing?

12:46

17 A. Yes.

18 94 Q. I know they are two different things. Is there an
19 indication, whether in guidance or as per the
20 licensing, for, if you like, a prescription, a lifetime
21 prescription of 50mg of Bicalutamide?

12:46

22 A. No, that's not a licence indication. But, as I say,
23 doctors do treat patients off licence. You can treat
24 patients on what they call a named patient basis.
25 Before we had a licence for Sildenafil, Viagra,
26 I prescribed it for thousands of patients off licence
27 with a named patient basis, because while we were
28 waiting for the licence to come through, they were
29 desperate to get hold of it. That's what we did.

12:47

1
2 Mr. O'Brien, he could be criticised but I think it's
3 not a -- what's the word? -- not negligence to
4 prescribe that dosage. We need more information about
5 why he choose to do that but you could ask him about
6 that yourself. 12:47

7 95 Q. I think the concern, and there are other cases which
8 the lookback has demonstrated where men, where patients
9 have this lifetime prescription, multiple year
10 prescription of Bicalutamide. 12:48

11
12 Returning to Dr. Mitchell and the concerns he was
13 expressing here, here he was writing in 2014 to
14 Mr. O'Brien, saying I'm hearing that this patient first
15 came in to MDT two years ago and you're only sending 12:48
16 him to me now; you've had him on 50mg of Bicalutamide
17 for a year and he's eventually coming in to
18 radiotherapy.

19
20 If we pull up Mr. Mitchell's statement again -- sorry, 12:48
21 his transcript again, I should say. We'll orient
22 ourselves to what he is saying precisely. Page 2242
23 for you, Prof. Kirby, and TRA-07771. Just around about
24 line 14. Just bear with me, Prof. Kirby.

25 12:49
26 He is being asked about the 50mg dose, he is being
27 asked about the impact of it, and he is being asked
28 what's the issue for you as a clinician if you don't
29 think it is clinically mandated. He said:

1
2 "I think it is very difficult to prove in the short
3 term that it really changes their management, but it
4 has the possibility to induce delay to referral. So we
5 would be keener to see patients and make hormone 12:50
6 decisions ourselves rather than a wrong dose be
7 prescribed and a patient referred at a much later
8 date."

9
10 The suspicion, perhaps, is that Mr. O'Brien is trying 12:50
11 to manage the patients on 50mg before making the
12 referral, and that inevitably, given its less than
13 optimal dose, is taking much longer to produce good
14 fruit. Do you recognise the problem there?

15 A. Yes, I do see the problem. Again, it is something 12:51
16 I think you have to ask Mr. O'Brien himself.

17
18 I think another factor you have to remember, there
19 is some rivalry between urological surgeons and the
20 radiotherapists that deal with some of the cancers for 12:51
21 us. There have been many arguments about surgery to
22 remove the prostate versus radiotherapy to treat it and
23 sometimes that has got acrimonious. I think we can see
24 that Mr. O'Brien has a preference for the use of
25 Bicalutamide, at an admittedly suboptimal dose, and 12:51
26 a reticence to refer patients for radiotherapy. I
27 think probably you're going to have to ask him why
28 he does that, why that comes from some deep belief that
29 he has. I can see the patients who have gone along

1 with him in that. It's true that radiotherapy can have
2 some rather devastating side-effects, and he may have
3 seen patient with rectal injuries, bad urinary
4 problems, bladder problems from radiotherapy. So I
5 think you have to address him with that.

12:52

6
7 I would say Casodex is an anti prostate cancer
8 treatment, best used at 150 rather than 50. Some of
9 these patients will have actively wanted to avoid
10 radiotherapy, which is given over this long period and
11 involves a lot of travel.

12:52

12 96 Q. There may be some debate on the evidence before this
13 Inquiry about the relative transparency of
14 Mr. O'Brien's approach. As I understand it, he would
15 say that it was perfectly obvious or ought to have been
16 perfectly obvious to the MDT that he was treating some
17 patients with 50mg and he was never called up on it.
18 There's other evidence that's perhaps contrary to that.
19 We clearly have the email from Dr. Mitchell in 2014
20 laying down, as he saw it, the rules or the guidance in
21 relation to that, and then it is reflected in the
22 guidance.

12:53

12:53

23
24 You say that Mr. O'Brien did nothing wrong here, it was
25 merely a suboptimal dose and it was a matter for him
26 and the patient. Forgive me if I'm repeating myself
27 but if he's providing a suboptimal dose, the patient
28 needs to be given a full explanation in relation to
29 that and it needs to be set out and documented in the

12:53

1 clinical notes. Is that fair?

2 A. Sorry, I missed that. My Internet connection was...

3 Could you just repeat the last two sentences?

4 97 Q. Yes. If the patient is to be prescribed a suboptimal
5 dose -- you say Mr. O'Brien did nothing wrong but if he 12:54
6 is being prescribed 50mg outside of the guidelines and
7 outside of the licence, 50mg as a monotherapy, that has
8 to be explained to the patient in terms of it being off
9 licence and potentially suboptimal, and it has to be
10 documented? 12:54

11 A. Yes, I would agree with that. That should definitely
12 have been the case, yes. A discussion should have
13 taken place and it should have been documented.

14 98 Q. What's more, we need to look to see where the evidence
15 takes us on this, but in terms of communication with 12:55
16 your multidisciplinary team colleagues, if it's your
17 practice over a period of time to use 50mg as
18 a monotherapy when you are otherwise recommended to use
19 LHRHa or ADT, I think the members of the MDT would
20 regard ADT as either the LHRHa or 150mg monotherapy. 12:55
21 So if you are proposing to use less than that, again
22 there should be full transparency around that in terms
23 of discussing that with your team members?

24 A. Yes, there should. In governance terms, it's
25 surprising that it wasn't an issue that could have been 12:56
26 brought up by the MDT and, you know, agreement reached
27 amongst all the partners there. I think it implies
28 there's a bit of a dysfunction in the way the MDT
29 works. You know, the issue was raised back in 2012 but

1 still not resolved until 2023; that's 11 years where no
2 challenge was made and no mutual agreement was reached.

3 99 Q. Thank you.

4 MR. WOLFE KC: It is coming up to one o'clock. A
5 convenient time for a break?

12:56

6 CHAIR: Yes. We'll stop now and come back at two
7 o'clock.

8
9 THE INQUIRY THEN ADJOURNED FOR LUNCH

14:01

10
11 CHAIR: Good afternoon, everyone.

12 MR. WOLFE KC: Good afternoon, Chair, good afternoon
13 Panel. Good afternoon, Prof. Kirby.

14
15 We'll get through your evidence in the course of the
16 afternoon, Prof. Kirby. The next issue I want to raise
17 with you is borne out of your consideration of the
18 kinds of issues that arose in Patient 5's case. That's
19 Service User C.

14:02

20 A. Yes.

14:02

21 100 Q. We used it at an earlier point in our discussion this
22 morning to, at my suggestion, illustrate the benefit
23 that a key worker or a cancer nurse specialist might
24 bring to a case where things are delayed or might have
25 been forgotten. This was the case where Mr. O'Brien
26 had the results of a CT scan showing a possible
27 sclerotic metastatic disease. I'll come back to that
28 case in a moment.

14:02

1 I want to bring it to a slightly wider context and
2 indicate to you that the Inquiry is aware of, I
3 suppose, Mr. O'Brien's approach of actioning scan
4 results that date back some years before it, before
5 this incident. I want to just look at the issue
6 through that lens as well.

14:03

7
8 If I can draw your attention then. Perhaps you read
9 this Serious Adverse Incident report concerning Patient
10 95. If you go, please, to page 1483 of your bundle.
11 We will have page WIT-17471. That's the cover page.
12 Do you have that?

14:03

13 A. Yes.

14 101 Q. Good.

15
16 Let me just summarise the facts of this case, if I may.
17 Patient in for abdominal surgery in 2009. There was,
18 unfortunately, a misstep in retrieving the swabs from
19 her cavity -- or a swab -- so they weren't accurately
20 counted in or counted out. So, a retained swab case.
21 I think the profession would call that a "never event",
22 or it's categorised as a "never event". The patient
23 comes in for a routine scan four months later and it
24 identifies an abnormality. It was described in no more
25 detail than that.

14:04

14:04

14:05

26
27 If we could pick up then on what was done or not done
28 with that report. If we invite you to go to page 1490,
29 and we'll move forward to 17478.

