

**Oral Hearing**

**Day 16 – Wednesday, 7th 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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**Gwen Malone Stenography Services**

1           THE INQUIRY RESUMED ON WEDNESDAY, 7TH DECEMBER 2022 AS  
2           FOLLOWS:

3  
4           CHAIR: Good morning, everyone.

5           Mr. Devlin. Mr. Wolfe.

6           MR. WOLFE KC: Good morning. Your witness this morning  
7           is Mr. Shane Devlin. I think he proposes to take the  
8           Oath.

9  
10          MR. SHANE DEVLIN, HAVING BEEN SWORN, WAS EXAMINED BY  
11          MR. WOLFE KC AS FOLLOWS:

12  
13         1    Q.    Good morning, Mr. Devlin.

14            A.    Good morning.

15         2    Q.    Thank you for coming to the Inquiry.

16  
17            Can I just start by asking you to confirm your witness  
18            statements for us? You've, so far, provided the  
19            Inquiry with responses to two Section 21 notices, which  
20            we call witness statements for ease of reference. The  
21            first one, if we can have it up on the screen, is  
22            WIT-00520. That's the first page. I don't think you  
23            have any changes to make to that, Mr. Devlin?

24            A.    I do not. No.

25         3    Q.    If we go to the last page, WIT-00103, please. That's  
26            your signature, Mr. Devlin?

27            A.    That's correct, yes.

28         4    Q.    It is dated 11th February 2022. Would you like to  
29            adopt that statement as part of your evidence to the

1 Inquiry?

2 A. Yes, please.

3 5 Q. As I've said, you provide a second response to the  
4 Inquiry. It can be found at WIT-21153. The Inquiry  
5 will note that statement is particularly focused on the  
6 MHPS part of your terms of reference. I can see  
7 Mr. Devlin nodding his agreement to that. So it is  
8 a short statement. The signature page is at WIT-21166,  
9 dated 24th June 2022. Same again, Mr. Devlin, do  
10 you wish to adopt that statement as part of your  
11 evidence to the Inquiry?

12 A. Yes, please.

13 6 Q. I'm obliged. Thank you.

14

15 Just a short housekeeping matter. I'm not sure that it  
16 will be necessary for you to mention the names of any  
17 patients in your answers. I don't anticipate that.

18 A. I don't believe so.

19 7 Q. But if that was to arise in your thought processes,  
20 whether to explain any particular matter, please  
21 refrain from naming the patient.

22 A. Certainly.

23 8 Q. We'll supply you with a cipher list. There's not one  
24 in front of you at the moment but that can be easily  
25 arranged.

26

27 Inquiry, by way of introduction to this witness, as you  
28 know, Mr. Devlin was the Chief Executive of the  
29 Southern Trust between March 2018 and February of this

1 year. Accordingly, he is particularly well placed to  
2 set the scene for the future work of the Inquiry by  
3 providing evidence in respect of the Trust's Corporate  
4 and Clinical Governance procedures and arrangements in  
5 relation to the circumstances which led to the early  
6 alert and the commencement of the Lookback Review,  
7 including by providing his views on whether there were  
8 shortcomings in those arrangements and their operation  
9 in connection which the Inquiry must consider under its  
10 Terms of Reference. That's the framework, or the  
11 parameters, I suppose, under which you are going to  
12 give your evidence over the next day and a half,  
13 Mr. Devlin.

14  
15 we will look at the Governance structures, but it is  
16 not intended this will be a deeper detailed dive into  
17 those Governance structures at this stage.

18 A. Okay.

19 9 Q. A little bit about your background. If we could have  
20 on the screen you're curriculum vitae, WIT-00104.  
21 while that's coming up, what's your current occupation  
22 or role, Mr. Devlin?

23 A. I'm currently the Chief Executive of Integrated Care  
24 System in Bristol, North Somerset and South Gloucester.  
25 An Integrated Care System is the process where we are  
26 collaborating health and social care across England  
27 into 42 systems, and I'm the Chief Executive of  
28 Bristol, North Somerset and South Gloucester.

29 10 Q. You have been in that role since February of this year?

1 A. February of this year. February 14th.

2 11 Q. This is your CV, as we can see from the top. If  
3 we scroll down again, just for convenience for the  
4 Panel's note, to 106 in that sequence, WIT-000106. If  
5 you just scroll down you'll get there. Thank you. In  
6 the middle of the page those are your qualifications?

7 A. That is correct. Yes.

8 12 Q. We needn't bring it up on the screen, but within your  
9 witness statement, WIT-00042, you set out some of your  
10 in-job or on-job continuing training. That's one  
11 thing, as appears from your statement you appear to  
12 take seriously, the need for continuous development  
13 through training courses and that kind of thing?

14 A. Absolutely. I think one of the key elements, I hope  
15 you can see from the CV and from the rest of the days,  
16 that for me training isn't going on a training course,  
17 it is about experiencing and learning and improving.

18 13 Q. On the job?

19 A. On the job, absolutely.

20 14 Q. Scrolling down again to WIT-00108. Just highlight the  
21 bottom of that for me. I think I'm right in saying,  
22 Mr. Devlin, that you have 20 plus years experience of  
23 working in the public health sector commencing with  
24 your first HSC post, I think I'm correct in saying?

25 A. That's correct.

26 15 Q. In Lisburn, as it then was?

27 A. It was. I had graduated in Economics. I had worked  
28 for a small startup organisation looking at economic  
29 development competitiveness and then I moved into the

1 Health and Social Care arena in 1998 as a Quality  
2 Manager in what was then Down and Lisburn Trust, which  
3 then became the Southeast Trust in the re-organisation  
4 of the health service in 2007.

5 16 Q. If we go back to WIT-000104 in this sequence, we can  
6 see that immediately before you took up your post in  
7 the Southern Trust, you had been Chief Executive of the  
8 Northern Ireland Ambulance Trust?

9 A. That's correct, yes.

10 17 Q. Before that you had a role in the Belfast Trust?

11 A. I was Director of Performance, Improvement and  
12 Informatics in the Belfast Trust. Before that I was  
13 a Director in the business services organisation  
14 looking at the transformation of back office functions  
15 for Health and Social Care. I was Performance Director  
16 for Northern Ireland for the back office functions of  
17 Health and Social Care.

18 18 Q. One of the things I picked up from what you said of  
19 your various posts, certainly the Belfast Trust post  
20 and the Ambulance Trust post, improving performance  
21 seems to be a key task in each of those posts?

22 A. Absolutely. In terms of organisational performance,  
23 I'm looking at how we can continuously improve, both  
24 Quality Improvement as well as a wider range of what  
25 you might call business improvement functions, so both  
26 the corporate and also working in the clinical and  
27 social care governance, and quality improvement arena  
28 as well.

29 19 Q. The Southern Trust posts to which you were appointed in

1 March, I think you took it up on 19th March 2018?

2 A. Correct.

3 20 Q. That was your first Chief Executive post within  
4 a Health and Social Care Trust as distinct from the  
5 Ambulance Trust.

6 A. The Ambulance Trust itself is a Trust, and delivery of  
7 Health and Social Care Trust is a very small Trust, and  
8 quite a different trust because it is providing  
9 emergency medicine and emergency care prehospital. It  
10 is a Trust in the sense that it has a Trust Board, it  
11 has all of the appropriate governance. It has many,  
12 many clinical and social care governance and corporate  
13 challenges, so it is a Trust. It is Northern Ireland's  
14 sixth trust. What it isn't is an integrated health and  
15 social care delivery trust, which you are correct,  
16 therefore, this was my first Chief Executive job in an  
17 integrated care delivery trust, although obviously  
18 I had worked in that for most of my previous  
19 20-something years in health and social care.

20 21 Q. In that sense was this a step up for you?

21 A. Yes.

22 22 Q. Career progression?

23 A. It certainly was. I mean I enjoyed greatly my time in  
24 the Ambulance Service. I think the Ambulance Service  
25 is much underplayed and it is a hugely important part  
26 of the system, but it was a step up to come into  
27 a Health and Social Care Integrated Trust which was, at  
28 that time, about 13,500 employees employing all  
29 services from the cradle to the grave as it would have

1           been described on many indications. So it absolutely  
2           was a step up.

3    23   Q.    I'm going to come on to look, shortly, at some of the  
4           challenges that you faced. Just looking at the job  
5           description, first of all, for the Southern Trust  
6           position of Chief Executive. We can go to TRU-02126.  
7           Here we have, I suppose, a summary description of your  
8           role. You were the Accountable Officer for The Trust?

9           A.    Yes.

10   24   Q.    That means accountable to various, I suppose, internal  
11           entities and also externally to the HSCB and the  
12           Department. Does the external element of that involve  
13           much in the way of contact with the Department, for  
14           example? Meetings? What was the form of  
15           communication?

16           A.    Yes, certainly. First of all, as officially the  
17           Accounting Officer for the organisation, clearly  
18           whenever I was appointed the Permanent Secretary writes  
19           to me as Accounting Officer, and, therefore, there is  
20           a delegated responsibility as Accounting Officer from  
21           the Permanent Secretary, as a result there is  
22           considerable engagement with the Permanent Secretary.  
23           I explain the various elements of the Department. Over  
24           time, and over my four-year tenure, that relationship  
25           changed quite a lot because of COVID, obviously, in the  
26           second half of my tenure. The structures changed quite  
27           dramatically. In terms of the relationship,  
28           absolutely, I would have met with the Permanent  
29           Secretary, and all the other Chief Executives



1 collectively, at least monthly, maybe even towards --  
2 certainly in the COVID period, weekly, but certainly  
3 pre-COVID at least monthly. We would have looked at  
4 how we can improve the whole system, it was called the  
5 Transformation and Implementation Group, TIG. There  
6 was a lot of engagement on a monthly basis with the  
7 Permanent Secretary, and TIG involved both the  
8 Permanent Secretary, Chief Medical Officer, Chief  
9 Nursing Officer, etcetera. So there was a huge amount  
10 of engagement as Chief Executive of the Trust with the  
11 Department in looking at systems working.

12  
13 In terms of looking at the Trust working, as opposed to  
14 the systems working, there would have been formally, at  
15 least twice a year, there would have been a formal  
16 engagement with myself as Chief Executive, the Chair  
17 and also the Permanent Secretary. Then there would  
18 have been regular engagement with Deputy Secretaries  
19 around issues that may have come up. I mean I was  
20 engaged a lot with the Department. I previously had  
21 worked in the Department as a secondee, and I knew  
22 a lot of the people in the Department as well. There  
23 was both the formal, but I also would have engaged  
24 informally with the Chief Nursing Officer, the Chief  
25 Social worker, etcetera, so there was lots of  
26 engagement with the Department both formally through  
27 TIG, as well as informally, and then on at least  
28 a six-monthly basis.

29

1           with regard to the Health and Social Care Board --

2    25   Q.    Stop for a moment.

3           A.    Yes, certainly.

4    26   Q.    As you will appreciate from the Inquiry's Terms of

5           Reference one of its interests is communication between

6           the Trust and the Department, HSCB and HSA. It is

7           right to say, isn't it, that the Department would have

8           known nothing about the issues within Urology in terms

9           of those issues that give rise to the Inquiry until it

10          received an early alert in late July, 31st July 2020?

11         A.    Certainly, from my understanding, I would not have

12          discussed it with the Department at that point of time.

13          There may have been clinicians who worked in the

14          Department who may have been aware of, as many

15          clinicians are in the Department, about what is going

16          on in the Trust on an informal basis. I couldn't say

17          there was or there wasn't. But in terms of me

18          personally, I had not been engaged with the Department.

19          I had not formally notified the Department of anything

20          with regards to Urology. Therefore, in terms of

21          Urology, it is not a topic that I had had any

22          conversation with anyone in the Department with before

23          the issue of the early alert in 2019.

24    27   Q.    Presumably there --

25           A.    2020.

26    28   Q.    -- would have been conversations with the Department

27           about the pressures being felt within various

28           Directorates of The Trust, and Urology, as you probably

29           realise from the reports that were going to Trust Board

1 and from your senior management team directly to you,  
2 urology was a division that was particularly under  
3 pressure?

- 4 A. No, from a Chief Executive perspective there wouldn't  
5 have been those conversations with the Department. The  
6 conversation on pressures would have been with the  
7 Health and Social Care Board, the nature of the Health  
8 and Social Care Board being the performance element of  
9 the Health and Social Care system. So, the  
10 conversations I would have had, for example, in the six  
11 monthly reviews with the Permanent Secretary would have  
12 come after what was called ground clearing. Ground  
13 clearing was a process whereby the Department would  
14 meet with the Trust, not at Chief Executive level, it  
15 would have been at Director level, and Director level  
16 with Director level in the Department, they would have  
17 looked at a range of issues and only following ground  
18 clearing meeting -- during my time that would have been  
19 led by a Department Secretary level in the Department,  
20 and then from the Trust it would have been the Director  
21 of -- probably Director of Performance would have been  
22 at the ground clearing meeting. I would have to  
23 double-check, but it certainly was Director of  
24 Performance. The ground clearing meeting was the place  
25 where the Trust could talk to the Department about what  
26 was happening in the Trust. I would then meet with the  
27 Permanent Secretary after ground clearing and issues  
28 that were highlighted from the ground clearing meeting  
29 may have been discussed -- could be discussed, sorry --

1 at the meeting with the Permanent Secretary.  
 2 As far as I recall, and certainly when I look at the  
 3 notes, we did not discuss Urology with the Permanent  
 4 Secretary at those meetings. The pressures that may  
 5 have been felt in the organisation may have been  
 6 discussed in ground clearing meetings. I was not party  
 7 to those ground clearing meetings because they were at  
 8 the Director and Deputy Secretary level.

9 29 Q. Yes. By the sounds of that, Mr. Devlin, pressures  
 10 within Urology wasn't something you were pushing on to  
 11 the agenda then with the Department?

12 A. No. I mean issues -- and I'm sure we'll come on to  
 13 it -- but issues of pressure in general and, clearly,  
 14 pressures with regard to both staffing, so pressure is  
 15 both a demand issue and a supply issue, staffing being  
 16 a supply issue, and demand being a pressure issue, they  
 17 in general were talked about and how we would manage to  
 18 address those issues. I was not pressing on any  
 19 speciality in those meetings with regards to the  
 20 Permanent Secretary at Departmental level.

21 30 Q. Thank you for that. Let's move to the HSCB.

22 A. Certainly.

23 31 Q. In terms of communication with that organisation,  
 24 obviously they're the commissioning organisation within  
 25 Northern Ireland?

26 A. Yes.

27 32 Q. On that level there's obvious engagement Between Trust  
 28 and HSCB.

29 A. Yes.

1 33 Q. Tell me about that.

2 A. So the role of the HSCB, as was, and I'm very aware now  
3 that is a different position, but if I'm describing the  
4 position when I was in role. If I could describe the  
5 process by which the HSCB and commissioning worked, and  
6 then I can talk about how we then communicated. The  
7 process was very clear. On an annual basis there would  
8 be a commissioning direction created, usually at a  
9 policy level in the Department. A commissioning  
10 direction would indicate what the big areas of  
11 development for the Health and Social Care sector would  
12 be in the year. That commissioning direction would  
13 become a commissioning plan. That commissioning plan  
14 was something the Health and Social Care Board would  
15 produce. That commissioning plan would identify,  
16 usually through programmes of care, so Acute,  
17 Children's, Mental Health, their programmes of care,  
18 usually through programmes of care would identify:  
19 here are the things we, as a system, believe need to be  
20 done in Northern Ireland this year. The commissioning  
21 plan was always an annual process. That commissioning  
22 plan would then be issued to Trusts to say, as  
23 a Commissioner, we would like to do these things this  
24 year. It was a detailed document, it was in many  
25 cases, two to three hundred pages of a commissioning  
26 plan. What would happen is every Trust, in this case  
27 the Southern Trust, would then digest that  
28 commissioning plan and would respond in what was called  
29 a Trust delivery plan; would respond and say, well,

1 actually, you want us to do this in the Family and  
2 Childcare world, or you want to purchase a thousand  
3 tonsillectomies, whatever the case may be, and we would  
4 respond through the Trust delivery plan. That Trust  
5 delivery plan would be approved through Trust Board.  
6 Alongside that, in that Trust delivery plan there would  
7 be issues around the sourcing of the plan or issues  
8 around, in terms of human resource and financial  
9 resource. That Trust delivery plan would indicate how  
10 much of the commissioning plan we could meet. It was  
11 very rare that we could ever meet everything the  
12 Commissioner wanted, as is evidenced in the delivery  
13 plans. You would show that we can do this but for  
14 various reasons we can't do this. That Trust delivery  
15 plan would be approved by our Trust Board and submitted  
16 to the Health and Social Care Board.

17  
18 what would then happen is that Trust delivery plan and  
19 that commissioning plan would come together and the  
20 Board would then issue to us what is called a Service  
21 and Budget Agreement. That is, basically, the  
22 signed-off agreement that says, we have given you our  
23 commissioning plan, we have returned the Trust delivery  
24 plan, and here is what the contract will be for the  
25 year between the Commissioner and the provider.  
26 Then there would be regular communication with the  
27 Health and Social Care Board. That could take the form  
28 the Directors of Performance and Performance Managers  
29 meeting regularly with the Board. When I say

1 "regularly" certainly in my early days in Health and  
2 Social Care that would be weekly. What I would say  
3 over the last three to four years it hasn't been  
4 weekly, it has tended to be more monthly, to look at  
5 that Service and Budget Agreement and see are  
6 we delivering on what that agreement said that the  
7 organisation should deliver on. What would happen at  
8 Chief Executive level then is that once a month the  
9 Chief Executives would meet with the Chief Executive of  
10 the Health and Social Care Board, and that's the  
11 opportunity for the Chief Executive at the time to  
12 discuss with us how the system was performing, other  
13 things we needed to do differently, etcetera. So,  
14 that's the formal mechanism. Therefore, there was  
15 always formal performance relationships between the  
16 Health and Social Care Board and with the Trust. That  
17 would have allowed for conversations around particular  
18 specialties or particular challenges, and those  
19 performance meetings. In my previous life when I was  
20 a Director of Performance in the Belfast Trust, I would  
21 have been meeting with the Director of Performance in  
22 the Board and, I mean, at that point it would have been  
23 weekly, actually. We would be looking specifically at  
24 performance challenges and what can be achieved.  
25 34 Q. One performance challenge, I suppose -- if it is  
26 correct to frame it in that way -- which we have come  
27 across already in the Inquiry, is the need to deliver  
28 the service safely all along the care pathway. The  
29 example of that that stands out, and I propose to look

1 at this in more detail with you in the course of your  
 2 evidence, an example that stands out is that there's  
 3 guidelines for the delivery of prostate cancer care.  
 4 One, of course, hopes that all clinicians are going to  
 5 deliver the care with the guidelines, but that  
 6 shouldn't be on trust, that should be something that  
 7 should be monitored or tracked, and, perhaps, audited.  
 8 Do you recognise within that that there's obviously  
 9 a resources issue? In order to deliver care safely in  
 10 the way I've described it has to be resourced?

11 A. Absolutely.

12 35 Q. In short terms -- I want to go on to this in more  
 13 detail -- is that something that is the subject of  
 14 specific discussion, with, for example, the HSCB, or do  
 15 you get a lump of money and you are expected within any  
 16 particular Directorate to simply deliver safely as best  
 17 as the money will allow?

18 A. I think your latter description is closer to the  
 19 process. I don't think it is as simple as it is one or  
 20 the other. I think, clearly, there is an amount of  
 21 money in the commissioning plan to deliver certain  
 22 services, and it is expected that it would be delivered  
 23 within that cost frame. What I would stress is that at  
 24 performance level, and those conversations with the  
 25 Health and Social Care Board, those conversations were  
 26 being had around the outputs. In other words, did  
 27 we deliver 100 of this, did we deliver 200 of this?  
 28 I do not recall getting into very many conversations  
 29 with the Health and Social Care Board about how we



1 would deliver that, because that was not the  
 2 relationship. The performance relationship was, did  
 3 you deliver 100, as opposed to, tell me how you  
 4 delivered 100? I think that's the important  
 5 reflection.

