Urology Services Inquiry

# Oral Hearing

## Day 96 – Thursday, 13th June 2024

**Being heard before:** **Ms Christine Smith KC (Chair)**

**Dr Sonia Swart (Panel Member)**

**Mr Damian Hanbury (Assessor)**

**Held at:** **Bradford Court, Belfast**

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INDEX

WITNESS PAGE

THE INQUIRY RESUMED ON THURSDAY, 13TH JUNE 2024
AS FOLLOWS:

CHAIR: Good morning, everyone, it's a very full house today, and welcome back, those of you who I haven't seen for a while. Mr. Lunny, I've seen you. 10:02

CLOSING SUBMISSION BY MR. LUNNY:

MR. LUNNY: Good morning, Chair, good morning, Dr. Swart, and good morning, Mr. Hanbury. 10:02

The Southern Health and Social Care Trust is very grateful for the opportunity to make a short oral closing, because we recognise, having regard to your procedural protocol, that the making of any form of closing is not something we have a right do. 10:02

As you're aware, the Trust, for whom I appear, is the independent legal entity that came into existence on 1st April 2007 under the Southern Health and Social Care Trust (Establishment) Order (Northern Ireland) 2006, but it is also its staff, because when the Trust interacts with its patients, it does so through its nurses, its doctors, its secretaries and its other staff, and as Mr. Haynes put it on Day 14 of the Inquiry's hearings, and I quote: "We are the Trust". 10:03 10:03

In terms of managing your expectations this morning,

and as we did at the start of our oral opening statement, it's important that I outline to you what this closing is not. It is not, you will be grateful to hear, an attempt to summarise all the evidence heard by you or all the evidence given by Trust witnesses or even our written closing. You have all of those, and you will undoubtedly assess them carefully, comprehensively and fairly, and you'll reach your conclusions in due course. 10:04

It is also not a Defence - with a capital D - nor an attempt to shift blame or responsibility onto others and it is not aimed at some other audience like the GMC or the media. Rather, it is addressed to you, Chair and Panel, and to those whom you represent through this Inquiry, the public, and, it is an attempt to say or, perhaps more accurately, to repeat, a small number of things, things that the Trust considers to be important, and those things are, in summary, first and fundamentally, we are sorry. 10:04 10:05

Second, we believe that we have engaged cooperatively, collaboratively and in the correct spirit with the Inquiry. 10:05

Third, we have recognised and reflected upon our failings and we have engaged meaningfully with the issues being examined by the Inquiry, viewing them more as a positive opportunity rather than a negative

challenge.

And fourth, finally, and perhaps most importantly of all, we have improved.

10:05

I'll now deal with each one of those four topics briefly and in turn.

So, first, we are sorry. The Trust, as you are aware, apologised at the very outset of your public hearings. 10:06
We did not wait until the end of those hearings to do so. We said, in quite some detail across what ultimately became more than six pages of your transcript, that we are sincerely sorry for our failings and for the harm that has resulted. We did 10:06
not mince our words, we did not offer a pseudo-apology, we did not use the passive voice or phrases like "it is regrettable". Our apology, given at the outset of the hearings, has been repeated and endorsed by several of our witnesses, most notably by the Chief Executive of 10:06
the Trust, Dr. Maria O'Kane, on her very first day in the witness box, on Day 15, and by the Chair of the Trust Board, Eileen Mullan, on her first day in the witness box on Day 77.

10:07

I don't propose to repeat verbatim the apology I gave at the outset, but it can be found at TRA-00641 to TRA-00647, but I will, if you will allow me, attempt to distil it to its essence.

The Trust apologises to affected patients and their families, because, ultimately, it is the patients whom each of the Trust and this Inquiry serves; to the broader public and to its staff, many of whom do, as Mr. Wolfe KC very fairly acknowledged in his opening on Day 6, "every day go beyond the call of duty". 10:07

The Trust apologises for the fact that the care given by it to a number of patients fell below what was acceptable and that, in some cases, this will have caused or contributed to harm. The Trust also apologises for the fact that this substandard care was the result not only of failings on the part of individuals for whom the Trust is responsible, but also of broader, more fundamental failings in the Trust's systems, The Trust's processes and its structures in areas of management and clinical and social care governance. 10:08 10:08

As was the case back on Day 8 when I offered the detailed public apology, both Dr. O'Kane and Mrs. Mullan were present, and they are here again in the chamber today and, by their presence, they again endorse the apology that I make. As you know, both Dr. O'Kane and Mrs. Mullan have been present on other days during the life of the Inquiry. They have both provided evidence themselves and participated very significantly in the Inquiry. Their written answers to 10:08

the questions posed by the Inquiry across a number of Section 21 notices fill more than 500 pages, excluding their exhibits, and, between them, they spent almost six days in the witness box.

10:09

Finally, in relation to the 'we are sorry' theme, in our opening I stated that the Trust's apology was neither a token nor an empty apology. I acknowledged, whilst the Chair had quite rightly highlighted that the Inquiry cannot, because of Section 2 of the Inquiries Act, determine the civil liability of the Trust in respect of its treatment of any patient, the Trust, nonetheless, wish to state openly, in respect of any cases where harm had occurred that ought to have been avoided, its clear commitment to meeting any resulting claims in a timely way.

10:09

10:10

By way of an update and cognisant of that particular commitment, I can confirm that, to date, 11 statements of claim have been received and we have so far admitted breach of duty in respect of most of them.

10:10

If I can turn now to the second point I identified, and that's the question of our cooperation and collaboration with the Inquiry.

10:10

Paragraph 44 of the Inquiry's procedural protocol of October 2021 sets out in clear terms the Inquiry's expectation that those engaging with it will adopt a

collaborative and cooperative approach. In your opening of the Public Inquiry hearings on Day 6, Chair, you made it clear what you expected in this regard. You said at TRA-00293:

10:11

"It is our hope that all who were asked to help the Inquiry in fulfilling its Terms of Reference, do so frankly and openly and in a spirit of collaboration, remembering that the entire raison d'etre for the Inquiry is to help secure patient safety." 10:11

In our opening on Day 8, I indicated that the Trust wished to reassure the Inquiry and the public of its continued cooperation and, on the part of the Trust's legal team, I assured the Inquiry of our commitment to 10:11 the two-way street of collaboration and cooperation with the Inquiry's lawyers. We hope the Inquiry considers that the Trust has lived up to those commitments. In this regard, I can confirm that, as of yesterday, 12th of June 2024, the Trust has disclosed 10:12 almost 415,000 pages of potentially relevant documents to the Inquiry; it has provided, through witnesses whom the Trust legal team represents, 158 Section 21 statements; the Trust has directly assisted, through the legal team, 85 witnesses, 45 of whom were called to 10:12 give oral evidence across approximately 60 of the 92 days on which the Inquiry heard from witnesses; the Trust has 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, for example, Mrs. Gishkori; and the Trust has assisted other staff who have been amongst the 200-plus nurses and registrars who received questionnaires from the Inquiry. 10:12

We also hope, Chair, that the Inquiry can see that the Trust's witnesses have cooperated and collaborated fully and, as I will come on to shortly in my third topic, that they have attempted to meet the Chair's 10:13 expectation that witnesses would use the Inquiry as an opportunity for reflection on what has occurred.

As you recognised, Chair, in your opening of the public hearings on Day 6, engagement with a public inquiry can 10:13 be challenging for individuals. There are multiple reasons for this, but, as lawyers who have acted in different capacities in a number of public inquiries over the years, there is always a risk that we will overlook or underestimate those significant challenges 10:13 and stressors, and it's, therefore, if you will allow me, important to remind ourselves and the public of what some of those challenges and stressors are.

First, the context in which any public inquiry takes 10:14 place is usually an unhappy one. Some crisis or catastrophe will have occurred, leading to an inquiry being set up, and just as it is natural for people to seek to avoid crisis and catastrophes, it is also

entirely natural to seek to avoid association with them or to seek to avoid any reminders or reliving of them.

Second, a public inquiry inevitably means exposure to forensic examination by lawyers, both in writing through Section 21 notices and orally at hearings, as well as focused questions from an eminent, experienced and expert Chair and panel, interactions or events that, at the time when they occurred, may have occupied mere minutes during a hectic working day, can be the subject of quite appropriate detailed questioning which lasts exponentially longer than the interactions or events themselves. Few, few of us welcome such levels of scrutiny. 10:14 10:15

Third, a public inquiry's hearings take place in public, and in the modern era, and in this jurisdiction at least since the RHI Inquiry in 2017, this means that a witness's oral evidence to an inquiry will be live-streamed to as many members of the public as want to watch it, with snippets being available for editors to broadcast on the radio or TV news. Again, few welcome such public exposure, but it is an entirely necessary part of a modern public inquiry process and, entirely separate from the Inquiry's ultimate report, it does perform a vital role in discharging the inquiry's accountability function. 10:15 10:15

Fourth, whilst those at the higher levels of any

organisation, such as directors, chief executives, chairs of boards, may reasonably expect to have to account publically for the organisation or for their own actions or omissions, for example, before a public meeting of a board or before a committee of the Assembly, such an expectation does not attach to employees like nurses and administrators, secretaries, managers and doctors, and yet, most witnesses before an inquiry like this one will be nurses, administrators, secretaries, managers and doctors. 10:16

Fifth, a public inquiry may look into events that occurred several years ago. For example, in this Inquiry, we've spent quite significant portions of time looking at issues relating to IV antibiotics and fluids and cystectomies, all of which occurred between 10 and 15 years ago, and, of course, not every important human interaction will be recorded in contemporaneous documents. Even when such interactions are recorded, the recording may be in summary form only, such as is the case with minutes of meetings. So, public inquiries can present significant memory challenges for many witnesses. 10:17

Sixth and penultimately, many witnesses will have to manage the challenges of a public inquiry whilst holding down a demanding day job. This is particularly true in respect of public inquiries in the healthcare sector. 10:17

Seventh and finally, there is always the potential that an inquiry will criticise a witness's actions or omissions. Naturally, very few of us welcome criticism, even less so the potential occupational or professional consequences that might flow from it. Many of the challenges I've just mentioned are unavoidable. However, it's important that I acknowledge that where it has been possible to ameliorate them, the Inquiry has done so, whether that be by way of granting extensions to witnesses in respect of Section 21 statements or by attempting to ensure that any potential hearing date suits a witness or by affording clinician witnesses ample notice of their hearing dates so that rotas could be managed to ensure no patient was inconvenienced, or by getting witness disclosure bundles issued earlier so as to allow busy clinicians time to read them, or, finally, by vacating a hearing date at short notice when tragic events, in the form of a fatal road traffic accident, affected some of those in the Urology service. For these actions on the part of the Inquiry, the Trust was, and remains, extremely grateful. 10:18 10:18 10:18 10:19

In spite of the various challenges, Trust witnesses have engaged positively with the inquiry. In particular, every single Trust witness from whom the Inquiry has sought a Section 21 witness statement, has provided one, indeed some have provided several 10:19

statements, and all have applied themselves to the task of providing detailed, meaningful, considered answers to the Inquiry's questions, and every single Trust witness from whom the Inquiry wished to hear orally has provided oral evidence to the Inquiry, even if it meant returning, sometimes unexpectedly in the case of a few of Mr. Wolfe's witnesses, for an additional day or days in the witness box. 10:20

If I could move on then briefly to the third issue I mentioned at the outset; namely, how the Trust and its witnesses have recognised and reflected upon our failings and engaged meaningfully with the issues being examined by the Inquiry. This goes beyond the headline statistics that I have just summarised of Trust cooperation in terms of pages disclosed or statements submitted or witnesses called, and relates really to the quality and substance of the Trust and its witnesses' engagement with the issues being investigated by the Inquiry. 10:20 10:21

Again, on Day 6, in your opening of the public hearings, Chair, you rightly encouraged those persons and bodies with whom the Inquiry was engaging, to reflect upon their relevant actions and omissions, and the reference is TRA-00293. You said: 10:21

"We recognise that the Inquiry process is challenging for everyone involved, but hope that those who are

involved see the Inquiry process in itself as an opportunity for reflection on what has occurred and an opportunity to correct mistakes that might have been made."

10:21

We submit to you that our witnesses have been appropriately reflective and they have been willing to confront the spectre of their own shortcomings and acknowledged them. There are numerous examples of this throughout the evidence, throughout the landscape of the written and oral evidence that lies before the Inquiry, but by way of a few brief examples, we have the following:

10:22

First, Mrs. Corrigan, who was Head of Service for Urology, along with one, then two and then three other specialities from 2009 to 2021, she recognised her shortcomings in her very first witness statement to the Inquiry, when she said:

10:22

"I will also acknowledge from the outset that there have been failings on my part."

