Urology Services Inquiry

Oral Hearing

Day 76 – Thursday, 7th December 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY CONTINUED, AS FOLLOWS, ON THURSDAY, 7TH DECEMBER 2023

CHAIR: Good morning, everyone.

1 Q. MR. WOLFE KC: Good morning, Mr. Donoghue. Welcome back and thank you for coming on that miserable morning. 10:06

You were last with us on 11th October. Apologies that I was hospitalised, I'm not sure that you were the cause of that, and the conclusion of your evidence has been delayed. 10:06

Just for your note, members of the Panel, the transcript for Mr. O'Donoghue's first day of evidence is to be found at TRA-08452 and it runs through to 08592. 10:06

Just by way of recap, Mr. O'Donoghue, you'll recall that we covered a wide range of issues associated with your experience of working in the urology department of the Southern Trust since August 2014, and your evidence included discussion of methods of working, aspects of the multi-disciplinary team mode of working, which we'll look at further today. Urologist of the Week, we'll commence this morning by just going back on a few aspects of that. We looked at management arrangements, governance arrangements, including appraisal, incident reporting, SAI, and the Patient Safety Meeting. 10:07 10:07

We spent some time focusing on stent management and the sign off of results. We also looked at the role of admin support and the delegation of tasks, and we took some account of the environment in which you worked in terms of the pressure placed on services and the impact of that pressure on staff and patients. I think we closed on the last occasion, having had a fairly in-depth look at triage?

A. Yes.

2 Q. I just want to commence this morning by going back a step into triage and just asking you a few questions in terms of triage and its impact on other urology or Urologist of the Week duties. 10:08

Could I ask you this: Did the emphasis, if that's the right word, which was placed on the need to complete triage when Urologist of the Week, did that impact markedly on the other duties that were fundamental to the UOW model? Here I'm thinking, obviously you were responsible as Urologist of the Week for the care and oversight of all acutely admitted and electively admitted patients, and you also had an advisory role across the three hospitals in the Southern Trust estate, patients coming in to the emergency department and other inpatients, for example, with urology problems. It's a long way round to get back to the question: Did triage impact markedly on the time that you could give to these other duties? 10:09 10:10

A. Well, it didn't take away from the other duties.

I managed my time, I think, reasonably well. I mean, triage I usually did later in the day when the other activities had all been completed, so when patients had been taken to theatre, when the ward round had been done and more urgent things had been dealt with. So if I needed to stay in the evening, I stayed in the evening and did it. So, you know, I could be triaging, 8, 9, 10 o'clock at nighttime but I completed it on the day, it was done every day. It wasn't at the expense of other activities, it was a lot of work but I don't think other activities suffered. 10:10 10:10

3 Q. Maybe another way of looking at it is that the emphasis on triage diminished the time that you could and would otherwise might have liked to give to the other duties associated with UOW? 10:11

A. No, again, I think I spent enough, the amount of time needed on the other activities, I spent on those activities. Triaging was something that didn't need to be done immediately and so it was dealt with when I had time to do it. So I didn't sort of cut corners in other activities or do less in the other activities at the expense of triage. 10:11

4 Q. One of the things you spoke about on the last occasion was the ward round when, I suppose Thursday morning, if my recollection is right -- 10:12

A. That's right.

5 Q. It had been built into the model, at least originally, that the person ending his UOW week would hand over to the incoming consultant. I think you explained to us

that that has now fallen away. I think I took from your evidence that it has fallen away completely, at least so far as your arrangements are concerned, and it's more typically done and more conveniently done, I think you said, over the phone the night before you would come on --

A. Or the morning after because admissions would come in overnight, so you would do that in the morning.

6 Q. Yes. And I'm not sure if you used the term 'it was a better use of time' to do it that way, but I think that was the impression that you gave me, and gave us?

A. Yes, I think you're quite right and I probably did use that term. I felt that morning ward round went on for most of the morning, particularly when Mr. O'Brien used to hand over to me which went from 9 o'clock in the morning until practically 1 o'clock. It might have been Mr. O'Brien being overly verbose, spending a lot of time on each patient, not necessarily gleaning anything useful for a lot of the patients, the sicker patiently certainly but that information can be -- you don't have to be standing next to somebody to relate what's going on with a patient.

7 Q. Could I bring you to a minute or a record of the Urology Service Development Meeting which took place in September 2018, AOB-81797. I don't know if you recall this. I think the meeting took place 24th September 2018. You joined the meeting late, it would suggest. And just there was a discussion of the Urologist of the Week model and it says that:

"This topic was discussed tentatively with each consultant able to contribute to the discussion. The consensus was that the inpatient ward round was of prime importance requiring consultant presence. The structure for referral and advice provided needs to be improved and where possible definitive care should be delivered during the current inpatient stay."

10:15

The word consensus suggests agreement across the team that the ward round was of prime importance. This is September 2018. Was that your view or did you share that view at the time with colleagues?

10:15

A. I'm sure I did at the time, if it was consensus, but I think things evolve. And I think as the years went by, I think it was -- I probably didn't agree with it as much, probably after Mr. O'Brien retired. Because I felt five hours of not contributing much apart from very sick patients, the patients -- when you could be doing other things was probably a waste of time.

10:16

8 Q. Yes. The current position where you don't have a formal ward round but conduct it essentially remotely by telephone with your partner, when I say partner, the person handing over to you; is that the approach now across the urology team at Southern Trust?

10:16

A. To the best of my knowledge, because it works very well. We have also reconfigured how the registrars work, because the registrar who has been on earlier on in the week is also on the Thursday. So they actually

know the patient even better than the consultant because they're on the ground, they're seeing the patient all day. The junior doctors are there. So it's probably better for the consultant coming on that way, I think. Because doctors who see the patients every day will know the patients intimately. The consultants see them in the morning on the ward round and that's it.

9 Q. I've put to you or asked you to respond to the suggestion that putting priority on triaging might have compromised the time that you could spend on other duties, and you've dealt with that. I suppose, conversely, did these other duties associated with UOW compromise or impact on the time that you would have liked to have spent on triage? 10:17 10:18

A. Well, there are always competing duties for a doctor and, you know, if you're going to theatre you can't triage. But going to theatre is obviously more important than triaging because the patient is an emergency. So, again, it's prioritisation. 10:18

10 Q. You explained on the last occasion that when you were Urologist of the Week you had to spread yourself, I think you used the term "sensibly and safely", and that the sheer numbers of referrals coming in precluded you from booking investigations for them all or for all that might otherwise have been appropriate to book. You had to be selective, was the term that you used. You would recognise, I think, the scenario that if a patient is referred in as routine or urgent, the 10:19

likelihood is that they are not going to be seen at a clinic for some time. Is that something you recognise?

A. Yes, but in saying that, GPs may prioritise a patient incorrectly, so you have to read it carefully. If a GP has referred a patient with an elevated PSA as routine, one would obviously upgrade that to red flag.

11 Q. Of course?

A. So you obviously don't just follow what the GP writes.

12 Q. Yes. I suppose my point is a slightly different one. Where you have routine and urgent referrals coming in and you are not able to find the time during Urologist of the Week to go through them other than to confirm that they are urgent or routine, and not take any additional steps by way of investigation, does that create a risk for a patient where they're not going to be seen at an outpatient's clinic for 12 months or longer, given the waiting lists that were in play?

A. I suppose it may do in that you're only as good as the information that's related to you by the GP. But, in saying that, I look at NIECR anyway so I get a feel for what's going on with the patient. So a patient whose coming in with voiding difficulty doesn't necessarily need a scan. In fact, if they are going to be seen a year down the line, the scan is going to be -- you would have to repeat the scan, probably, anyway. So I think you've got to look at it sensibly, and those patients, you know, you -- I think patients who need scans more urgently could end up suffering at the

10:19 10:20 10:20 10:21 10:21

expense of patients who don't need scans more immediately. You can also overbook, you know, overburden the extra service, although that wouldn't be something in my mind.

13 Q. Should I interpret your answer as painting a picture of scans are booked as a result of the triage process in all cases, whether routine, urgent or red flag where it is appropriate or, just to be clear, are you finding yourself in a situation where you're being selective and not booking scans for some routine and urgents because you know that the system wouldn't be able to cope, wouldn't have the capacity to cope with that kind of approach? 10:22 10:22

A. Scans would be booked, I think, where it is clinically indicated, where I think where a patient needs a scan in the foreseeable future. I don't book scans for every single patient that I triage. 10:22

14 Q. And where you don't book a scan, is that simply because, having reviewed the referral papers quickly, as you must do to move on when you are the Urologist of the Week, is that because at that time you have reached a clinical decision that it is not urgent or necessary to have a scan booked at that time? 10:23

A. Yes, that would be my decision making. So I would decide the patient doesn't need a scan at that time. 10:23

15 Q. Could I ask you just a practical question. Do you think that enhanced or advanced triage could be effectively undertaken by personnel other than consultants?

A. It could be undertaken by a Clinical Nurse Specialist, certainly, with wide experience, I would have thought.

16 Q. You had spoken a moment or two ago about the need, when looking at referrals, to be careful to position yourself so that you're able to upgrade, where it's appropriate to upgrade, such as from urgent to red flag? 10:24

A. Yes.

17 Q. Do you consider that the pressurised environment, which is the lot of the Urologist of the Week, you explained on the last occasion how, I think you said you didn't like it very much because it was so busy. If that's a false memory you can correct me. But you gave the impression of an extremely busy environment. Maybe just deal with that? 10:24 10:25

A. Well, as a personality I don't like lots of competing things at the same time anyway, whether it is a work environment or any environment.

18 Q. Do you think that that environment placed you at any risk of not having adequate time to always correctly go through the process necessary to determine whether a referral needed upgraded? 10:25

A. No. I think I would have examined each of them as carefully as I could. But, human nature being what human nature is, you can never get something right 100 percent of the time. So if you're looking at 50 referrals, you may get it wrong. But, I mean, whether you have an hour to do it or ten hours to do it, you can still make that error, it's human nature. So I'm 10:25

sure that 100 percent of the time I didn't get it right. I would be foolish if I said I did.

19 Q. Yes. Could I refer you to one case, it concerns a Patient 205, which you may recognise the name from the -- so we'll deal with the number as opposed to the name on the designation sheet. There's a record of an MDT meeting concerning this patient. If we can pull up AOB-80120, and just at the bottom of the page we can see reference to this patient? 10:26

A. Yes. 10:27

20 Q. The name has been removed, which is why I was struggling to recognise it. It is Mr. O'Brien's patient.

A. Yes.

21 Q. The MDT is taking place in November 2017, and the suggestion that is made on Mr. O'Brien's behalf is that you triaged this patient in or about May of 2017 pursuant to an urgent referral and didn't upgrade it, the suggestion being that it would have been an appropriate case for upgrade. Subsequently, a CT urogram was arranged in July of that year leading to a diagnose of right ureteric carcinoma for which a right nephroureterectomy was performed in November of that year. Do you remember the case? 10:27 10:28

A. I don't. And I've only seen this in the last hour, and so I probably need to see the original paperwork before I sort of give any pronouncement on my decision making. 10:29

22 Q. Yes. I did ask you in the general, before coming to the specific, and I think you fairly admitted that

everyone is -- you are, like everyone else, capable of human error.

A. Absolutely, yes.

23 Q. And you accept that there may obviously be cases where an upgrade should have been the decision. 10:29

A. And if I had seen haematuria, visible haematuria I would certainly have upgraded it to red flag. So that certainly would have been a red flag.

24 Q. So if the referral had come in mentioning haematuria, the correct decision would have been to upgrade. If 10:30 the referral didn't mention haematuria, you would forgive yourself for not upgrading, but if it did you would...

A. Yes, but I suppose one can also say the patient was triaged on the day that the patient was seen and so the 10:30 patient got into the system and was picked up, so the patient was triaged, albeit red flag would have been, certainly, if it was sent in -- if the referral letter had mentioned haematuria, certainly I would have upgraded to red flag, maybe. But I don't know the 10:30 particular circumstances.

25 Q. Yes but back, I suppose, to my original point. Is the pressure of time a factor in terms of your ability and your colleagues' ability to get this right, or do you stand by the point you made earlier that you could 10:31 still make a mistake, even with the luxury of time?

A. I think it's human nature. You know, I wouldn't rush through triaging because it's a recipe for disaster. So I'm sure if I had ten hours and I had missed it, it

would happen anyway because you can never get anything 100 percent right all the time. But triaging, you know, it is important to triage because at least the patient will get into the system and hopefully the other mechanisms along the way will pick this up as, seemingly, it had been picked up. So the patient wasn't sitting, not triaged.

26 Q. The suggestion would appear to be that at the time you were triaging the patient it would have been appropriate to request a CT urogram. Again, you can't answer specifically whether that would have been an appropriate decision for you at the time, but -- sorry, go on? 10:32

A. Visible haematuria would have certainly made me book a CT urogram. 10:32

27 Q. Is that a time consuming process to arrange that during the triaging process?

A. It adds on another five or six minutes because it is done online. You have to go into the X-ray part of the patient's record and you have to enter all the details. 10:32 If you miss a detail, the record won't -- it won't go, so you have to make sure you have all the boxes ticked. So it is five or six minutes usually.

28 Q. Yes, but that's --

A. And you have to put clinical details, obviously, so... 10:33

29 Q. So it is time consumption to that extent but it doesn't appear, from your answer, to be suggesting a disincentive to doing it properly?

A. No, it wouldn't be a disincentive, no. If the patient

needed it doing, it would be done.

30 Q. Just going back to a particular point that you made in association with Mr. O'Brien's practice around triage. If we can bring up your statement at WIT-50551. Just go to 69.1. You've remarked: 10:33

"I think there was a failure to engage by Mr. O'Brien with the Urology Service. Mr. O'Brien failed to triage urology referrals and he failed to refer a patient from the uro-oncology MDM onto another clinician." 10:34

That's an incident report that you raised and we'll look at that later. You say:

"With regard to his failure to triage, he should have let the head of service know that he was struggling to complete the triage." 10:34

We have heard from Mr. O'Brien in his evidence and he says that he made it clear to the head of service, to relevant personnel that he found it impossible do complete the triage. Let me just bring you to what Mr. Young says about that. He commented on this just this week when he gave evidence. If we go to WIT-51820. And at 64.14 he records: 10:34 10:35

"It was appreciated that Mr. O'Brien was vocal about saying he had a difficulty in completing triage as he did not have enough time."

So a bit of a difference between what Mr. Young recalls and what Mr. O'Brien is saying, I found it impossible and I communicated that, and that was clear, it should have been clear that I wasn't able to do routines and urgents, seems to be his line. Mr. Young's line is that Mr. O'Brien at no point came to me and said I wasn't doing it, but it was appreciated, nevertheless, that he had great difficulty in completing triage as he did not have enough time. So there's that distinction. 10:35 10:36

Would you agree, upon reflection, that there was knowledge across the team that Mr. O'Brien was at least struggling, even if you didn't appreciate that he had stopped doing it? 10:36

A. Well I felt he was very inefficient doing his triage because he did letters on patients, which I said before, and they were four A4 pages long on a patient and, really, they were just crowded in facts. I'm not entirely sure how useful they were. The people afterwards reading those letters, they were just too full of facts. Also, to compose all the letters must have taken Mr. O'Brien half an hour, I mean they were so full of detail. So if you have a couple of hundred referrals a week and you are doing letters like that, you can't, nobody in their -- no one person could possibly complete triage with that in-depth. 10:36 10:37

Also, I tended to follow him on call and I noticed on ECR or even when the hard copies were there that he didn't do them every day. There were days upon days of triage not done and there were often emails back and forth saying that the red flags hadn't been done during his week. So you could see virtually the entire week not triaged, because I tended to look at it the day before I came on to see what was waiting there. 10:37

31 Q. Okay. Just getting back to my original point, and we'll come to some of those other points, you're saying Mr. O'Brien ought to but failed to engage with Urology Service to inform Head of service that he was struggling. Were you unaware that he was making it clear, and Mr. Young vouches this, he was making it clear and was vocal about saying he had a difficulty in completing it. Did you not hear that? 10:38

A. I knew that he was struggling but not to the extent that he was struggling. I mean, it's a workload for everyone and perhaps he was more vocal than others. But was I aware that things were not triaged apart from what I could see? I mean possibly not. But I knew he was struggling, certainly. 10:39

32 Q. But you weren't ever aware of him saying "this is impossible"?

A. Well, I can remember an instance, him saying it's impossible? I don't think so, no. But I remember him saying he was finding it difficult. That doesn't mean he wasn't doing it. 10:39

33 Q. Your earlier answer pinpoints something you had said

before in your evidence. It's essentially your diagnosis of why he would find is difficult, and that is he was going into too much detail composing letters that, I take it from your evidence, you felt were unnecessary and unhelpful and time consuming? 10:39

A. Certainly I think it was a contributing factor. I am sure it's not the entire cause of the problem, but I think certainly it was a contributing factor, a major probably contributing factor.