6 36 Q. Yes. We didn't get very far into your job description  
 7 before paused for those --

8 A. You also asked about the conversations with the Health  
 9 and Social Care Board.

10 37 Q. Yes.

11 A. There were also informal conversations. I think that  
 12 is important to stress. What I have described is the  
 13 formal conversations with the Health and Social Care  
 14 Board. The conversation was not simply between Chief  
 15 Executive and Chief Executive. There is a network of  
 16 conversation between employees of the Trust and  
 17 employees of the Board, because the Health and Social  
 18 Care Board, in line with the Public Health Agency, who  
 19 were partners at that time, have clinical specialists.  
 20 It's not just this formal, there is quite  
 21 a considerable network of conversation that goes on  
 22 between the Health and Social Care Board and people at  
 23 all levels in the Trust. It is not just a simple  
 24 performance related conversation.

25 38 Q. A particular issue that has achieved prominence already  
 26 is conversations around Serious Adverse Incidents.

27 A. Correct.

28 39 Q. There's a particular pathway between the organisations  
 29 to work that out.

1 A. That's correct.

2 40 Q. I think the Inquiry sees that's quite a broad  
3 relationship at a number of levels.

4 A. It is.

5 41 Q. Just let's scroll down, please. Within your job  
6 description a number of -- just scroll down, please, to  
7 the next page -- results areas are identified:  
8 Delivery. Patient/client care. Strategic Leadership.  
9 Corporate Management. Governance. Just pause there.  
10 That's obviously a key interest from the perspective of  
11 the Inquiry. You are required to ensure robust  
12 arrangements are in place to meet the statutory clinical  
13 integrated governance requirements. Number 25 there,  
14 and we'll look at that in a moment.

15

16 Just scrolling down. External Relationships. Finance.  
17 BAF Resources. I think I said ten. Development of  
18 Self. Human Resource Management Responsibilities.  
19 Then I think an eleventh is these general requirements.  
20 It is a broad portfolio and no doubt a difficult job,  
21 particularly in the climate which you were to occupy  
22 the role with COVID affecting costs and its ability to  
23 deliver in anything approaching a normal way from the  
24 spring, early in 2022; isn't that right?

25 A. Yes. March. Late February when we knew.

26 42 Q. If you just go back to WIT-00104. Under Key  
27 Achievements you say that you're very proud of all your  
28 achievements, but the key achievements within the  
29 Southern Trust were set out in those five bullet

1 points. Leading the Organisation through the pandemic,  
2 designing and delivering a Trust Board development  
3 programme which focused on improving accountability and  
4 developing a new culture and strategy. That doesn't  
5 tell us an awful lot, but is part of this, what I'm  
6 going to come on to talk about shortly, your proposals  
7 to redesign the corporate structures to integrated  
8 a new Directorate Learning from Improvement?

9 A. It is actually more than that.

10 43 Q. It is broader than that.

11 A. Would you like me to explain how it is broader than  
12 that?

13 44 Q. We'll come to that. Designing and leading on a process  
14 of agreeing the key purpose and objectives for each  
15 Directorate and turning those into Directorate  
16 dashboards and safety thermometers. Can you explain  
17 that for us?

18 A. Yes. What I would stress is this got tied up in the  
19 COVID agenda, but what we were trying to do was -- for  
20 each of the Directorates have key objectives. One of  
21 the challenges I felt the Directorates had many, many,  
22 many things to do but actually focusing on what the key  
23 outcomes were. So we created score cards for each of  
24 the Directorates that looked at key outcomes for each  
25 of the Directorates. That allowed me to then meet with  
26 each Directorate on a fairly regular basis, but  
27 formally at least every quarter to understand where we  
28 were against those key Directorates. One of the  
29 Directorates then, actually through Maria O'Kane as

1 Medical Director, we began to explore safety  
2 thermometers like in Mental Health. That was the idea  
3 of having indicators that would highlight where  
4 potentially things were starting to go slightly in the  
5 wrong direction, and that would allow the Directorate  
6 to manage and looking at those safety indicators.  
7 Mental health was the place that was also tried as  
8 well. Fundamentally what the scorecard was trying to  
9 do was get key indicators around, for example, the  
10 Acute Directorate around elective care, around  
11 unscheduled care, around monthly training, finance,  
12 those kinds of things, and making sure we were managing  
13 those on a very regular basis. I would stress that  
14 when COVID happened we changed a lot of our management  
15 processes and it became much more command and control,  
16 but up until that point we were regularly holding those  
17 meetings with Directorates and looking at the wider  
18 scale of performance.

19 45 Q. Was this use of scorecards within Directorates to --

20 A. It was.

21 46 Q. Was this something that surprised you in the sense that  
22 it wasn't there before?

23 A. Yeah. I mean having come from organisations where they  
24 were and had implemented them, I was a little surprised  
25 at the lack of structure to the management of the  
26 Directorates. What I was trying to do was bring some  
27 structure that brought together finance indicators,  
28 performance indicators, HR indicators, and allowed me,  
29 as Chief Executive, to know that the Directorates were

1 functioning in line with their objectives. That didn't  
2 exist when I came in.

3 47 Q. Just touching on the two other matters you mentioned.  
4 You led a codesign programme of improvement for the  
5 Daisy Hill Hospital. You set that out there, and you  
6 were part of the HSE Regional Management Board. That  
7 was of particular significance in the context of COVID  
8 and the need to reimagine the delivery of health  
9 service in the region?

10 A. Correct. The Regional Management Board was set up,  
11 actually, as part of the COVID legislation. It was  
12 part of how we would manage the system as one whole  
13 system of command and control, because we were in  
14 a global pandemic, a major incident.

15 48 Q. Yes. Obviously you set out with pride your  
16 achievements but, obviously, with every job there are  
17 things you reflect upon that could have been done  
18 better, perhaps. Were there disappointments or regrets  
19 from your time in the Southern Trust?

20 A. Not that I could control pandemic, but I think we would  
21 have delivered an awful lot more as an organisation,  
22 organisation development. We were building a very  
23 strong team. I came in and actually I had four  
24 vacancies in the team. I brought them together.  
25 We created a new team. We were starting to put  
26 controls in such as scorecards, such as weekly  
27 governance meetings through the Medical Director,  
28 etcetera. We were starting to do stuff. We were  
29 unable to finish out a lot of that because we spent two

1 years in pandemic mode. My disappointment is not, it's  
2 not a disappointment in any one, but my disappointment  
3 was there were things that I would liked to have  
4 delivered out on that did not come to its full account  
5 because we completely changed the organisation  
6 overnight.

7  
8 I would love to have seen us be able to move much more  
9 care, and we did a lot of care in the community,  
10 I would love to have seen us move a lot more care into  
11 the community. That's a disappointment because I think  
12 the Southern Trust is exceptional at Care in the  
13 Community, and has been evidenced as being exceptional  
14 at care in the community through many, many programmes.  
15 I would liked to have been able to do more that and  
16 really take emergency medicine into the community a lot  
17 more, to avoid our hospitals becoming jammed. I also  
18 then reflect on our elective position. Because of what  
19 happened during COVID, but not just COVID, our  
20 inability to balance the unscheduled Care challenges  
21 with Elective Care challenges. I am disappointed that  
22 we were unable to do more Elective Care. That's  
23 something that, I think, if we hadn't have had the  
24 pandemic situation we had, and been able to get more  
25 care into the community, then we could have returned  
26 more elective care, and I am disappointed that I was  
27 unable to do that. I think if you can return more  
28 elective care you can keep people safer. That's just  
29 the way that it works.

1 49 Q. Yes. In terms of the circumstances that give rise to  
2 this Inquiry, have you had moments to reflect on that?

3 A. Absolutely.

4 50 Q. Obviously we'll go into some of the detail of it. But  
5 at a high level, perhaps, have you reflected on that  
6 and whether you have any cause for disappointment in  
7 perhaps your own involvement or lack of involvement?

8 A. Yes. I have reflected a lot. I don't think you can be  
9 a Chief Executive of an organisation heading into  
10 a public inquiry without reflecting deeply. I think  
11 there were clearly opportunities that my involvement,  
12 my deeper involvement may have addressed some of the  
13 issues earlier.

14

15 For example, at the end of the MHPS process, accepting  
16 that we had an action plan, accepting that the action  
17 plan was very focused on what were considered  
18 administrative challenges, that's a massive reflection  
19 to me. In the cold light of day when I reflect on  
20 that, I don't believe there are administrative  
21 challenges because they are all connected to Health and  
22 Social Care. Therefore, I have reflected a lot on  
23 that, and my relationship with Ahmed Khan at the time  
24 and whether I could or should have done more at that  
25 moment in time, and focused on it at that moment in  
26 time as opposed to the other major challenges I was  
27 trying to deal with. I have reflected a lot on that.  
28 I think that, for me, is the biggest opportunity where,  
29 as Chief Executive, I could have been more involved in

1 the process, was at end of the process MHPS process  
2 when Ahmed presented to me, here's the outcome.  
3 I said, thank you very much. Is it being managed?  
4 Yes, it's being managed. I went, thank you very much.  
5 And I moved on to the other big challenges, of which  
6 there were many. That's the key point I have reflected  
7 on.

8 51 Q. We'll certainly poke at that a little bit further as  
9 we go on.

10 A. Yeah.

11 52 Q. When you were about to take up this post, had you  
12 a sense that it was going to be a particularly  
13 challenging post, or what did you have in mind in terms  
14 of what was going on in the Southern Trust, which had  
15 gone through a number of chief executives in the years  
16 prior to your appointment?

17 A. That's correct.

18 53 Q. Some temporary post holders. Did you have a sense of  
19 what the challenge was ahead of you?

20 A. Absolutely. I mean, Northern Ireland and Health and  
21 Social Care in Northern Ireland is a very small place.  
22 Therefore, I had lots of conversations with people  
23 working in the Southern Trust. I lived in the  
24 Southern Trust and that's part of the reason I was  
25 attracted to it, because I wanted to do something back  
26 in my own community. I had lots of conversations and  
27 lots of people had said it's a great place to work.  
28 Others had said, don't go there because there are real  
29 challenges. I was very well aware that, having --



1 I mean, if I were to be successful, which I was,  
2 I would be the fifth Chief Executive in three years.  
3 I was very aware that the Southern Trust was  
4 undoubtedly held up as the performance -- the key Trust  
5 of successful performance during the Elective Care  
6 reform years. It was the end of the 00s, into the  
7 early teens. I'm very well aware that its unscheduled  
8 Care performance was the highest in Northern Ireland,  
9 and I was also very well aware that the years before me  
10 taking up the post that it had fallen from those  
11 positions. I was very aware that I was coming into an  
12 organisation that was challenged. I was aware of the  
13 elective pressures that were on. I was also aware that  
14 it was starting to see 12-hour breaches in the  
15 Emergency Department, which it had never seen before.  
16 Therefore, I was very well aware of the challenge  
17 I had. But, part of the desire to take on a job as  
18 a Chief Executive is to take on the challenges that are  
19 there in front of you. You don't take on a job to come  
20 to work at 9 o'clock, go home at 5 o'clock, and send  
21 a few emails. That's not what a Chief Executive job  
22 is. Therefore, I was well aware of the challenge and  
23 I wanted to be able to make a difference.  
24 Particularly, as I say, I live in the area. Most of  
25 the people who work in the Southern Trust also live in  
26 the area, and it's about doing the right thing for the  
27 people that you live and work with.

28 54 Q. Yes. I want to take a short walk through some of the  
29 Governance structures.

1 A. Certainly.

2 55 Q. You can help me with what was important from your  
3 perspective in your role, given that the requirement to  
4 provide assurance to the Board and, obviously, that  
5 assurance is required for elsewhere. You have told us  
6 in your witness statement that the role to ensure that  
7 the Trust had robust and effective arrangements in  
8 place for Clinical and Social Care governance. You go  
9 on to reflect within your statement about the important  
10 role of all of the Board's committees and the  
11 subcommittees, but drawing particular attention to  
12 the Trust's Governance committee, which is required to  
13 provide the Board with assurance on all aspects of the  
14 Governance agenda, except Finance, using Clinical  
15 Governance metrics and other evidence. The Governance  
16 committee is at the heart of the, by definition the  
17 Governance exercise, the Governance function.

18 A. Correct. It is the one committee that looks in detail  
19 at the key elements of both Clinical and Social Care  
20 Governance and also elements of Corporate Governance.  
21 Even though when I'm saying that, they totally  
22 intertwine and they look at integrated governance. It  
23 is absolutely the committee where those issues are  
24 looked at in detail for the organisation as a whole.  
25 In terms of its agenda, I'm very well aware that the  
26 Inquiry will know what is on its agenda, but in terms  
27 of its agenda at the core of that is the Governance  
28 report, that Governance report looks at Clinical  
29 indicators as well as issues of other areas, such as

1 litigation, etcetera, but, primarily, it focuses on  
2 clinical indicators, both Health and Social Care  
3 indicators.

4 56 Q. This is the Clinical and Social Care indicators that  
5 comes to this committee?

6 A. That's a fundamental report that it looks at SAIs, it  
7 looks at incidents, it looks at clinical indicators,  
8 the outcome indicators, etcetera. That is really the  
9 channel by which Clinical and Social Care Governance is  
10 visualised at a Board level. I'm more than happy to go  
11 into, I think there are challenges in that process, but  
12 that's the vehicle by which that report presents to  
13 the --

14 57 Q. As I work through this, and I'm conscious I'm going to  
15 ask you questions about -- if I can call it your reform  
16 agenda, your change agenda. I want to ask you  
17 questions in that context in a moment or two. But  
18 another aspect of the Governance committee that I wish  
19 to address just now is: is the use of Clinical  
20 Governance metrics? Is the use of metrics something  
21 that you were familiar with in your role?

22 A. Absolutely, yes. The idea that Clinical and Social  
23 Care Governance and performance is both data driven,  
24 which clearly is metric and, therefore, intelligence,  
25 as well as looking at processing systems. So  
26 absolutely. That's fundamental to that particular  
27 report. It has been reviewed on numerous occasions to  
28 try to home in on those metrics. But, absolutely, at  
29 the heart of that report is a range of statistical

1 process control charts. It looks at the indicators and  
2 how we are safe or how we can become more safe.

3 58 Q. Was that process of gathering data and then using it  
4 intelligently, was that in good health when you came?

5 A. Given the fact it's an area that I think I engaged  
6 quite early on with the both Medical Director and Chair  
7 of the Committee, there was improvements to be made in  
8 that area. I think the challenge in the Health and  
9 Social Care system, and in this case the Health and  
10 Social Care Trust, is that the range of indicators  
11 could run to thousands. It really could. The  
12 challenge was to try to narrow it down into what are  
13 the key safety, quality and social care governance  
14 indicators. It was a constant challenge to try to get  
15 the right indicators. But, fundamentally, it is an  
16 area that I was involved in heavily to see how we could  
17 improve the measurement that we brought to those  
18 committees.

19 59 Q. You also refer in your statement to the importance of  
20 the patient/client experience committee. Its purpose  
21 was to provide the Board with assurance that the  
22 Trust's services, systems and processes provided  
23 effective measures of patient, client and care  
24 experience.

25 A. Yes.

26 60 Q. That was an opportunity, through that committee, to  
27 take a deeper dive into certain areas of clinical  
28 practice and patient experience.

29 A. Yes. It was a deeper dive often to patient experience.

1 I wouldn't suggest it was a deeper dive into clinical  
 2 practice, although the experience, obviously, is as  
 3 a reflection of the practice that somebody received.

4 61 Q. Yes.

5 A. Yes. The committee was there. I think anyone who  
 6 works in the world of patient and public involvement  
 7 understand that no one patient or no one small group of  
 8 patients could ever reflect the complexity of what it  
 9 is like to be a patient of the Health and Social  
 10 Care Trust. However, those individuals provided very  
 11 good feedback through to the Chair of the committee,  
 12 who was John wilkinson, very good feedback on their  
 13 experiences as patients/clients, of our service. It  
 14 allowed that voice to be heard around the Board table  
 15 via the Chair and, also, a layout of some of those  
 16 patient stories to be heard directly by non-execs and  
 17 execs. It provided a real opportunity for that voice.  
 18 I don't believe you could ever have a holistic  
 19 committee that could ever represent all voices of  
 20 patients and clients, but it was a good way of allowing  
 21 that voice to be heard by execs and non-execs.

22 62 Q. We know, for example, on 24th October 2019, one of the  
 23 Specialist Nurses from Urology came to speak to that  
 24 committee to reflect the patient experience reflecting  
 25 the waiting list pressures, its impact on patients,  
 26 spoke of the difficulties, sometimes, in meeting cancer  
 27 targets and the impact on patients.

28  
 29 For the Inquiry's note, the reference to that it

1 TRU-128158.

2

3 I don't need to bring you to that, but I want to ask  
4 a general question. When you have a practitioner  
5 coming to that committee, reflecting the difficulties  
6 faced during the patient experience as a result of the  
7 patient experience, where does that go to? If there's  
8 real difficulties facing the staff and their ability to  
9 deliver for patients in a way that conforms with the  
10 guidelines or expected norms? Where does the  
11 information from that go to in order to, perhaps, drive  
12 change or lead to proposals for change?

13 A. All committees have a space on the Trust Board to raise  
14 issues that have been raised at a committee at a Trust  
15 Board level which would allow -- you'll see from the  
16 minutes every single committee, the committee notes and  
17 committee Chair reports to the Trust Board. In  
18 practice, any committee Chair could raise to the Trust  
19 Board as a whole. In that particular case I do not  
20 recall, off the top of my head, that was raised to the  
21 next Trust Board meeting, because you raised it with me  
22 and I genuinely don't know.

23 63 Q. I believe the report from the committee is part of the  
24 Trust Board pack for the next meeting, perhaps.  
25 I can't say off the top of my head?

26 A. Yes.

27 64 Q. Our impression, perhaps, and you could maybe assist us  
28 with it, our impression, perhaps, is reports coming  
29 from the committees aren't generally the subject of

1 great debate or input at Board level. Clearly Board  
2 members form parts of these committees and maybe that  
3 is the Board having the debate at the committee level,  
4 but when it gets to full Board, little apparent  
5 appetite -- and this is a general observation, of  
6 course -- little real engagement on some of the meatier  
7 issues that emerge from the committees?

8 A. I think that's a very fair reflection. The job of the  
9 committee is to try to deal with those issues at  
10 committee. However, there was always the vehicle that  
11 if the Chair of the committee felt it should be  
12 discussed at Board, then it should be discussed at  
13 Board. But I'm reflecting on the minutes and  
14 reflecting having been at four years worth of Trust  
15 Board minutes. I think it is a fair reflection you  
16 make. It was not a regular occurrence for information  
17 that was discussed at committees to have any detailed  
18 conversation at the Trust Board. We did, in  
19 probably October, November 2021, then begin to have  
20 a conversation about risk appetite and about what the  
21 process should be for escalating from committees to  
22 Board. We brought in the Good Governance Institute,  
23 I believe it was, to help us understand how best to  
24 escalate from committee to the Board. That was,  
25 actually, the last workshop I was part of before  
26 I tendered my resignation because I remember it was the  
27 day I actually tendered my resignation. That workshop  
28 was to help the Board to understand how we could  
29 improve that process and having some kind of tiered

1 level of risk being carried at committees, and then  
 2 being moved into the Board environment. I do not know  
 3 whether that was delivered on post my exit.

4 65 Q. Thinking about it, and we can obviously tease this out  
 5 with those who are there still and now, you would have  
 6 been hopeful that some form of mechanism or test or  
 7 trigger would have been identified for that purpose?

