Urology Services Inquiry

Oral Hearing

Day 95 – Friday, 12th April 2024

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.

Gwen Malone Stenography Services

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THE HEARING COMMENCED ON FRIDAY, 12TH APRIL 2024, AS FOLLOWS:

CHAIR: Morning, everyone.

MR. WOLFE KC: Morning, Chair. 09:57

CHAIR: Welcome to what is hopefully our last day of oral evidence. Disasters permitting!

MR. WOLFE KC: We'll certainly not be continuing into a Saturday.

CHAIR: Good! Because I won't be here! 09:57

MR. O'BRIEN, PREVIOUSLY SWORN, WAS QUESTIONED BY MR. WOLFE AS FOLLOWS

1 Q. MR. WOLFE KC: Good morning, again, Mr. O'Brien. 09:57

A. Good morning, Mr. Wolfe.

2 Q. Thank you for coming along for what is your sixth day of evidence.

A. It is.

3 Q. On Wednesday, when you were last here, I was taking you through a number of incidents or issues in which the Trust had suggested through its evidence that you were resistant to Trust expectations. The issue we left with was the whole area of reviewing results, DARO, and that area. I want to move on this morning, briefly, to look at the area of the irrigation fluid and equipment which was used for endoscopic procedures, and you will recall, and you'll certainly recall from the materials that you've been supplied with, that the Chief Medical 09:57 09:58

Officer received a letter from the senior coroner for Northern Ireland, Mr. Leckey, in October 2013, pointing to surgical and anaesthetic failings in connection with a gynaecological case that was the subject of an operation in the Ulster Independent Clinic, unfortunately leading to the death of a young woman, and from that piece of correspondence, under the auspices of Julian Johnston, a review of the use of glycine in connection with a monopolar device was instigated, leading ultimately to the Deputy Chief Medical Officer on 18th August 2015, issuing a policy, making the case for changes to both urological practice as well as gynaecological practice, and we can see that policy at WIT-54023. And -- sorry, that's the action plan. Thank you. So there's the -- just for illustration purposes, more than anything else, the correspondence and the summary of the action required at the top. 09:59 09:59 10:00

Now, I want to bring us quite quickly to the issue that relates to you in association with this. 10:00

A. Hmm.

4 Q. And assume that the policy and its intent is well-known to, certainly this audience. Mr. Young has explained that as a group of clinicians in the urology team, you engaged in the testing of bipolar equipment in saline from 2015 into 2016. You'll remember that? 10:01

A. Mm-hmm.

5 Q. And if I can draw the Panel's attention to one of your

reactions to using a particular example of the bipolar equipment, the Olympus system I think it was called, and TRU-395975. And you're writing, 7th February 2016, you say:

10:02

"I suspect that any comments from me will be perceived to have been prejudicial. However, I honestly did approach using the much hailed Olympus with a view to giving it a fair wind. And was I bowled over?"

10:02

And you say "no", and you set out some detail of the deficiencies as you found, and you say at the end of that:

"I was so glad that neither prostate was large as I certainly would not have used the bipolar." 10:02

And that's the analysis you put forward to the team.

A month later, if we -- just if we go forward to TRU-395978, you're saying at the end of another experience: 10:02

"I have pledged not to do so again. I will not use or try bipolar resection again." 10:03

Was that the end of it for you? Was that the last time you used bipolar resection?

A. I believe it probably was, yes.

6 Q. And this was -- this was a period of trialling different devices?
A. Mm-hmm.
7 Q. It ultimately came to a decision amongst the team in relation to which device to recommend to the Trust for purchase, and if we can just briefly look at that. A decision was taken to recommend the purchase of a STORZ system, S-T-O-R-Z, and we can see at AOB-78271, that following a departmental meeting in September 2016, and it's written up in some detail there, it says that, it came down to a debate about whether to purchase the OLYMPUS, which you have already expressed your views about, or the STORZ system. And one of the commending factors in support of the STORZ system was that it could also be adapted to enable it to be used in glycine as well as saline, and a decision was made, it says here, that all the urologists have backed the decision in favour of the STORZ system, with a unanimous vote. 10:03 10:04 10:04 10:05

If we go back to the top, we can see that you attended that meeting or were party to those discussions.
A. Mm-hmm.
8 Q. So, although you've expressed your concerns about this mode of operating, albeit with a different system, you were prepared to support the purchase of the STORZ system? 10:05
A. Mm-hmm.
9 Q. Is that right? Was your lending your support to that

decision, is it right to suggest that you weren't lending your support to the conduct of endoscopic procedures using bipolar equipment per se?

A. It's simply a matter of me agreeing with the purchase of the STORZ system as opposed to the OLYMPUS, for the criteria -- for the reasons that have been set out in that document. 10:06

Q. Yes.

A. And I thank you for showing the two earlier e-mails, because one of them -- the first one ends with, you know, I do hope that I will be able to continue to use monopolar, for the reasons that I set out in that, and then my concern about the use of bipolar in my hands was further compounded by the experience as related in the second e-mail. 10:06

Q. Yes. Now, we've heard from Mr. Young in respect of this issue, and indeed other of your colleagues, and it was Mr. Young's evidence that, although there was never a formal direction to cease the use of monopolar procedures, he regarded the change, or the need to change, as being in the form of a directive; he said -- and he went on to say: 10:07

"I think that there was an expectation that he..." 10:07

- that is you, Mr. O'Brien:

"...would move like the rest of us too. I don't remember him informing us that he had not moved over."

So, let me -- just to be clear, we can turn to the retrospective audit of TURP cases that was conducted by Mrs. Corrigan recently for the purposes of this Inquiry, and it shows across ten -- a sample of ten procedures, affecting your patients in 2019.

A. Hmm.

12 Q. Nine of which were performed by you, one by Mr. O'Donoghue, you proceeded to use monopolar in glycine? 10:08

A. Mm-hmm.

13 Q. You've no challenge to that audit?

A. Absolutely not.

14 Q. That's entirely accurate?

A. That's right. 10:08

15 Q. And that demonstrates that you didn't move over to bipolar?

A. That's true.

16 Q. Okay. Did you understand that you were required to move over? 10:08

A. I wasn't required to move over. I was certainly facilitated in continuing to use monopolar resection, using glycine, with all of the precautions that I had been used to since my training days in Dublin in the 1980s and which were further reinforced and regimented, 10:08 in fact as I had experienced them back in Dublin in the 1980s, with regular biochemical analysis during resection and so forth. So, I mean, I have a long experience of resecting prostate using glycine. I have

addressed that in the recent addendum, and I think the only thing I would add to that recent addendum, I did relate that the only severe case of TUR syndrome that I have ever experienced, or known of, was in Dublin; it happened to be the first I've ever experienced, and when you experience a severe TUR syndrome, you don't forget it. I remember it vividly in about 1987/'88, or thereabouts. So I've always been very vigilant with regard to biochemical derangement during resection of the prostate. I have found it to be, using monopolar with glycine, to be safe in my hands. I did give it a fair wind, even though I declared upfront that my fair wind may have been considered prejudicial, but, in my hands, I was much happier with, and for the safety of the patient in my hands, I continued to use monopolar, with glycine, and was facilitated in doing so. 10:09 10:10 10:10

17 Q. Just to come back on the point I made to you which prompted that answer. You have indicated that you weren't required to move over? 10:10

A. That's right.

18 Q. Others appear to have interpreted it as a directive or as akin to a directive, the policy handed down by the Deputy Medical Officer, which was then translated into an implementation plan by the Trust, was to introduce bipolar resection equipment, for the reasons set out in the policy. It might be read as indicating a policy that, while there was a recognition that it might take some time to transition to the new equipment, and 10:11

suggestions were made as to how things could be kept safe, particularly on the fluid balance front in the interim period, were you not of the view that the powers-that-be are really requiring me to move forward and to change? Was that not signalled to you? 10:12

A. No, I wasn't of that view. It wasn't my interpretation. It was never made clear to me or by -- or hinted that there was that expectation, and to the contrary, I was facilitated with continuing to use glycine. 10:12

19 Q. Mr. -- again, just to come back to something Mr. Young said, and just to get it exactly right, I'll bring it up on the screen. WIT-103616. And at paragraph 6.7, he says: 10:12

"To the best of my knowledge I am not aware of the Southern Trust ever directing cessation of monopolar procedures"

He added a caveat to that in his oral evidence, which I've explained a moment or two ago, which was that he regarded it as a directive. 10:12

He goes on to say however: 10:13

"There was a delay in the supply of resectoscopes due to purchasing issues from the Trust. The scopes..."

- I'm just skipping on:

"The scope systems were eventually installed in April 2018. There was, however, a proviso that saline was the principal median to be used but if, for example, the surgeon felt there was a tissue coagulation issue at the time of surgery, this could be changed to glycine. This was to accommodate all members of the team."

So he's putting it rather more strongly in favour of requiring a movement, albeit that if you ran into difficulty with coagulation of the tissue during surgery, then you could weigh it up and make a change at that point. But you, as I understand it, failed to make the change at all; your default position was to continue with bipolar and glycine -- sorry, monopolar and glycine.

A. Hmm. That is correct, yes.

Q. Did you, notwithstanding your years of experience and your familiarity with the monopolar approach, did you not recognise the safety issues that were prompted by the Deputy Medical Officer's intervention?

A. I did. Ehm, but you will have seen another wealth of correspondence, which we don't necessarily have time to go to, where many urologists in Northern Ireland, you know, expressed their reservations about the change and the application of that dreadful experience during a gynaecological procedure to the urological field, and particularly by some with regard to using saline during

trans-resection of bladder tumours, more so than with the -- of the prostate, because of -- there's a -- there's a preciseness and a sharpness to dissection with glycine that you don't get with saline irrigation. But as I said, and most importantly I think, if it's helpful, and that is, I would have -- I would have had to change over with all of the reservations if it was mandatory, or if I was told it was mandatory, but I was facilitated and I expressed -- or I had some surprise in hearing, you know, Mr. Young expressing lack of awareness that I was continuing to use glycine, because it was readily available. And I, to repeat my answer to you earlier, you know, I wasn't aware of or told that one had to change over. But I certainly -- I mean I've been aware of those safety issues since I started in Urology in 1985. So... 10:15 10:16 10:16

21 Q. Let me move on.

A. Thank you.

22 Q. We are going to spend much of the rest of our time looking at some of the more significant structural issues that emerged from the SAI cases that were the subject of review by Dr. Hughes and his team in 2020 and 2021. You'll be aware that those reviews made some strident criticisms of your work, but also pointed, more importantly, I think, from the perspective of this Inquiry, to governance failings. So the focus is going to be on some of the more structural elements in my questioning, in the fine detail of the individual cases, which are set out, of course, extensively in the 10:16 10:17

materials, including the material you've presented, Professor Kirby has presented and, of course, on the other side of the argument, generally, the reports of Mr. Gilbert.

10:17

So, you will again appreciate that the Review Team made findings across a range of issues, including diagnosis and staging, in relation to whether targets were met for patients, the conduct of multidisciplinary meetings, failures of referral, as well as governance and leadership.

10:18

In respect of you, I want to give you an opportunity to respond to this. There was a general finding, if we can bring it to -- bring us to DOH-00128. It says as regards yourself, that:

10:18

"The review of nine patients has detailed significant healthcare deficits while under the care of one individual in a system. The learning and recommendations are focused on improving systems of multidisciplinary care and its governance."

10:19

But just holding on to that first sentence and moving down the page, it says that:

10:19

"The primary duty of all doctors, nurses and healthcare professionals, is for the care and safety of patients. Whatever their role, they must raise and act on

concerns about Patient Safety. This did not happen over a period of years, resulting in MDM recommendations not being actioned, off guidance therapy being given, and patients not being appropriately referred to specialists for care." 10:19

So those remarks are directed to you, Mr. O'Brien.

A. Hmm.

23 Q. And your practice. Conscious that you've worked your way through each of the nine cases. 10:20

A. Hmm.

24 Q. And you've also made general remarks about what you say was the failings of the SAI process, its accuracy, or its correctness in some respects?

A. Hmm. 10:20

25 Q. Its failure to take certain things into account, and primarily, as I think you see it, the failure to give you adequate opportunity to respond, which you've set out at paragraph 679 of your primary witness statement, an approach you say was grossly unfair. Is there 10:20 anything you want to add to the general remarks that you've set out in your witness statement about the approach of the SAI Review Team and the conclusions that they reached?

A. Yeah, I think that -- I think that they were somewhat 10:21 prejudicial. I think that there was -- I think that that was manifest in several of the expressions that were recorded in the notes of meetings that were held. I think particularly a good example is that relating to

my usage of or engagement with clinical nurse specialists, for example. I think that -- I think, possibly the thing that caused me most alarm since the Inquiry was established, was Dr. Hughes' belief that patients entered a contract with a multidisciplinary team, and irrespective of whether one uses the word "contract", or "agreement", or "pact", or "understanding", or whatever, and that the multidisciplinary team dictates or directs the care of the patient, the notion that I was acting in a uni-professional manner, I -- I have no experience of that at all. I was very much involved with, and I was the lead clinician for the multidisciplinary team for years. The Inquiry is entirely familiar with the difficulties with regard to quoracy along certain lines. I have, in my addendum, related my philosophy with regard to the integrity of the patient, patient participation in their management decisions and their care. So I don't recognise a lot of what this tends to infer, and perhaps you may want to tease out some of those issues in more detail as we go along.

10:21 10:22 10:22 10:23 10:23

26 Q. We will, of course. Is it fair to say, and I have scrutinised your responses to the nine cases quite carefully, is it fair to say that you see no real substantive basis for criticism of your input into any of those cases?

A. No, that's not the case. I have concerns about two cases in particular, and if you want me to detail those now, or later, I can.

27 Q. Just briefly, now, if you would.
A. My concern, actually, with regard to Patient 9, who was otherwise known as Service User B, my concern there, basically I think when I reviewed him in July 2019, following his prostatic resection when there was no evidence of prostatic carcinoma present when I expected it to be, and he was still quite symptomatic of his lower urinary tract, and I was concerned about him having infection, and I remember clearly sitting there wondering; how can I send off urine for culture? How can I prescribe antibiotics for a period of time so as not to subject him to prostatic biopsy with an increased risk of infective complication? And how can I possibly ensure that I will definitely be reviewing him within an intended timeframe? And in retrospect, the thing that concerned me is that I overlooked the possibility; why didn't I request an MRI scan to be done in September, which would have been the three-month interregnum that we allowed as an MDT following TURP prior to MRI scanning because of the architectural distortion that you get following resection of the prostate? So I regret not choosing that option, or thinking of that option that day, because I could have had an MRI scan done with a view to it being discussed at MDM, which would have mandated my review subsequently, and it might also have given some advanced insight into the possibility that he might have had a urethrorectal fistula, even then, never mind one year later.

10:24 10:25 10:25 10:26 10:26

28 Q. And the second patient you wish to mention?
A. And the second case is that -- is in the case of Patient 3, and that is that when he was first discussed at MDM in April -- April 2019, it wasn't an MDM at all, it was a virtual MDM. It was myself who did it. There was no one present. I think we have familiarised the Inquiry with the concept or the practice of virtual MDMs. They weren't by Zoom, it was a singular person doing it. And the one thing that I am disappointed in, is that, for some reason my MDM outcome was to review the patient to arrange a CT scan of chest, abdomen and pelvis, but that's not typical, it was exceptional to my MDM outcomes, because it should have been followed by further subsequent MDM discussion. And then, on top of that, when, at the end of May or June -- I reviewed him anyhow, and then at the end of June I recall being surprised that his CT scan wasn't already done, and I did not include this in my clinical history of him because I've only included things that I have been certain of, and I thought that I had requested it, and why isn't it done? Why isn't it requested? And it was only recently, on listening to Mr. Haynes giving evidence on his last day, that he referred to the times when a request may not go through, and I didn't want to include that in case it would be regarded as excusing because I wasn't certain of it. So I have that concern about him because that would have brought forward his whole pathway. And in a sense, as well, having found that he did have enlarged lymph nodes in his left groin

10:27 10:27 10:28 10:28 10:28

-- a report I should add, do you know, that I did see, and I arranged his review -- in a sense I regret not just proceeding on with lymphadenectomy at that stage following MDM discussion, rather than going through the process of fine needle aspiration cytology to confirm that he did have metastatic disease.

So those are my self-criticisms, about which I have thought a great deal.

10:29

In his case, and I know it's not the concern of the Inquiry directly, whether that would have altered his eventual outcome, is another matter.

29 Q. Yes. Thank you for that. Professor Kirby gave evidence, as you know, instructed by your legal team, and one of the things he said about you was that, although he didn't know you, but he had taken soundings about you, as we know, he -- he spoke to somebody or received e-mail communication from somebody who knew you quite well, I think; he had all of the relevant papers, and what he said was:

10:30

"I think, he..."

- that is Mr. O'Brien's:

10:30

"...is old-fashioned in his approach, and that comes from the fact that he has been in practice for many years and has found it difficult to adapt to a changing

landscape of the way medicine is practised."

He goes on later in his evidence to make other points about relationships with Oncology and that kind of thing, and I'll touch upon that later. But is there -- 10:31
maybe it's hard for you to self-analyse in this respect, but is there -- is there anything in that? The institution of the MDM approach to medicine came in the last ten years or so of your professional career. You were obviously an active participant in it, a Chair 10:31
and an MDT lead for a number of years, but were you -- maybe "old-fashioned" isn't necessarily the right word -- but was the MDT concept something that you found difficult to embrace, in the sense that it involved, if you like, giving up an element of your autonomy to -- 10:32
your professional autonomy to your colleagues, following -- it was intended that you should at least give consideration to recommendations, and we'll come to what that precisely means in a minute, for referral on; did any of that not sit well with you in terms of 10:32
your practice?

A. No, I don't recognise that at all. I, I embraced the multidisciplinary team approach. I put a great deal of time-consuming effort into making multidisciplinary meetings work as effectively as they possibly could. 10:32
And they would have worked a lot better if we didn't have the problems with Radiology and Oncology. There were deficits acknowledged way back, do you know, when Peer Review took place. So I mean there were

deficiencies, they're all well rehearsed, you're all well aware of them, but I mean I made every effort that I could possibly undertake to make them as comprehensive and as inclusive as possible. And, you know, the biggest deficit in multidisciplinary 10:33
meetings, and it's acknowledged internationally, is that you don't have the patient there. Actually having the patient present has been tried in some countries, but it hasn't been found to be necessarily appropriate, because you can't discuss things frankly or candidly 10:33
necessarily in the presence of the patient, and it slows down the whole running of the MDM enormously. So there is a -- there's a gap, and I tried to fill that gap as much as possible by amending and adding to the clinical summaries that were submitted by other 10:34
clinicians. I think I made reference the last day to the fact that clinical summaries were not actually submitted at all, but just a copy of a letter to a GP. So there were -- and even if you have a clinical summary presented, that doesn't actually enable the 10:34
multidisciplinary meeting at the end of staging, for example. For example, in prostate cancer. You know, you have to bring all of that back to the patient with the recommendations of MDM, and even go further back to make sure that they understand exactly what they have, 10:35
what we have learned, what we haven't learned, the limitations of that, to explain to them as objectively as possible the benefits and risks of every course of action. You then place the recommendations of MDM in

that context, and you must give the patient time to assimilate all of that and to formulate their views, and some people come along with their predetermined preferences, do you know, "I want it removed" or I don't want it removed", and so forth. 10:35

30 Q. Let me come to that in a moment.

A. Hmm.

31 Q. So the description of you as an old-fashioned practitioner and whatever that necessarily conveys, it doesn't sit easily with you? 10:36

A. I mean, old-fashioned can mean experienced; old-fashioned can mean having accumulated a great deal of wisdom and insight along the way.

32 Q. He defined it, just to be clear, as showing an inability or a difficulty in adapting to a changing medical landscape? 10:36

A. Well, it depends on what the -- the adaptation precisely is. But I don't recognise the generality at all.

33 Q. Very well. You've touched on the difficulties posed by an absence of quoracy over a lengthy period of time, and that was generally as a result of the failure or the inability to supply the Southern Trust's MDM with an adequate resource of oncological expertise, and regularly, and towards the end more regularly, really illogical input. 10:36 10:37

A. Hmm.

34 Q. The SAI process in the overarching -- in its overarching report -- and I'll just give the reference,

we don't need to bring it up on the screen. It's DOH-00124. It found that the MDM quoracy was only 11% of meetings in 2017, 22% in 2018, none in 2019, and 5% in 2020. So from a quoracy perspective, I suppose the school report would be: Could do much better. You've commented upon all of this, what you described as persistent problems around quoracy, and you say that the lack of quoracy impacted effectiveness and arguably the legitimacy of the MDT system.

A. Hmm. 10:38

35 Q. Would you care to elaborate on that? How did you -- how did the absence of these specialisms impact upon effectiveness and what do you mean by your concern in relation to legitimacy?

A. Well, it's self-evident, you know, that they would have 10:38 impacted negatively upon the -- by definition, the multidisciplinary efficacy of a multidisciplinary meeting. And, do you know, it got to the stage over a period of years -- I mean, we did discuss as a multidisciplinary team at those meetings, informally, 10:39 several times, do you know, whether our continued existence was at all valid. If you don't even meet the definition of the requirements of the Cancer Peer Review measures in having an oncologist, preferably a clinical oncologist, because if you have a medical 10:39 oncologist, a medical oncologist is not a radiation oncologist, so if you have a radiation or a clinical oncologist they also double up as a medical oncologist, so we did need to have an oncologist present, and we

needed to have consistent radiological presence. And it was interesting to contrast that with the ever presence of pathology, and I had discussions with Clinical Leads in Radiology concerning that matter, and you may have read e-mail correspondence from me in that regard. We had a wonderful radiologist, as I alluded to last day, in Dr. Marc Williams. But I couldn't convince the Department of Radiology that MDM was not an optional extra; it was mandatory, it was a core issue. And in fact, actually, I met with Dr. Wright in April 2016, I arranged a meeting with him to discuss this, and he did make an effort, as a radiologist himself, with the Department of Radiology, to try to free up Dr. Williams more. And to complete my answer to you: We did, several times, question whether we should continue; and we did, several times, wonder what would be the consequences of our continuing in the way that we did practice, and, alternatively, what would be the consequences if we said "time up, this is no longer valid"? How are all of these 40 cases being discussed each week? Where are they going to be discussed? How is that going to be catered for? It's almost like analogous to the whole thing of centralisation of radical pelvic surgery, was Belfast able to cope with us saying "time up"? And sometimes when you look back at the progressive deterioration in urological services, you often wonder whether it would have been better to hasten the end rather than trying to continue to provide services on the shoestring.