When, in her oral evidence on Day 57, she was asked by Ms. McMahon KC:

10:22

"Do you feel that you made any mistakes?"

Mrs. Corrigan's characteristically frank response was:

"Oh, absolutely."

And you can find that at TRA-07406 from lines 4 to 6.

Second, we have Mr. Mackle, Associate Medical Director with responsibility for Urology, in the period 2008 to 2016. He acknowledged his failure to view Mr. O'Brien's repeated issue with triage as a serious governance concern and acknowledged that a thorough investigation ought to have been undertaken, and that's at TRA-02176. 10:23 10:23

Third, Mr. Haynes, both in his Section 21 statement of September 2022 and in his oral evidence on Day 10, spoke of his personal regret that he didn't think that a deeper look into Mr. O'Brien's practice was required at the time of the MHPS investigation, and you can find that both in his witness statement at paragraph 77.1 and his transcript from TRA-00853 onto 00854 and again at 00862. 10:23 10:24

Finally, in this regard, Mr. Devlin, who was Chief Executive of the Trust between 2018 and 2022, in the context of the monitoring of Mr. O'Brien that went on after the start of the MHPS process, Mr. Devlin reflected on and apologised for the fact that they did not poke, prod or probe Mr. O'Brien's practice further and, therefore, failed to identify the issues that had not been in plain sight but which came to a head in 10:24

2020. He acknowledged further the possibility that the harm, or risk of harm, to the nine patients that became SAIs under Dr. Hughes in 2020, may have been avoided had this been done, and that's at TRA-01682. These are but a handful of examples of many such instances of sometimes difficult but entirely necessary and appropriate and helpful self-reflection. 10:24

Looking beyond individual witnesses to the Trust itself, you will recall that also on Day 6 of the hearings, Mr. Wolfe, in his opening statement to the Inquiry, offered the following profound call or challenge to all of those involved in the Inquiry: 10:25

"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." 10:25

At the very other end of the Inquiry, on Day 91, superficially in answer to questions posed at that point by Mr. Wolfe but perhaps also in answer to the broader call or challenge he laid down on Day 6, Dr. O'Kane offered her reflection on the Trust's Inquiry experience, and this is at TRA-11890, and I 10:26

preface this quote by giving you notice that I have edited out of it, just for completeness' sake and for clarity, I have edited out of it the verbal tick that so many of us here suffer from, of filling pauses with the phrase "you know". So, as I say, if you want to read the full, unvarnished or unpolished transcript, it's TRA-11890. And Dr. O'Kane said: 10:26

"But I honestly have to say that it has been helpful to us in that, even though it has generated a huge amount of work, I think it has made us think really carefully about our business, about the work, the work that we do and how we deliver it. I think it has helped us focus on the importance of governance and what's located within all of that. It has certainly given us the opportunity, I think, to reach outside the organisation in terms of really thinking about how things can be done well, and certainly the colleagues from across the rest of the UK have been hugely helpful in relation to that and I think it probably has helped the relationships within the Trust because we've had to depend very heavily on each other and to really support and understand the pressures that the clinical teams have been under, particularly the Urology team, in order to sustain this whole process. So, even though it has taken effort and time and all of the usual things, I do think, overall as a process, it has been enormously helpful to us." 10:27 10:27 10:27

In response to a question about whether the Inquiry had, to date, led to clinicians adopting a defensive practice, Dr. O'Kane, at TRA-11892, replied as follows:

"I think we've tried to approach this as an opportunity for learning rather than defensiveness and hopefully that is borne out." 10:28

We certainly hope that it's apparent to the Inquiry, through all that it has seen and heard, and, in turn, that it is apparent, through the Inquiry to the public, that the Trust has actively approached both the issues examined by the Inquiry and the process itself more as opportunities than as challenges. In particular, in this regard, the Trust has viewed the Inquiry and the events giving rise to it as an opportunity to identify, reflect upon and be candid about its failings, an opportunity to learn from its failings and improve and an opportunity to change, in particular, culture. Some examples of this include, but are not limited to, the following three steps: 10:28 10:28 10:29

First, before any public inquiry was ever anticipated, indeed before all of the shortcomings, the Trust's shortcomings relating to or, perhaps more accurately, revealed through Mr. O'Brien, were even apparent, the Trust had recognised that there were significant shortcomings in its systems and had taken steps to address these. An exemplar of this is the 10:29

commissioning of the June Champion Clinical and Social Care Governance Review in 2019, and that was commissioned by the then-Chief Executive, Mr. Devlin, and the then-Medical Director, Dr. O'Kane, each of whom was, at that time, relatively new to the Trust. And I will come on presently just to mention briefly some of the reforms associated with that, that review, under topic four. 10:30

Second, in 2019, the Trust began and has, during the currency of the Inquiry, developed its engagement with Mersey Care NHS Trust, which is a high-performing English Trust, and this has been to assist in developing what is known as a just and learning culture, where staff, rather than feeling inhibited about speaking up when they have concerns, are supported to do so. 10:30

Third, in November 2022, the Trust set up an External Reference Group, or ERG, chaired and populated by experienced people from outside the Trust, along with some senior Trust personnel, to assist the Chief Executive and directors in their work to address the shortcomings which the issues giving rise to the Inquiry have exposed. The last of these, the External Reference Group, may be considered to be of particular note on the theme of critical self-reflection, because it was entirely a Trust-initiated project at a time when the Trust was already subject to a large amount of 10:30 10:31

scrutiny, not only by the Department, through The Urology Assurance Group, but also by the Inquiry.

Mrs. Trouton explained the purpose of the ERG to colleagues during 2023 as being: 10:31

"To fulfil the role of a critical friend by providing independent challenge and support to the Chief Executive and directors who were leading the Southern Trust's improving organisational effectiveness programme." 10:31

And the reference for that is TRU-303726.

Dr. O'Kane, in answer to questions from Mr. Wolfe, described the ERG's origins and purpose in the following terms at TRA-11629, and again I am editing out the "you knows": 10:32

"I was particularly shocked by the fact that we'd had this blind spot that we discovered in the summer of 2020 and I felt that the history in recent times in relation to Mr. O'Brien and what had happened, was full of blind spots and actually here was another one. And I had been inadvertently complicit with it and that troubled me, and I think that, on the basis of that, I started to have conversations with people. I mean, it resonated with some of the other members in SLT just in relation to how we would take this forward. So, I 10:32 10:32

spoke broadly to trusted advisers around the system in relation to, if you're faced with something like that, how do you develop a reflective mirror for your own organisation to spot things that you don't normally see? Because there is a whole psychology of groupthink and finding yourself repeating mistakes, and all of that, inadvertently. So the advice I got back then was to maybe think about bringing together a group of experts, which I did." 10:33

10:33

And she then described the various external experts she was able to secure to sit on the group.

She stated then at TRA-11632:

10:33

"That, I felt, gave us a really robust group of experienced experts who wouldn't be frightened to challenge us as a group in terms of some of our thinking, had huge years of experience in the NHS and understood it ultimately or intimately and had enough distance from the system at this point in time to be able to see us a bit more clearly than we could see ourselves." 10:33

And the Inquiry has seen some of the outworkings of the ERG in the evidence and in the documents, including the documents periodically produced by the ethicist Veryan Richards, who listened to our Inquiry hearings, who identified themes under headings like leadership and 10:34

governance, quality and patient safety, culture and behaviour, and then provided feedback and posed challenging questions to the Trust, some of which Dr. O'Kane, in her oral evidence, very frankly described as being hard for the Trust to hear, and again, the reference for that is TRA-11909.

One example of a positive change borne out of the ERG through the involvement of colleagues from NHS Improvement Scotland, has been the increasing use by the Trust of the Scottish analytical framework, what I think Dr. O'Kane, in her evidence, described as the "Scottish heat map", and this has been used now across all directorates in the Trust. This framework is used to keep an eye out for early warning signs of deterioration in systems and processes which may lead to patient harm if not identified and remedied. In the context of the sorts of issues the Inquiry has been considering, this tool reduces the likelihood of there being blind spots and it increases the ability of the Trust to join the dots and, therefore, to intervene to address issues at an earlier stage, and I am instructed this has already been found to be helpful in both mental health services and laboratory services.

So, in light of these and many other initiatives, we submit that the Trust could not reasonably be accused of sitting back and waiting for the Inquiry to tell it what to do or how to change; rather, the Trust has

embraced the opportunity for self-improvement identified in both the Chair and in Mr. Wolfe's opening remarks.

This takes me on then to the fourth and final issue identified at the outset: improvement. This is, very obviously, an important topic in any public inquiry because of the inquiry's key purposes of ensuring that lessons have been learned so as to avoid any repeat of any past mistakes and restoring public confidence in the relevant institution - in this case, the Southern Trust. 10:36 10:36

As we outlined in our written closing submission, improvement in the context of healthcare is a perpetual journey. Nonetheless, we suggest that, in the context of the issues being considered by the Inquiry, the Trust has travelled quite some distance in its improvement journey over the last four to five years. This journey has obviously been the subject of much written and oral evidence received by the Inquiry; for example, from witnesses like Dr. O'Kane, Mr. Devlin, Eileen Mullan and Mr. Haynes. Some of it has been summarised in our written closing, much of it has been evidenced in our disclosure. In short, the Trust has 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 10:36 10:37 10:37

the Trust which were revealed by the Mr. O'Brien issues.

For present purposes, I seek only to illustrate how things have been improved with a small number of examples. 10:38

If we, first of all, consider improvement at the level of the individual patient and through the lens of a case with which the Inquiry is very familiar, and that is Patient 1. We have seen his IR1, his SAI Review Report and his relevant medical notes and we've heard compelling oral evidence from his daughter, in the presence of his widow, back on Day 5. We have also had the unusual but substantial benefit of access to his personal diary from the relevant time and we have also heard expert oral evidence in respect of his treatment pathway from Mr. Gilbert and from Mr. O'Brien's expert, Professor Kirby. For present purposes, his case can be summarised as follows: 10:38 10:38 10:39

On [redacted], Patient 1 was advised by Mr. O'Brien of his diagnosis with Gleason 4 + 3 prostate cancer and commenced on Bicalutamide 150 initially, but then switched to 50 because of the effects of that drug. 10:39

On 31st October 2019, he was considered at MDM, which recommended commencing androgen deprivation therapy

(ADT) and referral for external beam radiotherapy (EBRT).

[redacted], he was seen again by Mr. O'Brien, and then again on a number of occasions in 2020, in January and March and beyond. We know all of that from his medical notes. From his diary, we gain an insight into how he was feeling and how he deteriorated over that time. I will not open those entries today, but they run from PAT-001402 to 001414, and they are compelling. 10:39 10:40

What we can also see from his diary are two entries which relate to the issue of his referral to Oncology for EBRT. The first is at PAT-001379 and it's on [redacted], the day he was advised of his diagnosis. He has recorded: 10:40

"Not a good day really, intermediate risk cancer, referred for radiotherapy and hormone replacement." 10:40

Then, on [redacted], at PAT-001400, a date when he saw Mr. O'Brien, he appears to have noted what he understood to have happened:

10:41

"Referred to oncologist at City Hosp."

However, in spite of the MDM recommendation of October 2019 and in spite of what had been recorded in

Patient 1's diary in [redacted] and [redacted], he wasn't referred to Clinical Oncology for EBRT until June 2020, when he was seen by Mr. Haynes. He sadly passed away [redacted].

10:41

Two of the key deficits identified by the SAI review were the failure to action the MDM recommendation and the failure to ensure he had a key worker.

Mr. Gilbert is very clear in his opinion that the MDM recommendation, in particular the referral to Oncology for EBRT, ought to have been implemented straight away. Mr. O'Brien disagrees with that. And it is, of course, important to note in this regard that whether either deficit made any difference to Patient 1's ultimate outcome, is properly a matter for civil proceedings and, if necessary, a civil court, not for the Inquiry. Quite correctly Mr. Gilbert, for his part, was clear in his oral evidence to avoid expressing any opinion on whether earlier referral to Oncology for EBRT would have made any difference.

10:41

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10:42

Nonetheless, from the Inquiry and the public's perspective, key concerns arising from this case are that an MDM recommendation went unactioned and no key worker was allocated and, whatever the reason for these omissions, the Trust appears to have been unaware of both of them.