8 A. Correct. Yes. One thing that did happen is that the  
 9 committee Chair would meet with myself and the Trust  
 10 Chair not long after the committees, a very short  
 11 meeting, where they could, if they felt it important to  
 12 raise any major issues to us. But, again, it was not  
 13 a thing. There would not regularly have been any  
 14 issues raised with us from the committee because the  
 15 assumption was the committee was doing its job, and if  
 16 it needed to, it would raise. I think there's quite  
 17 a considerable point of learning in that in terms of  
 18 making sure that committees regularly raise issues to  
 19 the Board rather than by default don't. I think  
 20 there's a big point of learning.

21 66 Q. You refer in your witness statement, WIT-00026 -- we  
 22 have it up on the screen. It is not entirely  
 23 necessary -- to your initiative to create a performance  
 24 committee?

25 A. Yes, that's correct.

26 67 Q. You introduced a performance committee, the purpose of  
 27 which is:

28 "Assists the Trust Board ... overseeing the delivery of  
 29 planned results by monitoring performance against



1 objectives".

2  
3 The idea of this committee was to allow the space and  
4 the time, which wasn't otherwise available at Board  
5 level, to consider a detailed analysis of key  
6 performance indicators?

7 A. That's correct. It was clear, having worked in other  
8 organisations, other organisations had performance  
9 committees. It was also clear to me when I arrived  
10 that the length of time that people are able to spend  
11 going into detail at a Trust Board meeting around  
12 performance was limited, because Trust Board meetings  
13 themselves are limited by time. I had suggested to the  
14 Chair that it would be wise and the right thing to do  
15 to provide a space for non-execs and execs -- not just  
16 non-execs, the whole Board, to explore performance at  
17 a greater detail, and also then to take deep dives into  
18 different areas of performance at every meeting. One  
19 might have been about cancer, one might have been about  
20 mental health and learning disability, and allowing the  
21 Directorates to present to that committee how they were  
22 performing, often against that which was articulated in  
23 the Trust delivery plan, which I had mentioned earlier,  
24 how they were performing against that. It wasn't just  
25 that. It could have been wider clinical guidelines, it  
26 could have been wider issues of the wider performance.  
27 That meeting became, I think, an important opportunity  
28 and, in some cases, got behind some performance issues.  
29 But, again, I would stress that it was deep dive into

1 certain areas. I think across the complete Health and  
2 Social Care Trust it is difficult to get behind every  
3 element of performance, hence the importance of  
4 Directorate Performance and Directorate Governance.

5 68 Q. One of the things we may reflect upon later, perhaps,  
6 was when you look at some of the shortcomings that were  
7 identified through the Serious Adverse Incident reviews  
8 conducted by Dr. Hughes and Mr. Gilbert and others in  
9 2020 and into 2021, there was an absence of data to  
10 highlight departures from expected norms. What was  
11 available, perhaps, and maybe, it is a matter for the  
12 Inquiry, maybe insufficiently used was knowledge,  
13 informal anecdotal knowledge about shortcomings that  
14 wasn't reflected back to the leadership. In  
15 a performance committee context, would it be possible  
16 to get that kind of thing on to the agenda, and how  
17 would that be done?

18 A. Yes. If you think about the performance reports and,  
19 again, the Inquiry, I'm sure, will have a couple of  
20 those performance reports, it was very broad and tried  
21 to look at the complete range, and then it would go  
22 into deep dive and, therefore, in those deep dives it  
23 would certainly have been the case to look at how  
24 things were measured and monitored; were we measuring  
25 the right thing, who was learning from that? But by  
26 the nature of the deep dives you only go into  
27 a particular area. I can't recall when we started it,  
28 but I'm certain there would only have been six or seven  
29 performance committees in my tenure, maybe slightly

1 more than that, in no way would it go into every  
2 specialist area. It could not have done that. But  
3 that was the purpose of the deep dive, to try to go  
4 underneath and understand how performance was being  
5 monitored, being measured, and whether it was working  
6 or not, and whether it was improving performance and  
7 keeping people safe. That was the reason for the  
8 committees.

9 69 Q. Moving away from the committees, and there are other  
10 committees but they appear to be the ones most relevant  
11 to the Inquiry's interest. You also talk about the  
12 Risk Management Strategy within the Trusts --

13 A. Correct.

14 70 Q. -- and the fact those arrangements are audited?

15 A. Yes.

16 71 Q. You refer us to the use of local directorate risk  
17 registers with issues of significant importance to  
18 wider Patient Safety being escalated to the senior  
19 management team and, presumably, inappropriate cases on  
20 to the Corporate Risk Register?

21 A. That's correct. Each team, each Service Area but  
22 primarily Directorate will have a risk register. They  
23 will review that risk register at their governance  
24 meeting. In many cases that will be, I think, at least  
25 on a monthly basis. There is an opportunity, and it  
26 does happen, whereby risks can be escalated. A risk  
27 obviously can be managed at a local level. It may be  
28 the case where a risk needs to become a corporate risk  
29 because it is much bigger than the local level. All

1 risk registers are managed in a fairly standard way.  
2 It would have been the previous Australian/New Zealand  
3 approach, which would have looked at risk, probability  
4 and impact. That changed a couple of years ago, but  
5 very similar. Risks are assessed based on that  
6 standardised approach and should, therefore, scores  
7 from that standardised approach become both high and  
8 also the Directorate feels it cannot manage that risk  
9 at a local level, then it can be put forward to become  
10 part of a Corporate Risk Register. The senior  
11 management team would then meet, as it did every week,  
12 but it would meet in Governance form to look at those  
13 risks and they may become part of a Corporate Risk  
14 Register. It is important to note that simply putting  
15 it in the Corporate Risk Register doesn't remove the  
16 importance of the Directorate to deal with it, but it  
17 allows us to look at key risks to the organisation.  
18 Certainly before I had left, maybe a year before  
19 I left, we began to explore: is there a better way to  
20 improve the way we manage risk? We did a lot of work  
21 on the Corporate Risk Register to look at major themes  
22 of risk rather than the risk register being built up  
23 from within the organisation but looking at what the  
24 objectives of the organisation are, and trying to look  
25 at risks around the workforce, the risk around safety,  
26 etcetera. A lot of work went on to try to evolve the  
27 Corporate Risk Register into a genuine management tool  
28 as opposed to a place to record a risk. I think  
29 there's always a danger of risk registers that people

1 assume, well I've recorded the risk, therefore. That  
2 isn't why we have a risk management strategy, that  
3 isn't why we had risk registers. Risk registers are  
4 a tool to help us improve, to become safer. So  
5 we spent a lot of time looking at the review of that.  
6 At a local level each Directorate has a Directorate  
7 risk register and Services will also have a Service  
8 Risk Register. That's what internal audit will have  
9 look at in terms of the connection between local risk  
10 and corporate risk.

11 72 Q. I am interested in the concept of the risk register as  
12 a management tool.

13 A. Yes.

14 73 Q. We will come on, in the course of your evidence, to  
15 look at, for example, standard guidelines, and I can  
16 tell you 2014 it comes on to the risk register for the  
17 first time and remains on the register for relevant  
18 purposes, and still on the register today, but I take  
19 it up to July 2020. During that period the level of  
20 risk goes from -- it's the bottom of the line -- low to  
21 moderate.

22 A. Low to moderate. Yes.

23 74 Q. I'll look at that with you later. In terms of the use  
24 of the risk register as a management tool, is that  
25 a way of saying management should see the risk and work  
26 out ways of dealing with it using the resources at  
27 their disposal?

28 A. I mean the key element of a risk register is both  
29 probing an impact to understanding the risk and

1 mitigation. That's fundamentally what a risk register  
2 is about. A mitigation is itself an action plan. In  
3 some cases the risk cannot be mitigated and there is an  
4 acceptance of risk. You sit it there and say, we are  
5 going to have to live with this risk. But in most  
6 cases in Health and Social Care that isn't the case.  
7 In most cases it requires mitigation, and in most  
8 cases, therefore, it is a tool for management because  
9 it is a tool for action. It is not a tool for  
10 observation. It is a tool for action which is, if we  
11 are going to mitigate this risk, what are the things  
12 we're going to do? That's where we would talk at both  
13 the Governance Committee and the senior management  
14 team, about what action are we taking as a result of  
15 what we are learning through our risk management  
16 process. Clearly, in a high-performing system, that is  
17 the kind of thing that happens throughout the whole of  
18 the hierarchy of the organisation. I think there is  
19 learning and challenge in that because I don't believe  
20 that in every part of the organisation that is the way  
21 risk management and risk registers are used. I think  
22 it is clear now, having reflected on the evidence, both  
23 read and my understanding, I think in many cases risk  
24 registers are used as a place to hang stuff on as  
25 opposed to being a tool for management.

26 75 Q. These various components, the risk register, risk  
27 management, the committee structure, they're all  
28 components of what you have described as the Integrated  
29 Governance Framework?

1 A. Correct.

2 76 Q. Those tools within that framework are, in theory, used  
3 to provide assurance to the Board?

4 A. That's correct.

5 77 Q. The Board, in turn, is working in the context of  
6 a Board assurance framework. If you can, the  
7 relationship between those two concepts, those two  
8 entities?

9 A. Certainly. The Board assurance framework, the BAF as  
10 it is referred to. The BAF is produced on an annual  
11 basis, if you start at the top and I'll explain how it  
12 connects. The Board Assurance Framework is produced on  
13 an annual basis. That looks at what the main  
14 objectives of the organisation are and, in many cases,  
15 that is about provision of safe services, meeting  
16 performance, etcetera. What the assurance framework  
17 looks at is, if we are to be successful in meeting  
18 those objectives, what are the key actions we need to  
19 take, and what are the controls that we will put in  
20 place to make sure we meet those requirements? The  
21 risk register is reflecting on, well, actually, what is  
22 the risk to us not being able to meet those objectives?  
23 In many cases that risk will be quantified, or at least  
24 qualified, in both the probability of it happening and  
25 what's the impact if the risk occurs. They are  
26 absolutely connected. You start with the Board  
27 Assurance Framework saying, here with the big  
28 objectives we want to achieve and if we are to be  
29 successful, here's the things we will have to have

1 delivered. The risk register looks at what is the risk  
 2 to us achieving those things. It is both at a Board  
 3 level but also at a local level, therefore risks will  
 4 come up and you will be saying, if that risk becomes  
 5 reality, we have a real difficulty in achieving that  
 6 objective of safety or performance, or whatever the  
 7 case may be. They are absolutely interconnected.  
 8 The Board Assurance Framework is an annual document or  
 9 statement of where we are going. The risk register is  
 10 a regular, live issue that needs to be looked at on  
 11 a regular basis. The Board Assurance Framework is  
 12 reviewed on an annual basis to say, did we achieve what  
 13 we were meant to achieve on, and did the things that  
 14 we thought were going to help or stop us, did they  
 15 actually materialise.

16 78 Q. Another different but important part, I suppose, of  
 17 delivering health services safely is the ability for  
 18 members of the team, your workforce, to be able to  
 19 communicate to those who they feel can make  
 20 a difference. You have reflected in your statement  
 21 staff do engage with you on Clinical Governance issues,  
 22 and you refer to staff going through their own  
 23 Directorate lines, staff coming directly to you,  
 24 whistle blowing, and you, yourself, had an open door  
 25 policy?

26 A. That's correct.

27 79 Q. You met with your senior management team once formally  
 28 and once informally every week, in addition to,  
 29 I suppose, incidental discussions and meetings.



1           A.    If I start with the latter. In terms of the meetings  
2                   with the senior management team, very clearly the door  
3                   is open and physically is open, continuously. We all  
4                   share the one corridor and therefore there is the  
5                   opportunity for people to be able to always interact.  
6                   There's a general informal nature about that. There  
7                   was a formal nature for the senior executive team which  
8                   was, as I say, every week on a Tuesday. Every week on  
9                   a Thursday there is the opportunity to come together.  
10                  The Tuesday meeting is really the business meeting.  
11                  The Thursday is an opportunity for people during the  
12                  week to reflect and share on anything that is  
13                  considered a challenge. Obviously we added to that  
14                  during COVID where, actually, it was every single day  
15                  we were meeting as what is called bronze command, every  
16                  single day on top of that.

17  
18                  In terms of ways in which people could raise Clinical  
19                  and Social Care challenges, there's the initial formal  
20                  route through the datix system, through incident  
21                  reporting, and many people do that. Ultimately, the  
22                  collection of those incident reports come through to me  
23                  as Chief Executive through the Clinical and Social Care  
24                  Governance report. Clearly that's a route, not  
25                  a direct route to the Chief Executive, that's a route  
26                  in which most people would raise absolutely see  
27                  something, say something, which is our approach to  
28                  while blowing. We reintroduced and re-energised about  
29                  four years ago. That gives the people, we trained

1 people and give them an opportunity to say if you want  
2 to raise something here are the routes that can be  
3 done. Not quite like the freedom to speak up guardians  
4 of the NHS, not quite that level, but a similar  
5 approach to the freedom to speak up guardians. Then on  
6 top of that clearly clinicians and anyone knew my door  
7 was open. There were occasions on which clinicians did  
8 walk in and say, can I talk to you about something? Or  
9 in many cases would have rung the office and say,  
10 I would like to come to talk to Shane about X, Y, Z.  
11 These were clinical issues. They would, and then  
12 I would have discussed it with the appropriate Director  
13 or, in some cases, with the Medical Director, the  
14 Nursing Director, etcetera. That was a vehicle that  
15 people could use. I think in a large organisation, the  
16 most obvious route people will not be with the Chief  
17 Executive. The most obvious route will be through  
18 their own line and through incidents, but the door was  
19 open and, on a number of occasions, people choose to  
20 use that as a vehicle.

21 80 Q. Yes. I want to come on, obviously, in due course to  
22 look at how that cultural aspect, if I can call it  
23 that, worked between you and members of your senior  
24 management team, in particular, the Director of Acute  
25 and the Medical Director in the context of the issues  
26 that we are concerned about.

27  
28 Is it of concern to you that no one at staff level, on  
29 the ground level, if I can put it in those terms, below

1 the hierarchical positions of Director, approached you  
2 with any concerns in relation to Mr. O'Brien's  
3 practices or other issues that were going on within  
4 Urology?

5 A. I can certainly say that no one from that level did  
6 approach me. Is it a concern? I think if individuals  
7 in any team feel that they are not being listened to  
8 and they feel that, actually, I want to have this  
9 raised, it is disappointing that people couldn't come  
10 to my door as Chief Executive. You always want that.  
11 I'm not too sure that would have been the case in  
12 Urology, or any other service, because I think people  
13 would have seen the Director of Acute Services as more  
14 accessible than the Chief Executive by the nature of  
15 the Director of Acute Services being there, head of  
16 their hospitals, as opposed to the Chief Executive who  
17 was physically not in the hospital. You know, I think  
18 that in a large Health and Social Care organisation,  
19 I think people would be more likely to raise it to the  
20 management team of the hospitals than directly to the  
21 Chief Executive. But it didn't happen with Urology.

22 81 Q. If the findings, as we know it to be from the Serious  
23 Adverse Incident reviews, was, to take one example, it  
24 was widely known within the MDT that Cancer Nurse  
25 Specialists were not deployed, for whatever reason, by  
26 Mr. O'Brien, and that represents a departure from  
27 a standard, a well-known standard. If that information  
28 is not leaving that MDT and going up even a level to  
29 the Head of Service, let alone to the Directorate,

1           whether Medical Directorate or Acute, what does that  
2           say about the health of the organisation?

3           A.    I think what it might say about the health of that  
4           particular part of the organisation, and I think we  
5           have to be careful that there are teams where other  
6           information may flow differently, but in terms of your  
7           point, I think what it says is individuals didn't want  
8           to, or feel comfortable to, or didn't recognise that.  
9           They could have raised it in the organisation whether  
10          through an IR1 form, whether through see something, say  
11          something, or whether by knocking on my door. What it  
12          tells me is that particular team didn't. It may be you  
13          could infer that they didn't know that they could, know  
14          that they should, or felt comfortable and confident  
15          that if they said it, it would be listened to. I think  
16          you would have to explore that with those individuals.  
17          What I can state by fact is they didn't.

18       82   Q.    Are you confident that kind of keep it in-house  
19          scenario that I've depicted wasn't part of the broader  
20          culture at Southern Trust?

21       A.    I think what I began to understand as I came into the  
22          role -- and we may get on to this with regards to the  
23          Governance review, etcetera -- is that Governance was  
24          managed, without fail, within the Directorates, not as  
25          a corporate. It is one of the things I discovered  
26          quite early. I've used this statement before with  
27          other people, it felt like the organisation was  
28          a confederacy rather than a corporate. What I mean by  
29          that is it became very strong business unit, Acute,

1 Mental Health, Disability, etcetera, therefore that's  
2 why I reflect on I think it stayed within the  
3 Directorate rather than the Corporate, and that's what  
4 we were trying to change. I know you will have heard  
5 from Dr. O'Kane yesterday and you briefly talked about  
6 the weekly governance report, that is such an important  
7 part of trying to take it out of the confederacy and  
8 the siloed approach into a corporate approach. What  
9 I can say categorically is when I came into post there  
10 was not a corporate approach to Clinical and Social  
11 Care Governance, there was Directorate approaches.  
12 That may be an indicator as to why people wouldn't have  
13 raised it to the Corporate because they saw their  
14 employer as being that Directorate.

15 83 Q. I want to explain that in greater detail through you in  
16 a moment. Another feature that you've alluded to, more  
17 positively perhaps, the flow of information to the  
18 Board. You set out three examples within your witness  
19 statement. I think if we maybe have it up on the  
20 screen to illustrate it. WIT-00047. You spend 20 or  
21 so pages explaining how --

22 A. Correct.

23 84 Q. It is not a criticism, but I'm not going to go through  
24 the detail of that. What you say, it illustrates  
25 through those three examples, one example being poor  
26 quality of care, or the alleged poor quality of care in  
27 obs and gynae in the delivery suites. Another issue  
28 was the concerns triggered by an alleged assault in  
29 a mental health ward, and that review expanded out into

1 looking at the whole Bluestone Unit. A third concern  
2 is by Dr. A concerning what he regarded as the  
3 mis-categorisation of incident reviews. Those specific  
4 clinical matters, perhaps, in some respects, wider  
5 Patient Safety issues, all make it up on to the Board  
6 through Committee reports and are there to be discussed  
7 by the Board if they have the appetite or the interest  
8 to do so beyond what the Committee have said about  
9 them. Is that fair?

10 A. Yes, absolutely. I mean, the reason why I included  
11 this in the evidence was to demonstrate how the Trust  
12 Board can work to deliver both safety and improvement.  
13 These three individual activities. Dr. A just predated  
14 me, although the activity of the identification of the  
15 problem predated me, but the actual delivery was during  
16 my time. The obs and gynae and mental health one were  
17 absolutely within my timeframe. They identified key  
18 safety challenges, particularly the mental health and  
19 the obs and gynae one, and the way in which Trust Board  
20 dealt with those through myself, my Directors and the  
21 Trust Board indicate how Trust Board can work to ensure  
22 both safety and improvement. As you say, there's 20  
23 pages there and I'm not going to go through it in  
24 detail, you will have seen it. It was clearly  
25 identification of a problem. If you take the Bluestone  
26 one, identification of a problem, a very strong  
27 director at the time, a gentleman called Barney  
28 McNeany. Working in partnership with the Medical  
29 Director, Dr. O'Kane, and really driving how can we

1 understand how we stay safe, how we become safe,  
2 bringing in a third party in the Royal College of  
3 Psychiatrists who provide independent review as well,  
4 and then driving an action plan and improving, and  
5 keeping the Trust Board continually engaged in that  
6 process. It indicates that the Trust Board system can  
7 work -- did work in those particular cases -- and kept  
8 patients safe and addressed clinical challenges.

9 85 Q. Yes. The Inquiry will no doubt observe from its  
10 reading that these issues individually were on the  
11 agenda month after month for quite a period of time --

12 A. Correct.

13 86 Q. -- allowing the Trust Board to take cognizance of the  
14 various developments and, as I say, challenge, if they  
15 saw fit. You described these three examples as  
16 revealing clear engagement, challenge, planning and  
17 ultimately improvement. Another example that comes to  
18 mind is the circumstances that give rise to this  
19 Inquiry in August 2020. We'll look at it in some  
20 detail later?

