Urology Services Inquiry

Oral Hearing

Day 15 – Tuesday, 6th December 2022

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

Held at: **Bradford Court, Belfast**

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I n d e x

DR. MARIA O'KANE

EXAMINED BY MS. McMAHON 2

QUESTIONED BY THE INQUIRY PANEL 167

1 INQUIRY RESUMED ON TUESDAY, 6TH DECEMBER 2020 AS
2 FOLLOWS:
3
4 CHAIR: Good morning, everyone. Dr. O'Kane.
5 Ms. McMahon. 10:07
6 MS. McMAHON BL: The witness this morning is Dr. Maria
7 O'Kane. The Medical Director for the Southern Trust
8 1st December to 30th April 2022. Also, the Temporary
9 Acting Officer since 14th February 2022, and she was
10 appointed the Trust Chief Executive from 1st May this 10:07
11 year. She's here with all of those hats on but, as
12 regards her evidence today and tomorrow, we'll be
13 working through the scene-setting aspects of that as
14 they relate to governance. I understand Dr. O'Kane
15 wishes to take the oath. 10:07
16 CHAIR: Thank you.
17
18 DR. MARIA O'KANE, HAVING BEEN SWORN, WAS EXAMINED BY
19 MS. McMAHON AS FOLLOWS:
20 10:08
21 MS. McMAHON BL: Good morning. Thank you for attending
22 today. My name is Laura McMahon. I'm junior counsel
23 to the Inquiry. The Panel you'll see on your right,
24 and the legal representatives, in various roles, on
25 your left. I think you have some water in front of 10:08
26 you. If you need to take a break at any time, please
27 just say.
28
29

1 You've provided the Inquiry with quite a number of
2 Section 21 replies. Eight in total with, I think, two
3 of those were amended. We'll just work our way through
4 those. If you can confirm your signature, that those
5 are your statements, and that you're happy to adopt 10:08
6 those as part of your evidence.
7 A. Yes, there are two amendments I'd like to make, please.
8 WIT-44959 paragraph 1.14, I make reference to paragraph
9 (ix) but actually it should say 1.12. Then the second
10 one is WIT-45048, paragraph 40.1. That should say 10:09
11 26th November 2020. There's a 0 missing.
12 1 Q. It has fallen off the end of the table, I think.
13 A. Yes.
14 2 Q. Is there, perhaps, one more typo? It may be I misread
15 it, but at WIT-44977? You've said: 10:09
16
17 "In my role as Medical Director (1st December 2019)".
18 I think that should be 2018?
19 A. It should be 2018, yes. Thank you.
20 3 Q. Other than that, are there any amendments you have at 10:09
21 this point?
22 A. Not at this point, thank you.
23 4 Q. If I take you to those statements and we will take you
24 to the signature pages of them. The first one
25 Section 21 notice number 1 of 2022, your signature can 10:10
26 be found at WIT-04502. That's dated 28th March?
27 A. Yes.
28 5 Q. Do you recognise your signature on that, and do
29 you wish to adopt that as part of your evidence?

1 A. Yes. Thank you. Yes.
2 6 Q. The next Notice is 1A of 2022, and the signature can be
3 found at WIT-10900. Again, that's 29th March at the
4 end of that.
5 A. Yes. 10:10
6 7 Q. That's your signature. Again, do you wish to adopt
7 that as your evidence?
8 A. Yes, thank you.
9 8 Q. Statement number 3 of 2022, WIT-11172.
10 A. Yes. 10:11
11 9 Q. That's dated 1st April. Again, you wish to adopt that
12 as part of your evidence?
13 A. Thank you. Yes.
14 10 Q. Then we have statement number 4, which is the amended
15 number 1. We'll go to that. WIT-20106. Again, that's 10:11
16 your statement on 13th May 2022?
17 A. Yes. Thank you.
18 11 Q. You wish to adopt that as part of your evidence?
19 A. Yes.
20 12 Q. Then we have amended Section 1A notice again. 10:11
21 WIT-20169. I think this might be the one that --
22 20169 -- yes, that's fine. That`s dated 13th May 2022.
23 Do you adopt that as your evidence?
24 A. Yes, thank you.
25 13 Q. Notice number 29 of '22, WIT-45187, dated 23rd August 10:11
26 2022, and that's your signature?
27 A. Yes, thank you.
28 14 Q. You wish to adopt that?
29 A. Yes.

1 15 Q. We have notice number 64 of 2022 at WIT-55914. That's
2 dated 22nd September 2022. That's your signature?
3 A. Yes.
4 16 Q. And you wish to adopt that?
5 A. Yes, thank you. 10:12
6 17 Q. The final one is notice 51 of '22. That's WIT-57972?
7 Again, I don't know if there's a date on the next page
8 of that. It's 26th September 2022. Again, previous
9 page, please. That's your signature, and you wish to
10 adopt that? 10:13
11 A. Yes, thank you.
12 18 Q. A lot of those statements are as a result of your role
13 as Chief Executive, and also you have been sent
14 specific notices around MHPS, around Lookback Review,
15 and seeking updates on the various things the Trust 10:13
16 have done since you became Medical Director and also
17 Chief Executive, so there are a variety of topics
18 littered throughout those notices.
19 A. Yes. I want to take the opportunity to thank the
20 Inquiry for giving me the additional time to complete 10:13
21 the six witness statements and the two amendments
22 between April and September 2022. I am very grateful
23 for being supported in that way.
24 19 Q. Thank you for that. We appreciate it was quite a lot
25 of work and we did ask for a lot of information. We're 10:13
26 grateful for you taking the time to do that.
27 A. Before we start, can I just take the opportunity just
28 to repeat and echo the apology issued by the Trust by
29 Mr. Lunny KC on 10th November at the opening of the

1 Inquiry. Just to, again, apologise for the failings of
2 The Trust in relation to any harm that has been caused
3 to patients and their families.
4 20 Q. Okay. Thank you.
5 10:14
6 Just by way of roadmap and where we might take the
7 evidence today, given the time that we have, we can't
8 cover all of those Section 21 notices. They don't need
9 to be covered, in any event, for the purposes of this
10 part of the Inquiry, which relates to scene setting. 10:14
11 We may touch on some more than others. I want to focus
12 mainly on those aspects of your evidence, which will
13 allow the Panel to have a broad overview of Governance
14 and how it was applied, what was done, perhaps what
15 wasn't done, what might have been done, to give the 10:15
16 Panel an idea, at this stage, of events during your
17 time as Medical Director, in particular at this point.
18 Your evidence will speak to the Governance and
19 management actions and decisions through the duration
20 of concerns around Mr. O'Brien during your 10 years as 10:15
21 Medical Director.
22
23 You have been informed that you will, no doubt, be
24 returning at later stages in the Inquiry as we move
25 through different aspects of it. I'll try and take 10:15
26 your evidence in some sort of chronological order, but
27 you touch on so many points, we might jump about a bit.
28 I'll keep it on track as far as possible.
29

1 I just wonder at the outset if I could ask you, did you
2 get the opportunity to listen to the evidence of Mark
3 Haynes?
4 A. I listened to all but the last day of his evidence.
5 Yes. 10:15
6 21 Q. Did you listen to the evidence of Dr. Hughes and
7 Dr. Gilbert?
8 A. I did, yes.
9 22 Q. I just wonder, given that, is it your view that the
10 Corporate Governance procedures and arrangements within 10:16
11 the Trust were effective in highlighting and addressing
12 the concerns raised and known about in relation to
13 Mr. O'Brien given what you have heard so far?
14 A. When I came to the Trust and started as Responsible
15 Officer effectively from 1st January 2019, I think one 10:16
16 of the things I quickly began to discover was that the
17 Governance structure within the Southern Trust was not
18 as robust as it needed to be. On the basis of that,
19 I commissioned a review of the Governance structures,
20 and that took place in the course of 2019. That 10:16
21 produced 48 recommendations that The Trust has been
22 working its way through. Certainly we have
23 significantly invested in improving in all of that.
24 I think some of the work that was being done at that
25 point in time, and certainly some of the struggles that
26 we had in terms of bringing together some of the
27 information around Mr O'Brien and other aspects within
28 the Trust, I think highlighted to me that some of the
29 aspects of that, that you would ordinarily expect to be

1 in place weren't. So what we have done is I believe we
2 are in a very different place now to where we were
3 then.
4 23 Q. I will come on to that. What I want to do is ask
5 a general question. Has your position changed from 10:17
6 your position from your witness statement? Do
7 you consider now that from what you've heard that it
8 appears clearer that there could have been more done?
9 A. Yes.
10 24 Q. Do you think the issues around communication between 10:18
11 staff and the escalation, now that you've heard that
12 evidence, was ineffective?
13 A. Yes, I do.
14 25 Q. We will go on to speak to the changes you've made but
15 that's helpful. The Panel has heard quite significant 10:18
16 evidence from Mark Haynes and a lot of the information
17 overlaps with your evidence. I don't want to repeat
18 any of that. Given your position, that allows me then
19 to modify what I need to take you to.
20 10:18
21 Just if we can start out from the beginning, your role
22 and your occupational history. If we look at your
23 Section 21 response at WIT-44957. You've been Chief
24 Executive since 1st May 2022 and, before that that post
25 was held by Shane Devlin? 10:18
26 A. That's correct, yes.
27 26 Q. You've been Temporary Accounting Officer
28 since February 2022 and the Medical Director for, more
29 or less, four years, three and a half years, roughly,

1 from 1st December 2018 to April 2022?
2 A. Yes.
3 27 Q. Before you arrived, Mr. Khan was the interim Medical
4 Director for a short period?
5 A. Yes. He had been there, I think, for nine months. 10:19
6 28 Q. He was there from April to December 2018. Before him,
7 then, it was Richard Wright?
8 A. Yes, that's right.
9 29 Q. He had held the post from 2015 to 2018. Just before
10 we go into the detail of your qualifications, if I can 10:19
11 just ask you at this point, did you know either
12 Dr. Wright or Dr. Khan before you took up post?
13 A. I didn't know Dr. Khan. I had worked as Associate
14 Medical Director with Dr. Wright in the Belfast Trust.
15 He was Associate Medical Director for some of the 10:19
16 services there. We had worked together as part of the
17 senior medical leadership in Belfast.
18 30 Q. You qualified as a medical doctor in Queens 1990. You
19 completed your MA in Psychoanalytical Studies in 2001,
20 and an MSc in Health and Social Services Policy and 10:20
21 Management in 1998. You also completed the Scottish
22 Patient Safety Fellowships through NHS Scotland in 2014
23 to 2015, and you worked in the NHS for 30 years. Prior
24 to your employment in the Southern Trust, you held
25 a number of senior managerial and leadership roles in 10:20
26 the Belfast Trust, and nationally through the Royal
27 College of Psychiatrists. Your clinical expertise is
28 in Psychiatry?
29 A. Yes.

1 31 Q. You never worked in the Southern Trust before taking up
2 that post; is that right?
3 A. That's right, yes.
4 32 Q. But you spent most of your time in the Belfast Trust?
5 A. Belfast, the Northern, and I'd worked in the Western 10:20
6 and South Eastern in the past, but I had never, as
7 a trainee or as a medical student, been in the
8 Southern Trust other than, I think, for a few weeks in
9 Paediatrics in the '80s.
10 33 Q. You weren't familiar with the management structure down 10:21
11 there or anything about that?
12 A. No.
13 34 Q. If we could look at your job description as Medical
14 Director. WIT-45271, it starts substantially in 272.
15 WIT-45273 relates to Clinical Governance. In short 10:21
16 form, your role is to provide professional leadership
17 and guidance to support the Associate Medical
18 Directors, the Clinical Directors and the Lead
19 Clinicals throughout the Trust in relation to
20 Governance of the medical workforce, and in relation to 10:22
21 Clinical Governance you're a member of the senior
22 management team and the Trust Board. You assume
23 corporate responsibility for ensuring an effective
24 system of integrated governance within the Trust which
25 delivers safe, high-quality care, a safe working 10:22
26 environment for staff and appropriate and efficient use
27 of public funds.
28
29

1 In a nutshell, the buck stops with you, I suppose, as
2 regards Clinical Governance. Ultimately, the Chief
3 Executive, which you are now, is responsible entirely
4 for all of it, but you're the most senior medical
5 person on the SMT. You were when you were Medical 10:22
6 Director?
7 A. Yes. The role of a Medical Director is about
8 supporting, I think, the medical management structure
9 in relation to professional governance, and then in
10 relation to Clinical and Social Care Governance it has 10:22
11 been around quality assurance of the systems and
12 processes in place.
13 35 Q. When you speak to systems and processes, that
14 incorporates any of those that touch upon Clinical
15 Governance as well? 10:23
16 A. Yes.
17 36 Q. Just to clarify that just a little bit more. Do you
18 see any distinction from your role as Medical Director
19 between Clinical Governance and Operational Governance?
20 Do you see those as two separate entities or do you 10:23
21 think that sort of separation is no longer in vogue?
22 A. I think there are different ways of describing this.
23 I think the lines between them are very blurred. In
24 terms of Operational Governance, I mean what we would
25 mean in relation to that, on a day-to-day basis, is the 10:23
26 operational management leadership within each
27 Directorate. In terms of the Clinical and Social Care
28 Governance responsibility that the Medical Director has
29 is not in the day-to-day management of those functions

1 but in being able to assure SMT And Trust Board that
2 the systems and processes that are in place to support
3 those are robust.
4 37 Q. We'll go on to discuss the information you've provided
5 in your Section 21 as to how you, as Medical Director, 10:24
6 ensured those systems were robust, or at least relied
7 on them in order to provide assurance to the Board?
8 A. Yes.
9 38 Q. When you took over from Dr. Khan, was there a handover
10 at that point? Did he provide you with a handover? 10:24
11 Did you have either a formal or informal handover as he
12 departed the role? I think you overlapped. He left in
13 January 2019 and you took up post in December 2018?
14 A. In December 2018 I had leave to take, and I also had
15 the remaining weeks that weren't Christmas to take as 10:25
16 an induction. So basically given I had never worked in
17 the organisation that was about me familiarising myself
18 with some of the key people there. The handover took
19 the form of 2 pages, which I think are submitted in
20 Dr. Khan's submission and mine, basically with a long 10:25
21 list of areas that he had been involved in. Then
22 I think we met for about an hour and a half and he took
23 me down through some of the aspects of that. There was
24 not, I have to say, a huge concentration at that point
25 in time in relation to Urology. I think he explained 10:25
26 they had been through a Maintaining High Professional
27 Standards process, but a vast majority of the rest of
28 the discussion was around different aspects of
29 the Trust he had been concerned about and that,

1 essentially, was the handover.
2 39 Q. Was the Maintaining High Professional Standards, was
3 that only one of those, or had other doctors been put
4 through that process and reflected in the handover?
5 A. There were others ongoing at that point in time. 10:26
6 I had, again as part of my induction, I joined a matter
7 with the GMC ELA, I think, on 4th December, basically
8 to get a handover from that aspect of it to learn about
9 those doctors. Again, Urology was mentioned there but
10 very much in the context of Maintaining High 10:26
11 Professional Standards has been done and finished.
12 There was an awareness that a grievance had been placed
13 at that point of time, but other that there was little
14 discussion about it.
15 40 Q. Was that the meeting you had about Dr. Khan and Joanne 10:26
16 Donnelly?
17 A. Yes.
18 41 Q. That was referred to, Panel, for your note WIT-44957,
19 paragraph 1.4. I will just read that out because you
20 have referred to that as being part of your handover 10:26
21 and I want to look at that a little bit more.
22
23 "As part of the hand-over between the then Interim
24 Medical Director Dr. Khan and the GMC ELA Joanne
25 Donnelly, I learned that an MHPS investigation had been 10:27
26 carried out in relation to a Urology Consultant, the
27 result of which was an action plan in relation to
28 administration activity. There were not thought to be
29 any concerns about his clinical practice and did not

1 require formal referral to GMC."
2 The minutes of that meeting are found at WIT-4508.
3 CHAIR: I'm sorry to interrupt. Perhaps whenever the
4 documents are called up on the screen, if they could
5 move to the paragraph that you're reading from. It is 10:27
6 very difficult to see it on the screen.
7 MS. McMAHON BL: Apologies. It is paragraph 1.4.
8 I have it in my notes, I'm not looking at the screen,
9 but thank you for that.
10 CHAIR: Thank you. That's better. 10:28
11 MS. McMAHON BL: Thank you. I think that reflects what
12 I have read out.
13 42 Q. In summary form, you attended a meeting, Dr. Khan was
14 still in post at the time, Joanne Donnelly was there,
15 and they discussed Mr. O'Brien? 10:28
16 A. They discussed that there had been a Urology Consultant
17 who had undertaken Maintaining High Professional
18 Standards, and I think there was mention at that point
19 in time about him having raised a grievance against the
20 process, and that he had not necessitated referral to 10:28
21 the GMC.
22 43 Q. Was that the only doctor discussed at that meeting?
23 A. No, there were other doctors who were discussed as
24 well.
25 44 Q. Was any detail gone into around the build-up to the 10:28
26 MHPS process, given you were new in post and you hadn't
27 had any background in understanding what had led to
28 this point?
29 A. Not comprehensively, but the way the GMC records its

1 minutes, it updates the minute before, so eventually
2 you get a summary of the previous. There were mentions
3 all the way through that certainly Dr. Wright and
4 Dr. Khan had had discussions with Joanne Donnelly about
5 Mr. O'Brien. 10:29
6 45 Q. Did you ask any questions at the meeting? Did you
7 think, 'I'm taking over here, this is someone who has
8 actually been through had the MHPS, a determination has
9 been made'. Did you enquire about the details of it?
10 A. I didn't enquire very much at that meeting. 10:29
11 I listened. The sense, certainly from the meeting, was
12 this was done and discussed. He had been through the
13 Maintaining High Professional Standards process. There
14 was now an action or -- you know, the recommendations
15 had been made but were being stalled by the grievance. 10:29
16 Then after I left that meeting I asked Vivienne Toal,
17 who is our Director of HR, if I could have
18 a conversation with her about anything that I needed to
19 be concerned about in relation to this. She and I met,
20 I think it was 10th December, and had a discussion 10:30
21 while she took me through the outworkings of
22 Maintaining High Professional Standards and explained
23 that there was a grievance process in place. Alongside
24 that I spoke to Simon Gibson, who was the Assistant
25 Director in the Medical Director's office and asked him 10:30
26 if there was anything about any of the doctors that
27 I should know that wasn't obvious to me in the GMC
28 writing. He gave me information about a number of
29 other doctors and then directed me towards the

1 Maintaining High Professional Standards files on
2 Mr. O'Brien and said it would probably be helpful for
3 me to read those. I took those home and, over the next
4 couple of weekends, worked my way through them. That's
5 how I ended getting back in contact with the GMC. 10:31
6 46 Q. Just from what you say, was the impression given to you
7 this wasn't an ongoing concern?
8 A. The sense had been this man had been involved with HR
9 and Medical Director processes since 2016, 2015/2016.
10 They had worked their way through a process in terms of 10:31
11 understanding what the shortcomings were and
12 the February 2017 action plan had held the situation.
13 I certainly wasn't aware at that point in time that
14 there had been concerns in 2018 about deviation. And
15 that, with all of that in place, that the patients were 10:31
16 safe. That was my understanding of it. In addition to
17 that, I think, when I read down through Dr. Chada's
18 case investigation and the determination from the Case
19 Manager, who was Dr. Khan, and looked at the witness
20 statements, that was reiterated throughout. There 10:32
21 were, I think, three fairly senior doctors in there who
22 said that clinically he was sound, but what they were
23 concerned about were his administrative processes.
24 Certainly the phrase that sticks in my mind when
25 I spoke to Simon about him was, he said this is done 10:32
26 and dusted. Those are the Maintaining High
27 professional standards files. Now we have to do is to
28 make sure we operationally manage his administration.
29 47 Q. You mentioned, just at the beginning of your answer,

1 that you were reassured patients were safe?
2 A. Yes.
3 48 Q. Was that explicitly stated to you?
4 A. It was not explicitly stated in that way. It was
5 stated that there were no clinical concerns about 10:32
6 Mr. O'Brien, that they felt they had bottomed out any
7 concerns about patients through the review that had
8 been undertaken in relation to discovering the 783
9 un-triaged referrals, the looking at the process of the
10 notes that were held at home and in his office, the 10:33
11 un-dictated clinics, the aspects around private
12 patients. There was a sense all of that had been
13 looked through and all that was arising out of that
14 were operational concerns about his administration.
15 49 Q. Just on that point, when you speak about operational 10:33
16 concerns. Is it right to separate clinical concerns
17 from operational precisely in that sort of setting
18 where, if someone doesn't get an appointment or their
19 clinic isn't dictated, or later on their reports aren't
20 looked at, is that not, in effect, a clinical concern? 10:33
21 A. That was certainly my thought whenever I then asked to
22 refer him to the GMC because I thought it was difficult
23 to separate out aspects of a Consultant's work from
24 their technical ability as a surgeon, because all of
25 that was part and parcel of patient care. 10:34
26 50 Q. Presumably you would accept that people having delays
27 to treatment isn't just an administrative concern, it
28 clearly has a Patient Safety impact and raises the
29 potential of significant clinical risk?

1 A. Yes. The simple rationale behind managing his
2 administration operationally was to eliminate the risk
3 of that. The rationale was that if that was managed
4 then the patients would be safe.
5 51 Q. When you say about being managed, you're referring to 10:34
6 the action plan from February 2017; is that right?
7 A. Yes, that's right.
8 52 Q. Did you look at that at the time this was brought to
9 your attention? Did you consider the action plan at
10 that point? 10:34
11 A. Yes.
12 53 Q. When you looked at that, the Inquiry will have heard
13 from Mr. Haynes that he now looks at that and thinks --
14 I paraphrase him -- it wasn't adequate for the task
15 that it was set to do. Did you take the view, at that 10:35
16 time when you looked at that action plan, that it was
17 appropriate and proper given the MHPS concerns and also
18 the determination from the MHPS?
19 A. When I looked at it at that point in time, the areas
20 that were highlighted in relation to Mr. O'Brien's 10:35
21 practice were around triage, dictation, record-keeping,
22 and in relation to private patients. The private
23 patients aspect, there were fewer concerns about
24 delays. In fact, very much the opposite, there were
25 concerns about escalation. 10:35
26
27 In relation to the other three aspects of it, it was
28 felt that certainly, if there were monitoring of all of
29 that and he was nudged constantly, basically, to do

1 those things, that actually the treatment of those
2 patients would fall into place. I think what I came to
3 learn from July 2020 onwards was that the statements
4 around management of Outpatient dictation and booking
5 appointments and following up of results didn't 10:36
6 automatically translate to the multi-disciplinary
7 meetings. Right? Because my understanding had always
8 been that whenever particularly a cancer patient comes
9 through a system, they get referred to an MDM, they are
10 picked up by that system, they have a tracker and 10:36
11 a nurse assigned to them, and that on the basis of the
12 advice from the MDM, the patient will be reviewed at
13 Outpatients and everything flowed from that. I think
14 I made the assumption that, actually, when we were
15 talking about Outpatients we were talking about those 10:36
16 patients too. I think, when we got to July 2020,
17 we realised that was something we had been blind to.
18 54 Q. I just want to take you back, because the Inquiry has
19 heard outline from the opening and will hear further
20 detail of episodes of harm and potential harm that 10:37
21 occurred. During your time as Medical Director while
22 that action plan was being relied on, so I will push
23 back a little bit on that and seek to establish with
24 you how you assured yourself when you looked at that
25 action plan that the Clinical concerns that you've 10:37
26 acknowledged arose from Mr. O'Brien's behaviour were
27 appropriately addressed by him? What did you do to
28 re-assure yourself? How did you test that action plan?
29 How did you stress test it? How did you consider it

1 against the information you were receiving? What gave
2 you reassurance about that for a period from
3 January 2019 until June 2020?
4 A. At the point I inherited the action plan it had been in
5 place for nearly two years. Throughout that time -- 10:38
6 I mean what became obvious in July 2020 was there had
7 been nonadherence in 2018, and that, I think, wasn't
8 robustly communicated within the system. My
9 understanding at that point in time, and I think it's
10 written through various things that are there, was that 10:38
11 there had been no deviation. There are emails to the
12 effect from Mr. Haynes, I think, in and around March,
13 where he raises queries about this. Again, in the lead
14 up to that, and at the time that I inherited the
15 Maintaining High Professional Standards files, I went 10:38
16 back and spoke to Simon, Dr. Khan, the various other
17 people including, eventually, Mrs. Gishkori in relation
18 to making sure that all of those things were in place.
19 They were saying to me that they weren't aware of any
20 deviation at that point in time, they felt this was 10:39
21 accurate. I took my reassurance from that because if
22 it had been running successfully for 2 years, I had no
23 reason to believe it wasn't, and there had not been any
24 other Patient Safety concerns that had been turned up
25 in the midst of all of that. 10:39
26
27 What Mr. Haynes queried in March 2019 was he said he
28 wasn't clear about how the information was
29 communicated. Again, I think that was to do with the

1 escalation processes within the Directorate. Then,
2 secondly, what he also raised attention to was Patient
3 90 who he wondered about in relation to he had been
4 through an SAI process from February 2018 and he
5 wondered about his care. 10:40
6
7 On the basis of that, I went back down through all of
8 this to double-check that what was supposed to be in
9 place was in place, and people felt it was operational.
10 In addition to that, I spoke to anaesthetists and 10:40
11 various others to try to ascertain if there were any
12 concerns about Mr. O'Brien's practice but also
13 particularly in relation to the recommendations that
14 came out of that SAI. Those were very much in relation
15 to Preoperative Assessment, VTE monitoring, consent, 10:40
16 and -- sorry, my memory escapes me. But there were
17 various aspects of that. When I worked my way down
18 through that, with the anaesthetists and other people,
19 they were basically saying this was not attached to one
20 professional's behaviour. This was a systems problem. 10:40
21 In relation to that, what we then started to look at
22 what is how we enhanced improvement in preoperative
23 assessment, consent and all of those aspects.
24 55 Q. If I can summarise that before bringing you to some
25 examples of the previous two years when concerns were 10:41
26 still ongoing?
27 A. Yes.
28 56 Q. I know you said you took comfort that the action plan
29 was being effective?