10:42

Because of the Trust's improvement work since that time, we can now provide reassurance that these deficits are much less likely to arise now. In this regard, Mr. Haynes described in some detail to you, in his evidence on Day 88, how there are now monthly snapshot audits of the implementation of the recommendations of all local cancer MDMs to identify any failures of implementation. This development is also recorded in the RAG-rated SAI Action Plan, which the Inquiry has seen, which charts the implementation of all of the Dr. Hughes' SAI recommendations, and I shall return briefly to it in a moment, but for your note, the most recent iteration of it, provided this week in disclosure, is at TRU-309818. 10:43 10:43 10:44

We also, in relation to the deficits I have just mentioned, know from witnesses like Martina Corrigan and the various clinical nurse specialists, that there is now a full complement of clinical nurse specialists able to undertake the role of key worker and, from the SAI Action Plan, we know that the name of the key worker assigned to a patient is now recorded on CaaPS, either during or soon after their cancer MDT meeting, and that pending an enhancement to the CaaPS system that is related to the Encompass rollout, a BOXI - B-O-X-I - report is now run monthly from CaaPS to ensure that all patients are allocated a key worker. Both of these changes form part, and I stress only part, of what Mr. Haynes, in answers to questions from 10:44 10:44

the Chair at the end of Day 88, considered to be the most important change in the Trust in recent years; namely, much greater visibility into individual clinicians' practices and how they work, and this is gained, for example, through audit and through data collection and data reporting. Mr. Haynes emphasised that, without such visibility, there is a risk of a clinician practicing in isolation, something which Mr. Haynes recognised could be "dangerous for the individual clinician as much as it is for the patient. With the benefit of such data, this risk is significantly reduced." 10:45 10:45

And Mr. Haynes' overall verdict on the current state of the Urology cancer MDT, in light of the above and other improvements, was as follows, and the reference for this is TRA-11478: 10:45

"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." 10:46

To finish this issue, the Inquiry has seen the evidence of how implementation of all of the Hughes SAI recommendations has been tracked and monitored through the RAG-rated SAI Action Plan I mentioned a moment ago. You've heard how, for example, by November 2023, 65% of 10:46

the recommendations had been implemented in full, with the remaining 35% being partially implemented, with work ongoing.

As of June 2024, the position is that 86% have been fully implemented, with the remaining 14% partially implemented, with work ongoing. And I'm instructed that some of the partially implemented issues are beyond Trust control. 10:46

10:47

Moving beyond the example of improvement viewed through the prism of an individual patient to broader structural change across the Trust, we have the Champion Review, and again, for your note, that report can be found at WIT-46954. 10:47

As the Inquiry is aware, the Champion Review of Clinical and Social Care Governance in the Trust was commissioned in the spring of 2019 and it reported near the end of that year. Its origins lay on a realisation 10:47 on the part of both Mr. Devlin, then Chief Executive, and Dr. O'Kane, then Medical Director, both of whom were relatively new to the Trust, that Trust government systems were inadequate.

10:47

Dr. O'Kane, in her witness statement, number 29 of 2022, spoke of her perception that some of the key functions that were required to assure governance supporting patient safety, were rudimentary and some

were not fit for purpose, and you can find that in her answer at paragraph 71.16 in that statement, and she elaborated on this in her oral evidence on Day 15 at TRA-01419 and Day 89 at TRA-11608.

10:48

Shane Devlin, for his part, in his witness statement, in answer to question 29, explained that the review in respect of the Cawdery murders was a major catalyst for him to commission the governance review so as, in part, to improve the SAI process.

10:48

As you know, the Champion Review made recommendations for significant change across a large number of areas. I won't list them all, but they include Board governance, the Being Open Framework, controls

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assurance, management of adverse incidents, including SAIs, complaints and litigation management, clinical audit, morbidity and mortality, governance information management systems such as Datix, corporate and clinical social care governance structures and the

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interface between corporate and directorate clinical and social care governance.

In her evidence on Day 15 at TRA-01419, Dr. O'Kane described how the Trust has been working its way

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through the 48 recommendations that Ms. Champion produced and how they had significantly invested in the related improvements and how she believed that, even by that point, in December 2022, the Trust was "in a very

different place to where it had been previously". And both Maria O'Kane and Eileen Mullan gave evidence about how, at Trust Board and Trust Board committee, governance structures have significantly improved with, for example, a much better flow of relevant information up to and, if appropriate, on through the Board's Governance Committee. 10:50

The state of implementation of the Champion recommendations has moved on since Dr. O'Kane gave her evidence in March of this year, with the up-to-date position being that 35-and-a-half of the recommendations have been fully implemented, while 12-and-a-half are in the process of implementation. Of the recommendations that are in the process of implementation, a few are outside the control of the Trust, many are well under way, some are parts of longer-term pieces of work and some have been delayed pending regional work; for example, work in relation to the SAI framework. 10:50 10:51

Improvement work in the Trust is clearly ongoing. Work remains to be done to implement fully the SAI recommendations and the GIRFT recommendations, but much progress has been made, and its continuing, and I've given you the update in relation to the SAIs and the Champion Review. I haven't given you the update in relation to GIRFT, which, as you know, is an October 2023 report. 10:51

Having been at 33% green in November 2023 and then 39% green when Dr. O'Kane gave evidence to you in March of this year, we are now at 56% green, 33% amber, i.e. in progress, and 11% red, and I am instructed that the two red recommendations are regional recommendations that require implementation across the entire region, and you can see all of that in the document at TRU-309783. 10:51

So, we submit that both the Inquiry and the public can, therefore, be reassured by the very substantial improvements that have been made, and that are continuing to be made, by the Trust across the Board. 10:52

All of these improvements significantly reduce the chances of the problems that manifested themselves in or through Mr. O'Brien's practice recurring. Of course, it is an inescapable fact that these improvements have occurred and must continue to occur in a Health Service that exists in an ever more challenging financial landscape. One only need look at any of the newspapers here in the last week to see what our health minister has been saying about the inadequacy of what has been allocated to his department in the most recent budget and the potential serious consequences that could flow from that. This, undoubtedly, represents a very significant challenge to our Trust and to all of the other Trusts in Northern Ireland. It also, we submit, brings into sharp focus 10:52 10:52 10:53

the need to identify improvements that do not consume more resources, what was described as "working differently" during exchanges between Mr. Wolfe and Mr. Haynes on Day 88 of the hearings.

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In this particular regard, we heard Mr. Haynes' evidence about the need to make better use of existing resources, whether that be in terms of being more efficient about who needs a review appointment or utilising virtual reviews for some patients or 10:53 expanding the range of clinicians who can perform procedures on a patient and, on the last of these, the Inquiry has received evidence about how the Southern Trust is a leader in terms of ensuring that its highly skilled clinical nurse specialists are trained and 10:54 equipped to perform ever-greater numbers of procedures, thereby freeing up the relatively scarce consultant urologist resource for procedures that only a consultant surgeon can perform, and there is a good example or a good summary of all of that in the GIRFT 10:54 report, as to where the Southern Trust sits with clinical nurse specialists relative to other Trusts. We submit that the current financial climate also highlights the important of initiatives like GIRFT and the implementation of the recommendations, not just by 10:54 the Southern Trust but regionally and by all Trusts. Mark Haynes perhaps provided the best explanation of the importance of GIRFT in today's stretched NHS environment, in his evidence on Day 88 at TRA-11502.

He said:

"I think effectively the aim of the GIRFT document is about what things outside of more resource can be done to deliver care more effectively. It encourages, as you see within that recommendation that is in front, the use of advanced nurse practitioners and physicians' associates to deliver care which would have previously been delivered by doctors. It encourages the developments of high volume, low complexity surgical centres. It encourages network working for a service to support and maintain the service, in the case of kidney cancer services in the recommendations here. It encourages the development of specialist centres, so you make, if you like, the non-specialist centres attractive to recruitment. It aims to address all the things outside of more resource being put in that can improve the service for patients but also for the staff delivering that care." 10:55 10:55 10:55

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All of that said, greater efficiency can only ever deliver so much. It can only ever be one part of a bigger jigsaw, and it obviously remains essential to the running of a safe Urology Service and a safe hospital and a safe Health and Social Care Trust that they are properly funded by government to do their essential work. 10:56

Finally, on the topic of improvement, and as

improvement is always, as I've said, a journey rather than a destination, over the months ahead the Trust will continue to implement the improvements that are relevant to the Inquiry's work, whether it be in respect of the Champion Review or the Hughes SAI recommendations or GIRFT. The Trust is keen to keep the Inquiry and, through it, the public, updated as to this progress and hopes, therefore, that the Inquiry will remain open to continuing to accept disclosure updates from the Trust on this topic. 10:56 10:57

So, to conclude these brief oral closing remarks, I want to do three things: first, to sound a note of caution; second, to summarise; and third, to express gratitude. 10:57

So, by way of caution, we would caution the Inquiry to beware of the benefit of hindsight. As we reminded the Inquiry in both our opening and in our written closing, there is almost no human action or decision that cannot be made to look more flawed or less sensible in the misleading light of hindsight. 10:57

In the particular context of this Inquiry, we say be wary of the temptation, sometimes encouraged by Mr. O'Brien in his representations, to construe past omissions, such as the Trust's failure to give direction to consultants about what was expected in terms of triage, as omissions but for which there would 10:58

have been some significantly different outcome. We would also caution the Inquiry not to be distracted from the important points by minor issues.

In the particular context of this Inquiry, much ink has been spilt and many words uttered on Patients 104 and 105, and the Trust's -- the mistake that the Trust appears to have made in early June 2020 in believing that neither patient was on the Trust PAS. It looks like the Trust was wrong about this and, that being the case, an inaccurate reference to those patients was included in documents when it ought not to have been, but to focus on that, on that error, would be to risk missing the real point. The chain of events set in train by the belief that neither patient was on PAS, led to the uncovering of significant other issues with other patients. It was a stepping-stone to both a rapid lookback and to the Dr. Hughes' SAIs. If it was an error, and the preponderance of the evidence very much suggests that it was, then it was a fortunate error.

Finally, by way of caution, we would caution the Inquiry not to ignore the context, and there are multiple aspects to this, but just by way of example, we've heard a lot of evidence about the capacity demand mismatch and its consequences. Do not lose sight of the impact the resulting workloads may have had on the ability or capacity of doctors and managers to connect

the dots or to stand back and look at Mr. O'Brien's issues. Equally, do not lose sight of the impact the mismatch had in terms of the risk to patient safety posed by some of Mr. O'Brien's deficits or how it increased the importance of a task like triage. 11:00
Contrast, for example, the minimal risk of harm to a patient whose urgent referral goes untriaged and, therefore, not upgraded to red flag, in an environment where the difference between a red flag and an urgent waiting list is a matter of weeks, with a much greater 11:00
risk of harm in such a situation when the difference between an urgent and a red flag waiting list is many months, and, we submit, do not be myopic when considering the context. Do take account of Mr. O'Brien's point about the heavy workload placed 11:01
upon clinicians like himself as a result of the capacity demand mismatch, but don't forget that his colleagues managed do their triage and their dictation, or that, in spite of his workload, he managed to maintain a private practice. 11:01

So, to return to where we started and to summarise, we are sorry. We have co-operated wholeheartedly with the Inquiry. We have reflected and viewed this entire process as an opportunity for learning and positive 11:01
change rather than as an attack, and we have changed things for the better so that the public can be reassured that lessons have been learned and that past mistakes are much less likely to recur.

And finally, expressing our gratitude. The Trust wishes to acknowledge and express its sincere gratitude for the hard work, dedication and patience of the Inquiry Panel, its counsel, its solicitors and staff. The Inquiry's close forensic examination of working practices, procedures and systems in the Trust has certainly not always been a comfortable experience for the Trust or for those who have had to provide written or oral evidence, nor should it be, but, as I have said, it has necessarily provoked reflection and positive change. 11:02 11:02

The Trust also 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 that fairness to Core Participants and to witnesses in the way it has done to date and, in the event that it's considering making any significant criticism of them, will afford them a reasonable opportunity to respond to that before the report is finalised and published. 11:03 11:03

That's all I propose to say, you will be relieved.

CHAIR: Thank you very much, Mr. Lunny. The Inquiry has heard, from the evidence and from your helpful submissions, both written and orally today, about the work the Trust has undertaken to improve its systems of governance, and we've heard, for example, that you've gone at risk in some instances to do so. But the Inquiry is interested to know what further support does 11:03

the Trust require from either the Department or elsewhere to deliver these improvements?

