Urology Services Inquiry

Oral Hearing

Day 17 – Thursday, 8th December 2022

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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MR. SHANE DEVLIN

THE INQUIRY RESUMED ON THURSDAY, 8TH DECEMBER 2022 AS FOLLOWS:

CHAIR: Good morning everyone. Mr. Wolfe.
MR. WOLFE KC: Good morning. Good morning, Mr. Devlin.
THE WITNESS: Good morning, Mr. Wolfe.
MR. WOLFE KC: Is it me or is it a little bit dim in here this morning? Maybe it's just my eyesight failing on me.
CHAIR: It is bright outside so it can't be.
MR. WOLFE KC: I better put the glasses on.

MR. SHANE DEVLIN CONTINUED TO BE QUESTIONED BY MR. WOLFE KC AS FOLLOWS:

1 Q. MR. WOLFE KC: Mr. Devlin, within your first Section 21 response you very helpfully offered us some reflections in respect of the Urology Service and what you think might have been contributory factors in terms of obscuring the issues from you and, more generally, in terms of what might have gone wrong. I propose to spend some time this morning looking at those and then, from a slightly different angle, taking a deeper cut at an aspect of what went wrong by reference to the Serious Adverse Incidents reviews and the conclusions reached in that, and you might assist us with your opinions on that. That will take us some time this morning.

If we could start at the bottom of WIT-00093. This is your witness statement. The very last question on that page reflects back to you the fact that there had been several Medical Directors prior to your appointment. Dr. Maria O'Kane appointed December 2018, and then you're asked a series of questions about that. I want to focus on the answers to 2, 3 and 4, if I can, for a moment or two.

The second question is (ii) at the top of WIT-00094.

"Did the turn-over in personnel impact on your ability to be properly appraised of clinical governance and patient care and safety oversight within Urology Services or more generally?"

You've referred to the considerable changes in governance processes that you oversaw during your tenure. You say in your view the need to make these changes was not as a result of staff turnover, however, you say:

"However given my newness to the organisation, and with hindsight, I believe it would have been beneficial to have a stable Medical Director role. Therefore, on reflection, director turnover may have impacted on my ability to be properly appraised of clinical governance and patient care and safety oversight within Urology Services."

Then linking that to the next answer at (iii):

"At the time of the instability I would not have recognised the personal impact."

That should say "personnel".

A. Personnel it should say. Apologies, so:"At the time of the instability."

2 Q. That's the instability in staff turnover?

A. Correct.

3 Q. "I would not have recognised the personnel impact. With hindsight and on reflection, the newness of me to the role of Chief Executive coupled with an acting Medical Director, meant that I was not getting the same level of assurance as I am now getting with revised processes and an excellent Medical Director in Dr. Maria O'Kane."

Just parsing that a little; Dr. Khan was in post at the point when you took up the reins, or shortly thereafter you took over from Dr. Wright?

A. That's right.

4 Q. He was in position to December 2018. For the next 18 months up to that, sort of, critical point in June 2020, Dr. O'Kane was in post. When you say that you weren't getting the same level of assurance as I am now getting with revised processes and an excellent Medical Director in Dr. O'Kane, that seems to be

pointing something of a finger at Dr. Khan and the assurance that he was able to give you?

A. I'm reflecting on the fact that as I worked more with Dr. Maria O'Kane and we built new ways of managing governance, such as the weekly governance meetings, such as looking at new structures, I became considerably more assured, and I was getting regular engagement with Maria, but also we were formally looking at governance every week at the senior management team. That was not happening when I came into post in March 2018.

Q. Mm-hmm.

A. It's not necessarily pointing the finger of blame, but we didn't have the system whereby we were regularly looking at governance via the Medical Director at every senior management team meeting, and that's a fact because I didn't have that when I came into post.

Q. Mm-hmm.

A. What I would say is that obviously Dr. Khan himself was new to the post, had not been a Medical Director before, and I was new to the post. I had not been a Chief Executive of an integrated Trust, I had been Chief Executive of the Northern Ireland Ambulance Service, which has a slightly different governance arrangements and, therefore, there was newness. What I would say is latterly in my career in Southern Trust there was a relationship built up with the Medical Director, and also there were processes put in place with the Medical Director; neither of those would have

been there when I first started at the Trust.

7 Q. Okay. I understand how you might have answered that question using a broader angle or broader approach. But, you would agree with me that in terms of assurances in relation to as to how the question is being asked in relation to Urology Services as well as more generally, in relation to Urology Services throughout the 18 months between December '18 and June 2020, you didn't obtain any assurances from Dr. O'Kane in respect of Urology Services, and particularly in relation to Mr. O'Brien?

A. Not --

8 Q. Because those issues weren't discussed at all?

A. Those issues weren't, and certainly not variation from an action plan were discussed, no. What we were building was a system of governance for the organisation. But, no, I was not regular discussing with Dr. O'Kane about Urology.

9 Q. In fact, as we discussed yesterday, specifically in relation to Mr. O'Brien --

A. No.

10 Q. -- you weren't discussing that --

A. I was not.

11 Q. -- at all in the whole of the 18 months between December 2018 and June 2020?

A. Not that I can recall in any way.

12 Q. To the extent that there's any implication there that you received an additional level of assurance from Dr. O'Kane in respect of Urology matters pertaining to

Mr. O'Brien, that would be a wrong interpretation?

A. As I recall it, that would be the wrong interpretation; the assurances I was getting were on areas of governance across the whole of the organisation.

13 Q. Just moving down the page to (iv). Again the initial premise of your answer is the period of instability before you joined. You had to steady the ship, and you reflected that yesterday and we looked at that in some detail. You had to recruit a senior management team and, secondly, deal with a governance environment and you say:

"I would consider that during this process of creating steadiness it is likely that identification and addressing of problems was not optimal."

Just drilling down into that a little more, some of your answers yesterday afternoon seemed to be of that flavour. For example, Dr. Khan came to you, you sought assurance, you say, in respect of Mr. O'Brien and going forward. You got that assurance. You didn't interrogate it particularly. It's not recorded. The validity or the robustness of that assurance, you accept, with hindsight, may not have been great, and you point to the other things that were obviously occupying your time and your attention, and that's this answer in a nutshell, is it?

A. That's correct.

14 Q. Thank you. If we turn to the latter part of your

statement at WIT-00100. You group five questions together and provide answers. I suppose the questions that I wish to explore is: do you have an explanation as to what went wrong within Urology Services and why? You say, just skipping down into -- it's "from my perspective" you set out how you envisaged Urology Services should have worked. It should have worked in the same way as any other service, and you list how services should operate. Did you have any sense at all that Urology Services wasn't operating in an appropriate manner?

A. In terms of it was clear that the Elective and the challenge of demand was obvious because that was coming through in terms of the performance reports, etc. and I obviously was aware that once the report from Dr. Khan, in terms of the Maintaining High Professional Standards it was clear in that report that there was a challenge with regard to Mr. O'Brien and obviously, as referred to yesterday, potentially wider. I was aware from the Maintaining High Professional Standards, and I was aware from the demand capacity mismatch, which clearly articulated was through the fact that there were considerable waiting lists. I was aware on both of those situations.

15 Q. Yes. The Inquiry has received evidence from Mr. Haynes, indeed, it's reflected in Mr. O'Brien's witness statement as well, that the whole area of waiting list challenges within Urology was fundamentally the biggest risk to patients that the

Service faced. Indeed, I think you reflect in your statement that you were aware of waiting list challenges. Mr. Haynes specifically has said that Urology Services were commissioned at a level where it would fail to meet population need and, as I say, he pointed to the biggest detrimental impact on quality of care experienced by Urology patients, not just in the Southern Trust but regionally, relates to waiting times. Is that something you'd had a general appreciation of?

A. Absolutely. I had a general appreciation of the gap in the commissioned services versus the demand for many services. As Chief Executive clearly the performance reports would come to me and I could see that and it was clear that there were a range of services where that position was the case. But I'm also clear that Urology was on that list as one that was struggling with regards to the gap between capacity and demand. So, yes, I was aware.

16 Q. In what way was that being discussed or managed internally? We'll go on to look externally in a moment.

A. Internally the regular performance meetings between the Performance Directorate and the Acute Directorate would look at opportunities to improve performances within the resources we had, and we would be looking at what we could do with regards to additional clinics, different ways of working, etc. So that's regular performance meetings at a Directorate to Directorate

level. Obviously at a Trust board level then the performance report would be reviewed and, in many cases, unfortunately, it would have been, well, we'll look at the range of the gaps, not just in Urology, and clearly it was, unfortunately, we have to do the best with the resources that we have that have been commissioned. Internally it was about trying to get the most for the resource that we have.

Moving on to externally, there would have been meetings between the Commissioner and the performance teams again, but accepting that the Commissioner commissioned services based on the resources that it had, there would be negotiation, there's no doubt about that, between the performance teams and the Commissioner. But ultimately the Commissioner commissioned the services based on the resources that it had and based on how it saw need. We could, of course, try to influence that, and I do know at a performance team level they would have tried to influence that, but at a Chief Executive level to Chief Executive level or Board to Board, that would not have been the case. I think at the early stages of this process it was very clear Commissioners commission, providers deliver. That was clearly the setting out position. I do believe there was lot of conversation between performance teams and the Board, but not just on Urology.

17 Q. Was it any part of the Trust's roles to tell the

Commissioners, perhaps even the Department, that people are coming to harm because of waiting lists backlog?

A. I think it was -- first of all, yes, the Trust would have told Commissioners in those Commissioner meetings, and I think the Commissioners fully understood that everyone waiting on a waiting list had the potential to come to harm. Not just Urology. Everyone waiting on a waiting list has the potential to come to harm. The Commissioner also has an X pot of money that the Commissioner choose to commission services, so I think everyone with their eyes open is very clearly aware that when resources do not meet the demands that are in the system, people will come to harm.

18 Q. We'll come on later to look at the whole area of early alerts. Is this the kind of problem where you put an early alert out, or an alert or some other form of flashing red light, to the Commissioners and say, you know, 300 weeks for treatment for some categories of patients is just beyond acceptable? Or, how is that message communicated so that the public is aware that action is needed?

A. Again, through those performance meetings. The Directorate of Performance and his or her team would be meeting with the Commissioner. If it were just a single service with a flashing red light, then I could totally understand that there would be a real focus on that particular service. The situation within Northern Ireland now, and actually over that period of time, is that many, many, many specialities did not

have the capacity, either the resources as in money, or the resources as in the human capital, to deliver against the demand. It wasn't that there was a flashing red light; there were a range of services across Northern Ireland that everyone was trying to do their best with the resources they had.

19 Q. Going back to your answer here, one of the things you highlight is that -- it's a theme I wish to further explore with you this morning -- that in a standard service, patient outcomes should be monitored to ensure patients are receiving the care that they need. What was your sense of that within Urology before June 2020?

A. I was not aware of patient outcomes being monitored, and certainly not being presented to me as the Chief Executive or as to the Board.

20 Q. You weren't aware of them being monitored?

A. No, I wasn't aware of the patient-related outcome measures or Urology. They were not presented. We weren't capturing that at a senior management team level or at a Board level. If you look at the governance reports we had, we didn't present patient -related outcome measures at any service in our governance reports.

21 Q. Your assumption that was that this wasn't being done?

A. It certainly was not being presented to me, and I'm very clear that in a systematic way in Northern Ireland Trusts are not regularly measuring patient-related outcome measures, which is not the case in other parts in the NHS in England where patient-related outcome

measures, referred to as PROMS, are regularly being monitored and measured.

22 Q. Was this in part of your reform agenda that you were working through?

A. It wasn't at that moment, no. I think I was looking at other elements of the reform process. I would have no evidence that I was looking at a PROMS environment. It wasn't something that I was looking at at that moment in time.

23 Q. When you say here that from your perspective Urology Services are supposed to operate in the same way as all other services, I take that within the Trust?

A. I was reflecting actually on the way any service should be delivered in Health and Social Care, but that clearly should be the way the Trust should be delivering it. We weren't regularly monitoring patient related outcomes.

24 Q. In that sense Urology was no different?

DR. SWART: Clinical outcomes.

A. Correct.

25 Q. I think the part that we are interested in is the patient outcomes; did they get the right treatment, did they follow best practice rather than PROMS. Just to clarify.

A. I was interpreting it as patient-related outcomes.

DR. SWART: I think that is what Martin is asking.

MR. WOLFE KC: That's helpful, Dr. Swart.

26 Q. I'm focusing on the answer you have given. My interpretation is that this is what you would expect in

any Service within the Trust, and Urology ought to have been no different. In terms of the patient care pathway --

A. Yes.

27 Q. -- and relating the service provided to a patient in Urology Cancer, was it your expectation that that kind of service would be measured and outcomes for patients in terms of compliance, what comes out of it, in terms of compliance with regional guidelines, for example?

A. Correct. It is my expectation in my current role as well, but at that point it would have been my expectation that care would have been delivered in line with appropriate professional guidance. Clearly it would have been my expectation that we would have developed a strong audit function to be able to review whether that was the case. I think it's been referenced, certainly if not referenced by me, by others, clinical audit was not a strong feature of the Southern Trust.

28 Q. We're going to actually focus on that in just a few minutes.

That's how a typical service should operate. You go on, just at the bottom of the page, to set out probable issues and failings that occurred. The first point you make is:

"Demand grew at a faster rate than resources."

That's not just a monetary issue, it's also an issue to do with capacity, supply of Urologists to do the work. That's a general problem --

A. Correct.

29 Q. -- as opposed to specific to Mr. O'Brien?

A. It's a general problem in Urology, but a general problem in Health and Social Care at a senior clinical level. But specifically, at this point, I was referring to Urologists.

30 Q. One reflection which the Inquiry has received is that there was so much going on for clinicians in Urology, chasing their tail to improve throughput, doing extra clinics, that their ability, the voice of Mr. Haynes predominately so far, the ability of himself and colleagues to spot the problems, spot the shortcoming was rendered more difficult because, you know, whether it might be fatigue or distraction on these issues; do you recognise that in terms of your experience as a Health Service administrator or manager as being a potential risk when things are spinning out of control?

A. I think there is always a risk when you are running very hard that you may not see things that otherwise you would have seen. I think we all have a professional responsibility for the care that we deliver, and to understand where there are gaps and opportunities. I can appreciate that if people are really working very, very hard they might not see things in a particular way. But many, many people of

the 75,000 people in Health and Social Care in Northern Ireland are working very, very hard, and many people are able to identify gaps and to try and address those. So I understand the point Mr. Haynes was making, and I think that is a possibility but I still think there are responsibilities on us all.

31 Q. Yes. I suppose one riposte to that is that if a service is under stress and if its clinicians and personnel are under stress, if mistakes are happening, they should be caught and identified by the governance arrangements, if they're fit for purpose?

A. I would agree with that, yes, that's correct.

32 Q. Rather than necessarily having to rely upon word of mouth. The hard data should be available to identify the problem and that, as we will see, wasn't there, at least in the particular respects that were identified in the SAIs.

A. I would agree with you. The system is there to protect, and that's the purpose of the system.

33 Q. Just going over the page; so you set out a range of -- item 3 you say:

"Patient outcome and other safety indicators were not managed at a local level. For example, historically peer reviews were carried out yet there is little evidence of the action plans being delivered and little evidence of a clinical governance system identifying the lack of progress."

What specifically did you have in mind with regards to peer reviews?

A. When I was looking back to try to collect information, I was made aware that there were peer reviews taking place in Cancer and in Urology. There were reports going back a number of years, and when I was trying to understand were there action plans as a result of those peer reviews, I was unable to find those action plans. Therefore, I was reflecting historically. It was not something I was involved in, but I was reflecting, historically when I looked for those action plans I couldn't find them, and when I spoke to people they made me aware that they were unaware of those action plans. That's what my reflection is there.

34 Q. Let me bring you straight to that for your comment. If you go to WIT-84531. Just actually go to the earlier page to start with, please. Thank you.

There had been a peer review of Urology MDT in 2017 and the RAG rating was 65%, and a number of concerns were identified, and here's the update in May 2018 in respect of those concerns. Some of them are very familiar, by now, with the Inquiry. The one I want to touch on, if we scroll down the page, is in respect of audits. It records that there's a lack of resource to support the implementation of audits, to inform quality improvement in service development. We'll see, this morning, that's essentially the concern that Dr. Hughes reflected back to the organisation in early 2021 when

he wrote his report.