1 A. Yes.
2 57 Q. I'm assuming you're saying that because it wasn't
3 brought to your attention that it hadn't been?
4 A. There was an escalation process within it. Basically
5 what was active at that point in time was that 10:41
6 Martina Corrigan checked the information weekly, and if
7 there were any deviations from that she then reported
8 those to Dr. Khan. He had asked for exception reports
9 before I arrived, and that had been agreed, so that
10 basically if she had any concerns about deviation on 10:41
11 that, then those automatically went to him.
12 58 Q. Sorry to cut across you, but just as regards timing.
13 He asked for, effectively, a default where she didn't
14 report compliance, she reported noncompliance?
15 A. Yes. 10:42
16 59 Q. He asked for that to start in December 2018?
17 A. Yes.
18 60 Q. That was when he was leaving post and you were coming
19 in?
20 A. Yes. 10:42
21 61 Q. His position up until that point was, let me know the
22 numbers so I can keep an eye on it, and later on we'll
23 go and look at those numbers and the robustness of that
24 data that was being relied on. But his position was
25 only let me know if you need to, if there's been 10:42
26 a deviation?
27 A. Yes.
28 62 Q. And we'll look at the deviation that
29 subsequently didn't get escalated in 2018, then the one

1 in 2019.
2
3 Did you have any concerns that Dr. Khan would make
4 a decision like that just as he was handing over the
5 baton to you? 10:43
6 A. I don't think I was aware that the exception reporting
7 was in place until we got to about the summer of 2019.
8 I had assumed that that was part of the way it had been
9 done up until that point. I think what had changed
10 with that as well was, I think prior to that it had 10:43
11 been monthly reports, and the exception reporting then
12 moved to weekly reports. On the face of it, it looked
13 like a stepping back but, actually, on a different
14 level it was an increase in the monitoring. Just to
15 say as well, I think whenever the deviation reports 10:43
16 came through when the secretarial staff had noticed
17 these in March 2019, I think as well it offered an
18 assurance to me as well that, actually, there were eyes
19 on the bigger system. They were aware that this was an
20 issue, and they were actively chasing any results that 10:43
21 seemed to be outstanding or any appointments that
22 seemed to be outstanding. What I took from that was
23 actually these systems and processes were working
24 because the system seemed to be aware of them.
25 63 Q. Just now that you've mentioned that particular point, 10:44
26 we're jumping about a little bit, but there's so much
27 happening at the one time. You mentioned
28 Martina Corrigan, who was Head of Service, was
29 responsible for oversight of the action plan and

1 ensuring compliance and reporting any deviations, and
2 the secretaries then for alerting their line managers
3 of administrative failings. You've already said, at
4 the start of your evidence, that these administrative
5 failings are clearly Clinical Governance concerns. Do 10:44
6 you think it is appropriate that non-medics and people
7 who are not in positions of authority, if I can put it
8 like that, like secretaries, for example, are left to
9 monitor Consultants and to report any deviations in
10 their practice? Did you feel assured by that? 10:45
11 A. The Consultant secretarial staff are Band 4 workers and
12 they are trained in different aspects of managing
13 clinical processes. My experience, I have to say from
14 my own clinical practice, was that secretaries in
15 relation to that would have been really proactive. 10:45
16 They would have understood that that was part of the
17 role, if there was deviation in the system, they didn't
18 just report to the Consultant, they also reported to
19 their own admin system. Actually I would have had
20 experience in the past where Clinical secretaries would 10:45
21 have spoken to managers and to me to say, you know, I'm
22 concerned about how things are. Right? So that would
23 have been my experience over the years in relation to
24 how secretaries work.
25 10:46
26 I do think it is a significant responsibility. I also
27 think it is particularly difficult if you have a very
28 good working relationship with a Consultant, then to
29 feel that, actually, you're also reporting on their

1 activity and, essentially, that's what that is.
2 I think that needed to be more clearly described,
3 I think, to the secretarial staff than it was at the
4 time to understand that the job is not just to provide
5 for the Consultant's patients, but also to report to 10:46
6 the Operational Managers in relation to activity.
7 I don't think we described that clearly enough.
8 64 Q. Setting the description aside, this wasn't a scenario
9 where secretaries who were being asked to chase up
10 tardy admin, this was a doctor who was subject to an 10:46
11 action plan?
12 A. Yes.
13 65 Q. Who had been through the MHPS procedure, and the
14 monitoring of that particular Consultant was left to
15 admin staff? In hindsight, from this perspective now, 10:47
16 do you still consider that to be appropriate?
17 A. The collecting of the information was left to the admin
18 staff. The monitoring of it, at that point in time,
19 sat with Martina, Martina Corrigan. My reflection on
20 that is I think we should have been a lot clearer in 10:47
21 terms of what our expectation was of everybody at the
22 different levels. I also think that Martina shouldn't
23 have been left to do that on her own. I think there
24 should have been more clinical wrap round to support
25 her. 10:47
26 66 Q. The Inquiry has received evidence from Noeleen Elliott
27 who was Mr. O'Brien's secretary at the time. Aspects
28 of that evidence would then perhaps suggest that she
29 hadn't been escalating information. When you mentioned

1 earlier on about secretaries, some of them can be very
2 loyal to the Consultant that they work for, and that
3 puts them in a pretty invidious position, perhaps, in
4 then having to pass on information that may reflect
5 badly on that consultant? 10:48
6 A. Yes.
7 67 Q. Is Noeleen Elliott an example of what happens when that
8 sort of relationship prevents good governance being
9 monitored?
10 A. Yes, I think so. Yes. 10:48
11 68 Q. Do you see that then as a failing, from you as Medical
12 Director, in having proper oversight to ensure that you
13 got proper information on which you could assess
14 whether the action plan was effective or something else
15 needed to be done? 10:48
16 A. In hindsight, I would do things differently. Right?
17 I would have asked probably different questions in that
18 context. But I think the context is important. I had
19 just arrived in an organisation. It takes a year to
20 get into a job like that properly. I didn't know 10:48
21 anybody. I didn't know the systems and processes. One
22 of the experiences I had was that when I asked
23 questions, you know, I think some people felt that
24 those were critical rather than curious, and that was
25 a really difficult environment to work in. In 10:49
26 hindsight, if I were doing this again I would do it
27 differently, but at the time what I was reliant on was
28 people who had worked in the organisation for a long
29 time, understood how it worked, to give me information

1 and responses to the questions that I asked in relation
2 to systems and processes. I think, you know, one of my
3 concerns in referring Mr. O'Brien to the GMC was in
4 relation to insight. I also think, looking back on all
5 of that, we didn't have full insight either in terms of 10:49
6 how we managed that process.
7 69 Q. You have mentioned you didn't know anybody at the time.
8 Sometimes that can be an advantage in a new job where
9 you don't have friends or enemies. You are coming in
10 as a new brush and that gives you the opportunity to do 10:50
11 things that are more difficult had you been promoted
12 from within. Essentially your answer is you got
13 a little bit of push back from some staff. You felt
14 they thought your queries were criticisms. Did that
15 play a part in your decision making as to how to manage 10:50
16 this situation?
17 A. I don't think so, but I do think it made it a bit more
18 difficult.
19 70 Q. Can you expand a little bit more on what that criticism
20 was aimed at and how it may have impacted your choice 10:50
21 of behaviour at that time?
22 A. There were, certainly, on a number of occasions, when
23 I was very robustly challenged by middle managers
24 within the Trust -- not Martina Corrigan and not any of
25 the other people who worked to her -- in relation to 10:51
26 what my role and function was, why I was asking these
27 questions, and I think were a bit alarmed, I think,
28 about the level of curiosity in relation to how this
29 worked. That didn't stop me asking the questions but

1 it did make it more difficult in that I had to keep
2 coming back and back and back to try to get the answers
3 that I needed.
4 71 Q. Did you consider that to be a difficult working
5 environment, that the culture of being robust towards 10:51
6 the Medical Director --
7 A. Yes.
8 72 Q. -- probably a little bit ambitious for people to take
9 on the most senior medic in the SMT. Did you see that
10 as a sign there was some reluctance to do things 10:51
11 differently?
12 A. Yes.
13 73 Q. You've mentioned who it wasn't. You haven't mentioned
14 who it was in your Section 21. You're clearly not
15 going to say any names. You're very free to do so now 10:52
16 if you wish to, but obviously the Inquiry would like
17 the opportunity to ask certain individuals, if we had
18 the information, how their behaviour may have impacted
19 on clinical decision making. I'll leave that thought
20 with you. 10:52
21
22 One of the things I did want to look at, and
23 we mentioned it a while ago, and I don't want to forget
24 to do it, is to just give the Panel some examples of
25 issues that arose immediately preceding your 10:52
26 appointment, because you said you were reassured there
27 hadn't been any concerns, that the action plan had
28 worked well since 2017, and it is really just for
29 reference. I'll just give two examples, and these are

1 from Mr. O'Brien's AOB-01929. I am not sure exactly
2 which case this is, but its emails from W Clayton,
3 R Carroll and Martina Corrigan dated 16th October 2018.
4 You'll see there, there are 82 charts tracked out
5 specifically to Mr. O'Brien. There were other issues 10:53
6 about the action plan. We might have to go down 01936.
7 These are a series of emails from Ronan Carroll. These
8 are emails back and forward. Did you work much with
9 Ronan Carroll?
10 A. Only with him being Assistant Director in Surgery. 10:54
11 74 Q. I'm not sure what that means. Did you have much
12 contact with him?
13 A. Not a huge amount. No.
14 75 Q. Did he ever speak to you about Mr. O'Brien?
15 A. My contact with Mr Carroll would have been through any 10:54
16 of the Surgical meetings or any of the discussions that
17 we would have had in relation to Mr. O'Brien. He would
18 have mentioned him then. But I think he found -- my
19 sense was, certainly, he found him difficult to manage.
20 76 Q. I ask you that because it's clear from emails, as the 10:54
21 Inquiry will hear, that Mr. Carroll had considerable
22 knowledge of issues around Mr. O'Brien. I'm just
23 wondering, in his position did he ever come to you and
24 say, you know, that action plan isn't effective?
25 We have had to highlight some issues along the way and 10:55
26 chase him up. Did that conversation ever take place?
27 A. No. He didn't volunteer that information to me.
28 77 Q. This is an update from Martina Corrigan. This is an
29 example of the updates that were provided before the

1 system of only deviations to be reported. For example,
2 there in concern 2 at the bottom of that page:
3
4 "I have checked as today on PAS. There are 74 charts
5 tracked to Mr. O'Brien's office. I've asked Maria to 10:55
6 go to his office to check, and she confirms there are
7 a large number of charts in the office, sitting in
8 bundles on the floor, on his desk and in pigeonholes,
9 so this is in breach of the action plan."
10 10:56
11 That's just one example among several in the papers.
12 I won't take you to them all. Because I made the point
13 to you that the action plan, perhaps, wasn't as
14 effective, I just wanted to make that good by showing
15 you evidence of that on the papers. As far as I know, 10:56
16 that wasn't escalated, even though it is clearly
17 expressed as a breach of the action plan.
18
19 Just looking at the engagement with staff. You've set
20 that out in your statement at WIT-45033 at 10:56
21 paragraph 28.1:
22
23 "The Urologists form approximately 1% of the Medical
24 Workforce in the Southern Trust."
25 10:57
26 What was the workforce you were in charge of as Medical
27 Director? Do you have an idea of numbers?
28 A. In relation to the entire number of doctors, between
29 Consultants and SAS Doctors there's about 700, 730,

1 then the junior doctors there are between three and
2 400.
3 78 Q. As a percentage at that time, how many had been through
4 the MHPS procedure and had determinations adverse to
5 them made? 10:57
6 A. Every month in the Trust we have a doctor who goes
7 through the formal or informal aspects of Maintaining
8 High Professional Standards, and that's not out with
9 the region.
10 79 Q. That was the case even back then? 10:57
11 A. Yes.
12 80 Q. If we look at 28.2:
13
14 "Prior to the concerns that were raised in June 2020 in
15 relation to Mr. O'Brien, I had limited engagement with 10:58
16 all of the staff of the Urology Unit."
17
18 When you talk about limited engagement, what does that
19 look like for a Medical Director?
20 A. In relation to, I suppose, daily contact with Urology 10:58
21 staff, whether the Consultants and SAS and junior
22 doctors -- SAS and junior doctors and with the nursing
23 staff, my contact would have mostly been through
24 Mr. Haynes. There would have been meetings with the
25 general surgical family at various stages to look at 10:58
26 issues in relation to all of that, but other than that
27 it wouldn't have been a department I would be in and
28 out of on a daily basis because of concerns or things
29 that needed attention.

1 81 Q. Did you know that Mr. Haynes wasn't aware of the action
2 plan?
3 A. He made reference to it, which I was surprised at but
4 I understand why. He made reference to it in
5 March 2019 that he wasn't familiar with the aspects of 10:59
6 it. Again, when I had explored that -- and this is,
7 I think, what caused some of the confusion at an early
8 stage because there was a view that he wasn't involved
9 in the early monitoring of it because he was the person
10 who had raised the concerns, and there was a concern 10:59
11 about him being involved in all of that.
12
13 I took the view, I have to say, that I didn't think
14 that was reasonable. I thought given he was the
15 Associate Medical Director he needed to know about it. 10:59
16 He and I did have discussions about that in March 2018
17 when I discovered he wasn't au fait with it.
18 Particularly since we know from the emails, Mr. Haynes
19 was very well placed to raise any concerns if there
20 were concerns. 10:59
21 82 Q. Did you give him an active role in monitoring the
22 action plan once you realised that he was an
23 appropriate person to be involved in that?
24 A. At that point I didn't physically say to him, you're in
25 charge of it, because the monitoring of it still sat 11:00
26 with the Case Manager because it was the outworkings of
27 the Maintaining High Professional Standards process
28 given the grievance had slowed everything up.
29 Certainly what I was very clear about was that he had

1 to be involved in the discussions and the monitoring in
2 relation to this.
3 83 Q. Do you think it was a mistake, in retrospect, prior to
4 your taking up post, that Mr. Haynes wasn't actively
5 involved in that action plan given his position? 11:00
6 A. I think he should have been, yes. I think there was
7 probably a greater role for the Clinical Director.
8 Again, the history of this, as you know, has been
9 challenging because they had a number of Acute
10 Directors, they had a number of Clinical Directors, 11:00
11 they had a number of Medical Directors and they had
12 a number of Associate Medical Directors that were
13 involved with all of this. So the constant turnover in
14 staff, I think, in terms of people having
15 responsibility was quite challenging in terms of 11:01
16 maintaining any consistent narrative around all of
17 these aspects of the history.
18 84 Q. Do they have a lot of turnover in Chief Executives as
19 well?
20 A. There was significant turnover in Chief Executives over 11:01
21 a relatively short space of time. The history of
22 Medical Director role before I arrived was obviously
23 Dr. Wright was there then had to be off for periods of
24 time, and Dr. Khan was there essentially for 9 months.
25 That was very unstable as well. 11:01
26 85 Q. The impact of staff turnover and vacant posts,
27 obviously, must, by its very nature, impact badly on
28 Clinical Governance systems.
29 A. It does. I think principally because you lose the

1 narrative. The history is really important in relation
2 to all of this. If that starts to break down because
3 there are too many interfaces or too many changes, then
4 you do lose the impact of it, yes.
5 86 Q. Going back to what we were discussing earlier, it's an 11:02
6 even greater significance on handovers.
7 A. Yes.
8 87 Q. So people have that corporate knowledge moving forward?
9 A. Yes.
10 88 Q. I seem to recall when Dr. Khan took up position as 11:02
11 Medical Director Dr. Wright had already gone off?
12 A. Yes.
13 89 Q. I don't think he had a handover. Of course Dr. Khan
14 was intimately knowledgeable about this issue with
15 Mr. O'Brien, having been the MHPS case manager? 11:02
16 A. Yes.
17 90 Q. Just while we're on that subject. What's the position
18 around handover now for staff? Is there a formalised
19 system in place? Have the Trust sought to codify in
20 some way, the way in which information should be passed 11:02
21 from one person to the next when roles are taken over?
22 A. I think its difficult to set a template for each
23 individual situation but, certainly, I have been very
24 mindful. Our new permanent Medical Director has now
25 started in the last couple of weeks in the Trust and, 11:03
26 certainly I think, mindful of my experience and the
27 experiences before, we're in the process of making sure
28 that that handover is very robust to the point that,
29 you know, I will attend meetings with him and make sure

1 that, actually, all of that is handed over, as will
2 over people to make sure that the history isn't lost.
3 Inevitably, I think it is very difficult for it to be
4 perfect because, again, what takes priority at a point
5 in time loses priority maybe with the next person 11:03
6 coming along, as we've seen with this. Then picking up
7 on what went before can be very challenging, you know.
8 91 Q. That again shifts the spotlight, I suppose, to
9 Governance systems as such, such as the Risk Register,
10 the Acute Governance meetings where someone could look 11:03
11 at those, look back and capture the picture of what may
12 present clinical risk. For example, if I were to take
13 over as Medical Director and I wasn't told, you know,
14 the top of this handover list are your red light
15 concerns, this is what you need to keep your eye on 11:04
16 immediately. These are the escalating concerns of your
17 day-to-day job at the top. If that information isn't
18 provided, then I may look at the Risk Register or the
19 Acute Governance, look at meeting notes of Division and
20 the Directorate and the Board in order to get a fuller 11:04
21 picture. I just wondered at this juncture if we could
22 have a look at some of that.
23
24 It does seem, on a look at all of those documents, that
25 there's almost no mention of the clinical concerns 11:04
26 around Mr. O'Brien until late on -- I think in 2017 it
27 was mentioned about the Board, about the MHPS. Then
28 I think you mentioned in 2020 about the new concerns.
29 But if I could say, the silence was deafening from the

1 Corporate and Clinical Governance paperwork
2 highlighting -- there's no highlighting of those
3 clinical concerns. Does that surprise you?
4 A. I think, knowing what I know now, yes. At the time,
5 you know, the understanding was that this was a doctor 11:05
6 who had been through a process over a number of years,
7 that there were escalations in relation to any
8 deterioration in his performance, that those then were
9 explored and understood. They didn't raise any Patient
10 Safety concerns at that point in time and, as such, you 11:05
11 know, were definitely being discussed as they arose and
12 worked through. But because, on the face of it,
13 it didn't look like there was anything different to
14 what the starting point was from within Maintaining
15 High Professional Standards there wasn't, I think, 11:06
16 a clear rationale for escalating at that point in time.
17
18 I suppose, to assure you as well, I spoke to the GMC on
19 9th January because I was concerned. I had, if you
20 like, third level assurance on that as well, because 11:06
21 everything that we knew we were giving to them in
22 relation to that. There had been previous discussions
23 with NHS resolutions in relation to this doctor and,
24 again, we had followed their advice in relation to all
25 of that. There were eyes on, inside and outside the 11:06
26 organisation. There weren't any changes made to the
27 fundamentals, I think, of the management plan as
28 we went along, because we hadn't anything at that point
29 in time that it needed to be changed. There was

1 a lengthened period of time for him to sign off results
2 that had been given in early 2019. There was an
3 understanding of the impact of, you know, an unwell
4 relative in terms of his performance later in 2019.
5 But, to all intents and purposes, there was a rationale 11:07
6 for things having happened the way that they did. In
7 terms of acute escalation there wasn't anything
8 immediate at that point in time to take back to
9 the Trust Board to say we have concerns here.
10 92 Q. You were sufficiently concerned to contact the GMC. 11:07
11 That was based on, initially, concerns around his lack
12 of insight?
13 A. Yes.
14 93 Q. Mr. O'Brien's lack of insight. Then Patient Safety
15 became an issue for you subsequent to that? 11:07
16 A. Yes. That was initially in relation to Patient 90, in
17 terms of the anaesthetic concerns. When we went back
18 and looked at all of that we couldn't locate that
19 principally with Mr. O'Brien. That was a systems
20 difficulty. 11:08
21 94 Q. When you contacted the GMC, what was your expectation
22 at that point? Dr. Khan had looked at the same
23 information and hadn't triggered a referral. You
24 looked at all of the information available to you and
25 considered that it was appropriate. Joanne Donnelly, 11:08
26 I think it's fair to say, was very professionally
27 involved and proactive in seeking information and to
28 assist in the appropriateness of that referral. When
29 you had that in your mind and you thought, yes, this is

1 appropriate for a referral, first of all, how did
2 you think that would improve Mr. O'Brien's insight,
3 which was the basis for your referral and, secondly,
4 what did you expect to happen as a result of it?
5 A. In order to make the GMC referral what I also had to do 11:08
6 was to review -- and I made mention of it in various
7 aspects -- I had to review all of his paperwork.
8 I looked at his appraisals, his medical report, any
9 complaints there had been about him, any other
10 characters they were there with our CHKS systems, which 11:09
11 is part of our outcomes data. It is limited because of
12 GDPR processes and how we compare with the rest of the
13 UK, so it is very limited, and I knew that. Based on
14 that, there wasn't anything that was jumping out at me
15 from that. 11:09
16
17 In addition then to Maintaining High Professional
18 Standards -- and there was no comment about insight or
19 anything else in relation to those documents. What
20 concerned me was when, as I say, Dr. Chada undertook 11:09
21 Maintaining High Professional Standards investigation
22 and some of the responses she got to that. The fact
23 when I listened to that it was very much apportioning
24 blame to other people rather than any sense of remorse,
25 concern, regret for any of his patients, which, I have 11:09
26 to say, I found highly unusual in a doctor. That was
27 the bit I was concerned about. All of that information
28 was handed over to the GMC, along with then the Patient
29 90 concerns initially and anything we were concerned

1 about was handed across. They acknowledged in January
2 that he met the threshold. It took a while to gather
3 up some of that information because, back to the lack
4 of robustness in our governance structures, that did
5 not come easily, that had to be dug about for, 11:10
6 essentially. But, on the basis of that, they then
7 formally accepted him as requiring investigation and
8 his revalidation was suspended on 27th April 2019 on
9 the basis of all of that.
10 95 Q. I just want to get underneath the process. You 11:10
11 described the process very well, and the Panel are
12 familiar with that. The Inquiry will be interested to
13 understand what it was you thought the GMC would be
14 able to do to reduce any risk you perceived to exist at
15 that point as a result of what you considered 11:11
16 Mr. O'Brien's lack of insight and lack of remorse?
17 What did you think? Why would that be the first thing
18 you would think, I know how we can approach this, we'll
19 go to the GMC, as opposed to, maybe he needs a greater
20 intensity of supervision? 11:11
21 A. I think in relation to that, my sense was, from what
22 had been written in the documentation that had gone
23 before, that, actually, Mr. O'Brien wouldn't have
24 agreed he had lack of insight. I think that anything
25 local I'm not sure would have landed. Having been 11:11
26 through cases before with doctors where there's been
27 lack of insight, there are no kind of ready-made
28 programmes that help with that. Usually very often
29 those cases do end up in front of the GMC. I suppose

1 my experience of working with them before was that once
2 they take on a doctor in relation to investigation and
3 management, that then they follow through a process and
4 they come back and ask, you know, really robust,
5 challenging questions in terms of what has been done, 11:12
6 what needs to be done, and they become involved in all
7 of that.
8
9 I think the thing that surprised in all of this was
10 that I was sending information but, despite 11:12
11 conversations, actually I wasn't clear that there was
12 an investigation proceeding in the way I had expected.
13 Also, I think they possibly took comfort as well from
14 the fact that the Maintaining High Professional
15 Standards investigation had been carried out and that 11:12
16 there was an action plan, albeit it was a 2017 one.
17 Again, throughout 2019 they were fully in receipt of
18 the information but my hope would have been that they
19 would have come back with questions to me, questions to
20 the system, if they weren't content with what they got. 11:13
21 Given that wasn't in the system, you know, usually you
22 take the assurance that, actually, they are content
23 with how things are progressing.
24 96 Q. Given your knowledge of the action plan, was it not
25 clear at that stage that the action plan was really 11:13
26 just asking Mr. O'Brien to do what was expected from
27 him, rather than provide any, either support to him or
28 training or any programme that would allow him to gain
29 insight into the potential impact of his administrative

1 practices? Were you at all concerned that when you
2 read the action plan it certainly seems, from an
3 objective reading, you really asked him to do what
4 everyone else was doing?
5 A. I think the action plan relied on the fact that 11:14
6 whenever -- you know, again, what's stated at various
7 points in the communication and the emails and various
8 other places, is that when the action plan was put in
9 place there was a sense that that would contain him
10 well enough to actually get the job done. Right? And 11:14
11 that he might continue to be upset about what he saw as
12 other failings in the system but, actually, in terms of
13 reinforcing to him his own personal responsibility for
14 looking after his patients, that that should be enough
15 to do it. I suppose, you know, in 2019, I wasn't aware 11:14
16 there had been any deviation in the usefulness of that
17 plan, and my understanding was that that actually was
18 enough to contain him at that point in time. I think,
19 you know, insight is a really difficult thing to
20 tackle. We were never going to do it through just an 11:14
21 operational plan. My hope was that actually through
22 some of the dealings with the GMC that when it
23 eventually got underway, that actually that would be
24 helpful in terms of, you know, reminding him that it
25 wasn't just about the system, it was also about 11:15
26 personal responsibility.
27 97 Q. Do you think that staff fell into the error of looking
28 through the wrong end of the telescope and focusing on
29 containing Mr. O'Brien and not focusing on making sure

1 patients were safe?
2 A. I think the assumption was made at that point in time
3 that if the admin processes were sorted out that would
4 contain the system and keep the patients safe. Knowing
5 what we know now and given, I think, how far we have 11:15
6 come in terms of the development of our governance
7 processes and the information that's available to us
8 that wouldn't have been available then, I wouldn't have
9 been making those decisions. I don't think other
10 people would have been either. I think we would have 11:16
11 taken a different approach.
12 98 Q. The information that was available then, either through
13 asking or through questioning other staff who had
14 corporate memory, was a series of historic attempts to
15 deal with Mr. O'Brien and his inability or reluctance 11:16
16 or resistance to adopt suggestions to improve his
17 practice and his administration. It had been going on
18 for years. No one ever said to Mr. O'Brien, we have
19 tried this before with Mr. O'Brien and it seems to make
20 some small difference and then it falls by the wayside. 11:16
21 No one ever said, anything we tried before hasn't been
22 effective?
23 A. No. In fact, it was a bit different from that. What
24 I gradually learned over a period of time, and some of
25 it came to light in the discussions with the Urology 11:17
26 Oversight Group with the Department of Health was there
27 had been prior knowledge of Mr. O'Brien. Right? Right
28 back to 2009/2010 where there had been concerns about
29 antibiotic prescribing and cystectomy, and other

1 aspects, the narrative I was picking up at that point
2 in time was there certainly had been difficulties in
3 the past, but when they put systems and processes in
4 place to manage it, actually the problem had
5 disappeared or certainly been managed. 11:17
6 99 Q. Who told you that? Who assured you previous attempts
7 had been successful?
8 A. That was some of the discussion that came through in
9 relation to conversations that I would have had on the
10 way around. Mr. Haynes was in the same position as me. 11:17
11 He started in the Trust around 2014/2015, so he didn't
12 have all that memory from the past in relation to what
13 had gone on. But when we got to, I think, the summer
14 of 2020, and then beyond that particularly, as I say,
15 with the Departmental meetings, some of that came 11:18
16 through then with discussions from the PHA and the
17 Department. In the past they had had some awareness,
18 particularly in relation to antibiotic prescribing and
19 cystectomy there had been previous difficulties.
20 100 Q. You had Head of Service Martina Corrigan from 2009, did 11:18
21 she never tell you that previous attempts had been
22 unsuccessful? She had been directly involved in a lot
23 of this in different guises of trying to find
24 a solution. Did she never say to you, it hasn't worked
25 in the past. That action plan is really just asking 11:18
26 him to do what everyone does, and it will slip. Did
27 she never indicate that or suggest that would happen?
28 A. When I found out from PHA Department and other places
29 there had been the previous concerns, the conversations

1 I would have had with Martina were specifically in
2 relation to cystectomy and antibiotic prescribing.
3 101 Q. If I can just cut across you again. I'm trying to draw
4 a line from what you subsequently knew and what you
5 could have found out at the time just by asking. If 11:19
6 I can be as blunt as that.
7 A. Yes.
8 102 Q. Did you have any curiosity at the time that people were
9 pushing back, there was an action plan that could be
10 seen to be oversold by calling it an action plan, which 11:19
11 was really just asking someone to comply with
12 reasonable standards in their practice. There seemed
13 to be no-one who was telling you what had happened
14 before. There had been a letter given to Mr. O'Brien,
15 had you been told about that, on 23rd March 2016, 11:19
16 setting out the concerns that they had at that time?
17 A. Yes.
18 103 Q. When did you know about that?
19 A. That was part of the Maintaining High Professional
20 Standards bundle. It was in there at that point in 11:20
21 time.
22 104 Q. Did that not ring alarm bells at that time when you
23 read that and saw in 2016 the same issues, it's almost
24 identical these issues. Again here we are now with the
25 action plan. A lot of this is replicated. This is now 11:20
26 two years later, three years by the time we turn the
27 corner into 2019. There's a potential that people are
28 being harmed for all of that time. Did that not ring
29 alarm bells and you think, I need to do something more

1 than refer to the GMC?
2 A. The letter, if we are talking about the same letter of
3 23rd March 2016, and it is the one written by
4 Mrs Trouton and Mr. Mackle. Yeah? It's in relation to
5 concerns about those aspects of his care that were then 11:20
6 dealt with through Maintaining High Professional
7 Standards. I certainly didn't pick up from that letter
8 that prior to 2015 that that had been a concern that
9 had been dealt with before and failed. Right.
10 105 Q. Just to stop you there. It is correct that eventually 11:21
11 it was dealt with under Maintaining High Professional
12 Standards, but there was a period between March and
13 December when Ester Gishkori had indicated that
14 informal route would be a more appropriate way, and
15 that didn't come to fruition. It seems to have tailed 11:21
16 off, if I can put it like that.
17 A. Yes.
18 106 Q. The Maintaining High Professional Standards was
19 something that was entered into after attempts to try
20 and resolve it informally. It didn't just go from 23rd 11:21
21 March into MHPS. There had been windows of opportunity
22 where other staff sought to assist. Did you work with
23 Esther Gishkori?
24 A. I did briefly, yes.
25 107 Q. Did you work with Heather Trouton? 11:21
26 A. Yes.
27 108 Q. Did you work with Eamon Mackle?
28 A. No.
29 109 Q. Did you work with Colin Weir?