MR. LUNNY: Well, I will say that's obviously an important question and a very good question and I hope it's also a question the Panel will raise with the Department later this morning -- 11:04

CHAIR: Don't worry.

MR. LUNNY: -- if that's not throwing a grenade at my learned friend, Mr Reid.

11:04

There are a number of aspects, I suppose, to the answer I can give.

First, there is more the Department maybe can do and there is more that can be done at a regional level. 11:04 Some of the examples of governance, important governance changes we have made at risk include some of the clinical audit resource that you've heard evidence about and also some of the resource that's now deployed on the tracking or snapshot audits of MDM 11:05 recommendations. Now, there maybe a time lag in the Department seeing the benefits of investment like that, and that, in turn, is perhaps related or tied in with the fact that we haven't had more than a one-year budget in health, or anywhere, for some time. It seems 11:05 obvious, Chair, that whilst there might be a time lag associated with the financial benefits that accrue from governance steps like that, there undoubtedly is a benefit. The Department spending money and giving

Trusts money to spend on governance, will ultimately, in the medium to longer term, save more money than it will cost.

Resources spent in governance will usually help to identify and resolve problems before they become serious, and we know that serious and entrenched problems not only can have serious consequences which cost more to treat, but consequences in terms of clinical negligence litigation as well. 11:06

So it might, in one sense, be better if posts like that were promoted to the Department, not under the heading of governance, but as posts that, in the medium to longer term, will save money. But I do say that they -- being able to front-load funding in anticipation of medium to long-term benefit, is something that appears to be very closely tied up with the budget, and it would appear to be much easier to do if three- or five-year budgets for health are set, rather than annual budgets. 11:06 11:07

But it is -- I suppose the other aspect to it, and it ties in with evidence, I think, that Mr. May gave, is that Trusts are given money; it isn't necessarily ring-fenced for anything in particular. Perhaps there should be a ring-fenced portion of the budget for governance. And it probably also ties in with what Mr. Pengelly said in some of his evidence, that there 11:07

is maybe a lack of understanding sometimes amongst politicians and the public, that administrators, as they are sometimes known in the NHS, actually perform a very valuable function, and you've heard a lot of evidence about regional challenges in terms of recruiting and retaining clinicians like nurses or consultant urologists. A huge and important difference with a resource like tracking and some audit resource is that you don't need to recruit those people from the clinician class; you can recruit people without professional qualifications to perform those tasks. So an obstacle that exists in other parts of the Trust and other parts of the Health Service in this region, doesn't exist in relation to those, those important roles. So I hope that's an answer, at least in part. 11:08

CHAIR: It certainly is. Thank you very much, Mr. Lunny.

We are going to take a short break, ladies and gentlemen, before we hear then from Mr Boyle. Sorry, I should have said 15 minutes. 11:09

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

CHAIR: Thank you, everyone. Mr Boyle. 11:23

CLOSING SUBMISSION BY MR. BOYLE:

MR. BOYLE: Thank you, Chair, Dr. Swart, Mr. Hanbury.

These are the oral closing submissions on behalf of the Core Participant, Mr. Aidan O'Brien.

You already have his written closing to assist you with your work, which is in keeping with the assistance which Mr. O'Brien has personally provided to the Inquiry as it progressed. He submitted a detailed Section 21 statement, which ran to some 260 pages, with linked chronologies and further addenda as the Inquiry continued. 11:23 11:24

He attended in person to give you evidence over the course of three days in the spring of 2023 and for a further three days in the spring of this year. He sat where I am standing, I think for longer than any other witness in the Inquiry. 11:24

My first heading for you is context.

At the very beginning of this Inquiry, in the opening statement on his behalf, we observed that, regrettably throughout Mr. O'Brien's tenure as a consultant, the Urology Service at the Trust was seriously and significantly under-resourced for over three decades, which could obviously not be attributed to the likes of more recent phenomena such as Brexit or Covid. There had been a profound and continuous failing presided over by Trust management, commissioners of health services and the Department of Health to adequately 11:24 11:25

resource the Urology Services at the Trust.

The evidence heard during the course of the Inquiry has confirmed that the above was an accurate description. It was not mere puff or hyperbole. It is obviously of 11:25
the utmost importance that this context informs the Panel's approach to its work, as Mr. Lunny alluded to just a moment or two ago. Indeed, the lack of resources or the resource constraints, as they are described in the Trust's submissions at paragraph 4.83, 11:26
are, in fact, relied upon by the Trust itself as part of what it describes as "important context" as to why the Trust itself did or did not address matters from a governance perspective.

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It, hopefully, goes without saying that if it be fair and appropriate for the Trust to pray in aid the lack of resources to seek to explain or mitigate omissions or failings on its part, it must equally be fair and appropriate for Mr. O'Brien to do likewise. 11:26

What the evidence has also now revealed is that the grossly inadequate and unsafe service has been disproportionately the case for the Urology Service compared to other specialities. The Panel have now 11:27
seen the evidence presented in an email in May of 2018 from Mr. Haynes in which he wrote:

"Unless immediate action is taken by the Trust to

improve the waiting times for urological surgery, another potentially avoidable death may occur."

A month later, he included a table in an email to show the disparity in relation to the waiting times for other specialities. That exemplified, in clear terms, that which Mr. O'Brien, and indeed the lead clinician Mr. Young, had been concerned about for many years. It also begs the rather obvious question: why wasn't that disparity grappled with as a matter of governance over the course of time? Urology waiting lists were endangering lives and Urology patients were having to wait disproportionately longer than any other speciality. 11:27 11:28

In the early part of the following year, in January 2019, the comparative analysis for the longest waiting times for first outpatient appointments for patients referred as red flag referrals due to concerns that they may have cancer, showed that the longest waiters were Urology patients by some distance. Urology patients were waiting ten times longer than patients with skin or gynaecology concerns and six times longer than patients with ENT or general surgical concerns. Urology had the majority of the 62-day pathway breaches and the longest waits for urgent and routine admissions for surgical treatment, at some 269 weeks, i.e. over five years, the average across all specialities being 37 weeks. 11:28 11:29 11:29

The situation had become so dire by the autumn of 2019 that the Urology Service was not, in fact, delivering any routine inpatient urology surgery at all.
Mr. Haynes wrote in an email at WIT-54708:

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"Effectively, as you are aware, routine inpatient urological surgery is not being delivered at present."

That almost bears repetition:

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"... routine inpatient urological surgery is not being delivered..."

Put another way: If you were a patient waiting on routine urology surgery, the shop was shut. There 11:31
wasn't any. The Urology Service for routine patients was bankrupt.

For the avoidance of any confusion, the shop was not just shut for routine surgery, it was also shut to the 11:31
majority of patients awaiting admission for surgical management considered to be of an urgent nature, because, by 2019, there were patients awaiting admission for urgent management since 2014. And so the Trust had to resort to a familiar response to these 11:31
kinds of intolerable delays in patient treatment, as reflected in the email from Alanna Coleman in September of 2019. When referring to the booking times for red flag patients, she posed the question:

"Should we just ask the consultants if they are willing for their clinics to be overbooked to accommodate?"

That extracted the telling reply from Mr. Glackin: 11:32

"If the Trust cannot deliver this, then there is an issue of demand outstripping supply. Simply relying on me, or any other clinician, to overbook a clinic will not solve this supply issue and I am not willing to do 11:32 this work unpaid or to the detriment of my existing workload."

Irrespective of whether Mr. Glackin was to be paid for taking on additional work, it is notable he was saying 11:33 he was not willing to have additional work cause detriment to his own clinical practice.

Mr. O'Brien, as you know, had, for decades, taken on additional work. 11:33

What is alarming about all of this from a governance perspective is the evidence given to the panel by Ms. Mullan, the Non-Executive Chair of the Trust, and Dr. O'Kane, as the then-Medical Director of the Trust, 11:33 when confronted with these horrifying statistics and the obvious potential for patient harm - it couldn't be clearer, avoidable deaths - was an acknowledgment from Ms. Mullan that the focus at the Trust had been on

targets set by successive ministers of health and that "patient safety was not the first and foremost concern".

In other words, the Board's focus was figures in a spreadsheet, not patients in their care. And then the evidence of Dr. O'Kane, that whilst difficulties with waiting lists, compounded by staffing shortages, were brought to her attention informally, "none were being raised as specific patient safety issues". 11:34

How can it be the case that the Medical Director of a healthcare Trust did not seem to appreciate that having patients waiting years on waiting lists, with waiting times compounded by staff shortages, was not a patient safety issue of the highest order? 11:35

The evidence received by the Inquiry would strongly suggest that, while it placed the long waiting lists for outpatient appointments and for admission for surgical management on risk registers, the Trust had little, if any, real insight into the actual risks to which patients were exposed. How could it be that the most senior management personnel in the Trust could retain such little, if any, awareness of these risks to patient safety, even though they were repeatedly being brought to their attention by the likes of Mr. Young, Mr. O'Brien and others over the years? 11:35

Is it the case, from the evidence that the Inquiry have heard, that senior management gave greater weight and priority to responding to the expectations of commissioners and the Department of Health than it did to responding to concerns raised by the clinicians and the nursing staff? Ms. Hunter's departure as a result of her concerns about the safety of the ward being a case, perhaps, in point. 11:36

There is no surprise then that the response, over time, has been an abdication of responsibility to patients and their safety by Trust Board and Department, coupled with an expectation that the staff and practitioners should, and inevitably would, shoulder the responsibility instead. The response to inadequacy in the resourcing of Urology and the increasing demand over time was to depend upon practitioners doing more, then expecting them to do more and, finally, requiring them to do more, and this was so facilitated by the ethical commitment of doctors and nurses to caring for patients. 11:36 11:37 11:37

As the gap between need and service capacity widened, the transfer of responsibility became progressively overwhelming, until the accompanying expectations became, as Mr. Haynes described them, unmeetable. The introduction of the IEAP, which transferred responsibility for triage of referrals to all consultant clinicians in all specialities, without any 11:37

consideration as to their individual or collective capacity to undertake this responsibility, is a case in point. The Trust, at the time, and for years subsequently, did not have a triage policy of its own. The Trust, it seemed, considered that it did not need one as it simply transferred the responsibility of its IEAP obligations to consultants. 11:38

There was the increasing dependence and requirement on clinicians, over time, to progressively review, action and record on all results and reports, regardless of their nature, which eventually morphed into a requirement that doing so would additionally include and/or replace patient review, the DARO scheme. 11:38

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Similarly, there was an expectation that the Urologist of the Week would undertake triage of all referrals. As the Inquiry is aware, it was to become Mr. O'Brien's experience and observation that it was impossible or unmeetable to additionally triage all referrals received whilst Urologist of the Week without either compromising the quality of inpatient care or compromising the quality of triage, or both. 11:39

These are significant examples of the progressive transfer of responsibility to clinicians, with seemingly little or no consideration of, and certainly little or no provision of, any or any adequate personnel, resource or time to enable the inadequate 11:39

numbers of personnel to take them on, and so it is in that context that the Inquiry are invited to view the issues which have been raised.

My second heading is the commitment of Mr. O'Brien and his work ethic to try and mitigate the risks to patients. 11:40

The Inquiry has before it a wealth of evidence about Mr. O'Brien's work ethic over the 20 years he worked at -- 28 years, forgive me, he worked at the Trust. I doubt I can put it any better or more succinctly than Dr. McAllister did when he said that Mr. O'Brien "was generally considered to be extremely hardworking, if not the hardest working surgeon in the Trust". 11:41 He worked late nights, weekends, when he was on annual leave. He postponed his own medical treatment to work, and when he did go on sick leave in the December of -- November/December of 2016, he was working then, too, and the Trust knew all this. 11:41

In the period 2012 to 2016, the Trust also knew that Mr. O'Brien had additional onerous roles as Lead Clinician and Chair of NICaN's Clinical Reference Group in Urology, in which he steered all of Northern Ireland's Urology MDTs in preparation for the national peer review in 2015, and that was in addition to being Lead Clinician of the Southern Trust's Urology MDT and Chair of its MDM. 11:42

The Trust knew that Mr. O'Brien took patient records home to do dictation and administration and, when asked for them, they were promptly brought to the hospital department which required them. They knew he wasn't able to do all of the triage because they set up what has become known as the informal default system. 11:43

What is also notable about triage is that there was not any fixed or defined way of doing it, as a matter of fact. It had been the subject of debate. Does it just require the reading of the letter of referral from the GP? Should it involve the reading of or review of letters, results and reports relating to the patient, if they exist? Does it also require the reviewing of the digitalised images of all scans? In the context of increasingly long waiting times for first outpatient appointments, does it require a form of advanced or enhanced triage directly contacting patients on occasion to ascertain fitness for investigations? 11:43 11:44

When you have a group of seasoned practitioners undertaking all of the activities of the Urologist of the Week, they may well develop their own way of managing or prioritising in the absence of some defined structure. 11:44

Patient 10, which became known as the index case, is perhaps a case in point where the nature of the triage, to have appreciated a renal cyst may be malignant,

would have required a view of the scanned images. And we invite the Inquiry to consider Mr. O'Brien's response to the SAI in that case at AOB-01392, where he expressly raised the nature of triage and what it was to involve. 11:45

If a consultant urologist would have needed to spend 10 minutes, let's say, to review scanned images, and if only one third of the 120 patients referred each week at the time that Patient 10 was referred, the 11:45 requirement to review the scanned images would have taken almost six hours to conduct. At the time, that would have been almost twice the total amount of time allocated to Mr. O'Brien in his proposed job plans for all of his administrative work each week. 11:46

The Inquiry is aware that the clinicians made attempts to discuss the competing requirements of the role when Urologist of the Week, culminating in the meeting scheduled for December of 2018, but that meeting, as 11:46 you know, was cancelled.

