



**Oral Hearing**

**Day 95 – Friday, 12<sup>th</sup> April 2024**

**Being heard before: Ms Christine Smith KC (Chair)  
Dr Sonia Swart (Panel Member)  
Mr Damian Hanbury (Assessor)**

**Held at: Bradford Court, Belfast**

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

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**Gwen Malone Stenography Services**

I N D E X

W I T N E S S

P A G E

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

3  
4 CHAIR: Morning, everyone.

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

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

8 MR. WOLFE KC: we'll certainly not be continuing into  
9 a Saturday.

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

11  
12 MR. O'BRIEN, PREVIOUSLY SWORN, WAS QUESTIONED BY  
13 MR. WOLFE AS FOLLOWS

14  
15 1 Q. MR. WOLFE KC: Good morning, again, Mr. O'Brien. 09:57

16 A. Good morning, Mr. Wolfe.

17 2 Q. Thank you for coming along for what is your sixth day  
18 of evidence.

19 A. It is.

20 3 Q. On Wednesday, when you were last here, I was taking you 09:57  
21 through a number of incidents or issues in which the  
22 Trust had suggested through its evidence that you were  
23 resistant to Trust expectations. The issue we left  
24 with was the whole area of reviewing results, DARO, and  
25 that area. I want to move on this morning, briefly, to 09:58  
26 look at the area of the irrigation fluid and equipment  
27 which was used for endoscopic procedures, and you will  
28 recall, and you'll certainly recall from the materials  
29 that you've been supplied with, that the Chief Medical

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

19  
 20          Now, I want to bring us quite quickly to the issue that 10:00  
 21          relates to you in association with this.

22          A.    Hmm.

23          4    Q.    And assume that the policy and its intent is well-known  
 24                to, certainly this audience. Mr. Young has explained  
 25                that as a group of clinicians in the urology team, you 10:01  
 26                engaged in the testing of bipolar equipment in saline  
 27                from 2015 into 2016. You'll remember that?

28          A.    Mm-hmm.

29          5    Q.    And if I can draw the Panel's attention to one of your

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

5  
6 "I suspect that any comments from me will be perceived  
7 to have been prejudicial. However, I honestly did  
8 approach using the much hailed Olympus with a view to  
9 giving it a fair wind. And was I bowled over?"

10:02

10  
11 And you say "no", and you set out some detail of the  
12 deficiencies as you found, and you say at the end of  
13 that:

10:02

14  
15 "I was so glad that neither prostate was large as  
16 I certainly would not have used the bipolar."

10:02

17  
18 And that's the analysis you put forward to the team.

19  
20 A month later, if we -- just if we go forward to  
21 TRU-395978, you're saying at the end of another  
22 experience:

10:02

23  
24 "I have pledged not to do so again. I will not use or  
25 try bipolar resection again."

10:03

26  
27 Was that the end of it for you? Was that the last time  
28 you used bipolar resection?

29 A. I believe it probably was, yes.

1 6 Q. And this was -- this was a period of trialling  
2 different devices?  
3 A. Mm-hmm.  
4 7 Q. It ultimately came to a decision amongst the team in  
5 relation to which device to recommend to the Trust for 10:03  
6 purchase, and if we can just briefly look at that.  
7 A decision was taken to recommend the purchase of  
8 a STORZ system, S-T-O-R-Z, and we can see at AOB-78271,  
9 that following a departmental meeting in September  
10 2016, and it's written up in some detail there, it says 10:04  
11 that, it came down to a debate about whether to  
12 purchase the OLYMPUS, which you have already expressed  
13 your views about, or the STORZ system. And one of the  
14 commending factors in support of the STORZ system was  
15 that it could also be adapted to enable it to be used 10:04  
16 in glycine as well as saline, and a decision was made,  
17 it says here, that all the urologists have backed the  
18 decision in favour of the STORZ system, with  
19 a unanimous vote.  
20 10:05  
21 If we go back to the top, we can see that you attended  
22 that meeting or were party to those discussions.  
23 A. Mm-hmm.  
24 8 Q. So, although you've expressed your concerns about this  
25 mode of operating, albeit with a different system, you 10:05  
26 were prepared to support the purchase of the STORZ  
27 system?  
28 A. Mm-hmm.  
29 9 Q. Is that right? Was your lending your support to that

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

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

8 10 Q. Yes.

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

16 11 Q. Yes. Now, we've heard from Mr. Young in respect of  
17 this issue, and indeed other of your colleagues, and it  
18 was Mr. Young's evidence that, although there was never  
19 a formal direction to cease the use of monopolar  
20 procedures, he regarded the change, or the need to 10:07  
21 change, as being in the form of a directive; he said --  
22 and he went on to say:

23  
24 "I think that there was an expectation that he..."

25  
26 - that is you, Mr. O'Brien: 10:07

27  
28 "...would move like the rest of us too. I don't  
29 remember him informing us that he had not moved over."

1  
 2 So, let me -- just to be clear, we can turn to the  
 3 retrospective audit of TURP cases that was conducted by  
 4 Mrs. Corrigan recently for the purposes of this  
 5 Inquiry, and it shows across ten -- a sample of ten 10:08  
 6 procedures, affecting your patients in 2019.

7 A. Hmm.

8 12 Q. Nine of which were performed by you, one by  
 9 Mr. O'Donoghue, you proceeded to use monopolar in  
 10 glycine? 10:08

11 A. Mm-hmm.

12 13 Q. You've no challenge to that audit?

13 A. Absolutely not.

14 14 Q. That's entirely accurate?

15 A. That's right. 10:08

16 15 Q. And that demonstrates that you didn't move over to  
 17 bipolar?

18 A. That's true.

19 16 Q. Okay. Did you understand that you were required to  
 20 move over? 10:08

21 A. I wasn't required to move over. I was certainly  
 22 facilitated in continuing to use monopolar resection,  
 23 using glycine, with all of the precautions that I had  
 24 been used to since my training days in Dublin in the  
 25 1980s and which were further reinforced and regimented, 10:08  
 26 in fact as I had experienced them back in Dublin in the  
 27 1980s, with regular biochemical analysis during  
 28 resection and so forth. So, I mean, I have a long  
 29 experience of resecting prostate using glycine. I have



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

18 17 Q. Just to come back on the point I made to you which  
 19 prompted that answer. You have indicated that you  
 20 weren't required to move over? 10:10

21 A. That's right.

22 18 Q. Others appear to have interpreted it as a directive or  
 23 as akin to a directive, the policy handed down by the  
 24 Deputy Medical Officer, which was then translated into  
 25 an implementation plan by the Trust, was to introduce 10:11  
 26 bipolar resection equipment, for the reasons set out in  
 27 the policy. It might be read as indicating a policy  
 28 that, while there was a recognition that it might take  
 29 some time to transition to the new equipment, and

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

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

11 19 Q. Mr. -- again, just to come back to something Mr. Young  
12 said, and just to get it exactly right, I'll bring it  
13 up on the screen. WIT-103616. And at paragraph 6.7,  
14 he says:

15  
16 "To the best of my knowledge I am not aware of the  
17 Southern Trust ever directing cessation of monopol ar  
18 procedures" 10:12

19  
20 He added a caveat to that in his oral evidence, which 10:12  
21 I've explained a moment or two ago, which was that he  
22 regarded it as a directive.

23  
24 He goes on to say however:

25  
26 "There was a delay in the supply of resectoscopes due 10:13  
27 to purchasing issues from the Trust. The scopes..."

28  
29 - I'm just skipping on:

1  
 2 "The scope systems were eventually installed in April  
 3 2018. There was, however, a proviso that saline was  
 4 the principal median to be used but if, for example,  
 5 the surgeon felt there was a tissue coagulation issue 10:13  
 6 at the time of surgery, this could be changed to  
 7 glycine. This was to accommodate all members of the  
 8 team."

9  
 10 So he's putting it rather more strongly in favour of 10:13  
 11 requiring a movement, albeit that if you ran into  
 12 difficulty with coagulation of the tissue during  
 13 surgery, then you could weigh it up and make a change  
 14 at that point. But you, as I understand it, failed to  
 15 make the change at all; your default position was to 10:14  
 16 continue with bipolar and glycine -- sorry, monopolar  
 17 and glycine.

18 A. Hmm. That is correct, yes.

19 20 Q. Did you, notwithstanding your years of experience and  
 20 your familiarity with the monopolar approach, did you 10:14  
 21 not recognise the safety issues that were prompted by  
 22 the Deputy Medical Officer's intervention?

23 A. I did. Ehm, but you will have seen another wealth of  
 24 correspondence, which we don't necessarily have time to  
 25 go to, where many urologists in Northern Ireland, you 10:14  
 26 know, expressed their reservations about the change and  
 27 the application of that dreadful experience during  
 28 a gynaecological procedure to the urological field, and  
 29 particularly by some with regard to using saline during

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

17 21 Q. Let me move on.

18 A. Thank you.

19 22 Q. We are going to spend much of the rest of our time  
 20 looking at some of the more significant structural 10:16  
 21 issues that emerged from the SAI cases that were the  
 22 subject of review by Dr. Hughes and his team in 2020  
 23 and 2021. You'll be aware that those reviews made some  
 24 strident criticisms of your work, but also pointed,  
 25 more importantly, I think, from the perspective of this 10:17  
 26 Inquiry, to governance failings. So the focus is going  
 27 to be on some of the more structural elements in my  
 28 questioning, in the fine detail of the individual  
 29 cases, which are set out, of course, extensively in the

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

5  
6 So, you will again appreciate that the Review Team made  
7 findings across a range of issues, including diagnosis  
8 and staging, in relation to whether targets were met  
9 for patients, the conduct of multidisciplinary  
10 meetings, failures of referral, as well as governance  
11 and leadership. 10:17

12  
13 In respect of you, I want to give you an opportunity to  
14 respond to this. There was a general finding, if we  
15 can bring it to -- bring us to DOH-00128. It says as  
16 regards yourself, that: 10:18

17  
18 "The review of nine patients has detailed significant  
19 healthcare deficits while under the care of one  
20 individual in a system. The learning and  
21 recommendations are focused on improving systems of  
22 multidisciplinary care and its governance." 10:19

23  
24 But just holding on to that first sentence and moving  
25 down the page, it says that: 10:19

26  
27 "The primary duty of all doctors, nurses and healthcare  
28 professionals, is for the care and safety of patients.  
29 Whatever their role, they must raise and act on

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

6  
7 So those remarks are directed to you, Mr. O'Brien.

8 A. Hmm.

9 23 Q. And your practice. Conscious that you've worked your  
10 way through each of the nine cases. 10:20

11 A. Hmm.

12 24 Q. And you've also made general remarks about what you say  
13 was the failings of the SAI process, its accuracy, or  
14 its correctness in some respects?

15 A. Hmm. 10:20

16 25 Q. Its failure to take certain things into account, and  
17 primarily, as I think you see it, the failure to give  
18 you adequate opportunity to respond, which you've set  
19 out at paragraph 679 of your primary witness statement,  
20 an approach you say was grossly unfair. Is there 10:20  
21 anything you want to add to the general remarks that  
22 you've set out in your witness statement about the  
23 approach of the SAI Review Team and the conclusions  
24 that they reached?

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

1 my usage of or engagement with clinical nurse  
2 specialists, for example. I think that -- I think,  
3 possibly the thing that caused me most alarm since the  
4 Inquiry was established, was Dr. Hughes' belief that  
5 patients entered a contract with a multidisciplinary 10:21  
6 team, and irrespective of whether one uses the word  
7 "contract", or "agreement", or "pact", or  
8 "understanding", or whatever, and that the  
9 multidisciplinary team dictates or directs the care of  
10 the patient, the notion that I was acting in 10:22  
11 a uni-professional manner, I -- I have no experience of  
12 that at all. I was very much involved with, and I was  
13 the lead clinician for the multidisciplinary team for  
14 years. The Inquiry is entirely familiar with the  
15 difficulties with regard to quoracy along certain 10:22  
16 lines. I have, in my addendum, related my philosophy  
17 with regard to the integrity of the patient, patient  
18 participation in their management decisions and their  
19 care. So I don't recognise a lot of what this tends to  
20 infer, and perhaps you may want to tease out some of 10:23  
21 those issues in more detail as we go along.

22 26 Q. We will, of course. Is it fair to say, and I have  
23 scrutinised your responses to the nine cases quite  
24 carefully, is it fair to say that you see no real  
25 substantive basis for criticism of your input into any 10:23  
26 of those cases?

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

1 27 Q. Just briefly, now, if you would.

2 A. My concern, actually, with regard to Patient 9, who was

3 otherwise known as Service User B, my concern there,

4 basically I think when I reviewed him in July 2019,

5 following his prostatic resection when there was no 10:24

6 evidence of prostatic carcinoma present when I expected

7 it to be, and he was still quite symptomatic of his

8 lower urinary tract, and I was concerned about him

9 having infection, and I remember clearly sitting there

10 wondering; how can I send off urine for culture? How 10:25

11 can I prescribe antibiotics for a period of time so as

12 not to subject him to prostatic biopsy with an

13 increased risk of infective complication? And how can

14 I possibly ensure that I will definitely be reviewing

15 him within an intended timeframe? And in retrospect, 10:25

16 the thing that concerned me is that I overlooked the

17 possibility; why didn't I request an MRI scan to be

18 done in September, which would have been the

19 three-month interregnum that we allowed as an MDT

20 following TURP prior to MRI scanning because of the 10:26

21 architectural distortion that you get following

22 resection of the prostate? So I regret not choosing

23 that option, or thinking of that option that day,

24 because I could have had an MRI scan done with a view

25 to it being discussed at MDM, which would have mandated 10:26

26 my review subsequently, and it might also have given

27 some advanced insight into the possibility that he

28 might have had a urethrorectal fistula, even then,

29 never mind one year later.



1 28 Q. And the second patient you wish to mention?

2 A. And the second case is that -- is in the case of

3 Patient 3, and that is that when he was first discussed

4 at MDM in April -- April 2019, it wasn't an MDM at all,

5 it was a virtual MDM. It was myself who did it. There 10:27

6 was no one present. I think we have familiarised the

7 Inquiry with the concept or the practice of virtual

8 MDMs. They weren't by Zoom, it was a singular person

9 doing it. And the one thing that I am disappointed in,

10 is that, for some reason my MDM outcome was to review 10:27

11 the patient to arrange a CT scan of chest, abdomen and

12 pelvis, but that's not typical, it was exceptional to

13 my MDM outcomes, because it should have been followed

14 by further subsequent MDM discussion. And then, on top

15 of that, when, at the end of May or June -- I reviewed 10:28

16 him anyhow, and then at the end of June I recall being

17 surprised that his CT scan wasn't already done, and

18 I did not include this in my clinical history of him

19 because I've only included things that I have been

20 certain of, and I thought that I had requested it, and 10:28

21 why isn't it done? why isn't it requested? And it was

22 only recently, on listening to Mr. Haynes giving

23 evidence on his last day, that he referred to the times

24 when a request may not go through, and I didn't want to

25 include that in case it would be regarded as excusing 10:28

26 because I wasn't certain of it. So I have that concern

27 about him because that would have brought forward his

28 whole pathway. And in a sense, as well, having found

29 that he did have enlarged lymph nodes in his left groin

1 -- a report I should add, do you know, that I did see,  
2 and I arranged his review -- in a sense I regret not  
3 just proceeding on with lymphadenectomy at that stage  
4 following MDM discussion, rather than going through the  
5 process of fine needle aspiration cytology to confirm 10:29  
6 that he did have metastatic disease.

7  
8 So those are my self-criticisms, about which I have  
9 thought a great deal.

10 10:29  
11 In his case, and I know it's not the concern of the  
12 Inquiry directly, whether that would have altered his  
13 eventual outcome, is another matter.

14 29 Q. Yes. Thank you for that. Professor Kirby gave  
15 evidence, as you know, instructed by your legal team, 10:30  
16 and one of the things he said about you was that,  
17 although he didn't know you, but he had taken soundings  
18 about you, as we know, he -- he spoke to somebody or  
19 received e-mail communication from somebody who knew  
20 you quite well, I think; he had all of the relevant 10:30  
21 papers, and what he said was:

22  
23 "I think, he..."

24  
25 - that is Mr. O'Brien's: 10:30

26  
27 "...is old-fashioned in his approach, and that comes  
28 from the fact that he has been in practice for many  
29 years and has found it difficult to adapt to a changing

1           landscape of the way medicine is practised."

2

3           He goes on later in his evidence to make other points  
4           about relationships with Oncology and that kind of  
5           thing, and I'll touch upon that later. But is there -- 10:31

6           maybe it's hard for you to self-analyse in this  
7           respect, but is there -- is there anything in that?

8           The institution of the MDM approach to medicine came in  
9           the last ten years or so of your professional career.

10          You were obviously an active participant in it, a Chair 10:31

11          and an MDT lead for a number of years, but were you --  
12          maybe "old-fashioned" isn't necessarily the right word

13          -- but was the MDT concept something that you found  
14          difficult to embrace, in the sense that it involved, if

15          you like, giving up an element of your autonomy to -- 10:32  
16          your professional autonomy to your colleagues,

17          following -- it was intended that you should at least  
18          give consideration to recommendations, and we'll come

19          to what that precisely means in a minute, for referral  
20          on; did any of that not sit well with you in terms of 10:32

21          your practice?

22          A. No, I don't recognise that at all. I, I embraced the  
23          multidisciplinary team approach. I put a great deal of

24          time-consuming effort into making multidisciplinary  
25          meetings work as effectively as they possibly could. 10:32

26          And they would have worked a lot better if we didn't  
27          have the problems with Radiology and Oncology. There

28          were deficits acknowledged way back, do you know, when  
29          Peer Review took place. So I mean there were

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

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

6    30   Q.    Let me come to that in a moment.

7           A.    Hmm.

8    31   Q.    So the description of you as an old-fashioned  
 9           practitioner and whatever that necessarily conveys, it  
 10          doesn't sit easily with you? 10:36

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

14    32   Q.    He defined it, just to be clear, as showing an  
 15          inability or a difficulty in adapting to a changing 10:36  
 16          medical landscape?

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

20    33   Q.    Very well. You've touched on the difficulties posed by 10:36  
 21          an absence of quoracy over a lengthy period of time,  
 22          and that was generally as a result of the failure or  
 23          the inability to supply the Southern Trust's MDM with  
 24          an adequate resource of oncological expertise, and  
 25          regularly, and towards the end more regularly, really 10:37  
 26          illogical input.

27          A.    Hmm.

28    34   Q.    The SAI process in the overarching -- in its  
 29          overarching report -- and I'll just give the reference,

1 we don't need to bring it up on the screen. It's  
 2 DOH-00124. It found that the MDM quoracy was only 11%  
 3 of meetings in 2017, 22% in 2018, none in 2019, and 5%  
 4 in 2020. So from a quoracy perspective, I suppose the  
 5 school report would be: Could do much better. You've 10:38  
 6 commented upon all of this, what you described as  
 7 persistent problems around quoracy, and you say that  
 8 the lack of quoracy impacted effectiveness and arguably  
 9 the legitimacy of the MDT system.

