Urology Services Inquiry

Oral Hearing

Day 23 – Thursday, 2nd February 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 THURSDAY, 2ND DAY OF
2 FEBRUARY, 2023 AS FOLLOWS:
3
4 CHAIR: Good morning, everyone. A bright and early
5 start this morning. Mr. Wolfe. 09:31
6 MR. WOLFE KC: Apologies in advance for getting
7 everybody out of their beds earlier.
8
9 Your witness this morning is Dr. Richard Wright.
10 I think he intends to take the oath. 09:32
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1 DR. RICHARD WRIGHT, HAVING BEEN SWORN, WAS EXAMINED BY
2 MR. WOLFE KC AS FOLLOWS:
3
4 1 Q. MR. WOLFE KC: Good morning, Dr. Wright.
5 A. Good morning. 09:32
6 2 Q. You should have in front of you a cipher list.
7 A. Yes.
8 3 Q. I anticipate only needing to refer to one patient by
9 name or by cipher, and that's Patient 10, I think.
10 A. Yes. 09:32
11 4 Q. That comes up in the context of an SAI, but before we
12 get into all of that, the first thing I should do is
13 refer you to your Section 21 statements, which you have
14 sent in to the Inquiry, and ask you whether you wish to
15 adopt them as your evidence, just the formality of 09:33
16 that. The first one is number 27 of 22. We find the
17 first page at WIT-17829. Do you recognise --
18 CHAIR: Just pause you there. Can we check the
19 lighting here. It seems rather dark up at our end.
20 Check if the lights on, maybe, or is it my eyesight? 09:33
21 Okay. It must be me, then. Sorry, I interrupted you.
22 5 Q. MR. WOLFE KC: So that's the first page of your first
23 Section 21. It's recently been annotated in red ink,
24 as you can see on the right-hand side there, because
25 there are a number of corrections -- 09:34
26 A. That's correct.
27 6 Q. -- which I will take you to shortly. One of those
28 corrections we notice right away is at the top of the
29 page. It should be 27 of 2022, a fine detail, but

1 there's other corrections I'm going to address with you
2 in a moment. Let's go to the last page of your Section
3 21. It's WIT-17900. We can see that you have signed
4 it on 16th June of last year. Subject to those
5 corrections, do you wish to adopt this notice or this 09:35
6 response as part of your evidence?
7 A. I do.
8 7 Q. We will go to the second of your responses. It's
9 number 43 of 2022. It's to be found at WIT-18421.
10 Again, the same annotation as the first page. Let's go 09:35
11 to the last page, WIT-18453. We can see that you
12 signed it on 16th June of last year. Again, would you
13 wish to adopt that document as part of your evidence?
14 A. I do.
15 8 Q. The corrections that you wish to make are multiple and 09:35
16 you have, through your legal team, committed them to
17 a written document. If I could just have that up on
18 the screen, please? It's WIT-91875. That is in the
19 form of a letter sent to the Inquiry at the start of
20 this week. It explains what's happening. It says: 09:36
21
22 "We refer to the two witness statements of Dr. Wright
23 and we refer to consultation with myself and Inquiry
24 counsel the week before."
25 09:36
26 It says: "As we discussed at the consultation a number
27 of errors in the statements of Dr. Wright have come to
28 our attention, and we understand that Dr. Wright will
29 seek to correct these at the appropriate point"

1
2 Now, at the start of your oral evidence.
3
4 "... in ease of the Inquiry and as discussed at the
5 consultation, we understand that the errors that 09:37
6 Dr. Wright will seek to amend are as follows",
7 and they are set out in writing.
8
9 Just scroll down. Let's just go through the document
10 slowly and you can see the number of them, Chair. Just 09:37
11 scroll down through the page, on over the page, please,
12 and all the way through to 879. You say, through your
13 lawyers, that you wish to apologise for the errors and
14 any inconvenience caused to the Inquiry.
15 09:38
16 Dr. Wright, the number of corrections that have to be
17 made to both statements is somewhat out of the
18 ordinary, certainly so far for this Inquiry. Can you
19 explain, in brief terms, without perhaps having to go
20 to too many of these corrections individually, but why 09:38
21 was there such a difficulty in delivering an accurate
22 statement?
23 A. A lot of them are related to dates, I think. I've
24 obviously not been working in the Trust for some
25 considerable time, so some of the information and the 09:38
26 dates I was only able to confirm when I received the
27 bundle not so long ago, so that's part of the
28 explanation. There was some confusion about some
29 timings around, especially in relation to Mr. Haynes'

1 evidence, which I did try to clarify but at the time of
2 writing this, and I think I pointed out at the start of
3 my evidence, I did have a discussion with him and
4 neither of us were too sure about the dates at that
5 point, but it subsequently became clear, as he gave 09:39
6 evidence, and he had obviously reflected on things,
7 that the dates were clearer so that then became
8 possible for me to firm up some of those dates.
9 9 Q. If we go back, just in ease of you, perhaps, to
10 illustrate what you are saying in respect of 09:39
11 Mr. Haynes. If we go to WIT-91876, just back a couple
12 of pages. If we just -- yes, focus on number 3,
13 perhaps. I might need to correlate this, I suppose,
14 with the witness statement itself. The words in
15 brackets that have been crossed out should have been 09:40
16 deleted. I think it should be previously -- I am
17 looking at that now and it seems it doesn't appear in
18 that form in the printed document I have in front of
19 me. Okay.
20 CHAIR: Something has been lost in translation. 09:40
21 MR. WOLFE KC: Yes, I think it's sort of printer
22 gobbledegook. Let me just see if I can rescue the
23 situation and illustrate it neatly.
24
25 Dr. Wright, at various points in your witness 09:40
26 statement, you refer to a conversation with
27 Mr. Haynes --
28 A. That's right.
29 10 Q. -- which you date to September 2016?

1 A. Yeah.
2 11 Q. Frequently when you refer to that date, you, in
3 brackets, as is suggested by this document, you refer
4 to Mr. Haynes as Associate Medical Director?
5 A. That's right. That's right. 09:41
6 12 Q. As if he was Associate Medical Director in September
7 2016?
8 A. That's right, and that was a mistake on my part. The
9 reason for that was there had been a number of changes
10 in personnel at that level, and at that point 09:41
11 Dr. McAllister had stepped down or the role was
12 changing. Mr. Haynes was appointed as Clinical
13 Director but for reasons that probably will become
14 apparent as we go through, we had been asking all
15 Clinical Directors at various times to step up to take 09:42
16 on part of the duties of the Associate Medical
17 Director. I apologise, I was confused as to the date
18 that he actually became a substantive Associate Medical
19 Director.
20 13 Q. Yes. 09:42
21 A. That was an error of recollection.
22 14 Q. In fairness to you, the Inquiry has already heard from
23 Mr. Haynes and his witness statement had to be
24 corrected by him because he had fallen into the same
25 error of recollecting that he had wrongly recollected 09:42
26 that he was Associate Medical Director from a point in
27 2016. Just to clarify it, and let me test this with
28 you. Is it now your understanding that Mr. Haynes was
29 appointed Associate Medical Director in October 2017?

1 A. '17, that's correct.
2 15 Q. Is it your understanding that when you spoke to him in
3 September 2016, and I understand that that remains your
4 memory, that in September 2016, that, at that time, he
5 was Clinical Director within Surgery and Elective Care? 09:43
6 A. That's correct.
7 16 Q. Did you know that his responsibilities as Clinical
8 Director within that part of the Directorate did not
9 include Urology?
10 A. Yes. Yes, I would have been aware of that at the time. 09:43
11 17 Q. Say that again?
12 A. Yes.
13 18 Q. You were?
14 A. Yeah.
15 19 Q. Is it your recollection that Mr. Weir, from in or about 09:43
16 June 2016, also became a Clinical Director within
17 Surgery and Elective Care and did have responsibility
18 for Urology?
19 A. That's correct.
20 20 Q. Furthermore, and it's perhaps another error that you 09:44
21 have now corrected, you didn't, on occasion when
22 writing your statement, recall that Mr. McAllister had
23 become Associate Medical Director within Surgery and
24 Elective Care?
25 A. Yes. 09:44
26 21 Q. I want to test your recollection on that.
27 A. Okay.
28 22 Q. Is it your understanding now that Mr. Mackle stood down
29 from the role of Associate Medical Director in or about

1 April 2016?
2 A. That is correct.
3 23 Q. To be replaced by Dr. McAllister?
4 A. Yes. If I could just explain possibly the reason for
5 the confusion there? Dr. McAllister was already an 09:44
6 Associate Medical Director for Anaesthetics and
7 Intensive Care and we asked him to take on the
8 additional role of Surgery at that point, so that was
9 probably part of the confusion. There wouldn't have
10 been a formal interview process in the way you would 09:45
11 normally expect for an appointment like that.
12 24 Q. Dr. McAllister, for his part, had to step down from AMD
13 in Surgery and Elective Care covering Urology in or
14 about the autumn, I don't have a precise date, but in
15 or about the autumn of 2016? 09:45
16 A. That's correct.
17 25 Q. In other words, he was only in the role for a very
18 short period of time?
19 A. Yes, that is right.
20 26 Q. Until Mr. Haynes took up the role a year later in 09:45
21 October '17, you were without an Associate Medical
22 Director covering that Directorate?
23 A. That is correct.
24 27 Q. Just while we are on that subject, as Medical Director
25 had you some responsibility for trying to fill that 09:46
26 role?
27 A. Yes, absolutely. Jointly with the Service Director,
28 Mrs. Gishkori, we had, I think every other role of
29 medical leadership as in Clinical Directors and the

1 Associate Medical Director filled at that time within
2 the Trust but the Surgical Director was a particular
3 challenge for a variety of reasons, partly due to the
4 staffing pressures, so it remained unfilled for
5 a considerable period of time. During that time we had 09:47
6 asked the four Clinical Directors within that
7 Anaesthetics and Surgical Directorate to, between them,
8 share the AMD duties out until we were able to make
9 a substantive appointment.
10 28 Q. You refer to asking the Clinical Directors, in a sense, 09:47
11 to step up; is that fair?
12 A. That's right.
13 29 Q. We can see that reflected in an e-mail that you sent,
14 TRU-163346. This is November 2016. Dr. McAllister
15 stepped temporarily aside, as you put it here, and you 09:48
16 are writing to Messrs Scullion, Tariq, Weir and Haynes.
17 They are your Clinical Directors in this area?
18 A. Yes.
19 30 Q. You are saying to them: "During this period I would
20 expect management issues to be dealt with by the 09:48
21 Clinical Directors in liaison with the Director for
22 Acute" that's Mrs. Gishkori, and yourself?
23 A. Yes.
24 31 Q. In relation to professional matters?
25 A. Yes, mm-hmm. 09:48
26 32 Q. I think that tidies up an aspect of the confusion.
27 I am not proposing to go through each of your
28 corrections, quite apart from the fact that the printer
29 has scrambled out the document in the wrong way or it's

1 the wrong way in the screen, I should say. If there is
2 any uncertainty about what you say in your statement,
3 we will try and clarify that. Your evidence,
4 Dr. Wright, is particularly important in the context of
5 this module. This module is focusing on the MHPS 09:49
6 Framework and its outworking in the case of
7 Mr. O'Brien. The Inquiry is charged with looking at
8 the effectiveness of the MHPS Framework in that case,
9 and, therefore, we will be looking at your evidence,
10 the Inquiry will be looking at it with a view to 09:50
11 judging the effectiveness of the MHPS investigation.
12 Was it thorough? Was it conducted properly? Was it
13 conducted fairly? Did it achieve its objectives? Or
14 does the process, in light of your experience of using
15 it, require strengthening? Those are the kinds of 09:50
16 issues we are going to get into with you today.
17
18 Just then going back to the start, I suppose. You were
19 appointed Medical Director in the Southern Trust on
20 1st July 2015; is that correct? 09:50
21 A. That is correct, yes.
22 33 Q. Just in ease of the Inquiry's note, just let me touch
23 upon your qualifications and background. Again, your
24 witness statement up on the screen, WIT-17837. Those
25 are your qualifications. I should say, you are now 09:51
26 retired from the medical profession; isn't that
27 correct?
28 A. That is correct, yes.
29 34 Q. When did you retire from your profession?

1 A. I retired from a full-time post in 2018, but continued
2 to work in a part-time capacity for the Health and
3 Social Care Leadership Centre, and, for a short time,
4 covering a Paediatric Radiology maternity leave.
5 I haven't done any medical work for the last few months 09:52
6 of any sort. Before that I had only been doing a few
7 hours a week as the Responsible Officer for RQIA, which
8 is the local regulatory body.
9 35 Q. I note at 4.2, you are a founding member of the Faculty
10 of Medical Leadership and Management? 09:52
11 A. That's correct, yes.
12 36 Q. Where did that interest come from and what is that
13 faculty?
14 A. Okay. I began my career as a medical manager back in
15 the Ulster Hospital in what's now the South Eastern 09:52
16 Trust as Clinical Director in Radiology. That was
17 quite some years ago. I worked there as a Consultant
18 for 12 years, and after that time moved to the Belfast
19 Trust.
20 37 Q. Just scroll over on the page, we can see some of that 09:52
21 at 5.1.
22 A. So I was working in --
23 38 Q. Your first medical management role, as you said, was in
24 the Ulster in 1993?
25 A. I was appointed Consultant in 1993 and I think 1998 or 09:53
26 thereabouts, 2000, I would have been appointed as
27 Clinical Director, and subsequently became Deputy
28 Medical Director just for a brief period before I left
29 the Trust to go to Belfast. When I moved to Belfast,

1 initially I was working as a Paediatric and General
2 Radiologist and then became Associate Medical Director,
3 as a result of the reorganisation of the Health Service
4 and the Trusts they created these new roles and
5 I applied for and was appointed Associate Medical 09:53
6 Director of what was then Clinical Services, which was
7 the Radiology Laboratories and Anaesthetic Service in
8 Belfast. Subsequently there was a bit of
9 reorganisation and I became AMD, Associate Medical
10 Director, for the Specialist Hospitals Directorate, 09:54
11 which was really all the non-acute hospitals. Things
12 like the non-acute adult hospitals, so children's, the
13 maternity service, regional orthopaedic service, the
14 Dental Hospital and Community Dental Service, ENT, ear,
15 nose and throat, eyes, special clinic of general 09:54
16 urinary medicine clinic. I suppose all the things that
17 weren't acute medicine or surgery in Belfast. I did
18 that role for five years, and at that time I also was
19 the Appraisal Lead for the Trust, implementing the
20 regional appraisal system. 09:54
21 39 Q. Just scroll down we can see aspects of this on the
22 screen, just on down further, please.
23 A. In my last two years at Belfast, I also took on the
24 role as Head of School for the newly founded School of
25 Clinical Diagnostics at NIMDTA - which is the Northern 09:55
26 Ireland Medical and Dental Training Agency, with
27 responsibility for training Radiologists and
28 Histopathologists. I suppose over my career
29 I developed an interest in the medical management side

1 of the profession as well as doing a clinical post.
2 The Faculty of Medical Leadership in Medicine evolved
3 during that time. It was a new institute set up to try
4 and develop medical management as a professional entity
5 with professional standards and to develop as a career 09:55
6 pathway for potential doctors. It was very embryonic
7 and small in those early stages, and has grown since
8 then. I am a member still but I am not active in the
9 organisation now.
10 40 Q. Yes. Did you hold office within the faculty? 09:56
11 A. No, no, no.
12 41 Q. As AMD in Belfast, assumedly quite a busy role and
13 a complex role --
14 A. Yes.
15 42 Q. -- in terms of the challenges that you might have met? 09:56
16 A. Yes. It was quite a dispirit breadth of specialties
17 that were on my patch, a very interesting group towards
18 the end, none of which were my own speciality in
19 Radiology, and we had significant challenges within
20 that group. A lot of the regional services were based 09:56
21 in Belfast. We had a lot of MHPS cases that I would
22 have been involved in at various levels and various
23 ways. To give you a flavour, this would have covered
24 things like doctors who are sick, who have drug
25 problems, who have alcohol problems, doctors who are 09:57
26 under-performing clinically, doctors who needed support
27 with NCAS, doctors who were working in failing systems
28 where that was a major factor, so the usual breadth.
29 I would have been Case Manager, I was trying to recall,

1 probably for about six or seven cases and Case
2 Investigator for around about the same number during
3 that time. I was involved, for a while, on one of the
4 attempts to improve the MHPS process by the Department,
5 I gave evidence to that way back when I was AMD. 09:57
6 I would have sat on our Directorate Oversight Panel for
7 all the cases that involved within the Directorate. We
8 would have had a weekly meeting with the Medical
9 Director to discuss issues across the patch. As well
10 as my own patch, we would have shared learning and 09:58
11 experience across the rest of the Trusts as well. That
12 wasn't an area that one particularly enjoyed or sought
13 but it came with the job and there would have been
14 a significant number of cases during my time.
15 43 Q. Yes. I think maybe just if we look specifically at 09:58
16 this aspect now, just going through to your second
17 witness statement, WIT-18423. And you say -- just
18 scroll down the page, please, to 4.1, where you say:
19
20 "I was involved in applying the MHPS process throughout 09:58
21 my time in Belfast in those five years"
22
23 Then obviously as Medical Director in the Southern
24 Trust.
25 09:59
26 "During that period I had experience of many MHPS
27 cases, more than 30. Belfast I would have acted as
28 Case Investigator or Case Manager."
29

1 You have also delivered, I think you have said, just
2 scrolling down to 4.6, a series of talks on issues
3 associated with MHPS, at least in part?
4 A. Mm-hmm.
5 44 Q. It's familiar territory for you by the time 2016 comes 09:59
6 along and you are dealing with the matter that we are
7 most interested in.
8 A. Yes.
9 45 Q. Just on your movement from Belfast to the Southern
10 Trust. The first time you took up the role of Medical 09:59
11 Director was within the Southern Trust?
12 A. That's correct.
13 46 Q. No prior involvement with the Southern Trust?
14 A. No, never worked there before.
15 47 Q. Was that a natural progression to move from an AMD role 09:59
16 in combination obviously with your clinical duties in
17 Belfast, but to go into Medical Director, top of the
18 hierarchy in terms of medical management and, in
19 a sense, leaving the clinical duties behind?
20 A. I don't know if I'd describe it as a natural 10:00
21 progression but it was certainly a direction of travel
22 and it seemed there was an opportunity arose in the
23 Southern Trust, which was unlikely to come up again in
24 the near future, so I thought I would apply for it, and
25 I am very glad I did. 10:00
26 48 Q. The job description for the role, if we could just
27 briefly look at that, TRU-101577. You might recognise
28 that. I suppose we don't really have the time to get
29 bogged down in the minutiae of these job descriptions,

1 but, in a nutshell, you were responsible for all
2 professional medical and dental matters?
3 A. That's right.
4 49 Q. That involved overseeing appraisal, training, job
5 planning, those kinds of things? 10:01
6 A. Yes. Obviously I was the Responsible Officer as well
7 for all the medics, and clearly whilst I was
8 responsible for it, we had a large number of people
9 working with me and with the Trusts to deliver on those
10 issues, but, yes, I was the designated person and 10:02
11 doctor responsible for professional issues.
12 50 Q. Just the role of Responsible Officer. Was that within
13 the Medical Officer's role or is that an adjunct to it?
14 A. It was a key part of the Medical Director's role, and
15 obviously people are familiar with the process. This 10:02
16 was a system that was brought in by the General Medical
17 Council a few years ago. It requires every doctor to
18 be revalidated on a cyclical basis on the basis of
19 appraisal and evidence of good practice. There's quite
20 a system that has to be put in place to allow that to 10:02
21 happen. I think we had demonstrated that we had
22 a system that certainly could deliver on the mechanics
23 of the appraisal process very well, in that we
24 achieved, almost every year, 99%, and some occasions
25 100%, of all doctors appraised on a yearly basis and 10:03
26 during my time the revalidation process worked fairly
27 smoothly. The challenges around appraisal are well
28 recognised in terms of how effective it is. We had
29 a tight system for monitoring appraisal but I was well