1 A. No.
2 110 Q. Did you work with Ronan Carroll? You said you did work
3 with him.
4 A. Yes.
5 111 Q. You worked with Martina Corrigan. 11:22
6 A. Yes.
7 112 Q. These are names that are all very familiar over the
8 years. You never thought of approaching them to find
9 out a fuller picture beyond what you were able to read
10 in the paperwork? 11:22
11 A. The history that was given about Mr. O'Brien was that
12 he had always been problematic. That, basically, he
13 was difficult to manage. He felt that the system was
14 always to blame. Didn't take any personal
15 responsibility for anything going wrong at any point in 11:22
16 time. I think the sense I got from people was they
17 were hugely frustrated with having to manage him.
18 I suppose my reading of the -- there were bits and
19 pieces of information but no coherent story. Right?
20 I would have heard about the antibiotics and 11:23
21 cystectomy. Then there was some point in 2020 there
22 was something about him having thrown notes into a bin
23 that caused a bit of alarm. But, again, in terms of
24 getting a clear picture of what that was about or what
25 the working out of it was about, you know, there was 11:23
26 a sense that he was told to stop doing that, he did,
27 and it didn't happen again. Same with the antibiotics,
28 that's what happened.
29

1 In relation to the backlog of patients, the sense was
2 that had gone back to 2015 whenever the numbers of
3 referrals and everything else had gone up and the
4 Consultant numbers had changed. There was always --
5 part of the narrative was incredibly difficult to 11:23
6 manage, difficult to work around, but each time they
7 hit a problem it was dealt with, and then everybody
8 moved on. Right?
9
10 I think the thing about 2016, between March, between 11:23
11 Heather Trouton and Eamon Mackle letter in 2016, then
12 the email communication that Esther Gishkori sent in
13 September was a reversal of the position that had been
14 taken by the Medical Director in September 2016.
15 Dr. Wright, I think, was proposing one form of action, 11:24
16 then Mrs Gishkori came back and said, I've spoken to
17 the Clinical Director, the Medical Director, I think
18 we can do that differently. That wasn't the advice
19 coming from the Medical Director. I think essentially
20 that caused a lot of confusion in there and -- 11:24
21 113 Q. Would that be usual for a Director to overrule
22 a Medical Director in a Clinical concern?
23 A. Not like that, no.
24 114 Q. You have been very general in what you say you heard
25 around Mr. O'Brien. 11:24
26 A. Yes.
27 115 Q. Did anyone ever come to you formally or come into your
28 office and say, I have ongoing concerns, or, he's
29 difficult or all of the words you used. Was that said

1 to you directly or was this information you might have
2 picked up?
3 A. This was information I picked up on the way round.
4 I never had a formal approach. Probably the person who
5 came closest to it was Mr. Haynes in terms of 11:25
6 identifying, you know, and he put those emails in terms
7 of what he had identified. I didn't have a formal
8 approach from anyone else to say, I am discerned about
9 Mr. O'Brien.
10 116 Q. He might have been difficult to manage but you were 11:25
11 being paid to manage him, you were the Medical
12 Director.
13 A. Yes.
14 117 Q. That was your role?
15 A. Yes. 11:25
16 118 Q. You were a couple of roles above his grade. There were
17 people below you paid to manage him, but ultimately you
18 were in charge of the medics. Was there any other
19 factor, anything else that prevented you from dealing
20 with him directly? Mr. Haynes has referred to being 11:25
21 frightened of the fear of litigation, family members
22 and the law. Did any of that play any part in what you
23 heard or how you felt?
24 A. I heard that through the system. I think what made the
25 job of managing more difficult, I think, is the facts 11:26
26 you referred to there, among other things, was
27 a concern throughout the system about Mr. O'Brien's
28 connections. You know, one of the first things I heard
29 about him was he had legal connections. Then the other

1 thing I heard about him was that he was a close friend
2 of the Chair of the Trust. I think that put people
3 off, actually, challenging him. You know, what they
4 would have said to me was he made threats back to them
5 about who he was connected with and how he would get 11:26
6 them into trouble if they challenged him in any shape
7 or form.
8 119 Q. Did he ever say that to you?
9 A. No, he didn't.
10 120 Q. This is information you heard? 11:26
11 A. Second-hand, yes. The only experience I had of that
12 was after I started in the Trust in January 2019, in
13 the one -- the first one-to-one I had with Mrs Brownlee
14 she made comment about the fact she felt he had been
15 essentially persecuted by my predecessors, he was an 11:27
16 excellent Surgeon and a good man, and she hoped
17 I wouldn't treat him in the same way.
18 121 Q. We'll come on to look around the information around
19 Mrs Brownlee. Just before, I think it might be
20 appropriate to take a break, but just before we do 11:27
21 that, finally, on that particular section. Would it be
22 fair to say that those concerns that you heard about
23 Mr. O'Brien, or the perception he may have had some
24 sway, either personally or professionally, operated
25 a chill factor in dealing with him? 11:27
26 A. Yes, it did. Definitely.
27 MS. McMAHON BL: Chair, I don't know if that's
28 a convenient moment?
29 CHAIR: Yes. A quarter to 12.

1
2 THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
3
4 MS McMAHON BL: Doctor O'Kane, I wonder if I could pick
5 up on one of the points you mentioned in passing, the 11:47
6 revalidation issue about Mr. O'Brien. He contacted you
7 on 1st May seeking recommendation for revalidation.
8 We don't need to go to the document but for the Panel's
9 note it is AOB-04269. You replied to him, stating that
10 the GMC has been informed. It might be helpful to look 11:48
11 at that, AOB-04271. You had written to the GMC in
12 April prior to this?
13 A. Yes.
14 122 Q. If we stop there, 1st May, 2019.
15 11:48
16 "Dear Dr. O'Kane, I have received the below email from
17 the GMC advising that a recommendation regarding my
18 revalidation is overdue. I have been advised to
19 contact my Responsible Officer."
20 11:49
21 That would be you as the Medical Director?
22 A. That's correct, yes.
23 123 Q. "I would be grateful if you would communicate your
24 recommendation to the GMC."
25 11:49
26 You reply on 2nd May, the next day. You say:
27
28 "Mr. O'Brien thank for your email. The GMC has been
29 informed".

1

2 What does that mean, that email, the GMC has been
3 informed? What did you hope to convey by that?
4 A. Once a referral has been accepted by the GMC they
5 automatically move to suspending a person's 11:49
6 revalidation until the investigation is complete.
7 124 Q. Probably I should have asked a question before that.
8 Did Mr. O'Brien know that you had written to the GMC?
9 A. He did.
10 125 Q. Who told him that? 11:50
11 A. It had been communicated to him by letter by
12 Mr. Haynes.
13 126 Q. You have informed him that the GMC has been informed
14 that you're not going to revalidate him, is that
15 correct, or you're not going to put him forward? 11:50
16 A. No.
17 127 Q. Explain that to me?
18 A. He was informed he had been referred to the GMC. The
19 decision about revalidating him wasn't my decision, it
20 was the GMC's decision. Again, what I thought he was 11:50
21 intimating in that was he was suggesting I hasn't been
22 in contact with them. We had been in contact with them
23 to say he was still on the books and we had made the
24 referral to the GMC. On the basis of that, then they
25 withheld his revalidation. 11:50
26 128 Q. What's the effect of, I think it is pausing the
27 revalidation at that point because it is only
28 a referral; is that right?
29 A. Yes.

1 129 Q. Does that have any impact on the ability to practise as
2 a doctor?
3 A. It doesn't. No, it doesn't.
4 130 Q. Was that in your mind whenever you referred to the GMC
5 that one of the outworkings of that would be that the 11:51
6 revalidation process would be paused pending
7 consideration of that referral?
8 A. That would be in the hands of the GMC. I mean,
9 I referred him to the GMC based on my concerns. They
10 made the decision that he met the threshold in terms of 11:51
11 an investigation, and then in the course of that they
12 made the decision about deferring the revalidation.
13 The decision I made in the middle of that was to refer
14 the rest of it is the decision of the GMC. It wasn't
15 in my mind that it would be disruptive to any of this, 11:51
16 because I didn't know if they were going to accept the
17 referral or not and I didn't know how long it was going
18 to take them.
19 131 Q. The first time you wrote to the GMC was it January 2019
20 or was it April? 11:52
21 A. The first time I spoke to them was January 2019, then
22 I had a number of conversations with them in between
23 times. Then, as we collected the information, because
24 of annual leave and everything else, I think they
25 eventually got the final draft of the submission on 11:52
26 2nd April 2019.
27 132 Q. You do refer to that in your statement. At the point,
28 whenever you referred to the GMC, whenever you made the
29 decision to do that, had you had conversations with

1 Dr. Hughes and that point around any of the SAIs?
2 A. No.
3 133 Q. Had you spoken to him around any of that information?
4 Were you aware that was ongoing?
5 A. Yes, but I hadn't had any clear conversation with him 11:52
6 about it at that point. I referred to the GMC in
7 January 2019, so Dr. Hughes became involved at the end
8 of 2019 into 2020.
9 134 Q. Sorry, that's my mistake. When you did speak to
10 Dr. Hughes initially, was it early on in the 11:53
11 commencement of his looking at the SAIs? Was it
12 around October 2019?
13 A. Yes. It was quite soon. Because, obviously, we
14 started to discover in the course of June 2020 that
15 there were concerns. There was a significant amount of 11:53
16 work done in terms of rapidly reviewing charts and
17 having, you know, scoping up what the extent of this
18 might be. Some of the concerns that were raised
19 obviously meant the threshold for Serious Adverse
20 Incident. Given the seriousness of this and given 11:53
21 there had been SAIs connected to Mr. O'Brien
22 previously, we approached Dr. Hughes to become an
23 independent Chair in relation to all of that. Then in
24 and around this time we had discussions with the
25 Invited Review Service in the Royal College of 11:53
26 Surgeons.
27 135 Q. That was all around the latter end of 2019?
28 A. That was all around the end of summer 2020.
29 136 Q. 2020?

1 A. Yes.
2 137 Q. Did Dr. Hughes update you before he ultimately
3 published his findings on the SAI? Did he update you
4 as he went along?
5 A. We had a couple of phone calls in the course of all 11:54
6 that. He raised the Bicalutamide difficulties with me
7 and his concerns about that.
8 138 Q. When was your first knowledge of that?
9 A. In and around the time Mr. Haynes then undertook the
10 rapid review of Bicalutamide. That was around 11:54
11 November/December 2020, I think, from memory. The
12 other discussion then he had with me was he talked
13 about a concern about the cancer multi-disciplinary
14 team meetings and the nonengagement with the CNSs, the
15 Clinical Nurse Specialist by Mr. O'Brien. I remember 11:55
16 that conversation because I think both of us were a bit
17 shocked. I think he had come across this information,
18 and I think he talked about it last week, in the course
19 of speaking to the families who were involved and
20 realising as they were trying to manage their cancer 11:55
21 care in the course of the pandemic they didn't have
22 access to a Clinical Nurse Specialist, so he spoke to
23 me about that. Then the other area he spoke to me
24 about before he published the SAIs in draft and then
25 finally was he was exercised around we used EGRESS, 11:55
26 which is an electronic record transfer system which is
27 held on a cloud so it means the records don't
28 physically leave the Trust but they can be viewed, and
29 he was concerned because there had been comments made

1 in relation to the SAI in relation to the use of EGRESS
2 to respond to that just to let me know that that had
3 happened. Those, I think, were the different times
4 I spoke to Dr. Hughes.
5 139 Q. At that point then you became aware that there were 11:56
6 actually verifiable or potential clinical concerns
7 around the practice?
8 A. Yes.
9 140 Q. These are new issues, as it were, for you?
10 A. Yes. 11:56
11 141 Q. At that stage did you think it might be best to take
12 some action or to do something around clinical practice
13 of Mr. O'Brien at that point?
14 A. Mr. O'Brien retired from the Trust on 17th July. When
15 we had discovered the difficulties after -- I think 11:56
16 I was informed on 11 June and the Clinical team,
17 principally Mr. Haynes and Mrs Corrigan had been
18 working on an email that they had received that
19 suggested there was a discrepancy in two waiting lists,
20 and that caused them a bit of concern. When they 11:57
21 worked their way through that they realised there
22 wasn't a discrepancy, but what they also discovered on
23 the back of those explorations were the concerns then
24 around the cancer multi-disciplinary team meeting.
25 142 Q. I think Mr. Haynes explained the issue around the 11:57
26 waiting list and the two patients.
27 A. Yes.
28 143 Q. If we go back to 2019, there was a bit more
29 information, if I can put it that way, a bit more

1 information coming through your office around concerns
2 that meant that you then thought it was appropriate to
3 have a meeting in October. Do you remember that
4 meeting? Mr. Haynes indicated in his evidence that he
5 wasn't able to attend. 11:57
6 A. Yes. That was about 16th or 18th September. Martina
7 contacted me and the other people involved basically to
8 say that she had noticed that there wasn't dictation
9 and sign-off and triage done. I can't remember the
10 exact details of it. Basically on the basis of that, 11:58
11 that was escalated. Again, whenever that was looked at
12 there was a discovery that Mr. O'Brien had been off for
13 a period of time across August -- the end of July,
14 August, early September, in relation to his
15 mother-in-law being unwell, and that that had delayed 11:58
16 the management of those results. Those were addressed
17 then and taken forward at that point. At the same time
18 I think Mr. Haynes also raised a concern about an MDM
19 patient that had been discussed in Belfast. Again,
20 when we looked at that there were concerns about 11:58
21 a patient who had missed a window of opportunity in
22 terms of Radiotherapy or Chemotherapy treatment that
23 had to be taken.
24 144 Q. What time did you find about the MDM patient?
25 A. 16th September 2019. 11:59
26 145 Q. In 2019 there were clinical concerns coming to you?
27 A. But in relation to -- so when we looked at the MDM, so
28 when we looked at this patient, what was very clear was
29 the reason there had been the delay was right back to

1 this delay in the dictation and referral that had come
2 about because Mr. O'Brien actually wasn't physically
3 there. So those were all tied in together. That
4 wasn't seen as a separate issue. But also what
5 I thought that highlighted to me at that point in time 11:59
6 was, actually, the MDM was being captured through those
7 clinical processes that we already had in place.
8 146 Q. You thought the governance system was working then?
9 That was an example of it working?
10 A. It had that appearance of it at that point in time, 11:59
11 yes.
12 147 Q. The backdrop to that, of the dictation and
13 noncompletion of administrative tasks, you hadn't
14 realised the year before, when Martina Corrigan was off
15 for a prolonged period, that no-one was overseeing 12:00
16 Mr. O'Brien at that point?
17 A. Yes.
18 148 Q. This was before you started. You hadn't been informed
19 of that, there was a period when the reporting system
20 to Dr. Khan just fell away because she was off longer 12:00
21 than anticipated and no-one was reporting back that
22 there had been a previous deviation you weren't aware
23 of?
24 A. No, I wasn't aware of it. I have really struggled to
25 think did we have any conversations about that and 12:00
26 I definitely can't remember any, and I couldn't find
27 anything written down to suggest I had been told.
28 I think, to be honest with you, particularly when the
29 time frames were not dissimilar in 2018 and 2019,

1 I think then, eventually, if it was mentioned at the
2 end of 2019, I think some of the history was getting
3 a bit conflated. Certainly, whenever we looked at that
4 issue in 2019 I hadn't been aware of 2018, no.
5 149 Q. In February 2019, you refer to that period in your 12:01
6 statement at WIT-45094. You've mentioned this earlier.
7 I just want to put this in the time frame. You'll see
8 the top box there:
9
10 "On 19th February 2019, Mr. Haynes brought SAI 82946 to 12:01
11 my attention. On the same date, I contacted
12 Mrs Gishkori, Director for Acute Services, about my
13 concerns, based on my review of the SAI and the MHPS
14 paperwork. She did not identify any ongoing concerns
15 and expressed the view that he was a 'well-respected 12:02
16 surgeon'."
17
18 Were you contacting Mrs Gishkori about any concerns?
19 A. Yes. That was the point, because I had looked at what
20 was there. I started the conversations in relation to 12:02
21 what might be the underlying contributory factors in
22 relation to the SAI Patient 90 that Mr. Haynes was
23 concerned about. Again I had looked at his medicolegal
24 work or any legal claims against him, serious adverse
25 incidents, those kind of things, appraisals, and there 12:02
26 wasn't anything jumping out from me. The natural
27 approach would be to go to the Director and ask her to
28 find out whether or not there are any concerns, and she
29 said she hadn't heard any.

1 150 Q. Would it have been the natural approach to go to the
2 AMD?
3 A. I had spoken to Mr. Haynes, yes.
4 151 Q. What about the Clinical Director?
5 A. I know that Mr. Haynes had spoken to the clinical -- 12:03
6 I think the Clinical Director at that point in time --
7 again, there was quite a switch in people at that point
8 in time was either Mr. McNaboe or Mr. Weir. Certainly
9 he wasn't getting -- I think it may have been
10 Mr. McNaboe at that point in time. He wasn't getting 12:03
11 any concerns at that time.
12 152 Q. Did you ever speak to Mr. Young about Mr. O'Brien as
13 the Lead Clinician?
14 A. No. Not until after -- no, I hadn't any conversation
15 with Mr. Young until, I think, autumn 2020. 12:03
16 153 Q. Did you ever speak to Mr. O'Brien? Did you ever go and
17 see him and speak to him about issues?
18 A. No. I haven't spoken to Mr O'Brien.
19 154 Q. Did you ever meet him?
20 A. No. 12:03
21 155 Q. Were you at any meetings with him ever?
22 A. No.
23 156 Q. Do you think, in hindsight, it might have assisted in
24 getting a better insight into managing him or finding
25 a way forward if there had been a meeting at that 12:03
26 level?
27 A. In my mind, right, and again I think I was wrong at
28 that point in time. In my mind, he was being managed
29 through a system of escalation, and everything else.

1 The GMC were involved. The usual clinical managers
2 were involved. In an organisation the size of ours,
3 you know, Mr. O'Brien didn't approach me. I know that
4 previously he had approached Medical Directors and
5 Chief Executives to complain about his treatment. 12:04
6 He didn't make any approach to me during all of that.
7 I corresponded with him through the usual lines of
8 management that would have been there. That wouldn't
9 have been unusual. That's not unusual practice in
10 terms of how doctors are managed who have been through 12:04
11 Maintaining High Professional Standards or other
12 procedures.
13 157 Q. Just to keep in sequence around actions you took around
14 that time. I know yesterday you provided the Inquiry
15 with a couple of documents that you had recently found. 12:04
16 A. Yes.
17 158 Q. Handwritten notes. I think you had been moving offices
18 and found in a box some notebooks that you then
19 discovered they had relevant notes in them. They have
20 been Bates numbered. They are at WIT-90980. They run 12:05
21 for 4 pages. I'm afraid I'm going to have to ask you
22 to translate some of this. I wouldn't want to guess
23 anyone else's handwriting. This first one is
24 a handwritten note of your meeting with Mark Haynes in
25 relation to AOB -- I'm reading out the description 12:05
26 provided to us of what this is, and that the meeting
27 took place, we can see the date at the top, 11th March
28 2019. I know it is a couple of years ago. Does that
29 note trigger memories, I suppose, why you were meeting

1 Mr. Haynes and what was the outcome of the meeting or
2 what was discussed?
3 A. Mr. Haynes and I would have been in fairly regular
4 phone contact at various stages. Again, in relation
5 to -- I'm slightly perplexed because there's an 12:06
6 identified name on that belonging to a patient. Can
7 that be redacted?
8 CHAIR: It will be redacted, I can re-assure you.
9 There's also a restriction order so that anyone in this
10 chamber who sees any patient name is prohibited from 12:06
11 disclosing it in any way.
12 DR. O'KANE: All right. Thank you.
13
14 There were others issues that we had in relation to
15 Mr. Haynes's responsibilities in relation to that time. 12:06
16 We had concerns about different aspects of staff
17 shortages and surgery and, you know, various aspects of
18 the Trust he had responsibility for. I would have had
19 conversations with Mr. Haynes on a fairly regular
20 basis, as I would have done mostly by phone with the 12:07
21 other Divisional Medical Directors, because it is
22 a fairly big diffuse Trust. It is difficult -- I know
23 you visited, but the parking and everything else around
24 the Craigavon site or Daisy Hill site is challenging,
25 so a lot of the discussion I would have had is over the 12:07
26 phone. On this occasion I met with Mr. Haynes in
27 person. We were there to talk about a variety of
28 things, but including Mr. O'Brien, for me to get an
29 update, because this was just a couple of months after

1 I started, in terms of where we were. What I was
2 checking out with him, I think, in relation to this,
3 you know, were there any complaints, had he concerns
4 about appraisals and, I think, was there anything in
5 relation to litigation, was there anything coming 12:07
6 through from his point of view? Because I had checked
7 on my side and I couldn't see anything.
8
9 Then in terms of the management of these results and
10 everything else, it was to get him to try and explain 12:08
11 to me just exactly how these were managed and who was
12 responsible for what in relation to all of this, and
13 also to have a conversation with him about the fact
14 that I was in the process of referring Mr. O'Brien to
15 the GMC. I think I was double-checking with him that 12:08
16 there wasn't anything else that I was missing in midst
17 of all this I needed include.
18 159 Q. Is this page a reflection of the concerns that you were
19 discussing with Mr. Haynes?
20 A. Yes, in relation just to Mr. O'Brien. There were other 12:08
21 pages at the back of that, but that was all to do with
22 other aspects of Surgery and other aspects of patients
23 that came from within the rest of the Directorate.
24 160 Q. I see the top one says "complaints." Is that asking if
25 there were any complaints? 12:08
26 A. Yes.
27 161 Q. It was a negative answer, was it?
28 A. When you look at the pattern of complaints, actually,
29 there were very few. Mostly they were about patients

1 waiting times. They weren't about Mr. O'Brien, per se.
2 162 Q. Then you have "appraisal" circled and asterisked. What
3 was the significance of the appraisal and that point?
4 A. One of the things I came to realise when I came to the
5 Southern Trust was how the Appraisal system was quite 12:09
6 interesting. At that point in time the number of
7 people being appraised was quite low. Secondly, the
8 doctors chose their own appraiser, right, and they also
9 brought their own information into the appraisal. It
10 was purely based on the principle of probity. I think 12:09
11 I was concerned about that because appraisal isn't
12 about performance management, although there are
13 aspects of professional governance that come into it
14 that you have to be really mindful of; it is about
15 supporting the doctor to develop. I thought there 12:09
16 needed to be more objectivity and robustness in that
17 process. Mr. Haynes began to explain to me what the
18 enactment of appraisal looked like in the Trust. On
19 the back of all of that I went back to Mr. O'Brien's
20 appraiser and had discussions with him. His appraiser 12:10
21 is a very experienced appraiser. I went through all of
22 this and everything else, and he was able to produce
23 the evidence that he had available to him in terms of
24 where all this was. Mr. O'Brien hadn't been appraised
25 since he had gone through the Maintaining High 12:10
26 Professional Standards investigation, so that hadn't
27 been mentioned. But to all intents and purposes the
28 rest -- at that point in time -- but with hindsight
29 I think there was a lot of things missing out of it.

1 At that point in time it looked like the information
2 was in there that needed to be in there, but it didn't
3 stop me going back, on a regular basis, to make sure
4 any time there was an issue raised to check those all
5 those usual parameters in relation to Mr. O'Brien's 12:10
6 safe practice.
7 163 Q. Can the Inquiry take from that that you consider the
8 appraisal process and subsequent documentation should
9 be reflective of live concerns as well as ongoing
10 issues around both Clinical Governance and Operational? 12:11
11 A. Yes. It's supposed to be a platform if there are any
12 concerns about a doctor's practice they are given the
13 opportunity for improvement, and I wasn't picking that
14 up. What was in the appraisal was any comments that
15 Mr. O'Brien made were basically around his concerns 12:11
16 about waiting times and the lack of support in the
17 system, you know, generally to provide for patients.
18 But there wasn't anything about anything else in there.
19 164 Q. Is the appraisal process and that documentation a valid
20 route by which a doctor can indicate that they would 12:11
21 require some support or help?
22 A. Yes. Usually that's where it's raised. You know,
23 typically there's a section, I think it is Box 3B or 3C
24 would be one of my go-to places in terms of the
25 appraisal to find out what the doctor's reflections 12:12
26 are. In relation to that, what he did on a couple of
27 occasions was raise concerns about waiting times and
28 the support in the system, but no concerns were raised
29 about, you know, the fact he was struggling to do his

1 dictation, return his patient notes, anything like
2 that. There was no mention of it.
3 165 Q. If he had raised issues like that, when we look at the
4 appraisals, you would have expected that to trigger
5 a response? 12:12
6 A. Yes, and an action plan. Again, I think one of the
7 things that was interesting about the appraisal process
8 was it seemed to act in isolation from ordinary medical
9 management. Right? Again, there has to be a degree of
10 independence with it. If we're going to really support 12:12
11 doctors to, you know, do their work and improve, then
12 actually it has to be linked in with that in some shape
13 or form. One of the improvements that had been made
14 over the last couple of years has been completely
15 revamping all of that so it is a lot more robust to 12:12
16 support the doctors and to bring together the
17 information. But also now, again, and it's the follow
18 through and the use of appraisal to revalidation,
19 there's a very comprehensive document that has been
20 developed in terms of checklists of all the things that 12:13
21 need to come through, as well as appraisal, to
22 determine whether or not the RO will recommended
23 a doctor for revalidation. So this was the beginning
24 of a lot of change.
25 166 Q. When you talked about the appraisal being someone that 12:13
26 you could choose yourself --
27 A. Yes.
28 167 Q. -- or the appraiser, do you think that served to
29 undermine the robustness of appraisals as a governance

1 tool?
2 A. Yes.
3 168 Q. Would you agree that it may have done it in both
4 spheres as in the doctor may not have responded to or
5 been minded to, as you say, rely on probity in relation 12:13
6 to information, but also may not have concerns
7 triggered or actioned upon because of the nature of the
8 relationship? It wasn't built or being proactive
9 around that?
10 A. I think human nature, you will generally choose people 12:14
11 who are sympathetic to you in your own mind. Whether
12 they are or not is another issue. I think that
13 probably helped determine how people chose their
14 appraiser at that point in time. Appraisal has to be
15 objective, so it is really important that actually the 12:14
16 appraiser is well trained, comes into that with an
17 objective point of view, knows what the job is, and
18 gets the person out the other end and isn't concerned
19 about their relationship with the person interfering
20 with the questions that they have to ask. 12:14
21 169 Q. Rather than put those forms in a drawer and leave it
22 until the next appraisal, if concerns were raised, if
23 there was some seeking assistance or it was clear from
24 the information being provided that someone could do
25 with some support, what would you have envisaged was 12:14
26 the duty of the appraiser to do with that information?
27 What was the next step in the Governance ladder, if
28 that concern was raised?
29 A. The system I had developed in Belfast, before I left