10:40 10:40 10:41 10:41 10:41

36 Q. Yes. I needn't bring you to the e-mails, the Inquiry has the note of them, but certainly on repeated occasions the threat of packing up the tent and going home because of the inability to adequately service the MDT was made by, I think on one occasion you, and certainly by your colleagues, Mr. Glackin and Mr. Haynes. 10:42

A. Hmm.

37 Q. But it would appear that the decision was made to muddle through. What were the -- we've heard about work rounds -- sorry, work-arounds -- where the oncologist isn't there that week, or the radiologist isn't there that week, the conversation would take place later on the telephone and the message would be brought back to the team or, in the alternative, discussion of the case would be postponed perhaps to the following week, and sometimes four weeks down the road, until the relevant expert could attend to thoroughly discuss, perhaps, a complex case. Does that all resonate with your memory of it? 10:42 10:43 10:43

A. Oh, absolutely.

38 Q. That you had to develop these kinds of solutions?

A. And they weren't solutions at all. I mean if you are -- if you're without a radiologist for two or three weeks -- and one of the things that we often discussed was whether we should have the cases to be discussed sorted out so that the radiologist is only required for the first ten, and an oncologist for the next ten, or whatever. My philosophy in that regard was, you know, 10:43

multidisciplinary meetings are not a drop in/drop out venue. We listed them in alphabetical order. We, as urologists, collectively felt, on balance and pretty strongly, that that's how a multidisciplinary meeting should be conducted, that people should be present for the duration. And even when we did have oncologists present during the time when we had an acute Oncology service, for usually, I gather, family reasons, they didn't always necessarily were able to stay for the duration. So it was most unsatisfactory. 10:44

39 Q. Yes. Can I bring you to a concern that you have articulated in respect of the MDT and its working, which doesn't necessarily flow from the SAI reports, and it's to be found at WIT-82505. And at paragraph 306, I think -- 305 is looking at quoracy. 306 is discussing the quality or the need for quality to be found in your chairmanship of the process. And I think if I can just -- just scrolling down. There it is. So on the right-hand margin on the screen in front of you, after discussing the need for the Chair to be of adequate quality, you said: 10:45 10:46

"Greater concern over recent years has been the increasing tendency of the MDT members at MDM finding themselves agreeing to management recommendations which had not only already been recommended to the patient by the Consultant Urologist and Core Member but had already been implemented. In most cases, the MDM would have agreed in retrospect with the recommendations 10:46

already shared with the patient, if not already implemented."

And you go on, I think, just over the page, to refer in particular to the case of Patient 10. I don't feel that we necessarily need to go into the detail of that, but you're pointing to a situation where, in advance of the MDM, the clinician has already implemented a management, or at least communicated a management plan to the patient. 10:46 10:47

A. Hmm.

40 Q. And it's -- it's really -- it really becomes a rubber stamping exercise...

A. Hmm.

41 Q. When it reaches the MDT. 10:47

A. Hmm.

42 Q. Because the -- if you like, the cat has already been released from the bag.

A. Hmm.

43 Q. Was that a particular problem or regular problem? 10:47

A. I think, just to clarify the situation with regard to Patient 10. I think that was only, I can only recall a similar incident occurring once before where the operation was actually performed prior to MDM discussion. And I think the -- the plan being recommended to the patient, not yet implemented but recommended, with a plan in action before MDM discussion, that was -- that was a very -- that was a pretty regular occurrence, and I think became more 10:48

frequent over the years. I should emphasise that in retrospect, in the vast majority of cases, we would have concurred with the recommendation, but nevertheless, it's not in the spirit of MDM, particularly in more complex major surgery, to be recommending to the patient and setting in place a management plan before MDM have -- before there's an opportunity to discuss it at MDM. 10:48

44 Q. Mm-hmm. I mean, obviously, in your role as MDT lead, or as Chair, you would have had an opportunity to prevent this, or at least applying pressure to prevent this form of practice. Is it something you did try to address? 10:49

A. I did, and particularly when it occurred. I didn't realise in the case of Patient 10 that that had been the case. But in another case where one of my colleagues had performed a nephrectomy before being discussed at MDM, he held his hands up, said "sorry, shouldn't have done it, it's an oversight". It wouldn't have made any difference, quite frankly, to the management plan if we had discussed it before because it was plainly evident that that was the right course of action. But, you know, MDM, in contrast to you enquiring as to whether I had difficulty in embracing it, I felt it was of such importance that it shouldn't be circumvented in that manner. 10:49 10:49 10:50

45 Q. You talk in that sequence about the case actually reaching the MDM at least, albeit the management plan may have already happened or communicated. In her

evidence, Dr. O'Kane, and this was TRA-11755, she said that the Lookback Review into your cases, or some of your cases, indicated that patients had come through the system, had a diagnosis of cancer, and weren't always -- this is line 18: 10:51

"...and weren't always referred to the MDT."

And adding to that:

10:51

"And for others were referred to the MDT, but may not have had their results enacted."

And we'll come to that second part in a moment. Do you accept that there were occasions for which, for 10:51 whatever reason, you didn't send the cancer case, the diagnosis, to the MDT for discussion in relation to management?

A. No, I don't, unless, you know, it's an oversight, like I've just referred to in another aspect. You know, one 10:51 of the things that concerns me about having reviewed as much as I can, without clinical records, some of the comments and findings that have been made throughout the course of the structured clinical record review, is that there's no record of a discussion at MDM, 10:52 sometimes even before we actually even had an MDM. But, you know, in the period -- I think, actually, the MDM outcomes were not recorded on NICAR until about 2014, I think I'm correct in saying that, and they

should all have been on the CaPPS system, which is a separate system, the Cancer Archival Patient Pathway System, they were not always included in patient records in the early years, so it concerns me that just because there hasn't been an apparent record that there's a conclusion that it wasn't discussed. Every newly diagnosed patient -- I should add, however, if patients actually had been diagnosed prior to April '10, if they had been diagnosed two years previously, and we now had an MDT/MDM structure, I wouldn't have necessarily brought them to MDM just because there wasn't an MDM at the time of their diagnosis, unless they progressed or something. 10:53 10:53

46 Q. Yes. Could I bring you to two examples and, in fairness, because this is -- this has been shown to the Inquiry and you'll want to make whatever comment you feel is appropriate. Patient 25 has been the subject of an SCRR process? 10:53

A. Mm-hmm.

47 Q. Mr. Awry was the reviewer, and if I could bring you to his SCRR review. It's to be found at TRU-309747. And he said, it says in respect of this patient: 10:54

"There is no evidence that the patient's condition was discussed in MDT. The patient was started on a suboptimal and unlicensed dose of Bicalutamide 50mg, rather than complete androgen deprivation." 10:54

And he goes on to describe, just scrolling down the

page, just on down there's a score sheet towards the bottom, he describes this as very poor care. But just in respect of no evidence of discussion at MDT, how do you respond to that?

A. Can you remind me, if at all possible, the year of the diagnosis? 10:55

48 Q. I've looked at that report and I don't think the year is cited in it?

A. Yes. Well I mean I would be very, very sceptical. I wouldn't rush to the conclusion that because there was no evidence of an MDM discussion in the records with which he was provided, that there was no MDM discussion, for the reasons that I've outlined. 10:55

49 Q. And a second example has been drawn to our attention. Patient 75, again the subject of an SCRR process in the hands of a Mr. Stephen Brown, Urologist, and it's to be found at TRU-309763. And: 10:55

"On 14th November 2011..."

10:56

- so we have the date for this one:

"Patient with wife was seen by a specialist registrar and a diagnosis of high risk Gleason 4+5 prostate cancer and need for staging investigations and MDT review. MDT did not happen, which should have, and instead the patient was seen by AOB and diagnosed and started on 50mg of Bicalutamide and 10mg of Tamoxifen. There appears to have been no discussion at this point 10:56

of referral for consideration of DXT. This was an inappropriate management with use of an off license dose."

So, again, he's saying MDT in respect of this patient does -- did not happen on the basis of what he has seen. Your response to that? 10:57

A. Well I think that it's -- I have reservations about anybody coming to the conclusion that it did not happen just because there was no record of it happening. Irrespective of who he had been reviewed on 14th November 2011, and if this is an accurate and reliable summary, that the diagnosis was given, and the need for staging investigations and MDT review; I mean that would have been very, very standard. I do not know -- I mean, that would have been listed for MDM discussion. So for the reasons that I've already alluded to, I would be very concerned about, you know, concluding, as Mr. Brown has done, that there was no MDM discussion. I cannot comment, because I would be delighted to if I was provided with access to all the records, but -- and I find it frustrating from that point of view. But it's just to highlight to you that in those early years, it wasn't on ECR, should be on CaPPS, it wasn't always in the patient records, so if Mr. Brown and others have been provided with NICAR records and the printed clinical records, and without having been provided with CaPPS, he may have come to that conclusion. 10:57 10:58 10:58 10:58

50 Q. Yes. Well, you put the point out there. The Trust has supplied the Inquiry with its SCRR summary?

A. Hmm.

51 Q. In response to our request, and it's provided us with some reports, and probably the majority of the reports, and the Inquiry has had to make a decision in terms of what it might be relevant to supply to other Core Participants, you've seen those two reports and you've made your observations. 10:59

10:59

I mean just finally on this point, I mean can I interpret your evidence as suggesting that there was no culture at the Southern Trust of seeking to avoid MDT consideration of cases? That if it happened, it was accidental and infrequent, but you can't remember it happening terribly frequently? 10:59

A. I would concur with that, and I would be most concerned that anything to the contrary was the case with any clinician, and it certainly wasn't the case with me.

52 Q. Yes. Can I bring you to the MDT's Operational Policy for 2017? We can find it at WIT-84538. And if we just scroll down. It sets out a definition in terms of the cases that come -- should come to an MDT, and it says: 11:00

"All new cases of urological cancer and those following urological biopsy will be discussed. Patients with disease progression or treatment-related complications will also be discussed and a treatment plan agreed. Patient's holistic needs will be taken into account as 11:01

part of the MD discussion. The clinician who has dealt with the patient will represent the patient and family concerns and ensure the discussion is patient-centred."

Part of the evidence that we have received in terms of that part of that definition that talks about complications, treatment-related complications, has brought evidence sometimes to suggest that where the clinician, following the MDT, has spoken to the patient about the MDT's recommendation and has come to a different view as to the treatment plan, that as a matter of good practice that scenario should be brought back to the MDT, so I wanted to add that into the definition by way of expansion. Is there any part of that definition that wasn't reflective of the operation of the Southern Trust's MDT? 11:01 11:02 11:02

A. Or the practice of it?

53 Q. Yes.

A. Yes. Well, all new cases of urological cancer should certainly have been discussed, and, indeed, we did, for a period of time, it didn't involve a great number of patients, but we have listed for MDM discussion as a safety measure anybody undergoing a urological biopsy, even though, very often, the biopsy found no evidence of malignancy, but that was easily dealt with. But sometimes, actually, that's equally important, because the biopsy is done on the grounds that there's a suspicion of malignancy. So -- anyhow, that's sentence one. 11:02 11:03

Sentence two; patients with disease progression. It's an interesting one, because disease progression was very often more defined by a particular milestone, like, for example, a further resection of bladder tumour, or recurrent bladder tumour, irrespective of whether it represented disease progression or otherwise, increase in the size of a renal mass that had been under surveillance. Treatment related complications, I cannot recall that being a particular issue that we would have brought back. I mean certainly if you had -- if a person had a radical nephrectomy, or a partial nephrectomy - that's a good example - by the time that we would have been discussing their pathology, the complication would very often have arisen by then, so we would have had the opportunity of discussing it. There wouldn't have ever been an inhibition to doing so. And the treatment plan agreed, and that's what you're referring to, did we have a practice of bringing back to MDM, where there's a divergence, as it has been described, to the treatment plan? We didn't have a practice for doing that. And one of the things actually that we discussed a great deal, at great length on several occasions where you have management options available to the patient, is to be less prescriptive in our MDM outcomes or plans, as they have been variously entitled as the years went by, so that if, in the case of prostate cancer, you were discussing, or you were recommending

11:03 11:03 11:04 11:04 11:05

that the patient could have active surveillance, or they could have management with curative intent -- even actually the use of to review the patient, to discuss the diagnosis and prognosis, to consider the management options with a view to considering management with curative intent, that kind of terminology. So, we did place a great deal of trust in the clinician discussing all of the options, so that left less of a need to bring back a divergence -- holistic needs assessment, of course, that's another issue -- as part of the multidisciplinary discussion. 11:05 11:06

54 Q. Yes.

A. Insofar as that could be undertaken. And in a sense, that it is patient centred is very much the same...

55 Q. Well, I want to explore some of those aspects. Before I do, I want to set out for you -- if we scroll back in this policy -- to, it's I suppose the philosophy of an MDT, and it's to be found at 535 in this series, three pages back. And it's described as, at the top of the page, it's: 11:06 11:06

"An MDT brings together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care for patients with cancer." 11:07

It goes on to say:

"The primary aim of the MDT is to ensure equal access

to diagnosis and treatment for all patients in the agreed catchment area. In order to achieve this aim we provide a high standard of care for all patients."

And it goes on then importantly to say: 11:07

"The MDT ensures a formal mechanism for multidisciplinary input into treatment planning and ongoing management and care of patients with urological cancer with the aim of improving outcomes." 11:07

And it goes on to list another -- list a number of features of the MDT approach.

In terms of MDT recommendations. 11:08

A. Mm-hmm.

56 Q. If we -- if we view this through the lens of an MDT being a formal mechanism to bring together all that's necessary to inform the decision-making around the care of the patient. So if the MDT provides you with 11:08 a decision or a recommendation --

A. Hmm.

57 Q. -- that is something that you should be doing your best to implement in conjunction with your patient, and if that's not possible, it's something that you should be 11:09 recording and, as a matter of good practice, bringing it back to the MDT for further discussion?

A. Well, you know, the MDT ensures a formal mechanism for multidisciplinary input to the treatment planning. I

mean I have, in that -- I have referred to -- there are two very, very good documents which the Inquiry does have; the characteristics of an effective MDT and meeting patients' needs, improving the effectiveness of multidisciplinary meetings in Cancer Services, and I 11:09
have the Bates reference numbers. And when you -- when you look at this globally, it's very interesting, because I think when you look at the language of various documents, including the one on the screen in front of us, there is -- there is a -- there is room, 11:10
I think, for differing interpretations of the rigidity, or the obligations that are placed upon the patient and the clinician in charge of that patient with regard to implementing, as you said -- you referred to it as implementing the MDM recommendation. The clinician 11:10
actually implements the MDM recommendation by ensuring that the patient is informed of the MDM recommendation. There's a major dichotomy here: Is it the case that the MDT in the vehicle of the MDM is actually deciding how this patient is to be managed, and that you bring 11:11
that recommendation to the patient with a degree of obligation that is not entirely respectful of the patient's own autonomy, and which we can get on to at a later date with regard to, and particularly with regard to prostate cancer, the whole reality of 11:11
management decision regret? So, is it, as Dr. Hughes indicated, that the MDT is actually treating and managing the patient? Or is an MDT that formal structure, which I had every faith in, and which

I participated in so much, and which I valued so highly, in actually arriving at, with the best knowledge that it had at that moment in time, how this particular pathology should be managed? And it is the clinician's responsibility to bring that to the patient, and did we have a practice where there's a divergence from that recommendation to bring it back? We didn't have that. I would have had no problem with doing so, except for the fact, actually, that it would have overwhelmed an MDM that, as you know, was already deficient. 11:12 11:12

58 Q. You've referred to Dr. Hughes. You've said the word "contract" in this context.

A. Hmm.

59 Q. And I think I'm correct in saying that he added an explanation to that when I asked him about that. Certainly, for Mr. Gilbert's part, he said in his -- one of his witness statements: 11:12

"I agree that MDT recommendations are not mandatory but neither are they simply advisory. The recommendation is a consensus on the optimal treatment and should be explained as such, recorded in the notes, and deviation recorded and best practice is to re-discuss deviation with colleagues." 11:13 11:13

Is that something with which you could concur?

A. Yes, except we didn't have a practice of, you know, returning any divergence. I mean, it's best --

actually, the best expression of this dichotomy is in the first page of every NICE guidelines, if you look at NICE NG131, which pertains to prostate cancer, it lays it out there quite explicitly. It states:

"We expect the clinician to take on board the recommendations in these guidelines..."

But --

60 Q. A slightly different context? 11:14

A. It is a slightly different context.

61 Q. It's talking about guidelines and not MDT?

A. Yes, but it is a parallel. And, in my view anyhow, I think there is an agreement that the MDM decision, as it's often referred to, is nothing other than 11:14 a recommendation, and I put those recommendations to all patients. In the context, actually, of -- as objectively as possible, with all of the information aids like Prostate Cancer UK, and, again, actually, the NICE guidelines have really objective detailed risks 11:15 and benefits that you can share with the patient. So, I did all of that. I spent so much time doing that that I didn't actually record -- I mean, if you are reviewing the patient post MDM, you are reviewing the patient to catch up to that moment in time, inclusive 11:15 of imparting to them the MDM recommendation. And the course of action that is taken thereafter, I would have been very, very happy, and it would have been a good governance practice to take that back to MDM, but I'm

not aware that any of us did that as a matter of routine.

62 Q. Mm-hmm. One of the things --

CHAIR: Mr. Wolfe, I'm just very conscious of the time.

MR. WOLFE KC: Yes. If it's -- glancing across -- if it's okay I could finish this particular issue about 11:30 and then we'll take our break, but I'm quite content to break. 11:15

CHAIR: Is the witness content to sit on?

A. I'm quite happy. 11:16

CHAIR: Very well.

MR. WOLFE KC: I am obliged. Thank you all round.

63 Q. One of the things you've said is that one of the, I suppose, the that hamstrings, or potentially hamstrings an MDT, is that the patient isn't in the room? 11:16

A. Hmm.

64 Q. And a decision or a recommendation emerges and you take it back and review it with the patient?

A. Mm-hmm.

65 Q. We see through the SAIs that the reviewers are commenting that eight out of the nine recommendations which emerged from the MDT in the nine cases that they looked at were correct, in their view, but they weren't always implemented. If you are discussing a patient at MDT, and if one of your concerns, say in the context of prostate cancer, is the ability of that patient, because of a cardiovascular history, or a diabetic history, or a wish to retain sexual potency. 11:16 11:17

A. Mm-hmm.

66 Q. If you have that knowledge, that should be brought to the MDT for discussion in terms of, for example, what form of preparation for radiotherapy, or if radiotherapy is appropriate, that kind of thing should be brought and discussed? 11:18

A. Mm-hmm.

67 Q. Is that "mm-hmm" a yes?

A. Yes, ideally it's very aspirational, do you know. Very often that information wouldn't have been there. Very often, actually, it's only at this stage when you go 11:18 back to the patient with recommendations that you - well, I would have raised these issues, such ask erectile function, such as cardiovascular history and so forth. But as I have alluded to earlier, that kind of information wasn't always available. And even if it 11:18 is available, it's when you go back to the patient and you discuss all of this holistically, that you start to allow the patient to formulate their own priorities to be able to say to themselves, "well, the risk of being incontinent of urine, that would be a major issue for 11:19 me". So this is not a simple matter. It is a time-consuming, complex matter. It is one that all too frequently, and I'm not just referring to the Southern Trust, MDT, MDM set-up, but I know from the literature, and internationally, it is all too 11:19 frequently a case where the focus of MDM is the cancer, it's the pathology, and people are -- can be shoehorned into a pathway that they ultimately severely regret, and which turns out -- in fact, if I may, it just

resonates with me, I think, Patient 18, we heard from a way -- last year sometime, where the patient had curative treatment, which he appeared to be impatient to have -- I think I've got the right patient, I hope I have, but his retirement years were blighted by the consequences, or the -- yeah, the consequences of his treatment, the adverse toxicity of it, if you remember with faecal urgency and faecal incontinence and so forth. 11:20

68 Q. The point I'm making to you, Mr. O'Brien, is that if the information critical to the care pathway -- 11:20

A. Hmm.

69 Q. -- only emerges after the MDT.

A. Hmm.

70 Q. And if it's that that is crucial in determining, in your mind, with the patient, the way forward, but it hasn't been shared with the multidisciplinary team, including the oncologist if he or she is present -- 11:20

A. Hmm.

71 Q. -- then that is running -- failing to bring it back to the MDT is running a coach and horses through the underpinning principle of multidisciplinary working? 11:21

A. Well, I would question that conclusion, because it isn't. I mean multidisciplinary working is bringing all of that information to the patient, but the patient -- it is the patient's prerogative to determine their future pathway. That's a separate issue from taking it back to MDM. I agree with you, I would have had no difficulty in bringing back all such cases to MDM if we 11:21

had had the ability to cope with it, provided, actually that -- it was interesting to listen to Dr. Hughes that they had to sign it off, like as if, you know, the patient actually has to have the approval. That goes back to his earlier sort of perspective on the patient having entered into that pact with MDT, of which the patient -- 11:22

72 Q. Just help me with that. Who has to sign it off?

A. He indicated that, you know, the MDT needed to sign off the divergence, they needed to take ownership of it. 11:22

73 Q. And -- yes. So he -- I can't honestly recall the precise way in which -- the way in which you have described it.

A. Hmm.

74 Q. But in essence, his evidence came to this: That there is a requirement, as he sees it, if you don't implement an MDT decision -- and this is taken from his oral evidence at TRA-01060 -- that you would bring it back to your colleagues and discuss it and agree how the care plan would be achieved. He says that: 11:22 11:23

"The other issues are that because the team focused on first diagnosis and first treatment patients weren't brought back to the MDT for discussion as their care needs changed." 11:23

A. Hmm.

75 Q. So, to summarise: You disagree with the perspective that there's any requirement to bring it back?

A. I wasn't aware of any requirement to bring it back. I think it would have been a very, very good practice to do so. I don't think it would have been practically possible to have been able to do so necessarily, and I think that it -- if we had done so, it may have been very, very positive development, because that would have -- that would have obliged us all to scratch our heads and say, "that's interesting", do you know, "how do we -- let's take another recommendation back to this patient", do you know? I mean, I'm not contrary to that whole principle, but I didn't believe that there was a requirement at that time, and I wasn't aware of there being a requirement. 11:24 11:24

76 Q. What about disease progression or complications with the treatment? 11:24

A. Hmm. Mm-hmm.

77 Q. Disease progression might be interpreted as meaning where the disease has got worse?

A. Mm-hmm.

78 Q. Or the patient has deteriorated? 11:24

A. Mm-hmm.

79 Q. We see that, for example, with Patient 1.

A. Mm-hmm.

80 Q. We see that with Patient 4. And I think also -- yes, Patient 4. The recommendation flowing from the SAIs in these kinds of cases is that where there has been disease progression, there should be a re-discussion of the patient, and that didn't happen in either of those cases? 11:25

A. Well as we have discussed in recent times, with regard to Patient 1, the first indication of possible disease progression was when his serum PSA level was found to have increased to 5.4, or something of that order, on 5th March 2020. And as I explained in my letter to the general practitioner at that time, that -- that should not have necessarily been interpreted as an indicator of disease progression, because it could have been spurious, there may have been a medication compliance issue, there may have been other factors that caused that increase, even though it was a significant increase in a period of two months from January 2020, and then by the time that I was aware, that in addition to a serum PSA level having increased, he was running into problems with increasing lower urinary tract symptoms, which ultimately ended up requiring catheterisation in early April, and because of all of the logistical communication issues with Covid during that period of time, I didn't become aware of that until May, the end of May, and then when I contacted the patient, the most important thing for him at that point in time was this indwelling catheter and being relieved of it. So the argument you may have is, well, should you not have actually then at least brought him to MDM before you proceeded to resect his prostate? My practice would have been to have resected his prostate, which was his priority, to alleviate him, hopefully, of having a catheter in, and then brought the whole issue to MDM. That was my plan. In the case of -- in the

11:26 11:26 11:26 11:27 11:27

case of Patient 4, I mean, he was admitted acutely in January '20 under the care of Mr. Haynes, and it would have been Mr. Haynes' responsibility at that time, rather than mine, to bring him to MDM. And I did review him then subsequently -- 11:28

81 Q. 27th February, I think it was?

A. Yes, yes. And I didn't likewise -- so it was a failure on the part of both of us.

82 Q. Yes. In principle, you agree with the proposition that disease progression cases should be brought back? 11:28

A. Yes, yes.

83 Q. And you recognise that in both those cases, that they weren't?

A. Yes.

84 Q. Albeit that, certainly with Patient 1, you think 11:28 there's good reasons for not doing so?

A. Well, I think there were understandable reasons. I think they're reasonable, if one was to be particularly didactic about it, I can understand the contrary view, but that was my plan at the time, and 11:28 I certainly would have been returning him to MDM for further discussion because I had planned to have him staged and so forth.