1 A. Got that, yes.

2 102 Q. The author describes two issues. The primary issue is
3 the retention of the swab. The second issue was the
4 delay in diagnosis. There was a three-month follow-up
5 scan of the abdomen. A diagnosis of retained swab was 14:06
6 not made on this scan but the reporting consulting
7 radiologist described a mass measuring 6.5cm in the
8 region of the right renal bed. The differential given
9 for this mass included a seroma or a local occurrence.
10 The high density areas within the mass lesion were 14:06
11 described as multiple surgical clips.
12

13 "Although a diagnosis of a retained swab was not made,
14 this report...". I'll reread that.
15 14:06

16 "Although a diagnosis of a retained swab was not made
17 on the CT scan report, a pathological abnormality was
18 described. However, this report was not seen by the
19 consultant urologist as it is his routine practice to
20 review radiological and laboratory reports when the 14:07
21 patient returns for postoperative follow-up. The
22 planned four-month follow-up never took place due to
23 the waiting times for review at Outpatients".
24

25 Then, belatedly, the patient came back into the system 14:07
26 as an emergency in some distress and was operated upon
27 and relieved, I think, six or eight months later.
28
29

1 This failure to read the report and to pick up on the
2 abnormality as soon as it could be picked up was
3 addressed in email correspondence By Trust managers
4 with Mr. O'Brien and, indeed, his consultant
5 colleagues. The standard set was 'read your scans
6 reports promptly as soon as they are available to you'.
7 Mr. O'Brien's response to that, I wish you to have
8 a look at. If we go to page 1666 of your bundle, and
9 we'll go to TRU-276805. You're on 1666. This is 2011
10 and this is Mr. O'Brien writing to Martina Corrigan,
11 who is the head of the service, the Head of the Urology
12 Service:

14:08

14:09

13
14 "I write in response to the email informing us that
15 there is an expectation that investigative results and
16 reports be reviewed as soon as they become available
17 and that one does not wait until patients' review
18 appointments. I presume that this relates to
19 Outpatients and arises as a consequence of patients not
20 being reviewed when intended. I am concerned for
21 several reasons."

14:09

14:09

22
23 He sets out a number of questions and a number of
24 issues. I probably oversimplify it to say there are
25 resource issues, there are time management issues,
26 asking questions about what actions are to be taken,
27 other legal implications, etcetera.

14:09

28
29 Help us with this, Prof. Kirby. In your own practice,

1 one understands that clinicians get an avalanche of
2 investigative reports placed on their desk, but do
3 you have a method of ensuring, back in the day when you
4 worked in the NHS, that you got to see the reports of
5 investigations in a timely fashion?

14:10

6 A. Yes, ideally. Just a general comment first about this
7 case. Leaving a swab inside a patient is a never
8 event, but it does happen, especially if you have
9 a change in nursing staff during the operation, as
10 I think occurred in this case. So really it was the
11 nurse's job to hand you the swabs and count as they
12 come out, and then they should display them on a rack
13 so you can count them off, 10x10x10. At the end there
14 should be a number of swabs checked. It shouldn't
15 happen but it does happen. When it happens, the
16 surgeon is responsible but really the nurse -- the
17 surgeon himself -- or herself these days -- doesn't
18 count the swabs in and out, that's the nurse's job so
19 you do rely on the nurses giving you the right
20 information. That's the first thing.

14:10

14:11

14:11

21
22 That report, it was unfortunate that the
23 radiologist didn't make the right diagnosis of
24 a retained swab, which would have been a major red flag
25 event, but, as you say, there was an abnormal finding
26 there. That should have been a sort of lesser red
27 flag. Retained swab is a major one because it nearly
28 always leads to litigation because the patients nearly
29 always sue for that particular reason. But had it been

14:11

1 a recurrence or another tumour, that would be very
2 important to the patient too.

3 103 Q. I dare say, professor, you would be sued if you don't
4 read your reports for eight months?

5 A. Yes. Yes, you would, really.

14:12

6
7 Then it comes back to a sort of administration issue.
8 I think you can see with Mr. O'Brien, he was a very
9 good surgeon, a good communicator with patients, formed
10 good relationships with patients. Where he fell down
11 was dealing with the administration. I mean keeping
12 some of his notes at home, as we've seen, for example,
13 but then not checking the results as they come through.

14:12

14
15 I mean, having said that, dealing with so many new
16 patients and old patients and backlogs, it is easy to
17 see how you could miss that. What I used to do at
18 St George's, even more so in the Prostate Centre, is
19 have the results put on my desk for me to check before
20 they got filed away in the patients' notes. These days
21 it is all switching over to digital but there are ways
22 of having red flags set out for clearly abnormal
23 results. The kind of results you would look for is,
24 you know -- I mean, take the example of the Lucy Letby
25 case where the children there were being poisoned by
26 her, but there were results coming back suggesting
27 there were very high insulin levels in the blood but
28 they just got filed away in the patients' notes and
29 nobody looked at them so she went on to damage more, to

14:12

14:13

14:13

1 injure more children. It is a big issue right across
2 the NHS and it is a sort of governance issue.

3
4 X-ray reports, CT reports and histology results showing
5 cancer or noncancer, abnormal blood sugars, abnormal 14:14
6 insulin levels as in the Lucy Letby example, there are
7 certain things that are crucial to pick up amongst a
8 whole load of background noise, which is just routine
9 results coming through, all of which look perfectly
10 satisfactory. Sometimes looking at the result separate 14:14
11 from the patient's notes, so all you have is a result,
12 not all the other information, makes it even more
13 difficult. Ideally, you want the notes and the
14 results, check them and then they go back to filing,
15 and the patient is seen in a timely way. 14:14

16
17 of course, the doctor's strike, where they are now
18 rebooking clinics again and again and again is making
19 this even harder to manage at the current time.

20 104 Q. I think you are agreeing with me then that healthcare 14:14
21 professionals, healthcare managers, are entitled to
22 expect that their clinicians should action results
23 promptly. No doubt they can provide some kind of
24 systems assistance for the clinician, but primarily the
25 responsibility rests with the doctor to get it done 14:15
26 promptly?

27 A. Yes. If you order a scan and then you're unaware of
28 the results and the results show something sinister and
29 you missed that, then you're the one responsible

1 really. Again, you need a good back-up system to help
2 you deal with that, a medical secretary or a nurse
3 specialist.

4 105 Q. Yes. I think the system is assisted now by some form
5 of electronic sign-off so that a failure to read or 14:15
6 engage with the report will be noted electronically by
7 the system auditing facility and you will get
8 a rebuke -- I'm not sure if it is a sharp rebuke -- but
9 you'll get a rebuke or reminder if you don't do that?

10 A. Sure. 14:16

11 106 Q. We will, of course, speak to Mr. O'Brien in due course
12 about his approach; is this a one-off case or is it
13 reflective of a wider approach or a broader approach to
14 these cases? We know, for example, Patient 92's case,
15 which was the subject of an SAI report in 2020 -- not 14:16
16 one you've considered but if I can invite you to take
17 a look at it. If you go to TRU-162180 -- sorry, if
18 we go to TRU-162180, and if you can pull up 1584,
19 Prof. Kirby. Just scroll down so we can see that.

20
21 To summarise, professor, this was a patient who
22 attended for a repeat CT scan in March 2018. It
23 reported a solid nodule suspicious of renal cell
24 carcinoma. There was a failure to follow-up on the
25 scan. The patient came in when her general 14:17
26 practitioner realised the deficit some months later.

27
28 If we just go through the report to some of the
29 analysis. If you go to 1587 and we'll go to

1 TRU-162183, just a few pages along. Just at the bottom
2 of the page, please. It's explaining at the bottom of
3 the page just some of the finer facts of this in terms
4 of when the report was communicated to the consultant
5 urologist, Dr. 3, who was Mr. O'Brien. It says, just 14:18
6 the last few lines:

7
8 "The review team have used that the report was
9 completed in a timely manner and escalated to the
10 referring consultant immediately by the radiology team. 14:19
11 The review team, on the other hand, cannot confirm that
12 the doctor read the report. The secretary has advised
13 the review team that in an instance like this, one
14 whereby an urgent report is emailed, the secretary
15 would print off the report and leave it in the 14:19
16 consultant's office for follow-up. The review team can
17 neither confirm or rule out that Mr. O'Brien received
18 the email or a paper copy of the actual report".

19
20 That would be a fairly standard approach in your 14:19
21 experience. The report would come in, the secretary --
22 an experienced secretary -- would see it and put it out
23 for your retention. You're the referring doctor;
24 you're only referred for a report because you think
25 there might be something interesting or important to 14:20
26 see, and therefore you would consider it a priority to
27 look at the report fairly quickly to either rule in or
28 rule out the need for further steps?

29 A. Yes. Ideally the secretary would pick that up, put it

1 on your desk, and put some yellow highlights on the
 2 crucial point to bring it to your attention, or put
 3 a sticky on it or something, yes.

4 107 Q. I think one of the problems here, as Mr. O'Brien
 5 appears to have seen it, was that he, judged by this 14:20
 6 case and perhaps judged by the case we're going to look
 7 at and which you did look at, the case, I think it is
 8 Patient 8, isn't it? No, Patient 5; we'll come to
 9 Patient 5 in a minute. His approach appears to be
 10 I realise I've referred for a report; probably 14:21
 11 recognise that that report is coming back but I have
 12 other demands on my time and I will read the report at
 13 the time the patient comes back for review. The
 14 problem with that in this particular service, which was
 15 under stress for resources -- it had a demand/capacity 14:21
 16 mismatch of some significance -- was that the reviews
 17 often didn't happen. I will ask Mr. O'Brien whether he
 18 must have appreciated the risk that they wouldn't
 19 happen.