1 there, was around how appraisal concerns could be
2 escalated. Basically in the system I was used to
3 previously the Clinical Director and the Associate
4 Medical Director -- sorry, the Associate Medical
5 Director signed off the appraisals -- right? That was 12:15
6 an opportunity for them to have a look at the appraisal
7 documentation, see whether the doctor needed support
8 and everything else. If there were concerns raised in
9 it, then when I was Associate Medical Director
10 I wouldn't have signed off that appraisal until I had 12:15
11 an action plan out the back of that to see how exactly
12 the improvements were going to be made. None of that
13 was happening in the Southern Trust when I arrived.
14 Now we have that in place. Now there's not the same
15 disconnect between appraisal and medical management, 12:15
16 so, actually, if there are doctors raising concerns in
17 there that they need support with, there should be
18 overall signoff in relation to that, and there should
19 be an action plan and support put in around them.
20 170 Q. The appraisal is not for performance, really, it is for 12:16
21 professional practice?
22 A. It depends how you define performance. Right? In the
23 true sense mostly in the NHS performance is looked on
24 as being activity. It is not about quality of care or
25 patient experience. The appraisal doesn't take 12:16
26 activity into consideration. That's mostly dealt with
27 in a job plan. But it should take the quality of care
28 and the patient experience in there. Hence the reason
29 for having the 360-degree and the patient feedback, but

1 also an emphasis on the four different domains of
2 appraisal that include Quality Improvement, Audit, and
3 things like that.
4 171 Q. Leaving appraisal aside just for the moment, I want to
5 go back and ask you more about the culture as in the 12:16
6 scene-setting aspect our evidence gathering at the
7 moment. I'm sure you would agree that culture in an
8 organisation can very much influence how it is
9 governed, both clinically and organisationally.
10 A. Mm-hmm. 12:17
11 172 Q. When you first started in December 2018 you said in
12 your statement at WIT-45034 -- I will go back to those
13 notes I just want to deal with this before dealing with
14 some of the issues later on in those notes. 45034 at
15 30.1 you were asked about the relationships, and you've 12:17
16 said:
17
18 "From my limited interactions with them my sense
19 is that --."
20 12:17
21 Sorry, I should read the question first of all for the
22 transcript. You were asked.
23
24 "During your tenure did medical and professional
25 managers in Urology work well together." 12:18
26 You have been asked to explain that.
27
28 "From my limited interactions with them my sense is
29 they did and do work well together with the exception

1 of the working relationship with Mr. O'Brien."
2
3 You also say: "My impression is that the remaining
4 staff had the greatest respect for each other
5 regardless of discipline and were very professional in 12:18
6 their interactions and their patients and each other.
7 They appeared to work well together outside the
8 challenges of having to manage and work with
9 Mr. O'Brien.
10 12:18
11 My impression based on reading MHPS papers, including
12 witness statements and SAI documents, was that over the
13 years Mr. O'Brien's colleagues had developed ways of
14 not confronting him for fear of having to deal with
15 unpleasantness, but had found ways of constantly 12:18
16 working around him to avoid antagonising him and get
17 the work of treating patients done."
18
19 When we spoke about this earlier you said you got these
20 views from other people telling you that their 12:19
21 impression rather than anything you experienced. Did
22 you ever have anyone directly indicate that you should
23 not engage with Mr. O'Brien in any managerial way? Was
24 that ever intimated to you or said to you directly?
25 A. The only time was, and it's mentioned there in 30.4, in 12:19
26 terms of my interaction with Mrs. Brownlee, when I took
27 up post, basically, and, you know, apropos of nothing,
28 she said this to me. Certainly, in terms of, you know,
29 not pursuing him, she believed he had been badly

1 treated by people before, she felt he was an excellent
2 surgeon, he`d helped a lot of people, he'd saved her
3 life. I was quite surprised, actually. I didn't say
4 anything to her, but I went round after that to speak
5 to Mr. Devlin, the Chief Executive, to say to him that 12:20
6 Mrs Brownlee had said this to me, and I wanted to make
7 him aware that, from a professional point of view, that
8 could not interfere with my work. He completely
9 agreed.
10 173 Q. Did he indicate that he had any similar conversations 12:20
11 or that he was aware of that having happened before?
12 Did he indicate any of that?
13 A. He didn't mention to me about any discussions he'd had
14 with her, but he said to me that he knew that she had
15 a close working relationship with Mr. O'Brien. I'm not 12:20
16 sure whether it was then or at a later point, he
17 mentioned the fact that they both had been part of the
18 same charity, and he didn't say very much beyond that,
19 other than to say to me he agreed with me, I had to get
20 on and get my job done. 12:21
21 174 Q. Just two words jump out there. "Fear" and
22 "unpleasantness." They are quite strong words. Are
23 they words people used to you or is this an atmosphere
24 you picked up? I'm trying to get an impression of what
25 it was like in the Department, in the Directorate? 12:21
26 A. They certainly have used the word "fear." The
27 unpleasantness was what I picked up in relation to
28 people's description of what his response to them was.
29 I think probably the one that stands out most in my

1 mind is I had a conversation with Mr. Eamon Mackle at
2 a point in time, and he talked about the fact that
3 whenever he was Associate Medical Director, and that
4 was in and around March/April 2016, and again I think
5 was trying to put some kind of structure and process 12:21
6 around the management of Mr. O'Brien at that point in
7 time was approached, by, I think it was maybe the
8 Director or the Assistant Director of Acute Services at
9 that point in time to be told basically that
10 Mr. O'Brien, on the basis of that, had raised bullying 12:22
11 and undermining allegations against him. He said to me
12 he found that quite shocking at that point in time and
13 he felt he had nowhere to go with it because he felt he
14 was being warned off him.
15 175 Q. Mr. Mackle intimated -- did he tell you this directly? 12:22
16 A. He did, yes.
17 176 Q. That the complaint had been made to Mrs Brownlee; is
18 that right?
19 A. I'm not sure he said to me about Mrs Brownlee or
20 whether it was his impression, whether she had spoken 12:22
21 to someone else at that point in time. But he
22 certainly felt he was being told to stop doing what he
23 was doing.
24 177 Q. The Inquiry will hear conflicting evidence on that and
25 we'll hear from the witnesses as well. Mrs. Brownlee 12:22
26 denies there ever being a complaint made or her being
27 involved in anything like that, and Mr. O'Brien also
28 says he didn't raise an issue. But several witnesses
29 have raised that, and the Inquiry can listen to the

1 evidence and make their own decision around that.
2
3 One of the things that Mr. Haynes talked about at
4 length, and also referred to in his statement quite
5 a bit, was his inability to properly do his job because 12:23
6 of the tension and conflict in his roles. I mean that
7 as regards time and his ability to meet the demands of
8 his role. Was that something that you could see when
9 you took up post?
10 A. Yes. Mr. Haynes, I think, was allocated about three 12:23
11 PAs which is 12 hours a week to do clinical management
12 of a fairly big Directorate or Division within the
13 Directorate. I think in relation to his job planning,
14 he had had to change that down at times to around 2 PAs
15 because physically that's all the time he could give to 12:24
16 it. Like hopefully all doctors he prioritises patient
17 care above all else, but the difficulty, I think, for
18 him, on a personal level, then was in terms of trying
19 to keep up with patient workload, the demand around
20 that, really furthering the cause of cancer management, 12:24
21 all of things he was involved with, the part that got
22 squeezed was the medical management bit of it. He did
23 speak to me about that on a regular basis in terms of
24 how we could give him support to actually manage that.
25 I also think, as well, that was part of the driving 12:24
26 change behind me undertaking a review of the medical
27 management structures in the Southern Trust. It was
28 partly to do with the busyness of the clinicians there.
29 I could see they were incredibly busy, they had the

1 management roles they were trying to do on top of their
2 ordinary day jobs. There are significant shortages
3 across the piste in terms of off-setting the workload.
4 Urology is a very high-volume speciality. A lot of
5 patients coming through very fast. I could see that he 12:25
6 wanted to do a good job but he hadn't got the time to
7 do a good job, so that was concerning. On the basis of
8 that I undertook the review of medical management and
9 leadership in the midst of all of that. We have
10 a greater number now of Divisional Medical Directors 12:25
11 instead of Associate Medical Directors, and we have
12 a significantly increased number of Clinical Directors,
13 and also then within each Division we have shared out
14 the different Governance roles across the different
15 medical staff, so it all doesn't just sit with the 12:25
16 one person in terms of managing that.
17
18 Again, I think I have submitted an update in relation
19 to that in recent days but, basically, that's almost at
20 completion. That got slowed up, obviously, with the 12:25
21 pandemic and everything else and retirements and
22 everything happening, but it is more robust than it was
23 then.
24
25 As well as that we appointed two permanent Deputy 12:26
26 Medical Directors and a third for the purpose of
27 Inquiry in terms of appraisal revalidation and the
28 aspects of professional governance. In addition to
29 that, as I say, we've recently now appointed

1 a permanent Medical Director. It is in a lot better
2 shape than a couple of years ago when I got it.
3 178 Q. You have covered a lot of my questions in the one
4 answer, that's helpful. One of the things I would like
5 to ask you about, because the Panel may be interested 12:26
6 to hear. You mentioned in your witness statement that
7 WIT-45063, this is about training induction. I just
8 want to read what you said. You identified an area
9 that might require improvement, you can update us if
10 there have been any. Yes, 46.1, just halfway through 12:26
11 that paragraph:
12
13 "Medical Leaders had limited time in their respective
14 time plans to deliver on their areas of responsibility.
15 Medical Leaders also had not traditionally had much in 12:27
16 the way of formal training or induction to their rules
17 and, as such, at times struggled to provide
18 leadership."
19
20 The first question that springs from mind from that, do 12:27
21 you believe that impacted on the quality of Governance?
22 A. Yes. I don't think there was confident -- there wasn't
23 universally and consistent confident leadership
24 throughout the system. I think that really has
25 impacted on it in that in terms of having the 12:27
26 confidence to speak up or feel that they will be taken
27 seriously or, you know, feeling that they can access
28 information. I think that has been problematic.
29 Again, to address that, you know, we've engaged now

1 with the new medical leaders to develop their
2 management roles, and we're now in the process of
3 developing fairly robust leadership training in
4 relation to all that. I think, you know, when you make
5 reference to culture, my sense of the Southern Trust 12:28
6 has been that they have been incredibly busy and that
7 we ended up in situations where doctors were seen
8 purely as -- not universally but at times I think
9 because of the busyness, almost as technicians, that
10 they had to do their job but the management and 12:28
11 leadership bits were left to everybody else. In my
12 experience it works well if doctors are good leaders,
13 because they have a lot of experience and training, and
14 they also bring a system with them, and I think that
15 bit had been lost. Part of the aspiration at the 12:28
16 minute is to try to really develop that. Again,
17 I think that hadn't been around for a while, and I do
18 think it was partly because of the busyness and demands
19 on the system.
20 179 Q. One of the things that does come across is really how 12:29
21 busy everyone is to try to meet the Service needs, and
22 also the little time they had to do that and the stress
23 and anxiety that certainly seems to have come across in
24 a lot of the witness statements. Do you think there
25 might have been a reluctance to raise issues or to 12:29
26 identify concerns if you thought then that you would
27 have to get involved in dealing with them because you
28 had little enough time as it was?
29 A. I don't know whether that was a conscious concern but

1 I would expect at some level it was an unconscious
2 concern. It meant more work for people, and we have
3 seen that. I don't think anybody was consciously
4 obstructive, but I do think it did require a lot of
5 effort to be able to speak up. 12:29
6 180 Q. That works back to the human nature of how to inform
7 Governance as well, to factor in people's response when
8 they are under pressure. I suppose that's a difficult
9 concept to try to feed into any Governance process?
10 A. We're very dependant on openness and candour. Again, 12:30
11 I think if people are tired and they're beleaguered
12 with workloads and everything else, I think that's
13 quite hard for people to, you know, probably give as
14 much thought to at times as they probably needed to.
15 181 Q. I know we we will come on to a lot of the improvements 12:30
16 that have been made around governance, but would
17 you agree that it is difficult to develop systems that
18 are only as good as the information that is put into
19 them, and is responsive to that information? They
20 would seem to be the two main triggers in any of the 12:30
21 governance processes, certainly, that the Inquiry have
22 looked at. It is the quality of the information it
23 receives, and also whether that triggers the
24 appropriate reaction or not defines the effectiveness
25 of that process? 12:31
26 A. I think that's right. I think there's something about
27 the breadth and depth of the information and about it
28 being robust. But there's also what information is
29 actually useful in unusual circumstances. I think

1 there's a suite of information that you would normally
2 use if you had concerns about a doctor you would run
3 down through. Those were used, and it still wasn't
4 throwing this up. I think, you know, that has made
5 me wonder. Again, I think it has influenced how 12:31
6 we have developed Governance processes in the
7 Southern Trust and thought about how we feed in
8 revalidation, and everything else. If you have
9 a doctor who is particularly hard to manage, or any
10 healthcare professional particularly hard to manage, 12:31
11 almost reminding yourselves to constantly take a step
12 back and think about it from a different angle rather
13 than doing what we normally do. I think that was one
14 of my learnings out of this as well.
15 182 Q. In your role as Medical Director, what weight did you 12:31
16 place on the data you were receiving? Without looking
17 at the source, first of all, when you got information
18 in what best of your knowledge of your decision making
19 was informed by that data?
20 A. I could only know what I was told after I asked for it 12:32
21 or what I found out. Right? Again, you are relying on
22 systems being robust and information being given to you
23 in good faith. I think I make reference throughout my
24 statement about the realisation I now have that there
25 were false assurances in there. I don't believe that 12:32
26 anybody was consciously telling me lies, but I do think
27 they didn't fully understand again the breadth and
28 depth of the information that I was asking them to
29 report to me, if you know what I mean. The

1 significance of it was lost a bit. But also I think
2 what we weren't good at was the system was joining up
3 all the dots and recognising that triangulation was
4 a really important aspect of this. We needed to put
5 out all the aspects at the same time. But also that we 12:33
6 were sensitive enough to what the smoke signals were in
7 the system in terms of how we thought about the system.
8 183 Q. Would you have expected data to be interrogated
9 robustly before it reached you --
10 A. Yes. 12:33
11 184 Q. -- so your default position would be to rely on it?
12 A. Yes.
13 185 Q. Whose role would that be?
14 A. That should have come up through the Operational and
15 Professional Governance lines. Again, in relation to 12:33
16 appraisal revalidation data, complaints, all of that,
17 in relation to any of the clinical outcomes or any of
18 the information that was shared in relation to the data
19 about dictation, all of those kind of things. I was
20 working on the assumption that we had been over this so 12:33
21 many times that what I was given was robust.
22 186 Q. I can't remember the name of the witness just at the
23 moment, someone gave an example of there being eight
24 letters up for dictation and three of them are done, it
25 could be that those three letters are for one patient. 12:34
26 A. Yes.
27 187 Q. As a very simple example, that shows a straightforward
28 piece of data actually can completely misrepresent the
29 true backlog in a situation like that?

1 A. Yes.
2 188 Q. It sounds easy from this perspective to say how did no
3 one notice that, but I wonder who should have noticed
4 that and where the fault line would lie in data being
5 sent to you, and to others, that is so clearly 12:34
6 erroneous?
7 A. I don't think the fault lies with any one person.
8 I think it lies with the system.
9 189 Q. I said fault line. I wasn't looking for anyone to
10 name. What part of the governance pyramid, if there is 12:34
11 a pyramid, was fractured to stop that information being
12 properly sent up?
13 A. I think probably the assumptions around how much people
14 understood the importance of the information they were
15 working with and the relevance of it. 12:35
16 190 Q. Does that go back then to the absolutely fundamental
17 significance of having the right people oversee at the
18 right time?
19 A. Yes, it does. Also I think, probably more broadly than
20 that, being very clear that the communication 12:35
21 throughout is well understood and shared; that
22 everybody has the same understanding of what it is
23 they're trying to do.
24 191 Q. In a system where there is any sort of power imbalance,
25 even perceived, or knowledge around the importance of 12:35
26 that sort of data, it does lend itself to being more
27 likely to provide data that is not reliable. Wouldn't
28 that be right?
29 A. Yes. It does, yes.

1 192 Q. I know we have talked about the secretaries before.
2 We'll go into that at another time. Stephen Gibson,
3 I think, was someone who raised the issue about the
4 robustness of data. I don't know if you have had sight
5 of Melanie McClements statement, but at the moment it 12:36
6 is just one --
7 A. I don't think I have seen her statement.
8 193 Q. It is for the Inquiry as well as our own notes that he
9 raised this at WIT-34231 and 34233. He refers to the
10 backlog information that had been sent had significant 12:36
11 weaknesses in it, and was raised by Simon Gibson at
12 a meeting he chaired on 24th January 2020 where backlog
13 reports were discussed. It is also something that
14 Mr. Haynes gave evidence about. He raised concerns
15 about the information not representing the reality. 12:37
16 A. Would you mind if I saw that on the screen?
17 194 Q. Okay. I'm trying to get exactly where that is.
18 I think it might be WIT-34235. I copied and pasted it
19 out of context. Sorry.
20 12:37
21 What you did here, Mr. Haynes also raised concerns
22 about the data that was being relied on. He also was
23 concerned that it wasn't reflective of the proper
24 numbers?
25 A. Would it be possible, can I have a copy of that to look 12:38
26 at it, because I think the context is probably
27 important.
28 195 Q. Of Mr. Haynes's evidence?
29 A. Just in terms of what you are referring to.

1 196 Q. We'll do that. We'll come back to that this afternoon.
2 A. Yes.
3 197 Q. I suppose, just in general terms then, when we are
4 looking at governance and scene setting, rather than
5 just focus on the date, part of the terms of the 12:39
6 reference the Inquiry would be interested in is the way
7 in which governance operates and how reliable it is and
8 how any unreliability may lead to outcomes that impact
9 on Patient Safety.
10 12:39
11 Just in general terms, as the Medical Director how did
12 you re-assure yourself about the information that you
13 were given and the Governance systems that you were
14 responsible for? How did you re-assure yourself that
15 they were fit for purpose? 12:39
16 A. I think, as I stated at the beginning, I was concerned
17 about them, and that's why, obviously, I asked for the
18 review of governance structures across the Trust.
19 198 Q. If we just pause there. I don't want to stray into
20 that just at the moment. When you go into the job you 12:39
21 say you were worried about them. What triggered that
22 concern?
23 A. I think it seemed to take a lot of time to get
24 information. Also then it seemed to take -- you know,
25 again, when I went looking for information around 12:40
26 Mr. O'Brien it seemed to take an inordinate amount of
27 time and effort to pull down things that should
28 automatically be there. That concerned me. Then
29 I realised there were people involved in all of this

1 and that very often they were trying to do other jobs
2 and get this done for me at the same time. So there
3 was that aspect of it. I think, you know, some of the
4 electronic systems had only been developed about
5 2016/2017, so in terms of getting information beyond 12:40
6 that was really problematic. Again in terms of the
7 systems then bringing together, for example, Serious
8 Adverse Incidents, complaints, it all seemed to be
9 dealt with in silos down through the different
10 Directorates but not shared or given oversight by the 12:40
11 Medical Director. Again, I think historically there
12 had been a view that governance was managed by the
13 Operational Directors and the Medical Director was
14 there, then, basically to comment or give an opinion on
15 some of the processes, without it being a full 12:41
16 assurance process. There was very little audit going
17 on of actually governance processes. There was very
18 little, I think, transparency in relation to how some
19 of those things were done. Again, back to my earlier
20 comments in terms of trying to get information, if 12:41
21 I asked for anything at all that was governance
22 related, and given at this point in time I was mostly
23 concentrating on the Acute Directorates and, to some
24 extent, the Mental Health Directorate which also was
25 undergoing significant challenge at that point in time 12:41
26 too, it took an inordinate amount of time to get the
27 information. Then sometimes it wasn't of good quality
28 and you had to go back and ask for it again. Then you
29 had to try and make sense of how it all fitted

1 together, I think what I increasingly realised was then
2 that my sense of governance and what that should look
3 like, in terms of being systems and processes to ensure
4 Patient Safety, was not that shared with the
5 organisation. I think over the years what had happened 12:42
6 was, between numerous changes in Chief Executive,
7 Medical Director, Acute director, Mental Health
8 Director, that, as I say, they had lost their narrative
9 in terms of how understanding how a good governance
10 structure within a Trust should function to ensure 12:42
11 patient safety, but when there had been savings to be
12 made, those were the posts that disappeared. They kept
13 the Clinical posts but in terms of the governance
14 structure post -- there was no clinical audit team.
15 For example, there was no Datix Manager. The SAIs were 12:42
16 managed in a whole different series of ways. How
17 complaints were dealt with were always within the
18 Directorates but never coming to the Medical Director's
19 office. There were things like that that you should
20 automatically expect to find in an organisation that 12:43
21 weren't there.
22 199 Q. Was part of that the sense that people worked in their
23 own lines of management?
24 A. Yes.
25 200 Q. I don't want to use the word "silo", but there were 12:43
26 events that people knew what their line were doing but
27 not necessarily what the other?
28 A. Yes.
29 201 Q. Do you think then by its very nature that structure led

1 to confusion about roles and responsibilities?
2 A. I think it did. Also when you look at the job
3 descriptions. I mean it was one of the -- you know, in
4 the course of responding to the Inquiry I went down
5 through -- I knew the work I had had to do in relation 12:43
6 to the Divisional Medical job descriptions to get all
7 of those to align. Each of the AMDs when I arrived all
8 had different job descriptions. They had been
9 developed at different times, they did different
10 things, and had different levels of responsibility. 12:43
11 We're in the process of virtually replacing all of the
12 senior management team in terms of reappointments and,
13 again, all of those jobs are now lined up with each
14 other and their connection with the system are a lot
15 clearer. The other part we have been working on then 12:44
16 in particular the Assistant Director roles because,
17 again, no two Assistant Directors had the same level of
18 responsibilities. I think there were aspects I looked
19 at and between the Associate Medical Director and the
20 Assistant Director, nobody seemed to have 12:44
21 responsibility for Governance explicitly. They were
22 doing it but, again, in terms of who had overall
23 responsibility that wasn't clear. All of that is being
24 tidied up or has been tidied up.
25 202 Q. Do you think there was, perhaps, not necessarily an 12:44
26 error but there was a perception from the outset that
27 the problems were administrative in nature and,
28 therefore, fell more on the operational side of the
29 house, if I can put it that way, and that perhaps

1 inadvertently blinded the potential patient risk issues
2 that have subsequently arisen?
3 A. I think we collectively had the perception that if the
4 administration side of it improved, because that's
5 where all the problems were being pointed to, if we had 12:45
6 good governance around that and that was working well
7 in relation to Mr. O'Brien's administration, then the
8 patients would be safer as a result. I think that was
9 the basic premise we worked on. There wasn't anything
10 coming from any other information at that point in time 12:45
11 to suggest otherwise. When I did the sweep of the
12 usual professional clinical social care governance
13 review in terms of the other indicators, there wasn't
14 anything red flagging in there to suggest there were
15 others problems. As I say, it wasn't until June 2020 12:45
16 when we had come at it from a different angle in terms
17 of waiting lists, we realised there were other
18 difficulties in there.
19 203 Q. I know the issues are in triage and there's electronic
20 systems in place. If the issues that are live to this 12:46
21 Inquiry were to arise now in the Health Service and
22 that they would fall under what might traditionally be
23 seen as administration, where would the governance
24 route lie for that? Who would be responsible? Is that
25 now, if I can use the word, tied up as to who is in 12:46
26 charge of those sort of issues?
27 A. I suppose we've tested this in recent times in two
28 different areas to see. It's very clear now where that
29 goes. I think the admin staff are very cognisant of

1 the fact these things need to be escalated. In recent
2 times that was brought forward by the admin staff and
3 the clinical staff in relation to particular concerns
4 escalated to the Director, brought to me initially as
5 Medical Director, then Chief Executive, and brought to 12:46
6 senior management team. Again, we have very clear
7 sight of any concerns like that now.
8 204 Q. I just want to take you back, briefly, to the
9 photographs of the notes. You don't have a hard copy
10 of those. You can see okay on the screen? 12:47
11 A. It hasn't come up yet, but it will. Thank you.
12 205 Q. I'll find the reference. It is WIT-90980. That was on
13 11th March 2019 and there are a few words that jump out
14 that are very familiar and raise insight in MHPS,
15 results, NIECR. What is that in reference to? 12:47
16 A. That's the Northern Ireland electronic record system.
17 It's an interface between primary and secondary care.
18 Basically it tends to be, very simplistically it tends
19 to be a communication tool between primary and
20 secondary care for patient information. So aspects of 12:48
21 it can be used for making patient referrals, holding
22 patient results across the system, sending letters, all
23 of that kind of thing.
24 206 Q. It holds information that might be readily available
25 for people coming into the hospital? 12:48
26 A. Yes.
27 207 Q. Why is it on this page, the results? Why would you
28 have written that down?
29 A. What I was trying to ascertain -- again, the other set

1 of people who look at NIECR are the GPS. I suppose
2 just to say, the GPS hadn't raised any concerns with
3 Mr. O'Brien either. They talked about the delay in his
4 administration processes, but they didn't talk about
5 any concerns about prescribing or any other aspect of 12:49
6 it. He has a high-volume speciality. He had a lot of
7 contact or interfaces with the general practitioner.
8 Again as another assurance system --
9 CHAIR: Sorry, Dr O'Kane. We are trying to get
10 a transcript. If you can talk into the microphone. 12:49
11 Thank you.
12 A. Sorry. That was another area that wasn't -- again it
13 was on my mind in relation to this. I put down some of
14 the aspects there. CHKS data, I know that Mr. Haynes
15 and I discussed that because he explained to me, at 12:49
16 that point in time, the limitations of that. As
17 I understand, if we were functioning like the rest of
18 the UK, that would yield a lot more clinical
19 information for us in terms of some of the parameters
20 that are important in terms of understanding the 12:49
21 robustness of surgical practice, such as blood loss
22 and, I think, knife to skin, things like that. I'm not
23 exactly over it, so I don't know the details of it. He
24 was explaining to me that we were limited in terms of
25 CHKS data and all that gives us is an indication of 12:50
26 volume. In terms of the results, he was describing to
27 me that in terms of where results should be located,
28 you know, they could be found down through NIECR. It
29 is not just secondary care that has access to that, it

1 is General Practice.
2 208 Q. Would you be familiar with that through your previous
3 practice the NIECR?
4 A. Slightly. I would have used the Paris system instead.
5 209 Q. Would you be raising any concerns that results weren't 12:50
6 being looked at?
7 A. In relation to that? I don't think we specifically
8 had that conversation at that point in time. I think
9 this was about where we would find results if we were
10 looking for them. 12:50
11 210 Q. Were you aware that results weren't being looked at
12 promptly at that point?
13 A. I think that came through shortly after that in an
14 email that he sent me where he raised concerns about,
15 I think it was a 4 or 7-day delay on results being 12:51
16 reported by Mr. O'Brien.
17 211 Q. When was that email? Do you remember the date?
18 A. I think it was about -- was it about 24th March?
19 212 Q. At this point did he raise it with you at this meeting?
20 Did he mention it? 12:51
21 A. I don't think he would have -- now we're relying on my
22 memory here, but I think at that point in time Vicky,
23 who was one of the admin managers, I think she was
24 raising a concern about results not being signed, and
25 I think it was over a period of 4 or 7 days before 12:51
26 that. I think from memory it was 24-26 March, I think,
27 rather than February. I think it would have outdated
28 this time frame, if my memory is right, but you would
29 probably need to check the dates.

1 213 Q. I see the results DARO processed. That's another issue
2 that has arisen about some reluctance on Mr. O'Brien's
3 part to use. Was this something you discussed with
4 Mr. Haynes in March 2019?
5 A. I think it was purely -- I don't think I was aware of 12:52
6 Mr. O'Brien's reluctance in relation to DARO. I think
7 what I was interested in was if we were looking for
8 information, where would we find it. I think where he
9 was saying clinical information store was through CHKS
10 NIECR and DARO. 12:52
11 214 Q. Was this all information in relation to Mr. O'Brien's
12 practice?
13 A. Generally.
14 215 Q. I see Noeleen Elliott's name there as well. She's
15 Mr. O'Brien's secretary. 12:52
16 A. Yes.
17 216 Q. Were there discussions around her?
18 A. Yes. That's why I'm wondering about the dates of that,
19 whether it was February or March. What I was trying to
20 understand at that point in time is who would know and 12:52
21 where would the escalation be. I think what he was
22 explaining to me was that Mr. O'Brien's secretary was
23 Noeleen Elliott, then she reported to Colette McCaul
24 and Katherine Robinson.
25 217 Q. What the word "Trust." Does that mean -- 12:53
26 A. I think in that case it is, I put there trust -- sorry
27 my handwriting is so bad -- trust processes.
28 218 Q. What is just beside that to the left? Sorry, I just
29 can't make it out?