85 Q. Thank you. Thank you for that. Thank you for your indulgence in sitting on that bit little bit longer. 11:29

CHAIR: I think we're going to take a little bit of a longer break, given that we've gone on this length of time. So we will sit again at ten to twelve.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Thank you, everyone.

86 Q. MR. WOLFE KC: I want to ask you some questions, Mr. O'Brien, about the governance aspects of what we have just discussed. 11:48

A. Hmm.

87 Q. So, as you know, the finding of the SAI Review was that eight out of nine cases were the subject of what they called "appropriate recommendation", but there was no mechanism to check that those recommendations were 11:49 implemented, whether that was for investigations, staging, treatment or referral. So, in circumstances where you think it might be good practice to be able to refer back to your MDM when you are unable or unwilling for any particular reason in conjunction with your 11:49 patient to implement the recommendation, was it the case that there was no other mechanism in place to superintend that decision?

A. I think apart from where the cancer tracker would have not been aware of an outcome of a clinic, there wasn't 11:50 a supervisory mechanism in that regard. It may actually, do you know, on foot of the discussion that we've just had before break, I would have thought, actually, that it would be -- a good starting point would be to a practice and a capacity to bring the 11:50 patient back for discussion at MDM, because that would obviously be the foundation upon which any kind of supervisory audit, exercise, or structure could be built. It would be a rather sterile exercise if you

just built a structure on top of a situation to monitor outcomes and their implementation and recommendations, without actually having reasons provided. So I think -- I think in retrospect, and prospectively, for those still there, it would be a very good idea to be -- have the capacity to bring patients back to MDM for discussion and build that kind of supervisory monitoring audit structure on top of that.

88 Q. And for that matter, once the patient has been discussed at MDT, and a recommendation, if you like, delivered, there was no tracking of that patient's care pathway through the rest of the -- through the next steps in his or her management, so that, for example, if there was a need for treatment because of disease progression, there was nothing interrupting the process to check that that had been done?

A. Hmm. That is the case. And, do you know, ultimately, and I'm -- I apologise if I sound like a broken record, or pointing the finger of blame, but at the end of the day, you know, it was an inadequate service, and having listened to some of the improvements that have been made in that regard, there's an enormous learning journey to go on for a multidisciplinary team to learn from that whole interface between recommendations and the patient and the clinician and bringing back and so forth. It would be a much more enriched patient pathway if that were all possible.

89 Q. I mean, the effect of these governance shortcomings was that decisions that were incorrect, and it's suggested

that aspects of your decision-making were incorrect, and I know you disagree with that, you say "nothing to say here" as regards your practice, but to hypothesise that there is a rogue practitioner in your midst as part of that team, the absence of these governance features that I am describing means that their decision-making is beyond the reach of the MDT and beyond the reach of the Trust authorities? 11:53

A. That is true, and I mean the only -- you know, the only sort of additional perspective that I would have on that, is that, in addition to that enrichment of the patient pathway that I've already referred to, you know, perhaps, actually, the rogue practitioner may turn out not necessarily to have been as rogue or as maverick as was considered, and maybe there is a lot of learning for the mainstream as well. I'm just being philosophical about it. But that's the kind of thing that is so possible if you have adequate capacity and adequate time allocated to it, and I would be entirely supportive of that moving forward. 11:54 11:54

90 Q. Yes. As a member of this MDT for ten years since its inception and its coordinator, or, sorry, as its lead for several years, and a Chair and a rotating Chair thereafter.

A. Hmm. 11:55

91 Q. Did you have a sense of these inadequacies in the governance support for the MDT? Had you an awareness of it?

A. Yeah, well we didn't have any -- you know, I've

listened to the contributions of others with regard to audit, for example. I mean we were -- we were struggling to, to discuss, as wholesomely as possible, 40 cases per week, which was the cap I put it on at one stage, because otherwise people suffer from fatigue and 11:55
patients don't get adequately discussed. So we were struggling for all of the reasons that we have already mentioned this morning in terms of quoracy and whatever. Do you know, it's one of the concerns or views I have with regard to this whole issue of 11:56
adequacy of service and governance. In many ways it -- the emphasis, to my mind, should be on providing an adequate service and, in terms of MDM, along the lines that I've just been articulating, rather than continuing -- to govern and to audit a service which is 11:56
patently inadequate. And in MDM terms, do you know, I mean all of the issues were there, they're known. I've made reference in my aide-mémoire to a Bates number where, in the 2015 Peer Review, it was acknowledged then that there was a deficiency in holistic needs 11:56
assessment and the appointment of key workers. So when you are -- when you have deficiencies so fundamental as we did have in that MDM, I mean, you can govern and audit it until the cows come home but, you know, unless that results in some kind of improvement, and we 11:57
tried to get the improvement, Mr. Glackin and myself, prior to him, we did our best to try to improve quoracy and to try to improve all of the other features, such as key workership and so forth, but ultimately

unsuccessful. So it's a difficult tango to be involved in.

92 Q. Thank you for that. I want to move on now to look at what the SAI reviews regarded as incorrect decision-making on your part, and I want to particularly focus on the management of prostate cancer and the use of Bicalutamide? 11:58

A. Yeah.

93 Q. Delayed referral, and sometimes non-referral to Oncology, those series of issues. It isn't just the SAI series that has commented on those issues; we know that it has been the subject of comment in the Royal College of Surgeons' Report, which the Inquiry has seen, and it was the feature of many of the SCRR reports, which you have at least in summary form. But I want to focus on the various, if you like, alarms that might be said to have sounded in respect of your practice in this respect and your responsiveness to that. 11:58 11:58

11:59

I want to bring up on the screen before delving into this, a remark that Mr. Kirby, or Professor Kirby has made, which may be relevant in this context, and to ask for your views on this. If we go to TRA-09468. And I've asked him, if we just go to the bottom of the last page, to comment on whether he has formed any view -- just scrolling down -- in terms of whether you could be considered to be a team player, or whether he had any sense of you working in isolation, and he answered by 11:59

saying:

"To his detriment..."

- I think to the patient's detriment. 12:00

"He didn't seem to want to collaborate with his colleagues as well as he should have done, especially the radiotherapists in Belfast. That would have been -- a close relationship would have been ideal. He had 12:00 his own way of doing things and perhaps was reluctant to change."

What about that, Mr. O'Brien? Is he -- is he right that relationships with radiotherapists in this context 12:01 are important but that you did not engage with the Radiotherapy Oncology service as much as you should have?

A. I don't recognise that at all. I had -- I had great regard for the Clinical Oncologists in Belfast. Having 12:01 experienced Clinical Oncology in Dublin during my years of training, and then in Belfast, I think the standard of the service that they provide has been excellent and, quite frankly, do you know, I don't understand how Professor Kirby could make such comment just on reading 12:01 the views of others, without knowing me. I think he was probably comparing the very close relationship that he has with radiotherapists in London, in the prostate centre in London, in the prostate clinic, where they're

in the same room, and that would create a greater closeness -- out of proximity, but I don't, I don't see any reason why he may have come to that view and I don't recognise it.

94 Q. Yes. 12:02

A. Because I had no difficulty with the oncologists in Belfast and I valued their input and so forth.

95 Q. Yes. We've seen, and we'll explore your thinking in terms of your approach to prostate cancer management as we go on. 12:02

A. Hmm.

96 Q. But we've seen perhaps multiple examples of cases where you have maintained the patient on Bicalutamide, sometimes on 50mgs over a lengthy period of time, a lifetime in some cases, sometimes going from 50 to 150, maintaining on that monotherapy, and then, in some cases, the patient's PSA rising, arguably unexpectedly, but certainly rising to an extent where a referral is ultimately needed. One might infer from that, perhaps, that you're reaching management decisions in conjunction with your patient, whereas you really should be engaging with Oncology to discuss the wisdom in any particular case of that form of management? 12:03 12:03

A. Well, in all of those cases, that would have been the patient's preference. I would have outlined all of those prospects of patient management with the patient. That was -- I spent quite some considerable time doing so. And it's important to emphasise that in the doing of it, I avoided being subjective in my views in that 12:04

regard. I provided them with all of the objective information that is available with regard to management options. So, as I briefly explained to you in recent times, you know, I never -- I never embarked upon androgen deprivation therapy using Bicalutamide at either dose with the intent that this was going to be monotherapy. And the reasons why some patients were introduced at a dose of 50mgs was because they were concerned about embarking upon androgen deprivation therapy, never mind radical radiotherapy. You know, patients didn't want to be referred for radical radiotherapy. Now I do appreciate that there is counterview where the oncologists have said "I would have preferred to have seen this patient earlier", but if the patient doesn't want to be seen earlier by the oncologist, I mean, that doesn't negate the oncologist's view, but that is -- that is the reality. I think, actually, in my primary witness statement, I think I chronicle the case of -- oh, yes, Patient 35, whose son gave evidence to the Inquiry from Personal Information. 12:04 12:05 12:05 12:05

97 Q. Yes.

A. You know, a perfect example of where all of those options and the recommendations of MDM were discussed with his father, that patient, many, many times over a period of years, where he chose to have active surveillance in the first instance. Remarkably I was criticised I think for that, because active surveillance had not been included in the 2008 Prostate Cancer Guidelines, the NICE guidelines, for that 12:06

category of disease. But, for example, you know, his erectile function was of significant importance to him, and that's the reason why I started him on medication for that, before introducing him at 50mgs, before increasing it to 150mgs, and he was so keen to avoid embarking upon any management of his prostate cancer that would negatively impact upon his quality of life, as he viewed it, and the various aspects of that.

98 Q. Yes. I'm going to bring you in just two minutes to the rationale, particularly the rationale that you've set out in your addendum statement, having had an opportunity to reflect on all of the evidence received by the Inquiry, and you set out, in very clear and detailed terms for the Inquiry's benefit, your approach. 12:06 12:07 12:07

Could I -- just before reaching that, could I bring up on the screen, please, something you said in your primary statement two years ago. It's at WIT-92585. And that is -- sorry, 825, perhaps? Yes. At paragraph 544, please, you said: 12:07

"At no point during my years of clinical practice as a Consultant Urologist within the Trust from 1992 until 2020, was any concern raised with me in respect of the manner in which I prescribed Bicalutamide. Indeed, it was well known within both the Urology Service and the Oncology Service that Bicalutamide was being prescribed, and how it was being prescribed. No issues 12:08

were ever raised with me in that regard. The first time concerns were raised with was in correspondence with the DLS in October 2020."

Now, I know you corrected that in an addendum statement. 12:09

A. Hmm.

99 Q. And in that addendum statement at WIT-98807, you reflected that you had located an e-mail from Dr. Mitchell, sent to you on 20th November 2014. 12:09

A. Hmm.

100 Q. But in terms of what I've just read out, you were emphasising that nobody within the Urology Service, or indeed the Oncology Service, had challenged your, or commented adversely upon your use of Bicalutamide, and 12:09 had you simply forgotten that that was simply wrong?

A. Because of this e-mail that was sent to me?

101 Q. Yes.

A. Absolutely. I -- I -- I was very, very keen to have myself and my legal team check whether there was any 12:09 communication at all, and that's how we turned up the e-mail of November '14. And as I commented recently with you, and that is, it's now ten years on, almost, and I would simply love to be able to comment at this stage if I had access to the clinical records of that 12:10 particular patient. It is very, very difficult to respond to issues like that without having the records, and that -- that's a separate issue from my not having done so in 2014 or 2015, but I'm sure there would have

been an explanation for his management at that time.
102 Q. Mm-hmm. We'll come to that e-mail in a moment, but there's no record of you responding to it?
A. There's no record of my responding to it. I do not know whether I have responded to it in letter form? I requested that we would be provided with the referral letter, which turned out to be an inter Trust transfer referral, and I think my legal team had requested that we would be provided with the complete clinical records, but I haven't been provided with those. 12:11
103 Q. Now, I want to allow a little time to enable you to address the key points in your -- in defence of the approach that you've taken to prostate cancer management. Rest assured, the Inquiry has read your primary statement and your addendum statement, and in your most recent addendum statement, from paragraphs 24 to 47, you've set out, indeed by reference to some patient cases, including, I think, Patient 35, the -- sort of the key features of your approach. I suppose what you're saying, to summarise, is that you're acutely aware of the Regional Guidelines? 12:11 12:12
A. Mm-hmm.
104 Q. You have an appreciation every time an MDT makes a recommendation, but you are obliged to adopt a patient-centred approach, I think you call it? 12:12
A. Mm-hmm.
105 Q. And, in consultation with your patient after the MDT has recommended, you have to find the best solution for that patient, regardless of the guidelines, regardless

of the MDT's recommendation, and that conversation, quite often throws up issues about cardiovascular disease, diabetes, those kinds of comorbidities. There may be a view expressed in relation to the desire to maintain sexual potency. You cite another case where the, I think it was Patient 4, where the -- no, it was Patient 6, where there was an anxiety issue, as you describe it. 12:13

A. Mm-hmm.

106 Q. You wished to prescribe low dose Bicalutamide while the patient's disease was either confirmed or staged, one or the other. 12:13

A. Hmm.

107 Q. So, those seem to be the cardinal features of your explanation, is that fair and sufficiently complete? 12:14

A. Yeah, it's reasonable. Along the way you said "regardless of the guidelines", I think you've said. I've never disregarded guidelines. I'm very, very aware of the guidelines. So it's a reasonable summary. We may have left out some things but -- 12:14

108 Q. Of course.

A. Okay.

109 Q. Well rest assured that embroidered into the four prostate cancer cases that made up the SAI reviews -- is it four or five? 12:14

A. Five, I think.

110 Q. Five. So your responses to those, as well as your addendum statement, set out your rationale in a great bit more detail than we have time for perhaps today.

A. Hmm.

111 Q. You have said, perhaps if we go to WIT-107576 - let me see if that's just about where I need to take you? Yes, paragraph 43. You explain that:

"...when the patient has been optimally informed of the anticipated benefits of differing management options and of the comparative risks associated with those options, it has been my experience that a great proportion of men, probably the majority, were most keen to embark upon a journey to achieve the benefits while incurring the least risks. It has been in that context that androgen deprivation using Bicalutamide has been prescribed, irrespective of the dose initially used." 12:15 12:15 12:16

So, you're alluding to the kinds of conversation that you engage in with your patients, and that is a not infrequent response from the patient; "I want to take the least risky approach to my treatment, having regard to all the relevant factors in my life and personal circumstances", I suppose? 12:16

A. Hmm.

112 Q. Does that conversation involve you telling them that the guidelines are the recognised standard for most prostate cases? 12:17

A. Mm-hmm.

113 Q. And that any departure from that could be regarded as a suboptimal management approach?

A. Well, any departure from -- I mean the guidelines themselves specify, as I've already alluded to earlier on, that the guidelines -- the clinician is expected to take them on board because a lot of effort has been put in to drawing up guidelines and, indeed, actually, the MDT at MDM is expected to be cognisant of the guidelines as well. So the guidelines are "embroidered", is a good term, into all of this discussion, but it's not just a matter of diverging from the guidelines; I mean, the guidelines are based upon all of the evidence, and the published evidence -- and I'm sure Mr. Hanbury will acknowledge that. For most stages of prostate cancer, let's say, for example, organ confined prostate cancer, I mean the recent results from the Protect study show that if you go for radical prostatectomy, your cancer-specific survival, or mortality -- let's express it in mortality terms -- the risk of you dying of prostate cancer within 15 years is 2.2%. If you go for radical radiotherapy it's 2.9%. If you go for active surveillance in the first instance, it's 3.1 %. So as Professor Hamdy and Mr. Donovan have said in their various publications around those results, you know, the risk of dying of prostate cancer, if you have organ-confined disease, is so low that there should be a trade-off between the benefits of those treatments and the risks associated with them. You know, there's a greater awareness now, or there has been there for a decade, that, you know, it's one of the most negative legacies of prostate

12:17 12:18 12:18 12:18 12:19

cancer management, the whole issue of overdiagnosis and overtreatment, it's just -- those two words are an expression of an earlier experience where not a lot was always gained by curative management, and it is the risks associated with each, and there's a whole body of literature, I mean I can refer to, I can provide it to the Inquiry, which is supportive of that. There's a whole body of literature to say what really needs to be considered are the relative risks associated with each. I provided those to all of my patients in the years before they were readily available through Prostate Cancer UK, or on the screen. In more recent years I was able to go directly to the screen and show them the NICE risks and benefits, I used to take out an A4 page out of my drawer and I would do all of that and let them take it home with them to consider it. All of that is well documented. It's not just a matter of O'Brien coming along with some kind of maverick view. And very, very rarely, I should add, very rarely did a patient turn around to me and say "What would you do?" It's always a challenge. And sometimes I would say, "Well, if it were me and you're not me and I'm not you, I think these are the issues that would be important to me, but, do you know, take that away and I'll see you back in a week's time or two weeks' time when we'll make a further decision." 12:20 12:20 12:20 12:21 12:21

114 Q. Were you approaching this from the viewpoint that the guidelines, and we will come and look at the guidelines in a moment, were a manifestation of a tendency towards

the overtreatment or the unnecessary treatment of prostate cancer?

A. No, I think the guidelines -- I have the greatest regard for the guidelines. There's only one deficiency in guidelines, and that is that the guidelines of 2024 are, by definition, maybe two or three or four years behind the further emerging evidence. That's less of a lag period now than it used to be when, in the early years when NICE or the European Association of Urology formulated their guidelines, because it was a growing industry, for want of a better further, at that time, so there was a lot of different disease entities to go around. But in more recent years it's less an issue. The NICE guidelines, I think, probably, you know, with regard to prostate cancer management are outstanding, particularly as we have more -- we have more knowledge in more recent years of the different Cambridge Prognostic Groups with regard to prostate cancer and how those should be approached and managed. 12:21 12:22 12:22

115 Q. So we've started with your approach and your viewpoint on this, and I want to set aside that the approach of the Belfast clinicians? 12:23

A. Hmm.

116 Q. Dr. Mitchell, as I noted earlier, wrote to you in November 2014, and he had been in practice as an oncologist in the Belfast Trust since 2008, and he has given evidence that in the years prior to 2014, and he couldn't be precise about the cases or the number, he had come across, in terms of referrals from you, and 12:23

uniquely from you as opposed to any other clinician from the Southern Trust, referrals coming down the road where the patient had been on a, what he regarded as a therapy or a monotherapy at 50mgs, and he took the view that this was incorrect and maybe it was just a simple mistake. I think he at one point expressed the view that "I wonder is that a typographical error?", and he would have, in respect of those cases, made the appropriate change by writing to the general practitioner, and he said "I would have copied the letter changing" -- I've written down the word "diagnosis", but it may not -- but changing, I think what he intended to say, the medication to you, to the consultant. 12:24 12:24

A. Mm-hmm. Mm-hmm. 12:24

117 Q. Do you remember getting such correspondence?

A. Well, yes -- not necessarily -- I can't remember specifically from Dr. Mitchell, but certainly from, you know, several of the oncologists.

118 Q. Dr. McAleese, for example? 12:25

A. Dr. McAleese, for example.

119 Q. Made much the same point.

A. Yes. Yeah.

120 Q. I'm not sure Professor Sullivan made quite the same point, but he certainly came across cases where low dose Bicalutamide seemed to have been the favoured medication, inappropriately, in his view, across a range of cases. 12:25

A. Hmm.

121 Q. So you can remember those changes being made by the oncologists in correspondence to you?

A. Hmm. Hmm.

122 Q. And then the 2014 e-mail from Dr. Mitchell. We can have it up on the screen, please, at AOB-71990. And 20th November 2014, he -- he's referring to a: 12:25

"Young man within high grade organ confined disease from 2012."

12:26

And he is pointing out what he regards as a number of deficiencies in the -- in the management of this patient, albeit he allows the caveat that he isn't aware of any of the comorbidities or performance status. But he says that: 12:26

"The patient should have been offered neo-adjuvant hormones."