10 A. Hmm. 10:38

11 35 Q. would you care to elaborate on that? How did you --  
 12 how did the absence of these specialisms impact upon  
 13 effectiveness and what do you mean by your concern in  
 14 relation to legitimacy?

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

1 needed to have consistent radiological presence. And  
 2 it was interesting to contrast that with the ever  
 3 presence of pathology, and I had discussions with  
 4 Clinical Leads in Radiology concerning that matter, and  
 5 you may have read e-mail correspondence from me in that 10:40  
 6 regard. We had a wonderful radiologist, as I alluded  
 7 to last day, in Dr. Marc Williams. But I couldn't  
 8 convince the Department of Radiology that MDM was not  
 9 an optional extra; it was mandatory, it was a core  
 10 issue. And in fact, actually, I met with Dr. Wright in 10:40  
 11 April 2016, I arranged a meeting with him to discuss  
 12 this, and he did make an effort, as a radiologist  
 13 himself, with the Department of Radiology, to try to  
 14 free up Dr. Williams more. And to complete my answer  
 15 to you: we did, several times, question whether we 10:41  
 16 should continue; and we did, several times, wonder what  
 17 would be the consequences of our continuing in the way  
 18 that we did practice, and, alternatively, what would be  
 19 the consequences if we said "time up, this is no longer  
 20 valid"? How are all of these 40 cases being discussed 10:41  
 21 each week? Where are they going to be discussed? How  
 22 is that going to be catered for? It's almost like  
 23 analogous to the whole thing of centralisation of  
 24 radical pelvic surgery, was Belfast able to cope with  
 25 us saying "time up"? And sometimes when you look back 10:41  
 26 at the progressive deterioration in urological  
 27 services, you often wonder whether it would have been  
 28 better to hasten the end rather than trying to continue  
 29 to provide services on the shoestring.

1 36 Q. Yes. I needn't bring you to the e-mails, the Inquiry  
 2 has the note of them, but certainly on repeated  
 3 occasions the threat of packing up the tent and going  
 4 home because of the inability to adequately service the  
 5 MDT was made by, I think on one occasion you, and 10:42  
 6 certainly by your colleagues, Mr. Glackin and  
 7 Mr. Haynes.

8 A. Hmm.

9 37 Q. But it would appear that the decision was made to  
 10 muddle through. What were the -- we've heard about 10:42  
 11 work rounds -- sorry, work-arounds -- where the  
 12 oncologist isn't there that week, or the radiologist  
 13 isn't there that week, the conversation would take  
 14 place later on the telephone and the message would be  
 15 brought back to the team or, in the alternative, 10:43  
 16 discussion of the case would be postponed perhaps to  
 17 the following week, and sometimes four weeks down the  
 18 road, until the relevant expert could attend to  
 19 thoroughly discuss, perhaps, a complex case. Does that  
 20 all resonate with your memory of it? 10:43

21 A. Oh, absolutely.

22 38 Q. That you had to develop these kinds of solutions?

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



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

11 39 Q. Yes. Can I bring you to a concern that you have  
 12 articulated in respect of the MDT and its working,  
 13 which doesn't necessarily flow from the SAI reports,  
 14 and it's to be found at WIT-82505. And at paragraph  
 15 306, I think -- 305 is looking at quoracy. 306 is 10:45  
 16 discussing the quality or the need for quality to be  
 17 found in your chairmanship of the process. And I think  
 18 if I can just -- just scrolling down. There it is. So  
 19 on the right-hand margin on the screen in front of you,  
 20 after discussing the need for the Chair to be of 10:46  
 21 adequate quality, you said:

22  
 23 "Greater concern over recent years has been the  
 24 increasing tendency of the MDT members at MDM finding  
 25 themselves agreeing to management recommendations which 10:46  
 26 had not only already been recommended to the patient by  
 27 the Consultant Urologist and Core Member but had  
 28 already been implemented. In most cases, the MDM would  
 29 have agreed in retrospect with the recommendations

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

3  
 4 And you go on, I think, just over the page, to refer in  
 5 particular to the case of Patient 10. I don't feel 10:46  
 6 that we necessarily need to go into the detail of that,  
 7 but you're pointing to a situation where, in advance of  
 8 the MDM, the clinician has already implemented  
 9 a management, or at least communicated a management  
 10 plan to the patient. 10:47

11 A. Hmm.

12 40 Q. And it's -- it's really -- it really becomes a rubber  
 13 stamping exercise...

14 A. Hmm.

15 41 Q. When it reaches the MDT. 10:47

16 A. Hmm.

17 42 Q. Because the -- if you like, the cat has already been  
 18 released from the bag.

19 A. Hmm.

20 43 Q. Was that a particular problem or regular problem? 10:47

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

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

9 44 Q. Mm-hmm. I mean, obviously, in your role as MDT lead,  
10 or as Chair, you would have had an opportunity to 10:49  
11 prevent this, or at least applying pressure to prevent  
12 this form of practice. Is it something you did try to  
13 address?

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

27 45 Q. You talk in that sequence about the case actually  
28 reaching the MDM at least, albeit the management plan  
29 may have already happened or communicated. In her

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

10:51

6  
7 "...and weren't always referred to the MDT."

8  
9 And adding to that:

10  
11 "And for others were referred to the MDT, but may not  
12 have had their results enacted."

10:51

13  
14 And we'll come to that second part in a moment. Do you  
15 accept that there were occasions for which, for  
16 whatever reason, you didn't send the cancer case, the  
17 diagnosis, to the MDT for discussion in relation to  
18 management?

10:51

19 A. No, I don't, unless, you know, it's an oversight, like  
20 I've just referred to in another aspect. You know, one  
21 of the things that concerns me about having reviewed as  
22 much as I can, without clinical records, some of the  
23 comments and findings that have been made throughout  
24 the course of the structured clinical record review, is  
25 that there's no record of a discussion at MDM,  
26 sometimes even before we actually even had an MDM.  
27 But, you know, in the period -- I think, actually, the  
28 MDM outcomes were not recorded on NICAR until about  
29 2014, I think I'm correct in saying that, and they

10:52

1 should all have been on the CaPPS system, which is  
 2 a separate system, the Cancer Archival Patient Pathway  
 3 System, they were not always included in patient  
 4 records in the early years, so it concerns me that just  
 5 because there hasn't been an apparent record that 10:53  
 6 there's a conclusion that it wasn't discussed. Every  
 7 newly diagnosed patient -- I should add, however, if  
 8 patients actually had been diagnosed prior to April  
 9 '10, if they had been diagnosed two years previously,  
 10 and we now had an MDT/MDM structure, I wouldn't have 10:53  
 11 necessarily brought them to MDM just because there  
 12 wasn't an MDM at the time of their diagnosis, unless  
 13 they progressed or something.

14 46 Q. Yes. Could I bring you to two examples and, in  
 15 fairness, because this is -- this has been shown to the 10:53  
 16 Inquiry and you'll want to make whatever comment you  
 17 feel is appropriate. Patient 25 has been the subject  
 18 of an SCRR process?

19 A. Mm-hmm.

20 47 Q. Mr. Awry was the reviewer, and if I could bring you to 10:54  
 21 his SCRR review. It's to be found at TRU-309747. And  
 22 he said, it says in respect of this patient:

23  
 24 "There is no evidence that the patient's condition was  
 25 discussed in MDT. The patient was started on a 10:54  
 26 suboptimal and unlicensed dose of Bicalutamide 50mg,  
 27 rather than complete androgen deprivation."

28  
 29 And he goes on to describe, just scrolling down the

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

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

7 48 Q. I've looked at that report and I don't think the year  
8 is cited in it?

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

14 49 Q. And a second example has been drawn to our attention.  
15 Patient 75, again the subject of an SCRR process in the 10:55  
16 hands of a Mr. Stephen Brown, Urologist, and it's to be  
17 found at TRU-309763. And:

18 "On 14th November 2011..."

19  
20 10:56

21 - so we have the date for this one:

22  
23 "Patient with wife was seen by a specialist registrar  
24 and a diagnosis of high risk Gleason 4+5 prostate  
25 cancer and need for staging investigations and MDT 10:56  
26 review. MDT did not happen, which should have, and  
27 instead the patient was seen by AOB and diagnosed and  
28 started on 50mg of Bicalutamide and 10mg of Tamoxifen.  
29 There appears to have been no discussion at this point

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

4  
 5 So, again, he's saying MDT in respect of this patient 10:57  
 6 does -- did not happen on the basis of what he has  
 7 seen. Your response to that?

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

1 50 Q. Yes. Well, you put the point out there. The Trust has  
2 supplied the Inquiry with its SCRR summary?  
3 A. Hmm.  
4 51 Q. In response to our request, and it's provided us with  
5 some reports, and probably the majority of the reports, 10:59  
6 and the Inquiry has had to make a decision in terms of  
7 what it might be relevant to supply to other Core  
8 Participants, you've seen those two reports and you've  
9 made your observations.  
10  
11 I mean just finally on this point, I mean can  
12 I interpret your evidence as suggesting that there was  
13 no culture at the Southern Trust of seeking to avoid  
14 MDT consideration of cases? That if it happened, it  
15 was accidental and infrequent, but you can't remember 10:59  
16 it happening terribly frequently?  
17 A. I would concur with that, and I would be most concerned  
18 that anything to the contrary was the case with any  
19 clinician, and it certainly wasn't the case with me.  
20 52 Q. Yes. Can I bring you to the MDT's Operational Policy 11:00  
21 for 2017? We can find it at WIT-84538. And if we just  
22 scroll down. It sets out a definition in terms of the  
23 cases that come -- should come to an MDT, and it says:  
24  
25 "All new cases of urological cancer and those following 11:01  
26 urological biopsy will be discussed. Patients with  
27 disease progression or treatment-related complications  
28 will also be discussed and a treatment plan agreed.  
29 Patient's holistic needs will be taken into account as



1 part of the MD discussion. The clinician who has dealt  
 2 with the patient will represent the patient and family  
 3 concerns and ensure the discussion is patient-centred."  
 4

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

17 A. Or the practice of it?

18 53 Q. Yes.

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

1  
2 Sentence two; patients with disease progression. It's  
3 an interesting one, because disease progression was  
4 very often more defined by a particular milestone,  
5 like, for example, a further resection of bladder 11:03  
6 tumour, or recurrent bladder tumour, irrespective of  
7 whether it represented disease progression or  
8 otherwise, increase in the size of a renal mass that  
9 had been under surveillance. Treatment related  
10 complications, I cannot recall that being a particular 11:03  
11 issue that we would have brought back. I mean  
12 certainly if you had -- if a person had a radical  
13 nephrectomy, or a partial nephrectomy - that's a good  
14 example - by the time that we would have been  
15 discussing their pathology, the complication would very 11:04  
16 often have arisen by then, so we would have had the  
17 opportunity of discussing it. There wouldn't have ever  
18 been an inhibition to doing so. And the treatment plan  
19 agreed, and that's what you're referring to, did we  
20 have a practice of bringing back to MDM, where there's 11:04  
21 a divergence, as it has been described, to the  
22 treatment plan? We didn't have a practice for doing  
23 that. And one of the things actually that we discussed  
24 a great deal, at great length on several occasions  
25 where you have management options available to the 11:05  
26 patient, is to be less prescriptive in our MDM outcomes  
27 or plans, as they have been variously entitled as the  
28 years went by, so that if, in the case of prostate  
29 cancer, you were discussing, or you were recommending

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

12 54 Q. Yes.

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

15 55 Q. Well, I want to explore some of those aspects. Before 11:06  
 16 I do, I want to set out for you -- if we scroll back in  
 17 this policy -- to, it's I suppose the philosophy of an  
 18 MDT, and it's to be found at 535 in this series, three  
 19 pages back. And it's described as, at the top of the  
 20 page, it's: 11:06

21  
 22 "An MDT brings together staff with the necessary  
 23 knowledge, skills and experience to ensure high quality  
 24 diagnosis, treatment and care for patients with  
 25 cancer." 11:07

26  
 27 It goes on to say:

28  
 29 "The primary aim of the MDT is to ensure equal access

1 to diagnosis and treatment for all patients in the  
2 agreed catchment area. In order to achieve this aim we  
3 provide a high standard of care for all patients."  
4

5 And it goes on then importantly to say:

11:07

6  
7 "The MDT ensures a formal mechanism for  
8 multidisciplinary input into treatment planning and  
9 ongoing management and care of patients with urological  
10 cancer with the aim of improving outcomes."  
11

11:07

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

14  
15 In terms of MDT recommendations.

11:08

16 A. Mm-hmm.

17 56 Q. If we -- if we view this through the lens of an MDT  
18 being a formal mechanism to bring together all that's  
19 necessary to inform the decision-making around the care  
20 of the patient. So if the MDT provides you with  
21 a decision or a recommendation --

11:08

22 A. Hmm.

23 57 Q. -- that is something that you should be doing your best  
24 to implement in conjunction with your patient, and if  
25 that's not possible, it's something that you should be  
26 recording and, as a matter of good practice, bringing  
27 it back to the MDT for further discussion?

11:09

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

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

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

12 58 Q. You've referred to Dr. Hughes. You've said the word  
 13 "contract" in this context.

14 A. Hmm.

15 59 Q. And I think I'm correct in saying that he added an 11:12  
 16 explanation to that when I asked him about that.  
 17 Certainly, for Mr. Gilbert's part, he said in his --  
 18 one of his witness statements:

19  
 20 "I agree that MDT recommendations are not mandatory but 11:13  
 21 neither are they simply advisory. The recommendation  
 22 is a consensus on the optimal treatment and should be  
 23 explained as such, recorded in the notes, and deviation  
 24 recorded and best practice is to re-discuss deviation  
 25 with colleagues." 11:13

26  
 27 Is that something with which you could concur?

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

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

5  
 6 "We expect the clinician to take on board the  
 7 recommendations in these guidelines..."

11:14

8  
 9 But --

10 60 Q. A slightly different context?

11:14

11 A. It is a slightly different context.

12 61 Q. It's talking about guidelines and not MDT?

13 A. Yes, but it is a parallel. And, in my view anyhow,  
 14 I think there is an agreement that the MDM decision, as  
 15 it's often referred to, is nothing other than

11:14

16 a recommendation, and I put those recommendations to  
 17 all patients. In the context, actually, of -- as  
 18 objectively as possible, with all of the information  
 19 aids like Prostate Cancer UK, and, again, actually, the  
 20 NICE guidelines have really objective detailed risks

11:15

21 and benefits that you can share with the patient. So,  
 22 I did all of that. I spent so much time doing that  
 23 that I didn't actually record -- I mean, if you are  
 24 reviewing the patient post MDM, you are reviewing the  
 25 patient to catch up to that moment in time, inclusive  
 26 of imparting to them the MDM recommendation. And the  
 27 course of action that is taken thereafter, I would have  
 28 been very, very happy, and it would have been a good  
 29 governance practice to take that back to MDM, but I'm

11:15

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

3 62 Q. Mm-hmm. One of the things --

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

5 MR. WOLFE KC: Yes. If it's -- glancing across -- if 11:15  
 6 it's okay I could finish this particular issue about  
 7 11:30 and then we'll take our break, but I'm quite  
 8 content to break.

9 CHAIR: Is the witness content to sit on?

10 A. I'm quite happy. 11:16

11 CHAIR: Very well.

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

13 63 Q. One of the things you've said is that one of the, I  
 14 suppose, the that hamstrings, or potentially hamstrings  
 15 an MDT, is that the patient isn't in the room? 11:16

16 A. Hmm.

17 64 Q. And a decision or a recommendation emerges and you take  
 18 it back and review it with the patient?

19 A. Mm-hmm.

20 65 Q. We see through the SAIs that the reviewers are 11:16  
 21 commenting that eight out of the nine recommendations  
 22 which emerged from the MDT in the nine cases that they  
 23 looked at were correct, in their view, but they weren't  
 24 always implemented. If you are discussing a patient at  
 25 MDT, and if one of your concerns, say in the context of 11:17  
 26 prostate cancer, is the ability of that patient,  
 27 because of a cardiovascular history, or a diabetic  
 28 history, or a wish to retain sexual potency.

29 A. Mm-hmm.



1 66 Q. If you have that knowledge, that should be brought to  
 2 the MDT for discussion in terms of, for example, what  
 3 form of preparation for radiotherapy, or if  
 4 radiotherapy is appropriate, that kind of thing should  
 5 be brought and discussed? 11:18

6 A. Mm-hmm.

7 67 Q. Is that "mm-hmm" a yes?

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

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

10 68 Q. The point I'm making to you, Mr. O'Brien, is that if 11:20  
 11 the information critical to the care pathway --  
 12 A. Hmm.

13 69 Q. -- only emerges after the MDT.  
 14 A. Hmm.

15 70 Q. And if it's that that is crucial in determining, in 11:20  
 16 your mind, with the patient, the way forward, but it  
 17 hasn't been shared with the multidisciplinary team,  
 18 including the oncologist if he or she is present --  
 19 A. Hmm.

20 71 Q. -- then that is running -- failing to bring it back to 11:21  
 21 the MDT is running a coach and horses through the  
 22 underpinning principle of multidisciplinary working?  
 23 A. Well, I would question that conclusion, because it  
 24 isn't. I mean multidisciplinary working is bringing  
 25 all of that information to the patient, but the patient 11:21  
 26 -- it is the patient's prerogative to determine their  
 27 future pathway. That's a separate issue from taking it  
 28 back to MDM. I agree with you, I would have had no  
 29 difficulty in bringing back all such cases to MDM if we

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

8 72 Q. Just help me with that. Who has to sign it off?  
 9 A. He indicated that, you know, the MDT needed to sign off  
 10 the divergence, they needed to take ownership of it. 11:22

11 73 Q. And -- yes. So he -- I can't honestly recall the  
 12 precise way in which -- the way in which you have  
 13 described it.

14 A. Hmm.

15 74 Q. But in essence, his evidence came to this: That there 11:22  
 16 is a requirement, as he sees it, if you don't implement  
 17 an MDT decision -- and this is taken from his oral  
 18 evidence at TRA-01060 -- that you would bring it back  
 19 to your colleagues and discuss it and agree how the  
 20 care plan would be achieved. He says that: 11:23

21  
 22 "The other issues are that because the team focused on  
 23 first diagnosis and first treatment patients weren't  
 24 brought back to the MDT for discussion as their care  
 25 needs changed." 11:23

26  
 27 A. Hmm.

28 75 Q. So, to summarise: You disagree with the perspective  
 29 that there's any requirement to bring it back?

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

14    76   Q.    What about disease progression or complications with  
 15                   the treatment? 11:24

16           A.    Hmm. Mm-hmm.

17    77   Q.    Disease progression might be interpreted as meaning  
 18                   where the disease has got worse?