34 Q. Did you ever speak to him about his technique or his approach to it? 10:40

A. No.

35 Q. Why not? Is that not something you would feel a responsibility to do?

A. I think at the time I was a more junior consultant so I think coming up to the senior consultant in the department and saying, 'I think you are doing this totally wrong'. Perhaps I should have, but it's not something I thought about doing, no. 10:40

36 Q. You refer to four-page letters, I think that was the -- 10:40

A. Yes.

37 Q. I mean, is that just a phrase that's maybe --

A. No, no, I have counted the pages.

38 Q. -- slight hyperbole?

A. No. I counted the pages, full A4 pages on patients that have been referred in. 10:41

39 Q. Are you describing here a triage letter or the outcome of a triage?

A. So is a patient is referred in with visible haematuria,

Mr. O'Brien would have dictated a letter with all the clinical details for the last several years and most of it irrelevant or certainly not relevant to the problem at hand I think.

40 Q. I think I picked up on you saying earlier -- sorry, just before leaving that point, you're not able to pinpoint any particular letter or particular patient in terms of lengthy letters? 10:41

A. No. Because I think if you look at Mr. O'Brien's letters in general, they're all quite lengthy. I don't think I've every seen a short letter from Mr. O'Brien, on any patient. 10:41

41 Q. In terms of him being behind in dealing with triage, I mean it's clear, we've lots of evidence of that. But focusing on Urologist of the Week period from tail end of 2014, that model of working was introduced. The sense of it perhaps on the evidence before this Inquiry was that ultimately The Trust found that there were a large number of routine and urgent referrals simply not done, simply not touched, maybe glanced at on Mr. O'Brien's account every so often to check whether the patients are progressing through the system in any event. But in terms of the red flags, again, seeing some evidence of delays around that, but your evidence this morning was you were seeing evidence sometimes of two week delays? 10:42 10:42 10:43

A. Well certainly when I would come on call there would be triage from his on call left, and sometimes I would do them, sometimes I would leave them for him, let him

know they were there.

42 Q. In terms of red flags, your observation is that you were seeing delays even on those?

A. Whether I can say there were red flags, I mean, there were referrals. I'm not probably willing to say they were red flag, whether they were urgents. 10:43

43 Q. Can I move from the issue of triage to dictation and the compilation of records as a result or as a consequence of engaging with a patient at clinic. You will know, obviously, by now that one of the issues that fed into the MHPS investigation was a failure on Mr. O'Brien's part to promptly deal with his responsibilities as The Trust viewed it to promptly dictate and make records after a clinical encounter. 10:44

10:45

We've heard from you on the last occasion, albeit briefly on this broad issue. You said, for example, that you always dictate letters when you receive results. But I want to hear from you in terms of your approach to dictation, say, following an outpatient review clinic. What records were you responsible for making and when did you make them and for what purpose? 10:45

A. So at the end of clinic I used to dictate. I didn't leave clinic until I dictated. I now actually do it after each patient encounter because I find it easier to do it that way. But I never left a clinic without dictating. That's what I have done as a registrar and when I was a consultant in England. In fact when I arrived in Craigavon, the first week I arrived in 10:45

Craigavon, I noticed from Mr. O'Brien's side the lack of dictation.

44 Q. I think you spoke to us on the last occasion about that first week. I think you were covering a theatre list --

A. Yes.

45 Q. -- for Mr. O'Brien and when you went to the chart you realised there were no letters. Your language "no letters in the charts" and it took a long while for you to work out why the patient was on the list. Just coming back to your own practice. To whom would you direct letters following a clinic?

A. So, if it's a clinic letter I direct it to the GP. If it's results I direct it to the patient and copy to the GP. When I was in England I copied letters to the GP -- to the patient, but since I've come here, I haven't been doing that.

46 Q. There's some interest on the part of the Inquiry in terms of communication with the patient. What was the thinking in England in relation to writing to the patient, and why is it different here, do you think?

A. Well, I think in England it was that the patient would know what is happening. You obviously have to write a different kind of letter if you are writing to the patient and the GP. You have to dumb it down a little bit. I think Roger Kirby said a couple of weeks ago that he actually enjoyed doing letters to patients. It just wasn't done here, so that's why I didn't do it here. But it is not something -- I wouldn't be adverse

to doing.

47 Q. Mr. Young spoke yesterday about perhaps an increasing trend in Northern Ireland or a movement towards writing to patients. Do you think there's merit in that and has it caught on with you yet? 10:48

A. As I said, I write to the patient with results but I haven't yet done clinical letters.

48 Q. Would there be merit in doing that do you think or do you see merit in it?

A. It is, because patients may not always pick up what you're saying in clinic because there's a lot of information overload. So when they go home, if they get a copy of the letter, it sort of certainly informs them and lets them know what's happening in case they didn't pick it up in clinic. 10:48 10:48

49 Q. Back to Mr. O'Brien's practice and what you noted and what others noted. Could I draw your attention to Mr. Haynes' evidence. He has commented, and I don't need to bring it up on the screen, TRA-00867. He remembers that when the service moved up to six clinicians, when you started you would have tried to work as a team and yourself and Mr. Haynes seeing some patients who Mr. O'Brien had seen previously and you both raise a concern. He said, along with Mr. Glackin and Mr. Young, when you were doing that, when you were doing Mr. O'Brien's patients because you didn't have any documentation about the decision making that had gone on before. 10:49 10:49

To what extent was that a real problem or was it maybe just a small problem that you could easily work around?

A. Well, it's not really -- it's quite a big problem. In patients who have rather thick notes it can be difficult to find exactly where doctors write their notes. Mr. O'Brien wrote notes but they were always, probably for his benefit than anybody else coming afterwards, you know, they were short, they were a few lines long. So he obviously knew what he was trying to say but anybody else coming in, 2 or 3 lines may not be enough to give the whole picture of what is going on, particularly if there isn't a letter. 10:50 10:50

50 Q. So the gap was the letter, as you saw it, that was the important communication tool so that you would understand what would come next for the patient? 10:51

A. Yes. I found that very difficult because I had been brought up doing correspondence for everything, so I found it very strange.

51 Q. Another feature of Mr. O'Brien's practice that we have heard about in evidence was the not irregular occurrence whereby patient charts wouldn't be available in the hospital when a patient perhaps came in as an emergency or where he or she was coming into clinic. Was that something you experienced? 10:51

A. It was something I was aware of and, again, something I found very strange because I trained in Oxford and one of the urologists there has a big medicolegal practice and we were constantly reminded that it should be a never event to take notes outside the hospital. 10:51

So I found that bizarre when I arrived and didn't agree with it obviously, particularly when there were no letters. So if the notes were home and you had no typed letters, you know, you had no idea in an emergency situation what was going on.

52 Q. Could I draw your attention to, I suppose, one such emergency arrival or arrival at the emergency Department of a patient which Mr. Haynes has drawn our attention to. If we go to WIT-54882. Here he is explaining a problem he experienced in 2016 when a patient called Patient 103 arrived at the hospital. I don't know, if you glance at the designation sheet, whether the name Patient 103 has any meaning to you. So this patient, Patient 103 according to Dr. Beckett, is it? Are you familiar with him?

A. I'm not familiar with -- the name Beckett is obviously something I'm aware of but I don't know him in person.

53 Q. As he records this girl, it was at the emergency department at Daisy Hill with him that morning. There was the some suggestion of a further USS, is that ultra scan?

A. Ultrasound.

54 Q. "But I deferred organising that until I hear what the urologists are doing".

so this is brought to Mr. Haynes' attention by Martina Corrigan. If we scroll up, she explains to him -- or, sorry, she is explaining to Mr. Beckett this patient was admitted under Mark Haynes via A&E and,

scrolling up, Mr. Haynes then explains the problem that he faced:

"I saw this lady this morning on my ward round. I have not been involved in her care to date. I have not received a referral. There are no letters on the ECR, and her notes detailing previous consultations were not available to me on the ward."

He discussed the plan going forward which will depend on how her current pain settles. 10:55

So he came to the Inquiry and he spoke about this case and he explained how the absence of appropriate documentation on the ECR really placed him at a disadvantage, coupled with the fact that the notes were not available to him for whatever reason. Is that -- maybe you don't recognise the case, but is that a scenario that is typical of what you were experiencing? 10:55 10:56

A. As a scenario, I mean, how many times it happened to me, I don't know because it wouldn't have been that common. But I mean certainly it's an example of what can happen by not dictating, by not having paperwork. Because it demonstrates somebody who has all the information on the patient himself, but other people are involved and if he's not there nobody knows what's going on. I say to my registrars, you know, you have got to dictate because if I'm knocked down by a car, 10:56

nobody will know what's going on so at least if it is all dictated somebody can take over, know what's going on.

55 Q. You said it didn't happen terribly much for you.

A. Not that I remember. But I'm sure it probably has, just nothing is coming to mind right now. 10:56

56 Q. Dr. Chada looked at this issue for the purposes of her investigation and a bit of a dispute on how many cases and how many clinics there was an absence of dictated letters. Mr. O'Brien would put it at the low couple of hundreds, a higher figure from Dr. Chada. Regardless of the precise numbers, clearly an issue of concern for Mr. O'Brien's colleagues? 10:57

A. Absolutely. Because, as I say, if you don't have the notes or if you only have 2 or 3 lines on the notes and you don't have letters, it takes a lot more effort as well because you have to go through -- you know, it is like starting from scratch. You have to piece it together, work out what is going on. 10:57

57 Q. You noticed this the first week in the job -- 10:58

A. Yes.

58 Q. -- in August 2014. It's still a feature of his practice, it would appear, into 2016, and then comes to a head, I suppose, with the MHPS investigation. Did you ever speak to him about his practice and "challenge" might be the wrong word, but seek to persuade him to a better course? 10:58

A. I didn't and perhaps I should have. Perhaps I just got on with things. I was new in the job, by 2016 I had

been there two years. At that point I was still aware that he probably wasn't dictating, but I just got on with things.

59 Q. Yes. We can see from what Mr. Haynes and perhaps others have said that there was clearly a conversation going on between you and him, and you would agree with that? 10:59

A. Yes.

60 Q. Probably reflecting the inconvenience and, to some extent, difficulties posed for patients. I don't know if you would put it as high as patient risk? 10:59

A. Well, it is a patient risk. I mean if you don't -- if a patient can't tell you what's going on and you need to act quickly. So it's certainly a potential risk, yes. 10:59

61 Q. Yes. Can you help us understand why this was allowed to fester, if "fester" is the right word. It wasn't challenged certainly by you?

A. It certainly wasn't challenged by me and, you know, on reflection I should have challenged it. It's always a bit difficult, I would have thought, with a senior colleague. But that shouldn't have stopped me, I suppose. I should have said it to him really, I suppose. 11:00

62 Q. I suppose when the Inquiry is reflecting about issues such as this, it sees the potential for patient harm and it sees that colleagues in the team are aware of the problem. And on your account it is put into the "too difficult to challenge" box and the problem goes 11:00

on. And you have expressed it, perhaps, on understandable human terms, I'm the junior consultant, he's the senior, it's difficult. But reflecting on that, and we can look at other issues where that seems to be the explanation for the behaviours, it's not good enough, would you agree, and, secondly, is that -- is these kinds of behaviours, can they be cured, can the culture be changed? 11:01

A. Certainly it's not good enough. On reflection I probably would -- if I was in the same situation now I probably would and with another colleague I probably wouldn't let it continue, I would certainly act on it. Can it be changed? You are probably trying to change a personality to some extent. I don't know what Mr. O'Brien did earlier on in his career. I don't know whether he dictated letters in those days, I don't know. But, certainly, it shouldn't have been left to go on. It shouldn't have been left to fester, as you said. 11:01 11:02

63 Q. Your options, you are on, I suppose, the receiving end of these behaviours and your patient is. You are facing into the frustration of not knowing what's going on with this patient and having to dig a bit around the edges to come up with a viable plan. Your option, having faced into this issue, maybe across a number of patients, is to speak to Mr. Young, the clinical lead, or perhaps the Clinical Director, Mr. Brown and/or to complete an incident report. It would merit an incident report, do you think? 11:02 11:02

A. Absolutely, it would have. I certainly should have taken more action -- I should have taken any action, I should have taken action on the matter because it is a risk and I hold my hands up, I should have acted on it.

64 Q. For fear that you may think I'm beating up on you, I asked Mr. Haynes -- Mr. Haynes was aware of the example I drew to your attention, Patient 103, he didn't raise an incident report on that. He dealt with it by way of airing his frustrations with Mrs. Corrigan, so that the issue was known about but it wasn't put on that formal footing of an incident report?

A. And I think I probably would have aired it as well and I would have talked about it but didn't do anything formally about it. But I certainly would have vented my frustration.

65 Q. Can I move on to the issue of private patients. Again, an issue that was considered by Dr. Chada as part of her investigation was the extent to which, if at all, Mr. O'Brien was giving advantage to patients he saw in his private room ahead of NHS patients. You came from England to working in the Southern Trust in summer of 2014. Did you have a sense that private patients were coming into the Urology Service of the Trust ahead of time or ahead of the time that an NHS patient would come in?

A. Well certainly seeing patients on the ward, I wouldn't have known where they came from. I had heard some

rumours from registrars that there may have been private patients had been seen, but I wasn't aware of whether they had gone in early or how they'd got into the hospital, I was just aware they had seen Mr. O'Brien privately in his rooms. It wasn't something I pursued.

66 Q. Yes. It is something that Mr. Haynes pursued. I will just briefly introduce you to what he did when the concerns arrived at his door, TRU-274504. At the bottom of the page, this is May 2015, you are in the Trust just coming up a year or so, or just less than a year. And he is explaining that he is feeling increasingly uncomfortable discussing urgent waiting list problems when he says: 11:05 11:06 11:06

"We turn a blind eye to a colleague listing patients for surgery out of date order, usually having been reviewed in a Saturday non-NHS clinic."

He says: 11:06

"On the attached total urgent waiting list there are 89 patients listed for an urgent TURP, the majority of them with catheters in situ, and they have been waiting up to 92 weeks." 11:07

And he contrasts that with a patient who went retention in the middle of March '15, failed the TWOC test, seen in a private clinic two weeks, three weeks later, and

surgery a little after a month later. So that's, I suppose, a turn around from problem to procedure within two months, two and a half months or so. Would it be your experience that ordinarily a patient coming on to the NHS waiting list at that time needing a TURP would rarely be seen within two and a half months?

A. Yes. It wouldn't -- unless they had a prostate cancer and they needed radiotherapy or something they may be done quickly because that is time sensitive. But I think a patient being on the list with a catheter, needing TURP, that would be very unusual to be done that quickly. 11:07 11:08

67 Q. Obviously there may be particular circumstances --

A. Yes.

68 Q. Clinical features in a specific case that may merit particular approaches to a patient. Could I draw your attention to a second email that Mr. Haynes sent some six months later, WIT-54106. He is again writing to Mr. Young, Mrs. Corrigan. He is referring to his earlier email and making broadly the same point, that waiting lists are not being managed chronologically and private patients being brought in on to NHS lists having significantly jumped the queue or the waiting list. So that was his concern. Did Mr. Haynes or anybody else speak to you about it? 11:08 11:09 11:09

A. Not directly. I'm not aware of these patients. I had heard rumours from registrars but I wasn't aware of particular patients who were coming in that quickly and having procedures done, no. But I had heard rumours

but they were just registrars on ward rounds saying it to me.

69 Q. You've told us already that you have a private practice?

A. I do, yes. 11:10

70 Q. Did you bring patients from your private practice into the Southern Trust facilities for procedures?

A. So the patients I brought in weren't private, they transferred to the NHS and they -- I always tell my patients that they don't get any advantage by going to 11:10 the NHS, they go on the waiting list at the point that they have been referred. So obviously clinically dictated but I don't give patients any advantage, in fact I forgot the names very quickly, so they go on the list. There's also an NHS transferral form where 11:10 they're transferred into the system.

71 Q. So just take us through, so that we can better understand the process. If you see a private patient, say for the first time on a Friday afternoon, I think you've explained to us that your private work is 11:11 typically done on a Friday, and you decide that the patient's -- maybe you have done some investigations, but you have reached the conclusion that a TURP is the necessary intervention and you tell the patient that will be a sum of money to deal with that privately and 11:11 the patient decides, no, I can wait, I would prefer to have it done via the NHS. What steps do you take from there?

A. So, one, they're aware that they are not getting any

advantage, they're not displacing an NHS patient. So I dictate a letter to my secretary so that there is a dictated letter gets on the system so that it's copied into the notes and it goes on ECR now as well. There's an online NHS transfer form now which I do, which has come on recently, before that it was a paper letter.

72 Q. To illustrate that, I think we can bring one up, TRU-267692. That's the 2016 form. There have been earlier iterations of it. It may well have changed since. 11:12 11:13

A. It's gone online now as well.

73 Q. You would complete that at the point at which you are dictating a letter in to your secretary?

A. Yes or I just ask her to give me the names and then she lets me know the names and I fill that particular form out afterwards, I do them in batches. 11:13

74 Q. Where does that go to the best of your understanding?

A. I don't know. It goes into the system somewhere. It's emailed, presumably, to -- I don't know where it goes. But it goes somewhere in The Trust. 11:13

75 Q. As we understand it, it is ultimately a decision for the Medical Director's office to approve or disapprove of the transfer.

