Urology Services Inquiry

Oral Hearing

Day 21 – Tuesday, 31st January 2023

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

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

1 THE INQUIRY RESUMED ON TUESDAY, 31ST DAY OF
2 JANUARY, 2023 AS FOLLOWS:
3
4 CHAIR: Good morning, everyone. Mr. Mackle.
5 10:00
6 MR. EAMON MACKLE CONTINUED TO BE EXAMINED BY
7 MR. WOLFE KC AS FOLLOWS:
8
9 MR. WOLFE KC: When we were last with you, Mr. Mackle,
10 last Thursday, one of the last points you were making 10:00
11 to us was that, as Associate Medical Director you had
12 to raise certain issues with Mr. O'Brien, and that
13 while he was gentlemanly and outwardly pleasant, you
14 sensed that he, I suppose, resented the fact that you
15 were challenging him on a range of issues. I just want 10:00
16 to pick up on that theme to start with this morning.
17 If we could turn to your Section 21 at WIT-11769. At
18 paragraph 92 you say that in 2012, you were unsure of
19 the exact date but you were informed that the Chair of
20 the Trust, that's Mrs. Roberta Brownlee, had reported 10:01
21 to senior management that Aidan O'Brien had made
22 a complaint to her that that you had been bullying and
23 harassing him, and I want to ask you some further
24 detail about that. You say that this matter was drawn
25 to your attention when you were called in to an office 10:01
26 on the administration floor of the hospital to inform
27 you of the allegation or the accusation. Just to be
28 clear, doing your best with your memory, is that the
29 issue that you were summonsed to the office to discuss?

1 A. When I say I was summonsed, I wasn't asked to come up
2 to the admin floor. I had arrived up at the admin
3 floor to go and see -- normally I would have called up
4 at different times during the day to go and see Heather
5 Trouton and/or the Heads of Service. There, from the 10:02
6 staircase that comes up, you turn right, there's a door
7 there into the admin part, you turn left, that corner
8 office is the Acute Director`s office or secretaries,
9 or PAs office, and then as you walk along that corridor
10 down to the far end just round the corner is where 10:02
11 Heather Trouton's office and the Head of Service's
12 office was. So I was on that corridor when I was asked
13 to come into an office.
14 1 Q. Yes. Doing your best on the issue, is that the issue,
15 the matter of this allegation, is that what was 10:02
16 addressed?
17 A. That was the sole thing that was discussed.
18 2 Q. Okay. In terms of how it was put to you, is that as
19 much detail as you are capable of giving?
20 A. Basically, yes. I mean I was completely shocked, 10:03
21 horrified, flabbergasted, gutted, whatever term you'd
22 like to use, which, as a result, I found it difficult
23 to -- I found it difficult to explain why I couldn't
24 remember with guarantee who spoke to me. I believe it
25 was Helen Walker, as I said immediately after I went 10:03
26 down to looking for either Heather or Heads of Service
27 it was Martina Corrigan who I met, but the only thing
28 that was said to me at the time was to warn me that the
29 Chair of the Trust had reported to management that it

1 had been reported to her that I had been bullying and
2 harassing Aidan.
3 3 Q. Before we get to the Martina Corrigan bit of the
4 transaction, can you recall whether this was a lengthy
5 conversation with whoever it was. You say it may have 10:04
6 been Mrs. Walker, and we will come to that, but was it
7 a short conversation?
8 A. It was a short conversation and I was advised to be
9 very careful.
10 4 Q. Did you sit down for the conversation? 10:04
11 A. No, it was just standing inside the doorway.
12 5 Q. Was there only one person present or more than one
13 person?
14 A. Well myself and the other person, yes, just the two of
15 us. 10:04
16 6 Q. Do you recall inquiring as to whether there was further
17 detail on this or what was to be done about it?
18 A. I was just so shocked, I didn't, I was completely
19 shocked to have been accused of it, you know. That was
20 it, really, I suppose. At the end of the conversation 10:04
21 I was advised to be very careful, and then I left and
22 went down the corridor.
23 7 Q. Did you challenge the allegation when it was made, to
24 the best of your knowledge?
25 A. I can't remember. I mean, whether I said something, in 10:05
26 fact, I don't believe, it's untrue or something like
27 that. I don't remember exactly what I said. Anything
28 I say in that respect I would be making up, I couldn't
29 tell you exactly.

1 8 Q. You say you left, went down the corridor to Martina
2 Corrigan's office. Was she on that corridor?
3 A. Yes. Yes, at the far end of the corridor, just at the
4 corner.
5 9 Q. What was your purpose in going to her? 10:05
6 A. Well, I had been en route to there -- I can't remember
7 if it was a specific route to Heather or the Heads of
8 Service, I often would have popped up to see if there
9 were any issues, I think it was a pop up for any issues
10 the time I called up. Then I wanted to talk to 10:05
11 somebody.
12 10 Q. Sorry?
13 A. Sorry. Then I wanted to talk to somebody. I suppose
14 at that stage I started talking rather than a few
15 minutes earlier, or a few seconds earlier. 10:06
16 11 Q. Yes. Again, when you spoke to Mrs. Corrigan, is that
17 the only person you spoke to at that time?
18 A. She was the only person in the room, yes.
19 12 Q. You go on in this section of the statement to say:
20 10:06
21 "In approximately 2020 I truthfully had difficulty
22 recalling who informed me, Martina Corrigan said I told
23 her at the time that it was Helen Walker -- that's
24 Assistant Director of Human Resources -- I now have a
25 memory of seeing but can't be 100% sure that it's 10:06
26 correct.
27
28 I recall having a conversation with Dr. Rankin who
29 advised that for my sake I should step back from

1 overseeing Urology and I was advised that Robin Brown
2 should assume direct responsibility. I was also
3 advised to avoid any further meetings with Aidan
4 O'Brien unless I was accompanied by the Head of Service
5 or the Assistant Director. As a result I instructed 10:07
6 Robin Brown to act on all governance issues regarding
7 Urology and in particular any issue concerning Aidan
8 O'Brien. At my next meeting with John Simpson" -- who
9 was Medical Director at that time?
10 A. Correct, yes. 10:07
11 13 Q. "I advised him of the issue and the change in
12 governance structure in Urology. There was no formal
13 investigation of the complaint and I checked with Zoe
14 Parks and she said there is no record on my file of the
15 accusation." 10:07
16
17 Just a few points arising out of that. You say you
18 discussed it with Mrs. Corrigan in 2020. Why were you
19 discussing it at that time with her?
20 A. Or approximately 2020. When the Inquiry was being set 10:07
21 up I expected to be called. And that's why I couldn't
22 remember at that stage who.
23 14 Q. Why did you think it might be an issue in advance of
24 the Inquiry or when the Inquiry was announced?
25 A. Well, for me it was a pretty significant event, whereas 10:08
26 I believe that Aidan O'Brien had made a complaint
27 against me, directly about bullying and harassment.
28 I thought that was a significant event and that's why
29 -- but I couldn't remember exactly myself and I thought

1 if I am asked, I couldn't be sure who it was, and that
2 is why.
3 15 Q. Have you ever spoken to Helen Walker about the issue
4 since?
5 A. No. 10:08
6 16 Q. In terms of anyone else in HR, have you spoken to
7 anybody else in HR about this?
8 A. The only person I spoke to in HR was Zoe Parks, and
9 that was in connection when I was preparing my
10 statement. 10:08
11 17 Q. Yes. Did she recall the issue?
12 A. No, she said she had no record, there's nothing on my
13 HR file in that connection.
14 18 Q. You say you recall having a conversation with
15 Dr. Rankin? 10:09
16 A. Yes.
17 19 Q. Who at that time was Director of --
18 A. Acute Director, yes.
19 20 Q. Just following this along the sequence. Who you spoke
20 to in HR telling about the issue, then Corrigan, in 10:09
21 what context were you speaking to Dr. Rankin about
22 this?
23 A. I can't recall exactly what way -- whether it came up
24 -- I think it came up at an informal meeting, it wasn't
25 a formal meeting we had in connection with it at all. 10:09
26 I remember it was discussed with her and, at that
27 stage, she advised me to be very careful not to meet
28 him on my own again, that I should always have Head of
29 Service or Assistant Director with me to avoid any

1 suggestion that I could have been bullying or harassing
2 him.
3 21 Q. Did you bring the issue to her attention or did she
4 know about it?
5 A. I don't recall. 10:10
6 22 Q. You then spoke to Mr. Brown, who at that time was
7 Clinical Director of Surgery?
8 A. Yes.
9 23 Q. You asked him, instructed him I think you said, to deal
10 with Mr. O'Brien if issues arose? 10:10
11 A. Yes.
12 24 Q. Essentially, was the thinking that he would stand in
13 your shoes in terms of his interactions with
14 Mr. O'Brien?
15 A. At that stage -- prior to that, with Robin being based 10:10
16 in Daisy Hill and myself being based in Craigavon
17 I tend to get more of the issues brought directly to me
18 and the point was then I wanted to deal -- I'd already
19 asked Heather and Martina knew to deal more with Robin,
20 and vice versa to Robin, I said to him, 'look, I need 10:11
21 you to take a closer eye on governance for Urology'.
22 25 Q. Did you tell him the reason for this?
23 A. I don't know that I did, but I can't be sure one way or
24 the other.
25 26 Q. But to be clear, Dr. Rankin was aware of the reasons 10:11
26 for the change?
27 A. Yes, Dr. Rankin, Mrs. Trouton, and Martina Corrigan.
28 27 Q. And John Simpson?
29 A. Yes.

1 28 Q. And John Simpson; you made him aware that Mr. Brown
2 would be more to the forefront in dealing with any
3 issue that might arise concerning Mr. O'Brien?
4 A. Yes.
5 29 Q. Was that change in approach, to your mind, approved as 10:12
6 such, because it appears somewhat unusual that you
7 would be handing over essentially an aspect of your
8 powers or your duties as AMD to somebody else?
9 A. Well, a lot of what I really did was CD role because
10 I was based in the Craigavon site. Things were fed 10:12
11 directly to me rather than to Robin, so a lot of that
12 was just being passed back to Robin.
13 30 Q. In terms then of your view of this, if we could go to
14 an earlier part of your statement, WIT-11745. At the
15 bottom of the page, and we are going to go over to the 10:13
16 other page as well, you recite what we know or what you
17 have said, and you say:
18
19 "I consider this to have been a false accusation and on
20 reflection I believe it may have been malicious. Prior 10:13
21 to 2012 I had acted as a major challenge to Aidan
22 O'Brien's opinions and views regarding development and
23 modernisation of the Urology Service and I think he
24 resented my input".
25 10:13
26 In paragraph 29 you deal with the kinds of issues that
27 you were addressing with Mr. O'Brien, including the
28 modernisation of the service, the job plan, and how you
29 had been involved in a process which ultimately reduced

1 Mr. O'Brien's pay by 3 PAs. You say:
2
3 Furthermore you helped organise the nine cystectomy
4 review and challenged him regarding breaches to the
5 protocol for managing the IV fluids and antibiotic 10:14
6 patients. You also challenged him over failure to
7 triage and being involved in discussion to refer him to
8 Human Resources regarding the disposal of patient
9 records in a bin, and also actively supported Gillian
10 Rankin regarding the necessity for Aidan O'Brien to 10:14
11 review the results of patients' investigations once
12 they are available.
13
14 As we saw on Thursday, many of those issues had
15 occurred in 2011 and you say that this issue was 10:14
16 brought to your attention in 2012.
17
18 Of the issues you were addressing with Mr. O'Brien, did
19 any of them become fractious? I know we reflected, to
20 some extent, on this on Thursday, and you said he was, 10:15
21 I suppose, gentlemanly or polite in his approach to
22 you?
23 A. It was frustrating, but no, they were not fractious.
24 There were no outbursts, shouting, things like that.
25 I mean, Aidan O'Brien, whatever else one may say about 10:15
26 him, he is a gentleman.
27 31 Q. You were assured, just scrolling down the page, that
28 management did not believe the false allegation. Who
29 gave you that assurance?

1 A. I believe Dr. Rankin.
2 32 Q. Does that suggest that it was, to your mind or to your
3 impression, discussed amongst management?
4 A. I don't know. I can't say. I admit I was very
5 relieved to have support and believed but I can't say 10:16
6 what discussion went on other than that, you know, what
7 discussion was held with other people I don't know.
8 Dr. Rankin did not make me party to any conversations
9 specifically that she had had with other people about
10 it. 10:16
11 33 Q. You go on to say that the failure to investigate and
12 exonerate you meant you had to be careful about acting
13 in any sort of challenge role, and your oversight of
14 Mr. O'Brien's practice was reduced for fear that it
15 could be misconstrued as evidence of harassment. 10:17
16
17 "On reflection I now feel he achieved his intended
18 objective."
19
20 Were you content at the time that the matter wasn't to 10:17
21 be formally investigated?
22 A. I don't deny that, yes. But as time went on I realised
23 I wished it had been.
24 34 Q. Why do you say that?
25 A. Well, at the time I felt -- I was relieved that I was 10:17
26 believed. I suppose one does not like to be subject to
27 a formal investigation and in that respect I was very
28 relieved from that point of view that I wasn't going to
29 be, but it did restrict my interactions with him and it

1 would have restricted even if it hadn't been a form of
2 bullying, I mean, even if I had been exonerated it
3 probably would have affected my interactions with him
4 from then on anyway even if I had been exonerated
5 because I still would have felt I had to be very 10:18
6 careful.
7 35 Q. In terms of the practical effect of you handing some of
8 the reins, if you like, or some of the issues to
9 Mr. Brown, what was the practical impact of that, in
10 your view? 10:18
11 A. I suppose it reduced the number of times I was getting
12 e-mails or comments or things like that directly about
13 Aidan O'Brien. It had that effect. It still meant --
14 I had a significant workload still as it was, both
15 clinical, but with the other specialties as well and 10:19
16 there are a lot of issues still ongoing within general
17 surgery, to a certain extent ENT and orthopaedics, so
18 I still had more than enough work in that aspect, if
19 you know what I mean.
20 36 Q. Yes. We know, as we will see as we go on this morning, 10:19
21 that issues such as triage, patient records being
22 retained and other issues that developed, they were
23 still happening. There were still issues so far as
24 management were concerned with Mr. O'Brien's practice.
25 You were still being told about those? 10:20
26 A. Some, maybe not to the extent, you know. To a certain
27 extent I was to some things, but I can't say how much I
28 was being told about. I suppose it reduced my direct
29 -- I would not have actively instigated something at

1 that stage as regards Aidan O'Brien's practice because
2 I did not want to be seen to the one to be driving it,
3 but, for example, the 2016 letter, once issues were
4 raised at the end of 2015 and said look, we need to do
5 something about, that was different. I was now not the 10:21
6 main initial driver, so to speak.
7 37 Q. Just to be clear. You obviously held the role of
8 Associate Medical Director?
9 A. Yes.
10 38 Q. Issues, let's pick one, triage, were coming through the 10:21
11 system as regards Mr. O'Brien, this was a problem for
12 operational management. It was still the case that
13 these issues were being drawn to your attention, but in
14 terms of interacting with Mr. O'Brien to try to resolve
15 those issues, that was being done face-to-face or by 10:22
16 e-mail, telephone, by Mr. Brown and Mr. Young?
17 A. Yes.
18 39 Q. Whereas previously perhaps it would be face-to-face --
19 A. I probably -- I was more hands on in a lot of those
20 things whereas afterwards I wasn't. But then again, 10:22
21 I would have thought, in most set-ups, the Clinical
22 Director would be the person would be more hands on
23 anyway rather than we only had one to two Clinical
24 Directors, now there are three. I didn't always have
25 two, that's why I was more directly involved. Plus, 10:22
26 when you add one of the Clinical Directors was not on
27 the same site, also meant that my role quite often
28 overlapped with what would have been the Clinical
29 Director's role.

1 40 Q. If I can ask you directly? Do you think the effect of
2 you stepping back, if I can use that term, had any
3 impact, adversely or otherwise, in terms of the
4 management response to Mr. O'Brien?
5 A. I can't give you a straight answer because I can't -- 10:23
6 the reason I can't give you a straight answer is
7 I can't say what the others felt they could do or not
8 do from an operational point of view or without me
9 directly being involved. It was known that, if
10 necessary, I would meet with him with Martina or 10:23
11 Heather with me. It wasn't that I was never to meet
12 him again, it's just I would be meeting him with one of
13 them if I had to. So, I think -- I can't say if they
14 felt it restricted the practice. I felt that there was
15 enough there still to have continued an oversight with 10:23
16 them plus Robin.
17 41 Q. As we'll see this morning, some issues were drawn
18 directly to your attention --
19 A. Yes.
20 42 Q. -- and you had an opportunity to contribute. Is there 10:24
21 any sense that this development left you in some sense
22 glad that the responsibility for managing Mr. O'Brien
23 at the top of the hierarchy, if you like, within that
24 division, was taken out of your hands?
25 A. You know, no, I wasn't that. I was I was glad, as I 10:24
26 said, that I had been supported by management. It
27 wasn't considered that I had been bullying him, I felt
28 glad about that, and that I wasn't, as a result, going
29 to be subject to a formal Inquiry into it. But with

1 time, I then realised that, you know, that was
2 restricting me to a certain extent and that I felt, by
3 that stage -- I can't say how long afterwards, it was
4 maybe six months, it might have been a year, I don't
5 know, I felt I wish I had been exonerated. 10:25
6 43 Q. In terms of the starting point for this, the
7 communication that you received in that office in 2012
8 was that Mrs. Brownlee had spoken to senior management
9 and she had been told that you were harassing and
10 bullying Mr. O'Brien and her informant was Mr. O'Brien. 10:25
11 Let's just look at that again. Your belief that it may
12 have been Mrs. Walker who shared that with you, and
13 I know that comes through Mrs. Corrigan --
14 A. Yes.
15 44 Q. -- and in assessing what you have said about that, you 10:26
16 tend to the view that it was Mrs. Walker but you can't
17 say for sure?
18 A. I personally can't say for sure, because I just cannot
19 visualise the situation at the time, if you know what
20 I mean. That's why I wrote it accordingly because 10:26
21 I realised if I put down anything else I couldn't stand
22 over it myself.
23 45 Q. Yes. Mrs. Walker has been asked about this. If you
24 just put up on the screen her response, WIT-91872.
25 Just in the middle of the page there, she's asked to 10:26
26 respond to what you'd said at paragraph 92 of your
27 witness statement, which we have just looked at. She
28 says, a few lines in:
29

1 "I have no recollection of ever hearing this and nor
2 have I had any discussion or correspondence with
3 Mrs. Brownlee about any matter concerning Mr. O'Brien
4 or Mr. Mackle. I have no recollection of having any
5 discussion in the context described by Mr. Mackle. In 10:27
6 light of this Section 21 I have double-checked with
7 Mrs. Zoe Parks and she confirmed there is no such
8 complaint on record."
9
10 So, she appears to be ruling herself out as the person 10:27
11 who had the conversation with you.
12 A. Mm-hmm.
13 46 Q. Mrs. Brownlee, for her part, says that she never made
14 a complaint about Mr. Mackle bullying or otherwise, and
15 Mr. O'Brien says that he did raise a complaint, 10:28
16 a grievance, about you in 2012, and he points to that.
17 It doesn't appear to have used the language of bullying
18 or harassment, it was, strictly speaking, a financial
19 complaint. Let's just look at that complaint.
20 10:28
21 If we go to WIT-90376. Sorry, that's the wrong page?
22 WIT-90380, please. Yes. We can see 30th January 2012.
23 It's the same year that you referred to when talking
24 about the bullying and harassment complaint. If we go
25 to the third paragraph, perhaps. He is saying that 10:29
26 back in 2010, he had agreed with the Head of the ENT
27 and Urology that he would be remunerated for some
28 additional work to be conducted in Thorndale on
29 Fridays, and he goes on to say when he received payment

1 in April 2011, he didn't recognise the amount. The
2 payment appeared to have been halved, and some sessions
3 he wasn't paid at all. When he inquired about this,
4 payroll personnel informed him that they were unable to
5 decipher the signature and he was then provided with 10:30
6 a copy of the claim form and he was able to ascertain
7 from that that you had made the deductions. That's the
8 complaint that he said he made in respect of you in
9 2012. That complaint was drawn to your attention, was
10 it? 10:30
11 A. Yes, by Dr. Rankin.
12 47 Q. If we go to WIT-90379, this is Mrs. Parks, who we have
13 heard something about. She records that she has spoken
14 to you about the issue:
15 10:31
16 "These claims were change by the AMD Mr. Mackle but
17 I have spoken to Mr. Mackle and Heather Trouton and it
18 seems there was some misunderstanding about what had
19 agreed against his job plan, however they agreed to
20 concede as changes shouldn't have taken place without 10:31
21 prior discussion with Mr. O'Brien."
22
23 There was, plainly, a complaint, a financial complaint.
24 You were spoken to about it by Zoe Parks, you also
25 think by Dr. Rankin? 10:31
26 A. Yes.
27 48 Q. Did you speak to Mrs. Trouton about it as well?
28 A. Yes. I can't recall exactly but I know we did talk
29 about it, because I had sat in her office originally

1 when it was being done.
2 49 Q. Yes. I don't think we need to get into the minutiae of
3 the financial issue but it appears that you were
4 prepared to give ground on the issue and the issue was
5 resolved? 10:32
6 A. I was wrong not to have referred it back to him rather
7 than sent the form on through to Finance. I should
8 have sent it back to him for further clarification, and
9 I accept totally I was wrong in that.
10 50 Q. Is it possible, Mr. Mackle, that your perception of 10:32
11 what was being complained about did become, in its
12 telling, somewhat confused when this issue, the
13 financial issue, was raised with you in 2012?
14 A. I don't think so, no. I mean, I can't remember the
15 timing. You know, that was not a good time for me from 10:33
16 a family point of view as regards my wife's health, and
17 so I cannot recall when in 2012. Was it before March
18 or was it after March the complaint was made to me? In
19 that respect I don't recall which, but what I was told
20 at the time was, it was Roberta Brownlee and that was 10:33
21 where the complaint had come from. That part I do
22 remember. That stuck out that the Chair of the Trust
23 would have been saying, you know, speaking negatively
24 about me, and that's the part of the conversation
25 I vividly remember. 10:33
26 51 Q. Are you now remembering two distinct issues raised, it
27 appears, that year, a bullying and harassment issue and
28 a financial issue; are they distinct events in your
29 mind?

1 A. I think they are but I can't say for definite. As
2 I say that occurred January/February time that the
3 complaint was made. March was a significant date for
4 me. I think it was later in the year but I don't know.
5 52 Q. Yes. I am conscious of what you say stands out in your 10:34
6 mind, the fact that Mrs. Brownlee was attached --
7 A. Yes.
8 53 Q. -- to the narrative? Let me just press this one point
9 finally. Is it possible that in the telling to you of
10 the financial issue raised by Mr. O'Brien, that 10:34
11 somebody could have said you need to be careful, your
12 behaviour in this could be construed as bullying and
13 harassment?
14 A. I don't recall it being said that way when I was
15 informed. No, I don't recall it being said that way. 10:35
16 I do recall Dr. Rankin advised me to be very careful to
17 make sure nothing else -- nothing I would do in the
18 future could be construed as bullying and harassment,
19 that part I do recall but not the initial telling.
20 54 Q. After this issue was put to bed, the financial issue, 10:35
21 and what you appeared to be saying the separate issue
22 of bullying and harassment, were those issues ever the
23 subject of conversation again after that period of time
24 elapsed?
25 A. Not that I recall, no. 10:35
26 55 Q. I want to spend the rest of the morning looking at the
27 developments that occurred after that, taking us up to
28 2016, when you met with Mr. O'Brien. In the period
29 after 2012, and before you met with Mr. O'Brien in

1 March 2016, did you have any face-to-face engagements
2 with him to challenge him about any aspect of his
3 practice?
4 A. I would have had face-to-face engagements with him over
5 clinical things I think but not that I can recall over 10:37
6 any challenge.
7 56 Q. Yes. We looked last week at the issues around triage,
8 for example, amongst other issues. In the period after
9 2012, it's fair to say that the issue of triage was
10 never resolved? 10:37
11 A. Correct.
12 57 Q. It was still an issue in March 2016, just as it had
13 been an issue at the start of your role as AMD. The
14 Inquiry will have an opportunity to look at the
15 correspondence in respect of that. It appears from 10:37
16 that correspondence, and the Core Participants can
17 comment on this as they wish, but Mr. Brown was more
18 often the recipient of correspondence from operational
19 side dealing with shortcomings in triage than were you,
20 but let me just look at aspects of that so that we can 10:38
21 work out what you were aware of. If we look at
22 TRU-276904. This is November 2013. Heather Trouton,
23 the Assistant Director, is writing to Mr. Young and
24 Mr. Brown, and the subject is "missing triage, needing
25 a response". If we can scroll down, please. Within 10:39
26 this she is also dealing with the issue of having
27 charts at home. She says that she had personally
28 spoken to Mr. O'Brien about this practice on various
29 occasions, Martina Corrigan also much more often?