What is the expectation of Chief Executive when a peer review update, such as this, is commenting, a year after the peer review that, really we haven't been able to get on with these things. The peer review outcome generates a discussion and an action plan and then, I suppose, there has to be discussion about resources; is that how --

A. Yeah.

35 Q. -- it develops?

A. I would expect that the peer review would be managed within the Directorate. I would expect that the kind of peer review, such as this, would be reviewed at the governance meeting and the operational meetings within the Directorate. I would expect that the gaps that were identified would have an action plan to fill. If that could not be filled, then it should follow an escalation process and it should find a way to be escalated through the Governance Framework. But, at a minimum, I would expect the Director to have a process to deal with peer reviews within any of the services, and that should be replayed and managed at the Directorate management team level.

36 Q. Yes. I want to explore that a little more later in the context of the Risk Register system?

A. Right.

37 Q. Thanks for now on that piece. If we go back then to where we were, which is WIT-00100, at top of the page,

please. Item 3, that's the point you were making that peer reviews identifying problems were not finding their way into action plans and so no progresses being made in some respects.

Then you focus on, if I can focus on number 4, you say:

"Despite attempts to manage Mr. O'Brien, there was evidence that opportunities were missed to address his behaviours. For example, action plans that were agreed to be developed and implemented in 2016 were not fully carried through."

What specifically do you mean by that? We know that the action plan, at least from the employer's perspective, remained live for the remainder of his employment?

A. Mm-hmm.

38 Q. His perspective was, well, if you look at the introduction of this action plan and its attendant monitoring arrangements, that reached a conclusion when MHPS reported but, as I say, from the managerial perspective the plan remained live. What it was, in particular, that you had in mind when you said that the action plan wasn't fully carried through?

A. I suppose I was reflecting on the fact that at this point in time when I was competing my Section 21, we, as a team, had walked through the core of the story, shall we say, and put everything that we knew

collectively as a senior management team, and it was clear to me, at that point, that from 2016 onwards, and as you reflected yesterday in the questioning, we were not actively managing the plan. As was made very clear yesterday, the plans, and if we were actively managing those plans there would have been regular updates, we would have been chasing, etc. What I meant by that when I was writing this, I was reflecting on the story that we had called out bar an understanding, and I think it is fair to say, as was described yesterday, is that from 2016 onwards and including the outcome in the MHPS the action plans that we committed to were not fully carried through. I referenced 2016 but that could easily have been the action plans that were identified as the actions from the MHPS. So, it's not just 2016. I think my reflection is we as an organisation did not manage the action plans well, and I think we went over that considerably yesterday.

39 Q. Right. If there was, as was reported in Mr. Haynes's evidence, for example, that there was deviation from the action plan, how do you now imagine that that should have been dealt with?

A. I would expect that any action plan would be owned very strongly by the Director in the Directorate. I would then expect that if there was major deviations I would hear, through a regular, a regular forum with the Medical Director. Clearly neither of those were happening, but that's what I would expect moving forward. The Operational Director would be managing it

and also there would be a line through the professional line which is the Medical Director.

40 Q. Item 6 you say:

"The governance and management systems of the time were not sensitive enough, or were deliberately evaded, so that issues of clinical or operational performance were not escalated. As a result, neither SMT nor Trust Board addressed the issues early enough as they remained invisible to them."

Can we just unpack that a little?

A. Mmm.

41 Q. We know that during the 18-month period that I've referred to earlier covering Dr. O'Kane's appointment through to June 2020, she wasn't reporting anything in respect of Mr. O'Brien into your part of the system, to the best of your recollection. At the same time, you've accepted, and you've given your explanation for why not, you've accepted that you did not engage as effectively as you now would have liked with Dr. Khan?

A. Right.

42 Q. You took no further involvement after 27th November 2018. It's fair to say that any governance system is only as effective as the people steering the ship. While there may well have been concerns, you may now have concerns about the sensitivity of those arrangements, the bottom line is people have to be taking the information that's available and using it

effectively; isn't that right?

A. Oh, absolutely, yes. At all levels of the system. Therefore, if there were variances from the agreed action plan, or variances in outcomes of clinical quality, the system -- as in the system of governance -- needs to be able to pick up on that and needs to be able to escalate that to the area that can take action.

43 Q. What do you mean by the phrase "deliberately evaded" in this context? Who was deliberately evading the governance and management systems?

A. I don't know whether the wording that I put there is exactly what I meant, but what I meant by that was whether people were reporting or whether people just had stopped reporting, or were choosing not to report, or were, in fact, accepting of things that were happening. That's why I said I'm not saying they were deliberately, but whether it was not sensitive enough, or whether there were times when people were not reporting, that may well have been the case. I think we can reflect on and I think there were many opportunities, throughout the layers of the organisation, to have collected information and to have reported it, and my point is either it was not sensitive enough or it could have been accidentally not reported or deliberately not reported.

44 Q. Yes.

A. I can't say what it was, but what I do know is if there were variations from agreements and variations from pathways, they were not being recorded and put up

through the governance system.

45 Q. Thanks. I don't want to go over old ground again but this is something, I think, Dr. Khan might have had in mind when he put forward his third recommendation in respect of an independent review of the administrative arrangements and how they were operated by management at various levels.

Just scrolling down the page, please. You set out in those paragraphs the efforts that you and your then Senior Management Team have taken to address governance issues in your time in the post. Just going down to the bottom section of the page, please. You say:

"In conclusion, it is my view that it is clear that the governance systems did not highlight the risks that were being carried at an individual clinical level up to the Trust Board. The line of sight from the boardroom to the bedside, which should be clear in a high functioning system, was not so in the case of Urology. Poor performance was not highlighted or addressed at many levels and opportunities to address the issues were not taken."

You're confident, you say in the last paragraph, that going forward, based on the work that's been undertaken, the risk or the chance of such failure in the future has been greatly reduced, but you apologise to the patients who have suffered harm.

We asked Dr. O'Kane to reflect, also, on what has gone before, and, with hindsight, what could have been done better. I would just ask for your reflections on an aspect of what she said. If we can turn to WIT-45178 and if we can go down to 3(i). She says if she had known in January 2019, shortly after taking up post, what she knows now, or certainly since June 2020 she would have done a number of things differently.

The first one is what I would ask you to focus on, she says:

As Medical Director with this hindsight, I would have advised the Director's oversight of Mr. O'Brien's MHPS case and the Chief Executive that a further restriction, if not an exclusion, to his clinical practise be instigated and, this should have been done while we undertook a review of all of his practise and not just the practise which had been highlighted as deficit at that point, namely in relation to triage, dictation, record access and private patients.

I see you nodding, Mr. Devlin. I think your nod is, perhaps, an acceptance that that reflection is unanswerable; it's clearly credible that that's what should have been done?

A. As Maria said, if she had known in 2019 what she knew in June 2020, that would have been a path that would

have been both acceptable to me as Chief Executive, but actually would have kept patients safer, yes.

46 Q. I wonder, in your reflections, if you were speaking to other Chief Executives about this experience, is it enough to say, in light of what I know now, I would have done A, B and C? If you count up what you did know at the time, or ought to have known at the time, the organisation should be going a bit further, shouldn't it? It should be saying, we did have enough information to have taken a much broader, much deeper inquiry into Mr. O'Brien given -- and I won't count it all out -- given the history and the firm conclusions reached by the MHPS process?

A. If I can go back to when we might talk about us looking at the core of the story. When we put it all on the wall the answer to that question has to be yes. When we placed everything on the wall and looked at the core of the story from the beginning of, well actually the end of the 00s through to now I think that is a truthful position. What I can say is when we were looking through the individual parts at that time, I don't believe we saw all of the parts connecting, and I don't believe that the system of governance, which would allow us to have looked at all the parts existed. So I understand the position that Maria has made there, if she had have known, because all of the parts -- certainly in January 2019 with Maria being a know appointment to the organisation -- I don't believe she would, as an individual, would have had visibility of

all of those parts. But I totally accept the position that when you look at all of the information that was available within the organisation over the period of the time to different people, when you look at all of that, you could make a very strong argument to say that if the systems had been working we would have seen them altogether. We didn't. We saw individual parts.

47 Q. Let me just push a little on that. It's about reasonable suspicion, isn't it? You see a clinician, an experienced clinician, no doubt with many attributes but you see shortcomings and serious shortcomings affecting patient safety. Based on that clear evidence, any Chief Executive and his Medical Director is bound to say, well is this all? Could there be more? Are there parts of his practise that are hidden from plain sight that need to be examined and explored?

A. Again, I go back to the point that I was at at that moment, and I think Maria was at, new to the organisation, we were grappling with lots of other things and trying to get the organisation -- I used the words steady the ship, we were trying to get the organisation to a particular place. Therefore, as I referenced yesterday I took assurance, and we've been through this. So, therefore, whenever I took an assurance that we have a plan, we are able to understand that it is about triage, dictation, records, and records being some where they shouldn't be, that assurance was taken because we had lots, and lots, and lots of fires to deal with in the system. I don't

disagree with you in the cold light of day and I don't disagree with Maria's position, which is if all the pieces had been put together, and you could argue that we should have put the pieces together, if all the pieces were put together we would have taken a similar path to what Maria has pointed in 70.3.1. But we didn't put the pieces together and, as I explained yesterday, I was busy trying to deal with many burning fires and, therefore, I took assurance and I moved on to other elements of the organisation.

48 Q. What's the learning for a busy Chief Executive who, in many organisations, is trying to pursue an improvement agenda, has other fires, no doubt, to manage? What is the learning that you take from this and would articulate to other Chief Executives facing similar circumstances?

A. Certainly. As you can appreciate, I have thought long and hard about this. I suppose, for me, one thing was having a steady team who can work as a team and we can have alerts and conversations. We didn't have that. We were a newly forming team, so we didn't have that team element. I have no doubt that if this were to happen in future years, and I had worked with the Medical Director for four or five years, the approach would be different, because the Medical Director would be seeing it, I would be seeing it, so there is an element of the consistency of the team. There is also an element of if something has gone through MHPS process, then that should find its way to the top of

the Chief Executive's inbox. That is a reflection that didn't because I saw it as being dealt with.

49 Q. Let me take a deeper cut into your reflections by looking at the area of standards and guidelines --

A. Mm-hmm.

50 Q. -- and what must be undertaken by a prudent and sensible Health Service provider to ascertain that those standards and guidelines are being implemented on the ground, having regard to, I suppose, the risk to patient health and safety and the quality of the service, if they aren't being implemented. I suppose the starting point for this is towards the end of the story with Dr. Hughes's conclusions. I'm sure you're familiar --

A. Mm-hmm.

51 Q. -- with them. Just to orientate ourselves, if we can. He reports in March 2021, he's looked at nine Serious Adverse Incidents, and in his overarching report, bringing together those nine cases, he sets out what he describes as some recurrent themes. Let's have a look at those. You'll see that one of the mainstays of his concern was departure from guidelines. If we can go to DOH-00126 please? It might be 000126. Thank you.

Just under the heading "governance and leadership" it has Dr. Hughes's findings. He says:

Having considered the treatment and care of nine patients, the Review Team identified a number of

recurrent themes following each review."

Bullet points 2 and 3 point to the fact that the treatment provided to eight out of nine patients was contrary to the NICaN Urology Cancer Clinical guidelines. He explains the origin of those guidelines, and goes on in bullet point 3 to say:

The Urology MDM made regulations that were deemed appropriate in eight out of nine cases but many of those recommendations."

-- which of course were recommendations compliant with the guidelines and there was one that wasn't, that accounts for the eight out of the nine. But eight out of the nine were, in essence, compliant with the guidelines but they were not actioned or alternative therapies were given.

Just going down to the fifth -- the MDT Guidelines, another set of guidelines, it has described for us as having international standing:

All newly diagnosed patients would have a key worker appointed, a holistic needs assessment conducted and adequate communication, information, advice and support given and all recorded in a permanent record.

Again, departure from these guidelines:

"None of the patients."

None of the nine had access to a key worker or Cancer Nurse Specialist.

If we go over the page please to 127. Thank you. In the context of failure to comply with the guidelines I'm sure you would agree that an effective service would have a means of spotting that, but he says:

Assurance audits of patient pathways within Urology Cancer Services were limited between 2017 and 2020. They could not have provided assurance about the care delivered.

Just the third bullet point please:

Annual business meetings had an express role in identifying service deficits and drawing up an annual work plan to address them. The Cancer Patient Pathway Compliance audits were limited and did not identify the issues within this report.

In other words, didn't identify the lack of consonance between practise and guidelines. Just turning to his overall conclusions, if we go down to DOH-000128. He starts by saying:

The patients in this review received unique

professional care despite a multidisciplinary resource being available.

Importantly: Best practice guidance was not followed and recommendations from MDM were frequently not implemented or alternative treatment chosen.

If we scroll down the page, please. He says:

The systems of governance within Urology Trust Cancer Services were in effective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent old patient journey and did not focus on areas of known concern. Assurances given to peer reviews were not based on systematic audit of care given by all.

Then just finally, by way of orientation, if we can drop down to DOH-00130 and recommendation 5 at the bottom. Dr. Hughes and his team make a number of recommendations in relation to guidelines and their monitoring. The concern here is the absence of resource and appropriate tracking of patients to confirm that agreed recommendations and actions are completed in accordance with the guidelines. He says :

This will be achieved by appropriate resourcing of the MDM tracking team to encompass a new role comprising

whole pathway tracking, pathway audit and pathway assurance.

Just scrolling down to the next page, please. He says, you can read the rest of that. Recommendation 6 is obviously of importance in this context as well, and he recommends the development of a proactive governance structure based on comprehensive ongoing quality assurance audits of care pathways and patient experience for all.

Did those findings in that respect, departure from the guidelines across the nine patients that they looked at, perhaps a tip of the iceberg situation because we know that what followed was an SCRR process that's so far identified 53 cases that reached the threshold for SAI. Did those kinds of conclusions, failure to comply with guidance and an inability of the service to pick it up, because it didn't have tracking and audit in place, did they come as a surprise to you?

A. Firstly, when I received the report and read it, I was disappointed because the assumption is that systems are followed and processes are followed, and once a guideline comes into the organisation and it becomes implemented. The assumption is that it is being delivered. Clearly, when I read it, the first thing that was we need to fix it, and we set about fixing it. I was disappointed and surprised that a service could get to that position of lack of compliance with an

agreed process. I think I was also disappointed that our system didn't pick that up. I was both disappointed and surprised that a service could deviate so far from an agreed pathway that was not identified.

52 Q. I asked that question, were you surprised because, as we can see from the independent report that you commissioned in 2019, Mrs. Champion's report, the whole question of compliance with guidelines and audit was flagged. Just to close the circle to some extent, let's look at that. The report starts at WIT-00507. I want to go to WIT-00542, just the bottom half of the page, please. We obviously looked at this report --

A. Okay.

53 Q. -- for a separate purpose yesterday, but the report was -- the evidence gathering took place over a period of 15 days, I think the author referred to. It involved a number of senior people --

A. It did.

54 Q. -- from the Trust having conversations with Mrs. Champion to enable her to understand how the systems worked and their shortcomings. We can see here, just in the second paragraph here she's saying that:

The Trust has a process for the management of standards and guidelines which is reliant on both Corporate and Directorate based systems. Standards and guidelines are logged on to the Trust's database system centrally by the Corporate Governance Team and then forwarded, on

a weekly basis, to the Directorates, including the Medical Director's office. Each Directorate has developed their own processes for the management of standards and guidelines.

It goes on to say: During the review, stakeholders expressed concern that where there was evidence that standards and guidelines were disseminated, there was a lack of assurance that they were being implemented as subsequent audit of practise has not always taken place.

This concern was reiterated by the chairperson, Mrs. Brownlee and Non-Executive Directors who identified that this was an area that required focus.

Just before I ask you the question, if we just go down to the next page, please, 543, third paragraph:

All of the Directorates have systems in place for the management of standards and guidelines. Acute services have a robust system in place for the dissemination of standards and guidelines which represents a best practice model.

Obviously Urology resides within Acute services. It goes on to say:

The downside of this system is that it is person

dependent. The patient and quality manager also identified the lack of clinical audit in providing assurance that standards and guidelines have been implemented and this was a systems issues.

It seems to be it's a good system for getting the guidelines out to where they need to be seen, but the task of seeing that they're actually being implemented on the ground leaves something to be desired.

Just one final read from this before we look at it. If we go to 544 in this sequence, down two pages, please. Thank you. Just scroll down to "the clinical audit", and just towards the bottom of the page. It emphasises that clinical audits will have an increasing and key function for the organisation. This is in the context of the hyponatremia implementation framework, but it is of general concern. That is set against -- if we go to the top of 545 -- the problem of the organisation described by stakeholders is the dilution of the clinical audit function over a period of time, which is an experience similar to that of other Trusts.