20 14:22
 21 Have you experience of working in an establishment
 22 where there was that level of stress on resources, that
 23 reviews would be sometimes difficult to arrange, put
 24 on, if not the long finger but certainly they took some
 25 time to filtered through, even for urgent cases? 14:22

26 A. Well, I think, you know, it is indicative of a service
 27 under stress but also somewhat indicative of
 28 Mr. O'Brien, the way he managed his administration. As
 29 I say, he's a good surgeon, a good communicator, an

1 academic, started a charity, etcetera, etcetera, but
 2 dealing with the paperwork is something that is
 3 integral to running a surgical practice. It's perhaps
 4 the least interesting aspect of what you have to do but
 5 it has to be done and, ideally, done in a timely way 14:23
 6 where you keep up to date. I think things sort of
 7 snowed -- he became snowed under and things sort of ran
 8 out of control for a number of reasons, which he'll be
 9 able to explain to you himself.

10
 11 As I say, there might be 100 results on your desk in
 12 the evening and only one or two would show a renal cell
 13 carcinoma on a CT scan, but you need some way of that
 14 being flagged up and put on the very top. I think in
 15 one sense, Mr. O'Brien says his secretary sometimes 14:23
 16 used to put the results on his chair so he couldn't sit
 17 down until he'd looked at them because, you know,
 18 that's her way of flagging up important results. There
 19 probably would a more efficient way of doing it than
 20 that but that's what she did. 14:24

21 108 Q. The Trust itself had developed what they called
 22 a failsafe called DARO. It's an acronym; the meaning
 23 of it escapes me for the moment.

24 CHAIR: Discharge awaiting results.

25 MR. WOLFE KC: Yes. I'm told it's discharge awaiting 14:24
 26 results.

27
 28 The idea was that rather than list or attempt to list
 29 the patient for review, you would discharge the patient

1 until the results came in, then you would be triggered
 2 to view the results and that would mean that the
 3 results would be read, that the patient wouldn't be
 4 missed. If the results showed an abnormality, then, as
 5 in this case that we've just looked at, I would venture 14:24
 6 to suggest that the consultant would then deploy a red
 7 flag approach to getting the patient in very quickly.
 8 That was a workaround, I suppose. Mr. O'Brien
 9 disagreed with it and wouldn't use it, it appears.

10
 11 would you understand or would you acknowledge where
 12 healthcare providers are under resource stress for
 13 whatever reason, it is appropriate to find workarounds
 14 or mitigation to try and keep everything safe.

15 A. Sure. It is a governance issue, isn't it, for the 14:25
 16 Trust, so you have to find a way of doing it. It
 17 reflects an NHS that offers everything to everybody
 18 with limited resources. I think a lot of Trusts are
 19 finding themselves more and more swamped and more and
 20 more difficult to avoid errors due to overwork. 14:26

21 I think that's probably what's happened in this case.
 22 But it does rely on the senior -- on the consultants to
 23 run an administration on behalf of their patients that
 24 works okay. DARO is one way of doing it but I can see
 25 that's a lot of extra work for the consultants. You 14:26
 26 have to negotiate that work with them, and I think
 27 that's where Mr. O'Brien ran into problems.

28 109 Q. Yes. I think his concern as well, just to be
 29 absolutely fair to him and his position, he feared,

1 rightly or wrongly, that discharging while they await
2 results was a fancy way of taking patients who needed
3 reviews in any event, regardless of results, taking
4 them out of the system. He disagreed with that, he
5 thought that was alien to his philosophy of providing 14:27
6 holistic and ongoing care to urological patients on his
7 list.

8 A. Yes. Well, the ideal scenario is whatever result you
9 have, it's looked at in a timely way, red flag if there
10 is an obvious abnormality, and then you have the 14:27
11 result, the patient, and the patient's notes all in the
12 same place so you can make a sensible decision on
13 behalf of that patient. But that is in an ideal world.
14 Remember, this is pre any kind of electronic patient
15 record. We still don't have that in many Trusts now. 14:27
16 But if you have an electronic patient record system, at
17 least you could connect the patient's notes with the
18 results rather than having the results only in
19 isolation.

20 110 Q. I think in light of what we discussed, we can deal 14:27
21 briefly again with Patient 5's case. You have provided
22 a report on that. If I can remind you, that was the
23 CT scan, 17th December. It showed a possible sclerotic
24 metastasis. Report available 11th January.
25 Mr. O'Brien had it in mind to review the patient in 14:28
26 January, but there was no booking made for a review
27 appointment so far as we can see. He didn't read the
28 report at that time. I think in his evidence he can't
29 be absolutely sure when he read the report but he

1 believes it was some time in or about February or
2 March, perhaps a period of six weeks later. But then
3 doesn't take any steps because we're into COVID. By
4 that I mean doesn't notify the patient, doesn't get the
5 patient in, doesn't notify the general practitioner
6 that perhaps a new PSA test would be helpful to advance
7 the diagnosis.

14:29

8
9 You've looked at that, as I say. If you can go to 498
10 of your bundle, you'll find your report on this. We'll
11 go to AOB-42578.

14:29

12 A. Got that.

13 111 Q. I think it's towards the bottom of the page. It was
14 after Mr. O'Brien had left the Trust in July of that
15 year that this case comes to the attention of
16 Mr. Haynes, one of his former colleagues, and then
17 steps have to be taken to further investigate the
18 condition. You make the point that the blame for this
19 delay cannot be laid entirely at the door of
20 Mr. O'Brien, it must be attributed partly to the Trust
21 itself with the lack of sufficient outpatient slots
22 available for patient SUC to be seen in clinic in
23 January 2020.

14:30

24
25 "Had that clinic attendance and consultation been
26 possible, the serum PSA could have been measured and
27 a radio nucleoid bone scan booked which would have
28 alerted Mr. O'Brien to the presence of metastatic
29 cancer".

14:30

1
2 Plainly Mr. O'Brien must have recognised he wasn't
3 working in an ideal world and, although he will point
4 to other demands on his administrative time, should he
5 not have recognised that having referred this gentlemen 14:31
6 for a CT scan in a context where review slots weren't
7 always available, that that mandated him, really, to
8 read the report in a timely fashion?

9 A. Yes. The answer to that is yes. I suppose in
10 mitigation (A) that scan was done as a routine 14:31
11 follow-up for renal cancer and the fact that
12 a metastasis from prostate cancer was picked up on it
13 was unexpected. The report doesn't make it entirely
14 clear, you know, it's not a red flag report, it's just
15 a suspicion of abnormality that needs follow up. 14:32
16 Ideally, I suppose it would have been sent back to his
17 secretary, who would have put it on his chair so he
18 couldn't sit down without looking at it, as he
19 describes. But that didn't happen. Then, there was
20 a great long delay until the summer before the patient 14:32
21 was seen, but that did coincide with COVID, didn't it?
22 One of the reasons they didn't come back for clinic is
23 because clinics were cancelled because of COVID and so
24 on. This was an elderly patient.

25
26 Actually, once you have got metastatic prostate cancer,
27 there isn't much evidence that the timing of
28 intervention with hormone -- with castration therapy
29 makes a huge amount of difference. I think in the end

1 that patient received hormonal therapy, so he hasn't
 2 suffered too much as a result. But it is, I have to
 3 admit, an omission. That result should have been seen
 4 and should have been acted upon.

5 112 Q. I think Mr. O'Brien fairly concedes that he could and 14:33
 6 perhaps should have written to the general practitioner
 7 when he was aware of this suspicion, even if he didn't
 8 want to, perhaps, annoy an elderly gentlemen during the
 9 COVID period and what have you. That's right, of
 10 course, isn't it? The patient's autonomy and right to 14:33
 11 know has to be respected in a case like this and
 12 perhaps the best way to do it is through the general or
 13 family doctor?

14 A. Yes. A letter could have been written to the GP saying
 15 this could be prostate cancer, so we couldn't make 14:33
 16 that -- metastatic prostate cancer, so we couldn't make
 17 that it diagnosis with a PSA. When they did the PSA,
 18 it came back at over 100. Or more than that, I think.

19 113 Q. Let me move on to another administrative-type issue
 20 that has the potential and, as we have observed from 14:34
 21 some SAI cases, the real risk of causing harm to
 22 patients if it's not performed. That's the whole area
 23 of triage.

24
 25 Triage appears to have been an issue in the practice of 14:34
 26 Mr. O'Brien for quite a number of years before the
 27 Trust determined, in 2017, to exclude Mr. O'Brien from
 28 practice for a period of four weeks and run an MHPS
 29 investigation. As part and parcel of that, they

1 imposed a monitoring arrangement in relation to his
2 practice to make sure that the triage was being
3 performed. At the point when the MHPS investigation
4 started its work, it was found -- I don't think that
5 these figures are uncontroversial -- that there were 14:35
6 783 untriaged referrals stored in Mr. O'Brien's office
7 of the routine or urgent variety, and he hadn't found
8 his way to triaging them.

9
10 You will have triaged, no doubt, in your time in the 14:35
11 NHS?

12 A. Yes. And in the Prostate Centre, yes.

13 114 Q. Perhaps its importance or significance is well
14 understood. From your perspective, working in a busy
15 NHS facility, no doubt -- if we focus on that rather 14:35
16 than your private practice -- how was it performed by
17 you and the team you worked with, and was it a struggle
18 sometimes to get through it?

19 A. To be honest, not really. Well, it depends on the
20 volume of referral letters. There has been a bit of a 14:36
21 change. There's been a change from GPs referring in to
22 a specific consultant to referring in to the hospital
23 or the Urology Department in general. Over time
24 there's more referred now into the unit rather than the
25 individual as the number of consultants has grown in 14:36
26 most departments.