1
2 "While we very much appreciate Aidan's response
3 I suspect that without further intervention by senior
4 colleagues it will not happen".
5 A. Sorry, could you scroll down, please? 10:40
6 58 Q. Yes, of course. She says, and this is referring to
7 correspondence that's come in from Mr. O'Brien:
8
9 "Mr. O'Brien recognises that they have been very
10 patient and that they have offered help in the past but 10:40
11 the delays continue."
12
13 The upshot of it is, that is the operational side:
14 "We really need you to speak with Mr. O'Brien in the
15 capacity of a colleague but also as your capacity as 10:40
16 Clinical Lead and Clinical Director in Urology as well
17 as of course as patient advocate."
18
19 I am bringing that to your attention. It appears it's
20 a cry for help from the operational side to get this 10:41
21 sorted out and it's going to the Clinical Director and
22 the Clinical Lead. The issue of triage clearly still
23 being spoken about. Is it coming to your attention as
24 well throughout all of this?
25 A. I can't say that there was -- that I thought there was 10:41
26 no issue with triage, but I can't recall -- I mean
27 I could not recall specifics of being raised as a major
28 issue until the end of 2015. I mean the triage was an
29 ongoing issue all the way through, and I admitted last

1 Thursday we collectively did not see an issue --
2 a Patient Safety issue with that. Debbie Burns had
3 introduced in 2014, the system whereby they were
4 automatically put on the waiting list and then the
5 triage may be upgraded, or triage may upgrade them. 10:42
6 But as I say, there was a collective failure to see
7 that there could be a serious risk from it.
8 59 Q. Yes. I mean, we needn't go directly to the e-mails
9 just in the interests of time, perhaps, but what we see
10 over the period of the next two or three years, 10:42
11 perhaps, leading up to 2016, is a series of what might
12 be described as workarounds, some polite pressure being
13 put on colleagues to help Mr. O'Brien help the service
14 out of this fix, another solution was well, he will
15 only deal with the named referrals? 10:43
16 A. Yes.
17 60 Q. Then, even that appears not to have corrected the
18 problem, and Mrs. Burns or the service -- maybe not
19 particular to her we will keep it general for the
20 moment -- comes up with the idea of using the general 10:43
21 practitioners' classification of the referral for
22 putting on to waiting lists while we await the triage.
23 Were you aware of these various fixes that were
24 attempted?
25 A. I was aware of the ones where Michael Young took on red 10:43
26 flags, where Mahmood Akhtar had a team of red flags of
27 the support he has given at times. When I was
28 initially preparing my report I had completely
29 forgotten about the workaround, no -- of having initial

1 knowledge of that of the GP using it, and when I saw
2 the evidence I realised I had known about that but
3 I had forgotten about that part.
4 61 Q. Mm-hmm. Mm-hmm. We have these workarounds, and as
5 I say, I think you acknowledge that they didn't 10:44
6 succeed. Could I have your reflections on why, rather
7 than attempt to broker these alternatives to
8 Mr. O'Brien doing the triage, why was his role not more
9 aggressively or robustly pushed?
10 A. When you see all the evidence, the documentation, the 10:45
11 e-mails, et cetera, all tabulated and all together,
12 it's obvious that something more should have been done,
13 you know, and I admit that. As I said on Thursday,
14 a lot of how we judged him was on, you know, he was not
15 somebody who kind of buzzed in for an hour during the 10:45
16 day, disappeared off to do his private all afternoon,
17 never seen after that that. He was there late in the
18 evenings. He had always that reputation of being
19 there. He was held in high regard by everybody, by the
20 anaesthetists, other doctors, the nurses in the wards, 10:45
21 and that's why he'd get judged accordingly. I think
22 it's easier if you have somebody who you get the
23 impression is an absolute slacker to start to take them
24 on managerial-wise and performance-wise, but he was
25 seen as performing and performing hard -- working hard 10:46
26 and that's why.
27 62 Q. Could I ask you for your impressions of the default
28 arrangement that was used, that's the idea we spoke
29 about earlier.

1 A. Mmm.
2 63 Q. If we go to TRU-277196. The timeline has moved into
3 2014. Look at the bottom of the page first. And it's:
4
5 "Can you arrange for the following Urology referrals to 10:46
6 be returned from triage as soon as possible?"
7
8 Then Catherine Robinson, in the booking office, is
9 saying, as you can see --
10 CHAIR: Sorry, Mr. Wolfe, could we move on to that, 10:47
11 please?
12 MR. WOLFE KC: Of course.
13 64 Q. That's the bottom of the page e-mail. Then brings
14 Mrs. Robinson's intervention. She is saying:
15 10:47
16 "These have all been chased several times."
17
18 It's all being dealt with on the operational side.
19 I am not suggesting that you have seen this,
20 Mr. Mackle. The discussion is around booking these 10:47
21 patients into the waiting list. At the top of the
22 page, Anita Carroll says to Mrs. Trouton:
23
24 "Don't panic, as you know we are going to the GP triage
25 anyway." 10:48
26
27 Your impressions of that. Does that suggest that this
28 default arrangement was in some sense a good solution
29 and that there was nothing to be concerned about?

1 A. It was a solution which I suppose was a fail-safe
2 solution, that something happened. As I said, I -- we
3 did -- in fact I think it was 2017 I published, with
4 Robert Spence a review of one year's red flag referrals
5 -- referrals to upper and lower GI in Craigavon we 10:48
6 found a very small percentage got upgraded. We didn't
7 have the numbers for those that produced cancers but
8 that was even lower again. So GPs largely get it
9 right, but we, from a colorectal point of view, used
10 the triage system not so much for the cancers but we 10:49
11 did look at it from that point of view, but things like
12 inflammatory bowel disease, et cetera, which were not
13 technically covered by the red flag process and
14 couldn't wait for an urgent appointment.
15 65 Q. But I think, as you acknowledged last week, triage was 10:49
16 something that was valued within the system?
17 A. Yes.
18 66 Q. If it isn't being triaged, if referrals are not being
19 triaged there is this risk, it may be low percentages
20 but there is this risk that patients who have come in 10:49
21 with an urgent referral or routine referral are not
22 being appropriately --
23 A. I don't disagree with that, yes.
24 67 Q. Yes. Certainly, as the timeline moves on, 30th
25 November 2015, Mrs. Corrigan is writing to Mr. Young. 10:50
26 If we can turn to TRU-258498. She says:
27
28 "I will really need help at getting this resolved as
29 there are currently 277 not triaged letters from

1 Mr. O'Brien who has been on-call dating back to October
2 2014."
3
4 As we go on this morning we will look at how this issue
5 became one of the issues that was looked at in March 10:50
6 2016 meeting. But within the Service and within the
7 Directorate, surely it was appreciated by this stage,
8 Mr. Mackle, that Mr. O'Brien, for whatever reason, and
9 he says he just didn't have the time to do referrals
10 other than red flag referrals, surely it was 10:51
11 appreciated that these non-red flag referrals just
12 weren't being done or were being done in fewer numbers
13 than ought to have been the case?
14 A. Sorry, I'm not sure all of those were red flag
15 referrals but I can't be 100% certain on that one. 10:52
16 68 Q. No, what I'm saying is, his position, that he could not
17 find the time to do anything other than red flag
18 referrals, was that position known to you?
19 A. I don't recall ever being told that Aidan had stopped
20 doing all referrals other than red flags. At that 10:52
21 stage they were working the Urologist of the Week
22 process, whereby they had traditionally what had
23 happened, in general we did that a bit early in 2000,
24 2002 I introduced it, where the surgeon was on-call for
25 emergencies but would still have clinics to do, maybe 10:52
26 was in theatre to do the next morning, would have
27 clinical issues and was trying to manage those patients
28 around that, that was not a particularly safe system,
29 so we introduced it in general surgery around, I think

1 it was 2014 but I can't remember exactly it was
2 introduced for Urology as well, where they had half
3 a day, where they could concentrate on emergencies,
4 they had no clinical issues and that was each morning
5 -- each morning during the week they had first access 10:53
6 to the theatre. We in general surgery said they could
7 always have the first slot in the theatre in the
8 morning, unless we had a really dire emergency, to get
9 their significant cases done, and as part of that,
10 during that time, they would do their triaging. That 10:53
11 was agreed by all, that they would take on to do that.
12 At no point in time did I know that Aidan O'Brien was
13 not doing it.
14 69 Q. What you do know and what the system knows is that,
15 taking these figures on this e-mail as they are, there 10:53
16 is a substantial backlog. It's going back 18 months.
17 What is the diagnosis?
18 A. That there's a failure -- there is a definite failure
19 for him from a performance point of view. This is one
20 of the issues that triggered the following month the 10:54
21 discussion about what to do with the Medical Director.
22 70 Q. Yes.
23 A. During December.
24 71 Q. Of course. But I say what is the diagnosis, was there
25 an attempt to diagnose what the problem was before we 10:54
26 got to that point in March?
27 A. No.
28 72 Q. It was, as you have described it and others have
29 described it, periods of compliance followed by lengthy

1 periods of non-compliance and chasing and chasing and
2 then, as it seems, a build-up that was never tackled.
3 Was there no attempt to grapple with a cause? What is
4 the cause of this so that solutions could be arrived
5 at? Or, was it considered insufficiently important or 10:55
6 too bothersome to actually effectively address it?
7 A. I can't give you a straight answer on that. As I say
8 when one looks back now, one thinks why on earth did we
9 let it go on? I can't give you a straight answer why
10 it -- I can't think -- I don't think there's one simple 10:55
11 thing that we said, you know, oh don't worry about it,
12 everything will be fine. It was not that. There may
13 have been an element of fatigue, I suppose, the number
14 of times he was challenged, he'd do it, challenged,
15 he'd do it, eventually people stopped challenging to 10:56
16 the same extent. I think there was probably reliance
17 on the fact that the fallback system introduced by
18 Debbie Burns at least would prevent the risk. There
19 was an element that Aidan would never say himself I am
20 not able to do them, I can't do -- he never would turn 10:56
21 around and say, I have all this backlog because I can't
22 get anything done. He never came forward and said --
23 well I tell a lie, sorry, because there was back in
24 2007 when he did ask for time for admin, but he wasn't
25 coming along and saying, 'I cannot do this, I'm 10:56
26 failing'. So I can't give you one simple reason why,
27 I'm sorry.
28 73 Q. Yes. You say fatigue, amongst several reasons,
29 perhaps, but whatever those reasons are, it is in the

1 face of what I think you now accept was risk of harm to
2 patients?
3 A. Yes.
4 74 Q. Maybe small numbers --
5 A. But. 10:57
6 75 Q. -- still relatively speaking, but we know that there
7 were six Serious Adverse Incidents generated in the
8 time that followed, starting in 2015/'16, and then with
9 one patient -- sorry, I don't have the cipher list in
10 front of -- and then a further five on top of that. 10:57
11 You say in your witness statement, if I can just bring
12 up WIT-14780, and if we go to item C at the bottom of
13 the page, you say that you accepted in the context of
14 the persistent and recurring issues regarding triage,
15 you don't recall ever considering the MHPS Framework 10:58
16 "as far as I can tell, none of the Acute Directors,
17 Medical Directors considered the MHPS Framework either.
18 I now believe on reflection that the repeated failure
19 by Aidan O'Brien to complete timely triage should have
20 triggered an investigation under the MHPS Framework." 10:58
21 A. Yes.
22 76 Q. That's obviously with the benefit of thinking about
23 matters now. What, in particular, would have justified
24 an MHPS investigation, do you think? Or why would that
25 have been an appropriate step? 10:59
26 A. I think the continued failure to triage, but when
27 I think back having to change the rules of how you book
28 patients on the clinics because one Consultant's
29 failure to triage when other consultants in the

1 speciality were, I think that should have been more
2 formally investigated.
3 77 Q. Yes.
4 A. As to whether he needed support or whatever or NCAS
5 involvement but to formally investigate it. 10:59
6 78 Q. Yes. It's the absence, as you now realise, of any
7 formal attempts to get to grips with this issue,
8 instead the repeated informal approach that you think
9 was problematic?
10 A. Yes. 11:00
11 79 Q. You said in your witness statement that, as regards the
12 retention of patient notes or charts at home, that was
13 a problem that was known to affect some clinicians,
14 perhaps many clinicians and not just Mr. O'Brien. The
15 issue you say was first flagged with you, as far as you 11:00
16 can recall, in 2013. If we just bring up Martina
17 Corrigan's input on that. WIT-11966. I will just
18 check the reference on that. Yes, sorry, I was
19 confused by the redaction. Ms. Corrigan is saying to
20 -- this is the bottom of the page, sorry, 21st 11:02
21 September 2013, to Mr. Brown, which he copied in, and
22 she says:
23
24 "Below is another Datix received in respect of charts
25 being at Aidan's home. This is the second one last 11:02
26 week and I am receiving at least one of these each week
27 as health work records are continuing to spend time for
28 charts that they discover are in Aidan's house."
29

1 Scrolling up the page, Mr. Brown said that you dealt
2 with this matter -- sorry, this matter was raised
3 a couple of weeks previously. He texted, that is
4 Mr. Brown texted Mr. O'Brien but he didn't reply.
5 11:02
6 "Last time there was a problem like this I drove over".
7
8 He says: "... did look like a bit of an ambush and
9 might have been a bit counterproductive. I think it
10 might be better if I could catch him at the beginning 11:03
11 or the end of an MDM".
12
13 And he proposes that. So Mr. Brown is going to address
14 the issue. But the issue wasn't resolved, was it,
15 Mr. Mackle? 11:03
16 A. No, it wasn't.
17 80 Q. It's still an issue in March 2016?
18 A. Yes.
19 81 Q. If we go to, for example, TRU-278656, and just start at
20 the bottom of the page, please. Pamela Lawson is 11:04
21 e-mailing Anita Carroll, and she is highlighting that
22 these are the details of the IR1 forms regarding charts
23 Mr. O'Brien has had to bring in from his home for
24 clinics and admissions. So detailing charts for which
25 incident reports have been raised from 2013 into 11:04
26 February 2014, and if we look at the top of the page,
27 we can see that you are copied into this. Again, more
28 than 50 incident reports raised in relation to charts
29 that cannot be found and assumed to be in Mr. O'Brien's

1 home. Mr. Mackle, in terms of an issue like that, we
2 can see that it raises data protection-type issues, so
3 clinical notes, property of the hospital and property
4 of the patient, they shouldn't be in a Consultant's
5 home, I suspect, except perhaps overnight, if he's 11:05
6 coming from a clinic, say, in Enniskillen and has yet
7 to reach hospital premises to return the chart. But
8 again, when you see and when you saw those kinds of odd
9 numbers, was there any consideration between you and
10 your colleagues as to what this was a symptom of? 11:06
11 A. No. I forwarded that e-mail, I see, to Deborah Burns
12 to make her aware as well.
13 82 Q. Yes.
14 A. But no, we didn't.
15 83 Q. It wasn't, as you now know, simply a data protection 11:06
16 issue. Assumedly if you had thought about it, one of
17 the issues that might have occurred to you was that
18 this was a retention of notes so that further work
19 could be done on the record and, as we now know,
20 a problem emerged from 2015, I think you say, where it 11:07
21 was recognised that Mr. O'Brien wasn't dictating the
22 outcome of clinics?
23 A. Yeah.
24 84 Q. But that wasn't recognised?
25 A. No, that wasn't thought of or considered at that time, 11:07
26 no.
27 85 Q. Was there any consideration of a diagnosis of the
28 problem? What lies behind the fact that so many charts
29 are not with us and not in the right place?

1 A. Aidan O'Brien, when I first went to -- when I went to
2 Craigavon and ultimately he was appointed a year or so
3 later, his office was next door to mine and he always
4 had charts in his office on the floors, loads of them.
5 His system from the very start always had that and 11:08
6 I think there was an element that it was kind of that's
7 the way Aidan does it and people tolerated it. If you
8 were looking for a chart you went into his office and
9 there were row upon row upon row on the floor of charts
10 so they would be easily looked at and identified, and 11:08
11 I think there was an element of, it was accepted, not
12 accepted that the charts weren't available but not
13 actively considered why.
14 86 Q. If we look, and I would be anxious to have your
15 observations on this, at an e-mail that was sent to 11:08
16 Mrs. Trouton in 2015. TRU-277895. Just if we start at
17 the bottom of the page. Anita Carroll writing to
18 Heather Trouton and Martina Corrigan.
19
20 I'm not sure what the first question means, but clearly 11:09
21 the subject matter is "charts at home and Aidan O'Brien
22 -- should have something on Risk Register in relation
23 to this. Suggests Anita Carroll. Mrs. Trouton says
24 that she spoke to Mr. Young about this last week and he
25 is going to speak to Aidan again. I will consider the 11:09
26 Risk Register below with that, you are supposed to
27 address the risk and eliminate it. This is down to
28 a personal way of working which seems impossible to
29 stop."

1
2 It appears to be an element of weariness in what's said
3 there and we will ask Mrs. Trouton about that.
4 A. Mmm.
5 87 Q. In terms of it being impossible to stop, what does that 11:10
6 say about the management of this clinician in respect
7 of a problem that has been prevalent for some several
8 years?
9 A. That the softly softly approach doesn't work or isn't
10 working. Most consultants, once you spoke to them, 11:10
11 would have acted, changed their practice and settled,
12 you know, without you having to continue to go back.
13 I think it just shows that that approach did not work,
14 or was not working.
15 88 Q. Yes. I know that you have reflected in your witness 11:11
16 statement that some issues were well dealt with. You
17 reflect the fact that the IV antibiotic issue, the
18 cystectomy issue, to take but two, were, in your view,
19 appropriately handled. We do have these other issues
20 which is, as I think you accept or acknowledge, were 11:11
21 not well-handled. Another example I want to ask you
22 about, and have your view on, is the issue of private
23 patients.
24
25 If we just bring up your witness statement, WIT-14787. 11:11
26 At paragraph 41 you say you cannot recall being
27 presented with any evidence that Aidan O'Brien was
28 prioritising patients for scheduling on the basis of
29 them having seen him privately.

1
2 "I believe the issue was raised as a possibility with
3 Heather Trouton on a few occasions but then when
4 challenged by Heather Trouton and Martina Corrigan
5 Aidan O'Brien had sound clinical reasons for his 11:12
6 prioritisation. I cannot recall when I was informed of
7 this, for the avoidance of doubt, I had no direct or
8 first-hand involvement in the matter."
9
10 Does that suggest that you were informed about the 11:12
11 issue by Martina or Heather at one point or another
12 A. An occasional time I had heard there had been
13 a question whether somebody had been admitted had been
14 private and Martina would check, and I believe it was
15 Martina checked, he would have a clinical reason why 11:13
16 they needed to come in, and so I was never raised with
17 me that patients without clinical reasons who had been
18 seen privately were queue-jumping.
19 89 Q. Can you see, Mr. Mackle, an anomaly in an operational
20 manager challenging a senior Consultant about an issue 11:13
21 such as this?
22 A. I take your point. It should probably therefore have
23 been Michael Young challenging him.
24 90 Q. Mr. Haynes took this issue up with Mr. Young on two
25 occasions. I just want to look at that with you. If 11:14
26 we go to WIT-54107. He is writing to Michael Young and
27 Martina Corrigan in May 2015. He is a recent
28 appointment. He has been in the Urology service just
29 about a year at this point?

1 A. Just about a year, yes.
2 91 Q. There has been discussion about the waiting list issue
3 and he is concerned about how Mr. O'Brien addresses
4 private patients in this context, and he says that:
5 11:15
6 "I feel increasingly uncomfortable discussing the
7 urgent waiting list problem while we turn a blind eye
8 to a colleague listing patients for surgery, out of
9 date order, usually having been on a Saturday non-NHS
10 clinic. On the attached total urgent waiting list 11:15
11 there are 89 patient listed for urgent TURP, the
12 majority of whom will have catheters in situ, they have
13 been waiting up to 92 weeks."
14
15 He cites the example of a patient, and we will redact 11:15
16 that patient's name in due course, and he says that:
17
18 "This patient was seen in a private clinic on 18th
19 April and admission arranged for 25th May 2015 against
20 a background of retention two months earlier." 11:16
21
22 He goes on in the remainder of the letter to say:
23
24 "This behaviour needs to be challenged and a stop put
25 to it." 11:16
26
27 He's happy to discuss and plan a strategy for taking
28 this forward. So, he is putting the ball into
29 Mr. Young's court to address.

1
2 If we can go to the earlier page, WIT-54106, and he is
3 writing again, it's now November and he recalls the
4 earlier correspondence and he says that, in his view,
5 particular private patients are being brought on to NHS 11:17
6 lists having significantly jumped the waiting list.
7
8 "I have expressed my view on many occasions, this is
9 immoral and unacceptable. Aside from the immorality of
10 patients who have the means to seek private 11:17
11 consultations having their operations on the NHS list
12 to the detriment of patients without the means who sit
13 on the waiting list for significant lengths of time,
14 the behaviour is apparent to outsiders looking in."
15 11:17
16 He asks: "Can you advise me what action has been taken
17 since I raised this?"
18
19 We will deal with Mr. Young in due course in relation
20 to this, but as the Associate Medical Director for this 11:18
21 Department, was Mr. Young coming to you and saying
22 these issues are now being addressed with me on two
23 occasions, and Mr. Haynes says he has expressed his
24 view on many occasions, I am not sure what forum that
25 was in? 11:18
26 A. No.
27 92 Q. No. What should have been done, in your view,
28 Mr. Young being familiar with the concern now on at
29 least two occasions?