Would you agree with me that the report is flagging up, at the end of 2019, the experiences of your staff, and it's the same reflection that's coming back to you, just under two years later, from Dr. Hughes's enterprise and that is, 1, the importance of disseminating guidelines and standards; 2, the

importance of going further and implementing them; and 3, the governance safety check of ensuring that they are actually implemented and feeding back to the centre if that isn't happening?

A. Yes, that's correct. Whenever the report was received by me, and we discussed yesterday the process of going through Trust Board, I identified three areas for the Medical Directorate to move forward on. Those three areas were complaints, SAIs, and standards and guidelines, that is well documented in Trust Board minutes. You will have seen from the report that was produced, you presented it yesterday in terms of the clinical governance, Clinical and Social Care Governance strategy moving forward, you'll see that that's what we said we were going to do, and you'll see the resources that we put against that. We clearly moved forward on complaints and SAIs, and also a plan to move forward on standards and guidelines, but, as I hope you can appreciate, at that moment in time, both the Medical Director and the Medical Directorate became heavily involved in the pandemic and in Covid and, therefore, I can happily say that the complaints and SAIs process was certainly moving forward. The issue of standards and guidelines was moving forward, and I am aware that there's more resource went into it, etc, and you'll note from that document, I hope, the intention to look at clinical audit and improve clinical audit, but it didn't happen at a pace over the time we got it to the Trust Board over the 2002 period

it did not happen at pace, because pretty all of the Clinical and Social Care Governance function in 2002 was focused on the management of the pandemic and, therefore, it didn't move through at pace during 2002. 2020, sorry. Apologies.

55 Q. The top line on this page suggests that the important function of audit may have been starved of resources over a period of time, not just within the Trust but across other Trusts, not just the Southern Trust but across other Trusts?

A. I think, as I reflected yesterday, I think there was a lack of investment in Clinical and Social Care Governance in the Southern Trust, and the clinical audit team was certainly smaller than I would have expected. In terms of similar to other Trusts, I would have to take June Champion's version of that. I have to say I have worked in a Trust before where clinical audit was quite a large function, so I would have to take June's point if that is her view. As I have stated, when I came into post I did feel that the investment in Clinical and Social Care Governance, of which clinical audit is a fundamental part, was not as strong as it would have been or maybe that I had expected it to be.

56 Q. I just want to broaden this out a little and then return to the topic. We can see on the Acute Directorate's Risk Register that this concern in relation to the implementation of standards and guidelines is flagged from a long way out. Just very

briefly we'll touch on it for references and walk through it quickly. If we go to the Directorate Risk Register for May 2014, TRU-137916. That's the start of the document. If we scroll down three pages to 919. We can see that non-compliance to standards and guidelines issued to the Southern Trust was opened on this Risk Register on 5th February 2014. This is the meeting of May 2014, or the discussion of this and, at that time, it is a low risk. You discussed yesterday, Mr. Devlin, that a Risk Register is not just for the purposes of cataloguing problems, it should serve as a valuable management tool for action --

A. Mm-hmm.

57 Q. -- or for making progress. When you see something like this identified as a specific risk, what is supposed to happen, or what ought to have happened on the ground during your time in terms of where that risk is taken to and how solutions are developed?

A. I certainly will. I haven't seen this Risk Register in 2015, but in terms of the mechanics of it, as that risk was rated as a low risk in the Risk Register, the expectation is that the actions in the action list would be taken forward at the Directorate level, so at the Directorate of Acute Services level. That would not be escalated to a Corporate Risk Register, so the team themselves have identified that as a low risk. They have identified the actions that they believe need to be taken, and, therefore, that would managed within the realms of the Acute Services Directorate.

58 Q. They'd be expected to take forward solutions?
A. Oh, absolutely. I mean that's the purpose of having, as I said yesterday, the purpose of having a Risk Register is to identify the actions, or identify whether there are weaknesses in control that need to be addressed. It is a tool for action not a tool for recording.
59 Q. I'm just trying to imagine the personnel involved in this. I suppose within the Acute Directorate the buck stops with the Director of Acute, but presumably he or she would say to the constituent parts of the Directorate, right, how relevant is this concern for your part of the business?
A. Yes. Actions would be expected to be taken at local level because Directors, as I said before, are managers of their business unit and if there are challenges that need to be addressed it should be addressed at a level. If it can't be addressed at that level, if that risk become a high risk, then it is something that should have been discussed at an Executive level.
60 Q. Yes. We can see that over time the risk level increases. If we go to TRU-71917. This is the Risk Register when you come in the door in March 2018. This is a summary page. About five entries up from the bottom you can see:

Non-compliance to standards and guidelines issued to the Southern Trust.
which we know from the earlier document was entered on

the Register on 5th February 2014, was as of, certainly the December update of 2017, now a moderate risk. We can see the finer detail in respect of that risk, if we scroll down the page, please, to 71923. There we have it at the top of the page. The description of the risk or of the potential for harm is, of course, of the same kind of order that Dr. Hughes is reflecting. Have you any sense, Mr. Devlin, I know it was a little before your time but it becomes moderate, the risk having been low, have you any sense of how that risk, in this context, developed in that way, or more generally; why would a risk of this nature increase in its severity?

A. From a technical perspective it would increase in its severity due to the probability of the thing happening and the impact of it, if it did happen. I would imagine it was because there were more and more guidelines coming in. I would imagine that there might have been a difficulty in the ability to deploy those guidelines and to monitor those guidelines as they became more and more because, as I say, it would move from low to moderate. If the probability of the risk appearing got higher or the impact of it, should it appear, and, therefore, someone will have made a decision, or the team will have made a decision, that either the probability or the impact was moving in that direction.

I haven't seen this document before but I suggest even by the second point in the progress of action may have

been the reason, the decision needs to be made regarding the viability of re-appointing an AMD for standards and guidelines. That might suggest to you that there wasn't, or there was a difficulty around the AMD for standards and guidelines. If there was a lack of a member of staff to do something that would often be the reason why a risk may become higher. I haven't seen this document before, but that would be an alarm bell if a decision is being made as to whether they should continue to invest in an AMD for standards and guidelines.

61 Q. Yes. I think it may be helpful just to see this over the full period. If we go to TRU-42751. This is taking us up to the summer of 2020, which is obviously an important month for the other reasons relating to this Inquiry. If we scroll down. Keep going, please. There we are. I didn't have the precise page number. So, the --

A. Sorry, to interrupt. Could you possibly make it slightly bigger?

62 Q. We'll zoom in on that. By this stage, just so we can see the right-hand margin as well, the point that you picked up on from the last occasion, Mr. Devlin, that there needs to be consideration to appointing an AMD for this discipline, appears still to be an issue, the information below remains current, it says. A decision needs to be made regarding the viability of re-appointing an AMD for standards and guidelines. I'm just looking at the left-hand margin. There had been

a system put in place, even for the basic task of disseminating the guidelines but as appears here, just towards the bottom of that left-hand column, given the number of standards and guidelines that are now held on the system, there's a risk of it collapsing. It doesn't appear that by July 2020, even something as basic as getting the guidelines safely out to where they should be within the particular business areas is free from risk or free from danger. The system looks incredibly frail and that's even before you get to the specific concern identified by Dr. Hughes about tracking and audit. Did it remain the case, as you left the Trust, that this was an issue of concern within Urology Service?

A. In terms of with regards to the overall standards and guidance, I'm aware that resources were being put in to -- and I'm led to believe and I would have to check -- I'm led to believe appointments were made to strengthen the team to bring in people to be able to bring the standards and guidelines in and get them out to the organisation. I'm led to believe obviously they invested in technology to allow them to do so.

With regards to Urology, I don't know is the answer, as to whether that was, whether the standards and guidelines processes within the Acute Directorate, specifically Urology, were better than as described in this Risk Register. I don't know that. If they were a major issue I would have expected them to have come

through the governance processes, and I think that's one of the reasons why we were introducing the weekly report which would allow the Medical Director to bring to SMT any concerns around standards and guidelines, any concerns around complaints, incidents, etc, that's why we had that weekly report. I couldn't recall the weekly reports as to whether standards and guidelines had been indicated regularly with regards to Urology. I don't think it had, but I would have to go back through each of those weekly reports to see whether that was the case but I don't recall that it was.

63 Q. In terms of the task of recognising a gap in the Clinical and Social Care Governance arrangements, right down at the level of an MDM or an MDT and how it operates, where does the responsibility lie; the responsibility of identifying the gap, reporting it and getting action around it?

A. The responsibility for running the MDT and running the system well is that of the manager of that service. That's ultimately the manager of the service has the responsibility to make sure the guidelines are followed and the service runs in line with the guidance. An assurance of that process would, of course, be some form of audit, but as we've described earlier, the audit process was something that hadn't been invested in heavily in the organisation. But managers are accountable and responsible for running their service in line with guidance. If they can't do that they're also accountable to raise that through the appropriate

processes, and managers above them are responsible for addressing those issues. If they're unable to be addressed, then they should be escalated as such. We cannot remove the responsibility of the local manager to do the thing in line with the guidance. That could be a Clinical Manager as well as an Operational Manager, but ultimately we all have a responsibility to deliver to our job description, and that is about running the system properly.

64 Q. Did you appreciate, at any point prior to receipt of Dr. Hughes's report, that there was what was characterises as a disconnect between Cancer Services management on the one part and, on the other part, Urology Services who, by and large, provided the personnel who staffed the MDT?

A. Not at the Chief Executive level, that was never raised to me. Those kind of issues, I would expect to be managed at a local level. In an organisation, as I said before, of 15,000 employees, you would expect, within the system, managers to manage. I appreciate that it should be audit around that, but I would expect managers to manage their level and, therefore, the issue of Cancer operating in a separate way to Urology had certainly never been raised to me, or raised through an appropriate Risk Register, or those kinds of things.

65 Q. You've said in your witness statement that, if I can just have it up on the screen please, WIT-00045. Question 19, just down the page. Thank you. You were

asked as CEO about your view of the efficacy of the quality and safety monitoring systems in place in the Trust and executed through your operational teams. You're asked:

"Are there specific aspects of these systems that you find particularly helpful and are there parts of these systems that require improvements? What changes have you sought to put in place" etc.

You seem to be, in the answer you give, expressing a high degree of confidence in the systems that were available to you for ensuring quality and safety. You say:

"As I have stated elsewhere, and published in my annual governance statement ... I am content that the systems that we have to monitor quality and safety are effective. However as with all systems there are opportunities for improvement."

You go on to explain what you've commissioned and the improvements that might follow. In light of the historic difficulties with audit and with respect to the implementation of standards and guidance reaching a crescendo, I suppose, with Dr. Hughes's report, how could you express such contentment or confidence in the arrangements for quality and safety, as is contained in this answer?

A. The view I took when I was writing that was a reflection on my assurance statement from Internal Audit and External Audit, I take assurance from the systems that we have, which are now, as you identified particularly with regard to standards and guidelines, there are weaknesses. But, the overall system of control which looked at controls assurance, looked at Internal Audit, External Audit through our governance committees, etc, the overall system of governance I see as for an organisation within control. I do take the point in terms of quality and safety, and effective quality and safety as highlighted by Dr. Hughes's SAIs, indicated very clearly we had a breakdown within standards and guidelines within Urology. Therefore, in terms of if I were to rewrite that statement now, knowing what I know, having reviewed all of the documentation that I have reviewed in preparation for today, I would say that there were weaknesses in that system of governance around standards and guidelines, and weaknesses in the governance in terms of reporting upwards when standards and guidelines were not correctly followed.

66 Q. Could I briefly, just before we maybe go for a break, just ask about resources in this context?

A. Mmm.

67 Q. I needn't turn to it but I'll give the Inquiry the reference, WIT-84162, where Dr. Hughes recommends to the Trust -- this is within his statement, I'm paraphrasing -- that there must be resources for

tracking and without it patients come to harm, and that's a reflection of don't comply with the guidelines, these risks come with it. Within your statement, and we touched briefly on this yesterday and I said I would come back to it, WIT-00074, please, towards the bottom of the page. Thank you. We asked you some questions about budget allocation, the delivery of services, and the ability to deliver services safely. Paraphrasing your answers, if we continue on to the next page, if you just want to glance at them. What you say over the page, if we can scroll down please is -- if I can paraphrase. It has not been your experience that departments within the Trust seek additional budget based on risk?

A. Correct.

68 Q. There is a monitoring round which belongs to a different context, but there's an opportunity --

A. Mm-hmm.

69 Q. -- there's always an opportunity to come back and say, listen, the balance between risks, benefits and costs is out of kilter. We need to make improvements in a particular area, is that a reasonable summary?

A. That is correct. What would happen on a very regular basis, at least monthly with the Directorate accountants, they would look at where there might be a risk or a pressure and they would move money around, and it's very clear, as you can see, that at a Corporate level and at a Directorate level that money is moved around the organisation to meet those kind of

needs. That doesn't increase the total amount of money that is available to the Trust, but what it allows is managers to move that appropriately. For example, in the last couple of years, certainly in the last couple of years that I was the Chief Executive, considerable amounts of money were moved into Acute Services to meet the demands, and that is available in our monthly performance reports. You can see considerable overspend in Acute because you don't alter the budget, you just move more money in. Considerable growth and expenditure in Acute Services, much to the detriment of other Directorates, because it's not an increased amount of money for the organisation and, therefore, it is moving money from other areas that there may be challenge in spending money or considered less risk, into Acute Services and there's a considerable history over the last couple of years of moving large amounts of money in Acute Services to meet the demands and the risk.

70 Q. If we go back to the practical example of Multidisciplinary Team in Urology --

A. Yes.

71 Q. -- dealing with cancer patients. If you start from the proposition that we have a set of guidelines approved at regional level and adopted by that part of the service and confirmed to peer review, is there a logic in saying -- and tell me that this isn't the real world if it isn't the real world -- is there a logic in saying that in order to deliver that service safely, we

need to know that our clinicians are going to be compliant with the guidelines, and that needs to be checked because you can't simply Trust clinicians as much as you would like to do so, so in designing that service why doesn't the conversation start with, we need funding to do it safely? By that we mean having in place a mechanism for charting progress across all of the patient's care pathway, and that must mean some form tracking and, sitting above that, some form of audit?

A. I think a couple of angles to that. The first one is when a brand new service is commissioned, if you go back to the basics, that service is commissioned in negotiation with the Commissioner. The vast majority of the resource that the Commissioner would provide is for direct clinical care, and there is often a small amount of resource within that commissioning instruction which offer other supporting functions. Okay? The Commissioner would not regularly provide a resource to manage a lot of those functions. I think it's important that you go back to core basics. It tends to be a small overhead for other functions other than delivery of direct care, and certainly my experience of commissioning that has been the case.

I think what I would like to see is that if a service believes it does not have the resource to do the job, so in this particular case if it didn't have the resource to have enough cancer trackers, or it didn't

have enough resource to do audit, the vehicle is there to raise that with the manager and the Director and, as I described, the Directors have enormous budgets. There is the opportunity for the Director to look at the budget that he or she may have and decide how best should we spend our resources. There is evidence that that happens in many places in the Trust. To begin with, there has to be a clear understanding of we need this resource, and then there must be a mechanism for the Director, with their accountant, to look at the budget. In terms of the Acute Services that budget was in and around £400,000,000 per annum, it's a large budget. Therefore, in many of the Directorates there are discussions, and in Acute, about service pressures and looking at how best to spend the money, based on those service pressures.

In many cases, and there is lots of evidence, that process works. In terms of why were cancer trackers not brought in and why was this service not resourced to the level, I don't know the answer to that. My expectation is at a local level that's what managers have. They look at the budget they have, they look at the resources they have, they look the services they have to provide, and if they cannot do that they have a responsibility to raise that to their Director to say, I cannot deliver the service. There is plenty of examples in the Trust where that has happened over my tenure.

72 Q. It may occur to the Inquiry Panel that this is getting close to the fundamental question. I can't remember when this MDM was commenced, I suspect it was 2010, but at that point of saying: this is a service we are going to deliver; it's fundamental, isn't it, that it should be designed within an inch of its life almost. This is how it is to be done safely, including tracking, including audit, and that should be in place at the start.

A. When you design a new service -- and I can't comment on the 2010 because I wasn't here. When you design a new service that is absolutely the case, you should be looking at all elements of that design and, if a commissioning providing system is working well you would negotiate that with the Commissioner to ensure that you got what you needed to run the service. It does bring it back to core basics, which in designing a new service that is what you would wish to do with the Commissioner. I think what has happened over time in a cash-strapped Health and Social Care system often what happens it isn't a negotiated position with the Commissioner. There is a fixed amount of money and we are asked to go away and to deliver a service based on that fixed amount of money.