May we also sound a note of caution regarding the assertion made in the Trust submissions at paragraph 4.11(a), that Mr. O'Brien's colleagues were 11:46 able to perform triage and then "without any evidence of any significant risk or harm to patients".

So far as we are aware, there has been no audit

conducted to determine whether there is any evidence of significant risk or harm to patients as a result of triage being undertaken by other clinicians or by other means.

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On the other hand, it has been reassuring to note from the Trust's closing submission that whilst concerns were expressed in relation to the use by Mr. O'Brien in relation to monopolar resectioning glycine, there has been no evidence of any higher incidents of Hyponatraemia or other issues arising from him doing so. That, perhaps, confirmed his concern about the safety measures and precautions that he could use during endoscopic resection as performed by him.

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Also, we note that the assertion that Mr. O'Brien was in some way an outlier in relation to the use of BCG for muscle invasive bladder cancer, that has, likewise, been found to be without foundation following audit.

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My third topic is the Trust's response when concerns were raised by Mr. O'Brien and Mr. Khan, the Case Manager at the time of MHPS.

Mr. O'Brien did raise concerns of public interest magnitude about the Trust's failure to comply with its duty of care to patients, in his grievance in 2018, which were not urgently addressed. He raised the increasing disparity between the waiting lists and

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those for other specialities and he gave specifics, and, in relation to the delays, he told the Trust that of the then-400 patients awaiting prostatic resection, based on international data, it could be expected at least 10% would have a delayed diagnosis of carcinoma. He wrote that he was disclosing these facts "in the interests of the public in general and these urological patients in particular". 11:49

From a governance perspective, it seems that nothing was done in response to that. 11:49

At the turbulent time at the end of his time at the Trust in June of 2020, Chair, you will recall that he wrote a letter to the Chief Executive which was copied to others. During the course of Pauline Leeson's evidence, you queried whether, in fact, that was a letter which was tantamount to whistleblowing on the part of Mr. O'Brien. The issues that he was raising in that letter, likewise, were not urgently addressed. 11:50 11:50

The Trust's failure to address these issues is indicative of that mindset where responsibility was being transferred to be shouldered by the individual as opposed to the Trust itself. That was also exemplified by the Trust's failure to act upon the final conclusions and recommendation by the Case Manager at the time of MHPS. He concluded that the investigation had highlighted issues regarding systemic failures by 11:50

managers at all levels, both clinical and operational, within the Acute Services Directorate, and he recommended an independent review of the full system-wide problems.

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Whilst the Trust embarked upon a course of action against the individual, Mr. O'Brien, it simply ignored the system issues that the Case Manager had highlighted. No independent review was commissioned and, as we now know, the Case Manager's findings were neither shared with the Trust Board nor with the Department of Health.

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My next heading is Mr. O'Brien's return to work and his working full-time between 2017 and 2020.

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Despite the devastating impact upon him personally and professionally of his exclusion, which he spoke to you about in evidence, and despite the length of time he then had the 2016 matters hanging over him, with the consequent uncertainty, Mr. O'Brien returned to work full-time in early 2017 and he continued to work full-time and as hard, if not harder than ever, between 2016 and 2020. You have heard how he arranged annual leave now after his shifts as Urologist of the Week and he would then work on those annual-leave days, in addition to undertaking extra operating sessions available to him.

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In a telling piece of evidence, he described how he tried to do "more of all of it". Despite the enormous strain upon him of having a process hanging over him for the remainder of his career - over three-and-a-half years went by with it remaining unresolved, from 11:53
December 2016 to June of 2020 - he tried, as he had always done, to maximise the amount of work he could do for the benefit of the maximum number of patients on waiting lists that were, in the words of Mr. Wolfe, "sky-rocketing". 11:54

My next heading is: Should Mr. O'Brien have adopted more efficient ways of working?

The point has been made that perhaps Mr. O'Brien should 11:54
have adopted more efficient ways of working; that his colleagues were able to perform triage and the like, as Mr. Lunny spoke to you about a moment or two ago. It has been observed that Mr. O'Brien was offering a "Rolls Royce service" to his patients or "an 11:54
excessively high standard of service" to some patients.

It is an odd position to find oneself criticised against that backdrop where you are offering a first-class service to patients or offering too high a 11:55
standard of service to patients. But in fairness to Mr. O'Brien, in his evidence to you he accepted that it was possibly the case that the balance, as he said, tilted too far on occasions.

As we observed in written closing submissions, issues that arose were never because he was idle, never because he was not pulling his weight; on the contrary, because he was trying to shoulder too much weight. An observation has been made in relation to private practice which he did not undertake during job planning times, during weekdays. The little that he did, he did on a Saturday morning. 11:56

Mr. O'Brien, as he said to you in evidence, very much regrets the fact that, on occasion, he did not have the time to do it all, and he accepted as much, particularly in relation to the cases of Patients 92 and 95, with respect to reviewing the reports of their scans. 11:56

My next topic is: Intended retirement from full-time employment and return to part-time employment.

Mr. O'Brien took up his post as a Consultant Urologist on Monday, 6th July 1992. He planned to step down from full-time employment on 30th June of 2020 due to an increased desire for him to share a caring role within his family. 11:56

He intended to return to part-time employment in August of 2020, which would have been at the height of the Covid pandemic. As you know, he notified the Trust that those were his intentions and initially no one 11:57

raised any concerns with him about his proposal. He has been gravely disappointed to learn, through the Inquiry, of the communications that Mr. Haynes raised with Dr. O'Kane and the invocation of what we now know to be the flawed claim about what has become known as the two out of ten which was used to exclude him. 11:57

His disappointment at the ending of his career, against a backdrop of a lack of openness, transparency and candour, has been obvious, after 28 years of service in the care of thousands of patients. 11:58

Whilst it may be apt to refer to it as a fortunate error, it did, of course, deprive patients, even on a part-time basis, of some work that Mr. O'Brien could have done which he had been capable of doing from 2017 to 2020 at the height of a pandemic, when, arguably, some patients may have benefitted from his input. 11:58

My next topic is: Issues arising since 2020 and the lack of engagement with and input from Mr. O'Brien to the SCRR and Royal College reviews. 11:59

In terms of the issues that have arisen since 2020, as addressed in the SCRR and the Royal College review, it is only fair to point out that Mr. O'Brien has not been asked to participate in any way in relation to either of those reviews. He has had no opportunity to provide any input or insight into the cases being considered, 11:59

and it is important that, in fairness to him, if conclusions are to be drawn from those reviews, that the fact that he has had no input into them is placed on the record. Not only has he not been asked for any input at all, despite being the treating clinician in many of the cases, who may have had some helpful light to shed, he has not been provided with access to medical records or correspondence which might, even now, enable him to assist, correct or accept any concerns in particular cases and enable him to make a positive contribution of what lessons could be learned moving forwards. 12:00 12:00

It is also, hopefully, an entirely uncontroversial point to make, that where a patient's management has been altered or changed as a result of such a review, firstly, the practice of medicine recognises that there will be different schools of thought and/or approaches to patient treatment and management; and secondly, the practice of law recognises that medical practitioners may have different, but both entirely acceptable, ways of manning a patient or patients. You will be familiar with the test that's applied in clinical negligence cases, Bolam and Bolitho and the like, responsible body of medical practice. 12:00 12:01 12:01

One issue which has been raised is noted to be compliance with MDM recommendations and/or adherence with guidelines. And there was something of a sense

from the evidence of Dr. Hughes, and indeed, more recently, the Trust's now auditing of compliance with recommendations of MDMs, that there is something of a binding nature to them or that the recommendations are a directive to be complied with, which is in danger of trumping the autonomous participation of the patient in his or her own management. To approach MDM recommendations and guidelines as, in some way, a directive to be complied with in terms of the management which must be delivered, would, in fact, be wrong in law, after the Supreme Court decision in Montgomery, where primacy is the autonomy of the patient, not the paternalistic approach to medicine of the past. 12:02 12:02 12:03

In passing, in relation to the SAI review conclusions with regard to Patient 1, we sound a note of caution, particularly given paragraph 5.7 of the Trust's closing submission, where it says: 12:03

"The Trust accepts the review that Patient 1 was diagnosed with prostate cancer on [redacted] and was subsequently started on an antiandrogen therapy as opposed to androgen deprivation therapy. The Trust accepts that this did not adhere to the Northern Ireland Cancer Network Urology Cancer Guidelines." 12:03

An antiandrogen, such as Bicalutamide, is, in fact, androgen deprivation therapy. The Trust is also

incorrect to accept that the use of Bicalutamide, prescribed initially in a dose of 150 milligrams daily for a high-risk locally advanced prostate cancer, was not compliant with the NICaN Urology Cancer Guidelines of 2016, and that Bicalutamide 150 milligrams daily was unlicensed for that category of prostate cancer because it is, and those observations you will know have been made previously in relation to corrections that needed to be made to that SAI. 12:04

12:04

My final topic, you'll be pleased to hear, is: Looking forward or recommendations.

In the final part of his written submissions, Mr. O'Brien canvassed a number of potential recommendations for the Inquiry to consider, and I intend to touch upon two of those. 12:05

Firstly, one of the recommendations he invites the Inquiry to consider is the perimeter of practice beyond which a physician cannot or should not go. Is it to be defined by a job plan and that is it, regardless of the waiting lists, regardless of the obvious risk of patient harm, the time waiting for stents to be removed or the time waiting for review appointments? Has the time now come for an inquiry to recommend a perimeter beyond which a practitioner should not go? Is there scope for some kind of recommendation to protect practitioners from themselves which will potentially 12:05 12:05

have a collateral benefit upon the patient experience? May I try to give you an example of what I'm trying to describe?

CHAIR: Please do.

MR. BOYLE: If a group of consultants are told by scheduling that there are available sessions for additional operating or additional clinics and they all have long waiting lists, are they morally and ethically entitled to decline, irrespective of the risks and suffering that their participation would alleviate, or is there an obligation upon them to avail of such additionality so as to do no harm? In short, what should give first? Should there now be some guidance, given that we are likely to have long waiting lists for a long time? Should there be some guidance for practitioners about how they should approach that particular dilemma? 12:06 12:06 12:07

Secondly, and relevant to patient experience, the focus of SAIs is currently very much incident-centered, a snapshot in time, if you will, whereas there is surely the potential for greater learning and improvements to patient safety if SAIs were recalibrated as a serious adverse experience which would have the dual benefit of being more patient-centered and enabling those responsible for the investigation to look at the whole patient experience, not just a single episode of care that may have triggered it? 12:07 12:08

Many serious adverse incidents are, understandably and legitimately, precipitated by a single incident or event. Their reviews are often set time frames surrounding those particular incidents or events and those time frames may exclude more longitudinal reviews of the patients' experiences that may otherwise reveal factors or features which may have as great an influence on clinical outcomes than the incidents or the events themselves, without, of course, detracting from the significance of the triggering incident. 12:09

Finally, on Mr. O'Brien's behalf, can I repeat what he said at the very end of his evidence, that he very much regrets any suffering or harm that patients may have experienced due to any decisions, actions or failings on his part. 12:09

Chair, those are my submissions.