1 aware there are always improvements that can be made to
2 that to be more effective. In terms of the mechanics
3 of the appraisal and revalidation process, we had
4 a very well established system. I think, and
5 I believe, and many doctors told me that they felt well 10:03
6 supported within the Southern Trust with that process,
7 which is not something that's found everywhere.
8 51 Q. Yes. The professional leadership aspect of your role,
9 which is set out within paragraph 2 of the job
10 description -- we don't need to turn it up, it will be 10:04
11 a familiar feature to you. You had to provide support
12 to your Associate Medical Directors, Clinical Directors
13 and Lead Clinicians throughout the Trusts. Presumably
14 there was an element of reciprocation in that. They
15 had to be, in some respects, your eyes and ears on the 10:04
16 ground or closer to the ground in terms of drawing
17 professional issues to your attention?
18 A. Very much so. Particularly the Associate Medical
19 Director team was critical to the running of the
20 professional system within the Trust, so that was 10:04
21 something I spent a lot of time developing and
22 improving. Certainly by the time I left post, I felt
23 we had a very highly trained, competent and effective
24 and quite diverse team of Associate Medical Directors
25 who were in a good place to deliver that going forward. 10:05
26 The Clinical Directors, I always think, to be honest,
27 I have always said the Clinical Director role I think
28 is the most difficult role in the Health Service. You
29 are delivering high volumes of clinical work and you

1 are also trying to manage a team of colleagues who can
2 be challenging at times. I was very conscious that
3 they had to be supported through training and, well, in
4 other ways as well. I think there was evidence that we
5 usually had good numbers of applicants for most of 10:05
6 those posts, but one of the most difficult areas, and
7 this is a recurring theme, was in the whole area of
8 Surgery, throughout my time, to fill those posts, and
9 I think that reflected on the complexity and the
10 demands on the job of the clinicians practising, not 10:06
11 that there wasn't a desire for them to become involved
12 but they were so busy clinically. One of the
13 challenges of the post was that, in terms of workload,
14 most of the clinicians in the Southern Trust carried
15 a very high workload burden, working in much smaller 10:06
16 teams than, for instance, they might have been in
17 Belfast. So, my main challenge was making sure they
18 didn't work too hard as opposed to trying to get them
19 to do work, and that could be as big a problem at
20 times. The Clinical Directors were key to that and 10:06
21 certainly my role would have been to support them and
22 to have used them as a conduit in both directions to
23 receive information and to share information with the
24 body of doctors and dentists.
25 52 Q. The Inquiry, I think, is particularly interested in 10:07
26 this area of medical management and the stresses that
27 affect both the CD level and the AMD level and,
28 I suppose, their practical capacity to be able to do an
29 effective job, and obviously the setting for our

1 interest is within the Surgery sector. You think by
2 the end of your tenure the place was in a better state
3 of health than when you arrived because you oversaw
4 improvements. If we just go back to the beginning. In
5 2015, how would you assess the state of health of 10:07
6 medical management within Surgery in particular, and
7 what ultimately did you do to move it on to a better
8 place?
9 A. The post holders had been in post for a considerable
10 time. In Surgery in particular the Associate Medical 10:08
11 Director and some of the Clinical Directors were
12 approaching retirement, so that gave an opportunity to
13 refresh and renew, I think, and just to look at how the
14 system worked. There were particular challenges in
15 Surgery because we were trying to deliver acute 10:08
16 surgical services across two acute hospitals with
17 a very small team, so that was problematic. As has
18 recently, there have been developments in the public
19 sphere recently where that service has been re-profiled
20 within the last few months. We were still trying to 10:08
21 manage an acute site on two sites. When they indicated
22 they were retiring it was challenging to fill those
23 posts, and it took quite a wee while before we had
24 a static workload or workforce in those posts. I think
25 there had been difficulties in the past with 10:09
26 relationships within the Directorate between
27 individuals and between some of the surgical team which
28 didn't help things and took a while to settle down,
29 it's probably fair to say. I like to think that the

1 opportunities for people filling those posts were
2 improved by the amount of training we did over three
3 years that I was in office with doctors who were
4 interested in management roles. This was something
5 they had sought and we designed a bespoke training 10:09
6 programme around clinical management for doctors, in
7 association with the Leadership Centre and our own
8 Human Resources Department to try and fill the gaps
9 that they saw in their own training and to encourage
10 medical management as a possible career path. One of 10:10
11 the main stumbling blocks, I think, would have been the
12 amount of time and resource given to clinicians wanting
13 to take on those roles. There would have been limited
14 programmed activity or PA allocations for them, and
15 limited administrative support staff to help them in 10:10
16 the roles. Part of this was because of funding issues,
17 but, to be fair, a large part of it would also have
18 been the clinicians themselves who really didn't want
19 to give up significant parts of their clinical practice
20 to take on these roles. They would prefer to do them 10:10
21 on top of full-time posts.
22 53 Q. Yes. Just if I can come in on that, and we can
23 continue the discussion along this. If I can frame it
24 in this way: Mr. Haynes, in his evidence, painted
25 a picture of a busy clinician. 10:11
26 A. Mm-hmm.
27 54 Q. He had a role in Belfast as well as a role in
28 Craigavon?
29 A. Mm-hmm.

1 55 Q. And no doubt Daisy Hill. The impression perhaps might
2 have been, to some extent at least, about fitting the
3 managerial aspects around the practice, the clinical
4 practice, and if something had to give, it had to be
5 the managerial element, whether that's not being able 10:11
6 to attend a meeting or not being able to give enough
7 attention to a particular issue that might have been
8 blowing up and he, I suppose, to generalise slightly,
9 bemoaned the absence of effective support for that
10 role. Has that changed? 10:11
11 A. I'm not sure. I haven't been in the Trust for a number
12 of years.
13 56 Q. No, but did it change during your time or was there
14 a process to try and --
15 A. There was a process in place to try and improve that. 10:12
16 One of the last things I did, when I came back from
17 a period of sick leave just before I retired, I was
18 asked to do a number of projects by the Chief Executive
19 rather than to step back into the Medical Director's
20 role, because I was retiring a few months later. One 10:12
21 of them was an exercise around job planning and how to
22 recruit and retain doctors. As part of that we did
23 a lot of interviews with the staff as to what would be
24 helpful. At that point we had identified certainly
25 a need for better admin support for a lot of these 10:12
26 management roles and more PA allocation if that was
27 available. I presented that report not long before
28 I left, and I understood that that was being taken
29 forward. But there clearly was an issue in that

1 respect which we had not really bottomed out by the
2 time that I left the Trust. This would have been,
3 I have to say, common across the health sector system,
4 although, and this is one difference I had observed,
5 when I was working in Belfast as an AMD, for example, 10:13
6 that would have been half-time post and half-time
7 clinical. We weren't, at that stage, in the Southern
8 Trust where often it was two or three programmed
9 activities for the AMD role, so although the Belfast
10 patch would have would have been bigger there was 10:13
11 a disparity in the resource for medical admin time. As
12 I say, part of that was a funding issue but part of it
13 was the clinicians themselves who hadn't yet got their
14 mind into the place where they really wanted to give up
15 sufficient of their clinical activities to allow them 10:13
16 to take on that amount of time. That's always a always
17 a problem in the small team when you have very few
18 colleagues to share your work around. It's easier in
19 a bigger team to shed some of your clinical work.
20 57 Q. Help us with this: What is the importance of that tier 10:14
21 of management, the CD role and the AMD role?
22 A. When it's working well, it's absolutely crucial to the
23 running of a hospital. The CD is the person who will
24 pick up issues early and has the ability, and often the
25 authority, to sort them out quickly and rapidly. When 10:14
26 the role is working well, it's a very effective post
27 and a very effective way of managing governance issues,
28 as well as all the other staffing issues and so on that
29 they have to do. It's also a role whereby, again when

1 it's working well, a clinician has the opportunity to
2 develop new services to bring in new ideas, to really
3 make a change. So the reason why a lot of people would
4 want to do a CD's role is because they have perhaps
5 a particular project or an issue that they want to 10:14
6 bring to the fore and, in that position, you have the
7 ability often to do that. The downside is you often do
8 have to give up sufficient clinical time to allow that
9 to happen, and that's a difficult journey for a lot of
10 clinicians. 10:15
11 58 Q. When you came into post on the surgical side, the AMD
12 was Mr. Mackle?
13 A. Mm-hmm.
14 59 Q. The CDs included Mr. Brown?
15 A. Mm-hmm. 10:15
16 60 Q. I think there was one other person in post, Sam --
17 I forget, it doesn't much matter. In general, when you
18 came into the post, did you meet with the people in
19 each of the Directorates occupying these key management
20 roles? 10:16
21 A. Yes, I would have. We would have had regular monthly
22 Associate Medical Director team meetings, which
23 I chaired, where they gathered together at AMD level,
24 but as well as that I would have had pretty regular
25 one-to-one meetings with each of the Associate Medical 10:16
26 Directors. I would have had less frequent one-to-one
27 meetings with the Clinical Directors, but I did try to
28 meet with them individually as often as possible.
29 There would have been other opportunities, such as the

1 regular medical staff meetings, which I attended most
2 times on both the Daisy Hill and the Craigavon hospital
3 sites, and we'd have opportunities to meet together.
4 Then occasionally one would have tried to meet with the
5 clinical teams, so I would have tried to meet with 10:16
6 specialty groups as a group on an occasional basis when
7 the opportunity arose, but time pressures didn't allow
8 it to happen as one would have liked. I would have
9 been engaging with -- I would have known all the
10 Clinical Directors well, I would have met with them 10:17
11 reasonably frequently, and certainly the Associate
12 Medical Directors, we would have been on frequent and
13 almost daily contact with them.
14 61 Q. I believe you were in the chamber yesterday and you
15 would have heard me taking Mrs. Trouton through a list 10:17
16 of concerns in a broadly chronological fashion that had
17 preoccupied her, as well as medical management, in
18 reference to Mr. O'Brien's practice over a period of
19 years. And come 2015, there were still, what she would
20 have described, as recurrent issues around triage, 10:18
21 around retention of patient notes and, I get the
22 impression, towards the end of 2015 issues in relation
23 to record-keeping in terms of dictating actions or the
24 history taken at clinics. We will come to what
25 I understand was a meeting in January of '16 with 10:18
26 Mr. Mackle and Mrs. Trouton. I know you've difficulty
27 recalling that and we will look at that. Prior to
28 that, when you are coming in the door and trying to get
29 to grips with what's going on in each of the various

1 departments, were concerns in relation to Mr. O'Brien's
2 practice referred to at that time?
3 A. I have no definite recollection, before that meeting,
4 of them being formally raised in any way. That's not
5 to say there might have been some comment at 10:19
6 a one-to-one that was un-minuted, but he certainly
7 wasn't -- this wasn't an issue that was high on my
8 radar at the time that I arrived, until that meeting in
9 January. I had met Mr. O'Brien on a number of
10 occasions. I was aware of -- I mean, I had met him. 10:19
11 I was aware of his practice, but really until that
12 meeting in January, I wasn't aware of the extent of the
13 difficulties that were -- having.
14 62 Q. What, in general terms, were you hearing about the
15 Urology Department upon commencement of your post? 10:19
16 A. Okay. The Urology Department was -- I met with them as
17 a team fairly early on in my time. We were certainly
18 under a lot of pressure clinically in terms of waiting
19 lists targets, as were all the surgical departments and
20 that was very clear. They did have reasonable staffing 10:20
21 levels as the funded levels that were agreed but, in my
22 opinion, they probably did need additional support.
23 They certainly weren't one of the departments that was
24 on my risk list for immediate staffing crises. There
25 were others that were, but Urology was functioning 10:20
26 reasonably well. They were delivering well. They were
27 actually seen within the Trust as being one of the
28 innovative teams. They had won the Chairman's Award
29 for team work, I think the first year that I was there.

1 They had participated in a number of regional
2 initiatives for some very advanced forward looking,
3 they were experimenting with different types of
4 tele-radiology or telecommunications on projects. They
5 took the first adept fellow, which the adept fellow 10:21
6 programme was a programme of clinical management
7 trainees and they were the first and, in my time, the
8 only Surgical Department in the province to take an
9 adept fellow, who was a urological trainee, who fed
10 into their lithotripsy programme which is a regional 10:21
11 service. My impression of them was these were a very
12 high performing team, very clinically competent. They
13 were prepared to work with colleagues across the
14 region. On a practical network they shared patients
15 and expertise on a regular basis, but they were 10:21
16 probably suffering from the same as many other surgical
17 specialties of being overworked. My impression I got
18 from them was that they were functioning well as
19 a group and they were high performers and valued,
20 certainly within the Trusts and across the region. 10:22
21 63 Q. In terms of those kinds of interactions and the
22 information that flows from that, there was nothing
23 written down by you as an issue that you were going to
24 have to follow up and work on?
25 A. There were many other issues across the Trust related 10:22
26 to medical staffing that were just of a higher order in
27 terms of staff shortages, and there were other doctors
28 where their performance and behaviour issues which were
29 of quite a serious nature which we dealt with in my

1 first few months of arriving in the Trust. They were
2 on my desk. Mr. O'Brien was not at that stage.
3 64 Q. You say, if we could just bring it up, WIT-17894, and
4 paragraph 67.3:
5 10:23
6 "When I initially came to the Trust in July '15 it
7 became apparent to me there was a lack of trust between
8 Consultant medical staff and some of the senior medical
9 and non-clinical leaders over a number of preceding
10 years. This seemed to be an issue, particularly within 10:23
11 the Surgical and Anaesthetic teams. There was also
12 a lack of knowledge among many of the medical
13 non-clinical leadership staff regarding possible
14 options open to them for dealing with difficult issues
15 among colleagues. Mr. O'Brien was probably the most 10:23
16 senior colleague in the entire Trust which was an added
17 factor. This may have led to a reluctance for medical
18 staff to escalate some significant issues."
19
20 I am anxious to explore maybe the general point you 10:24
21 make first about the Trust issue. Can you better
22 explain that or broaden it out for us?
23 A. Okay. I remember coming to the Trust and having my
24 first Associate Medical Director team meeting and being
25 surprised at just the general atmosphere within the 10:24
26 meeting, which was not open and appeared to be quite
27 defensive. So, that was a significant issue which had
28 to be addressed fairly early on. Some of that was
29 because of interpersonal issues that had obviously been

1 going on for a while between some of the team members,
2 and between them and previous issues before my time.
3 I made it very clear at the start that we were going to
4 change that culture and behaviour, and we set out
5 deliberately to do so at a very early stage because 10:25
6 that was unacceptable to me. I think, by and large,
7 that was welcomed by most of the people that were
8 there. We went on an away weekend, if you like,
9 specifically to tackle this issue of culture, and we
10 brought in expertise from the Beeches Health and Social 10:25
11 Care Leadership Centre, and we took a stock-take of
12 where we were with that. Part of that was to identify
13 training needs. I think possibly, to be honest, that
14 was where some of the members maybe felt that it was
15 time to move on to do other roles and it was time to 10:25
16 refresh some of the team members, which was part of
17 that process as well. I think, to be fair, that turned
18 around fairly quickly. I'm not sure what the original
19 source of all that was but it was a very definite --
20 maybe it was a mistrust of me coming in from an outside 10:26
21 Trust, it may have been that, but, certainly, my modus
22 operandi was that we were a team, that even though we
23 had certain areas of Directorates to cover, there was
24 to be cross-cooperation between the AMDs and mutual
25 support, and that was the way they were going forward. 10:26
26 It was a factor right at the start but it was fairly
27 rapidly turned around.
28 65 Q. Just a discrete point lying within that paragraph:
29

1 "There was also a lack of knowledge among many of the
2 many medical non-clinical leadership staff regarding
3 possible options open to them for dealing with
4 difficult issues among colleagues."
5 A. Yes. 10:26
6 66 Q. What are you getting at there?
7 A. I think particularly options such as the MHPS process.
8 People had a very superficial understanding of how it
9 operated and what help could be attained from it.
10 There wasn't a great awareness of the goal of NCAS and 10:27
11 the National Clinical Service, for instance, and the
12 potential it had to assist and help with difficult
13 cases. My way of working was, where problems were
14 identified, to deal with them at an early stage, to
15 intervene with a process that was overseen by the Trust 10:27
16 Oversight Committee, with a view to preventing them
17 escalating into more serious issues. When I arrived in
18 the Trust, there were a number of issues that had
19 clearly been going on for some years. Some of them had
20 been dealt with and there were a few outstanding ones. 10:28
21 I made it clear to my AMD team that was going to stop
22 and that the way forward was to deal with issues by the
23 appropriate process in a formal manner. The reason for
24 doing that is often you can prevent a relatively minor
25 issues from escalating to a more major one, before 10:28
26 behaviour becomes entrenched. I have had experience of
27 that in a number of previous areas where that has
28 worked well, and I have seen the effects where not
29 doing that has led to very significant problems that

1 are almost impossible to fix if left un-dealt with.
2 That was part of the reasoning behind developing then
3 the training package for clinicians for medical
4 management.
5 67 Q. Yes. Obviously, just to pick up on your point about 10:28
6 knowledge of MHPS and understanding of its import and
7 how to use it, you are coming obviously with
8 a background in a bigger Trust, probably more
9 throughput of MHPS cases with a larger demographic?
10 A. Yes. 10:29
11 68 Q. Could I suggest to you that really should only be part
12 of the explanation for the lack of knowledge that
13 Mr. Mackle and, for that matter, Mrs. Trouton, revealed
14 in their evidence over the past couple of days. They
15 didn't seem to know too much about MHPS at all. In 10:29
16 Mr. Mackle's case that was notwithstanding that he had
17 been asked to be a Case Manager once, and Mrs. Trouton,
18 for her part, had never heard of it.
19 A. Mm-hmm.
20 69 Q. Is that surprising to you when I put it in those terms, 10:29
21 given their roles in senior operational management and
22 senior medical management?
23 A. It clearly couldn't be allowed to continue. You can't
24 have an Associate Medical Director who is ultimately
25 unfamiliar with the MHPS process, which again is one of 10:30
26 the reasons why we developed a bespoke training
27 programme for them because it was apparent that there
28 was a deficiency of knowledge amongst senior clinical
29 staff in that area, and that did surprise me, but it

1 probably reflected the relative lack of number of cases
2 that they'd had going through previously. Yes, it was
3 a concern. Our training programme was specifically
4 aimed at the medical staff, so that we had a cadre of
5 potential candidates then for Clinical Director and AMD 10:30
6 roles. It hadn't extended out to non-medical staff at
7 the time I was there, but that probably would be
8 something that would be worth doing, clearly.
9 70 Q. Yes. Presumably, your concern about the lack of
10 knowledge about how to deal with difficult issues among 10:31
11 colleagues isn't solely focused, isn't limited to MHPS.
12 Presumably there's a range of tools or strategies that
13 you would expect management to be aware of in order to
14 deal with that kind of issue?
15 A. Yes. I have to say, the Human Resources Department, 10:31
16 I found them very supportive and knowledgeable around
17 these processes. I think there was a hesitancy among
18 clinical staff to bring issues to the fore because they
19 were uncertain of the options that might have been open
20 to them, and I think that was a block. People 10:31
21 sometimes saw these processes as punitive in
22 themselves, whereas, in fact, often they were aimed at
23 trying to get to the bottom of an issue so you could
24 address the core issues. There was a gap of
25 understanding, I think that is fair to say, and that 10:32
26 was my experience.
27 71 Q. Just going back to issues around your job, your job
28 description, how that interacted with other people.
29 You have made it clear, and the job description makes