73 Q. It would be surprising if the Commissioner didn't know that this service was being operating safely. I use that phrase deliberately because that is what Dr. Hughes says. Nobody could be assured that the service was being delivered safely in the absence of

tracking and audit. If that's not happening, the Commissioner must, inevitably, know about that?

A. The Commissioner would know of the performance-related indicators. The Commissioner would know about how many people were on a waiting list and for how long. I don't know if the Commissioner would have been made aware of whether there were cancer trackers and/or whether there was audit. I don't know because I'm not too sure the vehicles we would have to communicate with the Commissioner got into issues with quality and safety. I think the issues with the Commissioner were about volume; how many of something that was done. As I say, I wasn't directly involved in the Commissioner conversations around Urology volumes, but in terms of as a Chief Executive and as a previous Director of Performance in a different organisation, the conversation I would have had with the Commissioner was about volume and cost, it wasn't about quality or safety. My conversation was volume and cost.

74 Q. If that reflection is correct, the organisation or the person, the legal person purchasing these services on behalf of the public doesn't take any initiative to work out how that service is being provided in terms of its quality and safety?

A. Our response to a commissioning intention or commissioning plan is our Trust Delivery Plan. We would articulate in our Trust Delivery Plan more than just numbers. But would the Commissioner come back and view whether we were providing the quality and safety,

that isn't the process that exists with the Commissioner. The processes that exist with the Commissioner are waits and volumes. If there were no waits, clearly there would be a safe system or a safer system. I can understand why volume and wait is a really important part of a commissioning process. If you need a thousand of something to keep the population safe you want to buy a thousand of something. If you deliver that thousand of something then, by default, you are meeting the demand and, hopefully, meeting the needs of the population. I understand why volume and wait are important, and that's the focus of the Commissioner. However, the focus of the Commissioner was not around quality and safety, it was about volumes and waits.

75 Q. You wouldn't buy a secondhand car on that basis, would you?

A. I don't know how that would be -- I can't see the connection to that.

76 Q. If I'm spending public money on a service where patient safety ought to be at its core, not to interrogate what the provider of that service is giving in return seems to me to be, and might appear to the public to be a very odd way of doing business. You wouldn't purchase any everyday item with your eyes closed to what you're getting?

A. I think what, as I described earlier, the Service and Budget Agreement does, which is the agreement between the Trust and the Commissioner -- and by the way these

haven't happened over the last couple of years because of Covid -- if we go back the Service and Budget Agreement clearly articulates the volume of activity the Commissioner wishes to buy, the money is it is prepared to pay for that, and it is assumed that that will be provided at a level of safety and quality to meet the appropriate quality standards. The Commissioner wouldn't come in and test that, but the assumption from the Commissioner is if they are buying a thousand hip operations, that those thousand hip operations are delivered within the appropriate standards, guidelines, and within the quality and safety level. There is an assumption that the money provided is not just to deliver the volume, but also the Trust has a responsibility for the quality and safety of the services it provides.

MR. WOLFE KC: Thank you. Would now be an appropriate time for a break?

CHAIR: How much longer do you think you'll be, Mr. Wolfe?

MR. WOLFE KC: I think if we took a break now and we worked through to two o'clock, say, from ten past 12, I think we could probably finish at or about that time, obviously within a few minutes either way. Do people prefer...

CHAIR: There's two options. We can either take an early lunch break or we could, say, half an hour now and then work through to finish early this afternoon. I am looking for a consensus view here as to what is

preferable for people. I should ask Mr. Devlin, first of all, what you would prefer.

THE WITNESS: I have no preference. Whatever suits, suits.

CHAIR: Thank you for that.

MR. WOLFE KC: With a slightly longer break now, say half an hour, and then we can work through to conclusion?

CHAIR: If we can finish in or around two o'clock, I think that would be the preferable route. Thank you very much. Half an hour would be twenty past.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Thank you everyone for coming back on time. I appreciate that it was a bit of a rush to get out of the building, for those of you who left it, and back again, so thank you.

MR. SHANE DEVLIN CONTINUED TO BE QUESTIONED BY MR. WOLFE KC AS FOLLOWS:

77 Q. MR. WOLFE KC: Okay, could you we can up please with Mr. Devlin's statement at WIT-0096? Towards the bottom of the page the question to you, Mr. Devlin, was:

"Please explain how and in what circumstances you first became aware of possible concerns regarding Urology Services in the Trust."

You set out obviously the chronology from September 2018. Taking you to, if you like, the last part of the chronology:

"In the middle of June 2020 (I do not have a note in the diary of the exact date) Maria O'Kane, Medical Director, approached me in my office to raise her serious concerns about an issue that had come to her attention. She had been made aware by Mark Haynes, Associate Medical Director (Surgery) that an e-mail had been sent from Mr. O'Brien to request that his patients that had not been added to the waiting list were to be considered for an urgent bookable list. When Mr. Haynes reviewed this further it was clear that there were other patients that required to be investigated.

At that point Dr. O'Kane had already commenced an administrative review and suggested that the offer for Mr. O'Brien to return to work following his retirement should be withdrawn. I supported this proposal."

If I could stop there. In terms of the --

A. Sorry, could I please ask, Mr. Wolfe, that this statement is on the screen. It's not on the screen. The top of the page is on but what you just read isn't.

78 Q. You're right to point that out, I'm reading from the paper version. Let's scroll down to the bottom of

that?

A. Thank you.

79 Q. Just take your time and orientate yourself.

A. That's fine, I'm aware of the reference.

80 Q. Apologies for that. In terms of the issues that Mr. Haynes had identified and reported to Dr. O'Kane and she was taking forward, to what extent did you interrogate the detail of that, or did you leave it to Dr. O'Kane to work through?

A. Maria had made me aware of the situation. She'd made me aware that she felt that it was considerable and serious, and that she'd been working with Mr. Haynes to begin to understand the detail behind it. I asked her how serious she felt it was, if I recall, and she said, well, we've identified these two things and we need to look at them, and we need to understand what else that might tell us. Quite clearly, given the fact that we both understood the history of the case, there is no doubt it raised alarms in my mind, and obviously in hers as she wished to come to tell me about it.

81 Q. I mean, as we've reflected, your last dealings with Mr. O'Brien as a person, I suppose, as well as an issue, was 27th November 2018, nothing until the point of this conversation, to the best of your recollection, as reflected in your statement. This must have been a what has been going on moment for you?

A. It was absolutely that moment. Very clearly I supported Maria's decision and action to really begin to understand what had happened. As I referenced in

this particular conversation as well, it was the issue of Mr. O'Brien's desire to come back to work.
I supported Maria very strongly that until I fully understood what was happening, I would agree with Maria in the sense that he shouldn't return to employment. So, yes, it was, it was a moment where we both agreed that this would set us on a path to begin to really understand what had happened.

82 Q. At that point, I can only assume that you must have been somewhat surprised that an issue that had left your desk in November, 18 months earlier, November 2018, was now coming back --

A. I was.

83 Q. -- to the organisation. Was there any form of an inquest or inquiry at that point, 'Dr. O'Kane, what has been happening over the last 18 months'?

A. Well it was. 'Maria, what has happened and what are we now going to do?' It wasn't so much who did what, it was what are we now going to do to get a better understanding of this? Obviously Maria indicated she'd already begun some work on this, quite clearly and this was now about going into detail into, as it turns out nine cases but it wasn't known at that point in time. Clearly, yes, it was a wake up moment, and it was Maria, what are we now going to do. It was very clear. She would work with Mr. Haynes. As you know that then triggered the engagement with our Board, both in August and in October. It was very clear that, you know, both I and Maria, and certainly Maria made me aware that

day, that this was going to be the beginning of us trying to understand what had had happened. What is happening, sorry, rather than what had happened.

84 Q. Is there any attempt, at that point, by you to dig into what had happened in the interim, leaving aside the specific flare-up in June 2020 which is now the subject of an administrative lookback?

A. Not at that moment. The reaction at that moment is what are we going to do? It wasn't, 'can you please tell me what has been happening in the last 14 or 15 months?' The reaction was, 'what are we now going to do?'

85 Q. Have you had conversation with Dr. O'Kane about that period before June, in other words --

A. I think we've had many a conversation as a gathering of senior managers and with Maria, and, as I say, putting it all out on the wall and working our way through what has happened year by year by year, absolutely since then. That meeting was not a meeting about that. That meeting was an alert meeting and then it was Maria, what are we now going to do? How are going to move this forward? It wasn't an attempt to say Maria talk me through the last 16 months, because I don't believe Maria would have been able to talk me through the 16 months. It was, we now have a problem what are we going to do?

86 Q. Part of the conversation, as you have described, is Mr. O'Brien wants to return to work following retirement. Her proposition was this should be

withdrawn?

A. Correct.

87 Q. You supported this proposal. What was the reason for its withdrawal?

A. Having identified the two issues, having an understanding that there was a previous issue obviously, well documented, and Maria's view. I'm led to believe she would have had conversations with Mark Haynes in his role, but Maria's view to me that day was to keep patients safe until we know more, I believe that we shouldn't support Mr. O'Brien returning to work. I appreciate that was a decision that was taken at that moment based on the information we knew at that moment. Since then I believe it was the right decision, after what we have discovered and encountered. However, the decision was being made day, being told me to on that day on the basis of, now we have a problem that we need to fully understand.

88 Q. Mr. O'Brien was in conversation with Mr. Haynes on 8th June --

A. Okay.

89 Q. -- on Mr. Haynes's account, really before even Mr. Haynes had discovered the problem that was reported to you by Dr. O'Kane. On 8th June the offer of reemployment was withdrawn, not at what appears to be a later point when an administrative process, as you have alluded to here, has commenced. I just --

A. That may well have been --

90 Q. -- want to understand your understanding of the

chronology. Do you have a date?

A. I don't because it was when Maria would have walked into my office and said, Shane, I need to talk to you. I wouldn't have recorded that in my diary. I would be surprised if that conversation was after Mr. O'Brien and Mr. Haynes had had that conversation. My recollection is the middle of June, but what I can do is I can go back to my previous secretary and ask to go through the diary again and see if there's anything. But I would be surprised if Maria was coming to talk to me to say, 'do you support this?' if that decision had already been taken. It would be an important thing for me to understand.

91 Q. We know beyond doubt, because Mr. O'Brien recorded the conversation covertly, on 8th June, that Mr. Haynes had a conversation with him which told him that the Trust doesn't re-engage people while there's ongoing HR processes.

A. Mm-hmm.

92 Q. That was 8th June?

A. Then I can only conclude my conversation with Maria would have been before that, because I do not believe that Maria would have been talking to me and asking do I support it if that decision had already been taken.

93 Q. But that doesn't make sense either in terms of the facts that we're aware of, in the sense that the e-mail sent by Mr. O'Brien, which gave rise to Mr. Haynes's concerns was only sent on 7th June?

A. Okay.

94 Q. Then he has a conversation on 8th June withdrawing the employment, and then in the days that followed, leading to an e-mail on, I believe, 11th June, Haynes to O'Kane, this is the problem that I've exposed or I'm concerned about.

A. Okay.

95 Q. Your idea that towards the middle of June you were appraised of a concern --

A. Correct, I was appraised of a concern.

96 Q. I don't argue with that, the bit I'm contesting you on is --

A. Okay.

97 Q. -- is the removal of the offer of employment?

A. Okay. All I can say, as a matter of fact, is that Maria asked did I support that at that meeting. Whether the engagement between Mr. Haynes and -- which you now say happened on those dates, what I can say, as a matter of fact, is Maria said to me in that meeting do I support the fact that we would not be offering the opportunity for Mr. O'Brien to return. Maybe those decisions had already been taken and what Maria was asking for was just my support of that decision being taken. It would not be unusual that employment decisions would not be taken by the Chief Executive. Maybe that was allowing me to know that was the decision and I did support that decision --

98 Q. Yes.

A. -- based on what we were beginning to understand. I can't comment on how Mr. Haynes was able to have that

conversation in early June if the issues that were raised to me that day hadn't been surfaced at that point in time.

99 Q. Yes. That perhaps answers my next question. It was your understanding that, at least in part, as you've already said, these issues which were described by Dr. O'Kane, it was your understanding that they were a feature of the decision to withdraw the offer of reemployment?

A. It would certainly have been my recollection because without that, I don't know what the conversation with Maria would have been and, therefore, my understanding was we have discovered things that we now need to explore in more detail, and one of the factors discussed was that Mr. O'Brien would not be return back to work. I made that connection, certainly in that meeting.

100 Q. Yes. The phraseology used by Mr. Haynes was that the Trust had a practice of not re-engaging people while there's ongoing HR concerns. Do you recognise that as a practice? He certainly couldn't point to any other case. He thought it might have been the first case?

A. I have certainly not been involved in anything like that. It's not something that I would automatically recognise. I think there could be a case made that it could be considered to be sound practice to do so until a decision has been made, but whether that is the rule I'm not too sure I could say that. I don't know all of the HR rules but I'm not sure, as a rule, I think it

could be argued it's a sound thing to do until you have a finished an investigation. But I could not say that I could put my hand on a rule that said that is the case.

101 Q. The impression that you're perhaps giving from your evidence is that these issues around taking forward an administrative lookback, decisions as regards Mr. O'Brien's continued employment or re-employment were being handled elsewhere, and you were simply being informed. You weren't a decisionmaker in the processes?

A. No. I would argue that that should be the case, the decision on employment of certain levels of the organisation need to be dealt with at the right level of the organisation. I was being informed and I gave my support to that, having been informed. I said to Maria, I think that is the right thing to do. But it is not a decision that the Chief Executive takes on employment of an individual.

102 Q. You've explained in your statement that the process of the Lookback Review was something that was brought to your attention and you were kept informed, but you didn't engage in the fine detail of it and didn't become involved in the process itself; is that fair?

A. Yeah. I was kept informed on a regular basis by both Melanie McClements and Maria O'Kane. Melanie was Director of Acute Services and Maria O'Kane, and regularly it would have been obviously discussed with me. As you will then see through my engagement with

the Board, I would have regularly shared updates with the Board in terms of where we were in the overall process at the weekly meeting. So, yes, I was kept well informed. I was not in the middle of the process, and I think it was important that I wasn't because I knew that it was quite likely we would go through a higher process with the Department and other things, and therefore I was not directly involved in the day-to-day running of the Lookback. Although both Heather Trouton as Director of Nursing, Melanie as Director of Acute and Maria would have sought my advice, guidance and input during the process.

103 Q. Yes. An early alert was sent --

A. Correct.

104 Q. -- to the new department. Let's just take a look at that to remind ourselves. DOH-19704. As we can see from the top of the page it is dated 31st July 2020. It's being notified by Dr. O'Kane. Just scroll down, please. The summary of the event is described. It takes its origin, I suppose, from 7th June, which is the e-mail from O'Brien to Haynes, which I referred to a moment ago, leading to a lookback which stretched the period January '19 to end of May '20, making the findings set out therein.

Just to orientate you on some of the detail to this, Mr. Devlin. Mrs. Corrigan, as Head of Service, was tasked with the duty of, I suppose, looking at the material and producing reports --

A. Correct.

105 Q. -- for Mr. Carroll and for Mr. Haynes and, in turn, through to Dr. O'Kane. She produced reports on 12th June 2020 concerning Emergency patients; 18th June concerning Elective patients; and Mr. Haynes was able to provide a report, having looked at aspects of the patients concerned, and produced a report on 6th July. You're aware, are you not, that the Department policy governing the notification --

A. Mm-hmm.

106 Q. -- of incidents that fall within the parameters of an early alert should be made within 48 hours --

A. (Witness nods).

107 Q. -- of the event in question. Let me just show the panel the document. WIT-13839. Scroll down, please. Sorry, the other way.

This is the Early Alert System which was extant in July 2020. If we scroll down, keep going please. It explains the purpose of the early alert, which is a channel between the Trust and the Department to provide timely information of events or incidents which trigger the threshold for an alert. In this particular situation you were looking into a difficulty which was likely to have to --

A. Correct.

108 Q. -- cause patients to be informed of shortcomings in their treatment and that was of regional, likely of be of regional, public and media interests. Those were

the kind of factors at that influenced the alert?

A. Correct.

109 Q. Scroll on down, please. Those are the criteria. You can see within the top paragraph there that:

HSE organisations should notify the Department promptly within, that is within 48 hours of the event in question of any event which has occurred within the services provided or commissioned by the organisation.

The events triggering the alert were well known in mid to late June. Certainly, by the time of Mr. Haynes's report in early July, would it have take, say, a further month or so, to put this into the hands of the Department using the early alert process? First of all, do you agree that there appears to have been a delay in notifying the Department?