19           A.    Mm-hmm.

20    78   Q.    Or the patient has deteriorated? 11:24

21           A.    Mm-hmm.

22    79   Q.    We see that, for example, with Patient 1.

23           A.    Mm-hmm.

24    80   Q.    We see that with Patient 4. And I think also -- yes,  
 25                   Patient 4. The recommendation flowing from the SAIs in 11:25  
 26                   these kinds of cases is that where there has been  
 27                   disease progression, there should be a re-discussion of  
 28                   the patient, and that didn't happen in either of those  
 29                   cases?

1           A.    Well as we have discussed in recent times, with regard  
 2                   to Patient 1, the first indication of possible disease  
 3                   progression was when his serum PSA level was found to  
 4                   have increased to 5.4, or something of that order, on  
 5                   5th March 2020. And as I explained in my letter to the 11:26  
 6                   general practitioner at that time, that -- that should  
 7                   not have necessarily been interpreted as an indicator  
 8                   of disease progression, because it could have been  
 9                   spurious, there may have been a medication compliance  
 10                  issue, there may have been other factors that caused 11:26  
 11                  that increase, even though it was a significant  
 12                  increase in a period of two months from January 2020,  
 13                  and then by the time that I was aware, that in addition  
 14                  to a serum PSA level having increased, he was running  
 15                  into problems with increasing lower urinary tract 11:26  
 16                  symptoms, which ultimately ended up requiring  
 17                  catheterisation in early April, and because of all of  
 18                  the logistical communication issues with Covid during  
 19                  that period of time, I didn't become aware of that  
 20                  until May, the end of May, and then when I contacted 11:27  
 21                  the patient, the most important thing for him at that  
 22                  point in time was this indwelling catheter and being  
 23                  relieved of it. So the argument you may have is, well,  
 24                  should you not have actually then at least brought him  
 25                  to MDM before you proceeded to resect his prostate? My 11:27  
 26                  practice would have been to have resected his prostate,  
 27                  which was his priority, to alleviate him, hopefully, of  
 28                  having a catheter in, and then brought the whole issue  
 29                  to MDM. That was my plan. In the case of -- in the

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

6 81 Q. 27th February, I think it was?  
 7 A. Yes, yes. And I didn't likewise -- so it was a failure  
 8 on the part of both of us.

9 82 Q. Yes. In principle, you agree with the proposition that  
 10 disease progression cases should be brought back? 11:28  
 11 A. Yes, yes.

12 83 Q. And you recognise that in both those cases, that they  
 13 weren't?  
 14 A. Yes.

15 84 Q. Albeit that, certainly with Patient 1, you think 11:28  
 16 there's good reasons for not doing so?  
 17 A. Well, I think there were understandable reasons.  
 18 I think they're reasonable, if one was to be  
 19 particularly didactic about it, I can understand the  
 20 contrary view, but that was my plan at the time, and 11:28  
 21 I certainly would have been returning him to MDM for  
 22 further discussion because I had planned to have him  
 23 staged and so forth.

24 85 Q. Thank you. Thank you for that. Thank you for your  
 25 indulgence in sitting on that bit little bit longer. 11:29  
 26 CHAIR: I think we're going to take a little bit of  
 27 a longer break, given that we've gone on this length of  
 28 time. So we will sit again at ten to twelve.  
 29 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

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CHAIR: Thank you, everyone.

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

11:48

A. Hmm.

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

11:49

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

11:49

11:50

11:50

1 just built a structure on top of a situation to monitor  
 2 outcomes and their implementation and recommendations,  
 3 without actually having reasons provided. So I think  
 4 -- I think in retrospect, and prospectively, for those  
 5 still there, it would be a very good idea to be -- have 11:51  
 6 the capacity to bring patients back to MDM for  
 7 discussion and build that kind of supervisory  
 8 monitoring audit structure on top of that.

9 88 Q. And for that matter, once the patient has been  
 10 discussed at MDT, and a recommendation, if you like, 11:51  
 11 delivered, there was no tracking of that patient's care  
 12 pathway through the rest of the -- through the next  
 13 steps in his or her management, so that, for example,  
 14 if there was a need for treatment because of disease  
 15 progression, there was nothing interrupting the process 11:52  
 16 to check that that had been done?

17 A. Hmm. That is the case. And, do you know, ultimately,  
 18 and I'm -- I apologise if I sound like a broken record,  
 19 or pointing the finger of blame, but at the end of the  
 20 day, you know, it was an inadequate service, and having 11:52  
 21 listened to some of the improvements that have been  
 22 made in that regard, there's an enormous learning  
 23 journey to go on for a multidisciplinary team to learn  
 24 from that whole interface between recommendations and  
 25 the patient and the clinician and bringing back and so 11:52  
 26 forth. It would be a much more enriched patient  
 27 pathway if that were all possible.

28 89 Q. I mean, the effect of these governance shortcomings was  
 29 that decisions that were incorrect, and it's suggested



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

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

21 90 Q. Yes. As a member of this MDT for ten years since its  
 22 inception and its coordinator, or, sorry, as its lead  
 23 for several years, and a Chair and a rotating Chair  
 24 thereafter.

25 A. Hmm. 11:55

26 91 Q. Did you have a sense of these inadequacies in the  
 27 governance support for the MDT? Had you an awareness  
 28 of it?

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

1 listened to the contributions of others with regard to  
2 audit, for example. I mean we were -- we were  
3 struggling to, to discuss, as wholesomely as possible,  
4 40 cases per week, which was the cap I put it on at one  
5 stage, because otherwise people suffer from fatigue and 11:55  
6 patients don't get adequately discussed. So we were  
7 struggling for all of the reasons that we have already  
8 mentioned this morning in terms of quoracy and  
9 whatever. Do you know, it's one of the concerns or  
10 views I have with regard to this whole issue of 11:56  
11 adequacy of service and governance. In many ways it --  
12 the emphasis, to my mind, should be on providing an  
13 adequate service and, in terms of MDM, along the lines  
14 that I've just been articulating, rather than  
15 continuing -- to govern and to audit a service which is 11:56  
16 patently inadequate. And in MDM terms, do you know, I  
17 mean all of the issues were there, they're known. I've  
18 made reference in my aide-mémoire to a Bates number  
19 where, in the 2015 Peer Review, it was acknowledged  
20 then that there was a deficiency in holistic needs 11:56  
21 assessment and the appointment of key workers. So when  
22 you are -- when you have deficiencies so fundamental as  
23 we did have in that MDM, I mean, you can govern and  
24 audit it until the cows come home but, you know,  
25 unless that results in some kind of improvement, and we 11:57  
26 tried to get the improvement, Mr. Glackin and myself,  
27 prior to him, we did our best to try to improve quoracy  
28 and to try to improve all of the other features, such  
29 as key workership and so forth, but ultimately

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

3    92   Q.   Thank you for that. I want to move on now to look at  
4           what the SAI reviews regarded as incorrect  
5           decision-making on your part, and I want to 11:58  
6           particularly focus on the management of prostate cancer  
7           and the use of Bicalutamide?

8           A.   Yeah.

9    93   Q.   Delayed referral, and sometimes non-referral to  
10          Oncology, those series of issues. It isn't just the 11:58  
11          SAI series that has commented on those issues; we know  
12          that it has been the subject of comment in the Royal  
13          College of Surgeons' Report, which the Inquiry has  
14          seen, and it was the feature of many of the SCRR  
15          reports, which you have at least in summary form. But 11:58  
16          I want to focus on the various, if you like, alarms  
17          that might be said to have sounded in respect of your  
18          practice in this respect and your responsiveness to  
19          that.

20 11:59  
21          I want to bring up on the screen before delving into  
22          this, a remark that Mr. Kirby, or Professor Kirby has  
23          made, which may be relevant in this context, and to ask  
24          for your views on this. If we go to TRA-09468. And  
25          I've asked him, if we just go to the bottom of the last 11:59  
26          page, to comment on whether he has formed any view --  
27          just scrolling down -- in terms of whether you could be  
28          considered to be a team player, or whether he had any  
29          sense of you working in isolation, and he answered by

1           saying:

2

3           "To his detriment..."

4

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

6

7           "He didn't seem to want to collaborate with his

8           colleagues as well as he should have done, especially

9           the radiotherapists in Belfast. That would have been

10          -- a close relationship would have been ideal. He had 12:00

11          his own way of doing things and perhaps was reluctant

12          to change."

13

14          what about that, Mr. O'Brien? Is he -- is he right

15          that relationships with radiotherapists in this context 12:01

16          are important but that you did not engage with the

17          Radiotherapy Oncology service as much as you should

18          have?

19          A. I don't recognise that at all. I had -- I had great

20          regard for the Clinical Oncologists in Belfast. Having 12:01

21          experienced Clinical Oncology in Dublin during my years

22          of training, and then in Belfast, I think the standard

23          of the service that they provide has been excellent

24          and, quite frankly, do you know, I don't understand how

25          Professor Kirby could make such comment just on reading 12:01

26          the views of others, without knowing me. I think he

27          was probably comparing the very close relationship that

28          he has with radiotherapists in London, in the prostate

29          centre in London, in the prostate clinic, where they're

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

5 94 Q. Yes. 12:02

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

8 95 Q. Yes. We've seen, and we'll explore your thinking in  
 9 terms of your approach to prostate cancer management as  
 10 we go on. 12:02

11 A. Hmm.

12 96 Q. But we've seen perhaps multiple examples of cases where  
 13 you have maintained the patient on Bicalutamide,  
 14 sometimes on 50mgs over a lengthy period of time,  
 15 a lifetime in some cases, sometimes going from 50 to 12:03  
 16 150, maintaining on that monotherapy, and then, in some  
 17 cases, the patient's PSA rising, arguably unexpectedly,  
 18 but certainly rising to an extent where a referral is  
 19 ultimately needed. One might infer from that, perhaps,  
 20 that you're reaching management decisions in 12:03  
 21 conjunction with your patient, whereas you really  
 22 should be engaging with Oncology to discuss the wisdom  
 23 in any particular case of that form of management?

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

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

21 97 Q. Yes.

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

1 category of disease. But, for example, you know, his  
 2 erectile function was of significant importance to him,  
 3 and that's the reason why I started him on medication  
 4 for that, before introducing him at 50mgs, before  
 5 increasing it to 150mgs, and he was so keen to avoid 12:06  
 6 embarking upon any management of his prostate cancer  
 7 that would negatively impact upon his quality of life,  
 8 as he viewed it, and the various aspects of that.

9 98 Q. Yes. I'm going to bring you in just two minutes to the  
 10 rationale, particularly the rationale that you've set 12:07  
 11 out in your addendum statement, having had an  
 12 opportunity to reflect on all of the evidence received  
 13 by the Inquiry, and you set out, in very clear and  
 14 detailed terms for the Inquiry's benefit, your  
 15 approach. 12:07

16  
 17 Could I -- just before reaching that, could I bring up  
 18 on the screen, please, something you said in your  
 19 primary statement two years ago. It's at WIT-92585.  
 20 And that is -- sorry, 825, perhaps? Yes. At paragraph 12:07  
 21 544, please, you said:

22  
 23 "At no point during my years of clinical practice as a  
 24 Consultant Urologist within the Trust from 1992 until  
 25 2020, was any concern raised with me in respect of the 12:08  
 26 manner in which I prescribed Bicalutamide. Indeed, it  
 27 was well known within both the Urology Service and the  
 28 Oncology Service that Bicalutamide was being  
 29 prescribed, and how it was being prescribed. No issues

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

4  
 5 Now, I know you corrected that in an addendum 12:09  
 6 statement.

7 A. Hmm.

8 99 Q. And in that addendum statement at WIT-98807, you  
 9 reflected that you had located an e-mail from  
 10 Dr. Mitchell, sent to you on 20th November 2014. 12:09

11 A. Hmm.

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

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

18 101 Q. Yes.

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



1           been an explanation for his management at that time.

2 102 Q.     Mm-hmm. We'll come to that e-mail in a moment, but

3           there's no record of you responding to it?

4           A.     There's no record of my responding to it. I do not

5           know whether I have responded to it in letter form? 12:11

6           I requested that we would be provided with the referral

7           letter, which turned out to be an inter Trust transfer

8           referral, and I think my legal team had requested that

9           we would be provided with the complete clinical

10          records, but I haven't been provided with those. 12:11

11 103 Q.     Now, I want to allow a little time to enable you to

12          address the key points in your -- in defence of the

13          approach that you've taken to prostate cancer

14          management. Rest assured, the Inquiry has read your

15          primary statement and your addendum statement, and in 12:11

16          your most recent addendum statement, from paragraphs 24

17          to 47, you've set out, indeed by reference to some

18          patient cases, including, I think, Patient 35, the --

19          sort of the key features of your approach. I suppose

20          what you're saying, to summarise, is that you're 12:12

21          acutely aware of the Regional Guidelines?

22          A.     Mm-hmm.

23 104 Q.     You have an appreciation every time an MDT makes

24          a recommendation, but you are obliged to adopt

25          a patient-centred approach, I think you call it? 12:12

26          A.     Mm-hmm.

27 105 Q.     And, in consultation with your patient after the MDT

28          has recommended, you have to find the best solution for

29          that patient, regardless of the guidelines, regardless

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

9 A. Mm-hmm.

10 106 Q. You wished to prescribe low dose Bicalutamide while the 12:13  
 11 patient's disease was either confirmed or staged, one  
 12 or the other.

13 A. Hmm.

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

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

21 108 Q. Of course.

22 A. Okay.

23 109 Q. Well rest assured that embroidered into the four  
 24 prostate cancer cases that made up the SAI reviews --  
 25 is it four or five? 12:14

26 A. Five, I think.

27 110 Q. Five. So your responses to those, as well as your  
 28 addendum statement, set out your rationale in a great  
 29 bit more detail than we have time for perhaps today.

1 A. Hmm.

2 111 Q. You have said, perhaps if we go to WIT-107576 - let me  
3 see if that's just about where I need to take you?  
4 Yes, paragraph 43. You explain that:

5  
6 "...when the patient has been optimally informed of the 12:15  
7 anticipated benefits of differing management options  
8 and of the comparative risks associated with those  
9 options, it has been my experience that a great  
10 proportion of men, probably the majority, were most 12:15  
11 keen to embark upon a journey to achieve the benefits  
12 while incurring the least risks. It has been in that  
13 context that androgen deprivation using Bicalutamide  
14 has been prescribed, irrespective of the dose initially  
15 used." 12:16

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

23 A. Hmm.

24 112 Q. Does that conversation involve you telling them that  
25 the guidelines are the recognised standard for most 12:17  
26 prostate cases?

27 A. Mm-hmm.

28 113 Q. And that any departure from that could be regarded as  
29 a suboptimal management approach?

1           A.    Well, any departure from -- I mean the guidelines  
 2                    themselves specify, as I've already alluded to earlier  
 3                    on, that the guidelines -- the clinician is expected to  
 4                    take them on board because a lot of effort has been put  
 5                    in to drawing up guidelines and, indeed, actually, the 12:17  
 6                    MDT at MDM is expected to be cognisant of the  
 7                    guidelines as well. So the guidelines are  
 8                    "embroidered", is a good term, into all of this  
 9                    discussion, but it's not just a matter of diverging  
 10                   from the guidelines; I mean, the guidelines are based 12:18  
 11                   upon all of the evidence, and the published evidence --  
 12                   and I'm sure Mr. Hanbury will acknowledge that. For  
 13                   most stages of prostate cancer, let's say, for example,  
 14                   organ confined prostate cancer, I mean the recent  
 15                   results from the Protect study show that if you go for 12:18  
 16                   radical prostatectomy, your cancer-specific survival,  
 17                   or mortality -- let's express it in mortality terms --  
 18                   the risk of you dying of prostate cancer within 15  
 19                   years is 2.2%. If you go for radical radiotherapy it's  
 20                   2.9%. If you go for active surveillance in the first 12:18  
 21                   instance, it's 3.1 %. So as Professor Hamdy and  
 22                   Mr. Donovan have said in their various publications  
 23                   around those results, you know, the risk of dying of  
 24                   prostate cancer, if you have organ-confined disease, is  
 25                   so low that there should be a trade-off between the 12:19  
 26                   benefits of those treatments and the risks associated  
 27                   with them. You know, there's a greater awareness now,  
 28                   or there has been there for a decade, that, you know,  
 29                   it's one of the most negative legacies of prostate

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

27 114 Q. Were you approaching this from the viewpoint that the  
28 guidelines, and we will come and look at the guidelines  
29 in a moment, were a manifestation of a tendency towards

1 the overtreatment or the unnecessary treatment of  
 2 prostate cancer?

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

20 115 Q. So we've started with your approach and your viewpoint 12:23  
 21 on this, and I want to set aside that the approach of  
 22 the Belfast clinicians?

23 A. Hmm.

24 116 Q. Dr. Mitchell, as I noted earlier, wrote to you in  
 25 November 2014, and he had been in practice as an 12:23  
 26 oncologist in the Belfast Trust since 2008, and he has  
 27 given evidence that in the years prior to 2014, and he  
 28 couldn't be precise about the cases or the number, he  
 29 had come across, in terms of referrals from you, and

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

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

16 117 Q. Do you remember getting such correspondence?

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

20 118 Q. Dr. McAleese, for example? 12:25

21 A. Dr. McAleese, for example.

22 119 Q. Made much the same point.

23 A. Yes. Yeah.

24 120 Q. I'm not sure Professor Sullivan made quite the same  
 25 point, but he certainly came across cases where low 12:25  
 26 dose Bicalutamide seemed to have been the favoured  
 27 medication, inappropriately, in his view, across  
 28 a range of cases.

29 A. Hmm.

1 121 Q. So you can remember those changes being made by the  
2 oncologists in correspondence to you?

3 A. Hmm. Hmm.

4 122 Q. And then the 2014 e-mail from Dr. Mitchell. We can  
5 have it up on the screen, please, at AOB-71990. And  
6 20th November 2014, he -- he's referring to a:

12:25

7  
8 "Young man with high grade organ confined disease  
9 from 2012."

10

12:26

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

12:26

16

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

19

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

12:26

24

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

12:27

28

29 He goes on to say:



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

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

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

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

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

14 123 Q.    If you had read it --

15          A.    Yes. 12:30

16 124 Q.    -- it would have warranted a response.

17          A.    It would have warranted a response. Absolutely.

18 125 Q.    You've accepted that other clinicians had written to  
 19          you or copied you into correspondence changing --

20          A.    Hmm. 12:30

21 126 Q.    -- your prescribing over a period of years.

22          A.    Hmm.

23 127 Q.    Dr. McAleese, for example, claims that --

24          A.    Hmm. Hmm.

25 128 Q.    -- he wrote in those terms. And, as I said, 12:31  
 26          Dr. Mitchell claims that he wrote in those terms.