A. Yes. I also fill out a waiting list form. 11:13

76 Q. Yes. And so do you yourself retain any control over when the patient would then be seen for the procedure?

A. No. It goes chronologically on the waiting list and when the turn comes. But down the line I don't

remember -- I don't look at a list and know whether were they private, were they originally private or not, I don't remember. So they are just done chronologically.

77 Q. Could you, within the system that exists or has existed, have reached for the patient who you know has been seen by you privately and give that patient an advantage? I'm not saying you would do that, but could you do it, unchecked? 11:14

A. You certainly could do it, I'm sure. You know, if -- probably less so now, I think. Systems have tightened up and we have a coordinator who books the lists now, so we just hand that over to her. But I think in the past you certainly could pick a name off a list and do it ahead of other people, yes. 11:14 11:15

78 Q. And speaking to colleagues who have private practices, did you form the impression that the process that you've described, which you are describing as being compliant with The Trust's policy, I assume, was that policy well known and observed by your colleagues, do you think? 11:15

A. Knowing my colleagues, I'm sure it has, but it's not something I've discussed with them. But I'm sure it has.

79 Q. Is there, if you like, any visibility in terms of the Trust's expectations around the management of private patients into the NHS? 11:16

A. In what sense? In that they want to be...

80 Q. In the sense have you been aware over the years of the

message being handed down from senior management that there's a firm expectation of compliance with this?

A. Well, I haven't received emails from -- or I'm not aware that emails go to people and says this patient has jumped ahead of or has been done far too quickly, so I'm not aware of that. But I don't do that so maybe that's why I'm not aware. But I don't know what happens otherwise. But I'm sure it is checked to make sure that private patients aren't given advantage. 11:16

MR. WOLFE KC: Would now be a suitable time for a break? 11:17

CHAIR: Yes. We'll come back at 11:35, ladies and gentlemen.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:17

CHAIR: Thank you, everyone.

81 Q. MR. WOLFE KC: Taking some steps forward now to the period from January 2017 when you, as a team of colleagues, were told that Mr. O'Brien has been excluded from work and there are issues in relation to triage that you would be expected to assist with, do you recall that? 11:39

A. Yes. I remember one of our meetings, being told about that, yes. 11:40

82 Q. And you and your colleagues in Mr. O'Brien's absence were expected to, I suppose, help out to look at the cases that weren't triaged and form a view and, secondly, to look at cases where there hadn't been

a dictated outcome from a clinical episode and, again, fill that gap.

You've said in your statement that the failure to triage was taken as a serious clinical issue and all four substantive consultants triaged the patients as quickly as possible and organised appropriate investigations and clinic appointments. You participated in that triaging exercise? 11:41

A. Yes. 11:41

83 Q. Did you, to the best of your recollection, come across cases that you had to upgrade? I think we know that roughly 30 or so were upgraded as a result of this process?

A. I can't remember precisely whether I upgraded to red flag or not. I don't remember that detail, no. 11:41

84 Q. Assumedly at that time, Mr. O'Brien excluded from work, this news arriving with you that a substantial number of cases hadn't been triaged and then the dictation issue. You were aware of, in a sense, aspects of both of those issues, but was it the volume that came as any form of surprise when you were told about it? 11:42

A. Well, no. I was aware that there had been delays in dictation but I wasn't aware that -- I only learned at that meeting that there was dictation that hadn't actually been dictated and various -- a number of, I think it was 700 and something -- 11:42

85 Q. In terms of charts?

A. Not triaged, I can't remember the precise number of --

86 Q. Leaving the final number to one side, I don't think we need to worry about that, but what I'm anxious to understand is in terms of the response amongst your colleagues in respect of that. Presumably there were discussions about what this -- I suppose what this meant, what the implications of this were? 11:43

A. I think we were all horrified. You know, we didn't expect in our wildest dreams that there were going to be untriaged referrals just left there. And, obviously, the implications of something that's untriaged and if a patient has been missed, yes. 11:43

87 Q. You say you were horrified. How would you characterise the significance of this disclosure on the triage side?

A. In what...

88 Q. How would you characterise it in terms of its significance? 11:44

A. Very serious. I mean, something that in my wildest dreams I didn't think could happen. And, obviously, the implications for the patients that were sitting there and hadn't been appropriately dealt with. 11:44

89 Q. Yes. Did your view of Mr. O'Brien as a practitioner change as a result of what you were now discovering?

A. Yes.

90 Q. How did you view him beforehand and how did you view him when you discovered this gap in his practice? 11:44

A. I think before this I had, in spite of his failings in updating, I had a lot of respect for him. Perhaps because I didn't know a lot of the problems that were ongoing. I didn't know the problems that were ongoing

even before I arrived at The Trust, going back to 2009, issues with management. So, I had respect for him, yes, in spite of him not dictating. Perhaps I didn't know the entire -- I hadn't an entire picture of what was going on in my head. I think as more and more -- as details were being revealed, I kind of was losing respect, yes.

91 Q. Another side of this is that Mr. O'Brien was running to stand still in what we observed on the last occasion was an environment where you said you didn't feel overly pressured but there was certainly a significant demand on the services of urologists such as himself and yourself. So he was burdened by the expectation of dealing with the need for throughput of patients at all levels and, inevitably, there will be casualties in terms of his ability to perform all of the duties expected of him; that's the other perspective. Is that one that you share or at least are sympathetic to?

A. One can be sympathetic and one can sort of explore why this happened. But at the same time, I mean if you are not triaging, you're having these problems, say I have this number of notes, I have not done them, and don't bury the problem because that problem will resurface at a later date. So at least put the problem on the table and say there is a problem. It is fine to say I'm having problems, but actually say 'the problem is I haven't dictated...' however many number of triages.

92 Q. Have you reflected at all since that some of these problems were obvious, perhaps more obvious now with

11:45 11:46 11:46 11:47 11:47

the benefit of some hindsight, but they weren't hiding behind the walls, they were the subject of some awareness, as we've acknowledged this morning. Is there a lesson to be learned there on the part of team members about how we responded, realising that there were problems over the years? 11:48

A. I mean some of the problems -- I think we couldn't have known that, you know, there would have been untriaged letters. I mean, that's not something one would ever sort of have guessed was going on. So I think things like that, I think, was a complete surprise to everyone. Because I think, working in a team, if you are working in a team you say 'I am having this problem, I have not done' whatever number, 'can something be done, help me'. So I think perhaps, rather than going on with -- you know, leaving the problem to get out of hand. And, okay, you can sort of become blinded by everything going on around you, but I think, you know, he just had to ask for help with that particular problem. But, yes, I suppose, to answer your question, now I think if we knew that a colleague was having problems, we probably would step in earlier. 11:48 11:49 11:49

93 Q. There's a fashionable term such called silo working or working in a silo. Perhaps when there are pressures in the system and you are running to stand still to get on with the day-to-day work, you're not as attentive or as sensitive to what is going on around you. Does that provide any explanation for -- 11:49

A. It does. I think we were all getting on with our own practices, which were busy, you know, dealing with our own issues. So, yes, I suppose that could have contributed to it. But I mean every profession is busy so you're not watching what your colleagues are doing. You get on and do your own work.

94 Q. Yes. I think you said in your statement that Mr. O'Brien returned to work during the middle of 2017. I think you would accept that he came back to work much earlier than that, I think it was around March 2017?

A. Yes.

95 Q. Just for the record, you're nodding your head in acknowledgment. Did it surprise you, given what you were hearing about the failure to triage, the number of undictated outcomes, to name just those issues, and there were other issues obviously being investigated by Dr. Chada. Did it surprise you that he was coming back to work so early?

A. Well, I hadn't thought about it too much. I knew that a mechanism had been put in place for him to make sure that he was triaging. My understanding was he was given the Friday off after on call to try and get on top of his triage. So I think things were put in to support him. So I hadn't really -- because I hadn't known about a lot of the other issues. So, no, I hadn't thought about it in that sense.

96 Q. I'll come back to that issue of support in a moment. You have spoken about having had confidence in this senior clinician prior to this being revealed and then

after this was revealed, I'm not sure if you used the words lost some respect for him or lost some confidence in him?

A. Perhaps confidence might be a better word than respect.

97 Q. Did you and your colleagues, recognising what had been going on around you before this revelation, discussed at any point whether you would need to work in a different way with Mr. O'Brien or keep him under, I suppose, closer observation as colleagues going forward, or was there any discussion of that type? 11:52 11:53

A. Well, I certainly wasn't privy to any conversation that we must keep him under closer observation. I mean that wasn't something I was aware. Maybe more senior management may have been involved in those conversations, but I certainly wasn't. 11:53

98 Q. We know that in 2020 other issues emerged and they were the subject of the Serious Adverse Incident reviews. The product of the work that you undertook and your colleagues undertook in the early months of 2017 was to triage and to work through -- this is the second element -- work through the cases that hadn't been dictated. Can you recall what the upshot of that second limb was? 11:53

A. So I had seen patients in clinic -- you're talking about where I had done clinics of his patients, is that what you're talking about? 11:54

99 Q. Well, I'm asking you to try to recall what work you did. It's not mentioned in your statement. So, as we understand it, you had these cases where there was no

record of a dictated letter, and those cases were shared around your colleagues to look to see what should come next for the patient, it not having been recorded in a letter. Were you doing any work around that? 11:54

A. I think I was. I can't recall now, but I think I was looking at some of the -- so I think I did three things: I triaged the referrals. I think I did look at some patients, where there were no letters. Then I think I did some clinics of his patients who needed 11:55 to be seen.

100 Q. Yes. When you think about what emerged in 2020 through the SAI reviews following Mr. O'Brien's retirement, do you think that more ought to have been done earlier such as around 2017 to better investigate all possible 11:55 or potential concerns in his practice?

A. As far as I remember I think that these subsequent things came to light sort of were known about in 2017 so I think it hadn't been realised that there were these SAIs, from my understanding out there. I think 11:56 these came to light as time went on.

101 Q. I suppose what was revealed in the SAIs were behaviours in association with multidisciplinary team working, and there's a range of themes emerged such as failure to engage a key worker for patients, delays in the 11:56 referral pathway, cases not coming back to the MDT, for example when there was disease progression, these kinds of behaviours. Then there was the issue around the prescription of Bicalutamide, all of which we'll look

at shortly. But would you agree that the behaviours around the MDT should have been looked at at an earlier point as part of an overarching examination of his practice, given what was revealed, albeit of a different nature, but what was revealed as shortcomings in 2017?

A. I'm not too sure whether a lot of those were known at that time. I certainly didn't know that he wasn't involving Clinical Nurse Specialists in seeing patients. But I think if they were known at that time they should certainly have been investigated. If it was known that he wasn't bringing patients back, it certainly should have been investigated at that time. I'm not sure if it was known or not. 11:57 11:58

102 Q. I'm not suggesting it was known. You were a member of the MDT and I assume you're telling me you didn't know? 11:58

A. I didn't know.

103 Q. Yes. But it would be possible to take a look at other aspects of his practice to see what is to be found?

A. I suppose if you're looking at somebody who is having problems, I suppose you've got to assume that there are problems in other areas rather than just the ones you're seeing. So I suppose it certainly would have been worth looking at the those areas as well, yes. 11:58

104 Q. Another issue, perhaps self-evidently, is to sit down with Mr. O'Brien to see what support, if any, he requires. It may well be that his colleagues are capable of meeting the standard set by the Trust, say, in relation to triage, but he is experiencing a genuine 11:58

difficulty, whether it's a difficulty of time management or a difficulty of prioritising what he sees as more important, that kind of thing. Was there any discussion amongst you clinicians, as a team, about whether you could better support your colleague or did you consider that to be a management issue to resolve? 11:59

A. Well, I'm not aware that we discussed it, but that's not to say that it didn't happen. I'm only surmising that Mark Haynes with his hat as Associate Medical Director, he might not have been in that post in 2017, might have been involved in that. I suppose the other thing is there's been a long history, going back to 2009 and before, Mr. O'Brien sort of engaging with management and not engaging with management. So there's a long history of him not really engaging. So whether -- but that's not to say -- I didn't sit down with him and see how I could help him. 12:00 12:00

105 Q. You're only surmising that --

A. I'm only surmising.

106 Q. Yes. You do say, if we could bring up your statement at WIT-50517, at paragraph 1.2, you say: 12:00

"The first time I became aware of issues of concern was during Mr. O'Brien's sick leave in mid November 2016." 12:01

I think you have since acknowledged it was later than that, it was January.

A. Yes.

107 Q. And the point I want to make to you is you say:

"On his return to work in mid 2017 ..."

You acknowledged it was earlier than that.

12:01

"Measures were put in place to enable him to do his triage in a more timely way. Most of the referrals for triage, except those from A&E, were online and he was given the Friday after on call off to triage, and the timeliness of his triage was looked at regularly by Mrs. Corrigan."

12:01

Just a couple of points of strict accuracy arising out of that. In terms of the Friday off, I think it's Mr. O'Brien's unchallenged evidence that he took Friday off when it was his Urologist of the Week period, but he took that as a holiday or annual leave. So he used his annual leave to perform triage to the standard that he thought was appropriate. In other words, he sacrificed his annual leave rather than simply being given the day off. Were you aware of that?

12:02

12:02

A. No, I wasn't. I assumed he had been given it off. So I stand corrected if that's what Mr. O'Brien was doing.

108 Q. You've described -- you've used the term:

12:02

"Measures were put in place to enable him to do his triage in a more timely way".

The placement of the triage materials on line, that wasn't a specific solution fashioned for him. That was

a broader innovation to assist the teams?

A. Absolutely. It was to keep -- you know, bits of paper can go missing, so having it online, there's a record of what happens to it. And you don't necessarily have to do it in the outpatients, you can do it in your office, you can bring the computer elsewhere, so things can't get lost.

109 Q. Were you aware of any specific Aidan O'Brien measures to assist him, apart from what you referred to here as Mrs. Corrigan keeping an eye on the situation to ensure that it was getting done in a timely manner?

A. I suppose what I thought, Friday was given to him, I was obviously mistaken. But I assumed, I didn't assume, I actually thought he was given it. And certainly that's what I understand and what I thought I had been told, that he was given the Friday off after on call to do that. But, as I said, if Mr. O'Brien says otherwise, I stand corrected.

110 Q. Yes. When he returned to work and was back in the fold, were working relations strained at all? Did the atmosphere amongst the team change?

A. I didn't notice that much. There was just one instance which at the time I didn't -- in isolation it didn't mean very much apart from I was a bit taken aback. But I rang him to see if -- because I was organising a Christmas dinner and I rang him to see if he was going to the Christmas dinner. He said to me in a very forthright way that he and his wife wouldn't be coming and left it at that and the conversation ended.

I thought that was a bit strange, and a bit rude. But he didn't elaborate and with all this going on, that might have been the reason why. But I was a bit taken aback by his brief response, and he just hung up on me.

111 Q. Did you speak to him directly about how he was feeling during what must have been a difficult experience for him? 12:05

A. No.

112 Q. You may have since become aware that Mr. O'Brien got into the habit, if I can put it in those terms, of recording a number of conversations with colleagues within The Trust, and including a meeting which you attended in December 2018. The transcript has been produced of that meeting. Nothing particularly turns on it. First of all, your reaction to discovering that this was being done, assumedly without your knowledge? 12:06 12:06

A. My respect for Mr. O'Brien got even less. I felt it was a very underhand, very -- and I heard about particularly some of the circumstances where he had taped and I was very disappointed in him. I've lost a lot of respect for him over that. 12:07

113 Q. It may, from his perspective and perhaps even more objectively, be reflective of a concern that trust across the team was not optimal and he felt the need to protect himself because decisions had been made within The Trust adversely impacting on him. Do you recognise that the circumstances arising out of 2017 and all that had given rise to trust issues on his part? 12:07

A. I personally don't think there's any excuse for that

behaviour. You know, as a team I think I thought we were getting on quite well. I wasn't aware of the undercurrents that were going on. I think that, from my understanding I think The Trust was fairly open with what was going on, and that's from me reading the documentation that I've had over the last few months. But, in saying that, I don't think there's -- I really can't excuse taping conversations without people knowing about it. Particularly because you can lead a -- you know, you can lead a conversation any way you want if you're taping it and the person doesn't know about it. 12:08 12:08

114 Q. I move on to a number of discrete issues, just to take your view on them. The Inquiry is interested in the governance arrangements primarily in association with clinical duties and particularly where there is perceived to be a shortcoming in the performance of a clinical duty or an aspect of a clinical duty and where that might be known the question arises well, what was done by the system of governance to either prevent it or address it. 12:09 12:09

The coroner for Northern Ireland, the senior coroner for Northern Ireland, Mr. Leckey, wrote to the Chief Medical Officer's office in or about 2013, before you came to The Trust, to raise concerns about the death of a patient in a private healthcare facility who had undergone a procedure and had suffered, I think, hyponatremia as a result the use of the irrigation 12:10

fluid, glycine. I'm just giving you this by way of background. That led to the CMO directing Trusts to develop policies to move away from monopolar instrumentation in glycine and towards saline and bipolar instrumentation. You're familiar with the background to that? 12:11

A. Yes, that was a female patient rather than a urology patient but I am aware of the background and the reasoning for it, yes.