1 A. It's something about a manager.
2 219 Q. Line manager?
3 A. Line manager. Yes, that's what it was. It was about
4 Noeleen Elliott, Colette McCaul, Katherine Robinson.
5 220 Q. They're her line managers? 12:53
6 A. Yes.
7 221 Q. What's Option 3, just on the right there, above the
8 right there, insight concern, guilt?
9 A. I'm just wondering, I can't remember what that was
10 about. I don't know if it is something to do with the 12:53
11 GMC referral form. But I talked to him about what
12 I was considering in terms of the GMC referral. So it
13 is probably in relation to that, whatever I was looking
14 at.
15 222 Q. Just go over the page. There's another handwritten 12:53
16 note of a meeting on 24th April 2019. We haven't
17 previously had these. This fills in a chronology of
18 actions, as it were, so it is helpful to look at that.
19 A. Can you make that bigger?
20 223 Q. Yes. Okay. This is March. Specifically a meeting 12:54
21 about Mr. O'Brien at the top left?
22 A. This is 24th April 2019. The reason I know that,
23 there's not a date on the top of that page but I looked
24 at the page before and the meeting immediately before
25 that had 24/4/2019, and the day after then -- it runs 12:54
26 in chronological series. I think whenever I checked
27 the diary there was a meeting in on 24/4/19 with
28 Dr. Khan, Siobhán Hynds and Simon Gibson, I think.
29 Those were all of us that were present.

1 224 Q. I don't want to read all of this out but was this
2 meeting called by you or did someone else call it?
3 A. No, I called it. I think it was to do with just trying
4 to mop up any concerns that there were in relation to
5 Mr. O'Brien at that point in time given that there had 12:55
6 been those emails prior to that, and the concern about
7 Patient 90. It was to try to bottom this out because
8 I thought we had an understanding where we were going
9 with this in relation to having a rationale for what
10 happened, but it was to make absolutely sure I had got 12:55
11 this right.
12 225 Q. This is after the email of 24th March from Mr. Haynes
13 about the results issue?
14 A. Yes. 24th March. Yes.
15 226 Q. Is that noted on this? First of all, I suppose, when 12:55
16 you got that email from Mr. Haynes, did you take action
17 in relation to that, about the results not being pulled
18 down from the system?
19 A. Yes. When we went back to check and spoke to Martina,
20 basically what had been agreed at that point in time, 12:56
21 and again it was part of the mitigations that were put
22 in place to try to support Mr. O'Brien. He had been
23 given a Tuesday morning to try and work with results to
24 help him along and get those done. Also then his
25 concern he raised was trying to process results on the 12:56
26 same week he was Consultant of the Week, which happened
27 on a one in six rota, I think. He found the volume of
28 all of that difficult. What had originally been
29 arranged with him would be that he would be reporting

1 by, I think, 4 o'clock on a Friday. But basically what
2 was then arranged with his operational managers was
3 he would get an extension through until the Tuesday to
4 get that done. So whenever these concerns were being
5 raised about 4 and 7 day delays, actually what it was 12:56
6 related back to was where those extensions and
7 those didn't seem to have been communicated back into
8 the system, but that was the rationale for the delays
9 with that.
10 12:56
11 Then the other issue that was around this point in time
12 was Patient 90 who was the man who had had the
13 intervention, I think, in February 2018, that
14 Mr. Glackin had chaired the SAI on, and then had raised
15 the five recommendations in terms of anaesthetic and 12:57
16 postoperative practice.
17 227 Q. There was no sense at this stage about the prolonged
18 period of failing to look at results.
19 A. No. And there was no mention of 2018.
20 228 Q. I just notice on the right-hand side, I presume this is 12:57
21 the same meeting?
22 A. Yes.
23 229 Q. Expectation -- sorry, about five out of service.
24 Manager action plan. At this point still relying on
25 the action plan from 2017? 12:57
26 A. Yes. I have written in there, 'escalated to case
27 manager by Dr. Khan`. That was me checking out all
28 that was in place.
29 230 Q. Just from, Mr. O'Brien considered that that action plan

1 expired at the end of the MHPS procedure in
2 September 2018. It had been intimated to him that that
3 action was with time limited. You weren't aware of
4 that?
5 A. No. 12:58
6 231 Q. I'll take you to that this afternoon, I just to see the
7 time. It is still the default position, even in light
8 of these new concerns, was default escalation and
9 reliance on the action plan?
10 A. Yes. I think just to, you know, to go back to what 12:58
11 I said earlier, because the secretarial staff seemed to
12 be raising concerns fairly immediately about delays,
13 I think it reinforced the idea that this was working.
14 232 Q. I see you have asked there:
15 12:58
16 "Are we confident that this is robust?"
17 A. Yes.
18 233 Q. Is that self-reflection or something you asked the
19 other members of the --
20 A. That's a question I put to them. 12:58
21 234 Q. What was the answer?
22 A. They were confident it was. That all was in place that
23 needed to be in place.
24 235 Q. I think that meeting was with Dr. Khan, Simon Gibson
25 and Siobhán Hynds? 12:58
26 A. Yes.
27 236 Q. They all reassured you there was no divergence of
28 opinion that we need to do more?
29 A. Mostly the assurance would have be come from Dr. Khan,

1 because he was the case manager. He was explaining to
2 me that he hadn't had any escalations, he knew what the
3 process was and he was confident that it was being done
4 because he was getting communication about it. Then
5 the other bit that I did in relation to that was I said 12:59
6 I would email Mrs Gishkori in relation to doubly making
7 sure so I emailed her. She didn't respond. But
8 recently I have seen -- I had a conversation with her,
9 I think we were at Trust Board the following week, and
10 she said to me she understood that was being managed 12:59
11 internally and there weren't any concerns. I think,
12 certainly in terms of recent discovery and, again, you
13 know, I've had 37 lever arch files in the last 14 days
14 so I can't tell you exactly where this is, but
15 certainly in the midst of Mrs. Gishkori's or someone 13:00
16 else's disclosure, I noticed she had sent my email on
17 to, I think other people to try to get assurance.
18 237 Q. I don't think she got any reply, if I remember.
19 I don't think anything came back. We can check that?
20 A. I think Mr. Haynes responded. I haven't seen 13:00
21 a response from Mrs. Corrigan. Again, I was basing
22 that I wasn't aware she had asked the rest of the
23 system as well. Certainly in terms of the response she
24 gave me it was the assurance that she thought things
25 were in place. 13:00
26 238 Q. Just before we finish, I see on the left "NED". Is
27 that "NED informed"?
28 A. Yes, NED is a nonexecutive director, that was John
29 Wilkinson.

1 239 Q. What was he informed about?
2 A. He was aware of the Maintaining High Professional
3 Standards process.
4 240 Q. He had been previously involved in that so he was aware
5 of that? 13:01
6 A. Yes.
7 241 Q. Was he informed of anything else?
8 A. I can't remember whether or not he was informed of the
9 recent concerns or not. I would need to check that.
10 I honestly don't remember. 13:01
11 242 Q. Just so we're right in the chronology of when the Board
12 were aware of issues, it would be helpful if you could
13 clarify that.
14
15 Chair, I just see the time, if that's convenient? 13:01
16 CHAIR: 2 o'clock then, everyone.
17
18 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:
19
20 243 Q. Dr. O'Kane, I wonder if we could pick up where we left 14:02
21 off, and the email you had referred to receiving from
22 Mark Haynes, 24th March 2019. I think we located that.
23 If you could call it up. TRU-279349. It is about
24 chasing up information. You'll see that is from
25 Katherine Robinson, the Booking Centre Manager; is that 14:03
26 right?
27 A. That's right.
28 244 Q. If you move up one email after that. This email is
29 dated 15th December 2018. It is from Mark Haynes to

1 Katherine Robinson and Colette McCaul in reply, talking
2 about the results. He said:
3
4 "The issue for me is not whether or not it was ever
5 received. My concern that there are individuals who 14:04
6 think the reported "results for dictation" data is
7 robust. It isn't. The number is generated at best for
8 some as a guess. Because this regular report is taken
9 by senior personnel in the Trust as robust it is seen
10 as a monitoring tool within Governance processes that 14:04
11 results are being actioned and communicated to patients
12 in a timely manner with no risk of unactioned
13 significant results. I fear your team are at risk, if
14 we have a situation where a patient comes to harm
15 because a result isn't actioned and subsequent 14:04
16 investigation reveals a large number of unactioned
17 results. Your team would be open for criticism for
18 reporting inaccurate information. For Tony, and me,
19 Liz/Leanne look at e-sign-off and the number
20 outstanding on here, plus any sets of notes with hard 14:05
21 copy reports, and this is the number reported.
22 Ironically, although we are the most up-to-date with
23 our admin, we regularly appear to be the ones who are
24 most behind. A question to all secretaries asking them
25 how they get the numbers that they report would be 14:05
26 a starting point, along with a meeting to highlight why
27 this information is collected and the potential
28 consequences of misreporting."
29 That was forwarded to you on 11th March 2019 by

1 Mr. Haynes as a result of results not being actioned.
2 The three months difference in date, was that the first
3 time, 11th March, that you were aware results not being
4 actioned was an issue?
5 A. Yes. I think not necessarily -- because it wasn't 14:06
6 a specific reference to -- I think what is confusing is
7 it wasn't a specific reference to the summertime of
8 2018 when there actually had been a default, and that
9 I learned about later on. I don't know what the email
10 trail was beyond 15th December then between Mr. Haynes 14:06
11 and Katherine Robinson, but my understanding of all
12 that at the time and when I spoke to him about it, he
13 had concerns that actually the secretaries were
14 managing the data in the same way, and it was to ask
15 her to make sure that they were. He talks there, 14:06
16 obviously, in terms of himself and Mr. Glackin in
17 relation to the signoff and the number outstanding and
18 just how that is managed. My understanding was that,
19 on the back of that, he was drawing her attention to
20 the fact that the system might be vulnerable and to 14:07
21 make her aware, I think along the lines of what we have
22 been talking about, which is to make sure that actually
23 they are monitoring the results in the way we expected
24 them to be, or we thought they were, and, you know,
25 warning them that basically being unable to do this 14:07
26 could result in patient harm.
27
28 My understanding of that was he raised concerns about
29 that, about having it drawn to her attention so at

1 least she would be aware of it when she was managing
2 them.
3 245 Q. You can see in the body of that email, whatever the
4 correspondence back and forth in advance of it, that
5 he's raising the issue that there's a risk of 14:07
6 unactioned significant result and the line":
7
8 "I fear your team are at risk if we have a situation
9 where a patient comes to harm because a result isn't
10 actioned and a subsequent investigation reveals a large 14:08
11 number of unactioned results."
12
13 Some of that sits four-square with the information that
14 the Inquiry has received.
15 A. Yes. 14:08
16 246 Q. I'm just trying to identify the point at which you had
17 knowledge of this. 11th March 2019, that was my
18 question, is that the first time you were aware that
19 that was an issue?
20 A. Yes, and that there had been concerns and that he had 14:08
21 been in contact with the administrators in relation to
22 this, just to make them aware they needed to keep eyes
23 on that.
24 247 Q. Did you action anything after that, when you became
25 aware -- when people use phrases like "patient harm," 14:08
26 does that trigger a certain escalation of response in
27 your mind that this is something that needs to be
28 actioned quite promptly?
29 A. Yes. I mean, from memory that email was shared with

1 a variety of people, including the people who had
2 a responsibility for the monitoring, just to make sure
3 that they were aware of it, and for them to come back
4 to me if they had any concerns about discrepancies and
5 that. Again, I don't have the email trail obviously on 14:09
6 there beyond that, but that would have been shared.
7 248 Q. Just, if it assists at all, this was sent to you on
8 11th March at 1703. That's the same day of the note
9 we just looked at 11 March 2019, which was when you had
10 the meeting with Mr. Haynes. 14:09
11 A. This would have been sent after that meeting. Yes.
12 249 Q. Would the results and the reference to results in that
13 be an acknowledgment that the results issue was
14 certainly flagged as a Governance concern at that
15 point? 14:09
16 A. Yes.
17 250 Q. Do you recall what action you took then after that?
18 A. My memory is -- but, again, I would need to check the
19 email trail on it -- my memory was that that was shared
20 with other people to make them aware of Mr. Haynes's 14:10
21 concern and for them to go back, check and, again,
22 based on the assurances they were given, to make sure
23 that they were aware of the same information that
24 Mr. Haynes and I were aware of.
25 251 Q. Did you take any action to interrogate that to see just 14:10
26 precisely what the situation was at that time; what
27 were the numbers, what was the potential harm, and had
28 some already occurred by, potentially, late
29 consideration of results? Was there any proactive

1 action on your part or anyone else's to look behind
2 this email?
3 A. I think in relation to this email and then what, again,
4 Mr. Haynes highlighted on 24th March, again it was
5 about bringing all that together again to make sure 14:11
6 with the system -- and you'll see it in the questions
7 I asked on 24th April -- around are we sure that all of
8 this is robust, that those systems and checks were in
9 place to make sure those were in place, because
10 I personally wouldn't have been in a position to 14:11
11 deconstruct all of that, understand every step and then
12 check it at every step. What I was relying on was the
13 fact the information was shared, I raised the concern
14 in relation to it, and the assurances I was getting at
15 that point in time indicated that this was reliable, 14:11
16 that that was being done.
17 252 Q. Those assurances, then, were received to you by email,
18 were they?
19 A. I think they were given to me, certainly, verbally on
20 24th April. 14:11
21 253 Q. Who was that by?
22 A. That was the meeting with --
23 254 Q. Simon Gibson, Dr. Khan and Siobhán Hynds?
24 A. Yes.
25 255 Q. At the meeting on 24th April those three individuals 14:11
26 were also aware that the results not pulling down
27 results from the system at the time was also a live
28 issue?
29 A. Yes. That was definitely discussed. I would need

1 to see the email trail on this, the full versions of
2 it, just to make sure.
3 256 Q. The email trail between 11th March and 24th April?
4 A. Yes.
5 257 Q. We can have a look at those so you can refresh your 14:12
6 memory about that.
7
8 If I could ask you to look at your witness statement,
9 WIT-45079. The background to the question was one of
10 the themes that is possibly emerging is the fragmented 14:12
11 way in which people knew of some things but not
12 everyone knew of everything. There was reliance on
13 governance processes that, perhaps, arguably not fit
14 for purpose, or not being fed the correct information,
15 or when they were being fed the correct information, 14:13
16 not being acted on. I just want to look at
17 paragraph 49.3. I'll just read the question. We can
18 leave that up on the screen.
19
20 "Having regard to the issues of concern within urology 14:13
21 services which were raised with you or which you were
22 aware of, including deficiencies in practice, explain
23 (giving reasons for your answer) whether you consider
24 that these issues of concern were -
25 properly identified, 14:13
26 their extent and impact assessed,
27 and the potential risk to patients properly
28 considered?"
29 You substantially addressed that at paragraph 49.3

1 where you said:
2
3 "I believe that the issues of concern were eventually
4 properly identified and fully acknowledged, but not all
5 at the same time. Until 2019 and the referral to the 14:13
6 GMC, I think that the system as a whole found it
7 difficult to identify the seriousness of the concerns,
8 despite the fact that a number of individuals over the
9 previous 10 years in particular had been trying to draw
10 attention to these." 14:14
11
12 Just over the page at WIT-45080, the bottom half of
13 that paragraph, the sentence begins "when the
14 concerns," about halfway through that. The second line
15 on the screen. 14:14
16
17 "When their concerns were not taken seriously enough by
18 the system, and in particular by Mr. O'Brien, the
19 colleagues had to resort to workarounds to make the
20 process work for patients. This had the unfortunate 14:14
21 and unintended impact (I believe) of helping to
22 minimise the impact of the behaviours and governance
23 failings and thus inadvertently hiding and prolonging
24 the difficulties in plain sight as various personnel
25 changed and the narrative and memory of the concerns 14:15
26 were thus diluted as a result."
27
28 The email we looked at, would that be an example of
29 a serious clinical concern hiding in plain sight?

1 A. I'm not avoiding the question but I think I would need
2 to see the entire email trail to see.
3 258 Q. Before you look at the email trail, which you
4 identified as being after 11th March -- between 11th
5 March and 24th April, on the bare face of the email 14:15
6 Mr. Haynes sent you, he is clearly identifying
7 a potential patient risk issue?
8 A. Yes. Yes.
9 259 Q. He actually used the word "harm"?
10 A. Yes. 14:15
11 260 Q. Is that an example of what you are referring to in your
12 statement when sometimes things are right in front of
13 people and it didn't trigger a Clinical Governance
14 alarm that one might expect?
15 A. Yes. I think, I mean -- and, again, not having full 14:16
16 context of it in front of me, I think there were
17 definitely smoke signals throughout the whole system
18 and, you know, always with a group of us, you know, or
19 groups of people at any given time having access to all
20 the information but not actually getting to -- again, 14:16
21 I think having this idea that actually he was doing his
22 best in the middle of it all, that actually if we could
23 get the Governance systems, if we could get the
24 administration systems to work, then everything would
25 be fine. I think it's not until you -- it is a bit 14:16
26 like taking a clinical history. Sometimes you get, you
27 know, ideas of what might be wrong with the patient
28 but, actually, until you get a period of time to
29 actually undertake the assessment diagnosis yourself it

1 can be really difficult to see what the pattern is and
2 what is emerging. I think this is the same. All of us
3 had different information at different points in time
4 and I think it is not until we got a bit further
5 through it and had some longitudinal history with this 14:17
6 and could see how all of the pieces fitted together and
7 where proxies for other things that we began to make
8 real sense of this and realise that some of these
9 things were smoke screens.
10 261 Q. Is it possible at this point in time, March 2019, was 14:17
11 actually the high watermark of your knowledge about
12 Mr. O'Brien, because you are preparing your GMC
13 referral? You've read the MHPS, you've had a look
14 around all the relevant data. It could be suggested to
15 you, and I will suggest, that if anyone knew the whole 14:17
16 picture as was possible to be available without
17 actually speaking to anything else from a paper review,
18 it was you. So would that have informed your referral,
19 or do you think maybe now looking back that other
20 actions should have been taken given the clear 14:18
21 indication of potential patient harm?
22 A. The information that I had stretched back to 2016 with
23 the beginning of the approach into Maintaining High
24 Professional Standards. Until, I think,
25 we got June/July 2020, a lot of the information that 14:18
26 had gone before that I was completely blind to it. It
27 had not been shared to me. I maybe had snippets of
28 things, but nothing very comprehensive. On the face of
29 it, it looked like this doctor had been difficult to

1 manage for a long time and had got into difficulties
2 since 2015/2016, and, again, the narrative at that time
3 was if the administration processes could be sorted
4 out, that would get him back on track again. Right?
5 In hindsight, knowing now what I know, these 14:18
6 difficulties were going back to at least 2009 and that,
7 actually, you know, these were symptoms of something
8 else, not what they looked to be on the face of it.
9 I think I would have approached it differently. I do
10 think if I had known then what I know now, my approach 14:19
11 to this would definitely have been different. Right?
12 But I also think, in fairness, the one person in all of
13 the middle of this who knew his entire history was
14 Mr. O'Brien. Again we were relying, I think wrongly at
15 this point in time, on his probity and honesty in 14:19
16 relation to letting us know if he wasn't doing the
17 things we asked him to do, and at no time did he
18 present that information.
19 262 Q. The next sequential email for the purposes of this
20 engagement is TRU-252529. It is an email from you sent 14:19
21 on 8th October 2019. You'll see your name at the top
22 of it and the date 8th October 2019 from you to Mark
23 Haynes, Melanie McClements, Dr. Khan and Siobhán Hynds,
24 subject AOB-oversight meeting. Attachment, urgent, AOB
25 concerns, urgent, oversight meeting request, action 14:20
26 plan. You have written this. I'll read it out for the
27 transcript?
28
29 Discussion draft notes:

1 1. Concerns re escalation,
2 2. Concerns process,
3 3. Concerns re PP. **I presume that means private**
4 **patients?**
5 A. **Yes.** 14:20
6 263 Q. Making arrangements for investigation through the NHS.
7 Query interface with PP policy. Letters no longer on
8 NIECR now that patients are on list without letter.
9 Consider how tracking.
10 14:21
11 Plan point 1, how can each be monitored and how is this
12 escalated if concerns. Monitor through the Information
13 Office.
14
15 2. Concerns re notes at home - weekly spot check? 14:21
16 Meant to sign notes out - he has a condition on his
17 action point that he is not to take notes home - make
18 assumption that if notes not in his office or clinic or
19 theatre they are in his home? No transport to take
20 notes between Cah and Swah. Monitoring difficult. 14:21
21
22 3. Martina can only monitor what she is given - his
23 secretary has not engaged. Martina has had to go on to
24 ECR to check if notes uploaded.
25 **There is no point 4.** 14:21
26
27 5, IR1 went in from MDT on Wednesday last re first
28 delayed cancer patient. AOB letter on patient sent
29 Friday.

1 6, second patient did not come to harm following
2 escalation to MBT by trackers, which builds contingency
3 checks into the system for all clinicians in Urology.
4
5 Then you put a plan. 14:22
6
7 1, We'll ask Mr. McNaboe to discuss concerns with AOB
8 to make aware that this has been raised with the MHPS
9 case manager on leave until Monday. Will consider
10 escalation plan including option to exclude. Will 14:22
11 consider the full system review September 2018 and
12 progress."
13
14 Do you remember what triggered this email?
15 A. Yes. This was the outworkings of the discovery that 14:22
16 Martina made in September 2019. Mr. O'Brien's
17 secretary had gone on annual leave and the secretary
18 who was in in her place brought to Martina's attention
19 that there was a discrepancy in the way results were
20 being reported. In relation to that, at about the same 14:23
21 time then, Mr. Haynes had raised with me that the
22 multi-disciplinary team in Belfast had raised concerns
23 about a delay in patient care about a patient who
24 potentially missed a three-month window of treatment.
25 Right? Those two issues were overlapping in terms of 14:23
26 the delay. So on the basis of that, and then on the
27 basis of discovering then that Mr. O'Brien had been on
28 leave in the midst of all of that, what I asked them to
29 do was to go back and check the systems and processes

1 to make sure that we were capturing the information and
2 that there weren't any gaps in all of that. Martina
3 had gone on and checked off against what was going on.
4 It was at that point then she discovered, I think from
5 the replacement secretary, that actually when she was 14:24
6 turning up, for example, to say to the secretary, you
7 know, Mr. O'Brien saw 11 patients last Monday, or
8 whichever day he went, is the dictation there? The
9 secretary was reporting back, yes, I can see 11 letters
10 on the system, but the bit of information that was 14:24
11 missing at that point at the time was those 11 letters
12 belonged to 11 patients rather than five patients with,
13 approximately, two letters apiece. Right? So that was
14 something she was concerned about, and went back and
15 checked all of that to make sure everything was 14:24
16 up-to-date and there wasn't anything else missing in
17 relation to that. That was a point that Martina made
18 in relation to saying that the secretary hadn't
19 engaged. She felt she had answered the question she
20 had been asked but she hadn't given the full answer 14:25
21 when she was asked these questions, do you have 11
22 letters? Yes I have 11 letters, but not the caveat to
23 it.
24
25 The IR1 that's in there, as I say, is in relation to 14:25
26 the Belfast MDT patient. We don't think an IR1 ever
27 went in, but what we did was we followed it anyway and
28 realised there was an overlap with one of the patients
29 we discovered in this that did have the delay.

1 264 Q. Is there an email trail before this then?
2 A. There should be emails back and forth, I think, from
3 September 2016 in relation to this.
4
5 But just to re-assure you, all of our business did not 14:25
6 happen on email. There were lots of conversations in
7 between times.
8 265 Q. You don't have to re-assure me. I appreciate that.
9 I think it was Melanie McClements -- and we'll come to
10 it -- where she suggests that the dominant form of 14:26
11 governance in Urology was by email. It springs to mind
12 when you say that, but that's a point for another day.
13 I think, from the information we have, that certainly
14 is borne out; a lot of the information that is
15 available is as a result of email. I know it is not 14:26
16 the be all and end all, people do talk to each other,
17 it's just trying to find the narrative. That's, you
18 know, where I'm at. We're leading up to the end of
19 2019 when I know there were attempts made then to meet
20 with Mr. O'Brien. He tasked Mr. McNaboe to arrange 14:26
21 a meeting with Mr. O'Brien. Was that in the hope that
22 all of those issues would be resolved? I assume this
23 was another informal way to try and get things sorted
24 out, if I can use that shorthand. You were asking
25 somebody to have a word with him? 14:27
26 A. Yes. Again, it is back to one of the things that
27 clearly did not exist within the Southern Trust that we
28 were working on at that time was a robust process
29 around job plan escalation and management. This had

1 been mentioned all the way through in terms of
2 Mr. O'Brien's nonengagement with the job planning
3 process, until he retired. Part of the discussion then
4 was in relation to asking Mr. McNaboe just to speak to
5 him about the Maintaining High Professional Standards, 14:27
6 concerns in relation to the records and how those were
7 being recorded, but also to speak to him then about his
8 job plan. There are other emails in the system about
9 that. I think Mr. McNaboe and Mrs Corrigan wrote to
10 Mr. O'Brien offering to meet with him in November. He 14:28
11 came back to say he didn't have enough notice and
12 cancelled the meeting, but that would have been
13 Mr. O'Brien's pattern. Then, I think, to try to have
14 the conversation with him Mr. McNaboe had met him in
15 passing one day, and I think had raised these issues 14:28
16 with him, basically to make him aware and also to raise
17 with him again that I was still wondering where this
18 job plan was, as was the rest of the system. The
19 assurance Mr. O'Brien, as I understood, gave to
20 Mr. McNaboe at that point in time was in relation to 14:28
21 the job plan that was in hand, and by the time,
22 I think, Mr. McNaboe got to speak to Mr. O'Brien we
23 were farther through in relation to this in
24 understanding that there had been a gap in the
25 proceedings because of his leave, and that we were -- 14:28
26 again the system was assuring itself that in terms of
27 results we were getting reporting on that.
28 266 Q. Just for the Inquiry note, Mr. O'Brien has included in
29 his bundle various emails. I'm just going to read out

1 the references. You don't have to go to them.
2 AOB-02259 to AOB-02261. That's email correspondence
3 between Mr. O'Brien, Martina Corrigan, Mr. McNaboe
4 dated 6th November 2019, arranging a meeting to discuss
5 concerns about Mr. O'Brien's deviation from the work 14:29
6 plan. Mr. O'Brien saying he won't have time as he
7 works through lunch than to risk to Patient Safety.
8
9 Then a further email, AOB-02262. This is a letter to
10 Martina Corrigan to Mr. O'Brien dated 7th November 2019 14:29
11 responding to requests for a meeting re deviation from
12 the work plan. Mr. O'Brien doesn't want to meet during
13 the cancer review clinics and said that the action plan
14 expired in September 2018 -- we discussed that
15 earlier -- with the conclusion of the MHPS 14:30
16 investigation. Then there is AOB-02269. This is an
17 email from Joanne Donnelly to you on 12th November
18 2019. She is looking for further information about the
19 alleged deviation from the action plan, asking if
20 Mr. O'Brien was complying before, has he made any 14:30
21 comments about it, what is the Trust's plan for action
22 taken, are measures put in place to address
23 Mr. O'Brien? You responded, and that letter is at
24 AOB-02270 to 02273. It is a letter from you to Joanne
25 Donnelly. It is undated but the body of it explains 14:31
26 that it's a response explaining the action plan put in
27 place, weekly, summary, email initially, then
28 from November 2018 only advised about significant
29 deviations as determined that Mr. O'Brien was