27
28 I mean, obviously, it's common sense that if you have
29 a patient with a palpable mass in the abdomen, that

1 could be a kidney tumour or blood in the urine, or
2 a PSA of 1,000 or something like that, that's going to
3 be urgent, that's quite easy. Less easy to find the
4 sort of nonurgent or routine because you always worry
5 that you might miss something. I mean, a good example 14:37
6 is the lad with the seminoma; that was triaged as
7 routine and yet he had a testicular tumour. But he had
8 a lump in his testicle for ten years before, you would
9 think why they would think that can't be a tumour, it
10 has been there for so long. So sometimes triage will 14:37
11 make a mistake, but you make an honest effort to
12 differentiate urgent from semi-urgent and routine. You
13 do so at your peril of occasionally making a mistake
14 because you don't have all the information. Some GP
15 letter will say, you know, Prof. Kirby, please see this 14:37
16 patient, full stop. How are you supposed to triage
17 that? The more information you have...

18
19 I think Mr. O'Brien got in a bit of a muddle, he wanted
20 to do advanced triage whereby he looked at the letter 14:38
21 and tried to decide which investigation to do on the
22 basis of the letter rather than seeing the patient and
23 having more information. I think that risked doing the
24 wrong investigation -- wasting time doing
25 investigations that weren't really necessary. Then not 14:38
26 really paying attention to the ones that he thought
27 were routine and storing them away in his desk drawer
28 and getting behind on his administration with those,
29 which was obviously not good.

- 1 115 Q. Yes. Plainly, within a healthcare setting that is
 2 under stress, it is important to be able to sort the
 3 urgent out from the red flags. I think we use the
 4 expression "red flag" for the top of the severity
 5 spectrum, through urgent down to routine. It's 14:39
 6 important to be able to upgrade, to triage for the
 7 purposes of upgrade, if you think that the referrer has
 8 got it wrong. That appears to be the big problem here,
 9 that when these 700-odd cases were picked up on
 10 eventually, it was found that there were 24 referrals 14:39
 11 that warranted upgrading to red flag, five of whom were
 12 diagnosed with a cancer of one form or another. So
 13 there, diagnosis and treatment was thereby delayed. In
 14 that context, you can understand the importance of
 15 triage? 14:40
- 16 A. You can. 700 sounds an awful lot but, remember, there
 17 are 160 referrals coming in each week. You can see how
 18 that's quite a bit of work to look through 160 letters
 19 and try and differentiate the super urgent from the
 20 urgent from the routine. It takes time to do that. 14:40
 21 You need some time and to pay attention to it,
 22 obviously.
- 23 116 Q. You will have observed, if you read the MHPS
 24 investigation report, for example, that triage coupled
 25 with the retention of patient charts at home were 14:40
 26 long-running issues. You probably will have observed
 27 that management at different levels were communicating
 28 informally with Mr. O'Brien. His clinical lead,
 29 Mr. Young, might have been having a word with him,

1 occasionally taking the burden of triage off of him but
2 having to hand it back at particular points. It was
3 always Mr. O'Brien's responsibility then.

4
5 Can you offer us any thoughts, based on your 14:41
6 experience, of the management of that? You were
7 a medical director in private practice. I'm not sure
8 if we asked you whether you had any managerial or
9 team-leading roles in your public practice. This was
10 a problem that went on for some years and wasn't 14:41
11 effectively tackled; presumably not a positive thing,
12 whether from a morale or a Patient Safety perspective?

13 A. Yes. You know, I think dealing with very senior
14 clinicians -- surgeons may be more difficult to deal
15 with than some other specialists -- a senior clinician 14:42
16 working in the Trust for 30 years or so, coming towards
17 the end of his career, that is not an easy situation to
18 deal with because often it has to be dealt with either
19 by more junior clinical colleagues or by the hospital
20 management. You can see it could have been handled in 14:42
21 a more tactful way, in a more positive way. I think
22 what happened, it sort of became a downward spiral and
23 the situation deteriorated rather than improved, people
24 took sides and conflict developed to add to -- what's
25 the word? -- the potential harm to patients. A lot of 14:42
26 energy was put into sort of battles within the system.
27 But it is quite hard to get senior clinicians to do
28 what you want them to do. I'm thinking back to --
29 I mentioned it before -- my own training with very

1 senior, very famous urologists in London, Prof. Blandy
 2 and Richard Turner warwick, super famous. They had
 3 their own rather bizarre way of practising which, you
 4 know, people accepted. We just found a way of running
 5 the department kind of around their idiosyncrasies. 14:43
 6 We wouldn't have dared to challenge them because they
 7 are a bit like James Robertson Justice in Doctor In the
 8 House house, you would have got an earful.

9
 10 I think Mr. O'Brien, I don't know him, but I think he's 14:43
 11 slightly old-fashioned in his approach, and that comes
 12 from the fact that he has been in practice for many
 13 years and has found it difficult to adapt to a changing
 14 landscape of the way that medicine is practised.

15 117 Q. Another administrative-type issue that you will have 14:44
 16 picked up on was his tendency to retain patient charts
 17 at his home, which would appear to have been
 18 a by-product of his inability to expedite the dictation
 19 that presumably necessarily follows or should follow
 20 from a clinical encounter with a patient, whether in 14:44
 21 a review clinic or other settings. We know from the
 22 MHPS report that he returned 307 sets of patient notes
 23 or charts from his home in January 2017.

24
 25 I suppose the mischief there, as described by some of 14:45
 26 his colleagues, was the chart oftentimes wasn't
 27 available at the right time, at the right place, when
 28 a patient perhaps came in as an emergency or
 29 unexpected, or sometimes came in to a review clinic and

1 the chart simply couldn't be found. Again, you would
2 appreciate or understand the importance of not bringing
3 charts out of the premise?

4 A. Oh, yes. You know, I think that obviously is something
5 to be discouraged. But again in mitigation, I think 14:45
6 that to do these clinics in the numerous small
7 hospitals that you have in Northern Ireland, the
8 consultant is expected to drive to the clinic with all
9 the notes, see the patients, load the notes back into
10 their car and then deliver them back into the main 14:46
11 hospital. I mean, I don't think that would happen in
12 London, at least. It may happen in other places.

13
14 Ideally, you want a centralised Outpatient Department
15 with scanning facilities handy and, ideally, electronic 14:46
16 notes. It does rather reflect the antiquated way of
17 doing clinics that date back 50 years rather than
18 reflect the modern medical practice, really.

19 118 Q. Yes. I think that practice has undoubtedly changed
20 with the use of the Northern Ireland electronic care 14:46
21 record, where it is less important for clinicians to
22 have the paper copy.

23
24 Could I just ask you, as I say a subset of this is the
25 delay in record-making which may significantly explain 14:47
26 the retention of the charts at home for a long period
27 of time. When you see a patient, whether publicly or
28 privately, what do you anticipate is the expectation of
29 you in terms of record-keeping, both within the chart

1 and externally?

2 A. Well, I think the rules are changing with that.

3 Ideally -- we don't live in an ideal world -- but (A)

4 you need a complete record of the interaction with you

5 and the patient, especially in terms of a plan, 14:47

6 especially in terms of the explanation you gave to that

7 patient, so it has to be written down. Then a letter

8 ideally to both the patient and general practitioner;

9 some people send it to the patient with a copy to the

10 GP, sometimes the other way around. That should be 14:48

11 done within a reasonable timeframe. 24 hours is

12 probably too short a timeframe. But the faster you do

13 it, the easier it is to do because you can remember all

14 the aspects of the patient without looking it all up

15 again and trying to find the results in the notes. It 14:48

16 is better to do it, really, at the end of the clinic

17 but the trouble is you're tired at the end of the

18 clinic. If it's in a place where you have to drive

19 back home with the notes, take the notes somewhere

20 else, you can see how there might be a temptation to 14:48

21 delay the dictation and perhaps forgot to do it all

22 together.

23 119 Q. Just on directing a letter to the patient and/or the

24 GP, what was your experience? Did you do both?

25 A. Yes. Actually, I think we were one of the first 14:48

26 people, particularly the Prostate Centre, to write to

27 the patient and copy the GP in. You know, because the

28 patient, somebody like yourself, for example, you want

29 to know what your PSA is and what the management is for

1 your prostate. Your GP is interested and needs the
 2 record but he is not nearly as involved as you are
 3 yourself. But that does depend on having good
 4 communication with patients and that depends on the
 5 patients you're dealing with. If you're dealing with 14:49
 6 very elderly patients, hearing difficulties and visual
 7 difficulties, etcetera, etcetera, you know, relying on
 8 them to understand what you're saying about complex
 9 urological issues can be difficult.

10
 11 That comes back to the nurses, the nurse specialists
 12 who would help communicate with the patients and help
 13 avoid some of the mistakes that were made in these
 14 cases.

15 120 Q. Help me, if you can. Is that decision to write to the 14:50
 16 patient being the person primarily interested in the
 17 results or the outcome or the next step in the
 18 investigation, whatever might be the content of the
 19 letter, is that new thinking where you are in England
 20 or has that been in place for a while, and does it vary 14:50
 21 from setting to setting?