115 Q. Yes. Obviously that transition or the need for that transition was a subject matter for discussion across the urology team and, as part of that discussion, you, as individual clinicians, trialed different types of instrument and then fed back your views. I want to draw your attention to the views expressed by Mr. O'Brien in association with that. Maybe take you to ne example, in the interests of brevity, if we go to TRU-395978. He is writing to the group, you included, and he is explaining that, just about halfway down, that he last used a bipolar instrument two weeks ago to resect a moderately enlarged prostate gland of an elderly patient. He had to abandon the bipolar resection after ten minutes because of bleeding and what he describes as poor irrigation and visualisation and moved across to, as he says salvaging the situation with monopolar resection. He says: 12:11 12:11 12:12 12:12

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

It didn't, I suppose, become an issue for close on two years because it took that length of time for The Trust to purchase the equipment. Did you observe any difficulty, personally, in using the bipolar equipment or, indeed, I should ask you, did you use it from the outset and what difficulties, if any, did you experience?

A. So I used it from the outset and I still use it. I don't use monopolar at all now, either privately or publicly. It is a slightly different way of doing it and you just have to change the way that you're doing it. It is a bit slower than what we were used to using monopolar. I think if you do it too quickly you don't fulgurate the vessels. One, I don't think it is inferior, it is obviously superior, it's much safer. I have done very large prostates with it and had no problem diatherming vessels I've had no problem with the irrigation. So I think it is a new technique and I think you just have to give it time and get used to it. I mean, it's a slightly different way to doing it to the monopolar, but it is certainly not inferior.

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12:14
12:14

116 Q. I have not taken you, again in the interests of brevity, perhaps, to any of the policy documents and what have you, but would you have been making the transition, making the switch upon the purchase of the equipment because you felt an obligation to do so? The Trust were telling you this is the policy, you must do it, or did you feel that you had a discretion in terms

of whether you moved?

A. Well, I knew it was coming in and so I knew that The Trust was changing over. But I also realised it was a much safer way, safer for the patient. The risk of what we call TUR syndrome, you don't get it with bipolar. So anything that's safer must be better, you just have to get used to it, and I'm very happy with it now. You know, at that time I was obviously in a period of transition but I certainly didn't have the strong feelings that Mr. O'Brien expressed in that email. 12:15 12:15

117 Q. This is the clearest, I suppose, indication of Mr. O'Brien's views that we're aware of being expressed, if you like, publicly to you as a group. Did you respond in any way to this, whether directly to him or to colleagues? 12:16

A. I certainly didn't send an email to him, because you'd have a copy of the email, and I know I didn't anyway. Two is, whether I had spoken to colleagues about it, I probably did but I don't know what I said and I don't know what the outcome of it was because it was just a conversation. 12:16

118 Q. Did you know or did you have any awareness of how Mr. O'Brien responded to the availability of the new equipment in 2018? In other words, do you know whether he -- did you know at that time whether he made the transition? 12:16

A. Well, I have a vague memory of him saying at a meeting some words to that effect, that he didn't like it,

perhaps that he wasn't going to be using it, I don't know. But I was never in theatre with him so, apart from meetings, I don't know what he did. But if he said he wasn't doing it, I assume he wasn't. But, as I said, I wasn't witnessing what he was doing. 12:17

119 Q. Yes. Just to broaden that question out, have you any recollection of him being challenged by colleagues, perhaps with Mr. Young as lead, any recollection of that type of conversation?

A. I don't have a recollection, but that's not to say it didn't happen. I just don't have a recollection of it. 12:17

120 Q. Are you of the view that colleagues were bound to make this switch to bipolar and that, taking into account patient safety concerns, there really isn't any excuse for not making the switch? 12:18

A. That was my understanding that, you know, that we were bound to do it and it wasn't a matter of you could or you can't -- you can do what you like. As a team, my understanding is that we were all moving that way. 12:18

121 Q. The Trust has produced a paper which might be described as a simple retrospective audit of what was done by clinicians in the urology team when the equipment was purchased. I'll just take your comments on that. If we go to TRU-396059. As I say, a retrospective 12:19 produced relatively recently at the Inquiry's request. And the question that was explored was whether it was known if Mr. O'Brien used the bipolar equipment or did he continue to use monopolar. The methodology is

briefly described as taking the period January to December 2019 and looking at the behaviours of all consultant urologists. Then if we scroll down to the next page, try and get this table on the same page. We can see, Mr. O'Donoghue, that during the period -- you weren't limited, just to explain, you weren't limited in what you did to simply five procedures, it was more than that, but in the interests of producing results quickly they looked at a sample of your cases and a sample of everyone else's cases on a pro rata basis, as far as we understand. So you are said to have -- they have looked at five of your cases and they were all performed by using bipolar instrumentation in saline. That would not be a surprise to you, assumedly, that's what you think you did? 12:20 12:20 12:21

A. Yes.

122 Q. That information is readily available to The Trust, isn't it? It's available on the theatre records for patients?

A. Yes. It probably would be going in the theatre book as well. 12:21

123 Q. Yes. As you can see, Mr. O'Brien, two up from you, consistent with what he said would be his approach when he spoke about it in the email in 2016, there were ten of his patients looked at, nine of which he had performed the procedure for and the one bipolar was -- you performed it for his patient is my understanding of the analysis. So Mr. O'Brien, of the ten cases looked at, nine have been performed with a monopolar 12:21

instrument, seven in glycine, two further cases where there's no indication of the fluid used because the balance fluid chart has not been found in the notes?

A. It must have been lost or something.

124 Q. Just from a governance perspective, could you help us with this. Plainly, Mr. O'Brien had made his views known but there was otherwise a method, even if you weren't in theatre with him, for Trust managers to understand with a little bit of work whether he was complying with Trust policy; is that fair? 12:22 12:23

A. Yes, absolutely, there's a record there. Is that from 2019.

125 Q. Yes?

A. That's kind of a year after we started or --

126 Q. It's a year after the introduction of the new equipment. 12:23

A. Okay.

127 Q. This is an example of, I suppose, of a safety issue which The Trust were aware of, aware of the potential for difficulty. They had been directed by the Chief Medical Officer's office to subject the process to an audit. It appeared that one wasn't done contemporaneously. Had you, and maybe you weren't aware of this at the time, but broadening this out, had you any sense more broadly of the Trust's governance arrangements failing to superintend the work of clinicians? 12:24 12:24

A. Well I wasn't aware they were keeping a -- I just hadn't thought of it, that they kept a record of what

we were using.

128 Q. This record, just to be clear, this audit has been done within the past several months and it has been performed by looking at available documentation. It wasn't gathered at the time and I suppose that's my point to you in asking for comment. There's a safety issue associated with a new policy. They have been asked to audit compliance with the new policy. It wasn't done, and I'm asking whether you had a broader sense whether the work of clinicians was the subject or ought to have been the subject of the production of governance-type data in the context of patient safety? 12:25 12:25

A. I assumed that all our activities were being monitored, obviously, and, if not, that is a governance issue. I mean certainly, if they were introducing a new technique and there was non-compliance or poor compliance, I mean we're all meant to be moving towards a government directive, well, there's a failing on the part of The Trust not to implement that or -- force is the wrong word -- not to ensure we are all using the same technique. 12:26 12:26

129 Q. We heard yesterday, in glowing terms, how the work of your Patient Safety Meeting is now, I suppose, much more interesting, much more dynamic in how it approaches matters. Its focus on audit, its focus on morbidity cases whereas the I suppose somewhat staler, more traditional approach had been to look at mortality as a primary focus. Is this kind of issue something that your Patient Safety Meeting takes on board? 12:27

A. I'm not entirely sure how it would get into the meeting, but certainly it is something I would have thought that certainly if we are developing or changing over to something, it is something that should get into our Patient Safety Meeting, because it is probably the forum where everybody is there and you can highlight that somebody is not adhering to it. So it really only gets into the Patient Safety Meeting if something goes wrong. I suppose that is something that has gone wrong, but you have to know about it to look for something. But I think it's certainly something that should go before the Patient Safety Meeting, but I'm not entirely sure how it would get into it. 12:27 12:28

130 Q. Moving to the issue of actioning the results of investigations, the scenario is you are the consultant who refers a patient for, whether it is bloods, whether it's pathology, whether it's some form of scan. The practice that you adopt in relation to that is what? How do you action the results, how quickly do you do it, and is there an importance associated with promptness? 12:28 12:29

A. So what I do now is different to what I did several years ago, the system has changed. So what I do now is that all results come on NIECR, and I sign them off. So I have changed over to that, I don't know, a couple of years ago, maybe two years ago. And that's a much safer way because all results come through that. So, again, I dictate on all of them but I sign them off as well, and action them. I do get emails from X-ray if 12:29

there's -- I would pick them up myself anyway, but I also get the emails if there's a CT or MRI or ultrasound that has something concerning on it, I would get an email from them as well. And so I would go in and action that. 12:30

My secretary also, she gets emails, and even though I've already actioned them, she also gives me a copy of the emails in case I haven't seen them. She looks out and ensures, she is very good at ensuring I get these 12:30 things done. She keeps badgering me, I mean that in a nice way. We also now get letters and some results as PDFs which my secretary puts into a folder and I deal with those on a weekly basis. Occasionally I get paper copies, but a lot of it has now gone 12:30 online.

131 Q. Your system prior to it going electronic?

A. So my system prior to it going electronically was all the results came back as paper copies. My secretary put them into a folder and I dictated them from that 12:31 folder and signed them and passed them back to her. I think I probably got emails from X-ray, I don't know when that started, but I would have got emails from X-ray as well. If something needs to be acted on, if she had been contacted by somebody, she would have 12:31 highlighted that for me as well. Again she ensured, I met with her and she ensured I did them in a timely fashion. So my secretary is very good for ensuring that they were done previously and they were safely in

a folder which I kept in the outpatients in the Thorndale unit, and I dealt with them.

132 Q. Was the DARO system a feature of your practice.

A. It was. So it also came back to her, she put them in the folder so I dealt with them. 12:32

133 Q. Was DARO of any assistance to you in managing the need to look at results?

A. Yes, because, I mean, patients that had been booked for a scan, the results came back a few months later, so those results were put in front of me. They weren't 12:32 appended to notes because that would create a mountain of -- so the paperwork is put in the folder and I could look to NIECR and get the details that way.

134 Q. Presumably DARO is for a number of purposes, but did it -- 12:32

A. It ensured for me I got the result and I acted on it and I always dictated a letter.

135 Q. Thank you.

A. To the patient, and copy the GP into it.

136 Q. Yes. We can see from your statement that a system -- 12:33 I'm not sure if you mentioned it just in passing there, but there's a system now in place were you receive a colour coded reminder of how far you might be in arrears, if ever. If I could just illustrate that and have your comments? 12:33

A. Every two weeks, I think.

137 Q. We saw it yesterday. TRU-301760. I think this is sent to you --

A. Yes, you're not showing the good ones.

138 Q. I think the explanation is that you had just come back off leave; is that right?
A. Yes. You know, if you have been doing, you know, in Lagan Valley, doing a list or something, you hadn't time that day to do it. It depends on your week. But in general I think that they're good. They don't look good there. But you know about it and just act on it. 12:34
139 Q. Does this kind of system give clinicians, perhaps you have spoken to colleagues about this, additional confidence that things don't get lost? 12:34
A. Well, I haven't talked to colleagues about it but I find it useful. You know, if I'm -- you know, I don't need that to know that I need to do some stuff, to do some paperwork. But it does remind me, you know, every week to get the numbers down on your results so that I don't have a red box. So, yeah, it keeps me on my toes, which is fine. I'm not unhappy with that system. I just don't like being in the red and I haven't been for quite a while. 12:35
140 Q. Thank you. The Inquiry has observed through a number of examples, not just associated with Mr. O'Brien, but there are some examples associated with him where there is a tendency to let the result sit in the expectation that the patient would be coming in for review and then, for waiting list reasons or perhaps other reasons, the review doesn't happen and the result goes unread and unactioned. If I could bring you to DOH-00041 by way of example. These are the findings that, essentially -- it's obviously a bit of a complex 12:35

background to this patient. But the important fact is that a scan was performed on 17th December 2019, reported by radiology on 4th January, but no follow-up occurred and the patient came back into the system then in July of that year and the scan itself had identified a suspicion of metastatic disease. Mr. O'Brien's response to that, if I could have that up please, AOB-41615. Commenting on the findings of the SAI report, if I can just move down the page, please. Yes, the point he's making is that the conclusions of the SAI that this result should have been read and actioned... 12:37 12:38

"Does not take account of the many administrative tasks and expectations which competed for my inadequate time, never mind provided to act upon. By the time I was able to act upon the reported finding, I was even more concerned with regard to the risk of this comorbid man who would have been particularly vulnerable had he been infected with the SARS corona virus". 12:38 12:39

That's a reference to the time in which we lived in the spring of 2020. Plainly, if a scan is available showing a suspicion of metastatic disease, I think Mr. O'Brien would accept this is something that requires urgent treatment in an ideal world. 12:39

A. Yes.

141 Q. But the mitigation that he puts forward is that he was fighting to deal with the many other competing

administrative tasks and this case, presumably, slipped down the priority list. Is that something that you recognise as an occupational hazard?

A. There are lots of competing duties, but I think responding to results is a very important one and, by not looking at them, you end up with an issue like this. I think my understanding is that Mr. O'Brien used to not act on results until the patient came to the clinic, the results were appended to the notes, which, in itself, is a very dangerous activity because our clinics are so busy, so booked up, you may not see a patient in a timely fashion. So it is just fraught with danger. So I think you can't depend on the patient coming into clinic in two weeks or one month because it may not happen. So that is a danger in itself. So I think you have to act on the result when it comes to hand. I think you just have to manage your time. 12:40 12:40 12:41

142 Q. Can you anticipate getting into these kinds of difficulties where you have other seemingly more important duties to perform and the actioning of the result gets lost, or do you have a system in place, perhaps with your secretary, that wouldn't allow for that? 12:41

A. Well, I hope it never happens. I mean, I do everything in my power to prevent it happening. As I said, things have changed, now it comes through NIECR, we get this tally of how we are doing. So there's lots of built in mechanisms to stop that happening, so I hope it never 12:41

happens.

143 Q. Yes. Just in relation to Mr. O'Brien, we heard from Mr. Young yesterday and his evidence suggested that there was a level of awareness of Mr. O'Brien's approach to actioning results, so much so that on some unspecified date he couldn't put, other than a broad period of time on this, but the issue was discussed with particular focus on Mr. O'Brien's practice on this at a departmental meeting. Is that you something you recall? 12:42 12:43

A. No, I don't recall. I have a memory of going to Mr. O'Brien's secretary's office with lots of notes and results stuck on the notes. But that's thinking about things after, now rather than then. I don't think I was aware, personally I wasn't aware that he was actioning results only when the patient came to clinic. 12:43

144 Q. Thank you. The issue of preoperative assessment of patients, we touched on it briefly on the last occasion when we were looking at patient 91's case. Patient 91's case was a stent management case. I think I was wanting to focus on stent management and you were were I think driving me toward the preoperative assessment aspects of that case. 12:43

A. Okay.

145 Q. More politely you thought that was the more important aspect of the case. You did, in your evidence, explain the issues around stent management were primarily ones of resources, and we know from Patient 91's case that there was a failure of preoperative assessment in 12:44

association with a midstream urine test.

The issue of pre-op assessment more generally, particularly where there are patients with significant comorbidities, is it written in practice and, perhaps more importantly, is it written into The Trust's systems that effective preoperative assessment has to be performed? 12:44

A. That's my understanding and that's the way I practice. Particularly, a lot of our patients are elderly, infirm, and not very fit, so I would want all of my patients preassessed. If I had even greater concerns I would want one of the anaesthetists attached to preoperative assessment to review the patient. I have done that when I think they may not get enough assessment from one of the nurses, I would get an anaesthetist to look at the patient, particularly complicated patients I would. 12:45 12:45

146 Q. How is that managed administratively? Say there's a clinician not as focused as you on the importance of it, how is it managed administratively to ensure that it is done? 12:45

A. Well there's a preoperative form that we fill out, and that goes to pre-op, so the patients are pre-oped. So I think in general in my understanding the patients are all preassessed but if a patient ends up on the ward on the day of surgery and has not been preassessed, the anaesthetist doing the operation will see the patient and I will see the patient. If they are having a stone 12:46

procedure, a kidney stone, and they haven't had urines done, that would be enough for me to cancel the patient. I would certainly want, if the anaesthetist was concerned about the medical side of things, they would cancel the patient. So it is not just the surgeon, it is the anaesthetist as well. What I'm really saying is if they have got through without having a preassessment and they are seen by an anaesthetist on the day and the anaesthetist is concerned about the medical aspects of the patient's health, that patient would be cancelled. 12:46 12:47

147 Q. We have, from time to time, looked at the case of patient 90. I think it is a case that made its way into the Patient Safety Meeting several years ago. You'll see the name of the patient in the list in front of you. You may be familiar with aspects of the case. But, in essence, that was a case of a patient with significant comorbidities. Mr. O'Brien was the surgeon. The case was, in late 2016, assessed and found to be in need of an echocardiogram. That wasn't performed, it wasn't signed off. Two years later, in May 2018, the patient comes in for surgery and there is -- at least the findings of the SAI show there was insufficient time to perform an adequate preoperative assessment and he wasn't -- so, for example, the echocardiogram issue wasn't addressed. The patient regrettably died shortly after surgery. 12:47 12:48 12:48

Knowing your case -- you are nodding your head, suggests you have some familiarity with it?