27          A.    Hmm.

28 129 Q.    Again, that must have puzzled you, thinking back, in  
 29          terms of "why are they doing that to a regime that I've

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

3 A. Yeah, I mean, I appreciated their view on the matter,  
4 as I speculated that it would be, do you know. This is  
5 the licensed dose for locally advanced disease, because 12:31  
6 that's the only stage for which it is actually  
7 licensed, 150mgs. So, they would have regarded that as  
8 the correct dose from the clinical trials that had been  
9 done, but the whole purpose -- I mean -- well, let me  
10 phrase it another way: There is a significant body of 12:32  
11 evidence to demonstrate that the Nadir Serum PSA level  
12 prior to initiation of radical radiotherapy is the  
13 single-most important factor and predictor of outcome  
14 response, apart from actually the further Nadir  
15 following radical radiotherapy. So in fact actually, 12:32  
16 Dr. Mitchell has -- was first author on a paper  
17 published about that very subject, where it was  
18 demonstrated that in terms of biochemical progression,  
19 and disease progression, and cancer-specific mortality,  
20 if the Nadir PSA was less than 1ng/ml, it was 12:32  
21 significantly better than if it was greater than  
22 1ng/ml.

23  
24 So you have an issue here. The issue is, if you have  
25 organ-confined disease in particular, and you have 12:33  
26 a patient who has had myocardial infraction two years  
27 previously, is still hypertensive and is diabetic, and  
28 with all of the body of evidence in support of the  
29 increased risk of significant cardiovascular

1 complications of a LHRH agonist, and you have  
 2 a regimen, for want of a better word, where  
 3 Bicalutamide 150mgs is not licensed for organ-confined  
 4 disease, and you can -- you're starting off with a PSA  
 5 of 5, and you prescribed Bicalutamide 50mg in the first 12:33  
 6 instance, and nine months later their PSA is 0.5, or  
 7 0.4, and you have arrived at that sweet spot without  
 8 actually having to use three times the dose, I mean --  
 9 and there is no evidence whatsoever that the duration  
 10 of androgen deprivation therapy prior to radical 12:34  
 11 radiotherapy is of any significance in terms of the  
 12 outcome. The important point, the most significant  
 13 point, more importantly than Gleason score, more  
 14 importantly than pretreatment PSA levels, is the Nadir  
 15 PSA level prior to the initiation of radiotherapy. 12:34  
 16 There is not one piece of evidence in the literature to  
 17 contradict that fact.

18 130 Q. That exposition may, Mr. O'Brien, be an entirely  
 19 respectable view. We have, I suppose, assembled before  
 20 this Inquiry, in terms of the evidence received, some 12:35  
 21 very decisive views to the contrary. We've got to look  
 22 at this through the lens of multidisciplinary working,  
 23 and what you have just said, in some detail, has never  
 24 been exposed to a multidisciplinary discussion, has it?

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

27 131 Q. Oh?

28 A. Oh, sorry.

29 132 Q. With Dr. Mitchell, he sent you correspondence?

1 A. Hmm.

2 133 Q. You can't say whether you replied, you can't say  
3 whether you've read it. Fair enough.

4 A. Mm-hmm, mm-hmm.

5 134 Q. He sent you the guidelines in their development stages, 12:35  
6 and you had, I suppose, in your role as Chair of NICaN,  
7 you had access to the final draft. At no stage during  
8 that process does he recall you engaging with him in  
9 the theory that you've just expounded in support of  
10 Bicalutamide as opposed to LHRH and radical 12:36  
11 radiotherapy?

12 A. You describe it as "my theory", it's not my theory, I'm  
13 just reporting to you the evidence. It's not my  
14 theory, it's the evidence that has been published by,  
15 you know, the most eminent oncologists and urologists 12:36  
16 from around the world over the past, we'll say almost  
17 two decades now. So, you know, I would have been  
18 delighted to have engaged in that kind of discussion.  
19 I think that there -- there is an issue here as well,  
20 and that is, in any area of clinical practice, there is 12:37  
21 an issue with regard to taking the findings of even  
22 a randomised control trial, which is regarded as Level  
23 1 evidence, and applying it rigidly to each individual  
24 patient. It's almost like -- I've often thought about  
25 this. If it was the case that there was a comparison 12:37  
26 between being prescribed insulin 20 units twice a day  
27 for a newly diagnosed diabetic, as opposed to 10 units  
28 twice a day for a newly diagnosed diabetic, and 20mgs  
29 was found to be more effective in lowering blood sugar

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

12:38

8 135 Q. But the important point, sorry, just trying to bring  
9 this to a fairly concise close.

10 A. Mm-hmm.

12:38

11 136 Q. 50mgs of Bicalutamide has been said before this Inquiry  
12 not only to be unlicensed for the purposes for which  
13 you prescribed it, but also suboptimal or ineffective  
14 in delivering the conditions preparatory for  
15 oncological intervention in the form of radiotherapy.  
16 The goal should be castration as opposed to seeking to  
17 control the PSA. So the primary object should be to  
18 prepare the patient for the radiotherapy intervention.

12:39

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

12:40

12:40

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

14  
 15 Now, I do appreciate that that doesn't mean to say that 12:42  
 16 any of those doses are going to be still as effective  
 17 at six months or nine months as they were at three  
 18 months, but that's where Serum PSA comes into play.

19 137 Q. Can I bring you back to Dr. Mitchell's evidence, which  
 20 you heard? His evidence, in essence, was that he was 12:42  
 21 motivated to develop the Regional Guidelines, at least  
 22 in part, because of his observations around the use of  
 23 50mgs Bicalutamide?

24 A. Hmm.

25 138 Q. He saw it as a monotherapy. I know you say it wasn't 12:43  
 26 a monotherapy, or it certainly wasn't intended on  
 27 prescription to be a monotherapy, although sometimes it  
 28 developed into being a monotherapy.

29 A. Hmm.

1 139 Q. But his motivation was, in essence, directed in part,  
 2 or in substantial part, perhaps, at your practice. Did  
 3 you appreciate that?  
 4 A. No.

5 140 Q. When the guidelines were being discussed through NICaN 12:43  
 6 when they were sent to you in final version in October  
 7 2016, his evidence was that they didn't bring any  
 8 response or any reaction from you, apart from, rather  
 9 comically, for you to correct his spelling of the word  
 10 "licensed"? 12:43  
 11 A. That's right.

12 141 Q. But he had hoped that in bringing the guidelines  
 13 forward through the NICaN apparatus, that it might be  
 14 an opportunity for you to engage in a discussion about  
 15 your practice. That discussion didn't take place. You 12:44  
 16 didn't at any point ventilate your approach in what we  
 17 know to have been a significant number of cases --  
 18 obviously not your whole practice, but in a significant  
 19 number of cases -- the guidelines prospectively and  
 20 retrospectively wouldn't have been followed? 12:44  
 21 A. No, I didn't see it as an invitation at all, and I know  
 22 that the comment was made that when we discussed the  
 23 draft guidelines in January '16, that there was --

24 142 Q. '15.  
 25 A. Was it '15? 12:45

26 143 Q. '15, I believe. The minutes --  
 27 A. No, I think actually it was in January -- it was my  
 28 last meeting that I chaired at NICaN, and he had been  
 29 formulating those throughout the year '15. We came up



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

- 1 144 Q. Mm-hmm. Mm-hmm. Just to pull up the guidelines  
 2 briefly, we've been talking about them for long enough.  
 3 It's WIT-84427. And if we go to the bottom by way of  
 4 example? Just to the bottom. Thank you.
- 5 A. I think it's the third last -- it's the single 12:48  
 6 sentence. Is that what you are looking for? "The  
 7 cardiovascular and metabolic".
- 8 145 Q. Two points. So in order -- it refers to the usage of  
 9 50mgs of Bicalutamide in the context of preventing  
 10 testosterone flare, that's just about one-third of the 12:48  
 11 way down the page as it sits in front of you.
- 12 A. Hmm.
- 13 146 Q. Was that an opportunity for you to say "well, actually,  
 14 there's another use for 50mgs of Bicalutamide in my  
 15 experience and in my practice"? 12:48
- 16 A. I didn't see it as such. I just thought it's  
 17 a statement in order to prevent testosterone flare  
 18 anti-androgen cover with Bicalutamide 50mgs is given  
 19 for three weeks. And why is it given for three weeks?  
 20 You know, because of its oncological effect. I mean I 12:49  
 21 have read I think in the case of another patient that  
 22 we have discussed already, in the SCRR, that you know,  
 23 Dr. O'Kane, in writing to the patient, advised, you  
 24 know, that 50mgs has no clinical effect. But it does.
- 25 147 Q. Okay. well -- 12:49
- 26 A. But, anyhow, I didn't see it as an invitation,  
 27 Mr. Wolfe.
- 28 148 Q. Yes.
- 29 A. I would have happily responded to an invitation in that

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

5  
 6 "The anti -androgen Bical utami de 150mgs can be used as  
 7 neoadjuvant hormone therapy especi ally in men when  
 8 preservation of physical capaci ty or sexual functi on is  
 9 i mportant. "

12:50

10  
 11 And those two terms, "physical capacity" and "sexual  
 12 function", they are terms, you know, taken from the  
 13 work of Tyrrell and others, you know, where they found  
 14 that whilst Bicalutamide 150mgs daily was as effective  
 15 as castration for non-metastatic disease, it was better  
 16 -- a significantly higher proportion of men had enjoyed  
 17 a better quality of life through sexual function and  
 18 retained physical activity. So those words are an  
 19 expression of that delay between the published evidence  
 20 and the formulation of guidelines. It's not to  
 21 disparage them, but I just wanted to draw attention to  
 22 that.

12:50

12:50

12:51

23 149 Q. Yes. But the -- the core of the guidelines, the core  
 24 message for the prostate cancer with which we are  
 25 concerned, was 50mgs of Bicalutamide, moving to LHRA,  
 26 moving to EBRT. That wasn't a core message with which  
 27 you disagreed?

12:51

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

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

4 150 Q. Yes.

5 A. And if I had prescribed, for example, Bicalutamide 12:52  
 6 50mgs for a period of a month, or three weeks or  
 7 something, surrounding the initial dose of an LHRH  
 8 agonist, and he had gone off on his holiday and he  
 9 suffered a fatal miocardial infarction whilst being  
 10 there, he would never have been an SAI. But this is 12:52  
 11 the reality, you know. The reality is that there is an  
 12 abundance of evidence in support of -- since -- since  
 13 Nancy Keating in 2006 first drew evidence to the  
 14 significantly increased risk of sudden cardiac death,  
 15 and then from the same centre in Boston, the following 12:52  
 16 year, that there was -- that patients treated with an  
 17 LHRH agonist for periods of between 3 and 8 months had  
 18 a shorter time to fatal miocardial infarction. You  
 19 can't ignore this.

20 151 Q. Yes. 12:53

21 A. So...

22 152 Q. Can I put this back through the lens of the  
 23 multidisciplinary working. You cite Patient 1's case  
 24 as an example.

25 A. Hmm. Hmm. 12:53

26 153 Q. Others might legitimately take the view that your  
 27 concern about the cardiovascular history is overstated  
 28 in the setting of what was intended by the MDT  
 29 recommendation. Let's say there's a legitimate debate

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

2 A. Hmm.

3 154 Q. What Dr. Mitchell says, if we can bring it up on the  
4 screen, WIT-96667, and just scrolling down. Yes. So,  
5 what he says is that:

12:54

6  
7 "Normal practice would have been to prescribe a dose of  
8 Bicalutamide that was within the licensed indications  
9 or to refer to Oncology for discussion and allow the  
10 Oncology team to discuss the treatment options  
11 including the use of hormone therapies such as  
12 Bicalutamide."

12:54

13  
14 At no stage is it fair to say that, did you move from  
15 consulting with your patient, taking the view that I  
16 have to use Bicalutamide in the fashion described and,  
17 thereafter, seeking a view from Oncology about the  
18 appropriateness of the regime, or whether there would  
19 be a better way of treating the patient in preparation  
20 for radiotherapy?

12:54

21 A. In general or in --

22 155 Q. In general.

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

12:55

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

4 156 Q. But they would have to consent to that after receiving  
 5 a proper explanation. The concern, perhaps, here, is 12:56  
 6 that you are not best placed to discuss with them the  
 7 next step. That is ultimately an oncological view  
 8 which ought to be reflected through the MDT --

9 A. Yes. Mm-hmm.

10 157 Q. -- if you find that there's a difficulty in 12:56  
 11 progressing.

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

28  
 29 I think, actually, my approach to the whole thing has

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

19          MR. WOLFE KC: Yes. Sorry, we've just overshot the  
 20          clock with that answer. 12:59

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

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

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

29          A. I am.

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

2 CHAIR: Thank you.

3

4 THE INQUIRY ADJOURNED FOR LUNCH

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THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

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- CHAIR: Thank you, everyone.
- 158 Q. MR. WOLFE KC: Just in concluding on the guidelines issue, Mr. O'Brien. Did those guidelines in any way affect the way that you practised the medicine of prostate cancer management? 13:56
- A. Of course.
- 159 Q. In what particular ways?
- A. In every way. I mean, they are the guidelines. They are the accumulated recommendations for prostate cancer in its differing stages, the options, the benefits, the risks, do you know, they are -- I don't think any clinician should be practising at all without being cognisant of the guidelines and having the guidelines influence their management. But the guidelines -- you know, I've heard some people saying, you know, they require adherence, but, in fact, actually, the guidelines themselves are prefaced with the direction that they do not require adherence. If they required adherence, they wouldn't be called guidelines. 13:57
- 160 Q. You, I think, refer, within your -- I'm not sure if it was your first statement or your addendum statement, to the NICE advice in relation to guidelines where you say, if I can find it, that guidelines must be taken into account. 13:58
- A. Mm-hmm.
- 161 Q. But they are, in essence, not to stand in the way or replace the needs of the patient, where the patient's

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

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

9 162 Q. Thank you.

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

12 163 Q. Yes. The local MDT in the Southern Trust, where you  
 13 attended a meeting and the decision was to manage this  
 14 patient's prostate cancer in accordance with a regime  
 15 that would involve LHRHa agonist, Bicalutamide for 14:00  
 16 flare-up as a prep, moving into EBRT, and if, in  
 17 hearing that recommendation, you had concerns about its  
 18 applicability for the patient concerned, no doubt you  
 19 would articulate your concerns?

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

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

4 164 Q.    But sticking to the point I asked you. If you had  
 5           a concern, you would articulate it within the MDT? 14:01

6           A.    You would, yes. Yes.

7 165 Q.    Yes. We've received some evidence that, in terms of  
 8           your use of Bicalutamide, it was the subject of  
 9           "challenge" was the word initially recorded, or the  
 10          verb initially recorded against Dr. Glackin's name, 14:02  
 11          Mr. Glackin's name, in terms of the information he  
 12          supplied to Dr. Hughes and his team. In his evidence  
 13          before this Inquiry he said "well, he would have  
 14          discussed the appropriateness of Bicalutamide", in  
 15          a case he couldn't remember the name of. Mr. Suresh 14:02  
 16          gave evidence -- we're not sure whether it was the same  
 17          case or a different case -- whereby the unconventional  
 18          treatment, as he put it, was discussed and it -- the  
 19          consensus of the meeting, he said in his evidence, was  
 20          that the patient shouldn't be on it. What's your 14:03  
 21          understanding of the extent of the Southern Trust  
 22          Urology MDT's appreciation of your use of Bicalutamide?

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

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

17 166 Q. And just to be clear -- sorry to cut across you --  
 18 you're saying there was never any challenge?

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

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

12 167 Q. Well, that's the point I wish to turn to. If the tenor  
 13 of your evidence is that your practise or your approach  
 14 to this was not covert, and that must mean, on your  
 15 evidence, that your colleagues must have had an 14:07  
 16 awareness of it but didn't challenge you, to the best  
 17 of your recollection?

18 A. Hmm.

19 168 Q. Equally, you're saying you had no sense that your  
 20 colleagues were practising in the way that you were 14:07  
 21 practising with regards to Bicalutamide?

22 A. Hmm. Hmm.

23 169 Q. They, to your concern, perhaps hidden, were using LHRHa  
 24 when it was inappropriate to do so, or potentially  
 25 inappropriate to do so because of the cardiovascular 14:07  
 26 risks.

27 A. Mm-hmm.

28 170 Q. why did that debate never happen?

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

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

10 171 Q. Can I build this into your thoughts? 14:08  
 11 A. Hmm.

12 172 Q. Is it the case that the MDT continued to dispense  
 13 a recommendation consistent with the guidelines, you  
 14 took that away with you?  
 15 A. Hmm. 14:09

16 173 Q. Spoke to your patient.  
 17 A. Hmm.

18 174 Q. Didn't bring back your contravening view, and the MDT  
 19 was none the wiser as to your practise?  
 20 A. Well, because, in the vast majority of cases my 14:09  
 21 management of the patient, and the recommendation I put  
 22 to them, and the management pathway we embarked upon,  
 23 was entirely consistent with the MDM outcome.

24 175 Q. But not always?  
 25 A. But not always, yes. 14:09

26 176 Q. Yes. And it's -- in the absence of tracking, in the  
 27 absence of effective audit, in the absence, perhaps --  
 28 and we'll look at some of the cases later this  
 29 afternoon, of a key worker...

1 A. Hmm.

2 177 Q. None of this was within view. Is that fair?

3 A. Well, you know my views, and you've read my views on  
4 key workership. But leaving that aside, I think we're  
5 concentrating particularly on this issue of 14:10  
6 Bicalutamide. I mean, I would have quite significant  
7 concerns now, looking back, at the risks that people  
8 were being subjected to by the automatic presumed  
9 notion that ADT required the prescription of an LHRH  
10 agonist, for all of the reasons that are outlined in an 14:10  
11 abundance of literature.

12 178 Q. But you didn't challenge it?

13 A. I wasn't aware of it.

14 179 Q. In the sense that you've just described it a moment or  
15 two ago, that was your view of what your colleagues 14:11  
16 were continuing to blindly apply?

17 A. No, I wasn't so aware of it, that's the point I'm  
18 making. I wasn't aware of it.

19 180 Q. Well is this -- is what you're describing, in essence,  
20 multidisciplinary team working, where nobody knows, on 14:11  
21 either side of this debate, what the other side is  
22 doing?

23 A. To a large extent, yes. I think in retrospect that is  
24 the case. And I think that in -- yeah, I think that is  
25 the case. Do you have -- we never had a system whereby 14:11  
26 a check was made on the nature of the androgen  
27 deprivation therapy that was prescribed or initiated,  
28 and the reasons why and so forth, and that's why, as I  
29 said earlier, if we had had the capacity, been

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

11 181 Q. It's really a matter for responsible clinicians to  
 12 discover how patients are being managed as a result of  
 13 MDT decisions and where there are concerns, such as  
 14 a concern that you say that you legitimately held about  
 15 being unable to follow MDT decision or MDT 14:13  
 16 recommendations on a regular basis, to actually have  
 17 that discussion with your colleagues?

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



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

4 182 Q. Yes. One final point around this. We see in Patient  
 5 1's case and Patient 6's case, that the recommendation 14:14  
 6 common to each of those cases was that, in the -- in  
 7 the event of divergence from an MDT decision, it should  
 8 be properly documented?