22 A. It does vary. It is relatively new. We started in
 23 2005, so nearly 20 years ago now. I think in private
 24 practice where the patient is not only -- they made the
 25 decision to come and see you, they are paying for the 14:50
 26 consultation fee, and they want the results pronto,
 27 pronto, pronto. If they have a very engaged GP, the GP
 28 wants results too. In some cases, if it's a GP whom
 29 you know personally, you'd write two slightly different

1 letters, one to the patient and one to the GP. Often
 2 just a letter to the patient copying the GP was quite
 3 a good way to do it.

4 121 Q. That, with all due respect to Mr. O'Brien, seems like
 5 a luxury position compared to what was observed here 14:51
 6 for several years under his practice. The key to
 7 dictating a good outcome letter promptly, or the
 8 importance of it, is to ensure good communication with,
 9 for example, the general practitioner, and also perhaps
 10 other specialisms within the secondary care setting, so 14:51
 11 that everybody knows what has gone on and what the
 12 intended next steps are?

13 A. Correct. Of course, there's another step because you
 14 dictate the letter, it's typed out traditionally by
 15 a secretary. All that is changing, specialists are 14:52
 16 beginning to type out their own letters now, but
 17 usually typed out by a secretary. Then it has to be
 18 checked to make sure they, you know, have done it
 19 accurately because it is done from a dictation.

20 14:52
 21 One example. I dictated a letter saying this patient
 22 has a narrow urethra, had restriction in the urethra,
 23 and the secretary typed out "This patient has a marrow
 24 in his urethra". Luckily I picked that up before
 25 sending it to the patient and the GP. 14:52

26 122 Q. I suppose the expectation is do it promptly, do it as
 27 soon as possible; that's both the notes in the charts,
 28 which can still be handwritten, of course, although in
 29 many settings the clinicians will be typing it into the

1 record, and, as well as that, to dictate the letter
2 promptly. To the extent that there's any specific or
3 prescriptive guidance on this, Good Medical Practice
4 speaks of -- I don't think we have it on your bundle
5 but you'll probably be well familiar with it:

14:53

6
7 "Documents you make to formally record your work must
8 be clear, accurate and legible. You should make
9 records at the same time as the events you are
10 recording or as soon as possible afterwards".

14:53

11
12 It may not be entirely pointless but doing it a year
13 after the event, or six months after the event, is in
14 nobody's interest; isn't that right?

15 A. Yes, that's right. You have to write down, physically
16 write down or these days type it into your phone or
17 something, the consultation and the outcome from that,
18 the plan, and then separately send a letter to the
19 patient and to the general practitioner summarising the
20 outcome of the interaction you've had. That is part of
21 the job of being a consultant clinician, really. It's
22 often regarded as the duller part of your job but
23 somehow you have to keep up with that.

14:54

24 123 Q. Can you understand the perspective, and it is echoed
25 through Mr. O'Brien's statement where he's saying --
26 we don't need to bring it up on the screen but
27 WIT-82572 for our reference. His approach to this is
28 that he was very concerned to use clinic time to engage
29 fully with the patient, to engage in verbal

14:54

14:54

1 communication so that the patient and him developed
2 a rapport and an understanding of what the patient's
3 needs and the clinician's response to those needs would
4 be. So, he placed an emphasis on that, it would
5 appear, to the detriment of using that time to get on 14:55
6 the Dictaphone, or to, in some cases, make a clinical
7 outcome note.

8
9 while that is understandable, you do have to find the
10 time to make adequate notes; isn't that right? 14:55

11 A. Yes, that's right. As I said before, Mr. O'Brien would
12 regard himself first and foremost a surgeon, second an
13 excellent communicator. If you asked him if he was
14 a brilliant administrator documenting what he had done,
15 he almost certainly would agree that he's not. You 14:56
16 know, everybody has a flaw in their nature, I suppose,
17 of some sort.

18 124 Q. But there's a danger, is there not. However innocently
19 downplaying these matters as mere administration,
20 chore-like though it may be, there are potentially 14:56
21 significant adverse clinical consequences if
22 administration isn't done appropriately?

23 A. Yes, there obviously is. But again, a mitigation would
24 be that there's a tsunami of work coming through the
25 system as the patient's age and the number of referrals 14:57
26 goes up. You can see how it is easy to become
27 despondent about this side of it and let things lapse.
28 But obviously you shouldn't.

29 125 Q. Could I turn to the issue of preoperative assessment.

1 we've included on your bundle -- and hopefully you've
2 had an opportunity, however brief, to pick up on some
3 of the issues -- there's maybe not large in number but
4 several cases where clinicians operating within the
5 Southern Trust have not carried out an effective
6 preoperative assessment before bringing the patient to
7 theatre. The importance of that, first of all -- maybe
8 it is obvious -- could you spell that out for us?

14:57

9 A. It is critical to perform a preoperative assessment
10 for Patient Safety reasons, number one; for
11 administrative reasons, number two. If you bring
12 patients in for surgery either the night before or
13 often these days on the day of surgery, and then you
14 find that you can't operate because they haven't
15 stopped their blood-thinning tablet or they've got some
16 other kind of problem, then you lose a slot on the
17 operating list and the waiting list gets longer and
18 longer.

14:58

14:58

19
20 The reason I'm not with you today is I've had my knee
21 replaced about five weeks ago, and I had a preoperative
22 assessment there which nowadays you can do remotely,
23 and it was done with a nurse, just to check that it was
24 okay to go ahead and do the operation.

14:58

25
26 If you are dealing in urology with elderly patients and
27 overweight patients, etcetera, diabetic patients, then
28 it's particularly important for Patient Safety reasons
29 that you do that. They often have comorbidities,

14:59

1 particularly cardiovascular comorbidities, which would
2 be another reason not to go ahead and operate.

3 126 Q. Cardiovascular comorbidity was the issue, I think, in
4 the case of Patient 90. You will have been sent a copy
5 of the serious event audit report. In that case, 14:59
6 essentially, Mr. O'Brien was the surgeon who conducted
7 extensive surgery on this patient, including bilateral
8 ureterolysis against the background of comorbidities.
9 If you go to 1554 and if we go to TRU-161142. This
10 patient, unfortunately, died following surgery on 15:00
11 9th May 2018.

12
13 One of the issues, as explained -- just scrolling down
14 under "Contributory Factors" -- it explains that
15 a CT scan back almost a year and a half, I think -- 15:00
16 yes, a year and a half prior to surgery, noted
17 a potentially haemodynamically significant coronary
18 atheroma. "The review team can find no evidence that
19 follow-up investigations were organised for this
20 finding". It goes on to say despite the discharge 15:01
21 letter from 2016 indicating that an outpatient
22 echocardiogram was required for the patient, the review
23 team were unable to identify that this was completed
24 before surgery.

25
26 This, of course, might have been spotted had
27 a preoperative assessment been conducted. If we go
28 over on to the next page, your 1546, it explains the
29 position around preoperative assessment. The patient 15:01

1 was added to Mr. O'Brien's list some 12 months prior to
2 the surgery actually taking place, pre-admitted for
3 surgery, as you see there, 3rd May 2018, but did not
4 have a formal outpatient preoperative assessment.

5 Mr. O'Brien's views on that, if we go over the page
6 again, please, to your 1546 -- just back a page, sorry.

15:02

7 Yes, just at the bottom of the page. Mr. O'Brien, it
8 is noted, says he didn't regret the surgery as the
9 patient's quality of life was terrible due to the

10 affects of indwelling ureteric stents. He does,
11 however, regret not sending the patient for a cardiac
12 work-up, including echo and coronary angiography. When
13 he did have the CT scan in December 2016, he was
14 reported to have the problem set out there.

15:03

15
16 In your experience is this a difficult issue for
17 hospital governance to get right, clinicians ploughing
18 on with surgery notwithstanding known risks with the
19 patient which could be addressed by a timely
20 preoperative assessment?

15:03

15:04

21 A. Well, another way around this governance issue is to
22 have a formal nurse-led preoperative assessment clinic
23 whereby each patient is contacted, asked which
24 medications they are on, whether they had any cardiac
25 difficulties, especially these days COVID, I suppose.
26 For safety reasons, that's crucial to do that. That's
27 much better than expecting the surgeons themselves to
28 do it.

15:04

1 I mean, another specialty where this sort of case might
2 occur is orthopaedics, where they are doing hips and
3 knees day in and day out. Of course, they will have
4 some patients who have high cardiac risk, and what you
5 need is a nurse-led clinic and then those patients are 15:04
6 filtered out and sent for a cardiovascular assessment.
7 It wouldn't be unusual for the cardiologist to say,
8 listen, you can't operate on this patient, his heart is
9 not good enough; if you operate, he won't survive.

10
11 But then, in this patient's case his quality of life
12 was terrible because of the stents. You can see the
13 dilemma that Mr. O'Brien was faced with.

14 127 Q. Yes. We've seen another patient -- Mr. O'Brien wasn't
15 the surgeon -- but there was a failure to 15:05
16 preoperatively assess the patient and, in particular,
17 a failure to conduct a midstream urine test before
18 a procedure crossing the mucosa in association with
19 stent replacement. So, it's a problem that's not
20 unknown within This Trust. You think the solution is 15:06
21 in dedicating a particular member of staff, perhaps
22 a nurse, to ensure that that check is done in every
23 case?

