Urology Services Inquiry

Written Closing Submission of

The Southern Health and Social Care Trust

(Core Participant)

31st May 2024

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Chapter 1

The Trust's Approach to this Inquiry

1.1 The Trust welcomes, and is grateful to the Inquiry for, the opportunity to make some closing submissions in writing to the Inquiry.

1.2 At the very outset of these submissions, the Trust wishes to repeat the detailed apology it provided in its oral opening on Day 8 of the Inquiry hearings, back on 10 November 2022. We will not repeat the apology verbatim (it can be found at TRA-00639 to TRA-00660) but would stress the following:

a. The Trust apologises ***to*** -
   i. affected patients and their families (because, fundamentally, it is patients whom each of the Trust and this Inquiry serves);
   ii. the broader public; and
   iii. its staff, many of whom do 'every day go beyond the call of duty'[1].

b. The Trust apologises ***for*** -
   i. the fact that the care given by it to a number of patients fell below what was acceptable and that, in some cases, this has caused or contributed to harm; and
   ii. the fact that this sub-standard care was the result, not only of failings on the part of individuals for whom the Trust is responsible (such as Mr O'Brien), but also of broader failings of Trust systems, processes, and structures.

1.3 On 8 November 2022, the first public hearing day of the Inquiry, Mr Wolfe KC in his opening submissions made the following profound statement[2]:

[1] Per Mr Wolfe KC in his opening on Tuesday 8 November 2022 at TRA-00306 lines 5-8.

[2] TRA-00321, Day 6, p48, from line 14 .

… The conduct of a public inquiry such as this can act as a watershed moment. If those who are to participate are prepared to engage cooperatively, authentically, and in a spirit of openness, and if they actively reflect upon what they, as well as their colleagues, could have done differently, or better, there will be a genuine opportunity to change healthcare provision in Northern Ireland for the better.

1.4 In its oral opening submission on 10 November 2022 the Trust, as well as apologising, responded to Mr Wolfe's statement by publicly affirming its commitment to work with the Inquiry in an open and candid way so as to ensure that past mistakes are not repeated, either by it or by any other Trust.

1.5 The Trust hopes that it has lived up to this commitment and responded to the Inquiry's call.

1.6 In this regard, we observe that, as of late May 2024, the Trust has:

a. disclosed in excess of 400,000 pages of potentially relevant documents to the Inquiry;

b. provided, through witnesses whom the Trust legal team represents, 158 S.21 responses[3];

c. directly assisted, through the Trust legal team, 85 witnesses, 45 of whom were called to give oral evidence across approximately 60 of the Inquiry's 95 hearing days;

[3] Including several provided promptly and dynamically in respect of discrete issues that arose during the hearing of other witnesses' evidence.

d. assisted, through the provision of documents, a number of former Trust servants or agents who are not represented by the Trust legal team (such as Mrs Brownlee and Mrs Gishkori);

e. assisted other staff who have been amongst the 200-plus nurses and registrars who received questionnaires[4] from the Inquiry.

1.7 Looking beyond the headline statistics of cooperation to an even more important issue, the Trust has sought to adopt a positive approach to the issues raised by this Public Inquiry; a positive approach that has extended both before and beyond the parameters of the Inquiry.

1.8 What this means is that the Trust has actively approached both the issues examined by the Inquiry and the Inquiry process itself as opportunities rather than as challenges. In particular, the Trust has viewed the Inquiry and the events giving rise to it as:

a. an opportunity to identify, reflect upon, and be candid about its failings;

b. an opportunity to learn from its failings and improve; and

c. an opportunity to change culture.

1.9 Examples of this include, but are not limited to, the following:

a. Before any Public Inquiry was ever anticipated, indeed before all of the shortcomings related to or revealed through Mr O'Brien were even apparent, the Trust had recognised that there were shortcomings in its systems and had taken steps to address these. An exemplar of this is the commissioning of the Champion *'Clinical and Social Care Governance Review'*[5]

[4] TRA-00322, Day 6, p49, lines 11-13
[5] WIT-46954 to WIT-47014.

in 2019 by the (then) Chief Executive and Medical Director, each of whom was, at the time, relatively new to the Trust.

b. In 2019 the Trust began, and has since developed[6], its engagement with Mersey Care NHS Trust (a high-performing English Trust) to assist in developing a just and learning culture where staff, rather than feeling inhibited about 'speaking up' where they have concerns, are supported to do so[7].

c. In November 2022 the Trust set up an External Reference Group ('ERG'), chaired and populated by experienced people from outside the Trust (along with some senior Trust personnel) to provide the role of 'critical friend' to the Chief Executive and Directors in their work to address the shortcomings which the issues giving rise to the Inquiry have exposed[8].

d. The Trust has already initiated multiple improvements in its systems and structures of management, training, corporate governance, and clinical and social care governance in order to address the shortcomings within the Trust which were revealed by the Aidan O'Brien issues[9]. It has not sat back and waited for the Inquiry to tell it what to do.

[6] By way of very brief non-comprehensive overview, this engagement began in 2019, with them delivering to the Trust presentations on an Open and Just Culture and their learning around a Zero Suicide Approach. The Trust HROD Director then underwent training with them on Restorative Just Culture in 2021, leading to the revision of Trust various Trust policies (e.g., disciplinary, conflict, bullying and harassment, and so on). Prof Joe Rafferty (CEO of Mersey Care from 2012) was the external representative when Dr O'Kane was appointed CEx in 2022 and has been carrying out a mentorship role since that time. In early 2023, this role expanded to 1:1 meetings with each Trust Director followed by a workshop and presentation to the Trust on his findings. Since then, work has included engagement by the Performance Director to assist with the Trust's strategy development work.

[7] See, e.g., Maria O'Kane's witness statement at WIT-45168 para 13 and WIT-45171 para 28 and her oral evidence at TRA-11652 Line 24 to TRA-11655 line 3, TRA-11669 lines 3-22, and TRA-11732 line 9 to TRA-11733 line 21. See also the evidence of Vivienne Toal at WIT-41009 para 1(iv) and TRA-03481 line 16 to TRA-03482 line 26.

[8] See, e.g., the evidence of Maria O'Kane at TRA-11632 to TRA-11646. An insight into the clear challenge function performed by this group is clear from the documents relevant to it disclosed by the Trust – see TRU-303646 to TRU-304283

[9] These are considered further in Chapters 4, 5, 6, and 7.

1.10 Finally in this regard, the Trust considers that it is important to acknowledge that all of the above has occurred in a particular context. One that includes, but is not limited to, challenges created by the following facts –

a. the Trust is operating in a health service that has been recovering from an unprecedented global public health emergency;

b. the Trust has had to face other significant challenges such as unprecedented pressures on its services at Daisy Hill Hospital due in no small part to regional difficulties in recruiting and retaining medical staff;

c. the Trust is operating with ever more constrained public funding in a health environment where demand is increasing all the time;

d. many of the Trust witnesses who have provided written and/or oral evidence to the Inquiry are serving doctors, nurses, managers, administrative staff, and Board members, all with very challenging 'day jobs'.

The Trust acknowledges that, conscious of these important contextual factors, the Inquiry has dealt with the Trust and its witnesses in an understanding, patient, and fair manner.

Chapter 2

The Trust's Approach to Closing Submissions

2.1 It is important to set out at an early stage what this closing submission is not:

a. it is not an attempt to summarise, or address the issues raised in, the evidence given by the 85 Trust witnesses from whom the Inquiry sought written and/or oral evidence;
b. it is not an attempt to summarise, or address the issues raised in, evidence given by non-Trust witnesses from whom the Inquiry sought written and/or oral evidence;
c. it is not an attempt to address every significant conflict of evidence or every significant issue that has arisen before the Inquiry;
d. it is neither in the nature of a denial defence nor of a plea in mitigation; and (perhaps most importantly),
e. it is most definitely not an attempt to write the Inquiry's report for it.

2.2 Rather, this submission is merely (in an attempt to adhere to the 'less is more' principle[10]) to do the following:

a. to draw together some of the issues that have emerged from the voluminous evidence;
b. to group those issues in a manner which might make it easier to understand them and the shortcomings on the part of the Trust that lay beneath or behind them;
c. to identify some of the relevant shortcomings and, where applicable, some of their root causes;
d. to highlight potentially relevant contextual factors;

[10] Discussed, albeit in the context of Inquiry recommendations, in the evidence of Peter May in his questions and answers with Dr Swart and the Chair on Day 93, p100, line 13 to p101, line 27.

e. to summarise where relevant changes have been, or are being, made which reduce the chance of the same shortcomings existing or persisting in the future.

2.3 Accordingly, we have grouped the issues under three broad heads, with a 'chapter' devoted to each. They are:

a. the issues with Mr O'Brien's practice which came to a head in 2016/2017;
b. the issues with Mr O'Brien's practice which came to a head in 2020; and
c. other issues with Mr O'Brien's practice.

This approach has been taken, not in an attempt to shift attention onto Mr O'Brien's issues and away from the Trust[11], but because the issues that emerged in Mr O'Brien's practice are the gateway through which the Trust's various shortcomings have come to light and they are, in the circumstances, an appropriate lens through which to view those shortcomings.

2.4 In each chapter, we have adopted the following broad approach:

a. we have summarised the main issues that arose in Mr O'Brien's practice;
b. we have analysed some of the Trust shortcomings that lay behind or were revealed by Mr O'Brien's issues including, where applicable, both immediate / frontline deficits in the handling of the relevant issues as well as the root causes that lay behind those deficits;
c. finally, we have summarised some of the improvements which have been (or are being) implemented in order to address those deficits, lessening the chance of reoccurrence and restoring public confidence.

2.5 Of course, none of the above is a substitute for the evidence itself, much of which the Inquiry has had the ample benefit of receiving orally, through forensic

[11] Which would be a foolish thing to do, not least because Mr O'Brien was part of 'the Trust' (or at least a significant servant or agent of it) at all material times.

questioning both by Counsel to the Inquiry and by the Inquiry Panel, and the Trust readily acknowledges that it is ultimately for the Inquiry to determine what failings there were, which of these were significant, and what their causes were. These submissions are advanced merely in an attempt to assist the Inquiry in performing those important tasks.

2.6 And in this regard the Trust also acknowledges the fact that the Inquiry is inquisitorial and subject to a duty of fairness[12] and that, regardless of the presence or absence of closing submissions, the Inquiry will consider all relevant evidence before reaching its conclusions and making its recommendations.

[12] See section 17 of the Inquiries Act 2005 and the exposition of the duty of fairness at chapter 9 of Beer, *Public Inquiries*, OUP, 2011.

Chapter 3

The Approach of the Public Inquiry

The Report of a Public Inquiry

3.1 Section 24 of the Inquiries Act 2005 mandates only two things in respect of a Public Inquiry's Report: that it set out the facts and that it set out the recommendations of the Panel.

> ***24*** *(1)The chairman of an inquiry must deliver a report to the Minister setting out –*
>
> *(a)the facts determined by the inquiry panel;*
>
> *(b)the recommendations of the panel (where the terms of reference required it to make recommendations).*
>
> *The report may also contain anything else that the panel considers to be relevant to the terms of reference (including any recommendations the panel sees fit to make despite not being required to do so by the terms of reference).*

3.2 However, it does not restrict the Inquiry to these two functions. Indeed, it affords it a wide margin to address in its Report '*anything else that the panel considers to be relevant to the terms of reference*'.

The Purpose(s) of a Public Inquiry

3.3 A consideration of the purpose(s) of a public inquiry assists us in answering the question: what other matters an Inquiry Report might seek to address or include in its report. Such purposes are discussed in various places, including in Jason Beer KC's leading textbook, Public Inquiries,[13] from 1.02 to 1.09.

[13] Oxford University Press, 2011.

3.4 Amongst the purposes of a public inquiry identified by Beer the following, several of which are interlinked and overlapping, are of most relevance to the current Inquiry[14]:

a. Establishing the facts;
b. Accountability;
c. Learning lessons (so as to avoid any repeat of past mistakes); and
d. Restoring public confidence.

3.5 These were reflected by the Chair in her opening on Day 6 when she described the purpose of this Inquiry as being to establish *'if things went wrong, if so, why they did go wrong and what lessons can be learned so that mistakes are not repeated'*.[15]

(a) Establishing the facts

3.6 Clearly, it is necessary for the Inquiry to establish some facts. For example, without establishing facts relevant to 'what went wrong' it might otherwise struggle to identify and articulate the recommendations it will make in order to reduce or remove the risk of recurrence.

3.7 However, when an Inquiry's investigations and hearings range across decades and hundreds of thousands of documents (both of which are the case in this Inquiry), there is a very real practical constraint on the Inquiry's fact-finding ability. Put simply: to reach a reliable conclusion on the facts of every event or interaction that has featured in evidence, or to resolve every factual dispute, difference, or uncertainty, would simply take too long.

[14] The other purposes identified by Beer, viz, catharsis, developing policy, and discharging investigative obligations under Article 2 or 3 of the ECHR seem to be of little or no relevance to a public inquiry of the current type.
[15] TRA- 00277, Day 6, p4, lines 12-14

3.8 Thus, in practical terms an Inquiry will usually establish the facts necessary to enable it to achieve its purposes of accountability, learning lessons, and restoring public confidence.

(b) Accountability

3.9 The modern public inquiry has been described as *'a major instrument of accountability'* by the House of Commons Public Administration Select Committee in the first report of its 2004-5 session *'Government by Inquiry'*[16].

3.10 This is undoubtedly accurate. And it is important to note that it applies to the entire public inquiry process. Accounting to the Inquiry (and to the public) for what one did or did not do is not a matter of choice. Witnesses are compelled to provide detailed answers to focused questions in s.21 notices, they are compelled to hand over copies of all potentially relevant documents that they hold or control, and they are compelled to answer forensic questions (sometimes across several days) in live-streamed, public hearings. In this regard, the process can be as important in terms of accountability as the ultimate outcome.

3.11 But there are significant limits to the accountability a public inquiry can lawfully hope to achieve in its Report. The Inquiry is expressly prohibited by s.2(1) of the 2005 Act from making findings in respect of any person's civil or criminal liability. Whilst s.2(2) of the Act acknowledges the risk of 'liability being inferred from facts that [the Inquiry] determines or recommendations that it makes', it would be wrong to interpret this as permitting or encouraging Inquiries to make findings of civil or criminal liability 'in all but name'. After all, a crucial distinction between a public inquiry on the one side and a criminal, civil, or professional misconduct case on the other side is that, in the latter, the subject of the proceeding faces precisely defined and pleaded allegations or

[16] Page 7 - https://publications.parliament.uk/pa/cm200405/cmselect/cmpubadm/51/51i.pdf

charges and has the right to call all admissible evidence (including independent expert evidence) on his or her own behalf in respect of such allegations or charges. Neither of those features pertain in the realm of public inquiries.

(c) Learning lessons (so as to avoid any repeat of past mistakes)

3.12 This has, in the past, been identified as the primary or key purpose of a public inquiry. For example, the House of Commons Public Administration Select Committee *'Government by Inquiry'* report (already referenced above), recorded that *'for the Government "the primary purpose of an inquiry is to prevent recurrence" and that it was also the government's view that "the main aim is to learn lessons, not apportion blame"*[17].

3.13 A notable feature of this Inquiry (which also sounds in respect of the next purpose of public inquiries, *viz*, restoring public confidence) is that it has, through its s.21 notices, its disclosure requests, and the oral evidence elicited in public hearings, focused extensively on the changes that have already occurred within the Trust (and beyond) so as to reduce or remove the risk of past mistakes in respect of the Trust's Urology Service being repeated in the future.

3.14 This is undoubtedly the purpose of public inquiries which is most closely connected to the recommendations the Inquiry makes in its report. Put another way: it is (at least in part) through its recommendations (and their implementation) that this key purpose is achieved.

(d) Restoring public confidence

3.15 Restoring public confidence is an important purpose of a public inquiry, particularly when it concerns a key public service such as in this case. As with the accountability issue addressed above, it is clear that the Inquiry has already sought to achieve this particular aim through its work to date and its focus on

[17] Page 8, para 10.

eliciting from the Trust and its witnesses evidence that lessons have been learned and that necessary changes have been made or are being made.

The Inquiry's Approach to its Findings

3.16 In her public opening remarks on Day 6 of the Inquiry hearings the Chair stated that[18]:

> *'it is the task of the Inquiry to find out what happened in relation to the care of patients within the Urology Department of the Southern Health and Social Care Trust; what were the systems that allowed that to happen? Did the systems in place to prevent it happening work? If not, why not? And to make recommendations to try to avoid it happening again.'*

3.17 Such a focus on systems, rather than upon individuals, when it comes to the Inquiry's findings would be entirely appropriate in light of the analysis above[19].

3.18 Such a focus would also be consistent with the following:

a. The *Cabinet Office Guidance for Inquiry Chairs, Secretaries and Sponsor Departments* makes it clear, in the section providing guidance about the Inquiry Report,[20] that individuals need not always be named:

> *How to handle criticisms in the report. Some inquiries have simply stated criticisms where they occur and others have included a specific section drawing attention to findings. The Inquiry should consider whether the public interest requires that individuals should be named. (See pages 46-48 on Salmon and Maxwellisation procedures.)*

[18] TRA- 00277, Day 6, p4, lines 23-29.
[19] Especially from paragraph 1.9 onwards.
[20] Page 39 - https://www.parliament.uk/globalassets/documents/lords-committees/Inquiries-Act-2005/caboffguide.pdf

Given the primacy of patients and their safety, the public interest is surely in respect of systems that were lacking (and the changes therefore required to prevent recurrence) rather than upon individuals.

b. It has been recognised that there is a public interest generally in avoiding or reducing the risk of defensive practice amongst healthcare professionals. Thus, Stephen Sedley QC (as he then was), following involvement in several public inquiries concerning the childcare system, observed as follows in his Modern Law Review article, *Public Inquiries: A Cure or a Disease*[21]:

> *This negative product is not only related to individuals, though it is at its sharpest there. It can have a damaging effect on practice generally, for if a child care initiative goes disastrously wrong it may no longer be a matter of simply seeing what can be learnt from the mistake: there may be a public inquiry, public obloquy, public sacrifices. It is probable that, like the defensive medicine generated in the United States by endless malpractice suits, defensive social work is developing as a passive response to the proliferation of public inquiries.*

c. The need to encourage people to speak up has been widely recognised as an important public policy goal in health service settings[22]. In *'Freedom to Speak Up - An independent review into creating an open and honest reporting culture in the NHS'*[23], Sir Robert Francis QC identified a number of key principles including the following:

> *Principle 2 – Culture of raising concerns*

[21] (1989) MLR Vol. 52 p469 at p477/478.
[22] See also the evidence of Vivienne Toal on this issue including her exchange with Dr Swart from TRA-03488 line 2 to TRA-03490 line 12 regarding the need for 'freedom to speak up guardian' roles in the NHS in Northern Ireland and developments in train on this front in the Trust.
[23] http://freedomtospeakup.org.uk/the-report/

> *Raising concerns should be part of the normal routine business of any well-led NHS organisation.*
>
> *31 Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. This will sometimes require acceptance by staff that their own performance may be the subject of comment, and that this needs to be seen as an opportunity to learn rather than a source of criticism. I appreciate this is not always easy.*

There is clearly a public interest in ensuring that committed NHS employees (i) are not discouraged from speaking up about potentially serious concerns because of fears that much less significant concerns in respect of their own practices will be subjected to public criticism and (ii) continue to have the opportunity to deploy their skills for the public good. To return to the Sedley article quoted above, it is surely vital to avoid any perception of the type he alluded to amongst social workers following a number of childcare inquiries: '*The aftermath of more than one recent inquiry has generated the legitimate fear among local authority staff that any public inquiry may for them turn into a hanging party.*'[24]

d. An adverse practical consequence of making criticisms of multiple individuals is the need for multiple warning letters and the resulting potential for delay. This real, evidence-based risk was recognised by the House of Lords in its *Post-Legislative Scrutiny Report*[25] into the 2005 Act. For example:

> '246. … *In evidence to us Mr Francis stated: "in practice I think my inquiry was extended by at least six months by having to undertake a rule 13 process." (Robert Francis QC of the Mid Staffordshire Inquiry)*

[24] Page 478, first full paragraph.
[25] https://publications.parliament.uk/pa/ld201314/ldselect/ldinquiries/143/143.pdf

The Approach to Inquiry Recommendations

3.19 On one reasonable view, the recommendations produced by the Inquiry are, amongst all of its important work, of paramount importance.

3.20 The Institute for Government, in its report of December 2017 entitled *'How Public Inquiries Can Lead To Change'*[26], had the following to say about the importance of the publication of the Inquiry Report and the period thereafter[27]:

> *Much of the most important work of inquiries is only just beginning when an inquiry report is published. As former inquiry chairs have put it:*
>
> *"Implementation is – of course – everything."*
>
> Sir Robert Francis QC
>
> *"The main reason for most inquiries is to find out how we can avoid something like that happening again and what changes to systems, training and procedures would help to avoid that happening. Therefore, I think [inquiries are] absolutely about action."*
>
> Lord Michael Bichard

3.21 In terms of the nature of the recommendations it makes, CEDR's 2015 Guidance for Public Inquiry Chairs and Commissioning Bodies entitled, *'Setting Up and Running a Public Inquiry'*[28], offers a number of useful observations and pieces of advice regarding the recommendations a public inquiry makes:

[26] https://www.instituteforgovernment.org.uk/publication/report/how-public-inquiries-can-lead-change
[27] At page 27.
[28] https://www.cedr.com/wp-content/uploads/2019/10/CEDR_Setting_Up_and_Running_a_Public_Inquiry_-_Guidance_for_Chairs_and_Commissioning_Bodies.pdf

a. It identified one of the 5 major points for reform as being– *'Ensuring that the recommendations that are produced by the Inquiry are valid and workable and more likely to be implemented'*[29].

b. It observed that, all too frequently, recommendations are not successfully translated into successful outcomes and that this constituted a failing that Inquiries should strive to avoid[30].

c. It identified the importance of the report publication stage of the inquiry process and the need for recommendations to be workable[31]:

The most critical point of any Inquiry is necessarily the publication of its conclusions and recommendations. Whilst there are considerable benefits (as we have outlined above) of carrying out the processes of the Inquiry in terms of reference to victim recognition etc., the ultimate success or failure of an Inquiry will be determined from whether it has clearly produced an analysis of what happened and produced workable recommendations for review. Ultimately, if an Inquiry is to have any impact, its conclusions will need to be reasoned, comprehensive, real world aware, succinct and practical.

d. It also stressed the importance of there being a mechanism for checking the implementation of the Inquiry recommendations[32].

3.22 The Trust is confident that the Inquiry will endeavour to make workable recommendations. With this in mind, the Trust would offer a number of observations on the issue:

a. The Trust would welcome recommendations which are rooted in the evidence received by the Inquiry about changes and improvements that have been

[29] Page, 10 Goal 4.
[30] Page 60.
[31] Ibid.
[32] Ibid.

implemented and borne fruit. For example, the Inquiry has heard evidence about how greater tracking and audit of MDM outcomes (funded 'at risk' by the Trust) has led to real improvements on the ground and a very significant reduction in the risk of MDM issues that had manifested themselves in respect of Mr O'Brien's practice being repeated in the future[33]. The Trust would welcome recommendations endorsing steps like these, which it has taken proactively and at risk.

b. As the Inquiry is well aware from the evidence it has received, the Trust is almost always engaged in the process of implementing recommendations from one Inquiry or Report or another (whether it be the HRDI or the 2020 Hughes SAIs or the INI or GIRFT). These recommendations are large in number. Where this Inquiry's conclusions about action that is required to prevent recurrence of harm coalesce with recommendations already made by a previous Inquiry or Report, the Inquiry should consider simply endorsing that prior recommendation rather than adding to overall numerical burden of recommendations.

c. The Trust would welcome the Inquiry devising or suggesting a mechanism for checking the implementation of its recommendations[34].

3.23 In short, the above points probably distil to this: that the Trust wholeheartedly endorses the approach aired in the evidence of Peter May,

[33] See, e.g., the evidence of Maria O'Kane on this issue from TRA-11742 line 19 to TRA-11744 line 16. See also the evidence of Mark Haynes on Day 88 from TRA-11463 line 12 to TRA-11465 line 3 regarding improvements in monitoring cancer pathway patients and ensuring they have key workers. See also his evidence about the audit roles that now ensure both that Key Workers are involved (TRA- 11464-11465, Day 88, p94 line 26 to p95 line 3 and p104 line 8-27) and that MDM outcomes are implemented (TRA- 11461-11462, Day 88, p91 lie 21 to p92 line 10 and TRA- 11476-11477 p106 line 3 to p107 line 27).

[34] By way of analogy, the Inquiry will be aware that the Chair of the RHI Inquiry secured the following assurance from the NIAO: '47 … *The Inquiry has asked the Comptroller and Auditor General for Northern Ireland to monitor and, as necessary, pursue the effective implementation of this Inquiry's Recommendations. The Inquiry records that it is very grateful that the NIAO has agreed to undertake this task' – see: Chairman's statement at the RHI Inquiry Report launch, Friday 13th March 2020 -* https://cain.ulster.ac.uk/issues/politics/docs/rhi/2020-03-13_RHI-Inquiry_Statement.pdf

when questioned by Dr Swart and the Chair at the end of Day 93 of the hearings[35]:

DR. SWART: And just -- I started off with learning from inquiries. We will obviously be producing a report. You will have looked at lots of inquiry reports, you've got this group set up, what is most useful in terms of how these things are phrased? So, you know, just to start you off, it's probably not useful to have 300 recommendations that are very specific, if I was on the receiving end of it. But what is most useful? Is it more useful to do what Bill Kirkup did in East Kent, which is to say "Look here guys, I've written lots of inquiries and nobody implements them and it's all too complicated, so I'm going to phrase these recommendations differently", and really what he's doing is getting to the spirit, to use your words, what is most useful?

A. So for me, as I think I said in my earlier evidence, I'm conscious that you are coming to this after other inquiries have reached recommendations. So I suppose my -- what would be most useful to me is if, in looking at what you recommend, you try to build on what is already there and, as I said, put wind in the sails of what you think is going in the right direction and be clear about what different or additional is needed in order to address the challenges. You've heard lots of evidence. Because time has passed quite significantly, the world has also moved on. So part of the -- so for me this is -- I would encourage you to take a system view of this. What is it that's needed systemically in order to address things? There may be some specifics, of course, but as you've helpfully hinted, vast numbers of recommendations can be, you know, if you start chasing ticks in boxes rather than a focus on what really matters. So it might be just because of the positioning of this Inquiry in the context of other inquiries, it just takes a slightly different approach in order to land it, and then again, if the Panel were, or representatives of the Panel were willing to be engaged with afterwards to make sure we had understood properly, that would be extremely helpful as well.

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

[35] From TRA- 12350-12351, Day 93, p100 line 13 to p101 line 27.

CHAIR: Thank you, Dr. Swart. Well if it's any reassurance, I'm a great believer in less is more, Mr. May, so I don't think you'll be getting 300 recommendations from this Inquiry.

Beware the 'benefit' of hindsight

3.24 Finally in this regard, the Trust would repeat the caution referenced in its oral opening when counsel quoted from the following part of Anthony Hidden QC's Report into the Clapham Railway Junction disaster in September 1989: '*there is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself constantly aware of that fact*'.

3.25 Put another way in the context of a concrete example: the Inquiry should be wary of the temptation (sometimes encouraged by Mr O'Brien in his representations to this Inquiry) to construe past omissions, such as the failure to pick up on, or interrogate, Mr O'Brien's alleged repeat assertion that he found triage impossible or the Trust's failure to follow up on the 23 March 2016 letter, as omissions *but for which* there would have been some significantly different outcome[36].

Chapter 4

[36] Another example is perhaps the suggestion that the information provided to Mr Haynes by BHSCT doctors in Spring 2019 ought to have triggered a wider concern about Mr O'Brien not implementing MDM recommendations or prescribing Bicalutamide in sub-optimal doses – see, in this regard, Mr Haynes' evidence on TRA- 11410-11417, Day 88 from p40 line 24 to p47 line 27.

Issues Which Came to a Head in 2016/2017

Issues

4.1 This chapter covers a number of issues in respect of Mr O'Brien's practice which came to a head in the period 2016-2017. Primarily, the issues were as follows:

a. Failure to triage, in time or at all, referrals to urology;
b. Taking patient notes to his home and retaining them there;
c. Failing to dictate, in time or at all, following patient episodes;
d. Advantaging some private patients.

4.2 Whilst these issues came to a head in 2016/2017, it is important to note that some of them were long standing and some were known about for some considerable time prior to 2016/2017.

4.3 It is also important to note that some of these issues were interrelated. For example, Mr O'Brien's failure to dictate in a timely way following patient encounters appears to have been one reason why he needed to bring patient records home and/or retain them there.

4.4 These issues engage a number of the Inquiry's Terms of Reference and in particular Terms (a), (b), (e) and (f).

(a) Triage

4.5 The Trust accepts that one key purpose, though by no means the sole purpose, of having consultant urologists triage referrals to urology from GPs and from other specialties is to ensure that the priority given to the case by the referring clinician is appropriate. In the event that a referral has been classified as 'routine' or 'urgent' when, in fact, it ought to have been classified as 'red flag', this misclassification

should be identified and remedied by the responsible consultant urologist at the referral triage stage.

4.6 In the case of Mr O'Brien, we know that there were times when he was responsible for triaging referrals to urology when he failed to complete triage, either in a timely way or at all.

4.7 A number of notable features of this problem have emerged from the evidence before the Inquiry:

a. There is evidence of the problem in documents from as far back as December 2008[37] and these suggest that it was not a new problem at that point.

b. Testimony from witnesses has been consistent with such documents in that it has confirmed that triage of referrals was a longstanding issue with Mr O'Brien's practice. Some of these witnesses suggested that the problem went back much further than 2008 – e.g., Katherine Robinson, who in her oral evidence expressed the belief that it dated back to the 1990s[38], and Mr Mackle, who in his witness statement recorded having to speak to Mr O'Brien about his triage in approximately 1996[39].

c. The problem was known to both medical managers[40] and operational managers[41].

[37] See, for example, an email chain beginning December 2008 at WIT-23742
[38] TRA-05179 line 28 to 05180 line 18.
[39] WIT-11815 para 210.
[40] Ibid.
[41] See, for example, emails from different points during 2010 at TRU-281814 and TRU-259492-259493

d. It was a recurring and fluctuating problem. In the words of Martina Corrigan: *'… when the issue of triage was raised with Mr O'Brien, it would resolve for a short time before re-emerging and the cycle would repeat …'*[42].

e. The extent of the problem was significant. For example, there is evidence that on multiple occasions the backlog of untriaged referral letters numbered in the hundreds[43].