9 A. Hmm.

10 183 Q. In other words, you would send out the reasons for the 14:15  
 11 approach that you're taking, what you've discussed with  
 12 your patient, and the reasons for the management plan,  
 13 if you consider it to have diverged, and you would  
 14 validate it with further MDM discussion. I think we've  
 15 had the debate about the practicality of further MDM 14:15  
 16 discussion earlier. When you reflect upon it, do you  
 17 think the quality of your note-keeping or recording of  
 18 your prostate cancer management decisions following  
 19 review of your patient after the MDT was all that it  
 20 should have been? 14:15

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

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

3  
 4 In the case of Patient 6, I need to be reminded of what  
 5 the MDM outcome was, because I do not instantly know in 14:16  
 6 what manner I diverged from it.

7 184 Q. The reference is DOH-00078. Hopefully, that might help  
 8 us. So I think the key feature of it was, and we  
 9 possibly don't have the material in front of us to --  
 10 if we go back to 77 I've been told with some optimism, 14:17  
 11 I think.

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

14 185 Q. Yes.

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

16 186 Q. That was the case where, I think it was Mr. Haynes was  
 17 the -- is that the case where Mr. Haynes was the  
 18 reviewer? It wasn't an MDM itself?

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

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

13 187 Q. I think your point is that you disagree with the  
 14          proposition that you diverged from the recommendations?

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

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

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

25 189 Q. And the point is, if you're taking the patient down 14:20  
 26          a route, which you think is appropriate or legitimate,  
 27          but if it departs from what your MDM, or the notional  
 28          MDM is telling you, then the recommendation here, the  
 29          criticism here, is that it's got to be adequately

1 recorded and invalidated by reference back to the MDM?

2 A. Well, as we have discussed earlier, I would have no  
3 difficulty in doing that whatsoever, and would have  
4 been robustly asserting that this patient should be  
5 offered the assessment and management of his lower 14:21  
6 urinary tract symptoms prior to referral for radical  
7 radiotherapy.

8 190 Q. But the point is, that didn't happen?

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

10 191 Q. Let me move to my next topic. It's an issue connected 14:21  
11 with Patient 139.

12 A. Mm-hmm.

13 192 Q. And I wish to explore with you whether you had any hand  
14 in inappropriately accessing that patient's records in  
15 order to advance an argument before this Inquiry? 14:21

16 A. Hmm.

17 193 Q. The context for this is as follows: Mr. Glackin was  
18 due before this Inquiry on 20th September?

19 A. Mm-hmm.

20 194 Q. And your legal team submitted questions to the Inquiry, 14:22  
21 entirely appropriately --

22 A. Mm-hmm.

23 195 Q. -- in order to be directed to Mr. Glackin, and one of  
24 those sets of questions involved enquiries into whether  
25 and why Mr. Glackin had continued a regime of low dose 14:22  
26 Bicalutamide --

27 A. Hmm.

28 196 Q. -- for that patient.

29 A. Hmm.

1 197 Q. On dates in 2016 and 2020.

2 A. Hmm.

3 198 Q. And in order to support the proposition that

4 Mr. Glackin was managing that patient, your legal team,

5 in September of last year, supplied a number of letters 14:22

6 --

7 A. Hmm.

8 199 Q. -- a number of pieces of correspondence which hadn't

9 been disclosed to the Inquiry.

10 A. Hmm. 14:23

11 200 Q. Save for a few days earlier when they were disclosed in

12 connection with questions that were also to be directed

13 to Dr. Mitchell?

14 A. Mm-hmm.

15 201 Q. In other words, this disclosure hadn't come with your 14:23

16 original disclosure?

17 A. Yes.

18 202 Q. It had come in September of last year.

19 A. Hmm.

20 203 Q. Can I show you the letters I'm referring to? 14:23

21 A. Mm-hmm.

22 204 Q. If we go to AOB-82836. And redacted. Dated 22nd

23 February, at least the time of the clinic is, and

24 Mr. Glackin is writing this and explaining what he's

25 doing, and in the context of Bicalutamide: 14:24

26

27 "If the result is stable, then he remains suitable for

28 continued Bicalutamide monotherapy."

29

1 So that's that letter. Then the next --

2 A. If you just scroll down?

3 205 Q. Yes.

4 A. Just to document, rather than having to come back to

5 it. Of course it's in the same scroll that the PSA was 14:24

6 1.02.

7 206 Q. Yes. Okay.

8 A. Yeah.

9 207 Q. Next page. Results have been -- sorry, he's writing to

10 you. He's writing to you. 14:24

11 A. Mm-hmm.

12 208 Q. Saying that he saw this patient and "with your kind

13 permission" he would take on the management of that

14 patient.

15 A. Hmm. 14:24

16 209 Q. And that's something I understand you agreed to?

17 A. Yes.

18 210 Q. So those pieces of correspondence are February and

19 March 2016. And then if we go over the page, we'll see

20 a letter 5th May 2020, and Mr. Glackin continues to be 14:25

21 responsible for the management of this patient, and the

22 upshot of this letter is that he's going to continue

23 him on Bicalutamide, and Mr. Glackin has given evidence

24 in relation to his thinking around that, which I don't

25 propose to engage you with. 14:25

26 A. Hmm.

27 211 Q. Now my question for you, Mr. O'Brien, is: how did you

28 come to be in possession of these three pieces of

29 correspondence?

1           A.    well --

2   212   Q.    In September of last year.

3           A.    well, in the first instance, the first two letters

4                   relating back to 2016, I was entirely happy with

5                   Mr. Glackin taking over the care of that patient, and           14:26

6                   if he had notified me that he was taking over the care

7                   of another ten I would have even been more delighted.

8                   The only reason I kept copies of the letter that he

9                   sent to me saying with my kind permission I would -- he

10                  would continue to care for the patient, and having           14:26

11                  received that letter, I had no memory of who the

12                  patient was, and when I looked back at the letter that

13                  accompanied it, or preceded it the month before,

14                  I noted that increase in his PSA level, and I was just

15                  concerned about that. That was -- within a year there           14:27

16                  was almost a 50% increase in his serum PSA level, which

17                  could have been entirely spurious. And I can't

18                  remember now whether I spoke to Mr. Glackin about it?

19                  I doubt if I did. I can't even remember, honestly,

20                  whether I intended to do it, but I just kept copies of           14:27

21                  those two letters in order to keep an eye on it,

22                  because when he said that his PSA level was

23                  satisfactory or stable, I just wondered if that was

24                  going to be the case. And then subsequently, at later

25                  dates, I can't remember the intervals now when           14:27

26                  I checked on it, that I was very pleased to see that it

27                  had reduced again. I think -- I can't remember whether

28                  it was somewhere in the region of what it had been the

29                  year before. And progressively did so. And then in --

1 when -- this is the last letter, yeah, in May 2020, you  
2 know, when I was updating my Oncology review waiting  
3 lists, and I had kept the two copies behind an old  
4 Oncology review waiting list, and I was naively looking  
5 forward to being able to clear off my Oncology review 14:28  
6 backlog on return in August '20, and I came across  
7 those and I thought "ah, I must check it again", and I  
8 had this printed off, and I put it with the other two  
9 and I forgot about it. And the only reason that  
10 I submitted these and raised this issue was not to 14:28  
11 undermine or impugn Mr. Glackin, because I entirely  
12 agreed with him that he should remain on it,  
13 particularly in view of that instability in his serum  
14 PSA level previously. My concern actually was, reading  
15 Mr. Haynes' letter, for a number of reasons; firstly, 14:29  
16 you know, it is legitimate after a period of ten years,  
17 when someone has evidently done so well, and you're in  
18 your 80s, to consider stopping the Bicalutamide, even  
19 though it has been my experience that intermittent  
20 androgen blockade is not all that it's cracked up to 14:29  
21 be. I don't think that you re-sensitise the prostate  
22 cancer, as has been hypothesised. I have frequently  
23 found that I haven't got the same response when  
24 I restarted the same treatment at some later date when  
25 PSA levels increased. But I was particularly concerned 14:30  
26 to find that -- I got the impression that maybe there  
27 was some resistance to this man coming off his hormonal  
28 treatment, and if that was to be the case, Mr. Haynes  
29 was offering castration, pharmacologically induced



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

4   213   Q.    Can I stop you there, Mr. O'Brien?  What you're now  
 5           answering is the -- is a quite different question.  I'm 14:30  
 6           not asking you about the reasoning?

7           A.    Oh, yes, okay.

8   214   Q.    -- for the questioning of Mr. Glackin or, indeed, your  
 9           concerns about Mr. Haynes' input.  I think you've  
 10          answered my question.  You've said with regards to the 14:31  
 11          first two letters --

12          A.    Hmm.

13   215   Q.    -- you retained them on a file and forgot about them.

14          A.    Hmm.

15   216   Q.    And then, four years later -- 14:31

16          A.    Mm-hmm.

17   217   Q.    -- or four years after you have come off the management  
 18          of this patient, it having been handed over to  
 19          Mr. Glackin, you decided to print off -- having checked  
 20          your waiting list, you decided to print off this letter 14:31  
 21          of May 2020.  You weren't responsible for that  
 22          patient's management in May 2020?

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





1 230 Q. Did you have any other patient records at your home?

2 A. No, just these. These were the charts of two patients  
 3 whom I had brought home with the intent that I would  
 4 compile reports pertaining to both of them. I can't  
 5 remember their names now. There were three that I had 14:35  
 6 to do in all, and I took two of them home, believing  
 7 that I would be able to do those during July '20. And  
 8 I had -- at that stage I had completely forgotten that  
 9 I had these three letters, and I hadn't really thought  
 10 of them again until I read the letter of Mr. Haynes 14:36  
 11 a short time prior to Dr. Mitchell coming along.

12 231 Q. So, just to be clear. In terms of what you had  
 13 retained after July 2020, it was only these three  
 14 letters?

15 A. Yes, that -- that was it, you know. I mean -- and in 14:36  
 16 any case, not that I considered it at the time because  
 17 I had sort of overlooked their being there, I still  
 18 actually had retained the waiting lists, and if you  
 19 remember I submitted to the Inquiry my five categories  
 20 of the urgent inpatients on the waiting list, but I had 14:36  
 21 completely overlooked the presence of those three,  
 22 because they were obscured because I had them behind an  
 23 old oncology review waiting list. I got a new one  
 24 about May or June, with the intent of validating it  
 25 from the old one, but I then turned my attention, in 14:37  
 26 June, to concentrating on making sure that all of the  
 27 urgent people who needed to be added to the urgent  
 28 bookable list for the inpatient were added. So it just  
 29 went out of my mind.

- 1 232 Q. So, in that sense, this instruction to your solicitor  
 2 was inaccurate; you had these three letters, you had  
 3 forgotten about them?
- 4 A. Yes. Yes.
- 5 233 Q. But if you had remembered them, they should have been 14:37  
 6 handed over in July 2020?
- 7 A. Yes. That's what I was about to say. But in fact,  
 8 actually, I would have assumed that all of these  
 9 records anyhow would have been disclosed to the  
 10 Inquiry, which is one of my grievances, in a sense, 14:38  
 11 that I don't have access to all of the records. But in  
 12 relation to your particular point --
- 13 234 Q. When did you discover them?
- 14 A. I remembered about them, actually -- I can't remember  
 15 the exact date upon which I read Mark Haynes' letter. 14:38  
 16 All I do know is, it was a short time before Darren  
 17 Mitchell and Mr. Glackin gave evidence, and the reason  
 18 for my disclosing them was not to disagree, or impugn,  
 19 or undermine Mr. Glackin; it was my concern with regard  
 20 to Mr. Haynes' proposed management, which I believe 14:38  
 21 should be, and it's just my belief, a governance  
 22 concern in its own right.
- 23 235 Q. In terms of your retention of the three letters which  
 24 I've brought to your attention, your solicitor is  
 25 writing to the Inquiry on 15th December last year, 14:39  
 26 explains that you were advising that you had retained  
 27 the letters of Patient 139 in a folder?
- 28 A. Hmm.
- 29 236 Q. -- which you kept for patients who were on your waiting

1 list.

2 A. Hmm.

3 237 Q. This patient was not on your waiting list and hadn't  
4 been on your waiting list since 2016, isn't that fair?

5 A. That is fair, but it was ineloquently put. You know, 14:39

6 I would have -- for example, if a patient was on my  
7 inpatient waiting list and I had suspended that  
8 patient, or I had referred that patient for  
9 cardiological assessment or some other issue, in order  
10 to avoid me having to look back to see why I haven't 14:40

11 dealt with that patient, I would often have printed off  
12 the letters that I wrote to a cardiologist, for  
13 example, and "Ah, that's the reminder", and catch up  
14 from there. And I would have placed those behind the  
15 previous old things. So he wasn't on my waiting list. 14:40

16 I have that old ring folder which I have had from the  
17 1990s, it used to be the folder that was referred to by  
18 Mr. Mackle for the people who need to be seen ASAP, and  
19 I would have had maybe eight or nine or ten Poly  
20 Pockets with all of the waiting lists in it, both up to 14:40

21 date and the previous one, waiting revalidation,  
22 working through them, and I did that for essentially  
23 inpatients' day cases, flexible cystectomies,  
24 urodynamics and oncology review clinics, because the  
25 other clinics I really didn't determine, or didn't 14:41  
26 appoint them, or didn't have any input into them.

27 238 Q. Yes. The Trust, through its legal advisers, has sent  
28 the Inquiry a narrative setting out the investigations  
29 that it has carried out in association with your former

1 secretary, Noleen Elliott.

2 A. Hmm.

3 239 Q. If I could just draw your attention to one point  
4 arising out of that. The narrative is to be found at  
5 TRU-320464. And if we scroll down to, I think it's 14:41  
6 paragraph 7 of it. Over the next page. Yes, thank  
7 you. And what they say they have discovered is that  
8 Mrs. Elliott, on both 29th January 2021 and 29th  
9 September 2021, accessed the records of Patient 139 and  
10 used the commands within the system to make a print 14:42  
11 request. It's our understanding that the Trust cannot  
12 say which particular documents associated with Patient  
13 139 were printed, but they have discovered that fact  
14 and have put that fact to her. Now, her explanation  
15 for it would appear to be that she was concerned that 14:43  
16 any error on her part as a secretary may have caused  
17 difficulty for this patient. She also gave an  
18 explanation which was that nobody had asked her to  
19 carry out this task, it wasn't done at anybody else's  
20 behest, and she hasn't shared the material with anyone 14:43  
21 else. Have you discussed that issue with her?

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

1 in recent months. So --

2 240 Q. Can you help us as to what precisely was her concern  
3 about her own behaviour that drove her to take this  
4 action in 2021, when, at that time, she was otherwise  
5 employed in another Directorate? 14:44

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

22 241 Q. Can I ask you this question directly, Mr. O'Brien: Did  
23 you ever engage with Mrs. Elliott to inappropriately  
24 access the medical records of Patient 139 in order to  
25 advance your cause before this Inquiry? 14:46

26 A. Absolutely not.

27 242 Q. Do you regard it simply as an unhelpful coincidence  
28 that the letters associated with Patient 139, which you  
29 have an interest in for the purposes of this Inquiry,



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

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

18   243   Q.   I want to move now to the subject of key worker.

19           A.   Hmm.

20   244   Q.   Which you, no doubt correctly, have explained in your 14:48  
 21          addendum witness statement is sometimes -- sometimes,  
 22          before this Inquiry, and mea culpa across this side of  
 23          the room, using the term "key worker" sometimes  
 24          interchangeably with CNS or Nurse specialist. So quite  
 25          often the Clinical Nurse Specialist, and more regularly 14:48  
 26          not the Clinical Nurse Specialist, is the key worker,  
 27          is appointed to be the key worker, isn't that right?

28           A.   Yes.

29   245   Q.   But it needn't always be so?

1 A. Hmm.

2 246 Q. Let me start my questions in relation to this area by  
3 reference to the operational policy for the MDT, which  
4 we can find at WIT-84545, at least with regards to key  
5 worker. And it's explained that:

14:49

6  
7 "The identification of the key worker will be the  
8 responsibility of the designated MDT core nurse  
9 member."

10 14:49

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

14 A. Hmm.

15 247 Q. It goes on to say that:

14:49

16  
17 "It is the joint responsibility of the MDT Clinical  
18 Lead and of the MDT Core Nurse Member to ensure that  
19 each urology cancer patient has an identified key  
20 worker and that this is documented in the agreed record  
21 of patient management."

14:50

22  
23 It goes on to say:

24  
25 "In the majority of cases, the key worker will be  
26 a Urology Clinical Nurse Specialist."

14:50

27  
28 Is it your understanding that this is the manner in  
29 which practice operated in the Southern Trust? In

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

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

15 248 Q. And in the time when you were Clinical Lead for the 14:51  
 16 MDT, did this approach apply?

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

23 249 Q. And when you were Clinical Lead, notwithstanding that  
 24 shortage of resources, how would you have sought to  
 25 discharge your duties with regards to the 14:52  
 26 identification of a key worker?

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

- 1 250 Q. In terms of the language of the policy, it seems to  
 2 suggests a joint responsibility to identify?
- 3 A. It's a joint responsibility to ensure that each urology  
 4 cancer patient has an identified key worker and it is  
 5 documented accordingly, but it is the core nurse member 14:53  
 6 whose job it is -- it's quite explicit, do you know,  
 7 it's the core nurse member's responsibility to appoint  
 8 a key worker.
- 9 251 Q. What is the joint responsibility?
- 10 A. I think the joint responsibility is -- the lead 14:53  
 11 clinician had a responsibility to ascertain to what  
 12 extent there was capacity for key workers to be  
 13 appointed by the core nurse member and in what way they  
 14 were appointed. And, frankly, in 2015/2016, it just  
 15 wasn't the capacity to have key workers appointed for 14:53  
 16 every newly diagnosed patient.
- 17 252 Q. And Mr. Glackin, am I right in saying, took over the  
 18 responsibility of MDT lead from you?
- 19 A. In January '17, that's right.
- 20 253 Q. And more resources came into the system in terms of 14:54  
 21 Clinical Nurse Specialists from around, I think I'm  
 22 right in saying, 2018.
- 23 A. Or even possibly before it. But irrespective of which  
 24 year it was, you've heard them detailing how they  
 25 actually were not Clinical Nurse Specialists with the 14:54  
 26 sole responsibility, or predominantly of being key  
 27 workers, that they had management roles, and their  
 28 capacity to be key workers was compromised for those  
 29 reasons.