He suggested that is typically in their experience the introduction of LHRHa, occasionally 150 Bicalutamide, followed by EBRT. He has said that there's been a two-year delay -- I'm only -- he says: 12:26

"I'm told he has only just been referred for radiotherapy at 2 years after initial MDT presentation." 12:27

He goes on to say:

"I am also told that he was on Bicalutamide 50 for the first year of his management."

And he suggests that that is not licensed for monotherapy. And he goes on at the bottom of the page to direct you as to the responsibilities of clinicians when prescribing off label or off license. 12:27

That, it appears from Dr. Mitchell's evidence, was a difficult e-mail for him to write. When his attention was drawn to it, he says, "Well, I've never written such an e-mail to a consultant before", albeit when he reflects upon the development of this issue over time he reckons that he should have been even more robust. Do you have any recollection of receiving this? 12:28 12:28

A. I honestly -- under oath, I have no recollection of receiving it. I wish that, you know, I had received it or, more correctly, read it and responded to it, because I would have -- I hope it's not an inappropriate thing to say -- I would have enjoyed exploring this case and discussing -- there had to be reasons why he was prescribed 50mgs daily. There had to be reasons why there was a two-year period of being on 50mgs for one year and then 150mgs for a second year, before he was referred for radiotherapy. I find it very frustrating during these past, we'll say couple of years, I would love to have all of the information 12:28 12:29

pertaining to this patient. I have tried to remember, and I have a reasonably good memory, but it's probably not as good as it was when I was 20 years younger, as to whether this particular patient was a patient who cared for his grandchild whilst the grandchild's mother, his daughter, went out to work, and couldn't travel to have -- I remember that particular discussion with a particular patient along those lines, but it may not be that patient at all. But there were reasons for it. I should say, it's interesting, if this man did have organ confined disease, Bicalutamide 150mgs daily is not licensed for the management of any organ-confined disease. 12:29 12:30

123 Q. If you had read it --

A. Yes. 12:30

124 Q. -- it would have warranted a response.

A. It would have warranted a response. Absolutely.

125 Q. You've accepted that other clinicians had written to you or copied you into correspondence changing --

A. Hmm. 12:30

126 Q. -- your prescribing over a period of years.

A. Hmm.

127 Q. Dr. McAleese, for example, claims that --

A. Hmm. Hmm.

128 Q. -- he wrote in those terms. And, as I said, Dr. Mitchell claims that he wrote in those terms. 12:31

A. Hmm.

129 Q. Again, that must have puzzled you, thinking back, in terms of "Why are they doing that to a regime that I've

deliberately implemented?" So did you respond to any of that?

A. Yeah, I mean, I appreciated their view on the matter, as I speculated that it would be, do you know. This is the licensed dose for locally advanced disease, because that's the only stage for which it is actually licensed, 150mgs. So, they would have regarded that as the correct dose from the clinical trials that had been done, but the whole purpose -- I mean -- well, let me phrase it another way: There is a significant body of evidence to demonstrate that the Nadir Serum PSA level prior to initiation of radical radiotherapy is the single-most important factor and predictor of outcome response, apart from actually the further Nadir following radical radiotherapy. So in fact actually, Dr. Mitchell has -- was first author on a paper published about that very subject, where it was demonstrated that in terms of biochemical progression, and disease progression, and cancer-specific mortality, if the Nadir PSA was less than 1ng/ml, it was significantly better than if it was greater than 1ng/ml. 12:31 12:32 12:32 12:32

So you have an issue here. The issue is, if you have organ-confined disease in particular, and you have a patient who has had myocardial infraction two years previously, is still hypertensive and is diabetic, and with all of the body of evidence in support of the increased risk of significant cardiovascular 12:33

complications of a LHRH agonist, and you have a regimen, for want of a better word, where Bicalutamide 150mgs is not licensed for organ-confined disease, and you can -- you're starting off with a PSA of 5, and you prescribed Bicalutamide 50mg in the first instance, and nine months later their PSA is 0.5, or 0.4, and you have arrived at that sweet spot without actually having to use three times the dose, I mean -- and there is no evidence whatsoever that the duration of androgen deprivation therapy prior to radical radiotherapy is of any significance in terms of the outcome. The important point, the most significant point, more importantly than Gleason score, more importantly than pretreatment PSA levels, is the Nadir PSA level prior to the initiation of radiotherapy. There is not one piece of evidence in the literature to contradict that fact. 12:33 12:34 12:34

130 Q. That exposition may, Mr. O'Brien, be an entirely respectable view. We have, I suppose, assembled before this Inquiry, in terms of the evidence received, some very decisive views to the contrary. We've got to look at this through the lens of multidisciplinary working, and what you have just said, in some detail, has never been exposed to a multidisciplinary discussion, has it? 12:35

A. Yeah, we have discussed cardiovascular risks, for example. 12:35

131 Q. Oh?

A. Oh, sorry.

132 Q. With Dr. Mitchell, he sent you correspondence?

A. Hmm.

133 Q. You can't say whether you replied, you can't say whether you've read it. Fair enough.

A. Mm-hmm, mm-hmm.

134 Q. He sent you the guidelines in their development stages, and you had, I suppose, in your role as Chair of NICaN, you had access to the final draft. At no stage during that process does he recall you engaging with him in the theory that you've just expounded in support of Bicalutamide as opposed to LHRH and radical radiotherapy? 12:35 12:36

A. You describe it as "my theory", it's not my theory, I'm just reporting to you the evidence. It's not my theory, it's the evidence that has been published by, you know, the most eminent oncologists and urologists from around the world over the past, we'll say almost two decades now. So, you know, I would have been delighted to have engaged in that kind of discussion. I think that there -- there is an issue here as well, and that is, in any area of clinical practice, there is an issue with regard to taking the findings of even a randomised control trial, which is regarded as Level 1 evidence, and applying it rigidly to each individual patient. It's almost like -- I've often thought about this. If it was the case that there was a comparison between being prescribed insulin 20 units twice a day for a newly diagnosed diabetic, as opposed to 10 units twice a day for a newly diagnosed diabetic, and 20mgs was found to be more effective in lowering blood sugar 12:36 12:37 12:37

levels, but you didn't bother actually measuring blood sugar levels, you just actually prescribed 20 units twice a day for everyone, but we have a marker for prostate cancer called Serum PSA levels, which is used in every other context. So I'm quite happy, I would have been quite happy to have engaged in this discussion. It's a pity that it didn't take place. 12:38

135 Q. But the important point, sorry, just trying to bring this to a fairly concise close.

A. Mm-hmm. 12:38

136 Q. 50mgs of Bicalutamide has been said before this Inquiry not only to be unlicensed for the purposes for which you prescribed it, but also suboptimal or ineffective in delivering the conditions preparatory for oncological intervention in the form of radiotherapy. The goal should be castration as opposed to seeking to control the PSA. So the primary object should be to prepare the patient for the radiotherapy intervention. 12:39

A. Well, with respect to those who have made such claims, I disagree with them. For non-metastatic disease, there is no evidence that Bicalutamide 150mgs has been significantly inferior in terms of oncological efficacy to castration, irrespective of how castration is provided. There is an abundance of evidence in support of it being safer to prescribe Bicalutamide 150mgs daily. And with regard to 50mgs daily, and I listened carefully to Dr. Darren Mitchell, and was quite surprised to hear him report that he had no knowledge of any of the data pertaining to the clinical efficacy 12:40 12:40

of Bicalutamide 50mgs, and you might find it rather surprising that castration, irrespective of how it is effected, will reduce serum PSA levels, even in advanced disease, by something ranging from 93 to 97% after a period of three weeks -- three months, sorry -- 12:41
that's just used as a measure. At the other end of the spectrum, Bicalutamide 10mgs will achieve a 50% reduction, 50mgs probably was best explored by Geert Kolvenbag back in 1999 he reported, that Bicalutamide 50mgs achieves 83 to 87% reduction. Mark Soloway found 12:42
it to be more -- higher than that at 91%, and by the time you get to 150mgs there is no difference in the efficacy.

Now, I do appreciate that that doesn't mean to say that 12:42
any of those doses are going to be still as effective at six months or nine months as they were at three months, but that's where Serum PSA comes into play.

137 Q. Can I bring you back to Dr. Mitchell's evidence, which you heard? His evidence, in essence, was that he was 12:42
motivated to develop the Regional Guidelines, at least in part, because of his observations around the use of 50mgs Bicalutamide?

A. Hmm.

138 Q. He saw it as a monotherapy. I know you say it wasn't 12:43
a monotherapy, or it certainly wasn't intended on prescription to be a monotherapy, although sometimes it developed into being a monotherapy.

A. Hmm.

139 Q. But his motivation was, in essence, directed in part, or in substantial part, perhaps, at your practice. Did you appreciate that?

A. No.

140 Q. When the guidelines were being discussed through NICaN when they were sent to you in final version in October 2016, his evidence was that they didn't bring any response or any reaction from you, apart from, rather comically, for you to correct his spelling of the word "licensed"? 12:43

A. That's right.

141 Q. But he had hoped that in bringing the guidelines forward through the NICaN apparatus, that it might be an opportunity for you to engage in a discussion about your practice. That discussion didn't take place. You didn't at any point ventilate your approach in what we know to have been a significant number of cases -- obviously not your whole practice, but in a significant number of cases -- the guidelines prospectively and retrospectively wouldn't have been followed? 12:44

A. No, I didn't see it as an invitation at all, and I know that the comment was made that when we discussed the draft guidelines in January '16, that there was --

142 Q. '15.

A. Was it '15? 12:45

143 Q. '15, I believe. The minutes --

A. No, I think actually it was in January -- it was my last meeting that I Chaired at NICaN, and he had been formulating those throughout the year '15. We came up

with the first draft, I think -- I'm not quite sure if we did have a first draft prior to Peer Review. So it was January '16 that there was a long pause. He thought that I was contemplating it. And I remember that because it wasn't on my mind at all. My long 12:45
pause was, I was -- I was sort of concerned, if you look at those guidelines, that if there was -- if the clinician had a concern about cardiovascular risks, that we would advise the patient, you know, to consult with their GP, and I thought that that was a rather 12:46
weak caring, but I was very conscious of a statement that had been made by -- on behalf of three societies in the United States of America, the AUA, that's the urological one -- the American Heart Association and the American Cancer Society -- with regard to LHRH 12:46
agonist and its use in metastatic disease, where they stated in 2010 that the benefits of LHRH agonists in metastatic disease outweighed the cardiovascular complications that could arise, and with which I agree. So I didn't want to upset the applecart at that time, 12:46
and maybe, maybe because it was my last meeting that I Chaired. But I didn't see -- and I would -- I mean when I read and listened to Dr. Mitchell describing the formulation of these, the regional guidelines as a circuitous oblique tangential mechanism of addressing 12:47
my prescribing 50mgs and, you know, why didn't he raise it in that forum directly? I would have been quite happy, as I am happily doing so now, discuss my views on the matter.

144 Q. Mm-hmm. Mm-hmm. Just to pull up the guidelines briefly, we've been talking about them for long enough. It's WIT-84427. And if we go to the bottom by way of example? Just to the bottom. Thank you.

A. I think it's the third last -- it's the single sentence. Is that what you are looking for? "The cardiovascular and metabolic". 12:48

145 Q. Two points. So in order -- it refers to the usage of 50mgs of Bicalutamide in the context of preventing testosterone flare, that's just about one-third of the way down the page as it sits in front of you. 12:48

A. Hmm.

146 Q. Was that an opportunity for you to say "well, actually, there's another use for 50mgs of Bicalutamide in my experience and in my practice"? 12:48

A. I didn't see it as such. I just thought it's a statement in order to prevent testosterone flare anti-androgen cover with Bicalutamide 50mgs is given for three weeks. And why is it given for three weeks? You know, because of its oncological effect. I mean I have read I think in the case of another patient that we have discussed already, in the SCRR, that you know, Dr. O'Kane, in writing to the patient, advised, you know, that 50mgs has no clinical effect. But it does. 12:49

147 Q. Okay. Well -- 12:49

A. But, anyhow, I didn't see it as an invitation, Mr. Wolfe.

148 Q. Yes.

A. I would have happily responded to an invitation in that

context of the formulation of those regional hormone guidelines. And I just -- you know, can I just also take you lastly to the next paragraph, which says about:

"The anti-androgen Bicalutamide 150mgs can be used as neoadjuvant hormone therapy especially in men when preservation of physical capacity or sexual function is important."

And those two terms, "physical capacity" and "sexual function", they are terms, you know, taken from the work of Tyrrell and others, you know, where they found that whilst Bicalutamide 150mgs daily was as effective as castration for non-metastatic disease, it was better -- a significantly higher proportion of men had enjoyed a better quality of life through sexual function and retained physical activity. So those words are an expression of that delay between the published evidence and the formulation of guidelines. It's not to disparage them, but I just wanted to draw attention to that.

149 Q. Yes. But the -- the core of the guidelines, the core message for the prostate cancer with which we are concerned, was 50mgs of Bicalutamide, moving to LHRA, moving to EBRT. That wasn't a core message with which you disagreed?

A. In -- it was a core message with which I disagreed if you had patient with significant cardiovascular

comorbidity. I mean all the evidence is there. I mean if you go -- Patient 1 is an example that I know that I have referred to in my addendum.

150 Q. Yes.

A. And if I had prescribed, for example, Bicalutamide 50mgs for a period of a month, or three weeks or something, surrounding the initial dose of an LHRH agonist, and he had gone off on his holiday and he suffered a fatal miocardial infarction whilst being there, he would never have been an SAI. But this is the reality, you know. The reality is that there is an abundance of evidence in support of -- since -- since Nancy Keating in 2006 first drew evidence to the significantly increased risk of sudden cardiac death, and then from the same centre in Boston, the following year, that there was -- that patients treated with an LHRH agonist for periods of between 3 and 8 months had a shorter time to fatal miocardial infarction. You can't ignore this. 12:52 12:52 12:52

151 Q. Yes. 12:53

A. So...

152 Q. Can I put this back through the lens of the multidisciplinary working. You cite Patient 1's case as an example.

A. Hmm. Hmm. 12:53

153 Q. Others might legitimately take the view that your concern about the cardiovascular history is overstated in the setting of what was intended by the MDT recommendation. Let's say there's a legitimate debate

to be had about that for the sake of this argument.

A. Hmm.

154 Q. What Dr. Mitchell says, if we can bring it up on the screen, WIT-96667, and just scrolling down. Yes. So, what he says is that: 12:54

"Normal practice would have been to prescribe a dose of Bicalutamide that was within the licensed indications or to refer to Oncology for discussion and allow the Oncology team to discuss the treatment options 12:54 including the use of hormone therapies such as Bicalutamide."

At no stage is it fair to say that, did you move from consulting with your patient, taking the view that I 12:54 have to use Bicalutamide in the fashion described and, thereafter, seeking a view from Oncology about the appropriateness of the regime, or whether there would be a better way of treating the patient in preparation for radiotherapy? 12:55

A. In general or in --

155 Q. In general.

A. Oh, in general. Yes. I would have been quite happy to do so, but very often, it was -- it was the patient's preference to avoid having radiotherapy. If you're in 12:55 a situation like that where you have a patient who wants to avoid an oncological cancer pathway, and the risks -- if at all possible, without good reason for it -- and if there is a reality that if you refer patients

to Oncology for consideration of radical radiotherapy, in 99% of cases they will have radical radiotherapy, in my experience.

156 Q. But they would have to consent to that after receiving a proper explanation. The concern, perhaps, here, is that you are not best placed to discuss with them the next step. That is ultimately an oncological view which ought to be reflected through the MDT -- 12:56

A. Yes. Mm-hmm.

157 Q. -- if you find that there's a difficulty in progressing. 12:56

A. Yes. I appreciate their view and I respect their view. It also has to be pointed out, you know, that the focus of the oncologist is the cancer. And urologists are not oncologists, and oncologists are not urologists, and I have never had -- I appreciate, you know, that if -- a lot of MDTs are set up with the provision of multidisciplinary clinics, for example, where you can have the patient attend in a clinic with urologists and oncologists present. Nevertheless, I had no difficulty in referring patients to Oncology. I have, on many occasions, tried to persuade people to be referred to Oncology, just for a discussion, and they said "no". Believe it or not, that does happen. And what are you to do, do you know? It's -- you can't railroad people along a cancer pathway, or even to consult about a cancer pathway. So that's been my experience. 12:56 12:57 12:57

I think, actually, my approach to the whole thing has

been, I have endeavoured -- and I think I believe I have succeeded in providing patients with all of the objective information that I have been able to access, for them to consider the risks and benefits of differing treatment options, including, in more recent years, brachytherapy and so forth, which I -- the quality of which provided by Belfast is outstandingly excellent, and set the MDM recommendations in that context, and give the patient time to consider it, and take it from there. And I -- you know, whether we should have a regimen that insists that irrespective -- that you don't even put it to the patient as to whether or not they want -- that they would like a referral to Oncology; that it is fundamental, you don't ask them, it just happens, is a counter view. It hasn't -- it's not that I disagree with it at all, but it's not the one that was practised with regard to our MDT. I don't know of anyone who practised that. 12:58 12:58 12:59 12:59

MR. WOLFE KC: Yes. Sorry, we've just overshot the clock with that answer.

CHAIR: I think we'll come back at ten past two.

MR. WOLFE KC: Can I beg your indulgence and come back at 2:00 o'clock sharp if we're to get through what we need to, to finish this afternoon?

CHAIR: Mr. O'Brien, we do still have to get through quite a lot of material today, and this is currently our last day of sitting in terms of oral evidence, so are you content to come back at 2:00 o'clock. 12:59

A. I am.

MR. WOLFE KC: I'm very much obliged to everybody.

CHAIR: Thank you.

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Thank you, everyone.

158 Q. MR. WOLFE KC: Just in concluding on the guidelines issue, Mr. O'Brien. Did those guidelines in any way affect the way that you practised the medicine of prostate cancer management? 13:56

A. Of course.

159 Q. In what particular ways?

A. In every way. I mean, they are the guidelines. They are the accumulated recommendations for prostate cancer in its differing stages, the options, the benefits, the risks, do you know, they are -- I don't think any clinician should be practising at all without being cognisant of the guidelines and having the guidelines influence their management. But the guidelines -- you know, I've heard some people saying, you know, they require adherence, but, in fact, actually, the guidelines themselves are prefaced with the direction that they do not require adherence. If they required adherence, they wouldn't be called guidelines. 13:56 13:57 13:57

160 Q. You, I think, refer, within your -- I'm not sure if it was your first statement or your addendum statement, to the NICE advice in relation to guidelines where you say, if I can find it, that guidelines must be taken into account. 13:58

A. Mm-hmm.

161 Q. But they are, in essence, not to stand in the way or replace the needs of the patient, where the patient's

needs cannot be accommodated by the guidelines, and I hope that isn't an ineloquent way of putting it, but it's emphasising that "take the guidelines into account but they are not mandatory in all circumstances", is that fair? 13:59

A. That's fair. And, in fact, that's most explicitly and eloquently put by the NICE guidelines themselves, and you've no need to refer to it on the screen.

162 Q. Thank you.

A. But if you wish to do so, it's explicitly stated in the guidelines that that is so. 13:59

163 Q. Yes. The local MDT in the Southern Trust, where you attended a meeting and the decision was to manage this patient's prostate cancer in accordance with a regime that would involve LHRHa agonist, Bicalutamide for flare-up as a prep, moving into EBRT, and if, in hearing that recommendation, you had concerns about its applicability for the patient concerned, no doubt you would articulate your concerns? 14:00

A. Yes, I normally would. I think that only applies to Patient 4, because usually what was, instead referred to was, you know, to commence ADT, as in the case of Patient 1, and it's an interesting -- I mean, I was taken aback by the evidence given by Mr. O'Donoghue, who was of the view that, "well, you know, ADT means an LHRH agonist", and if you, as I have done over the years, and continue to do, if you read the literature, probably 80/85%, 90% of the literature uses the term ADT to cover the whole gambit of hormonal treatments, 14:00 14:01

whereas in his defence, in a small minority, some of the literature uses ADT to refer to castration, however it is produced.

164 Q. But sticking to the point I asked you. If you had a concern, you would articulate it within the MDT? 14:01

A. You would, yes. Yes.

165 Q. Yes. We've received some evidence that, in terms of your use of Bicalutamide, it was the subject of "challenge" was the word initially recorded, or the verb initially recorded against Dr. Glackin's name, 14:02 Mr. Glackin's name, in terms of the information he supplied to Dr. Hughes and his team. In his evidence before this Inquiry he said "Well, he would have discussed the appropriateness of Bicalutamide", in a case he couldn't remember the name of. Mr. Suresh 14:02 gave evidence -- we're not sure whether it was the same case or a different case -- whereby the unconventional treatment, as he put it, was discussed and it -- the consensus of the meeting, he said in his evidence, was that the patient shouldn't be on it. What's your 14:03 understanding of the extent of the Southern Trust Urology MDT's appreciation of your use of Bicalutamide?