4.8 Mr O'Brien has at times acknowledged that he was significantly in default of his triage obligations[44]. However, he questions the precise extent of his default at certain points and he also seeks to place responsibility upon the Trust for his default.

4.9 In respect of the former issue, it is submitted that the Inquiry does not need to reach a concluded view regarding the precise extent of Mr O'Brien's triage default nor does it need to determine whose figures are correct in this regard. The inescapable reality is that Mr O'Brien was in default of his triage obligations to a significant extent on repeated occasions over a prolonged period of time.

4.10 In respect of the question of who bears responsibility for Mr O'Brien's default, his evidence can, in our submission, be distilled to the following core propositions:

a. His triage methodology was an involved one, sometimes akin to a virtual consultation that included a telephone call to the referred patient.

[42] WIT-26305 para 69.1 lines 4-5. Katherine Robinson described perhaps greater compliance by Mr O'Brien during Dr Rankin's tenure – see TRA-05177 lines 3-23. See also the evidence of Mr Mackle at WIT-11816 para 215.
[43] For example: TRU-281926 - April 2011 - 129 untriaged letters dating back to 1 February 2011,
TRU-258498 - November 2015 - 277 letters dating back to October 2014,
TRU-251446 – December 2016 – 318 letters dating back up to 78 weeks, and
AOB-01399 – Dr Chada in her MHPS report refers to 783 referrals dating back to June 2015.
[44] See, for example, his email of 16.3.14 at AOB-70487 or his response to the MHPS Case Investigator's Report (AOB-01879 at AOB-01893, first para under 'Triage').

b. It was not possible to perform triage duties within the limited time available and he conveyed this message to the Trust.

c. He was aware that his colleagues triaged in a different, quicker way which he did not consider to be optimal.

d. He sought direction from the Trust regarding how triage should be done (the implication being that if he was directed to perform it as his colleagues did he would comply), but no such direction was forthcoming[45].

e. He continued to triage in what he considered to be the optimal manner and therefore repeatedly found himself to be significantly in default.

4.11 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of the triage issue rests: is it with Mr O'Brien or with the Trust or with both of them? Alternatively, the fact that the problem existed and persisted may be all that needs to be acknowledged. In the event that it is deemed necessary to determine the issue, then the Inquiry will have to consider –

a. whether Mr O'Brien ought reasonably to have changed his approach to triage in light of the fact that his colleagues were able to perform triage timeously without any evidence of any significant risk or harm to patients[46];

b. whether Mr O'Brien ought to have made it much clearer to the Trust the significant extent to which he was defaulting in his triage obligations; and

[45] See, e.g., Mr O'Brien's witness statement at WIT-82450 at para 143.
[46] Consider, for example, Mr O'Donoghue's approach and his opinion that Mr O'Brien 'overcomplicated triage' – from TRA-08465 line 3 to 17.

c. whether the issuing of a direction by the Trust on this issue is likely to have made any positive difference in circumstances where we know that directions or protocols were issued on other matters[47] and not adhered to by Mr O'Brien.

4.12 Ultimately, the Inquiry might reasonably conclude that Mr O'Brien bore significant responsibility for the triage issues that arose in his practice.

(b) Patient Notes

4.13 The issue of patient notes is linked to the issue of dictation because it appears that one reason why Mr O'Brien brought patient notes to, and retained them at, his home is because he had not, whilst at work, dictated what he needed to dictate in respect of his clinical encounters with patients[48].

4.14 Notes would have been tracked out to Mr O'Brien or his secretary but be in neither person's office in the hospital.

4.15 The evidence to the Inquiry revealed a number of features, including:

a. that finding charts tracked to Mr O'Brien was an issue[49] during the tenure of Katherine Robinson, Medical Records Manager in the Trust from 2000 to 2013[50].

b. that the issue was escalated – e.g., in 2012 when Mr O'Brien was spoken to about it by Dr Rankin[51] and in the autumn of 2013 when it was escalated to Heather Trouton and IR1s were completed in respect of it (all at WIT-61512 to 61511);

[47] E.g., in respect of IV antibiotics and IV fluids, in respect of the use of the DARO List, and in respect of the use of bipolar resection in saline vs/ monopolar resection in glycine.
[48] See, e.g., the evidence of his secretary at TRA-06208 line 9 to 23.
[49] TRA-05171 lines 15-26; echoed by Martina Corrigan at WIT-26264.
[50] TRA-05170 lines 3-5.
[51] Recorded at TRU-251424, 2nd para.

c. that, in spite of escalation and the completion of several IR1s, the issue continued to be a recurring problem throughout the period 2013-2016 (see Martina Corrigan at WIT-26264);

d. that, by late 2016 / early 2017, Mr O'Brien had in excess of 300 sets of patient notes at home[52].

4.16 There was evidence to the effect that the issue of individual charts (or small numbers of charts) which were tracked out to Mr O'Brien or his secretary being missing was known to various layers of more senior management[53] including clinical management[54].

4.17 It appears that, whilst the issue of charts at home was a longstanding, recurring, and known issue, the extent of the charts that were held by Mr O'Brien at home at any one time was not known, albeit that this information could have been obtained by the Trust[55]. The true extent of the problem does not appear to have been appreciated until 2016/2017.

4.18 Whilst Mr O'Brien explained that some notes were at home because he had to transport them back from his clinic in SWAH (see, e.g., WIT-82554 para 435) it is also clear that this explanation did not account for the sheer volume of notes held by him nor the duration for which notes were held. Rather, the need to have access to notes in order to complete tasks such as dictation appears to be a key reason why Mr O'Brien retained so many patient notes at home.

[52] For example, 30 December 2016 letter at TRU-251446 records 365 notes at 23 December 2016. Mrs Corrigan – at WIT-26150 para a – records that 307 charts were returned by Mr O'Brien at the end of December / start of January 2017.
[53] See, e.g., the evidence of Helen Forde at TRA-05073-05075 and the finding of Dr Chada in the MHPS Case Investigator's Report at TRU-00702 (final para).
[54] Such as Mr Mackle as AMD – see, e.g., WIT-11745
[55] For example, in a review backlog validation exercise of the type described by Mr Mackle at WIT-11819-11820 para 227.

4.19 Whilst it may be difficult to identify any examples of cases where the absence of patient notes in the hospital exposed a patient to harm[56], the practice clearly created a risk of a patient being exposed to such harm.

(c) Dictation

4.20 As referenced at para 4.13 above, the issue of undictated clinics appears to have been linked to the issue of patient notes[57].

4.21 Whereas the practice of other consultants was to dictate immediately after each patient was seen[58] or at the end of each clinic[59], Mr O'Brien did not do this but instead dictated at a later point (sometimes much, much later)[60]. This ultimately led to a substantial backlog of undictated clinics.

4.22 The cause of this issue appears, at least in part, to have been Mr O'Brien's desire to perform the task in the way that he considered to be optimal (thereby echoing his approach to the referral triage issue mentioned above). In this regard, a number of witnesses gave evidence of Mr O'Brien's practice of writing very lengthy and detailed letters. For example, Mr O'Donoghue observed that 'when he did dictate he did exceedingly long letters which rarely got to the point'[61].

4.23 It appears that, although this issue was not known to some relevant personnel (such as Katherine Robinson) until a relatively late stage[62], it was apparent to

[56] See in this regard the evidence of Helen Forde at TRA-05127 line 23 to 05128 line 13.
[57] A point alluded to by the Inquiry on several occasions – e.g., Day 10 transcript at p76 lines 15-23.
[58] Mr Glackin described how he dictated 'immediately after I finish with the patient's consultation' TRA-08412 lines 12-22.
[59] Mr Haynes TRA-00856 last 3 lines; Mr Young, Day 74 TRA-09636 lines 4-6 and TRA-9644-9645 line 28 to p86 line 2 and lines 12-19.
[60] See, e.g., evidence of N Elliott at TRA-06124 lines 6-16 and TRA-06130 lines 18-23 and TRA-06135 lines 13-18 and TRA-06171 line 24 to TRA-06172 line 11 and TRA-06175 lines 3-22.
[61] TRA-08576 lines 21-23.
[62] TRA-05195 and WIT-60429 – Ms Robinson described how N Elliott alerted her in late 2016.

several of Mr O'Brien's colleagues[63] at much earlier stages. It is also evident from various contemporaneous documents[64].

4.24 It also appears that the dictation issue was one where, although the existence of the problem was appreciated by both clinical colleagues and a number of persons with clinical or operational management roles, the extent of the problem was not known[65]. However, its extent could likely have been ascertained upon the making of appropriate enquiries – e.g., by and/or of Mr O'Brien's secretary[66].

4.25 There has been, and there appears to remain, a dispute about the extent of the problem at the point when it ultimately came to a head in 2016/2017. Whereas there has been repeated reference to 61 clinics' worth of non-dictation[67], this has been disputed by both Mr O'Brien and his former secretary[68]. Nonetheless, there was undoubtedly a significant amount of undictated work outstanding from Mr O'Brien by the end of 2016 / start of 2017[69].

4.26 This created a real risk of harm - and potentially even caused some actual harm[70] – to patients.

(d) Private Patients

[63] At TRA-08150 line 25 Mr Glackin (who commenced in the Trust in August 2012) described how he encountered 'late dictation of letters, or letters not being present in the chart when I was seeing a patient'. At TRA-08151 line 29 to TRA-08152 line 2 he stated that 'I knew that he was having difficulty dictating his letters on time. That was widely known.' Issues known but extent not. Line 16-18. Mr O'Donoghue (who commenced in the Trust in August 2014) - at TRA-08573 lines 28 to TRA-08574 line 7 – described how he noticed within the first week of joining the unit (in 2014) that there were no letters in the patient notes. Mr Haynes (who commenced in the Trust in May 2014) gave similar evidence– see Day 10 transcript internal pages 51 line 19 to p51 line 10.
[64] Tru-258526-8 – August 2016 email exchange.
[65] E.g., see the evidence of Mr Glackin at TRA-08152 line 2 and lines 16-18. See also the evidence of Mr O'Brien's secretary at TRA-06136 lines 1-7.
[66] Or, according to his secretary, by interrogating the Data Quality Report – TRA-06192 lines 18-27..
[67] See the 15.12.16 email plus attachment from N Elliott at TRU-255968-to-255970; see also the 30.12.16 letter to Mr O'Brien – TRU-251446-to-251447.
[68] TRA-06184 lines 2-16.
[69] Even Mrs Elliott comes close to acknowledging this - TRA-06197 line 16 to TRA-06198 line 9.
[70] See in this regard the exchange between Inquiry Senior Counsel and N Elliott at TRA-06198 line 24 to TRA-06200 line 27.

4.27 The issue in respect of alleged advantaging of private patients can be summarised as follows: that some patients who had been seen privately by Mr O'Brien as outpatients, in due course had their substantive procedures performed within the NHS after a period that was significantly shorter than that for patients whose entire clinical journey had been within the NHS[71].

4.28 The issue appears first to have been recorded in a number of emails from Mr Haynes, to Mr Young and Martina Corrigan, the first dated 27 May 2015 (WIT-54107) and the second dated 26 November 2015 (WIT-54106), each one referencing a different patient (or patients) and each one requesting that action be taken. The issue was raised again (with a further patient example) by Mr Haynes by email of 23 December 2016 (TRU-00071) against the backdrop of the (then) looming investigation into a number of issues in Mr O'Brien's practice.

4.29 In an email of 26 November 2015 Mr Young said he had spoken to the person concerned and would do so again. (TRU-270116). In his oral evidence Mr Young recalled speaking to Mr Haynes about the issue TRA-09653 and believed he had spoken to Mr O'Brien about it TRA-09657-TRA-09658. Mr O'Brien rejected the claim that he had been spoken to about this (TRA-04742) and denied that he had inappropriately prioritised any private patients.

4.30 Mr Haynes in his oral evidence spoke of how he identified the patients that gave rise to a cause for concern whilst Urologist of the Week TRA-00896-TRA-00897 AND TRA-00900, prompting both of his 2015 emails, but that he was not aware of any action being taken to address the issue in response TRA-00900-TRA-00901. He did suggest in his written evidence, however, that the practice that he believed existed ceased after the MHPS process[72].

[71] In potential breach of the relevant principles in 'A Guide to Paying Patients' – see TRU-267665 at TRU-267673 para 7.4.1.
[72] WIT-53945 para 68.1. See also Mrs Corrigan's evidence at WIT-26280 para viii.a.

4.31 Mr Young's input into the MHPS process insofar as it related to private patients was addressed in his oral evidence TRA-09666. In short, any patient who underwent a procedure with Mr O'Brien in 2016 in respect of whom there was a short period of time between being added to a waiting list and their procedure being undertaken had their NIECR checked for a private patient letter[73]. This yielded 11 cases which Mr Young was asked to consider and opine on the reasonableness or otherwise of the waiting time. His resulting opinions were tabulated by Mrs Corrigan[74]. In short, he considered only 2 out of 11 of the waiting times to be reasonable. With the subsequent benefit of Mr O'Brien's responses to each case, and taking a 'generous' approach to some of Mr O'Brien's accounts[75], Mr Young in his oral evidence revised the reasonable cohort up from 2 to 6/7, leaving a number that remained unreasonably quick. Whilst he acknowledged that it was not in any sense a forensic analysis of the cases in question, he maintained that some of the time periods involved were quicker than he would, based on his experience, have expected, noting that 'some were within the month' (TRA 09674-09676).

Important Points to Acknowledge Regarding the 2016/2017 Issues

4.32 A number of points, reflective of failings on the part of the Trust and its systems, should be acknowledged in respect of the issues which came to a head in 2016/2017. In short, not only were many of the issues longstanding and known (such as his issues with referral triage, notes at home, and dictation), there had been a failure on the part of the Trust to address them effectively. Emphasis is placed upon the word 'effectively' because it is not the case that the Trust simply failed to act. Rather, it acted in a number of ways in response to a number of the above issues. However, many of its interventions were of limited effectiveness, as summarised in the examples below.

[73] See M Corrigan's description at TRU-283681.
[74] TRU-01069.
[75] TRA-09672 lines 2-4, plus TRA-09674, lines 1-14.

4.33 In respect of referral triage:

a. Managers, particularly the Head of Service, engaged in a cycle of pursuing Mr O'Brien in respect of outstanding triage and securing improvement for periods of time, only for backlogs to appear again[76].

b. The issue was escalated at various points to both operational and medical management[77] but the net result of this often appears to have been the tasking of the Head of Service to engage with Mr O'Brien to secure compliance.

c. Trust staff often developed workarounds and accommodations to cope with Mr O'Brien's triage deficits rather than challenge him directly to secure meaningful change. For example:

    i. Mr Young undertook Mr O'Brien's triage on a number of occasions[78].
    ii. Mr O'Donoghue followed Mr O'Brien as Urologist of the Week on a Thursday and would have triaged several referrals (from the day before) which had been left undone by Mr O'Brien[79].
    iii. The Referral Office kept a book which recorded referrals sent to Mr O'Brien so that he could be reminded and so that untriaged patients would not get lost[80].

d. The Trust ultimately developed in about 2014 (what has been referred to in the Inquiry as) a 'Default System' in respect of referral triage[81]. The risk it was designed to guard against was that of a patient failing to be added to <u>any</u>

[76] See, e.g., Mrs Corrigan's evidence at wit-26305 para 69.1 regarding the ebb and flow of compliance by Mr O'Brien. See also her evidence from WIT-26275.
[77] See Mrs Corrigan's evidence at WIT-26294 para 63.2 and WIT-26294 para 63.3.
[78] WIT-26283 para 58.1.a.
[79] TRA-08578 line 21 to TRA-08581 line 10, and TRA-08584 lines 14-18.
[80] TRA-05180 lines 3-21. See also TRA-05125 line 12 to 05216 line 9.
[81] See, e.g., WIT-26283 para 58.1.b; WIT-40949; or WIT-11784-WIT-11785 E Mackle mentioning D Burns introducing a new system in 2014.

waiting list whilst their letter awaited triage[82]. However, whilst the system removed this risk it failed to address another risk, *viz*, that a patient who had been classified at too low a priority would not get upgraded to the correct priority unless their referral was actually triaged[83].

4.34 In respect of patient notes at home, the pattern was similar in many respects to that in respect of referral triage. It arose repeatedly over the years, Mr O'Brien would have been contacted, and he would have brought in the missing notes[84]. However, for a number of years records staff also submitted IR1s in respect of cases of missing notes tracked out to Mr O'Brien or his secretary[85]. However, this formal escalation appears to have made little or no difference[86] and was eventually ceased[87]. It is also unclear whether the Trust ever made the link between the notes at home issue and the issue of delayed or undone dictation by Mr O'Brien.

4.35 In respect of dictation, it appears that the other consultants (who started in the Trust in the period 2012 to 2014) were finding no patient letters in Mr O'Brien's patients' notes when they saw them and were having to do their best based on the available notes and what the patients said. Beyond this workaround, it is not clear that very much else was done.

4.36 Finally in this regard in respect of private patients, at most it appears that a conversation took place between Mr Young and Mr O'Brien (at least on the evidence of Mr Young). It appears that no attempt was made to address the issue formally – e.g., by initiating the 'retrospective audit' Mr Haynes had advocated in his May 2015 email about the issue.

Attempts to Grapple with these issues in 2016/2017

[82] See, in this regard, the evidence of M Haynes at TRA-00880 at lines 13-23; and of K Robinson at TRA-05214 lines 19-28.
[83] See Mr O'Donoghue's evidence at TRA-08587 lines 1-10 in this vein.
[84] See H Forde at TRA-05112 to TRA-05113.
[85] See the evidence of H Forde at TRA-05088-05091 and the list of IR1s at WIT-61509.
[86] See evidence of H Forde at TRA-05092/3 on this issue.
[87] On the direction of Debbie Burns, according to Helen Forde - see TRA-05091.

4.37 It is clear that the Trust made more concerted attempts to address these issues in 2016/2017. These attempts included the letter of 23 March 2016 and the related meeting, the instigation of the MHPS process, and a number of SAIs. However, there remained several respects in which their attempts were sub-optimal.

4.38 Dealing first of all with the 23 March 2016 letter (TRU-274672) and meeting with Mr O'Brien on 30 March 2016 (at which he was handed the letter)[88]:

a. The issuing of a formal letter signed by senior clinical and operational managers was, on any reasonable view, an appropriate (albeit overdue) escalation of the issues.

b. However, there is evidence (not least from Mr O'Brien) that the meeting of 30 March 2016 was relatively brief and that there was no discussion regarding how he might conceivably address the issues. Whilst it would be reasonable to observe that no discussion was needed in respect of the issues of triage, dictation, and notes at home[89], a discussion on the (then) 4th issue of the review backlog may have been reasonable.

c. Following the meeting of 30 March 2016, it is clear than Mr O'Brien failed to revert with a plan for resolution of the issues, either immediately (as the letter in its final paragraph sought) or at all. Mrs Corrigan believed that he was told that a response was expected within 4 weeks[90]. In spite of this, there appears to have been no follow-up by the Trust in respect of the letter.

[88] The meeting is summarised in Martina Corrigan's email of 28 April 2016 at TRU-274671.
[89] Indeed, as Dr Colin Fitzpatrick frankly observed in his evidence at TRA-04327 from line 5 onwards, some of these issues were not difficult to solve – 'you have a whole pile of charts sitting on your dining room table, you just put them in the boot of your car and bring them in'.
[90] Ibid.

d. Thus, whilst the 23 March 2016 letter appears to have been a step in the right direction (and even perhaps to have triggered a reduction in the referral triage backlog[91]), it was not followed through.

4.39 Moving on to the MHPS process, a decision was made at an Oversight Group Meeting on 13 September 2016 to instigate an MHPS process in respect of Mr O'Brien[92]. However, there are multiple legitimate criticisms that can be made of that process. They include, but are by no means limited to, the following:

a. The process had a stuttered and confused start. The decision having been made by the Medical Director, the Director of Acute Services, and the HROD Director in an Oversight Committee to commence the process in light of the 4 areas of concern outlined above (and a draft letter to Mr O'Brien prepared[93]), a matter of days later (on 15 September 2016[94]) the Director of Acute advised her 2 colleagues of her desire to press pause on the process and allow the Associate Medical Director and Assistant Director responsible for Mr O'Brien the opportunity to arrive at a local solution[95]. Unfortunately, no such solution was in fact found and matters concerning Mr O'Brien progressed in any event due to the emergence of the SAI in respect of Patient 10 in or about November 2016[96]. As a result, and in spite of the decision made in early September, an MHPS process did not, in fact, begin in respect of Mr O'Brien until the very end of 2016 / start of 2017.

b. In spite of the preponderance of the evidence being to the effect that the timescales[97] laid down in respect of the MHPS process are unrealistically tight,

[91] In terms of the triage backlog between March and August 2016 – TRU-274672 (the 23.3.16 letter) suggests 253 untriaged letters whereas TRU-274723 (17.8.16 email) suggests 174 letters.
[92] TRU-00025-00026.
[93] TRU-251430; cover email at TRU-251429.
[94] See the Director's email at TRU-257642 plus responses at TRU-263683.
[95] Dr McAllister (then AMD responsible for Mr O'Brien) gave his view in his oral evidence that the Oversight Committee was deficient insofar as it did not involve him in its decision-making – see his questions and answers with Dr Swart on Day 24 from TRA-02815 line 11 to TRA-02816 line 20.
[96] See, e.g., Tracey Boyce's email of 9 November 2016 at AOB-01224.
[97] See WIT-18490 at WIT-18505 para 37 and TRU-83685 at TRU-83694 Appendix 2.

it seems clear that the MHPS process in the instant case took too long to complete (the Case Manager's Determination issuing in late September 2018). There appear to have been multiple reasons for this including:

i. The fact that key roles within the process such as Case Investigator and Case Manager were performed by experienced, busy clinicians with limited capacity given their demanding 'day jobs'.
ii. The fact that the investigation necessitated the interviewing of a large number of witnesses, all of whom were also busy clinicians or managers.
iii. The fact that Mr O'Brien appeared to approach the process as being akin to a legal proceeding, such that he made repeated and enormously detailed demands for disclosure of allegedly relevant documents[98].

c. It is clear that the process had to rely upon a number of persons performing important roles, such as the Designated Non-Executive Director ('NED') and Case Manager who, prior to their involvement in this process, had little or no MHPS experience.

d. It is also clear that, in the final stages of the MHPS process, there was a significant lack of clarity regarding when roles such as that of the Designated NED and Case Manager actually ended.

e. Following provision of the MHPS Case Manager's Determination, there was a failure on the part of the Trust to see through the 3 recommendations made by the Case Manager (action plan, conduct panel, and independent administrative review). In part, this was due to the grievance lodged by Mr O'Brien; in part it was due to the fact that an action plan already existed (and had been a driver

[98] See: AOB-01925. See also WIT-31934 to WIT-31945 Mr O'Brien to Dr Khan 30.7.17; and TRU-264105 to TRU-264108 Mr O'Brien to Dr Khan 12.11.18.

for some improvement on the part of Mr O'Brien since his return to work in early 2017); and in part the recommendation in respect of a review was overtaken by Dr O'Kane and Mr Devlin's Champion Review[99].

f. On one reasonable view[100], the MHPS process provided a false sense of security in that, because of its focus on the 4 areas mentioned above, it provided a false reassurance that there were no issues in Mr O'Brien's clinical practice whereas, as became evident from the issues that came to a head in 2020 (with which Chapter 5 is concerned), such issues did exist.

g. Finally in this regard, it is important to note that many of the structural problems with the MHPS system more broadly, as well as having been exposed in the corpus of evidence heard by the Inquiry between Day 20 and Day 39, had already been highlighted in consultation responses by the Trust (and by other Trusts) to the Department in each of 2011 and 2018[101].

4.40 The Julian Johnson SAIs (in respect of Patients 11 to 15) were triggered by the SAI[102] in respect of Patient 10 and the investigations carried out in late 2016 to ascertain if there were other cases like that of Patient 10. Whilst the Patient 10 SAI arose out of an IR1 in January 2016, was able to feed some of its learning back to the Trust to be factored into decision-making regarding Mr O'Brien in late 2016, and was completed by March 2017, the other 5 related SAIs took too long to be completed[103]. That said, whether they ultimately added significantly to what was already known about (or being done to address) deficits associated with Mr O'Brien is debatable.

[99] WIT-46954; See the written evidence of Dr O'Kane at WIT-44995 para 8..
[100] Articulated, for example, by Maria O'Kane in her evidence at TRA-11620.
[101] See WIT-42399 to WIT-42401, WIT-42998, WIT-43009 to WIT-43031, TRA-03410 from line 24, for some of the material on this.
[102] PAT-000001 to PAT-000011.
[103] They were not signed off until 22 May 2020 – see TRU-161175.

Root Causes of Trust Failings

4.41 Identification of the above failings on the part of the Trust brings into sharp focus the question of what caused such failings. Put another way: why were issues that were, in large part, (i) longstanding and (ii) known to at least some clinical and operational managers, not addressed either adequately or at all?

4.42 There appear to be a multiple root causes in play here, several of which are addressed in the paragraphs which follow.

(a) Cultural Issues

4.43 It is apparent from the evidence of multiple witnesses that there were what might conveniently be described as 'cultural issues' that served as barriers to the effective resolution of the 2016/2017 issues. These issues appear to have been related to (i) Mr O'Brien's standing, (ii) his attitude to challenge, and (iii) the size and location of the hospital. Taking each one in turn:

(i) Mr O'Brien's Standing

4.44 Mr O'Brien started the urology unit in 1992, ran it as a sole consultant urologist for approximately 4 years[104], and played a significant role in expanding it, particularly in its early years. At all times between 1992 and his retirement in 2020 he was the senior consultant urologist in the unit.

4.45 Mr O'Brien had a substantial reputation and was well thought of by many patients and staff. A clear example of the latter can be found in the June 2011 Report of the Disciplinary Investigation[105] carried out by Robin Brown[106] into Mr

[104] July 1992 to January 1996; and again from December 1997 to May 1998.
[105] WIT-103538 at 103544.
[106] Then Clinical Director, General Surgery.

O'Brien's disposal of patient charts in a bin. Mr Brown concluded his report by observing:

> *'Mr O'Brien says that he spends more time writing in and filing in charts than probably any other Consultant and from my own personal experience I can confirm that that is the case. Mr O'Brien has the utmost respect for patients, for their information and for the storage of records. This was an unusual behaviour …*
> *The motivation for the incident was honourable … '*

In 2013, in the context of Mr Brown having had to speak to Mr O'Brien about the latter's triage deficits, Mr Brown once again reflected his high opinion of Mr O'Brien – *'Aidan is an excellent surgeon and I'd be more than happy to be his patient'*.

4.46 Mr O'Brien's legal connections, through his brother and later his son, were also well-known by staff who worked with him in the Trust. Several witnesses provided evidence of how awareness of these connections may have contributed to a reluctance to challenge him[107].

4.47 Similarly, it was well known by several people with whom Mr O'Brien worked in the Trust that he was a friend of the Chair of the Trust Board, Mrs Brownlee[108]. Not only does it appear that Mr O'Brien mentioned their relationship on occasions but it is also the case that, on the day of Mr O'Brien's MHPS meeting with Mr Weir on 24 January 2017, Mrs Brownlee accompanied Mr O'Brien and his son a short distance within Trust headquarters to the room where the meeting was to take place and introduced him. The Inquiry has also received evidence about how Mrs Brownlee engaged with each of Esther Gishkori and John Wilkinson in a way that could be construed as advocating on behalf of Mr O'Brien. Vivienne Toal considered that knowledge of the friendship between Mr O'Brien and the Trust

[107] E.g., M Corrigan at WIT-26224 para 30.12. See also TRU-251964 email from Mr Haynes to S Gibson and Dr Khan and dealt with in S Gibson's evidence at TRA-02930 "Are you aware of this? Surely this behaviour (phone calls from wife and his son/legal adviser to Mr. Young, below with Mr. Weir) shouldn't happen? How can we (his colleagues) be protected.".
[108] See, e.g., the evidence of M Corrigan at WIT-26300-26301 para 67.5.

Chair had a *'chilling effect'* on how issues with Mr O'Brien were addressed prior to 2016[109].

4.48 Given the above factors, it is perhaps not difficult to understand how there may have existed at least a perceived imbalance of power between Mr O'Brien and each of his more junior clinical colleagues and his operational managers (such as the Head of Service). It is likely that this imbalance will have made at least some staff more reluctant to challenge Mr O'Brien.

(ii) Mr O'Brien's Attitude to Challenge

4.49 Mr Haynes described Mr O'Brien as 'a challenge to challenge'[110]. His Head of Service echoed this evidence[111], describing how *'there was no backing down by him when he believed that he was correct and it was the system that was wrong'*[112] and how *'he always challenged back and he wore people down'*[113].

4.50 The Inquiry is very familiar with Mr O'Brien's responses when reminded of the importance of using the DARO system[114].

4.51 And we are familiar with his apparent failure to change his practice when sent an email by Dr Mitchell in 2014[115] which the latter described as *'an email which I think if I'd received it, I'd have been quite shocked at, the forthrightness of the approach'*[116].

[109] TRA-03500 from lines 21-27 in particular.
[110] TRA-00842 lines 1-2; see also Mr Haynes TRA-11446 from line 1.
[111] WIT-26223-26224 paras 30.6 to 30.9.
[112] Ibid at para 30.8.
[113] WIT-26300 para 67.2 line 2.
[114] See the email chain at AOB-07574 to 07577 for the 2019 DARO exchange and an earlier similar email exchange between Mr O'Brien and Mrs Corrigan from 2011 about actioning results at TRU-276805 to 276808.
[115] AOB-71990
[116] TRA-07790 line 18 to TRA-07791 line 2.

4.52 We can also see, in Chapter 6, further examples of his general resistance to changing his practice in areas such as IV fluids and antibiotics and TURPs in glycine.

(iii) Size and Location of the Hospital

4.53 In many relevant ways, both the Trust and the community served by it are small. This is perhaps not surprising in a local hospital serving a largely rural community.