21 A. Correct.

22 87 Q. The Board is told about a series of Serious Adverse  
23 Incidents, as it was described at that time, which were  
24 to be investigated concerning a retired Consultant  
25 Urologist. Issues concerning Mr. O'Brien had not been  
26 on the agenda until then in the period January 2017  
27 when the Board was told, albeit the clinician isn't  
28 named in the minutes, that he had been excluded and  
29 there was to be an MHPS investigation. Can I have your

1 position on this, and we'll look at it in some greater  
 2 detail later. Should concerns in relation to  
 3 Mr. O'Brien have featured on the Board's agenda prior  
 4 to July/August 2020, or, at the very least, should  
 5 developments in the MHPS process have been reported to  
 6 the Trust Board prior to the developments in the summer  
 7 of 2020?

8 A. In terms of the MHPS process, and reflecting, looking  
 9 back on that, I would agree with you there should be  
 10 a position where we can regularly present back on MHPS  
 11 processes, and that wasn't the case. Therefore, with  
 12 regard to MHPS, absolutely there should be a process.  
 13 I'm pretty sure the learning has already been  
 14 implemented in the Trust around that area. So  
 15 absolutely on that case.

16  
 17 with regards to specific details in terms of  
 18 Mr. O'Brien and those things, I can understand why it  
 19 wasn't regularly on. I'm sure we'll come on to that  
 20 later in terms of the level of alarm that was being  
 21 driven at a senior level. I'm more than happy -- I'm  
 22 sure we'll explore this in detail. On reflection,  
 23 having read what I have read in terms of the many  
 24 thousand pages of witness statement, and on reflection  
 25 knowing where we, I think it would have been  
 26 advantageous for it to have been on the Board, but  
 27 I understand why it wasn't, and I'm more than happy to  
 28 explore that later.

29 88 Q. we'll explore that shortly.



1 I interpret your statement as telling the Inquiry that  
2 in terms of Corporate and Clinical and Social Care  
3 Governance, upon your arrival in the post of Chief  
4 Executive there were reasonable foundations in place  
5 but you faced a number of challenges which caused you  
6 some concern, particularly around Clinical and Social  
7 Care Governance. Is that fair?

8 A. I think it's fair to say having worked in more Trusts  
9 at that point, therefore I had experience of Clinical  
10 and Social Care functioning in a Trust, I came into the  
11 Southern Trust and it was not as invested in as I have  
12 seen in other organisations. That was my initial  
13 perception. I was also very well aware that at  
14 a Directorate level, the Directorate Governance  
15 meetings seemed to be quite immature in their  
16 development. I'm aware that certainly up until maybe  
17 2016, 2017, there wasn't a large investment in local  
18 governance. I was also very well aware, having worked  
19 in other organisations, where clinical audit was really  
20 to the forefront of the organisation. Clinical audit  
21 wasn't to the forefront of the organisation in the  
22 southern area. There were things that didn't quite  
23 feel as well invested in as I would have expected from  
24 other organisations.

25 89 Q. Just while you're saying that, let's bring up on to the  
26 screen how you articulated within your witness  
27 statement. WIT-00037, please, at the bottom of the  
28 page. The preamble to that was talking about what the  
29 system was on arrival. You say one of the steps that

1 you took was to commission the Health and Social Care  
2 Leadership Centre to review the governance system.  
3 This is how you articulate your concerns:

4  
5 "1. The level of expenditure in the governance  
6 functions felt light. I was used to appropriately  
7 funded teams for areas such as SAI management,  
8 complaints, standards and guidelines".

9 Let's work through these, not at any great length, but  
10 expand on that for me, if you would. Is that telling  
11 us that in order to do governance robustly and  
12 effectively you need people in places, in offices doing  
13 the hard graft of gathering and interpreting the  
14 material?

15 A. Yeah. I'm sure we'll come on to the governance review  
16 later, but one of the key things in the governance  
17 review were those three channels of SAIs, complaints,  
18 standards and guidelines. Whenever the governance  
19 review was completed -- I won't go through the detail  
20 of it now, I'll happily go through it when you ask me  
21 to do so -- the three areas I felt we needed to do more  
22 work on was not just the process of running these  
23 things, but the process of learning these things.  
24 Therefore, it is not just having the people to collect  
25 and enter the data, but it is the time that is required  
26 to take learning from SAIs, complaints, and also to  
27 ensure the standard and guidelines, of which there are  
28 many that come into organisations, are implemented  
29 fully. I suppose what I reflected when I arrived is

1 that the organisations I had worked in previously would  
2 have had more resource in both the collection of SAI  
3 information, complaints and standards, but actually  
4 would have had more resource in deployment and learning  
5 from those statements. That was my feeling. Clearly,  
6 what the Governance review managed to draw out was that  
7 comparison with another Trust, which I think in the  
8 report was the Northern Trust, it wasn't just  
9 a feeling, it was a fact. It was a fact that, in fact,  
10 the Southern Trust hasn't the level of resources in  
11 those areas that other organisations may have had. For  
12 me, that was my initial view which was then proven  
13 through the Governance review that we did need to put  
14 in resources in those places.

15 90 Q. The second concern that you had was a concern that  
16 there was some squeeze on or some restriction on the  
17 flow of information up from the Directorates to the  
18 SMT. In other words, you didn't have a clear view of  
19 what was actually going on on the ground?

20 A. With regards to Clinical and Social Care Governance, as  
21 I reflected earlier this idea of confederacy rather  
22 than a corporate, what was happening was governance was  
23 being managed at a Directorate level but we were not  
24 regularly at a senior management team looking at what  
25 was happening governance on a dynamic basis, on  
26 a weekly basis. What would happen, absolutely, the  
27 governance report would come to the senior management  
28 team before it went to the Trust Board, and we could  
29 discuss that. That's not dynamic clinical and social

1 care governance. Dynamic clinical and social care  
2 governance is constantly looking across the  
3 organisation, hence the agreement at the time to create  
4 that weekly governance meeting where issues of SAIs,  
5 complaints, incidents could be discussed across the  
6 organisation and then every executive manager then on  
7 the Tuesday, following the Thursday meeting, would then  
8 discuss what was happening in the whole of the  
9 organisation. Therefore, the win came when the  
10 Governance report came in preparation for the  
11 Governance Committee dynamic. That's a point in time  
12 and it's quite a length of time rather than a dynamic,  
13 our governance system.

14 91 Q. The third point, which may be a consequence of the  
15 level of expenditure, I don't know. You can maybe  
16 reflect back to me on that. You're saying that the  
17 level of data and statistical evidence being brought to  
18 the senior management team in respect of quality and  
19 safety was lower than what you were used to in other  
20 organisations. Can you put that into a concrete  
21 example for us?

22 A. If I can give you an example of an organisation that  
23 I previously worked in where there was high-level data  
24 analytics whereby issues would be identified. For  
25 example, under mortality there would be a regular  
26 mortality meeting, regular mortality reports, and they  
27 would be brought to the senior management team where we  
28 could look at the issue of mortality. If I give you an  
29 example of my previous organisation, that led us to

1 say, why does mortality, particularly in respiratory in  
2 one our hospital sites look very different from  
3 mortality in respiratory in a different hospital site,  
4 and we were able to go and explore why that was the  
5 case as a senior management team. That kind of  
6 detailed analysis and looking at, in this particular  
7 case mortality, was not regularly coming to the  
8 executive team. In fact, one of the things that,  
9 certainly again we introduced was to make sure that  
10 mortality was coming at least to the Trust Board on  
11 a regular basis, and then we were looking at mortality  
12 as part of a much more dynamic system.

13 92 Q. I know within your statement -- we needn't go into the  
14 fine detail of it -- but you've explained that you were  
15 coming into an organisation that had, I suppose, a high  
16 level of instability in the Chief Executive function,  
17 in the Medical Director's role perhaps to some lesser  
18 extent, but we know the history of people in posts for  
19 short periods of time in Dr. Wright's case, in an  
20 acting-up capacity in Dr. Khan's case. You talk about  
21 your immediate challenge being to recruit a substantive  
22 senior management team and to begin a process of  
23 creating a strong governance environment in order to,  
24 I suppose, provide the circumstances in which you can  
25 more readily provide robust assurance to the Trust  
26 Board. You set about doing this by instigating an  
27 independent review under the authorship of  
28 Mrs. Champion.

29 A. Yes.

- 1 93 Q. That review reported at the end of 2019. I want to  
2 come to that in a moment. At what point did you feel  
3 that some of these issues that you've highlighted, in  
4 particular around the creation of an environment by  
5 which information about Clinical and Social Care  
6 governance could more readily come to the senior  
7 management team as opposed to being siloed within  
8 directorates? By what point did you begin to feel you  
9 were making progress with that?
- 10 A. If I take you back a slight point, which I can then  
11 build on. My first challenge was to build a new team.  
12 I had an interim Director of Finance, an interim  
13 Director of Nursing, interim Director of Medicine, and  
14 interim Director of Mental Health and interim Director  
15 of Community Services. My first job, before I could  
16 get on to building new systems of governance, was  
17 actually to build a new team. That did take me until,  
18 I think the last two posts were Barney McNeany and  
19 Dr. O'Kane. That was probably in January 2019. The  
20 first job wasn't to try to create new systems, the  
21 first job was to be able to get a team that actually  
22 was the team that we could call the senior management  
23 team. That took me six, seven, eight months to do.  
24 Before I could really start looking at improvement,  
25 I had to get a substantive team in senior management.  
26 It goes back to your point about turnover. That was  
27 the situation that I was in. Once I had that, then we  
28 could start to look at what potential opportunities  
29 there were. Certainly working with the Governance

1 committee and working with Dr. O'Kane when she came in  
2 was to look and see what is the information we could be  
3 providing to the Governance Committee, and what  
4 information we can start to bring to the senior  
5 management team. It took me until January 2019 to get  
6 a team around. I came in in March 2018. That was the  
7 initialing timeframe. We quickly got on to then at  
8 that point we need to look at governance in its  
9 holistic approach, and that's when myself and Maria  
10 agreed to bring June Champion in, and agreed to look at  
11 the review. Before that was finished we were beginning  
12 to say the main areas are complaints, SAIs, and very  
13 much looking at standards and guidelines. We didn't  
14 wait for the overall report to come in. We were  
15 already starting to work on some of that. Then we were  
16 regularly looking at reviewing the governance reports  
17 and the performance reports, hence the creation of the  
18 performance committee, to understand are we getting the  
19 right information. Of course, I would like that to  
20 have been quicker, but the reality is I didn't have  
21 a team in place to begin with to begin to move that  
22 stuff forward.

23 94 Q. I think what you said in your witness statement is that  
24 a major catalyst for instigating this independent  
25 review was the revelations from the Cawdery Serious  
26 Adverse Incidents.

27 A. Yes.

28 95 Q. I don't think we need to open this in any detail,  
29 but at WIT-00070 you reflect there that the approach to

1 that SAI in terms of its terms of reference or its  
2 focus just wasn't specific enough on some of the  
3 issues. It tended to focus on the client as opposed to  
4 the implications for the victims of that incident.  
5 You would have discussed your concerns about governance  
6 with Dr. O'Kane as well.

7 A. Mm-hmm.

8 96 Q. She seems, in her witness statement, or one of her  
9 witness statements at WIT-45185, she reflects concerns  
10 about what she describes as the paucity of the  
11 functions usually associated with providing a robust  
12 system of governance. She says she brought those to  
13 your attention and you supported the commissioning  
14 of June Champion to investigate and report. Let's just  
15 look at her report. I suppose, the executive summary  
16 -- it is a lengthy report and obviously time doesn't  
17 allow us to look through it in detail. Let's look at  
18 the executive summary at WIT-00509. If you can help  
19 us. What was, in broad terms, your interest in  
20 securing a report from Mrs. Champion?

21 A. Certainly. If I can go back to the point that you made  
22 about the Cawdery situation. If I can explain why that  
23 triggered for me the alarm bells that I felt it was  
24 important I dug deeper into this. Going back to this  
25 issue of Directorates looking at governance rather than  
26 the organisation looking at governance, the first time  
27 I was involved in the SAI process for Cawdery, and  
28 I must stress, it started before I joined so therefore  
29 I couldn't have been involved very early. The first



1 point I was involved and, therefore, I would argue  
2 Corporate Governance was involved was when the report  
3 was finalised and presented to me as Chief Executive.  
4 That triggered an alert to me, which is this is not an  
5 SAI where learning and improvement only lies in the  
6 Mental Health Directorate, it is, in fact, learning and  
7 improvement that is for the whole of the organisation.  
8 That triggered my concerns because, actually, if we  
9 were looking at the Clinical and Social Care Governance  
10 as an organisation, then those kind of conversations  
11 would be having had at an organisational level, not  
12 at directorate level. There were secondary issues with  
13 regards to the Cawdery report, which I'm not going into  
14 detail, you have that. Clearly I, along with the  
15 Public Health Agency, instigated a second report on  
16 that. Putting that to the side, that was the trigger  
17 when then got me to think, why don't we have  
18 a corporate -- I'm going to call it a corporate  
19 approach to Clinical Governance. I know that confuses  
20 the terms of Corporate governance and Clinical  
21 Governance, but a corporate overview of Clinical and  
22 Social Care Governance. That's when I spoke to Maria,  
23 who had been in post a matter of a few months, and  
24 we agreed that it was important to really open up  
25 governance. Are we managing governance, both Clinical  
26 Governance and Corporate Governance, in the best way  
27 for the whole of the organisation? Because what was  
28 clear to me was that it was being managed within the  
29 units not as a whole organisation, and if we were to

1 drive -- going back to the Board Assurance Framework  
2 conversation we had earlier, if you were to drive to  
3 the overall outcomes of the system with regard to  
4 safety and quality, that was not being connected, it  
5 was being stuck in that process. That was the  
6 conversation I had with Maria O'Kane and we had agreed  
7 we wanted to look at both the wider aspect of Clinical  
8 and Social Care Governance and how that fit, and how  
9 that was fitting into the overall organisational  
10 governance environment, the integrated governance  
11 environment, hence why we wanted independent review and  
12 we had spoken and secured June Champion through the  
13 Leadership Centre to do that. June had been heavily  
14 involved in the implementation of a number of the  
15 improvements of the hyponatraemia outcome, and we were  
16 both, myself and Dr. O'Kane were very aware of June,  
17 having worked with June in perviously in previous  
18 organisations.

19 97 Q. The executive summary helps to orient us. The first  
20 paragraphs deal with the background. The third  
21 paragraph reflects the input from what she refers to as  
22 senior stakeholders within the organisation, giving  
23 some of the background. Down to the fourth paragraph,  
24 please. It describes senior stakeholders identifying  
25 a lack of connectivity across the existing governance  
26 structure and a lack of a robust assurance and  
27 accountability framework, which added to the perception  
28 that the core elements of the integrated governance  
29 were being delivered in silos with various reporting

1 lines. what she's talking about now is a proposed --  
2 my screen keeps lapsing on me. Is it the same?

3 CHAIR: I think our screens are fine. It may be an  
4 issue with --

5 A. It is the same for me, Chair.

6 CHAIR: I am just wondering, it might be an appropriate  
7 time to take a break and we can get the technicians to  
8 look at it. It is now almost a quarter to one. If  
9 we break for lunch and come back at a quarter to two,  
10 if that's suitable to everyone.

11 MR. WOLFE KC: Just to be clear, it blinks off every  
12 few seconds.

13 CHAIR: Yes. If we leave the AV operators here, you  
14 can try it out over the lunch break and see what  
15 happens.

16 MR. WOLFE KC: Very well. Thank you.

17

18 THE INQUIRY ADJOURNED FOR LUNCH AND THEN RESUMED AS  
19 FOLLOWS:

20

21 CHAIR: Good afternoon, everyone. Hopefully the  
22 technological issues have been resolved and we can  
23 continue on. If anybody does have any difficulties  
24 with any of the technology, please let us know, because  
25 it doesn't seem to apply across the board to everyone.

26 MR. WOLFE KC: Yes.

27 98 Q. Could we have up on the screen, please, WIT-00509,  
28 please. You'll recall, Mr. Devlin, we were looking at  
29 the Executive Summary of Mrs. Champion's report. I was

1 looking at a section -- just scroll on, please. I was  
2 reading from that part of the paragraph which  
3 commenced:

4  
5 "Senior stakeholders identified a lack of connectivity  
6 across the existing Governance Structure and a lack of  
7 a robust assurance and accountability framework which  
8 added to the perception that the core elements of  
9 integrated governance were being delivered in silos at  
10 various reporting lines."

11  
12 She then turns to a proposed revision of a good  
13 governance structure, and that will provide the Trust  
14 with an assurance and accountability framework which  
15 will address the concerns expressed. Is that what you  
16 had in mind, Mr. Devlin, when you were explaining the  
17 confederate --

18 A. Correct.

19 99 Q. -- centralised dichotomy?

20 A. It was. It was.

21 100 Q. You want to move to a more centralised or corporate  
22 views of Clinical Governance?

23 A. I think it was important not to take away the  
24 responsibility at the local level for Clinical and  
25 Social Care Governance. It was not an attempt to  
26 centralise everything, but it was an attempt to get  
27 line of sight into the centre and to have some control  
28 in the centre. You can't run an organisation's  
29 Clinical and Social Care Governance from an office

1            somewhere in the centre. It has to be local. But  
 2            it didn't have both of those and, therefore, what I was  
 3            hoping to get from the review is an appreciation that  
 4            we need something in the centre as well as having  
 5            tentacles out into the organisation.

6 101 Q.    If we go down the page to 510 in the series. I think  
 7            I'm right in saying -- yes, Mrs. Champion is pointing  
 8            out there are some good aspects already in place. You  
 9            weren't, I suppose, to use the old phrase, wanting to  
 10           throw the good out with the bad.

11           A.    No. No.

12 102 Q.    Here she says:

13  
 14           The core elements that underpin a good governance  
 15           framework, strategic and operational systems of  
 16           internal control and processes were evaluated against  
 17           best practice guidance.

18  
 19           She goes on to say: The analyses demonstrating good  
 20           building blocks are in place.

21  
 22           That's what you wanted to keep --

23           A.    Absolutely.

24 103 Q.    -- but changing the structure. As I say, it is a bit  
 25           of the race through this so the Inquiry is orientated  
 26           to the significance of the report as a starting point  
 27           for the reform I'm going to ask you to explain in  
 28           a moment.

29

1 Just before we do so, just down the page to 511, she  
 2 sets out the categories of the 48 recommendations that  
 3 are set out then commencing at WIT-00560. That's where  
 4 she sets out the recommendations in an appendix in some  
 5 detail.

6  
 7 I just want to draw some attention to this first  
 8 section of Board governance, because that was to become  
 9 a controversy with Mrs. Brownlee and I want to bring  
 10 that out in a moment. You can correct me if I'm wrong,  
 11 I think if we go to recommendations 45 and 46 at  
 12 WIT-00564. Am I right in saying that those two  
 13 recommendations in particular, and perhaps there are  
 14 others, gave the momentum to what the Trust was to do  
 15 next, which was to scope out a new model?

16 A. That's correct.

17 104 Q. Particularly 46, I think. The Trust should ensure the  
 18 Directorate reporting arrangements are included in  
 19 a review of Trust Board subcommittee structure and the  
 20 review of SMT Terms of Reference.

21  
 22 That was to give birth, ultimately, to the Learning For  
 23 Improvement Directorate?

24 A. And the Performance Committee.

25 105 Q. And the Performance Committee?