CHAIR: Thank you, Mr Boyle. Just, first of all, in terms of his proposed recommendation that we move from an SAI to an SAE experience, being the E in that, does Mr. O'Brien accept that the nine SAIs that we have looked at have not been single-issue SAIs, but they have identified a number of issues and that they have looked not just at outcome but into other points in time along the pathway? 12:10 12:10

MR. BOYLE: It's clear that, when one looks at them, they have looked at aspects of the patients' journeys which have identified issues in relation to, as we

know, Bicalutamide, the use of CNSs, for example. But there are potentially examples within them where, if the entire journey had been looked at, there might have been opportunities at earlier stages in relation to timeliness of referral, for example, which may have had an impact on the patient experience at an earlier stage of their experience, and so that's the point that he is trying to make, that if we focus simply on a particular consultation at a particular time and a decision that may or may not have been made, that will provide learning in relation to that, but are there lessons to be learned if one steps back and looks at the broader picture in relation to the patient's experience? That's, simply, what is intended in that. 12:11 12:11

CHAIR: Very well. Well, we'll consider it, certainly. Just in terms of the written submissions, the Panel is interested in what Mr. O'Brien is saying, particularly at paragraphs 5, 6 and 155 and 156. Are we correct in our interpretation that those paragraphs are in some way saying that this Inquiry has been unfair to Mr. O'Brien? 12:11 12:12

MR. BOYLE: Well, there are three -- there are three Core Participants to this Inquiry. So far as we are aware, only one of them - I can't speak for the Department - but only one of them has had access to full sets of records, all of the scans, all of the correspondence, all of the reports on all of the patients, the over 200 patients that are on the cipher list, only one Core Participant has had access to all 12:12

of those materials. Mr. O'Brien has not. And if it is to be the case that this Inquiry is to make factual findings of criticism in relation to that Core Participant as an individual, his role in the treatment of patients, where he has not had the benefit of having had even access - they don't need to be uploaded, he can come in and look at them, they don't need to be shared with him, he can simply have access to them - but even that hasn't happened, so if there are going to be findings of fact made which are going to be critical of a medical practitioner, about his treatment of a patient, in a public report, where he has not even had the opportunity to read a single page of some of the records, of some of them, that is unfair. 12:13 12:13

CHAIR: Very well, then. Just to be clear, I refute the suggestion that this Inquiry has been in any way unfair to Mr. O'Brien. The Inquiry has looked at the SAIs, the material provided in the evidence bundles, the Maintaining High Professional Standards Investigation and the governance processes around the SCRR. To look at those in order to see whether the themes identified in the SAIs, themes accepted by the Trust and by the Department leading to this Inquiry being set up, were more generally applicable. 12:13 12:14

12:14

As I have repeatedly made clear, Mr. Boyle, and to Mr. O'Brien, since he is sitting here, I hope he gets this message loud and clear, this Inquiry will not make any judgment regarding the clinical care provided in

individual cases. That is a matter for the Trust, for the GMC and for the courts. Accordingly, there is no need for Mr. O'Brien to dispute or accept the findings of the SCRR in order to assist this Inquiry.
Mr. O'Brien has had the opportunity to comment on issues identified in the nine SAIs, the MHPS investigation and some other discrete issues, both in written evidence and orally. Any suggestion that he has been hampered in doing so by not having access to medical notes and records from this Inquiry, is entirely refuted. He has been afforded every opportunity to explain how he practised in general terms and to deal with specific allegations regarding his practice. So, in light of that, Mr. Boyle, can I ask that you accept, on behalf of Mr. O'Brien, that there has been no unfairness in the Inquiry's treatment of him?
MR. BOYLE: Chair, as you know, I am an advocate, I am not a witness. I can't give evidence on behalf of Mr. O'Brien. But can I remind you just of a couple of examples that we have had in this Inquiry.

So, for example, in the closed hearings, there was a patient where a letter referred to a previous letter which had hadn't been disclosed, which was a relevant and important and significant letter.

There was the evidence of Mr. Hagan, during which he indicated that Mr. O'Brien had caused injury to a

patient during surgery being performed by Mr. O'Brien, but when the medical records were looked at, Mr. O'Brien wasn't conducting the surgery; it was Mr. Hagan who was conducting the surgery.

12:16

So, those are just two examples, and the Hagan one being a particularly telling example, where, with the benefit, with the benefit of access to a medical record, it can, perhaps, demonstrate that there is not a concern which then may give rise to a governance issue. 12:16

CHAIR: I repeat, Mr. Boyle, in any instance where there has been such an issue, as you have described, either Mr. Hagan's evidence or the patient evidence that you referred to, this Inquiry has sought that information and has shared it with Mr. O'Brien. 12:17

MR. BOYLE: Indeed, and that makes the point on behalf of Mr. O'Brien. Whereas in relation to the SCRRs, some of which have been referred to in the closing submissions of the Trust, Mr. O'Brien has seen nothing in relation to any of those. 12:17

CHAIR: Again, SCRRs, to our understanding, are -- we have looked at the process to assure ourselves that the process is being properly managed within the Trust. We have not looked at any individual cases and I certainly have seen no evidence of any individual cases, medical notes or records, because we are simply not determining the appropriateness of treatment in any of those cases. Our understanding of the SCRR process was to ensure 12:17

that those patients, who the Trust considered after review, were on the appropriate care pathway. That is our understanding of what the SCRR is about. Our concern with the SCRR is to ensure that that process is being properly managed, and the RQIA have looked at the SCRR process. It is a forward-looking matter; it is not for this Inquiry. I have repeatedly said, and I will repeat it again, we are not making judgments about care in individual cases, and therefore, there is no need to share any medical notes and records with anyone, Mr. O'Brien or any other Core Participant. The fact that one Core Participant has access to those medical notes and records, is simply because they hold them, rather than for any other reason. Anything that was shared with the Core Participants that is relevant, is in the evidence bundles. 12:18 12:18 12:18

MR. BOYLE: I understand. All I'm trying to get across is an attempt to demonstrate the appreciation on behalf of Mr. O'Brien that he cannot usefully comment or contribute or participate as a Core Participant in relation to anything do with the SCRRs or the Royal College reviews, because those -- he is blindfolded to that. 12:19

CHAIR: Those are not constructs of this Inquiry, Mr. Boyle, so how is this Inquiry being unfair to Mr. O'Brien? 12:19

MR. BOYLE: Because, in its closing submissions, the Trust have referred to the SCRR and they invite you to make findings in relation to the SCRR. We don't know,

or I don't know as I stand here on Mr. O'Brien's behalf, what conclusions you are going to reach in relation to the SCRR, and if you reach conclusions in relation to the SCRR that there were patterns of behaviour by Mr. O'Brien in relation to some of the patients in the SCRR cases, without giving him the chance to speak to any of that --

CHAIR: I have repeatedly said, and I will repeatedly say it again, we are not making any decisions about individual cases, be they the subject of SAIs, be they the subject of SCRRs, or any other cases that have come before this Inquiry. We are not making individual decisions about the standard of care provided. We are primarily looking at governance and, as Mr. Lunny quite aptly put it in his written submissions, Mr. O'Brien's practice is the gateway through which we are looking at those governance issues, and I have made it abundantly clear, so I am somewhat going to nail your colours to the mast here, Mr. Boyle; do you consider that this Inquiry has been unfair in its treatment of Mr. O'Brien?

MR. BOYLE: Chair, you have had my submissions in relation to it, you have had Mr. O'Brien's evidence in relation to it, you have had his witness statement in relation to it and you have his closing submissions in relation to it. I can't give -- I can't be expected to give evidence in relation to it myself.

CHAIR: Very well. I want to say that the Inquiry is cognisant of the history of the Urology Service in the

Trust, cognisant of Mr. O'Brien's contribution to that service and the conditions occasioned by an increasing demand for that service under which Mr. O'Brien and his fellow clinicians and the wider team had to operate. Further, the Inquiry accepts that Mr. O'Brien and others raised issues regarding the inadequacy of this service for many years. 12:21

Having said that, does Mr. O'Brien accept that his decision to practise in the manner in which he did contributed to the difficulties for that service and for patients? 12:21

MR. BOYLE: Well, Chair, that's -- I mean, that's a question that would need to be put to Mr. O'Brien, and he will, as he has indicated in his closing submissions, he will answer any further questions that the Inquiry may have. 12:22

CHAIR: Well, that is a further question, so if you can take instructions on that and we will accept your instructions in writing on that. 12:22

MR. BOYLE: Very well. Thank you.

CHAIR: Can you assist us with indicating, and this may be another matter that you want to come back to us in writing on, but can you assist us with indicating whether Mr. O'Brien, having heard different perspectives on issues, particularly from his fellow clinicians and from patients, has had cause to reflect and change his views at all? 12:22

MR. BOYLE: Chair, I think that's on a similar topic.

CHAIR: And I still am unclear as to what Mr. O'Brien means when he suggests we make a recommendation identifying the boundaries of clinical practice. I know you have done your best to try to explain it to us, but I still can't see how that is in our Terms of Reference. 12:22

MR. BOYLE: I'm not going to try and repeat it. It wasn't particularly eloquent the first time around; it will probably be worse the second time around.

CHAIR: Very well. Well, thank you, Mr. Boyle. We are going to take another break, ladies and gentlemen, and come back to hear from Mr Reid in 15 minutes. 12:23

THE INQUIRY RESUMED AFTER A SHORT BREAK AS FOLLOWS:

12:23

CHAIR: Thank you, everyone. Mr. Reid.

CLOSING SUBMISSION BY MR. REID:

MR. REID: Thank you, Madam Chair, members of the Panel, thank you for the opportunity to provide these brief oral closing submissions on behalf of the Department of Health, last but not least, Madam Chair. 12:37

The Inquiry already has the written submissions provided by the Department, together with the various witness statements from the Department's witnesses. I do not intend to rehearse the contents of those in detail today, you will be pleased to hear; rather, I 12:37

intend to focus on a few important aspects of the Department's work to date in relation to this Inquiry.

Now, firstly, on behalf of the Department, I would wish to acknowledge and to thank you, the Panel, and your 12:37
Inquiry legal and admin teams for all of your and their hard work and dedication to the task of progressing this Inquiry over the past three years. I hope and trust that the Inquiry has found the Department able and willing to assist it whenever called upon 12:38
throughout the course of these hearings, and, in particular, I would like to personally thank both Mr. Wolfe and Ms. McMahon, who have made themselves available to the Department's legal team throughout and have assisted the Department's witnesses very greatly 12:38
in focusing their evidence to the areas of the most importance and relevance to the panel.

Now, as I stated in my opening submissions to the Inquiry in November 2022, the Department wishes to make 12:38
clear that it is, and will always be, extremely concerned about any issue that involves the potential for patients to come to harm within our health and social care system. But it is important to acknowledge, at the outset, the role of the Department 12:39
of Health within the Northern Ireland healthcare structure.

Health and social care services themselves here are

provided by independent arm's lengths bodies such as the Trusts. Each of those Trusts is responsible for exercising the statutory functions delegated to them and each of those Trusts is accountable for its own performance and it is the responsibility of each of the 12:39
Trust boards to manage local performance and manage issues in the first instance when they arise.

Now, that is in no way to pass the buck. The Department fully accepts its statutory duties and 12:39
responsibilities under Section 2 of the 2009 Reform Act. It is the Department who provides direction and leadership for the health and social care system and it is the Department which retains the ultimate responsibility and ultimate accountability for all 12:40
aspects of the service and, to that end, I wish to repeat what I said in November '22: that the Department wishes to unreservedly apologise to those patients affected, and their families, for any upset and distress that this has caused. 12:40

While the experience of patients who use our health services is overwhelmingly that of a safe and quality service, these incidents, regrettably, dented the confidence of service users. The Department fully 12:40
acknowledges this and the Department will do all that it can to ensure that lessons are learned to prevent situations such as these occurring again.

The Department has considered a priority that any learning arising from this Inquiry into Urology Services in the Southern Trust must be identified and implemented at the earliest opportunity, both within the Trust and across the health and social care system as a whole, in order to minimise any risk of further recurrence or potential harm to patients, and the Department has, therefore, not stood still whilst the Inquiry's work has been ongoing. Significant work has been undertaken over the past three years to mitigate or prevent further the risk of recurrence of similar issues and risks. However, as I will come to at the end of these submissions, budgetary constraints are such that the Department is forced to carefully consider which actions are prioritised. 12:41

If I can first turn to culture. And, members of the Panel, culture is the element that underpins everything. Any work undertaken to address the concerns raised by this Inquiry will simply not be effective unless they are enacted alongside efforts to further improve the organisational culture within health and social care in Northern Ireland. 12:42

The Permanent Secretary, in his evidence, probably put it better than I can. He said: 12:42

"Culture is absolutely the heart of all the work here, both in terms of allowing individuals to raise issues

and ask questions, but also in terms of the engagement between the Department, the Trust and other arm's length bodies."