4.54 The urology unit itself has never been substantial. For example, it did not move beyond 3 consultant urologists until 2011/2012. In such a small unit, where a Head of Service works very closely with her consultants on a daily basis, there is an obvious tension between repeated challenge to a consultant in respect of his non-clinical work and the viability of a continued working relationship between them. Perhaps Mr Young encapsulated the point when he observed that, *'It's a small group. It's a small team. It's very important to get on to make the thing – to make the work gel, to make the whole as a unit gel.'*[117]

4.55 Looking beyond the urology unit to the Trust community and local community more broadly, the smallness and interconnectedness of them is undoubtedly a relevant feature. Staff largely lived in the locality where they worked. Thus, the Inquiry has encountered multiple connections beyond the professional. We have heard about how Mr O'Brien had been the Trust Board Chair's surgeon at a significant point in her past and how he treated a family member of a past Chief Executive[118]. We have seen how Mr Brown anticipated he might personally need to avail of Mr O'Brien's services in the future. And we have heard Mr Glackin's evidence of his family connection to Mr O'Brien and the latter's role as a mentor of sorts at an early stage in Mr Glackin's medical journey.

[117] TRA-09054 lines22-25.
[118] WIT-18567 para 1.7.

4.56 In this particular context, which might differ significantly from that of a large city hospital, it is possible that some managers were willing to exhibit greater tolerance of the ebb and flow of Mr O'Brien's compliance with expectations in respect of triage, patient notes and dictation, and that some colleagues were willing to either to work around him or, on occasions, to do his work for him[119].

(b) Inadequate Appreciation of the Risk to Patients

4.57 The issues that came to a head in 2016/2017 (particularly those in respect of referral triage, notes at home, and dictation) have at times been described as 'administrative' failings.

4.58 Such a label risks obscuring the real risk to patient safety that is posed if, for example, a patient's referral letter is not triaged (and, where appropriate, its priority upgraded) or if their notes are unavailable when they arrive in A&E or if their GP is not advised by letter of their urological diagnosis and treatment path.

4.59 It appears that there may at times have been an inadequate appreciation of the risk to patient safety created by these (superficially) administrative failings. Indeed, this was a particular reflection offered by Mr Mackle in his evidence regarding triage[120]. And the Inquiry has heard from witnesses who have stated that they appreciated the risks associated with failings[121] as well as from those who have acknowledged that they did not[122].

4.60 This inadequate appreciation of risk may also have played a role when the 'default system' in respect of triage was conceived. In her written evidence to the Inquiry[123], Mrs Trouton identified the two risks that accrued if triage remained undone:

[119] As Mr Young did with Mr O'Brien's triage on more than one occasion.
[120] WIT-11817.
[121] E.g., M Corrigan at WIT-26282 at para 57.1.
[122] E.g., K Robinson at TRA-05171 lines 27 to TRA-05172 line 2.
[123] WIT-12135 at para 441.

441.Regarding the concerns of untimely triage in relation to patient safety, these were:-

a. Patients not being afforded the expert opinion of a consultant Urologist as to their level of referral urgency (i.e., not having the opportunity to be upgraded from routine to urgent or red flag or from Urgent to red flag) and the potential to come to harm if not seen as quickly as their condition indicated.

b. Patients not being added to the waiting list in a timely manner and therefore missing their rightful chronological management for a routine or urgent appointment.

4.61 As is clear from the evidence before the Inquiry and as already alluded to above, the 'default system' in respect of triage addressed only the second of the above risks (a referral patient not being added to the waiting list). It did nothing to address the risk (even if it was only a small risk) of untriaged referrals missing out on an upgrade in their priority status.

(c) Confusion or a Lack of Clarity Regarding Roles and Responsibilities

4.62 It is clear that there was, amongst staff at several within the levels within the Trust who could have assisted in grappling with the deficits in Mr O'Brien's practice, confusion or a lack of clarity about their roles and responsibilities. Two clear examples of this should suffice:

a. We know, in respect of Mr O'Brien's delayed dictation problem, that his secretary was aware of it but did not raise the issue with anyone other than Mr O'Brien at least in part because she appears not to have considered it part of her role to do so[124]. At the same time, staff[125] further up the management line from the secretary appear to have considered it to be the duty of the secretary

[124] See, as an example of her evidence in this regard, TRA-06165 lines 22-24 and TRA-06166 lines 1-5 and 11-16.
[125] E.g., K Robinson.

to tell others when the consultant was behind in dictation[126]. Thus, there appears to have been at a material time a degree of confusion regarding the secretary's responsibilities, confusion which, if it had been avoided or removed, might have led to the extent of the O'Brien dictation problem coming to light at an earlier stage.

b. On the clinical side, we know that there was confusion regarding Mr Young's role and responsibilities as Clinical Lead[127]. He had no job description or job plan for the Clinical Lead role. He did not see himself as having any significantly greater clinical governance responsibility as Clinical Lead than as a consultant. He described his role as being 'the captain of the team'[128] and saw his responsibilities as lying more in respect of organisational matters such as rotas.

(d) Failure to deploy existing tools adequately or at all

4.63 It seems clear that there was a failure to deploy existing tools adequately or at all. There are several examples of this:

Escalation

a. In respect of dictation, Mr O'Brien's secretary gave evidence about how she raised non-dictation with him repeatedly but never escalated the issue to anyone else until December 2016, as she thought management already knew[129].

b. In respect of patient notes, there are multiple examples of the issue being drawn to the attention of a manager (such as, but not limited to, the Head of Service) but not being escalated further, potentially because every time it was raised the missing notes were returned.

[126] K Robinson evidence at TRA-05193 lines 3-7.
[127] See his evidence on this issue from Day 69, p72 line18 to p86.
[128] TRA-09044 line 24.
[129] TRA-06176 lines 24 to TRA-06177 line 23

c. Similarly in respect of triage, there are numerous examples of the issue being drawn to the attention of a manager such as the Head of Service and of it sometimes being escalated further up the chain[130] but there is little evidence of it having been escalated to the Medical Director prior to 2016[131]. Not unreasonably, Mrs Corrigan reflected in her evidence that this issue ought to have been escalated to the Medical Director at an earlier stage[132].

Use of Formal approaches

a. There are examples of staff not availing of formal routes to address concerns about Mr O'Brien. Examples include:

    i. In respect of the recurring referral triage issue there appears to have been a reluctance to complete IR1s[133]. Although Mr Haynes submitted the IR1 regarding Patient 10 in January 2016, he described the incident reporting system as being *'not the most user friendly'*[134] and provided evidence of his experience of no feedback being provided in respect of IR1s submitted nor input afforded to the IR1 'reporter'[135]. He was of the view that this lack of feedback contributed to the failure of Trust systems (such as Datix) to identify and address concerns about Mr O'Brien at an earlier stage[136]. He reflected that the absence of feedback could act as a deterrent to people reporting concerns[137].

[130] E.g., to the Assistant Director or Associate Medical Director - see 8 October 2013 H Trouton email to Mr O'Brien at AOB-06960 and also TRU-276904.
[131] See, in this regard, the list of interventions in respect of triage between 2009 and 2016 set out by H Trouton in his witness statement at WIT-12135 para 443 to WIT-12137 para 444.
[132] WIT-26307 para b.
[133] Note the exchange between Inquiry Senior Counsel and Mr Young on TRA-09084 regarding the fact that, prior to the 2016/2017 IR1s regarding Patients 10-15, it appeared that IR1s were not submitted regarding the triage issue.
[134] TRA- 876 lines 5-6.
[135] WIT-53915-53916 para 46.2.
[136] Ibid.
[137] TRA-00873 lines 8-24.

ii. In respect of missing notes, although IR1s were completed for a time (already referenced above), staff appear to have ceased doing so, at least in part because it had failed permanently to resolve the issue.

iii. When IR1s were submitted, it appears that on occasions, cases that might reasonably have been 'screened in' for SEA or SAI Review were simply not. For example, in the case of Patient 102 Mr Haynes saw him in October 2015 and noted that no letters had been dictated in respect of his previous clinical encounter in November 2014 and that the MDM recommendation (of referral for radical radiotherapy) appeared not yet to have been implemented. Although Mr Haynes completed an IR1[138] in respect of this patient, nothing further appears to have occurred. Neither Mr Haynes[139] nor Mr Cardwell[140] could explain this omission. Mr Haynes speculated that those involved in screening ought to have been *'more alert to potential [harm] and less focused on evidence of harm as the trigger for screening into an SEA or SAI'*[141].

iv. The potential to invoke or suggest invocation of the MHPS process may have been diminished by the fact that some staff who were aware of Mr O'Brien's deficits were unaware of the existence of the MHPS process. Prime examples of this are his Head of Service who was unaware of MHPS until 2016 or 2017[142] and Mr O'Brien's Assistant Director for the period 2009-2016 who was not aware of MHPS at any point during her tenure and who only became aware of it during the lifetime of the Public Inquiry[143].

[138] WIT-54874 to WIT-54881.
[139] See WIT-53915 para 46.2 and TRA-00870- TRA-00875
[140] TRA-07629
[141] TRA-00874
[142] WIT-39881 at para 4.1.
[143] See H Trouton's evidence at WIT-14810 para 8.

v. Similarly, the potential to involve NCAS appears similarly to have been reduced by reason of the fact that some were unaware of the potential assistance it could provide[144].

vi. Risks caused by Mr O'Brien's various failings could have been, but were not, added to risk registers[145].

Use of Informal approaches

a. Whilst it is clear that some informal methods were used (and used repeatedly), such as Mrs Corrigan speaking to or emailing Mr O'Brien to chase missing notes or undone triage, other informal methods appear not to have been used adequately. For example, whether because of a perception that Mr O'Brien was *'a challenge to challenge'* or because of cultural issues, it does not appear that a more structured meeting was ever arranged with Mr O'Brien to talk through the difficulties he was experiencing and the potential solutions to same. When a meeting was arranged in late March 2016, it was primarily to hand over the 23 March 2016 letter and some of the evidence about that meeting has already been described as creating an impression that it was a case of *'let's get this done and dusted and out of there as quickly as possible'*[146]. The Inquiry may form the view that, at times at least, there was some degree of paralysis amongst managers in addressing the O'Brien issues, caused in part by a misapprehension that it was a binary choice for managers between informal prompts to Mr O'Brien (whether by Mrs Corrigan or Mr Brown) and the 'nuclear option' of an MHPS process[147]. In this regard, Zoe Parks' evidence described how part of the motivation around the fresh MHPS guidance issued by the Trust in late 2017 was to ensure that the informal approach received appropriate emphasis as a management option[148].

[144] E.g., TRA-02513 line 7 to TRA-02514 line 4 - Dr Wright evidence.
[145] See, e.g., K Robinson's evidence at TRA-05205 lines 8-17.
[146] See the Chair's question of H Trouton on Day 22, p133, lines 8-11.
[147] In this particular regard, attention is drawn to the useful evidence given by Dr Colin Fitzpatrick on this issue in response to questions from Dr Swart between TRA-04372 line 22 and TRA-04375 line 24.
[148] TRA-05570 line 21 to TRA-05571 line 13. See also the evidence of Vivienne Toal on the importance of the informal element – TRA-03481 line 11 to TRA-03482 line 15.

(e) Problems with Existing Systems

4.64 Some existing Trust systems, which had the potential to identify and record (or even begin to address) some of the O'Brien issues, were not sufficiently sensitive to do so, even though it appears that it might have been possible with some additional effort to render them such. Furthermore, the potential governance role for such systems appeared to go unnoticed. For example:

a. Backlog reports – These reports completed by consultants' secretaries (examples of which can be found at TRU-164942-3 and TRU-165082) did record 'clinics awaiting typing' but did not, at the relevant time, record 'clinics awaiting dictation'. Katherine Robinson acknowledged this in her evidence[149]. Although Ms Robinson's evidence was to the effect that she would have expected a secretary to include in the report if there was a backlog of clinic dictation, the inclusion of such a column in the report would have ensured that this was done. Furthermore, although these reports could have performed this important function, their purpose was viewed as being solely in respect of secretarial workload management rather than governance[150].

b. Appraisal – Mr Young carried out Mr O'Brien's appraisals for the period 2010-2015[151]. Although not conceived as a performance management tool[152], appraisals had some potential to recognise concerns in a doctor's practice (and perhaps begin a process to escalate and/or address them)[153]. Although an appraiser had access to complaints about the appraisee[154], the process appears, in the words of Mr Young, only to be *'as good as the information that is supplied'*[155]. It did not, for example, have access to IR1s. It appears that known issues with

[149] From TRA-05188 line 23 – especially at TRA-05189 line 27 to 05190 line 24
[150] TRA-05190 line 25 to TRA-05191 line 17.
[151] TRA-09716
[152] TRA-09240 lines 19-21.
[153] Ibid TRA-09726, lines17-29 to TRA-09727 line 3.
[154] Ibid TRA-9727 from line 21.
[155] TRA-09088 lines 11-12.

Mr O'Brien's performance, particularly in the areas of triage and patient notes, were not 'brought to the table' in his appraisals. This was acknowledged as a potential missed opportunity in evidence given to the Inquiry[156]. Mr O'Brien does appear to have provided some information regarding triage in his 2015 appraisal (*'I triage red flag referrals when urologist of the week'*)[157] which, with the benefit of hindsight, might be construed as a warning sign requiring some probing. Of course, this appraisal appears only to have been completed in December 2016, by which point issues in respect of Mr O'Brien's triage were being actively addressed[158].

c. Patient Records Logged Out – The system recorded that patient notes were logged out to a consultant or his/her secretary but not whether the consultant had then taken them home.

(f) Staff Churn and Staff Vacancies

4.65 In the period from 1992 to 2020, Mr O'Brien was a constant in the urology service and it appears that some of the deficits with which this chapter is concerned (e.g., in respect of referral triage) may have been present throughout much of the period (albeit at different intensities and with different potential consequences[159]). In contrast, there was a significant turnover of both clinical colleagues and managers.

a. For example, during his tenure he has had at least 11[160] substantive consultant urologist colleagues in addition to multiple locums. Only Mr Young has been a constant presence throughout most of Mr O'Brien's tenure.

[156] See Mr Young's exchange with Inquiry Senior Counsel at TRA-09717 from line 5.
[157] TRU-251310 at TRU-251312
[158] Mr O'Brien included a similar sentence in his 2016 appraisal [TRU-251320 at 251331], completed in November 2017, when his appraiser was Dr Scullion and when he was, in fact and by virtue of his return to work plan monitoring, actually performing more than red flag triage.
[159] E.g., the consequence of a failure to triage a referral and upgrade its urgency may have made little difference when the difference between the most and least urgent waiting lists was relatively small.
[160] Messrs, Baluch, Young, Akhtar, Glackin, Ho, Pahuja, Connolly, Suresh, Haynes, O'Donoghue, and Tyson.

b. On the management side, there has been churn at almost all levels[161]. For example, on the clinical side in the decade between 2010 and 2020 alone he had 5 different Medical Directors[162], 3 different AMDs[163], and 3 different CDs[164]. On the operational side in the same period he had 4 different Directors of Acute Services[165] and 2 different Assistant Directors[166]. Only Mrs Corrigan was a relatively[167] constant presence, albeit she has borne a large and increasing burden of managerial responsibility beyond the realm of Urology.

4.66 In addition to the churn of managers, there were a number of related sub-optimal features of the managerial landscape.

a. For example, for the period of time when Robin Brown was his Clinical Director, Mr Brown was based primarily at Daisy Hill whereas Mr O'Brien was in Craigavon. This separation was of particular significance in the period from 2012 onwards when Mr Mackle (who had attempted to manage a number of issues with Mr O'Brien as AMD up to that point) took a step back from managing him due to an alleged complaint by Mr O'Brien against him.

b. In addition to the above geographical issue, there were points when certain managerial roles were unfilled, such as between Mr McAllister ceasing to act as AMD and Mr Haynes taking up the role.

4.67 The timing of some managerial change was also, on reflection, unfortunate. A prime example of this is the loss of both Heather Trouton and Eamon Mackle in or

[161] Including even at Chief Executive level, where for several years prior to the arrival of Shane Devlin in March 2018 there was a high degree of churn in this role. In the 3-4 years prior to S Devlin arriving the role was held by Mairead McAlinden, Paula Clarke, Francis Rice, and Stephen McNally. See, e.g., WIT-00026 at Q5 response, 3rd para where S Devlin reflects on this.
[162] P Loughran, J Simpson, R Wright, A Khan, and M O'Kane.
[163] E Mackle, C McAllister, and M Haynes.
[164] R Brown, C Weir, and T McNaboe.
[165] G Rankin, D Burns, E Gishkori, and M McClements.
[166] H Trouton and R Carroll.
[167] She was absent for a prolonged period during 2018.

about April 2016, just after Mr O'Brien had been challenged (by them) for the first time in a formal way (i.e., through the letter of 23 March 2016 and subsequent 30 March 2016 meeting). It is quite likely that the movement on of these key managerial personnel at this key point in time was at least partly to blame for poor follow up to the 23 March 2016 letter.

4.68 It is perhaps not difficult to understand how, in such an environment, there was sometimes a lack of cohesion and a lack of follow-through when it came to managing the deficits in Mr O'Brien's practice. The fact that, on several occasions, there was no handover between successive occupants of certain managerial roles could only have compounded this problem.

(g) A failure prior to 2016 to adopt a more coordinated and less siloed approach to, and/or to 'stand back and look' at, Mr O'Brien's Practice

4.69 It is clear that the Trust could, prior to 2016, have taken a more coordinated approach to Mr O'Brien's practice and the deficits apparent in it. There are a number of aspects to this.

a. First, they could have adopted a more coordinated approach to how they grappled with individual issues in Mr O'Brien's practice. If one considers the patient notes issue as an example, it appears that it was realised that notes were missing, a message then went out to Urology seeking the notes, (for a time at least) an IR1 was completed, the notes were (almost invariably) located and returned in time for the relevant patient encounter, and (if applicable) the IR1 was then closed. In one sense, each such event could be construed as a problem manifesting itself and then being solved. However, a more accurate view of the situation (and one that would be hard to resist for a manager 'standing back and looking' and coordinating the instances of the issue arising) might be of a continuing problem causing repeated 'near misses' necessitating a permanent solution.

b. Second, instead of dealing with the issues (e.g., triage or notes) separately as they manifested themselves, they could have adopted a more coordinated approach. This might have been as simple as identifying that Mr O'Brien was deficient in more than one aspect of his practice and considering whether more substantial action and/or intervention and/or escalation was therefore necessary. Instead, however, it appears that Mr O'Brien's separate deficits were addressed separately prior to 2016. The Inquiry has in this regard multiple examples of separate chains of emails passing up and down between staff on separate issues of triage or patient notes but few examples of any coordination until 2016.

4.70 There were no doubt obstacles (albeit, given the process ultimately begun in 2016, not insurmountable obstacles) to taking such an approach but an added value of such an approach is that it would overcome such obstacles. For example:

a. Silo working – The Trust is not alone (either amongst Health Trusts or large organisations more broadly) in sometimes conducting its operations in a siloed manner. There have been multiple examples of this in the evidence put before the Inquiry, one example of which was the evidence of Helen Forde who spoke about a siloed approach (in the context of the patient notes issue) to operational governance and clinical governance so that 'only medics could deal with medics'[168].

b. Non-triangulation of information – No single person (other than Mr O'Brien) was sighted as to all of his issues, or at least as to the extent of all of his issues. So, whilst the Head of Service was periodically tasked to chase overdue triage or missing notes, she had much less knowledge regarding undone dictation (where the key information was in the hands of Mr O'Brien and his secretary).

[168] TRA-05096 lines 6 to TRA-05098 line 8.

4.71 Nonetheless, it is hard to avoid the conclusion that, if the Trust had 'stood back and looked' in a more coordinated way at the issues in Mr O'Brien's practice that were known about in the years prior to 2016/2017, then:

a. the extent of those issues would have been realised sooner; and

b. more definitive action (either of the type initiated in 2016 and/or of a type including involvement of a body like NCAS) could have been taken at an earlier stage.

4.72 It is also important to acknowledge in this regard that, if the Trust had adopted such an approach, it might also reasonably have taken a broader look or a deeper dive into Mr O'Brien's practice, a point that has been fairly acknowledged as a potential missed opportunity by several witnesses[169].

(h) Governance Deficits

4.73 Many of the above failings are themselves governance failings. However, sitting behind them were a number of broader or deeper governance deficits.

4.74 Shane Devlin in his witness statement has described how, within a short time of his arrival in 2018, he formed the view that the clinical and social care governance architecture of the Trust was inadequate[170]:

> *… in 2019, I commissioned the HSC Leadership Centre to review the complete governance system within the Trust. I was concerned that the system was disjointed and that from my experience the system was not operating as I had experienced in other HSC organisations. I had a number of concerns based on my experiences;*

[169] E.g., Mr Haynes at TRA-11421 from line 2.
[170] WIT-00037.

1. *The level of expenditure on the governance functions felt light. I was used to appropriately funded teams for areas such as SAI management, complaints, standards and guidelines.*
2. *There was little evidence of a systematic and dynamic flow of cl inical and social care information to SMT on a regular basis. Cl early if there was an issue of concern there was evidence of items being raised. However my concern was that this was based on a 'push' system from the directorates, not from a regular systematic review process.*
3. *The level of data and statistical evidence being brought to the S MT, in respect of quality and safety, was lower that what I was used to in other organisations.*

4.75 Dr John Simpson, Medical Director between 2011 and 2015, gave evidence about how he had 'responsibility without power' for clinical governance and how he did not have a sufficient budget for it[171]. He described the impacts of 'austerity' and the tension between the resources needed for governance and the resources needed to meet targets[172] and the 'relentless pressure to produce so-called … efficiency savings'[173].

4.76 Tracey Boyce, Director of Pharmacy in the Trust at all material times, described the Acute Governance Team as being 'chronically under resourced for the size of the tasks expected of them'[174]. This description was her considered reflection, based on substantial first-hand experience of the relevant governance structures. In particular, she described how, in October 2014, she was asked to manage the Acute Governance Team for a few weeks[175] but that she ended up performing the role (in addition to all of her other responsibilities

[171] TRA-09215 line 6 to TRA-09217 line 2
[172] WIT-25701 TRA-09218-TRA-09219
[173] TRA-09224 line 28-29
[174] WIT-87671 para 43.1.
[175] following the departure of Margaret Marshall to another role.

as Director of Pharmacy) until April 2016[176]. She described how she only had capacity to devote a small portion of time to the role[177] and how, following the appointment of an Acute Governance Lead, in April 2016, Ms Boyce still had to retain a responsibility in this field[178] until mid-2019. Ms Boyce described how she had no job description or letter of appointment for either role and how governance in Acute was largely 'reactive'[179] and that even this aspect was only done 'to a certain level'[180]. In this regard, she gave the example of hundreds of IR1s which, in late 2014, were discovered unopened and which then had to be considered (leading to approximately 20 SAIs)[181]. She described the reason for the under-resourcing of governance in Acute as being a financial one, linked to significant financial constraints on the Trust[182], but reflected that this demonstrated an underappreciation of the importance of governance[183].

4.77 In answer to a s.21 Notice question[184] about 'learning … from a governance perspective' arising from the events with which the Inquiry is concerned, Martina Corrigan has reflected that '*governance departments do not have enough human resources*' and she went on to outline how operational managers, like herself, simply did not have the bandwidth to address complaints or '*to identify trends and patterns in areas such as complaints/SAI/queries …*'[185].

4.78 Though perhaps of greater relevance to the issues around Mr O'Brien that emerged in 2020 or some of the other issues addressed in Chapter 5, it also appears to be the case that clinical audit within the Acute Directorate was inadequate[186].

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[176] See her evidence from TRA-05831 line 16 to TRA-05835 end.
[177] TRA-05842 lines 22-24.
[178] TRA-05846 line3- 05848 line 29. She made it clear that the responsibility was properly that of the Director of Acute Services, then Esther Gishkori.
[179] TRA-05857 line 22.
[180] TRA-05837 line 8-9
[181] WIT-87671 para 43.4 and TRA-05874 line 17 to TRA-05879 line 11.
[182] TRA-05839 line 23 to 05842 line 11.
[183] Ibid.
[184] WIT-26301 Q68.
[185] WIT-26303 to 26304, all sub-para d.
[186] See, e.g., Tracey Boyce's evidence at TRA-05860 from line 11 onwards.

4.79 If governance had been better resourced in the period prior to 2016/2017, when the Aidan O'Brien issues with which this chapter is concerned came to a head, it is reasonable to believe that this may have led to those issues being grappled with at an earlier stage. For example, greater governance scrutiny of the many IR1s that were submitted during 2013 and 2014 regarding missing notes, may have identified the risk of harm associated with this, the core unresolved issue, its link to the related dictation issue, and led to an SEA or SAI process. Given the role that the Patient 10 SAI played in bringing issues to a head and prompting MHPS action in late 2016, it is not unreasonable to believe that earlier SAIs regarding notes and/or dictation would have had similar potential to bring matters to a head. A similar point can reasonably be made in respect of Patient 102 and the failure to screen his IR1 (which involved both missing dictation and non-actioning of MDM outcomes) 'in' for an SEA or SAI in 2016.

(i) Issues at Trust Board Level

4.80 Perhaps the single most pertinent deficit at Board level in respect of the issues that came to a head in 2016/2017 is the following: the lack of curiosity and follow up by the Board once aware of the MHPS process underway in respect of Mr O'Brien in early 2017. This has been acknowledged (e.g., by Ms Mullan[187]). It is not unreasonable to believe that greater curiosity and follow-up by the Board might have had the effect of ensuring that the MHPS process advanced with greater speed as well as ensuring that there was greater oversight of the implementation of the MHPS Case Manager's 3 recommendations.

4.81 In addition, greater curiosity and oversight by the Board on the MHPS issue might also have led the Board to identify that there was a significant governance

[187] Current Board Chair but, at the relevant time, a non-executive director.

deficit in the Acute Directorate given that, what the MHPS process undoubtedly revealed, was that the issues with Mr O'Brien had been of longstanding and had been known about by managers but had persisted without effective resolution for several years prior to the MHPS process.

Important Context

4.82 The Trust submits that it is essential, when considering the issues that came to a head in 2016/2017 and how the Trust did or did not address those issues (both before, and then from, 2016/2017), that the Inquiry does take account of the context in which events occurred, in particular, the points of context highlighted below.

(a) Resource Constraints

4.83 For much of the period with which we are concerned, in particular in the years after 2010, there have been significant constraints in respect of resources. The Inquiry has received substantial and wide-ranging evidence in respect of this issue. For example:

a. John Simpson's evidence has already been described above. He contrasted how a safe system should run at 85% capacity rather than full capacity (as the Trust was doing) (day 71, p31-32) as it allows 'room to manoeuvre to run, running repairs, developments, reflection, deal with peak demand' (p31 line 29 p 32 line 1).

b. Mairead McAlinden (Chief Executive from 2009-2015) described the 'challenges of securing funding for, and then recruiting, the workforce needed to ensure the Trust had sufficient capacity to meet the population demand'[188].

[188] WIT-18615 para 35.1, 3rd bullet.

c. Richard Pengelly (Permanent Secretary in the Department of Health from 2014 to 2022) spoke about a 'resource constrained environment' and 'the paucity of resources that we have'[189].

d. Sharon Gallagher (Chief Executive of HSCB up until March 2022 and thereafter Deputy Secretary in DoH responsible for the SPPG)[190] described how there still is not enough money in the health service here, how we are in a 'demand capacity deficit', how waiting lists in NI are longer than anywhere else in the UK, how from as far back as 2016 it was recognised that more money was required but how it has never arrived, and how it is *'a matter of public record that no service is currently achieving or receiving the funding that's required to meet the deficit'*[191].

4.84 These resource constraints (which continue today[192]) did have an impact upon some of the matters the Inquiry is investigating, as evidenced, for example, by the evidence of Tracey Boyce summarised above.

(b) Recruiting and Retaining Staff and the Capacity:Demand Mismatch

4.85 Related in part to the resource issue, it is clear that the Urology Service in the Trust has experienced significant staffing issues throughout most, if not all, of its existence. Against a backdrop of ever-increasing demand for urological services, particularly in an environment where the elderly comprise an every-greater portion of our population, these staffing difficulties have contributed to what has been described by multiple witnesses as the 'capacity:demand mismatch'[193].

[189] TRA-10368 at lines 8 and 13
[190] WIT-66180 at para 1.
[191] TRA-11015 lines 3-27.
[192] https://www.bbc.co.uk/news/uk-northern-ireland-68889278
[193] Or, to use Inquiry Senior Counsel's more compelling description, 'skyrocketing waiting lists' in Urology – TRA-09231 line 22.

4.86 Detailed written and oral evidence has been provided by multiple witnesses regarding the difficulties the Trust has experienced in securing funding for, and then recruiting, sufficient Urology staff, whether it be Consultant Urologists or Clinical Nurse Specialists. In particular, Mr Young[194], Mr Haynes[195], and Mrs Corrigan[196] have all provided detailed evidence regarding these difficulties. In this regard it is clear that Mr Young and Mrs Corrigan[197] each agree that there have been staffing issues since the very outset of their respective careers in the Urology Service. Mr Haynes spoke of his frustration at the HSCB's director of commissioning implying that a solution to the problem was for the existing staff to work harder[198] and Mrs Corrigan described the 'soul destroying' process of recruiting (much needed) new staff, integrating them into the team, and then seeing them leave after a short time for an opportunity elsewhere[199]. In this regard, it appears that, whilst there have been recruitment and retention issues in Urology (and, indeed, in other specialities) throughout Northern Ireland, they affect local hospitals like Craigavon more severely than regional Centres like Belfast City Hospital. Indeed, the Inquiry has received evidence from a number of consultant urologists[200] who began their consultant career in Craigavon, only to move on to Belfast when a vacancy arose there.

4.87 The resourcing and staffing issues extend well beyond Urology. For example, Helen Forde provided detailed evidence[201] of the pressures resource constraints created in the field of patient records. Issues with oncology and radiology staffing are all well-known to the Inquiry in the context of the Urological Cancer MDM.

(c) Workloads

[194] WIT-51720 to WIT-51733, paras 15, 16 and 17.
[195] WIT-53877 to WIT-53879, para 13.
[196] WIT-26296 to WIT-26199.
[197] WIT-26199 at para 17.1.
[198] WIT-53880 at para 16.1.
[199] WIT-26200 para 18.2.
[200] E.g., Mr Connolly.
[201] TRA-05128 to TRA-05133.