1 it clear, I suppose, that your responsibility is on the
2 professional side, there's an operational side,
3 obviously, and that responsibility lay in the
4 Directorate with a Director who, when you came into
5 post, was Ms. Gishkori? 10:32
6 A. I think she started around about the same time as
7 myself.
8 72 Q. Yes. Then, so far as Urology is concerned, you have
9 another tier below that?
10 A. That's right. 10:33
11 73 Q. Assistant Director, who, for a large part of the first
12 -- I suppose, the first six months, first nine months,
13 was Mrs. Trouton?
14 A. Yes.
15 74 Q. Then within Urology itself you have a Head of Service, 10:33
16 who was Mrs. Corrigan?
17 A. Mrs. Corrigan, yes.
18 75 Q. In terms of the operational management, medical
19 management dichotomy, if it's helpful to see it in
20 those terms, was that well understood in the context of 10:33
21 managing difficult doctors, difficult clinicians?
22 A. That were parts of the Trust that worked extremely well
23 and there were other parts where it didn't work so
24 well, and there were obviously reasons for that. To
25 give an example of one area that worked very well in my 10:34
26 experience was child health, paediatrics, where we had
27 a very motivated Associate Medical Director who was
28 very focused on quality improvement and developing
29 standards, and very innovative in his thinking and that

1 percolated in a very -- and they had a good working
2 relationships between them and the Director of the
3 service. There were lots of areas like that that
4 worked really well. I think the acute side struggled
5 to make it work so well, and part of that was simply 10:34
6 the size and the complexity of it, which was just so
7 much bigger than any of the other sections. They had
8 quite a number of AMDs working within the one
9 Directorate, working to the same Director. It's very
10 complex, they were managing emergency services as well 10:35
11 as elective services across a whole raft of
12 specialties. In parts of the Trust that divide, if you
13 like, worked very effectively. In other parts it was
14 less clear and blurred, and I think there was certainly
15 potential for improvement, which I understand has 10:35
16 happened. The Acute Service, to be honest, there were
17 tensions between the operational side and the
18 professional side, and whilst all parties tried to work
19 together, the reality is there's often a blur in those
20 boundaries and I'm not sure that, at all times, that 10:35
21 system worked as well as it could have.
22 76 Q. Yes. You are right to use the word blur or confusing,
23 as it's said in your statement. Just on that, we've
24 heard from Mrs. Trouton. She is an Assistant Director.
25 She is receiving from the Head of Service within 10:36
26 Urology concerns about, let's use the example of
27 triage. She, on occasions, tries to deal with it
28 directly with the practitioner. On some occasions, and
29 probably more occasions, she tries to escalate it to

1 the Clinical Director and sometimes the Clinical Lead,
2 but her frustration appears to be that they are not,
3 that is on the medical side, they are not seeing the
4 impact on her service as clearly as she is and are not
5 taking the kind of steps to provide an effective remedy 10:37
6 that she needs.
7 A. Mm-hmm.
8 77 Q. How is that difficulty to be resolved? Is it a case of
9 infusing the medical side of the management line with
10 a better understanding of the steps that they should be 10:37
11 taking to address the problem?
12 A. That would be part of the solution. It's really vital
13 that all parts of the system worked together and with
14 each other and with united purpose, especially in
15 a difficult, complex situation as arose with the 10:38
16 scenario we are dealing with today, which was
17 a long-standing problem, as it turns out. I suppose,
18 in a situation like that, it's really critical that all
19 relevant parties with responsibility worked together to
20 solve it. Certainly part of the issue would be a more 10:38
21 skilled medical leadership workforce who would know the
22 options available to them and know when to escalate,
23 and what is acceptable to be dealt with locally and
24 what is not.
25 78 Q. Is the picture that I've painted through Mrs. Trouton's 10:38
26 evidence, is that a familiar one to you of an
27 ineffective challenge function on the medical
28 management side?
29 A. It wasn't a norm by any means. Normally, and my

1 experience within the Southern Trust, was that we had
2 very effective challenge. We have lots of cases,
3 obviously we can't discuss them individually, to show
4 evidence of that, where we dealt with many, many cases
5 of great complexity, some of which were before the 10:39
6 courts, some of which were related to medical health,
7 some of which were related to under-performance. That
8 would have been the norm. This was unusual, in that
9 there seemed to be a reticence to deal with this issue
10 conclusively in this particular instance. There would 10:39
11 have been the exception rather than the norm, but
12 nevertheless, an important exception.
13 79 Q. I think, I can't quite put my finger on the quote from
14 your statement, and maybe we will come to it later, but
15 if I can paraphrase. Your impression, up to a certain 10:39
16 point, was that medical management had sought to deal
17 with things informally within -- and perhaps
18 operational management as well is captured by your
19 concern, tried to deal with matters informally within
20 their own sphere of influence within that Service or 10:40
21 within that Directorate, rather than bring it outside.
22 Do you recall that analysis? What was your thinking
23 there? First of all, where did that understanding come
24 from and what should have been done?
25 A. Where there's repeated issues that arise, such as arose 10:40
26 in this case, that have not been resolved within
27 a reasonable time frame, I mean it's always good to
28 deal with these things locally and informally if you
29 can, and that often works and that's great, and the

1 Clinical Director would be key in doing that. Where
2 that doesn't work, then I would expect that to be
3 escalated to myself and to the Service Director and for
4 a formal plan to be developed to deal with that. That
5 would be the normal way we would do business. 10:41
6 Historically, that may not have always been what
7 happened, but certainly that was the way I intended and
8 practised, and I made that very clear. I was somewhat
9 surprised when I appreciated the issues that had been
10 going on for so long and the extensive work that had 10:41
11 been done to try and manage them, but not really deal
12 with the issue at the heart of the practice. So, yes,
13 in this particular instance, it was unusual, but my
14 impression was that the issue had been allowed to
15 fester, if you like, for much too long before bringing 10:42
16 it to a formal procedure.
17 80 Q. When the Inquiry comes to write the history of this,
18 I suppose, the impression that has perhaps been given
19 by the evidence, and obviously there's much more
20 evidence to be received, was, as you've highlighted 10:42
21 there, informality of an approach while issues
22 continued to occur, not being effectively addressed,
23 sometimes not addressed at all. You are suggesting
24 that that is an unusual culture or an unusual approach
25 in your experience in the modern public health system 10:42
26 of this country?
27 A. Yes.
28 81 Q. This was perhaps a local culture that is somewhat
29 strange in your eyes?

1 A. I wouldn't say it was local. In the early days of my
2 involvement in medical management this would have been
3 quite not usual. Across all Trusts there would have
4 been practitioners who would have been behaving poorly
5 for long periods of time, who had been managed 10:43
6 ineffectively. During my professional life and my
7 experience that situation has changed to the point now
8 where it is really exceptional to find something like
9 that. I did have a few cases similar when I was in
10 Belfast in the early days, but not towards the end of 10:43
11 my time there. I was impressed, if you like, by the
12 way many of the difficult cases had been dealt with in
13 the Southern Trust when I arrived there, very
14 effectively, some of which I picked up the tail-end of
15 and saw to a conclusion. This was very unusual, but 10:44
16 you are right to say that in the modern NHS and modern
17 Health Service, in my opinion, this would not be
18 acceptable.
19 82 Q. Yes. When witnesses have given evidence to that effect
20 that this is how we did manage and, you know, they 10:44
21 accept that that, with hindsight, isn't a good way of
22 doing it. When you ask for explanations, some of the
23 explanations are to the effect that the person
24 concerned carried a certain reputation or medical
25 excellence in certain aspects of his practice? 10:44
26 A. Mm-hmm.
27 83 Q. And a generally positive reputation on a personal
28 level.
29 A. Mm-hmm.

1 84 Q. Is that, in your experience, a danger that medical
2 management has to guard against in general, this,
3 I suppose, sense that somebody is perhaps too important
4 and too popular to challenge effectively?
5 A. Again, in the early days of my professional life of 10:45
6 medical management that would not have been an unusual
7 problem, but it wasn't something I encountered in more
8 recent times. I think medical managers now would be
9 well aware of the dangers of giving undue importance to
10 personalities in the way that you have described. It 10:45
11 is challenging working in a small team. If you are
12 working with a close colleague -- I mean I have been in
13 this situation -- where there are under-performance
14 issues, it is a very difficult thing to deal with
15 those, which is why you need to seek help beyond the 10:46
16 immediate team to be able to deal with that
17 effectively, and there is help there. I suppose what
18 I'm saying is, in general in the Southern Trust that
19 was not an issue, but it did seem to be an issue in
20 this particular case. It may have reflected simply the 10:46
21 fact that Mr. O'Brien was a very senior -- he was
22 probably the most longest serving member of medical
23 staff in the Trust and so a lot of people working with
24 him would have given him a degree of respect, which is
25 understandable, but, in this particular instance, 10:46
26 probably not helpful.
27 85 Q. When you refer in your witness statement to the blurred
28 lines between professional or medical management and
29 operational side, what particular problems did you have

1 in mind caused by this blurring or this confusion, as
2 you have described it?
3 A. If there is an operational performance issue, such as,
4 to take for an example, dictating of patient notes, as
5 an example, it could happen anywhere and it does happen 10:47
6 occasionally there are issues around that. On one
7 level that's a very straightforward, you know you need
8 to get a dictaphone or a recorder. You need to sit
9 down and report. It's a very simple process issue that
10 is managed within the Directorate, and the Clinical 10:48
11 Director can manage at an operational level. It seems
12 at one level to be very straightforward. When it
13 becomes a persistent problem then it starts really to
14 become a professional issue. There can be confusion
15 then over who deals with that, and this is one of the 10:48
16 problems I think we have with our current Health
17 Service management systems. To give you an example
18 where I think things worked better, and this is just my
19 personal opinion. In the days when I was Clinical
20 Director in Radiology, the Clinical Director of the 10:48
21 Department would have been the budget-holder in the
22 Department and was Head of the Department and was
23 responsible for everything within that. They would
24 have clinical standards. They carried the can for the
25 budget, for the staffing levels, everything. It was 10:49
26 very clear who was in charge and who to go to if there
27 was a problem. We have a system now where that is not
28 so clear. The Clinical Directors are no longer the
29 budget-holders. I'm not sure they are not sorry they

1 are not, but they are not. There are two management
2 structures, if you like, there is a clinical line and
3 there's a management line. Sometimes people become
4 confused as to which is the right direction to report
5 issues to, and the managers themselves are confused as 10:49
6 to who should deal with them. The system can work
7 really well. We have got people who are well trained
8 and they have time to consider their actions, and they
9 have good relationships between teams, and that's great
10 and it often does work really well. But where 10:49
11 relationships are not so good and the clinicians and
12 the individuals are very busy and under a lot of
13 stress, that system cannot function as well. My
14 personal view is, the dual line can be confusing on
15 occasions and isn't helpful in this type of situation 10:50
16 because, in reality, there is a blur between
17 professional and operational matters.
18 86 Q. I'm not going to bring you to it now but just for the
19 panel's note, you deal with this in a number of places
20 in your statement, and, in particular, WIT-17895. 10:50
21 I think you have said one solution would be to have
22 a medically qualified person in sole charge to make the
23 reporting lines clear and simple. Is that, I suppose
24 back to the start of your career?
25 A. That would probably be a very unpopular thing to say 10:50
26 but, in many circumstances, I think that would be
27 clearer. But the key thing is the person is
28 appropriately qualified and has appropriate
29 capabilities. That's probably more important than

1 whether they are medical or not. It's often, in
2 reality, easier for a medical person to learn
3 management skills than a non-clinically qualified
4 person to become fully competent or conscious of all
5 the clinical issues. 10:51
6 87 Q. Yes.
7 A. The key thing is that the person has the appropriate
8 skill set. Because of the regulatory requirements
9 around doctors and so on, in some circumstances that
10 does need to be a doctor. 10:51
11 88 Q. While you came into this post after some of the issues
12 with which we are concerned had been brewing for some
13 several years, do you get a sense, given what you now
14 know, that this blurring, as you describe it, of
15 responsibility, may have contributed to this slow pace, 10:52
16 perhaps, of getting to grips with the issues and
17 resolving them?
18 A. I think it was a factor. It's my belief, yes.
19 89 Q. Urology itself, you have painted a positive picture of
20 what you observed at the commencement of your role, but 10:52
21 you were approached in certainly January 2016, and,
22 according to the memory of Mr. Mackle and Mrs. Trouton,
23 there was a discussion of Mr. O'Brien and the
24 difficulties that he was posing within the Urology
25 Service. Mr. O'Brien, had you met him by that point? 10:53
26 A. I had met him on one or two occasions, yes.
27 90 Q. I am just missing a point in my note and I will come
28 back to those. Yes, I have it here, sorry. You said
29 in your witness statement that you met him about half

1 a dozen occasions before the commencement of MHPS.
2 I suppose you take the commencement of the MHPS process
3 towards the latter end of the next year?
4 A. Yes.
5 91 Q. But I think you have reflected that you met him during 10:54
6 a training session in respect of private patients?
7 A. That's right. That's right.
8 92 Q. A walk-through of the surgical wards, a team meeting
9 with Urology, at the Trust Chair's birthday
10 celebrations? 10:54
11 A. I think we were both present. I can't recall if
12 I actually met him there.
13 93 Q. A few e-mail exchanges. Do you recall meeting him to
14 discuss Radiology attendance at multidisciplinary
15 meeting? 10:54
16 A. I saw that. I hadn't recalled that but I may well have
17 done. I do remember discussing the issue but I can't
18 remember who with.
19 94 Q. Yes.
20 A. I wouldn't dispute it. 10:54
21 95 Q. In terms of the meeting in January 2016, you have said
22 that you can't recall the details of that meeting. At
23 that time you would have assumed that the matter had
24 been followed up within the Service and that you would
25 have been informed if there were any further 10:55
26 difficulties. Do you have any recollection,
27 independent recollection of the meeting itself?
28 A. I do remember the meeting occurring and the general
29 tone of the conversation. I don't think anyone took

1 minutes at that meeting, it was an informal discussion.
2 Certainly listening to Mrs. Trouton's statement
3 yesterday was helpful for me to recall what happened.
4 96 Q. Yes. Obviously, up to this point, based on what you've
5 said this morning, you had no prior warning that 10:56
6 Mr. O'Brien was, from the perspective of those two
7 managers, causing difficulties. I think you said you
8 allowed for the possibility that something might have
9 been said informally at a meeting, but certainly the
10 suggestion of a great problem hadn't come to your door? 10:56
11 A. I think that's right, that's as I recall, yeah.
12 97 Q. Yes. At this meeting it's been said that you would
13 have been told about several issues, including the
14 triage issue?
15 A. Mm-hmm. 10:57
16 98 Q. Retention of patient notes at home, and a relatively
17 new issue, which was the alleged failure to properly,
18 and sometimes at all, dictate following a clinical
19 engagement with a patient. Do you agree that those
20 issues are likely to have been raised? 10:57
21 A. Yes. Yes.
22 99 Q. What were Mr. Mackle and Mrs. Trouton looking from you?
23 A. I think they wanted advice. Part of it was a listening
24 ear, because they had obviously been struggling with
25 this problem for quite a while and they wanted 10:57
26 a fresh --
27 100 Q. Did they tell you that?
28 A. I believe so, yeah. It's obviously difficult without
29 having minutes of the meeting, but as I recall. They

1 wanted a fresh pair of eyes looking at the situation.
2 It certainly struck me, and we discussed that this
3 matter had been clearly attempted to be managed very
4 informally and with workarounds for a long period of
5 time, and it was time now to deal with this in a more 10:58
6 deliberate and intentional manner to bring it to
7 a conclusion. I certainly didn't feel that there had
8 been a clear line of direction given to Mr. O'Brien as
9 to what needed to be done, or that the concerns were of
10 a significant nature in recent times. We discussed 10:59
11 possible options and I think we agreed it was still
12 worth a chance to resolve these matters relatively
13 straightforwardly by putting down a clear marker of
14 what was expected of him and giving him the opportunity
15 to resolve those issues in the first instance. 10:59
16 101 Q. Presumably the approach Mr. Mackle coming to you was
17 entirely appropriate?
18 A. Yes. Oh, yes, yes. I mean, strictly speaking, the
19 lines -- Mr. Mackle would have had the opportunity to
20 come to me at any time with an issue like that. 10:59
21 Usually, Mrs. Trouton would have gone through her line
22 manager, which would have been Mrs. Gishkori, but
23 I always made it clear if there were issues of
24 professional nature that were a concern to any member
25 of staff, they could approach me directly and I was 11:00
26 happy to see them. But it was a little unusual to have
27 the Associate Medical Director and the Assistant
28 Director come to me with an issue of this nature, that
29 was unusual but appropriate, I think.

1 102 Q. In terms of the issues raised with you, how grave were
2 they in patient-safety terms?
3 A. Yes. Obviously a very important question. Any of
4 those issues potentially could have serious
5 consequences. At that point, we weren't, at least 11:00
6 I wasn't aware of any actual serious incidents
7 happening. To my mind, they all seemed as issues
8 relatively straightforward to deal with, and the right
9 thing was to try and deal with those within the
10 Directorate, in the first instance, with a clear 11:01
11 direction. But, if that didn't work then, I think we
12 agreed that then that would be escalated. I had had
13 some experience of a similar nature before, which is
14 why this line of thinking was in my mind, in a previous
15 Trust, where we had an issue around patient letters and 11:01
16 note-keeping that was very similar. We dealt with it
17 with a meeting with the Clinical Director and the
18 individual presenting a similar action plan to the
19 doctor concerned. After that, it took probably one to
20 two months to finally get on top of everything, but the 11:02
21 issue was resolved relatively speedily once they were
22 clear about what was expected of them. I felt that
23 perhaps Mr. O'Brien wasn't fully clear as to what the
24 management structure wanted him to do or expected of
25 him, and it was important that they made that 11:02
26 explicitly clear as opposed to implicitly clear.
27 103 Q. That's an interesting point you make. If a clinician
28 isn't dictating contemporaneously, if he's bringing
29 multiple records home, to take those two examples --

1 I think triage might be a bit more complex in the
2 explanation. To take those two examples, Mr. O'Brien,
3 surely, couldn't have been unclear of the standard
4 expected?
5 A. I wouldn't have thought so. I mean, this is a basic 11:03
6 duty of a doctor under General Medical Council duties
7 of a doctor, it's bread and butter medical practice.
8 But it had been tolerated by the Trust for some time,
9 so he may have believed that that was acceptable. That
10 was my thinking. Whilst it was very clear that this 11:03
11 was not acceptable, in my mind, and we had to make that
12 very clear, the fact that the practice had been allowed
13 to go on for some time may have caused some confusion
14 for Mr. O'Brien, so it was reasonable to give him an
15 opportunity, when it was made very clear to him what 11:03
16 was expected, to put that right, and when he was
17 reminded of his duties as a doctor under good medical
18 practice. I mean, you know, taking notes home, for
19 instance, I mean, this is very easy to stop doing. You
20 just stop taking them home. Dictating notes. You have 11:04
21 to dictate notes eventually, so doing them
22 contemporaneously requires a little reorganisation, but
23 it's not an unreasonable thing to ask. I thought it
24 was reasonable to make it just incredibly clear what
25 was required of him and to give him the opportunity to 11:04
26 do that.
27 104 Q. I am anxious to know to what extent these issues were
28 set in their historical context. You would have heard
29 me yesterday asking Mrs. Trouton about various issues.