A. Yes, I know that case.

148 Q. I'm not going to take you to the SAI. I suppose the question that arises out of that is do you think that the issue of -- the importance, I should say, of preoperative assessment has been emphasised as a result of learning deriving from that case? 12:49

A. I mean that case, that patient had, as you said a lot of comorbidities. The patient had something called myelodysplasia. I think he needed a transfusion preoperatively. He obviously had cardiac issues if he needed an echo. He was having quite a major operation, he was having ureterolysis which is where you free up the ureters so a big operation. So, you know, something like that, you don't just tag on the end of your list. You know, it should have gone through preoperative assessment. It should have been planned, put on the list weeks down the line. An operation that's not done that often, either, in our hospital, it should have been well planned and not quickly put on the list and booked for surgery. I think it should have been worked up more fully. 12:49 12:50

149 Q. I'll read the recommendations that arose from that case and, in essence, it was: 12:50

"The Trust should develop and implement guidance for clinical results signoff."

Which is the echocardiogram point. Secondly:

"All cases undergoing elective surgery must have a formal pre-operative assessment."

12:51

Nice words, but how has that case, in practical terms, change the emphasis, if at all, in terms of the assessment issue?

A. Well, my understanding is that all patients coming to theatre now have been preassessed. I haven't seen a patient -- I can't remember the last time I've seen a patient that hasn't been preassessed for a list. They're taken off the list, the waiting list, patients who have been preassessed. So I would have thought patients wouldn't be picked who are not preassessed, who are not ready for theatre. 12:51

150 Q. Yes, but we saw in the case of Patient 90 that, whether it was the surgeon or whether it was the anaesthetist who ought to have taken responsibility, the patient underwent the procedure notwithstanding the absence of the assessment? 12:52

A. I don't know how he was picked, this patient, how this patient was put on the list, whether he was just taken off the list or how he was put on the operating list.

151 Q. So I suppose the question is in governance terms, is it possible to circumvent the requirement on the part of a decision by the surgeon, we're just going to get on with it, is it possible -- 12:52

A. I suppose somebody can actively, if they want to, avoid

having a patient who has been preassessed, if you want to do something like that, but why would you want to?

152 Q. Thank you.

MR. WOLFE KC: I'm just about to move on to another topic. Maybe, unusually for me take an earlier lunch, all seven minutes of it. 12:53

CHAIR: We'll come back again, I will give everybody an extra five minutes and come back at 2 o'clock. Thank you.

12:53

THE INQUIRY THEN ADJOURNED FOR LUNCH

THE INQUIRY RESUMED, AS FOLLOWS:

CHAIR: Good afternoon, everyone. 14:05

153 Q. MR. WOLFE KC: Good afternoon, Mr. O'Donoghue.

A. Good afternoon, Mr. Wolfe.

154 Q. Could I begin by just asking you about an answer you gave from the transcript about an hour before lunch. Unfortunately the transcript is still live, I can't bring you to the matter on the screen. But if I could read it out to you. I asked you a question to the effect of whether you and your colleagues considered offering support to Mr. O'Brien when he came back to work or did you consider that that was a matter for management to resolve, and your answer was: 14:06 14:06

"I suppose the other thing is there has been a long history going back to 2009 and before with Mr. O'Brien

sort of engaging with management, sort of not."

Can you help us to understand whether you were personally aware of him not engaging with management over that period of time or what do you rely on as the source for that answer? 14:07

A. I didn't know at the time. I subsequently knew from the paperwork I received in preparation for this. So that's why I became aware of it.

155 Q. So you are interpreting the paperwork that you have read that has been supplied to you for the purposes of the Inquiry? 14:07

A. Yes, it wasn't something I knew personally.

156 Q. Is there any particular aspect of it that suggested to you that he wasn't properly engaging with management, as you saw it? 14:07

A. Well, from what -- I can't remember the details but I think there were lots of Medical Directors and Clinical Directors and various other management people who were -- I can't recall one particular instance but I just remember that there was a constant to and fro. And I did see a comment last night where he said he wasn't going to be engaging with Mark Fordham for some reason. I didn't see why not. Maybe they had some issues, but I saw he wasn't having anything else to do with Mark Fordham so I don't know why. 14:07 14:08

157 Q. You formed a general sense --

A. I formed a general feeling rather than anything in particular. That was the impression I got.

158 Q. Just to be clear, you're not relying on any particular direct witnessing of a lack of engagement or anybody telling you that there was a lack of engagement, you formed this view from your reading?

A. Formed the view from my reading. 14:08

159 Q. Very well. Thank you. Moving on, I want to spend, I suppose, the remainder of our time on the disciplinary meeting in urology and aspects of that, that's the uro-oncology meeting. Just a brief issue in relation to quoracy of the meeting. The Inquiry has 14:09 been on this ground several times with several witnesses, but just to orientate you, it was the case for a number of years that the uro-oncology meeting struggled to secure the attendance, primarily of oncologists but also, on a regular basis, radiology. 14:09 2016, 51 percent attendance by radiology, 28 percent from clinical oncology, to quote the statistics from one year, and it continued over a lengthy period of time. Just pulling up a particular observation in relation to it, November '18 we look at this email, 14:10 AOB-81751. This is an email, just scrolling down, where Arthur Grey is saying in the context of radiology presence at uro-oncology MDM, that he hasn't reviewed the cases but he would be happy to display the cases and read out the reports. He says: 14:10

"The whole situation is dangerous and unsatisfactory. The issue has been raised numerous times before. It is up to the Clinical Director to assign a radiologist to

cover Dr. Williams. This may involve having to outsource clinical work or to allocate as a waiting list an initiative to accommodate it. An MDM cannot function without a radiologist."

14:11

That's it, I suppose, it encapsulates the problem. I suppose at a later point Mr. Glackin reflects that urologists are in a very exposed position. Reference for that is AOB-81757.

14:11

Did you feel, as a urologist participating in the MDM, that the absence of oncology frequently, radiology perhaps less frequently, was a major issue for the quality and the safety of the MDM?

A. Well, I suppose, when we didn't have a radiologist and there was only a single radiologist at that time, that reflects, I think, the difficulty in recruiting senior doctors in Northern Ireland. We would have to roll the patients over very often. So, in other words, if there wasn't a radiologist and we wanted an opinion, we would have to roll them over to the following week or the following week, depending on if a radiologist was there or not, which was far from satisfactory. And I think to be fair to Mark Williams, he was probably being pulled in other directions by management and the radiology department as well, or he was away, depending.

14:12

14:12

14:12

160 Q. So there was a work around, rolling a patient over to the next meeting?

A. Yes, which again is unsatisfactory because it delays a decision.

161 Q. Just reflecting on that, were you, I suppose, a straightforward participant in the MDM hoping that somebody on the outside was going to resolve this? Did you feel I suppose powerless in terms of improving matters? 14:13

A. I knew that emails were going to various people. So I knew that was happening. So I knew that the people who could change it were informed about it. But it's not as easy to pick a radiologist, more so a uro-radiologist, which is a subspecialty of radiology, you know, they're not that easy to get, particularly in Northern Ireland. 14:13

162 Q. We have the figures for more recent times and there does seem to be some improvement, albeit not complete perfection in terms of attendance. Just briefly looking at it, WIT-24251, which is the figures for the first five months of last year. You can see in red those meetings where there is an absence of one of the standing members or standing disciplines of the meeting. 14:14

A. I think if you were even to look at it now, last week we had three radiologist, you know, so things have certainly got better. I think you have obviously less oncologists. We tend to have two medical oncologists at the moment and one clinical oncologist, which is a radiation doctor. I suppose if the radiation doctor isn't there, we roll it over, if we want an opinion, 14:14

until the next week she is there. Things have got significantly better, much, much better than in the past.

163 Q. Do you think back on those, a period of several years, where the attendance couldn't be secured of these key disciplines that you were really operating in a meeting that didn't provide the kind of quality of multi-disciplinary involvement that patients had a right to expect? 14:15

A. Well, I suppose it wasn't a multidisciplinary meeting by definition, in that sense. So looking back on it, it was far from satisfactory. 14:15

164 Q. Yes.

A. I think. But in saying that, you know, if there was any -- as I said, if any patient needed an opinion from whichever specialty was absent, it could be rolled over and was rolled over until they were available. 14:16

165 Q. Could I move from that specific issue to an issue surrounding behaviour at MDM and try to get a sense from you as to the approach adopted, whether it was a collegiate atmosphere, whether colleagues could challenge each other in terms of the management of patients and the direction of travel for patients or whether there was any overbearing behaviour that might have impacted on the performance of the MDM. 14:16 14:17

I ask about that latter aspect, whether there was any overbearing behaviour, in light of the evidence we received from Kate O'Neill, Leanne McCourt, and

Mrs. Corrigan in relation to Mr. O'Brien's approach to you. It appears to be one incident, you can maybe help us on this. If I could set it up by just referring to Kate O'Neill's evidence, WIT-80959. She records, at 48.4, that: 14:18

"In the main communications were courteous in nature. Only on a few occasions have I ever felt a little ill at ease. One example I can recall was when Mr. O'Donoghue was chair of the MDT. The meeting 14:18 commenced a few minutes ahead of the agreed start time of 14.15 p.m. Mr. O'Brien joined the meeting at the agreed time or a few minutes later, I cannot be sure. Mr. O'Brien expressed dissatisfaction that the meeting had commenced ahead of schedule. He directed his 14:18 dissatisfaction toward the Chair. His voice was raised and tone forceful in nature. Mr. O'Donoghue apologised that the meeting had commenced ahead of time and after approximately five minutes, during which time Mr. O'Brien expressed his discontent, the MDT continued 14:18 to a conclusion. As none of the content of the communication was directed towards me, I did not dwell on this encounter, although at the time I felt embarrassed for Mr. O'Donoghue. I thought the encounter was unnecessary as the discussion and 14:19 outcomes up to that point could have been recapped. At no time did I feel that patient care or care planning was impacted upon."

So, to summarise, has felt ill at ease on a few occasions, generally communications were courteous, recalling one particular incident concerning you.

I want to ask you, was it a one-off incident or was it, as Mrs. Corrigan has reported in her evidence, that she couldn't actually believe the way Mr. O'Brien had spoken to you and she said that you told her that it was a regular occurrence. 14:19

A. Maybe "regular" is overstating. Probably a few occasions, I could probably count them, maybe two or three, it probably wasn't too many. I can remember that incident, certainly. 14:20

166 Q. Is it appropriate to put it down to somebody maybe having a bad day and it's no more significant than that, or did it affect relationships between you and him or relationships within the team? 14:20

A. I don't think it affected relationships between us. I was obviously quite miffed at the time because I did, I probably bumped into Martina and said it to her. But I forgot about it. I wasn't storing it up for future reference. But other people, lots of other people there noticed it and, obviously, didn't think it was appropriate. It wasn't appropriate in front of people. I mean, as I said, I had forgotten about it but it wasn't an appropriate way to act. 14:20 14:21

The circumstances was that I was chairing the meeting. Everybody was there, we were all sitting around.

I wasn't too sure whether he was going to come or not, so I started, probably two or three minutes before the actual start time, and that obviously annoyed him. He arrived and then spoke to me.

167 Q. Yes. So from his perspective he regarded it as a discourtesy perhaps, that you started it early and ahead of his attendance? 14:21

A. Sure. But I probably wouldn't speak to somebody in public like that. I think it probably wasn't an appropriate way to speak to somebody. If he had an issue, he probably should have done it privately, not in front of 10, 12 people. It wasn't an appropriate way to speak to somebody, not a colleague. Saying that, I had forgotten about it and I expected never again to remember it. It was brought up by other people. 14:22 14:22

168 Q. Within Mr. O'Brien's witness statement he has worked through his various colleagues and offered comments in respect of how he viewed them as clinicians or in other activities and he has drawn critical attention to you in particular. If I just bring it up on this screen, please, WIT-82540. It is paragraph 400. He says: 14:22

"The only reason for my having any concern regarding the practice of my former colleague, Mr. John O'Donoghue, was in his previewing of cases in preparation for urology MDMs which he chaired, and in the chairing of them. I have no doubt that he did not adequately preview cases for MDM. On inquiring why he 14:23

had not adequately previewed a case while that case was being discussed, he explained that he did not have adequate time to do so. In that regard, he could hardly be faulted as we did not have adequate time to prepare for MDM as Chairs, if at all. The lack of adequate preview probably also contributed to the quality of his chairing, as his dictation of the outcomes of MDM discussions was often truncated or incorrect, as in the case of Service User A." 14:23

14:24

I'm going to give you the opportunity to deal with each of the aspect of that, but he points to a specific occasion when he says he enquired from you whether you had adequately prepared. Can you remember him speaking to you in those terms? 14:24

A. I can't remember him speaking to me about it, but I can answer that statement very strongly. I mean, it's complete rubbish. I mean that sincerely. I put a lot of effort into the MDMs. I've asked my colleagues since then, since I've seen that because Mr. O'Brien never spoke to me about it, what they felt, and they totally disagreed with it. It is far from true. I put a lot of effort into -- you could not turn up to an MDM without preparing it because there's too much work, there's too much information that you can just read it. 14:24 14:25

If there was an incident, I don't know, maybe he asked me about something and I probably -- I might have been -- sometimes if I had a clinic or something or if

I had been on call, I may have said that I didn't know one particular minutiae of a patient, but I don't remember the incident. But I think that is complete rubbish.

169 Q. I want to be clear about what I'm asking you again. I think you've answered the question when I say he seems to be pointing, albeit to -- without identifying a case, seems to be saying 'I spoke to you and asked whether you were unprepared' and you gave an explanation but you don't remember him speaking to you? 14:25 14:26

A. I can't remember the incident. Certainly, if I did say something and I would have still prepared the patient because I spent, in those days I spent until 1 or 2 in the morning preparing, so I put a lot of effort into them. 14:26

170 Q. The Panel will recall your evidence from the previous occasion when you went into some depth about the preparation requirements. I don't propose to rehearse that. 14:26

Just expanding it out from this, he says, with regard to service user A, who we know as Patient 1, and I'm going to come to that specifically, but the question to you is did he ever come to you to say, with regard to the outcome recorded for this patient, its unnecessarily truncated and you have recorded something that's incorrect? 14:26

A. No. Not at all. And none of my colleagues have ever complained about the outcomes being truncated. But

then Mr. O'Brien, as I said, is very verbose and would have -- a short outcome to him would have been completely opposite to what he would do. He prefers much longer outcomes.

171 Q. Yes. The outcome, which we will come to look at it in a moment, is that available to the clinician who has charge of the case after the MDMs. So in this case it is Mr. O'Brien's patient, Patient 1. Can he access the outcome? 14:27

A. He would see the outcome afterwards. I know we are going to deal with it but Mr. O'Brien was also at the meeting. His patient was being discussed. So he would have been taking an active part in the discussion. He would have been listening to the outcome being given. Obviously, if he didn't agree with it, he didn't say anything at the time. So he was there himself. So I find when I'm at the MDM and my patients are being discussed, I'm listening even more acutely to their outcome because I'm going to be seeing these patients in clinic. He was either at the time not listening, that's the only explanation I can add, because he would have been listening to the outcome as well. 14:27 14:28 14:28

172 Q. I think the outcome he's concerned about was the meeting in late October 2019. If we bring up the reference for that. It is AOB-40070. So there had been a previous discussion of this case -- 14:28

A. Again by me.

173 Q. Sorry?

A. Again by me. I had chaired the previous meeting, so I had that outcome previously.

174 Q. On that occasion, we can see at the bottom of the page, 29th August, the gentleman's disease is described as high-risk prostate cancer. Just above that, the TRUS biopsy had shown that seven out of 20 cores, it is Gleason 7 case, were impacted by the disease. Scrolling down the page, we can see that there is a description of the regimen undertaken by Mr. O'Brien with the patient, which was the prescription of Bicalutamide 150 and tamoxifen, leading to what's described as an intolerable adverse toxicity. The plan was -- well, he had stopped, he discontinued, and the plan was to recommence on, coincidentally, the day after the MDM, on 1st November on 50 mg of Bicalutamide, something I want to ask you about as well. 14:29 14:30 14:30

Just dealing with the accuracy point, recalling that he said that your work in bringing together the outcome of the MDM discussions was both truncated and incorrect, the concern is that, just on the last line that we can see on the page: 14:30

"Discussed at urology MDM 31st October. Review with Mr. O'Brien as arranged. Has intermediate risk prostate cancer. To start ADT and refer to ERBT." 14:31

So his concern is that this disease should have been

described as high-risk. Help me with that. Is intermediate risk an appropriate categorisation? Is that --

A. No, not for this.

175 Q. Okay. Is that incorrect? 14:31

A. It is, and it was probably either a slip of the tongue or it was picked up incorrectly. But, as I said, Mr. O'Brien was actually at the meeting. He would have been listening to the outcome and he didn't at the time pick up on that either. In saying that, it makes no 14:32 difference to the outcome because the patient was recommended to start ADT. The patient was already on Bicalutamide 50 mgs, that's not ADT. And ADT, as Mr. O'Brien well knows, whilst it wasn't mentioned there, and I've changed it to an LHRH analogue, he would have 14:32 known we were talking about an LHRH analogue. He was at the meeting.