A. Well, I don't see any reason why they wouldn't have been entirely aware, because it was not something that was used in any covert manner. When I provided 14:03 updates, as I did by e-mail, to the cancer tracker to update the, the clinical summary that would have been there initially, what I had the patient on was always there, upfront, and for the reasons indicated. So,

I've listened to all of that evidence and I have read the transcripts and the witness statements. I suspect that the case that Mr. Suresh referred to may have been the only case that may have ever been discussed. I can't remember exactly the discussion, but I believe he said that I was to review the patient and to consider his further management. We don't know who the patient is. I don't know who the patient is. I've tried to identify the patient. And in fact, actually, I remember, in trying to do so, one date in April '16, or was it '14? My apologies. You know, I remember reading the MDMs where there were several patients clearly documented as being on Bicalutamide at either dose. So there was no -- there was no excuse, really, for a much more frequent and robust challenge, if anyone saw a difficulty with it. 14:04 14:04 14:05

166 Q. And just to be clear -- sorry to cut across you -- you're saying there was never any challenge?

A. I am not saying -- I don't recall any challenge, and I said so with honesty. I don't recall any challenge. I don't even recall the challenge that Mr. Suresh referred to. I'm not denying that it wasn't possible. He said I was to review the patient and consider their further management. I haven't been able to identify that patient. And this goes, actually, to what -- along the theme that I was discussing earlier, and that is, you know, governance is a two-way street, you know. It pertains to the challenge, or the lack of challenge within the MDM, it pertains to the challenge delivered 14:05 14:05

to me by Dr. Mitchell, and the rather sort of nebulous way he went about a circuitous route to attempt to challenge me with regard to formulation of the Regional Guidelines, I just wish there had of been a more direct challenge that we could have discussed that, because it is a two-way street, because you've listened to my views on this matter, and if I were to ascertain that my colleagues were using LHRH agonist, particularly in high risk patients with cardiovascular comorbidity in particular, do you know, that should have been challenged as well. 14:06 14:06

167 Q. Well, that's the point I wish to turn to. If the tenor of your evidence is that your practise or your approach to this was not covert, and that must mean, on your evidence, that your colleagues must have had an awareness of it but didn't challenge you, to the best of your recollection? 14:07

A. Hmm.

168 Q. Equally, you're saying you had no sense that your colleagues were practising in the way that you were practising with regards to Bicalutamide? 14:07

A. Hmm. Hmm.

169 Q. They, to your concern, perhaps hidden, were using LHRHa when it was inappropriate to do so, or potentially inappropriate to do so because of the cardiovascular risks. 14:07

A. Mm-hmm.

170 Q. Why did that debate never happen?

A. I do not know. And I think that the answer is, I do

not know. I have reflected on that a great deal, wondering why that was not the case. I think because we had a relatively laissez-faire approach to that -- I made reference earlier on to an attempt to be not prescriptive -- I was concerned, do you know, to hear Mr. O'Donoghue referring to the case of Patient 1 as "Well, he knew it was an LHRHa agonist". Well, frankly, no, I didn't. It's adjuvant deprivation therapy. 14:08

171 Q. Can I build this into your thoughts? 14:08

A. Hmm.

172 Q. Is it the case that the MDT continued to dispense a recommendation consistent with the guidelines, you took that away with you?

A. Hmm. 14:09

173 Q. Spoke to your patient.

A. Hmm.

174 Q. Didn't bring back your contravening view, and the MDT was none the wiser as to your practise?

A. Well, because, in the vast majority of cases my management of the patient, and the recommendation I put to them, and the management pathway we embarked upon, was entirely consistent with the MDM outcome. 14:09

175 Q. But not always?

A. But not always, yes. 14:09

176 Q. Yes. And it's -- in the absence of tracking, in the absence of effective audit, in the absence, perhaps -- and we'll look at some of the cases later this afternoon, of a key worker...

A. Hmm.
177 Q. None of this was within view. Is that fair?
A. Well, you know my views, and you've read my views on key workership. But leaving that aside, I think we're concentrating particularly on this issue of Bicalutamide. I mean, I would have quite significant concerns now, looking back, at the risks that people were being subjected to by the automatic presumed notion that ADT required the prescription of an LHRH agonist, for all of the reasons that are outlined in an abundance of literature. 14:10
178 Q. But you didn't challenge it?
A. I wasn't aware of it.
179 Q. In the sense that you've just described it a moment or two ago, that was your view of what your colleagues were continuing to blindly apply? 14:11
A. No, I wasn't so aware of it, that's the point I'm making. I wasn't aware of it.
180 Q. Well is this -- is what you're describing, in essence, multidisciplinary team working, where nobody knows, on either side of this debate, what the other side is doing? 14:11
A. To a large extent, yes. I think in retrospect that is the case. And I think that in -- yeah, I think that is the case. Do you have -- we never had a system whereby a check was made on the nature of the androgen deprivation therapy that was prescribed or initiated, and the reasons why and so forth, and that's why, as I said earlier, if we had had the capacity, been 14:11

a wonderful mechanism to actually report back, even if it is in the view of the clinician who is reporting back confirmative of the presumed treatment that was being recommended, that it had been initiated or whatever. But, you know, the cancer trackers were able to check on that from the letters that were written, but it wasn't necessarily the cancer tracker's role to be checking on the actual drug that would be prescribed. So you would need to have another system, you would you need to have some kind of audit. 14:12

181 Q. It's really a matter for responsible clinicians to discover how patients are being managed as a result of MDT decisions and where there are concerns, such as a concern that you say that you legitimately held about being unable to follow MDT decision or MDT recommendations on a regular basis, to actually have that discussion with your colleagues? 14:13

A. But I haven't said that I was unable to follow MDM recommendations on a number of occasions. That's an interpretation that is being put on it. What I'm saying is, the flip-side of that coin is that there's another kind of implementation of a recommendation, another interpretation that is adopted by one or two or three or four others, we don't know, and I wasn't so aware of that. I wasn't aware of it, basically, because we weren't watching over one another's shoulders in that regard. And I have learned a lot during the course of this Inquiry about how prevalent other views have been, and I have endeavoured, in my 14:13 14:14

addendum and in the evidence that I am giving today, to outline for you, as best I can, the reasons for the manner in which I managed patients.

182 Q. Yes. One final point around this. We see in Patient 1's case and Patient 6's case, that the recommendation common to each of those cases was that, in the -- in the event of divergence from an MDT decision, it should be properly documented? 14:14

A. Hmm.

183 Q. In other words, you would send out the reasons for the approach that you're taking, what you've discussed with your patient, and the reasons for the management plan, if you consider it to have diverged, and you would validate it with further MDM discussion. I think we've had the debate about the practicality of further MDM discussion earlier. When you reflect upon it, do you think the quality of your note-keeping or recording of your prostate cancer management decisions following review of your patient after the MDT was all that it should have been? 14:15 14:15

A. In handwriting, no, because what I -- I took it for granted, you know, my practice was -- the reason why I am reviewing this patient today following an MDM discussion is for all of the reasons that I have outlined previously. You know, I used my handwritten notes as an aide-mémoire to enable me to detail the other features, like the number of times a person was getting up at night, or whatever particular issues that they had to contend with, or what their priorities were 14:16

and so forth. And hopefully that was reflected in the letter that I would subsequently dictate.

In the case of Patient 6, I need to be reminded of what the MDM outcome was, because I do not instantly know in what manner I diverged from it. 14:16

184 Q. The reference is DOH-00078. Hopefully, that might help us. So I think the key feature of it was, and we possibly don't have the material in front of us to -- if we go back to 77 I've been told with some optimism, I think. 14:17

A. Yes, that's it. "MDM recommendation" -- if that's the right patient -- on 8th August 2019.

185 Q. Yes.

A. " Surveillance or radiotherapy with curative intent." 14:17

186 Q. That was the case where, I think it was Mr. Haynes was the -- is that the case where Mr. Haynes was the reviewer? It wasn't an MDM itself?

A. Okay. So, in any case, this man is the patient who was anxious in the first instance and for whom I prescribed Bicalutamide 50mgs. This man had significant lower urinary tract symptoms, and as I think I detailed in my commentary, or in the clinical history that has been shared with the Inquiry, it is one of the recommendations in the NICE guidelines that the patient would be offered investigation and management of his lower urinary tract symptoms prior to referral for radiotherapy, as the outcome following radiotherapy, then followed by the management of quite frequently 14:18

deteriorated symptoms, or worsening symptoms is much worse than if you manage it beforehand, followed by radiotherapy. So, here, I would dissent from the view that I hadn't followed the MDM recommendation. So in the first instance, you know, this man was actually being worked up for referral for radical radiotherapy. As you know he didn't have urodynamics done twice and, as you know, then he subsequently stopped his Bicalutamide I think because of some gastric symptoms, and then when he was reviewed by Mr. Haynes subsequently he didn't want to have any treatment. So -- so I -- 14:19 14:19

187 Q. I think your point is that you disagree with the proposition that you diverged from the recommendations?

A. Yes, because the recommendations in the NICE guidelines are that you offer assessment and management of lower urinary tract symptoms when they are of significance prior to radical radiotherapy, in order to achieve an optimal outcome. 14:19

188 Q. Yes. I'm not sure that's the point. The point is, whether you diverged from the MDM recommendation as opposed to what you think NICE was informing you of? 14:20

A. Well, it's not what I think NICE was informing me of; that is what NICE recommends.

189 Q. And the point is, if you're taking the patient down a route, which you think is appropriate or legitimate, but if it departs from what your MDM, or the notional MDM is telling you, then the recommendation here, the criticism here, is that it's got to be adequately 14:20

recorded and invalidated by reference back to the MDM?

A. Well, as we have discussed earlier, I would have no difficulty in doing that whatsoever, and would have been robustly asserting that this patient should be offered the assessment and management of his lower urinary tract symptoms prior to referral for radical radiotherapy.

190 Q. But the point is, that didn't happen?

A. The point is, that didn't happen, yes.

191 Q. Let me move to my next topic. It's an issue connected with Patient 139. 14:21

A. Mm-hmm.

192 Q. And I wish to explore with you whether you had any hand in inappropriately accessing that patient's records in order to advance an argument before this Inquiry? 14:21

A. Hmm.

193 Q. The context for this is as follows: Mr. Glackin was due before this Inquiry on 20th September?

A. Mm-hmm.

194 Q. And your legal team submitted questions to the Inquiry, entirely appropriately -- 14:22

A. Mm-hmm.

195 Q. -- in order to be directed to Mr. Glackin, and one of those sets of questions involved enquiries into whether and why Mr. Glackin had continued a regime of low dose Bicalutamide -- 14:22

A. Hmm.

196 Q. -- for that patient.

A. Hmm.

197 Q. On dates in 2016 and 2020.
A. Hmm.
198 Q. And in order to support the proposition that Mr. Glackin was managing that patient, your legal team, in September of last year, supplied a number of letters -- 14:22
A. Hmm.
199 Q. -- a number of pieces of correspondence which hadn't been disclosed to the Inquiry.
A. Hmm. 14:23
200 Q. Save for a few days earlier when they were disclosed in connection with questions that were also to be directed to Dr. Mitchell?
A. Mm-hmm.
201 Q. In other words, this disclosure hadn't come with your original disclosure? 14:23
A. Yes.
202 Q. It had come in September of last year.
A. Hmm.
203 Q. Can I show you the letters I'm referring to? 14:23
A. Mm-hmm.
204 Q. If we go to AOB-82836. And redacted. Dated 22nd February, at least the time of the clinic is, and Mr. Glackin is writing this and explaining what he's doing, and in the context of Bicalutamide: 14:24

"If the result is stable, then he remains suitable for continued Bicalutamide monotherapy."

So that's that letter. Then the next --
A. If you just scroll down?
205 Q. Yes.
A. Just to document, rather than having to come back to it. Of course it's in the same scroll that the PSA was 1.02. 14:24
206 Q. Yes. Okay.
A. Yeah.
207 Q. Next page. Results have been -- sorry, he's writing to you. He's writing to you. 14:24
A. Mm-hmm.
208 Q. Saying that he saw this patient and "with your kind permission" he would take on the management of that patient.
A. Hmm. 14:24
209 Q. And that's something I understand you agreed to?
A. Yes.
210 Q. So those pieces of correspondence are February and March 2016. And then if we go over the page, we'll see a letter 5th May 2020, and Mr. Glackin continues to be responsible for the management of this patient, and the upshot of this letter is that he's going to continue him on Bicalutamide, and Mr. Glackin has given evidence in relation to his thinking around that, which I don't propose to engage you with. 14:25 14:25
A. Hmm.
211 Q. Now my question for you, Mr. O'Brien, is: how did you come to be in possession of these three pieces of correspondence?

A. Well --
212 Q. In September of last year.
A. Well, in the first instance, the first two letters relating back to 2016, I was entirely happy with Mr. Glackin taking over the care of that patient, and if he had notified me that he was taking over the care of another ten I would have even been more delighted. The only reason I kept copies of the letter that he sent to me saying with my kind permission I would -- he would continue to care for the patient, and having received that letter, I had no memory of who the patient was, and when I looked back at the letter that accompanied it, or preceded it the month before, I noted that increase in his PSA level, and I was just concerned about that. That was -- within a year there was almost a 50% increase in his serum PSA level, which could have been entirely spurious. And I can't remember now whether I spoke to Mr. Glackin about it? I doubt if I did. I can't even remember, honestly, whether I intended to do it, but I just kept copies of those two letters in order to keep an eye on it, because when he said that his PSA level was satisfactory or stable, I just wondered if that was going to be the case. And then subsequently, at later dates, I can't remember the intervals now when I checked on it, that I was very pleased to see that it had reduced again. I think -- I can't remember whether it was somewhere in the region of what it had been the year before. And progressively did so. And then in --

14:26
14:26
14:27
14:27
14:27

when -- this is the last letter, yeah, in May 2020, you know, when I was updating my Oncology review waiting lists, and I had kept the two copies behind an old Oncology review waiting list, and I was naively looking forward to being able to clear off my Oncology review backlog on return in August '20, and I came across those and I thought "ah, I must check it again", and I had this printed off, and I put it with the other two and I forgot about it. And the only reason that I submitted these and raised this issue was not to undermine or impugn Mr. Glackin, because I entirely agreed with him that he should remain on it, particularly in view of that instability in his serum PSA level previously. My concern actually was, reading Mr. Haynes' letter, for a number of reasons; firstly, you know, it is legitimate after a period of ten years, when someone has evidently done so well, and you're in your 80s, to consider stopping the Bicalutamide, even though it has been my experience that intermittent androgen blockade is not all that it's cracked up to be. I don't think that you re-sensitise the prostate cancer, as has been hypothesised. I have frequently found that I haven't got the same response when I restarted the same treatment at some later date when PSA levels increased. But I was particularly concerned to find that -- I got the impression that maybe there was some resistance to this man coming off his hormonal treatment, and if that was to be the case, Mr. Haynes was offering castration, pharmacologically induced

14:28 14:28 14:29 14:29 14:30

castration, to a man who had been on 50mgs of Bicalutamide for ten years, with the outcome that you have seen evidenced on that letter.

213 Q. Can I stop you there, Mr. O'Brien? What you're now answering is the -- is a quite different question. I'm not asking you about the reasoning? 14:30

A. Oh, yes, okay.

214 Q. -- for the questioning of Mr. Glackin or, indeed, your concerns about Mr. Haynes' input. I think you've answered my question. You've said with regards to the first two letters -- 14:31

A. Hmm.

215 Q. -- you retained them on a file and forgot about them.

A. Hmm.

216 Q. And then, four years later -- 14:31

A. Mm-hmm.

217 Q. -- or four years after you have come off the management of this patient, it having been handed over to Mr. Glackin, you decided to print off -- having checked your waiting list, you decided to print off this letter of May 2020. You weren't responsible for that patient's management in May 2020? 14:31

A. Yeah. That's an abridged version. I had -- every time, do you know, every, we'll say, three to six months, when I would get an updated Oncology review waiting list, and I went through that same procedure of validating that waiting list as I did an inpatient waiting list that we have talked about previously, and I would have availed of that opportunity of checking 14:31

how he was, just out of interest's sake, nothing more than that, and very pleased to see that he had a progressive decrease in his PSA level, and at least on one occasion in that intervening period, I similarly printed off, or had printed off a letter -- I can't remember when that was or what his PSA level was at that time. So this was a continuum. And even though he was no longer my patient, it was purely out of interests that I did so. 14:32

218 Q. How many patients have been passed over for management to other colleagues, historically? 14:32

A. Well, I didn't really pass over this one.

219 Q. Okay.

A. This was taken off me.

220 Q. Yes. 14:33

A. And, do you know. I didn't actually give -- return to him either verbally and said "you have my kind permission". It was taken off me.

221 Q. So he's doing a backlog?

A. A favour -- 14:33

222 Q. Initiative.

A. Yes. Yes. Yeah.

223 Q. And he is taking on patients from colleagues such as yourself.

A. Hmm. Hmm. 14:33

224 Q. Did you do this for anybody else? Did you continue to follow the progress of other patients that were taken off you?

A. I could have done and I -- but, importantly, I wouldn't

have done in this case at all if I had noted his PSA increase. That was my --

225 Q. Could I ask you about this? AOB-02554. Just scroll up the page so that we can orientate ourselves. This is your solicitors writing to the Trust, just before you left the Trust's employment in July 2020. 14:34

A. Hmm.

226 Q. And there was concern on the part of the Trust to recover all patient records in your possession?

A. Hmm. 14:34

227 Q. And it's recorded at the bottom of the -- or the bottom of the letter, just if we scroll down to the top of the next page, that Mr. Anthony is saying:

"My colleague Patricia Rooney has been in touch with you in relation to the two NHS patient records which Mr. O'Brien had in his possession. Mr. O'Brien has confirmed that these have been collected from his home and he has no further records." 14:34

So --

A. Mm-hmm.

228 Q. That seems to have been an unequivocal instruction to your solicitor that you had no further MHPS -- NHS records at your home? 14:35

A. Hmm.

229 Q. Did you have the three letters that -- relating to Patient 139 at your home?

A. Yes.

230 Q. Did you have any other patient records at your home?
A. No, just these. These were the charts of two patients whom I had brought home with the intent that I would compile reports pertaining to both of them. I can't remember their names now. There were three that I had to do in all, and I took two of them home, believing that I would be able to do those during July '20. And I had -- at that stage I had completely forgotten that I had these three letters, and I hadn't really thought of them again until I read the letter of Mr. Haynes a short time prior to Dr. Mitchell coming along. 14:35 14:36
231 Q. So, just to be clear. In terms of what you had retained after July 2020, it was only these three letters?
A. Yes, that -- that was it, you know. I mean -- and in any case, not that I considered it at the time because I had sort of overlooked their being there, I still actually had retained the waiting lists, and if you remember I submitted to the Inquiry my five categories of the urgent inpatients on the waiting list, but I had completely overlooked the presence of those three, because they were obscured because I had them behind an old Oncology review waiting list. I got a new one about May or June, with the intent of validating it from the old one, but I then turned my attention, in June, to concentrating on making sure that all of the urgent people who needed to be added to the urgent bookable list for the inpatient were added. So it just went out of my mind. 14:36 14:36 14:37

232 Q. So, in that sense, this instruction to your solicitor was inaccurate; you had these three letters, you had forgotten about them?
A. Yes. Yes.
233 Q. But if you had remembered them, they should have been handed over in July 2020? 14:37
A. Yes. That's what I was about to say. But in fact, actually, I would have assumed that all of these records anyhow would have been disclosed to the Inquiry, which is one of my grievances, in a sense, 14:38 that I don't have access to all of the records. But in relation to your particular point --
234 Q. When did you discover them?
A. I remembered about them, actually -- I can't remember the exact date upon which I read Mark Haynes' letter. 14:38 All I do know is, it was a short time before Darren Mitchell and Mr. Glackin gave evidence, and the reason for my disclosing them was not to disagree, or impugn, or undermine Mr. Glackin; it was my concern with regard to Mr. Haynes' proposed management, which I believe 14:38 should be, and it's just my belief, a governance concern in its own right.
235 Q. In terms of your retention of the three letters which I've brought to your attention, your solicitor is writing to the Inquiry on 15th December last year, 14:39 explains that you were advising that you had retained the letters of Patient 139 in a folder?
A. Hmm.
236 Q. -- which you kept for patients who were on your waiting

list.

A. Hmm.

237 Q. This patient was not on your waiting list and hadn't been on your waiting list since 2016, isn't that fair?

A. That is fair, but it was ineloquently put. You know, I would have -- for example, if a patient was on my inpatient waiting list and I had suspended that patient, or I had referred that patient for cardiological assessment or some other issue, in order to avoid me having to look back to see why I haven't dealt with that patient, I would often have printed off the letters that I wrote to a cardiologist, for example, and "Ah, that's the reminder", and catch up from there. And I would have placed those behind the previous old things. So he wasn't on my waiting list. I have that old ring folder which I have had from the 1990s, it used to be the folder that was referred to by Mr. Mackle for the people who need to be seen ASAP, and I would have had maybe eight or nine or ten Poly Pockets with all of the waiting lists in it, both up to date and the previous one, waiting revalidation, working through them, and I did that for essentially inpatients' day cases, flexible cystectomies, urodynamics and oncology review clinics, because the other clinics I really didn't determine, or didn't appoint them, or didn't have any input into them. 14:39 14:40 14:40 14:40 14:41

238 Q. Yes. The Trust, through its legal advisers, has sent the Inquiry a narrative setting out the investigations that it has carried out in association with your former

secretary, Noleen Elliott.

A. Hmm.

239 Q. If I could just draw your attention to one point arising out of that. The narrative is to be found at TRU-320464. And if we scroll down to, I think it's paragraph 7 of it. Over the next page. Yes, thank you. And what they say they have discovered is that Mrs. Elliott, on both 29th January 2021 and 29th September 2021, accessed the records of Patient 139 and used the commands within the system to make a print request. It's our understanding that the Trust cannot say which particular documents associated with Patient 139 were printed, but they have discovered that fact and have put that fact to her. Now, her explanation for it would appear to be that she was concerned that any error on her part as a secretary may have caused difficulty for this patient. She also gave an explanation which was that nobody had asked her to carry out this task, it wasn't done at anybody else's behest, and she hasn't shared the material with anyone else. Have you discussed that issue with her? 14:41 14:42 14:43 14:43

A. When I was alerted to this communication last Thursday, I contacted her, because I was entirely unaware that she had been under investigation, and she gave to me the same explanation that she had this ongoing concern that it was -- you know, that she may have failed in some kind of administrative manner. She didn't advise me about it at all. The reason she didn't advise me about this was because she was aware of my ill health 14:44

in recent months. So --

240 Q. Can you help us as to what precisely was her concern about her own behaviour that drove her to take this action in 2021, when, at that time, she was otherwise employed in another Directorate? 14:44

A. Just as I explained, that's the explanation that she has given to me, and it's mirrored in the explanation that she gave to the Trust. She -- she did have this ongoing, I think unwarranted and disproportionate anxiety, that she had missed out on putting people on 14:45 waiting lists, or on review waiting lists or whatever, because she was meticulous, and that's why she -- she wasn't even able to recall, like, exactly who 139 was. I don't think she realised the potential significance of it in relation to these three letters and all of 14:45 that there. We just actually -- I mean I was completely taken aback by this disclosure last Thursday. I was out in the garden trying to get grass cut, and when I came in I was apprised of this, and I contacted her and she has found the whole thing very 14:46 annoying, after her long career in the Health Service.

241 Q. Can I ask you this question directly, Mr. O'Brien: Did you ever engage with Mrs. Elliott to inappropriately access the medical records of Patient 139 in order to advance your cause before this Inquiry? 14:46

A. Absolutely not.

242 Q. Do you regard it simply as an unhelpful coincidence that the letters associated with Patient 139, which you have an interest in for the purposes of this Inquiry,

which should have been handed back to the Trust four years ago, might also have been the interest of Mrs. Elliott, or at least her interest was in that patient? Is that just an unhelpful coincidence?