1 To take two examples from 2011 or so, intravenous
2 antibiotic regime or lower urinary tract issues.
3 Another issue in relation to the difficulties around
4 the following up on investigations, following up on
5 results coming through pathology investigations or 11:05
6 radiography investigations. Mr. O'Brien, at least in
7 the eyes of management, and these issues are no doubt
8 controversial, perhaps, but in management eyes, there
9 were these push backs from Mr. O'Brien across these
10 issues. Triage was an issue that was complex in the 11:05
11 sense that, while there was an expectation that this
12 would be done, there had been various workarounds in
13 association with that. That preamble leads to this
14 question: Did they set this history out to you?
15 A. The history of the more recent past was set out to me. 11:06
16 I can't remember if they mentioned the SAI or the other
17 issue, but certainly the extensive previous history
18 I was not aware of at that time in detail. Having said
19 that, the number and frequency of issues had arisen in
20 the past, you have mentioned two, whilst not ideal, 11:06
21 would not be unusual for a busy clinician over that
22 time period to have one or two issues like that. He
23 wouldn't have been an outlier in that respect. There
24 hadn't been any of those issues in the immediate five
25 years. He had been through a period of revalidation 11:07
26 with my predecessor Dr. Simpson, who would have
27 reviewed his practice over a five-year period with his
28 appraisals and looking at his performance indicators
29 and being satisfied that he was performing

1 appropriately. I had had no further incidents in my
2 time, so looking at what I was aware of at that time,
3 whilst I acknowledged the significance of those two
4 incidents, if you looked at any busy clinician's
5 practice over a ten-year period, you would be likely to 11:07
6 find at least one SAI, maybe several, and possibly
7 other complaints, that would be the norm. He wasn't an
8 outlier, I suppose is what I'm saying. Whilst
9 individually those incidents are significant and you
10 look back and say yes, there was a kick back, this 11:08
11 wouldn't have been a particularly outlandish pattern
12 that we were seeing.
13 105 Q. In terms of the tone or the demeanour with which
14 Mr. Mackle and Mrs. Trouton addressed you, from their
15 perspective, it seems, bringing this to the Medical 11:08
16 Director after years of informality, was different,
17 unusual. It may not have been unusual for you in terms
18 of who you received into your office across the range
19 of clinicians within the Trust.
20 A. Mm-hmm. 11:08
21 106 Q. Did that come across, that they were anxious to bring
22 this on to a new, formal, and more structured footing?
23 A. Yes, that was the impression I gleaned.
24 107 Q. Was that because they now appreciated, I suppose, a new
25 level of seriousness with the issues because of the 11:09
26 addition of what new consultants had identified within
27 the notes, the absence of dictation.
28 A. Yes, I believe so. I think that was, if you like, the
29 final issue or the final straw. They were worried that

1 this had developed new legs, if you like, and had
2 become more complex than before, and the measures that
3 were within place within the Directorate to do the
4 workarounds would not be appropriate for these new
5 issues. 11:09
6 108 Q. In terms then of your thinking, you've come from
7 a background of experience in MHPS. We now recognise
8 or you now recognise that some members of management
9 didn't appreciate what was in the toolbox for dealing
10 with difficult clinicians. Were you thinking MHPS at 11:10
11 this meeting with them or were you thinking in the
12 alternative, let's try an initial semi-formal step at
13 a local level?
14 A. I obviously had MHPS in the back of my mind, but I felt
15 at this stage -- and if they had been going to consider 11:10
16 that formally we would have called an oversight meeting
17 at that point to discuss. I felt that there was still
18 worth an opportunity to resolve this at a local level
19 because, on the face of it, the individual issues
20 should have been straightforward to resolve. I would 11:10
21 have been aware that -- but I did have it in my mind,
22 I thought there was a reasonable chance we might be
23 able to address this locally and informally, but the
24 potential was always there to go further with that.
25 I made it very clear to, I think, from my memory, 11:11
26 although it's not perfect, of the meeting, to
27 Mrs. Trouton and to Mr. Mackle that we would deal with
28 this matter locally if we could in this way, but that
29 if that didn't work, we would take the matter further.

1 I don't think I ever mentioned MHPS specifically, but
2 I was in no doubt that we weren't going to let this sit
3 indefinitely, and I don't think they were either.
4 109 Q. The plan or the advice that you offered them, can you
5 help us with that? 11:11
6 A. I felt that there had been a lack of clarity for
7 Mr. O'Brien as to what was expected of him. I think
8 also the fact that there had been so many workarounds
9 may have led him to believe that some of his behaviour
10 was acceptable. I couldn't see any evidence that that 11:12
11 had been laid out clearly for him. I suggested that
12 they met with him and wrote to him, outlining the
13 issues that were concerning them, and indicating that
14 he had to address them within a reasonable time frame.
15 After that, we would see what happened. I don't think 11:12
16 I discussed in detail, but there was an implicit
17 assumption that had he required any -- you know, had he
18 come back with a plan, that there would have been
19 support to try and help him achieve it if that was
20 required. I think both Mr. Mackle and Mrs. Trouton 11:12
21 suggested that that would be the case. I did think,
22 and others may judge me wrong, but I thought it was
23 better to ask him for his way of resolving this,
24 because of this history of kickback, the more direct
25 instructions that you give him, it might have been he 11:13
26 could have kicked back to any one of those. I wanted
27 the instruction to be clear about the issues that had
28 to be dealt with but to leave it over to him as to how
29 he resolved those, because he may have had his own

1 ideas of how that could be done and it was worth
2 listening to those, I think, if they had been
3 presented. I have lost my train of thought.
4 110 Q. It's quite okay. We will take a break now, or maybe
5 just finish with the last couple of questions on this 11:13
6 meeting. The meeting wasn't recorded. My words were
7 that it was a milestone meeting but maybe you, sitting
8 there, and the other participants, didn't necessarily
9 regard it as that. Is this not the kind of meeting
10 that rather ought to be recorded? 11:14
11 A. I think, with hindsight, it should have been. It began
12 as an informal meeting asking for advice and, with
13 hindsight, yes, I think it should have been recorded.
14 I would agree with that.
15 111 Q. We know that the meeting and the delivery of the letter 11:14
16 setting out the standards to be expected and asking for
17 a plan, weren't delivered until the end of March. Did
18 you expect quicker progress?
19 A. I would have liked to have seen that done a lot quicker
20 than that, but I understand there can be reasons why 11:15
21 these things, you know, with leave and so on. But yes,
22 I was disappointed it didn't happen sooner.
23 112 Q. This is a serious number of issues. Patient harm
24 issues folded in within it, the meeting should take
25 place the next week, allowing for leave and other 11:15
26 responsibilities, not six, seven weeks later?
27 A. I mean, I agree with you. I can't dispute that.
28 113 Q. One of the themes that we will be exploring is how
29 issues drawn to your attention in January, there's some

1 suggestion perhaps that Mr. Mackle spoke to you in
2 December, with a view to having the meeting, but I'm
3 not sure that's terribly important. It takes from
4 January to the other end of the year, December, for
5 some final plan to be adopted, and we will look at that 11:16
6 maybe after the break.
7 CHAIR: Half past 12 -- or 11. Sorry.
8
9 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
10 11:21
11 114 Q. MR. WOLFE KC: Welcome back, Dr. Wright. Could I draw
12 your attention to an e-mail that you were a participant
13 in on 9th February 2016 concerning Mr. O'Brien. This
14 is an e-mail less than a month after you'd engaged with
15 Mr. Mackle. TRU-257616. Just at the bottom of the 11:32
16 page, please. Mr. O'Brien is replying to Marian
17 Fitzsimons who has been pursuing Mr. O'Brien for
18 a response to a medical legal issue, clearly a claim
19 brought against the Trust. The details are relevant.
20 But consider, if you would, his response to Marion 11:33
21 Fitzsimons:
22
23 "I regret the delay in replying to your e-mails. I am
24 quite sure it must be difficult to appreciate that
25 something regarded so important could be so delayed. 11:33
26 I have to advise you I receive so many e-mails
27 regarding patients each day that it can take me two
28 hours to deal with each day`s definitively. As
29 a consequence, if I have already worked for 12 to 16

1 hours I do not get to even open all e-mails. I am now
2 sending this e-mail at 02:25 a.m., Friday, having been
3 working at 07 a.m. yesterday. As a consequence of
4 spending some hours compiling the attached comments,
5 I have not yet opened yesterday's e-mails and I start 11:34
6 again at 9 a.m. All that is how it is, day in, day
7 out. Thank you for your forbearance."
8
9 Scrolling up the page, please, this is forwarded to
10 you. Mr. O'Brien: "Has provided a detailed and 11:34
11 comprehensive response to the allegations of negligence
12 contained within the Statement of Claim which will be
13 of assistance to the Trust's barrister."
14
15 Then you comment back, and forward on to Esther 11:34
16 Gishkori:
17
18 "Hi Esther, this almost sounds like a cry for help. We
19 should discuss. Richard."
20 11:35
21 No doubt an appropriate response to what is a fairly
22 graphic and detailed description of Mr. O'Brien's
23 typical working day as he presents it, coming four
24 weeks after your discussion with Mr. Mackle.
25 A. Mm-hmm. 11:35
26 115 Q. Did you marry the two issues or the two incidents, if
27 you like?
28 A. Just if I may just set a little context before I fully
29 answer your question?

1 116 Q. Of course.
2 A. The legal issue, just to put it to bed, I'm assuming,
3 and in fact I know that Mr. O'Brien, there would have
4 been multiple communications about that over
5 a prolonged period of time and it wouldn't normally be 11:36
6 expected you'd have to respond in a 24-hour period, but
7 there had been a failure of engagement with the legal
8 team over a period of many weeks coming up to this. On
9 one level, yes, it's difficult that he had to do that,
10 but it wasn't that he was being forced into doing this 11:36
11 at the last minute without plenty of notice. Just to
12 put that to bed. But that said, yes, clearly he was
13 working under a lot of pressure and I did -- I had
14 forgotten about this e-mail but I clearly was
15 concerned, and I am sure I did mention it to Esther 11:36
16 afterwards about what was happening but I can't recall
17 that conversation. We would have been looking out for
18 other signs of problems. But, looking back at it now,
19 that looks like I was quite concerned about him at that
20 time. I suppose I was aware that we had the beginnings 11:37
21 of a process starting and we wanted to see how that
22 would work out, but I acknowledge that that is an
23 indicator of significant stress for Mr. O'Brien at that
24 time.
25 117 Q. In concrete terms, you can't remember any plan or 11:37
26 strategy or, in fact, any specific discussion whereby
27 the symptoms of a stressful professional life were
28 discussed, either with him or with others?
29 A. No. To be fair, I wouldn't normally get involved in

1 a one-to-one discussion with an individual about
2 matters like that, it would be something done much
3 closer to his line management. Either his Clinical
4 Director or his Lead or his AD. I would tend to keep
5 out of such conversations on a one-to-one because I am 11:38
6 often required at other levels to intervene, but
7 I would like to think that I would have discussed that
8 with Esther, but I can't recall.
9 118 Q. It's not just solely a pastoral issue in this
10 particular context, because, as I have said, three 11:38
11 weeks earlier, you are receiving information, for the
12 first time, perhaps, in your relatively new role of
13 Medical Director, which is showing deficits in clinical
14 practice or clinical administrative practice which are
15 having an impact on patients? 11:38
16 A. Mmm.
17 119 Q. So the two issues, one might think, are hardly
18 unconnected. A busy professional life as described
19 here, work not being done as described by managers?
20 A. Mm-hmm. 11:39
21 120 Q. It's in that context, I think, that we should perhaps
22 look at the letter that Mr. Mackle sent to Mr. O'Brien.
23 If we can pull that up, please, AOB-00979. This is the
24 letter that was handed to Mr. O'Brien at the meeting of
25 30th March. It had been through a number of iterations 11:39
26 since it was first drafted, about a week after
27 Mr. Mackle's meeting with you. You hadn't seen a draft
28 in the interim?
29 A. I don't think so, unless -- I don't recall seeing

1 a draft. No.
2 121 Q. Is it fair to say that when they left your office on
3 11th January, it was over to the Service, with
4 Mr. Mackle leading to deal with the issue, only to be
5 reported back to you if there were ongoing 11:40
6 difficulties? Is that how you left it?
7 A. That's the way we left the meeting, yes. We still
8 believed at that point this was best managed at a local
9 level unless it couldn't be resolved by this attempt.
10 Yes, we left it that they would get back to me should 11:41
11 there be any issues.
12 122 Q. One of the things you have said in your statement, and
13 now corrected, was:
14
15 "I was not privy to the March 2016 meeting or letter at 11:41
16 the time."
17
18 You now accept that the letter was sent to you?
19 A. Yes, it was copied in to me, yes.
20 123 Q. Yes. Why did you not seek a follow-up with Mr. Mackle 11:41
21 after the meeting?
22 A. It's a long time ago and it's difficult to remember.
23 We normally would have met, you know, on our
24 one-to-ones about AMD matters in general, and I would
25 normally have expected to have got some feedback about 11:42
26 issues like this at that time. But it wasn't long
27 after this that Mr. Mackle stepped down in his role as
28 AMD. I think there were a number of changes in
29 personnel around this time that were just unfortunate,

1 they all happened at the critical time, so I suspect
2 the reason is that he was no longer in post.
3 124 Q. Yes. If we just scroll down to the end of the letter,
4 and we will go back through it. Just to the last line.
5 Four issues are set out in the letter, and the last 11:42
6 paragraph is:
7
8 "You will appreciate that we must address these
9 governance issues and therefore would request that you
10 would respond with a commitment and immediate plan to 11:42
11 address the above as soon as possible."
12
13 That's what was left with Mr. O'Brien. Nobody came
14 back to you to say matters have been resolved?
15 A. No. 11:43
16 125 Q. Indeed, Mr. McAllister, who took over from Mr. Mackle,
17 wrote to you on 9th May 2016, and maybe we will go to
18 that in a moment, highlighting the same issues, amongst
19 many others, in surgery, highlighting these O'Brien
20 issues, without using his name, in May 2016? 11:43
21 A. Mm-hmm.
22 126 Q. You had no indication that matters had resolved?
23 A. I had no positive indication of that, that is correct,
24 yes. Just to comment on Dr. McAllister's letter.
25 Obviously he was a new doctor in post and he was 11:44
26 outlining a large number of issues that he had
27 correctly identified, many of which there were ongoing
28 processes for. So, I accept he did mention it in
29 general, but it wasn't a specific note about this

1 particular issue.
2 127 Q. Mm-hmm. Obviously there had been this changing of the
3 guard. Mr. McAllister replacing Mr. Mackle on the
4 operational side, Mrs. Trouton moving to a new post to
5 be replaced by Mr. Carroll. The two people who had 11:44
6 come to you with the issue of concern had left their
7 roles. How was progress on this issue, or lack of
8 progress, to come to your attention?
9 A. The expected means probably would have been via
10 one-to-ones with Mrs. Gishkori as the Service Director 11:45
11 and they may not have happened over that summer period
12 because of leave, but that would normally be the way
13 one would get feedback. But it was left to the Service
14 Director that they were to contact me should there be
15 any further issues. That was the way it was left. 11:45
16 I can imagine what you are thinking and, on reflection,
17 looking back --
18 128 Q. Sorry to be so obvious. Let's reduce it to a question.
19 A. Aha.
20 129 Q. As the Medical Director who was contacted in relation 11:45
21 to this concern, should you have been proactive in
22 pursuing information to assess whether it had been well
23 managed, if not resolved?
24 A. This is a rather long answer to a straightforward
25 question. There are multiple, multiple issues of 11:46
26 concern would have come across my desk every day, some
27 of which were of absolute immediate importance and some
28 of which were life-critical on a daily basis, so my
29 main focus was on them. This was an important issue

1 but not quite of the same high importance. We were
2 light in resource in the Medical Director's office, so
3 do I regret not asking for more regular updates from
4 the team? Yes, of course I do. But, the normal
5 process would be, when an issue is left to the 11:46
6 Directorate that they would contact me should they
7 require me again, because I cannot be, as a Medical
8 Director, the sole person, you cannot be contacting
9 each of the Directors on a daily basis about all their
10 concerns. That would be inappropriate. I do accept on 11:47
11 this one with hindsight I should have contacted them
12 earlier, and it is a regret of mine that I did not do
13 that.
14 130 Q. You would probably recognise that with the changing of
15 the guard in the key role of AMD, and indeed in the 11:47
16 Assistant Director's role, there is at least a risk
17 that issues that were prominent to the old team and
18 I suppose issues that they were anxious to try and
19 resolve, could fall down between the cracks when a new
20 team come into post? 11:47
21 A. That is always a concern. However, where the situation
22 was left, this was going to be handled at operational
23 Directorate level. That was my understanding and
24 I think that was their understanding. But, yes, with
25 hindsight, I should have been more proactive. I accept 11:48
26 that.
27 131 Q. Have you had an opportunity to reflect on -- scroll
28 back to the top of the letter. Have you had an
29 opportunity to reflect on the letter itself and whether

1 it did the job that you expected it would do?
2 A. I think it clearly outlined the issues explicitly to
3 Mr. O'Brien. It did make it clear that he needed to
4 respond. Where it could have been better would have
5 been to give him a more definite time frame for 11:48
6 a response. However, I think 'immediate' to most
7 people is fairly easily understood, so I think, with
8 that caveat, I think it, by and large, did do the job
9 in putting a marker down and outlining the issues.
10 Where it was light was in the time frame and what might 11:49
11 be the ultimate response, if there wasn't a response
12 from Mr. O'Brien. However, I do understand, from
13 reading some of the evidence that has been supplied to
14 me, that at the meeting there was a discussion.
15 Mrs. Corrigan remembers a discussion along those 11:49
16 issues. I understand Mr. Mackle perhaps doesn't recall
17 that, but -- and the timescale was explained to
18 Mr. O'Brien. It would have been better to have been
19 put in writing, I think, at the end of the letter.
20 132 Q. The need to build into the letter that kind of detail, 11:49
21 in what you are saying ideally, would you also liked to
22 have seen built into the letter some explicit
23 expression of support or the possibility of support or
24 assistance, particularly given what you knew by this
25 stage about Mr. O'Brien's apparent stressful work? 11:50
26 A. I think it would have been a better letter if that had
27 been explicitly stated, yes. However, Mr. O'Brien was
28 well aware that, over the intervening years, there had
29 been multiple interventions to support him in this

1 work. It wasn't that this wasn't available or he
2 wouldn't have been aware of it. I also think the
3 requests were for reasonable management instructions,
4 this was not something that was rocket science or
5 beyond the capabilities of even the most junior doctor. 11:50
6 This was a reasonable request to a very experienced
7 Consultant, who would have been aware of his
8 responsibilities. Yes, it would have been better if
9 that had been more explicitly outlined, but the short
10 answer to your question is did it outline the issues to 11:51
11 Mr. O'Brien? I think it did, and yes, it could have
12 been better done.
13 133 Q. At this stage of the process of January to March, was
14 your thinking that we don't need to up the ante too
15 much, we need to put a marker down and then await 11:51
16 a response to then decide the direction of travel?
17 A. The management of the situation on the ground was very
18 much with the operational Directorate, but, in general,
19 yes, I think we had to give a reasonable time frame for
20 a response and hope, and I think there was a reasonable 11:52
21 chance that there could have been a good response, that
22 the issue may have been resolved. I didn't want to up
23 the ante at this stage by suggesting any other
24 interventions. I didn't think that would be helpful,
25 to either to Mr. O'Brien or to anybody else, when there 11:52
26 was still an opportunity to resolve this locally.
27 134 Q. There was no HR input at this point. Was that
28 deliberate or was it just not thought about?
29 A. It wasn't deliberate, certainly. But, again, this type

1 -- maybe not as extensive as this, but issues of this
2 operational nature would be dealt with fairly routinely
3 within a Directorate as a matter of course by the local
4 management team. Yes, there are occasions when they
5 seek HR support and, in hindsight, it probably would 11:52
6 have been appropriate to have done so with this
7 particular one. I mean, this type of issue can
8 normally be resolved without any HR intervention in
9 terms of the operational nature of it. Knowing what we
10 know now and how the whole story unfolded and 11:53
11 developed, yes, it would have been better to have HR
12 involvement at an earlier stage.
13 135 Q. Obviously, HR are a presence as matters move into the
14 Oversight Group and we will look at that shortly. In
15 general terms, the Inquiry looking at the strengths and 11:53
16 weaknesses of an MHPS process, would this be typical of
17 how a process might start? You don't up the ante --
18 obviously, we are generalising here and there are
19 different issues. Even with hindsight, would you
20 reproach yourself for the process that was adopted here 11:54
21 as a starting point?
22 A. I've reflected long and hard on this. It probably
23 would have been better if we had gone into with an
24 oversight committee and considered the MHPS process
25 more formally earlier. I would absolutely concede 11:54
26 that. However, just to be clear that this was not an
27 MHPS process, and if it had been, Mr. O'Brien would
28 have been told that it was and the oversight committee
29 would have been supervising this, but this was not.