Now, the Department is committed to assisting the health and social care system to further embed a more open, just and learning culture, where staff feel safe to be open and candid at all times. Openness should not be -- sorry, openness should be routine, not just when things go wrong. 12:42

An open culture, with staff supported in feeling safe to speak up, results in enhanced patient safety, increased public confidence and a positive work environment for staff, and, to that end, the Panel will be aware that the Department is developing its draft Being Open Framework as a key component to assist in enabling and supporting that, and that is still on track to consultation later this summer, with the hope for implementation thereafter by the end of this calendar year. 12:43 12:43

In addition, the Department's revised Whistleblowing Framework and Model Policy, which was launched in March of this year, provides clarity as to the process and assures the health and social care workforce that it is safe to raise concerns. The Department considers that enabling staff to engage with the whistleblowing process in a positive manner is fundamental to 12:43

facilitating cultural change.

Along with cultural change, the Department is working to ensure it meets its workforce needs. Its current action plan, as part of its Health and Social Care Workforce Strategy, is a comprehensive and ambitious work programme that includes the development of initiatives to enhance retraction and retention of staff, commissioning increasing numbers of training places to grow the locally-trained workforce, removing barriers to recruitment, reducing agency spend, supporting employers in their provision of staff health and well-being services and harnessing workforce data to develop the Department's business intelligence. And significant progress has been made with a 15.7% increase in full-time equivalent staff in post across health and social care in Northern Ireland between March 2018 and December 2023. 12:44 12:44 12:44

The Department continues to work through delivery of the workforce strategy up to its conclusion date in 2026, but, and this may become a recurring theme, it depends upon the necessary resources being available to implement fully. 12:45

If I can turn to MHPS. 12:45

Now, a key theme of the Inquiry's hearings to date has been whether the current Maintaining High Professional

Standards - MHPS Framework - is fit for purpose. Since the start of the Inquiry's oral hearings, the Department has considered as a priority task that a review of MHPS takes place. To that end, the Independent Review Panel was established in May of last year, made up of individuals external to health and social care in Northern Ireland and tasked with reviewing the current MHPS Framework as is set out and applied in Northern Ireland. And I am informed that the Steering Group is meeting on Monday to consider their draft report with key findings and recommendations, and the hope is that they will sign off that report on that day or in the days following and the report will then be sent for approval from the Permanent Secretary and the Minister and that a report will be available towards the end of this month or the first week of July. 12:45 12:46 12:46

The Permanent Secretary, in his evidence, I believe, in answer to your question, Chair, indicated that, as soon as that report is available, that there may be informal engagement with the Panel in relation to that, and certainly the Department would find that very useful in considering an implementation plan on receipt of the report. 12:46 12:46

Looking at SAIs.

As with MHPS, the evidence before the Inquiry has

clearly highlighted that the current SAI procedure often does not work well for those involved, whether families or staff. The current learning reviews take too long and there is a need for more meaningful engagement, involvement and support with patients and families early and ongoing throughout the process. Redesign of the current SAI procedure is also a priority task for the Department. The Department is working towards a consultation on a new framework in autumn of this year -- sorry, autumn of next year, 2024, and that, I am informed, is on track, and there is hope for implementation in the first half of next year. Apologies, Chair, I think I said 2024. I think it's this year, not next year. It's this year, and the implementation is for the hope in the first half of next year. 12:47 12:47 12:47

The key aim of the new framework will be to ensure that all those involved in such incidents will be engaged with on a compassionate basis, including patients, families and staff, while streamlining and simplifying the process to help conclude reviews in a more timely manner, which is obviously key for all of those involved; to embed learning more quickly and to help optimise the use of health and social care resource employed in undertaking learning and improvement reviews. 12:47 12:48

This change the Department sees as an essential tool in

supporting the open, just and learning culture. And I should also say that some early scoping has taken place in relation to a review of the Early Alerts process and is currently anticipated, subject to the available departmental resources, that a review of the Early Alerts process will be undertaken by the Department later this year.

Moving to the 'Getting It Right First Time' - GIRFT - Review. 12:48

The Department has assisted Urology Services across Northern Ireland through the commissioning of that review last year. The commissioning of the review recognised the need to identify and implement recommendations at the earliest possible opportunity to facilitate the improvement in the extensive waiting lists in Urology Services and to ensure that patients are treated as quickly as possible. That report identified 40 recommendations to improve the service, in addition to a list of recommendations for each Trust. Those recommendations focused on the themes of maximising surgical assessment and diagnostic capacity, improving efficiency, strengthening pathways and protocols, exploring non-consultant grade skills mix and training and regionalisation and specialisation of services. Those recommendations are being overseen by the Department's Planning Implementation Group for Urology at a regional level to ensure a consistency of

approach so far as constrained budgetary conditions allow.

In addition, Panel, the Urology Lookback Review is largely complete. The final outcomes report for 12:50
cohort 2 of a Lookback Review is being finalised for publication by the Southern Trust, and the final report into the findings of the RQIA review of the Southern Trust's Urology services is also currently being completed, and both of those reports will be made 12:50
available to the Inquiry at the earliest opportunity.

If I can talk about the Encompass programme.

As the Inquiry is aware, the Department and the Trusts 12:50
are currently implementing the Encompass programme and that is seen as a clinical and operational transformation programme with an Electronic Patient Record system, supplied by Epic, at its heart. The Department's implementation of Encompass will 12:50
significantly enhance the drive for improvement in safety, quality and performance and inform integrated governance.

Northern Ireland is the first UK region to adopt this 12:51
unified approach to an Electronic Patient Record at integrated care system level and it is the first in the UK to incorporate social care and mental health as part of that endeavour.

The Encompass rollout is the largest implementation of the Epic EPR platform in Europe and the plan is that all Trusts and patients will be live on the platform by mid-2025.

12:51

The EPR will provide those working in acute and community care with a single holistic view of a patient or service users' interactions with a relevant adviser or agency. Primary care professionals will also have access to the system as appropriate and the system will 12:51
also provide near-realtime data, which can be used to benchmark health and social care, acute care and community care services across Northern Ireland and with other Epic system users in the UK and worldwide, and the hope is that this will significantly enhance 12:51
the drive for improvements in safety, quality and performance. But, perhaps most importantly, it will not only aid HSC staff, but greatly assist in the empowerment of patients through the My Care Patient Portal, which will allow patients much greater 12:52
knowledge of their own care, with access to some of their HSC records. Digital safety-checks are also built into the system to ensure the protection of their information, which is obviously key.

12:52

When the Permanent Secretary gave evidence just two months ago, on 9th of April 2024, Chair, you asked about any difficulties in terms of the implementation of Encompass. Mr. May explained Encompass is the

largest single-change programme the health and social care has undertaken. It requires radical change from all staff who interact with patients. He noted that there will inevitably be teething problems and teething challenges, as with all new systems, but he was confident that: 12:53

"The Encompass system will be a big step forward, particularly assisting the safety and quality agenda, and I think that's been the experience elsewhere of where it has been brought in." 12:53

This is not unique in being a healthcare-related Inquiry. The Inquiry's Terms of Reference require it to identify any learning points and make appropriate recommendations. So, upon receipt of the Panel's final report, the Department will include the Inquiry's recommendations within the work of the Departmental Inquiries Implementation Programme Management Board, which is chaired by the Permanent Secretary, Mr. May, himself. That Board continues to consider and implement recommendations from those previous health public inquiries and its key purpose is to develop a comprehensive and coherent programme of work across the Department in order to help ensure a robust implementation of inquiry recommendations. 12:53 12:53 12:54

On behalf of the Department, members of the Panel, I would like the Inquiry and the public to be assured

that the Panel's recommendations will be considered carefully and extensively by the Department upon receipt.

The Panel has seen, throughout its work, concerns in relation to patient waiting lists and their impact both on patient safety and on the health and social care workforce. The Department has acknowledged that waiting lists, as they are, are unacceptable. There must be a continuous focus on quality, productivity, efficiency and transformation, to ensure that the health and social care system delivers to the best of its capability and capacity, and the Department is, and has been, doing what it can to solve the problem, in particular, the Elective Framework, published in June 2021, which was revised last month to put in place the strategic direction and plan over the next five years. Work to date has delivered results, but it is recognised that there is still much more to do. The overall treatment waiting lists have reduced by over 14% in the 12 months ending 31st of March 2024 and we've had seven consecutive quarters showing reducing waiting lists. 12:54 12:54 12:55 12:55

The Department's creation of day procedure centres and elective overnight stay centres has provided a dedicated resource for less complex planned surgery and procedures and has enhanced the quality and consistency of care whilst helping to bring down waiting lists. 12:55

The Lagan Valley Day Procedure Centre itself has facilitated over 6,000 urology procedures since its inception and those centres have assisted in reducing Urology waiting lists and waiting times overall by 17.1% between March 2023 and March 2024. 12:56

The Department has also been working with the Southern Trust to increase the Trust's Urology capacity and has provided additional recurrent funding. From March 2021 to October 2023, the overall Urology outpatient waiting 12:56 list has been reduced by 18%, while the number of suspect cancer or urgent patients waiting for assessment has reduced by 31%. Over the same period, the number of patients waiting for a day case or inpatient procedure has reduced by 38%. However, it is 12:56 vitally importantly that the Panel understand the constraints within which the Northern Ireland health and social care system is operating. All parts of the public sector are facing significant budgetary pressures, but the budgets afforded to the Department, 12:57 and then to the individual Trusts, are significantly constrained. The capacity of the system is unable to keep up with demand, particularly when its finite resources have been significantly impacted by the demands of the Covid 19 pandemic. In particular, the 12:57 Panel will be aware of the recent budget allocation to the Health Service. Bringing the waiting lists in Northern Ireland to an acceptable level will require sustained and substantial recurrent investment through

multi-year budgets, workforce development and system-wide transformation. The Department's position is that, sadly, the '24/'25 budget outcome falls far short of the funding needed to maintain elective care services at their current level. The Department's 12:57
estimates are that approximately 75 to 80 million is required this year just to stand still for red flag and time-critical patients, so the 34 million that has been earmarked for waiting lists will not, therefore, even cover half of the required investment. 12:58

In addition, the Department has assessed that funding above the 75 to 80 million, of approximately 135 million per year for up to five years, could have been invested in waiting lists initiatives to address the 12:58
unacceptably long waiting lists in Northern Ireland. If this additional waiting list initial funding had been invested, significant progress could have been made, with an initial focus on those patients waiting over three years. Unfortunately, no additional funding 12:58
for waiting list initiatives for the remainder of this financial year -- sorry, no additional funding for waiting list initiatives for the remainder of this financial year could potentially have significant consequences, with a negative impact on patient 12:59
outcomes and waiting lists.

In addition, recurrent sustainable financial investment in core capacity is also required. That will allow

transformation of elective care services to help reduce demand, providing a more cost-effective way to reduce waits and to prevent the build-up of waits in the future. Without that investment, there is no realistic possibility of reducing waiting times in Northern Ireland to acceptable levels. It is estimated that this requires approximately £80 million per year, in addition to what is required to maintain the red flag and time-critical services and to tackle long waiters. 12:59

The waiting list initiative funding has been used previously to bridge the capacity and demand gap for red flag time-critical assessments and treatments across a range of specialities, including Urology. Given the proposed budget, Trusts may not have the required funding to continue those waiting list initiatives and this will have a direct impact on patient outcomes, particularly for patients waiting for procedures such as prostatectomies and nephrectomies. Now, this, undoubtedly, makes things difficult. The Panel will have heard me, throughout these submissions, mention budgetary constraints. The Department's ability to be able to progress with the GIRFT review recommendations, with the Workforce Strategy and with any future review of regulation, are all subject to constrained budgets. There is, unfortunately, no easy fix. It is clear that, without sustained investments and additional funding, the pace at which improvements can be made and sustained will be limited. However, 12:59 13:00 13:00

the Department, and I'm sure also the Trusts, will do what they can, but they will be required to make difficult decisions in relation to the work that can be delivered within current resources.

13:01

If I can move to my conclusion then, members of the Panel.