1 reasonably compliant at that point. Intend to meet
2 with Mr. O'Brien to agree an action plan but once
3 agreed it will be monitored and non-compliance will
4 lead to disciplinary procedures.
5 14:31
6 That particular email, given that you have asked
7 Mr. McNaboe to meet with Mr. O'Brien, and I know
8 there's a bit of toing and froing about whether that
9 actually happened. It's another area of contested
10 evidence the Inquiry will hear, but it, sort of, 14:31
11 doesn't sit with what you've told Joanne Donnelly.
12 There seems to be a suggestion that you are going to
13 meet with him to agree an action plan which will be
14 monitored, and non-compliance will lead to disciplinary
15 procedures. Was that a change in tact from what the 14:32
16 expectation was with Ms. Corrigan and Mr. McNaboe in
17 their being with Mr. O'Brien?
18 A. Would you mind if I saw that on the screen, please?
19 267 Q. Certainly. That is AOB-02270. That's your signature
20 at the end. 14:33
21 A. Mm-hmm.
22 268 Q. Then we go back, that's from you to -- the last email
23 from Joanne Donnelly had been dated 12th November 2019.
24 You have obviously dated her letter in your reply, so
25 that's where we know the sequence is because it's 14:33
26 dated.
27
28 She's asked you three questions: Can you advise
29 whether there's any evidence to demonstrate that

1 Dr. O'Brien was complying with his agreed local action
2 plan up to September '19 when the deviation occurred?
3 This is obviously February 2017 action plan. If you
4 just move down, you said it was shared with Mr. O'Brien
5 in February 2017, that there was a summary email weekly 14:33
6 by the Service Manager to the Case Manager. There were
7 occasions when the backlog reports identified small
8 deviations, but given the complex nature of the
9 monitoring process we could not be confident that these
10 were true deviations that actually resulted from delays 14:34
11 in transcription of clinic letters by administrative
12 staff and so continue to assess compliance. These
13 small deviations were not showing consistently from
14 one month to the next. In or around November 2018 the
15 Case Manager sought only to be advised on significant 14:34
16 deviations from the action plan as he determined that
17 Dr. O'Brien was reasonably compliant.
18
19 In terms of evidence of compliance with the action plan
20 the following monitoring arrangements were and remain 14:34
21 in place. Then the next page is the February 2017
22 accounts plan. You're familiar with that?
23 A. Yes.
24 269 Q. Clinical dictation, triage, keeping notes at home, and
25 the private practice issue. 14:35
26
27
28 The next question they ask is: Has Dr. O'Brien made
29 any comments to the Trust in response to the recent

1 deviation from his agreed action plan in September '19,
2 and he had made comments.
3
4 Then: Regarding the recent incident in September '19,
5 can you provide an update on what actionS the Trust 14:35
6 plans to take against Dr. O'Brien? Specifically, are
7 any measures being put in place to support Dr. O'Brien
8 and help him address current deficiencies?
9
10 The Trust had offered a meeting with Dr. O'Brien on 14:35
11 12th December for further discussions on his job plan
12 which will include measures to support him in working
13 practices. As this meeting has not yet taken place we
14 have not had the opportunity to discuss the issues
15 raised in this letter to clarify expectations, agree an 14:35
16 action plan, and consequence of continued
17 non-compliance. Once an action plan has been agreed,
18 it will be monitored and non-compliance will lead to
19 the implementation of appropriate Trust disciplinary
20 processes. 14:36
21 That's it.
22
23 I want to marry up the emails and the content of that
24 letter to Joanne Donnelly. It seems, taking it at face
25 value, that is suggesting to her that there is going to 14:36
26 be an attempt to meet Mr. O'Brien and to agree
27 a different action plan, or amend the current action
28 plan in the belief that that action plan was still
29 valid. Obviously Mr. O'Brien has a different view on

1 that, but is that what the expectation was, that talk
2 of an action plan was a new action plan that was
3 envisaged?
4 A. No. It's not very well expressed there. In my mind it
5 was reinforcement of the existing action plan to make 14:37
6 sure it was still in place, and if there were any
7 reasons it should be changed, then obviously, that
8 would be done. But, again, back to the point what we
9 were mindful of was that if there was significant
10 deviation from that that, then we would process that as 14:37
11 non-compliance.
12 270 Q. Sorry, just so I'm clear on your answer. It says to
13 agree an action plan and once the action plan had been
14 agreed. You're saying what you are talking about there
15 is the action plan from February '17? 14:37
16 A. Yes. To go back and revisit it to make sure that,
17 actually, the idea behind that was to make sure that he
18 knew that he was being monitored in all of those
19 domains, and if there was anything else that arose out
20 of that, that that would have been identified within 14:37
21 all of that. Again, just to emphasise if that wasn't
22 being complied, then we would be following the Trust
23 disciplinary processes, the same as we had been trying
24 to.
25 271 Q. This is 2019. Is it fair to suggest that he was being 14:38
26 monitored in all of those areas, given this was 2 years
27 later?
28 A. Yes.
29 272 Q. As regards an effective way forward, do you agree with

1 me if one were to read that letter and not ask you the
2 questions I've just asked you, it would seem to
3 suggest, on the bare face of the letter, that there's
4 going to be a new action plan?
5 A. I don't think I worded it particularly well but the 14:38
6 idea behind it was to reinforce what was already there.
7 Because, you know, the areas that were identified as
8 part of the action plan from 2017 still stood at that
9 point in time. Those were the areas that we were
10 monitoring. We hadn't had any discussion about 14:38
11 monitoring anything different at that point in time,
12 because there was nothing to indicate that we should.
13 273 Q. Given what you knew at that stage, the parameters were
14 broadening, the parameters of concern seemed to be
15 broadening. This is the point which you knew about the 14:39
16 results, for example. Do you think the way the letter
17 is worded might have given the GMC some sort of false
18 reassurance?
19 A. I hadn't thought about it until now but, yes, I think
20 there is a suggestion in there that we would be 14:39
21 proactive or do something we weren't already doing.
22 But in relation to how we were managing Mr. O'Brien
23 already and escalating any concerns we had to the GMC,
24 they knew that -- you know, I would have presumed they
25 would have -- I don't remember having a specific 14:39
26 conversation with them about it, but it wasn't any
27 deviation from what our usual plan would have been
28 which was, when we bottomed out, when we investigated
29 what was presented to us, bottomed out, and if there

1 was anything for us to be concerned about, we would
2 have managed it. But the difficulty, I think, is when
3 you talk about the parameters of this broadening,
4 I think what we're finding is there's a repeated
5 pattern rather than it getting any wider. Because, 14:40
6 again, it's still back to the business of how notes or
7 dictation is monitored from clinics and other work.
8 Again, I think the pattern with this was from early
9 2019, that's what the anxiety was raised about. In
10 late 2019 that is what the anxiety was raised about. 14:40
11 It wasn't being raised about any other point in his
12 practice at that point in time.
13 274 Q. Is it two consistent governance concerns were
14 non-compliance and deviation; would you agree with
15 that? 14:40
16 A. Yes.
17 275 Q. They alone maybe would have triggered a different
18 approach, perhaps, at this point?
19 A. Yes. My difficulty was there always seemed to be
20 a reasonable explanation for it. Right? In 14:41
21 retrospect, now I know a lot more about this, I think
22 that I wouldn't have accepted the reassurances that
23 I heard at that point in time. I think I would have
24 taken it a bit further.
25 276 Q. There was obviously a meeting held after this, a week 14:41
26 later. There's a letter from Joanne Donnelly. It's
27 not dated I am not sure if it was before or after. It
28 is WIT-90984. It is a written notes of meeting on
29 19th November 2019. This is your notebook again.

1 A. Mm-hmm.
2 277 Q. I don't suppose you remember if the letter predated
3 this?
4 A. I actually don't. I would need to --
5 278 Q. It's okay. 14:42
6 A. I honestly don't.
7 279 Q. I don't suppose point number 1 says AOB-letter, does
8 it? I just can't make it out?
9 A. Yes, it does.
10 280 Q. I should have read it before I asked the question. I'm 14:42
11 not sure it helps us, but there we are.
12
13 TED, number 3 there, I'm not sure what number 2 says,
14 but you will know?
15 A. JP, job plan, finalised. 14:42
16 281 Q. Just on the job plan. There's a lot of documentation
17 on that we're not going to go into detail on it today,
18 but it certainly seemed to take up a considerable
19 amount of administrative time backwards and forwards
20 and the negotiations, if I can put it like that, on 14:42
21 what would be an acceptable job plan. This was before
22 your time, but I can see that obviously the thread
23 continues to run during your tenure. Do you think that
24 negotiations around things like job plans can serve to
25 remove a governance lens from what time might be better 14:43
26 spent looking at? If you have staff here that are
27 constantly engaged in trying to settle job plans, is
28 that a potential governance weakness because they're
29 not doing other things?

1 A. Yes. The vast majority of people will engage with the
2 job planning process. You know, sit down with their
3 Clinical Director, Head of Service, and negotiate what
4 needs to be done, put it within a timetable, then if
5 there are deviations on that, they'll come back and 14:43
6 work that out. Right. Very often people are in
7 established ways of working, that will get rolled over
8 from year to year, maybe with some changes. But,
9 actually, it is a fairly straightforward process.
10 With Mr. O'Brien, as I understand it, the issue was 14:44
11 that he -- despite the fact we didn't ask him to --
12 worked late into the evening. He would have done ward
13 rounds at night or gone to see the patients at night,
14 he would have done various things at night, and he
15 wasn't job planned to do that and we didn't ask him to 14:44
16 do it because we didn't think it was necessary to do it
17 because there were people on the wards, junior doctors
18 and other people about. He was quite persistent, as
19 I understand it, in asking to be paid for that, even
20 though we were saying it is sitting outside hours of 14:44
21 work. What you need to do is finish the job and go
22 home. That is, as I understand it, what most of the
23 frustration was around. It was, again, about trying to
24 channel him back into that. He already was on
25 a reasonably high number of PAs to cover the work we 14:44
26 were asking him to do. Again, I know there had been
27 various attempts at various stages to do that.
28 I think back to the point earlier, the job planning
29 process escalation wasn't well embedded in the Trust at

1 the time. We have since rectified that, so there
2 should be a clear escalation if job plans aren't agreed
3 within a time frame of 3 weeks it starts the escalation
4 right through to appeal. There aren't any other job
5 plans that should sit for extended periods of time like 14:45
6 this in the way this did.
7
8 I think what it serves to you do, as you say, is
9 obfuscates from some of the main issues, which is a lot
10 of time and energy put intol trying to negotiate that, 14:45
11 and then it takes the time and energy off some of the
12 other areas that should be looked at.
13 282 Q. I was making the point in relation to a management
14 viewpoint rather than any suggestion otherwise, but
15 I think your answer has addressed that. 14:45
16
17 It is also the case that the job plan, in parallel with
18 an appraisal is a way in which someone could indicate
19 that they need support and help if they are not able to
20 either meet the demands of their current role or feel 14:46
21 that they need more time to do that. Is that fair
22 comment?
23 A. That's absolutely right. It is in the doctor's
24 interest to get their job plan, their appraisal done,
25 because the appraisal is based on the job plan. That 14:46
26 is what they are appraised against.
27 283 Q. Back on this note, head speaking to him about
28 retirement. Is that Mr. O'Brien?
29 A. Yes. There had been some suggestion at that point in

1 time, and I think -- if I remember this properly.
2 I think there was some suggestion that Mr. O'Brien was
3 suggesting he was going to retire at that point in
4 time. I think that had been mentioned to me, that
5 there had been a discussion about that. But that 14:46
6 discussion didn't go any further at that point in time
7 because very often you hear about people retiring in
8 the Health Service all the time, and until you actually
9 see the paperwork it may or may not happen.
10 284 Q. Were you involved in the lead up to Mr. O'Brien's 14:47
11 requirement? Let's just deal with that now, as it has
12 come up. Did you play any role in preparing him for
13 that or speaking to anyone about that? I know there
14 was an expectation or a hope that he would come back
15 after his requirement, which didn't come to fruition. 14:47
16 Did you play any part in any of that time period?
17 A. As I understand it, Mr. O'Brien contacted Mrs Corrigan
18 to tell her he was thinking of retiring. I think he
19 maybe alerted her to that about February 2020 and then,
20 I think, submitted the paper work in March 2020 with 14:47
21 a view to finishing end of July. In normal
22 circumstances what particularly senior consultants
23 would do is write to their Responsible Officer, who was
24 me, and Director of Operations, who was Melanie
25 McClements at that point in time just expressing the 14:48
26 fact that they are coming to an end to give the
27 Responsible Officer and the Operational Director time,
28 I suppose, to, you know, support them through that
29 process and actually then, you know, appoint

1 a replacement. I didn't have any communication from
2 Mr. O'Brien at all. I was being made aware that he was
3 certainly thinking about it. I know at the time when
4 HR spoke to me about processing his paperwork they
5 said -- now off the top of my head I can't remember 14:48
6 who it was in HR, but I know that I had a conversation,
7 you know, drawing their attention to the fact that he
8 had been recently managed under Maintaining High
9 Professional Standards. I had referred him to the GMC
10 and he had not been revalidated on 27th April, and that 14:48
11 had been rolled over. You know, if there were any
12 thoughts about him coming back that would be highly
13 unlikely because he was a doctor and we had concerns.
14 If he was going to retire, that would be the end of it.
15 285 Q. Who would be the final decision maker in that process 14:49
16 of saying no?
17 A. Well, there's no -- basically you don't -- it's not an
18 another right of passage that you retire and you come
19 back to work. You have to be invited by the Trust.
20 Neither Melanie McClements nor I invited him to come 14:49
21 back. I'm fairly sure Mrs. McClements didn't.
22 I haven't spoken to her but I'm pretty sure she didn't.
23 Usually it would be at that level, or at the level of
24 Associate Medical Director and Co-Director in
25 consultation with the system to make the Directors 14:49
26 aware. You can only practice as a doctor if you have
27 a Responsible Officer: If I was voicing concerns about
28 being his Responsible Officer he wasn't going to have
29 one if I wasn't happy to stand over, you know,

1 a continuation of what was going on.
2 286 Q. Once he retired then the Responsible Officer becomes
3 the GMC?
4 A. It automatically becomes the GMC, yes.
5 287 Q. Did you speak to Mr. Devlin about that, about the 14:50
6 possibility of both Mr. O'Brien retiring and the
7 decision to be made about whether he comes back or not?
8 A. The time that sticks out in my mind that I spoke to
9 Mr. Devlin about it was in and around the time that
10 we discovered the difficulties in June in relation to 14:50
11 the discrepancies, then explained to Shane that
12 Mr. O'Brien was planning to retire that summer. I made
13 a remark along the lines of there's some suggestion
14 that he wants to come back and work for us. He hasn't
15 made any formal approaches. We certainly haven't 14:51
16 invited him back but given all that's going on
17 I wouldn't be suggesting that. I wouldn't be happy to
18 stand over it, essentially. But that was the gist of
19 the conversation that we had. I think it was in the
20 context of making Mr. Devlin aware that we had these 14:51
21 concerns about Mr. O'Brien but, actually, we knew that
22 his tenure was coming to an end quite soon.
23 288 Q. It was ultimately Mark Haynes then who spoke to
24 Mr. O'Brien?
25 A. Yes. That would be typical. It would usually be the 14:51
26 Clinical Director, or the Associate Medical Director,
27 or the Head of Service. Yes.
28 289 Q. Just back to the note. Backlog -- if you could read
29 that out rather than me trying to get what it is.

1 Number 4. "Backlog." Can you read that out for me?
2 A. Backlog importance and response by 22nd.
3
4 I'm not sure -- I looked at this and I'm not sure if
5 that was in relation to Urology or if that was in 14:52
6 relation to Surgery generally, because the next points
7 we were talking about desist notices in surgery, which
8 was about blood desist notices and mental capacity
9 desist notices.
10 290 Q. You talk about ENT there as well. 14:52
11 A. Yes, ENT is mentioned there as well.
12 291 Q. Is this a general meeting?
13 A. Yes, this was a general meeting one. That discussion
14 with the IRS was a discussion not about urology, it was
15 a discussion about colorectal surgery at that point in 14:53
16 time.
17 292 Q. Where we are in relation to Mr. O'Brien is that you've
18 liaised with the GMC, Mr. McNaboe is to meet up with
19 him and discuss the concerns that you have articulated
20 in that letter to the GMC, and supposed to meet with 14:53
21 Martina Corrigan. Mr. McNaboe then indicates that he
22 met Mr. O'Brien in the corridor and had the discussion
23 with him. Martina Corrigan reflects in her statement
24 that she wasn't part of that discussion because it
25 happened in that more ad hoc way. Mr O'Brien's version 14:53
26 is he went to Mr. McNaboe's office, it was locked and
27 there never was that meeting. I just want to put that
28 to you. Did Mr. McNaboe report back to you after he
29 spoke to Mr. O'Brien?

1 A. I didn't speak to Mr. McNaboe himself, but Martina
2 explained to me that Mr. McNaboe had spoken to
3 Mr. O'Brien and it had been an informal conversation.
4 She meant it wasn't at a set time and place and in an
5 office. I think they met in a corridor, had the 14:54
6 conversation about it, and she wasn't party to it. The
7 original plan was both of them would meet with
8 Mr. O'Brien.
9 293 Q. As regards the assurance that you received that
10 Mr. O'Brien was going to try and adhere to the action 14:54
11 plan, I presume that was the assurance that you did
12 receive at that point?
13 A. I mean, as I understand it, and, again, we're relying
14 on my memory because I can't see where I've written it
15 down anywhere, Mr. McNaboe was to speak to him about 14:54
16 his job plan and he said he would get to that and to
17 draw to his attention that obviously we'd had concerns
18 about some of the discrepancies in this and to make him
19 aware that those needed to be kept up to date.
20 294 Q. Also about the -- I don't see any reference in that 14:55
21 email of the 8th October 2019 to the job plan but
22 there's certainly -- and I'll ask Mr. MaNaboe to
23 discuss concerns with AOB to make aware that this has
24 been raised with the MHPS case manager, will consider
25 escalation plan, including an option to exclude. So 14:55
26 that's what you thought he was talking to him about but
27 he talked to him about the job plan?
28 A. By the time Mr. McNaboe had got to speaking to
29 Mr. O'Brien, right, in relation to the thought about

1 exclusion, that had been stood down because whenever we
2 looked at -- that would have been in relation to the
3 combination of the delayed -- the discrepancies in the
4 reporting that Martina had picked up, plus the concern
5 that Mr. Haynes had raised in relation to it the 14:55
6 Belfast Trust MDM patient. Right? When we got in
7 underneath all of that we discovered that the MDM
8 patient wasn't an addition to the discrepancies in
9 reporting, it was part of that. What we found then,
10 whenever we got underneath the discrepancy and 14:56
11 reporting, that was to do with annual leave -- or not
12 annual leave, leave because his mother-in-law had been
13 unwell and there was a rationale for why it was delayed
14 at that point in time.
15 14:56
16 So is there wasn't enough clinically, at that point in
17 time, to suggest that he should be escalated at that
18 point in time and we thought we had got the monitoring
19 back on track again, after he had taken the leave.
20 295 Q. I don't want to the labour the point, but you have my 14:56
21 point about the results issue, the clinical harm, the
22 potential it's not -- I'm just going to remind you of
23 that.
24 A. Yeah.
25 296 Q. So this was September 2019. 14:57
26 A. Yes.
27 297 Q. What happened after that. What happened after
28 Mr. McNaboe spoke to Mr. O'Brien? I don't want to put
29 words in your mouth but do you agree you received an

1 assurance about that conversation through
2 Martina Corrigan?
3 A. Yes.
4 298 Q. As far as you were concerned, the GMC thing was going
5 on in the background effectively? 14:57
6 A. Yes.
7 299 Q. What happened as you turned the corner into 2020 with
8 you? Was there any change in approach, any concerns
9 raised, any issues?
10 A. No, there weren't. So there weren't any other 14:57
11 escalated deviations and there weren't any other
12 Patient Safety concerns raised. Then, as I say,
13 in February there was some mention that Mr. O'Brien had
14 announced that he was retiring. In March he submitted
15 his letter and by that time -- I mean by the end of 14:57
16 March the world had changed because we were in the
17 throes of trying to manage COVID. So a lot of surgical
18 activity -- I mean it has been one of the big victims
19 of COVID, there's been a lot of surgical activity,
20 including a lot of work the urologists did was stood 14:58
21 down. Again, in terms of patient contact and
22 everything else, that was really limited at that point
23 in time.
24 300 Q. Just before we move into the look-back area and what
25 triggered that -- 14:58
26 A. Yeah.
27 301 Q. -- I just want to briefly speak about the way in which
28 you engaged with the Board during this period of time.
29 As I said earlier this morning, there was one mention

1 in 2017 to the Board of MHPS and then there doesn't
2 appear to have been any discussion at all of
3 Mr. O'Brien at Trust Board meetings until 2020 - the
4 period we're just about to move into - there don't seem
5 to be any updates to the Board on the MHPS or the Board 14:58
6 don't seem to have sought any updates, to be fair, not
7 explicitly on the notes anyway.
8
9 Now, Roberta Brownlee, in her Section 21, indicates
10 that there was always an opportunity at the end of each 14:59
11 Board meeting for any member of the SMT present, or the
12 Chief Executive to raise any issue, it was basically an
13 open question: Is there anything we should know about,
14 are there any concerns? You attended many of those
15 Board meetings in your role as Medical Director; is 14:59
16 that right?
17 A. Yes. Yes.
18 302 Q. Just the way you were looking, I don't want to assume
19 anything. And you would have known about the MHPS and
20 the subsequent deviations and I think what we've 14:59
21 established is there's still inherent clinical risk and
22 certainly harm - the word harm has been used a couple
23 of times. Did you or anyone else ever, either raise it
24 with the Board or think of telling the Board about it?
25 A. There were definitely doctors who were discussed with 15:00
26 the Board in the confidential section of Trust Board,
27 right? But in relation to Mr. O'Brien because, on the
28 face of it - and I accept that it was a false truth -
29 on the face of it we seemed to be understanding these

1 deviations and managing it and we couldn't identify
2 that any patients had actually come to harm. There
3 wasn't anything that triggered an escalation. They
4 would have -- she was made aware, I think, certainly,
5 that Mrs. Brownlee was made aware that I had referred 15:00
6 him to the GMC at that point in time because I do
7 remember that was done. I can't remember exactly how
8 it was done but I do know that she was made aware of
9 that. But in relation to the rest of it, it didn't
10 trigger high enough to bring the doctor to attention on 15:01
11 its own. In retrospect it probably should have.
12 I think you're right, there wasn't a tradition of
13 reporting on MHPS to Trust Board and the
14 Southern Trust. That has now been established so
15 that's now in place but it certainly wasn't there up 15:01
16 until July 2020.
17 303 Q. It wasn't standard practice to tell them?
18 A. No. No. Hadn't been.
19 304 Q. Would it be fair to say there was a bit of timidity
20 about challenging Mr. O'Brien because you were unsure 15:01
21 of Trust expectations around some of the work you were
22 expecting from him, for example, triage or turnaround,
23 that there was no policy or guidance? Would you agree
24 that there was a little bit of reluctance to challenge
25 him directly? There wasn't a firm footing? Did 15:01
26 you have any recollection of that?
27 A. I don't think it was to do with a lack of policy on
28 triage because it is managed through the IAEP, which is
29 the national guidance in relation to that. And

1 Northern Ireland has its own standards for triage and
2 Mr. O'Brien, insofar as I know, when he was Chair of
3 NICaN many moons ago had signed up to all of that. So
4 I mean --
5 305 Q. What about the dictation? 15:02
6 A. In relation to the dictation there was no -- I'm trying
7 to think which policy that would come under, but I mean
8 there was a reasonable expectation, not necessarily
9 even from the Trust but from the GMC that you would
10 keep up to date in relation to your patients and record 15:02
11 and refer appropriately - all of those kind of things.
12 It's written in through different policies but
13 certainly it would be a good medical practice
14 expectation. But I don't think -- I mean speaking for
15 myself, personally I wasn't being timorous in terms of 15:02
16 challenging it but I got the feeling that over time it
17 had been worn down by, you know, trying to manage, you
18 know, trying to work around him and I think probably as
19 a system I don't think we were courageous enough in
20 doing that. 15:03
21 306 Q. Now, in relation to the Board, go back to that,
22 Roberta Brownlee, in her Section 21 - I'm sorry, Chair,
23 I haven't written down the WIT reference, but it's at
24 paragraph 9 - she indicates the way in which she gained
25 assurance. I'll just read the extract for you. It'll 15:03
26 be information you're familiar with but I want to ask
27 you about, number 1, was she right to gain reassurance
28 from that? And, number 2, should these processes have
29 been better reflective on what was happening on the

1 ground and in the unit?
2
3 As chair I regularly assessed the systems through
4 internal audit, external audit, Board Assurance
5 Framework, Performance reports, Board Committee 15:03
6 minutes, Serious Adverse Incidents, Medical Director
7 and Director of Nursing reports to the Board, Patient
8 Safety and quality of care reports to the Board,
9 Corporate Risk Register, and the Management Statement
10 signed by the Accounting Officer - the CX. Each CX 15:04
11 that I worked with undertook a Clinical and Social Care
12 Governance Review as well as the high-level,
13 overarching Governance reviews generally."
14
15 Just if I could pause there, the clinical and social 15:04
16 care governance review, everybody does that when they
17 come in and sets things up the way they think is the
18 most efficient, is that right?
19 A. I don't know. I certainly hadn't been aware of it
20 being done in recent times with previous Medical 15:04
21 Directors in the Southern Trust, maybe it was done I'm
22 not aware of it. It had definitely been done at
23 a point in time but it wasn't -- certainly what I saw
24 wasn't as comprehensive as the governance review that I
25 think was needed at the time that I arrived. But 15:04
26 governance is something I think that's really dynamic,
27 you know, what passed as governance in 2010 is not what
28 would pass as governance now. It's one of those
29 systems, I think, that has to be constantly thought

1 about and reviewed and updated in the context of what's
2 going on and the increasing, I suppose, evidence base
3 in terms of where you look to try and make sure that
4 patients were seen. So, you know, it wouldn't be
5 unusual for that to be carried out on a regular basis. 15:05
6
7 In relation to the governance review carried that was
8 out after I arrived, I know that Mrs. Brownlee was
9 certainly hesitant about the recommendations in
10 relation to Trust Board and that, I think, meant that 15:05
11 we then progressed with some of it in terms of the
12 improvement but the rest of it I think needed to be
13 teased out over a period of time. So the first 13,
14 I think there were concerns about what was being
15 suggested there, but in relation to the rest of it, 15:05
16 I took the view that that was operational, clinical and
17 social care governance and that we would proceed with
18 that to try and improve on it. Certainly that was the
19 support I got from the Chief Executive.
20 307 Q. I'll go on and read the rest of what she says. I just 15:06
21 want to know if you agree with it:
22
23 "At the end of every board meeting..."
24
25 This is the reference I made earlier. 15:06
26
27 "At the end of any meeting under Any Other Business'
28 I always asked the CX and the Executive Director of
29 Nursing, Medical Director and Director of Social Care

1 and Children's Services if they had anything further
2 that they needed to inform the Board about which was
3 not on the agenda. Minutes will confirm this monthly
4 meeting and this question posed to each I have
5 mentioned. 15:06
6
7 The Board always wished to learn and follow up on SAIs,
8 near misses and any governance issues that they were
9 made aware of. Follow-up reports would come to
10 Governance Committee for assurance of action and 15:06
11 completion. I ensured that there was always
12 a provision of clear reporting, ensuring the correct
13 structures and reporting lines were in place and
14 adequate time to discuss such issues. The CXs and the
15 SMT at every meeting always had the time allowed to 15:07
16 inform the Board of any Governance issues or concerns.
17 This was strongly encouraged and challenged by NEDs and
18 me."
19
20 Is that your recollection of the culture of the Board? 15:07
21 A. Certainly at the end of Trust Board each of the
22 Executive Directors - so that's Medicine, Nursing,
23 Social Work and Finance - are asked for any comments.
24 Up until that point I hadn't brought anything to the
25 Board because it wasn't anything particularly outside 15:07
26 the confidential section that needed to be raised,
27 until August 2020, when I was asked the question and
28 I raised it in relation to Mr. O'Brien. I think the
29 feedback that I got indirectly at that point in time