1 There was still an expectation, albeit it turned out to
2 be misplaced, that this issue would be resolved locally
3 and fairly speedily on my part, which was perhaps in
4 hindsight, naive.
5 136 Q. I am not suggesting -- obviously it's ultimately 11:55
6 a matter for the Inquiry -- that you should reproach
7 yourself. What I'm saying to you is that you were
8 informed of this issue in January and you knew that
9 there was some history, but you decided that a process,
10 informal is probably not necessarily a helpful word in 11:55
11 this context, but a process outside of MHPS was
12 possibly useful as a starting point?
13 A. That was my view at the time.
14 137 Q. Could we just turn to Mr. McAllister's note to you on
15 9th May, for your comment? WIT-14877. If we scroll 11:55
16 down to item 8. There are other items within this list
17 that may have an aspect of Urology about them, but you
18 probably recognise in number 6 aspects of the concerns
19 that Mr. Mackle drew to your attention. However he's
20 got to discover these, whether it was the handover, 11:56
21 informal handover with Mr. Mackle or whether he has
22 picked it up elsewhere from within the service, they
23 are now on his --
24 A. Mm-hmm.
25 138 Q. -- agenda? 11:56
26 A. Yes.
27 139 Q. Mr. McAllister didn't come to you beyond this list to
28 say Mr. O'Brien hasn't come back with a plan?
29 A. No, no, he didn't. This list is very extensive and

1 I recognise many of the things in it, and many of them
2 would have been very hot issues at the time, so he's
3 got a good grasp very quickly and I was very pleased to
4 see that, and he was clearly engaging in identifying
5 his priorities for the coming weeks, and I was 11:57
6 encouraged that he was aware of and had become briefed
7 on the issues within Urology, as the other. I mean,
8 I saw that as a positive letter in the right direction
9 and that did reassure me that he was aware of the
10 issues and the process that was ongoing. 11:57
11 140 Q. Do you think it reasonable for you to expect that if
12 Mr. O'Brien hadn't responded to the correspondence, as
13 we know he didn't, that Mr. McAllister would be taking
14 that up with the Service or with the Assistant Director
15 and Director? 11:58
16 A. That is what I would have expected of an AMD.
17 141 Q. If we scroll up. I think you suggest a meeting,
18 a get-together, an action plan. I mean, was that
19 a throwaway line?
20 A. There would have been ongoing meetings about all these 11:58
21 issues in different contexts at multiple times. There
22 wasn't a single meeting to pick up this letter, but
23 there certainly would have been multiple meetings at
24 various points to deal with each of those issues as
25 they arose, and some more than others. 11:58
26 142 Q. But not the O'Brien issue?
27 A. Not specifically about the O'Brien issue, no.
28 143 Q. If we fast forward to August of that year, you wrote to
29 Martina Corrigan on 9th August. If we could just bring

1 that up, please? TRU-274723.
2 A. Mm-hmm.
3 144 Q. At bottom of the page, please. You are writing to her:
4
5 "Did we ever make progress with regard to the issues in 11:59
6 Urology which Eamon had been dealing with? Regards
7 Richard".
8
9 She comes back a little over a week later with the
10 updated position, as she describes it -- 11:59
11 A. Mm-hmm.
12 145 Q. -- on triage and review backlog. She hasn't mentioned
13 the other issue that was raised with you in relation to
14 dictation. She hasn't commented on compliance or
15 otherwise with the letter that Mr. O'Brien had been 12:00
16 handed.
17 A. Yes.
18 146 Q. First of all, how did this come back on to your radar?
19 A. To be honest, I was going through issues that I had
20 been dealing with over time and doing some tidying up 12:00
21 and I thought I would check, there was no particular
22 issue, newer issue that arose, but I was conscious that
23 I hadn't had a positive feedback from the Directorate
24 and I would check to see what the position was. I was,
25 to be honest, expecting -- I was hoping and expecting 12:00
26 the reply would be more positive, and obviously was
27 concerned then when I realised there was still an
28 ongoing issue.
29 147 Q. Could I ask for your comments on something you've said

1 about your engagement with Mr. Haynes, just a month
2 later. WIT-17876. You have said that you weren't
3 aware of significant problems within team Urology until
4 early 2016 when Mr. Haynes highlighted the issues
5 around the patient administration performance of 12:01
6 Mr. O'Brien. These had come to the fore because
7 Mr. O'Brien was on sick leave and the Directorate had
8 appropriately arranged for his patients to be reviewed
9 by other consultants.
10 12:02
11 A couple of things on that. You were aware of
12 significant problems within team Urology from January
13 of that year, is that not fair to say?
14 A. Yes, I was aware of the problems with Mr. O'Brien, yes,
15 but not of the extent of them, I think, to the same 12:02
16 degree as was highlighted by Mr. Haynes.
17 148 Q. What was it that Mr. Haynes was drawing to your
18 attention that was different in quality from what
19 Mr. Mackle had drawn to your attention?
20 A. Mr. Haynes and some of his colleagues had been 12:02
21 reviewing patients of Mr. O'Brien's to help with the
22 backlog and I think they had come across some issues
23 around note-keeping and triage that were of concern to
24 them, that were of more concern even than we were aware
25 of before. He telephoned me about that one night, 12:03
26 saying, 'I need to speak to you about this'. He
27 described it in such a way that it was clearly of
28 significant risk to the organisation and to patients.
29 149 Q. Was he contacting you as a colleague or was he

1 contacting you -- at this stage we know he was Clinical
2 Director but not with regard to Urology?
3 A. Yes.
4 150 Q. Mr. McAllister was still in post?
5 A. That's right. 12:03
6 151 Q. On what basis was he contacting you then?
7 A. Well, he was Clinical Director. He didn't have
8 a responsibility for Urology but clearly as a Urologist
9 doing these review backlogs he had a unique insight
10 into this, and any Consultant I would have frequently 12:04
11 said to all the medical staff should they come across
12 an issue that's unexpected and concerning that they
13 should contact me at any time. I think it was really
14 in that light. The fact that he happened to be
15 a Clinical Director within the Department probably gave 12:04
16 him more confidence to do so, but it wasn't
17 specifically in his role as Clinical Director.
18 152 Q. The issues that he was bringing to you then, I don't
19 see them recorded anywhere. Did you make a record?
20 A. Except that we called the oversight meeting and to 12:04
21 review the issues, so I suppose that would be the forum
22 in which they were recorded.
23 153 Q. But in terms, I am just anxious to assess your view of
24 what Mr. Mackle was telling you. In January, he's
25 coming to you with these significant issues, in his 12:05
26 view. They are coming to you for advice. These were
27 now matters that couldn't be dealt with informally any
28 more, seems to have been their position. You are
29 saying, it seems, they weren't significant:

1

2 "I was not aware of significant problems" until
3 September?
4 A. I think it's the order of seriousness and immediacy.
5 I think earlier in the year, we thought we had 12:05
6 a process that we were in for sorting this out within
7 the Directorate. A letter had been sent. We were
8 allowing some time. We'd hoped that that would have
9 been resolved. I'm now getting evidence that there are
10 ongoing issues with Mr. O'Brien from one of his close 12:06
11 colleagues, which are fresh, if you like, and still
12 ongoing.
13 154 Q. Were they any different in nature to what Mr. Mackle
14 was clearly articulating?
15 A. To be perfectly honest, I can't remember the details of 12:06
16 the conversation, and this is one of the reasons why
17 I rang Mr. Haynes at the start of trying to put my
18 evidence together, to try and refresh our minds, and
19 neither of us could totally remember what was said on
20 that evening. Certainly the tone of it was one where 12:06
21 Mr. Haynes felt it was a more immediate concern for
22 Patient Safety and wellbeing. I cannot remember the
23 exact issue. I think it was the similar issues but of
24 a more recent nature, and particularly into one or two
25 patients where potentially Mr. Haynes was worried about 12:07
26 the consequences of the deficiencies.
27 155 Q. Pushing you on this, if I can. Was this a failure of
28 triage or was it a failure of dictation?
29 A. I honestly can't remember.

1 156 Q. Or perhaps it was neither of those?
2 A. I mean this was a phone call. It was out of hours. My
3 response to it was, okay, clearly we need to escalate
4 this to a different level. We will call an oversight
5 meaning and review, pull together all the information 12:07
6 we have and review it. I can't recall exactly what the
7 issue was, unless Mr. Haynes has a record of it.
8 157 Q. Can I just go back to a piece in your statement at
9 WIT-17862, 36.4. If we could just scroll down, please.
10 You have said here: 12:08
11
12 "I was reassured that Mr. Haynes brought these matters
13 to my attention but disappointed that the local
14 measures that had previously been put in place seemed
15 to have been unsuccessful." 12:08
16
17 Just that phrase "local measures". What were the local
18 measures that had been put in place?
19 A. I'm not on top of the details of them, but the measures
20 that Mr. O'Brien had been instructed on the issues that 12:08
21 had to be addressed and Mr. Mackle had met with him and
22 that there would be an expected response, and that
23 clearly had not worked. That's what I was referring
24 to.
25 158 Q. It's not a case of any particular local measure? 12:09
26 A. No.
27 159 Q. It was the request for a plan?
28 A. Yes.
29 160 Q. The day after you received the response from

1 Mrs. Corrigan in August, we find Simon Gibson writing
2 to Martina Corrigan. He worked in your office?
3 A. That's right. He was my Assistant Director.
4 161 Q. He had a medical background, did he?
5 A. No, no. He was formerly on Acute Service. He would 12:10
6 have had a role similar to Mrs. Trouton in Acute
7 Services before but had moved to my office a few months
8 before as my Assistant Director in a management role,
9 but he had a lot of experience of the Acute Service.
10 162 Q. Yes. If we just pull up the e-mail he sent. It's 12:10
11 TRU-274722. He is telling her, and copying you in,
12 that he has been briefed and asked to commence
13 a discrete piece of work on issues of concern and
14 actions taken to date. Could you forward any relevant
15 information you have on file and we can meet for an 12:11
16 initial discussion next week, and obviously it's
17 confidential, concerning Dr. O'Brien.
18
19 By this stage, you haven't had your conversation with
20 Mr. Haynes, so far as you both can remember. She has 12:11
21 sent you information indicating that triage remains an
22 issue and patient note retention, remains an issue.
23 What is your thinking at this time in asking for this
24 discrete piece of work?
25 A. Okay. It was clear that whatever measures had been put 12:11
26 in place or whatever procedures had been taken by
27 Mr. Mackle in the letter had not totally worked, or
28 possibly not worked at all. I now needed clear
29 evidence on what was the scale of the problem now

1 because we were going to put together, call an
2 oversight meeting and we needed some background
3 information to be able to discuss that with a view to
4 escalating this to a more formal procedure.
5 163 Q. We obviously have medical managers in place. We have, 12:12
6 by now, Mr. Weir, Mr. McAllister and the tier above
7 him. Why is this task of scoping out the extent of the
8 problem given to somebody in your office as opposed to
9 a Clinical Manager?
10 A. Okay. The first thing is, Mr. Gibson is very senior 12:12
11 manager with a lot of experience, and he would have
12 done this on numerous occasions -- well several
13 occasions for me before. He was working to me so this
14 was, if you like, a delegated role that I asked him to
15 do on my behalf. I wanted this done quickly. There 12:12
16 was a sense of urgency now because I had realised that
17 this was not working; the measures we put in place were
18 not working, and we wanted to get on top of this as
19 a matter of some urgency. If I had asked Mr. Weir or
20 any of the other Clinical Directors, this would have 12:13
21 been on top of their already incredibly busy workload,
22 and I don't think it would have been done just as
23 quickly. That's not to disrespect them or to make
24 light of their abilities, but the reality is that they
25 would have struggled to have done this in the time 12:13
26 frame. This would have been a normal way of working
27 for us in preparation for an oversight committee. We
28 hadn't formally started an MHPS process at this point.
29 This was simply background preparatory information to

1 have an informed discussion.
2 164 Q. The MHPS process seeks to define and designate who
3 might be responsible for initial steps.
4 A. Yes.
5 165 Q. If I could just have your reflections on this. 12:14
6 WIT-18501. If we go to paragraph 15. Under the
7 heading "informal approach", the first task it says of
8 the clinical manager, the clinical manager is defined
9 within an appendix in the document usually to mean
10 a Clinical Director: 12:14
11
12 "... is to identify the nature of the problem or
13 concern and to assess the seriousness of the issue on
14 the information available. As a first step,
15 preliminary inquiries are essential to verify or refute 12:14
16 the substance and accuracy of any concerns or
17 complaints. In addition, it is necessary to decide
18 whether an informal approach can address the problem or
19 whether a formal investigation is needed. This is
20 a difficult decision and should not be taken alone but 12:15
21 in consultation with the Medical Director and Director
22 of HR, taking advice from NCAS or Occupational Health
23 where necessary."
24
25 Is it fair to say that the task described there is the 12:15
26 one that you have given to Mr. Gibson, or is it
27 something different?
28 A. No, it's not quite the same. We were working obviously
29 within our own Trust guidelines on an oversight

1 committee formation so we had not -- the oversight
2 committee and effectively the Director of HR and myself
3 at the oversight committee would make a decision to
4 enter an MHPS process, and that would be a decision by
5 the Oversight Committee and to then appoint various 12:16
6 individuals. We subsequently did ask our Clinical
7 Director to do a scoping exercise shortly after the
8 first oversight committee member, so whilst
9 I appreciate it's a bit confusing, I would regard
10 Mr. Gibson as a, if you like, a preliminary stage 12:16
11 before MHPS kicked off.
12 166 Q. Just coming back on what you said there. Shortly after
13 the oversight committee you asked who to do a scoping
14 exercise?
15 A. Mr. Weir. 12:16
16 167 Q. Mr. Weir. What you are asking Mr. Gibson to do is
17 a step before all of that?
18 A. Yes, I think so, because it could have been that the
19 Oversight Committee could have met and deemed that MHPS
20 was not appropriate. This was simply gathering 12:16
21 background information to have an informed discussion.
22 It's splitting hairs, I agree. In our organisation,
23 this was by far the quickest way to achieve this at
24 this point, and I believe was within the Trust
25 guidelines on the issue that were in effect at that 12:17
26 time. They were to be replaced fairly soon after.
27 168 Q. Yes. Could I just, furthering this debate with you,
28 Zoe Parks, Medical HR, WIT-90077, and 39.4, please.
29

1 "I understand a screening report was completed in
2 September."
3
4 Clearly a reference to Mr. Gibson's report.
5 12:17
6 "But it is not clear why this was done by the Assistant
7 Director in the Medical Director's office. This should
8 have been the Clinical Manager who should have been
9 responsible for retaining ongoing oversight input from
10 NCAS now NH resolution could have provided additional 12:17
11 support if this was needed to assist the review of
12 notes."
13 A. Yeah.
14 169 Q. Equally, Vivienne Toal, if we can bring this up,
15 WIT-41059, if we go to -- yes. He says: 12:18
16
17 "It is unusual with Simon Gibson, as an Assistant
18 Director in the Medical Director's office would have
19 been the author of a screening preliminary Inquiry's
20 report. Given that the person responsible for this 12:18
21 role in both the MHPS and the Trust guidelines is the
22 Clinical Manager."
23 A. Yes.
24 170 Q. In this case Mr. Weir.
25 A. I can respond to that. First of all, it wasn't unusual 12:18
26 because this would have happened on a number of
27 occasions.
28 171 Q. You are saying it isn't unusual to depart from the
29 guidelines?

1 A. No, to use Mr. Gibson for this type of work for the
2 preliminary report. Prior to making a decision about
3 MHPS we would have used that at that time. Now, the
4 subsequent Trust guidelines that came into place
5 shortly after this, changed that, and made it very 12:19
6 clear, I think, that the Clinical Manager came into the
7 role. The reality is with the difficulties we had in
8 surgery at the time with medical leadership and
9 management, it would have been very unlikely we would
10 have been able to pull the information together in the 12:19
11 time frame for a speedy meeting by asking, and I was
12 not prepared, at that point, to ask the Clinical
13 Director to do that in that time frame on top of what
14 he was already doing. I think you can get into an
15 argument about when MHPS starts, and I would have 12:19
16 a different take on it than maybe Mrs. Toal would have,
17 because I think the decision to enter an MHPS process
18 is made by the Oversight Committee and it hadn't met by
19 that stage.
20 172 Q. Let's just look at Mr. Gibson's report. He provides 12:20
21 a report on 5th September, if we could just look at it,
22 TRU-251423. The context is set out there. It provides
23 background detail and current status of the issues and
24 provides a recommendation for consideration of the
25 Oversight Committee. What is your objective in asking 12:20
26 him for this investigation and report?
27 A. I really wanted to gather the background information,
28 the details of -- I wasn't looking for any
29 recommendations, to be honest, so I accept that was

1 probably going beyond his remit. Maybe I didn't make
2 that clear to him at that time.
3 173 Q. You think we are splitting hairs or the two --
4 A. I think there are very different interpretations of
5 when the process -- and we did recognise that in our 12:21
6 subsequent amended, I think, Trust guidelines around
7 this area. We recognised there was an area of
8 confusion.
9 174 Q. The criticism that comes through and is, I suppose,
10 reflected in the changed Trust guidelines in 2017, is 12:21
11 that the role of the Clinical Manager had been
12 subjugated or bypassed by the Oversight Group and the
13 emphasis that was placed on Mr. Gibson's role. I am
14 paraphrasing here.
15 A. Yeah. 12:21
16 175 Q. The Clinical Director has no part in this process?
17 A. At this stage?
18 176 Q. Well, at any stage until a decision to conduct an MHPS
19 investigation --
20 A. Yes. 12:22
21 177 Q. -- is made?
22 A. That's right.
23 178 Q. And he provides a report for the attention of the
24 Committee in the early months of 2017?
25 A. Yes. That's one of the reasons we did change our 12:22
26 guidance to make sure that that didn't happen going
27 forward.
28 179 Q. The point is, you didn't need to change your guidance
29 because MHPS and the guidance makes it perfectly clear

1 that it is a role that belongs to the Clinical
2 Director?
3 A. I don't think it says the Clinical Director as such,
4 the medical clinical manager.
5 180 Q. The clinical manager. And we are sure that Mr. Gibson 12:23
6 was not the clinical manager?
7 A. Absolutely sure about that, so I agree with that. We
8 had precedent in that we had done this before. I was
9 absolutely sure that had we asked any of our Clinical
10 Directors at that time to do this, this would have 12:23
11 taken a lot longer to have pulled together. It
12 certainly would have been ideal if a Clinical Director
13 had done it at the outset, but this was at a time when
14 they were under huge pressure. I can't be absolutely
15 sure but Mr. Weir was off sick around this point around 12:23
16 this too, so he may not have been available. In any
17 case, my concern was to have the oversight meeting in
18 a timely manner and to consider the information, and
19 that wasn't going to be possible was my judgment at
20 that point. Certainly going forward, the Clinical 12:24
21 Manager should have been doing it, but I didn't think
22 they were in a position to furnish us with that report
23 in the time that I needed it.
24 181 Q. Do you ask them?
25 A. No, but I would have been talking to them regularly 12:24
26 about issues at that time.
27 182 Q. Obviously, the Clinical Manager will have, or is likely
28 to have, connections and awareness in the practice area
29 which will arguably better enable him or her to make

1 that preliminary assessment of the scope and nature of
2 the difficulty and what is appropriate in terms of how
3 it might be dealt with. One of the criticisms that
4 might be made of this MHPS process is that, from the
5 outset, and we will step into that process shortly, but 12:25
6 from the outset, there was a failure to grapple with
7 all of the issues that were ultimately to be identified
8 as problematic in Mr. O'Brien's practice. Do you think
9 that that at least had a better possibility of being
10 cured or addressed with input from a Clinical Manager 12:25
11 at the outset?
12 A. From the time we commenced the MHPS inquiry we did
13 bring Mr. Weir into the fold, if you like. He wrote
14 a report for us, and he was the one that was assuring
15 us that there were no current clinical issues. I don't 12:26
16 think that would have made a material difference in
17 this instance. I do think it would have taken longer
18 to have instituted the process.
19 183 Q. We will look at Mr. Weir's report at the appropriate
20 point. Just on this report then, if we could just 12:26
21 quickly scroll through it. He deals with triage and
22 a figure is produced. In March 2016 Dr. O'Brien had
23 253 un-triaged letters which was raised in writing with
24 him and a plan to address this was requested. No plan
25 was received, and in August 2016 there had been, 12:26
26 nevertheless, improvement. 174 un-triaged letters
27 dating back 18 weeks, the rest of the Urology team
28 triage delay is 3 to 5 working days. You would have
29 noted that improvement?