1 A. I think once Michael was having it raised by
2 a Consultant colleague he should have escalated it.
3 93 Q. By escalating it, drawing it to your attention or
4 Mr. Brown's attention or dealing with it himself?
5 A. If he dealt with it in June and it was still happening, 11:18
6 then it hadn't been resolved, therefore he needed to
7 escalate even further and I would have said that was
8 something I would have taken on myself.
9 94 Q. Was it a known problem in the Southern Trust that
10 consultants were promoting their private patients 11:19
11 unfairly on to NHS lists?
12 A. No. As I think I said the other day, I have had --
13 I did private practice myself and occasionally they
14 would have been brought in, but there were clinical
15 reasons for bringing them, there were genuine clinical 11:19
16 reasons, not routinely, they were not routinely bumped
17 up the list, and I was not aware that other clinicians
18 routinely moved patients up the list. In fact, I was
19 not aware that anybody was routinely moving people up
20 the list because they had been seen privately. 11:19
21 95 Q. Was this an issue that was well-policed by the Trust,
22 in your view?
23 A. I don't think the Trust had a system for -- actually,
24 when you ask was it policed, the Trust, as far as
25 I know, did not have a formal system for assessing it 11:20
26 and for looking into that and for auditing it, no.
27 I don't know if other Trusts do but I know our Trust
28 didn't.
29 96 Q. Going back to your earlier answer that Mrs. Corrigan

1 and Mrs. Trouton would have received, to the best of
2 your understanding, acceptable clinical justifications
3 from Mr. O'Brien if challenged. That does suggest that
4 there was a level of conversation around this issue,
5 but it didn't particularly reach your ears? 11:20
6 A. Not particularly. I mean I think an individual case or
7 two was mentioned, something like that, but not
8 a routine thing. At least I was not aware that every
9 week, oh this patient has jumped the list or that, no,
10 I was not. 11:21
11 97 Q. You know that by the time of the MHPS investigation,
12 that I think the figure was nine cases were
13 investigated, nine private patients who had been
14 treated in an advantageous way, was the allegation.
15 Again, the fact that this issue appears not to have 11:21
16 been addressed, certainly not addressed to the
17 satisfaction of Mr. Haynes so that when it came to the
18 end of 2016, he was suggesting to the Medical Director
19 that it needed to be investigated formally through the
20 MHPS process, or added to the list of things that would 11:21
21 be formally investigated. Do you accept that, before
22 that, this issue was given a blind eye, it wasn't
23 properly challenged or explored?
24 A. I think -- it's difficult for me to answer for others
25 in that respect because what I knew there was not 11:22
26 a major issue, and there appeared to be clinical
27 grounds. I was not aware of Mark Haynes' e-mails. He
28 hadn't spoken to me about it, so I can't answer for
29 others on what happened after Mark sent the e-mail or

1 the second e-mail, I don't know.
2 98 Q. But what you can say is that Mr. Young didn't draw it
3 to your attention?
4 A. No.
5 99 Q. And what he ought to have done, in your view, was to 11:22
6 have escalated it if the issue couldn't be resolved at
7 his level?
8 A. Yes.
9 100 Q. Can I ask you about the particular issue of
10 pre-operative assessment? 11:23
11 CHAIR: Mr Wolfe, might this be an opportunity to take
12 a short break?
13 MR. WOLFE KC: Yes, I think so, Chair.
14 CHAIR: So 15 minutes, if we say about 25 to.
15 11:23
16 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
17
18 MR. WOLFE KC: Mr. Mackle. Just coming back to an
19 issue the pre-operative assessment I would like to ask
20 you to comment on. If we could have up on the screen 11:40
21 TRU-277928. At the bottom of the screen.
22 Mrs. McKeown, did you know her?
23 A. Yes.
24 101 Q. And her role was Head of Theatres?
25 A. Yes. 11:41
26 102 Q. She is saying to Martina Corrigan and others, copying
27 in Mrs. Trouton and Mr. Carroll, that:
28
29 "As you will see, three out of the five patients have

1 not been to pre-op. Can you please investigate why and
2 advise why these patients were never sent to pre-op, as
3 to get this level of notification of their surgery is,
4 as I'm sure you will agree, unacceptable. We are now
5 in a position where we are unable to get these three 11:41
6 patients pre-assessed due to the extremely tight
7 timeframe before their surgery. I have also attached
8 a second e-mail from Rachel -- that's Rachel Donnelly
9 -- regarding Mr. O'Brien's inpatient list on 4th
10 November". 11:42
11
12 There are again a couple of patients on the list who
13 have not been to pre-op.
14
15 That issue is ultimately forwarded to you. If we just 11:42
16 scroll up, please. Do you recall that issue being
17 raised with you?
18 A. Not specifically. I've read the e-mail, obviously,
19 with the witness bundle but I don't recall. I can't
20 specifically remember it at the time. 11:42
21 103 Q. Yes. Was a failure to provide for the pre-op of
22 patients or for the timely pre-op of patients, an issue
23 that was raised with you beyond this?
24 A. Prior to that, that I can think of, no, although pre-op
25 assessment came under Ronan Carroll's and Dr. Stephen 11:42
26 Hall who is over all responsible for that Directorate
27 or that -- Directorate, yes. The provision of theatres
28 -- theatre management was not under my remit at all.
29 104 Q. Okay. You tell us in your witness statement that in or

1 about late 2015, you became -- or the management became
2 increasingly aware of a concern regarding the patient
3 centre letter and outcomes. Let me just look at that
4 with you. If we can have up on the screen your
5 statement, please. WIT-11819. At paragraph 226, you 11:43
6 say that:
7
8 "In this context, some of the urologists were
9 undertaking waiting list work validation and found that
10 many of Mr. Aidan O'Brien's patients that clinical 11:44
11 outcomes and letters were not recorded and there was no
12 record in the chart. It is also noted that many of the
13 hospital charts were not available for clinics."
14
15 This takes me back to something we discussed earlier, 11:44
16 that the absence of the patient chart or the patient
17 file was undoubtedly symptomatic of Mr. O'Brien's need
18 to clear up dictation, that seems clear at this remove,
19 but it wasn't something that occurred to you at the
20 time? 11:44
21 A. Sorry, I didn't quite --
22 105 Q. The fact of him retaining patient notes at home being
23 symptomatic of this other issue --
24 A. No.
25 106 Q. -- wasn't something had occurred to you? 11:45
26 A. I assumed they were related to private patients rather
27 than related to NHS patient. I know they were NHS
28 charts but I didn't think of them as being charts of
29 clinics. I assumed charts were taken up because he had

1 seen a private patient or was seeing one.
2 107 Q. Yes. This issue was drawn to your attention by whom?
3 A. I'm assuming Heather Trouton.
4 108 Q. Could I just look perhaps at what might be an example
5 of what we are talking about. If we go to TRU-258492, 11:45
6 please. Sorry, if we go to 258494. If we start at the
7 bottom of the page, I am going to work up. If we keep
8 in mind the name of the patient without actually using
9 his name. We can see that this is from Alana Coleman
10 to Leanne Brown on 14th July: 11:46
11
12 "Please see attached referral, please forward to
13 Mr. O'Brien and advise of the outcome."
14
15 The next step, just scrolling up, please: 11:46
16
17 "Please advise of triage. Does this patient require
18 a review or is this just information?"
19
20 So that's August. Next e-mail, please? This is to 11:46
21 Mr. O'Brien's secretary:
22
23 "This patient was seen in June at the South-Western
24 Area Hospital. Patient has not been discharged or
25 reinstated for a review following last attendance. 11:47
26 Please advise of Mr. O'Brien's decision on the attached
27 referral. Is there the referral for info or urgent
28 routine review?"
29

1 Scrolling on up. It's now November and there has been
2 no response to the queries on this patient. It's still
3 November, Mr. O'Brien's secretary has been contacted
4 again and Leanne says:
5 11:47
6 "No follow-up has been arranged. Can you check the
7 outcomes sheet to see if he needs reviewed or
8 discharged, please?"
9
10 Andrea says to Martina Corrigan: 11:48
11
12 "See below. This Consultant does not use clinic
13 outcome sheets. The clinical decision is outstanding."
14
15 What's a clinic outcome sheet? 11:48
16 A. Basically, if you see a patient in the clinic you
17 dictate what you are going to do with him and it's
18 recorded whether the patient is for further
19 investigation, for discharge, for review, for
20 admission, and if they are for review how urgent the 11:48
21 review is.
22 109 Q. If you see a patient in clinic, is that something you
23 should do? You should complete this so that people in
24 the system have an idea of what has happened and what's
25 coming next, or is it something that's not in any sense 11:48
26 obligatory?
27 A. I can't remember exactly this one. There was a while
28 where actually the sheet appeared for us to fill in,
29 but largely the sheet was completed from the dictation

1 on the clinic and you said in your clinic letter what
2 all needed done. I think my secretary largely filled
3 it in at that stage. There was a spell where it did
4 appear in the clinic to fill in, but largely I think it
5 was filled in by the secretary, based on what you 11:49
6 dictated, and it was obvious from what you dictated
7 what you wanted done.
8 110 Q. If we could scroll up the page, please. Martina
9 Corrigan is writing to Michael Young in relation to
10 this: 11:49
11
12 "Can we discuss, please?"
13
14 Then at the top of the page, Michael Young has apprised
15 himself of the issue and he says: 11:49
16
17 "Appears to have been seen."
18
19 There's no letter. What does US mean?
20 A. Ultrasound. 11:50
21 111 Q. Ultrasound?
22 A. It's the ultrasound request. The form that would go in
23 with it? Not form, but electronically.
24 112 Q. Michael Young says:
25 11:50
26 "I would suggest this is not serious but the patient
27 and GP are not in the loop."
28
29 I think he is suggesting not that the issue is not

1 serious but that the patient isn't in a serious
2 predicament, but that the patient nor the GP are in the
3 loop, assumedly because -- they are not in the loop,
4 I should say, assumedly because there's been no outcome
5 from the clinic? 11:50
6 A. And ultimately no letter, either.
7 113 Q. Yes. So the options are put on to the AOB review
8 clinic, so this is probably what AOB is thinking or
9 send an e-mail to AOB asking for his outcome of the
10 consultation and if no response gained then patient 11:51
11 will be added to one of his clinics.
12
13 When you say in your witness statement that it was
14 starting to emerge in 2015 that Mr. O'Brien wasn't
15 dealing with patient-centre letters and outcomes, have 11:51
16 I interpreted that e-mail chain as being akin to what
17 you are referring to?
18 A. Yes.
19 114 Q. Is that an example?
20 A. Yes. 11:51
21 115 Q. I ask that, because upon perusal of the documents, that
22 issue is difficult to spot in a documentary form. We
23 don't see other examples. We could be wrong and
24 obviously if there are other examples in e-mail chains
25 or whatever, others might draw them to our attention. 11:52
26 You put your knowledge of this issue in the context of
27 other consultants reviewing what were Mr. O'Brien's
28 files for a validation exercise and this information,
29 this concern emerging through Mrs. Trouton and then on

1 to you, perhaps?
2 A. That was my recollection of how it came about. You
3 know, I don't recall seeing that e-mail until
4 ultimately with the witness bundle, but it was around
5 about that time that it was -- in fact, it was in 11:52
6 December, mid-December probably or mid to late December
7 that I was made aware of several issues that it was now
8 felt that, look, we have to tackle this, we can't be
9 softly softly.
10 116 Q. By this stage in 2000, the late end of 2015, there was 11:53
11 a new Medical Director in post?
12 A. Yes, he had come into post that summer.
13 117 Q. Dr. Richard Wright?
14 A. Correct.
15 118 Q. And he had replaced? 11:53
16 A. John Simpson.
17 119 Q. Yes. In terms of -- you and Mrs. Trouton decide that
18 you would meet with Mr. Wright or Dr. Wright?
19 A. I can't recall exactly the steps of what way that
20 happened. I know that, having discussed with Heather 11:53
21 we felt this needs escalated, this needs dealt with.
22 In one sense, I wonder -- I felt that we had cut to
23 Esther Gishkori before I approached Richard Wright and
24 yet, at the same time, I can't be sure that we did.
25 Essentially Heather and I discussed it and we felt it 11:54
26 had to go further and we decided to take advice from
27 Dr. Wright.
28 120 Q. What was the driver for going to Dr. Wright? I think
29 you're right, there was a meeting with Esther Gishkori

1 but what in substance was the reason for, after so much
2 time having passed without a formal initiative, what
3 was the driver --
4 A. There were now -- the patient letter centre -- patient
5 centre letters, the letter dictated at clinics and 11:54
6 outcomes, that was a new thing. The triage was up
7 around a couple of hundred while it was done, so it was
8 a combination of it. I don't know that we said this is
9 the one reason why; it was when you looked at --
10 there's several major issues now here that we need to 11:55
11 deal with, and I think that was why.
12 121 Q. Mm-hmm. Was the patient centre dictation issue, was
13 that qualitatively more significant than any of the
14 other issues?
15 A. I would think so, yes. Personally, I would put that in 11:55
16 the higher one, yes.
17 122 Q. And why, could you explain that for us?
18 A. Well, if a patient was seen at a clinic and you don't
19 know what's happening to them, then what's the point in
20 being seen at the clinic in the first place? There's 11:55
21 no idea of what the Consultant's view of the patient
22 was, what their plan was, what the management plan was,
23 none of that existed, and that, I think, then, left
24 a complete -- people in complete limbo as regards what
25 was going on. By this stage we were using electronic 11:55
26 care record so letters like that would have appeared on
27 the Northern Ireland Electronic Care Record which means
28 if you don't have a patient's paper records as not
29 unusually happens nowadays, we have the letters online

1 and we can see what's happening and what's been done in
2 the past.
3 123 Q. Did you discuss that particular issue with any of the
4 consultants who were discovering the problem?
5 A. That had been reported through to me by Heather so 11:56
6 I did not directly talk to them about it.
7 124 Q. Your meeting with Dr. Wright, people have said, I have
8 seen in a couple of statements, the thinking is that
9 that occurred in January?
10 A. I believe I talked to him in December and he said he'd 11:57
11 meet us in January.
12 125 Q. Yes. Who went to that meeting?
13 A. Heather Trouton, myself, and I can't remember who else
14 was there, if anybody else was there. And Richard
15 Wright obviously, yes. 11:57
16 126 Q. Yes. That was something of a milestone meeting, in the
17 sense that you were going to the Medical Director for
18 the specific purpose of drawing his attention to
19 a range of concerns in the practice of Mr. O'Brien?
20 A. Yes. 11:57
21 127 Q. This was a new departure, you hadn't taken this
22 initiative for the previous Medical Director?
23 A. No, no, not in the formal sense. Triaging had been
24 mentioned in the past with him but not, as I said
25 before, not that I raised it as a particular concern. 11:57
26 I just mentioned some of the issues we were having in
27 Urology, other issues we had -- and there were just
28 kind of a synopsis of what was going on. That was
29 a formal, when I say formal, that was we raised as

1 a specific problem or set of problems that we wanted to
2 discuss that we felt needed escalated.
3 128 Q. Yes. I have called it a milestone meeting, I think you
4 would tend to agree with me. No record of that meeting
5 made by anyone? 11:58
6 A. No. Not that I know of.
7 129 Q. Not by you, anyway?
8 A. No.
9 130 Q. Any reason for that? Should it have been recorded?
10 A. I can't give you a straight answer. It would be nice 11:58
11 to have had it recorded. On reflection it would have.
12 A lot of our meetings were not recorded. The
13 assistance was not provided for recorded meetings,
14 a lot of meetings that were held, technically I suppose
15 this was informal although he did come up to the 11:59
16 hospital, but it's not a formal meeting that there was
17 an agenda went out, which those meetings tended to be
18 minuted. And that's something, you know, as -- the
19 AMDs did not have that sort of support for their role
20 to have people take minutes at meetings that they were 11:59
21 at and to follow up on actions.
22 131 Q. In terms of bringing these issues to this Medical
23 Director, the fact that there was a new issue, so far
24 as you were concerned, the patient centred dictation
25 issue, if that issue, coupled with the others, had 11:59
26 arisen, say, during the time of Mr. Simpson's reign as
27 Medical Director, do you think you would have been
28 making the same approach?
29 A. I think we would have.

1 132 Q. In other words, would you have felt encouraged to make
2 that approach to previous Medical Directors?
3 A. I would -- I think there was enough at that stage that
4 we -- you know, I suppose we didn't have a choice but
5 do you know what I mean, it is obvious by then we 12:00
6 needed to progress it. If it had been with Dr. Simpson
7 I think with that amount of information, we would have
8 gone ahead as well.
9 133 Q. Yes. In other words, there would have been no
10 inhibition to you bringing that kind of information to 12:00
11 any of the previous Medical Directors?
12 A. No.
13 134 Q. What was your objective in going to see Dr. Wright?
14 What was the purpose?
15 A. Get his advice on what to do and how to manage it, and 12:00
16 I suppose at the same time it also meant then that
17 I was covered from the point of view of the previous
18 issue which I had mentioned about the bullying and
19 harassment so that I had cover from that point of view,
20 that I was being given advice on what to do and not 12:01
21 just starting something myself.
22 135 Q. Was that a conscious thought?
23 A. It would have been, yes. I can't specifically remember
24 now, but that would have featured definitely in my
25 thinking. 12:01
26 136 Q. In terms of the items of concern in relation to
27 Mr. O'Brien that you drew to Dr. Wright's attention,
28 was it simply the new issue or did you outline some
29 background to him?

1 A. The background to how Aidan O'Brien had practised and
2 worked over the time was mentioned and discussed but
3 the issues that were raised were the triaging, patient
4 centred letters and that there were the notes at home,
5 there appeared to be an increased problem with that. 12:01
6 As I mentioned in my statement, I can't recall that we
7 specifically raised with him the issue about validating
8 of review backlog. I think that was added in about
9 March time, by the time of the letter.
10 137 Q. Yes. Would you have mentioned to Dr. Wright your 12:02
11 concern about the bullying and harassment allegation?
12 A. I don't recall if I did or not.
13 138 Q. Yes.
14 A. I don't know that I did, but I can't recall if I did or
15 not. I think I didn't, but I don't know. 12:02
16 139 Q. Would Dr. Wright have been apprised of the, if you
17 like, historic attempts to get to grips with some of
18 these issues on an informal basis?
19 A. My re-election is we had been dealing with triage for
20 years, the patient centred letters and outcomes, they 12:02
21 weren't a long-standing issue but I can't remember what
22 was mentioned there. Then the notes at home was an
23 increasing problem.
24 140 Q. Dr. Wright says -- just pull up his witness statement
25 briefly, WIT-17863. At paragraph 37.1, I'm conscious 12:03
26 that there's a mistake in the date, he says:
27
28 "Once Mr. Haynes was appointed as Associate Medical
29 Director in the autumn of 2016" -- that should be

1 2017 -- "... I have confidence that professional issues
2 were being appropriately escalated to me. Prior to
3 that it now seems clear that such issues were not being
4 properly highlighted with a turnover the Associate
5 Medical Directors and Assistant Directors in the month 12:04
6 preceding this was not helpful for continuity of
7 approach."
8
9 If I could just bring up one other reference in this
10 kind of context? WIT-17876. He says: 12:04
11
12 "I was not aware of significant problems within team
13 Urology until early September 2016, when Mr. Haynes
14 highlighted the issues around the patient
15 administration performance of Mr. O'Brien. These had 12:04
16 come to the fore because Mr. O'Brien was on sick leave
17 and the Directors had appropriately arranged for his
18 patients to be reviewed by other consultants."
19
20 Obviously I asked Dr. Wright about that. Having met 12:04
21 him in December or spoke to him in December '15 and met
22 him in January '16, what's your perspective on the
23 degree of detail and coverage of the issues concerning
24 Mr. O'Brien?
25 A. I believe I forwarded him a copy of the letter. 12:05
26 141 Q. That was in March, that's right?
27 A. Yes. So I mean, he was informed -- he was forwarded
28 a copy of the letter which we had sent which he had
29 instructed us to do. He advised us to go back to get

1 the facts rechecked, to tabulate it, to put them in
2 a letter to Mr. O'Brien and start the process with
3 Mr. O'Brien to see what plan he would have to resolve
4 it.
5 142 Q. Yes. 12:05
6 A. And we followed his instructions.
7 143 Q. Yes. As you have said in your witness statement, he
8 provided you with directions or advice as to what would
9 come next. What was that direction and advice?
10 A. The advice was to produce -- to recheck the facts, 12:06
11 produce a letter, give it to Mr. O'Brien and ask him to
12 respond to it.
13 144 Q. You have said in your witness statement that, just the
14 reference is WIT-14764, paragraph 30, we don't need to
15 put it up, but you do not consider that the process 12:06
16 which you were now engaged in, moving to a meeting with
17 Mr. O'Brien in March 2016 with the letter, you don't
18 consider that that was an outworking of the MHPS
19 process?
20 A. It may have been Dr. Wright's thinking of that but he 12:06
21 did not say to us that this was the first stage or
22 working towards MHPS, so it was not part of MHPS.
23 145 Q. It's fair to say that it was, in your mind, a process
24 or it had a formality in terms of attempting to tackle
25 these issues that hadn't been in place before? 12:07
26 A. Yes, and to do it on a more formal basis than
27 conversations in corridors, et cetera.
28 146 Q. Mm-hmm. We can see TRU-277940, that on 18th January,
29 presumably some time after your meeting with

1 Dr. Wright, that Martina Corrigan is writing to you and
2 Mrs. Trouton --
3 A. Yes.
4 147 Q. -- with a draft of a letter. She apologises for not
5 getting it to you sooner. She wanted to rerun and 12:08
6 update the information before including this in the
7 correspondence. She wasn't sure if it was to be
8 a joint letter, and she's putting it over to yourself
9 and Mrs. Trouton to approve.
10 12:08
11 Scrolling up the page. It's 16th March before you have
12 gone through this letter, it seems:
13
14 "Eamon went through this today. Would it be possible
15 to just refresh the latest figures so that we can 12:08
16 send?"
17
18 Why the lack or apparent lack of urgency, Mr. Mackle?
19 Two months have passed. It was December when you first
20 sought a meeting with Dr. Wright, and even at this 12:09
21 stage you are looking to update figures rather than
22 just get on with sending the letter. Can you recall
23 the lack of urgency?
24 A. I can't give you a straight answer on that one,
25 I cannot recall, no. 12:09
26 148 Q. You meet with Mrs. Gishkori on 21st March. If we look
27 at TRU-277941, we can see at the top of the page the
28 date, I understand this to be her note:
29

1 "One-to-one, Esther and Eamon"
2
3 Scrolling down the page, it says: "Need to get letter
4 to AOB this week."
5 12:10
6 Was she impatient for the issue to be addressed? Or
7 should I say was she anxious for the issue to be
8 addressed as quickly as possible?
9 A. I can only say from reading her note of what she was
10 asking about, yes. I can't specifically recall the 12:10
11 meeting, but, yes.
12 149 Q. If we look at the letter that emerged then finally.
13 It's at TRU-282023. Is it your understanding that
14 Martina Corrigan drafted the letter?
15 A. I think she did, yes. I think I may have said in my 12:11
16 statement at one stage Heather drafted it, but I think
17 it was Martina. Basically Martina and Heather did the
18 principal between the drafting of it, yes.
19 150 Q. In terms of input, this letter didn't go back through
20 the Medical Director's office, it was essentially with 12:11
21 the Directorate --
22 A. Yes.
23 151 Q. -- to progress it, having received Dr. Wright's advice?
24 A. Yes. It went to the Medical Director's office on
25 30th March. 12:11
26 152 Q. No consideration given to taking Human Resources'
27 advice?
28 A. Medical Director didn't advise me to.
29 153 Q. In terms of this letter you intended would be handed,

1 and was handed, to Mr. O'Brien at the meeting which
2 took place I think on 30th March. What was your
3 objective with that meeting and with the letter?
4 A. It was to spell out in writing to Mr. O'Brien, as you
5 know, what the issues were, what needed done, and that 12:12
6 we required a plan for how it would be tackled, or they
7 would be tackled.
8 154 Q. Yes. You were prepared to attend the meeting,
9 notwithstanding the concerns of bullying and harassment
10 that we have discussed? 12:12
11 A. I was being accompanied. I wouldn't had held that
12 meeting on my own.
13 155 Q. Yes. You were accompanied by Martina Corrigan?
14 A. Yes.
15 156 Q. Do you know why the -- 12:13
16 A. I can't recall.
17 157 Q. -- the Assistant Director didn't attend?
18 A. I expected you were going to ask me that. I don't
19 recall why.
20 158 Q. In terms of the, I suppose, hierarchy or the power 12:13
21 dynamics, were you comfortable that it was the Head of
22 Service and not somebody at Director level or Assistant
23 Director level who accompanied you?
24 A. I was happy having somebody there who could vouch for
25 my behaviour during the meeting. 12:13
26 159 Q. In terms of the conduct of the meeting was it you who
27 did the speaking as opposed to Mrs. Corrigan?
28 A. Yes.
29 160 Q. So you led on the issues from a management perspective?