A. Well, I mean, I didn't commission or -- I mean, I completely refute and rebut the allegation or the inference that that was even a possibility, because I know how significant an issue that is, and she knows how significant an issue that is. It is -- it's just a coincidence. I don't have any other explanation for it. The interesting thing is, you know, I asked her, indeed, how is it that you were interested in 139, as he was no longer my patient? And she mentioned something about noting that there had been a particular new review clinic code or something of that nature, and she had just taken -- she had looked at a sample of patients to see had she followed through on them. 14:47 14:47 14:48

243 Q. I want to move now to the subject of key worker.

A. Hmm.

244 Q. Which you, no doubt correctly, have explained in your addendum witness statement is sometimes -- sometimes, before this Inquiry, and mea culpa across this side of the room, using the term "key worker" sometimes interchangeably with CNS or Nurse Specialist. So quite often the Clinical Nurse Specialist, and more regularly not the Clinical Nurse Specialist, is the key worker, is appointed to be the key worker, isn't that right? 14:48 14:48

A. Yes.

245 Q. But it needn't always be so?

A. Hmm.

246 Q. Let me start my questions in relation to this area by reference to the operational policy for the MDT, which we can find at WIT-84545, at least with regards to key worker. And it's explained that: 14:49

"The identification of the key worker will be the responsibility of the designated MDT core nurse member." 14:49

And that would have been Kate O'Neill in more recent times, or perhaps for quite a number of years in the Southern Trust.

A. Hmm.

247 Q. It goes on to say that: 14:49

"It is the joint responsibility of the MDT Clinical Lead and of the MDT Core Nurse Member to ensure that each urology cancer patient has an identified key worker and that this is documented in the agreed record of patient management." 14:50

It goes on to say:

"In the majority of cases, the key worker will be a Urology Clinical Nurse Specialist." 14:50

Is it your understanding that this is the manner in which practice operated in the Southern Trust? In

other words, the MDT Clinical Lead and the MDT Core Nurse Member saw to it that a cancer patient was in receipt of an identified key worker, if the patient consented to that approach?

A. I think that the responsibilities of the MDT Clinical Lead and the MDT Core Nurse Member are different; they're not the same. I think that the Clinical Lead had an overarching responsibility to ensure, insofar as it is was possible, capacity-wise and so forth, that each newly diagnosed cancer patient would have a key worker appointed, but it was the specific responsibility of the core nurse member to be the key worker or to allocate the key worker to each newly diagnosed cancer patient. 14:51 14:51

248 Q. And in the time when you were Clinical Lead for the MDT, did this approach apply? 14:51

A. The same responsibility pertained at that time, and as I referred to earlier, it was one of the key - forgive the pun - deficiencies that was identified in Peer Review in June 2015, in that there was a significant deficiency in the ability to appoint key workers and to have holistic needs assessment conducted. 14:52

249 Q. And when you were Clinical Lead, notwithstanding that shortage of resources, how would you have sought to discharge your duties with regards to the identification of a key worker? 14:52

A. Well, I wouldn't have been, you know, identifying any key worker. That was the responsibility of the core nurse member.

250 Q. In terms of the language of the policy, it seems to suggests a joint responsibility to identify?
A. It's a joint responsibility to ensure that each urology cancer patient has an identified key worker and it is documented accordingly, but it is the core nurse member whose job it is -- it's quite explicit, do you know, it's the core nurse member's responsibility to appoint a key worker. 14:53
251 Q. What is the joint responsibility?
A. I think the joint responsibility is -- the lead clinician had a responsibility to ascertain to what extent there was capacity for key workers to be appointed by the core nurse member and in what way they were appointed. And, frankly, in 2015/2016, it just wasn't the capacity to have key workers appointed for every newly diagnosed patient. 14:53 14:53
252 Q. And Mr. Glackin, am I right in saying, took over the responsibility of MDT lead from you?
A. In January '17, that's right.
253 Q. And more resources came into the system in terms of Clinical Nurse Specialists from around, I think I'm right in saying, 2018. 14:54
A. Or even possibly before it. But irrespective of which year it was, you've heard them detailing how they actually were not Clinical Nurse Specialists with the sole responsibility, or predominantly of being key workers, that they had management roles, and their capacity to be key workers was compromised for those reasons. 14:54

254 Q. And, again, was there any change in your understanding of how the Clinical Lead, Mr. Glackin, should have discharged this joint responsibility?
A. No, because it wasn't -- it wasn't my business, as it were, at that time, to be looking into how he was discharging his responsibility. 14:55
255 Q. If you are the clinician with responsibility for a patient, and if your interest is in ensuring that the patient has all of the resources necessary to help them through the care pathway -- 14:55
A. Hmm.
256 Q. -- would it be your responsibility to approach either of these joint responsibility holders to challenge them or to complain if a nurse had not been identified for your patient? 14:55
A. It would have been. I mean I frequently requested a key worker and a holistic needs assessment. I worked with Clinical Nurse Specialists. I do understand where you're coming from. If I had had an awareness that key workers were not appointed to my patients, what did I do about it? I think, actually, having listened to all of the evidence given, I think that there has been a conflation between the establishment or the allocation of a key worker to each newly diagnosed cancer patient, with the overriding priorities, is my understanding, and I think it's backed up by the literature regarding key workership, to undertake a holistic needs assessment and to make sure that they have a contact number. I think there has been 14:56 14:56

a conflation of that with the presence of a CNS, who supposedly would become the key worker, at the post MDM consultation. And I do know that --

257 Q. I must say, I'm not sure I'm following what you've just said in terms of a conflation. Can you maybe illustrate it by, if we -- I think if I'm right, if we move down the page we can see some of the responsibilities - if we stop there - for the key worker, which includes -- yeah. It includes at the second bullet point: 14:57

"The key worker should be present when the cancer diagnosis is discussed and any other key points in the patients journey."

14:58

Two bullet points below that:

"Ensure continuity of care along the patients pathway and that all relevant plans are communicated to all members of the MDT." 14:58

Clearly, significant responsibilities, and it would be unusual, would it, for a patient not to want access to a key worker, whether or not -- particularly a male, perhaps an elderly male, as I think you have alluded to, may not want a female nurse present during examinations. But leaving that aside, was it your general experience that the nursing input in the form of a key worker, and the responsibilities that go with 14:58

that, was to be welcomed?

A. It was to be welcomed, but I was going to add earlier that, on Fridays, it just wasn't available.

258 Q. Yes.

A. I mean, you've listened to the various mitigating circumstances that pertained, particularly on a Friday. Kate O'Neill didn't work on a Friday. Leanne McCourt was off doing her prescribing course, I think, on Fridays. And not infrequently, you know, gratitude and appreciation was extended to me for being able to manage on my own because of the lack of availability of Clinical Nurse Specialists. And as I said in my addendum, you know, I've never had, apart from the Leanne McCourt, what's a key worker incident, I've never had a nurse of any standing come to my door, come to my clinic and say: "I'm your Clinical Nurse Specialist for this clinic today and I'll be this -- the patient's key worker". It just never happened. 14:59 14:59 15:00

259 Q. Yes. Yes. But that isn't necessarily the end of the story, if the nurse isn't -- if the nurse, in the form of a key worker, isn't available? 15:00

A. Mm-hmm.

260 Q. But we'll come to that in a moment. Let me just touch upon the SAI findings. If we go to the overarching report at DOH-00124, it's the fourth bullet point. So it says: 15:00

"Safe cancer patient care and pathway tracking is usually delivered by a three-pronged approach of MDT

tracking, consultants and their secretaries, and Urology Specialist Nurses, in a key worker role. The review found that these 9 patients were not referred to specialist nurses and contact telephone numbers were not given. Therefore, the CNS were not given the opportunity to provide support and discharge duties to the 9 patients who suffered as a consequence." 15:01

It goes to say:

"The MDM tracking system was limited." 15:01

Which is, broadly speaking, another point.

So, if the key worker isn't available at the time of, for example, a review appointment giving the bad news of cancer diagnosis, there are other options to bring that contact between patient and key worker together, and the tenor of the evidence has been that that responsibility should fall or does fall on the clinician providing the information to the patient, providing the diagnosis, and then you go on to tell the patient about the availability of the key worker, and if he or she isn't in the room, or isn't in the corridor, or isn't available, you give the contact details. Is that something you were unaware of? 15:01 15:02 15:02

A. Well, I'm entirely unaware of it because it's non-existent. There is -- I mean you've read my addendum. I completely refute this notion, from

wherever it came, from Dr. Hughes, that it was the primary responsibility of the clinician to refer, use, engage, ensure that the patient has their contact numbers. That -- it's -- none of the literature includes that. The primary responsibility, and the screen that you just left, the fifth bullet point was, it's the responsibility of the key worker to ensure that they have contact details. I mean, frankly, you know, if there was capacity, I asked the fundamental question: Why did none of my key workers have -- why did none of those 9 patients have a key worker appointed? It wasn't my responsibility. 15:03 15:03

261 Q. You do agree, factually, that none of these 9 patients had a key worker appointed?

A. Well, I have asked that question as well, do you know. I referred Patient 4 on 1st March 2020 to the Palliative Care Clinical Nurse Specialist, and to Kate O'Neill, asking for a holistic needs assessment to be undertaken. As I sit here, I still do not know whether it was undertaken by either or both of them. 15:03 15:04

262 Q. That was a referral -- we obviously have the e-mail for -- it was in March 2020.

A. Hmm.

263 Q. But that was when the patient had reached the palliative care stage. The patient had been diagnosed with Gleason 5+5 prostatic cancer in June 2019. But you're inviting the key worker's involvement for palliative purposes nine months later? 15:04

A. Mm-hmm.

264 Q. The key worker should have been involved nine months earlier?

A. Absolutely.

265 Q. In a sense, the 9 patients that we and Dr. Hughes looked at, was a randomised sample from the perspective of the involvement of the key worker. These cases didn't arrive at the threshold of an SAI because of the absence of a key worker. There were issues about the care pathway, and diagnostics, and referral, but the key worker aspect was common to them all. And if we go on in this document to page 0126, I think two pages on, we can see the -- just scroll down -- yes, the bullet point at the bottom, it says: 15:04 15:05 15:05

"The Review Team considered if this..." 15:05

- non-involvement of key workers:

"...was endemic within the multidisciplinary team and concluded that it was not. Patients booked under other consultant urologists had access to a specialist nurse to assist them with their cancer journey." 15:06

Can you locate any explanation as to why that might be so? 15:06

A. No, I asked the question: Why -- why were my patients deprived of a key worker? And I -- I -- I know you made reference a year ago and more when all of this was being considered. I mean, I knew what key workership

was all about, I still know what key workership could be all about. In my recent addendum, I have tried to highlight what I think were the basics that were required in key workership; above all, holistic needs assessment and contact details. A couple of screens back, the fifth bullet point was, it was their responsibility to ensure that the patients had their contact details. 15:07

Like, quite frankly and candidly, if you take a patient like Patient 1, whom I reviewed at Southwest Acute Hospital, I ask myself the question: Why is it that this man did not have a key worker appointed, even when actually he had occasion to speak to one of the Clinical Nurse Specialists, as is evidenced from his own diary? And I do wonder whether the Clinical Nurse Specialist had a clear understanding of the basic obligations of key workership. 15:07

Now, I have tried in my addendum to blend that reasonably and proportionately with the inadequacy of the CNS resource as well, and whether the likes of myself doing my Oncology review backlog on a Friday was a circumstance that led my patients to be foul of that provision. 15:07 15:08

But I just take the opportunity, in the case of Patient 1. There was no reason, in my view, why Patient 1, just because he came from Enniskillen and just because

he was being reviewed in Enniskillen as an outreach clinic, and there's no CNS there, why did he not have the most important kind of support that he required in the months ahead?

266 Q. Yes. Could I bring you to PAT-001353? And this is correspondence which the Inquiry received on behalf of the family of Patient 1. And they chart through this, it's a response, actually, to the questionnaire which the Inquiry formulated for use by patients. And they chronicled Patient 1's various interactions, and they record that on 4th July they met with Mr. Haynes -- sorry 14th July, they met with Mr. Haynes. You had obviously had involvement with Patient 1 since the, I think the late summer of the previous year, and it would appear that it was only with the involvement of Mr. Haynes that a cancer nurse specialist became available to the family? 15:08 15:09 15:10

A. Mm-hmm.

267 Q. All those months had passed. Patient 1 didn't have the services of a cancer nurse specialist, and as it records here: 15:10

"A cancer nurse specialist was present who indicated her surprise that..."

15:10

- sorry, I shouldn't say the name:

"That Patient 1 had never been allocated to a cancer nurse specialist from the outset. They explained that,

no, from February to June, his only access to care was through A&E despite repeated attempts to access Urology Services."

Is that not telling, Mr. O'Brien, that when another consultant becomes involved, the Cancer Nurse Specialist receives an opportunity to connect with the family, when, during all of the months of your involvement, they don't appear to feel that they have that resource? Conscious that Patient 1 made contact on telephone with a nurse on one occasion, and that's recorded in his diary. But does this scenario suggest that you were failing in your responsibilities to connect a patient to a key worker? 15:11 15:11

A. I don't want to put this unreasonably, but it was not my responsibility to connect a patient to a key worker. I had -- I wrote the operational policy in -- starting in 2014-2015, I knew whose responsibility it was. And if it is a true record that the Cancer Nurse Specialist who attended on 14th July indicated her surprise that Patient 1 had never been allocated to a -- allocated to a cancer nurse specialist from the outset, it should really be, you know, in terms of syntax, the cancer nurse specialist had not been allocated to Patient 1 from the outset, and it's the responsibility of the Core Nurse Specialist to do so. It's clear, it's explicit, it's repeated, year after year. It was not my primary responsibility. It was not the primary responsibility of the clinician, as has been indicated 15:11 15:12 15:12

by Dr. Hughes.

268 Q. Hmm. We also see in the evidence from your colleagues, an ability to connect the patients with the key worker, whether that was ensuring that a nurse was going to be in the vicinity when the review was happening, or be 15:13
that in terms of, I think it was Mr. -- I'll not say because I can't remember -- but certainly evidence that the simple delivery of contact details to the patient, which, in Mrs. Trouton's evidence were readily available in the consultation room, in front of you, 15:14
but it wouldn't appear that you felt any obligation to do that, is that --

A. No, they weren't in front of me, they were in a cupboard that we had access to for all of those Prostate Cancer UK things and generic information and 15:14
so forth. Yes, I do repeat, and I feel, frankly, aggrieved on behalf of all of those patients. I mean I was as taken aback as anybody, surprised, that these people hadn't been allocated a key worker. I think that the experience of Patient 1 and his family is 15:14
something that could have been avoided if there had been a key worker appointed. I know whose responsibility it was to allocate the key worker.

269 Q. I know, Mr. O'Brien, that you and your colleagues are extremely busy professionals. 15:15

A. Hmm.

270 Q. You've had opportunity to explain that in your evidence. But here we have nine out of nine misses.

A. Mm-hmm.

271 Q. Nine out of nine cases where we don't have a key worker in place?
A. Hmm.
272 Q. Does that, if you like, fly completely below your radar so that you are not in any way aware that the connection between key worker and patient has not occurred? 15:15
A. Yes, that is the case. When I look at these patients, particularly Patient 1, Patient 4, and Patient 9, people who particularly needed to have holistic needs assessment and support provided to them along a pathway during which time their clinical status significantly changed, and particularly when, in the case of Patient 1, he has been in contact with those Clinical Nurse Specialists on two occasions, never mind actually having his biopsies performed by Mrs. O'Neill in the first instance, not that I expect that that precipitates key workership, but I just do think that as I've explained in that addendum, I don't -- I think Mrs. O'Neill certainly had an appreciation of what was basically required from key workership; I'm not quite sure that the same was shared by Leanne McCourt. And I can understand in some way that you find it difficult to appreciate how could I not have appreciated all of that? But, nevertheless, it wasn't my responsibility, and I simply cannot understand how it is the case that Clinical Nurse Specialists, having been contacted by a patient requiring help and advice and so forth, it couldn't have triggered that in fact, has a key worker 15:16 15:16 15:16 15:17

been appointed and perhaps I'll be the key worker for this patient? I don't understand why they didn't have a directory of all of the newly diagnosed patients. And should it be a week later, or two weeks later after a bad news review, that they didn't take it upon themselves to ensure that these people had been contacted by them in their key worker role.

273 Q. Let me move you forward to the -- I'm not sure whether it's forward or back at this stage -- but it's your concern that, in June 2020, what we've referred to as the two out of ten issue arose; in other words, the Trusts, through Mr. Haynes, became concerned, on his evidence, that two of your patients had not been properly administered through the PAS system, and that was an irregularity that, in his view, could give rise to a risk that patients would be -- would be lost. And as you know, that was to trigger other investigations, including the informal lookback, and ultimately an Early Alert to the Department. You have expressed your view variously, but you've said, for example, at WIT-82405, your first witness statement, at paragraph 19, you say:

"It appears that the very trigger for a lookback exercise of all of my patients to January 2019 was the totally untrue assertions in this letter about two patients who had been placed on the inpatient waiting list on PAS in the ordinary way and which any competent and impartial consideration of the medical records and

correspondence held by the Trust would have revealed."

Sometimes, in expressing that, and you express it variously, as I've said, instead of using the word "untrue" you've used the word "incorrect" - another synonym might be "inaccurate". I'm asking you this, Mr. O'Brien, are you suggesting that Mr. Haynes or anyone else is guilty of some form of bad faith, or ulterior motive, in how they've dealt with this issue? Or are you more of the view that it's likely to have been a careless, perhaps a very careless mistake on the part of Mr. Haynes, but not an untrue or a dishonest one? 15:20 15:20

A. I don't believe it is just a careless, even very careless mistake or error on his part. One of the features of Mr. Haynes' character is that he can, what's that word where the greyhounds come out of the -- do you know, he can be very quick off the mark in jumping to a conclusion. I think that's about the only mitigation that I could offer. I think that we have heard the story of the filter, about which I have the gravest of scepticism. Whether, you know, that the Trust became aware on Sunday, 7th June 2020, that two out of ten patients appeared, on the face of it, carefully chosen words, not to be on the patient administration system, and that the following day, do you know, I was getting the phone call to advise me that I would not be returning to part-time employment, and this untrue assertion keeps being pedalled right 15:21 15:21 15:22

through for years, as we were discussing last day, I think, I just find -- it's hard to believe that there was good faith in it all. I don't believe that there was.

274 Q. As you point out, this was to be the trigger for other investigations, including the lookback into an SCRR process into a Royal College review. Would you accept the proposition that even if the initial concern was unfounded, it was entirely valid for the Trust, and those that they retained, such as the Royal College, to follow their noses and to enquire into other aspects of your practice, even though the initial premise may not have been well-founded? 15:22 15:23

A. Yes, I do, but I do not think that Mr. Haynes or Martina Corrigan should have been involved in the selection of cases or the deselection of cases. I think, having got something so fundamentally wrong, leading, in particular, to a Minister for Health misinforming the Northern Ireland Assembly, and it wasn't even a specific two out of a specific ten patients, but it was two out of ten, giving the impression that 20% of my patients weren't on the patient administration system, I don't think that they should have been involved at all. And it is very, very interesting, for example, if I may just take the opportunity of, like, with regard to Patient 139, do you know, Patient 139 wasn't selected for a structured clinical record review. 15:23 15:24 15:24

275 Q. Can I bring you then to the issue of your retirement,

as it's sometimes described. You have specifically indicated within Section 8 of your recent addendum statement that you properly understood you not be considered as having retired?

A. That's right. 15:25

276 Q. You would rather frame it as your intention to retire from full-time employment had been notified with effect from 30th June, with the intention of returning on a part-time basis, but you were essentially forced to leave your employment and that wasn't of your choosing, 15:25 so it can't be considered retirement. It is the case that the Trust did not accept the validity of your withdrawal of your intention to retire, and it is the case that you didn't challenge that before the courts, as was sometimes suggested in correspondence? 15:26

A. Mm-hmm.

277 Q. And it is the case that you are in receipt of retirement benefits?

A. Mm-hmm.

278 Q. And it's further the case that you have been restricted 15:26 from medical practise by the General Medical Council?

A. Mm-hmm.

279 Q. In your contesting of the Trust's approach to you in June 2020, you wrote to the Chief Executive of the Trust, Mr. Devlin, amongst others, and you also wrote 15:26 to Mrs. Brownlee in her capacity as Chair of the Southern Trust Board?

A. Mm-hmm.

280 Q. You were writing to her -- and the letter is to be

found at -- sorry, I've lost the reference for that, but I'll come back to that -- you were writing to her asking her to bring your concerns about how your employment situation had been handled, to the attention of the Trust Board? 15:27

A. Yes.

281 Q. Why did you consider it appropriate to draw, what is in essence an employment issue, to the Trust Board, when, generally, matters of an operational nature are not the responsibility of a Trust Board? 15:28

A. Well, my -- I mean I wouldn't have been so conscious in my state of mind at that time of that distinction or the -- the possible impropriety of that in the view of some --

282 Q. Well I'm not saying it's inappropriate, but, that, as you say, in the view of some it may have been? 15:28

A. Yes.

283 Q. Obviously we don't need to retrace the steps of your relationship as a friend and an associate of Mrs. Brownlee? 15:28

A. Mm-hmm.

284 Q. But was any of your contact with her at that time designed to use an opportunity, not available to others, an opportunity granted through your friendship, to advocate on your behalf? 15:29

A. No, I -- if -- if she had -- if the Chair had been someone whom I had never met, I'd have written the same letter, with the hope that the Trust Board could bring some sense and mediation to the table. I particularly

wanted to return to part-time employment. I wouldn't have ever submitted a letter with intent to retire -- I just wouldn't have done it, I wasn't ready for it. I was looking forward particularly to tackling the backlogs that we did have, and I was, unusually, looking forward, actually, to being able, in the context of Covid, and the restricted operating that we had available to us at that time, to be able to review the hundreds of patients on review backlogs. 15:29

285 Q. Just for the record, the letter sent to Mrs. Brownlee, to communicate with the Trust Board, is to be found at WIT-90953. 15:30

Just finally, Mr. O'Brien, at WIT-82655, at paragraph 711, towards the end of your original witness statement, you describe, by way, I suppose, of a reflection, that: 15:30

"There was an abject failure by the Trust throughout your tenure to engage in a constructive manner and provide adequate support, management and resources to deal with the inadequate service clinicians could provide to patients. The statistics speak for themselves. The failure to engage left me stretched throughout my tenure, having to prioritise, as best I could, to deliver a service to patients. However, that inevitably led to issues occurring in my practice." 15:31 15:31

- which you had set out. I suppose as a general overall reflection that neatly encapsulates your view, obviously supplemented by all of the evidence that we have gratefully received from you.