A. In line with the policy, which talks about 48 hours of an event in question, then, yes, this is greater in 48 hours. My understanding was the team was still working to try to understand and didn't submit the early alert until the end of July. So that's correct, that is a delay in alerting the Department. I don't know the impact that that would have had on the actions the Department would have taken. Yes, you're correct. It says 48 hours from the event and it was the end of July, then that wasn't within 48 hours.

110 Q. The point is that it's not for the Trust to worry about what impact it would have on the Department and its

actions, nor is it the role of the Trust to try to work out what has happened; the important bit is to get the information into the Department's hands in a timely fashion?

A. Again, that is correct. I think the team were working on understanding, trying to get the best understanding before they submitted that early alert to the Department. But you are correct, I mean if it is a 48-hour window, it wasn't within the 48-hour window, but I believe the team were attempting to get the fullest understanding possible.

111 Q. Why is that relevant?

A. I'm just trying to justify why the time took -- why they took the time. You are correct, if it's 48 hours it should be 48 hours.

112 Q. It's not relevant to work out what has happened, is it?

A. I think the team wanted to try to understand what was happening.

113 Q. Is it relevant to the early alert?

A. To provide the fullest information to the Department as a result of the early alert, I think it is important that an organisation gives the fullest picture possible to the Department. As we are well aware, early alerts do become edited and added to, so therefore there would have been an opportunity if an early version of this had gone in, there would have been an opportunity to add to it. Absolutely, it was not within the timeframe of 48 hours.

114 Q. The obligation, as we have seen, rests with the Chief

Executive --

A. And/or his senior executives in the wording.

115 Q. Was there a conversation with you about the timing of this early alert?

A. No. There wasn't, no.

116 Q. The discussions between the team --

A. Yes.

117 Q. -- to try to obtain explanations ahead of sending the early alert so that they'd be in a position to answer questions from the Department; is that something you participated in?

A. No, not in that particular way. It would have been Maria, Melanie and the other members of the team, whether that be Clinical, etc.

118 Q. Was it Dr. O'Kane's decision on the timing of releasing the early alert?

A. Yes, Dr. O'Kane was responsible in this particular case for issuing the early alert. Most early alerts are issued following a telephone call with the Department. I'm assuming it may have actually been Martina who made the telephone call, but certainly a telephone call and then it issued, and in this particular case, as is the case with most early alerts, they are Director to the Department, they are not Chief Executive to the Department.

119 Q. The next step is to inform your Board --

A. Mm-hmm, that's correct.

120 Q. -- of what has happened. The Board meeting on 27th August 2020, which you attended, if we just bring it up

on the screen please, TRU-130977. I don't think I need to bring you to the opening page of the minute, but this is the confidential part of the Board for 27th August. Just scroll down. Under "any other business" it's recorded that, under the heading "SAI":

Dr. O'Kane brought to the Board's attention SAI investigations into concerns involving a recently retired consultant urologist. Members requested a written update for the next confidential Trust Board meeting.

That's a somewhat narrow description of what the Trust and its Senior Management Team knew at that point?

A. Yes. Then we brought back much fuller details as you'll see in the following meetings. That was the alert to the Board following the early alert to the Department, and the continued understanding of the problem.

121 Q. This is 27th August --

A. Correct.

122 Q. -- a month after the early alert has issued?

A. Correct.

123 Q. Two months after the problem arose, and as much as the Trust Board is being told is that there's a number of SAIs that are being looked at. It's not told about the early alert?

A. My understanding is the early alert would have been shared with the Trust Board members, early alerts

should have been shared with Trust Board members, but I will double-check with that. Early alerts should be e-mailed to Trust Board members.

124 Q. That's what I was going to ask you about. Is it something that should be consulted with the Chair of the Board?

A. No. If there were an early alert -- well, many early alert, my understanding is all early alerts but I check that -- will be copied to Trust Board members but I will certainly, absolutely go back to check that. Then obviously I had a conversation with the Chair to make her aware of the situation.

125 Q. Is there part of this, Mr. Devlin, where the Trust is trying to manage the bad news and release details at a time of its choosing? We have delay in telling the Department and delay in telling the Trust Board the full story of the administrative lookback, what flows from that, perhaps not telling them about the early alert, as we'll see at the next meeting with the Board. What was going on here?

A. I think for me what was going on, there was an attempt for us to do as much as possible to try to address the issues we were identifying and, therefore, the focus was on can we deal with this, can we understand it more, as opposed to alert the Board in huge details. We were trying to manage it, rather than in detail alert the Board. It became very clear as time progressed, as you know from the next board meeting and then further board meetings, we clearly identified to

the Board the challenges, but at that moment in time I do believe the Senior Management Team were trying to manage it to try to get a better understanding and see what we could do, and were not raising it through me to the Trust Board, and I was not raising it to the Trust Board.

126 Q. I'm not sure what that means. We have a situation, going back to 2017. Trust Board is told about Mr. O'Brien, subject to MHPS and excluded. All the way through to this meeting they hear nothing more about this, despite all of the problems --

A. Mm-hmm.

127 Q. -- that are known to the Trust. When it finally comes to the Trust Board in late August, they get a wholly underplayed description of the events that were known to the Trust Senior Management Team. That doesn't, in any way, reflect what was known to the Trust Senior Management Team, does it?

A. No, and we brought that to the next meeting.

128 Q. Did the Trust Board, its Chair and its Non-Executive Directors, have a right to know, in fact, a need to know what was going on, at the earliest possible opportunity?

A. Yes, and that didn't happen. As I say, we then corrected that and brought that to the next meeting in an attempt to try to engage the Trust Board fully on that detail. Quite clearly, when you read that statement, what came to the Board was a short understanding that we were trying to understand what

was happening and, on reflection, you are correct, the Trust Board had a right to have more detail at that August board meeting. Yes, the August board meeting.

129 Q. The next meeting was 24th September 2020. If we just pull up the record of that. TRU-130822. Just scroll up to the previous page, please.

Confidential meeting virtually of the Trust Board. Mrs. Brownlee present. In attendance. Scroll down please. Mrs. O'Kane, I think, is unable to attend that meeting. Scroll down. Apologies from her. She's being covered by Dr. Gormley?

A. Damian Gormley, yes.

130 Q. If you just scroll down to the next page, please. Declaration of interest. Stop there, please. The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda, and the Chair declared an interest in item 7. That's Mrs. Brownlee as Chair just declaring an interest in item 7, Urology, and left the meeting for the discussion of that item.

If we scroll down to TRU-130826 and bottom of the page. You introduce the item by setting the context, advising that there's likely to be significant media interest and reputational issues with the case. Over the page please, at the top of the page. Dr. Gormley then took over and provided a more detailed description of what was going on. He had supplied or Dr. O'Kane had

supplied to the meeting a very detailed paper along the timeline commencing back in 2016 and taking it right up to date, and we'll turn to that presently. It's an extremely detailed piece of work. This is the first detailed account that the Trust Board is receiving, some three months after the SMT was aware of the events. Were you, at that time, aware of why Mrs. Brownlee felt it appropriate to step out of the meeting at that point?

A. I was. Mrs. Brownlee had made me aware earlier on in my tenure at the Trust that she had been a patient of Mr. O'Brien's in her earlier life. In fact, I think she said that he saved her life actually. Therefore, I was aware that was a reason why she felt it was important not to be part of the conversation.

131 Q. The conversation proceeded without her. We can see reference to the early alert which may give an answer to the earlier issue you posed?

A. Mm-hmm.

132 Q. Ms. Donaghey, who was a Non-Executive Director, is that correct?

A. Correct.

133 Q. She asked at which point was the early alert to the Department submitted, and you undertook to clarify. Is that not something that was the tip of your tongue?

A. I actually think I said at the end of July, but I think I was clarifying the exact date. It was the end of July I think is probably what I would have said, but I undertook to clarify that.

134 Q. Was Ms. Donaghey reflecting the view that it's taking a rather long time for this to be brought to our attention?

A. I suspect you could infer that and that isn't what she said, as I recall, but I imagine that may have been, when the answer when was it submitted would have been to help her understand how long the process had been going on for, I would suggest.

135 Q. Yes. You raised the thought that perhaps --

A. Yeah.

136 Q. -- the Board members were sent the early alert or told about the early alert at some early point, and please check what for us?

A. I will do because it is common practice for early alerts to be shared with all Non-Exec Directors, and therefore I will check that.

137 Q. Why is that common practice or why is that considered appropriate?

A. It's something I introduced when I first came on board in a conversation with the Chair because there were early alerts going to the Department which, by the way, they can go to the Department, directly from the Executive to the Department but the Chair had wanted Non-Execs to be aware of what was happening on the early alerts. So that was my understanding that Corporate Services did copy early alerts to Non-Execs but I will absolutely go and check that.

138 Q. I want to just open the paper that was provided to that meeting. As I say, it's an extremely detailed paper.

TRU-130906. If we just scroll slowly down it. I don't intend to open it, save for one important point. It's supplied by Dr. O'Kane for the information of the Board. Scroll down, please. It starts by reflecting the issues that were part of the MHPS investigation. Sorry, that's not right. It starts by reflecting the issues that were the subject of the more recent administrative lookback. Scroll down, please. Then it sets out the actions that were taken immediately in June, reflecting the fact that Mr. O'Brien is no longer employed, referral to the GMC, setting up a panel of experts to review the adverse incident reviews, that was to become Dr. Hughes's review. Scrolling down, please. A process had been set up to manage this internally and externally involving the HSCB, the Trust itself, the PHA and the Department of Health. Going down. This is categorising the SAIs, what was to become the SAIs and the nature of the concerns initially identified. Scrolling down.

I suppose the only question I have from this, the detail is factual and no doubt the Inquiry panel will review it. If we go to TRU-139017. Sorry, it may not be that. Sorry, I should have said TRU-130917. It takes the reader through the MHPS process and ends with the submission of the grievance, and that was the date you met Mr. O'Brien. What the report to the Board didn't do, and what the Board had never been appraised of was the outcome of the MHPS in terms of Dr. Khan's

determination. The Board would never have been told about the actions that were necessitated at that time, including the conduct hearing, the action plan, the criticism of management, and the need for an independent review. Can you think of any reason why those issues or that information was withheld from the Board?

A. I can't. In terms of it being taken as a management report, a management action to be taken at the appropriate level, it was something that was consumed at an Executive level. It wasn't escalated to the Board. It was decided, as I explained yesterday, that in the Acute Directorate the Medical Director would take responsibility for the actions, etc. Even the HR related grievance issues, etc, were managed at the management level, they were not escalated.

139 Q. Just so --

A. I'm not too sure that issues such as that were regularly escalated to the Board in terms of HR related issues, etc.

140 Q. Perhaps you have missed my point. This is a full read out?

A. Yes.

141 Q. I'm sure the Inquiry will commend its detail, there's hardly a stone left unturned in what is reflected back to the Board here in Dr. O'Kane's paper. What appears to be missing from it is any description of Dr. Khan's analysis and the recommendations, including the criticism of the management of the Trust that was to be

addressed through an independent review. I'm not asking why that wasn't escalated to the Board, I'm asking you is there any good reason why the Board would not have been, for example, referred to the criticism of management's approach to these problems?

A. I can see no reason. Now you have brought it to my attention, I can see that clearly that wasn't in the document. I can see no reason. The author of the document, being Dr. O'Kane obviously, could give you a better understanding of her reasoning. However, that document and the content of the document was shared with us and we all contributed to the creation of that document. This isn't just Dr. O'Kane's pen and therefore I can see no reason why we wouldn't have included those other aspects.

142 Q. Not to put too fine a point on it, if there's failings on the part of management in dealing with these issues, as far as back as 2016/2017 and they're only the month before that is July 2020, being dealt with through an independent review, that's something that the Board ought to know about. For example, the Board might want to say: why have you taken the guts of two years before carrying out a recommendation? What lies behind these criticisms of management? Has management been disciplined for this or has training or support been provided? Those are the kinds of challenge function questions that the Board would be expected to make, but before they can make the inputs they need to have the information, and they were deprived of the information

here.

A. As for the document, they were. I cannot give an answer as to why that was the case.

143 Q. Notwithstanding Mrs. Brownlee's declaration of interest and her exit or recusal from the September meeting, she did attend the meeting that was to be held on 22nd October, and you've made some comments in relation to that in your statement. If we could just look at your statement, please, at WIT-00095. These are somewhat general observations about your relationship, first of all, with the Chair. You say:

"From a personal reflection, is that during my early tenure the relationships between yourself and Mrs. Brownlee were not as strong as they could have been. Outside of public Trust Board meetings we clashed a small number of times on the difference between the roles of a Chief Executive and a Chair. In my opinion, given the lack of consistency of personnel in the Chief Executive post prior to my tenure, the Chair had understandably become more involved in the operational delivery of the Trust. As the new Chief Executive, I found her approach 'overreaching' and in many cases unhelpful. On reflection, I know this imperfect relationship may have had an impact on the functioning of the Board and I know, through discussions, some members of the SMT found the relationship with the Chair difficult at times."

Can you help us just with some examples of what you say were clashes on the difference between your role and hers?

A. Yes. The role of the Chair, for me, is obviously to have overall responsibility for the running of the Board and to be assured of the governance of the organisation. The job of the Chief Executive is to ensure the organisation delivers to its objectives within that framework.

It would not have been unusual for the Chair to have made direct approach to Directors to enquire about issues, to ask them to do certain things. An example of that, for example, we discussed yesterday Mrs. Gishkori and Mrs. Gishkori's exit from the organisation. In the background, unbeknown to me, the Chair was having conversations with Esther to try and encourage Esther to take the job that I was suggesting that we wanted to explore. It was this idea that the Chair had huge authority, huge power, had been in the organisation and its predecessor for potentially 16 years, I think probably, she was a Non-Executive Director in the predecessor and then became of the Chair of the organisation. In many cases I found that if I were to want a non-executive to work with me on anything, I had to formally request permission to do so. However, the Chair was more than willing and able to walk down the corridor and start to have conversations with executive directors about things

that she would like to have done. I found that undermining, to a certain extent, and I found that a difficult relationship because your executive team are your team and you are managerially accountable for delivering the objectives, and the Chair and the Board are responsible for the governance and challenging of you to do that. I've now had the pleasure of working with seven Chairs. Every Chair is different. They have very, very different. But, in particular, I found that a difficult situation. I was new coming into the organisation and, as I said, and I do have regard to the fact that the Chair did not have a substantial Chief Executive for quite a period of time and, therefore, that will have required her to have more hands on. I really am not saying that this is a major issue in terms of she shouldn't have been doing that. I'm just saying I came into an organisation where that was the way that it was being done, and I would have expected that I would have not had that kind of level of direction from the Chair.

144 Q. Mm-hmm. I asked you for examples --

A. Yeah.

145 Q. -- and what you paint, I suppose, is a more general picture of the way she conducted herself with your execs, suggesting things instead of following what you might regard as the appropriate process of approaching you and following it through in that way. Are there any specific examples beyond that kind of general approach description?

A. I think in terms of clashing as opposed to -- we certainly clashed on, or we clashed on the issue of the governance, but we also clashed on the issue when there was an event that we were running, and very openly the Chair was unhappy with what I had done with regards to -- I would be regularly meeting the Permanent Secretary every week I would meet the Permanent Secretary. The Permanent Secretary was then coming down to visit theatres in Dungannon, and I went to visit the theatre in Dungannon with the Permanent Secretary and I asked the Permanent Secretary to come back to the organisation. She was, I think she described it as horrified that I would have invited the Permanent Secretary into an organisation without her knowledge and those kind of things. We just clashed on certain issues.

146 Q. Yes. You go on to say in this part that this approach, on reflection, or this imperfect relationship on reflection may have impacted on the functioning of the Board. What do you mean by that?

A. I think what I mean by that, and having worked for other Chairs, I felt less comfortable and less confident to simply walk through the Chair's door and say, Chair, what about this, what about this? I also found that if I were to give any feedback that was viewed as negative in any way, that was not received as an opportunity for learning. Having now, as I say, worked with a lot of Chairs and having been on a board since 2009, I do not feel I had the relationship with

the Chair to have that informal, 'can I just talk to you about', I think that's an important part of the functioning of the Chair and Chief Executive relationship.

147 Q. Your remarks have obviously been received through the statement, they were processed by Mrs. Brownlee and let me put to you what she says. If we can go to WIT-90881. She said that she's shocked to read those comments. She was under the impression that she had a very good relationship with you. Never once recalls clashing. Friendly meet-ups, whether over coffee, discussion of family and relationships. It goes on to describe attendance at a charity function, I think in her company or invited by her, or something to that effect.