1 A. Yes, yes.
2 161 Q. Where did the meeting take place?
3 A. I believe it was the -- there's -- opposite corner from
4 the Acute Director's office is an AMD -- in those days
5 it was an AMD office. 12:14
6 162 Q. Was it formal in the sense that you came in and sat
7 down and conducted the meeting with those kind of
8 niceties?
9 A. I can't recall exactly how we did, exactly that but
10 yes, I had planned this as a formal meeting and I had 12:14
11 thought about it, you know, beforehand.
12 163 Q. Yes.
13 A. About how I'd do it, and present it to him.
14 164 Q. Yes. I'm not sure I have seen the invitation that must
15 have communicated to Mr. O'Brien the need for 12:14
16 a meeting. I am not sure if we have that.
17 A. I have not seen it in my bundles so I can't recall.
18 165 Q. Yes. Do you know whether he was informed in advance as
19 to the purpose of the meeting?
20 A. I don't recall, no. 12:14
21 166 Q. You've said in your witness statement, and if we pull
22 up WIT-14785, at paragraph 33. You thanked him for
23 coming and explained that you had a letter to discuss
24 with him.
25 12:15
26 Upon informing him of the issues I asked him to respond
27 a commitment to address the issues and to produce
28 a plan to address all of the issues. Aidan took the
29 letter and my recollection is that all he then said was

1 he would have to consider the points in the letter.
2 I believe I also asked him to let us know if he needed
3 any help."
4 A. I can't -- I will be honest now, I have reflected on
5 this at different times. That last sentence I can't 12:15
6 recall if I actually did ask him or not. If he had
7 asked or had spoken to me I had planned to say
8 something like that, let us know, if he had said how am
9 I going to cope with this, I would have been saying
10 that in my planning for the meeting, but, to be honest, 12:16
11 I know I put that down there but I can't say
12 categorically that I actually did ask him.
13 167 Q. Yes. That's helpful. Just set against that what you
14 said in your account to Dr. Chada back in 2017 as part
15 of her MHPS investigation. If we go to TRU-00770, 12:16
16 paragraph 21. You say as it's phrased here:
17
18 "On 24th March 2016 a letter was sent to Mr. O'Brien
19 regarding concerns about triage backlog letters not
20 being done and notes at home. As AMD I took the letter 12:17
21 and went to speak with Mr. O'Brien. I didn't go
22 through the letter but it set out to him the actions he
23 needed to take and I asked him to address the issues.
24 We did not discuss any supports to address the issues.
25 My role as AMD ceased around this time and so I was not 12:17
26 involved in the follow-up after the letter went."
27
28 Just a couple of points about that. It says on 24th
29 March a letter was sent to Mr. O'Brien?

1 A. No.
2 168 Q. Do you think that's right?
3 A. No, it wasn't. There was a formal meeting.
4 169 Q. Yes. Your recollection is bringing the letter to the
5 meeting and handing it to him? 12:18
6 A. Yes.
7 170 Q. That would have been his first sight of the letter?
8 A. My recollection is I said there are issues, just the
9 bullet points that are there 1 to 4, not -- I don't
10 recall reading the letter out to him. 12:18
11 171 Q. Yes.
12 A. But said there are issues regarding the -- in fact
13 I think -- I probably but I can't confirm whether I did
14 or not, but I think I probably read out the first
15 paragraph effectively of what was said there, but said 12:18
16 there were several issues that we have concerns about
17 and these are what they are.
18 172 Q. Yes.
19 A. I handed him the letter and he, if I recall rightly he
20 just folded it and put it in his pocket. 12:18
21 173 Q. Yes. Just on that point, the letter, it wasn't sent to
22 him in advance?
23 A. No.
24 174 Q. It was given to him at the meeting?
25 A. Yes. 12:18
26 175 Q. You, in essence, outlined the points in the letter, the
27 four bullet points, if you like, or the four issues?
28 A. Yes.
29 176 Q. As you said here, "we did not discuss any supports to

1 address the issues". Just by contrast with what you
2 have said in your statement?
3 A. I know.
4 177 Q. "I believe I asked him if he needed any help." It
5 appears, on the basis of a more contemporaneous 12:19
6 statement to MHPS, that supports weren't discussed?
7 A. No, I don't believe -- I don't recall them being
8 discussed. Equally, I don't recall being asked.
9 178 Q. Yes. We will come to Mr. O'Brien's response in
10 a moment. But in terms of the letter itself, if we go 12:19
11 back to TRU-282023. We can just scroll down. The
12 issues are un-triaged Outpatient referral letters, you
13 put the statistic of 253 backdated to December are
14 outstanding, December 2014. Nothing specific there
15 about what needs to be done to get this on a proper 12:20
16 footing, it's a description of factually, of where you
17 are at?
18 A. Yes.
19 179 Q. Then if you go down to the current review backlog.
20 Just on that issue, Mr. O'Brien, in common with other 12:20
21 consultants, had a backlog in his review list?
22 A. Mmm.
23 180 Q. That's not an issue that was ever taken forward as part
24 of MHPS?
25 A. No. 12:20
26 181 Q. The issue, as I understand it, and help me with this if
27 you can, was that there was a need to validate that
28 backlog list to ascertain whether those on the list
29 were properly on the list and the degree of urgency

1 with which they needed to be seen?
2 A. Yes.
3 182 Q. What was the concern around that?
4 A. As I said, I don't recall discussing that, you know,
5 with Dr. Wright. That was something that Martina and 12:21
6 Heather I think felt was an issue as well that should
7 be put down, so it went into the letter. I didn't
8 object to it being in the letter, I don't disagree with
9 it being in the letter, but it was not something which
10 had originally been discussed with Dr. Wright as an 12:21
11 issue.
12 183 Q. Are you saying that although it went into the letter it
13 wasn't an issue that had been flagged as a significant
14 concern with you in advance?
15 A. I don't think -- well, not that I can recall. 12:22
16 184 Q. But it ends with the requirement for him to put a plan
17 on how these patients will be validated and proposals
18 to address the backlog?
19 A. Yes.
20 185 Q. That's what you were asking him? 12:22
21 A. Yes.
22 186 Q. Scrolling down, there's a reference then to the
23 patient-centred letters and a description of the issue
24 there, and it ends with:
25 12:22
26 "This lack of documentation combined with no record of
27 clinic outcome means further investigations or
28 follow-up may not be organised by admin staff."
29

1 Again, no specific detail there about what is expected
2 of him?
3 A. No.
4 187 Q. Then: "Patient notes at home, needs addressed urgently
5 and brought back to the hospital without further 12:23
6 delay."
7
8 Then the letter ends with: "You will appreciate that
9 we must address this governance issues and therefore we
10 would request that you respond with a commitment and 12:23
11 immediate plan to address the above as soon as
12 possible."
13
14 I suppose in terms of a target or a specific
15 requirement, it was an immediate plan. Was that 12:23
16 further fleshed out at the meeting, to the best of your
17 recollection?
18 A. No.
19 188 Q. Was he given a date or a timetable within which to
20 produce this? 12:23
21 A. No.
22 189 Q. In light of the history of informality and commitment
23 to change and changes made and then falling off on
24 certain issues such as triage and what have you, do you
25 now recognise that, in the absence of a fixed 12:24
26 timetable, compliance with what you were asking was
27 going to be difficult?
28 A. Yes.
29 190 Q. Why was there not a specific timetable?

1 A. I can't give you a straight answer. I can't recall why
2 we didn't put a timetable down. I just don't remember
3 or recall why.
4 191 Q. Was this simply a box-ticking exercise?
5 A. No, it was, in a sense for us, as had been advised by 12:24
6 Richard Wright, putting a line in the sand of where we
7 were so therefore from now on we will have a written
8 set-up of where we where were, for future follow-up
9 what's happened to that, and for that reason.
10 192 Q. If it wasn't a box-ticking exercise, was there 12:25
11 discussion amongst you, that is with Mrs. Trouton,
12 Mrs. Gishkori, Mrs. Corrigan, about what would
13 necessarily have to happen next if Mr. O'Brien didn't
14 produce an immediate plan?
15 A. I expected that we would be back to Richard Wright for 12:25
16 further advice.
17 193 Q. Who did you expect would go to Richard Wright for
18 further advice?
19 A. The AMD, me.
20 194 Q. You obviously didn't do that? 12:25
21 A. No.
22 195 Q. You sent him a copy of the letter, isn't that right?
23 A. Yes.
24 196 Q. You told him that you had met with Mr. O'Brien?
25 A. Yes. 12:26
26 197 Q. Did he seek any further feedback from you beyond that?
27 A. No. There was, I think Simon Gibson on his behalf some
28 months later did, but not at that time.
29 198 Q. Did Simon Gibson speak to you some months later in

1 relation to it?
2 A. There was an e-mail from Simon Gibson I know, but
3 I can't remember if Simon Gibson spoke to me at that
4 stage about maybe about six months later.
5 199 Q. Mr. O'Brien recalls that at the meeting he asked you 12:26
6 what should be done to address the situation which you
7 were particularising for him, and his recollection is
8 that you shrugged your shoulders and didn't provide any
9 indication that support would be available to help him
10 navigate these issues? 12:27
11 A. I would have been very careful of my body language for
12 that meeting. I would not have just been shrugging my
13 shoulders if I had been asked.
14 200 Q. Mm-hmm. Have you a recollection of how long the
15 meeting lasted? 12:27
16 A. It was a short meeting if I remember right, but I can't
17 tell you exactly how short.
18 201 Q. Did he engage on the issues?
19 A. There was no discussion from him to explain why any one
20 issue was an issue. As I recall, he took the letter, 12:27
21 I read the bullet points, he took the letter and then
22 basically folded it up and put it in his pocket.
23 I think, I think he may have said something like he'd
24 consider it, but I can't recall exactly what he said at
25 the end. But he did not go through the letter in any 12:28
26 detail or offer any explanation.
27 202 Q. Yes. So apart from you saying that he would consider
28 it, is there anything else you can offer the Inquiry in
29 terms of his response to it? We know what you have

1 said in broad terms?
2 A. Yes.
3 203 Q. But in terms of his response to it, 'I will consider
4 it'?
5 A. I think that was all he said, something like that. 12:28
6 204 Q. You had spoken earlier in your evidence about leaving
7 the post, Dr. McAllister taking over. Dr. McAllister
8 and you worked closely together. You would have had an
9 informal verbal handover to him?
10 A. Yes. 12:29
11 205 Q. I forget whether I asked you this last week, but would
12 he have been advised that Mr. O'Brien's practice was
13 causing concern and that you were fresh from a meeting
14 with Mr. O'Brien at which a letter calling for a plan
15 had been handed over? 12:29
16 A. I think actually it was even before that. I think he
17 knew we were going to, you know. Charlie McAllister
18 and myself operated on a Tuesday while he was my
19 anaesthetist, and as the AMD for Anaesthetics we had
20 conversations as friends, colleagues and that, and we 12:29
21 had conversations about issues within the Directorate,
22 yes, over not just at the end of -- I mean, over a long
23 period of time we had, so he was aware.
24 206 Q. Yes. Did you build on that with him, and, for example,
25 say this needs followed up. We have left him with the 12:30
26 letter. We are expecting a plan. If he doesn't
27 produce a plan, it needs action?
28 A. I can't remember what way. It was a verbal handover
29 but I cannot remember exactly what happened at that

1 handover, I don't know if he can, but I can't, I'm
2 sorry.
3 207 Q. We know, as you suggested, six months later Simon
4 Gibson is, at Dr. Wright's direction, carrying out
5 further work around Mr. O'Brien's practice. Just to be 12:30
6 clear, you had no further engagement with Dr. Wright
7 after the meeting, apart from sending a copy of the
8 letter to him?
9 A. No.
10 208 Q. Zoe Parks was the HR officer with responsibility for 12:31
11 clinicians and medical practices, that was her area?
12 A. Yes.
13 209 Q. Could I ask you for your reflections on what she has
14 said. WIT-90076. At paragraph 38.3 she is saying that
15 -- she is acknowledging that the letter was issued to 12:32
16 Mr. O'Brien in March 2016. She says that she
17 understands that HR were not informed of these concerns
18 giving rise to the letter at the time. She was on
19 maternity leave at that juncture. At 38.3 she says:
20 12:32
21 "I believe that this initial concern should have
22 prompted immediate preliminary inquiries by the
23 clinical manager to take a deeper dive and scope to
24 establish the full nature of the concern. The
25 fundamental consideration within the MHPS Framework is 12:32
26 the continued safety of patients and the public.
27 Action when a concern first arises requires the
28 Clinical Manager to consider if urgent action needs to
29 be taken to protect the patients and if a precautionary

1 restriction or exclusion on practice is required until
2 they can clarify the nature of the concern. The key
3 governance question I am asking is that no-one seemed
4 to understand to take accountability for determining
5 the full extent of the problem to ensure any necessary 12:33
6 protective measures for patients could be put in place
7 immediately and properly monitored."
8
9 The thrust of her concerns appears to be that you were
10 going to Mr. O'Brien on the basis of what you knew to 12:33
11 be wrong.
12 A. Yes.
13 210 Q. You identified four issues and set those out, but here
14 was a fork in the road or a milestone opportunity to
15 look deeper and fully identify, or more fully identify 12:34
16 issues of concern. She has a point, doesn't she?
17 A. Oh, yes, she does. As I said earlier, I mean, I did
18 not recall MHPS. I didn't recall it at the time.
19 Heather Trouton and I approached the Medical Director
20 for his advice and we followed his advice, and he did 12:34
21 not suggest that we approach HR or utilise the MHPS
22 process, MHPS process.
23 211 Q. Mm-hmm. Part of this, Mr. Mackle, I wonder would you
24 agree, part of this is a lack of appreciation, or
25 perhaps suspicion on the part of management, that there 12:35
26 could be other issues here, allied to perhaps an
27 assumption that there are no patients coming to any
28 particular harm here. Is that an explanation as to why
29 this was kept so narrow in terms of what was presented

1 to Mr. O'Brien?
2 A. Well, no. I mean, I think those were the main issues
3 that we had raised with Dr. Wright as ongoing things.
4 We took the patient outcomes, we saw that as -- and
5 patient dictation as a significant issue. The number 12:35
6 of charts that were not, you know, that he had at home,
7 were then proceeded to be significantly higher than
8 perhaps what people had originally considered. I think
9 it was in those grounds it was being dealt with, those
10 were the issues -- the issues there were then and the 12:36
11 triaging, they were the issues that were seen to be the
12 pertinent issues. As I said we approached Dr. Wright.
13 He gave us advice on what to do. But even if I had
14 recalled MHPS, with the previous allegation of bullying
15 and harassment I personally would not have instigated, 12:36
16 and even if there had been no issue of bullying and
17 harassment I don't think there's any other AMD or CD in
18 the hospital would directly start an MHPS process
19 without having discussed with the Medical Director
20 beforehand what they are going to do. 12:36
21 212 Q. But leaving the niceties of MHPS to one side, I mean,
22 if you go back over the history of this, and we have
23 explored it over the last day-and-a-half, if you join
24 the dots between IV antibiotics and Mr. O'Brien's
25 response to that and not complying with the rules, at 12:37
26 least initially, according to your evidence?
27 A. Yes.
28 213 Q. Patient Safety issue, triage, as you now recognise,
29 a Patient Safety issue, keeping records at home, which

1 is symptomatic of limited dictation from clinics, and
2 so we go on, the failure to action results from
3 investigations, told that he should do it and
4 responding to it in a way which you've indicated was
5 obstructive, if you join all of that together and then 12:38
6 read what Zoe Parks has said, it's quite clear whether
7 this is Dr. Wright's blind spot as well, but there was
8 a managerial blind spot in failing to recognise the
9 need for a deeper approach?
10 A. As you say, yes. I mean, the -- what's it -- the IV 12:38
11 antibiotics, IV fluids antibiotics, Medical Director`s
12 instructions on what to do, the cystectomies, the
13 Medical Director's instructions what to do, notes we
14 did follow up with HR at that stage, the review of
15 results of investigations, there was, you know, 12:38
16 Dr. Rankin did produce and everybody had to review them
17 and secretaries weren't allowed to file them until they
18 had been initialled or signed, and then this, we were
19 advised by Dr. Wright on what to do.
20 214 Q. Mmm. 12:39
21 A. What I'm saying is, yes, there was a collective issue
22 here, I don't deny that, I think collectively we
23 failed. I think we should have picked up on more, more
24 should have been actioned.
25 215 Q. But it's in the response from Mr. O'Brien that perhaps 12:39
26 your suspicions ought to have been raised. As your
27 evidence suggests, IV antibiotics raised with him, and
28 it takes a considerable period of time to achieve
29 compliance?

1 A. Yeah.
2 216 Q. Actioning results, issues drawn to his attention and he
3 pushes back on it. Triage, notes and records, all
4 these issues received an element of non-compliance or
5 pushback, and then this new issue arises, at least new 12:40
6 to you, at the end of 2015 when you see that there's no
7 dictation or limited dictation from clinics. Is it not
8 in that context when you see non-compliance or limited
9 compliance that suspicions should have arisen about
10 other aspects of his practice? 12:40
11 A. Knowing what we know now, yes. My understanding is the
12 MHPS process didn't throw up some of it either, that it
13 didn't work in that respect either. It's easy, with
14 hindsight, to say that, and I don't disagree with you.
15 But at the time, kind of, you deal with one issue as it 12:41
16 comes along, and we didn't join up all the dots as you
17 were suggesting.
18 217 Q. Dr. Wright's perspective is set out at WIT-17866. At
19 paragraph 42.2 he says in his opinion it seems that
20 there was significant data available regarding many of 12:41
21 the key issues and, as he sees the issue, the main
22 factor was a reluctance to formally address the issues
23 identified rather than a lack of data. Do you agree
24 with that?
25 A. Reluctance, you know, as it's written it says there's 12:42
26 a reluctance to formally address the issues. The
27 issues were identified to him as well. You know. And
28 the past issues were identified to him, and in that
29 respect, once he was not saying to do anything more

1 formal with regards to the issues, I admit I was not
2 going to raise that and say no, I want it to go formal.
3 218 Q. I suppose from his perspective is when it is brought to
4 his attention the advice from him is to bring this
5 element of formality into it? 12:42
6 A. There's that formality, yes.
7 219 Q. But he is standing back looking at it from the
8 perspective of the period before he came into post and
9 before these issues were drawn to his attention, so
10 within the Directorate, of which you were AMD, he is 12:43
11 seeing lots of informality and non-compliance and
12 a reluctance, as he puts it, to address it formally,
13 for whatever reason?
14 A. But the issues that had been addressed in the past were
15 given to him as background, so when we met with him in 12:43
16 January he was informed of the issues in the
17 background.
18 220 Q. Yes.
19 A. Sorry, in the past.
20 221 Q. Yes. And his point is, you went at those issues 12:43
21 informally and ineffectually because there was
22 a reluctance and this is the question I'm directing to
23 you. Was there a reluctance before he came into post
24 and you approached him, was there a reluctance on your
25 part and on your management team's part to address this 12:43
26 formally?
27 A. Well, not -- well, the reluctance -- you know, the
28 first ones I mentioned earlier, the notes was formally
29 addressed. Cystectomies, IV fluids, they were all

1 Medical Director involvement and managing it, and
2 perhaps that set the tone for how things should be
3 managed after that. So it wasn't that we -- I did say
4 earlier though where Aidan was concerned he was
5 considered a good clinician and hard-working, that 12:44
6 coloured how we looked at him rather than saying we
7 were reluctant to do anything formally it did colour
8 how we looked at him and how we assessed the issues as
9 they arose, because he was considered to be an
10 excellent clinician. 12:44
11 222 Q. It wasn't so much a reluctance, in fact it was an
12 interpretation of how he practised that while there are
13 some problems here, they are not terribly serious, he
14 has other attributes and, therefore, that becomes the
15 reason for not challenging him? 12:45
16 A. I think that would probably be more than reluctance.
17 223 Q. MHPS as a process. Just finally. You didn't have MHPS
18 in mind in any of your dealings with --
19 A. No.
20 224 Q. -- Mr. O'Brien? If you were suggesting to this Inquiry 12:45
21 what might be improved around the use or the awareness
22 of this process, as a means with other managerial tools
23 to address difficulties with clinicians, what would you
24 say?
25 A. As I say, I accept I had been on a form of training for 12:45
26 MHPS back in, as I said, 2008, for the Western Trust
27 but that was never utilised, that was never put into
28 practice. I think updates in that respect, I think
29 whether somebody from HR attends the governance

1 meetings when they are being held, the Directorate
2 governance just to hear the issues that are there,
3 I think that input from HR would be, and also in
4 highlighting when we should be using other processes.
5 By utilising only the Medical Director we took the 12:46
6 Medical Director's advice as being the ultimate way in
7 how to handle things, but I think that's something we
8 should have been -- not something that should have been
9 -- I think that's something that could be improved.
10 I think support for the Associate Medical Director, 12:46
11 I had a lot of support from Heather Trouton and the
12 Heads of Service, I'm not saying in that respect but
13 from a managerial support point of view, as AMD issues
14 perhaps there should be somebody there to support them
15 the way the Medical Director had at that stage, for 12:47
16 example, Anne Brennan to support him, and later on
17 Simon Gibson, someone who would support the AMD, not
18 just one AMD but several AMDs in their role so if
19 issues did arise they would be the ones to see things
20 were followed up and actioned, et cetera, from 12:47
21 a clinical point of view that weren't necessarily
22 operational.
23 225 Q. When you reflect in terms of your own personal exercise
24 of managerial responsibility around Mr. O'Brien, and
25 particularly in light of the issues that are now 12:47
26 reported by the Trust as being issues of concern, have
27 you any other reflections about the lessons that you
28 have learned as an AMD in relation to how these issues
29 should be handled?

1 A. I think the role as it existed then was significant and
2 large. I had a full clinician's role as well as
3 covering the general surgery in emergencies, I had
4 sub-specialties in oesophagogastric surgery and
5 colorectal, that was my prime reason for doing 12:48
6 medicine, for doing surgery, was that aspect of it.
7 The AMD role was on top of that but I think the amount
8 of time I had available probably -- not probably,
9 didn't allow me to fulfil it to the best of my
10 abilities or maybe to the best the post expected. 12:48
11 I think there is a potential issue in having AMDs who
12 are full clinicians whose post dictates that they need
13 to have a full clinical role, a full-time clinical
14 role. If I had been, for example, just a subspeciality
15 and not an emergency role, et cetera, that might have 12:49
16 allowed me a lot more time to devote to it, but I think
17 that's one of the issues of having AMDs who are
18 full-time clinicians. There are advantages, but
19 I think there are also significant disadvantages as
20 happened in my case, with time. 12:49
21 226 Q. Okay. Very well, thank you, Mr. Mackle, for your
22 answers. I understand that the Panel will have some
23 questions for you.
24
25 MR. EAMON MACKLE WAS QUESTION BY THE PANEL AS FOLLOWS: 12:49
26
27 CHAIR: Yes, thank you, Mr. Mackle, for your evidence.
28 We will all have separate questions to ask you. I am
29 going to go back to things you said, but if you can

1 just deal first of all with the lack of knowledge that
2 you are expressing about the MHPS procedure and even it
3 being on your radar as a tool in your toolkit to deal
4 as a manager with clinicians. Frankly, I have to
5 express the view that I find that surprising. If 12:50
6 I consider other professions, other professions would
7 know what might happen to them if they were not
8 compliant with rules and regulations of their
9 profession, for example. I just wonder do doctors
10 generally not know about MHPS and the fact that it 12:50
11 could be used, not just as a disciplinary tool but also
12 as a tool for their benefit?
13 A. I can't give you a straight answer of what people
14 thought of it. I think they probably have been
15 perceived by many as being disciplinary rather than 12:50
16 supportive. I think that aspect I don't think has been
17 fully emphasised to medical managers about their roles
18 in that aspect. I think information if -- knowledge,
19 if it's not used or updated, it tends to get forgotten,
20 and I think that is also an issue with it. I think 12:51
21 perhaps in approximately 2008 when I had that training
22 it was mentioned in that aspect, but when none of that
23 was being used or utilised it did forgotten. I can't
24 speak for all the other AMDs on their knowledge or
25 issues with, or perhaps they had issues that had 12:51
26 already been enacted under their flag and therefore --
27 227 Q. More familiar with it?
28 A. Yes. So I'm sorry, I can't answer you more clearly
29 than that.