15:31

Could I put, finally, the Trust's perspective in this.

We've observed over the past number of days areas of practice where you felt unable, and you've given your explanations, to comply with what the Trust expected 15:32
from you, DARO, an example of pre-op assessments, behaviours within the MDT, cystectomy, results, all of these issues are drawn together to suggest that, while the governance system may have been far from adequate, you, nevertheless, had a personal, individual and 15:32
professional responsibility to conduct your practice in a more orderly and more compliant fashion, and Mrs. O'Kane has said that you have a tendency to blame others, particularly managers, rather than accept any responsibility for your actions and their impact on 15:33
patient care, suggesting a lack of insight. She says you didn't appear to express any concern or remorse that patients had come to harm, or be concerned about the impact of your actions, and she says that at paragraph 55.37 of her witness statement. 15:33

Has she got you right, Mr. O'Brien, that you have a tendency to point the finger without taking responsibility for your own actions?

A. Not at all. And I don't know how someone whom I've never met could take upon herself to do a psychoanalysis, which I felt was particularly inappropriate. I think, you know, if you're inviting me to reflect?

286 Q. Of course, it's my last question. I wouldn't invite you to take all afternoon, because I think we're heading into a break.

A. Yes. Yes.

287 Q. And maybe your response just now is adequate. But, certainly, if you wish to respond further to her reflection, be my guest.

A. I read her two or three-page psychoanalysis of mine, and I think frankly I would prefer not to comment on it at all because I thought it was quite inappropriate. I think that's the most generous thing I could say about it. I think, actually, with regard to her introductory paragraph that I lacked insight, I think sometimes I have had insights that a lot of people would prefer that I didn't have at all, never mind express them. I am not lacking in insight, I'm an insightful person, but I've had 28 years of insights into the Southern Trust and its predecessor, and, you know, I go back to the core issues, and the core issues for me were, a grossly inadequate service, and I think there's no debate about that whatsoever. You know, the sort of contained professional personal practice in a square box, and whether you look over the wall and concern yourself with the risks of patients coming to

15:34 15:34 15:34 15:35 15:35

harm, and the suffering of patients waiting for years to be admitted for urgent surgery, never mind routine surgery, and the inability, and it is -- has to be acknowledged, there was an inability resource-wise for the Trust or, indeed, the Commissioner and the Department collectively to turn around and address all of that. So -- and I couple that with -- I was going to ask you, you referred to it briefly yesterday, but if you would indulge me just momentarily with, if I could ask for AOB-00308, and it's where I went to facilitation I think back in 2011 or 2012, and I was asking there for adequate time to undertake -- so if you would go on to the next page, possibly? So just before you do, go back up again. So, basically, I would just say inadequate time for administration relating to direct patient care, and I have listed those in general terms. And if you go over the page, and I was talking about review of waiting lists is about waiting lists management, and to be -- to be candid, you know, the Trust hasn't managed waiting lists since 2013, apart from validation exercises, dealing with all of the enquiries, at that time 40 queries per day, still my secretary selecting the 3 or 5 that most needed to be done. And skipping on down. This is, you know, what I was mindful of since I came here on Wednesday:

15:36
15:36
15:37
15:37
15:37

"It has recently been proposed that all laboratory results and radiological and pathological reports

pertaining to Outpatients be read when available in order to ensure that appropriate action is taken..."

And so forth and so forth.

15:38

Now:

"This clearly is a major issue for clinical governance. I believe that this is currently conducted on an ad hoc basis only." 15:38

That's when time was available.

"...and that it will require a significant consumption of administrative time if it is to be done completely." 15:38

Just scroll up briefly. And I think going on down to the next page, I think that I had endeavoured to quantify -- keep going -- all of the administration times that were required, and this is it, where 15:38 I reckoned, you know, at that time, and this was minimalist, that, you know, two hours, one hour, one hour, dictation two hours, MDT, Thorndale, results, and reports to be quantified. So, here, you had seven or eight hours then in 2011, and with results and reports 15:39 to be quantified. So I was asking for maybe eight to ten hours of administrative time and, in fact, the response was that your administrative time was being reduced. And, penultimately, I coupled that with Mark

Haynes' quantification of administration time required at 15.25 hours per week, and that's excluding AMD associated activity. And since this -- one year after this-- six months after this, the largest amount of administrative time I was allocated on any proposed job plan was 0.8 PAs, which is about three hours.

288 Q. We're in danger, Mr. O'Brien, of overstepping the mark in answer to my question. I asked for a brief reflection.

A. Yes. So -- 15:39

289 Q. We have had this evidence last year.

A. Yes, I appreciate that. So what I'm basically saying is that over 28 years I worked as hard as I could to address, as I have stated previously, those people who I felt were most in need of it at any particular point 15:40 in time, and as many of them as is possible. And insofar as I have failed in my duties to any of those people, and to others that I couldn't attend to, and insofar as those people have suffered harm, it is greatly regrettable, and we all need to apologise to 15:40 the hundreds of people who have suffered harm over the years.

MR. WOLFE KC: Okay. Well, listen, thank you very much for answering my questions over the three days of this week and three days of last year. I have nothing 15:40 further for you.

CHAIR: Well, unfortunately we do, Mr. O'Brien, but before we ask you some questions, we're going to take a twenty minute break and then we'll come back and

hopefully finish in and around 5:00 o'clock, ladies and gentlemen, just so you know.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

15:47

CHAIR: Thank you, everyone.

MR. O'BRIEN WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

16:04

CHAIR: Thank you everyone. Mr. O'Brien, we'll try to be as brief as we can, and Mr. Hanbury has some questions for you first of all.

290 Q. MR. HANBURY: Thank you very much for your evidence, it's been very interesting. Just I've got a few questions, mainly clinical, and hopefully we can rattle through them fairly quickly. 16:04

Mr. Haynes and yourself, I'm sure, produced that long elegant letter in about 2018 about essentially all your clinical -- your theatre capacity being basically used up by red flag and urgent cases, which is a very good and interesting analysis. And I was just wondering, it never seemed to make a difference, and I suppose my question is: Your Clinical Directors were almost entirely general surgeons, who obviously had some control on theatre allocation. Did you take that bit of evidence to the general surgical -- your Clinical Director and, if so, how did you get on with that? 16:04 16:05

A. Well, I didn't -- I wasn't involved in bringing it to a Clinical Director at all. I don't know if Mark did include a Clinical Director, or bring it forward to a Clinical Director, and the Clinical Director at that time in 2018 may have been Mr. McNaboe I think, and of course Mark was the Associate Medical Director at that time, so really he should have been, you know, taking it, if it was going to be worthwhile, to the Medical Director or to the Chief Executive. I think the most pertinent question that Mr. Wolfe asked in relation to that in recent days was, you know, was it brought to the Health and Social Care Board? Was there any interaction there? Because I don't know the answer to that. I doubt if it was. And, you know, from the history of our trying to do so, I'm not quite sure how much impact it would have made even if we had done all of that. 16:05 16:06 16:06

291 Q. I suppose you could have gone up to the Medical Director and that might have made a difference before health -- okay. So moving on. And also about the long waiting lists, we've heard a lot about that. By 2018 was realisation in the urological community that big benign prostates, certainly over about 80cc, were best and more safely managed by laser ablation, so called HoLEP, and I realise that that wasn't going yet in Northern Ireland, but did you -- you obviously knew that. Could you not have used that as an opportunity to actually send a few dozen cases away? It would have helped your waiting list and helped the patients 16:06 16:07

actually?

A. Well we didn't collectively do that. Why we didn't do that, I don't know. I think -- I'm not quite sure how -- the answer is I don't know. I'm not quite sure how much HoLEP for benign pathology, or a procedure for benign pathology would have been so accommodated, maybe they would sending them to Oxford or Cambridge to Mr. Tao or whatever. I mean I went -- 16:07

292 Q. There were a few centres --

A. -- and did a few workshops. I went to Spain with Michael Young, myself, some years ago, and watched the New Zealander who introduced the whole technique - whose name I've forgotten, do you know. And we thought about bringing it back to Craigavon. But we had so many balls and plates to spin that we found it difficult. 16:07 16:08

293 Q. Which is my point entirely, and we did that - because we specialise in robotics, and many departments did cross-refer, and we've heard from the Commissioner that that would have been available had you pushed it. So we've heard about the pre-op assessment and those two tragic cases that died in the early post-operative period, and it's a terrible thing to happen to a surgeon, and obviously when you look back, and I think you reflected on Wednesday that, on reflection, you should have -- or may have considered postponing the case, and the haematological aspect with a myelodysplasia case. I suppose my question is that there is a another step after pre-op assessment, and 16:08 16:08

that is actually the surgical huddle and the WHO checklist that we all do in theatres is now culture. I mean when you, as a group, look back and thought, "why didn't we stop it?", you know --

A. I think actually -- 16:09

294 Q. Why did we let that through? When in retrospect, as the MSU --

A. Well we do have WHO, and I, you know, where you gather around the operating table, and I sort of led that, introducing everybody and so forth. I often think, why 16:09 was it -- I mean I went back to the day clinical centre, and I forensically went through the documentation and spoke to the staff to make sure that he was -- actually had been transfused two units of packed cells the day before, because I couldn't believe 16:09 it when, in fact actually, his haemoglobin was still 86 in the morning. Where did it go to? He definitely had been given it. So, cause for regret. The consultant anaesthetist, who is a very good anaesthetist, you know, he didn't himself feel that there was any 16:10 contraindication to proceeding. But at the end of the day, it's tragic. Sometimes when you're under pressure to deliver and so forth, you can cut a corner, and if I had to do it all over again I would have said to him on the footpath, "Okay, we're going to do all of these 16:10 things". But even I didn't appreciate the significance of referring him for echo. But as I said to Mr. Wolfe yesterday, I think the myelodysplasia was, by far, the primary comorbidity.

295 Q. I suppose what we want to hear, in governance terms, is that there is a more robust process, and are you asking everyone in theatre whether anyone has got any concerns about -- sort of flattening the hierarchy, which we've found has been a big factor -- 16:11

A. Well, we would have done that. We would have checked everything.

296 Q. Yes.

A. Gone through everything. And, yet, in the best of systems, things can escape. 16:11

297 Q. Okay. Thank you. Just one question on the MDT quoracy, and we've heard that a lot, and it's just again a question you raised it, the Peer Review raised it, it was -- it was a big patient safety thing. I would argue that you haven't got radiologist, 16:11 prostate MRIs are difficult to read, as well as renal matters and the rest of it, not to go over that. But when you got nowhere, and the Cancer Services didn't seem to have a solution, and the Medical Director didn't seem to have a solution, why actually didn't you 16:11 stop? I know you threatened it, but actually if you had stopped, it would have -- even just temporarily --

A. It would have brought it to a head. Perhaps. And even if it had brought it to a head, was there definitely going to be a solution? Because even though I have 16:12 raised these matters with everyone, I was raising them with people who had several responsibilities like running a Radiology Department, and I actually went along and spoke to these people quite frankly about the

importance of this, but they had other importances to attend to as well, and it's very, very difficult.

298 Q. Which is fine, and you asked nicely, but you didn't get anywhere.

A. Didn't get anywhere. 16:12

299 Q. That's not a criticism on that.

A. But, no, I might have got a little bit for a while and then it disappeared again.

300 Q. Yes. You need to go up the food chain.

A. And I went to the Medical Director and specifically spoke about it, and he went to the Department and got some improvement, but it wasn't sustained. 16:12

301 Q. Okay. Thank you. Just one thing on the penile cancer case, and we've discussed this a lot, but when we started super-specialising penile cancer, there was a clause in the IOG requirements that if the patient couldn't or wouldn't travel, and you've determined that was a problem, then you could run the case through a specialist MDT, which you could do remotely then, and we were in early days of Zoom and things. I guess -- and that would mean that someone in a more remote setting from a specialist centre, as you are in Northern Ireland, could actually get a specialist centre's blessing for your proposed plan, and then if something happened you could maybe step up a gear. Did you do that or did you -- 16:13 16:13

A. We didn't do that. We didn't do that for any of our penile cancer cases prior to Northern Ireland having its own centre, and in a sense, actually, I happen to

know, like one of our former registrars who was a locum consultant with us, who is KJ Ho in Birmingham, I don't know if you know of KJ or heard of him.

302 Q. Yes:

A. Like I mean I have spoken to him about that case since. 16:14

303 Q. Yes.

A. So when I learned since that he had been appointed -- there were two of them in that network, and one has left and he's there, and it would have been possible. But, no, we didn't do. And should we have thought 16:14 about doing it? Possibly. But, you know, we didn't do it.

304 Q. Yes. Well what we found actually -- we sent the younger patients, who are much more prepared to move, and the very old ones we could do with backup. So that 16:14 has helped a lot of units. Bicalutamide. Again, I don't want to take you through all that, we've heard a lot about it. Just one question on that. The Inquiry are aware of two cases where you appear to prescribe it for benign prostatic enlargement? 16:15

A. Yes.

305 Q. Just to explain that?

A. Well over a period of we'll say 28 years I think I've thought about this, I can remember two patients before this in recent days, unusual case arose without 16:15 a letter being generated. So I think in about 3 or 4 cases in my 28 years, if I found a patient who was very comorbid and typically had an indwelling catheter and was very bothered by it, and really wanted to try

something that would alleviate that person of the catheter, I have prescribed 50mgs, typically for a period of six months, on one occasion for 12 months, and following trial removal of catheter during that period of time these people had the freedom of not having a catheter, and it has worked. 16:15

306 Q. I hear what you're saying, but we do have a drug called Finasteride --

A. Yes. These would be in addition to Finasteride.

307 Q. In addition to. 16:16

A. Because there was one trial done and that I have the papers at home that found it to be no more effective than Finasteride, but I would have been using it in addition to Finasteride. It has been reported to be effective, not a great deal of success, but if you use it I think with a patient with an indwelling catheter, I think that's the core issue, because as Professor Kirby alluded to, not all forms of androgen deprivation therapy, reducing the size of a prostate will reduce bladder outlet obstruction, as you know. 16:16

308 Q. Okay. So moving on, on to the thorny issues of CNSs. I mean, we're of the same era, and it was a great triumph when we got our first CNS and then, like yourself, it takes a while to recruit more. So it's a source of pride, I would suggest to you, for a department to have a few? 16:17

A. Hmm.

309 Q. And so that's why it sort of doesn't ring true about you not saying -- new cancer, and we may not have

a specialist nurse today because it's Friday, and it doesn't work with scheduling, and sort of big up the service and make sure it happens, I mean it's the sort of personal responsibility -- and Dr. Hughes, I know, wrote about that. But I was surprised that in a way it was a source of pride that you had been driving that for many years, but then where did the push go?

A. To have more?

310 Q. No, for you to make sure that the contact was established with the patient? 16:17

A. Because I genuinely and honestly believed, as I have set out in all of the addendum, that the responsibility lay with the key worker, and I think actually it's like -- I think in my primary witness statement I refer to the fact that the core nurse member was meticulous at 16:18 ensuring that we reviewed our patients post-MDM, and it seems strange that, you know, they didn't make sure that they fulfilled their key workership role, and I mean, it was a grave disappointment to me to see people suffering as a consequence of not being provided with 16:18 the support, and, really, when you think of it, if you had a list of people who were newly diagnosed, it would have taken very, very little, and I don't want to belittle the time because I've dwelt a great deal upon time, and there was an inadequate number of CNSs or 16:19 other nurses to do it, but I just find it very, very difficult to accept that it wasn't possible to ring a patient, as I did thousands of times, to ask "How are you? What do you need? What are the difficulties?

This is my number." I just find that very difficult.

311 Q. All right. Well, we've sort of covered that ground already, I know.

A. Hmm.

312 Q. Sort of moving back in time to IV fluids and antibiotics, and that was an interesting thing, because I've got, like you, a bit of interest in urinary tract infections and the success of recent vaccine therapies, and there are other ones too, and they're obviously a problematic group, and every Department of Urology has to deal with them. But I think what the Trust objected to sort of just how you did it and the sort of you setting forward a procedure which they didn't accept. So I suppose my -- you've got a bit of an academic background, you've raised money for research, you could have put -- proposed a research protocol randomising your novel technique IV fluids and antibiotics versus standard of care, and actually wrote a randomised protocol, written it up as a very strong paper, and find out really whether it did work or not, because the criticism I'd have of your case series was that there wasn't a controlled group so you sort of can't really be sure where it's going. So, I guess my question is: Did you think of that and, if not, why not? 16:19 16:19 16:20 16:20 16:20

A. Well, no, I personally did not think of that, but you know something, I think, frankly, that horse had bolted. I think that, you know, Mr. Wolfe was asking me yesterday about the paper that we did write, and

I forgot to say to him -- I mean we were drafting that paper and we had done our work and analysed the data when this issue arose, and I simply couldn't understand, you know, why -- you know, why there was a difficulty in arranging for people to be admitted for a period of time a couple of weeks before they would be admitted for a longer period of time for the same treatment and same bed and so forth.

313 Q. Yes.

A. So -- and I am aware that in someone's correspondence over this issue, I think it might have been Dr. Diane Corrigan's, that she suggested that possibility. 16:21

314 Q. Yeah.

A. But I think this was a directive from above. These were people who were sitting in a bed for five days. We can't afford that. They didn't see that they'd be in the same bed for seven days two weeks later, but that didn't matter. And we were to stop it and that was it. 16:21

315 Q. Yeah. So I'm aware of that. It was really just sort of in a way testing you, had you thought of that ten years before? 16:22

A. Oh, yes.

316 Q. Anyway. A couple more. Sort of benign sub-specialisation, along with the sort of 2010 changes, was I guess an onus of, if we do fewer than five complex cases a year, should we be sending them away? Which obviously might have helped you in your waiting list difficulty. I'm thinking now of sort of 16:22

paediatrics, it's not a great part of your practice but there were some cases. I read about surgical andrology, the surgery for penile deformity, reimplanted megaureters, these difficult cases for the reconstructive team, and also, dare I say, ureterolysis, which is not common a case, and that again would have helped your waiting times and helped the teams that are sub-specialising and need more cases to improve their outcomes too on the benign side. I mean did you think of that as a group? 16:22 16:23

A. Well we did, you know. Maybe we came to the wrong conclusion, because we did set up Northern Ireland Reconstructive Urology Network.

317 Q. Yes. Yes. And that's what gave me the idea, yeah?

A. And its fundamental aim was to try to retain those skills and competencies in the province, particularly the -- with regard to urethroplasty. 16:23

318 Q. Yes.

A. As you are aware. You probably have -- you're aware of all of that. And, basically, I probably was the person in the province who had the most experience in cystectomy and orthotopic bladder reconstruction before it was removed from us, along with Siobhán Woolsey. It was very good. And, in fact, on occasion we met with nephrologists as well to consider complex cases that had led to renal failure. 16:23 16:23

319 Q. Yes. So you were part of that group?

A. Yes. Yes.

320 Q. Yeah.

A. Oh, I was part that have group, and we attended that on a Friday afternoon in Lagan Valley Hospital, as it turned out, because that was quite central and, do you know, we showed the X-rays and the images and all of that kind of thing. So I suppose actually to answer your question, you're asking: Did you not think of sending them away? And we were trying to retain them in order to --

321 Q. Or sub-specialise within the province.

A. Yes. Yes. 16:24

322 Q. I guess that was my thing. Two more quick ones. One about dictation.

A. Yes.

323 Q. And most clinicians, and it's not just the Outpatient thing because I accept, you know, the pressures there. 16:24 But did you -- I mean when you were a trainee did you dictate after every case? Was that something that you sort of started missing things out when you became a consultant and --

A. No, no, we didn't dictate after every case. And in 16:24 fact you worked in teams that had, when I look back on it, unusual sort of dictation practices. For example, one of Professor John Fitzpatrick's colleagues, you know, he dictated a letter after he did an operation, never did a discharge letter, and then his next letter 16:25 was at first review afterwards. It is an important thing to some extent, and that is, in Craigavon, until I left, it was the practice of the registrars to do the discharge letters, and it has been said that I deferred

dictation until the entire end of the care journey. That's an exaggeration. I think that came -- if I saw someone who was going to have hydrostatic dilatation in three weeks' time, I would have combined that into one. But then I started from January or February or March or whenever it was '17, and I dictated then subsequently after each one, but not immediately after each consultation. 16:25

324 Q. Okay. Thank you. Last one, if I may. The glycine monopolar/bipolar question, this was talked about in England but wasn't a directive like it was here, but obviously you were under, I think you must have perceived more of a push to discontinue monopolar. When you tried out -- everyone else was managing it, but you were finding it just that sort of technique difficult or just didn't adapt to. Did you think of actually just saying "Well, it's just not good for me so why don't you give your cases to somebody else and you do something instead"? Did that go through your mind? 16:26

A. It never arose. And I'm not so sure how others would have been receptive to that. I mean, I was very happy and very competent to continue to use glycine with monopolar. I had had long experience, probably up to 4,000 prostatic resections. I have described how I had very, very few, possibly symptomatic cases. 16:27

325 Q. So, sorry, just to interrupt. I wasn't casting aspersions on your operative technique.

A. Yes. Yes.

326 Q. But it was different here and there was this push to stop.

A. Hmm. Hmm.

327 Q. And you didn't --

A. I didn't, because if it had have been -- if I had -- to answer your question, I would have preferred actually to have properly kept the cases on my waiting lists and done them myself and learned if I had -- if it was a directive that I had to, an instruction, to use saline -- 16:27

328 Q. So if it had come across as a more forceful thing you would have acquiesced?

A. Yes.

MR. HANBURY: Thank you very much. No more questions.