1 was that it shouldn't have been raised in that way.
2 308 Q. Before we move on to that, it's clear that the Chair is
3 indicating that the wish to learn and follow up on
4 SAIs; do you know if any SAIs ever reached the Board in
5 relation to Mr. O'Brien? 15:08
6 A. Well, the SAIs that were undertaken in relation to
7 Mr. O'Brien were released in, I think, March 2020 and
8 May 2020. So Dr. Johnson's SAIs had begun in 2016 and
9 then were reported at that point in time and
10 Dr. Hughes's then were reported in March 2020. So we 15:08
11 were in the process of working our way through that.
12 It had certainly come up through the Governance
13 Committee that those had been done and there was --
14 because they would have been part of the ordinary
15 reporting in relation to governance. But I think -- 15:08
16 309 Q. If they come up in the Governance Committee, are you
17 saying then that they made their way to the Board?
18 A. Well Governance Committee reports to Trust Board, yeah.
19 So there would have been a link there.
20 310 Q. Are you saying they should have done or did do? 15:09
21 A. There would have been a link there. So the Serious
22 Adverse Incidents, their number - and now their manager
23 - are mentioned through the Governance Committee.
24
25 The other part of it as well, though, just to bear in 15:09
26 mind, was because it was 2020 everything was really
27 disrupted. So the Trust Board meetings were disrupted,
28 governance was disrupted. Lots of things were not
29 working in the way that they normally did. So it was

1 a lot slower. So even in terms of us creating the
2 capacity to deal with all of that and then to bring
3 that back in proper form to Trust Board and everything
4 else would not have been done in the way it normally
5 would have been done. 15:09
6 311 Q. But prior to 2020, if we were to look at those Trust
7 Board minutes, you would expect us to find reference to
8 SAIs?
9 A. In relation to specific -- they would have been --
10 I think they would have been reported generally through 15:10
11 Governance Committee to Trust Board - and I could be
12 completely wrong because I haven't thought about this -
13 but I'm not aware -- there was an obstetric and
14 gynaecology SAI that certainly was brought to Trust
15 Board and discussed. That was mentioned. Obviously 15:10
16 there were elements in relation to the Cawdrey Review
17 that were brought and there were other issues brought
18 at various stages. So SAIs were not unknown to Trust
19 Board but they usually came there because there was
20 significant concern, usually about an individual case. 15:10
21 312 Q. I know you've mentioned the Cawdrey case, but having
22 looked through the minutes, there is no urology SAI
23 brought to the Board; is that news to you?
24 A. At that point in time, probably because of the timing
25 of it, yes, not at that point in time. It would have 15:10
26 been discussed. Now, in terms of the outworkings of
27 the SAIs and then, you know, what fell out of
28 everything in June 2020, that would have been in the
29 urology discussion with Confidential Trust Board. That

1 probably didn't start with Trust Board until
2 September/October 2020.
3 313 Q. The first reference in the confidential minutes is at
4 TRU-130799 and it's 27 August 2020.
5 A. About that time, yes. 15:11
6 314 Q. We'll look at that in a moment.
7
8 I want to just test with you your understanding or
9 agreement with what the Chair of the Board is saying.
10 If any of this, you disagree with it, for example it 15:11
11 wasn't routine to bring SAIs or they weren't actively
12 sought by the Board or any information like that, then
13 this is your opportunity in relation to this specific
14 issue. So that's why I'm pushing it a little bit on it
15 so we understand exactly what the contours of the 15:12
16 accountability was at that particular time.
17 Ms. Brownlee goes on to say?
18
19 The risk register, SAIs and reports from the Chief
20 Executive and SMT members was paramount. I nor any NED 15:12
21 would not know what was happening, operationally, on a
22 day-to-day basis unless the Chief Executive and the SMT
23 informed us. This was constantly stressed, the
24 importance of keeping the NEDs and myself informed.
25 All the Chief Executives that I had worked with on many 15:12
26 occasions would have phoned me to inform of Serious
27 Adverse Incidents and serious clinical issues but
28 I never recall any phone calls or informal meetings to
29 inform me of serious clinical issues in urology, other

1 than what is recorded in my statement.
2
3 Which is that she didn't find out anything until 2020,
4 just to give you an idea.
5 A. Okay. 15:12
6 315 Q. As Chair of the Board I was not aware of the detailed
7 information that is now before the Urology Services
8 Inquiry in relation to clinical issues with
9 Mr. O'Brien. As I refer later, I did not see the
10 detailed Medical Director's report on Mr. O'Brien, 15:13
11 clinical issues that came to the Trust Board
12 in November 2020.
13
14 So you can take it from that the Chair's position is
15 that no one told her anything about any of this and it 15:13
16 was only when the Board were in receipt of your report
17 in September 2020 that she had knowledge of that. How
18 does that sit with the evidence earlier that -- just in
19 relation to timeframe, forgive me, I can't remember,
20 where you felt -- well, I think you said she said, that 15:13
21 Mr. O'Brien had been, I think you said persecuted by --
22 A. That was 11th January 2019.
23 316 Q. If we just take that. Are you saying that from your
24 perspective she knew about the issues in relation to
25 Mr. O'Brien because she referred to that with you or 15:14
26 did you have another discussion with her at some other
27 point?
28 A. No, I never had another discussion with her at any
29 point. She made reference to that in January 2019 in

1 reference to what had gone on before I arrived. But
2 I hadn't had any further discussions with her in the
3 interim.
4 317 Q. So she could have been referring to the fact that the
5 MHPS was brought to the Board in 2017? That could have 15:14
6 been the extent of her knowledge at that point?
7 A. Eh --
8 318 Q. When she made that comment to you in 2019?
9 A. Yes, she could have been but she didn't specify that.
10 319 Q. She didn't indicate anything to you after 2017 or
11 before?
12 A. No. There was no timeframe put on it but she did talk
13 about all of my predecessors.
14 320 Q. You've set out in your statement as well, just for the
15 Panel's note, at WIT-44977, the systems from which you 15:14
16 obtained assurances. Now we've heard about what the
17 Chair looked to to satisfy her governance role. You
18 have a listed a list that includes the Weekly
19 Governance Debrief, the Governance Committee Report and
20 the SAI Oversight Group. 15:15
21
22 If we park the last one because obviously that became
23 quite central once the SAIs were triggered, but prior
24 to that formal instigation of investigation, the Weekly
25 Governance Debrief and the Governance Committee Report, 15:15
26 did concerns around Mr. O'Brien, or any other aspect of
27 urology, ever find a way to any of these reports during
28 your tenure as the Medical Director?
29 A. Not so -- that was one of the developments that we made

1 on the basis of just concerns about how we kept a
2 real-time eye on governance across the trust; right?
3 And that's a fairly comprehensive meeting, the Weekly
4 Governance Review that happens now on a Thursday
5 morning and brings together all aspects. 15:16
6 321 Q. Can I just ask who attends that weekly meeting?
7 A. It's chaired by the Medical Director with the Nursing
8 Director and the Director of Social Work present and
9 then all the governance leads attend, the Divisional
10 Medical Directors and the Education and Quality 15:16
11 Improvement leads.
12 322 Q. It's a broad church, if I can use that?
13 A. As well as people from Complaints and Medical
14 Negligence, all those aspects of it, yeah.
15 323 Q. So there's a potential there to get intelligence from 15:16
16 all those different specialties?
17 A. Yes.
18 324 Q. And professionals?
19 A. Yeah. All of the different areas provide a report into
20 that every week. Now that wasn't always there. That 15:16
21 was something that we developed throughout, I think,
22 2020 in particular in terms of trying to develop it,
23 because just to try to hold the system together in
24 relation to governance. There was quite a lot of work
25 went into it beforehand to get it up and running. So 15:17
26 by the time it was fully operational we had already
27 bottomed out some of the concerns about Mr. O'Brien and
28 we were dealing with that.
29

1 Now what gets mentioned on the Weekly Governance Report
2 is an update on where we are with the Urology Inquiry
3 in terms of servicing, you know, information, but also
4 then in terms of patients who we've referred for STRR.
5 So there's some mention in there in relation to all of 15:17
6 that. And any learning that comes out of that at all
7 is shared through that forum.
8 325 Q. But before we get to that stage, because at that stage
9 there's quite a number of spotlights on what's
10 happening -- 15:17
11 A. Mmm.
12 326 Q. -- quite a few processes have been instigated by that
13 point, we just come back into the darkness slightly in
14 the 2018/2019. When you talk about Weekly Governance
15 Debrief, you're saying that they didn't occur in 15:17
16 2018/2019?
17 A. Not to that extent.
18 327 Q. But there were weekly meetings in the Urology
19 Department?
20 A. There were -- I don't know if I was referring to that 15:18
21 specifically in the Urology Department. Was I or was I
22 talking about general -- because I know that I -
23 328 Q. I think you were talking about just your --
24 A. Governance.
25 329 Q. -- how you obtained assurance as Medical Director. 15:18
26 A. Yeah. So, basically --
27 330 Q. I suppose governance for me, just to -- I probably
28 should have framed the question somewhat better,
29 I presume that that is the Medical Directorate

1 Governance --
2 A. Yes, yes.
3 331 Q. -- scenario. All governance comes through there, I
4 presume if there's a potential to result in patient
5 harm or risk, increased risk at all, it's going to come 15:18
6 through that funnel.
7 A. Yes.
8 332 Q. But I don't think it was just a new invention in 2020,
9 I think there were procedures prior to that, in 2019,
10 that would have enabled the same concerns to come to 15:19
11 you through a different name?
12 A. Yes. So I think what I've referred to in that
13 question, if I'm remembering properly, is in relation
14 to the Medical Directorate Governance meeting on
15 a weekly basis. So the purpose behind that was to give 15:19
16 the Medical Directorate staff, from their contacts into
17 the governance world across the Trust, the opportunity
18 to escalate anything that had come to their attention
19 and to make me aware.
20 333 Q. So that could be the Director of Nursing could say it's 15:19
21 come to my attention that one of the consultants isn't
22 using the cancer nurse specialists and I'm concerned
23 about that from a governance perspective; that could
24 have been a route that that particular concern may have
25 been escalated through? 15:19
26 A. It could have been. It should have been. But actually
27 I think probably what was more likely to happen in
28 reality given, I think, the disconnect that we talked
29 about right at the beginning in relation to

1 Operational, Clinical and Social Care Governance and
2 Corporate Governance, that actually if it was known at
3 all it was known within the Acute Directorate and
4 probably didn't make its way out of it.
5 334 Q. You can see from a remove, when you look at all of 15:20
6 these possibilities for highlighting areas of concern,
7 and you don't see any concerns that are now so stark on
8 documents finding their way into those, do you see that
9 as a governance failure or an individual failing or is
10 it a combination of both of those? 15:20
11 A. I think it's a combination of both. I think, you know,
12 all doctors have a personal responsibility for their
13 own work. That's part and parcel of their training,
14 that's what you're brought up to believe. So
15 there's -- you know, there's a significant element of 15:20
16 personal responsibility in this. In addition to that,
17 we, as a system, I think, should have been more astute,
18 better developed, all of those kind of things, to try
19 and make sense of all of this at an earlier stage. If
20 we were faced with this today I think we'd be in 15:21
21 a stronger position to deal with it but there has been
22 a huge amount of learning has come out of this.
23 335 Q. You mentioned earlier about staff turn over --
24 A. Yes.
25 336 Q. -- it's clear from the information that you've made 15:21
26 available that you're still not at capacity --
27 A. No.
28 337 Q. -- for what your commissioned and funded for. I think
29 you're still a couple of consultants short. That's

1 something that has been ongoing for a while and, to be
2 fair to the Trust, they have advertised and sought
3 people but I think that's a UK-wide shortage of
4 appropriate consultants and everyone's trying to
5 capture probably the same individuals. 15:21
6 A. Yeah.
7 338 Q. But does that mean that the concerns we talked about
8 earlier this morning about when you're not at full
9 capacity, governance tends to fall slightly down the
10 pecking order; is that a real concern for you at the 15:22
11 moment?
12 A. It's always a concern but I think the message very
13 strongly at the minute is whenever we're at our busiest
14 or most challenged - so at the minute we're in the
15 middle of industrial action, you know, significant 15:22
16 shortages all over the place, the winter pressures, all
17 of those things, that's when you have to be
18 increasingly mindful of governance. So, you know,
19 I know that the systems are not standing down their
20 governance procedures at the minute to try to help them 15:22
21 support their way through that. But I also think, you
22 know, the jobs of the clinicians, I think, in a
23 situation where they're very short-staffed is really
24 difficult because what they tend to get then are the
25 sickest patient only, those are the people who are 15:22
26 prioritised. So our waiting lists in Urology in the
27 Southern Trust are not out of keeping with the rest of
28 the region and for some routine appointments extends as
29 far as, you know, 5 years. I mean it's very long. But

1 it does mean that the people that are coming to their
2 attention now are really unwell. Again, that's another
3 argument, I think, for us making sure that our
4 governance processes are really robust.
5 339 Q. I suppose it goes back to what we were discussing 15:23
6 earlier about culture.
7 A. Yeah.
8 340 Q. Even if you have a full capacity, a full complement of
9 staff, they have to be staff who are motivated to
10 utilise governance and feel confident about drawing 15:23
11 attention to what they consider to be potential risks.
12 A. Yeah.
13 341 Q. So it goes back to the learning, I suppose --
14 A. Yes.
15 342 Q. -- that you had identified in your statement. 15:23
16 A. Yes.
17 343 Q. The other thing that I just wanted to touch upon
18 briefly is the Risk Register.
19 A. Yes.
20 344 Q. Again, I won't go over all the points, the simple 15:23
21 direct point is that none of this risk, clinical risk,
22 operational risk, whatever way you want to define it,
23 found its way on to the Risk Register. Would you
24 expect it to? Is that what traditionally risk
25 registers were seen to be about or is there more of a, 15:24
26 well, that's for -- I know there are different types
27 but is it more well, clinical stuff doesn't really find
28 its way on to the Risk Register, it's more corporate
29 stuff and nonclinical risks? Or should it have been

1 on? Should the stuff that we're discussing have been
2 reflected in those registers?
3 A. I think I find -- so it's rarely -- in fact I don't
4 think I've ever seen it centred around one individual's
5 practice in the way that this has been, right? So it 15:24
6 tends to be more general than that. So I think how it
7 found its way on to the Risk Register was in relation
8 to waiting lists, staff shortages, latterly I think
9 electronically signoff, concerns about
10 multi-disciplinary working, I think, at a point in 15:24
11 time. It tends to find its way on that way rather than
12 specifically outlining the concerns located in
13 a particular service or individual.
14 345 Q. I think you'd said in your statement, I can't find the
15 bit of paper I've written it on, but you will recall 15:25
16 it, I think, you said sometimes willingness can
17 actually hide the problems?
18 A. Complete smokescreen because a lot of this was around,
19 you know, there was an acceptance that patients were
20 falling off the end in relation to getting 15:25
21 investigations and diagnostics done when, actually,
22 that wasn't the rationale, it was actually to do with
23 individual behaviour. So I think if we hadn't had such
24 long waiting lists we would have picked this up sooner.
25 346 Q. If there was a general reluctance to put the type of 15:25
26 concerns you were aware of and other people were aware
27 of, on the Risk Register, because they seemed so
28 difficult to solve?
29 A. Well, by and large, I mean anything that goes on the

1 Risk Register, as I understand it, has to align with
2 smart objectives in terms of it being something that
3 you can actually sort out and improve on. What tends
4 to happen is they tend to be a bit more generic than
5 that and they tend to be multi-system. I think 15:26
6 probably it was broken down into parts. And, again,
7 these concerns, particularly in terms of waiting times
8 and staff shortages and some of the issues around
9 electronic signoff general around Northern Ireland
10 aren't unique to Urology, they're part and parcel of 15:26
11 the NHS at the minute. So I think, you know, they
12 would have been thought about under that heading but,
13 actually, when you were reading it you wouldn't have
14 realised that Urology was also included in it. It
15 doesn't specifically mention. I mean Orthopaedics have 15:26
16 huge waiting lists as well, staff shortages and lots of
17 things. So I don't think it was an obfuscation,
18 I think it was just that given the level of the
19 corporate and directorate risk registers, I think that
20 it probably didn't give, I suppose, a minute enough 15:27
21 description of what this was about.
22 347 Q. And I suppose departments like Orthopaedics, obviously
23 falls is one of their significant risks so some of
24 those did find their way on and they're usually about
25 managed the environment or risk-managing the patient so 15:27
26 they do have perhaps a more streamline approach to try
27 to remedy that. The nuances of the issues that were
28 arising at different times through urology perhaps
29 don't lend themselves to such a straightforward answer.

1 A. Not easily. I mean something like falls, for example
2 there's a regional approach to falls. There's kind of
3 a national campaign around them. Again, it's not just
4 about orthopaedics, it's very often about, you know,
5 geriatric medicine and various other aspects. You 15:27
6 know, that's a good example of how that would be
7 something that would apply to the whole Trust and then
8 would be placed on there. But, again, in terms of
9 breaking down the elements of Urology, I think it was
10 trying to be captured under waiting lists, staff 15:28
11 shortages, those things we mentioned.
12 348 Q. Do you think that was a mistake given that the Board's
13 position -- well, certainly Mrs. Brownlee's position is
14 no one told us? Well, I'll let you answer that: Do
15 you think it was a mistake that the Board weren't made 15:28
16 aware of all these issues?
17 A. Well, I think, you know, there are reports that go now,
18 right? So I now get a monthly report from the Medical
19 Director in relation to Maintaining High Professional
20 Standards. That's now discussed with SMT. That now 15:28
21 goes to the Board, right? They're made aware of it now
22 and I think they should not have been made aware of it
23 in the past but that wasn't have been the tradition.
24 349 Q. And even though the individuals who knew about that
25 were sitting at the meetings do you still think it was 15:29
26 right that no one spoke out and said: We're having
27 problems in Urology that are coming from different
28 directions now and things are bubbling up? Do you
29 think that it should have been said?

1 A. And it's not to minimise the seriousness of this in any
2 shape or form but in the context of what we usually
3 deal with on a day and daily basis, right, because it
4 looked like these were local issues and they were being
5 resolved, they wouldn't have made it to the top of the 15:29
6 pile in terms of thing we had to talk to the Trust
7 Board about. So some of the other things that were
8 mentioned, I mean that particular year, 2019, I think
9 we had two invited review services into the Trust
10 because we'd concerns in different areas. We had the 15:29
11 Cawdrey discussions that are ongoing that haven't been
12 completed yet, for example. There were a few very
13 difficult coroner's cases that had to be negotiated.
14 There was a turndown in surgical activity because of
15 staffing. There was the beginning of the nursing 15:29
16 strike. So all of those were the big issues, as well
17 as waiting times in the Emergency Department and
18 waiting lists for surgery that would have got topped
19 there and it's in no way to minimise the harm that's
20 been caused. Bringing up an issue around what on the 15:30
21 face of it seemed to be a single surgeon who wasn't
22 managing to do his dictation and get through his work
23 in the absence of Serious Adverse Incidents Reports at
24 that point in time would not have been the first thing
25 we would have been talking to Trust Board about. 15:30
26 350 Q. And your answer lends itself to the suggestion that the
27 thing that wasn't brought is the subject of a public
28 inquiry.
29 A. Exactly. Yes.

1 351 Q. Just in the last part of your answer, you framed it as
2 a surgeon who wasn't doing his admin. Do you think
3 that what's permeated a lot of the information
4 available to the Inquiry that you would be familiar
5 with from the Trust as well is the failure to put the 15:30
6 patient at the centre of the concerns that were
7 arising? To look at it from the patient's perspective,
8 not from the doctor's?
9 A. Well, I think -- I think what we tried to do was to
10 keep the patient at the centre of it in relation to 15:31
11 getting him to perform the way that we needed to.
12 Okay? I think knowing what I know now, as I say,
13 I would have taken a different approach to all of this
14 and I think that, you know, one of my reflections on
15 all of this is that actually the patients weren't - and 15:31
16 I wouldn't expect them to - but the patients weren't
17 complaining about Mr. O'Brien. They weren't raising
18 any concerns with us about, you know, missed results or
19 delays or not having a nurse or any of those things.
20 They were completely quiet. And I think, you know, 15:31
21 I've often wondered why that is. I think it's probably
22 down to, you know, what their perception of the service
23 was that they were being offered, because obviously,
24 you know, he was very charming towards them. He seemed
25 to have been kind towards them and I think they didn't 15:31
26 realise what they were missing at that point in time.
27 352 Q. Given the subject matter of what they might want to
28 complain about --
29 A. Yes.

1 353 Q. -- and given the demographic of people who might
2 frequent Urology --
3 A. Yes.
4 354 Q. -- and the geographical location of your Trust all play
5 a factor in people's reluctance to complain? 15:32
6 A. Yes. I think it probably does. Yeah. Yeah.
7 355 Q. If we could just -- I'm not going to take you through
8 them but there are significant amounts of entries from
9 you making comments or attending the Trust confidential
10 meeting and finding your way on to the confidential 15:32
11 minutes then from 27th August 2020, October, November,
12 December, February '21, March, May 2021. I think it's
13 fair to summarise that to say it started with you
14 bringing to the Board's attention the SAI
15 investigations into a recently retired - so Mr. O'Brien 15:33
16 has left at this stage - consultant right through to
17 updating them on all of the activity that took place,
18 with the Lookback Review, RQIA, the Royal College
19 of Surgeons, all of the advancement that was made in
20 order to try to get on top of the issues. 15:33
21 A. Yea.
22 356 Q. Just give me a second, there's just a point I want to
23 raise. If you just give me a second.
24 One of the things that came across quite starkly,
25 I think, from Dr. Hughes and Dr. Gilbert's evidence and 15:34
26 from Mr. Haynes was the disconnect between the Cancer
27 Service and Urology.
28 A. Yes.
29 357 Q. You know, it sort of mirrored the operational clinical

1 ways of thinking. Everybody was working toward the
2 same general aim but they weren't really communicating
3 with each other.
4 A. Yes.
5 358 Q. That appeared, on the evidence so far, to create a void 15:34
6 that was filled by potential suboptimal practice. So
7 I'm just wondering, I know you have mentioned a couple
8 of times about the different advancements that have
9 been made when you became Medical Director and now
10 Chief Executive. What's the situation now? Has 15:35
11 anything been done to address that disconnect and, if
12 it has, could you maybe update us?
13 A. I mean, I think describing it as a "disconnect" is
14 a good description; right? I think, again, one of my
15 reflections in relation to the MHPS investigation and 15:35
16 the comments that were made in relation to all of the
17 information that we were working on at that point in
18 time was -- I think we were blind to the fact that
19 we concentrated on the surgical side but not on the
20 cancer side -- right? So that, again, has been 15:35
21 a learning, I think, for all of us. So I think my
22 sense is that it's more integrated than it was before.
23 Certainly I can see signs of better integrated working
24 and more, I think, joint ownership of some of the
25 challenges around that. 15:36
26
27 Now we have invested outside of our commissioned budget
28 in increasing the tracking system and that and trying
29 to put administrators in place and trying to address

1 some of the difficulties we had with the MDM tracking
2 before. Because what was happening was, as we know,
3 Mr. O'Brien's patients may or may not have been
4 referred into multi-disciplinary team meeting and then,
5 based on the advice of the multi-disciplinary team 15:36
6 meeting, may or may not then have been followed up
7 appropriately. And for all other services, the
8 lynchpin in all of that is always the CNS, the clinical
9 nurse specialist. So we have tied all of that in to
10 make sure that every patient who is receiving cancer 15:36
11 care has a clinical nurse specialist and also that the
12 trackers are on it in relation to not just the 31 and
13 62-day targets but that also there's an oversight to
14 make sure that patients are seen, their investigations
15 are done, and their results followed up. So that's 15:37
16 a lot more robust than it was before. And that's
17 involving both sides of the house in terms of surgery
18 and cancer.
19
20 Now, they are managed within the same directorate. One 15:37
21 of the things we have done in terms of the
22 restructuring and review of all of this is that we have
23 split the acute directorate. So, you know, about
24 two months ago I appointed the director for surgery as
25 an interim and then the medical side of it as 15:37
26 a substantive post to try to separate those two posts
27 out. Certainly what I'm seeing since that happened is,
28 because there's a greater concentration on the surgical
29 and cancer side now as opposed to the whole

1 directorate, the flow of information, I think, is much
2 faster and it is more robust, you know, as time goes on
3 and they get those systems developed. So I can see
4 that it is working better.
5 15:37
6 I think what we still have to test yet is the system.
7 So I do think there's a process of clinical audit that
8 needs to be undertaken with some of the patients who
9 have come through that system to make sure that we do
10 what we think we are doing and not falling into the 15:38
11 same mistake again.
12 359 Q. I think you've mentioned -- or maybe it was when being
13 consulted in advance -- that the 31, 62-day can act
14 like a smokescreen, a bit like the waiting list, people
15 fall off the end and, if they tick the box then, where 15:38
16 do they go after that? So you're saying that that
17 particular vulnerability in the system is through the
18 tracking process, there's a safety net for that?
19 A. Yes.
20 360 Q. I just want to dip back into MHPS, just very briefly. 15:38
21 The determination of Dr. Khan -- well, he made several,
22 and I presume you are familiar with what he thought
23 should happen?
24 A. Yes.
25 361 Q. Now, nothing did happen as a result of his findings or 15:38
26 his recommendations. What's your view on that and why
27 do you think that none of those were taken forward?
28 We'll talk about the review of administration
29 separately, but the other issues around the action plan

1 and things, why do you think there was a delay or
2 reluctance or a freezing of everyone when he had set
3 out a potential way forward?
4 A. So I think, as I understand it, the three elements of
5 action, of the out workings of maintaining high 15:39
6 professional standards, were to develop an action plan
7 around Mr. O'Brien's administration, make sure he was
8 properly job planned and make sure that, basically,
9 there was an administration review at the process.
10 Right. Mr. O'Brien launched a grievance against 15:39
11 Maintaining High Professional Standards and the
12 processes behind it which was lodged before I arrived.
13 So when I arrived, my understanding was it had been
14 paused because the grievance needed to be investigated.
15 And that took quite a long time to get out the other 15:39
16 end of appeal and everything else. But even with that,
17 even though on one hand we were saying we have paused
18 this, there was still work ongoing in relation to what
19 came out out the back of Maintaining High Professional
20 Standards. 15:40
21
22 So in the absence of the named action plan, we
23 continued. My understanding when I arrived was -- and,
24 you know, Dr. Khan was still involved, everybody else
25 was still involved that was there and, eventually, the 15:40
26 Associate Medical Director, when I brought him into it,
27 was around monitoring those aspects of administrative
28 practice that we had been concerned about. So those
29 were in it. There were repeated attempts to obviously

1 get him job plans but I think, in retrospect, I and
2 others should have been a lot more robust about that.
3 I think I should have been on that a lot sooner.
4
5 Then the third thing in relation to the admin 15:40
6 practices, I think that was in two parts. So the
7 actual admin in relation to looking at systems and
8 processes within urology, we made an attempt at it,
9 I think, about August 2019. And, again, I had prompted
10 Mrs. Gishkori to do that and I think that didn't 15:41
11 happen. Then Melanie McClements came in as a director
12 in the summer of 2019 and she did attempt to try to get
13 that done. Then we didn't feel that terms of reference
14 and everything else, it was robust enough, so then it
15 was passed to Anita Carroll and she eventually got that 15:41
16 done. But with COVID and everything else, that took a
17 bit of time to get that finished.
18 362 Q. Can I just ask you why you think Mrs. Gishkori didn't
19 do anything?
20 A. I don't know. I don't know. 15:41
21 363 Q. When you say that it was done in two parts, if I can
22 just push you a little bit on that. Because the
23 grievance that went in about the process of the MHPS,
24 we already discussed at length that Mr. O'Brien was
25 already subject to an action plan from February 2017. 15:42
26 A. Yes.
27 364 Q. In all possibility that could have been tweaked to
28 reflect the findings or tightened or -- you know, do
29 you accept that? I don't want to hammer the point but

1 I think you know the point I'm making, that there could
2 have been something proactive done at that point given
3 you had an existing -- in the Trust's mind anyway -- an
4 existing action plan.
5 A. Yes, I think -- I mean I suppose what I did was 15:42
6 continue on what was in place, what was there when
7 I arrived -- right? -- because I had been through that
8 process. Mr. O'Brien's performance and behaviour had
9 been known to the Trust for three years before
10 I arrived. It had been looked at in depth, it had been 15:42
11 talked about a lot, tried to manage it. This is what
12 had been produced out of that. And at the back of
13 that, that's what I understood was working. So
14 I continued on with that. Knowing what I know now,
15 I should have tried something difference. That's my 15:42
16 view.
17 365 Q. A grievance wouldn't have stopped that. I'll put that
18 to you. You could have done more, and I think you've
19 accepted that. The administration review, now that
20 wasn't started until June 2020. It seems from the 15:43
21 paperwork, just so you can answer the point I want to
22 make, it seems from the paperwork that the GMC were
23 knocking on the door trying to find out what was
24 happening and that seemed to have triggered the action
25 to carry out the administrative review as Dr. Khan had 15:43
26 envisaged. Is that a fair enough comment?
27 A. Well, they were prompting me about it and I was
28 prompting the system, I think is the way it worked.
29 Obviously, there were two parts to it. So there was

1 the -- what we had got to was there was obviously the
2 operational part in relation to what Anita Carroll
3 eventually carried out in relation to urology. But
4 then the other bit that Dr. Khan had mentioned in his
5 deliberations was around that he felt it was lacking in 15:43
6 terms of clinical and operational management. So
7 basically that's what provoked me then to look at the
8 clinical management and leadership structure along with
9 all the noise I was hearing in the system about doctors
10 not having enough time to do the job properly. That's 15:44
11 what provoked that review at that point in time.
12 And then, on the back of that, we revised the medical
13 management structure and redefined the job descriptions
14 for clinical directors, leads, everybody else in there.
15 So actually there's now a clear line of sight on that. 15:44
16 That was the out workings of that.
17 366 Q. That's a wider point.
18 A. It is.
19 367 Q. It is a wider point. And no doubt you had taken the
20 view that that change was necessary. 15:44
21 A. Yes.
22 368 Q. Do you see why there might be a perception that, after
23 all those years of concerns, having actually filtered
24 Mr. O'Brien through the first formal investigation,
25 nothing happened after it? You can see why that 15:44
26 perception arises on the papers?
27 A. I can. I think it is partly down to the fact that
28 actually what we did implicitly, we haven't sat down,
29 taken the action plan and said: As a result of that

1 this is what -- you know, his deliberations -- that's
2 what it looked like at that point in time and this is
3 what we have done as a result. I don't think
4 we expressed enough about it.
5 369 Q. Obviously it is specifically mentioned in the Terms of 15:45
6 Reference the look-back review. I just want to ask you
7 if you could just explain, in short form, why that was
8 started. What was the reason behind that? What was it
9 intended to do? Why was it considered necessary by the
10 Trust and how was that done? I don't think we need to 15:45
11 go into the figures. I know they are ever-changing and
12 evolving.
13 CHAIR: I am sorry to interrupt, Ms McMahon. I am
14 conscious that we haven't had a break this afternoon.
15 I don't know whether people feel they need one or not 15:45
16 or whether they are content to sit on until --
17 MS. McMAHON BL: Sorry, Chair.
18 CHAIR: That's okay.
19 MS. McMAHON BL: I forgot about it.
20 CHAIR: Certainly, for my part, I am happy to sit on if 15:45
21 everyone else is but I don't want to --
22 MS. McMAHON BL: I'm on the home straight, if people
23 want to hang in there.
24
25 This is the opportunity, I suppose, for you to tell us 15:46
26 what the Trust did. No doubt you'll be back, but
27 I want to give you the opportunity today to round your
28 evidence off, having taken you through the pitfalls,
29 perhaps you can give us the highs.