1 A. It was a slight improvement, yes, but not --
2 184 Q. The issue hadn't resolved?
3 A. The issue hadn't resolved, yes.
4 185 Q. Outpatient review backlog. The number of patients on
5 Mr. O'Brien's backlog is described as 667 as of August 12:27
6 '16. But no plan was received or had been received to
7 address that, so no change on that. Patient notes at
8 home is described. Scrolling down the page, please.
9 It reflects that for a period in 2013/'14 instances
10 where charts were not available were recorded on the 12:28
11 Incident Reporting system. There were 61 consultations
12 where charts were not available. It reflects that
13 Mr. O'Brien had been spoken to about this by the
14 Directors in Acute and that had not been recorded, so
15 that issue appears still to have been a live one. 12:28
16
17 Then issue 4: "Recording of outcomes of consultations:
18
19 Whilst there has been no formal audit of this issue,
20 concern has been raised by urological colleagues that 12:28
21 Mr. O'Brien may not always record his actions or
22 decisions regarding a patient following a period of
23 inpatient care or Outpatient consultation. This may
24 cause subsequent investigations or follow-up not to
25 take place or be delayed." 12:29
26
27 He proceeds to summarise the concerns. He places it in
28 the context of GMC's good medical practice. He
29 concludes by saying:

1

2 "This report recognises the previous informal attempts
3 to alter Mr. O'Brien's behaviour have been
4 unsuccessful. Therefore this report recommends
5 consideration of an NCAS supported external assessment 12:29
6 of Mr. O'Brien's organisational practice, with Terms of
7 Reference centred on whether his current organisational
8 practice may lead to patients coming to harm."

9

10 I think that's where the letter ends, yes. 12:29

11

12 You received that report. Is that when you start to
13 think about the need for an oversight initiative?
14 A. I was starting to think about it whenever I received
15 initially the letter from -- or the response from 12:30
16 Mrs. Corrigan, but certainly once I got this then it
17 was absolutely required that we set up an Oversight
18 Committee.
19 186 Q. In terms of the Oversight Committee, can we just look
20 at its role as set out in the Trust's guidelines. Just 12:30
21 before we do so, MHPS as a process, you have worked
22 with that in the Belfast Trust. Did the Belfast Trust
23 have a similar concept of an Oversight Committee or how
24 did it do its business?
25 A. Yes, they did. They called it something different but 12:31
26 it would have met more frequently obviously because the
27 case numbers would have been very significant in
28 Belfast, but they did.
29 187 Q. Let's just look at how its role is defined. TRU-83689.

1 Paragraph 2.5. It says:
2
3 "The Chief Executive will be responsible for appointing
4 an oversight group for the case. This will normally
5 comprise Medical Director with Responsible Officer, 12:31
6 Director of Human Resources and the relevant
7 Operational Director. The role of the Oversight Group
8 is for quality assurance purposes and to ensure
9 consistency of approach in respect of the Trust's
10 handling of concerns." 12:32
11
12 The Oversight Group that you were to work with for the
13 purposes of this case was -- was Ms. Toal of HR?
14 A. Yes.
15 188 Q. Yourself, obviously, and Mrs. Gishkori? 12:32
16 A. Mrs. Gishkori --
17 189 Q. Or her deputy?
18 A. Yes.
19 190 Q. Were they appointed by the Chief Executive?
20 A. Well, not specifically on this occasion, but the system 12:32
21 was always the Director of HR, Director of Medicine and
22 the relevant Service Director and that was the make-up
23 of it for any given case. The Service Director would
24 have changed obviously, depending on where the doctor
25 was working. 12:33
26 191 Q. Was it everyone's understanding that the role of the
27 Oversight Group or Oversight Committee was a, as it's
28 described it here, quality assurance role?
29 A. I think most of the understanding was that it was more

1 than that, so it would have had the role of instituting
2 or appointing Case Managers or case investigators for
3 MHPS investigations, if that was appropriate. That
4 would have been one role that maybe isn't made explicit
5 in that paragraph but that would have been how it was 12:33
6 done.
7 192 Q. How it was done. In practice, was this Oversight
8 Group, first of all, responsible for preliminary
9 investigations through Simon Gibson, leading to
10 a decision on whether MHPS, formal or informal 12:34
11 investigation was appropriate?
12 A. It would have been responsible for considering
13 information brought to it from whatever source and, in
14 this case it was from Simon Gibson, and it would have
15 been responsible, my understanding for deciding whether 12:34
16 an MHPS investigation was appropriate. Obviously we
17 would have to share it with the Chief Executive and
18 they would have to be in agreement with that. But
19 effectively, yes, it was the body that would have
20 decided that. 12:34
21 193 Q. Were other decisions such as exclusion?
22 A. That would be a decision of the Case Manager, but the
23 Oversight Group may have had a view, which it would
24 have shared with the Case Manager.
25 194 Q. And the Case Manager was ultimately Dr. -- 12:34
26 A. Dr. Ahmed Khan.
27 195 Q. Was he consulted on the exclusion decision? Did he
28 make that decision?
29 A. It would have been his decision. We would have advised

1 on what our view was on that, and in this case quite
2 forcibly. Obviously Dr. Khan at the stage of the
3 Oversight Committee hadn't been appointed, but when he
4 was appointed that would have been his decision but in
5 consultation with Medical Director or Director of HR 12:35
6 and the Chief Executive.
7 196 Q. Terms of Reference for an investigation if an
8 investigation is to be conducted formally or
9 informally, whose role is that?
10 A. It's usually drawn up by the Director of HR on behalf 12:35
11 of the Oversight Committee, and obviously agreed by the
12 Oversight Committee.
13 197 Q. Just scrolling down, just to get the Clinical Manager
14 and the nominated HR Case Manager would be responsible
15 for investigating the concerns raised and assessing 12:36
16 what action should be taken in response. Possible
17 action could include no action required, informal
18 remedial action, formal investigation or
19 exclusion/restriction. The Clinical Manager and the HR
20 Case Manager are not part of the Oversight Group? 12:36
21 A. That's correct.
22 198 Q. But from what you have just said, the Oversight Group
23 has taken from the Clinical Manager the duty of
24 deciding what action should be taken, in your Trust?
25 A. In practice, that's the way it's worked, yes, that's 12:36
26 correct. You could argue that I was the Clinical
27 Manager as the Medical Director, and the Director of HR
28 was the -- but you are correct in saying that that
29 decision was often taken, the recommendation was made

1 from the Oversight Committee.
2 199 Q. These were the kinds of issues that, I think, were
3 regarded as getting into a little difficulty and
4 requiring the 2017 changes --
5 A. Yes, that's right. 12:37
6 200 Q. -- to more properly recognise the role of the Case
7 Manager?
8 A. You know, we did recognise that needed to change, and
9 that paper was in preparation for quite a while before
10 we eventually implemented it. 12:37
11 201 Q. The first meeting of the Oversight Group took place in
12 September, isn't that right?
13 A. That's correct.
14 202 Q. If we put up on the screen, please, WIT-17882, 55.3.
15 By this stage on the timeline you've heard from 12:38
16 Mrs. Corrigan in August, that causes you to instruct
17 Mr. Gibson to provide a screening report. That
18 screening report is received. Mr. Haynes speaks to you
19 in September about what you have described as
20 significant clinical issues. 12:39
21 A. Yes.
22 203 Q. You say: "After the phone call I would have spoken
23 directly to Mrs. Toal and to Simon Gibson to establish
24 and arrange an oversight committee meeting to discuss
25 the issues raised. I asked Simon Gibson to contact the 12:39
26 National Clinical Assessment Service prior to the
27 oversight meaning to discuss possible approaches to
28 addressing the issue raised. The oversight meeting was
29 then arranged for 13th September."

1
2 You will recall that in his screening report,
3 Mr. Gibson rounds off with a recommendation that there
4 should be an NCAS type or an NCAS-led assessment of
5 Mr. O'Brien's practice. Was that further considered? 12:39
6 A. Yes. The first thing to say is that the recommendation
7 was going beyond really his remit for that screening
8 report and that we weren't asking him for
9 recommendations, we were asking him to provide the
10 information. But, that said, NCAS would always be 12:40
11 involved if we were considering an MHPS process of any
12 sort at the very outset, you would consider the various
13 ways they might be involved. My experience would be
14 often that they would want us to conclude, to go
15 through the MHPS process and they would obviously be 12:40
16 involved in key steps as to whether you were
17 considering exclusion or not, and they want to be
18 informed at the end of the process what the
19 recommendations were. They would often be prepared to
20 then help with possible solutions to an issue if that 12:40
21 was appropriate. We would keep that discussion going
22 with them live. We would rarely come in right at the
23 start before we'd done our own investigation. I've
24 never known that to happen. We would inform them of
25 what we were doing and they would guide us as to the 12:41
26 steps.
27 204 Q. Yes. Plainly, Mr. Gibson's suggestion or
28 recommendation contained in that screening report had
29 been made, you say, beyond his --

1 A. I believe.
2 205 Q. -- authority. It had been made or put on paper before
3 he had spoken to NCAS. His opportunity to speak to
4 NCAS comes later. We can see that following contact
5 with NCAS on 7th September they write to him. If we 12:41
6 just look at what they say back to him. It's
7 AOB-01049. We can see that this letter from NCAS to
8 Mr. Gibson is dated 13th September 2016. The Oversight
9 Group met on that date. They had not received this
10 report or this letter by the start of the meeting, by 12:42
11 the time of the meeting, which was a 10a.m. meeting.
12 That letter came in much later in the day, isn't that
13 right?
14 A. I think that is. I am not entirely sure but I believe
15 that's the case. 12:42
16 206 Q. Yes. Looking at what NCAS are saying. Scroll down
17 please. They reflect the history as reported to them.
18 He has a backlog, it's recorded here of about 700
19 review patients. It's recorded that this is different
20 to his Consultant colleagues who have largely managed 12:43
21 to clear their backlog. Do you know that to be
22 correct, that comparison?
23 A. I wouldn't be absolutely sure of the figures at that
24 stage.
25 207 Q. But was he lagging behind? 12:43
26 A. He was certainly lagging behind his colleagues.
27 I don't know of the exact figures.
28 208 Q. All of them? Was it verified by Mr. Gibson?
29 CHAIR: Was there not something, Mr. Wolfe, in

1 Mr. Gibson's letter that we read saying something about
2 the other colleagues managing to do the work within
3 three or four days, or was that triage?
4 MR. WOLFE KC: That was triage.
5 A. Yeah. 12:44
6 209 Q. Moving through the letter.
7 A. I am not sure is the answer to your question. I don't
8 know.
9 210 Q. The triage issue is highlighted. Can take him up to 18
10 weeks to triage a referral. You told me he often takes 12:44
11 patient charts home with him and doesn't return them
12 promptly. The problem caused by that.
13
14 "He told me that his note-keeping has been reported as
15 very poor and on occasions there are no records of 12:44
16 consultations. To date you are not aware of any
17 patient harm from this behaviour but there are
18 anecdotal reports delayed referral to Oncology."
19
20 Then over the page is a discussion. Sorry, just before 12:45
21 we get to the advice:
22
23 "The doctor has been spoken to on a number of occasions
24 about this behaviour. No records of this were kept.
25 He was written to in March of this year seeking an 12:45
26 action plan to remedy the deficiencies, but there's
27 been no obvious improvement to date." It is suggested.
28
29 The options are laid out. The Trust has a policy in

1 removing charts from the premises. This could lead to
2 disciplinary action. He was warned about this
3 behaviour in the letter sent, so it would be open to
4 you to take immediate disciplinary action, and that was
5 one possibility. But it's advised: 12:45
6
7 "I would suggest that he is asked to comply immediately
8 with the policy. With regard to poor note-keeping they
9 suggest that it might be useful to conduct an audit if
10 there's evidence of substantial number of consultations 12:46
11 with no record in the notes this is a serious matter
12 and may merit disciplinary action and possible referral
13 to the GMC. If, after the audit, it appears that
14 a concern is more about the quality of the notes rather
15 than there being no notes at all, a review by NCAS may 12:46
16 be appropriate. If you wish to consider that, get in
17 touch."
18
19 Then: "The problems with the review patients in the
20 triage could best be addressed by meeting with the 12:46
21 doctor and agreeing with way forward. It was discussed
22 with NCAS the possibility of relieving him of theatre
23 duties in order to address the backlog."
24
25 That's the advice that was being put forward. There's 12:46
26 provision for a review date on 7th October.
27
28 The meeting of the Oversight Group took place that day,
29 as we have heard. Mr. Gibson seems to recall that the

1 NCAS advice was discussed at the meeting. Presumably
2 what he means by that is the advice he may have
3 received verbally --
4 A. Yes.
5 211 Q. -- on the telephone prior to the letter coming in. 12:47
6 Let's just go to the minutes of the September meeting,
7 it's there to be found at TRU-00026. The meeting was
8 attended by yourself, Mrs. Toal, Mrs. Gishkori and
9 Malcolm Clegg. The first page concerns another doctor,
10 CT. I'm not interested in that. Just showing you who 12:48
11 was present. Then scrolling down to the AOB case. The
12 Oversight Group is informed about the background,
13 including 23rd March letter raising concerns about his
14 practice, asking him to develop a plan and not
15 prompting a response with the same concerns continuing 12:48
16 to exist after six months. At preliminary
17 investigation I should say Mr. Gibson's material had
18 been circulated in advance of the meeting. The
19 preliminary investigation has taken place on paper and,
20 in view of this, the following steps were agreed: 12:49
21 Mr. Gibson is to draft a letter for Colin Weir, that's
22 the --
23 A. Clinical Director.
24 212 Q. -- Clinical Director. And Ronan Carroll to present to
25 Aidan O'Brien. 12:49
26
27 "The meeting with Aidan O'Brien should take place next
28 week and this letter" -- I have just lost the screen
29 momentarily.

1
2 "This meeting is to take place next week and the letter
3 should inform Mr. O'Brien of the Trust's intention to
4 proceed with an informal investigation under MHPS at
5 this time. It should also include action plans with 12:50
6 a four-week timescale to address the four main areas of
7 his practice that are causing concern", and they are
8 set out there.
9
10 "Esther Gishkori to go through the letter with Colin, 12:50
11 Ronan and Simon prior to the meeting and AOB" -- Aidan
12 O'Brien -- "to be informed that a formal investigation
13 may be commenced if sufficient progress is not being
14 made within the four-week period."
15 12:50
16 Do you recognise any of the -- within what is proposed
17 there?
18 CHAIR: It might be an appropriate time to take our
19 lunch break. I think if we do, I'm sure the technology
20 issues can be -- if you want to finish this one 12:51
21 question.
22 213 Q. MR. WOLFE KC: Just finish with this meeting, if we
23 can, Dr. Wright. We have looked at the letter and it's
24 probably fair to characterise the NCAS advice as
25 setting out various options. 12:51
26 A. Yes, I think --
27 214 Q. It's not particularly prescriptive.
28 A. That's right. We hadn't seen the letter obviously at
29 this stage, but, yes, the discussion from Mr. Gibson.

1 215 Q. Do you think NCAS advice was discussed?
2 A. I can't remember, actually. I mean, it would have been
3 minuted if it had been, I think. It usually would have
4 been minuted.
5 216 Q. The option that -- 12:52
6 A. I think we would have been very wary about discussing
7 something we hadn't seen, you know, a hearsay from
8 a phone call is one thing. No, we didn't have it in
9 front of us for that meeting.
10 217 Q. Yes. I will just read out an e-mail from Mr. Gibson 12:52
11 that he sent to you on 28th September, two weeks after
12 the NCAS report came in. He said:
13
14 "I sought advice from NCAS which was discussed when the
15 Oversight Committee met", and he suggested that it 12:52
16 should be filed whilst what he describes as the
17 informal work with Mr. O'Brien was underway, and we are
18 going to come on to look at that informal work. He
19 certainly think it's discussed. It's not reflected in
20 the letter. 12:53
21 A. I can't recall to be honest. I am sure he has some
22 recollection of it.
23 218 Q. Just for your note --
24 A. Mr. Gibson would have made the minutes. He would have
25 recorded the minutes. 12:53
26 219 Q. Yes. The e-mail to which I refer, members of the
27 Panel, is WIT-41573. Are we going to have the letter
28 up again, please? No.
29 A. I would imagine it would have been -- I mean, there

1 might have been some mention of it but without actually
2 seeing the letter we couldn't have formally considered
3 it, really.
4 220 Q. Yes. The meeting leading to a decision to adopt an
5 informal MHPS investigation, along with a meeting with 12:54
6 Mr. O'Brien setting out a programmed or time-tabled
7 series of actions that would be required of him, who
8 led with those suggestions, can you recall?
9 A. Probably, me.
10 221 Q. The fact that they are recorded as actions, does that 12:54
11 suggest that there was consensus reached in terms of
12 what should happen next?
13 A. Yes, yes.
14 222 Q. What was the degree of concern reflected at that
15 meeting about the issues that had been raised? 12:54
16 A. Very significant and that this needed to be bottomed
17 out relatively quickly. He gave a four-week timescale
18 for action there so the level of concern was high.
19 223 Q. Can you recall whether you drew the Committee's
20 attention to what Mr. Haynes had been telling you? 12:55
21 A. I can't remember, to be honest.
22 224 Q. Presumably the focus was the Gibson screening report
23 that was with the committee?
24 A. Yes.
25 225 Q. In committees such as that, if there's dissent or 12:55
26 disagreement with the direction of travel or the action
27 that's going to be taken, is it generally talked
28 through and resolved if it can be?
29 A. Yes. I mean, absolutely, yes. I mean, the people here

1 on the committee are all Directors of HR, Director of
2 Medicine, Director of Operations, or Director of
3 a service group, and we would have robust and detailed
4 discussions around any actions, and differences of
5 opinion would be aired frequently and resolved with an 12:56
6 action plan at the end of it. It would have been
7 fairly normal business. But once we agreed the action
8 plan, then that would have been the decision.
9 226 Q. Can you recall any dissent or disagreement about the
10 actions to be taken? 12:56
11 A. No on that occasion. A long time ago, but I can't,
12 I think it was a fairly unanimous decision on the way
13 forward at that meeting. I don't remember any
14 particular dissent.
15 227 Q. Other options would have been available to you, 12:56
16 including a formal MHPS investigation and all that came
17 with that. Was that thought about?
18 A. It would have been considered.
19 228 Q. What do you see as the distinction in terms of what
20 would be required of the circumstances or of the issue 12:57
21 of concern that would influence you down one path or
22 the other?
23 A. If there had been evidence of patient harm.
24 229 Q. Is that, in your mind, a primary determinant?
25 A. Yes. It would be unusual to proceed straight to 12:57
26 a formal investigation without the informal aspect, and
27 usually in an informal investigation, I mean timescale
28 is a big issue I know in MHPS, but usually the informal
29 part can be completed fairly quickly, within a few