4.88 Related to both of the preceding issues, it is important to bear in mind the workload borne by many of the persons who worked closely with Mr O'Brien at key points in time. For example:

a. In respect of Mr Haynes, the following extracts from his first day giving evidence are illustrative[202]:

> *Q. In terms then of the role of AMD, you were conducting that role in addition to a busy urological practice which had you both in Craigavon, and no doubt the*
> *satellite hospitals of the Southern Trust, and in Belfast once a week, you were Chair of NICaN and you had this AMD role. Thinking about it with some hindsight perhaps, was that a role that you were capable of performing effectively, given your other commitments?*
> *A. I think, as I have included in my statement, I never felt I was in a position to give the time required to be Associate Medical Director, and part of that was driven by the waiting list, the length of time our patients are waiting for urological treatment, so I was always reluctant to pull back from any clinical work because of the direct impact that I could see on patients on a day-to-day basis. The inevitability of that was that I was not giving the time that would have been, I think, required to be AMD.*
> …
> *Q. At one point, it was October 2018, you indicated to the then Director of Acute, Ms. Gishkori, that you were minded to resign your position as Associate Medical Director, citing workload pressures and performing far in excess of what could be considered realistic or sustainable. Do you recall that?*
> *A. Yes, I do.*

The breakdown of his then working days at WIT-163344 is also striking.

[202] TRA-00834 from line 10 and TRA-00835 from line 27.

b. In respect of Mrs Corrigan, her first witness statement[203] contains a detailed account of the pressures of work she was under, including many working days that began between 7.00 and 8.00 am and ended more than 15 hours later.

4.89 This is important context for a number of reasons. First, pressure of work is likely to have had an impact upon the ability of other members of staff to manage Mr O'Brien and his issues or to adopt the type of coordinated approach to his issues that is considered at paragraphs 4.69 – 4.72 above. Second, it nonetheless shows (in the case of colleagues like Mr Haynes) that, in spite of pressures of work, it remained possible to perform duties in respect of matters like triage and dictation.

(d) Mr O'Brien

4.90 There are two points of context related to Mr O'Brien that the Trust submits should also be borne in mind in respect of the issues that came to a head in 2016/2016.

4.91 First, Mr O'Brien was in several ways an outlier. His deficits were not mirrored in the practices of the Trust's other consultant urologists. Stepping back and taking a broader view, the Trust itself did not have any known major issue in these areas. Indeed, in respect of some of these areas the Trust was a high performer. For example, in respect of patient notes Mrs Forde was able to describe how approximately 19,000 charts a month were being 'pulled' from Craigavon Hospital 'library' and how their average availability rate was 99.5%[204], an achievement which the Inquiry itself acknowledged was impressive[205].

[203] From WIT-26310 to WIT-26313, para 70.2, in particular sub-paras a and b.
[204] TRA-05083 lines 8-18.
[205] See Dr Swart's observations at TRA-05160 lines 3-4. See also Katherine Robinson at TRA-05171 lines 9-14.

4.92 Second, following the intervention at the end of 2016 / start of 2017, Mr O'Brien did improve his performance in the 4 areas in question. Whilst his performance remained at times imperfect (e.g., in respect of notes and dictation and particularly when Mrs Corrigan was unavailable to monitor him), and whilst legitimate issues have been exposed in respect of the monitoring of his performance (in particular, the reliability of the data provided in respect of dictation[206]), his improvement does suggest that the intervention in question was at least partially effective at remedying the 4 issues that came to a head in 2016/2017.

Trust Actions to Improve / Restore Public Confidence / Protect Patients

4.93 Consistent with one of its key roles, the Inquiry has sought and received voluminous evidence (in the form of oral testimony, written statements, and disclosure) that speaks to how systems in the Trust have improved so as to reduce the risk of the shortcomings highlighted above recurring.

4.94 Focusing initially on the 4 issues that came to a head in 2016/2017, the following brief summary of some of relevant improvements is offered.

4.95 In respect of referral triage, this is monitored through a monthly 'dashboard' and an escalation process is in place[207]. There are also monthly meetings, attendance at which includes Mr Haynes in his Urology Improvement role, the Head of Service, and the Cancer Service Manager, where issues of triage performance, dictation, and results management are considered.

4.96 In respect of patient notes, with increasing use of electronic records (such as NIECR) there has been a reduced need for hard copy charts[208]. In addition, 'iFIT' is an improved system which will the Trust to charts being outside the

[206] See the evidence of Mr Haynes in this regard.
[207] See Mr Haynes' evidence, e.g., at TRA-11380 line 25 and also TRA-11484 line 22 to TRA-11486 line 21.
[208] See Helen Forde's evidence at TRA-05059 at lines 1-12.

hospital[209]. Of course, the notes issue was linked to the dictation issue and the improvements in respect of dictation referenced below therefore also (albeit indirectly) reduce the chance of notes being removed from the hospital.

4.97 In respect of dictation, digital dictation has, at the very least, made it much easier to monitor what clinic has or has not been dictated[210]. Backlog reports have also improved so that (a) they are now on a shared drive, visible to service administrator, and 'clinics not dictated' is now included as a column[211]; a new report on Patient Centre advises if a clinic has occurred and no dictation done[212]. There is also the monthly dashboard mentioned at paragraph 4.95 above (which also covers dictation), and better guidance has been given to secretarial teams on data they are to record and input to these systems[213].

4.98 In respect of each of the areas of triage and dictation (as well as in respect of results management), Mr Haynes described the positive 'self-policing' phenomenon that accrues from ensuring that there is regular data-sharing (regarding triage, dictation, and results) amongst a team of clinicians[214]. In simple terms: no one wants to be the outlier. Thus, the development of sharing data within the team, even before the added layers of monitoring and escalation, in and of itself reduces the likelihood of deficits of the type experienced by Mr O'Brien from arising in the future.

4.99 Finally in this regard, in respect of private patients the risk of them being unfairly prioritised is much reduced by reason of audits of transfer forms and the fact that the urology waiting list is now pooled and controlled by a scheduler[215].

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[209] See Helen Forde's evidence at TRA-05163 line 19 to TRA-05164 line 14.
[210] See Noreen Elliott's evidence at TRA-06112 lines 6-8.
[211] TRA-06112 lines 3-4.
[212] See the evidence of K Robinson at TRA-05194 line 8 to 05195 line 2; see also TRA-05209 lines 18-28.
[213] See the evidence of Mr Haynes TRA-11485 line 25 to TRA-11486line 21.
[214] Ibid TRA-11381from line 7.
[215] Ibid TRA-11378 from line 23 – TRA-11379 line 20.

4.100 Adopting a broader focus, and cognisant of some of the root causes identified above for the Trust's failings in respect of the issues that came to a head in 2016/2017, the Trust has engaged in multiple improvement exercises across multiple areas. These are considered in part in Chapter 5 (where relevant to the issues that came to a head in 2020), are briefly summarised in Chapter 7, and have been a major theme of the written and oral evidence of multiple witnesses including, in particular, Shane Devlin, Maria O'Kane, Mark Haynes, Martina Corrigan, and Eileen Mullan. They have also featured in the evidence of other witnesses such as Vivienne Toal and Mr O'Brien's fellow urologists, Messrs Young, Glackin, Haynes, O'Donoghue, and Tyson.

4.101 These improvements cover multiple areas including, in particular, under the broad heading of 'clinical and social care governance': improvements in the areas of SAIs, clinical audit, complaints, morbidity and mortality / patient safety, whistleblowing, development of a 'being open' culture, MHPS, medical appraisal, revalidation, and job planning, as well as training and education. They extend from the 'coalface' right up to and including the Trust Board.

4.102 These improvements mean, selecting just some of the shortcomings identified above, that:

a. Medical management has been strengthened significantly[216] with more[217] and better training and greater numbers of medical managers in key roles and with new oversight structures[218], making it less likely that problems of the type exhibited by Mr O'Brien in the fields of referral triage or patient notes would persist today without being effectively addressed by management.

[216] See Mr Wolfe KC's questioning of Maria O'Kane on the improvements in this sphere from TRA-11686 line 20 to TRA-11697 and in particular from TRA-11689 line 25 to TRA-11690 line 8. See also the March 2020 Medical Leadership Review discussed there which can be found beginning at WIT-79127.
[217] E.g., 'managing low level concerns' training – see TRU-305570 to 305573.
[218] Such as the Medical and Dental Oversight Group, ToR for which are at TRU-305992 to 305996.

b. A doctor's appraisal now requires a greater focus on his or her shortcomings[219].

c. In respect of adverse incidents and SAIs, DATIX (and the staff deployed to it) has been enhanced to ensure IR1s are followed through, information is triangulated, and trends are more easily identified, there is now a corporate SAI chair role, SAI information is included in the weekly governance reports, and there is an 'early learning template' to assist clinical teams in learning the lessons of adverse incidents and implementing change before any related SAI process is complete[220].

d. There is now better, more widely delivered training for MHPS[221];

e. The Board is better sighted, and more curious in respect of, MHPS processes and the Trust has a much greater corporate and managerial awareness of the issues and themes arising through MHPS processes[222].

Conclusion

4.103 The Trust submits that all of this means that difficulties of the type that came to a head in 2016/2017, should they arise in any clinician's practice now or in the future, are much more likely to be identified, their potential implications recognised, and effective action taken to address them at an early stage.

[219] See, e.g., Mr Young's evidence on TRA-09718.
[220] See, e.g., Maria O'Kane's evidence from TRA-11778 line 19 to TRA-11780 line 17. See also TRU-306245 to TRU-306250 for an overview of CSCG improvements in place or in progress as of March 2024.
[221] See, e.g., Vivienne Toal's addendum witness statement and her evidence at: TRA-03300 line 27 to TRA-03301 line 8; TRA-03412 line 24 to TRA-03414 line 18; TRA-03429 and TRA-03478 line 24 to TRA-03480 line 24.
[222] See, e.g., Maria O'Kane's evidence at TRA-11662 from line 13. See also examples of the levels of data and data analysis that now exists as part of the oversight of MHPS such as the MHPS 'Trend Analysis' report, the January 2024 version of which is at TRU-305574.

Chapter 5

Issues Which Came to a Head in 2020

Issues

5.1 This chapter covers a number of issues in respect of Mr O'Brien's practice and that of the Trust which came to a head in 2020. Nine patients were identified as potentially suffering harm and their treatment and care were the subject of Serious Adverse Incident ("SAI") review. The Trust has accepted the recommendations of the SAI reports. The Trust recognises the life changing and devastating consequences to the 9 families. The Trust offered an unequivocal apology to all the patients and their families in this review and accepted that the cancer care received was not the cancer care expected.

5.2 Primarily, the issues were as follows:

a. Management with unlicensed anti-androgenic treatment – Bicalutamide;
b. Failure to allocate a Key Worker;
c. Failure to action MDM recommendations.

5.3 The issues identified also included:

a. Informed consent;
b. Follow-up;
c. Actioning of reports;
d. Delay in diagnosis.

5.4 Whilst these issues came to a head in 2020, it is important to note that, as with the issues that came to a head in 2016/2017, some of them were longstanding, with a number arising a considerable time prior to 2020. It is also important to note that,

as with the 2016/2017 issues, some may well be interrelated. For example, Mr. O'Brien's failure to action MDM recommendations, Mr. O'Brien's use of Bicalutamide, and informed consent.

5.5 It is also important to note that these issues arose in the context of multi-disciplinary working and referral.

5.6 These issues engage a number of the Inquiry's Terms of Reference and, in particular, Terms (a), (b), (c), (f), and (g).

(e) Management with unlicensed anti-androgenic treatment – Bicalutamide

5.7 The Trust accepts the review finding that Patient 1 was diagnosed with prostate cancer (Gleason 4+3) on 28 August 2019 and was subsequently started on an anti-androgen therapy as opposed to Androgen Deprivation Therapy (ADT). The Trust accepts that this did not adhere to the Northern Ireland Cancer Network (NICaN) Urology Cancer Guidelines 2016 and that Patient 1's management with unlicensed anti-androgenic treatment (Bicalutamide) delayed definitive treatment.

5.8 The Trust accepts the review finding that Patient 9 was diagnosed with prostate cancer and was commenced on Bicalutamide 50 mgs. The Trust accepts that Bicalutamide 50 mgs is currently only indicated as a preliminary anti-flare agent or in combination with an LHRH analogue and is only prescribed before definitive hormonal treatment.

5.9 In relation to Mr. O'Brien, we now know from the Bicalutamide Audit[223] in relation to data provided for patients who received a prescription of Bicalutamide (any dose) between March and August 2020 that, in relation to Low Dose Bicalutamide Prescribing (50 mg), a total of 466 patients were identified from the Western, Northern, and Southern Local Commissioning Group areas as having received a

[223] As referred to by Dr. O'Kane at WIT-20089 in response to Section 21 Notice 1a of 2022.

prescription for Bicalutamide 50mg. We now know that 34 of these patients were identified as being on the incorrect treatment as determined by the clinical indications used and that 2 patients had been commenced on the medication by services outside of NI Urology (1 by a GP and 1 in South Africa in 2005 and continued following their move to NI). We now know that, of the remaining 32 patients, 31 had been commenced on the low dose Bicalutamide by Mr O'Brien. We now know that 1 patient had been correctly commenced by Mr O'Brien on combined androgen blockade (LHRHa and 50mg bicalutamide) and had been switched to intermittent treatment by another Southern Trust Locum Consultant Urologist on review but that only the LHRHa (rather than both treatments) had been stopped at the time of this switch and that this patient has since been reviewed by the oncology team and the Bicalutamide discontinued. We now know that, from the remaining 31 patients, 2 were subjects of the 2020 SAIs – Patient 6 and Patient 4 - and that, of the 53 patients screened in for SCRR by 15 April 2022, 32 were on low dose Bicalutamide i.e., the same 32 patients.

5.10 In relation to the manner in which Mr. O'Brien prescribed Bicalutamide, Mr. O'Brien has informed the Inquiry that at no point during his years of clinical practice was a concern raised with him and that it was well known within the urology service and within the oncology service how Bicalutamide was being prescribed. Mr. O'Brien alleges that the first time a concern was raised was on 25th October 2020 when the Directorate of Legal Services wrote to his solicitors.[224]

5.11 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of patient management with unlicensed anti-androgenic treatment – Bicalutamide – rests. Is it with Mr. O'Brien or with the Trust or with both of them? In the event that it is deemed necessary to decide this issue, then the Inquiry will have to consider -

[224] WIT-82585 at paragraph 544. Though see further in this regard some of the evidence considered from para 5.38 below.

a. whether Mr. O'Brien ought reasonably to have changed his approach to Bicalutamide;
b. whether Mr. O'Brien ought to have made it clear to the Trust how he used Bicalutamide;
c. what did the Trust know in relation to Mr. O'Brien's use of Bicalutamide;
d. what steps the Trust should have taken in relation to Mr. O'Brien's use of Bicalutamide.

(f) Failure to allocate a Key Worker

5.12 All 9 patients reviewed did not have a Key Worker allocated to their care.

5.13 The NICaN Urology Cancer Clinical Guidelines 2016 state[225] that all patients should be assigned a key worker (usually a CNS) at the time of diagnosis, and appropriate arrangements should be in place to facilitate easy access to the key worker during working hours and an appropriate source of advice in his/her absence, as per National Cancer Peer Review standards.

5.14 The Trust's Urology Cancer MDT Operational Policy 2017[226] states:

"The identification of the Key Worker(s) will be the responsibility of the designated MDT Core Nurse Member.

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 Record of Patient Management. In the majority of cases, the Key Worker will be a Urology Clinical Nurse Specialist (Band 7) or Practitioner (Band 6)…".

[225] At WIT-85652.
[226] At WIT-84545 at paragraph 3.1. As did the Trust's previous Operating Policy Urology Cancer Service April 2015 (updated September 2016) at AOB-77999 at paragraph 7.1.

The Trust's Operating Policy Urology Cancer Service April 2015[227] states that the Responsibilities of the Core Nurse Member include:

"Acting as the key worker or be responsible for nominating the key workers for patients under care of the MDT, dealing with the team in line with the Trust Key Worker Policy."

5.15 Whilst the Review Team found there were no resources for a Urology Cancer Nurse Specialist to attend any outreach clinics, the Trust accepts that their contact numbers should have been provided to patients.

5.16 The Trust accepts that the allocation of a Urology Cancer Nurse Specialist as a Key Worker would support the patient on their journey as well as working collaboratively with the multi-disciplinary team to ensure key actions take place. The Inquiry has heard evidence from Kate O'Neill[228] and from Mr. Gilbert[229] that the purpose of the cancer nurse is 'continuity', which was not afforded to the 9 patients.

5.17 In relation to the allocation of a Key Worker, Mr. O'Brien has asserted that the first time he became aware of concerns in relation to an alleged failure to provide patients with access to CNSs was when he had sight of the SAI reports, that he was, for example, not the MDT Clinical Lead when Patient 1 received his diagnosis, and that it is untrue that he excluded all CNSs from the care of patients at clinics.[230] Mr. O'Brien has asserted that Kate O'Neill ensured that all patients were reviewed by consultants following MDM discussion and that, as the MDT Core Nurse Member, Kate O'Neill was responsible for ensuring that all newly diagnosed cancer patients had access to a CNS.[231]

[227] Updated in September 2016 at AOB-77998 at paragraph 6.1
[228] TRA-12104.
[229] TRA-01168.
[230] WIT-82583 at paragraph 537.
[231] WIT-82488 at paragraph 250.

5.18 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of the failure to allocate a Key Worker rests. Is it with Mr. O'Brien or with the Trust or with both of them? In the event that it is deemed necessary to decide this issue, then the Inquiry will have to consider –

a. what was Mr. O'Brien's approach to the allocation of a Key Worker;
b. did Mr. O'Brien exclude Cancer Nurse Specialists from the care of his patients at clinics;
c. what was known, or ought to have been known, by the Trust regarding whether Mr. O'Brien's patients were being allocated a Key Worker;
d. what steps the Trust should have taken in relation to ascertaining Mr. O'Brien's use of Key Workers.

(c) Failure to action MDM recommendations

5.19 The Trust accepts that recommendations made by the MDM were not actioned in the case of Patient 1. Patient 1 was discussed at MDM on 31 October 2019 and a recommendation to commence an LHRH analogue and to refer for an opinion from a clinical oncologist regarding EBRT was agreed. This was not actioned and Patient 1 was subsequently commenced on Bicalutamide 50 mgs once daily.

5.20 The Trust accepts that, in the case of Patient 4, the patient was discussed at MDM on 25 July 2019 when the recommendation to commence an LHRH analogue was made. Mr. O'Brien prescribed Bicalutamide (50 mgs once daily). The Trust accepts that the patient was started on an inadequate dose of a drug (Bicalutamide) which was not licensed for the treatment of prostate cancer and was contrary to the recommendations of the MDM. The Trust accepts that Patient 4 should have been referred to an oncologist to allow consideration of other treatment options. Patient 4's case was not brought back to MDM for re-discussion and multi-disciplinary input despite disease progression and the Trust accepts that, as a result, Patient 4's care was not co-ordinated with the palliative care team.

5.21 In the case of Patient 2, the Trust accepts that the patient was diagnosed with testicular cancer, that Patient 2's case was discussed at the Urology MDM on 25 July 2019 and that the recommendation was for Mr. O'Brien to review the patient and to refer him to the regional testicular cancer oncology service. The Trust accepts that the patient was reviewed on 23 August 2019 and the referral to oncology was made on 25 September 2019. The Trust accepts that a 2 month delay in referral to a medical oncologist complicated treatment choices.

5.22 The Trust accepts that, in the case of Patient 6, the patient presented with possible prostate cancer and was commenced on Bicalutamide 50 mgs. The Trust accepts that a diagnosis of prostate cancer was confirmed by biopsy in July 2019. The Trust accepts that Patient 6 was discussed at MDM on 8 August 2019 and that the plan was that Mr. O'Brien review the patient and discuss management with curative intent or surveillance. The Trust accepts that the Review Team found that, when Patient 6 was reviewed by a locum consultant in October 2020, Patient 6 did not recall any conversation about the options of external beam radiotherapy (EBRT) as a radical treatment and active surveillance.

5.23 The Review team found that in the case of Patient 7 an appropriate referral to the Regional Small Renal Mass MDM was omitted despite the MDM's recommendation on at least 2 occasions. The referral was not actioned by Mr. O'Brien.

5.24 In the case of Patient 3, who was diagnosed with penile cancer, the treatment provided was found by the Review Team to be contrary to the NICaN Urology Cancer Clinical Guidelines (2016) for Penile Cancer which state that local care is restricted to diagnosis and that all cases of penile cancer should be discussed by the supra-network MDT as soon as the diagnosis is confirmed by biopsy. However, a regional Penile Cancer Pathway was only agreed in January 2020 and Patient 3 was referred to the Regional Penile Cancer Service in February 2020.[232] The Review

[232] The Trust's Urology Cancer Services Operational Policy 2020 can be found at TRU-98103 and in particular at TRU-98113 in relation to penile cancer.

Team found that a referral to a specialist with appropriate experience should have been pursued. The patient was discussed at a number of MDMs between 18 April 2019 and 6 February 2020.

5.25 In relation to MDMs and their outcomes Mr. O'Brien has made a number of points in his witness statement[233] including:

a. the language used in expressing the agreed recommendation is of critical importance;
b. that he considered MDMs to have been effective within the constraints placed upon them;
c. the focus of MDMs was always on recommending the right approach for each patient;
d. that he never felt that anyone felt inhibited from expressing their views;
e. the decisions made at MDM were the agreed recommendations which would be considered and discussed with the patient at review;
f. the agreed recommendations could not dictate the next steps in all cases;
g. each consultant would have been responsible for considering, discussing, and informing the patients of the recommendations agreed following MDM discussion;
h. other members were not subsequently informed of a deviation from an agreed recommendation as there was an understanding that the clinician and patient had the right, and indeed responsibility, to deviate from the agreed recommendation if the latter was declined by the patient, or if the recommendation was concluded by the clinician and patient to be inappropriate.

5.26 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of any failure to action MDM recommendations rests. Is it

[233] WIT-82506 at paragraphs 307, 309, 310, 312 and 314.

with Mr. O'Brien or with the Trust or with both of them? In the event that it is deemed necessary to decide this issue, then the Inquiry will have to consider –

a. whether there were any reasonable reasons for not actioning MDM recommendations;
b. whether such reasons were discussed and recorded in patients' notes and records;
c. whether such reasons ought to have been discussed and recorded in patients' notes and records;
d. whether any failure to action MDM recommendations ought to have been brought back to MDM;
e. whether any other reasons, such as disease progression ought to have resulted in patients being brought back to MDM.

(d) Informed Consent

5.27 The review team noted that there was no discussion with Patient 1 that the treatment given was at variance with regionally recommended practice and that there was no evidence of informed consent. Likewise, the review team noted that Patient 9 was unaware that his care was at variance with regionally recommended best practice and that there was no evidence of informed consent. In the case of Patient 4, the review team found that there was no evidence in the medical records or from speaking with the patient's family of informed consent.

5.28 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of any failure to obtain informed consent rests. Is it with Mr. O'Brien or with the Trust or with both of them? In the event that it is deemed necessary to decide this issue, then the Inquiry will have to consider –

a. whether there is any evidence of informed consent;
b. whether discussions in relation to consent ought to have been recorded in patients' notes and records;

c. what would such recording of consent have entailed.

(e) Follow-up

5.29 Patient 9 was lost to follow-up after an appointment in July 2019. A routine review for September 2019 did not happen. Patient 5 had follow-up CT scans performed in June 2019 with a planned follow-up in July 2019. This did not happen. The Review team found that Patient 5 appeared to be lost to review. A repeat CT scan was arranged to be performed on 17 December 2019 with a plan for review in January 2020. This did not happen.

5.30 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of any failure to follow up rests. Is it with Mr. O'Brien or with the Trust or with both of them? In the event that it is deemed necessary to decide this issue, then the Inquiry will have to consider –

a. were there any reasons why follow up reviews did not occur;
b. were review backlogs known about;
c. were there any alternatives to planned follow up such as DARO.

(f) Actioning of reports.

5.31 The Review team found that Patient 5 had a CT scan report available on 11 January 2020 which showed a possible sclerotic metastasis in a vertebral body which had not been present on previous CT scans and that this report was not actioned until July 2020 when a new consultant reviewed the patient's care. Patient 5 was subsequently diagnosed with metastatic prostate cancer.

5.32 The Review team found that in the case of Patient 7 a CT scan showed a further increase in the size of a lesion to 3.5 cm but no action was taken.

5.33 In the case of Patient 8, the patient underwent a TURP on 29 January 2020 and histology confirmed a prostatic adenocarcinoma. Mr. O'Brien planned to review the patient in April 2020 but the patient was not seen until August 2020 at an appointment arranged by another doctor when the histology was explained as an incidental finding that required continuing surveillance with an up to date serum PSA and a prostate MRI scan.

5.34 In relation to investigation results Mr. O'Brien has set out in his witness statement that he believes that there is a place for both monitoring and communication of results and reports by staff provided with the time to do so, and review of the patient as well as their pathology.[234]

5.35 The Inquiry will have to decide whether it is necessary to determine where responsibility in respect of any failure to action reports rests. Is it with Mr. O'Brien or with the Trust or with both of them? In the event that it is deemed necessary to decide this issue, then the Inquiry will have to consider –

a. whether reports should be actioned in a timely basis;
b. if so, by whom;
c. whether it is reasonable not to action reports and to plan a review in the alternative;
d. the history of this issue.

Important Points to Acknowledge Regarding the 2020 Issues

5.36 The following points, many of which are reflective of failings on the part of the Trust and its systems, need to be acknowledged in respect of the 2020 issues summarised above:

[234] WIT-82540 at paragraph 398.

a. Five out of the 9 patients in the review experienced significant delay in the diagnosis of their cancer.

b. Three of the 9 patients were said to have met one of their 31/62 day targets:

    a. Patient 8 was said to have met his diagnostic target for 31 days despite his tissue cancer diagnosis being missed and the patient suffering an 8 month delay;
    b. Patient 3 was said to have met his 62 day target but was referred down a pathway that did not meet the NICaN Urology Cancer Guidelines 2016. (A regional Penile Cancer Pathway was only agreed in January 2020).
    c. Patient 9 was said to have met his diagnostic target of 31 days despite having a delay from initial presentation of 15 months.

c. The NICaN Urology Cancer Guidelines (2016) had been signed off by the SHSCT Urology Multi-Disciplinary Meeting (MDM) as its protocols for Cancer Peer Review in 2017.

d. Mr O'Brien was Clinical Lead of the Urology Clinical Reference Group from January 2013 – January 2016.[235]

e. Bicalutamide (50 mg) is currently only indicated before (as an anti-flare agent) or in combination with an LHRH analogue.

f. The NICaN Urology Cancer Clinical Guidelines 2016 state that all patients should be assigned a key worker (usually a CNS) at the time of diagnosis.[236]

g. The Trust's Urology Cancer MDT Operational Policy 2017 states that the identification of a Key Worker will be the responsibility of the designated MDT

[235] TRU-99723
[236] WIT-85652.

Core Nurse Member but that 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[237].

h. The SHSCT NICaN MDT Self-Assessment Report Proforma 2017[238] stated:

"Progress is ongoing in relation to the full implementation of the Key Worker, Holistic Needs Assessments, Communication and ensuring all patients are offered a permanent record of Patient Management. With the appointment of two more nurses to the Thorndale Unit and clerical staff, all newly diagnosed patients have a Key Worker appointed, a Holistic Needs Assessment conducted, adequate communication and information, advice and support given and all recorded in a Permanent Record of Patient Management which will be shared and filed in a timely manner".

i. There were no resources for a Urology Nurse Specialist to attend outreach clinics.

j. The use of a Cancer Nurse Specialist was common for all other urologists in the Trust's Urology Multi-Disciplinary team.

k. During MDM a quorum was not regularly achieved. For example, in the case of Patient 1 an oncologist had been absent.

l. There was limited oncology presence within the Urology MDT. For example, on the date Patient 2 was discussed there was no oncologist present.

m. The vast majority of Urology MDMs were not quorate due to the absence of an oncologist. For example, in 2019 the MDMs were 0% quorate.

[237] WIT-84545 at paragraph 3.1 and at paragraph 5.14 herein.
[238] WIT-84607.

n. Whilst it was the primary responsibility of the consultant in charge to make the referral to oncology, a failsafe mechanism to ensure agreed actions took place such as an MDM administration tracker, was not in place.

(a) Longstanding Issues

5.37 Members of the MDT may not have been aware of, for example, MDM recommendations not being actioned in the case of Patient 1 but similar practice on the part of Mr O'Brien in prescribing an anti-androgen had been challenged or arisen before. For example:

i. On 20th November 2014 Mr. Darren Mitchell at the BHSCT e-mailed[239] Mr. O'Brien indicating *inter alia* that:

"The NICAN hormone protocol (in process) would be useful in standardising our therapy across the region but Bicalutamide 50mg is not licensed for monotherapy use and will not be recommended in the protocol other than with the licensed context for the management of flare with LHRHa."

ii. Prof. O'Sullivan indicated[240] that he challenged Mr. O'Brien on a number of occasions in clinic letters (in respect of, he estimated, at least 3 patients), indicating something along the lines of '*the patient was receiving a sub-optimal dose of bicalutamide and I have now changed to the evidence based dose 150 mg daily or to another form of hormone therapy e.g. a Lutenising Hormone releasing hormone agonist*'.

(b) Known Issues

5.38 In relation to what the Trust knew about Mr. O'Brien's use of Bicalutamide and what steps the Trust should have taken in relation to Mr. O'Brien's use of

[239] AOB-71990.
[240] WIT-96648 at paragraph 1(iv).