1

2 So the look-back exercise, we discussed that earlier.
3 I would specifically, in relation to the early alert,
4 ask you to address the concerns of Mr. O'Brien about
5 why he wasn't informed. That's, obviously, an issue 15:46
6 for him. I know the Trust got very short notice as
7 well, but -- and the RQIA, the review. A small ask.
8 A. Just to get the chronology of this. On the back of
9 what Mark Haynes had raised concerns about, the
10 discrepancy in the lists in June 2020, what we found 15:47
11 was that the two patients he was initially concerned
12 about weren't the patients we had to be worried about.
13 It was whenever Martina went in and started to
14 deconstruct all of that, try to understand it, she
15 realised that actually there was a gap in relation to 15:47
16 the MDM connect with the rest of the system. That's
17 essential where a lot of this came out to begin with.
18
19 On the back of that we called it a look back
20 mistakenly. It actually wasn't a look back until 15:47
21 March 2021. So the original part really should have
22 been described as a scoping and review exercise. So
23 really what we got to very rapidly at that point,
24 within a week, was to pause the system and start to
25 unpick all of his work to see if there were any 15:47
26 concerns. And she and Mr. Haynes and various other
27 people did significant amounts of work over a short
28 period of time to identify that across the numbers of
29 patients that they were looking at that there were

1 patients they were worried about had been missed but
2 also had come to harm.
3
4 As we unpacked our way down through that, there were
5 a couple of things about that. Given that we became 15:48
6 really alarmed about what we were finding, our usual
7 approach in relation to that then is to raise an early
8 alert with the Department. So the purpose of the early
9 alert is -- Northern Ireland has its own system. So
10 basically, the purpose behind that is to alert the 15:48
11 Department of Health and others to the fact that we
12 have identity significant concerns in an area and it
13 may be media worthy. The so that was put into the
14 system on the basis of all of that. And then as well
15 as that we started to try to take advice from various 15:48
16 other people in terms of how this would be best
17 managed.
18
19 Some of us then -- I think it was, to begin with,
20 Stephen Wallace and myself -- met with the Royal 15:48
21 College of Surgeons to get their advice on them.
22 Because, I suppose, I used to chair the Invited Review
23 Service for the Royal College of Psychiatrists. I was
24 very familiar with the work of the RCS. We spoke to
25 them because I thought, well, we need experts outside 15:49
26 of the system who are used to undertaking this kind of
27 work and could give us expert advice based on their own
28 experience. So we went to them first of all.
29

1 They took this very seriously. Initially what they
2 said to us was that given that we were exploring an
3 individual practitioner's work they would need his
4 permission to do it. I was fairly confident at that
5 point he probably wouldn't give it, although I didn't 15:49
6 ask him. But then, in discussion with him, we agreed
7 that we could -- given that this was serious enough we
8 could go ahead and start to look at this without his
9 permission, so that's what we did. So they helped us
10 think our way through that in terms of what we needed 15:49
11 to think about. Also then, as the numbers grew and
12 we worked our way through the end of 2020, to try and
13 think about was the Serious Adverse Incident process
14 really going to help us or just slow down our access to
15 learning and awareness in relation to that? 15:50
16
17 So initially there were nine cases that were identified
18 and those were the nine cases then that were taken on
19 as a Level 3 Serious Incident Review by Dr. Hughes and
20 were reported on in the following year. The other 15:50
21 cases, then, that started to come through on that,
22 because of the volumes of them, we went back to the
23 Department of Health and in consultation with the
24 Department and the PHA, we described that possibly it
25 was best to use an historical clinical record review 15:50
26 approach, which is a kind of derivation of the
27 structured judgement review which is used commonly in
28 England but had also been developed by the Royal
29 College of Physicians for the Neurology Inquiry. So

1 we went back, we had discussions with the Belfast
2 Trust, we had discussions with others to try to develop
3 all of that. And on the basis of that, and then in
4 consultation with our legal team, devised 10 questions
5 for screening that would screen patients in into the 15:51
6 structured clinical record review process and then
7 start to identify learning at an early point.
8
9 So what rapidly started to come out of that were the
10 concerns around the Bicalutamide prescribing. And what 15:51
11 fell out of that was, obviously, Mr. Haynes's audit of
12 Bicalutamide prescribing across Northern Ireland. And
13 out of that was able to show that out of, I think
14 700-odd cases there were in and around 50 that there
15 were concerns about. Two of those belonged to other 15:51
16 doctors across Northern Ireland and all the rest
17 remained with Mr. O'Brien in terms of prescribing
18 practice. So that part was done.
19
20 Then there were other issues that started to come to 15:51
21 light. For example, when Dr. Hughes realised about the
22 nonengagement with the CNSs. You know, he had intimate
23 working knowledge in relation to how MDM processes
24 worked. He was able to unpick some of that as well.
25 So as we built up that body of knowledge, then that's 15:52
26 where we were directing our attention in terms of
27 trying to get the information out. And that is what
28 has informed our communication with UAG, which is
29 a departmental oversight group. The Health and Social

1 Care Board, as was, which is now SPPG Strategic Group,
2 and then latterly then our interactions with RQIA in
3 relation to SCRR process. So to quality assure that,
4 to make sure we were doing the right thing -- and a lot
5 of these external systems are there -- a bit like the 15:52
6 GMC and HS Resolutions -- are there for quality
7 assurance, third-line assurance to Trusts in terms of
8 their behaviour. We took that to our QIA to ask them
9 about the SCRR process and whether they felt that was
10 robust. They have now come back to us with an action 15:52
11 plan in relation to that. At the meeting that I have
12 been to in relation to that over the last week, we have
13 worked our way significantly through that. There's
14 a couple of areas that still have to be challenged.
15 370 Q. Is that family involvement? 15:53
16 A. Yes.
17 371 Q. I think there was some just general governance concerns
18 around that because the SCRR is SAI light. It just
19 doesn't have that filter in it. So have you adapted
20 that to reflect those concerns? I think the Royal 15:53
21 College of Surgeons had the same concern around it?
22 A. Yes. So the SCRR, unlike the Serious Adverse Incident
23 approach, usually involves the families at an early
24 stage and they are involved in terms of reference.
25 SCRR doesn't have terms of reference, it is based on a 15:53
26 very specific template. And the approach we had taken
27 with this, because of the speed of it initially, was to
28 try to get the learning out and get the SCRRs done.
29 Then, when we identified harm/no harm, suboptimal care,

1 then we went back and communicated with the families
2 and gathered more information at that point; right?
3 I think we realised that that's not the way we want to
4 engage with families. So we have now identified two
5 patient experts, essentially, to work with us in 15:54
6 relation to the oversight of all of this. Then, you
7 know, take their advice in terms of operationally how
8 we continue to manage some of this. Because, you know,
9 we're now approaching the second phase of all of this
10 in relation to where we're going and we have a huge 15:54
11 amount of learning, I think, and information from the
12 first part. And it is really important, I think,
13 we have been able to pause, think about all of this,
14 and then use RQIA recommendations and other people's
15 recommendations to try and take this forward. 15:54
16 372 Q. The RQIA made a recommendation about the temporal
17 scope, I think, of the look back, about extending the
18 years. Could you just explain that?
19 A. So the Royal College of Surgeons initially suggested to
20 us five years in the first instance; right? What 15:54
21 we had asked them to do at that time was to take 100,
22 which translated into 96 of Mr. O'Brien's cases, and
23 carry out an audit on them. They did a very thorough
24 piece of work. They have just recently reported on
25 that. The very sad realisation in all of that is that 15:55
26 the findings that they have from that mirror the
27 findings we've had now since 2020 in relation to some
28 of the findings about the patients; right? So that,
29 I think, quality assures our processes in terms of, you

1 know, we're all on the same bake page with this. But I
2 think there's a horrible realisation that this has been
3 going on for a very long time.
4
5 I think the other part of it, then, is what we are in 15:55
6 discussion with the Department of Health about at the
7 minute is just the extent and scope of the rest of the
8 look back. Because what we need to do is prioritise
9 the patients that we think are potentially at risk of
10 harm or where we can, you know reverse potential harm 15:55
11 at this point in time and risk stratify all of that.
12 So there's been quite a lot of work done over the last
13 period of time in terms of working out all the
14 different ways of doing that, the costs associate with
15 the personal involved, etcetera. So we are hoping that 15:56
16 between now and Christmas, hopefully, we will have
17 a decision in relation to what the next phase of the
18 look-back will look like. At this point in time
19 we have looked back on 2,112 patients. This is
20 a really high volume specialty. So in relation to this 15:56
21 there's probably about 12-, 1300 patients a year. So
22 for each year we go back, these are significant numbers
23 of people.
24 373 Q. I know that was a quick run-through but is that us up
25 to date as regards developments the Trust's 15:56
26 perspective? I think we're -- you're also -- the
27 urologists group you mentioned but we can deal with
28 that again.
29 A. Yes. I think just to assure the Inquiry that we

1 have -- you know, we have taken all these concerns
2 really seriously. I that what we have tried to --
3 certainly what I have tried to evidence in my
4 statements around actually what -- you know, what we
5 have learned and what we've done about it to try and 15:57
6 improve on all of that so that, you know, hopefully
7 reduce the risk of something like this happening again.
8 374 Q. Just a final question from me. It is just from left
9 field, slightly. But when you worked in the Belfast
10 Trust were you familiar with the doctor and dentist 15:57
11 case review meeting?
12 A. Yes. So that was -- I was party to that on a regular
13 basis. I was Deputy Medical Director for workforce and
14 education, but mostly workforce. So I attended that on
15 a regular basis. When I came to the Southern Trust, 15:57
16 that structure wasn't there. It tended to be very
17 reactive. So what happened was, if there were
18 concerns, there was a director oversight group set up.
19 So what we now have in place over the last -- I can't
20 remember the start date of it but I know that we did 15:57
21 a lot of work in terms of getting terms of reference
22 and all those things sorted out -- but now we have
23 a monthly meeting that has oversight from HR, the
24 Medical Director's office and the operational
25 directors, depending on who their doctors are, plus the 15:58
26 divisional medical directors from each directorate, and
27 all of that now systematically worked through and
28 action plans developed. Then the out workings of that
29 are now reported to me as Chief Executive.

1 375 Q. I have no further questions. The Panel may wish to ask
2 you some questions. Thank you.
3 A. Thank you very much.
4 CHAIR: Dr. O'Kane, I'm going to hand over to my
5 colleagues first of all and then I'll see if there's 15:58
6 anything I want to ask you today. Dr. Sward, I know,
7 does have some questions.
8
9 DR. O'KANE WAS QUESTIONED BY THE INQUIRY PANEL AS
10 FOLLOWS: 15:58
11
12
13 376 Q. DR. SWART: I wanted to ask you about something that
14 has come up in quite a few S21 responses from people.
15 It's come up during Mark Haynes' testimony. It is 15:58
16 associated with governance. And, appreciating the fact
17 that you have taken on two very big roles in quick
18 succession and have thought quite hard about
19 governance, and it is a difficult job when there's
20 a lot to do, what I'm not sure about is what the 15:59
21 approach would be to improving the evidence base, the
22 clinical outcomes, the different specialties, not just
23 urology, particularly in the context of clinicians,
24 particularly mentioned there hasn't been much clinical
25 audit as a sort of general statement. You mentioned 15:59
26 that one already. Also mentioned the fact that the
27 search in national databases and so on which have
28 caused issues in terms of Trust's participation.
29 Mr. Haynes mentioned that there was a problem with the

1 hospital episodes statistics and the way that's used.
2 From where I sit, all of those things make it difficult
3 to have some pretty basic clinical outcome data that
4 would help when you ask about a doctor. Because you
5 haven't got that. You've got some nursing metrics, and 16:00
6 you have harm events, but not data that says "this
7 specialty is delivering care according to the
8 recognised protocol according to this national audit",
9 for example.
10 16:00
11 My question to you is there a difficulty with the
12 hospital episode statistics? Is that on the Board's
13 radar, if so? And how much of a problem do you think
14 that is? That's the first bid. Then moving on to the
15 information governance issues that the Health and 16:00
16 Social Care Board raised with respect to some of these
17 national audits. Is there a plan to get over those in
18 any way?
19 A. So I'll answer it in reverse.
20 16:00
21 We do take part in some of the national audits that
22 we can take part in when the GDPR audits allow. So
23 snap audits, for example, around stroke are done.
24 We have been part of, through the Royal College
25 of Psychiatrists, some of their big audits and their 16:00
26 accreditation programmes, but it is patchy. It's
27 patchy across the specialties. Surgery, I think, is
28 really hampered by not being able to nationally
29 compare. I think that's really difficult. I think,

1 you know, particularly for high-volume specialties,
2 sometimes when you get Serious Adverse Incidents coming
3 through, you don't know whether, you know, in the scale
4 of things that's to be expected or not because,
5 obviously, it is not perfect. Unlike the likes of 16:01
6 radiology, where there's an expectation there could be
7 6 percent default reporting, things like that. So
8 I think it is really difficult to know.
9 377 Q. DR. SWART: Is there a plan to get over some of these
10 issues? It was mentioned by Mark Haynes, in the 16:01
11 context of the British Association of Urological
12 Surgeons -- and I know there are others -- and I agree
13 with your comment, one of the big issues in surgery is,
14 is this a recognised complication or has something
15 really gone wrong and how do we benchmark? Is the 16:01
16 Board aware of the issue? Is there any plan to
17 overcome it? Because other places do overcome it.
18 I don't know exactly what the issue is, I do know we've
19 had some, where I worked previously, that were
20 eventually overcome. 16:02
21 A. I don't know if we ever had a specific discussion with
22 the Board about it but I know at times we have
23 mentioned about the limitations due to GDPR.
24 In terms of sorting it out, that sits with the
25 Executive because it's part of the process in relation 16:02
26 to the UK-wide engagement and we can't -- I know that
27 it certainly was raised with the previous minister and
28 I was assured it was sitting on his desk. But,
29 obviously, it -- I mean, I'm presuming it is

1 a difficult thing to sort out because it hasn't been
2 done. So I'm not sure what the impediments are there.
3 378 Q. DR. SWART: You could perhaps ask the SPPG about that
4 one.
5 16:02
6 Then the HES data issue? I wasn't clear what the
7 problem with that was in the Trust that Mark Haynes
8 referred to, Hospital Episode Statistics. He said you
9 couldn't use it properly with CHKS and other things for
10 some reason, but I wasn't clear. 16:03
11 A. He is a lot more familiar with this than I am.
12 He would have been used to working with a different
13 system in Sheffield, when he was there. As
14 I understand it, the two don't align in terms of
15 activity, consultant episodes outcomes. But in terms 16:03
16 of the nuances of that, I don't know, but I will find
17 out.
18 379 Q. DR. SWART: It is just something that, when you are
19 looking from afar...
20 A. Yes. 16:03
21 380 Q. DR. SWART: Another quick thing. You mentioned that
22 many of the urology patients hadn't complained even
23 when they had come to harm. One of the issues
24 we talked about with Mr. Hughes and also with
25 Mark Haynes was the issue of copying letters to 16:03
26 patients. It is our observation that many letters are
27 not copied to patients and, hence, they don't have
28 a summary of their treatment plan and they don't
29 actually know what should happen. I think we were told

1 that there wasn't a hospital policy in this regard and
2 there certainly wasn't a Northern Ireland policy.
3 What's your stance on that? Do you have any comments
4 about that?
5 A. It is certainly a conversation I've had with the 16:04
6 clinicians before when I was Medical Director. Now,
7 I would need to double-check, but I do remember
8 putting -- certainly discussing it at a Divisional
9 Medical Director meeting. But also I think there's
10 a memo to the effect that what we were prepared to 16:04
11 do -- now I will double-check because I know it was
12 talked about at the time and I just want to make sure
13 that I have actually done that, not just talked about
14 it. But there was a discussion in relation to -- my
15 own clinical practice was I would have written to the 16:04
16 patient and copied it to the GP. That was standard
17 practice. I think that goes on in certain parts of the
18 Trust and isn't standard practice and, actually, that
19 is what we should be getting to. So, I mean,
20 absolutely, the patient should be king in their own 16:05
21 management.
22 381 Q. DR. SWART: Just one quick point. It is about the
23 Serious Adverse Incidents.
24 Looking through all the papers that we've had, which
25 there are considerable numbers, it is quite hard to 16:05
26 pull out a consistent Trust-wide eye level, Board
27 level, director level learning from specific incidents
28 kind of theme. I think you set up a new serious
29 incident oversight process; is that right?

1 A. Yes.
2 382 Q. DR. SWART: Is it your view that a serious incident
3 process should have director-level involvement and
4 scrutiny before they are signed off? Or what does this
5 oversight processes mean in terms of how things will be 16:05
6 different?
7 A. This fell into abeyance over the summer just with me
8 changing roles and the changeover in interim medical
9 director. So now that we have a new medical director
10 in place, along with a director of social work and 16:05
11 director of nursing, what they will do is -- and I had
12 a meeting before the summertime in relation to this,
13 before I stopped being medical director, and they are
14 going to continue on with the others, is taking
15 oversight of the Serious Adverse Incidents as they come 16:06
16 through to the Trust each week and then challenge them.
17 I think there's something about, I think, giving
18 feedback in relation to terms of reference and
19 recommendations. Then the other part of that is around
20 how, professionally, do you embed this learning down 16:06
21 through the different systems. So, again, what I'm
22 hoping is that develops back to our weekly governance
23 meeting, that that will all get fed back down through
24 all of that and then automatically then -- the
25 governance meeting is done on a Thursday and then 16:06
26 we have a senior management team meeting on
27 a Tuesday -- that actually then that's followed through
28 there. So that actually they have eyes-on all the time
29 in terms of what the Serious Adverse Incidents are.

1 You know, the real importance of that is then to be
2 able to see the themes across the Trust. You know, so
3 that what is not working in paediatrics may not be
4 working in psychiatry, may not be working somewhere
5 else, and to pull all of that together. 16:07
6 383 Q. DR. SWART: Is your plan then to close that loop and
7 perhaps do a themed report to the Board on occasions?
8 A. Yes, and to give them feedback in relation to that
9 trail. Yes.
10 CHAIR: Mr. Hanbury, any questions? 16:07
11 384 Q. MR. HANBURY: We have heard about the long-term problem
12 with capacity and demand, particularly long waiting
13 lists for in-patients and day surgeries, up to a point
14 with outpatients as well. It seemed to come to a head
15 about 2016 or so. Mr. Haynes wrote quite an eloquent, 16:07
16 in tabular form, comparison of the urology difficulties
17 compared to other specialties often who had much
18 shorter waiting times, and I think there was
19 frustration that nothing happened. If you had seen
20 that -- that obviously predated your time -- but if you 16:07
21 had seen that, how do you think a senior manager should
22 respond to that?
23 A. Well, I think what he outlined -- I think that was the
24 Blue Sky Paper, wasn't it?
25 16:08
26 What he was highlighting in relation to that, I think,
27 as you point out, was just the discrepancies in
28 relation to this. Now, I know that in recent times,
29 certainly, there have been discussions with the Board

1 as was and SPPG in terms of getting more commissioning
2 in and around that to try to build it up. And they
3 did, they have managed to build up the number of CNS's
4 and urologists, but not at the pace we needed.
5 Essentially, right from the get-go, I think what -- he 16:08
6 was certainly raising it. I think it was being raised
7 in different places, but I don't know whether we were
8 forcible enough about that or whether we didn't go the
9 right way around it. But it certainly took quite
10 a period of time, really, for that to gain any purchase 16:08
11 and to get some investment, as far as I can see.
12 385 Q. MR. HANBURY: In the same sort of line, obviously as
13 surgeons we are very worried about patients being on
14 the waiting list for a long time and, obviously, they
15 had come to harm and they are not necessarily seen back 16:09
16 in clinic to make sure they are all right. And there
17 are initiates for potential harm reviews after, say,
18 a certain length of time, say a year or something. Is
19 that something that you brought in or you would like to
20 see happen? 16:09
21 A. I'm not sure whether they have -- I know that I hear
22 mention -- and I haven't thought about this
23 specifically -- I know that I hear mention of patients
24 that they are concerned about as being long waiters
25 that they have checked up on. So That definitely does 16:09
26 get discussed. I haven't asked specifically is that
27 done through the CNSs or is that done through other
28 aspects of urology. But I can certainly check that out
29 and see. But I know, certainly, those long waiters are

1 on everybody's mind, particularly -- I mean, the vast
2 majority of what they do at the minute, almost entirely
3 with the exception of stints, I think, is red flag. So
4 a lot of those patients with long-term urology problems
5 are waiting to be seen. And I know that, certainly in 16:10
6 recent times, we have gone back -- and I will check
7 whether or not it is specifically urology, but I know
8 for some aspects in surgery we have certainly gone back
9 to patients in writing to check with them that they are
10 still on our waiting lists and that, actually, if 16:10
11 there's anything that we need to do to engage with
12 them. Again, that came out of the back of
13 recommendations marked RQIA and others in relation to
14 that.
15 386 Q. MR. HANBURY: Just one final question about waiting 16:10
16 list management. We've heard potentially the problems
17 that clinicians can run into if they are running it
18 with themselves and their secretary. What's your view
19 of maybe having a waiting list office where this is
20 controlled, there's more of an independent look and 16:10
21 people don't so get forgotten about and scheduled
22 stent-change type patients don't forgotten about as we
23 sort of mark the SAIs. There does seem to be a lot of
24 the section, the consultants themselves, seem to have
25 a lot of responsibility there with that particular 16:11
26 administrational task. Do you think that could
27 usefully go into more generalised administration system
28 such as a waiting list office?
29 A. I know that the current interim director for surgery is

1 in the process of developing that, because that's been
2 one of her concerns. I think what I hadn't appreciated
3 until she brought that to my attention was the
4 Southern Trust is the only Trust in Northern Ireland
5 that doesn't have that. So, as you say, a lot of that 16:11
6 is distributed across the secretaries rather than
7 actually coming through a central booking office. So
8 she is in the process of sorting that out.
9 387 Q. CHAIR: Dr. O'Kane, we will be looking in more detail
10 on the Maintaining High Professional Standards 16:12
11 operation within the Trust, particularly in relation to
12 this case, obviously. But you weren't involved in that
13 yourself and you then, once you had got on top of all
14 the information, when you came into the Trust, you then
15 must have formed a view on how that was handled. Is 16:12
16 there anything you would like to say about that at this
17 point?
18 A. Well, firstly, I don't think that -- I think
19 Maintaining High Professional Standards as an approach
20 for something as complicated of this, I think falls far 16:12
21 short of what it needs to be. I think that's the first
22 thing. I think, certainly, on the face of it, it was
23 followed, albeit that it took quite a long time, but
24 actually I think that probably the part of it that
25 I gained most insight myself from in relation to the 16:13
26 case was the case investigator's report. I think --
27 and, I mean, that's obviously why I went back to the
28 GMC -- the part I was concerned about was the
29 deliberation then in terms of referring him. I thought

1 he should have been referred.
2 388 Q. CHAIR: I won't press you on that any more today.
3 I see it is quite late in the day and you have had
4 a very long day with us, but it is something that
5 we will be revisiting as to how that was handled. You 16:13
6 might want to reflect on that and see if there's
7 anything else that you want to let us know about.
8 A. Okay. Thank you very much.
9 CHAIR: Is that it, Ms. McMahon?
10 16:13
11 I think we have finished, certainly, this stage of
12 Dr. O'Kane's evidence, but we will, I'm sure, be seeing
13 you many times over the next few months and years,
14 perhaps, at this rate.
15 16:14
16 We were due to start with Mr. Devlin, I think, tomorrow
17 afternoon?
18 MS. McMAHON BL: I haven't heard from Mr. Wolfe so
19 I wouldn't want to commit him to anything earlier at
20 this stage. But, certainly, if that changes we can let 16:14
21 people know, if that suits, Chair.
22 CHAIR: We plan to start then at 2 o'clock tomorrow.
23 But if we have managed to get in touch with the
24 witness, we will let you know.
25 16:14
26 THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 7 DECEMBER
27 2023 AT 1400
28
29