CHAIR: Thank you, Mr. Hanbury. 16:28

329 Q. DR. SWART: I've got some questions which are really about the culture of clinical governance and safety, to use your phrase, in a two-way bidirectional sort of way. Just as a preface, though, I do have a certain amount of empathy and sympathy for you in your journey 16:28 over the years. I was a single-handed consultant for many years, had to build up a specialty in a similar sort of way. I know what it's like being continuously on-call, seeing things change, having a big workload, it brings its pressures and it tests resilience, and 16:28 I get it, but it was a lot easier just to take your shopping list to the CEO and not have to navigate what seems to be a myriad of committees and a goodness knows what. But there's a "but", and the but is, over the

last 30 years medicine is more complex, we have many more innovations, there's much more need for assurance, there are regulatory frameworks to adhere to, and in order to do that in a hospital you have to set up some sort of management and leadership structure, and those 16:29
places that do this by putting senior doctors in charge, this is internationally now, do get better results. But my sense is that your experience of this, which is expressed really by your obvious difficulty with the medical management structures, and the 16:29
management structures as they were, led you to sort of lose your way a bit with it, you felt disenfranchised, you didn't -- not all the discussions you had with medical management or other managers were entirely fruitful, and you became disengaged I think in terms of 16:29
being able to plan productive services. So my question is: What do you think was responsible for that? What was lacking at the Southern Healthcare Trust that led you to feel like, and led you to not feel you had that connection with decision-makers, not feel you could 16:30
influence things? Have some difficulty with directives and things that were going on. What was it? Because we will need to think about that as an Inquiry, and I'm sure the Trust have thought about it already in terms of what should be done. The clinicians are the 16:30
powerhouses of hospitals, they make the decisions, they treat the patients. You don't want a situation where people are not connected, and there are a number of responsibilities in that, but what do you think was

responsible for you feeling like that?

A. Oh, I think I've alluded to it already today. There was no bidirectional -- there was no way, two-way traffic, you know, when it comes to governance. It was -- you will have heard witnesses giving evidence to the fact whether it was a departmental meeting and it worked if the directive was coming from above. You just got the impression that -- I often wondered, and my colleagues -- particularly Michael Young and I, often wondered why we had spent so many years training in this specialty, and your experience and your view around a particular issue just didn't matter. You can get the impression that the person on the other side of the desk is listening to you and listening very intently, and they're going to take you seriously, and it just washes like water off a duck, and it doesn't really impact. 16:31 16:31 16:31

So, do you know, in one of those e-mails from Mark Haynes where he referred to another specialty and another Trust having been chastised for not reminding the management frequently enough about the risks relating to long waiting lists, that's the kind of fatigue that we do have. You really do need to have -- you need to have a conversation as to how you're going to resolve the issues when the process and the protocol and the pathway meets with the reality of the situation. 16:31 16:32

330 Q. So, yeah, I understand that. You've also talked about

modernisation not necessarily being better, and I can understand that, and I think what you're trying to say is you don't want to lose the perspective of the whole patient, the clinical interaction and so on. However, you can modernise without losing those basic things, 16:32
and increasingly now the onus is really on the clinical staff to keep raising issues to make sure their voice is heard as part of a team, big emphasis on the team rather than the individual, and it means looking at things differently. Now, what was the support 16:33
available -- what was the culture of helping everyone to understand those bidirectional responsibilities? You know, what regular forums did you have where you could understand how everything worked and you were encouraged to keep pushing at that door? 16:33

A. Really, none, if they existed at all. I think that, you know, you referred to -- if you take the example, say, of Mr. Haynes, who, you know, was -- is to be commended for having raised the issues with regard to Patient Safety, and he's appointed to what's now called 16:33
a leadership role rather than a manager role, but you needed to have buy-in, you needed to have a structure that really said to the -- would say to the clinician, you know, "We will take you seriously and there will be results as a consequence of us taking you seriously", 16:34
so that you -- that the -- the agenda of the clinicians and that of the management, which might be quite divergent and discrepant.

331 Q. Why? Why should they be divergent?

A. Why?
332 Q. Hmm.
A. Why should they be? Well, they are.
333 Q. But they shouldn't be. They shouldn't be, should they?
A. They shouldn't be. And if you -- but you need a structure actually that -- I mean clinicians have been disenfranchised. There's no doubt about that. I'm not the only one who felt disenfranchised. 16:34
334 Q. Hmm.
A. And people are walking away from the job, and you listen to, you know, some of my former colleagues who are now doing four days a week and one in private practice, and you can't fault them, and they can't recruit, and I wouldn't even bother to trying to recruit if you can't retain in the first instance. So there are fundamental issues here around, do you know, what is the purpose? What are we there to do? I mean, process has become the purpose. Process has replaced the purpose. 16:34 16:35
335 Q. Hmm. 16:35
A. And the most important person in the centre of all of that soup is the patient.
336 Q. Okay. So moving on to that. You know, when I was first a consultant, I can remember being a bit worried about something I did, and somebody said to me "Oh, you're a consultant now. You can do exactly what you want. If you want to do something different, just do it", and I was a little bit nervous about that. But what this reflected was, there wasn't any culture of 16:35

assurance at that time. There wasn't any need really to demonstrate that you were following guidelines. There was very little clinical governance. And we're now at a position where this is really very different, and we should be able to provide assurance that our services are safe and effective and patient-centred. And the Board should be asking about that. They should be very curious. Are our services effective and how are we measuring that? But as also a clinician you should all be asking yourselves that, you know, how am I doing? How do I prove this? What's my evidence? I don't think there's -- I don't see a lot of information like that, from the evidence put before us, about those sorts of standards, not just in Urology, anywhere, you know, and I think that perhaps needs addressing. But if you could, if you could have measured things about your service, do you think you would have been keen to do that? Did you have any discussions about it? Did you talk about the lack of audit as a significant problem? What's your approach to that? 16:36 16:36 16:36 16:37

A. Well, I remember some years ago when Professor John Fitzpatrick was our boss in Dublin, and he arranged for the senior registrars, as we were called then, having dinner out with Patrick Walsh, the famous Patrick Walsh, and we were asking what made his institution the great place that it was, and he said, "Well, what you have to do is, you audit everything". 16:37

337 Q. Yeah.

A. "And you don't audit -- you don't audit things with

a particular question in mind" -- as is very much -- "you audit everything".

338 Q. Mm-hmm.

A. And when you have done it, you will find that 90% of what you're doing is as good as they're doing elsewhere; 10% isn't. 16:37

339 Q. Yeah?

A. Half of those actually will -- that problem will be -- has already been addressed.

340 Q. Okay. 16:38

A. And then you go on to -- the other 5% is audit-generated research, thinking about what can be done --

341 Q. But what should happening is we should be continually measuring outcomes. 16:38

A. Yes.

342 Q. We are not generally -- "we" using the biggest Health Service. Some places do it much better than others.

A. Hmm.

343 Q. Why was there no focus on measuring what happens to people, do you think? Where did that sit? And did you press for it? Did anybody ask you for it from the top? 16:38

A. I think really -- I'm being honest.

344 Q. Mm-hmm.

A. I think it's because we were -- we were running to stand still to try -- doing our best to try to provide a -- 16:38

345 Q. Did you realise this was a deficit? That you should be --

A. Of course. Of course.
346 Q. Did you tell anyone?
A. Yes, you can tell -- we did tell people. I mean, when I founded or set up CURE with Roberta Brownlee, we had four or five SPRs who did higher degrees, I mean I was very, very research-orientated, and I believe in a thing called clinical research, which clinicians should be doing, rather than laboratory research. 16:39
347 Q. Yes.
A. And I think that audit-generated research is so valuable because it closes the loop and all of that. But there is a limit to what you can do in addition to swimming against the tide of an inadequate service. 16:39
348 Q. I'm not suggesting that all clinicians should do this. I'm merely suggesting did you ask the question? Do you agree it's an important question? 16:39
A. Oh, absolutely yes.
349 Q. And you've talked about speaking to patients about the risks of various treatments and their choice.
A. Hmm. 16:39
350 Q. Did you document all of those risks in the notes and in letters to patients, for example?
A. No.
351 Q. Why didn't you?
A. Because -- because I'm not very good at writing and talking at the same time. So, you know, it's -- I did it. 16:40
352 Q. Mm-hmm.
A. And I think it's -- I mean that relationship between

doctor and patient is so important, and it's so important that patients are fully informed of that.

353 Q. I'm bringing that up as really a measure of patient-centred care.

A. Yeah. 16:40

354 Q. It's, you know, have they had the right information? Is it in writing?

A. Yeah.

355 Q. Because they do need to have something to refer to?

A. Yeah. 16:40

356 Q. And what is the ethos in the Trust? What's the spirit of that and what is done to assist you in these matters? Because the patient experience of that particular consultation I think is very important.

A. Hmm. 16:40

357 Q. You know, the post-MDT one where they are having that conversation with their treating clinician, trying to understand what's going on. So if you take that as an example of patient-centred care, was there an ethos of understanding the importance of that? 16:41

A. Well, there were some audits done of patient satisfaction and so forth, but I think there were --

358 Q. I'm going a bit further than that.

A. I think they were rather rudimentary, yeah. And in case I gave the wrong impression, it's not that I 16:41 didn't record it in the chart. I mean I wrote out all of the risks and benefits for the patient and gave it to them, in addition to the information booklets and so forth.

359 Q. But it's not in the notes, is it?
A. But not in the notes. Yeah.
360 Q. Hmm. And looking back on that, do you think you could have just photocopied it and put it in the notes, couldn't it? 16:41
A. Yes. I could have done, yes.
361 Q. Okay.
A. If I'd known actually I was going to be asked that question at a public inquiry I would certainly have insured it at the time, yes. 16:41
362 Q. Serious incidents. Lots of talk about that. If you look at serious incidents generally across the whole of the UK, if you look public inquiries generally, going back years and years, there are similar lessons everywhere, and learning from these things appears to 16:42 be problematic. Why is that, do you think?
A. Well, it's a hobbyhorse of mine. I don't know whether you will agree? I think the term "Serious Adverse Incident" is one that should be possibly done away with it. I prefer the one, Serious Adverse Experience, 16:42 because it's not patient-centred. I think, you know, I've sat at Patient Safety meetings at Directorate level, and at plenary session, and regionally for years, and you tend to have this incident, and the -- the discussion, and in fact some of the SAI reports are 16:42 rather circumscribed around an incident. Whereas, you know, I think actually a more holistic and more longitudinal look at the patient experience, you know, we listened to the son of a person who is deceased, who

was one of the 2016 un-triaged delayed, and he was talking about his father really, do you know.

363 Q. Yeah.

A. -- was not himself for six months waiting for the appointment, you know. And I -- I listened to that and 16:43 I thought to myself, "well, do you know, the man's PSA was similarly elevated two years previously and didn't know anything about it", you know. I'm just thinking, you know, of the longitudinal nature of it. So --

364 Q. So not to cut across you, I mean the modern thinking 16:43 about this is to involve patients and staff in the incident very early on and to learn quickly. From what we can see from much of the evidence brought before us, certainly historically, and even in these incidents in Urology, there wasn't enough learning on the spot 16:43 immediately when things needed fixing. Just to be very simple about it. Not enough learning for the doctors, the nurses, the patients. Why was that? Because it's not enough to talk about an incident, that's not really what it's about. Why was that learning not taken 16:44 forward, do you think? And I know it's very busy, and we're going to put that on one side, but what else was there about the culture that didn't allow that, do you think?

A. I don't know. I mean I think -- I'm not quite sure 16:44 that it is possible to leave all of that aside, because I think that does impact upon it significantly.

365 Q. But everyone is busy and -- you know.

A. Yes. I'm not quite sure actually that we didn't learn

anything as well.
366 Q. Well, I'm giving you the challenge - did you learn?
A. Yes, we did learn.
367 Q. Did you change processes as a result?
A. Well I certainly changed some practice things as a result. Pre-operative assessment and, do you know, the urine culture and all of that kind of thing may have been one of -- but learning has to be reinstated, it has to be reinvigorated. 16:44
368 Q. Yes. 16:45
A. And also just a cautionary note, I do think that perhaps there are some lessons that can be learned too quickly, and they may be the wrong lessons, and I think, you know, I've listened to this and I mean there have been inordinate delays in the completion of reports of these SAIs, which is not, you know, acceptable. But at the same time, in the more recent ones I think there may have been some lessons that have been learned, and with Task and Finish Group set up, without a more laid back view of it. 16:45 16:45
369 Q. But what would have led you to interact better with them? Bearing in mind you're very busy. I mean there's a sense that comes through that investigation takes a long time, there always very mechanistic, the point might be lost by the time it's come through. What would have engaged the Urology Team better and helped you more? 16:45
A. Well, I think actually, you know, the Urology Team did engage quite well with Serious Adverse Incidents under

the leadership of Mr. Glackin. I mean, I certainly presented cases, I think, that -- I think a lot of effort was put into dealing with them seriously. But I do think actually, to reiterate, the incident actually is often, the doctors are looking at the incident and how we can improve things so that this incident doesn't happen again, and I think actually, there's not enough patient involvement --

370 Q. Yeah, I think that's been corrected with the new frameworks? 16:46

A. Yeah. And I think actually that that would be a catalyst for learning more comprehensive lessons in a meaningful sense and making sure that they're implemented properly.

371 Q. So in that spirit the patients need to get clearer information, don't they, about what's happening to them? 16:46

A. Absolutely, yes. And with candour.

DR. SWART: Yes. But also what's happening to them. Okay. I'll leave mine at that. 16:47

CHAIR: Thank you.

372 Q. I'm not quite sure how long I'm going to be. I'll try and be as quick as possible.

A. That's okay.

373 Q. I think I could debate a lot of things with you for quite a while, Mr. O'Brien, but I'm not going to do that conscious of the time that we have. 16:47

A. Yes.

374 Q. One of the things that you have clearly demonstrated is

your care, if I can put it in that broad term, or perhaps you might even go further, your concern for the people that you care for, and your desire to give them the best treatment possible, and we've heard people describe that treatment as being, you know, if you got before Aidan O'Brien you got the Rolls-Royce treatment. But there were a lot of people who didn't get before you, partly because of the waiting lists, but also partly because they maybe weren't prioritised in the right way. I'm thinking, for example, of the issue about triage, for example. People -- you didn't have time to do all -- you did the red flags, you didn't have time to do all of the urgent or all of the routine, you did what you could in the time that you had? 16:47 16:47 16:48

A. Hmm. Hmm.

375 Q. Everybody else was able to do the triage in the time that they had, which was the same time as you had as Urologist of the Week, they just did it in a different way. 16:48

A. Mm-hmm.

376 Q. So that those people at least who ought to have been upgraded, were upgraded?

A. Hmm.

377 Q. And I just wonder, having heard all that you've heard in the course of this Inquiry, do you reflect that maybe there was a better way for to you do it? 16:48

A. Well, I think that in terms of ensuring that people who met the criteria for upgrading to red flag, certainly,

I regret that. I think, as well, and we have alluded to it the last day, there's a swathe of people there in the urgent list, or the urgent category, who are not red flag, who maybe even need earlier attention.

378 Q. Routine. Yes. 16:49

A. And I do appreciate that others were able to do it, but there were other parts of their practice whom I believe suffered as a consequence, and patients as a consequence. So, you know, this is exactly why I would have liked to have had a clear understanding, 16:49 so that management could come along and grasp this with us and put their arms around it, you know, and we would have a clear understanding as to what was required.

379 Q. I'm going to interrupt you to say, well, was it necessary for management to give you that 16:49 understanding? You could have reached that agreement amongst yourselves as a body of urologists, surely?

A. Well, I know that that view was articulated by Mr. Haynes. But it wasn't just my request, it was the view of us collectively that we would meet -- it wasn't 16:50 about -- I mean there were several interlocking aspects to that, and it was about Urologist of the Week, it was about, do you know, emergency surgery, it was about -- what was contained within that Urologist of the Week? Where did triage fit into that in the context of 16:50 ever-increasingly long waiting lists? And were we able to agree on that ourselves? I don't think we were. And I think that it would have been very, very welcome to have had, we'll say, a Medical Director and

a Director of Acute Services, or whatever was involved, just to actually get them engaged in that process, as kind of that governance structure that I was talking about, where you meet in the middle, and it might have taken more than one session, and these are our concerns, and we take on their concerns and what is required. I think that we would have been able to come away from that process with a clear understanding, a shared responsibility, a lack of indemnity, almost, if things didn't go right in every instance. That's what I would have liked to have happened. 16:51 16:51

380 Q. Okay. Again, coming back to you as a caring physician and clinician, and wanting the best for your patients, and you recognise the value of the key worker, did it ever at any stage occur to you to ask, "Well, have you talked to your key worker about this?", when you saw your patients? 16:51

A. No. When I -- when I acknowledged -- or when I reviewed a patient where it was evident, because I would ask them, do you know, about any needs or whatever, that they hadn't met a key worker. I mean it's not like as if I didn't ever ask people to be a key worker; I did. It just didn't manifest itself in these nine patients. And that's not to say that they were the only nine patients. So I did ask, and I did enquire. But did I ask each patient "Has a key worker been in contact with you?", I didn't. 16:52 16:52

381 Q. No. And you were being, your secretary was being tortured by phone calls from patients who were trying

to get some sort of help on a daily basis, according to the evidence we have heard, she was then coming to you and sending you e-mails and ringing you up saying, you know, "do something about this, please". Did you not say to her: "Look, get them to phone their key worker. That's what they're for"? 16:53

A. She phoned the Thorndale much more frequently than she would have bothered me about those patients, and still it would appear that this didn't translate into a nurse, irrespective of -- 16:53

382 Q. I'm just wondering, though, when you're getting those messages and you're getting this constant "this patient wants to know what's happening" type of phone call.

A. Hmm.

383 Q. Did you not say "Well, have they not spoken to the key worker?" Did that not cross your mind to check? 16:53

A. No, I thought if it was something that they were wondering about from my end I was to address that.

384 Q. That brings me on to another issue, it sort of flows from the same thing, and it's one about delegation. 16:53

A. Yes.

385 Q. You know, one of the things that -- you seem to have had a great deal of difficulty with time management, and part of the reason for that is that you didn't delegate enough. Would you accept that? 16:54

A. Hmm. Well the only person that I could really delegate to was my secretary, and my secretary told me several times, you know, I mean she wouldn't have been able to waiting list manage, or decide who was going to be

admitted or whatever. So I mean there's a form of delegation that was plainly evident, and that was to a key worker, you know, why did it not happen? I mean, when I look at these nine cases, I do not know and I cannot understand how it is that these nine cases did not have a key worker. In fact, actually, even in the case of, we'll say, Patient 1, where a clinical Nurse Specialist was in attendance on 14th July, did that person end up having a key worker the next month? I still don't know. I don't know if any of the nine cases actually ended up having a key worker even after they were no longer under my care. 16:54 16:54

386 Q. I accept that, Mr. O'Brien, but you seem to be suggesting that it was not your responsibility, and I accept that, to appoint them, according to the policy, the strict letter of the policy. 16:55

A. Hmm.

387 Q. But in the spirit of that policy and in the spirit of what key workers were meant to provide for a patient, was it not your responsibility to check that they had one? 16:55

A. Hmm. No, I mean I'm being honest with you, I didn't regard it as my responsibility to ensure that they had one, when it wasn't my responsibility to ensure that they had one in the first instance. So... 16:55

388 Q. Very well. Well, I'm going to leave it there, Mr. O'Brien.

A. Okay.

389 Q. And if there is anything else that when we're going

through and back over things that we need to know from you, we'll write and ask you, but I hope that that's the end of your engagement with the Inquiry for your sake.

A. Okay. 16:55

CHAIR: And thank you very much for coming along over a lengthy period of time to speak to us.

Ladies and gentlemen, just before we go, there are a few housekeeping matters. 16:56

As we reach the end, and our last day of oral evidence sessions, I wanted to say something about what's going to happen next.

16:56

I have previously indicated that each Core Participant should deliver any written submissions they wish the Inquiry to consider, on or before close of business on Friday, 31st May.

16:56

I would reiterate that those should be directed to the Inquiry's Terms of Reference, and I say this because anyone, and most of you have followed the Inquiry's hearings assiduously, will realise that a lot of what we have heard might properly be considered to go beyond 16:56 our Terms of Reference and the questions that we have to answer. However, the Inquiry considered it important to put into the public domain the full context in which the issues with which it is primarily

concerned occurred and to allow views and opinions to be aired.

The Inquiry also invites the Core Participants to make final oral submissions on the morning of Thursday, 13th June. Each Core Participant will be allocated a one-hour slot that morning to reflect on the issues and to make final remarks. 16:57

Following that day, the Inquiry will move into the report-writing stage of its work. Anyone who is criticised in the report will receive a warning letter from the Inquiry and have an opportunity to make written comments which will be considered by Dr. Swart and myself before the report is finalised. And I should say that, given that the Core Participants have all been well-represented throughout the course of this, all of the evidence is -- has been live-streamed and the transcripts are there. I would not anticipate that you will be given a great deal of time in which to reply, I'll give it a reasonable amount of time. But I can't give any dates as to when you're likely to get those letters and when the report will be finalised. 16:57 16:57

In light of the fact that we have received approximately 650,000 pages of written evidence, and heard from 75 witnesses over this 95-day period, in the past, over two years, I'm sure you'll appreciate the scale of the task that I have in writing the report, 16:58

however brief I'm able to make it, is somewhat daunting.

It would be foolish of me to say anything other than I will complete it as expeditiously as possible. 16:58

I am encouraged that neither the Trust nor the Department have awaited the outcome of the Inquiry and its recommendations in order to take what they have learned during the course of our work and seek to 16:58 improve matters for patients and staff.

As you are aware, the Inquiry has placed the transcripts of our hearings on its website. The written witness statements the Inquiry received in 16:59 response to its Section 21 notices will start to be posted on the website within a few weeks. It has not been possible to do this sooner due to the redaction that was required before they could be put into the public domain. 16:59

Thank you, everyone. I look forward to seeing you on 13th June, and in the meantime, if you have any questions between now and 13th June, please contact either Ms. Anne Donnelly, our Inquiry Solicitor, or 16:59 Mr. Alasdair MacInnes, our Inquiry Secretary.

And Mr. O'Brien, I neglected to give you the final word and to say was there anything that you felt you hadn't

had the opportunity to say, now is your chance.

A. No, I just think that it's such a pity that we weren't able to provide an even better service to more people, at least to the extent that we could ensure their safety, and insofar as we haven't been able to do that, 17:00
and particularly insofar as I haven't been able to do that, I regret that very, very much, as someone who devoted his life to the care of patients, when outcomes are not what they should be, you -- I have borne it heavily and I so regret and apologise to any patients 17:00
that have suffered harm as a consequence of any clinical decisions and shortcomings that I may have.

CHAIR: Thank you very much, Mr. O'Brien. Thank you, ladies and gentlemen.

17:00

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 13TH JUNE 2024