Bicalutamide, the following are some examples in relation to what does or does not appear to have been known regarding the issue of Bicalutamide:

a. Mr. Suresh indicated in his witness statement that he recalled a patient of Mr. O'Brien's being on unconventional treatment for prostate cancer – being treated with low dose Bicalutamide - and to adding this patient to the agenda of the next Urology MDM. Mr. Suresh indicated that the consensus was that treatment with long term low dose bicalutamide was unconventional and that Mr O'Brien was to review the patient and to discuss the appropriate options with the patient. Mr. Suresh could only recall that Mr. O'Brien was in attendance at the MDM and not the entire attendance[241].

b. Mr. Suresh referred to the patient being discussed at MDM in his evidence on Day 66[242]:

> *"Q. And the Bicalutamide 50 monotherapy issue, do you remember if it was you that raised that?*
> *A. That's right. The reason for discussion, obviously, when it comes up suddenly, then, yeah, I did raise this issue. Yes."*

c. Mr. Glackin commented on the issue of Bicalutamide being discussed at MDM in his evidence to the Inquiry on Day 63[243]. Mr. Glackin indicated that his only knowledge of Bicalutamide being discussed was at one MDT meeting when the discussion was that the patient needs to start ADT and to Mr. O'Brien nonchalantly saying *"50mg?"* and to those present saying, *"I wouldn't do that, I would give him an LHRH analogue."* Mr. Glackin did not know for sure whether the event he referred to was the same event to which Mr. Suresh had referred. Mr. Glackin went on to make the following point:

[241] WIT-50363 at paragraphs 49.3 and 49.4.
[242] TRA- 08636-08641
[243] TRA-08269-08270

"Now, the point that I would take away from that is, if you're in a meeting with your colleagues and they challenge you about the use of a particular medicine and they say that they would do something different, then I think you have to accept that perhaps what they're saying might be right, you have to reflect on what they've said to you, and you would then, you know, if it was me and it was a learning point, I'd go off and I'd read the documents and I'd reassure myself that what I was doing was correct or otherwise and I'd act accordingly. So, that's where -- that's the only time I recall that issue being discussed."

d. Patient 139[244], referred to in Mr. Glackin's evidence to the Inquiry on Day 63[245], had been placed on low dose 50mg of Bicalutamide daily with Tamoxifen 10mg daily by Mr. O'Brien in 2010. Mr. Glackin saw this patient on review on 22 February 2016 aged 79.

e. Mr. Haynes in his witness statement[246] indicates that, in 2020, he started to become aware of a pattern of treatment with regard to prostate cancer with patients being on a low dose of Bicalutamide and to one patient during a week as Urologist of the Week in February 2020 which, at the time, he assumed was an error.

f. Mr. Haynes was asked on Day 88[247] about Dr. Mitchell[248] saying that he had spoken to Mr. Haynes informally as he attended the regional urology MDM in 2019 and to having subsequently e-mailed Mr. Haynes about the off licence prescribing of Bicalutamide 50 in 2019 and 2020. Mr. Haynes indicated:

"I recall having a conversation with Dr. Mitchell about Bicalutamide. I can't remember the specifics of the date but it's recorded in Darren's email that we discussed on that date, and he followed that up with an email."

[244] AOB-82836.
[245] Commencing at TRA-08279
[246] WIT-53934
[247] TRA-11418
[248] WIT-96668.

5.39 The Inquiry has received evidence, both oral and written in relation to the issue of Key Worker allocation, some of which has been conflicting at times. In relation to what the Trust knew or ought to have known in relation to the allocation of a Key Worker to Mr. O'Brien's patients the following are some examples in relation to what was or what was not known regarding this issue and when:

a. Kate O'Neill in her witness statement[249] indicates:

i. The first time she can recall being present with consultants during results consultations was when the Urology MDT was established in 2010.

ii. As appointment to consultant roles increased over the years and as clinical activity increased her availability to every consultant clinic became limited.

iii. One-stop clinics limited her availability further.

iv. At the start of any results clinic it would have been her practice to inform the consultant of her availability.

v. Where possible, she would be available during the Consultant/patient consultation and was present throughout the consultation. More often (though not always) she was invited in at the end of the encounter to provide information, support and a contact number. This was not unique to any single Consultant.

vi. At no time was there an expectation that she would attend any satellite sites where cancer diagnosis may also have been discussed.

vii. Consultants managed such challenges differently referring to Mr. Glackin, Mr. Haynes, and Mr. O'Brien.

viii. At no stage did any of the nursing team within the Thorndale Unit recognise or raise a concern that CNSs were not invited to be present at uro-oncology consultations in general or by any particular Consultant.

[249] WIT-80961 at paragraphs 50.3 to 50.5.

b. Mr. Glackin indicated in his evidence to the Inquiry on Day 67 at TRA- 08737:

"So there wasn't any facility for us to bring our CNS team to Southwest Acute, largely because of staffing issues. Secondarily, until very recently the CNS activity was all delivered in Craigavon. It wouldn't have followed consultants to Banbridge, for instance, or to Armagh, or South Tyrone for that matter. So, you know, we really only had CNS capability in Craigavon until very very recently."

c. Kate O'Neill also indicates in her witness statement[250] that:

i. She never felt that Mr O'Brien prevented/obstructed CNS involvement in his clinic, nor did her colleague Jenny McMahon or Staff Nurse Dolores Campbell, who would both have deputised for her on occasions, ever raise this as an issue.

ii. Her job plan meant that she was generally available for uro-oncology clinics with Mr Glackin, Mr O'Donoghue, and Mr Haynes but to a lesser extent with Mr O'Brien and Mr Young.

iii. She does recall Mr O'Brien introducing her to patients to either plan prostate biopsy for them, engage or signpost to other services (such as Palliative Care Team), or for the provision of information, and that on those occasions she felt that she was able to offer information, support, and a contact number.

iv. In her absence for whatever reason, in the majority of situations, a colleague would have been available to support the clinic where necessary to provide documentation/contact numbers and at no time did they ever raise a concern in relation to this activity.

d. Kate O'Neill indicates in her witness statement[251] in relation to the specific issue of access to a CNS that:

[250] WIT-80968 at paragraph 54.4.
[251] WIT-80970

i. she was not aware of this issue until the report of the SAIs was made available in March 2021;
ii. she provided e-mail evidence dated 18 May 2015 entitled *'Involvement of Keyworker and provision of patient information'* and a further email dated 16 June 2017 entitled *'Issue raised at the Thorndale Unit Meeting today'*, asking all Consultant colleagues that all patients who require the input of a keyworker would be offered the opportunity to meet with the appropriate member of staff on the day; and
iii. had she known that this was as issue, she would have engaged with the HoS, Consultants, and nursing colleagues in order to seek a solution, to ensure that a CNS, where possible, was allocated to every uro-oncology results clinic.

e. The Inquiry has received notes of the meeting between Dr. Hughes, Martina Corrigan, and Patricia Kingsnorth dated 18th January 2021[252] which recorded that Martina Corrigan confirmed that Mr O'Brien never involved a specialist nurse which had always been the case from when she had started in the Trust and that Martina Corrigan confirmed that, during the time she had worked in the Trust, Mr O'Brien never recognised the role of the Clinical Nurse Specialists. Further, that Martina Corrigan confirmed that Mr. O'Brien never involved them in his oncology clinics and was then aware that some of the Clinical Nurse Specialists would have asked to be at the clinics but Mr O'Brien never included them. It was noted that Martina Corrigan advised that two of the Clinical Nurse Specialists did report that they did regularly challenge Mr O'Brien and asked him if he needed them to be in the clinic to assist with the follow-up of the patients but it got to the stage where staff were getting worn down by no action and they gave up asking as they knew that he wouldn't change.

[252] WIT-84355.

f. Kate O'Neill indicated in her evidence to the Inquiry on Day 42[253], when asked about the above notes of the meeting:

> *"Q…Do you recognise any of those complaints as coming from you in that paragraph.*
> *A. That would not be the experience that I had."*

g. Kate O'Neill was asked about Martina Corrigan's reply to a Section 21 Notice[254] in her evidence to the Inquiry on Day 42[255]. Kate O'Neill was taken to Martina Corrigan's response at paragraph 1.1, including where Mrs Corrigan indicated that it was her impression that Mr. O'Brien didn't recognise the potential value of having a nurse with him at clinics generally and that she personally felt that Mr. O'Brien didn't value the role that the CNSs held, which was an impression that had developed over time between approximately 2009 and 2015. Kate O'Neill indicated that her impression would be that Mr. O'Brien engaged with the two CNSs (as they were at that time) on a regular basis. Paragraph 1.4 of Martina Corrigan's Section 21 response was also read where Martina Corrigan emphasised that she did not ever recall during any of her conversations with nurses in the unit any specific mention of Oncology clinics or the cancer key worker role when they were mentioning Mr. O'Brien's non-use of nurses and that it was usually couched in much more general terms.

h. Relevant parts of Martina Corrigan's oral evidence to the Inquiry can be found on Day 57[256]. Martina Corrigan was referred to the Key Worker issue, to her original Section 21 response[257] concerning the timing of when she had been made aware of the allegation that Mr. O'Brien didn't allow access to Key Workers for oncology patients being in November 2020, to her interview by Dr. Hughes on 18th January 2021[258], and to a subsequent Section 21 Notice to ask

[253] TRA- 12076
[254] WIT-94939
[255] TRA- 12076-12081
[256] TRA-07353-07369
[257] At WIT-26267
[258] At WIT-84355/6

for clarity and her explanation for some of the issues. Her statement in response to that Section 21 Notice was read from[259] and paragraphs 1.2 to 1.5, 1.6, 2.1, 2.2, 2.4, 4.1, 4.2 , 6, 7, 8, 8.2 opened. Mrs Corrigan clarified her understanding or recollection of what was said at the meeting with Dr. Hughes. At paragraph 5.2.1 at WIT-94947, Martina Corrigan indicates as follows:

> *"I became specifically and acutely aware that Mr. O'Brien did not permit the Clinical Nurse Specialist to provide support as key worker to his oncology patients. I only became specifically and acutely aware of this from approximately Autumn 2020 from the investigations into the most recent SAI patients. I believe that this cancer key worker issue was never raised with me as a specific concern and as only oncology multidisciplinary meetings are part of the Head of Oncology Services remit, I was never involved in these. However, as mentioned in my response to Section 21 Notice No. 7 of 2023 at Question 1 thereof, the broad issue of Mr. O'Brien's non-use of nurses and Clinical Nurse Specialists was mentioned to me a number of times by nurses in the years prior to 2020 and I ought, upon reflection, to have appreciated the potential cancer key worker issue as a result."*

i. The Inquiry has received notes of the meeting between Dr. Hughes and the Acute Governance Urology MDM dated 18th February 2021[260] which record that Mr. Glackin confirmed that nurses were excluded from Mr. O'Brien's practice and advised that management were aware of no nurses.

j. Mr. Glackin indicated to the Inquiry on Day 67[261]:

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

[259] WIT-94940
[260] WIT-84347.
[261] TRA- 08751-08752

that it appeared that Mr. O'Brien was the only person who hadn't been using CNSs in a routine manner."

k. Kate O'Neill indicated to the Inquiry on Day 42[262]:

"Q. And then the paragraph that we can see on the screen beginning "Dr. Hughes confirmed" just before that Mr Glackin advised he was chair of Urology MDM he took over from Mr. O'Brien. He confirmed nurses were excluded from Mr. O'Brien's practice.
"Was that the first time you had heard that from Mr. Glackin?"
A. Yes.
Q. And was that your experience?
A. That wasn't my experience."

l. The Inquiry has received notes of the meeting between the Cancer Nurse Specialists Team and Dr. Hughes and Patricia Kingsnorth dated 22nd February 2021[263] which recorded that Leanne McCourt didn't feel that Mr. O'Brien valued the Nurse Specialists and that she recalled him asking in the kitchen what the role of the Nurse Specialists was. The meeting notes recorded that Jenny McMahon advised that she was not sure why Mr. O'Brien didn't invite CNSs into the room and that Mr. O'Brien spoke very highly of CNSs and that Jenny McMahon made the point that Mr. O'Brien had review oncology on a Friday and that she wasn't asked to attend. It was noted that Jenny McMahon advised that nurse specialists were not invited to attend appointments (Mr. O'Brien's) but felt that Mr. O'Brien was very supportive of Nurse Specialists. Jason Young advised that he may not have been in the room but would have been introduced after.

m. Leanne McCourt gave evidence to the Inquiry on Day 43[264] and indicated that:

[262] TRA-12070
[263] WIT-84357.
[264] TRA-05461-05462

i. she had no experience or knowledge of Mr. O'Brien not recognising or preventing the involvement of clinical nurse specialists or key workers;
ii. she felt supported by Mr. O'Brien;
iii. she did not recognise staff feeling worn down by no action to address Mr. O'Brien's issues;
iv. she didn't feel that challenging Mr. O'Brien regarding being available at clinics or having to make her presence felt was an issue;
v. she could not recall speaking to Martina Corrigan or Ronan Carroll about any issues regarding Mr. O'Brien;
vi. she did not express being frightened of Mr. O'Brien;
vii. she felt that she could approach Mr. O'Brien or confront him if the need arose.

n. Leanne McCourt's evidence to the Inquiry on Day 43[265], when asked '*what did you say and what message were you trying to impart to Dr. Hughes?',* was that she would have said (something) very similar to what she said in her Section 21, that Mr. O'Brien would have been very particular in his use of language and words, and that she thought it was just the "key worker" word that he didn't like. Leanne McCourt indicated that she didn't for one minute think that Mr. O'Brien didn't understand what a key worker was, or indeed what a CNS was and what her role was and that she believed that Mr. O'Brien did value that role.

o. Mr. Glackin[266] indicated that he became aware in 2020, through discussion with Kate O'Neill and Leanne McCourt, that they felt excluded from Mr. O'Brien's outpatient clinics and were not present to advocate on behalf of patients.

[265] TRA-05468
[266] WIT-42327 at paragraph 56.5 in response to Section 21 Notice No. 57 of 2022.

p. Kate O'Neill indicated in her evidence to the Inquiry on Day 42[267], when addressing paragraph 5.2[268] of Martina Corrigan's Section 21 response referenced at sub-paragraph h above, that:

i. between 2010, when MDTs started, right through to when the appointments were finally in place in 2020, the need for additional CNSs to perform the role of key worker and holistic needs were discussed at meetings with the Head of Service and the lead nurse on a repetitive and exhaustive manner;
ii. the standards set out in the operational policy couldn't be achieved without additional resources.;
iii. from about 2015 onwards (from peer review on) an A4 page would have been completed stating the information that was provided to the patient, the key worker name, and that the patient was provided with a contact number, which would have been put inside the patient's notes and that it would have required going to the patient's notes to see it;
iv. there was no audit process in place; and
v. after peer review, and following engagement with Mary Haughey, audit did occur in the autumn into winter of 2016, the findings were presented to the MDT team in March of 2017, and that there was agreement from that point forward that this should be completed at every key worker encounter.

q. Patricia Thompson, having referred to Leanne McCourt, Jason Young, and Dolores Campbell, indicated in her evidence to the Inquiry on Day 60[269], when questioned about whether she would have asked them whether Mr. O'Brien brought a nurse in or stopped them coming in, the following:

[267] TRA-12088
[268] WIT-94947
[269] TRA-07726 lines 12-23.

i. that she asked would Mr. O'Brien have brought nurses in but wouldn't have said 'did he stop nurses';

ii. that she would have asked did Mr. O'Brien bring nurses in or invite them in; and

iii. that they (Leanne, Jason, and Dolores) would have said that no, they wouldn't have been brought in to the consultation.

r. A final piece in the contradictory and somewhat confused evidential jigsaw on the issue of use or non-use of Key Workers is the Chair's questioning of Leanne McCourt on Day 43[270] where Leanne McCourt was asked about the potential tension between her witness statement to the effect that she was taken aback at Mr. O'Brien's condescending tone when he questioned her about the key worker role and her oral evidence to the effect that she rejected any suggestion that she had told Dr. Hughes that she felt that Mr. O'Brien didn't value nurse specialists.

5.40 In relation to the issue of failing to action MDM recommendations the following are some examples in relation to what was known regarding this issue:

a. Patient 102 (who has been mentioned briefly in Chapter 4) was discussed at Urology MDM on 20 November 2014 and the recorded outcome was that the patient's re-staging MRI scan had shown organ confined prostate cancer and that the patient was for direct referral to Dr. H for radical radiotherapy. The patient was reviewed by Mr. O'Brien on 28 November 2014 and no correspondence was created from this appointment. A referral letter received from the patient's GP in October 2015 stated that the patient had not received any appointments from oncology. The IR1 form[271] and the related oral evidence of Mr Haynes and David Cardwell[272] suggests that screening was not performed to decide whether the incident should be an SAI or otherwise.

[270] Commencing at TRA- 05504 and running to TRA- 05508.
[271] Which can be found at WIT-54874 – WIT-54881.
[272] Referred to in Chapter 4.

b. Patient 137's case was one where the recommendation was to refer the patient for an endocrinology opinion or review. The incident report[273] summarised matters as follows:

> "*Patient discussed at MDM 12th January. Outcome to be referred to endocrine MDM. Unfortunately this did not happen. Further GP referral - five months later, 12th May 2017 - brought this to my attention...*" *(Mr. Haynes).*

c. Mr. O'Donoghue indicates[274] that he submitted an IR1 on 3rd October 2019 when he was chairing the Uro-oncology MDM in relation to a patient of Mr O'Brien who had not been referred for a kidney biopsy as per MDM advice dated 27th June 2019.

(c) Failure to Address Effectively or at all

5.41 The Inquiry may consider that there was a failure to recognise and address issues such as Bicalutamide, Key Worker allocation, and the actioning of MDM recommendations effectively or at all. In relation to the examples of what was and what was not known regarding the issues of Bicalutamide, Key Worker allocation, and the actioning of MDM recommendations the Trust would make the following points:

5.42 Bicalutamide:

a. In relation to the patient which concerned Mr. Suresh regarding Bicalutamide 50mg as a monotherapy, Mr. Suresh's evidence on Day 66 was[275], having been asked did people say, "*Well, I have done that*", or "*I've seen that*", or "*I've never heard of that*", *was there any discussion around that?:*

[273] WIT-100386
[274] WIT-50543 in Mr. O'Donoghue's response to Section 21 Notice No. 62 of 2022 at paragraph 49.1
[275] TRA- 08638

"A. No, the discussion was mainly the indication like, as I told like with -- first question is whether "Is he on just purely on monotherapy, or are you sure that he is not on LHRH analogue injections as well?", and I said "No, that's why I am bringing up this issue". And they said "Oh, in that case the patient shouldn't be on", and then I told the patient wanted to see Mr. O'Brien to make the choice of different options, so they all agreed, yes, for to have the appointment with Mr. O'Brien for this patient to see in the clinic and to stop and then – yes".

b. Discussing this issue, Mr. Glackin indicated in his evidence to the Inquiry on Day 63[276] that, without knowing who was leading the MDT at the time as no date had been provided by Mr. Suresh, if he was the lead clinician he would have looked at this as a one-off, that he would have had no evidence to suggest otherwise, and that he had no particular reason to go digging around to find out if it was a repeat behaviour and that he just wouldn't have known that.

c. Mr. Haynes, in his witness statement[277], states:

"b. In June 2020, while in Daisy Hill Hospital for a theatre list, I reviewed Mr ------ and had immediate concerns regarding the care he had received. Amongst my concerns was that he had been treated with low dose (50mg) bicalutamide and this treatment was not the appropriate management for his prostate cancer. At a later date (I cannot recall the date of this conversation), in discussion with Dr Darren Mitchell, Consultant Clinical Oncologist and Urology MDM lead for Belfast Trust, I became aware that this had been raised directly with Mr O'Brien by the Oncology Team previously (although I am unaware of when this occurred)….

….I also advised the Medical Director of my concerns by email on 7th July 2020 regarding his and another patient's treatment (Mr ------). After completion of his staging scan, I arranged an outpatient consultation with me where I raised

[276] TRA- 08273
[277] WIT-53934 at paragraph 61.10 b.

my concerns regarding his previous care and assured the family that I would be reporting my concerns so that an investigation took place. Having informed them of my concern, I completed an IR1."

d. Mr Haynes also states[278] that, as there were then at least 2 patients who had been treated with low dose Bicalutamide, as a matter of urgency an audit of patients currently receiving Bicalutamide was conducted which identified a number of additional patients who were receiving low dose Bicalutamide.

e. Mr. Haynes explained in his evidence to the Inquiry on Day 88[279]:

"Q. What you seem to be clear about is that this seems to have come to you as an isolated concern and you weren't provided with the history of concerns that were raised with Mr. O'Brien, prescriptions changed in 2014/'15 leading to the regional guidelines; that whole context which Dr. Mitchell has given to this Inquiry wasn't shared with you?

A. Well, it may have been in the discussion but we've got -- when we look at that patient, his management, the point in time he was initially treated was at that period in time. It wasn't a practice that was happening in 2019, this was a patient who was raised in 2019 as a possible problem but whose management by Mr. O'Brien and decision to not refer was back in 2014."

f. Mr. Haynes further explained in his evidence to the Inquiry on Day 88[280]:

Q…But this e-mail to you in March 2019, I hope I'm correct in saying, was the first, if you like, externalisation of the problem. It was coming to you, wearing what would have been your Associate Medical Director's hat or your clinical director's hat; clearly wearing your management hat at that time. When

[278] WIT-53939 at paragraph 62.12.
[279] TRA- 11419
[280] TRA- 11417

you think about it now, should have done more? Should have asked more questions, perhaps, of your colleagues in Belfast as to the nature of their concern?

A. I think if I look back now, you'd started with a preamble around missed opportunities, this is another missed opportunity. I can explain my thought process but in the context, as you highlighted, of issues raised before directly with Mr. O'Brien that I wouldn't have been aware of, in the context of the sort of wider concerns you've mentioned, the oncologist -- they may have been aware of additional patients that they just corrected or changed the treatment when they saw them. I should or could have initiated a wider investigation but I didn't have all of that information to hand at that point and so I didn't know that. So I guess my review and my decision that actually I couldn't see anything to spark a deeper investigation was one that I formed out of an attempt to be fair to the individual. I'd got a letter that said -- that gave a plausible reasoning for why that decision had been made."

g. Mr. Haynes also indicated in his evidence to the Inquiry on Day 88[281] in relation to Patient 4:

"I can only presume I have assumed there has been an oversight rather than this representing his standard practice. Again, my degree of suspicion was too low."

and at Day 88[282]:

"In terms of that, if you like, reluctance to trigger investigation early, I think you have to recognise it is the first thing. I don't spend my emergency admission ward round conducting an analysis and critique of every patient's historic management. I've recognised there's an issue. I have not even -- I've managed him acutely, it is only later I've recognised that this fitted a pattern of behaviour. I've figured that it was an oversight, incorrectly. But as I've said,

[281] TRA- 11431
[282] TRA-11433

all patients who are going to start an LHRH analogue started on 50mg of Bicalutamide. I wouldn't be continuing it so I've assumed that there's an oversight; incorrectly."

h. Mr. Glackin indicated in his evidence to the Inquiry on Day 63[283] that, "*In some ways the Bicalutamide issue is a bit of a red herring. It's not quite seeing the wood for the trees. The bigger issue is not referring the patients to the oncologists for radiotherapy. That is the definitive treatment, and that is the thing that would be the key to managing the patient's disease.*"

5.43 Key Worker allocation:

a. In an e-mail dated 15th May 2015[284] Kate O'Neill indicated that, in relation to a Key Worker, it was planned to keep a record of information provided to all patients diagnosed with a cancer and that at the point of diagnosis after seeing the consultant/with the consultant it was hoped to have a member of the nursing team available to meet with the patient/family.

b. In a further e-mail dated 16th June 2017[285] to all Consultant colleagues Kate O'Neill asked that all patients who require the input of a Key Worker would be offered the option to meet with the appropriate member of staff on the day.

c. The 5 CNSs and their dates of appointment[286] were as follows:

i. Jenny McMahon 04.07.2005;
ii. Kate O'Neill 04.07.2005;
iii. Leanne McCourt 01.03.2019;
iv. Patricia Thompson 03.08.2020; and
v. Jason Young 31.08.2020.

[283] TRA- 08265
[284] WIT-81161.
[285] WIT-81166.
[286] As set out in Ronan Carroll's witness statement at WIT-13110.

d. Jenny McMahon[287] makes the point that she understood the absence of, or inadequate, CNS provision to be an inadequate resource issue, that in 2015 Kate O'Neill was the only urology CNS with a focus on cancer care, that she and Kate O'Neill were required to be available for one-stop clinics which limited the availability to provide key worker support at the times of oncology review clinics for all of the consultants, that the head of service and lead nurses were aware, and that the advice was that recruitment for further CNS posts was being pursued. As an interim measure, two Band 5 nurses were upgraded to Band 6 to help with the day to day running of clinics and would, at times, have provided key worker support.

e. Jenny McMahon also indicates[288] that:

> *"…regarding the absence of or inadequate CNS provision, I believe this occurred as a result of insufficient CNS staff in post to provide support for patients during or following a breaking bad news encounter. This was further impacted by both Kate and I having other responsibilities including clinical activities scheduled at the same time as oncology clinics, having managerial duties for staff and the unit and being counted in the core clinical team numbers to fulfil other clinical duties required at the time."*

f. Leanne McCourt[289] indicates that, although she was employed as a clinical sister in Urology from April 2017 and then as a CNS from March 2019, she did experience issues around absence or inadequate CNS provision from 2017. She did still undertake a portion of Key Worker activity and attend the MDM but could not support the single cancer CNS as much as was previously expected as she had other responsibilities within her role. Leanne McCourt also indicates that she understood that Kate O'Neill and Jenny McMahon did raise this as a

[287] WIT-81252 at paragraph 24.2.
[288] WIT-81255 at paragraph 25.1.
[289] WIT-85940 at paragraph 24.2.

concern with the HoS and that, when she was successful in her application and appointed to the role of Urology CNS in March 2019, this predicament did not really change until management duties were removed from the CNS team in March 2021.

5.44 Actioning MDM recommendations:

a. In relation to Patient 102, David Cardwell was asked in his evidence to the Inquiry on Day 59[290] why this incident was closed in the absence of a screening decision. He indicated:

> *A. Okay. At the beginning I would emphasise that I am extremely aware that the decision for closing of an incident rests with the operational team. In relation to this particular incident you will see on 17th June that I have went on and put in a final approve and a closed date. I can't explain why that has been done…*

David Cardwell was asked whether it is likely that he would have sought an explanation as to why the incident was to be closed to which he indicated that it would have been his normal practice to have sought an explanation as to why it had been closed and that he would have been asking for some information in relation to the outcome of the investigation to include that on the Datix report form. When it was put to Mr. Cardwell that it is difficult to conceive of any good reason that he could have been given to have avoided a screening decision in a case like Patient 102, Mr. Cardwell accepted that was correct and that the incident should have been screened for an SAI and would have met the criteria. If this incident had been screened in for an SEA or an SAI review it is possible that it may have brought the issue of actioning MDM outcomes to a head earlier.

[290] TRA-07629

b. In relation to Patient 137, there was a letter to Mr. Young[291] in August 2018 which read:

> *"The review team concluded that following MDM any actions must be progressed by the consultants nominated as responsible for the action required as per the MDM outcome report. Referrals for specialist care need to be sent from consultant to consultant.*
>
> *Can you provide reassurance that you have a process in place to ensure that MDT outcomes for patients under your care are actioned in a timely and appropriate manner?"*

c. Mr. Glackin indicated in his evidence to the Inquiry on Day 63[292] that, *"…if you're going to vary from a MDM recommendation, you'd need very good grounds to do it, and you need to record that, you need the consent of the patient. And I think as we've said, you would bring it back to the meeting if there's a significant variation."*

5.45 As mentioned above, some of the Mr. O'Brien issues were longstanding. Some of these issues had been known about for some time. There had been a failure to address the issues known about either effectively or at all. There was, for example regional knowledge in relation to Mr. O'Brien's use of Bicalutamide, albeit it appears that there was very limited sharing of it by BHSCT clinicians with the Trust (other than directly with Mr O'Brien) prior to 2019. There was also, for example, some internal knowledge in the Trust in relation to Mr. O'Brien's use of Bicalutamide. Again, however, it was very limited and not focused in any single colleague of Mr O'Brien's. Whether such limited examples as referred to above concerning Mr. Suresh, Mr. Glackin, and Mr. Haynes as well as the context in which they arose should have triggered an investigation is an issue for the Inquiry.

Root Causes of Trust Failings

5.46 The identification above of various shortcomings on the part of the Trust begs the question of what the root causes were. In particular:

[291] WIT-100383
[292] TRA- 08300

a. Why were some longstanding issues that were known about not addressed either adequately or at all?
b. Why were other issues not known about?

5.47 Again there appears to be a number of root causes in play here which have been referred to in the evidence.

Bicalutamide

5.48 In relation to Bicalutamide 50 mg:

a. Mr. Glackin indicated in his evidence to the Inquiry on Day 63[293] that *"… I think we would all agree in our MDT that managing people long-term on Bicalutamide 50mg is inappropriate."*

b. Mr. Glackin explained on Day 63[294] that:

"In Northern Ireland we provide essentially an advice note to the GP to prescribe these medicines. So, that goes out to the GP, the GP issues the equivalent of an FP10, and that goes to the local pharmacy and it's dispensed. I am aware that GPs in Northern Ireland get very detailed reports of their pharmacy prescribing, almost down to the tablet. So, the information about how these medicines are prescribed in Northern Ireland and dispensed was available. It was just never looked for until that audit."

c. Later during his evidence on Day 63 Mr. Glackin indicated as follows[295]:

[293] TRA-08266
[294] TRA-08267
[295] TRA-08269

"I suppose the other point is this: Many other medicines that are used in oncology within secondary care are prescribed and dispensed within secondary care. That's not true for these medicines. They're not on what's known as a red or amber list. There isn't a shared care protocol for these medicines between primary and secondary care. There are for lots of other medicines that would fall into these categories. So, you know, if these medicines had of been dispensed from secondary care and controlled from secondary care, our pharmacy departments in the Trust would have had oversight of that."

d. Mr. Glackin in his evidence[296] also addressed the question of how rotating MDT Chairpersons could have missed Mr. O'Brien's approach to hormone prescription if it had been started in advance of an MDT recommendation:

A. It probably wasn't starting in advance of the MDT, for the reason that most patients with prostate cancer come to the MDT when their histology is available, and then further after that when their staging scans are available, and it's usually at the point where their staging scans are available that the decision about treatment is made. So, following that, the patient would then be seen in an outpatient clinic, and it's at that point that the patient would receive the advice note for the GP to initiate the treatment. So, for my practice, that's how it works. The patient takes that note away and they get the GP to issue a prescription.

So, the MDT wouldn't necessarily have had sight of the advice note to the GP, and unless that patient was coming back to the MDT for some particular reason - and many of them wouldn't be - then we wouldn't be aware that they were on 50mg."

[296] Day 63 at TRA-08274

e. Vicki Graham explained the concept of 'first definitive treatment' and the role of the tracker in her evidence to the Inquiry on Day 42[297]:

"Q….Hormone treatments should count as first definitive treatment in two circumstances. 2. Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may, for example, be the case in patients with locally advanced breast or prostate cancer where hormone therapy is given for a planned period with the aim of shrinking the tumour before the patient receives surgery or radiotherapy".