1 weeks, so it's usually better to go down that route and
2 sometimes it's possible to resolve the issues by that
3 means. But, on occasions, you would move straight to
4 a formal but you would have to have very good evidence
5 for doing that. It would have to be extenuating 12:58
6 circumstances and, in my mind, that would be evidence
7 of patient harm.
8 230 Q. Okay. We will look after lunch at what follows from
9 this meeting. 2 o'clock?
10 CHAIR: 2 o'clock, Mr. Wolfe. Thank you. 12:58
11
12 THE INQUIRY ADJOURNED FOR LUNCH
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1 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:
2
3 CHAIR: Good afternoon, everyone.
4 MR. WOLFE KC: Good afternoon.
5 231 Q. Dr. Wright, we were just discussing over lunchtime 14:05
6 maybe the prospects of not finishing you today.
7 I don't think, given energy levels in the room amongst
8 all of us, we will sit much beyond 4:00 today, so the
9 prospects are having to come back to speak to me again.
10 14:05
11 Just one point arising out of the correspondence that
12 NCAS sent in to Mr. Gibson on 13th September 2016.
13 AOB-01049, please. We have already looked at this
14 letter in some depth, but just a point in it that
15 I want to go back to. Just the bottom of the page, 14:06
16 please. Just the last line, it says, this is
17 reflecting back, obviously, to Mr. Gibson and what he
18 has told NCAS. I think it was Dr. Fitzpatrick was the
19 author of this letter:
20 14:06
21 "To date, Mr. Gibson, you are not aware of any actual
22 patient harm from this behaviour but you tell us there
23 are anecdotal reports of delayed referral to Oncology."
24
25 Do you know the source of that concern, the delayed 14:06
26 referral to Oncology, the anecdotal source of that?
27 A. No, is the short answer. I wasn't aware of any
28 complaints or issues or SAIs, or anything of that
29 nature around this at this time. This may have been

1 tittle-tattle, I don't know.
2 232 Q. He's been sent to provide you with the information in
3 August, which he does in a screening report?
4 A. Yes.
5 233 Q. I don't think it's mentioned in that? 14:07
6 A. No, I don't think so. I don't think so.
7 234 Q. He is taking instruction from you, albeit that he's an
8 experienced man, by my sense of it anyway, he has been
9 in the Trust for some time by this. You don't recall
10 giving him this information? 14:07
11 A. I don't recall giving it to him, no. I mean no,
12 I can't, I'm not sure where that came from.
13 235 Q. Yes. Okay. Prior to lunch, we were looking at the
14 Oversight Group's meeting of 13th September. I just
15 want to pick up on a few strands coming out of that, 14:08
16 please. WIT-17832, and at the top of the page. Within
17 your witness statement you are reflecting on what has
18 taken place on 13th September. At that meeting you are
19 saying you were informed that a formal letter had been
20 sent to Mr. O'Brien on 23rd March 2016. That's the 14:08
21 Mackle/Trouton initiative, and all of that. It then
22 says:
23
24 "A preliminary investigation has taken place conducted
25 by Mr. Weir, Clinical Director. After this Simon 14:08
26 Gibson was asked to draft a letter."
27 A. Yes.
28 236 Q. Just the "Weir" point. We know of no preliminary
29 investigation conducted by Mr. Weir in September, and

1 you've corrected many things in your statement.
2 A. Yes.
3 237 Q. I don't know that you have corrected that?
4 A. No. That is a mistake and I was getting mistaken for
5 the subsequent intervention of Mr. Weir slightly later. 14:09
6 Apologies for that.
7 238 Q. I think you repeated it in your evidence this morning?
8 A. Yeah.
9 239 Q. I stopped you on that to clarify?
10 A. Yeah. 14:09
11 240 Q. Your understanding, when you think about it now, is?
12 A. When I think about it now, the preliminary
13 investigation was -- the initial investigation was done
14 by Mr. Gibson and then we subsequently asked Mr. Weir
15 to do further work. 14:10
16 241 Q. But that was --
17 A. Which is.
18 242 Q. Just to nail it down and be absolutely clear. The
19 further work that Mr. Weir did was by way of a report
20 in - let me just get the date. It was by way of 14:10
21 a further report to a case conference?
22 A. That's right.
23 243 Q. Which was held on 26th January 2017.
24 A. That is correct, yes.
25 244 Q. When he provided that report, he was wearing the hat of 14:10
26 Case Investigator?
27 A. Yes.
28 245 Q. Having been appointed to that role in late December
29 when the Oversight Group decided that there would be

1 a formal MHPS investigation?
2 A. That is correct, yes. That is correct.
3 246 Q. Is that clear? Okay. It probably is worth repeating
4 the point that the process written down on paper,
5 whether it's the MHPS or the guidelines, would put the 14:11
6 role for the provision of such a report in the hands of
7 the Case Manager -- sorry, the Clinical Manager?
8 A. Yes.
9 247 Q. We have had that debate?
10 A. Yes. 14:11
11 248 Q. You go on to say, with regard to that meeting:
12
13 "On this occasion, Mrs. Gishkori was not in attendance
14 but was represented by Mr. Carroll."
15 14:11
16 Again, you haven't corrected that, but we have looked
17 at the minutes for 13th September Oversight Group and
18 Mrs. Gishkori was in attendance, if that record is
19 correct?
20 A. That's right, yes. You are correct. 14:12
21 249 Q. I'm obliged, thank you. What appears to emerge after
22 that meeting and consistent with the action which was
23 recorded in the minute, was a draft letter issued by --
24 or drafted by Mr. Gibson. Let's pull that up, please.
25 It's TRU-251429. Forgive me, this is the preamble to 14:12
26 it, but let's just go with this before we move to the
27 letter. Assumedly very shortly after the meeting
28 concludes, it's the same day, 13th September. He is
29 enclosing a draft letter for comments back. Knowing

1 that his letter is containing some targets for
2 compliance by Mr. O'Brien, he informs Esther Gishkori
3 that he has phoned Martina Corrigan, presumably, with
4 regard to what is a realistic yet challenging target
5 with regard to the Outpatient review backlog and the 14:13
6 detail of her views is set there. We have gone with 70
7 per month every month until the end of December,
8 "operationally this is your call" he is saying to
9 Mrs. Gishkori, "I just wanted you to be aware of the
10 thought processes behind the target chosen." 14:14
11
12 This is consistent with what was being discussed at the
13 Oversight Group, if we scroll down the page to the next
14 page, please. Let me just see if I'm right with that.
15 Yes. This is the letter that was proposed to go to 14:14
16 Mr. O'Brien:
17
18 "I am writing to inform you of the Trust's intention to
19 proceed with an investigation under MHPS", and the
20 context is set. That's 13th March letter copy 14:14
21 attached, "in which a number of concerns was raised and
22 a plan was sought, no plan provided and the same
23 concerns still exist."
24
25 There would be an informal approach which would 14:15
26 consider four areas of practice, and then they are set
27 out below. Triage and the expectation that this would
28 be completed within the standard 72 hours is set;
29 Outpatient review backlog, he's expected, it says here,

1 to produce a reduction of a minimum of 70 per month;
2 patient notes at home; he is told that it's the
3 expectation of the Trust that all hospital notes at his
4 house would be returned to Head of the Service within
5 24 hours, there would be no exceptions to this; once 14:15
6 these charts are returned, they would be recorded and
7 their location tracked on PAS, et cetera.
8
9 Area 4: Recording outcomes of consultations; again,
10 the expectation is set out that there would be 14:16
11 contemporaneous notes and it says: "By way of
12 a checking mechanism, a clinical note review would be
13 undertaken of 20 sets of notes seen by yourself in the
14 four weeks following the date of this letter to assess
15 your compliance with this expectation." 14:16
16
17 Then it says: "In late October an assessment will be
18 made on your progress. Should the Trust conclude that
19 insufficient progress is being made, a formal
20 investigation will ensue under the Terms of Reference." 14:16
21
22 He is offered the services of Care Call, and it is
23 intended that the informal investigation will be
24 concluded by 31st October.
25 14:16
26 That's a letter you would have seen?
27 A. Yes.
28 250 Q. By contrast with the letter that went in March, it's
29 specific, time-tabled, it describes the process and

1 describes the risk of escalation in the event of
2 non-compliance. That letter would have been seen by
3 Mrs. Gishkori then; isn't that right?
4 A. I believe so.
5 251 Q. If we turn to TRU-257636. Just go to the bottom of 14:17
6 that page, please. This is the day after the Oversight
7 Group meeting. Mr. McAllister is in correspondence
8 with Mrs. Gishkori. I am not sure what prompts this
9 but he says:
10 14:18
11 "Further to our meeting today" -- that is McAllister
12 and Gishkori -- "here is the only communication that
13 I have received on the subject".
14
15 I am not sure to what he refers, but no matter. 14:18
16 Scrolling up the page, please, she says:
17
18 "Thanks. At least you have a starting point. I am
19 clear that I wish you and Colin" -- assumedly Colin
20 Weir -- "to take this forward ..." 14:18
21 This is in the context of confidential letter to Aidan
22 O'Brien.
23
24 "... and explore the options and potential solutions
25 before anyone else gets involved. We owe this to 14:19
26 a well-respected and competent colleague. I can
27 confirm that you will have communication in relation to
28 this before the end of the week."
29

1 Do you understand what's going on here?
2 A. It would appear that Mrs. Gishkori is exploring an
3 alternative way forward, but I'm only reading that.
4 252 Q. I thought maybe you might appreciate it more than that.
5 Let's just take you to some other e-mails. TRU-25742, 14:19
6 please. Sorry, you are right. TRU-257642. Thank you,
7 Mr. Beech. Just scroll down. On 15th September, two
8 days after the meeting, Vivienne Gishkori is writing to
9 you and Mrs. Toal and she is saying:
10 14:20
11 "Following our Oversight Committee on the Tuesday, the
12 13th, I had a meeting with Charlie McAllister and Ronan
13 Carroll. I mentioned the case that was brought to the
14 oversight meeting in relation to Mr. O'Brien and the
15 plan of action. Actually Charlie and Colin Weir 14:20
16 already have plans to deal with Urology backlog in
17 general, and Mr. O'Brien's performance was of course
18 part of that. Now that they both work locally with him
19 they have plenty of ideas to try out, and since they
20 are both relatively new into the post I would like to 14:21
21 try their strategy first. I am therefore respectfully
22 requesting that the local team be given three more
23 calendar months to resolve the issues raised in
24 relation to Mr. O'Brien's performance. I appreciate
25 you highlighting the fact that this long-running issue 14:21
26 has not yet been resolved, however given the trust and
27 respect that Mr. O'Brien has won over the years, not to
28 mention his life-long commitment to the Urology Service
29 which he built up single-handedly, I would like to give

1 my new team to resolve this in context and for good.
2 This I feel would be the best outcome all round."
3
4 What did you make of that correspondence when you
5 received it? 14:21
6 A. I was very frustrated. If Mrs. Gishkori and her team
7 had other plans to deal with this, that should have
8 been brought to the Oversight Committee meeting for
9 that discussion. We had taken a decision as to the way
10 forward, and it would appear that there was an attempt 14:22
11 here to change that decision. It might have been for
12 the best reasons and the best of intentions, but
13 I didn't find it was helpful.
14 253 Q. Yes. Can I just draw your attention to correspondence
15 between you and Mr. Gibson around that? We will come 14:22
16 back to this e-mail in a moment. But briefly,
17 WIT-34100. Down the page, please. Mr. Gibson is
18 obviously pushing for some progress. He is writing to
19 you saying:
20 14:23
21 "Please see below. Has there been an update in
22 relation to the meeting regarding Dr. O'Brien?"
23
24 I think the bit below is communication in relation to
25 the letter he had drafted. Scrolling up the page, your 14:23
26 frustration, I think, with Mrs. Gishkori is politely
27 exposed; you say:
28
29 "Classic Esther, about-turn after the meeting and

1 I asked her to outline her plans in detail for us to
2 consider. We haven't agreed to any change yet."
3
4 As you've said, she's about-turning or proposing to
5 about-turn on what had been nailed down in her presence 14:24
6 at the oversight meeting?
7 A. That's correct, and I think frustration comes out in
8 that e-mail.
9 254 Q. Why classic? Had she a reputation for such behaviour?
10 A. That would be unfair to say that, I think. There had 14:24
11 been a number of occasions where decisions had been
12 changed after discussion, but I couldn't give you any
13 hard examples.
14 255 Q. We know from the MHPS arrangements that, for example,
15 the guidelines, I will not bring them up on the screen, 14:24
16 but the Trust's guidelines at that time, paragraph 2.7
17 of the 2010 guidelines, which can be found at
18 TRU-83689, they say, where possible, and appropriate,
19 a local action plan should be agreed with the
20 practitioner and resolution of the situation by 14:25
21 a monitoring of the practitioner by the Clinical
22 Manager should be tried as, if you like, a first
23 initiative. Is that what Mrs. Gishkori is about as
24 opposed to the rather harder-nosed approach contained
25 in the Gibson letter, albeit that it had been agreed? 14:25
26 A. I think she obviously had a different interpretation of
27 what the local action plan was. I think we had been
28 down the route already before the oversight meeting
29 of -- I had a very light touch with this. We had

1 agreed a local action plan, outline how it should be
2 implemented with time scales and returns, and that's
3 what we should have stuck to. This was an alternative
4 local action plan that was being introduced, which
5 might eventually have had some merit but it wasn't what 14:26
6 was agreed.
7 256 Q. Going back to Mrs. Gishkori's e-mail to you, let's see
8 your response. If we go to TRU-257641, you are
9 replying to her saying:
10 14:27
11 "As Director of the Service naturally we have to listen
12 to your opinion. Before I would consider conceding to
13 any delay in moving forward with what was our agreed
14 position after the oversight meeting, I would need to
15 see what plans are in place to deal with the issues and 14:27
16 understand how progress would be monitored over the
17 three-month period", which she had proposed.
18
19 "Perhaps when we have seen these, we could meet again
20 to consider." 14:27
21
22 Is this one of these areas where, as we discussed at
23 the start of the morning's evidence, that professional
24 and the medical management line and the separation of
25 that is sometimes not ideal rather than it residing in 14:27
26 one person's hands to take a decision?
27 A. I think it could be seen as an example of that.
28 I think, though, in fairness, many of these ideas are
29 coming forward from the medical community within her

1 Directorate. I think the most frustrating thing here
2 was that she was present at this meeting and agreed to
3 it, agreed the way forward, and if she had had
4 reservations about the way forward, they should have
5 been brought to the table for open discussion, or if 14:28
6 she felt she would have within a day or two, she should
7 have told us that. This was stepping outside the
8 process and, in my opinion, was only likely to delay
9 resolution of the matter.
10 257 Q. This is now mid-September. The issues have been 14:28
11 brought to your attention in January. Mr. O'Brien is
12 presumably unaware of these discussions. He had only
13 been troubled to address his mind to the issues in
14 March. No follow-up on that, and no plan from him in
15 the context of -- 14:29
16 A. Which is why it was very important to progress this
17 rapidly now in a more controlled manner and why he
18 should have been informed of the decision of the
19 Oversight Committee fairly soon after the meeting, as
20 was agreed. 14:29
21 258 Q. The plan that seemingly -- Mrs. Gishkori has, I think,
22 copied or forwarded your e-mail asking for a plan,
23 chapter and verse, around this, "and my response will
24 be", she flags to Messrs Weir, McAllister and Carroll
25 and the response that emerges is -- if we just scroll 14:30
26 on up the page, please -- an eight-point initiative in
27 the hands of Colin Weir. I suppose the fine detail of
28 this is perhaps not terribly important but what this
29 approach of Mrs. Gishkori and the two people, two men

1 speaking to her on this, is to take it out of the MHPS
2 arrangement?
3 A. That's correct.
4 259 Q. The timetable inserted into Mr. Gibson's letter is much
5 more strict and measurable than what is contained in 14:31
6 this plan; isn't that right?
7 A. I believe so, yes.
8 260 Q. He is, nevertheless, that is Mr. O'Brien, if we scroll
9 up the page just further, we can see, I think, that
10 Mr. Carroll amends the plan slightly. He further 14:31
11 annotates the plan, making it clear, for example, that
12 at the first meeting with Mr. O'Brien the context will
13 be explained, the proposed plans need to be shared.
14 You can see, for example, that he is emphasising
15 clearer communication around some of these issues. 14:32
16 Ultimately did you see these plans?
17 A. No, I don't think I did. I don't have any recollection
18 or trail that would suggest I did.
19 261 Q. In terms of - maybe you don't see it this way - the
20 power dynamics of the relationship between you and 14:32
21 Mrs. Gishkori, do you have to give way to the Service
22 on these issues or is this a matter in which you could
23 have dug in your heels as Medical Director and said,
24 'we have a decision of the Oversight Group, we will go
25 with this'? 14:33
26 A. This had never happened before, in my experience, so it
27 was a very unusual situation. What we did was, we had
28 a discussion with the Chief Executive, as I recall,
29 with Mrs. Gishkori and myself, as to how we handle

1 this. It would have been very difficult to -- I mean,
2 all the actions that were decided by the Oversight
3 Committee would have to be implemented at operational
4 level. It would be very difficult to override
5 decisions taken by the Directorate if you didn't have 14:33
6 the support of the Operational Director. We had that
7 meeting and initially I think the consensus was that
8 they would agree to depart from the Oversight
9 Committee's ruling in the first instance. However,
10 events overtook issues rapidly, in any case, in that 14:34
11 Mr. O'Brien went off on sick leave.
12 262 Q. I have to correct you on that. Mr. O'Brien didn't go
13 on sick leave until November?
14 A. Okay.
15 263 Q. This is the middle of September? 14:34
16 A. Okay.
17 264 Q. There's another Oversight Group meeting in between.
18 A. Right.
19 265 Q. We will just look at that in a moment.
20 A. I suppose the short answer, I mean, could I have dug my 14:34
21 heels? Yes, I could have, but I think it would have
22 been very difficult to have implemented a decision
23 without the active cooperation and support of the
24 relevant Service Director.
25 266 Q. Mm-hmm. The developments here occurred after an 14:34
26 oversight group meeting in which there had been no
27 input from clinical management?
28 A. Mm-hmm.
29 267 Q. Mr. Weir's voice or opinion wasn't in that room?