24 A. Yes. A nurse-led preoperative clinic do a safety check
25 before even quite minor surgery, and a urine culture 15:06
26 done for patients, and a cardiac review organised by
27 a consultant cardiologist, if necessary.

28 128 Q. Okay. Well, that's all the questions that I have for
29 you, Prof. Kirby. I'm going to hand you over to the

1 Panel, who will introduce themselves. They may have
2 further issues for you.

3 CHAIR: Thank you, Mr. Wolfe.

4
5 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
6 FOLLOWS:

15:07

7
8 CHAIR: Thank you, Prof. Kirby. We do have some few
9 questions for you. I'm going to hand you over to
10 Mr. Hanbury, who you may well know, who will have some
11 questions for you first of all.

15:07

12 A. I do know Damian very well. A very good cricketer.

13 MR. HANBURY: Thank you very much, Prof. Kirby, for
14 your evidence, which has been enlightening. I just
15 have a few clinical things which you might help us in
16 the Inquiry out, in no particular order. I'm going to
17 start with some MDT and prostate cancer management side
18 of things.

15:07

19
20 You mentioned many patients indeed do have lower tract
21 symptoms when we are thinking about treating their
22 proposed radiotherapy or other treatments for prostate
23 cancer. There's controversy in the literature about
24 using an LHRH agonist verses Bicalutamide or
25 anti-androgens in favour of LHRH potentially for
26 shrinking the prostate. What's your view on that?

15:07

27 A. I think they are more efficient prostate shrinkers, if
28 you like. The profound castration effect does lead to
29 shrinkage of the total prostate volume and the tumour

1 within the prostate. The downside of them is that, as
2 I mentioned before, the hot flushes, the impact of
3 long-term very profound testosterone depletion. You
4 know, there's this emerging, again controversial, about
5 whether they have cardiovascular risks in at-risk 15:08
6 patients; whether there's higher risk of cardiovascular
7 complications from them. It is certainly in the
8 literature at the moment as a point of debate.

9 129 Q. Just to go on from that, if the lower attract symptoms
10 is the only thing holding up a patient from proposed 15:09
11 radiotherapy, maybe that might be worth considering.
12 We don't seem to see Mr. O'Brien changing tact from
13 Bicalutamide to an LHRH, at least, for that?

14 A. That might be something that he might -- I mean,
15 shrinking the prostate doesn't always improve lower 15:09
16 urinary tract symptoms, does it? Some of these
17 patients were profoundly obstructed with residual
18 urine, 300 or so. I think a lot of radiotherapists
19 would say, well, I really don't want to irradiate the
20 prostate with this much obstruction because as the 15:09
21 prostate becomes inflamed as a result of radiotherapy,
22 I'm very worried they are going to go into retention
23 and then I'll be blamed for the retention; could you
24 deal with the outflow obstruction first, often by a
25 TURP or something equivalent, then do the radiotherapy? 15:09
26

27 There are the other issues, Damian. You know, the
28 patient having to travel to Belfast. There may have
29 been resistance to the patients in wanting to undergo

1 what is quite a demanding course of prostate
2 radiotherapy, especially in an elderly patient.

3 130 Q. Thank you. Just moving on, another technique
4 Mr. O'Brien liked was to see a PSA response to hormone
5 therapy, if we broaden that, prior to referring to 15:10
6 radiotherapists. Is that something you are familiar
7 with or would you see any merit to that?

8 A. I think that is a bit idiosyncratic. I did say that
9 Mr. O'Brien is not mainstream in his approach, but I
10 think you can see there was a logic in his own mind 15:10
11 about that. It may have been sort of -- another factor
12 is he seems to want to keep the patient for himself
13 rather than refer him on. He failed, I think, to
14 develop a good relationship with a radiation
15 oncologist. If you are dealing with prostate cancer, 15:11
16 ideally you want to work in close partnership with
17 a radiation oncologist because often this decision of
18 surgery verses radiotherapy is a difficult one to
19 decide between, and you do need an MDT collaborative
20 approach rather than try and do the whole thing 15:11
21 yourself.

22 131 Q. Okay. Just moving on to one of the nine cases. There
23 was one case, one man that presented with acute urinary
24 retention. On analysis, they felt that the patient had
25 not had a digital rectal examination at presentation. 15:11
26 what's your comment about that? Sort of placed on the
27 list without ...

28 A. Ideally, what's the expression? If you're a urologist,
29 if you don't put your finger in it, you put your foot

1 in it, because you make a mistake by not doing that.
 2 Ideally, especially in acute retention, a digital
 3 rectal examination will give you two pieces of
 4 information - what is the volume of the prostate, very
 5 roughly, and is it a hard malignant-feeling prostate as 15:12
 6 opposed to a large benign-feeling prostate which will,
 7 you know, clearly alter the management. Although both
 8 patients, once they have a catheter in, will require
 9 something to get the catheter out.

10
 11 Actually I recently did some medial work with catheters
 12 in in the UK who are waiting, waiting and waiting to
 13 have their surgery done, and the misery That these
 14 chaps are subjected to by long-term catheterisation,
 15 with frequent infections and bleeding and so on is 15:12
 16 rather miserable. You know those issues yourself.

17 132 Q. Certainly. On the same subject, there was another case
 18 in the nine SAIs where, in fact, Mr. O'Brien had done
 19 a digital rectal examination, had clinically suspected
 20 prostate cancer but went ahead with the TURP as opposed 15:13
 21 to perhaps other diagnostic manoeuvres. I read your
 22 response to that but do you still feel that was
 23 a reasonable course of action?

24 A. Well, generally speaking, if prostate cancer is bad
 25 enough to produce acute retention, you'd expect to get 15:13
 26 some histological tissue to confirm it was prostate
 27 cancer. It relates a bit to the discomfort of having
 28 a catheter in for a long period of time. With long
 29 waiting lists for prostate biopsies and then waiting

1 the results of the biopsies, then seeing the patient
2 again, then getting them in for their TURP, he may have
3 felt that the kindest thing to do was do a TURP and get
4 the histology that way.

5
6 I think Hugh Gilbert suggested he could have done some
7 transrectal biopsies at the time of the TURP. Of
8 course, that does carry infective risk. You can cause
9 -- you can get septicaemia as a result of the
10 transrectal biopsy. I think he was unlucky that the
11 histology came back misleadingly showing benign disease
12 when in fact posteriorly there was aggressive prostate
13 cancer.

14 133 Q. Just lastly, one or two examples of Mr. O'Brien using
15 low dose Bicalutamide the pre-op scenario with an
16 anxious patient. Is that something you have used
17 yourself? I know there is some literature, certainly
18 over COVID when there were enforced delays. Generally
19 speaking, do you use that technique yourself?

20 A. I haven't done but I can see the rationale for that.
21 There's no question that Mr. O'Brien is a kind, caring,
22 clinician who forms very good relationships with his
23 patients. Most of his problems seem to come from his
24 administration rather than the way he handles patients.
25 I think a kindly clinician giving somebody bad news
26 that they've got prostate cancer so we're going to need
27 to verify this, but in the meantime I'm going to give
28 you a tablet with not many side-effects that will put
29 the situation on hold with an anxious patient, anxious

1 family, you could see that scenario might arise.

2 134 Q. I guess just to push you a little bit more on that
3 point, we're aware of another patient who was on low
4 dose Bicalutamide 50 for some time and then did develop
5 metastatic disease a few years later, in fact after 15:15
6 radiotherapy, and had almost no response to
7 conventional hormone therapy at the time. There's been
8 some discussion about the development of hormone
9 resistance disease as a potential side-effect of
10 Bicalutamide. I wonder if you had any thoughts on 15:16
11 that?

12 A. It's a theoretical possibility but I don't know of any
13 scientific data to verify that. I mean you are
14 blocking the engine receptors so I suppose you might
15 get mutations within the cancer to make it more hormone 15:16
16 resistant, theoretically. I think the science behind
17 that needs to be teased out more.

18 135 Q. Thank you. I'm going to move to MDT and quorum. The
19 team at Southern Trust obviously had difficulty with
20 radiology, clinician oncology attendance. At what 15:16
21 level do you think the urologists should have said
22 we just can't do this, or we're just not supported
23 enough to run a decent MDT? Because there's certainly
24 some reports of single urologists with no one else
25 there, which, I'm sure you would agree, is not right? 15:17
26 "Not ideal" to quote you.

27 A. I think that is a governance issue. Obviously it had
28 been looming for some time. They needed help,
29 especially in the form of a radiation oncologist.

1 I think the situation in Northern Ireland, as I said
 2 before, with so many small hospitals and such a massive
 3 workload coming through, getting people in the right
 4 place at the right time obviously was difficult. This
 5 was in the pre-Zoom era. Much easier now to do an MDT 15:17
 6 using the technology we're speaking with now. I think
 7 there are lessons to be learned in terms of that. To
 8 make sure it doesn't happen again, to have a quorate
 9 MDT with virtual input from oncology, radiation
 10 oncology, histopathology and radiology would be the way 15:18
 11 forward.