A. There was a charity event that, yes, the Chair invited me to, along with other people, which included Aidan O'Brien, I may add actually, an event that the Chair was running. The Chair had bought a table at an event for a cancer charity and myself and my wife were invited.

148 Q. Yes. Obviously people perceive relationships --

A. Yeah.

149 Q. -- in different ways. In terms of your assessment of her as a Chair, it's fair to say -- just pull up a document here, WIT-90934.

A. That was in 2019.

150 Q. Yeah. This is your assessment of the Chair's performance?

A. I had hoped this document would be an opportunity for us to have a conversation about how we could improve that relationship.

151 Q. First of all, most of the -- it's a box?

A. Yes, it is. 1, 2, 3, 4.

152 Q. Most of your assessment of her is in the very effective or effective category; is that fair?

A. Yeah.

153 Q. If you scroll through it, just scroll down through it?

A. It is fair.

154 Q. I think there's a specific -- just scroll down, please. Keep going. Keep going all the way through it, please. Just stop there. Effective relationships specifically on a relationship with you developed an appropriate relationship with the Chief Executive and SMT, supportive yet challenging.

You've described it as effective?

A. In the context of the document, I had hoped, as I said before, I found it very difficult to give feedback to the Chair because feedback was not often accepted in the way it was meant. I had hoped that by calling out a small number of twos there would be a point of conversation that we could have around those and explore why I felt it wasn't the top mark. That may sound a little odd to you, but it was really important to have an opportunity to raise, not everything is perfect, and here are things I would wish we would discuss. That didn't happen in that way and that's the

result. I also reflect on, having seen other Chief Executive's reviews of the Chair, I don't believe there is a single bad word said. It reflects that I did not feel confident that I could raise negative points, but this was an opportunity for me to raise a small number of 2s in this document, which I hoped could be a point of conversation that we could be begin to explore why did I say it was a 2 versus a 1, and why would I have felt that way? The conversation didn't go that way.

155 Q. Did the conversation happen?

A. There was a short conversation with the Chair and looked through it, and it was all 1s and 2s, therefore things are fine. That's a reflection. It was my first year working for the Chair. I mean the reality is, I was attempting to highlight to the Chair where I thought the relationship wasn't as good as it could have been, hence why there were a small number of 2s that stood outside.

156 Q. Not to be too glib, if you had marked it 3 or 4, which is perhaps what you're saying you felt?

A. I don't believe I could have done. I don't believe that could have been accepted. I am aware, having sat in an internal audit report back to the Chair from the Chief Internal Auditor, when that individual raised anything of that negative nature, it drew a response which was not in the way that it would be viewed as an opportunity of learning. I wanted to use this as a way that I could hopefully get into a conversation. It was not as successful as it should have been.

157 Q. I'm not aware of this exercise of assessing the Chair was conducted in subsequent years. I'm certainly not familiar with any material. Was it?

A. I believe not in a numeric way but I believe that previous Chief Executives would have completed an assessment of the Chair.

158 Q. There's some sitting behind this document?

A. Correct, but not of 1s and 2s. It would not have been a numeric exercise.

159 Q. Did you conduct any subsequent exercise of this nature?

A. No.

160 Q. Why not? This is the first year of your tenure?

A. There was no further of these, no. That's correct. We didn't have that conversation.

161 Q. What we're working off here is what Mrs. Brownlee has disclosed to us?

A. This was done as a once-off in 2019.

162 Q. I know your predecessors conducted some exercises of a slightly different nature?

A. That's correct, slightly different exercise.

163 Q. If you didn't conduct any more yourself, why not?

A. Because this was an exercise requested by the Chair to be done to support her appraisal with the Permanent Secretary, I assume. She did not request me to complete any more of them.

164 Q. Yes. Before we leave this specific issue, I just want to achieve clarity on what exactly you're saying. What you seem to be depicting is a sometimes problematic relationship with your Chair, but not one that led to

anything approaching a breakdown --

A. No.

165 Q. -- in working relations?

A. No. Also I would stress that in the Boardroom the Chair was excellent at managing the Board, excellent at bringing me in on the conversations, and, therefore, there is not a criticism in any way of the Chair's ability to Chair the Board. That is not what I'm saying. What I'm saying is that I found it difficult to build a relationship with the Chair in comparison to my ability to build a relationship with other Chairs that I have worked with.

166 Q. If we can go back to WIT-00095 please? Just the bottom half the page, please. Starting with the paragraph:

"Specifically with regards to Urology, during my tenure when items were brought to Trust Board I did not feel that the conversation was quite as open as with other topics. On reflection, I would question the total commitment of the Chair of the Trust to be totally open with regards to her willingness to criticise Urology and, specifically, Mr. O'Brien."

Then you move on to talk about the meeting of 22nd October, which I wish to deal with separately.

Just on the opening comments there; what were the issues that were being brought to the Trust Board in respect of Urology?

A. No, sorry. What I meant was, when it was brought to Trust Board, which was 22nd October, fundamentally the first time I was involved in a Trust Board conversation was obviously in the August meeting, but she wasn't in that meeting. I'm reflecting on the 22nd August meeting as opposed to, apologies, when it was brought to the Trust Board, other Trust Board meetings.

167 Q. In fairness, the sentence doesn't read like that at all?

A. I know it doesn't and, on reflection, I should have corrected that, so apologies.

168 Q. Just to be clear, there were no occasions, prior to August 2020 --

A. That's correct.

169 Q. -- when you were a participant in a Trust Board conversation about Urology or Mr. O'Brien?

A. That's correct. So apologies. That's correct.

170 Q. So the criticism here, which then develops into the 22nd October meeting is specific to that?

A. The 22nd, yes.

171 Q. Other of your colleagues within the Trust have expressed, through the Inquiry, concerns about Mrs. Brownlee. I think it was described on Tuesday when Dr. O'Kane gave evidence that the knowledge that Dr. O'Kane had been a patient and was friendly with --

CHAIR: Is it Dr. O'Kane?

172 Q. MR. WOLFE KC: Dr. O'Kane gave evidence of a chill factor?

A. I don't believe so.

173 Q. In her evidence on Tuesday, or at least she agreed with counsel's description of a chill factor arising out of the knowledge, personal to her, that Mrs. Brownlee had a friendship with Mr. O'Brien. First of all, do you recognise any sense of a chill factor created by knowledge of that relationship?

A. I think that, yes, I do recognise it. I am aware, because Maria O'Kane made me aware of the engagement between herself and the Chair. I was also aware of the fact, as I say, that Roberta was both a friend of Mr. O'Brien, an ex-patient of Mr. O'Brien, and latterly I was made aware that she was also the secretary of the charity that Mr. O'Brien had started for a period of time, not at the time that I knew her -- yes, not at the time -- a lot earlier. So I was aware of that. I was aware that, as I say, the conversation with Maria.

174 Q. Can I just bring you to that one specifically?

A. Yes.

175 Q. If we go to WIT-45034. Actually we'll go to WIT-40593. Thank you. If you scroll down the page, please. Dr. O'Kane was asked about issues of concern relating to Mr. O'Brien. She was asked:

Do you now know how long these issues were in existence before coming to you or anyone else's attention?

She's answered that question by saying:

Mrs. Brownlee volunteered to me that Mr. O'Brien had

saved her life, that she hoped I wouldn't raise concerns about Mr. O'Brien, as had been her experience previously with medical managers, that she that he had been poorly treated through the MHPS process and that he was an excellent surgeon.

Scrolling down please. She says it was a meeting on 11th January, it appears. She says:

I spoke to Mr. Devlin explaining that if there were concerns about any doctor I had a professional responsibility to pursue these concerns to assure patient safety, and he agreed.

The way that's been explained, it's not entirely clear in that bottom answer in blue, in the blue box, that she alluded, in her conversation to you, alluded to what Mrs. Brownlee had said to her.

First of all, do you recollect any conversation?

A. I do. My recollection is that she was reflecting on her first meeting with the Chair because Maria hadn't long started, had, in fact, probably been in about a week or so but I would have to check, reflecting on her first conversation with the Chair and did tell me that that's what the Chair had told her.

176 Q. You responded in what way?

A. I told Maria that she absolutely had my support to do the right thing as a Medical Director and would only

expect that to be the case.

177 Q. The description that Dr. O'Kane has provided might be regarded as a somewhat extraordinary intervention on the part of the Chair of a Trust, knowing that there was a process in train, MHPS, knowing that that hadn't concluded, knowing that Dr. O'Kane had her hands on the levers of power in that context. Did you take this up with the Chair?

A. No. I gave Maria my full support that if she needed to pursue safety and quality issues she had my support to do so. I did not take it up with the Chair.

178 Q. Assuming it to be true, as I think you might have, was there any other action you could or should have taken vis-à-vis the Chair?

A. I could have discussed it with the Chair, but at that point I did not feel that I could discuss it with the Chair.

179 Q. If the Chair was behaving in this way by flexing her muscles and creating what Dr. O'Kane has described as chill factor, on the face of it that would appear to be contravention of, for example, the Nolan Principles, that's now Trust chairs presumably shouldn't be using their influence to assist theirs friends in matters of professional conduct proceedings?

A. That is correct, yes.

180 Q. Is this not a matter, if it happened in the way that you and Dr. O'Kane describes, that should have been raised with the Department and left for them to address with the Chair?

A. As described now, yes. I did not see it in that way but you are correct. When you put it to me in that way, yes, you are correct, I should have raised it.

181 Q. Is there any other way to see it, and should it not have been blindingly obvious that that was something to be addressed?

A. Yes.

182 Q. Were you aware of any other members of staff within the Trust having concerns in respect of Mrs. Brownlee and her relationship with Mr. O'Brien?

A. Not at that time. I have subsequently, having read the witness pack. I'm aware that there are other people who have described, whether that's Mr. Mackle or Esther Gishkori.

183 Q. Mrs. Corrigan, Mr Mackle, Mrs. Gishkori?

A. I have read those.

184 Q. None of them have approached you?

A. Not approached me, no. As I say, I am aware having read it in the witness pack.

185 Q. Mr. Wilkinson didn't approach you about any concerns he might have had?

A. Not -- he was concerned about his --

186 Q. I should have said Mr. Wilkinson, Non-Executive Director?

A. He did raise in either a Trust Board meeting or one of the weekly meetings that he would wish to understand more the role of the Non-Exec in the process, and I know there was some further training organised via HR I think it was. He raised it in that context. He has

certainly never approached it with me and raised it with me to say directly, I have concerns. No. Nor did I have a real close relationship with any of the Non-Execs. I'm not sure any of them would have done so.

187 Q. If we go back to your statement then at WIT-00095. Going down to the bottom half the page, please, and picking up where we left off it says:

"At the confidential meeting of the Trust Board on the 22 October 2020, we tabled the details of the case so far and strongly debated the concerns with regards to Mr. O'Brien."

You include here a section of the minutes where the Chair intervenes.

A. Yeah.

188 Q. I don't propose to read out, but I read your interpretation of that.

"I was left with the strong impression during the meeting that the Chair was advocating on behalf of Mr. O'Brien, a feeling which was shared and relayed to me by a number of SMT colleagues. It was common knowledge amongst the Trust Board and the SMT that the Chair had previously been a patient of Mr. O'Brien and that she was a personal friend. I felt aggrieved that the Chair had not declared a conflict of interest in the conversation at the Board meeting. I discussed my

concerns with members of SMT and was considering what I should do. A few days later (I cannot recall the date as I did not note ...) I received a telephone call from the Permanent Secretary, Richard Pengelly, asking whether I was aware of 'Craigavon Urology Research and Education. I was not aware and advised him of this. He proceeded to explain to me that it was a charity that had been created in 1997 by Mr. O'Brien and he understood that Roberta Brownlee had been a director of the charity for 15 years up to 2012".

Scroll down, please.

"Richard Pengelly asked me if Roberta had been declaring a conflict of interest in our board meetings with regards to Mr O'Brien and Urology, which she had not. Richard Pengelly then instructed me to telephone the Chair and advise her of our conversation and request that she withdraw herself from any further Trust Board conversations on this topic."

You subsequently communicated with Mrs. Brownlee on that, and she excused herself from what was to be her final meeting in November 2020. You go on to say:

"It is important to note that, even though our working relationship was less than optimal, I do not believe that this had any impact on the path that was followed with the O'Brien Case and/or Urology. All appropriate

regard, to Mrs. Brownlee as Trust Chair, was given from me. Our relationship did not alter my behaviours with regards to sharing information with the Chair and the Board and I am of the view that the actions Mrs. Brownlee chose to take were not affected by our relationship."

Some questions arising out of all of that. First of all, you've alluded to the fact that after this meeting, the concerns that you had about her attendance and participation were shared with you by members of the SMT, and that was then the subject of conversation before speaking to Mr. Pengelly. Who specifically within the SMT did you speak to?

A. It would have been generally SMT. So I can remember talking to the Director of HR, the Medical Director, etc. There was also a conversation with one of the Non-Execs as well, with Eileen Mullen who is one of the Non-Execs who also felt as I felt in the meeting. I am very conscious that I was aware that the Chair was not going to declare a conflict of interest, because she had e-mailed me to say so, and I'm very conscious that I thought that that would be okay. I suppose the frustration I had at the end of the meeting was I think that was the wrong decision because actually in the meeting I felt that it was not as balanced as it should have been. Certainly after the meeting, initially after the meeting there would have been conversations, across all of SMT, and then explicitly I had

a conversation with Eileen Mullen as a Non-Executive about the meeting. She expressed her apologies to me, actually, for the way the meeting had progressed.

189 Q. It's fair to say that Mrs. Brownlee had attended the meeting on 27th August?

A. That's correct.

190 Q. When the issue that had been discovered in June, and the lookback and all of that, was, as I've described earlier, alluded to for the first time by reference to the SAIs. She attended that meeting and there was no protests from you, or anybody else, about her attendance at that segment of the meeting?

A. No, I don't believe so.

191 Q. Yes. She has said that she didn't attend that section of the meeting in August, and we'll ask her about that.

A. Mm-hmm.

192 Q. It's not recorded in the minutes that I can see that she stepped out?

A. Okay.

193 Q. Do you have a memory of that?

A. I can't. I mean I do know that Roberta would have stepped out of certain meetings.

194 Q. Yes.

A. I think the term wasn't conflict of interest, the term was because of her emotional connection or something. I can't say whether that was the 22nd, I'd have to refer to the minutes.

195 Q. We know, as I pointed out, that she exited the September meeting?

A. She did.

196 Q. That's recorded in the minutes and I put that on the screen earlier. It rather begs the question, when Mr. Pengelly, and this is the second paragraph, asked you if Roberta had been declaring a conflict of interest in your Board meetings with regards to Mr. O'Brien and Urology, you said that she had not, whereas, in fact, she had declared such an interest and it's recorded for the September --

A. September meeting.

197 Q. -- 2020 meeting?

A. She had not consistently probably I should have said because there was an incident where she had not and had not on the October meeting either.

198 Q. He's presumably asking a question looking back.

A. Yes.

199 Q. I think it's right to say that before your time, January 2017, she stepped out of that meeting?

A. Okay.

200 Q. Didn't step out of the August 2020 meeting, stepped out of the September meeting and back in to the October meeting?

A. Okay.

201 Q. That doesn't accurately reflect --

A. Okay.

202 Q. -- does it?

A. No, she had not on all occasions or had on some occasions. Apologies.

203 Q. In terms of the build up to that meeting, you point out

that her attendance at the meeting was to be the subject of discussion in advance of the meeting. If we just look at the e-mails that deal with that. TRU-253704. If we go to the bottom of the page and please work up. Just below that, please. Mrs. Brownlee -- just let me see if I can see the date on that. She's writing to you. No.

A. 19th October.

204 Q. The meeting is taking place on -- yeah. So she's writing to you to say:

I wish to confirm that I will be staying in for this item.

She's got the agenda obviously in advance.

An extremely serious matter for the Board and I need to be present. I have no conflict with this particular matter. My past personal illness I will try to overcome the emotions.

She goes on to say: I have spoken to Dr. Gormley because Dr. O'Kane is not coming to the Board to be able to confirm that one urologist, Dr. Haynes, has been reviewing the files.

She goes on to say: We need to make sure that the process is as perfect and robust as possible.

She alludes to the Neurology context with Dr. Watt and whether there's any learning from that. As this develops, just going up the page to 253074, you respond to that copying in Dr. O'Kane and other members of the Senior Management Team.

Can we have clear answers from for the Chair of the meeting.

Going further up the page please. Stop there. Dr. O'Kane is saying: Shane, my understanding from what the Chair has disclosed openly is that she has been a patient of this doctor in recent years. Given that we will be discussing the impact on patients potentially I am concerned. Maria.