176 Q. We'll come to that. Mr. O'Brien, through his representatives, instructed Prof. Kirby to look at these cases. A small point, perhaps, but if we can 14:32 bring up his statement with regards to this patient or his medical report. If we go to AOB-42542. Just the bottom of the page, the last paragraph. I just wonder whether there's any -- you say the intermediate categorisation is with -- looking at it again is 14:33 incorrect?

A. It was correct, the one before that.

177 Q. The point of this, that Prof. Kirby looking at this says that essentially at the point where the belief was

that it was three plus four equals seven Gleason, that that is -- I'll read the full sentence.

"The result of the original transrectal biopsies was misleading and had, in fact, undergraded the cancer to three plus four equals seven, intermediate risk, rather than the later discovered five plus five equals ten high-risk disease." 14:33

Interpreting that he is saying that at the point in time when the MDM had the case, 31st October, three plus four equals intermediate risk is accurate at that time, on the basis of the knowledge at the time -- 14:34

A. No it's not.

178 Q. -- he seems to be saying it was only later when a TURP was performed. You disagree? 14:34

A. Yes, because the PSA was 21. So the PSA would bring that into high-risk anyway. So three plus four with a PSA less than 20 would be intermediate risk, but once it goes over 20 it is high risk. So whether it is five plus five, three plus four with a PSA greater than 20, they are both high risk. 14:34

179 Q. I do want to unnecessarily develop this. Mr. O'Brien says you got it wrong. He seems to be suggesting that, apart from this example, you sometimes get it wrong or reach in correct -- 14:35

A. I don't think so, but --

180 Q. That seems to be --

A. That's what Mr. O'Brien says. But he's obviously

defending himself, isn't he? So there's that particular instance. As I said, he was at the meeting, he was listening, why didn't he correct it at the time?

181 Q. So you reject the allegation that, to use his language -- 14:35

A. Totally.

182 Q. -- "often incorrect". This was incorrect, but it was something that could have been corrected at the time --

A. Absolutely.

183 Q. -- by others? 14:35

A. I think often incorrect is disingenuous of Mr. O'Brien. Particularly, he never spoke to me about it so I totally disagree with him.

184 Q. Just to be clear, you're saying he was there, what is the methodology at the MDM that leads to the recording 14:36 of an outcome such as the one we've just looked at?

A. So the chairman presents the case, it's discussed, the histology is presented by the pathologist, the radiologist -- reviewed by the radiologist. The oncologist will have a say, if needed. The urologists 14:36 will discuss it, then we form a plan which is everybody agrees upon. It is not just the chairman making up an outcome, it is a collaborative approach. So if somebody says something that's different from what you expect, you would expect a person in the audience to 14:36 say, 'hey, you've got that wrong', it is high-risk, low-risk, whatever. Unless you are completely looking out the window and not taking part in the conversation...

185 Q. Just taking it back to the representation that emerged from that meeting at AOB-40070. His second point, that is Mr. O'Brien's second point, is that the referencing to the patient, this is Patient 1, to start ADT and refer for ERBT is also incorrect because the ADT regimen had already commenced with the prescription of 150 mgs of Bicalutamide, albeit discontinued for the reasons set out in the record, so it shouldn't have been recorded as "to start ADT"? 14:37

A. So ADT is either Bicalutamide 150 mgs or what we call an LHRH analogue. It is an umbrella term for both of those. We would have discussed at the meeting that the patient would be given an LHRH analogue. Okay ADT is not as precise, we changed that to a more precise term, mentioning LHRH analogue now more directly. But Mr. O'Brien would have known we were talking about an LHRH analogue. So, again, I think he is not being completely honest by saying the patient had -- he knew exactly what was implied unless, again, as I said, he wasn't listening to the conversation at the time. 14:38 14:39

186 Q. If it was intended as LHRH analogue as opposed to another form of ADT, such as the 150 Bicalutamide, why wasn't that recorded as a specific type of ADT?

A. It should have been, but we were already aware he was on the -- he already had the 150. So it would be highly unusual to go back, taking a treatment he was already on. But I take your point, I should have mentioned LHRH analogue directly. But you have experienced urologists, we're not spoon feeding. But 14:39

I agree, we should have said exactly what one wanted.
187 Q. You question his honesty in that respect?
A. Well, in that he knows exactly what was discussed. I think he's playing with -- I think he's playing with what's written there, to some extent. 14:40
188 Q. Just to be absolutely plain, what you're saying is that in this case, the discussion was with the knowledge that the 150 mgs of Bicalutamide didn't work for this patient because of the intolerable adverse toxicity, as described there, it was with that body of knowledge in 14:40 mind that the expectation was explicitly made known at the meeting that the recommendation was for LHRH?
A. It is. And I know because I rarely recommended Bicalutamide 150. I would always recommended an LHRH analogue. So I know that's what we would have been 14:41 talking about. I don't really recommend Bicalutamide 150.
189 Q. You would have observed from the paperwork in preparation, and no doubt at the meeting as well, that it was Mr. O'Brien's intention to commence the patient 14:41 on a dose of 50 mgs of Bicalutamide. Was that the first time you had observed that or was that something of Mr. O'Brien's practice that you were familiar with?
A. No, I wasn't familiar with it, no.
190 Q. Did it strike you as unusual that, as of itself, that 14:41 this was the plan for this patient?
A. It may have. But as far as I was concerned from the MDT he was going to be going on to the LHRH analogue anyway. He wasn't going to be staying on the

Bicalutamide 50, so he was going to be moving on to that.

191 Q. Just to expand this. We'll come back to the issue about whether your record is truncated, just to complete that in a moment. But just, it is convenient to ask you about Bicalutamide as a choice for the purposes of an ADT regime. Is 50 mgs as a dose, is that known to you as an appropriate practice for ADT purposes? 14:42

A. No, it is not used for ADT. It is basically used to cover, as you know, the flare, or when you are giving combined hormone therapy, in other words if somebody is developing what we call castration-resistant prostrate cancer and they are on a LHRH analogue, you can add in Bicalutamide 50. 14:42 14:43

192 Q. Just maybe slow up in the interests of the transcriber. I think I see her struggling there. Perhaps your Cork accent is ahead of us.

A. Perhaps it is. I'm getting -- yes.

193 Q. You had an oncology practice self-evidently. Was the management of prostate patients, prostate cancer patients a feature of your practice? 14:43

A. Yes.

194 Q. Would you have occasion to deploy an ADT regime for your patients? 14:43

A. ADT, as in the wider umbrella of -- yes.

195 Q. And I think you've explained that your regime of choice would be an --

A. LHRH.

196 Q. -- the injections. The Inquiry has observed from evidence presented by The Trust that Mr. O'Brien's patients were, on numbers of occasions, maintained on a 50 mg regime, sometimes for periods of years. And you've told us already that's not something you particularly recognised.

A. Or do.

197 Q. Or do. I suppose, just to be direct about it, was it something you recognised in the practice of Mr. O'Brien? 14:44

A. No.

198 Q. We have received evidence that, for example, Mr. Glackin has told us that the issue of 50 mgs as a dose was briefly mentioned at an MDT meeting where colleagues said to Mr. O'Brien, 'I wouldn't do that' or 'we wouldn't do that', a brief interaction, not minuted. Mr. Suresh has recalled that the issue was discussed at an MDM, the consensus was that treatment long-term with low dose Bicalutamide was unconventional, and Mr. O'Brien agreed to review the patient. Not memories shared by Mr. O'Brien, I would underline, and not memories shared by you? 14:45

A. No.

199 Q. Very well. Getting back to the final limb, I suppose, of Mr. O'Brien's criticism, and that is where he says that the record that we have in front of us is truncated. The criticism there is that no account is taken of the patient's stated intolerance to the Bicalutamide regime in the decision that is issued or 14:45

in the recommendation that is issued. There was a need, Mr. O'Brien will say, to consider this issue in the context of the ADT recommendation that issued. The MDT, knowing that it was Mr. O'Brien's intention to start on 50 mgs of Bicalutamide the next day?

A. The intention of the MDT was never that he was going to be given Bicalutamide, so it wasn't something that was considered. Two is, seven lines above that, quite clearly it's written "medication was accompanied by intolerable adverse toxicity". So its already written in the narrative. But, as I said, the intention was that the patient wasn't going to be given Bicalutamide, it was going to be an LHRH analogue.

200 Q. Just to be clear, this is the decision or the recommendation --

A. Yes.

201 Q. -- of the MDT?

A. Yes.

202 Q. The MDT was explicitly clear that it was not a Bicalutamide regime going forward, it was LHRH-A?

A. Yes.

203 Q. And that removed from the consideration or the concern any element of toxicity?

A. Yes, because he wasn't going to be getting it. And, as I said, Mr. O'Brien was at the meeting as well.

204 Q. It is said in this case that the preference for Bicalutamide arose out of a coronary history for this patient. Was that discussed at the MDT, to the best of your recollection?

A. It wasn't. But I think you have to risk/benefit and this gentleman had a nasty prostate cancer and so it was felt that an LHRH analogue was more appropriate. But there is a slightly increased risk of coronary events in patients who do have LHRH analogues. 14:49

205 Q. Now, as it happens, and we'll use this case for this further vehicle, or use it as a vehicle for this further issue. As it happened, Mr. O'Brien, after consulting with the patient tells us that, for various reasons, he felt it necessary to start the patient on 14:49 50 mgs of Bicalutamide by, I think, the end of January. He had increased the dose to 100 but hadn't yet referred to radiology for the purposes of fulfilling the recommendation around ERBT, but that was being held in consideration. In other words, he hadn't found it 14:50 possible, because of patient considerations, to implement the recommendation of the MDT. He didn't return to the MDT. The patient's case doesn't ever come back to the MDT.

14:51

Is there a practice in the Southern Trust with this uro-oncology MDT which would, if not require, but perhaps indicate that where you cannot implement the recommendation you should bring it back for further consideration? 14:51

A. Absolutely. Mr. O'Brien should have done that. I have brought patients back where I might have disagreed with the outcome or the patient wants something totally different. So it should go back to the MDT, and

there's no problem about bringing it back. Everybody is very receptive about rediscussing the case. You should bring it back. You shouldn't go off and do your own thing.

206 Q. It is often said before this Inquiry that the recommendation of the MDT is no more than that, it is a recommendation. You need then to bring the patient into the fold. How do you do that? Do you have a review shortly after the MDT with the patient? 14:51

A. Yes, it's usually the following week or the following two weeks. And, you know, if a recommendation is for radiation treatment and nothing else and the patient says no, I don't want it, I want an operation, I would certainly bring it back, no matter how wrong that decision of the patient is, but I would bring it back for discussion to let them know that's what the patient wants. I think if you start going off doing your own thing, because patients always want different things which aren't necessarily medically indicated. I think you have got to let the MDT know. 14:52 14:52

207 Q. Why do you consider it important to bring it back to the MDT?

A. Well, so that there's consensus on what's happening. I think you need -- that's the reason for the MDT. You need some consensus. There's no point of an MDT if people are going to go off and do their own thing anyway. 14:53

208 Q. If you find there's a situation where the patient is rejecting the recommendation, is that something you

would record?

A. Of course. You know, I mean, it's a holistic approach. Or if I see the patient and there's a recommendation for treatment and then I see the patient and they're very unwell and not fit for active treatment, I would bring that back and say can we change it to a watch and wait approach, which is where we just keep an eye on the patient. But I do it in a controlled fashion, I do it with the blessing of the MDT.

209 Q. Yes. In terms of where the recommendation is for a referral for radiotherapy in this instance and the patient is content with that, is that something that you delay until you get a satisfactory response from the ADT regime, or does the referral take place if the patient is content with it? Does the referral take place fairly seamlessly, fairly quickly after the meeting with the patient? 14:53 14:54

A. It is a bit senseless waiting for a PSA response. If you are going to refer the patient for radiotherapy I would do it immediately, the next time I meet the patient I will refer them on. Whether the PSA responds or doesn't respond, you're going to refer them to radiotherapy, you're going to involve the multi-disciplinary team. Things can be modified at a later date but holding on to them, waiting for a response is a bit pointless, and it's not good practice. 14:54 14:55

210 Q. Again going back to Patient 1, obviously the early months of 2020, we're into the pandemic. The patient

runs into greater difficulty in March of that month. It's observed at the emergency department that he's in retention, there's a need to catheterise him. The regime, in terms of the referral to radiotherapy, hasn't taken place. With there being information of disease progression or at least the basis for a suspicion, given the retention and the need for a catheter that there may be a complication or a progression here, is that a point in time where a case should go back to the MDT? 14:55 14:56

A. Yes, it should, because it may need to be restated, in other words it may need to be reimaged to see has the disease progressed. We saw that this gentleman had a Gleason five plus five. He had a very nasty, aggressive prostate cancer. So, yes, it should have gone back to the MDT. Particularly when the initial recommendations hadn't been followed. 14:56

211 Q. Just going back to the issue of accuracy of MDT outcomes, is that something you, as the Chair, would check at the end of the meeting or the day after, after things are written up, or is it unnecessary to check for accuracy in light of the description you've given of the process at the meeting itself? 14:57

A. No. The outcomes are emailed back to us, either that evening or within a few days of the meeting where we check over it. We make any corrections that are necessary, then it's distributed to everybody else. So it comes back first to the chairman to correct. 14:57

212 Q. Okay, so let me just drill into that a little. So who

types it up? Is that the --

A. The person coordinating the meeting.

213 Q. Yes. So it comes back to you to run your eye over?

A. Yes.

214 Q. And then this patient's outcome would be emailed to who? 14:57

A. The outcome is emailed to everybody who needs it, so all the urologists, oncologists.

215 Q. If it is Mr. O'Brien's patient, he would see it?

A. He would see it, yes. You know, if you disagree with an outcome, you could bring it back and have it rediscussed. 14:58

216 Q. You record in your statement that in October 2019 you raised an incident report in respect of Mr. O'Brien and his attention to a particular patient. If I can just bring up your witness statement in that respect. It's at WIT-50543. You say: 14:58

"The only issue I raised was an SAI from the uro-oncology meeting in 2019. I submitted an IR1 on 3rd October 2019 when I was chairing the uro-oncology MDM. This was in relation to a patient of Mr. O'Brien who had not been referred for a kidney biopsy as per MDM advice on 27th June 2019. He was seen in clinic the following week and arrangements were made for him to have surgery in the next few months. He had a nephrectomy in early January 2020. His latest review in relation to this was in early 2022, and he has suffered no consequences as a result of the delay up to 14:59 14:59

now. The investigation with regard to the circumstances of the delay is ongoing."

I wonder, Mr. O'Donoghue, are you unsighted on aspects of the developments in this case? You seem to be laboring under the misapprehension, perhaps, that this patient received a biopsy, albeit that it was delayed. It would appear that on other accounts before the Inquiry that a biopsy was contraindicated in circumstances where the patient was the subject of a chemotherapy regime in association with other disease. Were you aware of that? 15:00 15:01

A. I wasn't. We had discussed it at the meeting so maybe we weren't aware of that. As far as I remember this was brought back by someone because the patient hadn't had the biopsy, and that's why it came before the MDM again. 15:01

217 Q. Yes, let me just --

A. But I don't know the further details you have been describing. 15:01

218 Q. Let me work through it and we can have your comments on it. The IR1 which you filed can be found at WIT-50555. I should say this concerns Patient 112. You record essentially what I have already rehearsed, that this patient was discussed at the uro-oncology MDM on 3rd October 2019. It would appear outcomes from the previous uro-oncology MDM have not been actioned. So you're writing that some two months -- sorry, three months after the MDM recommendation of late June 2019 15:02

because, assumedly, you have not seen and your colleagues have not seen any action in association with the recommendation that it issued in June?

A. Yes.

219 Q. If we go then to a chronology that was formulated for the purposes of the Trust deciding or trying to decide whether this case should go to a Serious Adverse Incident Review, the chronology can be found at TRU-258993. I was hoping it was a chronology. Just scrolling down. So the MDM action is contained in the first entry. It was recommended that Mr. O'Brien would see and advise the patient -- 15:03 15:04

CHAIR: Sorry, Mr. Wolfe, if I might interrupt, is this a case of two pages, if we put them side by side we might get the chronology. 15:04

MR. WOLFE KC: I know that in preparation I was able to have them on screen side by side. We haven't been able to mend it. So if people disagree with anything I say or think it is inaccurate, I'm a bit handicapped from -- 15:05

CHAIR: It just looks as though the table has been spread over two pages. I wondered if we put two pages side by side, it might read across.

MR. WOLFE KC: I'm not sure we can do it today. We have been trying to speak to one of our colleagues to prepare this. 15:05

CHAIR: Can we not do it through this system?

220 Q. MR. WOLFE KC: It may not work. I think the key issue I wish to address with Mr. O'Donoghue is to be found --

if we can bring up TRU-258996. This, perhaps, brings clarification to how things developed in that month of October.