1 254 Q. And, again, was there any change in your understanding  
 2 of how the Clinical Lead, Mr. Glackin, should have  
 3 discharged this joint responsibility?  
 4 A. No, because it wasn't -- it wasn't my business, as it  
 5 were, at that time, to be looking into how he was 14:55  
 6 discharging his responsibility.  
 7 255 Q. If you are the clinician with responsibility for  
 8 a patient, and if your interest is in ensuring that the  
 9 patient has all of the resources necessary to help them  
 10 through the care pathway -- 14:55  
 11 A. Hmm.  
 12 256 Q. -- would it be your responsibility to approach either  
 13 of these joint responsibility holders to challenge them  
 14 or to complain if a nurse had not been identified for  
 15 your patient? 14:55  
 16 A. It would have been. I mean I frequently requested  
 17 a key worker and a holistic needs assessment. I worked  
 18 with Clinical Nurse Specialists. I do understand where  
 19 you're coming from. If I had had an awareness that key  
 20 workers were not appointed to my patients, what did 14:56  
 21 I do about it? I think, actually, having listened to  
 22 all of the evidence given, I think that there has been  
 23 a conflation between the establishment or the  
 24 allocation of a key worker to each newly diagnosed  
 25 cancer patient, with the overriding priorities, is my 14:56  
 26 understanding, and I think it's backed up by the  
 27 literature regarding key workership, to undertake  
 28 a holistic needs assessment and to make sure that they  
 29 have a contact number. I think there has been

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

4 257 Q. I must say, I'm not sure I'm following what you've just  
 5 said in terms of a conflation. Can you maybe 14:57  
 6 illustrate it by, if we -- I think if I'm right, if we  
 7 move down the page we can see some of the  
 8 responsibilities - if we stop there - for the key  
 9 worker, which includes -- yeah. It includes at the  
 10 second bullet point: 14:57

11  
 12 "The key worker should be present when the cancer  
 13 diagnosis is discussed and any other key points in the  
 14 patients journey."

15  
 16 Two bullet points below that: 14:58

17  
 18 "Ensure continuity of care along the patients pathway  
 19 and that all relevant plans are communicated to all  
 20 members of the MDT." 14:58

21  
 22 Clearly, significant responsibilities, and it would be  
 23 unusual, would it, for a patient not to want access to  
 24 a key worker, whether or not -- particularly a male,  
 25 perhaps an elderly male, as I think you have alluded 14:58  
 26 to, may not want a female nurse present during  
 27 examinations. But leaving that aside, was it your  
 28 general experience that the nursing input in the form  
 29 of a key worker, and the responsibilities that go with

1           that, was to be welcomed?

2           A.    It was to be welcomed, but I was going to add earlier

3           that, on Fridays, it just wasn't available.

4   258   Q.    Yes.

5           A.    I mean, you've listened to the various mitigating 14:59

6           circumstances that pertained, particularly on a Friday.

7           Kate O'Neill didn't work on a Friday. Leanne McCourt

8           was off doing her prescribing course, I think, on

9           Fridays. And not infrequently, you know, gratitude and

10          appreciation was extended to me for being able to 14:59

11          manage on my own because of the lack of availability of

12          Clinical Nurse Specialists. And as I said in my

13          addendum, you know, I've never had, apart from the

14          Leanne McCourt, what's a key worker incident, I've

15          never had a nurse of any standing come to my door, come 15:00

16          to my clinic and say: "I'm your Clinical Nurse

17          Specialist for this clinic today and I'll be this --

18          the patient's key worker". It just never happened.

19   259   Q.    Yes. Yes. But that isn't necessarily the end of the

20          story, if the nurse isn't -- if the nurse, in the form 15:00

21          of a key worker, isn't available?

22          A.    Mm-hmm.

23   260   Q.    But we'll come to that in a moment. Let me just touch

24          upon the SAI findings. If we go to the overarching

25          report at DOH-00124, it's the fourth bullet point. So 15:00

26          it says:

27

28          "Safe cancer patient care and pathway tracking is

29          usually delivered by a three-pronged approach of MDT

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

8  
9 It goes to say:

10  
11 "The MDM tracking system was limited." 15:01  
12

13 which is, broadly speaking, another point.

14  
15 So, if the key worker isn't available at the time of, 15:01  
16 for example, a review appointment giving the bad news  
17 of cancer diagnosis, there are other options to bring  
18 that contact between patient and key worker together,  
19 and the tenor of the evidence has been that that  
20 responsibility should fall or does fall on the 15:02  
21 clinician providing the information to the patient,  
22 providing the diagnosis, and then you go on to tell the  
23 patient about the availability of the key worker, and  
24 if he or she isn't in the room, or isn't in the  
25 corridor, or isn't available, you give the contact 15:02  
26 details. Is that something you were unaware of?

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



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

13 261 Q.    You do agree, factually, that none of these 9 patients  
 14           had a key worker appointed?

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

21 262 Q.    That was a referral -- we obviously have the e-mail for  
 22           -- it was in March 2020.

23           A.    Hmm.

24 263 Q.    But that was when the patient had reached the  
 25           palliative care stage. The patient had been diagnosed 15:04  
 26           with Gleason 5+5 prostatic cancer in June 2019. But  
 27           you're inviting the key worker's involvement for  
 28           palliative purposes nine months later?

29           A.    Mm-hmm.

1 264 Q. The key worker should have been involved nine months  
 2 earlier?  
 3 A. Absolutely.  
 4 265 Q. In a sense, the 9 patients that we and Dr. Hughes  
 5 looked at, was a randomised sample from the perspective 15:04  
 6 of the involvement of the key worker. These cases  
 7 didn't arrive at the threshold of an SAI because of the  
 8 absence of a key worker. There were issues about the  
 9 care pathway, and diagnostics, and referral, but the  
 10 key worker aspect was common to them all. And if we go 15:05  
 11 on in this document to page 0126, I think two pages on,  
 12 we can see the -- just scroll down -- yes, the bullet  
 13 point at the bottom, it says:  
 14  
 15 "The Review Team considered if this..." 15:05  
 16  
 17 - non-involvement of key workers:  
 18  
 19 "...was endemic within the multidisciplinary team and  
 20 concluded that it was not. Patients booked under other 15:06  
 21 consultant urologists had access to a specialist nurse  
 22 to assist them with their cancer journey."  
 23  
 24 Can you locate any explanation as to why that might be  
 25 so? 15:06  
 26 A. No, I asked the question: Why -- why were my patients  
 27 deprived of a key worker? And I -- I -- I know you  
 28 made reference a year ago and more when all of this was  
 29 being considered. I mean, I knew what key workership

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

9  
10 Like, quite frankly and candidly, if you take a patient 15:07  
11 like Patient 1, whom I reviewed at Southwest Acute  
12 Hospital, I ask myself the question: why is it that  
13 this man did not have a key worker appointed, even when  
14 actually he had occasion to speak to one of the  
15 Clinical Nurse Specialists, as is evidenced from his 15:07  
16 own diary? And I do wonder whether the Clinical Nurse  
17 Specialist had a clear understanding of the basic  
18 obligations of key workership.

19  
20 Now, I have tried in my addendum to blend that 15:07  
21 reasonably and proportionately with the inadequacy of  
22 the CNS resource as well, and whether the likes of  
23 myself doing my Oncology review backlog on a Friday was  
24 a circumstance that led my patients to be foul of that  
25 provision. 15:08

26  
27 But I just take the opportunity, in the case of Patient  
28 1. There was no reason, in my view, why Patient 1,  
29 just because he came from Enniskillen and just because

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

5 266 Q. Yes. Could I bring you to PAT-001353? And this is 15:08  
 6 correspondence which the Inquiry received on behalf of  
 7 the family of Patient 1. And they chart through this,  
 8 it's a response, actually, to the questionnaire which  
 9 the Inquiry formulated for use by patients. And they  
 10 chronicled Patient 1's various interactions, and they 15:09  
 11 record that on 4th July they met with Mr. Haynes --  
 12 sorry 14th July, they met with Mr. Haynes. You had  
 13 obviously had involvement with Patient 1 since the,  
 14 I think the late summer of the previous year, and it  
 15 would appear that it was only with the involvement of 15:10  
 16 Mr. Haynes that a cancer nurse specialist became  
 17 available to the family?

18 A. Mm-hmm.

19 267 Q. All those months had passed. Patient 1 didn't have the 15:10  
 20 services of a cancer nurse specialist, and as it  
 21 records here:

22  
 23 "A cancer nurse specialist was present who indicated  
 24 her surprise that..."

25  
 26 - sorry, I shouldn't say the name: 15:10

27  
 28 "That Patient 1 had never been allocated to a cancer  
 29 nurse specialist from the outset. They explained that,

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

4  
5 Is that not telling, Mr. O'Brien, that when another 15:11  
6 consultant becomes involved, the Cancer Nurse  
7 Specialist receives an opportunity to connect with the  
8 family, when, during all of the months of your  
9 involvement, they don't appear to feel that they have  
10 that resource? Conscious that Patient 1 made contact 15:11  
11 on telephone with a nurse on one occasion, and that's  
12 recorded in his diary. But does this scenario suggest  
13 that you were failing in your responsibilities to  
14 connect a patient to a key worker?

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

- 1 by Dr. Hughes.
- 2 268 Q. Hmm. We also see in the evidence from your colleagues,  
 3 an ability to connect the patients with the key worker,  
 4 whether that was ensuring that a nurse was going to be  
 5 in the vicinity when the review was happening, or be 15:13  
 6 that in terms of, I think it was Mr. -- I'll not say  
 7 because I can't remember -- but certainly evidence that  
 8 the simple delivery of contact details to the patient,  
 9 which, in Mrs. Trouton's evidence were readily  
 10 available in the consultation room, in front of you, 15:14  
 11 but it wouldn't appear that you felt any obligation to  
 12 do that, is that --
- 13 A. No, they weren't in front of me, they were in  
 14 a cupboard that we had access to for all of those  
 15 Prostate Cancer UK things and generic information and 15:14  
 16 so forth. Yes, I do repeat, and I feel, frankly,  
 17 aggrieved on behalf of all of those patients. I mean I  
 18 was as taken aback as anybody, surprised, that these  
 19 people hadn't been allocated a key worker. I think  
 20 that the experience of Patient 1 and his family is 15:14  
 21 something that could have been avoided if there had  
 22 been a key worker appointed. I know whose  
 23 responsibility it was to allocate the key worker.
- 24 269 Q. I know, Mr. O'Brien, that you and your colleagues are  
 25 extremely busy professionals. 15:15
- 26 A. Hmm.
- 27 270 Q. You've had opportunity to explain that in your  
 28 evidence. But here we have nine out of nine misses.
- 29 A. Mm-hmm.

1 271 Q. Nine out of nine cases where we don't have a key worker  
 2 in place?

3 A. Hmm.

4 272 Q. Does that, if you like, fly completely below your radar  
 5 so that you are not in any way aware that the 15:15  
 6 connection between key worker and patient has not  
 7 occurred?

8 A. Yes, that is the case. When I look at these patients,  
 9 particularly Patient 1, Patient 4, and Patient 9,  
 10 people who particularly needed to have holistic needs 15:16  
 11 assessment and support provided to them along a pathway  
 12 during which time their clinical status significantly  
 13 changed, and particularly when, in the case of Patient  
 14 1, he has been in contact with those Clinical Nurse  
 15 Specialists on two occasions, never mind actually 15:16  
 16 having his biopsies performed by Mrs. O'Neill in the  
 17 first instance, not that I expect that that  
 18 precipitates key workership, but I just do think that  
 19 as I've explained in that addendum, I don't -- I think  
 20 Mrs. O'Neill certainly had an appreciation of what was 15:16  
 21 basically required from key workership; I'm not quite  
 22 sure that the same was shared by Leanne McCourt. And I  
 23 can understand in some way that you find it difficult  
 24 to appreciate how could I not have appreciated all of  
 25 that? But, nevertheless, it wasn't my responsibility, 15:17  
 26 and I simply cannot understand how it is the case that  
 27 Clinical Nurse Specialists, having been contacted by  
 28 a patient requiring help and advice and so forth, it  
 29 couldn't have triggered that in fact, has a key worker

1           been appointed and perhaps I'll be the key worker for  
 2           this patient? I don't understand why they didn't have  
 3           a directory of all of the newly diagnosed patients.  
 4           And should it be a week later, or two weeks later after  
 5           a bad news review, that they didn't take it upon           15:17  
 6           themselves to ensure that these people had been  
 7           contacted by them in their key worker role.

8   273   Q.   Let me move you forward to the -- I'm not sure whether  
 9           it's forward or back at this stage -- but it's your  
 10          concern that, in June 2020, what we've referred to as           15:18  
 11          the two out of ten issue arose; in other words, the  
 12          Trusts, through Mr. Haynes, became concerned, on his  
 13          evidence, that two of your patients had not been  
 14          properly administered through the PAS system, and that  
 15          was an irregularity that, in his view, could give rise           15:18  
 16          to a risk that patients would be -- would be lost. And  
 17          as you know, that was to trigger other investigations,  
 18          including the informal lookback, and ultimately an  
 19          Early Alert to the Department. You have expressed your  
 20          view variously, but you've said, for example, at           15:19  
 21          WIT-82405, your first witness statement, at paragraph  
 22          19, you say:

23  
 24          "It appears that the very trigger for a lookback  
 25          exercise of all of my patients to January 2019 was the           15:19  
 26          totally untrue assertions in this letter about two  
 27          patients who had been placed on the inpatient waiting  
 28          list on PAS in the ordinary way and which any competent  
 29          and impartial consideration of the medical records and



1 correspondence held by the Trust would have revealed."

2  
 3 Sometimes, in expressing that, and you express it  
 4 variously, as I've said, instead of using the word  
 5 "untrue" you've used the word "incorrect" - another 15:20  
 6 synonym might be "inaccurate". I'm asking you this,  
 7 Mr. O'Brien, are you suggesting that Mr. Haynes or  
 8 anyone else is guilty of some form of bad faith, or  
 9 ulterior motive, in how they've dealt with this issue?  
 10 Or are you more of the view that it's likely to have 15:20  
 11 been a careless, perhaps a very careless mistake on the  
 12 part of Mr. Haynes, but not an untrue or a dishonest  
 13 one?

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

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

5 274 Q. As you point out, this was to be the trigger for other 15:22  
 6 investigations, including the lookback into an SCRR  
 7 process into a Royal College review. Would you accept  
 8 the proposition that even if the initial concern was  
 9 unfounded, it was entirely valid for the Trust, and  
 10 those that they retained, such as the Royal College, to 15:23  
 11 follow their noses and to enquire into other aspects of  
 12 your practice, even though the initial premise may not  
 13 have been well-founded?

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

29 275 Q. Can I bring you then to the issue of your retirement,

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

5 A. That's right. 15:25

6 276 Q. You would rather frame it as your intention to retire  
 7 from full-time employment had been notified with effect  
 8 from 30th June, with the intention of returning on  
 9 a part-time basis, but you were essentially forced to  
 10 leave your employment and that wasn't of your choosing, 15:25  
 11 so it can't be considered retirement. It is the case  
 12 that the Trust did not accept the validity of your  
 13 withdrawal of your intention to retire, and it is the  
 14 case that you didn't challenge that before the courts,  
 15 as was sometimes suggested in correspondence? 15:26

16 A. Mm-hmm.

17 277 Q. And it is the case that you are in receipt of  
 18 retirement benefits?

19 A. Mm-hmm.

20 278 Q. And it's further the case that you have been restricted 15:26  
 21 from medical practise by the General Medical Council?

22 A. Mm-hmm.

23 279 Q. In your contesting of the Trust's approach to you in  
 24 June 2020, you wrote to the Chief Executive of the  
 25 Trust, Mr. Devlin, amongst others, and you also wrote 15:26  
 26 to Mrs. Brownlee in her capacity as Chair of the  
 27 Southern Trust Board?

28 A. Mm-hmm.

29 280 Q. You were writing to her -- and the letter is to be

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

6 A. Yes.

7 281 Q. why did you consider it appropriate to draw, what is in  
 8 essence an employment issue, to the Trust Board, when,  
 9 generally, matters of an operational nature are not the  
 10 responsibility of a Trust Board? 15:28

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

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

17 A. Yes.

18 283 Q. Obviously we don't need to retrace the steps of your  
 19 relationship as a friend and an associate of  
 20 Mrs. Brownlee? 15:28

21 A. Mm-hmm.

22 284 Q. But was any of your contact with her at that time  
 23 designed to use an opportunity, not available to  
 24 others, an opportunity granted through your friendship,  
 25 to advocate on your behalf? 15:29

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

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

10 285 Q.   Just for the record, the letter sent to Mrs. Brownlee, 15:30  
 11           to communicate with the Trust Board, is to be found at  
 12           WIT-90953.

13  
 14           Just finally, Mr. O'Brien, at WIT-82655, at paragraph  
 15           711, towards the end of your original witness 15:30  
 16           statement, you describe, by way, I suppose, of  
 17           a reflection, that:

18  
 19           "There was an abject failure by the Trust throughout  
 20           your tenure to engage in a constructive manner and 15:31  
 21           provide adequate support, management and resources to  
 22           deal with the inadequate service clinicians could  
 23           provide to patients. The statistics speak for  
 24           themselves. The failure to engage left me stretched  
 25           throughout my tenure, having to prioritise, as best 15:31  
 26           I could, to deliver a service to patients. However,  
 27           that inevitably led to issues occurring in my  
 28           practice."  
 29

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

5  
6 Could I put, finally, the Trust's perspective in this.

7  
8 We've observed over the past number of days areas of  
9 practice where you felt unable, and you've given your  
10 explanations, to comply with what the Trust expected 15:32  
11 from you, DARO, an example of pre-op assessments,  
12 behaviours within the MDT, cystectomy, results, all of  
13 these issues are drawn together to suggest that, while  
14 the governance system may have been far from adequate,  
15 you, nevertheless, had a personal, individual and 15:32  
16 professional responsibility to conduct your practice in  
17 a more orderly and more compliant fashion, and  
18 Mrs. O'Kane has said that you have a tendency to blame  
19 others, particularly managers, rather than accept any  
20 responsibility for your actions and their impact on 15:33  
21 patient care, suggesting a lack of insight. She says  
22 you didn't appear to express any concern or remorse  
23 that patients had come to harm, or be concerned about  
24 the impact of your actions, and she says that at  
25 paragraph 55.37 of her witness statement. 15:33

26  
27 Has she got you right, Mr. O'Brien, that you have  
28 a tendency to point the finger without taking  
29 responsibility for your own actions?