Then you respond to that: Happy to discuss. Although the Chair has not been a patient in recent years she was a patient 20 years, I think as Chair she needs to be part of the conversation and the whole Board need to be in the middle of this.

You know about the personal relationships; you know she's been a patient of Mr. O'Brien; you know the history of Dr. O'Kane's concerns about Mrs. Brownlee and her intervening when she shouldn't have been intervening back in January 2019, but you give the green light for Mrs. Brownlee's attendance --

A. I do.

205 Q. -- through this e-mail?
A. Because I believed that if it was a balanced conversation, the Chair and all Trust Board, given the seriousness of what we were discovering, needed to be involved in that conversation, and I trusted the Chair's view that she felt she needed to be in that conversation because it was a wider issue than just Mr. O'Brien. I felt that based on her belief that it would be a balanced conversation that I said, what she was clearly saying, I haven't been a patient in 20 years, or a long time I think it was, and, as a result, she wished to be there as Chair of the Board. Clearly as Chair of the Board her Board directors needed to be informed in detail of the issues which at that point we all understood were wider than a single clinician. They were systemic issues that we were beginning to understand. I was happy to do so.

What I have to say then is as the meeting progressed, I reflected - I didn't reflect - as the matter progressed it didn't feel as balanced a meeting as I hoped it would be. That was the comment I made, probably with hindsight it would have been better if a conflict of interest had have been declared. I made that decision based on the fact that I felt it was important that the whole board was involved in the conversation which was an all Trust issue.
206 Q. It is difficult to understand your evidence that you were aggrieved at her failure to declare and her

attendance when you've given the green light?

A. That's what I'm trying to say. As the meeting progressed, at the end of it I thought well actually I was probably aggrieved myself for agreeing that that was the right thing to do because as the meeting progressed, the reality was, the content was too close to the Chair's personal experiences. So I was aggrieved. If I reflect on that, I was annoyed with myself that I allowed that decision, that I made that decision.

207 Q. Let's just briefly look at what was said at the meeting to see if we can understand your concern. If we go to the minutes for the meeting at 131853. That's the update on concerns within Urology. Scrolling over to the next page, please, we capture the Chair's input. So let's scroll up so that we have all of the Chair, from the Chair down in the screen. The Chair, takes the starting point to her input to the letters that were written to herself and indeed you about the concerns that she felt that his employment was ending without him having an opportunity to return and the concerns around that. She goes on to say that that was being progressed through HR, and she had been advised about that and she also raised the fact that a number of different Urology consultants had been in place over the years and asked why they hadn't raised concerns about the consultant's practise and why what his PA.

Is that his personal assistant?

A. Correct.

208 Q. Not raised concerns in relation to dictation of patient discharges, as she describes it. The Chair also asks should a GP not have described the prescribing of Bicalutamide as an issue? Anything wrong with those inputs? Or those general observations about the --

A. No, nothing wrong with those as if it were as part of a rounded conversation, but it was the only input which it felt to me, and I'm sure you could test this with other people who were at the meeting, it felt to me that it was constantly there was no question about Mr. O'Brien, there was no question about a practise, the question was about everything, everyone else is the best way I can describe it. The questions were put in: Surely the PA should have raised this? Surely the GP should have raised this? It was, for me the tone of it. As I say, I am one person in a meeting and I'm positive if you were to speak to other people they will give you their view of the meeting. I do know when I left the meeting, as I say explicitly one of the other Non-Execs approached me to apologise for the meeting. I'm conscious of the conversations I had informally being members of the non-executive team as well, but it didn't feel like a rounded meeting where it was asking the execs, challenging the execs on all part of the process that we had brought to the table in some detail that day.

209 Q. Putting this in context, this is her first detailed engagement with Mr. O'Brien, issues at Board since,

well ever, perhaps. The 2017 meeting was discrete to discussing his exclusion, the commencement of the MHPS process. As a Chair, this is her first opportunity to raise questions about essentially why has it come to this? Has nobody else spotted the difficulties? Reasonable questions?

A. Reasonable questions in the context of a detailed document which presented an awful lot of information. There was no questions or challenges on that document which you've already said is a very detailed document. The only questions were, why didn't everyone else do the job? That's my interpretation of that conversation. They are reasonable questions as part of a wider set of questions around a very detailed document.

210 Q. I should say, the detailed document we discussed earlier was the September meeting, a further detailed document perhaps supplementing aspects of an earlier document was before this October meeting?

A. It was, yes.

211 Q. Just scrolling down. Dr. Gormley responds to aspects of that by referring to the SAI process and the work that it would do. Mrs. McClements spoke about what had emerged in 2016, and the Chair comes in again at the bottom of the page.

A. Mm-hmm.

212 Q. Just scrolling up, please. Sorry. This is Mrs. McClements, I think, addressing the question about the process of reviewing patient files. I think

there's another intervention down the page from the Chair.

A. There is an intervention earlier that refers to Mark Haynes being the only clinician reviewing.

213 Q. What page please?

A. I think it was the page before.

214 Q. Just go on up the page, please. No matter. The point that you make is that she was advocating for Mr. O'Brien at this meeting, or that was your impression?

A. My impression was that -- maybe advocating is too strong a word. My impression is that the questioning that I would have expected around the whole of the case, which would have included questioning around the earlier stage, around Mr. O'Brien and all those kind of things, that that didn't happen. What happened were questions about things that other people should have done. I was left with the feeling that it was very much a meeting which was trying to deflect, maybe abdicating is too strong, trying to deflect. I can't today in writing describe the feeling, but I can say I left that meeting feeling uncomfortable because it felt as the Chair was guiding the meeting to deflect away from other important elements of the case.

215 Q. In her statement to the Inquiry she rejects that she was advocating on his behalf, and no doubt she will appreciate that reflection on your part and concession that it didn't go as far as that. She said, and we've seen it already, she was asking open questions about

what had gone before in her role as Chair in challenging the operational side of the Trust. That's the kind of thing that she can properly get involved with. What did you expect of her?

A. Given the level of detail that we were providing, I expected the conversation to be balanced around what management did, what clinicians did, and what others didn't do. It felt, as I described already, it felt as though the only questions were why didn't these other people see this, as opposed to the challenge we may have had with a clinician. I can only describe the feeling and then having had conversations outside of the room. I respectfully suggest that if you were to speak to other people and they didn't have that feeling, then clearly it was my feeling and only my feeling. If you speak to other people and they had a similar feeling then that's something that may be the case.

216 Q. If we go back to your statement, please, at WIT-00095, towards the bottom. Just on to the top of the next page, sorry. You received a telephone call from Mr. Pengelly?

A. That's correct, yes.

217 Q. Can you help us, in terms of trying to understand why he took the initiative of calling you on this subject matter? How did that come about?

A. Richard had been made aware through Companies House, so he must have had some of his staff trying to understand a bit more about, well probably Roberta Brownlee and

the case as a whole. He had been made aware through the Companies House search that Roberta Brownlee was a director, registered to Craigavon Urology. Richard rang me because the line between the Permanent Secretary as with the accounting officer with the accounting officer. The Chair is appointed by the Minister, not by the Permanent and, therefore, Richard would often have rung me about Trust-related issues and asked me, as you can see from my statement, he asked me was I aware of CURE, which I wasn't. Then he explained to me what he had been made aware of and he suggested, very strongly, that I should have a conversation with Roberta and ask her to declare a conflict of interest when she attends any further meetings that discuss Mr. O'Brien.

218 Q. That's slightly puzzling, isn't it, because you've had the meeting --

A. Yes.

219 Q. -- it caused you concerns, it caused members of your SMT concerns. Then it appears out of the blue and separately, but coincident in time, Mr. Pengelly is coming on the phone pointing out to you, from his perspective, a basis for a conflict of interest. Is that the way it came about, just whole independent of each other?

A. The only thing that Richard mentioned to me was that he had been made aware of the CURE connection. I have no other way that he would be made aware of anything that might have happened in that meeting. So I'm not too

sure if there is a connection. I think it's part of his process of getting an understanding of the case that this was made aware to him. If there is a connection, I can't answer that because I'm not aware of that, and obviously Richard Pengelly will be able to answer that question. To me, it was a telephone call. The timing of may have been coincidence, I don't know. All I know is I received a telephone from Richard asking me did I know the CURE issue and asking me to advise the Chair she was to declare a conflict of interest and therefore not attend.

220 Q. You don't say it in your statement, but you must have gone on to explain to Mr. Pengelly your concerns about her recent attendance?

A. I don't know if I did. The reason I was quite shocked to get the telephone call, and I was already thinking how am I going to ring the Chair and tell her the situation. So I'm not too sure I did. I accepted, yes, Richard, I will go and do so. Then I rang the Chair.

221 Q. Did he alert you to the fact that, at least according to Mrs. Brownlee's statement, that in advance of the October Board meeting, she had received a telephone call from Mr. Pengelly to encourage her to keep herself informed of the developments in Urology which --

A. I wasn't aware of that call until I was made aware through the witness pack.

222 Q. Yeah. She seems to have, and we'll have to ask her about this because she doesn't seem to go so far as to

say that Mr. Pengelly said 'go ahead' to the meeting, there's no difficulty there. But she seems to say, it seems to be her encouragement to attend the meeting at least in part?

A. I was not aware of that call.

223 Q. Mrs. Brownlee's connection with CURE, which, I understand it, started off as a directorship, and then what has been described as a committee role, having stepped down from the directorship, was fully declared --

A. Correct.

224 Q. -- to the Trust or the Department through the check processes, and she filled in the requisite forms for a period of time revealing that?

A. That's correct. I subsequently asked to see the declaration of interest forms with our corporate secretary and she made me aware that at the time when Roberta was involved with CURE she was declaring it.

225 Q. Your concern, as it appears, is not so much her attendance at the meeting which you, prior to the meeting, seemed content with, it was what she said at the meeting and her, I suppose, the mood that she created by what she had said; is that fair?

A. That is correct. Therefore, that led me to the reflection which was the decision I took to suggest that she should attend was, in fact, the incorrect decision, having now attended the meeting.

226 Q. Just finally on this topic, you do not believe that this issue - that is Mrs. Brownlee's conflict issue as

you describe it - had any impact on the path that was followed with Mr. O'Brien and Urology.

A. As a result of that, within that meeting context, no, because the meeting still moved forward. We still progressed. We were still progressing the lookback exercise. We were still going to progress with the Royal College of Surgeons. We were still going to do all the things that we wanted to do, so it didn't alter the path that we were travelling on as a result of that meeting. The one request that was made of me at that meeting was to have a conversation with the Department, which I subsequently had at the next Urology meeting, which was the weekly meeting which was not the Richard Pengelly meeting, but the meeting that would have included Ryan Wilson and Paul Kavanagh, to have a conversation to see whether the intention of the Department to go out with a public statement could be explored to see whether, in fact, we could have more time before the public statement. That conversation was had at that meeting and it was very clear that what the Department would choose to do with a public statement is the Department's choice of what they choose to do with a public statement, and there was no real conversation around that.

227 Q. Specifically no impact on what the Trust intended to do. In terms of the chill effect that what was created, according to Dr. O'Kane, and she may not have used those words to you, but she certainly reflected her concerns about Mrs. Brownlee's intervention. Have

you any reflections to offer the Inquiry in terms of whether more generally Mrs. Brownlee's position as Chair was able to cast any influence on the Trust's actions around these issues at an earlier point?

A. At an earlier point is all that I have read in the witness statement. In my tenure, no, and I'm pretty sure the decisions we would have taken, in fact I'm positive the decisions we would have taken were not taken off track by any conversation that we would have had. I am aware, having read the witness statement, that there are other witnesses who say that in the early days that might have been the case. In my case any conversations we had at Board, which included Roberta as the Chair, I believe we still continued on the path, which was the right path, to move forward.

228 Q. There were to be subsequent board meetings --

A. Mm-hmm.

229 Q. -- dealing with this issue. 12th November, Mrs. Brownlee didn't attend --

A. Yeah.

230 Q. -- and that was after her conversation that you understand took place with Mr. Pengelly?

A. (Witness nods).

231 Q. So matters developed obviously into the Lookback and the SAI process?

A. Correct.

232 Q. So I don't need to take you to those. Just finally, Mr. Devlin, could you try to characterise for us the impact of the Urology issues in relation to Mr. O'Brien

on the reputation of the Trust and staff; what impact do you think those issues have had?

A. Well if I can start with staff and not just Urology staff but staff within the organisation as a whole, staff as a whole were bruised - I'm speaking from my experience, I'm suing the past tense because I'm not there at the moment - but were bruised, there's no doubt about it. When an organisation that people come to work and give their all to are being presented as something which was not as good as it should be that certainly bruises. I think from a Urology staff perspective it meant not only do they have to do their day job but they also have to deal with the improvement agenda which we started and also then trying to deal with obviously the challenge of supporting an inquiry. So there's both supporting the Inquiry, doing the day job and doing the improvement work. And if you put all those three together that's a considerable impact on the Urology Team and on the Acute Directorate as a whole actually. So it had considerable impact on the Acute Directorate and, in particular, as we were, as you know in the last two and a half years, the last two years, trying to manage a pandemic and a lot of management effort and energy into the day-to-day running of the hospitals through, like a Trust through a pandemic, so it had a huge impact on Urology staff and it had a huge impact on Trust staff.

In terms of reputation, absolutely there's a

reputational issue. The public expect their organisations to be governed well and they expect Health and Social Care to be delivered safely. And what is clear from the -- what was made public and what is clear from the fact that this Inquiry is in public is that there are with weaknesses in both governance of the organisation and in elements of clinical care. That has a huge impact on public confidence and a huge impact on the organisation as a whole as an attractive employer, as a successful organisation, etc. So it has enormous impact.

233 Q. You've talked about the impact on staff and the work they day and to some extent on the morale, but impact on the work they would do has an impact on patients --

A. Absolutely.

234 Q. -- and their ability to be seen, Mr. Haynes I think reflected their ability to be seen as quickly as they otherwise might and, in turn, that affects confidence, confidence is affected probably in a number of ways. But in your time, were there any initiatives taken to try and restore that confidence of the public?

A. I think the best way we can restore the confidence of the public is bring capacity in to get people seen and make sure that people can get seen safely. So I know obviously we looked at external capacity, we looked at providers, etc. Clearly our ability to demonstrate learning and implement genuine improvement of learning will build confidence in the public. So immediately we set up three work streams: One was servicing the

Inquiry; one was about trying to get the job done and get people seen; and one was about improving the processes. And improving the processes then drove the issue of getting the cancer trackers and all of the kind of things that we know have been on.

I don't believe we can quickly build confidence back into the public because I think the public will look on and say, well actually there was a major failing in both governance and in care. And I don't believe we can quickly rebuild confidence, what we can do is try to get patients seen and try to get them seen and treated which is the important part, and also treat those, through the lookback, with respect and dignity and make sure that they get on to the correct pathways they need to be on

235 Q. I assume that there's been a financial cost to the Trust or the public purse arising out of all of this, both the direct cost of providing for the lookback and going back to patients and putting them on more appropriate care pathways and the costs of the various investigations that include ESAI review and that and there being direct costs as well. Has there been any initiative on the part the Trust, during your time, to try and measure this?

A. Yeah. During my time we put together a business case to outline what we believe we would need, because not forgetting I left nine months ago, so and what we believe we would need moving forward and what we had

already spent, getting it to the point that I left. Whether that is paid for by the Trust or by the wider public purse I don't know because discussions were going on when I was there to whether that was coming out of the Trust's bottom line or whether it's coming out of the wider public purse. It is semi relevant: it's coming out of public money. And therefore there was a business case put together to understand the cost of those three strands, continuing to do the business in terms of servicing the Inquiry and in terms of improvement and there was a business case put forward. And a business case is is an articulation of cost and benefit of what we get for it.

236 Q. I don't expect you to put a figure on it but a figure should be available, you'd anticipate --

A. At the time, certainly when I left there was a figure on that business case. Because it was a business case projecting forward and it was written nine months ago I don't know what has been spent because clearly I wasn't there. But that business case came to the Senior Management Team and therefore it is absolutely available. I couldn't tell you what that business case figure is now.

MR. WOLFE KC: Okay, thank you. We'll take that up with the Trust. Thank you for your evidence. I've no further questions.

THE WITNESS: Thank you.

CHAIR: Thank you, Mr. Devlin. I'm sure Dr. Swart has some questions for you.