When this Inquiry was confirmed by the former Minister of Health, Robin Swann, in August 2021, he stated that: 13:01

"The Urology patients and families affected will remain in my thoughts as the Inquiry embarks on its statutory responsibilities and I would like to again acknowledge the upset, distress and anxiety these matters have 13:01 caused. I am confident the establishment of the independent Urology Services Inquiry will enable a full and transparent investigation of the circumstances leading to the Urology Lookback Review and ensure lessons are learned in order to improve our healthcare 13:01 systems and restore public confidence in our healthcare services."

I would like to thank you again on behalf of the Department, the Inquiry Panel, for your full and 13:02 transparent investigation, as the Minister envisaged.

The Department is under no illusion as to the difficult challenges which have been presented to the Inquiry or,

indeed, that may be presented in the future, given the context of the issues arising within the health and social care services in recent years. Culture is difficult to change, but change will be necessary to realise the benefits to be gained and the improvements and changes to healthcare systems which will help the welfare of patients. The Department is fully committed to doing all it can to support the advancement of our healthcare system and looks forward to the Inquiry's recommendations to assist it in implementing the necessary change. 13:02 13:02

Unless I can assist you further, you may have some questions.

CHAIR: Yes, thank you very much, Mr. Reid. You did speak about the Department's responsibilities under the 2009 Act, and I just wonder does the Department accept that there is a responsibility to show leadership to the Trusts in the fulfilment of their obligations and, if so, how? 13:02 13:03

MR. REID: Well, the 'how' question, I think, is a difficult one, but if I can address the first part of your question, Chair.

Certainly the Department accepts, yes, that the responsibility falls on the Department to provide leadership to the Trust. In terms of the 'how', the hope is that the policies, governance and guidelines that the Department puts in place to assist the Trust 13:03

in any way in relation to governance, assists the Trusts in that endeavour.

I've gone through, throughout those submissions, certain areas in terms of culture and certain different frameworks that are being brought in or -- that have been brought in or are being brought in in the future in order to sustain that, both the Southern Trust and other arm's lengths bodies. Even though they are independent, as I say, the Department has the ultimate responsibility and, hopefully, the Department is doing all it can to assist them in their work. 13:03 13:04

CHAIR: I suppose the corollary of that is that the Department has set up this Inquiry and the other inquiries into our health and social care sector. When we do make recommendations, does the Department recognise that there is a requirement on the Department, having set us up, to assist the Trusts with implementation of any recommendations we make in respect of what they should do? 13:04 13:04

MR REID: I think there is two parts to your question, again. Obviously, the Department, through its Inquiry Implementation Board, will be looking at the different recommendations from the Inquiry and seeing -- considering those recommendations and implementing them where appropriate. If, Chair, you are also suggesting that the Department can also provide funding in relation to those, I suppose it very much depends on the recommendations and the budgets available at the 13:05

time and how they can be implemented. So, unfortunately, at this point, it may be a matter for another day.

CHAIR: I think the picture that you paint of the budgetary constraints is somewhat depressing, Mr. Reid. 13:05
I know it's not news to anyone in the room, but it, nonetheless, is difficult to hear.

You talked -- Mr. May talked about, and the Department have accepted in its submission, the need for the 13:05
regulatory regime to be reviewed and the evidence that was given was that it's currently on hold, but I wondered when we could expect any movement on it?

MR. REID: Well, I think as was also said in the written submissions and I think also in the evidence of 13:06
Mr. May, his indication was that what he wanted to do and what the Department wanted to do was to put in place the culture first before any review of regulation thereafter and, as I've said, those cultural changes will, hopefully, be coming through, through the 13:06
implementation of the Being Open Framework.

You'll note that, yes, no timetable has been set at this stage in terms of the review of regulation. It is a task that the Department is considering. 13:06
Unfortunately, with other competing priorities, it's not to the priority in the way that some of the others are, in terms of MHPS and SAI, but by the time -- but it's hoped that, obviously, that the culture will have

changed and that a review of regulation can take place in the future.

CHAIR: Okay. And one final question then about duty of candour, a more specific recommendation from another inquiry, and it's certainly five years -- six years, I think, since that recommendation was made in the Hyponatraemia Inquiry, and we were given evidence that it was ready to go out to public consultation this summer. Is that still on track? 13:07

MR. REID: Well, the Being Open Framework consultation references the Department's ongoing consideration of a duty of candour, both on an organisational and individual basis. The Department is also considering the recent Infected Blood Report, considering its recommendations, and, Chair, you'll also be aware, of course, that a review is currently taking place with the English Department of Health, I believe that was launched last December and that there was a call for evidence launched then in April in relation to that. So it is being -- 13:07

CHAIR: That is about the operation of the duty of candour --

MR. REID: It is being taken into account as part of the Being Open Framework at present, but not in an independent manner at the moment. 13:08

CHAIR: Very well. So, we can expect to hear something about that in the Being Open Framework responses?

MR. REID: Yes.

CHAIR: Well, thank you very much, Mr. Reid.

Mr. Wolfe, I think you wanted to say something.

CLOSING SUBMISSION BY MR. WOLFE:

MR. WOLFE: Chair, Dr. Swart, Mr. Hanbury, I anticipate 13:08
that this is my final duty as Counsel to the Inquiry
standing in this position, having walked to the
right-hand side of the room for the first time.

Thank you for allowing me to make the following brief 13:09
concluding remarks on behalf of the legal team.

Almost two years ago, on 21st June 2022, consonant with
the Panel's desire to place patients at the centre of
the Inquiry's work, you, Chair, convened the first of 13:09
the Inquiry's hearings, which was attended in private
session by former patients of the Southern Trust
Urology Service and their family members.

On 8th November 2022, the public-facing phase of the 13:09
Inquiry commenced with the delivery of opening
statements. All told, you have received oral evidence
from more than 60 witnesses. Other witnesses were
restricted to providing their evidence in statement
form through the Section 21 process or in response to 13:10
questionnaire. The range of witness testimony and
documentary evidence received by the Inquiry has been
wide-ranging and comprehensive by any standard.

In terms of oral evidence you've heard from a wide cross-section of medical and nursing expertise who have been, or remain, in the employment of both the Southern and Belfast Trusts, the majority of them occupying prominent roles in the field of Urology. You've also heard from a number of independent medical experts and, additionally, you've heard from senior healthcare leaders, including the current Southern Trust Chief Executive and her immediate predecessor. 13:10

13:11

Furthermore, a range of Trust operational and medical managers, including three former medical directors, and those holding important governance and administrative responsibilities, have appeared before you. Members of the Trust Board have given evidence, including the current and former Chair of that Board. You've also received the evidence of senior public officials, including the current and former Permanent Secretary of the Department of Health, the Chief Executives of the PHA, the RQIA, the Patient Client Council, the Strategic Planning and Performance Group and, importantly, you've received evidence in private session from 10 patients or their next of kin. 13:11 13:11

The documentary evidence disclosed to the Inquiry has been voluminous; it is still being received. As we heard from Mr. Lunny KC this morning, the Southern Trust alone has disclosed in excess of 400,000 pages of potentially relevant evidence. Each of the Core 13:12

Participants and others have disclosed significant volumes of material.

The compilation, consideration, cross-referencing, comparison and testing of the collected evidence is the 13:12
essential task of a public inquiry such as this. That evidence provides you, the Panel, with the critical material upon which to make your assessments and to base your findings. It is vital that this process is handled correctly in all of its stages, with a 13:13
thorough-going attention to detail.

Before any of this evidence can be used, whether to raise questions on paper or presented in the public sphere by Inquiry counsel, a huge body of work is 13:13
undertaken behind the scenes. The systematic, comprehensive and, above all, fair presentation of that evidence, depends upon the work of many Inquiry staff, both legal and administrative. I know, Chair, that you're going to speak to that in a few moments, but on 13:13
behalf of the Inquiry legal team, can I say this: If myself and Ms. McMahon have been successful in meeting our obligations in our roles, that has only been possible because of the unstinting efforts of our junior counsel, and I'll name them in alphabetical 13:14
order - Andrew Beech, Niamh Horscroft, Lara Smyth and Leah Traynor - as well as our team of solicitors, led by Anne Donnelly, and including Shauna Benson and Eoin Murphy.

They have done much of the heavy lifting and have been tenacious in their approach. Both myself and Ms. McMahon stand in awe of their work ethic, their attention to detail, their legal acumen and their willingness to answer emails at any time of the day or night. 13:14

As a legal team, we owe an enormous debt of gratitude to each of the members of the secretariat who have served this Inquiry with great diligence over the past three years. I hope they will forgive me if I do not name them individually, but I speak for all of the legal team when I say that, without the support of the secretariat, our work would have been rendered impossible. They are a highly-skilled team whose work has supplied the vital adhesive which has ensured that the legal team's processes have operated smoothly and efficiently day after day. 13:15 13:15

Could I also extend a word of gratitude to my learned friends for their helpful closing submissions this morning and to all of the members of the legal teams for their constructive collaboration with myself and my legal team. 13:15

We do not, as a legal team, forget that this Inquiry is resourced by the public purse and, as a legal team, we have been conscious throughout this journey that the public must have confidence in the work that we are

privileged to perform on its behalf.

When I provided the opening statement to this Inquiry on 8th November 2022, I boldly suggested that the work of the Inquiry provided a genuine opportunity to change 13:16
healthcare provision in Northern Ireland for the better. The specific work of the legal team, on behalf of the public, has been directed to advancing this goal by exposing shortcomings which have undermined the operation of healthcare provision for so long, placing 13:16
patients at risk. It will be a matter for others, after considering the Inquiry report in due course, to determine whether the goal of making meaningful change will be fully realised.

13:17

Today marks the 96th hearing day for the Inquiry. It is a significant day because it closes one chapter of the Inquiry's work and ushers in the next significant stage, involving your assimilation of all of the relevant evidence, further consideration of the oral 13:17
and written submissions and the formulation of findings and recommendations. There is much food for thought.

On behalf of the legal team, Chair and members of the Panel, I wish you every success in your endeavours. 13:17
Thank you.

CLOSING STATEMENT BY THE CHAIR:

CHAIR: Thank you, Mr. Wolfe. Well, thank you everyone. As Mr. Wolfe has just stated, this is the last planned hearing session of the Inquiry until the report is complete and ready to be put out into the public domain. There is still much work to be done before that can happen, particularly for me and for Dr. Swart, but I, therefore, want to say a few final words to you all. 13:18

I want to thank, firstly, all those witnesses, patients, families, staff, clinicians, managers and civil servants, both current and former, who have given written and oral evidence to the Inquiry. We appreciate that doing so involved a great deal of work, time, energy and concern. We hope that participation in the work of the Inquiry, while difficult, has allowed patients and families to feel that they have been heard and has allowed those who work for our Health Service to reflect on the important work that they do. 13:18

I also want to take this opportunity, like my Senior Counsel, to thank the legal representatives of the Core Participants and those representatives who appeared for some witnesses, for their attendance, their diligence and their collaborative approach to our work. 13:19

I would also like to give a special mention to Ms. Jane McKimm from the Trust who sat through almost as many hearing days as anyone within the Inquiry team.

I want to thank Gwen Malone, our stenographers, whose work allowed us to make the evidence available on our website, and to thank Pi Communications staff for their skills in live-streaming our public hearings and enabling all present in the chamber to see the documents referred to by counsel. 13:19

As Mr. Wolfe has said, much of what is seen during public hearings of an inquiry is a small fraction of the work that is carried out behind the scenes and, with that in mind, I want to publically thank the entire Inquiry team. The team was small at the start, but expanded to 22 in total, including myself, Dr. Swart, Mr. Hanbury, our legal team of nine, the secretariat of nine, as well as our communications adviser. I will not single out anyone, but want to thank each member of our team for all the hard work that they have carried out since the Inquiry officially commenced in September 2021. I appreciate and understand the pressures which everyone worked under to reach today's milestone, and while I wish I could say that our job is done, the team knows that there is more work to do for the report to be delivered. 13:20 13:20

As I previously stated, anyone who is to be criticised

in the report will be afforded the opportunity to comment on those criticisms. Dr. Swart and I will consider any responses before we finalise the report. I cannot say when that might be, but I promise to work as expeditiously as possible to complete it and, in due course, you will each be given notice of when we are ready to deliver the report. 13:21

So, thank you all, once again. I do hope that you have a good summer and look forward to seeing you all again when the Inquiry's work concludes. Thank you very much. 13:21

THE INQUIRY THEN ADJOURNED.