26 A. Also, then, the weekly approach to the dynamic  
 27 governance that I described earlier.

28 106 Q. Yes. Just before we get to -- the Trust scoped that  
 29 out, and there's another document I'm going to refer

1 you to. There was some dissent in respect of these  
 2 recommendations, and I want to take your view on it.  
 3 If we turn to WIT-00583. Take me to 582 first so I can  
 4 show the Inquiry the opening page. It's maybe down  
 5 a page again, 581. Yes. Thank you.

6  
 7 These are the notes of a Director's workshop. You  
 8 brought everybody together at Board headquarters to  
 9 discuss the Champion recommendations and how they might  
 10 be taken further; is that fair?

11 A. That's correct. Yes.

12 107 Q. Then if we go to 583, down a couple of pages, please.  
 13 00583, please. The Chair, who was at that time Roberta  
 14 Brownlee --

15 A. That's correct. Yes.

16 108 Q. -- she makes remarks towards the start of the meeting.  
 17 Stated that: Mindful of Board behaviours that all  
 18 members subscribe to and the spirit and honesty as  
 19 Chair of the Trust Board she felt very offended by the  
 20 report in how it was written in relation to Trust  
 21 Board. For example, she was named as a contributor  
 22 when, in fact, she had not been involved and only met  
 23 the author at the final draft stage. Whilst she agreed  
 24 with the Chief Executive that he can undertake a review  
 25 at any time, she understood that it was a review  
 26 specific to Clinic and Social Care Governance, yet it  
 27 went wider -- as we've seen from the recommendations,  
 28 albeit briefly -- it went wider than in its Terms of  
 29 Reference and strayed into Corporate Governance which

1 she felt should have involved herself and the  
2 non-Executive directors. She made the point that the  
3 Trust Board has responsibility to ensure the Trust has  
4 effective systems in place for governance, therefore it  
5 was important for the Trust Board to have discussion on  
6 the report and an agreed way forward.

7  
8 Did she have a point that the report of Mrs. Champion  
9 had strayed into an area of Board competence when, as  
10 she seemed to reflect, the Board and its nonexecutive  
11 directors weren't adequately consulted about it?

12 A. I think there is a point, but let me explain -- if  
13 I can explain around that point. I felt very strongly  
14 that we needed to understand what was working with  
15 regard to governance. I said earlier in my evidence,  
16 Clinical and Social Care Governance cannot be looked at  
17 in isolation of overall organisational governance. It  
18 is a physical impossibility to do so. I had raised  
19 with the Chair that we were carrying out this report  
20 and that I was keen we moved forward on that. I had  
21 offered the Chair the opportunity to be interviewed  
22 by June Champion, which happened. Clearly, in  
23 hindsight, I could have done a lot more with the Chair  
24 and the non-execs in advance to warm them up to the  
25 report. So I totally appreciate the point she was  
26 making. The point I was making was as Chief Executive,  
27 and you saw my job description earlier, with ultimate  
28 responsibility for systems and processes within the  
29 organisation, I felt it was important to do an



1 independent review and to take those independent view  
2 takings back to myself and the Trust Board, etcetera.  
3 I felt I had engaged with the Chair by letting her know  
4 we were doing the report and also with the author of  
5 the report, June Champion, being able to interview her,  
6 and other non-execs. But I think very strongly you  
7 cannot have a review of Clinical and Social Care  
8 Governance without having a review of overall  
9 governance of the organisation. I cannot suggest what  
10 would have happened if there had been different  
11 outcomes, but if it had been a report that said the  
12 outcomes were glowing and everything was fine,  
13 I suspect this would not have been the reaction. The  
14 reaction was that it highlighted a number of challenges  
15 that I, as Chief Executive, needed to take on Board, my  
16 colleagues, my exec team colleagues and my non-exec  
17 colleagues needed to take on Board. There is a point,  
18 I could have done more at the beginning of the process,  
19 but it doesn't take away my responsibility to make sure  
20 the processes are sound within the organisation.  
21 I felt I gave non-execs the opportunity to be involved  
22 in the process by being interviewed as part of the  
23 process, and I feel, as you can see from the minutes,  
24 I think the recommendations were fair because we did  
25 not have a perfect system of governance. The fact  
26 we're sitting here today, we did not have a perfect  
27 system of governance.

28 109 Q. You were able to move forward from this dispute, if  
29 I can put it in those terms, by agreeing only to

1 progress some of the recommendations but leaving --

2 A. That's correct.

3 110 Q. -- in abeyance those affecting the Board level.

4 A. 1 to 13, if I remember correctly, and I would have to  
5 go back to the report, are areas we didn't agree to  
6 take forward. For me, there was enough in the report  
7 that I needed to get on with with my new team, with  
8 Dr. O'Kane and the Director of Nursing that I needed to  
9 get on with, that I wanted to take forward. I came to  
10 the conclusion that I would get to the others.

11 I couldn't predict we were going to have a global  
12 pandemic and all kind of things, I believed I could get  
13 to the others pretty quickly, that clearly couldn't be  
14 the case because other things happened. But I did, to  
15 try to move the process forward, agree that we would  
16 not address items 1 through 13, I think.

17 111 Q. You reflect in your witness statement a degree of,  
18 I suppose, coldness or --

19 A. Yeah.

20 112 Q. -- less than good working relationships between you and  
21 Mrs. Brownlee on occasion?

22 A. Yes.

23 113 Q. Is this the primary example?

24 A. That is one occasion. I think it is fair to say that  
25 on this particular occasion there was a coldness, and  
26 I'm sure if you speak to other members of that Board  
27 meeting they might reflect that as well. That is not  
28 a complete reflection of my relationship with the Chair  
29 for the full time I was there. We had many

1 a productive Board meeting, as you can see from some of  
2 the other evidence I have provided. But there were  
3 periods of coldness, to use the term that's been used,  
4 and this would be one of those. Because I did feel  
5 very strongly that if we were to be a learning  
6 organisation, and to really drive improvement, then  
7 we had to learn how to take criticism. This was not  
8 a cold critical report but there were criticisms in  
9 that report and I felt we needed to take that on the  
10 chin and be a learning organisation. I felt the  
11 reaction in that meeting --

12 114 Q. Sorry to cut across you. Reservations were shared by  
13 other nonexecutive directors. I think they are  
14 reflected in the minute to some extent.

15 A. Yes.

16 115 Q. In general did this dissent hamstring your ability to  
17 take the organisation in the governance direction that  
18 you wished, or setting the first 13 recommendations to  
19 one side to go back to, was, nevertheless, a natural  
20 way of going about things, in any event?

21 A. I think, on reflection, I would like to have got more  
22 of those first 13 approved at that point in time,  
23 because I think, to go back to my original point,  
24 Clinical and Social Care Governance and Corporate  
25 Governance is not a separate entity. Therefore, to  
26 move forward with those considered Clinical and Social  
27 Care Governance without really challenging the  
28 architecture of governance, I think was not  
29 a successful as I wanted it to be, but sometimes you

- 1 have to go with something that gets movement as opposed  
2 to dig your heels in and actually get no movement.  
3 I felt it was the right way to go. I genuinely  
4 believed we would get to the others if I had time to  
5 work on convincing people. As I say, unfortunately,  
6 then the world changed slightly not long after that.
- 7 116 Q. Yes. Let's just go briefly to the scoping out of the  
8 recommendations which were the subject of a document  
9 later in the year. If we go to just the cover page of  
10 the document to orientate ourselves. WIT-00589,  
11 please. This is a document produced by your Governance  
12 team, presumably?
- 13 A. Primarily by the governance team supported by  
14 Dr. O'Kane. It was a document we discussed in detail.
- 15 117 Q. Yes. For present purposes, I know there's a lot in it,  
16 but one of the key changes or one of the key debates  
17 was between retaining what was then the current model,  
18 which it's described within the document as  
19 a distributed Clinical and Social Care Governance  
20 model.
- 21 A. That's correct.
- 22 118 Q. And the alternative, which I assume you were putting  
23 your weight behind, which was a corporate business  
24 partner model?
- 25 A. That's correct.
- 26 119 Q. We'll just look briefly at that, and the Inquiry can  
27 review the detail of that in its own time. Just  
28 looking at the extant model, as it was at that time,  
29 the distributed model, WIT-00596. The model was each

- 1 Directorate had a Director who was responsible for the  
2 Governance portfolio and reported to the Medical  
3 Directors; is that right?
- 4 A. No. Each Director had responsibility for the complete  
5 functioning of the Directorate. Within that area there  
6 was a Governance Coordinator, who was a senior manager,  
7 who would have had a professional governance line to  
8 the Medical Director. But the Director was responsible  
9 for everything within the Directorate, whether that be  
10 performance, staffing, delivery -- everything. They  
11 had a team and on top of that team was a governance  
12 coordinator, who was a senior manager.
- 13 120 Q. Yes. The features of that system or that arrangement  
14 are set out there. Going over the page to 597, some of  
15 the -- I suppose the disadvantages that you were seeing  
16 in that model were the -- I suppose across the  
17 Directorate there's different ways of doing things?
- 18 A. That's correct.
- 19 121 Q. Whether it was the screening process for an SAI  
20 identification. You might have an HSCB handing down  
21 a guidance document but, on the ground, in practice,  
22 within directorates you were seeing some disparity?
- 23 A. I think what it drove was variation because the  
24 directorates had been allowed to grow up over time --  
25 that happens in organisations -- grow up in time and  
26 therefore there was not a corporate standardised  
27 approach that was managed and monitored. There was  
28 local flavour which could drive variation. I suppose  
29 one of the obvious indicators of that variation was the

1 length of time that some of the things took in  
 2 different directorates. You could have had in  
 3 Community Services a Serious Adverse Incident taking  
 4 a very short length of time. You could have SAIs in  
 5 Mental Health taking a very long time. The reason was  
 6 the amount of resource each directorate would give that  
 7 that process was different. Therefore, having local  
 8 ownership drove variation, and we all know variation  
 9 can be the cause of harm. That was a big thing for me  
 10 was to try to drive out variation.

11 122 Q. Yes. One of the big drivers of the proposed change was  
 12 visibility, visibility of issues to the senior  
 13 management team.

14 A. Correct.

15 123 Q. If we just scroll down to look at some of the features.  
 16 I suppose that's a summary paragraph at 20:

17  
 18 The lack of standardisation of systems and processes  
 19 across directorate teams inhibits the ability for clear  
 20 corporate quality assurance and oversight.

21  
 22 Then the benefits of a corporate business partner model  
 23 are set out. Before we go to those, perhaps it would  
 24 be helpful to look at the organigram that you set out  
 25 in your statement. It is quite a complicated one set  
 26 out. Perhaps we'll go to the one in your statement  
 27 first at WIT-00033. I think, in the context --

28 A. Sorry, that's the proposed structure at that point in  
 29 time as opposed to the as-is structure.

- 1 124 Q. Yes. As I understand it, this is coming in this year.  
 2 I'm not sure if Mrs. O'Kane was asked about this  
 3 yesterday, but this is the plan.
- 4 A. It is. What I would say is that some parts moved  
 5 ahead. The likes of the Learning For Improvement  
 6 within the Executive Medical Directorate, in the  
 7 middle, a lot of the issues around SAIs, complaints,  
 8 etcetera, moved ahead in advance of the formal  
 9 structure being put in place because there were things  
 10 we wanted to put in place. This certainly was the plan  
 11 to appoint those individuals.
- 12 125 Q. Yes. Just talk us through this structure. I think, as  
 13 you've described it, all of the governance-related  
 14 issues ultimately, using this structure, flow to the  
 15 Medical Director?
- 16 A. All of the governance-related issues as per the local  
 17 Directorate Governance absolutely flow through the  
 18 Medical Director. What I would say is that the  
 19 responsibility for service delivery in the Directorate  
 20 still lies with the Director who is delivering. It is  
 21 important that -- it is not that the Medical Director  
 22 would take on all responsibility for all services, that  
 23 couldn't be the case, but certainly for Clinical and  
 24 Social Care Governance of those services.
- 25 126 Q. From her we see all these various boxes?
- 26 A. Correct.
- 27 127 Q. -- items of governance, including SAIs, including  
 28 audit, including complaints and compliments; all these  
 29 things go into this new Directorate?

1 A. That's correct.

2 128 Q. Headed by the Medical Director who then has a direct  
3 line into the senior management team and your office?

4 A. And my office.

5 129 Q. Yes. If we just go back to the scoping document that  
6 we were looking at at WIT-00597. The bottom of the  
7 page, please. We see the potential benefits of this  
8 include:

9

10 Corporate overall oversight of all clinical and social  
11 care governance processes including -- those listed  
12 there -- allowing depth of governance function to  
13 ensure that staffing levels remain commensurate with task  
14 requirements, a standardised focus on the elements of  
15 clinical social care governance and on those elements  
16 making up Learning and Improvement and Standardisation  
17 of Processes across service areas in those fields.

18

19 Just scroll down, please.

20

21 Benefits for monitoring of Learning and assurance of  
22 implementation, with the triangulation of data to  
23 inform improvement plans and Learning. Benefits for  
24 recording and development of action plans in response  
25 to those various bodies including RQIA. Processes  
26 governing the identification and implementation of  
27 standard and guideline processes. Benefits  
28 for Trust-wide standardised staff training and  
29 management of managing and responding to complaints.



1 It is your understanding that that has been has  
2 approved and is to be implemented in the course of this  
3 year?

4 A. It was approved before I left, so it was one of the  
5 very last things I took through Trust Board and,  
6 therefore, it is now my understanding, being  
7 implemented. As I say, there are elements of it that  
8 was being implemented along the new approach to  
9 complaints, the new approach to SAIs, the new approach  
10 to standards and guidelines, etcetera, irrespective of  
11 the new structures were being implemented because they  
12 were identified in the governance review and agreed at  
13 the meeting, that special governance meeting as really  
14 important things to move forward with now, particularly  
15 learning from the SAI processes, not necessarily within  
16 Urology but across the whole Trust.

17 130 Q. Have you thought about how would a structure such as  
18 this, this change of structure, improving consistency  
19 and standardisation, giving greater visibility to the  
20 senior management team of emerging governance issues;  
21 have you reflected on how, if at all, that would have  
22 impacted on any of the matters that this Inquiry is  
23 concerned about?

24 A. Certainly. I think one of the important elements of  
25 this structure is that single point of coming together  
26 of all of the information and, therefore, anything to  
27 do with Managing High Professional Standards or  
28 complaints or incidents, etcetera, would be discussed  
29 at that -- the screen would need to be moved up

1 slightly -- but at that level just below this box. So  
2 what you would then have is you would have an Assistant  
3 Director of Clinical and Social Care Governance for the  
4 whole organisation who would be managing the local  
5 governance coordinators and, therefore, at the  
6 governance meetings, where you would be looking at  
7 indicators, you would be looking at who has been  
8 excluded, all those kind of things, there is a single  
9 eyes-on, which is the Assistant Director of Clinical  
10 and Social Care Governance, who is looking into those  
11 meetings. Therefore I'm not saying it would be  
12 failsafe, because obviously this is future proofing,  
13 what I am saying there would be a much greater chance  
14 of understanding the signals because there was  
15 a central approach to coordinating governance across  
16 the whole of the organisation. Therefore, I think we  
17 would have had line of sight but also a vehicle to  
18 check and challenge, which is really what this is also  
19 about. It is having a vehicle for the Medical Director  
20 to check and challenge through the organisation.

21 131 Q. I suppose it is right to reflect that even an improved  
22 structure such as this isn't a panacea?

23 A. No, not at all.

24 132 Q. If the information isn't coming out of the area on the  
25 ground where the problem is, whether because the  
26 culture isn't right, people aren't speaking or not  
27 being encouraged to speak, or because the data isn't  
28 there because it is not being tracked or there's  
29 insufficient audit arrangements, then that doesn't

1 percolate up to a Head of Service and it doesn't reach  
2 the Medical Director?

3 A. I absolutely agree with that point. I think what this  
4 would have allowed us to do is where you would then  
5 start to see silence, you can then begin to ask  
6 questions. For a structure to work you need to have  
7 the architect for the structure, you need systems, you  
8 need data and you need culture, and those three come  
9 together. If, in this situation, one of those four  
10 acute governance areas were not regularly producing  
11 data, or were not regularly questioning, or were not  
12 regularly showing improvement, having that eyes-on you  
13 would then be able to say, why am I not getting it?  
14 I expect every Thursday when you come to the Trust-wide  
15 governance meeting you are coming with details of SAIs  
16 from last week, complaints from last week, incidents  
17 from last week, challenges from last week. If they  
18 weren't coming, I think you would start to say, what is  
19 happening. I agree with you, it is not the panacea,  
20 structures are the processes, data and culture, but  
21 actually this would have given eyes-on to be able to  
22 ask the question, well, why am I not seeing the data  
23 that I thought I should be seeing?

24 133 Q. You said quite properly, you reminded me several times,  
25 I think, quite properly, that it is not just about this  
26 change of structure under your watch. You were able to  
27 get on with other things, such as how SAIs should be  
28 dealt with, and that kind of thing. We discussed  
29 earlier, briefly, the CSCG report, the Clinical and

1 Social Care Governance report goes to the Governance  
2 Committee. We've all looked at the reports. Lots of  
3 data. Lots of reports on trends, statistics of that  
4 nature. What, if anything, is happening differently,  
5 for example, around SAIs and how they are looked at  
6 within the Governance Committee that wasn't the case  
7 before these changes were made?

8 A. Okay. The approach to SAIs, the approach that we took  
9 was to, first of all, try to standardise our approach.  
10 So there's a separate document, and I hope it is in the  
11 evidence bundle, which was the approach to SAIs. If it  
12 isn't I can certainly make sure that it is. It was  
13 approaching saying this is how we should do SAIs.  
14 I appreciate there's standard guidance but this is how  
15 we should do it. That was the first improvement with  
16 standardisation, with a big focus on user patient  
17 client care engagement, because that was a big bit that  
18 really wasn't as strong in the original guidance.  
19 In terms of them coming to the Governance Committee, as  
20 it's called, what that allowed us to do was to bring to  
21 the Governance Committee a section in that report that  
22 talks about SAIs, it allows us to say how many more  
23 have come on, how many have gone off, also then to  
24 summarise the immediate learning from the SAI, and also  
25 to be able to reflect on potential further learning.  
26 I think that was a process that was just really  
27 starting to be embedded. It did allow the non-exec  
28 members to challenge and question. I think if you were  
29 to look through the minutes there were some challenges

1 and questions. I think there is a further -- when  
2 I left there was a further journey on that to get  
3 a greater line of sight into the learning from the  
4 SAIs. I don't mean surfacing the knowledge but  
5 actually implementing change. That probably wasn't as  
6 fully embedded in the governance group or the steering  
7 group, as could be. I think that's still an  
8 opportunity for improvement, really embedding the  
9 learning into the Governance Committee.

10 134 Q. Certainly it was my impression of reading the CSCG  
11 reports, they come to the Governance Committee, as  
12 you've said -- this isn't meant to sound as  
13 pejoratively as it might, quite turgid in terms of the  
14 statistical detail, that kind of information. But you  
15 would struggle to see how the problem, such as  
16 a failure to Triage which might be at the core of an  
17 SAI report, or the failure to comply with whatever  
18 guidance, for prescribing or allocating a nurse to  
19 a cancer patient, you struggle to see how that learning  
20 emerges and is then shared. Is there more focus on  
21 these quality and improvement type issues at governance  
22 than there was before?

23 A. I think there's more focus, but I agree with your point  
24 in terms of it doesn't draw out the learning in the way  
25 it could draw out that learning. That's what I'm  
26 saying. I think there's further improvement in that.  
27 There's probably opportunity to reflect on not just the  
28 SAI. The way it is reported is an SAI, probably to  
29 look at thematically what happened in the last year,

1           etcetera, we were not at that point doing those kind of  
2           things.

3   135   Q.   That's the ambition?

4           A.   It was certainly my ambition.  But I imagine it  
5           probably remains Maria's ambition.

6   136   Q.   I hope I have dealt fairly and sufficiently with some  
7           of the changes, and the Inquiry will, no doubt, reflect  
8           whether it needs to hear more on that and will decide  
9           whether further evidence is needed in due course.