1 228 Q. Thank you. Just going back you said yesterday that you
2 were asked to apply for the AMD role. Can you recall
3 who that was that approached you and said you should
4 apply for this?
5 A. It was either Debbie Burns or Mairéad McAlinden or it 12:51
6 may have been Debbie saying that Mairéad it suggested,
7 I think it might be that way around. Although Mairéad
8 McAlinden was not the Chief Executive at the time, it
9 was Colm Donaghy, but I think it was between the two of
10 them but I can't remember which one specifically said 12:52
11 it.
12 229 Q. When you did apply were you aware of who else had
13 applied?
14 A. Yes.
15 230 Q. Was there was a process then that was gone through with 12:52
16 everybody yesterday and all of that?
17 A. Yes.
18 231 Q. I am sort of jumping between topics here, but looking
19 at the quality of service, you say that essentially in
20 terms took a back seat to output in terms of 12:52
21 performance numbers, target dates and that kind of
22 thing, and I just wondered where did that pressure to
23 meet the targets come from? Was it external, was it
24 internal, and why then did it have such an effect on an
25 assessment of the quality? 12:53
26 A. As I said, I think there was a major focus on
27 performance. That was fed to us through, we refer to
28 it as down the hill, which is Trust headquarters, it
29 came from Trust headquarters but the whole issue of

1 performance, how much pressure they were under from
2 service delivery unit, I can't tell you. I don't know.
3 I wouldn't be able to answer that.
4 232 Q. In terms of the focus then being on meeting target
5 dates, for example, did that take precedence over all 12:53
6 other aspects of it?
7 A. No, it wasn't that it took precedence -- well it took
8 up a significant amount of time, I suppose, rather than
9 precedence, if you know what I mean. It reduced the
10 amount of time available. 12:53
11 233 Q. Okay. Sort of connected to that there's the issue of
12 audits and what you have described were ad hoc
13 audits --
14 A. Mm-hmm.
15 234 Q. -- that were carried out by junior doctors? 12:53
16 A. Clinical audits.
17 235 Q. Am I right then there was nothing targeted from above
18 from managerial strata above you or indeed by yourself
19 to the clinicians, to the departments, to the services,
20 to say we need an audit on this? 12:54
21 A. Not that I know of. There were -- what was it? There
22 was a workload audits -- sorry, the Trust -- I can't
23 remember the name of the exact thing it was, but you
24 got feedback on how much workload you were doing
25 compared to other Trusts, your length of stay, your 12:54
26 number of day cases, things like that. CHPS is what it
27 was. That was a standard thing that came out but there
28 weren't -- I don't recall a lot of other audits being
29 commissioned by the Trust to look at patient pathways,

1 things -- except when they are setting up a new service
2 or developing a service, there was work put into
3 patient pathway at that time but not after it was set
4 up.
5 236 Q. You yourself, as Assistant Medical Director, you didn't 12:55
6 direct anybody to say I need some information about
7 this particular aspect of the service?
8 A. We didn't have anyone to direct.
9 237 Q. The Head of Operations, for example?
10 A. From an audit point of view, I don't think -- well, 12:55
11 I never would have thought of that because there was no
12 -- we weren't told you have people here who will carry
13 out specific audits if you want to carry out into your
14 speciality or Directorate or whatever else, we weren't
15 told we had that available. 12:55
16 238 Q. You wouldn't have thought to say to say I want to know
17 how well the service is operating, how well the
18 clinicians within the service are operating, and
19 therefore the type of audit you describe being carried
20 out on your behalf in terms of the triaging of your 12:55
21 clinical specialty you didn't think to maybe roll that
22 out across the other specialities to see whether there
23 was a general issue?
24 A. Sorry, I have lost you. Apologies.
25 239 Q. Sorry. I think you talked about when there was work 12:56
26 done that showed only a certain percentage of referrals
27 were --
28 A. Yes.
29 240 Q. You didn't think it was, for example, a useful exercise

1 to roll out in the other specialties of surgery?
2 A. We actually -- well that was basically the summary that
3 we put in the article in the Ulster Medical Journal.
4 It was an *ad hoc* article that I had suggested with Rob
5 Spence, the Registrar we had at the time, who was 12:56
6 working with me at the time, about doing it and he did
7 it, and in it we did put at the end we felt there
8 should be a review to see the benefit of triage
9 et cetera. But it wasn't --
10 241 Q. Was that something you could have directed as Associate 12:56
11 Medical Director for the Craigavon Area Hospital, for
12 example?
13 A. I don't think I would have been able to get that done.
14 This work was done by Rob.
15 242 Q. I don't mean you yourself doing it -- 12:57
16 A. The statement was done by the Registrar. There was
17 nobody -- there was nobody in admin there to help do
18 all the work for him, so he did that himself.
19 243 Q. Okay. You talked about the Wednesday meetings. To
20 what extent at those Wednesday meetings was there any 12:57
21 discussion about issues with clinicians?
22 A. There would have been, as issues arose -- I can't
23 remember all the specifics of it. Maybe Heather
24 Trouton or that could explain better than I can or
25 remember better than I can but if there were issues 12:57
26 with specific consultants or that they were raised.
27 244 Q. But it wasn't a regular agenda meeting item, for
28 example?
29 A. No, but each speciality was discussed and issues that

1 we would have had within the speciality rather than
2 what the patients problem were there in the speciality.
3 245 Q. I suppose then that -- I will come back maybe to that
4 question. Do you think that everyone knowing everyone
5 else, as you say, and needing everyone else to rely on 12:58
6 to help their own patients if that were needed, do you
7 think that is a feature of Northern Irish hospitals
8 compared to other hospitals, say?
9 A. I can't say about other hospitals but I think it is
10 a feature of Northern Irish ones. 12:58
11 246 Q. Yes. I know we have heard statistics that 80 something
12 percent of all doctors in Northern Ireland have gone
13 throughout the same medical school and know each other?
14 A. I was about to say that because during the Troubles we
15 didn't get inward investment from doctors elsewhere, it 12:58
16 was not a feature. Now, yes, the medical school has
17 lots of students from the UK who apply to Queens, but
18 when I went through Queens, two Malaysians and four or
19 six Norwegians, nobody from the South, one American but
20 his dad had been at Queen's and that was it. There 12:59
21 wasn't a collection of English.
22 247 Q. I think that might have been common across other
23 faculties at that time. Has that led to a specific
24 Northern Ireland medical culture that means that people
25 are reluctant to criticise their colleagues or to 12:59
26 challenge them?
27 A. I don't know. One of my roles was to challenge. I did
28 that on the Monday evening meetings was challenge, and
29 that was what -- you know, Gillian Rankin and I had

1 discussed, I think Heather as well, but Gillian
2 discussed I would do the challenge, and that was not
3 something I felt I couldn't do. Outside the formality,
4 perhaps, but I couldn't -- I can't tell you what other
5 people thought of it, you know, sorry. 13:00
6 248 Q. Mr. Wolfe was talking to you there at the end about
7 Mr. O'Brien's response when issues were brought to his
8 attention and how effective issues were dealt with. It
9 seemed to me from your evidence that where there was
10 eyewitness evidence, for example, he seemed to be 13:00
11 throwing the notes in the bin; where there's clear
12 information about the IV fluids and that, is coming
13 from objective evidence about that, that Mr. O'Brien
14 seemed to accept that there was an issue, and his
15 acceptance of it being perhaps inappropriate and 13:01
16 dealing with it was effective, yet whenever there is
17 anecdotal evidence or he is not presented with
18 objective evidence on a more formal basis, if you like,
19 nothing happens. I just wondered if there is an
20 importance or is there a lesson to be learned there 13:01
21 about the importance of having objective evidence about
22 practices, not for Mr. O'Brien particularly but for all
23 doctors?
24 A. I think, yes. I mean when you have objective evidence
25 it is a fait accompli, it is there. People have to, 13:01
26 they can't ignore it. Well they can but it's not easy
27 for them to ignore it.
28 249 Q. The second part of that question is in the role of
29 Associate Medical Director, AMD, is it not necessary

1 for you to be able to carry out your role appropriately
2 to have such objective evidence?
3 A. And to have -- yes, and to have objective evidence,
4 I think that's where the MD role needs support, you
5 know. I'm not saying each MD needs somebody to support 13:02
6 them but somebody to support --
7 250 Q. Someone to --
8 A. -- collective MDs.
9 251 Q. To pull all that information together and to present it
10 to you so that you have that -- 13:02
11 A. Yes.
12 252 Q. -- as a basis?
13 A. As a formality of it rather than just, you know --
14 a lot of meetings that were had were corridor. I am
15 not talking about with clinicians but even amongst the 13:02
16 senior management, a lot of it was done in corridors.
17 253 Q. I suppose that brings me back to your point about time
18 and whether you think it's appropriate for an Associate
19 Medical Director to maybe have a part-time clinical
20 role; I mean, you talk about the advantages of being 13:02
21 a clinician in that role but would you see it as
22 a semi-sabbatical, if you like, would be the
23 appropriate way to deal with it in terms of a 50/50
24 split?
25 A. Well, if you are going to have -- I think if 13:03
26 a clinician is going to do it they have to be in a role
27 where they can reduce their clinical activity without
28 reducing their clinical effectiveness and knowledge and
29 skills. Anaesthetics is a prime example where I think

1 they can easily do it. They can go to half time and
2 they still have half their sessions and are still doing
3 anaesthetics. Surgery is not one of those one,
4 unfortunately. It is very much a craft as well and you
5 need to maintain those skills by practising it. Other 13:03
6 specialties I think do lend themselves to it. I think
7 it's very difficult for a surgeon to do the role and be
8 effective as a manager and be a good clinician at the
9 same time and a good surgeon.
10 254 Q. Can I just ask generally if, why do you think that -- 13:04
11 I think you say that it was Mr. O'Brien supported by
12 his colleagues. Why do you think that they did not see
13 the advantage of moving to Team South, the
14 reconstruction of the Urology Services? Surely if
15 there was a risk if that was not implemented that 13:04
16 Craigavon and Daisy Hill would lose its Urology service
17 altogether?
18 A. I think -- oh they wanted the idea of Team South,
19 I think they wanted an expansion, but it was the other
20 issues that came with it were not appreciated, you 13:04
21 know, actual, you know, admitting on the day of
22 surgery, the use of pre-op, things like that.
23 255 Q. It was the practicalities of it, that was the issue
24 rather than the actual --
25 A. They did want. 13:04
26 256 Q. -- advantage of it?
27 A. That was in the end why they approved the five job
28 plan, they agreed their job plans at that stage because
29 they realised they weren't going to get the extra

1 consultants if they weren't prepared to agree on the
2 job plans.
3 257 Q. Okay. I just wondered, the impression is that having
4 this allegation made against -- well it's not an
5 impression, you say effectively you took a back seat in 13:05
6 terms of dealing with Mr. O'Brien because of that
7 allegation and you were advised to do so. I just
8 wonder did you ever have to do that in respect of any
9 other clinician for whom you had responsibility?
10 A. No, no. 13:05
11 258 Q. Another issue you talk a lot about Mr. O'Brien's
12 reputation as extremely hard-working, a gentleman, who
13 had time for everyone and was very highly thought of.
14 I just wonder given that reputation, which presumably
15 Mr. O'Brien himself must have been aware of, do you 13:06
16 feel that that then made it difficult for him to show
17 any weakness or vulnerabilities in terms of his
18 practice?
19 A. I can't say what his reason was. I just don't know.
20 It is a possibility, I accept what you are saying, it's 13:06
21 a possibility, but I don't --
22 259 Q. I know you can't speak for Mr. O'Brien and I'm not
23 asking you to, but I am asking you, I suppose, as
24 a medical manager with responsibility for clinicians
25 and perhaps, you know, more generally if someone is 13:06
26 highly thought of and is lauded by their colleagues and
27 by their peers and by their superiors, does that then
28 make it more difficult for that person in a general
29 sense then to say, 'look, I am struggling here, I need

1 help, I can't manage to do what needs to be done in
2 terms of my surgical responsibilities and my admin
3 responsibilities'?
4 A. I think perhaps, and I am being broad in this, I think
5 the nature of people who do surgery is you have to have 13:07
6 a certain ego to do surgery and a self-confidence that
7 you make decisions how to manage a patient and you
8 follow it through, but you can't do this and spend ages
9 dithering on it. I think maybe they attract that type
10 of personality. 13:07
11 260 Q. So it's the nature of the beast really?
12 A. Yes. Which came first though, that's the question.
13 261 Q. As a surgeon yourself you perhaps would not have been
14 best placed to see that somebody might have been
15 struggling; would that be fair? 13:07
16 A. That might be, yeah, could easily be, and not just
17 myself, the other surgeons as well.
18 262 Q. Okay. Just generally. Thank you Mr. Mackle. I have
19 no further questions for you but I am sure Dr. Swart
20 has, or Mr. Hanbury are you going to go first? 13:08
21 MR. HANBURY: I would also like to take you back to the
22 regional review in 2009 and the Monday evening
23 meetings. There are some couple of clinical things.
24 Firstly the review backlog. Many Urology Departments
25 have problems with Outpatients. What were your 13:08
26 proposals, do you remember any details or
27 recommendations?
28 A. One of the major problems we had with the backlog was
29 the view ratio we had in the Trust, we were the worst

1 in the province, and one clinician was the worst of all
2 of them.
3 263 Q. So what were your proposals?
4 A. We needed to improve the new to review ratio. One of
5 the things that was introduced and certainly the unit 13:08
6 pushed for this as well, the Belfast based, the
7 commissioners effectively, that you would have so many
8 reviews per new patient, but clinics were to be set up
9 with a certain need to view ratio, that in itself hides
10 the problem. Your backlog builds up but it hides you 13:09
11 still have a need to review problem. Add in the fact
12 that when they the unit waiting list wanted work done,
13 and this is not just in Urology, this is in general
14 surgery as well, they funded new patients but no
15 reviews, so that created a review backlog as well. 13:09
16 A general view of Urology was the number of consultants
17 and the staff support they had, that was also another
18 issue. That in itself was not a review backlog unless
19 you said emergencies get dealt with, to the detriment
20 of other patients. Part of it was the need to review 13:09
21 ratio and how that was looked at.
22 264 Q. Moving on to admissions on the day, well for general
23 surgery, what was the concern of the Urologists about
24 why that might not be a good idea? Do you remember
25 their objection? 13:10
26 A. The same problem I had with my colleagues, they have
27 always brought them in the day before. It's convenient
28 to bring patients in the day before. It gives you time
29 to see them, make sure the consent is done. It was no

1 different, I think, between the Urologists and my own
2 colleagues, they weren't keen to go down that route,
3 they did -- and with encouragement, but they didn't
4 automatically see it as an advantage to them in that
5 there was no direct benefit to the clinician by 13:10
6 bringing the patients in on the morning of surgery as
7 opposed to the day before. Yes, there is a benefit for
8 the patient will sleep in their own bed the night
9 before, and the bed throughput and everything else, but
10 from a clinician's point of view it was less 13:10
11 convenient.
12 265 Q. Okay. Thank you. Also about the nine cystectomies,
13 I mean one of the drivers in improving outcomes
14 guidance was not do things you do less often, and
15 Mr. Drake's analysis showed approximately 12 cases over 13:11
16 approximately a six-year period so the numbers are easy
17 to calculate. Was there resistance, did you see
18 resistance to stopping doing a benign cystectomy and --
19 A. Yes, the cystectomies -- sorry, my apologies.
20 266 Q. What was the resistance? 13:11
21 A. The resistance was that the review had detailed
22 malignant, radical cystectomies was what was mentioned,
23 not for benign disease. Okay, we can't do that but
24 they haven't said we can't do that and not for the
25 benign, that was the resistance, and they wanted to 13:11
26 continue to do it, that was checked with the
27 commissioners and THEY came back and said no, you can't
28 do them.
29 267 Q. And once that was established --

1 A. No, there was one patient, if I remember right, I don't
2 want to mention her name, who did get operated on after
3 that which I picked up, and then there's another edict
4 came out saying they had to stop.
5 268 Q. Thank you. The next thing about review of results, 13:12
6 both Radiology and Pathology we saw Patient 5 and 8
7 problems with missed results. I mean, you are a busy
8 colorectal general surgeon, what would happen in your
9 office when an unexpected malignant result would come
10 through, would you pick that up or MDT? 13:12
11 A. Now if there is unexpected results coming from
12 Radiology that is meant to be flagged as well by
13 Radiology and that's --
14 269 Q. Back in the time?
15 A. No, Radiology didn't routinely contact people to say 13:12
16 there's an issue. The results would have come back to
17 my secretary. My secretary, who had been with me for
18 years, would have looked at them and if she saw
19 something obvious she would have flagged it up, but at
20 the same time they sat on her desk until I went through 13:13
21 them and initialled them to make sure there's nothing
22 on them, and if there was anything on them then that
23 was actioned accordingly and there would be further
24 investigation, MDT or whatever.
25 270 Q. So it was up to you personally to pick that up? 13:13
26 A. Yes.
27 271 Q. Thank you. So pre-op assessment, obviously this worked
28 for you on bringing patients in on the day, the Inquiry
29 has been aware of two patients, 90 and 91, where the

1 lack of pre-op assessment had probably led to a poor
2 surgical outcome. What would your comments be on the
3 ease of referring patients through for pre-op
4 assessment, was it automatic, did it work well, was the
5 quality of the pre-op assessment when it was asked for? 13:13
6 A. Yes, I never had any problems with it. It was
7 straightforward. You'd put them on a list to say they
8 are for surgery and they get sent off to pre-op. My
9 recollection is, my recollection is it went off to the
10 clinic for pre-op assessment and then depending on when 13:14
11 theatre was going to happen, et cetera, maybe they had
12 further tests or a further check at that stage. If we
13 had somebody that I was concerned about, I would have
14 either said they need seen urgently, or if I was
15 worried in this respect would have been the oesophageal 13:14
16 patients since you are opening their chest, I would
17 contact Dr. McAllister and let him know there was one
18 there so he would organise this. The pre-op assessment
19 for them was more involved. We, in the early stages,
20 used to walk them up and down the stairs. In later 13:14
21 stages they were on a bicycle and had the function
22 tests, et cetera, physiological tests carried out that
23 way, so he would have been aware himself of those ones.
24 272 Q. But that may have taken a little time but that was easy
25 to organise from your point of view? 13:15
26 A. It was easy. It didn't take much time at all.
27 273 Q. Thank you. You mentioned Mr. O'Brien, his requirement
28 for a large amount of administration time. Could you
29 just repeat those 3.87 PAs. Could you just remind us

1 how much time per week that equates to?
2 A. Well four PAs is 16 hours.
3 274 Q. Per week?
4 A. Yes.
5 275 Q. Of administration? 13:15
6 A. Yes.
7 276 Q. You also comment in your statement that he would spend
8 some time organising admissions and waiting lists,
9 things like that. Would you make a comment on whether
10 that sort of work might well be devolved to a waiting 13:15
11 list office or some other --
12 A. I devolved it.
13 277 Q. -- arrangement?
14 A. It was not -- it's -- I do not consider that a useful
15 part of my time, to spend a lot of time on it, not to 13:16
16 say it wasn't worth doing but the waiting list
17 management was not -- I can't really -- it's one of
18 those things, you knew what was on the waiting list,
19 you just picked them off the top of the list unless
20 they are particular urgent things needed done or be it 13:16
21 cancers or a patient in significant pain and
22 discomfort.
23 278 Q. I suppose slightly refining the question. Did the
24 other Urologists have to do it themselves in the way,
25 that is themselves and their secretaries? 13:16
26 A. I can't answer straight you on that. I think Martina
27 Corrigan might be able to answer that because I know
28 they talked about a scheduling meeting they held on
29 a Thursday afternoon but I was never involved in, but

1 they had some sort of a scheduling meeting on
2 a Thursday afternoon and Martina Corrigan is probably
3 the best one to ask on that one.
4 279 Q. Thank you. Last question. Triage. Was this ever
5 a problem amongst the -- apart from Mr. O'Brien, didn't 13:17
6 seem to have a particular problem with it, was this
7 a problem among other surgical specialties?
8 A. Not that I ever had to talk to them about it. The odd
9 time somebody built up to maybe -- you do it within 24,
10 48 hours, I don't think we generally did that, if you 13:17
11 were operating all day Tuesday and you'd something else
12 on a Wednesday you wouldn't get it done. Generally it
13 was done on a weekly basis. The current system at the
14 start of the week, at the start of the week triage in
15 general surgery during their week they do the triage. 13:17
16 The colorectal is now split among the colorectal
17 surgeons and the general surgeons take the
18 non-colorectal elective stuff, but it is not -- there's
19 not a big backlog that I know of or have seen --
20 280 Q. It's works well? 13:17
21 A. Reasonably well. It's maybe not exactly the way they
22 say you have to have it done within 24, 48 hours,
23 I would be lying if I said that, but reasonably well,
24 yes. No significant backlog.
25 MR. HANBURY: I have got no further questions, thank 13:18
26 you very much.
27 DR. SWART: Thank you for giving your evidence.
28 I won't be too long. Back for a minute to your role as
29 Associate Medical Director. Undoubtedly this is a big

1 job, it has huge responsibility attached to it. Some
2 of that has been referred to today, and you yourself
3 have said you didn't really have enough time to do it
4 justice. One of the key responsibilities is that of
5 clinical governance and Patient Safety. Did you, when 13:18
6 you were doing the job, ever think to yourself I don't
7 really think I can do this justice? Did you question
8 how you were going to manage it at that time?
9 A. Well, Patient Safety and governance was, in many ways,
10 I suppose we devolved it out in the Trust and the Lead 13:19
11 Clinicians looked after the Clinical Directors and
12 ultimately the Associate Medical Directors. We had our
13 MDM and ultimately the Patient Safety meeting which we
14 were involved in introducing -- did I ever think to
15 myself, I did think at different times this job is very 13:19
16 busy, I did have difficult doing it. Did I verbalise
17 that to others? No, to be honest, I didn't.
18 281 Q. Did you verbalise it to yourself, that's what I'm
19 asking?
20 A. I did think it was a busy job and I had difficulty, at 13:19
21 times, doing it. When you get de-fibbed or
22 dc-converted you start to think why, but more than
23 that, I did not go along to people and say I can't do
24 this job. Back to question which was a question about
25 the surgical ego. 13:19
26 282 Q. Just phrasing it a different way as well. You have
27 a Medical Director, Medical Director really sets the
28 ethos of medical management and leadership, I think.
29 Did the Medical Director ever ask you, for example, at

1 the beginning, you know, how is it going, are you
2 coping with the responsibility? Is there anything that
3 you perhaps need help with? Did you have any of those
4 conversations?
5 A. Not that I can recall. 13:20
6 283 Q. Was there an open door to the Medical Director's office
7 so you could pop along and say can I have a word about
8 this or that?
9 A. Although they were on the same site they were not in
10 the same building. We talk about up the hill and down 13:20
11 the hill. Up the hill was the hospital, down the hill
12 was Trust HQ. I would have gone down the hill a lot
13 and just chat -- but not always necessarily with the
14 Medical Director, with some of the other -- Debbie
15 Burns at one stage was in performance and reform when 13:20
16 she was there I would have gone and chatted to her, and
17 you'd be down at times for meetings and various things.
18 I didn't feel that I was restricted from talking to the
19 Medical Director if that's what you are asking, no.
20 284 Q. Not so much restricting it's just the openness. You 13:21
21 did have meetings with the Medical Director with other
22 Associate Medical Directors I understand?
23 A. Yeah, we had our own one-on-ones and I think it was
24 a monthly, a Friday afternoon once a month.
25 285 Q. Those specific Medical Director meetings, did you have 13:21
26 the opportunity then to talk about difficulties in
27 managing doctors or about doctors who were in
28 difficulty and was there a general discussion
29 opportunity to share experiences?