- 1 A. Not at all. And I don't know how someone whom I've  
 2 never met could take upon herself to do  
 3 a psychoanalysis, which I felt was particularly  
 4 inappropriate. I think, you know, if you're inviting  
 5 me to reflect? 15:34
- 6 286 Q. Of course, it's my last question. I wouldn't invite  
 7 you to take all afternoon, because I think we're  
 8 heading into a break.
- 9 A. Yes. Yes.
- 10 287 Q. And maybe your response just now is adequate. But, 15:34  
 11 certainly, if you wish to respond further to her  
 12 reflection, be my guest.
- 13 A. I read her two or three-page psychoanalysis of mine,  
 14 and I think frankly I would prefer not to comment on it  
 15 at all because I thought it was quite inappropriate. 15:34  
 16 I think that's the most generous thing I could say  
 17 about it. I think, actually, with regard to her  
 18 introductory paragraph that I lacked insight, I think  
 19 sometimes I have had insights that a lot of people  
 20 would prefer that I didn't have at all, never mind 15:35  
 21 express them. I am not lacking in insight, I'm an  
 22 insightful person, but I've had 28 years of insights  
 23 into the Southern Trust and its predecessor, and, you  
 24 know, I go back to the core issues, and the core issues  
 25 for me were, a grossly inadequate service, and I think 15:35  
 26 there's no debate about that whatsoever. You know, the  
 27 sort of contained professional personal practice in  
 28 a square box, and whether you look over the wall and  
 29 concern yourself with the risks of patients coming to

1 harm, and the suffering of patients waiting for years  
 2 to be admitted for urgent surgery, never mind routine  
 3 surgery, and the inability, and it is -- has to be  
 4 acknowledged, there was an inability resource-wise for  
 5 the Trust or, indeed, the Commissioner and the 15:36  
 6 Department collectively to turn around and address all  
 7 of that. So -- and I couple that with -- I was going  
 8 to ask you, you referred to it briefly yesterday, but  
 9 if you would indulge me just momentarily with, if  
 10 I could ask for AOB-00308, and it's where I went to 15:36  
 11 facilitation I think back in 2011 or 2012, and I was  
 12 asking there for adequate time to undertake -- so if  
 13 you would go on to the next page, possibly? So just  
 14 before you do, go back up again. So, basically,  
 15 I would just say inadequate time for administration 15:37  
 16 relating to direct patient care, and I have listed  
 17 those in general terms. And if you go over the page,  
 18 and I was talking about review of waiting lists is  
 19 about waiting lists management, and to be -- to be  
 20 candid, you know, the Trust hasn't managed waiting 15:37  
 21 lists since 2013, apart from validation exercises,  
 22 dealing with all of the enquiries, at that time 40  
 23 queries per day, still my secretary selecting the 3 or  
 24 5 that most needed to be done. And skipping on down.  
 25 This is, you know, what I was mindful of since I came 15:37  
 26 here on wednesday:

27  
 28 "It has recently been proposed that all laboratory  
 29 results and radiological and pathological reports



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

3  
4           And so forth and so forth.

5  
6           Now:

7  
8           "This clearly is a major issue for clinical governance.  
9           I believe that this is currently conducted on an ad hoc  
10          basis only. "

11  
12          That's when time was available.

13  
14          "...and that it will require a significant consumption  
15          of administrative time if it is to be done completely. "

16  
17          Just scroll up briefly. And I think going on down to  
18          the next page, I think that I had endeavoured to  
19          quantify -- keep going -- all of the administration  
20          times that were required, and this is it, where  
21          I reckoned, you know, at that time, and this was  
22          minimalist, that, you know, two hours, one hour, one  
23          hour, dictation two hours, MDT, Thorndale, results, and  
24          reports to be quantified. So, here, you had seven or  
25          eight hours then in 2011, and with results and reports  
26          to be quantified. So I was asking for maybe eight to  
27          ten hours of administrative time and, in fact, the  
28          response was that your administrative time was being  
29          reduced. And, penultimately, I coupled that with Mark

1 Haynes' quantification of administration time required  
 2 at 15.25 hours per week, and that's excluding AMD  
 3 associated activity. And since this -- one year after  
 4 this-- six months after this, the largest amount of  
 5 administrative time I was allocated on any proposed job 15:39  
 6 plan was 0.8 PAs, which is about three hours.

7 288 Q. We're in danger, Mr. O'Brien, of overstepping the mark  
 8 in answer to my question. I asked for a brief  
 9 reflection.

10 A. Yes. So -- 15:39

11 289 Q. We have had this evidence last year.

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

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

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

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

3

4 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

5

15:47

6 CHAIR: Thank you, everyone.

7

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

10

16:04

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

14 290 Q. MR. HANBURY: Thank you very much for your evidence,  
15 it's been very interesting. Just I've got a few  
16 questions, mainly clinical, and hopefully we can rattle  
17 through them fairly quickly.

16:04

18

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

16:04

16:05

- 1 A. Well, I didn't -- I wasn't involved in bringing it to  
2 a Clinical Director at all. I don't know if Mark did  
3 include a Clinical Director, or bring it forward to  
4 a Clinical Director, and the Clinical Director at that  
5 time in 2018 may have been Mr. McNaboe I think, and of 16:05  
6 course Mark was the Associate Medical Director at that  
7 time, so really he should have been, you know, taking  
8 it, if it was going to be worthwhile, to the Medical  
9 Director or to the Chief Executive. I think the most  
10 pertinent question that Mr. Wolfe asked in relation to 16:06  
11 that in recent days was, you know, was it brought to  
12 the Health and Social Care Board? Was there any  
13 interaction there? Because I don't know the answer to  
14 that. I doubt if it was. And, you know, from the  
15 history of our trying to do so, I'm not quite sure how 16:06  
16 much impact it would have made even if we had done all  
17 of that.
- 18 291 Q. I suppose you could have gone up to the Medical  
19 Director and that might have made a difference before  
20 health -- okay. So moving on. And also about the long 16:06  
21 waiting lists, we've heard a lot about that. By 2018  
22 was realisation in the urological community that big  
23 benign prostates, certainly over about 80cc, were best  
24 and more safely managed by laser ablation, so called  
25 HoLEP, and I realise that that wasn't going yet in 16:07  
26 Northern Ireland, but did you -- you obviously knew  
27 that. Could you not have used that as an opportunity  
28 to actually send a few dozen cases away? It would have  
29 helped your waiting list and helped the patients

1 actually?

2 A. well we didn't collectively do that. why we didn't do  
3 that, I don't know. I think -- I'm not quite sure how  
4 -- the answer is I don't know. I'm not quite sure how  
5 much HOLEP for benign pathology, or a procedure for 16:07  
6 benign pathology would have been so accommodated, maybe  
7 they would sending them to Oxford or Cambridge to  
8 Mr. Tao or whatever. I mean I went --

9 292 Q. There were a few centres --

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

17 293 Q. which is my point entirely, and we did that - because  
18 we specialise in robotics, and many departments did  
19 cross-refer, and we've heard from the Commissioner that  
20 that would have been available had you pushed it. So 16:08  
21 we've heard about the pre-op assessment and those two  
22 tragic cases that died in the early post-operative  
23 period, and it's a terrible thing to happen to  
24 a surgeon, and obviously when you look back, and  
25 I think you reflected on wednesday that, on reflection, 16:08  
26 you should have -- or may have considered postponing  
27 the case, and the haematological aspect with a  
28 myelodysplasia case. I suppose my question is that  
29 there is a another step after pre-op assessment, and

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

5 A. I think actually -- 16:09

6 294 Q. why did we let that through? when in retrospect, as  
 7 the MSU --

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

- 1 295 Q. I suppose what we want to hear, in governance terms, is  
2 that there is a more robust process, and are you asking  
3 everyone in theatre whether anyone has got any concerns  
4 about -- sort of flattening the hierarchy, which we've  
5 found has been a big factor -- 16:11
- 6 A. Well, we would have done that. We would have checked  
7 everything.
- 8 296 Q. Yes.
- 9 A. Gone through everything. And, yet, in the best of  
10 systems, things can escape. 16:11
- 11 297 Q. Okay. Thank you. Just one question on the MDT  
12 quoracy, and we've heard that a lot, and it's just  
13 again a question you raised it, the Peer Review raised  
14 it, it was -- it was a big patient safety thing.  
15 I would argue that you haven't got radiologist, 16:11  
16 prostate MRIs are difficult to read, as well as renal  
17 matters and the rest of it, not to go over that. But  
18 when you got nowhere, and the Cancer Services didn't  
19 seem to have a solution, and the Medical Director  
20 didn't seem to have a solution, why actually didn't you 16:11  
21 stop? I know you threatened it, but actually if you  
22 had stopped, it would have -- even just temporarily --
- 23 A. It would have brought it to a head. Perhaps. And even  
24 if it had brought it to a head, was there definitely  
25 going to be a solution? Because even though I have 16:12  
26 raised these matters with everyone, I was raising them  
27 with people who had several responsibilities like  
28 running a Radiology Department, and I actually went  
29 along and spoke to these people quite frankly about the

- 1 importance of this, but they had other importances to  
2 attend to as well, and it's very, very difficult.
- 3 298 Q. Which is fine, and you asked nicely, but you didn't get  
4 anywhere.
- 5 A. Didn't get anywhere. 16:12
- 6 299 Q. That's not a criticism on that.
- 7 A. But, no, I might have got a little bit for a while and  
8 then it disappeared again.
- 9 300 Q. Yes. You need to go up the food chain.
- 10 A. And I went to the Medical Director and specifically 16:12  
11 spoke about it, and he went to the Department and got  
12 some improvement, but it wasn't sustained.
- 13 301 Q. Okay. Thank you. Just one thing on the penile cancer  
14 case, and we've discussed this a lot, but when we  
15 started super-specialising penile cancer, there was 16:13  
16 a clause in the IOG requirements that if the patient  
17 couldn't or wouldn't travel, and you've determined that  
18 was a problem, then you could run the case through  
19 a specialist MDT, which you could do remotely then, and  
20 we were in early days of Zoom and things. I guess -- 16:13  
21 and that would mean that someone in a more remote  
22 setting from a specialist centre, as you are in  
23 Northern Ireland, could actually get a specialist  
24 centre's blessing for your proposed plan, and then if  
25 something happened you could maybe step up a gear. Did 16:13  
26 you do that or did you --
- 27 A. We didn't do that. We didn't do that for any of our  
28 penile cancer cases prior to Northern Ireland having  
29 its own centre, and in a sense, actually, I happen to



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

4 302 Q. Yes:  
 5 A. Like I mean I have spoken to him about that case since. 16:14

6 303 Q. Yes.  
 7 A. So when I learned since that he had been appointed --  
 8 there were two of them in that network, and one has  
 9 left and he's there, and it would have been possible.  
 10 But, no, we didn't do. And should we have thought 16:14  
 11 about doing it? Possibly. But, you know, we didn't do  
 12 it.

13 304 Q. Yes. Well what we found actually -- we sent the  
 14 younger patients, who are much more prepared to move,  
 15 and the very old ones we could do with backup. So that 16:14  
 16 has helped a lot of units. Bicalutamide. Again, I  
 17 don't want to take you through all that, we've heard a  
 18 lot about it. Just one question on that. The Inquiry  
 19 are aware of two cases where you appear to prescribe it  
 20 for benign prostatic enlargement? 16:15

21 A. Yes.

22 305 Q. Just to explain that?  
 23 A. Well over a period of we'll say 28 years I think I've  
 24 thought about this, I can remember two patients before  
 25 this in recent days, unusual case arose without 16:15  
 26 a letter being generated. So I think in about 3 or 4  
 27 cases in my 28 years, if I found a patient who was very  
 28 comorbid and typically had an indwelling catheter and  
 29 was very bothered by it, and really wanted to try

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

7 306 Q. I hear what you're saying, but we do have a drug called  
 8 Finasteride --

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

10 307 Q. In addition to. 16:16

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

21 308 Q. Okay. So moving on, on to the thorny issues of CNSs.  
 22 I mean, we're of the same era, and it was a great  
 23 triumph when we got our first CNS and then, like  
 24 yourself, it takes a while to recruit more. So it's  
 25 a source of pride, I would suggest to you, for 16:17  
 26 a department to have a few?

27 A. Hmm.

28 309 Q. And so that's why it sort of doesn't ring true about  
 29 you not saying -- new cancer, and we may not have

1 a specialist nurse today because it's Friday, and it  
 2 doesn't work with scheduling, and sort of big up the  
 3 service and make sure it happens, I mean it's the sort  
 4 of personal responsibility -- and Dr. Hughes, I know,  
 5 wrote about that. But I was surprised that in a way it 16:17  
 6 was a source of pride that you had been driving that  
 7 for many years, but then where did the push go?

8 A. To have more?

9 310 Q. No, for you to make sure that the contact was  
 10 established with the patient? 16:17

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

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

2 311 Q. All right. Well, we've sort of covered that ground  
3 already, I know.

4 A. Hmm.

5 312 Q. Sort of moving back in time to IV fluids and 16:19  
6 antibiotics, and that was an interesting thing, because  
7 I've got, like you, a bit of interest in urinary tract  
8 infections and the success of recent vaccine therapies,  
9 and there are other ones too, and they're obviously  
10 a problematic group, and every Department of Urology 16:19  
11 has to deal with them. But I think what the Trust  
12 objected to sort of just how you did it and the sort of  
13 you setting forward a procedure which they didn't  
14 accept. So I suppose my -- you've got a bit of an  
15 academic background, you've raised money for research, 16:20  
16 you could have put -- proposed a research protocol  
17 randomising your novel technique IV fluids and  
18 antibiotics versus standard of care, and actually wrote  
19 a randomised protocol, written it up as a very strong  
20 paper, and find out really whether it did work or not, 16:20  
21 because the criticism I'd have of your case series was  
22 that there wasn't a controlled group so you sort of  
23 can't really be sure where it's going. So, I guess my  
24 question is: Did you think of that and, if not, why  
25 not? 16:20

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

1 I forgot to say to him -- I mean we were drafting that  
 2 paper and we had done our work and analysed the data  
 3 when this issue arose, and I simply couldn't  
 4 understand, you know, why -- you know, why there was  
 5 a difficulty in arranging for people to be admitted for 16:21  
 6 a period of time a couple of weeks before they would be  
 7 admitted for a longer period of time for the same  
 8 treatment and same bed and so forth.

9 313 Q. Yes.

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

13 314 Q. Yeah.

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

20 315 Q. Yeah. So I'm aware of that. It was really just sort 16:22  
 21 of in a way testing you, had you thought of that ten  
 22 years before?

23 A. Oh, yes.

24 316 Q. Anyway. A couple more. Sort of benign 16:22  
 25 sub-specialisation, along with the sort of 2010  
 26 changes, was I guess an onus of, if we do fewer than  
 27 five complex cases a year, should we be sending them  
 28 away? which obviously might have helped you in your  
 29 waiting list difficulty. I'm thinking now of sort of

- 1           paediatrics, it's not a great part of your practice but  
2           there were some cases. I read about surgical  
3           andrology, the surgery for penile deformity,  
4           reimplanted megaureters, these difficult cases for the  
5           reconstructive team, and also, dare I say, 16:22  
6           ureterolysis, which is not common a case, and that  
7           again would have helped your waiting times and helped  
8           the teams that are sub-specialising and need more cases  
9           to improve their outcomes too on the benign side. I  
10          mean did you think of that as a group? 16:23
- 11          A.    Well we did, you know. Maybe we came to the wrong  
12          conclusion, because we did set up Northern Ireland  
13          Reconstructive Urology Network.
- 14    317    Q.    Yes. Yes. And that's what gave me the idea, yeah?
- 15          A.    And its fundamental aim was to try to retain those 16:23  
16          skills and competencies in the province, particularly  
17          the -- with regard to urethroplasty.
- 18    318    Q.    Yes.
- 19          A.    As you are aware. You probably have -- you're aware of  
20          all of that. And, basically, I probably was the person 16:23  
21          in the province who had the most experience in  
22          cystectomy and orthotopic bladder reconstruction before  
23          it was removed from us, along with Siobhán Woolsey.  
24          It was very good. And, in fact, on occasion we met  
25          with nephrologists as well to consider complex cases 16:23  
26          that had led to renal failure.
- 27    319    Q.    Yes. So you were part of that group?
- 28          A.    Yes. Yes.
- 29    320    Q.    Yeah.

- 1 A. Oh, I was part that have group, and we attended that on  
2 a Friday afternoon in Lagan Valley Hospital, as it  
3 turned out, because that was quite central and, do you  
4 know, we showed the X-rays and the images and all of  
5 that kind of thing. So I suppose actually to answer 16:24  
6 your question, you're asking: Did you not think of  
7 sending them away? And we were trying to retain them  
8 in order to --
- 9 321 Q. Or sub-specialise within the province.
- 10 A. Yes. Yes. 16:24
- 11 322 Q. I guess that was my thing. Two more quick ones. One  
12 about dictation.
- 13 A. Yes.
- 14 323 Q. And most clinicians, and it's not just the Outpatient  
15 thing because I accept, you know, the pressures there. 16:24  
16 But did you -- I mean when you were a trainee did you  
17 dictate after every case? Was that something that you  
18 sort of started missing things out when you became a  
19 consultant and --
- 20 A. No, no, we didn't dictate after every case. And in 16:24  
21 fact you worked in teams that had, when I look back on  
22 it, unusual sort of dictation practices. For example,  
23 one of Professor John Fitzpatrick's colleagues, you  
24 know, he dictated a letter after he did an operation,  
25 never did a discharge letter, and then his next letter 16:25  
26 was at first review afterwards. It is an important  
27 thing to some extent, and that is, in Craigavon, until  
28 I left, it was the practice of the registrars to do the  
29 discharge letters, and it has been said that I deferred

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

9 324 Q. Okay. Thank you. Last one, if I may. The glycine  
10 monopolar/bipolar question, this was talked about in 16:26  
11 England but wasn't a directive like it was here, but  
12 obviously you were under, I think you must have  
13 perceived more of a push to discontinue monopolar.  
14 When you tried out -- everyone else was managing it,  
15 but you were finding it just that sort of technique 16:26  
16 difficult or just didn't adapt to. Did you think of  
17 actually just saying "well, it's just not good for me  
18 so why don't you give your cases to somebody else and  
19 you do something instead"? Did that go through your  
20 mind? 16:26

21 A. It never arose. And I'm not so sure how others would  
22 have been receptive to that. I mean, I was very happy  
23 and very competent to continue to use glycine with  
24 monopolar. I had had long experience, probably up to  
25 4,000 prostatic resections. I have described how I had 16:27  
26 very, very few, possibly symptomatic cases.

27 325 Q. So, sorry, just to interrupt. I wasn't casting  
28 aspersions on your operative technique.

29 A. Yes. Yes.



1 326 Q. But it was different here and there was this push to  
 2 stop.  
 3 A. Hmm. Hmm.  
 4 327 Q. And you didn't --  
 5 A. I didn't, because if it had have been -- if I had -- to 16:27  
 6 answer your question, I would have preferred actually  
 7 to have properly kept the cases on my waiting lists and  
 8 done them myself and learned if I had -- if it was  
 9 a directive that I had to, an instruction, to use  
 10 saline -- 16:27  
 11 328 Q. So if it had come across as a more forceful thing you  
 12 would have acquiesced?  
 13 A. Yes.  
 14 MR. HANBURY: Thank you very much. No more questions.  
 15 CHAIR: Thank you, Mr. Hanbury. 16:28  
 16 329 Q. DR. SWART: I've got some questions which are really  
 17 about the culture of clinical governance and safety, to  
 18 use your phrase, in a two-way bidirectional sort of  
 19 way. Just as a preface, though, I do have a certain  
 20 amount of empathy and sympathy for you in your journey 16:28  
 21 over the years. I was a single-handed consultant for  
 22 many years, had to build up a specialty in a similar  
 23 sort of way. I know what it's like being continuously  
 24 on-call, seeing things change, having a big workload,  
 25 it brings its pressures and it tests resilience, and 16:28  
 26 I get it, but it was a lot easier just to take your  
 27 shopping list to the CEO and not have to navigate what  
 28 seems to be a myriad of committees and a goodness knows  
 29 what. But there's a "but", and the but is, over the

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

1 responsible for you feeling like that?