10          I want to move on and look at, specifically, what was  
11          going on in Urology, try to get to grips with what you  
12          knew and when and how you responded to it.

13

14          How would you characterise your role in connection with  
15          the shortcomings associated with the Trust's Urology  
16          Services?

17          A.   In terms of my connection with the shortcomings, over  
18          the period of 2018 and 2019 my connection was very  
19          loose.  I explained how and why, but I think it's fair  
20          to say that when I came into post there were clear  
21          things that I needed to get on with, articulated by my  
22          predecessor, etcetera, articulated by the Board, and  
23          that didn't include the challenge in Urology.

24          Therefore, my connection with Urology primarily began  
25          when the then Medical Director, Dr. Khan raised to  
26          me -- I think possibly August, it could have been  
27          September but I think it was August -- the coming to  
28          the conclusion of the MHPS process, and then certainly  
29          in September raised to me the outcome of that process.

1 I had not been involved up until that point at all, not  
2 been raised to me at all at that point. My focus was  
3 very much on those areas building the team but also  
4 addressing the issues identified to me when I came into  
5 the organisation.

6 137 Q. Mr. McNally was your predecessor?

7 A. Stephen McNally was my predecessor.

8 138 Q. I think you shared with us recently a note, it is  
9 described as "continuing issues." Just open that for  
10 a moment. WIT-90985, please. Could you help us  
11 identify that document?

12 A. Yes, certainly. That was the document that Stephen  
13 gave me and we met, and he talked me through it for  
14 about an hour.

15 139 Q. Was that the hand-over document?

16 A. Yes.

17 140 Q. At a hand-over meeting with Mr McNally?

18 A. With Stephen, yes, before he was leaving, yes.

19 141 Q. If we just scan through it, please. Paediatrics,  
20 hyponatraemia fall out, the report had just been issued  
21 in January?

22 A. It had in January. The specific issue that Stephen was  
23 raising to me is obviously one of the young children  
24 who was part of that Inquiry was a patient of the  
25 Southern Trust, and Stephen was making me aware of  
26 that, and also the mother of that patient wanted to  
27 meet with me and the clinician.

28 142 Q. Some of these things are public knowledge. Obviously  
29 the Cawdery killings was raised with you.

1 A. That's Dr. A referred to in the Trust Board meeting.

2 143 Q. Yes. A whole area of elective cancellations, and  
3 various other specific incidents, 6 and 7, medical  
4 revalidation, and issues to do with --

5 A. Private GP practice.

6 144 Q. Thank you. I don't think there's another page.

7 A. No, that's it.

8 145 Q. Yes. They were being introduced to you as key issues  
9 that you need to get to grips with quite quickly.

10 A. That's correct.

11 146 Q. These were the priority areas?

12 A. Absolutely.

13 147 Q. Not the only priority areas, no doubt, but the ones  
14 that Mr. McNally was apparently dealing with and you  
15 needed to hit the ground running with them?

16 A. That's correct. Some of them became very large issues.  
17 The Cawdery murders and the SAI's, etcetera,  
18 particularly elective care became an enormous issue,  
19 elective cancellations, but all nine of those were  
20 issues that needed to be addressed.

21 148 Q. Nothing, as we see in this document, about Urology  
22 Services, nothing about the commencement of an MHPS  
23 investigation in respect of Mr. O'Brien?

24 A. No, nothing..

25 149 Q. As you tell us in your witness statement, certainly  
26 within a few months Mrs. Toal was speaking to you about  
27 Mr. O'Brien's practice. We'll come to that in  
28 a moment.

29



1

2

Given you were, I suppose, at that point a stranger with anything to do with the issues in Urology in the broadest sense, including any concerns about Mr. O'Brien's practice, what would you regard as the, if you like, the test or the trigger which your staff ought to have been aware of for bringing issues or matters of concern to your attention?

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A. Most directors would have brought to me -- because I would have met directors on a one-to-one basis every month, so most directors would bring to me those issues that they felt were new and were causing a potential Patient safety harm, a finance deficit, the various things that you would expect. So I would expect a director to bring to me new things that were coming up but, also, if there were things they were actively working on that they were challenged by or were concerned they couldn't deliver, I would also have expected them to bring to me that. And they did. They did on a regular basis. Particularly around operational issues of winter, for example, Unscheduled Care, etcetera. They did and we had lots of conversations, as I say, on a monthly basis about issues that they needed to raise to me.

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150 Q. They should unload their in-tray on to your desk, albeit at different levels of detail, depending on the issue, or do you expect them, I suppose, to be more selective? Directors are paid to manage.

26

27

28

29

A. They have to be selective. Ultimately, if I were to do

1 everyone's -- to do all the in-trays, as you describe,  
 2 that's a dysfunctional operation. These are directors,  
 3 they have job descriptions, they have roles, etcetera.  
 4 What I was asking of them is if there are things they  
 5 are concerned they cannot deliver, or they are  
 6 concerned that raise a risk, financially, Patient  
 7 Safety, etcetera, then we have that opportunity.  
 8 Directors did. If we take the Director of Children's  
 9 Services, it was a regular basis that the Director  
 10 would talk to me about looked-after children that they  
 11 were concerned about, or whatever the case may be. But  
 12 it is not their job to offload their in-tray to me.  
 13 Far from it. It is their job to do their job. Many  
 14 raised to me when they felt they needed to raise to me.

15 151 Q. Let me take a moment to recap on what had gone before  
 16 your appointment and what was to continue in relation  
 17 to Urology after your appointment up to June/July 2020,  
 18 so we have that contextual framework.

19  
 20 You've told us that Mrs. Toal came to you. You are not  
 21 able to put a date on it, and you don't have a record  
 22 of it, so far as I can establish?

23 A. No.

24 152 Q. She came to you and expressed concerns in relation to  
 25 Mr. O'Brien's practice?

26 A. She raised to me, as part of my regular meetings with  
 27 Vivienne and all Directors, she wanted to raise to my  
 28 attention there was an MHPS case ongoing, and that was  
 29 Mr. O'Brien, and raised to me that it was Ahmed who was

1 the case manager, and I should expect to see an outturn  
2 of that case within a matter of months.

3 153 Q. She gave you detail about the scale of the issues in  
4 relation to triage, dictation --

5 A. Correct.

6 154 Q. -- private patients, retention of notes, etcetera?

7 A. Yes.

8 155 Q. In speaking to you, that suggests, I suppose, what  
9 I called the trigger. There is a trigger of concern  
10 and that's a Patient Safety concern associated with  
11 practice that you needed to be aware of?

12 A. That's certainly what I would interpret Vivienne  
13 speaking to me about.

14 156 Q. When you come into post the MHPS investigation was  
15 about a year old. You may not have known that  
16 immediately.

17 A. No.

18 157 Q. It reports in June '18 in terms of the investigation,  
19 and then a determination is made in late September by  
20 Dr. Khan?

21 A. Yes.

22 158 Q. You come into it. Mrs. Toal has spoken to you in  
23 advance of that, but you come into it with Dr. Khan at  
24 that point. We'll look at that.

25 A. Yes.

26 159 Q. The determination isn't progressed because, at least in  
27 part, I understand the grievance of Mr. O'Brien issued  
28 in November 2018 stymied that. Also going around at  
29 that time Dr. O'Kane is appointed Medical Director in

1 December '18, and in March '19 Mr. O'Brien is reported  
2 to the General Medical Council by Dr. O'Kane. During  
3 2018 and throughout 2019 there are episodic concerns  
4 expressed between the Head of Service in Urology and  
5 the Associate Medical Director and encompassing  
6 Dr. Khan, that there has been departures from the  
7 monitoring plan which had been put in place in respect  
8 of Mr. O'Brien. We'll look at aspects of that.

9  
10 I suppose what the Inquiry is aware of, certainly, from  
11 some of the evidence it has received, and there's more  
12 evidence to be received, that there isn't an appearance  
13 of actively challenging Mr. O'Brien in relation to  
14 these matters. All of the evidence is yet to unfold  
15 and the Inquiry will look at that. Come January 2020,  
16 concerns are being expressed in relation to the  
17 reliability of the data available to the monitors of  
18 Mr. O'Brien and questions are being asked about  
19 whether, given the weaknesses identified in that data,  
20 whether challenges can be made to Mr. O'Brien; all the  
21 while there are these difficulties in achieving  
22 compliance. Set beside that are a number of new  
23 adverse incidents arising out, at least in part of  
24 Mr. O'Brien's care of patients. I'll come back to this  
25 just in a moment. There was an active Serious Adverse  
26 Incident investigation taking place arising out of  
27 events in 2016, and I know your attention was drawn to  
28 that. That's by way of context.

29

1 Let me take you to the conversations that you were  
2 having. As you have said, Mrs. Toal, as presumably  
3 part of her normal stock-taking type meeting with you,  
4 explains to you her concerns about Mr. O'Brien. Are  
5 those meetings typically unrecorded?

6 A. Yes. They would be one-to-one catch-ups, which would  
7 be supervision style, but it would be an informal  
8 conversation. I would record if there was any major  
9 decisions were made, but that wasn't the purpose of the  
10 meetings. It was an opportunity for directors to meet  
11 with me to share thoughts, comments, and then if there  
12 were things to be formally noted, then I would do so.  
13 I did not formerly note something from that meeting  
14 I had with Vivienne Toal.

15 160 Q. Would it be fair to say you had made no record at all  
16 of your engagement with Mrs. Toal in respect of  
17 Mr. O'Brien, Dr. Khan in respect of Mr. O'Brien, and  
18 Mrs. O'Kane in respect of Mr. O'Brien?

19 A. I would say no, I haven't. It was a series of  
20 conversations that then Maria, Vivienne and Ahmed would  
21 have taken action to take action. They would have left  
22 the room to take action.

23 161 Q. In terms of your dealing with Mrs. Toal, that was at  
24 a point when MHPS had yet to report, what was the  
25 upshot of that meeting?

26 A. It was part of a monthly meeting where I was starting  
27 to learn the organisation, learn what was happening,  
28 and I was asking directors what were important in their  
29 portfolio. It would have been part of that

1 conversation. Again, as part of me learning what was  
 2 happening in the organisation. I was three months into  
 3 the organisation at the time.

4 162 Q. Yes. Dr. Khan spoke to you at one point about his  
 5 ability to continue as --

6 A. That's correct.

7 163 Q. -- both case manager and medical director. Do you  
 8 remember that?

9 A. There was a series of emails, actually. I don't think  
 10 it would have been a formal conversation but there was  
 11 a series of emails where Ahmed did note the fact that  
 12 from a capacity perspective, primarily, he didn't feel  
 13 he could do both. But then my understanding, when he  
 14 came back following conversations he had with Vivienne,  
 15 I think, Vivienne Toal, he came to the conclusion it  
 16 was too late in the process to be withdrawing from  
 17 being the case manager, was my understanding.

18 164 Q. If we just put up on the screen WIT-00084. This  
 19 documents your meeting with Dr. Khan. He recalls that  
 20 -- you had regular meetings with him?

21 A. At least monthly. Often it would be slightly more  
 22 because Ahmed was new and I was new.

23 165 Q. Yes. He recalls that he kept you advised of MHPS  
 24 progress.

25 A. He did. He kept me advised in the short period of  
 26 time, and he would make me aware it was happening and  
 27 he would make me aware that he was coming to  
 28 a conclusion.

29 166 Q. Just in general, the MHPS process in this case

1 commencing with investigation March 2017, it had  
 2 a lengthy enough lead-in prior to that, Terms of  
 3 Reference to be agreed, change in the identity of the  
 4 case manager, etcetera. In your experience have  
 5 you seen an investigation take as long as this one,  
 6 through to late June the following year?

7 A. I would not have experience of an MHPS process taking  
 8 that long.

9 167 Q. Although you were aware of it at some point, you didn't  
 10 see the need to become involved --

11 A. No.

12 168 Q. -- to try to turbo boost the process?

13 A. No. I took assurance from Vivienne Toal, from Ahmed  
 14 that it was being managed, being processed, and  
 15 I didn't. It did not become a major area of focus for  
 16 me. I said that in the beginning and it is with  
 17 regret, with hindsight. But I did not see it in that  
 18 way. I saw it was a process about a doctor who was in  
 19 an MHPS process and I took assurance that both Ahmed  
 20 and Vivienne were managing that process. That's  
 21 a massive learning point for me.

22 169 Q. In one sense the Inquiry is generally, of course,  
 23 interested in MHPS as a stand-alone issue, and would be  
 24 happy to receive your observations on what you should  
 25 have done, or others should have done, to improve this  
 26 process?

27 A. In this particular case there is no doubt in my mind to  
 28 improve it I should have prioritised MHPS as a major  
 29 thing for the Chief Executive to become involved in.

1 what I was looking at were the nine or ten issues that  
2 I had taken over three months previous. What I was  
3 looking at was we were facing into a very difficult  
4 winter. I had challenges in the unscheduled care  
5 environment. I was also looking at real changes at  
6 Daisy Hill Hospital with regards to medical workforce.  
7 They were the things I was prioritising. Learning from  
8 that as a Chief Executive, MHPS is the thing that  
9 should be prioritised. I have to be 100% honest in  
10 that. Learning there if -- and it is unlikely in my  
11 future career where I am now, but if an MHPS case were  
12 to come across my desk it would be a priority. It  
13 wasn't because I was looking at other organisational  
14 priorities, including building a new team, which  
15 I didn't have any directors. So I was looking and  
16 I was not seeing it as the priority that now, on  
17 reflection, it was.

18 170 Q. Just specifically, and leaving any sense of culpability  
19 or blame out of it, what point do you see opportunities  
20 for Chief Executives, such as in your position, should  
21 get involved if we were writing the MHPS framework  
22 again?

23 A. I think they should absolutely get involved in the  
24 action planning stage. When an action plan has been  
25 agreed, it becomes one that the Chief Executive takes  
26 personal responsibility for making sure that action  
27 plan is implemented. As you're very well aware, we are  
28 not talking about hundreds of MHPS cases a year. We're  
29 talking, certainly in the Southern Trust, less than



1 a dozen at any one period of time. Therefore, if  
2 rewriting that policy, given the importance, it should  
3 be a standing agenda item for the Chief Executive with  
4 his or her senior management team. It wasn't. I hope  
5 it is now. I hope within the Southern Trust it is now,  
6 but it wasn't under my watch.

7 171 Q. Do you agree with Mr. Khan that he came to you at the  
8 stage where he had, I suppose, a draft determination  
9 and he was looking at -- sorry. He came to you at the  
10 point when the investigation had reported and he was  
11 looking for advice on how to write his part of it and  
12 he sought advice from you?

13 A. He sought advice, and the only advice I gave him, which  
14 was, this has to be seen as an independent process and  
15 you have to write this in the way that you see it.  
16 I think his concern, because it is a challenging thing,  
17 I think, for clinicians to criticise other clinicians  
18 at times. The advice I gave, and I don't think he  
19 needed the advice, was that you have to write it 100%  
20 as you see it. That is the only way I can describe it.  
21 You have to write it as you see it.

22 172 Q. Do you recall specifically that he was told that  
23 he should base his recommendations on the evidence and  
24 follow the image based framework?

25 A. Absolutely. Play it as you see it. There's nothing  
26 else you can do in that situation.

27 173 Q. You say you sought assurances from Mrs. Gishkori and  
28 Dr. Khan that the issues which had been identified two  
29 years earlier that gave rise to the MHPS had been

1 addressed. I think it is just in the -- go down  
2 a little, please. It's the third paragraph. You say:

3  
4 "I was advised that an SAI was being carried out to  
5 fully understand the learning, however in the interim  
6 control measures had been put in place. This involved  
7 monitoring by the service lead. Martina Corrigan, and  
8 the Assistant Director for Surgery, Ronan Carroll.  
9 This involved weekly monitoring of agreed actions.  
10 Following these conversations, I was assured that the  
11 existing issues were being dealt with."

12  
13 Just to be clear, are you sure you sought that  
14 assurance from Mrs. Gishkori?

15 A. No. I certainly sought that assurance from Dr. Khan,  
16 and Dr. Khan had subsequently spoken to Esther Gishkori  
17 about that. Apologies, when I read the way that was  
18 written. I sought assurance from Ahmed, and I think  
19 Ahmed put it in an email back, he had spoken to Esther.  
20 But I can go back and look at that to be certain, but  
21 certainly from Dr. Khan.

22 174 Q. Yes. In terms of the assurance, again, I can find no  
23 documentary record of either any request for assurance  
24 or the nature of the assurance provided. Is there any  
25 documentary record?

26 A. No. It is my recollection of a meeting with Ahmed,  
27 where I asked him were the issues being addressed. He  
28 said they were. He also then raised to me more  
29 information in an email at a slightly later date which

1 indicated he felt that maybe the -- the indicators were  
2 not quite Mr. O'Brien had stepped out of slight  
3 control, but he was assured that the activities were  
4 back in control.

5 175 Q. We'll come to that email presently. Would you agree  
6 with me that when you're seeking assurance in respect  
7 of the -- I suppose the safety of the practice of  
8 a clinician in the context of whether things had arisen  
9 in the previous two years, whether they were under  
10 control or resolved or whatever the phraseology is,  
11 that is something that should be committed to writing?

12 A. I do accept that. But I also reflect on the meeting  
13 which was: if things were out of control I would have  
14 expected to be told. But I agree with you, in  
15 hindsight I should have documented those conversations  
16 with Ahmed.

17 176 Q. The nature of the assurance that you sought was in  
18 respect of what had given rise to the MHPS you wanted  
19 to establish whether they were now under control.

20 A. That's correct.

21 177 Q. Did you interrogate the assurance you were given?

22 A. No. Again, I would go back to the point I made  
23 earlier, this was not considered as a major issue for  
24 me on my radar. And I was not interrogating. The  
25 Medical Director said to me it is being managed,  
26 we have a report, we have an action plan. I was not  
27 seeing any indication coming through to me, either  
28 numerically or from other people. If the Medical  
29 directors said to me, yes, we have a plan, a plan will

1 be developed; I was accepting of that. I have learned,  
 2 and I am learning that I should have probably have dug  
 3 deeper. But given what was on my in-tray, to use your  
 4 term earlier, given what was in the in-tray, given  
 5 where we were, there were many other things that as  
 6 Chief Executive I was focusing on in a large integrated  
 7 trust. If one of my senior staff says, Shane, this is  
 8 under control, we have an action plan. Then I said,  
 9 thank you, and I move forward. There is learning in  
 10 that, there really is.

11 178 Q. I suppose the learning might be several-fold. You had  
 12 an Acting Medical Director who wasn't experienced in  
 13 the role, so I suppose the question arises there's  
 14 a need to be effectively superintending him to make  
 15 sure his sense of it is just about right. He's not  
 16 failing to see things that he should be seeing or not  
 17 failing to ask questions he should be asking, and that  
 18 wasn't done?

19 A. That's correct. It wasn't.

20 179 Q. I suppose, when you think about the assurance that was  
 21 in place, it was monitoring of the work that  
 22 Mr. O'Brien was expected to do, but it was monitoring  
 23 a limited basket of clinical or -- I think you agreed  
 24 with me clinical and administrative in this context --  
 25 just say clinical -- the clinical activities that were  
 26 in the basket for monitoring were limited in nature?

27 A. They were limited in terms of they only refer to those  
 28 things that were being deemed as administrative in  
 29 nature, which we both now agree were not administrative

1 in nature. But they were the areas of focus, yes.

2 180 Q. They were, I suppose, the obvious issues that were in  
3 plain sight which you wouldn't have known necessarily  
4 that the Trust were aware of, at least in part for  
5 several years?

6 A. No.

7 181 Q. I suppose the point being that it took until 2020 for  
8 issues that weren't in plain sight, at least some of  
9 those issues, to become visible.