Is that a standard or definition that you work to?
A. Yes. Hormone therapy was a treatment.
Q. Yes. We'll come on to look at it in the context of the SAI review in a bit more detail later. When you saw that the patient had reached the point of first definitive treatment, was that the end of your role?
A. That was when our role, yes. That's when we would have ceased tracking.
Q. Yes. You wouldn't have tracked to see the outcome of that treatment?
A. Post first definitive, no, we wouldn't have been tracking that patient…"

Key Workers

5.49 In relation to the allocation of Key Workers:

a. The 9 patients were not referred to Specialist Nurses and contact telephone numbers were not given.

b. Kate O'Neill explained in her evidence to the Inquiry on Day 42[298] that there was an emphasis on productivity in terms of meeting cancer targets and that the agreement with the Head of Service was that the

[297] TRA-11961
[298] TRA- 12043

CNS would not go out to any satellite clinics. The CNS focus was to be on the Craigavon site.

c. Kate O'Neill explained the allocation of a Key Worker in practice in her evidence to the Inquiry on Day 42[299]:

A. So if it is appropriate to say now the operational policies, I understand were written at a time when there was an expectation that new appointments were imminent. They had been outstanding for a significant number of years at this stage, so the biggest challenges to me were still resourced based in terms of identifying a key worker. It could not be done at the MDT setting because we didn't know when next clinic review was occurring, so in the same way as holistic needs assessment wasn't being done formally it was being done in formally at that time due to resources. So what we managed as a team on daily basis then, was when the clinic was appointed as I said Mr Glackin's was on a Monday afternoon, well then someone I was able to be at that clinic or I delegated someone to be at it. It only became more complicated when there were parallel clinics going on, and it required the consultant to come out and get us when they were seeing patients, yeah."

d. Kate O'Neill addressed what she knew in her evidence to the Inquiry on Day 42 at TRA-12053:

"Q. And just did you ever speak to Martina Corrigan to the effect that Mr. O'Brien doesn't allow us access or it's difficult or he is obstructive in any way?
A. No the issues would I have raised with Martina Corrigan would be more about over run of clinics or productivity within clinics I wasn't aware that anyone was being prevented from having access to a key worker in any role, no.
Q. Not using CNS when available?
A. Yes."

[299] TRA-12049

e. At the same time, Mr. Haynes indicated in his evidence to the Inquiry on Day 88[300] in relation to the number of key workers available in 2018, 2019, and 2020, that the same shortage would have applied to him and his colleagues and that it didn't stop him from letting the team know whether a patient required key worker input.

f. Mr. Glackin indicated in his evidence to the Inquiry on Day 67[301] in relation to the MDT Operational Policy:

"…The statement is there really to reinforce the fact that all the patients should have access to a cancer nurse specialist, and in order to have some oversight of that, that should be the responsibility of the MDT lead and the core nurse member. I think they're the two appropriate people for that responsibility. As the MDT clinical lead currently I have the overall responsibility, and clearly the core nurse member themselves being a CNS, would have, if you like, not line management responsibility, but a responsibility to ensure that the other CNSs are available to do this kind of work for the patients."

g. Mr. Glackin went on[302]:

"So I had no awareness first of all that they didn't have a CNS, but if I had have had an awareness then it would have been up to me to address that with the CNSs and the core nurse member to say, to ask them, you know, were they aware that these patients hadn't been offered the opportunity of CNS input, and if they hadn't been offered it, why not, and you know, to dig into that a little bit and understand why it hadn't happened. So, you know, that's I think where my responsibility lies.

[300] TRA-11472
[301] TRA-08739
[302] Also on Day 67 at TRA-08739:

I think there's an equal responsibility on the core nurse member to undertake that kind of questioning activity..."

h. Mr. Glackin also indicated[303] that the Key Worker's allocation wouldn't happen in practice at the time of the MDM meeting and that it happens afterwards.

i. Finally in respect of Mr. Glackin, he indicated in evidence on Day 67[304] that he was surprised that the 9 patients had not had a CNS involved in their care and that:

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

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

j. Patricia Thompson in her evidence on Day 60[305] made the point:

"A. Yes, I felt that it was very much blaming Doctor 1. Whereas if you looked at some of the SAIs, there was events, there was times that a key worker could have been introduced by, maybe, another doctor or a registrar or another Nurse Specialist. And that's learning from the SAI that maybe there could be systems

[303] Also on Day 67 at TRA-08741
[304] TRA-08742
[305] TRA- 07721

put in process for referral to key workers from other nurses or other doctors if a patient is presented through their journey."

MDM Outcomes

5.50 In relation to actioning MDM Outcomes:

a. There was no mechanism to check MDM actions were implemented, including further investigations, staging, treatment and appropriate onward referral;

b. NICaN Regional Hormone Therapy Guidelines for Prostate Cancer 2016 were not followed. The Guidance was not subject to audit within the Trust.

c. Issues around prescribing were long standing.

d. MDMs operated in circumstances where the Urology MDM was under resourced and frequently not quorate due to a lack of professionals. This was often due to a lack of clinical oncology and medical oncology, both identified as regional issues .

e. MDMs operated in circumstances where the Urology MDM was under resourced for appropriate patient pathway tracking. Patient tracking related only to diagnosis and first definitive treatment (31 and 62 day targets). There was never a whole pathway tracking process.

f. When asked to reflect on why the Trust was at such a low level of performance with regard to its cancer MDMs, Dr. O'Kane gave the following evidence to the Inquiry (which is relevant, in part, to the MDM outcomes issue)[306]:

[306] TRA-11744

" Q. It appears at least on the papers to be a chalk and cheese situation. Can I ask you to reflect, because it's important that the Inquiry has your perspective on why this Trust was at such a low level of performance with regard to its cancer MDMs, not just Urology, it would appear to be short in critical respects across the cancer environment. So how do you account, or what's your perspective on why this organisation was so short that this extensive rebuilding exercise has had to take place?

A. Well, I think just to start with the MDM process to begin with. I mean there were concerns I think throughout raised about quoracy, but I think they didn't go beyond a certain level in the organisation. And then, you know, some of those who were involved from the Belfast Trust who raised concerns at points in time, I think, as I understood it, they had particular concerns in relation to some of the practices there and wrote to the consultant involved, but I think probably didn't know how to access our medical management structure, or we didn't make it explicit in terms of how that was actually done. So that kept all of those concerns at a certain level in the organisation and I think weren't addressed, and I think there was a kind of a hopelessness around it, which was, "well, this has been going on for a long time. It has never been sorted out. You know, we've complained about it before and it hasn't been dealt with", right, and I think that bred complacency.

Then I think what compounded all of this, because, you know, the other consultants who were working in that system, you know, they saw their patients through from start to finish, they kept a running score on where they were in the system, so that if they were concerned about them and, you know, if they needed CTs, MRIs, whatever, they got them followed through, they brought them back to their secretaries. They automatically followed through on any of the recommendations that came out of the MDM, and they made sure that all of their patients that they were worried about went into the MDM.

I think the difference in relation to Mr. O'Brien was, if he wasn't taking the patients to the MDM in the first place, then the MDM didn't know about them. And if the MDM was reporting on improvements or investigations to be done and he wasn't following through on those himself, then they weren't getting done.

So the enhancement in all of this - and that applies to all of those patients who were there on the cancer side. So the enhancement from the patient's point of view is that this does not solely rely on a consultant being aware. There is a safeguard in place now with the trackers. So they will pick this up and make sure that it goes back in. And the MDM itself is alive to the possibility that these patients need to go back into a system to be further investigated."

Governance Shortcomings

5.51 In relation to systems and governance and whether the systems of governance were ineffective:

a. Dr. O'Kane explained in her evidence to the Inquiry on Day 90[307]:

Q. And clearly you can't have a system dealing with this kind of medicine which is vulnerable to the behaviours of one clinician. The system needs to be arranged to pick that idiosyncratic practice up, challenge it and provide solutions.

So what is the explanation for that not, those basic systems not being there? What is the Inquiry to write into its report by way of an explanation for that low base?

A. I think there was a failure to recognise the complexity of the systems that we're dealing with, you know. These systems, I mean the level of referral into

[307] TRA-11747

cancer services goes up. I think it's gone up by 50% in the last five years, so it's rising exponentially, and the spend around that hasn't increased in keeping with that, in terms of, you know, commissioning a service. But also, the complexity of the care has increased over time as well. You know, there are treatments available today that wouldn't have been available two or three years ago. So I mean that's constantly an evolution and it is incredibly dynamic.

So I think we failed as a system to appreciate the complexity of all of this, the fact that, you know, where there are many points of change in a process that they are always vulnerable to things going wrong. So every time you change a treatment, or you add something in or take something away, it's vulnerable to not being followed through, and we really need to heavily manage all of those stages. And, you know, to enable us to do that, the team needs to be robust and we need to have someone, other than the clinicians, basically managing all of that and doing that. So, you know, we're not perfect, but we're definitely stronger than we were in that regard."

b. On Day 89[308], Dr. O'Kane addressed the issues of Mr. O'Brien and the then state of governance within the Trust:

"Q. And on the issue of Mr. O'Brien and all that came with that, I think you were asked to reflect on the last occasion on the weaknesses within the Trust which caused or contributed to a situation where shortcomings in his practice, which from the Trust's perspective placed patients at risk, you were asked to reflect on what caused or contributed to that, and I suppose the headline from your answer was that the Trust and those who were charged with responsibilities in the governance area were unable to join the dots, and they were unable to join the dots and therefore unable to see what was, I suppose, hidden in plain sight, and that led to a situation where you and others, perhaps

[308] TRA- 11606

not deliberately as you suggested, were given false assurance. Is that again a fair reflection of how you see it?

A. Yes. Yep.

Q. So, you have problems with the governance structures identified by you quite quickly, and then a whole raft of other areas emerging from what you saw in June 2020. Would you like to give the, I suppose, the Inquiry a summation of looking back at it from today's standpoint, bearing in mind all that you've heard in a yet uncompleted inquiry. What's your key reflections on the state of governance within the Trust, pick any date, 2019/2020, which you have had to go about trying to fix, what were the key problems?

A. Em, so I think in terms of my reflection of the stages of all of these, I think that it is, you know, for any of us who have been involved in this throughout that period of time, I think it would be fair to say that it is a source of regret to us that we didn't know in 2019 what we learned in June 2020. Okay. And hence the reason that, as you say, it has been a two-stage approach.

So in relation to governance, or in relation to the state of play and what I see as the fundamental challenges, it probably falls within the four areas of culture, governance - and within that I mean clinical and social care governance and corporate governance - how we've used data, and then the quality and safety within the organisation. And as I've mentioned in some of the previous submissions, we have brought on board an External Reference Group to help us with the thinking in relation to all of that, and I think, you know, in terms of those four main domains, then within all of that, if we apply, you know, a model for improvement such as, you know, the Vincent model, which looks at, you know, were we safe yesterday, are we safe today, will we be safe tomorrow, are our systems and processes sensitive enough to operations so that we understand that if things are going askew that we have the governance arrangements in there to pick that up at an early stage? And also the fifth leg of all of that, which is, then how do we drive improvement based on all of that? If I use that as the framework for thinking of this, this is my easiest way into it.

So in relation to where we were in relation to corporate governance. As you have pointed out, the June Champion review was undertaken across the summer of 2019 and, again, that was in response to my concerns about the lack of framework and structure around some of the patient safety and quality issues that we were dealing with. As you know, there were 48 recommendations in that report. We have filled out on the vast majority of them. The first 13 were to do with corporate governance at a point in time and, again, I think in fairness, Eileen, as Chair of the Trust, has really grasped those 13 now, but there was a period of time when that took a bit of debate for us to try and understand, and I think, you know, fair to say before Eileen arrived a realisation and acceptance that actually the corporate governance across the organisation needed to be strengthened, along with all of the other governance aspects that were there."

c. Dr. O'Kane further explained in her evidence on Day 89[309]:

"Q…So when we think about that, and this may not be an entirely straight line, if we bring it to what we know about the urology multi-disciplinary team, but it could be any service in the Trust estate, you have a practitioner, according to the SAI outcomes, who is not complying with NDT recommendations. So patients don't get the recommended treatment, they don't get referred down the road to oncology and what you have, but behind that it can't be spotted, it can't be identified, or it's going to be difficult to identify it because you don't have resources into audit or tracking, or whatever label we put on it, it's - is it as blunt as that in some respects?

A. Yes, I think so, and I think, you know, if people had concerns in certain areas then they didn't readily have the tools available to them to help them understand what the problem was, you know. So if you were concerned about, you know, some of the clinical processes in relation to urology, it would have

[309] TRA-11618

been very difficult to have had an audit project down around that because you didn't physically have the staff there do it for you."

d. Dr. O'Kane in her evidence further indicated[310]:

"A. Yes, and I think, you know, there's an old adage which is "What gets measured gets done". Right. So at a point in time in the past what got measured was how much money you spent and how much activity you did. Right. There was less attention given to - and it's difficult to put a figure to it - quality and safety. So the two things that were easily measurable were done extremely well in relation to that. But then behind that, I believe that that was at a cost in terms of the clinical governance construction within the Trust.

Q. …So when we go back to my question about how the senior leadership team - and maybe my premise is wrong? I said Senior Leadership Team standing in Craigavon Hospital June 2020, before Mr. Haynes and Mrs. Corrigan do their scoping work, you think all is well, obviously the June Champion Report freshly delivered late the previous year, and you have to work through some structural changes which are obviously very important, but it doesn't seem to me that you or your colleagues in the Senior Leadership Team had a sense of - and take the cancer services as our primary example, you didn't have a sense of how degraded the governance arrangements had become?

A. I think that's a fair reflection. And if you think back to the Maintaining High Professional Standards Investigation, right, which I think at this point in time was misleading, you know there was a suggestion that a wide range of people were consulted with at that point in time and that the feedback they gave was - I mean, one of the ultimate decisions that came out of that was that there weren't any concerns about Mr. O'Brien's clinical practice and, again, that was - and what was presented through the Maintaining High Professional Standards

[310] Also on Day 89 at TRA-11619

Report suggested that this was about administration and about professional, you know, management, but actually wasn't about - there weren't any clinical concerns. And I think that reassurance, and it was a reassurance, it wasn't an assurance, I think blinded us to the fact that actually what really hadn't been looked at in there was the cancer side of the house. So in normal circumstances, you know, if I were, for arguments sake, asking for a dermatologist or a psychiatrist, you know, to be investigated, you would assume that all of the activity would be within their department. I think what wasn't appreciated within that investigation was the fact that there was a part of his clinical activity sat without the people who were spoken to and that there was information in interest, and that I think came to light very forcibly then in June 2020.

Q. Mmm.

A. So that side of the house, the cancer side of the house was quiet until we got to June 2020, and then there was a realisation that actually all of this was going on in there. And, in fact, you know, the concerns about workload, waiting times, triage, all of those things were important but didn't completely map on to what we found then in relation to cancer."

Important Context

5.52 Against the backdrop of the Aidan O'Brien issues that came to the fore in 2020, particularly in the context of the Urological Cancer MDT, and the related failings on the part of the Trust these issues laid bare, it is nonetheless important to bear in mind (in addition to the contextual points referred to already in Chapter 4) the following specific contextual points:

a. The MDM made appropriate recommendations for 8 out of the 9 patients.

b. The Trust had invested in additional resource to provide a specialist nurse to all urology cancer patients by 2020.

c. The role of Multidisciplinary Chair is now defined by a Job Description[311] with specific reference to governance, safe care and quality care and resourced to provide needed oversight.

Trust Actions to Improve / Restore Public Confidence / Protect Patients

5.53 The Trust has accepted the recommendations of the Hughes and Gilbert SAI reports. The *'Update on the Action Plan in response to the Dermot Hughes SAI Recommendations Action Plan'* can be found at TRU-306489 – updated 8th March 2024.

5.54 Dr. O'Kane explained in her evidence to the Inquiry on Day 90[312] that there were 68 recommendations which came out of the 9 SAIs, that there were overlaps in terms of the recommendations across the 9 reports, and that they were then streamlined into 11 areas with subtitles.

5.55 Dr. O'Kane in her evidence[313] also addressed the BSO Audit[314] and the updated position:

> *"Q….. As of November 2023, 65% or 17 of those 26 actions were deemed to be fully implemented by the Trust, and the remaining nine actions are deemed to be partially implemented, with work ongoing across the teams to ensure compliance. That was late last year, November. Is that the current position or have things moved on beyond that, in your view?*
> *A. I haven't counted them up in the latest report, but, no, that has moved on. Yep. Yep. So I mean overall I think nine out of the 11 recommendations, I think when they reviewed it they put green against it. How that measures up specifically about the action - in relation to the actions, I haven't counted that..."*

[311] TRU-403313 – TRU-403316.
[312] TRA- 11739
[313] Day 90 at TRA-11748
[314] TRU-305875

5.56 By way of example the Action Plan Update referred to above records[315] - in relation to Recommendation 5, *viz*, that the Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations/actions are completed – that the following substantial progress (with potentially significant points highlighted in bold) had been achieved by 28 February 2024:

- *The Trust track patients from referral to first definitive treatment in line with what happens across all HSC Trusts in NI. The Trust is resourced to enable tracking to this scope and the CAPPS system can only support tracking from referral to first definitive treatment.*
- *Cancer Services monitor tracking monthly to ensure this is kept up to date to support escalation of any delays patients may experience on their cancer journey.*
- *The Trust has been commended by SPPG for keeping cancer tracking up to date, especially given the high and increasing trend in Red Flag Cancer referrals.*
- *All patients with a new cancer diagnosis discussed are discussed at a Cancer MDM.*
- *All patients will be allocated a Cancer Nurse Specialist as their Key Worker.* ***A monthly report is produced by Cancer Services to evidence that patients are being allocated a Key Worker in line with the Cancer MDM Principles document (January 2023).***
- ***Monthly snapshot reports are completed for all local Cancer MDMs to check that the plan agreed at MDM is implemented. These audits are completed by Cancer Services and issues flagged to Cancer Senior Management Team in line with an agreed escalation process.***
- ***A pathology cross check mechanism has been established to check that all patients that are diagnosed with cancer via the laboratory are being brought to a Cancer MDT with monthly reports to evidence that this is happening.***
- ***The Cancer Tracking Team are now resourced to cover all cancer MDMs.***
- ***The team are fully staffed with no gaps currently and are up to date with tracking.***

[315] TRU-306502

- ***Cancer Services received a monthly report to monitor tracking position.***
- ***If cancer trackers identify any delays with patients on cancer pathways, they follow up on these issues with consultant secretaries and consultants as required. Cancer MDM chair may also be alerted to significant delays or issues. Cancer Senior management team and specialty Heads of Service / Assistant Directors will also be alerted to any significant issues***

5.57 Dr. O'Kane put the following flesh on the bones of the above summary during her evidence to the Inquiry on Day 90[316]:

"We put additional funding against the MDM in relation to not just the job planning process but also increasing the number of CNSs who take part in all of that, making sure that there is medical presence there, and also then we invested in trackers, so that when a patient comes through this process now the tracker picks them up and makes sure that there is no gaps in terms of, you know, the outcome of the MDM being followed through…

…That is then audited on a regular basis, and they will take - out of samples of 38 they will take 5 cases and make sure, based on that sample size, which is, you know, in and around 12%, they'll do that on a regular basis to make sure that there aren't any patients falling through the gaps. Right."

5.58 Dr. O'Kane in her evidence[317] in relation to Recommendation 1[318] – *the SHSCT must provide high quality Urological Cancer Care for all patients* - also explained the following:

"Q…And then a third stage, or a third portion of the work, there was data mapping for

[316] TRA-11742
[317] Also on Day 90 at TRA- 11751
[318] TRU-306490

each patient pathway or each condition pathway. One can see that that has a yellow rating. Some of the work in urology and I think in renal services isn't yet complete. We can see in the middle paragraph:

"The immediate work needed to be delivered in relation to Urology has been completed but the Trust is adopting an ongoing improvement focus across all cancer pathways supported by the cancer service improvement league."

So the RAG status for this sub-action is therefore yellow, it's ongoing work.
A. Mm-hmm.
Q. Are you satisfied or are you in a position to be satisfied or assured that this aspect of the recommendation is in a good place, has been appropriately conducted and applied?
A. I think I would have liked it closed out, but I know that they are working on the aspects of this. To try - for the parts of this that haven't been delivered on yet, this will now - I mentioned yesterday about the External Reference Group and about how we're now moving the programme for improvement within the Trust completely, so that will be overseen by the Director of Transformation and Improvement in terms of ensuring and, you know, holding to account essentially the directorate in relation to making sure that these are delivered on over the next few months. So, I mean, we would all like it to be green, but I am confident that, you know, as this works gets underway that we will have this done."

5.59 Dr. O'Kane explained, when questioned in her evidence[319] in relation to Recommendation 2[320] - *All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care – this should meet the standards set out in Regional and National Guidance and meet the expectations of Cancer Peer Review* – which was the only recommendation to have an amber RAG, the following:

[319] Also on Day 90 at TRA- 11763
[320] TRU-306493

"Q. ….It concerns the allocation of a key worker and the Trust is not currently in a position to stand over in every case that those allocations are taking place. It records here:

"As the new CaaPS functionality is not yet available which will allow monitoring of this and other KPIs, and given that sample audits have been undertaken for Urology, we have a level of assurance on this. However, we cannot fully sign the recommendation off as being green."

So there's that frailty in the system whereby you don't currently have a methodology to stand over appointments of key workers and compliance with their key performance indicators in every case, is that right?
A. We have - we do it manually, you know, in terms of trying to keep a running score to make sure that the patients are aligned and there's a monthly feedback in relation to that. But in terms of it being recorded on the system robustly and signed off by the CNSs, they're not able to do that. And CaaPS is one of a number of pieces of software, you know, that functions across the NHS at the minute that is awaiting the implementation of Encompass. That rollout of Encompass regionally started with the Southeastern Trust in November last year. The Southern Trust will get to this in April 2025. So this is going to take at least another year/18 months."

5.60 In her evidence[321] on Day 91, Dr. O'Kane also provided the following additional information in relation to the Key Worker issue:

"MR. WOLFE: Good morning. Good morning, Dr. O'Kane. Just going back to something I was asking you about yesterday. We were looking at the outworking of the recommendations following the Serious Adverse Incidents Reviews, and we were looking at the audits that were and have been carried out in respect of, for example, quoracy, in respect of cross-referencing from pathology, and then we came to nursing and we identified something of a gremlin in the works in the sense that CaaPS requires

[321] TRA- 11818

further work so that we can have an electronic record of the allocation of key workers to patients, and I was raising that with you as a concern because it's essentially a concern within the recommendation report that you have helpfully brought to our attention. You did say that there is nevertheless a paper check or a manual check that key workers are being allocated, and I just wanted, after that long introduction, to bring you and bring the Panel to some references for that.

If we go to TRU-304474. And we can see this dates back to November 2022. And Kate O'Neill, one of the nurse specialists, is writing to Wendy Clayton in response to a request for data outcomes, or audit outcomes I should say, and she sets out some information which helps to clarify that in the vast majority of cases key workers had been allocated, and gives explanations for the cases where allocation had not yet taken place. Any further comment you'd like to make on that?
A. I have seen more up-to-date information in the weeks that suggests that that has moved on but is still being, the information is still being collected in the same way, so we can provide the Inquiry with that."[322]

5.61 In relation to the actioning of MDM outcomes, Dr. O'Kane explained[323]:

"Q. MR. HANBURY: Just another thing on the audits of the multi-disciplinary team working after Dr. Hughes's review of the nine SAIs - you've already answered one of them. In Recommendation 5, about the extended tracking, which you remember, the problem for a few patients, especially with prostate cancer, is that they were started on hormones and subsequently not referred for radiotherapy. Are you confident that that has been picked up with the new system of extended tracking?
A. Yes. And certainly in terms of the audits that are being done, you know the 5 out of 38 every week in relation to the patients described, it would suggest that they are being done. And that - again the trackers were specifically employed to undertake that function and to make sure all aspects of the treatment was actually happening, yes."

[322] Please see TRU-409752 – TRU-409752
[323] Also in her evidence to the Inquiry on Day 91 at TRA- 11895

5.62 And in respect of the prescribing of Bicalutamide 50 mg and the prevention thereof, Dr. O'Kane had the following to say[324]:

> *"Q. MR. HANBURY: So what's to prevent that happening now? What's to prevent that happening now?*
> *A. Well, all of those prescriptions should originate within the Urology Department. So they have a good programme in terms of, I think, being aware of all of this and making sure that everybody - I mean this is talked about a lot in terms of being compliant with all of this. Right. Our pharmacy processes at this point in time aren't robust enough to pick up, you know, if it's still being prescribed for the wrong reason, in terms of whether it's 150 or 50 milligrams of Bicalutamide. But certainly pharmacy is very aware of this and, you know, will appropriately challenge if they're concerned. But I think the ultimate solution to this will again be the implementation of Encompass next year. Now, I appreciate that's a year away. Because the Northern Ireland version of Encompass should bring together the different aspects of the clinical pathway, and the artificial intelligence that's built into the Encompass programme should try totally the prescription of Bicalutamide to the diagnosis and should be able to pick up that actually this is outwith what it should be in terms of, you know, the cancer disease process and metastasis. So that artificial intelligence that kind of guides the system and it should be helpful with that."*

5.63 In relation to picking up the use of medicines contrary to Guidelines and outside of licence, Mr. Haynes explained in his evidence[325], when questioned by Dr. Swart, that the starting point for such a patient would be a recommendation from MDT for specific treatment and that the concern about Bicalutamide was the patient not receiving the appropriate prostate cancer treatment. Mr. Haynes explained that the audit process of the MDT outcomes would highlight the patient who has not had the recommended treatment which would in turn bring the patient back both to the consultant and to the MDT allowing for peer challenge. Mr Haynes further indicated that he would expect the MDT chair to bring that

[324] Also on Day 91 at TRA-11899
[325] Day 88 at TRA- 11520

patient to the medical line management – escalating the issue. Mr. Haynes also referred to support in terms of contact directly through the Deputy Medical Directors and the Medical Director and to those relationships and the regularity of meetings being such, that the issue would be able to be raised.

5.64 In respect of clinical audit, Dr. O'Kane explained in her evidence on Day 89[326] that, at a point in time in the past in order to save money, the clinical audit team had been stood down and that now as part of the whole governance review it had been reinstated. On the same issue, asked whether there had been any identifiable change in respect of clinical audit in recent times, Mr Haynes described to the Inquiry how there had been a 'huge change' for the better[327].

5.65 Dr. O'Kane also gave evidence on Day 89 in relation to the Champion report[328], indicating that it gave her a framework in terms of improvement in relation to the overall corporate governance of the organisation and had been helpful in developing the operational governance within the Trust and that:

> *"…we have concentrated on completely reforming the way we undertake corporate governance and, again, that has taken a lot of engagement, reflection, discussion, and we now have a revised corporate governance structure in place that brings patient safety and the quality of care very much into the minds of staff within the organisation, and feeds into the Governance Committee and sits alongside the Risk and Assurance Committee - or, sorry, the Risk Assurance and Audit Committee - that basically then quality assures some of that work that comes in. And then the other committees that are developed, the other five committees that are alongside that then are to support the overall approach to corporate governance."*

5.66 Mr. Haynes commented on the actions taken as a result of the Task and Finish Group (taking forward the Hughes SAI recommendations) and assurance

[326] TRA- 11617
[327] TRA-11487 line 22 to TRa-11488 line 24.
[328] TRA- 11609

processes surrounding the MDM in his evidence on Day 88[329] when asked about a number of new support staff being brought into the MDT arena indicating that the roles are very much part of the assurance processes that surround the MDT, that the Cancer Information and Audit Officer was the individual who does a monthly audit of the outcomes recommended from MDT addressing the question are they being actioned and that he gets a report from that individual. Their role, according to Mr. Haynes, is the assurance process around MDT.

5.67 Mr. Haynes also gave evidence on Day 88[330] addressing culture change in results sign-off. Mr. Haynes referred to the first step of the monitoring process being undertaken by himself and Wendy Clayton and to all of the consultants and nurse specialists within Urology using electronic sign-off for their results management. Mr Haynes referred to a red/amber/green table for each consultant's reporting and indicated that it tells him how long a result has been outstanding and awaiting action. Mr. Haynes referred to an escalation process indicating to the consultant that they have fallen into amber and a formal meeting to establish a way back to green if a consultant had fallen into red. Mr. Haynes suggested that the mere availability of an overview had helped to change the culture and that "*we all know how each other is doing, and no one wants to be bottom of the table. You don't want to be bottom of the class so it generates a culture whereby everyone keeps on top of things. If you get an e-mail that shows you as an outlier, it changes the way you behave*".

5.68 Mr. Haynes gave evidence[331] in relation to Key Worker allocation and in relation to reports directed to the role of the Key Worker indicating that :

> "*A. Yes, to the best of my knowledge that is all implemented. I think there is an aspect to it that was required for the monitoring, for ease of monitoring, that required some regional input on the CAPP system, the cancer -- the computer system that's used for*

[329] At TRA- 11461. Further comment is at TRA-11463 to TRA-11465.
[330] TRA-11466
[331] Also on Day 88 at TRA- 11474

recording the cancer patients. The actual, the physically doing it and auditing it and recording it is all being done."

5.69 In respect of the actioning of MDM outcomes, Mr. Haynes gave the following evidence[332]:

" A. So the audit is done on a monthly basis. Where there are, if you like, discrepancies, where there's an outcome or a query regarding the outcome, it is raised first-off with the clinician themselves. As I mentioned earlier, there may be a simple oversight or failure of the requesting process that means something hasn't been requested, or it may be that the clinician has forgotten to bring the patient back to MDT when they've changed it, so it allows for the clinician to actually look at it and bring it back if required. But if there's no action, then my understanding is that that is then escalated to the MDT Chair to bring it back to the MDT...

…A. So the commonest situation we've had - and from memory it has not been this process that brought the patient back to MDT, it has been the clinician who has brought the patient back to MDT - has been where the patient's wishes are different to those that have been put or recommended by the MDT. Where you have that consultation taking place with the clinician and the Clinical Nurse Specialist, and you have in that well-counselled patient they are making an effective decision to go with a different plan, it is very difficult to change a patient's decision when they've made a reasoned judgement themselves. We haven't had to challenge a clinician, saying I think we should do something different."