MR. SHANE DEVLIN WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

237 Q. DR. SWART: Thank you very much for all of our answers so far. I just want to pick up a few things, they are related to governance and to data so I'm hoping you'll be able to help us with them. Starting perhaps with your desire as a Trust and the desire of staff to be able to produce evidence to keep the confidence of the public that they are providing excellent and safe services. You've talked a lot about the improvement in governance, there's quite considerable evidence about the improvement in measuring safety metrics, SIs and so on. There isn't much evidence about how clinical outcomes are measured at specialty level and certainly how they're recorded or discussed or any evidence of a line of sight to the Board. Now, talking to the witnesses so far and from the witness statements, there are various statements about a focus on performance metrics in the usual way and also specifically saying that the commissioning is mainly about performance measures in the standard way, not about quality; also mentioning the paucity of clinical audit which you've already recognised and hopefully the Trust is working on that. But there are a couple of issues that come out that relate to difficulty with data sources. So in my experience national audits and national registries are an excellent way of benchmarking a service and

being able to state whether or not it meets the standards or to what extent and that can be done through direct entry to those databases. And another source is the Hospital Episode Statistics which can be interrogated by CHKS in your case or Dr. Foster in other places and some of the improvement programmes also use that same source of statistics.

Now, we've heard that there's some problems entering people into these national databases because of GDPR issues and that the Health and Social Care Board had pronounced that they weren't to enter the cases. So my question is around that: Was there an awareness of this problem at Board level and do you know of any discussions that were had as to overcoming this barrier?

A. The secondary I think it's called, I can't remember the exact title but it's the secondary information legislation, which is legislation to allow for the secondary use of information, clinical information because we do have different rules being in Northern Ireland. I was aware that there was a piece of work being carried out either by the Health and Social Care Board or by the Department to try to introduce new legislation to allow that to happen and it would have been an area that I would have, I, as Chief Executive, would have been involved discussing at the wider informatics community and my understanding is it had progressed quite far as a potential piece of

legislation. Having been out of the country for ten months, I don't know how it progressed but it was recognised as a challenge for the whole of the system. My understanding is there was secondary legislation being drawn up but I don't know whether that legislation -- in fact I'm pretty sure it hasn't progressed because I think I probably would have heard if it had had been progressed.

238 Q. So you would agree that it's important?

A. Oh, absolutely. You can't enter into national audits unless you can share your information. So any audits we could enter into it were via Northern Ireland - and that's only five Trusts - so absolutely and was recognised as such across the HSE.

239 Q. Did you have discussions at the Board about this?

A. Not that I can recall. It may have come up once when we talked at Governance Committee looking, at one point, about the secondary legislation requirements, but it certainly came up at regional meetings that I was part of because it was completely accepted across Northern Ireland that without that we cannot partake in national audit.

240 Q. And what about the Hospital Episode Statistics issue? We heard from Mr. Haynes that there was a problem with those numbers in a way that didn't allow the maximum accuracy and scope of the CHKS work, were you aware of is this?

A. I wasn't aware of that and I would have used CHKS and the navigational tool and in fact I presented CHKS data

to the Board, both on mortality, morbidity and in particular around the obs and gynae work that we had done. So I don't recognise that. Now that might be a Urology-specific issue because I do not recognise a known challenge with the HES data because it's fundamental CHKS, if you don't HES data you can't benchmark.

241 Q. The other thing that was brought up in that regard was the CHKS data was provided to individual consultants for appraisal but never discussed as the Urology Team even though it includes some very basic things, like readmission rates and day cases and so on?

A. Mm-hmm.

242 Q. Were you aware that it was being siloed off to individuals and not used in the specialty or was that a general practice in the Trust or was that, again --

A. No, because I am aware of teams that would have looked at it on a team base obs and gynae being one of them, actually, hence presenting to the Board. So I am aware it is prepared individually for appraisal because that's a sound piece of information. But I am aware of teams that do use it and I would recommend that teams do use it because it's a good source of information.

243 Q. So in your governance review, the intention was to start to progress towards these kind of outcome measures at specialty level, was that discussed?

A. It was certainly an outcome measure. I don't think we talked about it at speciality level. It would be a natural next step but I don't see it recorded as that.

244 Q. Thanks for that. The other thing is around the overview of cancer; so the Performance Committee talks about the 31 and 62-day targets and of course this is an ongoing issue, as it is all over the UK.

A. Mm-hmm.

245 Q. Is there any opportunity at that Committee to look into the overall compliance with peer review across all Cancer Services and are there any deep dives that take you into what are essentially the standards of cancer care to be expected for patients?

A. I don't recall. We would have to look back at the agenda for the Performance Committee I don't recall the Cancer --

246 Q. Do you think that would be valuable?

A. I think it would be. I think we need to look holistically at all indicators. As you rightly said, there is quite a focus on 31 and 62 days because it seems a good indicator but it is so much deeper than that. So it absolutely would be an opportunity to look at -- and if we get into the PROMS world as well, to take at that in the round what people's views are of cancer. So absolutely. I think that might take the Inquiry into a sort of what are the right performance indicators at a service level.

247 Q. I was just raising it because it's a clear sort of paucity of data at the Southern Health Care Trust and I think it would help us to say to the public: This is the standard we achieve.

One last question: You were embarking on a big change in the whole governance agenda and all the things said in the report are easy to understand, difficult to implement and it essentially is a huge cultural change programme. How have you signalled the need for that cultural change across the organisation, or how did you signal it?

A. For me, to begin with, it was very clearly to take it in small pieces and to look at complaints, SAIs and standards and guidelines but the biggest cultural change would have been the creation of the learning for improvement part of the organisation to put it at the heart of the organisation and say actually sitting within the Medical Director, reporting directly to the Chief Executive, will be this single focus and it will be the centre point for all issues of quality and improvement and that would have been a massive signal, as I say, and the issue of Covid and obviously Maria has now taken over. I hope Maria continues that because that, for me, is the biggest signal which says, actually you've got a big finance function, you've got a big performance function and in the middle you've a big performance and quality and improvement function and that's of equal standing; whereas in the organisation finance and performance would have had a higher standing than quality and safety. I don't think that's just the Southern Trust but we're talking about the Southern Trust today.

DR. SWART: It does come through exactly as you

described. Thank you. That's all from me.

CHAIR: Mr. Hanbury.

248 Q. MR. HANBURY: Thanks Mr. Devlin, for your evidence so far. Can I just take you back to the capacity and demand problems.

A. Yes.

249 Q. We've heard from the urologists, in particular in their witness, this many of years of frustration with the extending lists and obviously it's a growing department and lots of demand. What would your approach have been to the severity of waiting list problems for one specialty compared to perhaps other specialities with much shorter waiting times as we saw in Mr. Haynes' statement? There didn't seem to be a response in allocating perhaps extra theatre sessions to a more needy specialty and I wondered if you'd been involved in that that question, how had you responded?

A. I think it's two things, at a system level there were attempts over time to create Urology capacity at a Northern Ireland-wide level. During that period there were things like Team South created, Team North created, and there was an attempt to try to bring together capacity at system level over that whole time period. It wasn't just a Trust problem, the whole of HSE was trying to understand it.

With regards to at a Trust level, it would be the expectation that obviously managers would take decisions based on the demand and, where possible, flex

that demand. What I would say is that we had a history over the last of couple of years of having to turn down considerable demand because of unscheduled care pressures linking into elective care beds and also a massive downturn of all elective care due to Covid, but it would be expected that managers would look across and say how best can we use our theatre resources to try to level across specialties? I think it's evidenced - and I did read Mark Haynes's transcript - certainly in his evidence he felt that that wasn't the case for Urology and I think in his evidence he might have reflected there were other specialties he felt actually had a more opportunity for theatre time, etc.

250 Q. Thank you. So one other thing, briefly, I think the independent sector were used to improve capacity and that was, I think quite successful as a one-off?

A. Yes.

251 Q. Did the Board think, it may have been before your time but did the Board consider using that again as a safety valve?

A. The Health and Social Care Board created a thing called the Service Delivery Unit and Service Delivery Unit had a - I won't say huge - a very large budget that could be used for independent sector provision as well as managing patients and the flow of patients. So there was a considerable injection of money. I'm going to say, and a number of years ago, it certainly wasn't in my time in the Southern Trust, and that independent sector money absolutely helped to bring Northern

Ireland, as a whole, including all specialties, to a level that was comparable actually with other parts of the United Kingdom and that was a huge injection of money for the private sector. That money slowly was removed across a number of years and I know that there is a proposal, a plan for elective recovery across Northern Ireland which, if approved, would require considerable private sector involvement. That's a ministerial plan, not a Trust plan and for obvious reasons that won't past through ministers at the moment. But it is a plan that was worked up, I believe, because I was part of that conversation, has been worked up and part of that would include -- would need to include investment in both public health, public services and also private services.

252 Q. Okay. Thanks. I've just got a couple of questions on Cancer's MDT work in recruitment really. Obviously it was frustrating to the MDM as it was set up that there was a shortage of radiology and oncology and many meeting were non-quorate with resultant reduction possibly of clinical decision-making. Could you say something about the recruitment difficulties, particularly in radiology?

A. In terms of recruitment difficulties across Northern Ireland, including radiology, it is clear we have a supply and demand mismatch. We do not have -- often the issue was not money, often the issue -- we could find money to do things but often the case that people within the small province that is Northern Ireland

would not be available and, also, there is a very large pull to Belfast. Many people who train in Belfast remain in Belfast so we know that the number of trainees, for example, that travel through our system, the vast majority of the trainees would not travel through the other four Trusts, would travel through the Belfast Trust and therefore it's often the case that if trainees grew up in a system they often remain in a system and therefore if jobs were made available, often people will choose to stay in different Trusts. So it was very rarely a money issue, it was often a supply and demand issue.

253 Q. Okay. Thank you. Just Oncology, it's a similar sort of thing but slightly different in a way because mostly Oncology is based in Belfast. And there's quite a lot of remote working so it was quite frustrating for me to read how little input there was when videoconferencing has really been part of MDT structure for so long. So when you had that problem or when there was this problem with Oncology access at multidisciplinary working, did you have conversations or did someone have conversations with opposite numbers in Belfast to try and fix that problem?

A. That would not have been at the Chief Executive level so if there were conversations they should have happened between clinical leaders and directorate leaders. Now I am aware, having spent time in Belfast, having been a Director in Belfast in earlier this decade, last decade, videoconferencing was a common

thing to be used in Belfast with regards to MDMs, Cancer MDMs. There in fact a number of Cancer MDM videoconferencing suites that would have been used. So I wasn't aware, until obviously I became aware through this process, that we weren't availing of that.

254 Q. It's probably just a job planning problem?

A. Yes.

MR. HANBURY: Thank you very much.

255 Q. CHAIR: Just following on from one of Mr. Hanbury's questions about the issues about recruitment and the fact that money wasn't the major issue --

A. Mm-hmm.

256 Q. -- I'm just curious to know what other steps or innovations or initiatives there may have been discussed or even delivered to try to recruit?

A. In terms of Urology, I would have to say that I wasn't involved in many discussions about Urology. I was involved in our challenges in recruitment in other specialties and became very involved with recruitment of medical staff in Daisy Hill, recruitment of staffing in Daisy Hill in general through the Daisy Hill Pathfinder. So when it was raised to me specific areas, I would have been involved. I was not directly involved in the challenges of recruitment for Urology. I would have expected the local HR and Director to have been involved in that but it wasn't something that came to the Senior Management Team to look at how can we best deal with the Urology. Certainly sorry not to me, the Urology Services challenge.

257 Q. I'm speaking more generally here rather than just Urology. Would it not be the case that overall responsibility for delivery of care then the Chief Executive would have to be involved in any initiatives for general recruitment?

A. General recruitment, absolutely.

258 Q. I'm just curious to know what initiatives you may have come up with that could have attracted people then?

A. Absolutely. So in general recruitment. A number of things, first of all if you take the issue of making sure that the trainees and the juniors have a good experience because there's a lot of connection between trainees and juniors having a good experience and staying in the organisation. We introduced a completely new programme for our new doctors, which looked at education and really making it a great place to be a trainee. That was done through the Medical Director's Office and that was a really important part because our surveys from GMC told us that actually whenever, if they have a good experience they stay, if they don't, they don't. That was the first thing, really invest in the trainee environment.

The second thing we did a lot of was we also looked overseas and we had overseas recruitment - both nursing and medicine - to see whether we can bring oversees recruitment. We also had a very good training programme for SAS doctors - which are not at consultant level, just below - and again really driving an engaged

process for SAS doctors, again to try and drive recruitment in SAS doctors. Overall you'll see in the overall Corporate Risk Register, the inability to recruit is actually one of the top six risks. And we had, as I said, a lot of conversation with the exec team, which drove different approaches.

The Daisy Hill Pathfinder is another example where we looked specifically at the challenge we had in a particular area of recruitment in Daisy Hill, and then we began to work with the community to try to create it as a good place for people to come and work and it was work in the local community, etc. So many things in general recruitment to try to encourage people to want to come and stay. But I go back to the point: if you get them as trainees and give them the experience they will put down roots and that, for us, was where we focused very heavily. Could we do a great trainee progress and really make trainee doctors/junior doctors really want to stay in the Southern Trust?

259 Q. And is there any evidence of the efficacy of that?

A. It's working now, yes, and that would be important. One of the last presentations I was involved in actually, in the Executive Team, when the doctor responsible for it presented back to us and absolutely it's a process that is, I'm glad to say is working.

260 Q. One other matter, just that occurred to me was that tools are only useful if the people provided with them know how to use them. And I suppose what I'm looking

at in that context is we can have all the guidelines and standards about all different areas of practise but I'm just wondering what training there was about implementation of guidelines and so forth? For some people it would enough to provide them with a document to say you must do A, B, or C or the best practice is A, B, C, D and E, but I'm just wondering were there any other means of training and encouraging and I suppose a second corollary of that was, was that part of what you envisaged the new learning for improvement limb of the organisation to take care of?

261 Q. Not quite. Any standard or guideline that came in would now need to have an individual responsible for the deployment of that standard and guideline and as part of that individual's role, it is not simply to say there you go, there's the policy, but they would need to work to say how best do we -- so an individual is identified as responsible for the responsible owner for that standard and guideline and part of that, they would need to explore how best to share that knowledge. How to deploy that knowledge.

What we could have, in the learning for improvement directorate would be the opportunity to look at wide scale how do you learn and how do you implement learning which is not the same as a specific policy to policy or standard or guideline. The owner of that standard and guideline is responsible and should report back to their respective Governance Committee to say

how they have ensured that that policy or standard and guideline is being deployed and shared.

262 Q. Just by way of example, one of the things that we discovered, for example, was that Heather Trouton had never been told anything about MHPS, didn't know that it existed or what it was or what it was meant to do which, you know, given the role that she moved into, might not have been so directly relevant to her work but certainly at a given time it would have been. I'm just using her as one example. There are other examples that we have seen from the evidence where policies weren't properly disseminated, weren't understood, weren't applied because they weren't understood, which is my point about the tool is only so good if you know how to use it?

A. I have reflected on that and thought about that and one of things that struck me was the recent Messenger Review which was the review of leadership in the NHS, the gentleman who carried it out was Sir Colonel Messenger and he talked about the core competencies of a good officer as part of that. And maybe there is learning in that Health and Social Care that there are core competencies of a good officer and different levels of being an officer that you could realistically suspect that those individuals should have those core competencies of a good officer and if there is something in it. So maybe when you get to a certain level there are certain policies and guidance and certain processes that you need to be able to

demonstrate you've experience of running.

263 Q. Well there's that side of it but also is there not the training aspect of those --

A. Mm-hmm.

264 Q. -- officers, they may have the competent skills with which to carry out a particular job but unless they're provided with the leadership --

A. The tools.

265 Q. -- tools, the right tools --

A. Yeah.

266 Q. -- then --

A. Correct.

267 Q. -- perhaps that job wouldn't be as effective no matter how good their skills?

A. Yes, I would agree.

268 Q. So is that something that is being looked at or was being looked at by you in the Trust about training?

A. I was not looking at training. We were developing a people plan which would look at giving people competencies, a feeling of belonging, values, etc. and we were at the early stages of that as part of the transfer. The people plan, I'm sure, will be something you might be able to explore with Vivienne as the Director of HR.

CHAIR: Okay. Thank you very much, Mr. Devlin.

THE WITNESS: Thank you very much.

CHAIR: I think that concludes our business for today thank you for coming along today. Thank you, ladies and gentlemen.

Our next sitting of the Inquiry will be a private patient hearing day on 24th January. On the 25th I think we have Mr. Gilbert and Dr. Hughes returning. Beyond that, I cannot give you any indications of what the timetable will be but do keep an eye on our timetable on the website and we will, in due course, inform the Core Participants as to who is coming next, as it were, and when.

In the meantime I wish everybody a very happy Christmas, I hope you all get a break and come back refreshed in 2023 and I'll see you all then.

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY 24TH JANUARY 2023