10 A. Absolutely. I mean it became visible at the point when  
11 Mr. Haynes and Maria, and other things which I'm sure  
12 we'll come on to. But at that time I took assurance,  
13 I learned and I'm reflecting that that assurance should  
14 have been poked and prodded and tested, but I go back  
15 to the point it was not on my list of major issues.  
16 I reflect and I apologise for that, because actually in  
17 that period between that point and when it was actually  
18 identified, there was at least nine people, which  
19 we now know through the SAI process, who could have  
20 come to harm. I have reflected on that, but I was  
21 focusing on the areas that I saw important in building  
22 the organisation, and I did not see a clinician, who  
23 we now know is Mr. O'Brien, a clinician and the  
24 challenges that clinician had did not land on to my  
25 desk as: this is the most important thing you need to  
26 deal with. On reflection we can all see the evidence,  
27 but I have to say what happened at that moment in time.

28 182 Q. If we turn to Dr. Khan's determination or decisions  
29 arising out of MHPS. If we could have on the screen,

1 please, TRU-464548. Did you read it at the time?

2 A. I did read it at the time because Ahmed had discussed  
3 it with me. I did read it at the time.

4 183 Q. If we go through to 26453, please. Go to 264553,  
5 please. Go down the page to number 5. Thank you.  
6 You will recollect, perhaps, some aspects of this. No  
7 evidence of concern about his clinical ability, but  
8 clear issues of concern about his way of working,  
9 administrative processes, and management of workload.  
10 It sets out some of the impact statistics. The third  
11 bullet point picks up on an issue of insight, which was  
12 commented on by Dr. Chada in the final paragraphs of  
13 her investigation report. Presumably some level of  
14 concern if the clinician isn't reflecting well on what  
15 has emerged?

16 A. Yes.

17 184 Q. There's an issue of communication.

18  
19 A clear obligation to ensure managers within the Trust  
20 were fully and explicitly aware that he was not  
21 undertaking routine and urgent triage.

22  
23 scrolling down, please.

24 Remarks upon the impact on the Trust's ability to  
25 properly manage patients.

26  
27 scrolling down, please. Some other incidental findings  
28 in relation to the GMC's Good Medical Practice,  
29 comments in relation to his advantaging of private

1 patients, and it says the issues of concern were known  
2 to some extent for some time by a range of managers and  
3 no proper action was taken to address and manage the  
4 concerns. It's not just a concern within this report  
5 about the actions -- the reported actions of  
6 an aberrant practitioner, but questions to be directed  
7 to managers within the service as well.

8  
9 Just scrolling down to the next page, down to 55,  
10 please. Dr. Khan's adopts three determinations for  
11 action. First of all, he identifies the need for  
12 a conduct panel. I think just before that there's  
13 reference to the need for an action plan. Just scroll  
14 up to that. Yes. Scroll up a little higher.

15  
16 It is in order for The Trust, in order to continue to  
17 have assurance, that Mr. O'Brien's administrative  
18 practices and management of his workload be the subject  
19 of an action plan which should be put in place with the  
20 input of PPA, NCAS, the Trust and Mr. O'Brien. He  
21 provides for the review and monitoring of that action  
22 plan and how that should be done.

23  
24 The action plan must address any issues with regards to  
25 patient-related administrative duties and there must be  
26 an accompanied, agreed, balanced job plan.

27  
28 Did you appreciate by this stage -- I think you did --  
29 that because of the assurance you got that there was

1 already an action plan in place but this was --

2 A. Over and above.

3 185 Q. -- a new one, a revised one, which was to be scoped out  
4 with the input of all of these people? The need for  
5 a a conduct hearing. Then if we can go down to 26 --  
6 let me just see the digits on the page number again,  
7 please? Scroll down to 557 in that series. Down two  
8 pages, please. Scroll down towards the bottom.

9

10 In his final conclusion section, Dr. Khan has remarked  
11 that the investigations has highlighted issues  
12 regarding what he has described as systemic failures by  
13 managers at all levels, both clinical and operational  
14 within the Acute Services Directorate. The report  
15 identifies there are missed opportunities by managers  
16 to fully assess and address the deficiencies in  
17 practice. No one formally to assess the extent of the  
18 issues, or properly identified the potential risk to  
19 patients.

20

21 He says in order for the Trust to understand fully the  
22 failings in the case he recommends that the Trust  
23 conduct an independent review of relevant  
24 administrative processes.

25

26 It is the case, Mr. Devlin, that two of these items  
27 weren't progressed at all. One was only progressed in  
28 the summer of 2020. Have you any observations to make  
29 in relation to, first of all, the failure to progress



1 the independent review of administrative actions prior  
2 to the summer of 2020?

3 A. In terms of the actions, I had assumed those actions  
4 would take place through the directorate. But my  
5 overarching view is that once the grievance came in,  
6 we stopped the progress of these activities. Again, I  
7 think there's learning and reflection on that. I'm not  
8 saying it is the right thing, I'm just saying given  
9 that level of pushback from Mr. O'Brien through the  
10 grievance and that the actions themselves were driven  
11 from the MHPS process, which is the issue that he was  
12 questioning, we did not progress those actions because  
13 we stopped because of the grievance. We wanted the  
14 grievance to happen, and then the actions, clearly.  
15 But I agree, in the cold light of day, it could have  
16 been possible to progress those other two. But the  
17 decision we took -- I mean, certainly I was advised by  
18 HHR and Medical Director that once the grievance had  
19 come in, that stops what we need to do. Clearly it  
20 would have stopped one of those but we managed to make  
21 it stop all three. On reflection, I think there's two  
22 ways to look at it. One, they were all connected to  
23 MHPS which he was taking the grievance against the way  
24 we ran MHPS, but there was probably the opportunity to  
25 have continue with at least one, if not two.

26 186 Q. The review of administrative actions was commenced,  
27 albeit some time after this report issued, but was  
28 commenced before the grievance had ever completed.

29 A. That's -- I believe it had but I would have to go back

1 to see. I had assumed that the actions would be taken  
2 forward by the Director of Acute Services in  
3 partnership with the Medical Director. And that was my  
4 assumption on these actions.

5 187 Q. It is quite clear, is it not, even if you have to use  
6 hindsight, that failures of management in implementing  
7 aspects of their own administrative process described  
8 the systemic are not only worrying for an organisation  
9 but require urgent action?

10 A. Reflecting using hindsight, you are correct. I did not  
11 drive urgent action when I read that report. I asked  
12 the organisation through the directors to take it  
13 forward. I'm not saying that's correct, I'm just  
14 reflecting on what happened. On reflection, if I had  
15 paid more attention to this particular issue as opposed  
16 to the other issues that were on my desk, I may have  
17 taken a different approach. But what I would say is  
18 that once that grievance came in, the advice clearly to  
19 me was: Right, the grievance is in. Right, we now  
20 need to deal with the grievance and we won't be dealing  
21 with the other action.

22 188 Q. Of course you readily appreciate the dynamic that says:  
23 Got to do something about this. Because the same  
24 managers could be making the same mistakes and the same  
25 practitioner is in place working in accordance with  
26 management direction, or should be. So there is a  
27 recipe for repeating the mistakes of the past if they  
28 are not specifically identified and addressed.

29 A. I agree. I am not defending that position. I agree

1 with you.

2 189 Q. Nor are you saying, as I understand it, that there was  
3 any particular mitigation or so they shouldn't put in  
4 place to try to address what are identified here as  
5 shortcomings by management?

6 A. Not at my request there wasn't. As I say, the  
7 assumption that I made was that these actions would be  
8 taken forward in the way that many reports, many  
9 actions are taken forward by the appropriate director.  
10 Reflecting on that assumption, it was the incorrect  
11 assumption.

12 190 Q. These issues were, as I understand it, discussed with  
13 you in the next year, in 2019. I just want to see if  
14 you can -- it is Dr. O'Kane's note which she supplied  
15 us with this week, I think. I just want to see if you  
16 can help us with this. Obviously we will have to  
17 direct questions to Dr. O'Kane.

18  
19 WIT-90981. There's a meeting regarding AOB. You will  
20 see at the top of the page some discussion about AMC.  
21 And some discussion, I think, about Mr. O'Brien's  
22 concern that some of his colleagues were not practising  
23 safely. Then it goes on to organisational part  
24 discussed. Meeting with Shane, that says after the  
25 report Vivienne/Shane. A systemic dip. It appears to  
26 be the kind of language of the determination. Can you  
27 recall ever having a discussion -- and this may not  
28 necessarily be a record of the meeting with you, it  
29 could be between Mr. Haynes and Dr. O'Kane, but can you

1 recall discussing with Dr. O'Kane whether you should  
2 get on with the investigation into the organisation's  
3 managerial failures?

4 A. I don't recall that. What date, may I ask, was that?

5 191 Q. I can't tell, unfortunately. There is -- if we go on  
6 to WIT-90983. Scroll down, please. Stop there. Can  
7 we have the whole page up, please. So there is an  
8 entry on this page which says, two-thirds of the way  
9 down, I will talk to Shane re organisational part.  
10 I can't help you with dates. My question is can you  
11 recall discussing if this is what this document means,  
12 proceeding or not proceeding with the organisational  
13 part of Dr. Khan's determination?

14 A. I can't recall discussing that with Dr. O'Kane.

15 192 Q. Just so that we can nail it down. The advice that you  
16 received that we shouldn't process with this was  
17 received from who?

18 A. I'm going to say that it would have been through  
19 Vivienne and HR. But I can't explicitly recall a time  
20 when someone said "we are stopping everything because  
21 of the grievance". So I'm very well aware we received  
22 the grievance. I personally received it. And I am  
23 aware, then, as a result of that, Vivienne would have  
24 told me we cannot progress. But I could not recall  
25 a date when that would have been the case.

26 193 Q. Yes. One can readily understand the inability to  
27 proceed with the conduct hearing and the obstacle  
28 placed in the path of that by the grievance. Did  
29 Mr. O'Brien meet with you, I think it was 27th --

1 A. He met with me to give me the box of grievance; yes.

2 194 Q. And he sought specific assurance that you wouldn't move  
3 ahead with that pending completion of the grievance.

4 A. Right.

5 195 Q. But in terms of the action plan that Dr. Khan imagined,  
6 the new action plan with buy-in from NCAS and  
7 Mr. O'Brien, did you receive similar advice that that  
8 one could not be taken forward either?

9 A. No. No, I didn't receive that advice. The assumption  
10 was that we were not moving forward because we stopped  
11 because of the grievance. I didn't receive any advice  
12 or guidance as to why we were not progressing with that  
13 action plan. Nor did I challenge or ask. The  
14 assumption was, the grievance came in, this process  
15 will stop until the grievance is heard and outcomes are  
16 made. In my mind the logic was because they were all  
17 connected and, therefore, I didn't question it  
18 stopping. They were all connected. All of the  
19 outcomes, all of the actions were driven by an MHPS  
20 process that was being questioned. Therefore, in my  
21 mind, I didn't question it. But I assumed that was the  
22 reason we were stopping, because it was all connected  
23 to the one overarching review and report.

24 196 Q. And those decisions were made or resided in Human  
25 Resources?

26 A. Well, I certainly didn't make those decisions -- okay?  
27 So the running of the MHPS process, and certainly  
28 running of grievance would have been in HR. When other  
29 things were not progressing I was not challenging them

1 because I presumed that everything was stopped because  
2 of the grievance.

3 197 Q. You didn't question or challenge them?

4 A. No. I didn't. I didn't. Again, I go back to the  
5 point that I still -- I did not at that point in  
6 time -- I saw this as an issue with "a" clinician that  
7 needed to be addressed. An issue that clearly  
8 articulated in the document there were no clinical  
9 concerns over Mr. O'Brien. And we can go back to the  
10 beginning of the day, we all now agree that clinical  
11 and social care governance and governance is connected.  
12 But at that moment of time the document said that there  
13 were no clinical concerns with Mr. O'Brien as a  
14 clinician and the issues were administrative in nature.  
15 I did not put my personal attention into this process.  
16 I was looking at the other major organisational  
17 processes. I can't say any more than that. That was  
18 really the position i was in.

19 198 Q. But you would agree with me that the conclusion that  
20 may be reached here, legitimately reached, was that  
21 this was the height of complacency, to let MHPS  
22 reproach and determine and, notwithstanding the  
23 grievance, to fail to have done anything?

24 A. I believed that action was in place from the existing  
25 action plan and therefore I believed that we were safe  
26 from that existing action plan. I have never in my  
27 career become directly involved in an MHPS process,  
28 whether as a chief executive or as a director. Because  
29 those processes were being managed through a medical

1            directorate route, through an HR route, and in many  
2            cases I would not have been involved. Therefore,  
3            I read the review, I acknowledged that in my reading of  
4            the review as very early in the review it talks about  
5            no direct clinical concerns as regards Mr. O'Brien's  
6            practice. I was made aware there was an existing  
7            management plan to try to govern the things that were  
8            identified in '16, '17 and, therefore, I said I was  
9            satisfied by that and I moved on to other areas that  
10          I was being challenged with as a new chief executive in  
11          an organisation. I can reflect, have reflected, but  
12          that's the fact of what happened at that moment in  
13          time.

14 199 Q.    Can we take a short break now?

15            CHAIR: It is 3.10 now, so 25 past.

16            THE INQUIRY ADJOURNED FOR A BREAK AND THEN RESUMED AS  
17            FOLLOWS:

18  
19 200 Q.    MR. WOLFE KC: I just want to finish with this whole  
20            area of whether it was, essentially, safe or otherwise  
21            to fail to interrogate the assurances that you were  
22            given and to accept that MHPS determinations couldn't  
23            be taken forward or shouldn't be taken forward. would  
24            you agree with me that as chief executive, with patient  
25            safety issues on the line, it's entirely within your  
26            remit to countermand or at least, take a step back from  
27            that, energetically discuss the prudence of, on the one  
28            part the action plan to a small range of clinical  
29            matters and, on the other hand, the wisdom of not

1           pursuing any of Dr. Khan's recommendations?

2           A.    I agree it would have been prudent to have done so.

3                    I would still go back to the point of what I was

4                    dealing with at that time and, therefore, the choices

5                    I made were based on what I saw was important in front

6                    of me to try to manage the overall safety of the

7                    organisation. I didn't view this -- and, in hindsight,

8                    we can clearly have all the evidence -- I did not view

9                    this as a major, major safety issue because I viewed it

10                   in terms of being, as the first line of the report

11                   says, there are no obvious clinical issues and, also,

12                   I viewed it as something that was being managed under

13                   an existing process around administration. I do not

14                   question the point you are making. It would have been

15                   prudent for me. I'm not questioning that. But I'm

16                   trying to help the Inquiry understand the reasons why

17                   I did what I did, which was I focused on other parts of

18                   the organisation because I saw them as more important

19                   at that time based on the challenges we were facing.

20   201   Q.    I have to press you on this, Mr. Devlin, again. It

21                   takes one hour to bring a few people around the table

22                   to say, "Listen, I'm worried about this. We need to

23                   think more". Sometimes you have to go from the macro

24                   down to the micro when there is, on the face of

25                   Dr. Khan's determination, a concern for patients.

26            A.    I know. I'm not denying that. I'm trying to help the

27                   Inquiry understand why I did what I did.

28   202   Q.    One of just -- if we could open, again, WIT-00084.

29                   It's the paragraph beginning "When the matter was



1 raised with me". You asked for the assurance. We have  
2 gone over that.

3  
4 You were advised that an SAI was being carried out to  
5 fully understand the learning. Then you go on to speak  
6 about the interim control measures. Is it fair to say,  
7 Mr. Devlin, that you didn't revisit the issue of the  
8 SAI and ask what the full learning was that had  
9 emerged?

10 A. I did at a later date, absolutely. And I sought that  
11 from Ronan Carroll, I think I remember at the time.  
12 Absolutely. And that was an issue that I wanted to  
13 explore and did explore with Maria and other people.  
14 But absolutely I wanted to understand what the outcome  
15 of that final SAI was.

16 203 Q. We know that that SAI concerned the failure to triage  
17 five patients, one in 2015 and four in 2016. And  
18 we know that that SAI was instigated in 2017. I think,  
19 ultimately, it was the autumn of 2017. It reported in  
20 May 2020. Are you aware of that?

21 A. Yes, that's correct. Yes, I am aware.

22 204 Q. Do you know what happened to delay the SAI to such an  
23 extent?

24 A. No. Sorry, I don't.

25 205 Q. It wasn't something you were keeping an eye on?

26 A. No. In terms of SAIs, I mean, again, overarching  
27 approach would be to be taken at directorate level, and  
28 I was not taking an overarching view of this SAI.

29 206 Q. So just looking at how you phrased it in your

1 statement, the SAI was there to give us better or  
 2 fuller learning in respect of this practitioner.  
 3 You didn't ask any further questions about it at the  
 4 time. It emerges as a report six weeks before he  
 5 retires in May 2020 against a backdrop where we have  
 6 a monitoring plan that isn't looking at the issue of  
 7 clinical practice and where we've stopped any further  
 8 action on the determinations and where you have an SAI  
 9 not producing the learning, I suspect, in the kind of  
 10 time frame that the Trust would like to expect. This  
 11 was a situation, was it not, where, despite the MHPS,  
 12 nothing new was happening to manage and control the  
 13 actions of this clinician?

14 A. Nothing from me, that is correct. I was not -- and, in  
 15 fact, when I got the SAI report I don't believe it  
 16 would have been six weeks before Mr. O'Brien retired,  
 17 I think I probably got it at a slightly later date than  
 18 that. But you are correct, I was not monitoring the  
 19 Mr. O'Brien case. That's exactly what it is. I would  
 20 expect directors to have raised it to me if there were  
 21 issues that they wished me to -- they were concerned  
 22 about, but I was not monitoring the Mr. O'Brien case.

23 207 Q. You weren't receiving periodic updates on --

24 A. Not at all.

25 208 Q. -- deviations from the --

26 A. Not at all. No. No.

27 209 Q. When you say "not at all", I want to take you just to  
 28 something that Dr. O'Kane says in a moment.

29

1 But just looking at the format of your statement here,  
2 you talk about obtaining the assurance in 2018 and  
3 explaining that, and then you jump ahead to the middle  
4 of 2020. And, indeed, if we go to your second  
5 statement, please. Just allow me a moment. If you go  
6 to WIT-21154 WIT-21154. Scroll down the page, please.  
7 You say at paragraph 6 that: "My next and last  
8 involvement with the case was on 27th November 2018."  
9 That's before we get to the summer of 2020, when you  
10 spoke to Mr. O'Brien about his grievance.

11  
12 I want to ask you about Dr. O'Kane's recollections. If  
13 I could have on the screen, please, WIT-45159.

14  
15  
16 She's asked: Did you raise any concerns about the  
17 conduct or performance of Mr. O'Brien? And, if yes,  
18 a series of questions follows. So scrolling down to  
19 the table, please. So the nature of the concern on the  
20 left-hand box, Mr. O'Brien deviated from the 2017  
21 action plan formulated following MHPS. And this was  
22 raised with that list. And "Actions Taken" is the  
23 third column. So he recalls discussing -- Dr. Khan,  
24 case manager, discussing with those involved, including  
25 Mr. O'Brien, Dr. Lynn, etcetera. This was discussed in  
26 oversight group on 3 October and updated by Mr. Haynes  
27 by email on 7 October. This, in turn, was discussed  
28 with the Chief Executive at one-to-one meetings and at  
29 Trust Board confidential sections.

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She recalls that deviations from the 2017 plan were discussed with you at one-to-one meetings and at Trust Board confidential sections. Now I see no record of such discussions being raised with the Trust Board in the confidential section and I know, just to fully orientate you, that Mrs. Brownlee has recalled that no issue in respect of Mr. O'Brien's practice was raised with the Board after January '17. One-to-one meetings with Dr. O'Kane, she was bringing to your attention deviations from the monitoring plan?

A. I would not recall that, to be perfectly honest. What I certainly did discuss with Maria later on in the process was, once the 2020 period arrived, we would have regularly discussed it at our one-to-one but not the deviations from the plan and certainly not in confidential sections of the Board meeting.