12 136 Q. Thank you. Just a couple of questions about specialist
 13 surgery referrals, firstly in the cancer scenario. The
 14 small renal mass or small kidney mass-type referrals
 15 with colleagues at Belfast seem to be somewhat patchy, 15:18
 16 was my assessment. I mean, is there a way around that,
 17 in your view? If you were sitting around that table,
 18 would you have done something differently?

19 A. I mean, the case in point that I looked at actually was
 20 a small, very slow growing, relevantly benign renal 15:18
 21 mass. It didn't make any difference at all when it was
 22 referred. The scenario we have now with small renal
 23 masses is that partial nephrectomy can be done,
 24 especially robotically now. People like Ben
 25 Challacombe at Guy's are especially good at it and they 15:19
 26 can remove the small tumours with very low morbidity.
 27 It is becoming more and more important to refer
 28 patients to the people who have the skills to deal with
 29 them, and also the experience, to have a better system.

- 1 I think laparoscopic partial nephrectomy seems to be
 2 working well in Belfast but I don't know whether they
 3 are doing it robotically there yet. That's definitely
 4 a better way of doing it.
- 5 137 Q. That's sort of my point in a way because it started at 15:19
 6 2cm and ended up at 4cm, by which time the patient
 7 needed a radical nephrectomy, so they by definition
 8 missed a chance for ablative, minimally invasive
 9 treatment. I guess one could always refer directly to
 10 the team in the old-fashioned way of writing a letter. 15:20
- 11 A. Yes, absolutely.
- 12 138 Q. The penile cancer case is another case in point. The
 13 original IOG and Northern Ireland NICA guidance does
 14 have a clause, which in fact we've used in England,
 15 that if the patient can't or won't travel to 15:20
 16 a specialist centre, then the local team could do the
 17 biopsies and communicate, and the specialist centre
 18 would run it through their MDT and give you remote
 19 advice.
- 20 A. Yes. 15:20
- 21 139 Q. That's something that I think most DGH urologists use.
 22 Understanding there are transport difficulties and sort
 23 of historical opinions about going to specialist
 24 centres in England, would you think that that was
 25 possibly a missed opportunity as well with that case? 15:20
- 26 A. Yes. It would have been good to have more oncological
 27 advice, particularly earlier on. But Mr. O'Brien did,
 28 I think, quite a good lymphadenectomy. He got five
 29 nodes, two of which were positive. He is a very

1 experienced urologist in the kind of general urologist
2 way that we don't really see any more. We are more and
3 more are specialised within our specialty, or
4 super-specialised, I suppose. I can understand why he
5 thought he could deal with this case himself. I think, 15:21
6 obviously looking back, he would have been better to
7 have more advice. Whether or not it would have changed
8 his patient's outcome. I think he had a really
9 aggressive penile cancer that spread like wildfire so
10 actually you would be playing catch-up whatever you 15:21
11 did. Unfortunately chemo and radio, these tumours are
12 not very sensitive to that.

13 140 Q. I agree up to a point. The patient was only ■■■, very
14 young. You elegantly pointed out all the delays, many
15 of which were known about. In a way, that might have 15:22
16 been a push to ask a specialist colleague, at least for
17 an opinion, let alone transfer of care?

18 A. Yes, I agree with that. In a well-functioning MDT,
19 that would have been flagged up as a sort of MDT -- it
20 would be the urology unit as a whole looking after that 15:22
21 patient rather than one individual clinician.
22 A well-functioning MDT would have got round that
23 problem.

24 141 Q. I just have another question on specialist surgery on
25 the benign side. We have noticed Mr. O'Brien -- you 15:22
26 have been show a case of a poor outcome after a
27 urethrolisis. The only other thing I would add to the
28 pre-op assessment there is the patient was known to
29 have myelodysplasia but did seem to have been seen by

1 a haematologist. These are relative rare major
 2 operations now which, certainly, in England are being
 3 sub-specialised. Does that paediatric sort of invasive
 4 Botox bicystoscopy for overactive bladders in the
 5 teenage paediatric population, and historically 15:23
 6 cystectomy reconstruction and Mitrofanoff procedures
 7 for young women with pelvic pain, UTI, I mean what's
 8 your view on a generalist urologist and a DGH doing
 9 that kind of stuff?

10 A. Clearly, the advantages of sub-specialisation is that 15:23
 11 people get better and better doing smaller numbers of
 12 operations. In the end, the only operation I did was
 13 robotic prostatectomy, virtually nothing else at all.
 14 But Mr. O'Brien is sort of -- although he is younger
 15 than me, he sort of comes from a different era. 15:24

16
 17 I remember when I was training with Richard Turner
 18 Warwick, we operated on a patient to do a urological
 19 procedure and he felt a lump in the stomach, so he said
 20 we better do a gastrectomy whilst we're here. He not 15:24
 21 only did a urology operation, he took the stomach out
 22 at the same time. These very general surgeons with
 23 a lot of general surgery -- urologists with general
 24 surgery experience used to do everything, and
 25 Mr. O'Brien, I think, is slightly locked in the idea 15:24
 26 that he has this very broad experience and expertise so
 27 he can do everything, whilst more and more people of
 28 a younger generation are specialising and doing less
 29 and less. That has its disadvantages too because

1 we may end up with super-specialists who can't do some
2 of the very general things that need to be done.

3 142 Q. Just to push you on that last point. You're someone
4 who has a very general experience in a long career,
5 similar to Mr. O'Brien's stage, I won't say age, but 15:25
6 you have sub-specialised. Obviously what would you say
7 the advantages to your patients would have been with
8 that?

9 A. Well, I followed one route but you remember my friend
10 and colleague, Tim Christmas, a brilliant surgeon who 15:25
11 went to the Royal Marsden. He used to love doing all
12 types of surgery. He opted to do open major cancer
13 surgery for lymph nodes testicular teratoma, for
14 example. I found it much more reassuring to just do
15 a few things and do them really well. My anxiety 15:25
16 levels were lessened by that. Other people say it is
17 just boring doing the same operation endlessly, why
18 don't you spread your wings and do what you can do,
19 which I think Mr. O'Brien's approach.

20 143 Q. Thank you very much. I have no other questions. Thank 15:26
21 you, Prof. Kirby.

22 CHAIR: Thank you, Mr. Hanbury.

23
24 Dr. Swart.

25 DR. SWART: Thank you for your evidence. I'm not going 15:26
26 to go into specific urology things, not being
27 a urologist, so just some general questions.

1 You have talked about your practice of writing to
2 patients and GPs. I think in England that has been
3 mandated for quite a long time now anyway. Since 2008,
4 it's actually an edict.

5 A. Yes.

15:26

6 144 Q. Before that, I think the cancer world had adopted it to
7 a varying degree. What is your view about the benefit
8 that brings? I'm thinking particularly of the fact
9 patients aren't in the MDT and thinking of the need to
10 summarise the discussions in terms of a treatment plan
11 and the MDT decisions. What have you found about that?
12 The reason I'm asking the question is it's not mandated
13 in Northern Ireland and it hasn't been consistent
14 practice here. I would like your view on what it has
15 taught you in your own practice.

15:27

16 A. Well, we at the Prostate Centre found it really helpful
17 and the patients really liked it. There are issues with
18 it because technically you would want to put more
19 information in to the general practitioner with
20 a medical degree, whilst to the patient you want to
21 make it clear and concise and understandable. I used
22 to take a bit of pride in -- I like writing in general,
23 it's something I enjoy doing. So writing,
24 communicating with patients by letter and copying in
25 the GP worked for me. I don't think we had any
26 complaints about it.

15:27

15:27

15:27

27
28 I used to sometimes worry that the GPs would feel, you
29 know, they were the second order, but the GPs didn't

1 seem to mind either as long as they got the information
2 they wanted in a timely fashion. And, yes, we would
3 never keep a patient waiting more than a week before
4 they got the letter and the GP got the copy.

5 145 Q. Thank you.

15:28

6
7 Another thing which has been of interest is in relation
8 to the way things operated at the Southern Trust, and
9 to some extent more broadly in terms of governance, but
10 also whose role it is to spot things that are going
11 wrong. Could you give me your view of the importance
12 of the collegiate atmosphere amongst the consultant
13 body in a department with respect to keeping patients
14 safe? what has been your experience of (A), the
15 importance and (B), the results when that becomes
16 dysfunctional?

15:28

17 A. Well, it is crucial, really. I think there were, you
18 know, red flag warning signs that there was dysfunction
19 within this unit that could have been picked up. But
20 then, it is quite easy to sweep things under the carpet
21 because it is so difficult. Some people are very
22 difficult to deal with, especially senior surgeons
23 perhaps.

15:29

24
25 In quite a few units we've seen around the UK,
26 interpersonal rivalries develop, and one surgeon will
27 say to the nurse on the ward, "I would never have done
28 that operation and my colleague can't operate for
29 toffee", something like that. Then that can get out of

15:29

1 control and sort of vendettas develop. You are dealing
2 with human nature. But when problems arise, they need
3 to be addressed. Most hospitals now have -- it used to
4 be three wise men but now I'm not sure, that system is
5 out of date now. But the equivalent of that, sort of 15:30
6 troubleshooters. In this case I think the
7 troubleshooters should have gone in there, shaken the
8 system up and devised better ways of doing things.