You will recall that you filed the Datix on 3rd October. Here you have the second entry from the top, an update is being provided from Mr. Haynes and it is being provided following the Datix, in other words after the Datix has been entered. And Mr. Haynes is saying: 15:06 15:07

"Mr. O'Brien has responded to me with an update regarding this patient. In summary, the patient is mid- chemo and not able to proceed to management of his renal mass. He also had an up to date CT. Aidan has listed him for MDM discussion next week. I have planned to see the patient next week and his renal management will be organised once he has completed and recovered from his lymphoma chemotherapy." 15:07 15:07

So the problem here it would appear, Mr. O'Donoghue, is that you appeared to have filed the Datix not knowing that the biopsy had been ruled out or contraindicated because of the nature of the other treatment required by this patient because of a lymphoma disease. 15:08

At the point of completing the Datix, had you been told by Mr. O'Brien that the biopsy not only was no longer required but would be harmful for the patient to

proceed with?

A. No. I'm not entirely sure Mr. O'Brien was at the meeting. Because, if he was, he obviously could have clarified it, the reason for it.

221 Q. Clearly there are good reasons, there is a good reason why the biopsy wasn't performed. In terms of how you've drafted your witness statement for the Inquiry, were you not aware of that? 15:09

A. No. This is the first time I've seen this.

222 Q. Yes. You've also described the investigation into this as ongoing. Is that your understanding? 15:09

A. Well, it may not be ongoing now because that was written a year ago. My understanding at the time when I wrote it, it was ongoing, but I don't know what the present situation is. Probably not. 15:09

223 Q. Mr Gilbert, who was one of the participants in the 2020 SAI examination process was, I suppose, handed this case for consideration to help advise The Trust whether an SAI view was appropriate. If we touch upon his evidence. If we go to TRU-0928. So he's explaining to Patricia Kingsnorth the background to this. He said he was seen by Mr. O'Brien with the written plan to assess after restaging. It is reasonable to assume he meant post chemotherapy staging. 15:10

15:11

"The biopsy was, in my opinion, reasonably deferred."

And he gives the reasons for that:

"The potential complications of infection, haematoma, spread during immunosuppression or even the loss of the kidney outweighed any benefit in knowing the histology."

15:11

He goes on to say that a letter describing this plan was not generated until October 2019. In other words, Mr. O'Brien had delayed in his communication around this and this caused unnecessary concern and work for Mr. O'Brien's colleagues. So that appears to be -- 15:12
there's probably other strands to the picture but that's the thrust of it.

Perhaps it points out, in light of what you said and the beliefs you had formed about it in your statement, 15:12
that although you were the originator of the concern, you seem to be indicating that nobody in the Trust came back to you to inform you of why your concern, as set out in the IR1 was somewhat unfounded?

A. Absolutely. I mean the decision to defer biopsy is 15:13
very reasonable in light of what's going on with this gentleman's chemotherapy but, yes, as I said the first time I've seen all this information is just now.
I suppose, as it says there, a letter wasn't generated until October 2019. If there was a letter summarising 15:13
what was going on, that certainly would have been helpful.

224 Q. Do you consider that it was any of your responsibility as MDT Chair for that matter to have pursued directly

Mr. O'Brien to obtain an explanation from him before filing an IR1?

A. I suppose it would have given more information. I probably felt at the time that I had got it on NIECR but obviously if I got it from Mr. O'Brien it would have clarified the matters clearly for me, yes. 15:14

225 Q. Let me move to the issue of safety nets. The SAI reviews that were conducted in 2020, looking at the cases in the round reported that not only was there a prolonged treatment pathway in a number of cases, but there was no mechanism to check or track that actions were implemented. We saw that just earlier with Patient 1's case. 15:15

A. Yes.

226 Q. The findings were also that the MDT was underresourced for appropriate patient pathway tracking. Is that a criticism or a concern that you would have been aware of in live time before these SAIs reported? 15:15

A. In relation to Mr. O'Brien or just in general?

227 Q. More generally in terms of the governance of the MDT within which you worked. You can perhaps think about it in terms of you have a recommendation to implement with the consent of your patient. Was anybody or any aspect of this system going to be looking over your shoulder to ensure it was done? 15:16

A. Well, I thought that the cancer tracker was probably keeping an eye on it. I probably had a secretary who was good as well. So if I hadn't done a letter, she will also have the outcome, said have you done a letter

to oncology so she would have been looking.
I certainly received emails from the cancer tracker as well about sort of booking scans and things. But I don't know how much they actually did. But I certainly had people making sure that I was achieving what I was meant to do with from the multidisciplinary meeting.

228 Q. You make a point in your statement, if I just bring it up, WIT-50539, at 41.1. You say:

"Cancer trackers ensure that patients with cancer pass through the uro-oncology MDM in a timely manner. Issues with MDM patients are often only picked up when patients are discussed again at the MDM and this can be several months down the line from the original discussion."

Is that pointing -- is that just pointing to the natural flow of activity in the MDM or is it highlighting a concern on your part that there can be delay in getting to grips with problems in patients' cases because of how the meeting is set up and supported?

A. Well, I suppose, one, I felt the cancer trackers were making sure things happened. That was my understanding. In the last sentence what I was implying was that if there was a change from the plan and if the cancer tracker hadn't picked that up, it wouldn't have been picked up until it had been

rediscussed. That's probably what I was thinking about when I wrote that.

229 Q. Just looking briefly at some of the examples which emerge from these 2020 SAIs, if we go to DOH-00122. So they're saying that five of the nine patients in the review experienced significant delay in diagnosis of their cancer. That was related to patients with prostate cancer and reflected variable adherence to the regional agreed diagnostic pathways. 15:19

Just scrolling down. Yes, there's a number of specific examples beyond the prostate arena. A delay in a penile cancer case and a failure to follow up on a recommendation for referral to the regional small renal lesion team. 15:20

I suppose the Inquiry's interest is, as well as looking back or looking forward, we are trying to chart whether there's been any remedial action taken around the kinds of concerns which emerged from the SAI. Do you feel that the MDM is better resourced, better supported for the purposes of governance and keeping patients safe? 15:20

A. I think it is now, certainly. I'm sure these sort of delays wouldn't happen now. But --

230 Q. And why is that, in practical terms? What is the enhancement that has been brought to bear since these cases emerged? 15:20

A. Well, I don't know what his title is, but there's somebody now who does snapshot audits and ensures that

patients are being referred and their treatments done in a timely fashion. I think this is a lot more auditing going on, that things are happening.

231 Q. How is that visible to you? So you get your three or four outcomes for your patients on the Friday afternoon after the MDT the previous day or whatever day it is. How do you feel the presence, if you like, of the system or the person whose responsibility it is? 15:21

A. You'll get -- I do the referrals as soon as I see them, but you would certainly get an e-mail from this chap, I can't remember his title, saying, 'have you organised this MRI, have you done that'? So he would certainly check. And I think the cancer tracker would be checking more closely now as well, as well as my secretary, as I keep saying, she checks as well. She gets a separate list of the patients of mine and she makes sure she checks them off as I do whatever I'm meant to do. 15:22 15:22

232 Q. Yes. Is there anything about the current working practices of the MDM that you would change or improve if it was within your gift to do that? Particularly in the area of Patient Safety and the governance of the actions that are part of the everyday life of the MDT? 15:22

A. Well, it certainly runs much better now. I certainly welcome people looking on, making sure that -- the cancer tracker is ensuring that the patients are going through the system effectively. I think our Clinical Nurse Specialists also are actively involved with the patients and they're also another failsafe mechanism, 15:23

and they are ensuring that patients are going through the pathway effectively. So there's lots of people that take part. I think, certainly, the nurse specialists, because they are the key worker for the patient and they make sure the patient goes through the system as well. 15:24

233 Q. Could you help us understand how you work with the Cancer Nurse Specialists. The MDT looks at a patient's case, makes a recommendation. You are -- let's deal with the prostate cancer -- you are to see the patiently within the next week or fortnight to discuss the MDT recommendation. The recommendation is for ADT and referral. Where does the nurse come into it and how? Procedurally or practically how? 15:24

A. So the nurse is always in the room when I'm seeing the patient -- 15:24

234 Q. How does the nurse get there, how does the nurse get to know that you want her there this with patient?

A. Well the Cancer Nurse Specialists know when I'm seeing cancer patients I always have a nurse. So whatever nurse is assigned to my clinic, Clinical Nurse Specialist, comes into my clinic from the start because they know I have a nurse all the time. I don't call them in selectively. If I'm seeing cancer patients they're automatically in there, I don't have to ask any more. 15:25

235 Q. So the nurses will know that this clinic on this day is your cancer --

A. They don't have to be invited. They know that they're

going to be there.

236 Q. You've given the answer, necessarily, in terms of today. Has it always been like that? What was the position in 2019/2020, several years ago?

A. I can't see any difference in my particular practice. Again, I didn't have to invite the nurses in, they were involved from the start. You know, I always had a nurse there so I don't see any difference from that point of view. 15:26

237 Q. What additionality or what point of difference in terms of the services being provided to the patient does the specialist nurse offer in your opinion, which is to contrast with your role? 15:26

A. One is a point of contact. Very often patients can talk to nurses much more easily. They may not want to talk to the doctor. So she takes them out of the room, talks to them. She gives them a card and they can ring her up with any issues. She signposts them to various agencies that may provide support, either financial or otherwise. She gives them literature and details on their cancer and the various treatments they're going to have. She makes sure that they go through the system. I think it's a presence. I think a patient -- maybe I'm wrong -- I think a patient feels they can probably talk to a nurse about nonmedical things more easily. 15:26 15:27 15:27

238 Q. The SAIs reported that in nine out of the nine cases that they looked at, the Cancer Nurse Specialist wasn't assigned, wasn't allocated, had no role with these

patients. These were 2019, 2020, cases came from that time. To the best of your understanding was there any resourcing issue that would have prevented the allocation of nurses or the assignment of nurses to these patients? The Inquiry understands that over time the nursing resource has improved. 15:28

A. Well, I think on occasion if there wasn't a nurse available for some reason I would have copied the nurses into the letter and they would have contacted the patient the following day or when they were back. So there have been a few occasions, for some reason they weren't there, but they would have contacted the patient afterwards and I would have done that automatically. So the patients would always have had a nurse involved. 15:28

239 Q. Thank you. Just finally, I want to ask you about your understanding of the circumstances of Mr. O'Brien's retirement. Were you aware that Mr. O'Brien intended to retire from his consultancy and hoped to return to The Trust in a part-time capacity? 15:29

A. That was my understanding and that's what he said to me. I think he had given me the impression that he was going to retire, stay off whatever length of time, then come back in a part-time basis.

240 Q. Yes. So that was something you discussed with him? 15:29

A. Yes. I think he had mentioned it to me in a social sort of --

241 Q. We discussed earlier your concern about his practices at the revelations of 2017 and all of that, you went

from a position of confidence in him to something of a situation where you were less confident in him or less trusting of his approach. When you spoke to Mr. O'Brien and he told you about that, were you -- did you form any view in terms of whether it was a good idea that he should come back?

A. I didn't really, no. I took it at face value. I didn't know a lot of these things when we spoke. I obviously had known about the triage, there hadn't been triage, so I'd known about those. I don't think I knew a lot about the SAIs. No, I hadn't formed -- I probably hadn't thought about it too much.

242 Q. So when he told you he would be coming back or hoped to be coming back, that --

A. I took it at face value.

243 Q. You didn't say that wasn't a good idea?

A. It didn't cross my mind as far as I remember, no.

244 Q. Mr. Haynes gave evidence to say that he spoke to consultant colleagues, other colleagues in The Trust about the idea that Mr. O'Brien would return or could return or that was the request. Did he speak to you?

A. I think he did. And that probably might have been some time after when Mr. O'Brien had said to me that he was going to come back.

245 Q. What was Mr. Haynes' purpose in speaking to you?

A. I'm trying to remember. I think he might have asked me what did I think about him coming back, I think. I think at that point I might have formed an opinion because I'm -- I probably wasn't as enthusiastic as

when Mr. O'Brien spoke to me before that. I might have formed an opinion at that point, I think.

246 Q. What was that opinion?

A. Well, I think Mr. Haynes might have said to me that either they were thinking of -- because of all these issues -- but I can't remember the exact details. I thought until these issues were sorted out it probably wasn't a good idea that he came back. 15:32

247 Q. The issues in association with the MDM postdated his requirement? 15:32

A. And the triaging and all these things that were coming to light -- that had come to light.

248 Q. So what you're saying is your memory is of him saying that there were unfinished issues, the issues from 2016, 2017 that had been investigated and were still to be the subject of a disciplinary hearing after grievance hearings? 15:32

A. I probably formed an opinion at that time but I think before that, when Mr. O'Brien said something to me about coming back, I probably hadn't formed an opinion at that point. 15:33

249 Q. Can you recall, precisely or otherwise, how you expressed that to Mr. Haynes?

A. He may have said to me that they were thinking of not bringing back -- I can't quite remember. I'm sort of -- I'm searching. It is not something I thought about until you've asked me right now so I'm trying to search my memory. I can't remember the finer details of it. 15:33

250 Q. My question is what did you say to him as opposed to what did he say to you?

A. I must have said to him that I probably thought it wasn't a good idea he came back. I assume I said something along those lines, but I'm sort of -- but I can't remember the details, to be perfectly honest. 15:34

251 Q. Do you hold a memory of your view on the issue being shared or being communicated to you -- sorry, I'll put this in a different way.

15:34

You seem to be indicating that you had a view -- that you formed a view he shouldn't come back. Was Mr. Haynes communicating a similar view back to you?

A. I think he was but I might do him a disservice if I'm saying strongly that he said yes, so I'm not too sure. 15:34

252 Q. Yes. In terms of your other colleagues, Mr. Glackin, Mr. Young, did you speak to them about whether he should be coming back?

A. I'm not definite. Because his coming back wasn't something that I was actively pursuing or canvassing or finding out. I don't know whether I had or not. 15:35

MR. WOLFE KC: Thank you very much.

CHAIR: Ladies and gentlemen, we're going to continue on rather than take a break if that's fine with you. If anybody needs to take a comfort break, please do so but I think we're all anxious to get today over with. And I'm sure Mr. O'Donoghue is but before you can go anywhere, some questions from us and Mr. Hanbury first of all. 15:35

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

253 Q. MR. HANBURY: I just have a few urological questions. Just start off on waiting lists and particularly the changing of double J stents, it's something that every department struggles with. We were involved in this in the Inquiry, especially with Patient 16. You worked in England in various places and, obviously, in Northern Ireland. Everywhere has its different waiting list methods of doing it. I was aware that you and colleagues were sent big Excel spreadsheets full of 800 cases and upwards. How did you cope with this workload, in particular the routine changes which often are a sort of Cinderella type of case. Did you have help there or was that all on your shoulders? 15:35 15:36 15:36

A. I think things have changed now but in those days we had all our own patients and so we sort of took responsibility for them whereas now it's a pooled list. But certainly I felt pressurised because there were a lot of patients with stents in, to try to get them done in a timely fashion. So I tried to go through them chronologically or when they were due to be changed, so six months, nine months, whatever. 15:36

254 Q. That would fall on your shoulders rather than the schedulers, certainly in the early days? 15:37

A. Yes, also I had used the BAUS. The BAUS had a database, which they have got rid of now, but they had a database where you could record patients with

stents and you got emails back from it. It was quite a cumbersome system, it was quite slow, but I certainly tried using that for quite a while, probably a year or so. But I dictated letters for every patient with the dates the stents went in so there was as much information available as possible, ensuring that the booking forms were done. But I think a lot of it was still on our shoulders individually to change our own stents, so to speak.

255 Q. You mentioned BAUS there, the British Association of Urological Surgeons. I was interested in the last couple of days when Mr. Young was giving evidence, he picked up that Mr. O'Brien, around that time, I think it was around 2013, wasn't a member of BAUS. Would that surprise you or... 15:37 15:38 15:38

A. I don't think he was a member up until he retired, but I might be corrected. But I don't think he was, whereas the rest of us were members of BAUS. So, yes, I thought it was a bit strange that he wasn't a member of our parent organisation, yes. 15:38

256 Q. What do you think he missed out on in not being?

A. Well, I suppose he could still have gone to the annual meeting. I mean, what he missed out on, day to day it probably doesn't make any difference but at the same time, I think psychologically you feel part of a larger group of urologists and it is our professional organisation. So I would have thought everybody should be a member of a professional organisation. But day to day running of your practice, I don't think it makes 15:39

any difference. Although you do get information on various courses relevant to your practice, which is important.

257 Q. So education?

A. So education which is important. Although actively you can find those out, whether you are a member or not. 15:39

258 Q. National audits?

A. Yes, those kind of things, certainly. And, similarly, EAU. I don't think he was a member of that either. He certainly was a member of the Irish Society of Urology. 15:39

259 Q. Certainly when he was chairing NICaN, a lot of that was based on UK and European guidance?

A. Yes.

260 Q. We have heard a lot about TURP and saline TURP, maybe things have moved on but I was struck that there was, certainly up to a couple of years ago, no Northern Irish urologists interested in laser TUR and other minimally invasive techniques for the bigger prostates; what is your comment there? 15:40

A. We certainly do green light. We are trying to get HoLEP up and running, myself and Mr. Glackin. I have done a course previously, but both of us are interested in getting it up and running and that is certainly a plan for the future, to do HoLEP, possibly in Daisy Hill. 15:40

261 Q. We heard about the new day case innovations and overnight stays.

A couple of things on Urologist of the Week. When it

was set it up, there didn't seem to be prospective cover, it seemed to be you took your turn in a one in seven, although there weren't seven people, which slightly confused me?