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

18  
19 So, do you know, in one of those e-mails from Mark  
20 Haynes where he referred to another specialty and 16:31  
21 another Trust having been chastised for not reminding  
22 the management frequently enough about the risks  
23 relating to long waiting lists, that's the kind of  
24 fatigue that we do have. You really do need to have --  
25 you need to have a conversation as to how you're going 16:32  
26 to resolve the issues when the process and the protocol  
27 and the pathway meets with the reality of the  
28 situation.

29 330 Q. So, yeah, I understand that. You've also talked about

1 modernisation not necessarily being better, and I can  
2 understand that, and I think what you're trying to say  
3 is you don't want to lose the perspective of the whole  
4 patient, the clinical interaction and so on. However,  
5 you can modernise without losing those basic things, 16:32  
6 and increasingly now the onus is really on the clinical  
7 staff to keep raising issues to make sure their voice  
8 is heard as part of a team, big emphasis on the team  
9 rather than the individual, and it means looking at  
10 things differently. Now, what was the support 16:33  
11 available -- what was the culture of helping everyone  
12 to understand those bidirectional responsibilities?  
13 You know, what regular forums did you have where you  
14 could understand how everything worked and you were  
15 encouraged to keep pushing at that door? 16:33  
16 A. Really, none, if they existed at all. I think that,  
17 you know, you referred to -- if you take the example,  
18 say, of Mr. Haynes, who, you know, was -- is to be  
19 commended for having raised the issues with regard to  
20 Patient Safety, and he's appointed to what's now called 16:33  
21 a leadership role rather than a manager role, but you  
22 needed to have buy-in, you needed to have a structure  
23 that really said to the -- would say to the clinician,  
24 you know, "We will take you seriously and there will be  
25 results as a consequence of us taking you seriously", 16:34  
26 so that you -- that the -- the agenda of the clinicians  
27 and that of the management, which might be quite  
28 divergent and discrepant.  
29 331 Q. why? why should they be divergent?

1 A. why?

2 332 Q. Hmm.

3 A. why should they be? well, they are.

4 333 Q. But they shouldn't be. They shouldn't be, should they?

5 A. They shouldn't be. And if you -- but you need 16:34

6 a structure actually that -- I mean clinicians have

7 been disenfranchised. There's no doubt about that.

8 I'm not the only one who felt disenfranchised.

9 334 Q. Hmm.

10 A. And people are walking away from the job, and you 16:34

11 listen to, you know, some of my former colleagues who

12 are now doing four days a week and one in private

13 practice, and you can't fault them, and they can't

14 recruit, and I wouldn't even bother to trying to

15 recruit if you can't retain in the first instance. So 16:35

16 there are fundamental issues here around, do you know,

17 what is the purpose? What are we there to do? I mean,

18 process has become the purpose. Process has replaced

19 the purpose.

20 335 Q. Hmm. 16:35

21 A. And the most important person in the centre of all of

22 that soup is the patient.

23 336 Q. Okay. So moving on to that. You know, when I was

24 first a consultant, I can remember being a bit worried

25 about something I did, and somebody said to me "Oh, 16:35

26 you're a consultant now. You can do exactly what you

27 want. If you want to do something different, just do

28 it", and I was a little bit nervous about that. But

29 what this reflected was, there wasn't any culture of

1 assurance at that time. There wasn't any need really  
 2 to demonstrate that you were following guidelines.  
 3 There was very little clinical governance. And we're  
 4 now at a position where this is really very different,  
 5 and we should be able to provide assurance that our 16:36  
 6 services are safe and effective and patient-centred.  
 7 And the Board should be asking about that. They should  
 8 be very curious. Are our services effective and how  
 9 are we measuring that? But as also a clinician you  
 10 should all be asking yourselves that, you know, how am 16:36  
 11 I doing? How do I prove this? What's my evidence? I  
 12 don't think there's -- I don't see a lot of information  
 13 like that, from the evidence put before us, about those  
 14 sorts of standards, not just in Urology, anywhere, you  
 15 know, and I think that perhaps needs addressing. But 16:36  
 16 if you could, if you could have measured things about  
 17 your service, do you think you would have been keen to  
 18 do that? Did you have any discussions about it? Did  
 19 you talk about the lack of audit as a significant  
 20 problem? What's your approach to that? 16:37  
 21 A. Well, I remember some years ago when Professor John  
 22 Fitzpatrick was our boss in Dublin, and he arranged for  
 23 the senior registrars, as we were called then, having  
 24 dinner out with Patrick Walsh, the famous Patrick  
 25 Walsh, and we were asking what made his institution the 16:37  
 26 great place that it was, and he said, "well, what you  
 27 have to do is, you audit everything".  
 28 337 Q. Yeah.  
 29 A. "And you don't audit -- you don't audit things with

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

3 338 Q. Mm-hmm.

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

7 339 Q. Yeah?

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

10 340 Q. Okay. 16:38

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

14 341 Q. But what should happening is we should be continually  
 15 measuring outcomes. 16:38

16 A. Yes.

17 342 Q. We are not generally -- "we" using the biggest Health  
 18 Service. Some places do it much better than others.

19 A. Hmm.

20 343 Q. Why was there no focus on measuring what happens to 16:38  
 21 people, do you think? Where did that sit? And did you  
 22 press for it? Did anybody ask you for it from the top?

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

24 344 Q. Mm-hmm.

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

28 345 Q. Did you realise this was a deficit? That you should be  
 29 --

1 A. Of course. Of course.

2 346 Q. Did you tell anyone?

3 A. Yes, you can tell -- we did tell people. I mean, when  
4 I founded or set up CURE with Roberta Brownlee, we had  
5 four or five SPRs who did higher degrees, I mean I was 16:39  
6 very, very research-orientated, and I believe in  
7 a thing called clinical research, which clinicians  
8 should be doing, rather than laboratory research.

9 347 Q. Yes.

10 A. And I think that audit-generated research is so 16:39  
11 valuable because it closes the loop and all of that.  
12 But there is a limit to what you can do in addition to  
13 swimming against the tide of an inadequate service.

14 348 Q. I'm not suggesting that all clinicians should do this.  
15 I'm merely suggesting did you ask the question? Do you 16:39  
16 agree it's an important question?

17 A. Oh, absolutely yes.

18 349 Q. And you've talked about speaking to patients about the  
19 risks of various treatments and their choice.

20 A. Hmm. 16:39

21 350 Q. Did you document all of those risks in the notes and in  
22 letters to patients, for example?

23 A. No.

24 351 Q. why didn't you?

25 A. Because -- because I'm not very good at writing and 16:40  
26 talking at the same time. So, you know, it's -- I did  
27 it.

28 352 Q. Mm-hmm.

29 A. And I think it's -- I mean that relationship between



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

3 353 Q. I'm bringing that up as really a measure of  
 4 patient-centred care.

5 A. Yeah. 16:40

6 354 Q. It's, you know, have they had the right information?  
 7 Is it in writing?

8 A. Yeah.

9 355 Q. Because they do need to have something to refer to?

10 A. Yeah. 16:40

11 356 Q. And what is the ethos in the Trust? What's the spirit  
 12 of that and what is done to assist you in these  
 13 matters? Because the patient experience of that  
 14 particular consultation I think is very important.

15 A. Hmm. 16:40

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

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

23 358 Q. I'm going a bit further than that.

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

1 359 Q. But it's not in the notes, is it?

2 A. But not in the notes. Yeah.

3 360 Q. Hmm. And looking back on that, do you think you could  
4 have just photocopied it and put it in the notes,  
5 couldn't it?

16:41

6 A. Yes. I could have done, yes.

7 361 Q. Okay.

8 A. If I'd known actually I was going to be asked that  
9 question at a public inquiry I would certainly have  
10 insured it at the time, yes.

16:41

11 362 Q. Serious incidents. Lots of talk about that. If you  
12 look at serious incidents generally across the whole of  
13 the UK, if you look public inquiries generally, going  
14 back years and years, there are similar lessons  
15 everywhere, and learning from these things appears to  
16 be problematic. Why is that, do you think?

16:42

17 A. Well, it's a hobbyhorse of mine. I don't know whether  
18 you will agree? I think the term "Serious Adverse  
19 Incident" is one that should be possibly done away with  
20 it. I prefer the one, Serious Adverse Experience,  
21 because it's not patient-centred. I think, you know,  
22 I've sat at Patient Safety meetings at Directorate  
23 level, and at plenary session, and regionally for  
24 years, and you tend to have this incident, and the --  
25 the discussion, and in fact some of the SAI reports are  
26 rather circumscribed around an incident. Whereas, you  
27 know, I think actually a more holistic and more  
28 longitudinal look at the patient experience, you know,  
29 we listened to the son of a person who is deceased, who

16:42

16:42

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

3 363 Q. Yeah.

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

10 364 Q. So not to cut across you, I mean the modern thinking 16:43  
 11 about this is to involve patients and staff in the  
 12 incident very early on and to learn quickly. From what  
 13 we can see from much of the evidence brought before us,  
 14 certainly historically, and even in these incidents in  
 15 urology, there wasn't enough learning on the spot 16:43  
 16 immediately when things needed fixing. Just to be very  
 17 simple about it. Not enough learning for the doctors,  
 18 the nurses, the patients. Why was that? Because it's  
 19 not enough to talk about an incident, that's not really  
 20 what it's about. Why was that learning not taken 16:44  
 21 forward, do you think? And I know it's very busy, and  
 22 we're going to put that on one side, but what else was  
 23 there about the culture that didn't allow that, do you  
 24 think?

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

28 365 Q. But everyone is busy and -- you know.

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

1 anything as well.

2 366 Q. well, I'm giving you the challenge - did you learn?

3 A. Yes, we did learn.

4 367 Q. Did you change processes as a result?

5 A. well I certainly changed some practice things as a 16:44

6 result. Pre-operative assessment and, do you know,

7 the urine culture and all of that kind of thing may

8 have been one of -- but learning has to be reinstated,

9 it has to be reinvigorated.

10 368 Q. Yes. 16:45

11 A. And also just a cautionary note, I do think that

12 perhaps there are some lessons that can be learned too

13 quickly, and they may be the wrong lessons, and I

14 think, you know, I've listened to this and I mean there

15 have been inordinate delays in the completion of 16:45

16 reports of these SAIs, which is not, you know,

17 acceptable. But at the same time, in the more recent

18 ones I think there may have been some lessons that have

19 been learned, and with Task and Finish Group set up,

20 without a more laid back view of it. 16:45

21 369 Q. But what would have led you to interact better with

22 them? Bearing in mind you're very busy. I mean

23 there's a sense that comes through that investigation

24 takes a long time, there always very mechanistic, the

25 point might be lost by the time it's come through. 16:45

26 what would have engaged the Urology Team better and

27 helped you more?

28 A. well, I think actually, you know, the Urology Team did

29 engage quite well with Serious Adverse Incidents under

1 the leadership of Mr. Glackin. I mean, I certainly  
 2 presented cases, I think, that -- I think a lot of  
 3 effort was put into dealing with them seriously. But  
 4 I do think actually, to reiterate, the incident  
 5 actually is often, the doctors are looking at the 16:46  
 6 incident and how we can improve things so that this  
 7 incident doesn't happen again, and I think actually,  
 8 there's not enough patient involvement --

9 370 Q. Yeah, I think that's been corrected with the new  
 10 frameworks? 16:46

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

15 371 Q. So in that spirit the patients need to get clearer 16:46  
 16 information, don't they, about what's happening to  
 17 them?

18 A. Absolutely, yes. And with candour.  
 19 DR. SWART: Yes. But also what's happening to them.  
 20 Okay. I'll leave mine at that. 16:47  
 21 CHAIR: Thank you.

22 372 Q. I'm not quite sure how long I'm going to be. I'll try  
 23 and be as quick as possible.

24 A. That's okay.

25 373 Q. I think I could debate a lot of things with you for 16:47  
 26 quite a while, Mr. O'Brien, but I'm not going to do  
 27 that conscious of the time that we have.

28 A. Yes.

29 374 Q. One of the things that you have clearly demonstrated is

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

16          A.    Hmm.    Hmm.

17    375    Q.    Everybody else was able to do the triage in the time  
 18           that they had, which was the same time as you had as  
 19           urologist of the week, they just did it in a different  
 20           way. 16:48

21          A.    Mm-hmm.

22    376    Q.    So that those people at least who ought to have been  
 23           upgraded, were upgraded?

24          A.    Hmm.

25    377    Q.    And I just wonder, having heard all that you've heard 16:48  
 26           in the course of this Inquiry, do you reflect that  
 27           maybe there was a better way for to you do it?

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

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

5 378 Q. Routine. Yes. 16:49

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

14 379 Q. I'm going to interrupt you to say, well, was it  
 15 necessary for management to give you that 16:49  
 16 understanding? You could have reached that agreement  
 17 amongst yourselves as a body of urologists, surely?

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

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

12 380 Q. Okay. Again, coming back to you as a caring physician  
 13 and clinician, and wanting the best for your patients,  
 14 and you recognise the value of the key worker, did it  
 15 ever at any stage occur to you to ask, "well, have you 16:51  
 16 talked to your key worker about this?", when you saw  
 17 your patients?

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

28 381 Q. No. And you were being, your secretary was being  
 29 tortured by phone calls from patients who were trying



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

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

11 382 Q. I'm just wondering, though, when you're getting those  
 12 messages and you're getting this constant "this patient  
 13 wants to know what's happening" type of phone call.

14 A. Hmm.

15 383 Q. Did you not say "well, have they not spoken to the key 16:53  
 16 worker?" Did that not cross your mind to check?

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

19 384 Q. That brings me on to another issue, it sort of flows  
 20 from the same thing, and it's one about delegation. 16:53

21 A. Yes.

22 385 Q. You know, one of the things that -- you seem to have  
 23 had a great deal of difficulty with time management,  
 24 and part of the reason for that is that you didn't  
 25 delegate enough. would you accept that? 16:54

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

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

13 386 Q. I accept that, Mr. O'Brien, but you seem to be  
 14 suggesting that it was not your responsibility, and  
 15 I accept that, to appoint them, according to the 16:55  
 16 policy, the strict letter of the policy.

17 A. Hmm.

18 387 Q. But in the spirit of that policy and in the spirit of  
 19 what key workers were meant to provide for a patient,  
 20 was it not your responsibility to check that they had 16:55  
 21 one?

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

26 388 Q. Very well. Well, I'm going to leave it there,  
 27 Mr. O'Brien.

28 A. Okay.

29 389 Q. And if there is anything else that when we're going

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

5 A. Okay. 16:55

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

8  
9 Ladies and gentlemen, just before we go, there are  
10 a few housekeeping matters. 16:56

11  
12 As we reach the end, and our last day of oral evidence  
13 sessions, I wanted to say something about what's going  
14 to happen next.

15 16:56  
16 I have previously indicated that each Core Participant  
17 should deliver any written submissions they wish the  
18 Inquiry to consider, on or before close of business on  
19 Friday, 31st May.

20 16:56  
21 I would reiterate that those should be directed to the  
22 Inquiry's Terms of Reference, and I say this because  
23 anyone, and most of you have followed the Inquiry's  
24 hearings assiduously, will realise that a lot of what  
25 we have heard might properly be considered to go beyond 16:56  
26 our Terms of Reference and the questions that we have  
27 to answer. However, the Inquiry considered it  
28 important to put into the public domain the full  
29 context in which the issues with which it is primarily

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

3  
4 The Inquiry also invites the Core Participants to make  
5 final oral submissions on the morning of Thursday, 13th 16:57  
6 June. Each Core Participant will be allocated a  
7 one-hour slot that morning to reflect on the issues and  
8 to make final remarks.

9  
10 Following that day, the Inquiry will move into the 16:57  
11 report-writing stage of its work. Anyone who is  
12 criticised in the report will receive a warning letter  
13 from the Inquiry and have an opportunity to make  
14 written comments which will be considered by Dr. Swart  
15 and myself before the report is finalised. And 16:57  
16 I should say that, given that the Core Participants  
17 have all been well-represented throughout the course of  
18 this, all of the evidence is -- has been live-streamed  
19 and the transcripts are there. I would not anticipate  
20 that you will be given a great deal of time in which to 16:57  
21 reply, I'll give it a reasonable amount of time. But I  
22 can't give any dates as to when you're likely to get  
23 those letters and when the report will be finalised.

24  
25 In light of the fact that we have received 16:58  
26 approximately 650,000 pages of written evidence, and  
27 heard from 75 witnesses over this 95-day period, in the  
28 past, over two years, I'm sure you'll appreciate the  
29 scale of the task that I have in writing the report,

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

3  
4           It would be foolish of me to say anything other than I  
5           will complete it as expeditiously as possible. 16:58

6  
7           I am encouraged that neither the Trust nor the  
8           Department have awaited the outcome of the Inquiry and  
9           its recommendations in order to take what they have  
10          learned during the course of our work and seek to 16:58  
11          improve matters for patients and staff.

12  
13          As you are aware, the Inquiry has placed the  
14          transcripts of our hearings on its website. The  
15          written witness statements the Inquiry received in 16:59  
16          response to its Section 21 notices will start to be  
17          posted on the website within a few weeks. It has not  
18          been possible to do this sooner due to the redaction  
19          that was required before they could be put into the  
20          public domain. 16:59

21  
22          Thank you, everyone. I look forward to seeing you on  
23          13th June, and in the meantime, if you have any  
24          questions between now and 13th June, please contact  
25          either Ms. Anne Donnelly, our Inquiry Solicitor, or 16:59  
26          Mr. Alasdair MacInnes, our Inquiry Secretary.

27  
28          And Mr. O'Brien, I neglected to give you the final word  
29          and to say was there anything that you felt you hadn't

1 had the opportunity to say, now is your chance.  
2 A. No, I just think that it's such a pity that we weren't  
3 able to provide an even better service to more people,  
4 at least to the extent that we could ensure their  
5 safety, and insofar as we haven't been able to do that, 17:00  
6 and particularly insofar as I haven't been able to do  
7 that, I regret that very, very much, as someone who  
8 devoted his life to the care of patients, when outcomes  
9 are not what they should be, you -- I have borne it  
10 heavily and I so regret and apologise to any patients 17:00  
11 that have suffered harm as a consequence of any  
12 clinical decisions and shortcomings that I may have.  
13 CHAIR: Thank you very much, Mr. O'Brien. Thank you,  
14 ladies and gentlemen.

15  
16 THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 13TH JUNE  
17 2024  
18  
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