5.70 Mr. Glackin gave evidence on Day 63[333] addressing the actioning of MDM outcomes, indicating that there is now in place a random audit of whether or not outcomes have been adhered to and that information is brought back to the MDT and shared with the MDT. Mr. Glackin indicated that he also receives that report as the lead clinician, and that if there are cases that don't appear to match what the

[332] Also on Day 88 at TRA-11476.
[333] TRA- 08243

outcome was, then those cases are addressed on an individual basis. Mr. Glackin's evidence on Day 67[334] addressing the audit of MDT outcomes included the following:

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

5.71 Kate O'Neill's evidence[335] in relation to Key Worker allocation referred to a proforma[336] allowing for improved auditing of Key Worker activity and explained that the Key Worker is named and that the system operates by way of a minimum data set and is audited.

5.72 Kate O'Neill also gave evidence[337] addressing other improvements and Key Worker allocation including how increased resources *'have transformed [her] working life'*. When asked about the potential for the issues around Key Worker allocation in the 9 SAIs to arise again, she offered the following evidence:

> *"A. I think we have eliminated that significantly. There is still improvements that I feel could be done and we'll work towards those. One of those would be more engagement with the ward-based patients, whether it could be considered or not going forward if we had sufficient resources to actually have a CNS on the ward round. You know, that provides a format for engagement with the ward staff and patients."*

[334] TRA-08725
[335] Day 42 at TRA-12059
[336] At WIT-81164.
[337] Day 42 at TRA- 12106

5.73 Leanne McCourt gave evidence[338] comparing the current system in relation to Key Worker allocation as compared to that at the time of the SAIs in the following terms:

" A. I think, as I said, comparing the CNS role in terms of key worker then to now, absolutely. It's a more robust system, it's a more proactive system. There is now a person within Cancer Services that is in charge of audit, and they would send us a retrospective list at the end of every month of all the new diagnoses from that month. We appoint a CNS each month to cross-check that with the key worker activity so we can identify if indeed any patient doesn't have a key worker and rectify that."

5.74 Also in her evidence on Day 43, Leanne McCourt discussed the system now and whole of pathway tracking as an idea for improvement[339]:

"Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently?

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of pathway tracking that was alluded to in the testimonies yesterday but, to the best of my knowledge, that isn't currently in position at present.
Q. And do you think that would be a good idea?
A. Absolutely."

5.75 The progress made is perhaps best summed up by Mr. Haynes when he gave evidence on Day 88, when he said[340]:

[338] Day 43 at TRA-05479
[339] TRA-05487
[340] TRA-11478

"Q….Overall, taking into account your experience of working within this MDT before 2020 and knowing the environment now in light of these changes, how would you characterise the improvements? Has there been meaningful progress and is it a safer environment for your patients?

A. I think there has been significant progress. It's a safer environment for patients. It's also an environment where we as clinicians feel safe. We know that there are processes to make sure that everything is happening as it should be."

Conclusion

5.76 The issues in respect of Mr O'Brien's practice and that of the Trust which came to a head in 2020, and which were subject to SAI review led on to further patient scrutiny by the Trust in the Look Back Review and the SCRR process.

5.77 The Trust accepts that the cancer care received was not that which would have been expected.

5.78 Nonetheless, it is hoped that the Inquiry, patients and their families, and the public will be assured now by the steps taken by the Trust in relation to the issues identified to improve processes surrounding cancer care and the Urological Cancer MDT so that the risk of similar issues arising now or in the future has been significantly reduced.

Chapter 6

Resistance to Change

Issues

6.1 The Inquiry has heard and received much evidence regarding the almost exponential growth in demand for urology services over the last three decades. In the face of such rapid growth, the qualities of deftness and adaptability in respect of practice management and reacting to changing demands are essential attributes in the professionals providing urology services.

6.2 This chapter reflects on different aspects of Mr. O'Brien's practice which, viewed together, suggest that he was a professional who was often resistant to change and who seemed to be 'set in his ways'. We have already referenced in earlier chapters Mr Haynes' experience that Mr. O'Brien was 'a challenge to challenge', a view echoed by several other witnesses including his long-time Head of Service. The Inquiry will have to test this evidence against the corpus of other evidence it has amassed. When challenged with this characterisation of him, Mr O'Brien has been dismissive of it, describing it as 'gossip' and 'confetti': "*I don't buy into 'the challenge to challenge' gossip at all. I think we have listened to chill factors, legal connections, knowing Roberta Brownlee, and frankly I find it confetti really*" [341].

6.3 This chapter will focus upon issues that arose in Mr. O'Brien's practice which might illustrate a resistance to change. In this regard, it is of course the case that some of the issues in Mr O'Brien's practice addressed in the two previous chapters evince a resistance to change: for example, his approach to referral triage and his approach to the prescription of Bicalutamide 50mg. In the circumstances, this

[341] TRA- 12210, Day 92, Pg.88, 18-24

chapter will attempt to focus primarily on other issues in his practice, not yet considered in previous chapters. These include the following:

a. Admission for IV fluids and antibiotics;
b. Cystectomies;
c. Results and DARO;
d. Pre-operative assessment;
e. Monopolar in glycine *vs*. bipolar in saline resection in TURPs; and
f. Issues already addressed in previous chapters.

6.4 These issues engage a number of the Inquiry's Terms of Reference and, in particular, Terms (a) and (b).

6.5 At the outset of this chapter, the Trust acknowledges that it has been guilty of a number of failings in this area. In some instances, there was a failure to recognise that Mr O'Brien had not changed his practice to conform with what the Trust considered to be best practice. On other instances, the Trust had such a knowledge but was deficient in how it acted on foot of this knowledge.

(a) Admission for IV fluids and antibiotics

6.6 Notes of a meeting held on 20 April 2009 referred to the Trust having identified a cohort of patients who were admitted as elective cases for IV antibiotics and IV fluids as prophylaxis for recurrent UTIs. Dr. Damani, Consultant Microbiologist, met with the urology team to agree guidelines. Following this it was agreed that, if a patient were to be admitted for IV fluids and antibiotics, a meeting had to be held with Dr Sloan and a microbiologist and that "this pre-requisite was non-negotiable".[342]

[342] TRU-281944, Eamon Mackle to Mr O'Brien 16.6.11

6.7 Notwithstanding this protocol, Mr O'Brien continued to admit patients over a number of years, apparently without microbiology notice or agreement. See, in this regard, examples from the years 2010 to 2013 inclusive at TRU-259410 to 259411, TRU-281944, TRU-259904, and TRU-276833.

6.8 Mr Wolfe KC questioned Mr O'Brien about whether he considered that he was obliged to comply with the Trust's antibiotic policy. Mr O'Brien did not concede that he was so obliged but attempted to justify his actions.[343]

6.9 Mr Young gave evidence acknowledging that he also admitted patients after the protocol had been agreed (albeit in much smaller numbers than Mr O'Brien[344]) but sought to differentiate himself from Mr O'Brien, highlighting that his patients would have been symptomatic[345].

(b) Cystectomies

6.10 After March 2010 radical pelvic surgery, by direction of the Commissioner following the Drake report, was to be undertaken at the Belfast City Hospital. Mr O'Brien did not agree with this move, as was clear from his appraisal for 2011.[346] However, he further conveyed his misgivings to his patients, prompting Dr Stevens of the Belfast Trust on 28 September 2010, to write to the Trust in the following terms regarding Mr O'Brien:

> "*The lack of insight displayed by the surgeon, who then wrote letters suggesting that there was a callous disregard for patient welfare, is rightly unbelievable given the circumstances and the poor management decisions.*"[347]

[343] TRA- 12452, Day 94, Pg.74, Lines 5-13
[344] See, for example, the lists of their respective patients at TRU-259410-259411 and TRU-281847-281852
[345] See, for example, TRA- 09708 and TRA- 09710, Day 75, p32 and p34
[346] TRU-251248, November 2011 Appraisal
[347] WIT-99146 and TRA- 12445, Day 94, pg.87, Lines 23-28

6.11 Mr O'Brien did not accept that this had been drawn to his attention at the time. However, his evident reluctance to comply with the requirement to refer patients to Belfast City Hospital, notwithstanding the direction, highlights an intransigence and a reluctance to change his practice.

(c) Results and DARO

6.12 In 2011 the Head of Service wrote to all urological consultants relaying Mrs Trouton's direction that "*there is an expectation that investigative results and reports be reviewed as they become available and that one does not wait until patients' review appointments.*" Mr O'Brien wrote back to his Head of Service on 25 August 2011 in an email with 12 bullet points taking issue with the requirement[348]. A reasonable interpretation of this email was that Mr O'Brien would not be complying with the direction.

6.13 When asked about this resistance on Day 94 of the Inquiry Mr O'Brien claimed to be in agreement with the requirement in principle but qualified, "… The practicality of everything that we had to do, with inadequate time to do it, you know, you couldn't guarantee that you would be able to review all results."[349]

6.14 Mr. Wolfe KC also questioned Mr. O'Brien about his reluctance to use the DARO arrangement as a useful safety net[350] in a context where Mr. O'Brien's practice was instead to arrange a review with the result of the investigation being considered at that time, thereby leading to potential delay. Mr O'Brien continued to voice his 'grave reservations' about DARO in evidence. Mr Wolfe KC was forced to press Mr O'Brien as follows before he would accept the usefulness of the system at all:

[348] TRU-276805 to 276808 - email chain 25.7.11 to 25.8.11
[349] TRA- 12468, Day 94,Page 110, Lines 16 - 19
[350] TRA- 12489, Day 94, page 131, Lines 3-10

"*Given your experience of missed results jeopardising the safety of patients, is it not remarkable that when the Trust constructs this kind of governance arrangement that you decide to isolate yourself and your colleagues and not use it?"*[351]

6.15 These same reservations, and his opposition to using DARO, were also illustrated by an exchange of emails in 2019[352]. Collette McCaul emailed consultant secretaries on 30 January 2019 reminding them that DARO needed to be used and emphasising that, 'there is no way of ensuring that the result is seen by the consultant if we do not do DARO, this is our fail safe so patients are not missed'. Mr O'Brien replied on 6 February 2019 expressing his great concerns about the process , leading both Mr Haynes and Mrs Robinson to reply to him the following day emphasising, between them, the need to comply with the process, the 'safety net' role it performs, the fact that it is a Trust-wide process, and that it has been in place since Dr Rankin was Director of Acute.

6.16 And the Inquiry is aware that the backdrop to all of the above was not some theoretical or hypothetical concern for patient safety. In fact, all of the above occurred against a backdrop of there having been a patient of Mr O'Brien's where the failure to read and action a result did contribute to harm suffered by the patient, viz, the 'never event' in respect of Patient 95 when a surgical swab was retained post-surgery and not picked up due, in part, to a failure of Mr O'Brien to review and action results in a timely manner[353].

(d) Pre-operative assessment

6.17 On Day 94 of the Inquiry Mr Wolfe KC asked Mr. O'Brien, was it not the case that every patient required a pre-operative assessment. Mr O'Brien did not accept this.[354] He was referred to the cases of Patients 90 and 91 who missed out on the particular attention that a pre-operative assessment would have provided, which

[351] TRA- 12496, Day 94, Page 138, Lines 14-18
[352] AOB-07574 to 07577
[353] See WIT-17471 SAI report Patient 95.
[354] TRA- 12483, Day 94, Page 125, Lines 5-16

would likely have altered their treatment plans and he acknowledged that, if he had to do things over again, he might do things differently it. Nonetheless, he still appeared unwilling to shift in his view that pre-operative assessment was not necessary for every patient.

(e) Monopolar in glycine *vs*. bipolar in saline resection in TURPs

6.18 Mr O'Brien's reluctance to embrace change was amply illustrated by his response to the need for changes in urological and gynaecological practice announced by the Deputy Chief Medical Officer on 18 August 2015.[355] Mr O'Brien engaged in testing of new equipment for bipolar resection in saline but on 7 February 2016 declared: "*I will not use or try bipolar resection again.*"[356]

6.19 Mr O'Brien denied that he was required to "move over" to the new way of working answering:

> "*I wasn't required to move over. I was certainly facilitated in continuing to use monopole resection using glycine with all of the precautions that I had been used to since my training days in Dublin…*"[357]

6.20 Mr O'Brien described that there was a precision to dissection with glycine and so it was his preferred median notwithstanding that by April 2018 there was a requirement that saline was to be used.

6.21 Whilst there is no evidence of any higher incidence of hyponatraemia or other issues arising for his patients due to the continued use of monopolar resection in glycine, Mr O'Brien's response to this change of practice again illustrates an unwillingness to change to bring his practice into line with what was expected of him by the Trust and the Deputy Chief Medical Officer.

[355] WIT-54032
[356] TRU-395978 and TRA- 12503, Day 95, Page 5, Lines 20-25
[357] TRA- 12506, Day 95, Page 8, Lines 19-24

(f) Issues already addressed in previous chapters

6.22 Mr O'Brien's unwillingness to change his ways is, as acknowledged above, also evident from some of the issues addressed in previous chapters. Some notable features of those issues include the following.

6.23 In respect of the dictation issue, Mr Glackin was at something of a loss to understand Mr O'Brien's intransigence on the issue of dictating after each clinical encounter, describing it, in terms, as perverse[358]:

> *" It was raised with Mr O'Brien in the departmental meetings and … Mr Haynes raised a particular issue … the necessity to have a clinical letter dictated and available in the chart for every patient, and Mr O'Brien perversely expressed the view, perversely from my perspective, that it wasn't necessary to dictate on every patient, that he knew what was going on and he didn't have to write to the GP."*

6.24 In respect of triage, the Chair broached the issue of whether, on reflection, Mr O'Brien ought to have moved from his Rolls Royce approach to triage (which, at times, included Mr O'Brien telephoning the patient and having a mini consultation) to the way everyone else did it. A careful series of questions[359] culminated in the following: *'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 you to do it?'*. Mr O'Brien gave a long answer[360], expressing regret for people who missed out on an upgrade, alleging that the other consultants who got their triage done did it at the expense of patients, and bemoaning the fact that the Trust never gave them a clear understanding of what was expected from them in the form of triage.

[358] TRA-08755, put to AOB on Day 92, pg.75
[359] TRA- 12655 – 12656, Day 95 from p157 line 29 to p158 line 27.
[360] TRA- 12656 – 12657, Day 95 from p158 line 28 to p160 line 11.

But ultimately, he steadfastly declined to acknowledge that he ought, on reflection, to have adopted a different approach to triage, akin to that of his colleagues[361].

6.25 In respect of the Bicalutamide issue, Mr O'Brien's intransigence was also demonstrated in response to a question by Mr Wolfe KC on the last day of evidence to the Inquiry. Notwithstanding the breadth of evidence received in relation to the difficulties caused by prescribing too low a dose of Bicalutamide, Mr. O'Brien maintained that he was correct:

> *"Mr. Wolfe KC: 50mgs 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.*
> *Mr O'Brien: Well, with respect to those who made such claims, I disagree with them… ."*[362]

Failings on the Part of the Trust

6.26 The clear failings on the part of the Trust in respect of the above issues are both obvious and familiar. They can be summarised as:

a. failing effectively to grapple with some issues of which they were aware in a timely manner;

b. failing to grapple with other issues of which they were aware at all; and

c. failing even to be aware of further issues.

[361] The same refusal to accept that there was a better way than his way was evident in his response to Dr Chada's MHPS investigation – see, e.g., AOB-01893 2nd para under '1. Triage'.
[362] TRA- 12568, Day 95, Page 70

6.27 Category a. includes the issues of IV antibiotics and fluids and cystectomies, each of which were ultimately grappled with, albeit not as quickly as they might have been (in the case of IV).

6.28 Category b. includes DARO and results. The results issue was known about from as early as 2010 in the case of Patient 95 and the 2011 email exchange with Mr O'Brien. The DARO issue was also an issue that appears, based on the 2019 exchange of emails, to have been known about (at least in some quarters in the Trust beyond Mr O'Brien and his secretary) for some time.

6.29 Category c. includes the issue of continued use of monopolar resection in glycine after the bipolar resection equipment was available in the Trust[363].

Root Causes of these Failings

6.30 The root causes of these failings also appear to include causes which are both obvious and familiar (and which have been discussed at length in previous chapters). They include:

a. An inability or reluctance on the part of management fully to use both informal and formal tools to deal with Mr O'Brien, particularly when faced with what could be described as open defiance (as was the case in respect of DARO and results).

b. A lack of clarity about who was responsible for escalating or addressing issues coupled with an over-reliance on persons such as the consultant's secretary to raise an alarm (e.g., in respect of DARO or results).

[363] WIT- 103811 – 103812, S 21 No 20 of 2023- Mark Haynes Paragraph 1.18 *Consultants do not attend each other's operating lists and therefore I did not have an opportunity to identify that he was continuing to use monopolar resection. I do not have any specific recollection of being made aware by others that Mr O'Brien continued to use monopolar resection in glycine.*

c. A lack of coordination of information by, or between, managers (possibly due to silos) and/or a lack of time to 'stand back and look' at his practice and make the necessary links between his resistance to change in multiple areas.

d. Too high a level of deference towards and/or trust in Mr O'Brien, which is perhaps best encapsulated by Mr Haynes' evidence (given in the context of questions about Mr O'Brien's DARO email in early 2019 and an IR1 Mr Haynes submitted about Patient 92 shortly thereafter)[364]:

> *As I think I reflected about the 2017 concerns, I failed to recognise, broadly grouped together, the administrative concerns, the concerns that he wasn't actioning results, the concerns that he wasn't triaging; these issues. I failed to recognise that underneath these there was also an individual who wasn't managing patients in the way that they were supposed to be. I didn't have a high degree of suspicion at this time, and that's a failing on my part, that he was doing things in a different way. I wouldn't have imagined that an individual who had acted in the role I fill now as a Clinical Reference Group Chair for our cancer network group, who in sitting in that role had been instrumental in the development of guidelines in how to manage prostate cancer for Northern Ireland, had reviewed the NICE guidance as part of that; as part of that, as we've heard, that group had developed hormone treatment guidelines. I wouldn't have -- it didn't cross my mind as a suspicion that this individual, who seemingly has held positions that direct how things should be managed, is then in his own practice doing something completely differently."*

e. A lack of visibility into certain areas of his practice (e.g., in respect of his TURPs after bipolar resection equipment was available), perhaps in part as a result of deficiencies in clinical audit within the Trust.

Important Context

[364] TRA- 11419 – 11422, Day 88, Page 49 line 25 to p52 line 24.

6.31 It is important to recognise, in addition to the important points of context already identified in chapters 4 and 5, a number of pieces of context discrete to the above issues such as the following:

a. Mr O'Brien does appear to have conformed, albeit perhaps unwillingly, in respect of cystectomies and (more slowly) IV antibiotics and fluids. Mr Mackle, for one, considered that these were examples of issues in respect of Mr O'Brien ultimately being managed appropriately: *"Cystectomies, IV fluids, they were all Medical Director involvement and managing it, and perhaps that set the tone for how things should be managed after that."* [365]

b. Mr O'Brien appears to have believed, based on his own experience, that the IV antibiotic and fluid practice worked. He went as far in this regard as to publish a detailed letter (co-authored by Mr Young and Mr Kho) in a respectable medical journal setting out his results and experiences on this issue[366].

c. There is no evidence that Mr O'Brien's continued use of monopolar resection in glycine led to any harm.

d. There was a delay, related in part to the fact that capital expenditure demand always exceeded available capital (such that the Trust was always forced to deny or delay many requests for new equipment), in obtaining the bipolar equipment, such that, between testing the bipolar equipment and it arriving permanently, Mr O'Brien (like his colleagues) was reasonably able to continue using monopolar equipment.

Trust Actions to Improve / Restore Public Confidence / Protect Patients

[365] TRA- 02272-02273, Day 21, Pages 72-73
[366] WIT- 82743 - 82745

6.32 Many of the improvements initiated by the Trust in respect of the above issues have already been referenced in these submissions (and/or will be summarised in Chapter 7). For example:

a. In respect of results, the substantial improvements in this sphere have been addressed in chapters 4 and 5 and include the e-sign off facility, better training and guidance to secretarial staff, and the monthly information dashboard (including information regarding their triage, dictation, and results) available to all consultants[367].

b. In respect of medical management, significant improvements on this front have been described in the written and oral evidence of Maria O'Kane and Mark Haynes[368]. Maria O'Kane summarised the remodelling of medical management as follows: '*So, on the back of this report in 2020, what we did was revised - the job descriptions as Clinical Director and Associate Medical Director did not lend themselves to supporting the medical leadership that was needed. So we, you know, we undertook a complete revision of all of that, strengthened those roles, introduced an increased number of Clinical Directors and Divisional Medical Directors instead of Associate Medical Directors, increased - introduced Deputy Medical Directors and strengthened that function. All of the people who were selected were put through a fairly rigorous interview process and then have been given some support and training around that*'.[369] In short, the improvements include both better training given to, as well as greater numbers of, medical managers.

c. In the area of drugs Tracey Boyce[370] in her evidence to the Inquiry explained the pitfalls that exist with a paper based prescribing system and the positive changes which will be brought about with the introduction of Encompass: "*Today, we still have a paper-based system until Encompass starts in the South Eastern*

[367] See also Mark Haynes Transcript TRA- 11465 – 11468, Day 88, Page 95-98 and TRU-320269-Administrative and Clerical Standard Operating Procedure, Mark Haynes
[368] See also the Medical Leadership Review March 2020 at WIT-79127.
[369] TRA- 11689, Day 90, Page 17
[370] TRA- 05908, Day 46, Page 83

Trust later this year. If you have a full electronic prescribing system administration, you can sort of set safety alerts and safety nets for your junior staff and your senior staff as well into the system. If someone tried to prescribe subtherapeutic gentamicin, it would either stop them or they would have to put in a reason why. It would allow you then to sit back in my role or my team's role to run reports and overviews. There is an antimicrobial monitoring team in Trust now; that would be very useful for them. At the minute they have to hand collect the data. There was no way of sitting back and having alarms ringing, shall we say, that there was something unusual happening."[371]

d. And in terms of visibility of issues such as Mr O'Brien's continued use of monopolar resection, we have already touched in previous chapters upon significant improvements in the area of clinical audit. Mark Haynes summarised those improvements as follows: *"It's a huge change. So we have a member of staff from the audit team assigned to urology for audit purposes. She attends our Patient Safety meetings with us. She's constantly in communication with us with regard to the ongoing audit projects and, indeed, just yesterday was in contact with me about -- I think it's one of them on there or it's one that's on the current one. It's one of the ones through BAUS. It is there. It's the top one. So it's a much greater engagement and it's led to a massive improvement through the audit programme that we undertake in the team. As you say, what we have there is multiple levels of priority in terms of the department for audit, and they go down from "external must dos", down to "for interest", if you like, audit. The findings are presented at our Patient Safety meeting by our trainees. They have presented at our regional audit meeting for urology as well, and I know the trainees are looking at -- where appropriate, they're looking to put their projects in for presentation at national meetings as well."*[372]

e. And finally for present purposes, in respect of pre-operative assessment, Mr Haynes[373] described in his evidence how different the approach to pre-operative assessment is now: "*The preoperative assessment team are engaged and*

[371] TRA- 05909, Day 46, Page 84
[372] TRA- 11488, Day 88 Page 118
[373] TRA- 11484, Day 88, page 114

clinically led to try to improve that position. As I've said, within our service our theatre scheduling is done by our scheduler, so where patients haven't been through preoperative assessment, they are not added, or an active decision needs to be made and is made in communication between an anaesthetic team and a surgical team as to whether it is reasonable to proceed without it. Invariably the answer to that is no."

6.33 Thus, the panel can take comfort from the improvements implemented already by the Trust in this regard that the deeply unfortunate issues that arose with Patients 90 and 91 are unlikely to occur today.

Conclusion

6.34 As indicated above, the Trust accepts that it failed to take a sufficiently robust approach to managing Mr O'Brien's resistance to change / idiosyncratic practice across a number of areas and across a wide span of time. His unusual intransigence was undoubtedly a significant contributory factor in all of this and a feature that may well have posed significant challenges for any healthcare trust. Nonetheless, his unilateral, *'I know best'* approach to aspects of his practice was permitted to continue for too long.

6.35 The Trust also recognises that some of the above failings may have exposed patients to the risk of harm, for which it apologises.

6.36 However, the Trust believes that the Inquiry and the public can be assured by the remedial measures it has subsequently taken that recurrence, now or in the future, of the issues that arose in the above areas is unlikely.

Chapter 7

Trust Improvement Work

7.1 Substantial improvement by the Trust in its systems of management and in its clinical and social care governance architecture are essential in order to help achieve the related goals of restoring public trust and confidence and reducing the risk of the events with which the Inquiry is concerned recurring.

7.2 The substantial improvements the Trust has carried out across multiple areas have already been considered at various points in previous chapters, in particular in chapters 4, 5, and 6 in the context of the specific issues that arose in Mr O'Brien's practice and the failings that those issues laid bare in respect of the Trust's systems of management and governance.

7.3 However, the depth and breadth of the improvement piece (coupled with the fact that it is, necessarily, always a work in progress) means that it would simply not be practicable to seek to enumerate in a submission of this nature every significant improvement undertaken by the Trust, particularly where the Inquiry has itself elicited and digested multiple witness statements, many thousands of pages of disclosure, and many hours of testimony on this important topic.

7.4 In the circumstances, all that this chapter does is to seek to supplement what has gone before in chapters 4, 5, and 6 by providing a guide to where some of the important evidence on the whole Trust improvement piece can be found. In doing so, it will approach the topic under the following headings:

a. The Champion Review;
b. Chief Executives' evidence;
c. The Dr Hughes SAI Reviews;
d. The Royal College of Surgeons Invited Review;
e. The RQIA Report;

f. GIRFT;

g. Trust Board Reform.

(a) The Champion Review

7.5 Some of the backdrop to why the June Champion Review was considered necessary during 2019 can be found in the evidence[374] of Shane Devlin, Trust Chief Executive from 2018 to 2022. In short, he had concerns that the 'spend' on governance seemed light, that he had a concern about the absence of regular flow of Clinical and Social Care Governance ('CSCG') information to the SMT, and he was concerned regarding the level of data on quality and safety coming to SMT. Similar evidence was given to the Inquiry by Maria O'Kane, who was Medical Director at the relevant time and who, together with Mr Devlin saw the need for clinical and social care governance reform within the Trust[375].

7.6 The November 2019 June Champion 'Clinical and Social Care Governance Review'[376]made 48 recommendations (which are at WIT-47007 to 47012) covering everything from Board Governance to 'being open' to management of adverse incidents and SAIs to clinical audit to morbidity and mortality.

7.7 Since the publication of the report, the progress of the Trust implementation of Ms Champion's recommendations can be charted by reference to a Trust spreadsheet which is updated as the recommendations are implemented. The version applicable when Dr O'Kane gave evidence in March 2024 can be found at TRU-306233 to 306243 and was up to date as at 05 March 2024. Of the 48 total recommendations, 34 had been completed and 14 were in progress.

7.8 Maria O'Kane put flesh on the bones of the report and the implementation spreadsheet by explaining in her oral evidence[377] the impact of the Review and the

[374] WIT-00036 bottom third of page to WIT-00038
[375] TRA-11605 -11606
[376] WIT-46954 to WIT-47012
[377] TRA-11676 and TRA-11772

changes brought about under it, she explained some of the progress of its implementation and what it has led to including her Corporate Governance and CSCG Governance Functions and Structures Proposal[378] as well as the restructuring of the Acute Directorate into two smaller, more manageable directorates[379].

(b) Chief Executives' Evidence

7.9 Not only have the current Chief Executive and her predecessor been able to provide evidence about the backdrop to, and drivers for, initiatives like the Champion Review, they have been able to provide the Inquiry with other useful evidence regarding improvements in governance and other areas.

7.10 For example, Shane Devlin's evidence also provides details of reforms he initiated in respect of the senior management team structure[380].

7.11 In a much broader sweep, Maria O'Kane has in her evidence been able to provide considerable detail of improvement and reform work undertaken during her tenure as both Chief Executive and Medical Director – i.e., from 2019 onwards. For example:

a. In her statement no. 29 of 2022 (from WIT-44934) she summarises multiple governance improvements introduced during her tenure. For example:

i. From WIT-44973 to WIT-44977 (para 7.9) she details governance improvements in multiple areas including adverse incidents, SAIs, clinical audit, patient safety, complaints, medical oversight of litigation, M&M, learning from experience, whistleblowing, 'being open' culture, MHPS, medical appraisal, revalidation, job planning, private practice,

[378] WIT-47270
[379] TRA- 11772 to TRA-11778
[380] WIT-00031-00033 at question 7

medical education, infection prevention and control, R&D, emergency planning, and business continuity.

ii. From WIT-445014 to WIT45027 (para 21) she provides details of some of the above improvements under the headings of medical professional governance improvements, clinical and social care governance improvements, and strengthening of medical leadership (including, in particular, in Urology).

iii. Some further detail on the above changes is contained in the tables at para 36 (WIT-45041) and para 37 (WIT-45043) and, in more detail, in para 51 (WIT-45082) and the attachments referenced there. An overview is then provided at para 71.16 (WIT-45184 to WIT-45186).

b. In her statement no. 3 of 2022 (from WIT-11149) she summarises improvements undertaken in response to the 2018 MHPS Determination and the Mr O'Brien SAI Reviews (at WIT-11161 to WIT-11172).

c. In her oral evidence to the Inquiry in March 2024 (TRA-11525 to TRA-11944) and through more recent disclosure to the Inquiry (such as that running from TRU-305017 to 306518) she has been able to bring the Inquiry up to date in respect of the reforms outlined in the above witness statements.

(c) Dr Hughes' SAI Reports

7.12 The 9 SAI Review Reports and Over-arching Report were produced in the Spring of 2021 and can be found at DOH-00001 to DOH-00135.

7.13 A 'Task and Finish Group' was created to oversee the implementation of their recommendations, Terms of Reference for which are at WIT-11509 to 11510.

7.14 Mark Haynes addresses the 2020 SAIs in his oral evidence on Day 88.[381]

[381] TRA- 11456- Transcript 22 February 2024 p86 line 107- p108 line 132 and at TRA- 11522 p152 line 4- line 22.

7.15 Maria O'Kane also addressed the progress of implementation of the recommendations in her evidence from TRA-11737 to 11754 and 11763 to 11766.

7.16 The BSO audit (TRU-305875 to 305886) of implementation of the recommendations has also been made available to the Inquiry and was considered in evidence at TRA-11748. It showed 65% implementation by November 2023.

7.17 A more up to date picture of the state of implementation (as of 8 March 2024) can be found in a tabular document at TRU-306489 to TRU-306514 and was addressed by Dr O'Kane in her evidence, the 68 SAI recommendations were 'streamlined' into 11 major recommendations with 'subtitles' beneath them. A simple overview of the table reveals that the overwhelming majority of the recommendations have been shaded green, meaning that they have been implemented.