9 146 Q. Have you ever had to work in a dysfunctional department
10 like that? 15:30

11 A. I'm lucky I didn't. I had a lovely department with two
12 wonderful urologists at Bart's, and then St George's
13 was a great team. Then we set up the Prostate Centre
14 where we handpick the people we worked with.
15 I personally haven't but I do know of other places. 15:30
16 The Royal College of Surgeons have a sort of
17 troubleshooting team that parachute in and deal with
18 these things when they get out of hand. Maybe they
19 should have had the Royal College of Surgeons in
20 Aidan's hospital to sort it out. 15:30

21 147 Q. Then just a final question. This will be obvious to
22 you but could you just make some comments on the value
23 of cancer guidelines, cancer networks and so on in
24 terms of standardising therapy to some degree and so
25 thereby reducing inequality, you know, between the 15:31
26 wealthiest, the poorest, the best informed, the worst
27 informed. What have you seen in terms of answers to
28 that. Do you have any comments?

29 A. I do. They're very helpful. In fact, I went to the

1 funeral of Prof. Sir Mike Rawlins, who set up the NICE,
 2 National Institute For Clinical Excellence. Mike
 3 Rawlins lived up in Newcastle and died aged 90 just
 4 a few months ago. Him and Prof. Gill Leng, my
 5 successor as President of the Royal Society of Medicine 15:31
 6 came up with the idea of the NICE guidelines and they
 7 have got better and better, I think, and more accepted.
 8 I think that guidelines are guidelines, they're not
 9 rules, they're not mandatory. They help us make
 10 decisions because, in the end, as I've said several 15:32
 11 times today, that the patient's choice has to be
 12 preeminent, guided by the clinician who understands the
 13 patient and patient's family and takes into account
 14 guidelines as well as the view of the MDT. So all of
 15 these things need to be put into the mix to end up with 15:32
 16 a patient who is happy with what's being recommended
 17 and what treatment is being given to him.

18
 19 Guidelines are very important. I think we're lucky to
 20 live in a country where such good guidelines are 15:32
 21 produced and constantly updated in such an admirable
 22 way.

23 148 Q. Would you agree that it does improve equality of access
 24 for the population?

25 A. Absolutely. In my career over 50 years now of 15:32
 26 medicine, it's improved dramatically. Guidelines have
 27 been one of the major facets in improvement.

28 DR. SWART: Thank you. That's all from me.

29 149 Q. CHAIR: Just a couple of things to pick up on some of

1 the things you told us, Prof. Kirby, if I may and
 2 I wonder what your view is.

3
 4 You variously described Mr. O'Brien as an excellent
 5 surgeon, you described him as someone who was kind, 15:33
 6 caring, and a good communicator with his patients.
 7 Now, you've told us you only ever met the man on one
 8 Zoom call so I wonder where you were getting that
 9 information from?

10 A. Well, I've read nearly 2,000 pages about Aidan O'Brien 15:33
 11 so I feel I know a lot about him now. Actually, he
 12 mentions in his own -- one of his submissions - that he
 13 trained one of our professors in London here, Prof.
 14 Shamim Khan, who received the OBE and professorship at
 15 Guy's Hospital and, actually, St Peter's Medal just 15:34
 16 recently at the British Association of Urological
 17 Surgeons. So I did send an email, yesterday or the day
 18 before, to Shamim, who was trained by Aidan, asking for
 19 his opinion of him. He said just what you said to me,
 20 that he's an excellent surgeon, a kind, caring 15:34
 21 clinician, but he is not mainstream in his view of the
 22 management of some conditions. His strong point is
 23 definitely not administration and dealing with
 24 correspondence or stashing notes in the place where
 25 they are supposed to be stashed. 15:34

26 150 Q. Would you accept from me, perhaps, that having
 27 excellent knife skills does not an excellent surgeon
 28 necessarily make?

29 A. No. You do need the administration, the communication

1 and the surgical dexterity. So, there is an issue
2 there with Mr. O'Brien.

3 151 Q. I'm sure it's just we all have different ways of
4 speaking and it may be just your own particular verbal
5 tick, but I was struck by the fact that you kept refer 15:35
6 to "ideally" things would happen. You used it in
7 connection when you were explaining the risk and
8 benefit to document discussions with patients in the
9 notes. You used the word "ideally" in that sense. But
10 I'm sure that you would accept, would you not, that 15:35
11 that is actually something basic rather than ideal?

12 A. Yes. I think the more that is written down now, the
13 more important it is. You know, for example, the issue
14 of consent. We just used to originally ask the patient
15 to sign the form consent for a TURP, sign it, and go. 15:35
16 Now you need a long explanation of what you've said to
17 the patient and what they're committing themselves to.
18 So, things are changing. The better the documentation,
19 the better for the patient.

20 152 Q. The better for the patient and, arguably, for the 15:36
21 surgeon also?

22 A. Yes.

23 153 Q. Because you have speculated about whether or not some
24 of Mr. O'Brien's patients would not have wanted to
25 travel to Belfast to get radiotherapy. We'll never 15:36
26 know because it is not documented in some cases.
27 Whether they would have wanted to retain their sexual
28 function rather than have the particular androgen
29 therapy; we again won't know because it is not

1 documented. So while protecting the patient, it also
2 protects the surgeon?

3 A. Yes, absolutely right. That's more and more important
4 in an increasingly litigious society.

5 154 Q. One other thing just in relation to -- we were talking 15:37
6 about actioning scans. Would you accept that if the
7 waiting lists are long and a review appointment cannot
8 be held as soon as the clinician would like them to be,
9 it is more incumbent upon the clinician to check scans
10 as soon as they come back, or results as soon as they 15:37
11 come back?

12 A. Yes, I mean, ideally what we need is a joined-up
13 electronic system. The technology is there now to do
14 remote consultations, order scans online, look at the
15 results online and, you know, action urgent cases, you 15:37
16 know, literally within a few days. It could be done
17 but the problem is that we're dealing with such an
18 overloaded system. It is quite hard to change things
19 within the system because doctors are brought up to do
20 things in a certain way. We were all brought up in the 15:37
21 sort of paper era where we had to have the notes and
22 the patient in front of us, but now suddenly all these
23 things can be done online. You can see that there are
24 all sorts of issues. Dealing with the very senior
25 surgeons in the department can be the trickiest issue, 15:38
26 really. It is hard to get them to change.

27 155 Q. Clearly in the 2,000 or so pages that you've read and
28 your conversation with a colleague, you formed an
29 opinion of Mr. O'Brien. I just wonder if you would

1 share some of these views; that he was someone who
2 worked in isolation rather than as a team player?

3 A. Yes, I think he obviously did. To his detriment,
4 I think, to the patient's detriment. He didn't seem to
5 want to collaborate with his colleagues as well as 15:38
6 he should have done, especially the radiotherapists in
7 Belfast. That would have been -- a close relationship
8 would have been ideal. And he had his own way of doing
9 things and perhaps was reluctant to change. I think
10 a lot of energy has been wasted in battles about who 15:38
11 should do the triage and who should be the urologist on
12 call and the urologist of the week, and how should
13 we run the MDTs, instead of dealing with the issues.
14 They were allowed to sort of spiral out of control.

15 15:39
16 That does raise the issue, if you have a problem within
17 a department within a hospital, it shouldn't be left
18 just to deteriorate further and further and further and
19 end up with an inquiry. A lot of these problems could
20 have been addressed and dealt with at a much lower 15:39
21 level than what's happened now.

22 156 Q. You may well be right and we'll certainly be reflecting
23 on that when we come to write our report.

24
25 Thank you very much, Prof. Kirby. You're not getting 15:39
26 away just yet. Mr. Wolfe wants to speak to you again.

THE WITNESS WAS FURTHER EXAMINED BY MR. WOLFE KC:

157 Q. MR. WOLFE KC: Just one other issue. I think you said you wrote to -- was it Dr. Khan -- to seek information by way of his experience or her experience of working with Mr. O'Brien? 15:39

A. Just a one-line email to Mr. Khan. I'm not sure, was I allowed to do that or is that ...

158 Q. It's not something I'm raising any controversy about. what I'm really asking you or wanting to ask you is did you seek the views of anyone else? 15:40

A. No, only Mr. Khan. Because I read Mr. Khan's name in some of the documents I received just a few days ago being used as an exemplar of a trainee who'd benefitted from Mr. O'Brien's experience, and he certainly has been a major asset to urology. 15:40

That's another facet of Mr. O'Brien's career that we haven't really covered, that as a trainer of other surgeons and as a generator of, I think you call it the CURE charity where he raised £85,000, I think, and so on and so forth. He has made contributions as a trainer and as a researcher. I think he sees himself as one of the leading, most senior urologists in Northern Ireland but, unfortunately, he seems to have become a bit isolated towards the end of his career. 15:41

159 Q. Thank you for that. That was just that one query. Everybody else content?

1 Thank you for your evidence, Prof. Kirby.

2 CHAIR: Thank you, Professor.

3
4 Ladies and gentlemen, that concludes this week's
5 evidence. We will be back again on 4th December for
6 a rather long week because we have four days sitting
7 that week.

15:41

8
9 THE INQUIRY ADJOURNED TO MONDAY 4TH DECEMBER 2023