210 Q. So what you are saying is, as you said in your statement, that after saying good-bye to Mr. O'Brien in late November 2018 in respect of his grievance, you weren't reconnected into this issue --

A. No.

211 Q. -- or issues concerning Mr. O'Brien until the summer of 2020.

A. And I've clearly documented my evidence when Maria then approached me to say, in 2020, what had happened with regard to Mark Haynes, etcetera.

212 Q. Knowing what you know now, and I've explained to you that during 2019 the email materials available to the

- 1 Inquiry show concerns about deviation both in triage  
2 and in dictation post clinics continued to be an issue.  
3 Mr. Haynes was raising issues about the robustness of  
4 the data, particularly the robustness and reliability  
5 of the backlog reports that come from medical  
6 secretaries into the admin system and then to head of  
7 service and beyond. And there were also concerns then  
8 raised about SAI reports. One further SAI initiated  
9 Patient 90 or 92. Certainly one further SAI initiated  
10 in 2019, and a further concern being reported emerging  
11 from the Belfast Trust's MDM. Are you telling the  
12 Inquiry that none of that was drawn to your attention?
- 13 A. No. None of it was drawn to my attention. And people  
14 would have had the opportunity to do so through formal  
15 and informal mechanisms and, therefore, I do not recall  
16 it being drawn to my attention.
- 17 213 Q. Do any of those matters cross the threshold for raising  
18 with the chief executive by medical director, by  
19 director of acute, whoever it might be?
- 20 A. I would have expected issues of patient safety, in the  
21 way you've described them, would have been raised to me  
22 in detail. And they weren't. Nor did I ask, as  
23 I explained to you before. Nor, as I openly said to  
24 the Inquiry, was I curious about that because my  
25 attention was drawn elsewhere.
- 26 214 Q. The director of acute services up until the middle of  
27 2019 was Esther Gishkori?
- 28 A. That's correct.
- 29 215 Q. You said in your statement that -- if I could just have

1 up WIT-00030, please. At the bottom of the page,  
2 please.

3  
4 In terms of the issues we were discussing, she was in  
5 a somewhat pivotal position as director of acute  
6 urology services. This came under her directorate and  
7 if there were concerns about the practice of  
8 a clinician within that directorate, she should have  
9 been over the detail; is that a fair synopsis?

10 A. That is, yes.

11 216 Q. She resigned in April 2020, and that was pursuant to  
12 a negotiated settlement --

13 A. Yes.

14 217 Q. -- between herself and the Trust?

15 A. That's correct.

16 218 Q. We don't need to explore the fine detail of that.

17

18 Just go over the page, next page. Thank you.

19

20 The issues from the Trust perspective were performance  
21 and capacity issues, capability issues?

22 A. That's correct.

23 219 Q. She disputed the position.

24 A. Yes.

25 220 Q. You had a couple of meetings with her in 2019.

26 A. Yes.

27 221 Q. I just want to ask you about some aspects of those. If  
28 we go to TRU-299682. This is a meeting between  
29 yourself, Esther Gishkori, and Vivienne Toal?

1 A. That's correct, yes.

2 222 Q. 3 June 2019.

3 Could you help the Inquiry, what was the purpose of  
4 this meeting and series of meetings with her?

5 A. Yes. Certainly.

6

7 I had become more concerned about the performance of  
8 the acute directorate and, as you can see from the  
9 summary at the top of that document, performance was  
10 dropping. Financially the directorate was overspending  
11 in excess of £10 million a year. We had major issues  
12 in Daisy Hill Hospital, which is one of our hospitals  
13 with regard to consultants -- letter of concern from  
14 consultants. I'd had an anonymous letter of concern as  
15 well from other doctors and I had been visited by  
16 a number of doctors as well who were concerned about  
17 the management of the directorate.

18

19 I had attempted to discuss with Esther the concerns and  
20 try to find a way to find a new role for Esther in  
21 a way that, I think, many chief executives try to do.  
22 That new role would have been in a nursing capacity, in  
23 a patient/client user capacity, which would have  
24 allowed me to look at the management attempt within  
25 Acute and to try to support that management team and  
26 bring in fresh blood. And there is no doubt that the  
27 Acute directorate was enormous -- is enormous. It is  
28 as big as many Trusts in England and it is just  
29 a directorate. And the management was struggling. And

1 that was the purpose of the initial meeting.

2

3 I would like to have been able to do this in a much  
4 more humanly way and I would like to have not got to  
5 the point of having an agreed resignation. I would  
6 like to have got to a different place but,  
7 unfortunately, it became clear that Esther did not  
8 agree -- and still does not agree, I assume -- in the  
9 position that I was making. And we went through  
10 a negotiated process through the labour relations  
11 agency, and we came to the conclusion that Esther would  
12 leave the organisation. So, for me, it was very much  
13 focused on a range of issues that were coming up to me  
14 from the Acute directorate.

15 223 Q. Towards the bottom of this page she makes a point, not  
16 to put too fine a point on it "you want me out, plain  
17 as the nose on your face", which probably reflects an  
18 element of distrust had crept into the relationship.

19

20 Over the page you raise an issue about the management  
21 of associate medical directors and clinical directors.  
22 Let me just put you in touch with that bit of the note.  
23 About halfway down, please. Yes. This isn't  
24 a verbatim record and the Inquiry will recognise that,  
25 but what was the issue and is it at all germane to the  
26 Inquiry's interests that you're putting to her  
27 managing -- that is associate medical directors, is  
28 it? --

29 A. And clinical directors.



- 1 224 Q. And clinical directors -- presumably within acute  
2 services?
- 3 A. Correct.
- 4 225 Q. -- is part of her role as director.
- 5 A. Correct.
- 6 226 Q. What was the problem there?
- 7 A. The point that was being made to me and had been made  
8 to me in previous times from Esther, which is the  
9 responsibility for managing AMDs and CDs lie with the  
10 Medical Director. And I didn't agree with that.  
11 Irrespective of the fact that there is reference in  
12 both job descriptions to AMDs, ultimately you can't run  
13 a management team and part of that management team see  
14 themselves being managed by the clinical line. There's  
15 a role of the operational director. In the same way as  
16 if you had a nurse in there or you had a pharmacist,  
17 etcetera, you would expect that overall director to  
18 be -- well, sorry -- "I" expected that overall director  
19 to be managing the team. And Esther's view, as  
20 I recall it, was, well, they are managed by the Medical  
21 Director, performance is managed by the performance  
22 director, HR is managed by the HR director. I don't  
23 agree with that and that's really where that comment  
24 came from.
- 25 227 Q. What was the shortfall, then, for the service if she  
26 wasn't performing her management functions as you  
27 envisaged?
- 28 A. I think the shortfall lies -- is a grip of the  
29 directorate understanding what is happening and being

1 able to take corrective action. If you don't see  
2 yourself as having a management responsibility for the  
3 members of the team, then it could be argued that when  
4 something has to be done with that team, you may feel  
5 that somebody else is responsible for that action.

6 228 Q. Is it also part of her role to provide support to  
7 associate medical directors?

8 A. I think it is part of the director's response to  
9 provide support to all of the team members within that  
10 senior team. So if we are talking about team  
11 management, then we are talking about the director  
12 being the leader of that team and therefore it is  
13 important to provide support and advice and to be  
14 there, but also to be challenging as well.

15 229 Q. In what ways, if at all, did you see the shortcomings  
16 in her performance as impacting on the urology service  
17 or was it more general than that?

18 A. I didn't see it directly on urology services. What  
19 I saw it was that I had heard a number of doctors  
20 concerned that they felt the directorate wasn't being  
21 managed well. Performance was dropping. As I say,  
22 there were challenges of money, challenges of locum  
23 doctors -- there were challenges all over the place.  
24 Therefore, for me, it was a matter of could I help her  
25 get a grip on that and, if she can't get a grip on  
26 that, could I find somewhere else for her to deliver  
27 value for patients and clients and allow me to get on  
28 with looking at a new director and maybe a new team.

29 230 Q. You make a remark at the next meeting, and forgive me

1 if it seems I'm just picking up on phrases. Some stand  
2 out. And if you wish to say anything to more properly  
3 contextualise these records, feel free to do so.

4 A. I will do.

5 231 Q. You say, at TRU-299686 -- and if you bring us towards  
6 the bottom of the page, maybe two-thirds of the way  
7 down. Yes, just stop there.

8

9 She's reflecting upon the senior management team. She  
10 doesn't need to be part of the senior management team  
11 in any role that you might envisage for her, is my  
12 reading of that. You make the point to her: "I need  
13 to be sure you will drive radical change." Now, this  
14 meeting is June 2019. It may even -- forgive me, it  
15 may have been July. She went on sick leave and you had  
16 a follow-up meeting with her. It doesn't matter about  
17 the date. It was the middle of 2019. Have you any  
18 sense of what you meant by that, the need to drive  
19 radical change?

20 A. Yes, I do. And we were looking at the situation  
21 whereby locum expenditure was going out of control,  
22 agency expenditure was going out of control, our front  
23 door, as in emergency department, was clogging like  
24 never before, we had shortages of nurses, and the  
25 system just -- so irrespective of human beings, I think  
26 everyone in the system was working unbelievably hard,  
27 the system wasn't working -- isn't working or wasn't  
28 working. And, really, what I was looking for was  
29 radical thinking about the system. It goes back to the

1 point I made earlier about trying to drive care out of  
2 hospital into the community in terms of really getting  
3 to grips with the role and function of Daisy Hill  
4 Hospital, which is a really important part of our  
5 system. So it wasn't about the day-to-day management  
6 of a directorate. I don't pay a director to manage day  
7 to day. And I was looking for genuine innovation and  
8 change. Because it felt like it was mechanically  
9 running a system and the system wasn't getting better.  
10 Because the system won't get better if you are  
11 mechanically running every day. You need to radically  
12 think about the system. That's what I was asking for.  
13 That's what I was looking for.

14  
15 I suppose my comment in that meeting was, I need to  
16 know you are up for that. Because if Esther was up for  
17 that then I was up to how can we try to manage to make  
18 this work. Because this wasn't an attempt to say no  
19 matter what those meetings showed I wanted  
20 Mrs. Gishkori to leave. I didn't. I wanted the system  
21 to work. That's why I specifically asked the question:  
22 Will you be able to drive radical change? Because this  
23 was not a matter of tweaking, this was about radical  
24 change. There were fires everywhere going on.

25 232 Q. Yes.

26  
27 I think you made the point to me earlier that at no  
28 juncture did Mrs. Gishkori draw your attention to any  
29 particular concerns within urology?

1 A. No. Not at all.

2 233 Q. None related to Mr. O'Brien. She was replaced by  
3 Mrs McClements.

4 A. Melanie McClements. That's correct.

5 234 Q. That was at the point she went off on sick leave  
6 initially, in the summer of 2019.

7 A. Initially when Esther went off sick there was  
8 a different manager that came in. Anita Carroll came  
9 in for a short while, who was an deputy director or  
10 assistant director, then Melanie came in after that.

11 235 Q. Did either of those women draw your attention to any  
12 concerns within urology?

13 A. Not at that point, no. I mean, clearly they were --  
14 Melanie was heavily involved in the 2020 work, but not  
15 at that point.

16 236 Q. Let me, having taken that sojourn, go back to the  
17 grievance and the MHPS issue. MHPS isn't the  
18 determination -- or the outcome of MHPS isn't moving  
19 forward, it is stuck behind the grievance. The  
20 grievance is lodged in October/November 2019?

21 A. October 27th, I think. I would have to check.

22 237 Q. It doesn't attract a hearing until the summer of 2020.  
23 Now, the grievance in pieces of paper terms looked  
24 significant. There were requests on the part of  
25 Mr. O'Brien for disclosure of relevant documents which  
26 were processed on several occasions. But the  
27 grievance, as I say, doesn't receive a hearing for  
28 some -- I'm trying to calculate in my head --  
29 18 months? 20 months?

- 1 A. Yes.
- 2 238 Q. Have you ever heard the like of it?
- 3 A. Not in a grievance, no.
- 4 239 Q. Was the hope that this might wither off on the vine and  
5 you wouldn't have to deal with it?
- 6 A. In terms of the organisation, I hope not. I don't  
7 believe so. But, clearly, it was not being enacted as  
8 quickly as it should have been enacted. I don't think  
9 anybody would have thought it would wither on the vine.
- 10 240 Q. What we do know, of course, is this has to be viewed  
11 through of patient safety lens. You can't get to deal  
12 with the issues set out in the determination -- rightly  
13 or wrongly. You have made your pitch on that and given  
14 your explanation for what you think HR or whoever else  
15 it was owned that decision. But 20 months, 18 months,  
16 is far too long even in a COVID context to be  
17 addressing this?
- 18 A. And I believed that the action plan was in place.  
19 I believed that my directors would raise to me if they  
20 felt that the action plan was required to raise to me  
21 as a patient safety issue. Wrongly now, of course.  
22 And I'm not saying it was right. But I believed that's  
23 what would happen, the directors would raise to me, if  
24 they had concerns over that period, because it was out  
25 of control. It was not raised to me in those ways.
- 26 241 Q. The Board was unaware --
- 27 A. That's correct.
- 28 242 Q. -- of any of these developments.
- 29 A. Unaware of the -- they were aware, obviously, at the

1 very beginning, MHPS. Nothing came to Board, but I'm  
2 not sure it would have done. Nothing came to me to  
3 come to Board. Nothing came to Board during that  
4 period of time.

5 243 Q. Yes. What did come to you was MHPS investigations, the  
6 determination as issued, roadblock (called grievance)  
7 decision not to move forward, but were content to rely  
8 on our monitoring arrangements.

9 A. That's correct.

10 244 Q. Now, that particular set of issues, content to rely on  
11 existing monitoring arrangements, notwithstanding the  
12 views expressed by Dr. Khan about the need for a new  
13 action plan, not withstanding the views expressed about  
14 the need for an investigation into management  
15 arrangements, those kinds of issues are the issues that  
16 you might expect a Trust Board to have some interest in  
17 from a scrutiny and challenge perspective?

18 A. Reflecting on this, yes, you would. But,  
19 unfortunately, that was not the line of sight that  
20 I was looking at it from. As I said before, I was  
21 looking at it: well, it was in control, there is an  
22 action plan, there are many things going to Board that  
23 I saw were immediate issues of both safety, money, HR,  
24 and those are the things I was bringing to Board.  
25 I did not bring an update on the MHPS process of an  
26 individual clinician where I believed there was an  
27 action plan in place and I believed the action plan was  
28 governing the issues of administrative nature. I can  
29 keep going through that point because that's the

1 position I was at.

2

3 reflecting on it, absolutely. You would imagine that  
4 if, God forbid, there was ever to run it again.

5 Absolutely. Because one of the issues was clear was  
6 the action plan was not being monitored and managed in  
7 the way that I believed it was. I wasn't hearing from  
8 my team on a regular basis that there was deviation.  
9 So I had nothing to bring to the Board because it was  
10 not coming to me in that way.

11 245 Q. Yes.

12 A. But with hindsight, absolutely. I couldn't agree more  
13 with you.

14 246 Q. There were three people with a seat at the Board table  
15 who had knowledge of MHPS having reported and the rest  
16 of package that I just outlined: yourself,  
17 Mr. Wilkinson who was the non-executive director  
18 attached to the MHPS process and, interchangeably,  
19 Dr. Khan, moving on to the new medical director  
20 Dr. O'Kane, for the longest part of this timeline.

21 A. Also the director of HR who always was in attendance at  
22 the Board meeting. The Board -- there were only five  
23 executive staffing members of the Board but all of my  
24 senior team attend the Board and are treated as members  
25 of the Board.

26 247 Q. Yes. And no discussion between yourselves about the  
27 need to bring this to the Board?

28 A. No.

29 248 Q. Was there any sense then or now that matters of,



1 I suppose, an employment nature shouldn't go to the  
2 Board until they are fully worked through or would it  
3 be wrong to think that that's any kind of explanation  
4 or excuse?

5 A. My recollection, employment matters are brought when  
6 they have been concluded. I would be very surprised if  
7 there's a trail of bringing employment matters.

8 249 Q. Yes.

9 A. Because those individuals involved in the employment  
10 matters wouldn't be in a public or confidential Trust  
11 Board environment. I would suspect you are correct.  
12 I suspect employment matters would come as part of the  
13 HR director's report or, otherwise, once something has  
14 been concluded as opposed to in process.

15 250 Q. Yes, but this wasn't, of course, purely an employment  
16 matter.

17 A. No.

18 251 Q. In the sense that the Board had the right to know about  
19 the exclusion and the commencement of the MHPS, it  
20 surely had a need to know -- I think you agree with me  
21 in hindsight -- about the outcome of that and, in  
22 particular, the fact that we couldn't move forward with  
23 it or the view had been taken that we couldn't move  
24 forward.

25 A. And I think, you know, clearly, and as I've explained  
26 to the Panel, a part of that, it could be argued, was  
27 the responsibility of the Chief Executive, the  
28 responsible Medical Director. Nor was the Board asking  
29 information of me on this particular case either.

1 Therefore, whereas the Board was asking of me  
2 information on many other things that were happening,  
3 as you can see from the agenda. So I just think there  
4 was a range of issues that it didn't come to Board.  
5 I can't say anything other than that.

6 252 Q. Just finally for this afternoon, just going back to the  
7 issue of SAIs, Serious Adverse Incidents generally. At  
8 that time was delay in the production of reports  
9 a feature of life in the Southern Trust more generally?

10 A. It was a feature more generally because the number of  
11 SAIs verses the resources that were available to  
12 deliver SAIs meant that there were quite a few that had  
13 long progression. That was part of the idea of  
14 introducing the weekly monitoring, to see where we are,  
15 what we are closing, etcetera. But it was not unusual  
16 and, again, I think in the governor's report I shared  
17 in my papers, you will be able to see the length of  
18 time that SAIs were taking given the resource  
19 challenge. I think there are other ways in which  
20 we can do SAIs from a learning perspective and possibly  
21 having, you know, employed panels and all kinds of  
22 things. But the way we were trying to do it was by  
23 asking clinicians both within the organisation, outside  
24 of the organisation, to spend time doing these. And  
25 I think there is potential opportunity for improvement  
26 by thinking of a different way and to resource SAI.

27 253 Q. I think you'll agree with me, if the principle at stake  
28 here is learning, learning in the context of patient  
29 safety, then producing a report three years after the

1 incident has taken place, and the SAI we're thinking  
2 about four years after the incidents had taken place,  
3 that's getting to the stage of being almost worse than  
4 useless?

5 A. Yes. The opportunity for learning has disappeared.

6 254 Q. More generally, the Inquiry will no doubt be interested  
7 in what can be done to address that. One of the  
8 reflections the Inquiry so far heard is the fact that  
9 the panels that populate these reviews, these SAI  
10 reviews, tend to be, quite often, made up of busy  
11 clinicians, and trying to bring them together at the  
12 same time to discuss issues and reach consensus on what  
13 have you is a systemic difficulty that's difficult to  
14 overcome?

15 A. That's correct. And I think there are other options  
16 such as having employed panels of maybe retired  
17 clinicians, maybe asking third parties: Come in and do  
18 SAIs. I think there are opportunities. And also  
19 probably looking at the thresholds on what could be  
20 a structured clinical judgment review verses an SAI. I  
21 think there's lots of opportunity to see how it can be  
22 better. But my understanding -- and apologies, I have  
23 not been in Northern Ireland for nine months -- but my  
24 understanding is the Public Health Agency and/or the  
25 RQIA were looking at the review of the SAI process.  
26 I could be wrong on that but I think either of them  
27 were.

28 MR. WOLFE KC: If it is convenient, we could break now  
29 and hopefully get through most of it in the morning,

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maybe early afternoon finish?  
CHAIR: A 10 a.m. start then?  
MR. WOLFE KC: I'm content with that; yes.  
CHAIR: see you all then.

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 8 DECEMBER  
2023 AT 10.00