(d) The Royal College of Surgeons Invited Review

7.18 This has been described in the previous chapter. In summary, within their report the Review Team identified 17 recommendations which fell into two categories, urgent recommendations to address patient safety risks, and recommendations for service improvement.

7.19 These recommendations were the subject of an implementation action plan within the Trust. The iteration of the action plan considered in evidence is dated 9th October 2023 and can be found at TRU-304948 to 304965. As with other such plans it use a 'RAG' rating and, of the recommendations in October 2023, 4 were red, 9 were amber, and 4 were green. Implemented steps include developments such as the implementation of a new consent police (recorded at TRU-304951). Of the recommendations where implementation had not commenced by late 2023, some of these related to issues beyond the control of the Trust. For example, recommendation 12 - '*The Trust must ensure recognition amongst management and*

clinicians that no patient should wait for longer than a pre-agreed period for surgery and follow up'[382]. Commissioning and resource restraints evidently hinder the Trust's capacity to act on same. Recommendations 4 and 14, marked 'red', relate to recommendations for audits which capacity is awaited. It is submitted that, of the recommendations which have been completed or are in progress, the action plan contains a detailed timeline of steps taken to address the recommendations[383], and it shows that significant improvements have been made.

7.20 In terms of oral evidence on the issue, Maria O'Kane gave evidence back on Day 15[384] about the backdrop to inviting the RCS in to carry out the review and she was taken to a number of the above documents regarding implementation of their recommendations in her evidence on Day 90 from TRA-11766 onwards.

(e) RQIA

7.21 The RQIA produced a review report in respect of the Trust's SCRR process in September 2022 [385]. It contained 18 recommendations which can be found from TRU-157770- TRU- 157773. Briege Donaghy of RQIA gave evidence on Day 86 of how these recommendations were accepted by the Trust[386].

7.22 Evidence of the progression of implementation of these 18 recommendations (which were broken down into 25 separate required actions[387]) can be found in a number of places including, for example:

(a) TRU-181971- TRU-181981- This 11-page tabular document (in the familiar RAG-rated format) shows the state of play in respect of implementation in

[382] TRU-304960
[383] TRU-304959- By way of example recommendation 11 which is now marked 'green' required the Trust to review waiting list processes, the specific steps taken to implement this recommendation are date stamped and include recruitment of a Scheduler, confirmation audits will be undertaken relating to private patients moving to the public sector and waiting list processes/prioritisation of patients, and exploration of pooled waiting lists ,
[384] TRA-01572 Day 15, p161, line 19 to p162 line 15 and TRA- 01576 p165 line 19 to p166 line 3
[385] TRU 157737-TRU157782
[386] TRA-11217 Day 86, p56, lines 7-13.
[387] i.e., some recommendations distilled to more than one action.

November 2022, very shortly after the RQIA report was issued. At that stage, 9 actions were rated green, 13 were amber, and 3 were red.

(b) TRU-183363–TRU183377- This (now 15-page) version of the same document shows the state of play by April 2023, approximately 6-7 months post-publication of the report. By that stage, 22 actions were rated green, 2 were amber, and 1 was red. This remains the position and is related to the fact that the lookback has not yet concluded.

(f) Getting it Right First Time ('GIRFT')

7.23 The October 2023 *'Getting It Right First Time - Urology across Northern Ireland'* Report can be found at TRU-320188, and its general recommendations at TRU-320193 to 320195 and its Southern Trust specific recommendations at TRU-320218 to 320220.

7.24 The GIRFT report is enlightening because it gives the Inquiry some potential insight into how the Trust's Urology Service compares with others in Northern Ireland. As we have done in the other chapters, we highlight this as a potential important point of context. Of potential note in this regard are a number of features including:

a. The recruitment issues that are apparent in the Trust compared to its comparators – see the table at TRU-320200;

b. The impressive array of services performed by CNSs in the Trust compared to other NI Trusts – see the table at TRU-320201;

c. The waiting time averages across the Trusts – see the table at TRU-320202;

d. The breadth of stone services the Trust offers – see the table at TRU-320213.

7.25 In the family of reports and reviews yielding up recommendations to the Trust, GIRFT is a mere youth, having reported only in October 2023. Nonetheless, the Trust have been actively implementing the recommendations and, even at November 2023, it is clear that substantial progress had been made with 33% of recommendations 'in the green' – see in this regard the TRU-320313 to TRU-320331.

7.26 By 6 March 2024 the updated Action Plan updated (at TRU-306468) 39% of the recommendations had been implemented.

7.27 The impact of the GIRFT report was described in detailed terms by Mark Haynes in his evidence on Day 88[388]. He described how it was 'broadly welcomed'[389] that 'it supported the direction of travel we wanted to go'[390] and that GIRFT is led by clinicians and supported by the urology team in the Trust[391] Again, by way of potentially important context, and as fairly noted by Mr Wolfe KC in his questioning of Mr Haynes, the GIRFT report recognises the decade long deterioration of urology services in NI and how it is underrepresented in terms of urologists per head of population[392] .

(g) Trust Board Reform

7.28 Eileen Mullan, who has been a non-executive director on the Trust Board from 2016 and Board Chair since December 2020 has provided quite a bit of written and oral evidence charting improvements at the level of the Trust Board and its committees. This can be found in her witness statement from WIT-100434 to WIT-100568 and in the transcript of her evidence on Days 77 and 78 from TRA-09938 to TRA-10190.

[388] TRA-11493 Transcript page 123, TRA-11496 p 126, TRA-11500 p130 line 17 – p137 line 5
[389] TRA-11501 Transcript p131 line 12
[390] TRA-11504 Transcript p134 lines 23-24
[391] TRA-11505 Transcript p135 lines 11-14
[392] TRA-11505 Transcript p135 line 28 to p136 line 20

7.29 A non-exhaustive list of examples of improvements and reforms covered by Ms Mullan in her detailed witness statement include the following:

a. Ms Mullan, who was still a NED when the Champion Review was commissioned has provided evidence on the outworkings of the Review at WIT-100462 to 100464.

b. On the issue culture, she has described initiatives taken by her to encourage an 'open, honest and psychologically safe environment' (WIT-100466 at para 15.7).

c. She has described improvements in reporting from committees to Trust Board which she has initiated (WIT-100475 para 18.8) and in developing a Trust Risk Appetite Statement (WIT-100479 para 21.5).

7.30 In her oral evidence on Day 77, Ms Mullan provided multiple examples of improvement at Board level. Some examples include the following:

a. She was asked to look at the Terms of Reference of the Governance Committee and what she then knew about the evidence, and she indicated that the Governance Committee was not provided with the information in light of what we know now, through the Inquiry[393] .She went on to indicate that the Governance Committee's Terms of Reference would now be satisfied by the way in which information is brought to the committee. She referred to being at a changeover in relation to what comes to the Governance Committee and how it is coming. In particular, she referred to a requirement now that Committee Chairs in their reports to Trust Board detail escalation, meaning that the Committee Chair must take ownership of what the committee is escalating or not escalating[394].

[393] TRA- 09953- TRA 09954 Transcript Day 77 p16-17
[394] TRA-09955- TRA09956 p18-19

b. She referred to a layer of oversight now present which wasn't previously when asked about the Board or the Governance Committee having any involvement in the outworking of SAI recommendations and ensuring themes of governance that might emerge are dealt with, referring to an action plan being expected and follow up to the Board or the Committee in relation to progress[395].

c. She also addressed the Trust's new process of reporting from MHPS to the Governance Committee, referring to a synopsis of the issues and details of any out-workings and updates which now provides Board visibility into any MHPS processes underway in the Trust.[396]

7.31 In her evidence on Day 78, she provided further examples of improvement including:

a. In relation to separate processes of MHPS, Appraisal, and SAI, and to the joining up of intelligence, she gave evidence about how different things are now.[397]

b. She referred to improvements in reporting aspects of clinical and social care governance including the Champion Review, clinical audit, and unified governance leads.[398]

c. She addressed the learning from a Board governance perspective at WIT-100557 and, in her evidence[399], addressed the issue of culture and her efforts to demystify what the Board is, to take away any view that the Board is a secret place, and to open it up, given its importance to what happens in the hospital.

[395] TRA-09975 p38
[396] TRA-10060- TRA10061 p123-124
[397] TRA-10106- TRA 10107 Transcript Day 78, p4-5
[398] TRA- 10110 Day 78, page 8
[399] From TRA- 10125, page 23

d. She gave evidence about the positive changes made to the committees of the Trust Board.[400]

e. She spoke about the challenge of, and her efforts in, trying to shift the culture of the leadership walk from one of inspection to one about getting a real sense and feel for what is going on in the unit and to bringing the Board closer to the teams.[401]

f. When asked by Dr. Swart what was the most significant improvement that she has been able to make and what she still thought needed to be done she responded as follows:

> *'I think it's making the Board a collective, responsible Board together. I think that has been achieved in the last three years. My worry list would include having the resources and capacity to deliver and what we need to do to really transform Health and Social Care for the Southern Trust but to effect the changes so that patient safety issues and concerns no longer exist'.*[402]

g. She was also asked by Dr. Swart about lessons learned, whether the right people go to meetings now, whether that is working, and whether she had got to the stage of presenting thematic learning to the full Board for the year and what had been changed. She answered:

> *'I'll take the last one first. We are not there yet, we are not there yet. The outworkings of the Champion review, the operation of governance layer that has been put in place, we are only starting there in terms of that feeding through. My aspiration is it will do just that, it will do just that. But I am hoping over the course of this incoming year we will see that bed in, the committee bedding it in and the teams then certainly being able to feed up what needs to be the focus of attention for the committee and the areas of*

[400] TRA- 10133, p31
[401] TRA-10157, p55
[402] TRA- 10162-TRA-10163, Transcript Day 78, p60-61

concern and risk. I do get a sense, though, listening to our Directors, because they are a few months ahead of us in terms of their delivery of the operation, that they are being exposed to more than they have ever been exposed and they are unpacking things more than they unpacked before. I am getting a sense that there is a real visibility for them across a broader piece and they are joining dots.'[403]

h. She also, in answer to questions from the Chair about recommendations the Inquiry might make, gave evidence about the burden of work involved in implementing various extant Inquiry recommendations, the resource-consuming nature of that, and her desire to see Trusts supported to deliver that implementation rather than having to place the burden on existing employees with 'already very demanding and difficult jobs'.[404]

Conclusion

7.32 Then Trust hopes that the above overview and guide to some of the main improvement initiatives discussed in evidence before the Inquiry will assist the Inquiry in navigating the broad expanse of evidence that is now before it on the issue of improvements and reforms undertaken by the Trust which should significantly reduce the risk of the problems of the past recurring.

[403] TRA-10164, p62
[404] TRA-10184-TRA-10185 p82-83

Chapter 8

The Impact of Our Failings

8.1 Mr Wolfe KC rightly emphasised, at the very outset of the Inquiry's hearings, that, 'while the Inquiry will be anxious to learn of and understand the patients' clinical experience, it is not the function of this Inquiry to make findings about the clinical outcomes in individual cases'[405].

8.2 The Inquiry has, of course, examined some individual cases very closely but this has primarily been in the realm of cases which were, or which ought to have been, SAIs and this examination has taken place, not so as to enable findings to be made about individual patient outcomes, but to enable the Inquiry to reach an informed decision about the governance of patient care and safety in the Trust's urology specialty (in discharge of its obligations under Terms of Reference (c)).

8.3 One outworking of this has been that the SAIs, in particular (but not exclusively) those in respect of Patients 10-15 and those undertaken by Dr Hughes, have received a substantial amount of attention and their facts are therefore well-known to the Inquiry.

8.4 Cognisant, however, of the Inquiry's important public role and, in particular, its purpose of restoring public confidence, the Trust considered it appropriate in this submission to point the Inquiry to some of the broader evidence, beyond the SAI Review Reports, that addresses the question of the impact upon patients of the issues which the Inquiry is investigating. In the circumstances, this chapter will briefly address the following issues:

a. The Lookback Review (and related SCRR process) undertaken by the Trust in respect of Mr O'Brien's patients;

[405] TRA-00011 lines 17-20.

b. The Royal College of Surgeons Invited Review;
c. The BCG Audit undertaken by Mr Haynes;
d. The Bicalutamide Audit undertaken by Mr Haynes.

(a) Urology Lookback Review

8.5 Details of this Review and the related SCRR process can be found in a number of places in the evidence provided to the Inquiry to date including in:

a. the amended Section 21 witness statements No.1 of 2022[406] and No. 1A of 2022[407] of Maria O'Kane, both of 13 May 2022; and
b. in the *Urology Lookback Review Activity and Interim Outcomes Report Cohort 1* of 9 August 2023 [408].

8.6 The details of the Cohort 2 portion of the Review have not yet been put into a formal report. When they have been, the report will be promptly shared with the Inquiry. The details in respect of Cohort 2 that have been factored into the paragraphs below emanate from the current draft *'Southern Trust Urology Lookback Review Activity and Outcomes Report for Cohort 2'* (which includes a summary of the Cohort 1 and Cohort 2 outcomes combined)[409] and are included so as to provide, at the date of these submissions, the most up-to-date picture possible.

8.7 The first cohort of the Lookback covered the period 1 January 2019 to 30 June 2020 and involved all of Mr O'Brien's patients during that time. It amounted to a total of 2112 patients.

8.8 The second cohort covered the periods 1 April 2010 to 31 December 2018 in respect of patients diagnosed with a urological cancer and 1 April 2013 to 31 December 2018 in respect of renal stone disease patients. These two groups of patients were

[406] WIT-20070
[407] WIT-20108
[408] TRU-305965 to 305991
[409] It is anticipated this will form part of the June upload of disclosure to the Inquiry.

identified because experience of the Trust with Cohort 1 was that certain patient groups were more likely to have the potential to require a change in their management plans. In addition to the above 2 groups, Cohort 2 also any patient who, at the time of its commencement in 2023, continued to have an "open episode" under the care of Mr O'Brien (i.e., was at that time on an outpatient review waiting list and / or on a waiting list for a procedure) and who was not already included in one of the above 2 groups. It was also open to any private patient of Mr O'Brien who had any concerns about their clinical management. Unlike Cohort 1, Cohort 2 covered only patients who were alive because the primary focus of the Lookback Review was to establish if patients were on a secure clinical pathway and, if not, to remedy that error.

8.9 Certain cases (albeit not all cases[410]) in Cohort 1 that met the threshold for an SAI went on to be considered through the SCRR process.

8.10 Across Cohorts 1 and 2, the outcome can be summarised as follows:

a. A total of 2302 patients (2112 in Cohort 1 and 190 in Cohort 2) have had their treatment and care reviewed. There are currently no remaining patients in either Cohort left to be reviewed.

b. There were no concerns in respect of 1810 Patients.

c. Concerns, both clinical and non-clinical, were identified in respect of 492 patients.

d. 543 patients were seen in a recall clinic. The reason this number is larger than the 492 patients in respect of whom there were concerns is because it was

[410] From 7 March 2023 onwards, only case that met the SAI threshold and disclosed some new learning point (i.e., one not already raised in one or more of the cases already processed for SCRR) went on for SCRR.

decided that any 'no concerns' patient who had cancer would still be seen at a clinic. These no concern cancer patients numbered 51.

e. 353 of the 543 patients required a change in their treatment at care. The categories of these changes were treatment, medication, referral, and diagnostics. Many of these changes were relatively minor. Only 1 of the 353 was in Cohort 2.

f. However, 163 of the 543 patients met the SAI threshold. 141 were from Cohort 1 and 22 from Cohort 2.

g. 78 of the 163 cases were considered in SCRR. The detailed outcomes are beyond the scope of this chapter but the themes (in terms of patient impact) and clinical learning can be themed as follows:

i. Delays or absence of reports/ investigations;
ii. Lack of / poor communication;
iii. Incorrect treatment;
iv. Un-actioned MDM outcomes including onward referrals and planned reviews;
v. Delays / omissions in triage;
vi. Not following up on / actioning outcomes of diagnostic scans;
vii. Prolonged use of intravenous antibiotics;
viii. Practice in relation to operative procedures, including the removal of stents and gaining consent;
ix. Prescription of unlicensed medication as an incorrect form of treatment;
x. Not utilising / referring to the Cancer Nurse Specialists for support and nurse-led interventions;
xi. Not providing patients with options and choice in relation to their treatment pathway (i.e., informed consent);
xii. Not following NICE guidelines.

8.11 The Cohort 2 Outcomes Report, referenced at para 8.6 above, is in draft and is being forwarded to the DOH-led Urology Assurance Group for consideration. The Trust hopes to publish this report, once finalised, by the end of June 2024.

8.12 The Trust is currently conducting a review of the deceased patients who were under the care of Mr O'Brien during the period 2010 – 2018 and who would have been included in Cohort 2 had they been alive (para 8.8 above refers). Once complete, the Trust intends to produce a composite report which will capture all of the clinical learning that has emerged from this entire lookback exercise.

(b) The Royal College of Surgeons Invited Review

8.13 On 9 November 2020, Dr O'Kane, then Medical Director of the Trust, asked the Chair of the RCS Invited Review Mechanism (IRM) to perform an invited clinical record review of some cases of Mr O'Brien's.

8.14 The review team were to consider 100 patients from the period January and December 2015. Their terms of reference asked them to consider the standard of care with specific reference to a number of (now familiar) issues including, for example, communication with patients (including patient consent), follow up action including onward referral, and completeness of patient records in respect of episodes of care. They were to identify if harm had occurred and any patients who may require follow up[411].

8.15 The RCS Review Team began their work in April 2021 and reported on 29 September 2022[412]. In his opening speech to this Inquiry, Martin Wolfe KC stated that: *'The Inquiry may take the view that the Trust cannot be blamed for the delays on the part of the Royal College … often thorough and comprehensive work is beset by unavoidable and unanticipated delays."* [413]

[411] Section 2 of the Report.
[412] TRU-345848-TRU-345965
[413] Day 7, Page 101, lines 16-26

8.16 The RCS team, for reasons they explain in their report, ultimately reviewed 96, rather than 100, patients' notes[414]. Some of the points emerging from the review were as follows:

a. The review team identified multiple areas for improvement.

b. They identified concerns in multiple cases on issues such as investigations (e.g., failing or delaying in obtaining them and in acting upon them)[415], team working[416], follow-up action on patient care[417], completeness of patient notes[418].

c. They identified significant concerns in several cases in areas such as assessment of patients[419], treatment (e.g., in respect of the prescription of Bicalutamide and delayed surgery)[420], and communication (e.g., in respect of consent)[421].

d. The review team did not consider there to be significant concerns arising in respect of patient harm in 90 of the 96 cases reviewed. Their view was that clinical management of these patients was acceptable and had led to no harm[422].

e. In 3 cases the patients' care was deemed unacceptable and, as a consequence, these patients' standard of care was of concern[423].

[414] Section 3.
[415] Section 3.2
[416] 3.6
[417] 3.7
[418] 3.9
[419] 3.1
[420] 3.3
[421] 3.5
[422] 3.10
[423] 3.10

f. 7 out of 96 cases were identified as requiring clinical follow up to ensure patient safety (although the team acknowledged that some of these 7 may, by the time of the report, actually have been followed up)[424].

8.17 The Inquiry may feel it can reasonably conclude that the RCS Invited Review provided important assurance to the Trust (and to the public) because it identified issues the Trust were aware of through their own identification of issues with Mr O'Brien's practice and Lookback Review. Many of the recommendations mirror recommendations in processes such as SAI Reviews relating to a number of cases. Maria O'Kane acknowledged this in her evidence[425]*:*

'I think one of the things that stands out for me is that the work that was undertaken by the Royal College of Surgeons, and they reported on 96 patients over a period of time, I think it was in and around 2010 to 2015, triangulates the findings that we had discovered in relation to our own lookback review in cohorts 1 and 2. So in terms of adding assurance to the robustness of our process, I thought that was helpful, because essentially they had similar findings, and I think there is certainly an overlap in terms of approach to the outworking's of, you know, what has come out of the nine Hughes's SAIs, you know, what we've learned in terms of our own internal lookback process and then what has resulted from the Royal College of Surgeons document.'

(c) BCG Audit

8.18 On 17 August 2022[426] the Chair of the Public Inquiry wrote to the Trust identifying a patient safety issue arising from the Section 21 witness statement of Mr David Connolly (received by the Inquiry on 11 August) which the Chair asked the Trust to investigate. It arose out of the following portion of Mr Connolly's statement[427]: "*Similarly, he* [Mr O'Brien] *did not like using intravesical BCG therapy for high-risk non-muscle invasive bladder cancer and preferred Mitomycin therapy*".

[424] 3.12.
[425] TRA-11767-TRA-11768
[426] TRU-309777-TRU-209778
[427] WIT-41996 para 70.3

8.19 On 30 August 2022[428] the Chief Executive, Dr O'Kane, indicated that the Trust would carry out an audit, which was duly carried out by Mr Haynes.

8.20 In his report on the audit[429], Mr Haynes describes how they investigated patients in the Lookback cohort plus patients first diagnosed with *high risk non muscle invasive bladder cancer* during the 2012-2013 and 2013-2014 financial years (as Mr Connolly worked in the Trust from September 2012 to March 2013). He also recorded an important point of context, viz, that there have been times in the past when the supply of BCG has been problematic and that this has, on occasions, had a bearing on the treatment available to patients.

8.21 While the data set for the twenty-seven 2012-2014 patients lacked some information in a few cases (e.g., clinical justifications were missing from some patient notes), Mr O'Brien was not deemed to be an outlier in any respect and Mr Haynes was able to conclude as follows:

> *From the data collected over this time period there is therefore no evidence that patients under the care of Mr O'Brien during this time period were less likely to be offered BCG in the management of their high risk non muscle invasive bladder cancer than patients under the care of the rest of the urology team.*

(d) Bicalutamide Audit

8.22 In October 2020, Mark Haynes conducted a 'rapid review'[430] of patients receiving Bicalutamide in the management of their prostate cancer. The purpose of the review was to identify if those patients required change to their prostate cancer management, in light of the patient safety concerns raised relating to Mr O'Brien's prescribing of 50mg Bicalutamide. In a letter to the GMC dated 21

[428] TRU-309779 to TRU-309782.
[429] TRU-320011 to 320015 plus attached documents from TRU-320016 to 320185.
[430] TRU-346161

October 2022[431], Mr Haynes stated: '*The purpose of the review was simply to identify patients who required clinical review as a matter of urgency in order to consider their ongoing prostate cancer care.*' The review covered patients receiving both Bicalutamide 50mg and 150mg prescriptions during the period between March 2020 and August 2020, as this cohort of patients were most likely to be still receiving the treatment and potentially be in need of change. He describes reviewing 764 patients records on NIECR.[432]

8.23 Mr Haynes discussed the parameter of the review in evidence on Day 88:

> *"What I've done is look at all 764 patients in them Trust areas which included all consultants in the Southern Trust and also included patients who were under the care of urologists in the Western Trust, so the Altnagelvin team; also included patients in the Northern Trust which covered some of the Altnagelvin team. So there were patients who were under the care of all Southern Trust consultants, under a number of consultants from other Trusts, and patients who were under the care of oncology teams. So that piece of work was not limited to Aidan O'Brien, but that was not the Lookback Review. That piece of work to identify patients who needed a change in their treatment."*[433]

8.24 The outcome of the review is detailed by Maria O'Kane[434] and is referred to in detail at paragraph 5.9 above. In summation, a total of 466 patients were identified from the Western, Northern, and Southern Trust areas as having received a prescription for Bicalutamide 50mg. Of these, 34 were identified as not meeting the recognised indications and 31 of these patients had been commenced on Bicalutamide 50mg by Mr O'Brien.[435] The management of the patients concerned was reviewed accordingly and corrected.

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[431] TRU-346161
[432] TRU-346162
[433] TRA-11400-TRA-11401
[434] As referred to by Dr. O'Kane at WIT-20089 in response to Section 21 Notice 1a of 2022.
[435] See above, paragraph 5.9 for detail relating to these patients and Transcript Day 88, Page 31, line 23-29, Page 32, lines 1-6

Conclusion

8.25 These different lookback exercises (save for the BCG Audit) demonstrate that shortcomings in the practice of Mr O'Brien and in the management and systems of the Trust have had an impact on many patients' care, albeit that, fortunately, the impact appears to have been of potential significance in only a small percentage of cases.

8.26 It is believed that all of these exercises should provide significant reassurance to the public, to the Inquiry, and to the Trust because, where issues need to be addressed, these exercises have identified them clearly, thereby enabling the Trust to address them.

Chapter 9

Conclusion

9.1 The Trust is very grateful to the Inquiry for having considered this written closing which has undoubtedly already gone on for longer than is optimal.

9.2 This closing chapter is not intended to rehearse or summarise all that has gone before. The Inquiry will, by this point, have considered not only the preceding pages but also the voluminous documentary evidence placed before it over the last 2-plus years.

9.3 More importantly, the Inquiry has had the enormous benefit of receiving detailed testimony from the many witnesses who were at the heart of the failures the Inquiry is considering and/or who have been involved in the substantial improvement efforts aimed at ensuring such failures never recur.

9.4 In this particular regard, and focusing (as these submissions must) on the current and former servants or agents of the Trust who have provided evidence to the Inquiry, we submit that the following points should not be controversial:

a. These witnesses are or have been hardworking, diligent public servants.

b. Many have been truly impressive.

c. They have all demonstrated their desire to assist the Inquiry by putting large amounts of thought, care, time, and effort into their engagement with the Inquiry, whether that be in their written statements, in their consultations with Inquiry Counsel (and their preparation for same) or in their oral evidence (and their preparation for same), all of which can be very stressful. Many have been in the witness box for more than a day.

9.5 Almost every Trust witness has acknowledged that opportunities were missed by them and others or that mistakes were made. There was broad consensus that things could, and often should, have been done better across multiple areas and that many of the Trust's systems simply were not good enough.

9.6 When witnesses have acknowledged missed opportunities or mistakes, on their own part and/or in respect of others, it is important also to acknowledge that such shortcomings are almost never the result of the relevant person simply being careless in how they go about their work. Indeed, it is clear that many of the witnesses frequently went beyond the call of duty in the workplace (as Mr Wolfe KC very fairly acknowledged in his opening) and that many of them exist and operate at a level of concentration and precision in their work that may be foreign to many of us.

9.7 Looking back, and as the analysis in chapters 4 to 6 (as well as the various lookback and review exercises considered at chapter 8) hopefully shows, it is clear that the causes of the Trust's failings were multifactorial. They range from:

a. cultural issues, e.g., in respect of a reluctance to challenge a consultant of Mr O'Brien's standing or in respect of an apparent paralysis in some managers, rooted in their perception that their remedial options were strictly binary: either a very informal prompt or a very formal MHPS process;

to

b. systems failures in the Trust's clinical and social care governance structure, e.g., in the field of the reporting, coordinating, screening, and (if appropriate for SAI review) reviewing adverse incidents;

to

c. management failings, e.g., in the coordination of information about the extent to which Mr O'Brien was deficient in multiple areas of his practice and the need to consider his practice more broadly;

to

d. factors which, often to a large degree, are beyond the Trust's control, related to: resource constraints, increasing service demand, and the resulting capacity:demand mismatch (with the attendant impact upon the workload and busyness of clinicians, managers, administrative, and support staff).

9.8 Together, these failings created a situation where:

a. known and unknown issues with a clinician grew and worsened; and

b. colleagues and managers had either little or no time, and/or no obvious facility, to enable them to 'stand back and look' and assess the threat posed to patient safety by this doctor.

9.9 When referencing the opportunity for Core participants to file written closing submissions, the Chair rightly reminded those before the Inquiry of the importance of its Terms of Reference ('ToR'). Turning to them now, and recasting the Terms as questions, they perhaps reduce to the following relatively straightforward questions, with the following relatively straightforward answers (in light of all that has been said in the preceding chapters of this Submission):

a. *ToR (a)* –

Q: Were there concerns or circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation into Mr O'Brien's practice at an earlier stage?

A: Yes.

b. *ToRs (b) and (c)* –

Q: Were the corporate and clinical governance procedures and arrangements within the Trust at the time adequate?

A: No.

c. *ToR (d)* –

Q: Were the experiences of patients what they ought to have been?

A: No.

d. *ToR (e)* –

Q: Was the MHPS process or its application an effective tool in addressing the issues with Mr O'Brien?

A: No.

9.10 Fortunately, the above distillation is not an end to the matters being considered by the Inquiry and it is hopefully clear to both the Inquiry and to the public that very substantial work[436] has already been undertaken by the Trust to improve in all of the areas where it has been exposed as deficient, some of which was commenced before this public inquiry was announced.

9.11 Of course, securing and protecting patient safety must, in the world of health care, necessarily always be a journey rather than a destination. As the authors of the July 2019 NHS England *'Patient Safety Strategy - Safer Culture, Safer Systems, Safer Patients'*[437], observe: *'Safety is not an absolute concept and has neither a single objective measure nor a defined end point'*. The Trust is acutely conscious of this and, from a very practical perspective relevant to the Inquiry, it necessarily means that the state of the Trust's improvement initiatives will be different now than it was when the last Trust witness (Dr O'Kane) gave oral evidence in March 2024, and it will be different again by the end of this year, and by the time the Inquiry is

[436] Some of which improvement work has been addressed in chapters 4, 5, 6, and 7.
[437] https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

readying its Report for publication. Thus, there is a need for the Trust to continue to keep the Inquiry informed, in whatever manner the Inquiry would prefer, of the improvement journey, so that the Inquiry and the public can be assured that past mistakes are much less likely ever to be repeated, thereby restoring public confidence.

9.12 Finally, the Trust wishes to acknowledge and express its gratitude for the hard work, dedication, and patience of the Inquiry Panel, Counsel, Solicitors, and Staff. The Inquiry's close, forensic examination of working practices, procedures, and systems in the Trust has (as alluded to above) not always been a comfortable experience for those who have had to provide written and/or oral evidence, nor should it be. But it has necessarily provoked reflection and change within the Trust. The Trust recognises that the Inquiry has sought to be fair to all those from whom it has heard. No doubt the Inquiry will continue to exercise fairness to Core Participants and witnesses in the way it has done to date and, in the event that it is considering making any significant criticism of them, will afford them the opportunity to respond to such criticism before its report is finalised and published.

9.13 The Trust remains ready to assist the Inquiry in its important task and looks forward to the Report of the Inquiry in due course.

31st May 2024

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Michael McGarvey BL
Elizabeth Ferguson BL
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