A. Yes so one of those weeks was a locum week and because there wasn't, so we covered it. It's a bit like now, that we have two weeks to cover because we don't have -- although we're getting some new consultants starting in December and January. So there are two weeks on the rota which were covered as locum cover. 15:41

262 Q. And you usually got that, because otherwise that would affect your scheduling?

A. It could affect us, the scheduling. We sort of distributed it among us so it wasn't a whole week or it isn't the a whole week. 15:41

263 Q. You mentioned triaging until 9 or 10 o'clock at night, and obviously they were very full weeks. Did you think of just doing office hours, so to speak, not that surgeons ever respect those, and not doing the nights on call or any other manoeuvres to make the Urologist of the Week a little less onerous? 15:42

A. No, because if I complete the triaging, I probably felt a bit elated and I could start a new day by starting again. So I was much happier sort of clearing everything and then going home, rather than having something waiting for me the next day. 15:42

264 Q. That suited your colleagues in general?

A. Suited as in -- but I was on call. It didn't affect them, it only affected me, really. The on call is day

and night, so whether I'm there at 9 or 10, it doesn't affect them in any way.

265 Q. Right. We're aware, looking at one particular case, of a patient who came in with a bleeding kidney tumour on a Thursday and -- this wasn't your week -- 15:42

A. No.

266 Q. -- that there didn't seem to be much consultant presence over the weekend. What's your comment there. Did it usually work well? The consultants would normally go in to either do a full round or see at 15:43 least the unwell patients at the weekend? What is your experience?

A. Well I can only speak for myself. So I went in on Saturday, spent all day on Saturday. On Sundays, if I had a locum, I would go in or if there were ill 15:43 patients. If I had an experienced registrar and the patients were unstable, I let him do the ward round on Sundays and I came in if the patients needed to go to theatre.

267 Q. Would you be surprised if there was a fairly sick 15:43 person who had not been seen by someone senior?

A. If I knew there was somebody sick, I would certainly be in. I wouldn't leave it to a registrar.

268 Q. Okay. Thank you. Just one more thing about pre-op assessment. We spoke about Patients 90 and 91, and 15:43 obviously things do slip through with pre-op assessments, but there's another hurdle that should be gone through, the World Health Organisation checklist before things finally click into action. Did you look

at that in terms of PATIENT SAFETY and say how did these two get through and perhaps think about that?

A. Absolutely. I mean the WHO happens automatically. I've never done an operation in the last few years without the WHO happening. But the WHO is a more sort of correct side, has the patient been given antibiotics, is the site marked. Any concerns, I suppose, yes, about the patient. But I think if you get on the table and if your comorbidities haven't been set out before, I think the WHO is not going to stop that, I think. 15:44 15:45

269 Q. A shame, though. Maybe a missed opportunity?

A. Maybe I am wrong because the anaesthetist will have seen the patient already on the ward, so if they get past the anaesthetist and get to the operating theatre, they've already got over the hurdles. 15:45

270 Q. Just it wasn't really mentioned in the SAI reports.

A. Yes.

271 Q. One last very quick one. Mr. Wolfe has mentioned, I think, Dr. Gray, a Belfast -- 15:45

A. Yes, he is a radiologist.

272 Q. You saw the email there. Something that wasn't read out was "debacle of the small renal masses". I wasn't quite sure what that meant. Was that a reference to radiology or the process of looking after that group of patients which, in Patient 7, I wondered whether that was a reference to the process of looking at that group of patients or was that a reference to the radiology particularly? 15:45

A. I'm not too sure what he meant by that. I assume it was the radiology. I don't know what debacle he meant, but I assume it was the radiology side of things, but I can't direct you to any --

273 Q. It is a fairly strong term though. 15:46

A. Yes, it does sound -- calling it a debacle, it doesn't sound.

MR. HANBURY: I think I'll stop there.

CHAIR: Dr. Swart.

274 Q. DR. SWART: We heard a lot about the waiting list and 15:46 the pressure of work in Northern Ireland. I think in the last session you talked about the use of the independent sectors and as offloading patients. We have been quite interested in patients on the waiting list coming to harm and how that's looked at or 15:47 not looked at. I think you mentioned that there was a priority group for the independent sector which where people are awaiting TURPs with catheters; is that right.

A. Yes. 15:47

275 Q. Who made that decision as to which patient should be prioritised, in particular was it a group of urologists, did it come through the CMO office, did it come through commissioning, where did it come from?

A. I don't know where it came from. It wasn't just 15:47 Craigavon patients, it was Belfast patients as well. There was a certain number of patients were sent to Dublin to The Mater Hospital for TURPs, but we were also sending patients now to the private sector for --

some urologists are coming from Sheffield and Manchester who are seeing patients in clinic --

276 Q. So it was a directive, was it?

A. Yes.

277 Q. You weren't asked -- 15:47

A. It must be Government, I presume it must be because it's quite a lot of money.

278 Q. But you weren't asked which ones should have priority on these waiting lists?

A. I wasn't anyway, no. 15:48

279 Q. As a group of urologists, as far as you are aware?

A. I don't know. I wasn't privy to that conversation.

280 Q. I'm just trying to get a sense of how the risk priority is clinically assessed?

A. At the same time somebody must have picked them because 15:48 you can't just decide what patients are going. In saying that, certainly one of our staff grades, she has left now, she did go through our waiting list of patients waiting for TURPs, and she did prioritise hose who were suitable to go to the independent sector. She 15:48 certainly looked at those. And there were patients who went to Dublin, I think.

281 Q. A few questions which were really around safety culture, safety culture, governance culture, whatever you like. It is quite a complex area and it comes from 15:48 both ends, it comes from the department, it also comes from the Board, it is the government to some extent. It is all about how things work rather than what processes you have.

Just as a starter on that, there's a lot of evidence that the way you work together as a team, the way you support colleagues, the conversations you have, the openness with which those conversations take place is the softer part of safety culture, which is critical. Without that you can have lots of systems, but people don't necessarily give of their best. 15:49

In terms of the safety culture of your department, I'm struck by the fact that there were quite a lot of serious patient issues in terms of just letters, triage, results, pre-op, even I might say the efficacy of the WHO checklists in terms of I would say these pre-op issues should come in the first phase of that. What is your view as to why some of these issues weren't really discussed openly in the first place and, also why, when there was a significant issue when you were sat down in 2017, in the January, why didn't you all individually speak to Mr. O'Brien and why didn't you talk to each other about the atmosphere in the department and how what needed to change to improve this. What is your feeling about the cause of that? 15:49 15:50

A. There wasn't a negative attitude in the department. I think we all got on well. 15:50

282 Q. If you got on well, why didn't these things come up?

A. Apart from Mr. O'Brien, perhaps. The rest of us got on well. I think it was probably a difficulty -- I think to use a phrase, and it wasn't something I experienced,

but a phrase Mr. Haynes had used, a challenge to challenge.

283 Q. Do you think it was just that?

A. It is probably not as simple as that, I suspect. I think it is probably a complex situation that has arisen over a long period of time. 15:51

284 Q. These are really critical issues and it is never just one person. One person may be a catalyst for things not being totally open, but it's clear that these things didn't regularly get discussed in the way that I would expect. I mean, I can't envisage a department where you have somebody excluded, coming back to work, all these serious issues, and no frank conversations. I can't envisage that. So it does indicate there are some barriers there. You say the rest of you get on. Do you recognise the fact that building trust among everybody is critical for patient safety? 15:51 15:51

A. Absolutely. If you get on, you can speak to people. You can -- and you are not afraid to bring -- if you're having problems, bring it up. So, no, I think it is very important. 15:51

285 Q. And you have said a few times you can't just do what you like, you can't just do your own thing and yet this was tolerated. Now that, I suppose, you would say is the challenge to challenge issue. Who, in your view, should be dealing with that? Were you clear, for example, on the respective roles of the clinical lead and the Clinical Director and people going up the hierarchy? Did you have a clear view in your own mind 15:52

about who should be picking up some of these issues, which were evident to various people, even if they weren't totally joined up?

A. Well, I assumed, more than assumed because I can see in the evidence that lots of people had been trying for the last 20 something years to get somewhere, not successfully in the slightest. Whether people should have been more forceful in getting things agreed -- 15:52

286 Q. Do you have a view as to where that responsibility should sit? 15:53

A. I suppose ultimately these things sit with the Medical Director and come down. I mean, he's obviously not -- he or she is the last person in the chain. But...

287 Q. Is that right or should there be more interaction? How much interaction did you have with people, say, like the Medical Director? 15:53

A. I have had no interaction with the Medical Director. I think, serious issues going on like this, you know, would certainly, and the Medical Director would have been aware of it. But no, there are several people in the chain before the Medical Director who, from what I have read -- 15:53

288 Q. But were you yourself clear on it, I know you have read some things now but at the time did you have a clear picture in your own mind of who did what? 15:53

A. Well if I had an issue I would probably have gone to Mr. Young first. I would also involve Martina Corrigan. That would have been my direct contact.

289 Q. Okay. There's been a lot of favourable comment about the change in the Patient Safety Meeting and the improvements that have happened, which is clearly good. But you said a couple of things today. One of them was it only gets to the Patient Safety Meeting if something goes wrong. And you've also said you weren't sure how something should get to the Patient Safety Meeting. So I just want to ask you about whether any efforts had been made to support the department to look at data and information in a way that would actually give you a bit of a heads up. So, for example, you have a nice little scorecard about results. That is helpful if consultants are provided with that. My own experience is that is usually done on a comparative basis and consultants are quite competitive so they don't want to be in the red, whatever it is, you know. You can do it with triage, for example, you could do it with pre-op assessment compliance, you could have done it with the glycine issue. Have you had any support as a department in terms of developing those sorts of metrics to be automatically collected for you? Time to stent insertion would be another one? 15:54 15:54 15:55 15:55 15:55

A. Yeah, the clinical governance department, the manager of the clinical -- comes to all our Patient Safety Meetings, she has been coming for the past year, has been guiding us in audit and has been --

290 Q. This wouldn't necessarily be audit. This would be automatic data. Has anybody had that conversation is the question?

A. No. But it is something I may visit and add it into the Patient Safety Meeting. I think it would be useful. I will speak to clinical governance about it.

291 Q. It just helps to build trust?

A. No, I think it is certainly something I will add in. 15:56

292 Q. The other aspect of patient safety which has increasingly come to the fore is the patient's role in understanding about their own treatment and in asking questions. Now, you mentioned that you copied letters in England and not here because it wasn't done and 15:56 I know it is not mandated in Northern Ireland. What's the barrier? Why are people not keen on it? You yourself didn't seem to be that keen.

A. There's no barrier, really. There's nobody said you shouldn't do it. It just wasn't done, but there's no 15:56 barrier.

293 Q. Would you agree, it is another check. If you are supposed to have a scan and you haven't had it, you'll be on the phone, won't you?

A. Saying that, I copy results to the patient. But yeah, 15:56 but I do say to patients, you know, I do summarise at the end of the consultation, you are having this, this, this and this --

294 Q. I know?

A. -- but it is not written in a letter and I think 15:57 certainly perhaps I'll change my practice.

295 Q. I can remember when it was introduced many years ago now and lots of people were resistant. But actually it seems to have brought benefits generally?

A. I think it is not something that would bother me, it is just something I will do.

296 Q. The Inquiry must have put an enormous strain on everybody in the department, I imagine. What benefits have you seen, if any, so far, and how do you think you personally could use the learning from this Inquiry for the benefit of the department going forward? 15:57

A. Well, I suppose results -- whether it is because of the Inquiry or just has evolved over time, I mean they are now coming electronically. We have a little tally of how we're doing. So that has improved. You know, it's -- we're not dependent on bits of paper. Even the bits of paper we used to get come as PDFs to us now and we sign them on line. That's become more secure rather than having bits of paper floating around. 15:57 15:58

I think, certainly, we've got more Clinical Nurse Specialists. We had eight or nine. So those numbers have gone way up. So I think things are certainly improving. 15:58

297 Q. Those are some specific things. What about, you know, your feeling that you maybe slightly more empowered to raise things for long-term strategic planning of services. That has been a huge problem for a long time in terms of demand and capacity. This has really come to the forefront. What opportunities does that bring for you as a group of urologists? 15:58

A. Well, we have a meeting once a month. We can certainly talk about that or if we have any ideas, put it on the

agenda for discussion.

298 Q. Do you recognise it is your role to do that? I think what I've seen a little bit of, people thinking somebody else is going to do something?

A. Some people are better at big ideas than others. 15:59

299 Q. Of course.

A. And some people are grafters. But I think --

300 Q. Because actually you have a lot of good things going on, is my observation.

A. Absolutely. 15:59

301 Q. What I am trying to say is how you can use this and have you thought of it in this way?

A. There's no inhibition. It's a very encouraging department. I mean, it has all these issues but as a department itself, it encourages new ideas and it is 15:59 quite receptive to new ideas. It functions very well. MDT functions well. It's not an unhappy place to work.

302 Q. That's good. Do you think you'd like to tell us anything that you would like to see as a particular recommendation? 16:00

A. Well I personally would like to get the HoLEP up and running, that an operation for -- that's my abiding concern at the moment, that I want to get up and running. That's what I really want to do.

DR. SWART: That's all from me. 16:00

303 Q. CHAIR: Just one issue that was raised with you first thing this morning, was you were asked specifically about patient 205 and the failure to triage to red flag and you didn't have the notes or records. I just

wanted to assure you, if assurance is needed, that the Inquiry is really not interested on whether or not that was an appropriate -- whether it should have been upgraded or not. That's not what the Inquiry is concerned about. When we're looking at triage we're looking at the failure to triage rather than mistakes being made in triage because it is clear that everyone can make mistakes. I just wanted, in case there is any misunderstanding about that, to assure you about that? 16:01

A. No, no, I understood that. 16:01

CHAIR: Other than that, just to thank you for coming along. I think you're the last of the urologists to be heard from. I know you weren't planning to be the last one but it turns out that you are. So thank you and thank your colleagues for the evidence they have given to us because it has been very important for us to hear from you all. 16:01

A. Thank you.

CHAIR: You are free to go. I am not letting everyone go just yet because there are a couple of housekeeping matters. Before we do break up for the holiday I wanted to say something about the remainder of our public hearings. 16:01

The Inquiry team has been working on the post-Christmas timetable which I understand will be shared with the solicitors for all core participants by the end of next week. You will appreciate that there's a lot of toing and froing about that. We hope to finalise it. I say 16:01

finalise it, you are well aware at this stage that things change, but we hope to get that out to you in the very near future.

Our hearings will recommence the week of the 8th January, we think it is going to be the 9th January, but that will be confirmed. But you can plan to be here on 9th January, currently. 16:02

We considered whether we needed to hear from any further patients or family members, and you will recall that I asked anyone who wished to contact the Inquiry to do so by 31st October. A few people did do so and the Inquiry has considered what it is that they have told us. We have concluded it is not necessary to hear any further oral evidence from any more patients or family members. What we have been told recently confirms themes that the Inquiry has already identified from other evidence and will be taken into account when we make findings relevant to Term C of our Terms of Reference. 16:02 16:02 16:03

We had hoped that we would be able to conclude our public hearings before Easter. Unfortunately, it is looking that that will not be possible and it is anticipated that we will have to sit for a short period post-Easter, after the Easter break. How far post-Easter will be dependent on nothing unforeseen happening that might affect our timetable and, as 16:03

I have said, we have had some hiccups along the way. Obviously we will react to any such events as we have done previously.

I know you that will all be very anxious to provide the Inquiry with written submissions and I want you to know that the Inquiry will welcome same, provided they are directed solely to our Terms of Reference. We Have now heard 76 days of evidence and I do not need what we have heard repeated in those submissions, but would rather welcome reflective views on what has been heard together with the major points that you wish to make on behalf of your clients and referencing the evidence, where appropriate. 16:03 16:03

I'm sure that each team has been working on those submissions for some time, but you should know that the deadline for written submissions will be 31st May. 16:04

Thereafter, the Inquiry will sit again on a date to be confirmed in mid June, when counsel for each core participant will be given the opportunity, should they so wish, to deliver a short oral closing submission to the Inquiry. 16:04

I also want to take this opportunity to thank all of those we have heard from to date. Dr. Swart, Mr. Hanbury and I appreciate that, for many, appearing before us has not been an easy experience, but we have 16:04

found oral evidence to be invaluable in our consideration of the matters that we have to determine.

Finally, I want to wish each of you a happy and peaceful Christmas. Enjoy the break, and I look forward to seeing you all again in 2024. Happy Christmas, everyone. 16:05

THE INQUIRY ADJOURNED TO TUESDAY 9TH JANUARY 2024