1 A. I don't recall individual doctors ever being discussed
2 at that, I could be wrong but I don't recall. I think
3 those would have been carried out more than the
4 one-on-one meetings. As I mentioned in my evidence,
5 the one time that the doctors in difficulty proposal 13:21
6 came up I was on leave, is all I remember. It's 2011,
7 I was on leave and it never got re-presented. But
8 I know, because the official document went out less
9 than a week later, and it was meant to be drafted.
10 286 Q. There wasn't a culture of understanding the need to 13:22
11 remediate problems with doctors and actually think
12 a bit further as to what kinds of issues are causing
13 problems, particularly of behaviour, for example?
14 A. Not that I can recall offhand. I don't recall the
15 set-up -- the interactions what you do -- how you 13:22
16 manage meetings, how you do bullying -- I don't recall
17 those.
18 287 Q. What about the direction, the strategic direction for
19 audit and particularly clinical audit, did you get
20 a sense of direction from the Medical Director or the 13:22
21 senior management of the Trust in that regard?
22 A. No.
23 288 Q. No. Okay. Similar though but not the same. We have
24 heard a lot about serious incidents in this Inquiry and
25 I am quite interested in your experience of identifying 13:22
26 serious incidents in your Directorate. Who did you see
27 as responsible for leading that process in terms of
28 deciding it was a serious incident in the first place,
29 if we just start with that?

1 A. There was a review I believe of Datixes carried out
2 with one of the ENT surgeons did that with -- he was
3 involved in that. Then when it went beyond that some
4 of them would go to Heather, and Heather would flag
5 them up to myself on a Wednesday afternoon and we'd 13:23
6 discuss them.
7 289 Q. Were you actively involved in deciding it is a serious
8 incident or it isn't?
9 A. At that point, yes. Not the initial filtration.
10 290 Q. Okay. Once the investigation has been completed, most 13:23
11 Trusts have extensive numbers of investigations with
12 action plans attached to them. Where did the action
13 plans go and did they get properly monitored, or was it
14 a difficult thing to control for you? What was your
15 view of that? 13:24
16 A. Any learning from SAIs was then presented at the
17 Patient Safety meeting and I would have presented them
18 in general at that stage, I would have been presenting
19 them.
20 291 Q. How did you make sure it all got finished off, because 13:24
21 when there's learning there's nearly always things to
22 do?
23 A. There are, and I can't say that was always followed
24 through.
25 292 Q. What about informing the rest of the Consultant body 13:24
26 and other relevant people about the serious incidents,
27 was that well shared or was that problematic?
28 A. It was shared amongst the Surgical Anaesthetic
29 Directorates, specific things for -- well, the

1 medicines issues were shared at all Directorates. The
2 pharmacist would come to each one at the start of the
3 meeting and present them. The issues that we had that
4 we felt were relevant to another Directorate, usually
5 at the Patient Safety meeting would have been discussed 13:25
6 and then flagged for them -- or this SAI, you need to
7 -- you are involved and there are issues for your
8 Directorate as well.
9 293 Q. Thank you. We have heard about a few information
10 governance issues last week and this week. I will just 13:25
11 start with one that a patient's family flagged up,
12 which was a patient which went to a private hospital
13 for an operation, the notes did not go with the
14 patient, there was quite a bad incident and part of the
15 issue was this issue of information travelling between 13:25
16 Trusts and who is responsible, and so on, which I don't
17 think was ever fully explained. We have got the issue
18 of lots of charts at home, which clearly is a risk to
19 Patient Safety for a variety of reasons. We also had
20 some problems around people appearing on operating 13:25
21 lists on the day of surgery not being registered at the
22 Trust having come from somewhere else, so quite a lot
23 of different things. In your view, how strong is the
24 focus on the information governance risks and the links
25 to Patient Safety, and how would that have been dealt 13:26
26 with in your Surgical Directorate? Because it's quite
27 a big issue, as we see it; was there a good awareness
28 of this, do you think?
29 A. I don't think there was, not an awareness of the

1 numbers of charts, that was very definitely not known,
2 that I think would have been --
3 294 Q. Is that not a serious incident in its own, really?
4 I mean, what would your attitude to that have been at
5 the time? 13:26
6 A. The number of the charts, those number of charts, that
7 is a serious incident, but I suppose by that stage it
8 was beyond that, it was into raised it with Richard
9 Wright for advice on how to manage it, et cetera.
10 I suppose some things may not have made it directly to 13:26
11 have been an SAI when they are being actioned and
12 followed up by the team, by the management team. If
13 that's what you are asking me, sorry, I am not sure --
14 295 Q. I am trying to get sort of what was the culture in
15 terms of understanding the risk to Patient Safety from 13:27
16 these issues which start off as maybe it's a small
17 issue, and actually, when you think about it, it's
18 quite a big issue?
19 A. I don't think that was understood. As I said, I think
20 it was he was judged on the basis of what people 13:27
21 thought of him rather than just on the facts alone.
22 When you see it tabulated it's very difficult to ignore
23 it now. In fact, it's impossible to ignore now.
24 296 Q. It's obviously easier for us with hindsight but I'm
25 just trying to get an idea of what the culture was 13:27
26 like. Another cultural issue that comes out is this
27 issue of job planning where job planning is meant to be
28 a tool for managing doctors to some extent, but with
29 job planning best practice would be that you sit the

1 team down and you work out what work needs to be done
2 and you come to an agreement. You can also set
3 objectives for the team and so on. What was the
4 general direction given to you as Associate Medical
5 Director for what you needed to do with job planning, 13:28
6 and how did that feel as Associate Medical Director and
7 were you able to do what you needed to do?
8 A. There was great difficulty doing it. As you can see,
9 there was over a prolonged time trying to get
10 agreement. They would not agree. In fact, Mr. O'Brien 13:28
11 was not prepared to agree to a job plan with any
12 reduction in PAs, and ultimately his salary.
13 297 Q. Did you sit down with the team of urologists and do
14 this in an open way?
15 A. A lot of the job planning earlier on was done through 13:28
16 the Monday evenings trying to agree objectives and how
17 it would be done and how we'd work them, et cetera. It
18 wasn't -- it may have been set out but it wasn't -- you
19 know, there was a lot of pushback.
20 298 Q. Yes. Okay. You didn't use job planning individually 13:29
21 with objectives for each Consultant in that way?
22 I can't see that in the paperwork.
23 A. No, job planning didn't entail that and still, to my
24 knowledge, does not entail that for any of the --
25 299 Q. No. The private patient issue has come up, mainly from 13:29
26 some of the witnesses so far, as a significant issue.
27 Just in simple terms, the Trust has a private patient
28 policy, I understand, which says that if you see
29 someone privately and you bring them into hospital you

1 need to transfer them to be an NHS patient?
2 A. Yes.
3 300 Q. This clearly was not particularly being adhered to in
4 the way it was meant to. Do you think that was
5 a general problem in the Southern Trust or do you think 13:29
6 it was specific to some areas, or do you have any feel
7 for that at all?
8 A. I can't say specifically. I think it probably existed
9 in other areas, not, shall we say, not that people were
10 key jumping but utilising the process of how patients 13:30
11 when they transferred and the form filling, et cetera,
12 for that, that may not always have been done.
13 301 Q. You talk about softly softly. But somewhere when you
14 are managing a problem like this the buck has to stop
15 with somebody in the chain in terms of you have 13:30
16 a doctor in difficulty and there are patients who are
17 therefore either coming to harm or at risk from harm.
18 Where does the buck stop? Where does the final buck
19 stop for managing a difficult doctor, do you think?
20 Who has got that job card? 13:30
21 A. I actually think the Medical Director, which is why we
22 went to him for advice each time, because we felt the
23 buck stopped with him.
24 302 Q. Mm-hmm. Do you think that all the people involved in
25 that chain have been given the right tools and the 13:31
26 right support to execute their duties in this regard?
27 A. When you say the chain?
28 303 Q. Did you have the right tools in your box to --
29 A. I have to admit no, because I didn't think of utilising

1 -- I didn't so I can't claim I had the tools. The
2 tools were there but I didn't recognise them.
3 304 Q. Okay. Thank you.
4 CHAIR: Thank you very much, Mr. Mackle. We are going
5 to rise now. It's just half past one, so half past two 13:31
6 for our next witness.
7 MR. WOLFE KC: During one question of Mr. Mackle I drew
8 attention to a document at TRU-277941. You will
9 remember it was a handwritten note of a meeting of the
10 21st March 2016 at which Mr. Mackle attended with 13:32
11 Mrs. Gishkori. It was not Mrs. Trouton -- sorry, it
12 was Mrs. Trouton's note. It was Mrs. Trouton's note of
13 the meeting and not Mrs. Gishkori, and I am sure I will
14 be asking Mrs. Trouton about that this afternoon.
15 CHAIR: Thank you very much. 13:32
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17 THE INQUIRY ADJOURNED FOR LUNCH
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1 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

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3 CHAIR: Good afternoon, everyone. Sorry for the slight
4 delay. Mr Wolfe, I understand there's to be an
5 amendment to the statement and I think that was the 14:37
6 hold-up. I think they were going to get it amended on
7 the screen but I don't think we should wait any longer.
8 MR. WOLFE KC: I think that relates to a witness
9 tomorrow, perhaps.
10 CHAIR: I was told it was this witness but we can check 14:37
11 it out anyway.
12 MR. WOLFE KC: This witness this afternoon then is
13 Heather Trouton and I think she intends to take the
14 oath.
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1 MRS. HEATHER TROUTON, HAVING BEEN SWORN, WAS EXAMINED
2 BY MR WOLFE KC AS FOLLOWS:
3
4 305 Q. MR. WOLFE KC: The first thing we are going to do is
5 bring up on the screen the Section 21 responses, which 14:37
6 you have placed before the Inquiry. The first one is
7 number 2 of 2022. It's dated 3rd March of last year.
8 The first page, WIT-11988, you will recognise that,
9 I think. If we take you to the last page and your
10 signature, it's a lengthy response, I think it's 174 14:38
11 pages. WIT-12161, and that's your signature?
12 A. Yes, it is.
13 306 Q. Can I assume that you would wish to adopt that
14 statement, subject to one correction, as part of your
15 evidence? 14:38
16 A. Yes.
17 307 Q. In fact, the correction I think you need to make is in
18 the second of the statements. The second statement is
19 number 37 of 2022. The first page is WIT-14808, and
20 you are familiar with that? 14:39
21 A. Yes.
22 308 Q. The last page, bearing your signature and the date
23 WIT-14837, and it was signed on 8th June by yourself?
24 A. That's right.
25 309 Q. Again, would you wish to adopt that as part of your 14:39
26 evidence, subject to the correction I am going to --
27 A. Yes.
28 310 Q. The correction or the revision you would wish to
29 address is at paragraph 48, WIT-14826. It concerns an

1 issue I think we touched on this morning. So paragraph
2 48, to paraphrase you are saying that you don't that
3 a copy of the letter sent to Mr. O'Brien on 30th March
4 was given or shared with the Service Director or the
5 Medical Director that's what you are saying in that 14:40
6 paragraph, and you wish to correct that. What do you
7 wish to say about it?
8 A. When I read my witness bundle I saw that Mr. Mackle had
9 sent a copy of the letter to the Medical Director at
10 that point, so I was unaware of that but I now know it 14:40
11 to be the case.
12 311 Q. He also provided a statement to the MHPS investigation
13 which you will recall was led by Dr. Chada. I want to
14 bring you to that statement and just take a moment to
15 explain to the Inquiry a little wrinkle around that. 14:41
16 I am told that CaseView is currently down.
17 CHAIR: Okay. I think that will need sorted out.
18 Perhaps Mr. MacInnes could check that for us, please.
19 Can I just ask if everyone is happy to continue without
20 case use and just make use of the transcript when it's 14:41
21 available, or would you rather take a break until it is
22 up and running?
23 SPEAKER: Chair, it may be an Internet issue rather
24 than CaseView. The internet is sporadic.
25 CHAIR: Can we take a straw poll of how many people -- 14:41
26 is it just the Inquiry laptops that it's not working?
27 MR. WOLFE KC: Maybe just take five minutes.
28 CHAIR: We will take a short break until we see if we
29 can get it resolved quickly or not.

1
2 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
3
4 CHAIR: I understand that the technical issues have
5 been resolved. It seems to be Tuesdays that we 14:53
6 encounter these technical difficulties, but hopefully
7 not too often. I understand also, Mr. Wolfe, that it
8 was Mrs. Trouton's statement that was being updated and
9 it has been, just the amendment that you are referring
10 to. 14:53
11 MR. WOLFE KC: Okay. Thank you.
12 312 Q. Before the break, Mrs. Trouton, you were indicating
13 that you had provided a statement to Dr. Chada's
14 investigation and there's a little wrinkle around that
15 that we need to clarify, so if we go to TRU-00795. We 14:54
16 can see the first page of a four-page statement. We
17 can see that your name is at the top. The statement is
18 given on 5th June 2017. As you can see, it runs
19 through to TRU-00798. We can see then, if we move on
20 to the next page TRU-00799, and just slowly scroll 14:54
21 through that, please. This is again I think
22 a four-page statement but it's got tracked changes.
23 So, for example, at the top of the second page, we can
24 see that some changes have been tracked into it. We
25 can then see, if we go to TRU-00803 -- just I will 14:55
26 pause here to say that the live note is down again?
27 CHAIR: Can I just say the issue is not at our end and
28 we will get it fixed.
29 CHAIR: Sorry, I think it might be resolved,

1 Mr. MacInnes. Is it working? Can I just check
2 everybody has it working again? No, not everybody.
3 I understand the broadband is external to this building
4 so we have little control over it, where the issue is,
5 but it sounds to me as though there is an intermittent 14:56
6 problem with the broadband then at their end. I am not
7 quite sure how we resolve this. Can I just check is
8 everyone -- is there at least one person on each Core
9 Participant team who has it? Mr. Millar, Mr. Reid,
10 yes, and the Inquiry? One of us has it. I think we 14:56
11 will continue rather than take another break. We need
12 to get through some of Mrs. Trouton's evidence without
13 disturbing her any further.
14 MR. WOLFE KC: Okay.
15 313 Q. Is it correct to say, Mrs. Trouton, that after you saw 14:56
16 how your statement had been typed up by the MHPS
17 investigation you noticed some difficulties with it
18 that you would have liked to change and you did make
19 those changes by way of a tracked note?
20 A. Yes. 14:57
21 314 Q. What appears to have happened, and we will maybe need
22 to check this with Dr. Chada, is that your unchanged,
23 in other words your original version, complete with the
24 bits that you were unhappy with, was taken by the MHPS
25 investigation to be your final view, and they didn't 14:57
26 appear to have used your tracked change version, is
27 that your understanding?
28 A. That's my understanding, yes.
29 315 Q. Just to be clear, the tracked changes that we can see,

1 for example, at TRU-00800, were made by you back in
2 2017?
3 A. Yes, that's right.
4 316 Q. Yes. You will have to help me with the e-mail that you
5 have sent to Siobhán Hynes in February 2022 which we 14:58
6 find at TRU-00803. So you were sending this to her in
7 2021, for what reason?
8 A. I was looking at my original statement, obviously in
9 preparation for the Inquiry, and I didn't recognise it
10 as a true version, so I went back to check what 14:58
11 amendments I had made, because I was sure I had made
12 amendments. Then I found the e-mail where I did make
13 the amendments and then I went back to Siobhán and said
14 I had sent amendments, you don't seem to have noted
15 them. I think that's what I was doing at that point. 14:58
16 317 Q. Without overcomplicating it, this e-mail explains your
17 thinking behind the amendments?
18 A. Yes.
19 318 Q. Okay. I hope that doesn't overcomplicate things, Madam
20 Chair, but I thought we should deal with that in 14:59
21 a little bit of detail.
22
23 Members of the Panel, Mrs. Trouton, obviously we know
24 from Mr. Mackle's evidence that you were a co-signatory
25 of a letter that was handed to Mr. O'Brien on 30th 14:59
26 March, that letter bearing the date 23rd March 2016.
27 It obviously contained reference to a number of
28 concerns about Mr. O'Brien's practice that had been,
29 some of them at least, part of your managerial concerns

1 with others for a period of some time before the March
2 meeting. You didn't attend that meeting, and we will
3 look at that, but your evidence gives us the
4 opportunity, the Inquiry the opportunity to look at
5 those concerns, how they were dealt with, managerial 14:59
6 response to them and we will look at that in the
7 context of the MHPS Framework as well. But just
8 starting with your career and your role, you are
9 currently the Executive Director of Nursing, Midwifery
10 and Allied Health Professionals in the Southern Trust? 15:00
11 A. That's correct.
12 319 Q. You have been in that position since January 2018?
13 A. That's right.
14 320 Q. If we go to your witness statement, WIT-12012, in ease
15 of the Panel's note, at answer 86A, you take us through 15:00
16 your career. You are a nurse by profession, isn't that
17 correct?
18 A. That's correct.
19 321 Q. You have occupied a number of nursing roles in your
20 early career. In October 2009 you took up the role 15:01
21 with which we are most interested and that's Assistant
22 Director for Surgery and Elective Care, isn't that
23 right?
24 A. That's correct.
25 322 Q. You were stationed within the Surgery and Elective Care 15:01
26 Directorate?
27 A. Yes.
28 323 Q. Is it fair to say that was your first engagement with
29 Urology Services upon taking up that role?

1 A. Yes, and no, because my other previous posts, for
2 example, patient flow coordinator, et cetera, would
3 have managed the flow of Urology patients in the
4 Trusts, so it wasn't that I wasn't familiar with
5 Urology, but it was the first post where I had direct 15:02
6 managerial responsibility for the Urology Service.
7 324 Q. You remained in that Assistant Director role right
8 through until March 2016, isn't that right?
9 A. That's correct.
10 325 Q. You took up a new role in April 2016 as Assistant 15:02
11 Director for Integrated Maternity and Women's Health
12 and Cancer and Clinical Services?
13 A. That's correct.
14 326 Q. So you had, in essence, seven years in the Assistant
15 Director role in SEC, Surgery and Elective Care. Your 15:02
16 movement to a new role in April 2016, you have
17 described it I think as due to a general reshuffle of
18 Assistant Directors, and you were replaced by
19 Mr. Carroll, Mr. Ronan Carroll?
20 A. That's correct. 15:03
21 327 Q. When you think about it now, of course the timing of
22 that in some respects was unfortunate, given the issues
23 that the Inquiry is grappling with; you, as I have just
24 outlined briefly, were the co-signatory of this letter
25 to Mr. O'Brien? 15:03
26 A. Yes.
27 328 Q. We will look at the fine detail of that, but Mr. Mackle
28 agreed with my characterisation of that as being
29 a formal attempt, certainly compared to the informality

1 of previous initiatives, to try to get to grips with
2 some of these difficulties?
3 A. Certainly more formal than previous.
4 329 Q. Yes. You were in a new post within a week or so after
5 the delivery of that letter? 15:04
6 A. Yes, 1st April. It was delivered on 30th March and
7 I started my new role on 1st April.
8 330 Q. Yes. That's not to say Mr. Carroll was a stranger to
9 these issues. He had some working knowledge of
10 Mr. O'Brien and some of the difficulties, if I can put 15:04
11 it in those neutral terms, that occasioned his practice
12 and managerial response to it?
13 A. Yes. Ronan was the Assistant Director of Theatres and
14 Cancer and other areas that obviously had a close
15 affinity with Surgery. 15:04
16 331 Q. In terms of the role that you perform as Assistant
17 Director, I want to spend some moments looking at that.
18 You would have reported to a Director of Acute
19 Services, isn't that right?
20 A. That's correct. 15:05
21 332 Q. During the currency of your role, you reported to four
22 Directors in total, Joy Youart?
23 A. Yes.
24 333 Q. I will get these in right order, Gillian Rankin?
25 A. That's right. 15:05
26 334 Q. Then Debbie Burns and then, lastly, and for
27 a relatively short period of time, Esther Gishkori?
28 A. That's correct.
29 335 Q. Right. Just in terms of the things that we are looking

1 at, and you have sat and observed and heard the
2 evidence over the last day or so with Mr. Mackle, is
3 that changing of the guard in the top job within the
4 Directorate, was that unhelpful in terms of grappling
5 with these issues, or neutral? 15:06
6 A. I would say neutral. Joy Youart was very, very short
7 with me because she left literally a few months after
8 I started. I started in the beginning of October 2009
9 and I believe Dr. Rankin took over in December 2009, so
10 it was very short for Mrs. Youart. Dr. Rankin was 15:06
11 quite a period of time, so there was a good bit of
12 stability with Dr. Rankin. Similar with, two years
13 with Deborah Burns, and then Esther Gishkori was
14 towards the end of my time in SEC. So you are right
15 there was a change of personnel. I would say that 15:06
16 there was a very similar approach by Dr. Rankin and
17 Mrs. Burns, very strong, in control type Directors.
18 That's not to say Joy Youart and Esther Gishkori
19 wasn't, but Mrs. Gishkori maybe had a wee bit more,
20 maybe it was because she was new into post, but a wee 15:07
21 bit more devolved, maybe, style, whereas Dr. Rankin and
22 Debbie Burns had a very much more involved style.
23 336 Q. Mm-hmm. Sometimes when I ask witnesses questions about
24 issues concerning Mr. O'Brien and the management of
25 him, I am in danger of giving the impression I didn't 15:07
26 think there was anything else in your in-tray to be
27 focused on, but with that apology, or expression of
28 understanding, your role was obviously more than just
29 the management of one clinician. But thinking about

1 those issues and just trying to paint in some of the
2 detail at this point, were you well supported in
3 general terms by your Directors if you wanted to bring
4 concerns, escalate concerns about a clinician, or
5 indeed any issue to them? 15:08
6 A. Yes, I had a good working relationship with all four
7 Directors.
8 337 Q. Yes. Were they, I suppose the question is receptive to
9 you bringing problems, difficulties, to their door?
10 A. Yes, yes. 15:08
11 338 Q. That was one tier of management upwards?
12 A. Yes.
13 339 Q. We will come on to talk in a moment about, sort of,
14 operational management side of it which you belonged to
15 and the medical or professional management, and I am 15:08
16 sure not sure if you find that dichotomy helpful, and
17 we will look at that. But the tier below you in your
18 work within Surgery and Elective Care there were
19 a number of specialties, isn't that right? There was
20 general surgery, breast surgery, ENT, Endoscopy, 15:09
21 Urology was one of several others, and each of those
22 services or sub-specialties had a Head of Service, or
23 at least there was, just help me with this, three Heads
24 of Service; is that right?
25 A. Three Heads of Service. Martina Corrigan was 15:09
26 responsible for Urology and ENT and Outpatients, five
27 Outpatients Departments. Head of Service changed a wee
28 bit, but Trudy Reid was General Surgery and Louise
29 Devlin, I think at that point, was Trauma and

1 Orthopaedics, would have been the three Heads of
2 Service.
3 340 Q. If we could maybe just focus on Mrs. Corrigan,
4 helpfully I suppose from our perspective, she is in
5 that role as Head of Service with responsibility for 15:10
6 Urology for as long as you were in post as Assistant
7 Director?
8 A. Yes, correct.
9 341 Q. Indeed when we look at the medical management side,
10 Mr. Mackle was Associate Medical Director for that 15:10
11 expanse of time as well. In terms of how you worked
12 with Mrs. Corrigan, what was your expectations of her,
13 if there were difficulties, and her expectations of
14 you?
15 A. For the most part because my remit was so large across 15:10
16 a lot of areas, the Heads of Service would have much
17 more close working relationship with each of their,
18 because it was devolved down a bit smaller, so I'd have
19 expected Martina to manage the day-to-day business of
20 the services, manage -- I mean a Head of Service is 15:11
21 quite a senior post in itself so she would have been
22 able to manage a number of problems and issues and be
23 able to sort, and then escalate to me whenever she had
24 done really what she could and then escalate to her
25 manager, as I did to the Director of Acute Services. 15:11
26 342 Q. We will see, when we look at some of the specific
27 examples, how she would have copied you in, that is
28 Mrs. Corrigan copied you into correspondence raising
29 issues with you, not always but perhaps she had to take

1 them so far, run into an obstacle and then escalate to
2 you, is that?
3 A. That's usually normal. You manage within your sphere,
4 or as much as you can do using all the people around
5 you, and then whenever you need a feel you need a bit 15:11
6 of help and support, then you escalate.
7 343 Q. Take a brief look at your job description, WIT-12164.
8 "You will be responsible to the Director of Acute
9 Services for the delivery of high quality care to the
10 patients in the Trust Surgery and Elective Care 15:12
11 Division. You will be responsible for the operational
12 management of all specialties in the division".
13
14 Those are set out. It's across two sites, is it?
15 A. Yes, mm-hmm. 15:12
16 344 Q. Craigavon and Daisy Hill?
17 A. Yes.
18 345 Q. Your responsibility is to collaborate closely with
19 senior clinicians and other disciplines to implement
20 the objectives of the Trust's delivery plan and ensure 15:12
21 effective multidisciplinary working. You are to
22 provide clear leadership to staff, all staff in the
23 division and be responsible for effective financial
24 management.
25 15:13
26 "The job holder will also support the Director of Acute
27 with long term planning of service reform initiatives."
28
29 In a nutshell, a very worthy document and it's broken

1 down. In a nutshell was your job to oversee everything
2 that supported the delivery of care?
3 A. In a nutshell, yes. Probably more around the
4 operational management of everything that goes into
5 support care, so the function of the wards, the 15:13
6 function of the Outpatient Departments, the function of
7 the nursing staff, whoever goes around it, and then, as
8 you will be aware, there was the medical line which you
9 will see in the job description I work closely with and
10 collaborate closely with senior clinicians, but 15:14
11 I didn't manage clinicians, I worked closely with them,
12 but I felt that my role was to provide everything that
13 was needed to allow those senior clinicians to be able
14 to provide care, and all clinicians, for that matter,
15 whether you are nurses or allied health professionals, 15:14
16 et cetera.
17 346 Q. Okay. You didn't manage clinicians, you make that
18 distinction but we see, I suppose, plenty of attempts
19 on your part to manage their output?
20 A. Yes. 15:14
21 347 Q. Or what they are failing to do. Is it fair for me to
22 suggest that you were in a managerial role in respect
23 of them?
24 A. I certainly was responsible for the overall patient
25 care, and where there were any element that impinged on 15:14
26 good patient care, it would have been remiss of me not
27 to try and do something about that, and that included
28 obviously looking at the work of the medical staff as
29 well as every other, if that makes sense?

1 348 Q. Yes. To what extent, I suppose, did you have the power
2 to instruct a clinician in his or her behaviour or
3 conduct in respect of a duty? If a duty wasn't being
4 performed, did the power lie with you to say please do
5 that? 15:15
6 A. Power to instruct didn't lie with me. The power to
7 encourage, support, enable, provide the circumstances
8 by which they could do, I certainly was involved in
9 that, whether it was coming up with a new process. But
10 the power to instruct them to do something, I didn't 15:16
11 feel lay with me.
12 349 Q. Do you think that power, if I can use it in those sort
13 of hierarchical terms, did that rest on the medical
14 management side of the line?
15 A. If you look at the job description of medics there, the 15:16
16 line management is either through their Associate
17 Medical Director up to Medical Director and through the
18 Director of Acute Services, so probably both those two
19 lines would have had more power. It seemed to bypass
20 the Assistant Director and go directly to the Director 15:16
21 of the Acute Services on the operational side, but
22 obviously, obviously I was needed to ensure that the
23 Director of Acute Services had the information to be
24 able to make decisions.
25 350 Q. When we see you writing to Mr. O'Brien saying, 'please 15:17
26 get this done', or being copied into an e-mail from
27 Martina Corrigan inviting Mr. O'Brien to get this done,
28 that is encouragement, facilitation, but it's not, in
29 essence, an exercise of the power that could go

1 anywhere except to escalate it across to the medical
2 management to action it if it wasn't responded to?
3 A. That's certainly how it was back then. It was quite
4 hierarchical in its set-up in that there were lines of
5 engagement, for want of a better word, and that's the 15:17
6 way it was.
7 351 Q. Yes. There is reference in your job description to the
8 issue of disciplinary management, just look at that
9 briefly, WIT-12168, and at number 42 under "human
10 resource responsibilities", it says that you have to 15:18
11 "take such action as may be necessary in disciplinary
12 matters in accordance with procedures laid down by the
13 Trust."
14
15 Where did your disciplinary jurisdiction extend to or 15:18
16 who were you responsible for in disciplinary terms?
17 A. I think it was everyone except medics.
18 352 Q. Another feature of your job description is to -- just
19 briefly look at it WIT-13165, just three pages back.
20 At paragraph 6 you are: "To ensure high standards of 15:18
21 governance in the division, include compliance with
22 controls, assurance standards, the assessment and
23 management of risk, and the implementation of the old
24 Department safety first framework."
25 15:19
26 It's showing its age, that document?
27 A. It is.
28 353 Q. In governance terms, what did you understand your role
29 to be? What were the parameters of that?

1 A. Governance, from my perspective, was very wide, really,
2 because I had financial governance, I had Human
3 Resources and all the governance that goes around that,
4 we have heard about information governance, Clinical
5 Governance, governance of good standards at ward level, 15:19
6 Outpatient, Admin, so it was very, very wide. I know
7 I have been looking at it very much in Medical
8 Governance or Clinical Governance which, of course, it
9 included, but it was just using everything that was
10 available to me with regards to complaints, adverse 15:19
11 incidents, SAIs, standards and guidelines, to ensure
12 that we were adhering to good practice, and obviously
13 then good patient care.
14 354 Q. Just to take any one of those examples, what would have
15 been your role if an Incident Report or a Datix had 15:20
16 been raised and there was to be consideration as to
17 whether that should go down an SAI route. Do you have
18 a role in that?
19 A. Yes, I did. Once a week myself and one of the Clinical
20 Leads I think for a period of time it was Mr. Reddy but 15:20
21 it could have been others, and we would have gone
22 through the moderate to major incidents, not every
23 incident but the moderate to major and we would have
24 looked at, I suppose, trends, but then obviously those
25 particular incidents that stood out. Then if we felt 15:20
26 that some needed screened for an SAI, and sometimes it
27 was the Governance Coordinator brought it to my
28 attention that a particular incident had happened and
29 it may need screening, myself and Mr. Mackle would have

1 sat and went through the screening criteria that was
2 set out by the Department to see if it met the
3 criteria. If it did, then we said yes that needs to be
4 an SAI. Or back then -- way, way back then it could
5 have been an RCA or serious event, and then the 15:21
6 Governance Coordinator set up a panel then to go
7 through the SAI. So it was more in the screening part
8 of it, safe medical criteria.
9 355 Q. As that process unfolded through its stages of review
10 or investigation and then conclusions, recommendations 15:21
11 and action planning, did you have any input in those
12 various stages?
13 A. Rarely. I think in my career in that period I was
14 asked to sit as a member of one SAI, not in the
15 Surgical Directorate, I think it was medicine, but 15:21
16 rarely was I involved in an actual SAI.
17 356 Q. Yes. But say there was a recommendation in an action
18 plan affecting Surgery and Elective Care at the end of
19 an SAI process, would that have come to your desk to
20 assist with implementation, or did that sit on the 15:22
21 Clinical and Medical side of the house?
22 A. It didn't come directly to my desk. What tended to
23 happen was there was a Friday morning meeting from 8:00
24 to 9:00, as I recall, chaired by the Director of Acute
25 Services, and at that meeting all the Assistant 15:22
26 Directors and Associate Medical Directors would have
27 gone to that meeting collectively, the SAIs would have
28 been tabled and the recommendations looked at, and then
29 the recommendations were taken collectively because

1 usually an SAI recommendation rarely just transposes to
2 one part of the system, it's usually system wide
3 learning, so usually it was the Friday morning meeting
4 that those recommendations would have been discussed
5 and then action taken collectively. 15:23
6 357 Q. In terms of how you interacted with those on the
7 operational management side, both below in terms of
8 Heads of Service and then your fellow Assistant
9 Directors and then Directors, you met on a weekly basis
10 with Heads of Service, is that right? 15:23
11 A. That's correct.
12 358 Q. What was the focus of those kinds of meetings?
13 A. Usually, and probably foremostly, performance, because
14 that was the big drive during those years. Probably
15 performance. It definitely would have been finance, 15:23
16 because I was responsible for a 50 million pound budget
17 to stay within a financial envelope, governance issues
18 obviously, maybe nursing issues, ward issues, anything
19 pertinent that came up, and it was a two-way process
20 because they brought issues to me but I also brought 15:24
21 issues from the Acute Senior Management team to them,
22 if that makes sense, so it was a two-way information
23 sort of sharing session as well as looking at issues.
24 359 Q. Your engagement with your Directors, there were four of
25 them obviously, and perhaps that varied over time, but 15:24
26 what was their means of engaging with you and what was
27 challenging for you in how you do your job?
28 A. I mean, we all worked on the same floor and quite close
29 to each other so there was a lot of informal

1 engagement. Formally, we met as a Directorate group of
2 ADs with the Director one afternoon a week and those
3 meetings would have been themed week on week. One week
4 we may have focused on performance and the performance
5 team would have come and gave us all the data. The 15:25
6 next week governance. The next week would have been HR
7 and Finance, so it was themed in that way and most
8 Directors followed that pattern. So we met once a week
9 for a whole afternoon to go through all those things,
10 informal meetings, Friday morning governance meeting, 15:25
11 that I have already alluded to, would have been the
12 main ways of engaging but it was quite informal as well
13 as formal.
14 360 Q. Would those kinds of meetings, both with the Director
15 and below that your meetings with the Heads of Service 15:25
16 was that an opportunity to discuss, amongst the wide
17 variety of other things that you no doubt discussed,
18 but would you have opportunity to examine doctors in
19 difficulty, or difficulties being caused by doctors in
20 your services? 15:26
21 A. Probably more on a one-to-one, though. And I would
22 have had a one-to-one obviously with each of my Heads
23 of Service. So the meetings that were collective were
24 more the general issues and the general, whereas the
25 one-to-ones would have been more likely to be where 15:26
26 Martina and I would have discussed particular
27 consultants. It could have happened in Trauma and
28 Orthopaedics, it could have happened in General Surgery
29 but in the one-to-ones.

1 361 Q. Yes. Sometimes because we have this great public
2 inquiry looking at aspects of Mr. O'Brien's practice,
3 we could run away with the idea that Mr. O'Brien and
4 his perceived shortcomings in practice was a constant
5 item on the agenda, or a constant source of 15:26
6 conversation with your management, whether above or
7 below you. Was that the case?
8 A. No, it wasn't. I had, as you have said all the various
9 services, but as well as all my various services I was
10 a member of Acute Services Senior Management team so 15:27
11 I had other responsibilities. So Unscheduled Care, for
12 example, we had a system of Assistant Director of the
13 Week, for example, so I would have spent one week in
14 six responsible for the patient flow through the
15 hospital. As the overseer of a number of surgical 15:27
16 wards I am responsible for flow through ED for all the
17 emergency admissions. I spent a lot of time with
18 planning and the Planning Department around creating
19 investment proposal templates for new services and
20 expanded services. Then, of course, it was general 15:27
21 nursing issues and as a nurse, I found myself often
22 leading nursing issues for the Directorate. In fact
23 between '14 and `15 I was the nurse who took
24 responsible for leading Nursing Development in the
25 whole of the Directorate, so the time spent 15:28
26 specifically with Mr. O'Brien was probably a very small
27 proportion of what I did on a daily basis, and a lot of
28 regional meetings as well. So you will have heard
29 about during those years the huge drive from the

1 Department to the Board around productivity,
2 efficiency, outcome, so I spent probably a lot of time
3 at Linenhall Street going over performance, so that was
4 the level that I was, sort of, working at, and then
5 obviously dealing with the other issues as they arose. 15:28
6 362 Q. I might get different answers to this question when
7 I ask different managers, but can you help us with
8 a characterisation of the extent to which Mr. O'Brien
9 was a feature of the work that you had to do?
10 Obviously, and I think you will accept this yourself, 15:29
11 but there were issues that you didn't know about, and
12 you might accept when I ask you to perhaps ought to
13 have known about or Inquiry might have be made into,
14 but in terms of what did come across your desk over
15 that period of seven or eight years or so, how would 15:29
16 you characterise his imprint on your responsibilities
17 and time?
18 A. There's no doubt, certainly, at the start of my time in
19 post, which would have been the end of 2009, beginning
20 of 2010 and probably through 2012, you will have heard 15:29
21 about the Team South model and the working with the
22 Department and the Board around getting investment into
23 Team South and building up the service, and you will
24 have heard of the Monday night meetings that I went to,
25 which was every Monday night from five o'clock to half 15:30
26 six. So therefore Urology, certainly in those earlier
27 years, it was a significant part of my job because we
28 were trying to get and secure Team South, so from an
29 operational perspective I absolutely was involved in

1 that, and Mr O'Brien was a part of that, although that
2 was a collective. So I suppose once Team South was up
3 and running, probably from 2012 to 2016, not as much of
4 my time, because the service was sort of established,
5 there was, as I have said in my statement, a huge issue 15:30
6 with securing consultants to get it up to the
7 five-person model, so I was involved obviously in that
8 and the middle grades, getting all the investment in
9 and all the things that go with creating a service, so
10 yes, I was involved certainly at that investment level, 15:31
11 if that makes sense?
12 363 Q. In terms of the difficulties that your statement
13 suggests he caused within this Service, Triage and
14 et cetera, et cetera, in terms of them coming on to
15 your agenda, was that but a small feature of your work? 15:31
16 A. It was definitely a feature of my work, yes, there was
17 lots of other work but it was a feature. I mean right
18 from the word go, and I think there's notes of
19 a meeting on 1st December 2009 with the Chief Executive
20 then Mairead McAlinden, Medical Director, whatever, so 15:31
21 there was notes of that meeting which categorised the
22 triage issue right upfront, and other issues so I was
23 only two months in post at that stage, so right from
24 the get-go these issues were there and widely known
25 about so it was a challenge. I mean urologists in 15:32
26 total were a challenge. I think this morning, I hope
27 you don't mind me referring to the fact you asked about
28 were they reluctant to take on the service, they
29 weren't reluctant to take on the service but they

1 didn't readily want to modernise their service, if that
2 makes sense. They wanted the bigger service but they
3 didn't want to change their practice, and Mr. O'Brien
4 most definitely would have been one of those
5 consultants who would have pushed back quite a bit with 15:32
6 the BAUS guidelines and the requirements from the HSCB
7 et cetera, et cetera, so there would have been a lot of
8 clinical push back and I would have been very aware of
9 that.
10 364 Q. Just before we come to look at this in a little bit 15:32
11 more detail, let me ask you about the medical
12 management side of the house then. I think you have
13 said in your statement that you worked closely with the
14 Associate Medical Director?
15 A. That's correct. 15:33
16 365 Q. Again, helpfully throughout that period was Mr. Mackle,
17 but you say your roles were distinct. There was some
18 overlap in, for example, reviewing adverse incidents,
19 as you have just outlined, and working to address
20 operational issues as they arose. Where was the, if 15:33
21 you like, the cut-off, if that's not an unhelpful term,
22 between your role in the management of personnel-type
23 issues, performance by the clinician of their role and
24 what was expected of that clinician? Is there a way of
25 easily or readily explaining that or was there so much 15:33
26 overlap that the roles were almost as a partnership?
27 A. I think it was probably more of a partnership. I think
28 when I relied on any of my medical colleagues was
29 around their expertise of medical things. You know,

1 I would have sought their guidance as to is this
2 acceptable, is this normal practice, is this not normal
3 practice? What's a risk et cetera, et cetera? So
4 I would have -- I am a nurse by background, I have
5 a certain level of clinical insight, obviously you 15:34
6 don't go through being a nurse without having a certain
7 amount, but when it comes to challenge, and certainly
8 Consultant challenge, I definitely would have relied on
9 my consultants and my medical management line to do
10 that clinical challenge, because it's difficult enough 15:34
11 I think to do that as a medic, I think it's even more
12 difficult to do that as a nurse. So I did rely on that
13 heavily.
14 366 Q. I think you have reflected in your witness statement in
15 several places that the challenge that you sometimes 15:35
16 brought to Mr. O'Brien, this isn't your word, it's
17 mine, wasn't particularly well-respected, it was
18 difficult, he was polite, but you were a nurse and as
19 a clinician your perception was he knew better and he
20 didn't take that challenge well? 15:35
21 A. I think that's a fair reflection. He was very polite
22 and he was a gentleman, but the word dismissive might
23 be too strong, but it certainly was, I hear what you
24 say, and he was polite and on many occasions he did do
25 what I asked him to do, but I don't think it would have 15:35
26 been strong enough to change his practice, at a core
27 level.
28 367 Q. Can you think of any -- what are you reflecting there
29 by way of a concrete issue?

1 A. If you think of triage, for example, and you will have
2 seen the number of times he was asked to do his
3 triaging, and many occasions he did, and I looked back
4 and there was intermittent parts where he seemed to do
5 it okay, but, as he has reflected and I have seen in 15:36
6 the various statements, he really strongly felt he
7 wanted to do advanced triage, which was not what we
8 required of him, and I would have said to him we don't
9 require you to do advanced triage we just need you to
10 check if the GP referral category is the right one. So 15:36
11 I can ask him to do that, I can suggest that's all we
12 require of you, I can say that's all I need of you.
13 Was I going to change his mind so he went okay,
14 Heather, I hear what you are saying, I will not do
15 advanced triage. I think that's an example of where he 15:36
16 felt he would know better than I did.
17 368 Q. That's where you rely on the medical management side of
18 the line?
19 A. Yes.
20 369 Q. You have said at WIT-12049 -- we don't need to bring it 15:37
21 up -- it's on the screen, at paragraph 171:
22
23 "The key responsibility of the Associate Medical
24 Director role was regarding the Clinical Governance of
25 the consultants and clinicians." 15:37
26
27 Do you mean that in the wider sense of ensuring that
28 where issues arose, that the clinician concerned was
29 properly managed from a Patient Safety and a clinical

1 correctness perspective?
2 A. I think it probably meant from a good medical
3 management perspective, so the standards required of
4 a medical practitioner, that those were adhered to by
5 each clinician. 15:38
6 370 Q. Yes. The medical management line involved
7 hierarchically the Associate Medical Director
8 Mr. Mackle, the longest period of time, I think?
9 A. Yes.
10 371 Q. Mr. Brown in a Clinical Director's role, and Mr. Young 15:38
11 in a Clinical Lead role.
12 A. Yes.
13 372 Q. Just thinking about the latter two, what was your
14 connection with those managers in terms of your role
15 and in terms of theirs? 15:38
16 A. I didn't have a huge amount of interaction with
17 Mr. Young. He would have had a lot of interaction with
18 Martina Corrigan. I would have had more interaction
19 with Robin Brown who was Clinical Director. He'd
20 probably have been really my first go-to person, and 15:39
21 certainly after 2012 he was my go-to person for Urology
22 and then obviously Mr. Mackle. Mr. Mackle and I would
23 have met every Wednesday, just for a short period of
24 time, and talked about various issues. So probably not
25 so much Mr. Young, yes, Mr. Brown and yes, Mr. Mackle. 15:39
26 373 Q. Given your responsibilities to deliver on the
27 operational side, and given the issues that were posed
28 by Mr. O'Brien in terms of those operations, are you in
29 a position to comment on the effectiveness of the

1 medical management line in terms of their ability to
2 provide a sufficient or adequate challenge function to
3 Mr. O'Brien?
4 A. To my experience, it was two things: One, Mr. Young
5 and Mr. O'Brien had worked very closely together, and 15:40
6 certainly in early days you will reflect there was only
7 the three consultants; Mr. Akhtar, Mr. Young and
8 Mr. Mr. O'Brien. They obviously worked very, very
9 closely together and therefore it may have been
10 difficult to challenge each other when you are in 15:40
11 a group. Mr. Brown did some Urology, some low level
12 Urology, so again he would have worked probably
13 relatively closely with the group of urologists. So
14 again, probably difficult to challenge but should have
15 been a wee bit more removed because he was based in 15:40
16 Daisy Hill, he was a general surgeon, he did different
17 things. Then Mr. Mackle, you have heard, he worked in
18 Craigavon and did try that challenge. I think, rightly
19 or wrongly, but after the 2012 issue of bullying and
20 harassment perception, whatever that was, that 15:41
21 certainly cast a shadow over the medical management and
22 I was therefore heavily reliant on Mr. Brown, and there
23 seemed to be a style of support and encouragement and
24 speaking to, and I will talk to him and leave that with
25 him, I will talk to him. I have talked to him, and 15:41
26 that seemed to be, I couldn't seem to get much more
27 purchase than that through the medical management lines
28 during those years.
29 374 Q. Yes.

1 A. My honest reflection.
2 375 Q. Just dealing with what I think you are doing, which is
3 setting up something of a contrast, were you better
4 satisfied with the effectiveness of the medical
5 management when Mr. Mackle had his full powers pre-2012 15:42
6 as compared with, if you like, his substitute in that
7 role after 2012, Mr. Brown?
8 A. I think so. I think Mr. Mackle was probably more
9 willing to challenge, and I think we lost a lot when
10 that disappeared. 15:42
11 376 Q. I just want to ask you your recollections in relation
12 to this bullying and harassment issue. Were you in
13 this room this morning when Mr. Mackle was asked about
14 that?
15 A. Yes. 15:43
16 377 Q. You don't deal with this issue in your Section 21
17 statements, but I note from what you said to Dr. Chada
18 that you had some awareness of this. If I can just
19 bring up your statement TRU-00797. And just scroll
20 down so we can see paragraph 14. Thank you. Maybe we 15:43
21 will work with the amended version, I'm not sure if
22 there's much of a difference in the text. Paragraph
23 14, you address the issue and you say:
24
25 "Some time ago Eamon Mackle tried to address the issues 15:44
26 but Dr. Rankin had said not to do anything further
27 because a complaint had been received accusing Eamon
28 Mackle of bullying and he was told he should not
29 address further issues with Mr. O'Brien. Eamon Mackle

1 appointed Robin Brown to be a go-between with Urology.
2 Mr. Brown made attempts to improvements for short term,
3 then the went back to his behaviours again. There was
4 a general eventual that Eamon Mackle was unable to deal
5 with the issues because he was told not to. In my 15:45
6 opinion Mr. Young and Mr. Brown felt uncomfortable
7 holding Mr. O'Brien to account."
8
9 Do you stand over that --
10 A. Yes. 15:45
11 378 Q. -- impression of events?
12 A. Yes.
13 379 Q. In what you have said about Mr. Mackle being told about
14 a bullying complaint, and that he should not address
15 further issues with Mr. O'Brien, how did that come to 15:45
16 your knowledge?
17 A. Probably told about it by Mr. Mackle himself and
18 Mrs. Corrigan. I wasn't there on the day, but I was
19 told about it thereafter, and obviously the outworkings
20 of that was me being directed to deal with Mr. O'Brien 15:46
21 thereafter.
22 380 Q. Obviously, you are recalling that in the statement here
23 in 2017. You don't put a date on it. Could it have
24 been 2012 or do you not know?
25 A. It could have been. It did feel like about halfway 15:46
26 through, you know, so there was a significant amount of
27 time afterwards where I dealt with Mr. Brown so it
28 feels about right, but I don't know exactly.
29 381 Q. Yes. I just want to focus a little bit on what

1 Mr. Mackle said to you, if I can push your memory
2 a little bit. What did he tell you about this
3 complaint of bullying? Did he give you any detail?
4 A. Not really. He just said he had been, I think the
5 words he used to me was warned off dealing directly 15:47
6 with Mr. O'Brien due to concerns about bullying and
7 harassment. I mean it was just as general as that.
8 There was no detail.
9 382 Q. Did you, in turn, speak to anybody about it, because
10 the fact that Mr. Brown was now in the role of 15:47
11 challenging Mr. O'Brien and you were more often going
12 to Mr. Brown, that had an impact on you, so did you
13 speak to anybody about that?
14 A. I have no doubt, I mean it was discussed with my
15 director because my director wouldn't have known 15:47
16 anything about it, then they would have expected me to
17 be dealing with Mr. Mackle, so the fact that I openly
18 discussed how I dealt with Mr. Brown, therefore it was
19 known.
20 383 Q. Yes. 15:48
21 A. As I went through my witness bundle, I noticed that the
22 Directors often dealt directly with Mr. Brown as well.
23 384 Q. Mr. Mackle -- your director was Dr. Rankin at that
24 time?
25 A. Dr. Rankin at that particular time, yes. 15:48
26 385 Q. Yes. Did she, in any of your discussions with her, let
27 it be known to you that she was aware of this issue?
28 A. I genuinely can't recall a conversation specifically
29 about that. I really can't remember whether it was

1 spoken about or just an understanding.
2 386 Q. Did you ever discuss it with Mrs. Corrigan?
3 A. Oh, I am sure I did.
4 387 Q. Any specific memories of addressing it with her?
5 A. No, just, again, her coming in to tell me because 15:48
6 I believe that Mr. Mackle appeared in her office on the
7 day in a badly shaken state, and I think Martina told
8 me that that had happened and that was the reason why.
9 388 Q. Just so that I'm clear, are you saying that your first
10 awareness of this general issue that Mr. Mackle had 15:49
11 been confronted with this allegation, I suppose, was
12 through Mrs. Corrigan?
13 A. I believe so. Whoever spoke to me first I can't say
14 100%, but it would have been either Martina or
15 Mr. Mackle himself. More likely Martina. 15:49
16 389 Q. But your belief is that at some time or other you spoke
17 to both of them about aspects of the issue?
18 A. I must have, otherwise I wouldn't have known to deal
19 with Mr. Brown.
20 390 Q. Yes. You may recall that in 2012 Mr. O'Brien submitted 15:49
21 a complaint, it was a financial complaint. I will just
22 bring it up on the screen. WIT-90380. He is writing
23 to Dr. Rankin. It concerns what he regarded as
24 a shortfall in a payment due to him pursuant to what he
25 says was an agreement to carry out additional work in 15:50
26 Outpatients. Can you recall that issue being drawn to
27 your attention?
28 A. I don't recall this letter being drawn to my attention
29 at the time, no.

1 391 Q. Do you recall the issue generally being brought to your
2 attention, even if you didn't see the letter?
3 A. To be honest, not really, I don't. I'm not saying
4 I didn't because obviously I signed the sheet along
5 with Mr. Mackle with the amendments on it so I'm not 15:51
6 saying I didn't, but I'm not -- I don't recall being
7 involved in the aftermath.
8 392 Q. Yes. Just one other piece of correspondence I will put
9 to you. WIT-90379. This is the remarks in medical HR
10 writing to, I think, HR colleagues regarding these 15:51
11 waiting list initiative claims. Zoe Parks says:
12
13 "These claims were changed by the AMD Mr. Mackle."
14 Zoe Parks "had spoken to Mr. Mackle and Heather
15 Trouton, and it seems there was some misunderstanding 15:51
16 about what had been agreed against his job plan.
17 However they had agreed to concede that changes
18 shouldn't have taken place without prior discussion
19 with Mr. O'Brien."
20 15:52
21 Does that help you at all?
22 A. Well it must -- she obviously did speak to him, I have
23 no reason to believe she didn't.
24 393 Q. Yes.
25 A. But it obviously didn't resonate, stay in my mind. She 15:52
26 obviously did.
27 394 Q. Obviously, if you don't remember that conversation, you
28 have no recollection of any suggestion being made to
29 you that this type of conduct changing the payment to

1 Mr. O'Brien could give rise to bullying and harassment
2 allegations?
3 A. No, that wasn't something I was aware of at the time.
4 395 Q. I'm not suggesting it was, I am just pondering with you
5 whether that is a possibility that could have occurred. 15:53
6 A. I suppose it's possible.
7 396 Q. It's not something you remember?
8 A. It's not something I remember being a specific issue
9 that would have eventually caused the other.
10 397 Q. In general terms then, the suggestion, if it was made, 15:53
11 and this is obviously the subject of some debate, that
12 Mr. Mackle's behaviour towards Mr. O'Brien went beyond
13 the proper line and could have amounted to bullying and
14 harassment, in terms of your exposure to the
15 relationship in the period up to 2012, how would you 15:53
16 characterise Mr. Mackle's management style?
17 A. I suppose it would have been -- I was mostly party to
18 it in meetings, probably the Monday night meetings,
19 probably, most frequently. There's no doubt Mr. Mackle
20 was frustrated by the lack of progress, so my 15:54
21 recollection was that you have discussed a specific
22 issue and you would have thought that you had made
23 progress with the specific issue, and then the
24 following Monday night you would have come back and
25 there would have been -- Mr. O'Brien would have said 15:54
26 no, I didn't agree to that, that's not what I said,
27 that's not what I recall, and you had to start the
28 whole process over again. I think there was a level of
29 frustration there, both Dr. Rankin and Mr. Mackle, but

1 I didn't see any bullying behaviour, it was more just a
2 sense of frustration more than anything else, was my
3 recollection of it.
4 398 Q. Would you have been conscious, and I have no doubt
5 there are other personnel involved, but that Mr. Mackle 15:55
6 was involved, I don't say to the fore, but involved in
7 issues which Mr. O'Brien may not have taken kindly to,
8 and the job plan was an issue?
9 A. The job plan, the IV antibiotics.
10 399 Q. Yes. The triage, and things like that. Would you have 15:55
11 appreciated that Mr. Mackle was engaged on those issues
12 with Mr. O'Brien?
13 A. Yes, well certainly on the IV antibiotics and seeing
14 through the process and to hold to account to the
15 process, absolutely. I wasn't involved in the 15:55
16 cystectomy piece because I have only seen that lately,
17 but again, that sort of review of work, and then, of
18 course, the challenge around the NICE guidelines no the
19 need to review ratios, how many patients in a clinic
20 and bringing in the morning of surgery, so those sort 15:56
21 of developmental pieces Mr. Mackle would have
22 challenged.
23 400 Q. In terms of Mr. Mackle then taking a back seat, if
24 that's an appropriate expression, just so that I am
25 clear about this, it's not that Mr. Mackle was removed 15:56
26 from the managerial tier vis-à-vis Urology or even
27 vis-à-vis Mr. O'Brien still was periodically kept
28 informed of issues concerning Mr. O'Brien as they
29 arose?

1 A. Yes, absolutely.
2 401 Q. And his input was sought and discussions had with him?
3 A. Yes.
4 402 Q. Where do you then see the deficit or the dilution of
5 the challenge if Mr. Mackle was otherwise kept abreast 15:57
6 of these issues but stopping short of dealing with
7 Mr. O'Brien directly?
8 A. I suppose an example, if I can give an example, was in
9 my e-mail to Mr. Young and Mr. Brown, I think it was
10 November '11, November '11 -- November '13, where I am 15:57
11 obviously frustrated about the lack of response to
12 triage and notes at home, and I really seek the support
13 of Mr. Young and Mr. Brown from a clinical, I think
14 I used the word peer challenge and patient advocate and
15 whatever, and the response was from Mr. Brown was, 15:57
16 well, I hear what you are saying but I have spoken to
17 him and I will speak to him again but he is a wonderful
18 doctor and he is a fantastic clinician and if I had
19 a Urology problem I would want him to deal with it, so
20 therefore, I would want our approach to be how can we 15:58
21 help, how can we support? I suppose at the end of '13,
22 four years later --
23 403 Q. Maybe just while we are talking about that, if I could
24 put a document on the screen. It is one I had intended
25 to return it to later but you have introduced it -- 15:58
26 A. Sorry.
27 404 Q. It's convenient, we can look at it now, it's an example
28 or an illustration of the point you are making.
29 TRU-77039. I am not sure if that's the one you are

1 referring to. I think it's a longer e-mail, isn't it?
2 A. If you go down.
3 405 Q. Go down, please.
4 A. Go down to ... that's my e-mail.
5 406 Q. Okay. This is you writing at the end of 2013. 15:59
6 A. Mm-hmm.
7 407 Q. You have been in post for four years?
8 A. Mm-hmm.
9 408 Q. You are writing on triage, an issue that's preoccupied
10 at least part of your time in this role. You were 16:00
11 explaining you had written to the two of them. If you
12 scroll on down, I think you say at the end, you are
13 writing both about patient notes and triage, but you
14 say:
15 16:00
16 "We really need you to speak with Mr. O'Brien both in
17 the capacity of a colleague but also in your capacity
18 as Clinical Lead and Clinical Director for Urology as
19 well as of course patient advocates and need a response
20 within one week." 16:00
21
22 What was your impression of what you got back?
23 A. I think if you scroll on up --
24 409 Q. We will see that e-mail as well, yes.
25 A. Mr. Young says "I understand I will speak". 16:00
26 410 Q. Yes. Mr. Brown does speak, I think?
27 A. Yes.
28 411 Q. If we go on up.
29 A. Refers to a lengthy one-to-one meeting he had in July

1 on the subject.
2 412 Q. Yes.
3 A. And a phone call the week before last, and agreed that
4 we're making a lot of headway, but at the same time
5 recognise he devoted every waking hour to his work. 16:01
6 Perhaps Michael and Aidan and Robin could meet and
7 agree a way forward and then "excellent surgeon; more
8 than happy to be his patient, prefer the approach to be
9 how can we help?"
10 413 Q. Yes. 16:01
11 A. That's very, very appropriate to help, absolutely, very
12 appropriate, but four years in, I think I was looking
13 for something a wee bit more.
14 414 Q. Yes. What you are getting back, if I can elaborate on
15 this, is the emphasis on his attributes rather than, 16:01
16 I hope this is fair to Mr. Brown, rather than the kind
17 of challenge and solution that the service was
18 obviously requiring for the benefit of the patients, is
19 that fair?
20 A. That's fair. 16:02
21 415 Q. In terms of your abilities or powers when met with this
22 kind of response from the medical management side of
23 the line, were you powerless or could you have taken
24 that response elsewhere?
25 A. Well, I obviously did take it to my Director, which was 16:02
26 Debbie Burns at that point, because Debbie meets with
27 Mr. O'Brien I think in February, which is what, two
28 months later.
29 416 Q. Yes.

1 A. So I obviously do go on ahead and take it further and
2 I'm sure Mr. Mackle knew at the same time. But within
3 the hierarchy, and certainly at that time, I didn't
4 feel I could go outside of those two lines, so in the
5 course of asking myself, should I have gone directly to 16:03
6 the Medical Director myself, should I have gone to the
7 Chief Executive myself, but that's good in hindsight
8 but then you stayed within the relation lines.
9 417 Q. Yes. It's perhaps a convenient example upon which to
10 ask you about your reflections or your impressions of 16:03
11 the effectiveness of the medical/operational management
12 split and whether it had the potential to have,
13 I suppose, gaps within it when the focus of both sides
14 of management should be on Patient Safety, mitigating
15 risk and delivering an effective service. Does that 16:04
16 illustrate perhaps a gap you can't -- well, you can
17 take it further, but if medical management are not
18 going to push it, you have got to spend time taking it
19 further, and then I think it was February before
20 Mrs. Burns is able to come up with a solution with 16:04
21 Mr. O'Brien which involved him only taking named
22 referrals?
23 A. I know we are looking at an issue that didn't work out
24 and there were many issues where operational and
25 professional management worked very well together to 16:04
26 come to very good solutions, but I think in this
27 particular issue that was maybe much more difficult and
28 more challenging. It didn't work as effectively
29 obviously as it could have or should have done.

1 418 Q. Apart from people being more energetic or more robust,
2 or whatever the appropriate adjective is, is there
3 structurally or systemically that you have reflected
4 upon might serve to avoid such difficulties or ensure
5 that the challenge is more effectively directed? 16:05
6 A. I have worked with consultants quite a long time, not
7 so much in my latter years because I am more focused on
8 nursing, but certainly in those years and my reflection
9 particularly is that they are largely seen as
10 independent practitioners, and they have a lot of 16:05
11 autonomy. I think that's even recognised amongst their
12 peers that they have a lot of autonomy, and I think,
13 therefore, there's a recognition that each will act as
14 to how they see fit as in managing their patients, with
15 the understanding, of course, which really is a given, 16:06
16 that their practice is safe and they look after their
17 patients well, but there is a level of autonomy in all
18 Consultant practice that is difficult to challenge both
19 from a management line, probably difficult to challenge
20 professional to professional when you get to 16:06
21 a Consultant level, and that's what I have experienced
22 and witnessed over the years. That autonomy probably
23 still exists, largely.
24 419 Q. You had certain information or certain data about
25 particular issues, we have talked about triage in 16:06
26 passing already, it's an obvious issue, it was in your
27 face?
28 A. Yes.
29 420 Q. Taking notes home after clinics and retaining them,

1 that was an issue in your face.
2 A. Yes.
3 421 Q. What wasn't quite in your face on that was what that
4 issue was symptomatic of. It was symptomatic, I would
5 suggest, and we can test this with other witnesses, 16:07
6 that dictation post clinic wasn't being done and the
7 notes were being retained to afford Mr. O'Brien a more
8 convenient time to process that element of his
9 administration, I may be right, I might be wrong about
10 that, but the issue of dictation was hidden from you 16:07
11 until, as I understand it, Mr. Haynes, and other new
12 consultants were validating aspects of the review list.
13 More generally, do you think at that time the Trust
14 emphasised sufficiently the importance of data and
15 audit in order to gather relevant data about patient 16:08
16 experience, patient care pathway, and aspects of
17 clinical performance?
18 A. I don't think it was as well developed, 2009, 2016, as
19 it is now. There was clinical audit. The audit was
20 largely done by the junior doctors as part of their 16:08
21 training and development. There was a very small Trust
22 central audit team but there was not an audit facility
23 function in surgical management at all. There was
24 a lot of audit done into nursing practice. We had
25 a suite of nursing quality indicators that were audited 16:09
26 regularly, but there wasn't the same level of audit
27 into medical practice, so therefore those things were
28 hidden, to me, until such times as Mr. Haynes and the
29 new people coming into the Service, through their

1 opportunity to review some of Mr. O'Brien's patients,
2 started to speak out and say, and sort of escalate
3 those concerns so that would have been hidden from me
4 up until...
5 422 Q. Mm-hmm. We will maybe look first thing tomorrow when 16:09
6 we get going with the evidence, that I think you have
7 reflected in your witness statement the kinds of
8 performance issue pressures?
9 A. Oh, yes.
10 423 Q. And the demands that that placed on you and on surgery 16:09
11 as a Directorate, but was the -- is there any sense
12 that that emphasis on output and performance took the
13 place or was regarded as more of a priority than
14 Patient Safety indicators and Quality of Care
15 indicators? 16:10
16 A. I don't think it was overtly placed as more important.
17 I think the amount of energy and time and effort that
18 went into performance left less time and capacity for
19 a deeper focus on patient quality outcomes. There was
20 a huge drive from the Department and the HSCB, as it 16:10
21 was then, on waiting times, and there's nothing wrong
22 with that because people need to be seen and they need
23 to be seen timely, but huge energy on meeting your
24 nine-week and, you know, time to be seen, et cetera,
25 et cetera, for theatre, huge focus on theatre 16:11
26 utilisation, Outpatient clinics, and at that time as
27 well there was a huge focus on efficiency, so finance
28 was a big driver as well, so it didn't negate the need
29 for good quality care, of course it didn't, but

1 probably 80% of your energy went into doing
2 performance.
3 424 Q. You probably think back now and recognise some of the
4 gaps in terms of the information that was available to
5 you and your managerial team around important issues - 16:11
6 for example, and we will come to it tomorrow again, how
7 quickly are consultants accessing results of
8 investigations and moving into action? How quickly are
9 they reading them? Is there any shortfall? Is there
10 any exceptions? Is that impacting on patients? The 16:12
11 multidisciplinary team in cancer, the whole area has
12 been sort of identified as being without audit of the
13 cancer-care pathway, save for the, if you like, the
14 statutory or the ministerial directions on 4182 day
15 access times. So what does the absence of audit around 16:12
16 those kind of, and they are just two examples, tell us?
17 Does that tell us that we are now a more mature service
18 and we can do that kind of thing better now and audit
19 was in its infancy, or was it that you didn't have the
20 capacity, whether resources or personnel, to get that 16:12
21 kind of work done because of other pressures?
22 A. I think it was both. I think the concept of audit,
23 et cetera, probably wasn't as well-developed and
24 capacity was most definitely an issue, and when
25 services were commissioned by the Board, they were 16:13
26 commissioned solely for the people to see patients or
27 the theatre staff or the ward staff. There was nothing
28 in the funding or the commissioning around a quality
29 post or an audit post or -- it was purely focused on

1 service delivery. Now, I am sure, implicitly, quality
2 is there, of course it is, and they would expect it to
3 be, and rightly so, and I think the quality was
4 expected implicitly by any qualified clinicians, that
5 they would do the right thing, that they would have the 16:14
6 best outcomes for their patients. Looking back, of
7 course, that wasn't to be possible, but that was the
8 thought process.
9 425 Q. Yes. As we can see with the Mr. O'Brien issues, there
10 was kind of an ad hoc gathering of information. When 16:14
11 the letter went in March, Mrs. Corrigan had to, to some
12 extent, scramble around and count up the number of
13 outstanding triages, the number of clinics that weren't
14 dictated, there was uncertainty around the number of
15 files, patient charts, so, in the absence of hard data 16:14
16 evidence, it's -- and that data obviously became
17 available, but more broadly across a clinician's
18 practice, the absence of that kind of hard evidence
19 causes difficulties in terms of visibility and then
20 challenge? 16:15
21 A. And it wasn't being collected of any Consultants to
22 that level.
23 426 Q. Yes. In terms of the management of doctors with
24 difficulties, or difficult doctors, what was in your
25 toolkit, if you like, as a manager, to do anything 16:15
26 about that? Was it, as you have outlined already, try
27 to address it yourself or through your management team
28 and, if it's not working, push it across to the medical
29 side?

1 A. It was a combination of medical side but also the
2 Director of Acute Services. As I said in my second
3 statement, I was completely unaware of the MHPS process
4 until the public inquiry. It would have been extremely
5 useful, I think, if I would have known about it. 16:16
6 I wouldn't have been able to enact it because all the
7 roles in it are obviously medical, but I certainly
8 would have been able to digest it.
9 427 Q. I am conscious that you have said that you weren't
10 aware of it until the public inquiry. Were you 16:16
11 conscious, in 2017, when you gave your statement, that
12 you were contributing to an MHPS investigation?
13 A. Well, that might sound naive, but, no, I wasn't.
14 I went in and gave my statement and didn't appreciate
15 the totality of the process that they were -- 16:16
16 428 Q. I am glad I asked you that question because I'd rather
17 assumed that that was maybe an error of expression on
18 your part?
19 A. No, no, I --
20 429 Q. So you didn't know that while you sat down with 16:17
21 Dr. Chada, that you were contributing to a formal MHPS
22 investigation?
23 A. I knew it was an investigation, but I didn't know it
24 was a maintaining professional standards investigation.
25 430 Q. Yes. And your lack of awareness, of course, indicates 16:17
26 that you'd no training in either the MHPS framework or
27 indeed the Trust guidelines that sit beside MHPS. Has
28 that position changed now, 2023? You are Executive
29 Director of Nursing and I suppose your engagement with

1 medical clinicians is less direct, in a managerial
2 sense, than your Assistant Director role, but are you
3 now aware of training provided to your former
4 colleagues on the operational management side in MHPS?
5 A. I believe there is going to be training. So, yeah, I'm 16:18
6 certainly aware of the process now, of course, and
7 there's now a report brought to Governance Committee
8 with more detail on the MHPS process and how many
9 doctors are going through it, et cetera, et cetera, so
10 I am very familiar with it now in this role, but 16:18
11 I wasn't previously...
12 431 Q. Given that it's really a tool of medical management and
13 their HR supports and you were on the other side of the
14 line, now that you know of the process, can you
15 articulate to what extent it might have been helpful 16:19
16 for you to have known about it in -- throughout that
17 period when you were Assistant Director, but
18 particularly perhaps in 2015 when you were finally
19 going to see the Medical Director?
20 A. I think it would have been. I have read it, obviously, 16:19
21 now in detail. The service that NCAS provide I think
22 is very valuable. I think what really appealed to me
23 about it was, it was patient-centred, so it was really
24 focused on Patient Safety, but it also focused on the
25 doctor themselves and the support mechanisms, whatever. 16:19
26 It really looked at peer challenge, which I think was
27 something that we really could have been doing with as
28 an independent peer challenge, though if you think
29 about the patient-centeredness and the support and the

1 challenge and the, sort of, the standards, the
2 objectiveness of what the NCAS could have offered, from
3 an independence perspective, I think that might have
4 been very helpful, both to the Trust and to Mr. O'Brien
5 himself, if it had been done and done well. 16:20
6 432 Q. Mm-hmm. So are you suggesting that if you had had
7 awareness of this, you could have, in the midst of your
8 frustrations around triage and the other issues that we
9 will look at, you could have started a conversation
10 about the need to consider the MHPS process, NCAS 16:20
11 input, and that kind of thing, to at least get a debate
12 going about the need for a more structured solution?
13 A. Well, I think I would have found it helpful. In saying
14 that, those who would have known about the MHPS process
15 were aware of the issues, but yet it wasn't, certainly 16:21
16 in those first six years, picked up on, so whether
17 I would have got any traction with it, I will never
18 know, but at least I would have had it to open that
19 discussion.
20 MR. WOLFE KC: Okay. It's twenty past four. I think 16:21
21 it's a suitable place to leave it for today.
22 CHAIR: It's been a long enough day for everyone.
23 MR. WOLFE KC: I know we have Dr. Wright coming along
24 tomorrow as well. I have indicated to Mr. Lunny that
25 it's unlikely he would be called before 2 o'clock, 16:21
26 possibly even a bit later, so he will make his own
27 arrangements. I think he might come, anyway, earlier.
28 CHAIR: He is certainly welcome, we are not trying to
29 keep him away, Mr. Lunny, but, equally, if he has

1 something to do in the morning, we are not expecting
2 him here in the morning.
3 MR. WOLFE KC: Yes.
4 CHAIR: Thank you, everyone. Then, 10 o'clock tomorrow
5 morning. 16:22
6
7 THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY,
8 1ST FEBRUARY 2023, AT 10 A.M.
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