1 A. Mm-hmm.
2 268 Q. Or Dr. McAllister's, for that matter. Mrs. Toal, if we
3 turn to WIT-41138, she was obviously a party to the
4 decision as well as a member of the Oversight Group.
5 She, at paragraph 26.3, reflects upon the absence of 14:35
6 clinical management input and she said:
7
8 "This meant that the Oversight Group was driving the
9 decision-making in relation to the early actions in
10 September 2016 as opposed to the Clinical Manager. 14:36
11 Whilst the Oversight Group has outlined in paragraph
12 2.5 of the Trust guidelines what's described as
13 a quality assurance role, the absence of the Clinical
14 Manager at the meetings meant that the Oversight Group
15 determined the actions to be taken. On reflection, 14:36
16 this resulted in an approach in September 2016 which
17 was, in effect, contrary to section 1 paragraph 15 of
18 MHPS, which outlines that the role of the Clinical
19 Manager is to identify the nature of the problem or
20 concern and to assess the seriousness of the issue on 14:36
21 the information available. What happened in the
22 Mr. O'Brien case was that a non-medical assistant,
23 Simon Gibson, took the lead in the preliminary
24 inquiries".
25 14:37
26 If we scroll down, just skipping the next few lines:
27
28 "The absence of the Clinical Manager Mr. Weir also
29 permitted a divergence both from what was the agreed

1 course of action at the oversight meeting on that date.
2 Those agreed actions were subsequently debated outside
3 of the meeting by the Clinical Managers."
4
5 We have just looked at the results of that. The views 14:37
6 of clinical management, spoken outside of the Oversight
7 Group, were what held sway, whereas what Mrs. Toal
8 seems to be suggesting here is that those views ought
9 to have been expressed within the Oversight Group where
10 they could have been properly debated -- 14:38
11 A. Yeah.
12 269 Q. -- and understood before key decisions were made?
13 A. I think I would certainly support the move towards
14 doing that in the subsequent amended Trust policy, and
15 that was genuinely very helpful. However, given that 14:38
16 the oversight group was constituted in the way it was,
17 it would have been the Service Director's
18 responsibility to bring those views to the table at
19 that meeting. It wasn't that they couldn't be heard,
20 but I agree, it's much better to have them present at 14:38
21 the table. That was certainly, you know, a conclusion
22 that we all drew from this incident.
23 270 Q. Mm-hmm. You said earlier this morning that a concern
24 that you quickly identified in coming into this job was
25 the need to put things on proper procedural footing. 14:39
26 A. Mm-hmm.
27 271 Q. You recognised a culture where things were -- in some
28 departments, not all of them -- allowed to be dealt
29 with informally, were allowed to fester. This is an

1 example, is it not, of an informality, triggered by
2 a deference or a reputational respect as opposed to
3 doing it the proper way, through an informal MHPS
4 process with a properly time-tabled action plan?
5 A. It's an example of that, yes. 14:40
6 272 Q. The fact that you, as Medical Director, weren't able to
7 get it back on the rails at that point, back to the
8 Oversight Committee's decision, is that just
9 a reflection of, I suppose, the realpolitik of getting
10 things done in a big organisation? 14:40
11 A. We did eventually get it back on track but it took
12 a while, in that we eventually got back to the MHPS
13 process. This plan, as was suggested, as far as I'm
14 aware wasn't implemented fully. But, yes, very
15 difficult as a Medical Director in that situation where 14:40
16 you have a divergence of opinion. Opinion differences
17 are fine but when there is a structure that is
18 established by the Trust and that's not followed, that
19 is a difficult situation to be in. Normally in that
20 sort of situation one would be relying upon your other 14:41
21 colleagues at Trust Board level and Senior Executive to
22 help you, but we were in a situation where we had
23 a very fluid Chief Executive level, so there wasn't the
24 same continuity or strength of senior support that
25 there might normally be in that situation. 14:41
26 273 Q. You mentioned briefly a meeting with the Chief
27 Executive, with Mrs. Gishkori. Can you remember who
28 was Chief Executive?
29 A. Mr. Rice would have been at that time.

1 274 Q. Francis Rice?
2 A. Francis Rice.
3 275 Q. Was he being cast in the role of refereeing this debate
4 or how was --
5 A. He chaired the discussion which I think was cordial. 14:42
6 Eventually I think I conceded that this alternative way
7 forward may be worth trying for a while. This is not
8 what I initially would have wanted to have done, but
9 I recognised the practicalities of the situation we
10 were in. 14:42
11 276 Q. The Oversight Group meet again on 12th October. If we
12 could just pull up the record of that, please. It's
13 AOB-01079. The same people are in attendance as with
14 the September meeting a month earlier. I think the
15 redaction on the page is probably because it relates to 14:43
16 another clinician.
17
18 "Mr. O'Brien. Mrs. Gishkori reported that Mr. O'Brien
19 was going for planned surgery in November and was
20 likely to be off for a considerable period. It was 14:43
21 noted that Mr. O'Brien had not been told of the
22 concerns following the previous Oversight Committee.
23 It was also noted that a plan was in place to deal with
24 the range of backlogs within Mr. O'Brien's practice
25 during his absence. Mrs. Gishkori gave an assurance 14:44
26 that when Mr. O'Brien returned from his period of sick
27 leave that the administrative practices identified by
28 the Oversight Committee would be formally discussed
29 with him to ensure that there was an appropriate change

1 in behaviour. It was agreed this would be kept under
2 review by the Oversight Committee."
3
4 A couple of things. Did you expect that the alternate
5 plan, which involved meeting with Mr. O'Brien and 14:44
6 talking him through what was expected, as developed by
7 Mrs. Gishkori and Mr. Weir and Mr. McAllister, did you
8 expect that that meeting would have taken place by now?
9 A. Yes, I did.
10 277 Q. Did you interrogate the failure to progress it in the 14:44
11 four weeks that had elapsed?
12 A. Other than the meeting with the Chief Executive, no.
13 That was in the hands of the operational director to
14 address that. We knew we had another oversight meeting
15 coming up and that would be reviewed. That was when we 14:45
16 brought up on the further actions.
17 278 Q. We have reached 12th October.
18 A. Mm-hmm.
19 279 Q. Nothing has happened. Mr. O'Brien is still at work.
20 For all you know, in the absence of monitoring, the 14:45
21 same problems are continuing. He is not off work with
22 planned medical treatment until November. There seems
23 to have been a decision taken that it will wait until
24 after that, even though he's still in work for at least
25 another two or three weeks. How could that situation 14:46
26 have been tolerable for a Medical Director, knowing
27 that these issues were raised with concern in January
28 and then raised again, albeit in a different way by
29 Mr. Haynes, but more significantly, in terms of how he

1 had framed the concerns, in September?
2 A. Mm-hmm. It was a very difficult situation I found
3 myself in, to be honest. I think it was clear that the
4 service Directorate had a plan. It had been agreed
5 with the Chief Executive. I was very disappointed that 14:47
6 we hadn't had that meeting at this point. I felt that
7 the situation was changing by the day because we knew
8 then that Mr. O'Brien was going off on sick leave very
9 soon, and that would have to be handled sensitively,
10 obviously. But I didn't think I had the authority or 14:47
11 the ability to impose a change upon the Directorate
12 given the outcome of the last oversight meeting, at
13 that point.
14 280 Q. Can I draw your attention to this. If we pull up
15 TRU-281300. Okay. 5th October, a week before the 14:48
16 oversight meeting, Colin Weir, the author of the plan,
17 in conjunction with Mrs. Gishkori, the alternative to
18 the Oversight Group decision, is inviting Mr. O'Brien
19 to a meeting to discuss his job plan. As we scroll up,
20 we can see that various contacts in relation to this, 14:49
21 and if we go to the top of the page, T281300, it's
22 agreed that -- they agree to make contact to arrange
23 a time on 25th October to discuss a job plan.
24 A. Mm-hmm.
25 281 Q. When those in the Service have been charged with the 14:49
26 responsibility to implement an action plan, and yet no
27 emphasis at all, it appears, has been given by the
28 Oversight Group to do that as urgently as the issues
29 caught by the matter deserve. Did you know that there

1 was a plan to meet to discuss the job plan?
2 A. I don't think so. I mean, I might have been copied.
3 I don't recall. I wouldn't normally be told about such
4 things.
5 282 Q. When you see that that issue appears to be prioritised 14:50
6 and the actions arising out of what the Trust views as
7 shortcomings of practice, are not being pursued until
8 whenever, what's your reflection?
9 A. I think both could have been done. I don't think
10 there's anything wrong with meeting to discuss the job 14:51
11 plan, I think that's appropriate. Clearly it was
12 possible to arrange meetings with Mr. O'Brien and that
13 should have been pursued more urgently.
14 283 Q. Was there a fall out between you and Mrs. Gishkori
15 around this? 14:51
16 A. I wouldn't call it a fall out. We had our discussions
17 and disagreements but I wouldn't say it was a fall out,
18 no. I think, as professionals working in an
19 environment, you often have strong disagreements with
20 your colleagues and you learn to share those opinions 14:51
21 and views but to behave professionally. I would have
22 thought we had a professional and reasonably good
23 otherwise working relationship.
24 284 Q. We can see from the evidence you have given and the
25 actions that you have taken up to this point, an effort 14:52
26 to accelerate through these issues to get something
27 formal in place, encouraging Simon Gibson or directing
28 him to bring a report to the table, contact NCAS, take
29 advice and then the meeting on 13th September. Did the

1 intervention of Mrs. Gishkori after that, did that
2 essentially, and her ability to, I suppose, impose her
3 view of how it should be done, did that essentially
4 lead you to surrendering any further ability to
5 influence how this was done? 14:53
6 A. No, I wouldn't have said that at all. I had been at
7 the meeting with the Chief Executive and, in fairness,
8 I did concede to the change in approach. It wouldn't
9 have been my preferred route but I did concede to that.
10 We did have a subsequent Oversight Committee meeting. 14:53
11 We wanted to see the situation move forward. I think
12 there was a feeling that because Mr. O'Brien was about
13 to go off on sick leave, that it would be untimely to,
14 if you like, face him with the issues again in a formal
15 meeting. I suspect that was the thinking behind the 14:54
16 delay. I think that was very unfortunate but
17 understandable, but I wouldn't accept that I was
18 neutered or dis-empowered in any way. There was still
19 potential for the process that was agreed to yield some
20 fruit and there would have been when he went off, to 14:54
21 have got things back on track before he returned.
22 285 Q. Come December, you, if I can put it this way, started
23 to hear some background noise about what an SAI process
24 concerning Patient 10 -- you maybe didn't know the
25 patient's name at the time. 14:54
26 A. Yes.
27 286 Q. This was an SAI that focused on the failure of triage,
28 and there is a Radiology context to it as well. The
29 information around that was a further layer or a new

1 layer of concern for you; is that fair?
2 A. That is correct, yes. I think we were now getting into
3 the area where there was real potential for patient
4 harm and, to my mind, that escalated the situation
5 significantly. The SAI had not fully reported so this 14:55
6 was an early, if you like, progress report, on it.
7 I think we decided we wouldn't wait until the SAI had
8 completed its investigation, but to move things forward
9 on the basis of what we knew at that time.
10 287 Q. Before the next oversight meeting takes place, and one 14:56
11 is arranged for 22nd December, Mrs. Gishkori has
12 written to you to say that Mr. O'Brien has a sick line.
13 Notes that he had been holding on to had been returned
14 and the plan was to speak to him to set out the ground
15 rules for what was expected of him when he returns from 14:56
16 sick leave. You thought that reasonable, I suppose, in
17 the context that he wasn't in work.
18 A. That's right.
19 288 Q. So what else could be done?
20 A. I mean, you wouldn't speak to him when he was on sick 14:56
21 leave, that would be inappropriate.
22 289 Q. Can I have up on the screen, please, WIT-41585. The
23 bottom of the page. You are writing to Mr. Gibson
24 saying:
25 14:57
26 "Esther rang me regarding worrying developments. Aidan
27 O'Brien and lost notes. Ronan is to report tomorrow
28 with preliminary findings. I will come in tomorrow.
29 If you are about we could set up a meeting with Ronan

1 and, if possible, Mark Haynes to consider the findings,
2 Esther is off, and next steps. I don't think we can
3 wait for the formal completion of the SAI. Regards,
4 Richard."
5 14:58
6 Mark Haynes' involvement in that context, is that
7 because Mr. Weir was off?
8 A. I think so. I can't quite recall but I think Mr. Weir
9 was off on sick leave, possibly, around then, and so
10 Mark was covering some of his duties. 14:58
11 290 Q. Yes. Can you recall what exactly the update was from
12 Esther Gishkori that was a worrying development? It
13 seems to be in the context of lost notes?
14 A. Yes. I can't remember the details of that.
15 291 Q. By this stage, a summary of what was emerging from the 14:58
16 SAI process had been circulating. Can I just draw your
17 attention to that, please? AOB-01245. It's titled
18 "Dear Tracey". I don't think it has a signatory.
19 I believe it comes from the SAI team which was being
20 led by Mr. Glackin. Do you remember seeing that 14:59
21 document? It summarises the concerns that were, on
22 a preliminary basis, emerging from the SAI. If we
23 scroll down.
24 A. Yes, I think I did see it.
25 292 Q. Scroll down, please. 14:59
26 A. Certainly I was aware of the main findings of it.
27 293 Q. Yes. It sets out the number of bullet points, the
28 issues of concern. The first issue of concern was the
29 default arrangement which had been implemented in

1 '14/'15, for handling cases that had not yet been
2 triaged. The second issue was in section with patient
3 charts leaving the premises. Thirdly, a case of
4 dictation. What is said here, that Patient 10 was one
5 of 8 patients not triaged during the week in October 15:01
6 '14. The team reviewed seven other patients to check
7 whether they were okay. Six were found to have had an
8 appointment and not suffered any adverse harm. The
9 seventh patient's notes were missing, were tracked to
10 Mr. O'Brien and the notes were returned on 28th 15:01
11 November with dictation to be typed at that time, some
12 two years or so after the incident. These issues were
13 coming to the fore. Is that what drove the need for an
14 Oversight group discussion?
15 A. Yes, I think that would be right. We probably were due 15:02
16 to have an oversight meeting possibly anyway, but that
17 would have been one of the reasons why we would have
18 resumed the Oversight meeting, yes.
19 294 Q. Just pick up on the meeting itself. It took place on
20 22nd December. We can see the record at TRU-251441. 15:02
21 On this occasion Ronan Carroll is substituting for
22 Mrs. Gishkori. In advance of the meeting a list of
23 outstanding triage had been circulated to members of
24 the group. The Dear Tracey letter, which I just opened
25 to you, had been summarised and provided to the group, 15:03
26 and the draft report for the Patient 10 Serious Adverse
27 Incident had been circulated. Do you remember that?
28 A. I remember it being circulated, yes. Mm-hmm.
29 295 Q. If you just scroll down. The context is described

1 taking us to 13th September Oversight Group meeting,
2 range of concerns have been identified, it says:
3
4 "A formal investigation was recommended"
5 15:04
6 In fact, it was an informal investigation had been
7 recommended; isn't that fair?
8 A. That's right, yes.
9 296 Q. "And advice had been sought and received from NCAS. It
10 was subsequently identified that a different approach 15:04
11 was to be taken as reported to the Oversight Committee
12 on 12th October".
13
14 It records that Dr. O'Brien is scheduled to return to
15 work but, "an ongoing SAI has identified further issues 15:04
16 of concern."
17
18 Issue 1 is described, and that is the SAI issue. It
19 says:
20 15:04
21 "Part of this SAI also identified an additional patient
22 who may also have had an unnecessary delay in their
23 treatment for the same reason. It was noted as part of
24 this investigation that Dr. O'Brien had been
25 undertaking dictation whilst he was on sick leave." 15:05
26
27 That seventh patient that I referred to, the dictation
28 had arrived in to his secretary while he was on sick
29 leave. Ronan Carroll, having done some further

1 research, documents that between those dates July '15
2 to October '16 there were 318 letters not triaged, of
3 which 68 were classified as urgent, the delay ranging
4 from four up to 72 weeks. There was certain action to
5 be taken on that. If we scroll down, just quickly go 15:05
6 through these issues. Notes tracked to Dr. O'Brien on
7 PAS believed to be at his home address. Issue 3,
8 un-dictated clinics, a backlog of 60 un-dictated
9 clinics, it said, over 18 months, approximately 600
10 patients may not have had their clinic outcomes 15:06
11 dictated, and action to be taken on that.
12
13 The consideration of the Oversight Committee led to the
14 following decisions.
15 15:06
16 It has been agreed to exclude Dr. O'Brien for the
17 duration of a formal investigation under the MHPS
18 process using an NCAS approach. It was agreed that you
19 would make contact with NCAS to seek confirmation of
20 this approach and then to meet with Dr. O'Brien on 15:07
21 Friday, 30th December and follow up the decision in
22 writing. Then two other decisions agreed.
23 Appointments of Colin Weir as a Case Investigator and
24 Ahmed Khan as the Case Manager and that completed that
25 meeting's business. 15:07
26
27 The decision of the Committee to now move from, if
28 I call it Mrs. Gishkori's informal meeting approach
29 dating from the middle of September, to a formal MHPS

1 approach, what was the determining rationale for that
2 significant switch of emphasis?
3 A. I mean I had evidence from an SAI Inquiry which
4 revealed that there was significant delay to patient
5 treatment and potential or possible harm, you know, 15:08
6 impaired outcomes as a result of that. That was hard
7 information that was indisputable. For me, we'd gone
8 beyond the stages of any informal process and we now
9 had to move in a more formal manner.
10 297 Q. In reaching that decision, was that the consensus view 15:08
11 of the group?
12 A. Yes, yes.
13 298 Q. No dissent?
14 A. I'm sure we had an in-depth discussion around it but
15 I don't remember any dissent, no. 15:09
16 299 Q. The inputs into that decision, Mr. Haynes, you'd
17 suggested, as we saw earlier, that he might consider
18 attending the meeting. He didn't attend the meeting?
19 A. No. I think this just reflects the difficulty of
20 calling a meeting at short notice in a busy clinical 15:09
21 situation.
22 300 Q. What rights would he have had at the meeting?
23 A. He would have been in attendance.
24 301 Q. In attendance?
25 A. He could have been acting on behalf of Mr. Weir if 15:09
26 Mr. Weir was still off on sick leave, I can't quite
27 remember. He would have been merely there in
28 attendance, he wouldn't have had any voting rights
29 under that.

1 302 Q. Would the purpose of such attendance be to provide
2 a clinical perspective on the issues that were
3 emerging?
4 A. Yes, yes. Obviously, as a Urologist, that would have
5 been helpful. 15:10
6 303 Q. But you didn't have any clinical perspective at the
7 meeting except yours, perhaps?
8 A. That's right.
9 304 Q. I think you have sometimes described yourself as
10 essentially acting in a de facto clinical management 15:10
11 role within this?
12 A. Mm-hmm.
13 305 Q. NCAS hadn't been spoken to since September in
14 connection with this case, albeit that there had been
15 a review date marked down in their correspondence? 15:10
16 A. Mm-hmm.
17 306 Q. You were mandated by the Committee's decision to go
18 speak to NCAS?
19 A. Yes.
20 307 Q. But that's after your decision had been made? 15:11
21 A. That is correct, although obviously had there been
22 anything contradictory coming back from NCAS we would
23 have had to have considered that, but, yes, that's
24 right.
25 308 Q. The decision to appoint Messrs Weir and Khan to those 15:11
26 roles, that was taken without their input or
27 consultation with them at that stage?
28 A. At that stage, yes. Obviously we would have to meet
29 with them to get their agreement to that but that's

1 right.
2 309 Q. We spoke earlier about the decision to exclude
3 Mr. O'Brien, which has been taken at that meeting.
4 A. Mm-hmm.
5 310 Q. I understood your answer earlier to indicate that 15:12
6 Dr. Khan was the person who made the exclusion
7 decision?
8 A. That would be his decision. It was our opinion that he
9 should be excluded. Technically, the Case Manager, we
10 obviously had to appoint a Case Manager, so it would be 15:12
11 the Case Manager's decision ultimately but he would
12 have been aware of our view. So, yes.
13 311 Q. I'm struggling to follow the logic of that, given
14 events that happen. You meet with Mr. O'Brien on 30th
15 December, whatever numbers of days later, six days 15:12
16 later, eight days later. I don't see any decision on
17 the part of Dr. Khan to weigh up issues and take a view
18 that an exclusion should apply from 2nd January or
19 whatever date it's to apply from?
20 A. The intention to exclude was that of the Oversight 15:13
21 Committee. I think the final decision to do that has
22 to be the Case Manager. We hadn't appointed a Case
23 Manager at that point, so that was a difficulty.
24 Things were moving very fast, but my understanding is
25 that the Case Manager usually is the decision maker 15:13
26 ultimately. He would have known the view of the
27 Oversight Committee's decision when he took on the role
28 and didn't disagree with it. Arguably, he could have
29 had had more time to consider that. That's possibly

1 correct.
2 312 Q. I wonder are you becoming confused over two separate
3 decisions? There was a case conference on 26th January
4 at which a decision had to be made as to whether there
5 was a case to answer, and, secondly, as to whether 15:14
6 there should be continuing exclusion. Certainly
7 Dr. Khan attended that meeting. We'll look at the
8 record of that. Is that the decision which he was
9 involved in? In other words, the 26th January decision
10 to end exclusion? 15:14
11 A. He was definitely involved in that decision.
12 313 Q. Yes.
13 A. I think the problem here is, he was appointed as Case
14 Manager in between this oversight meeting and the
15 exclusion starting, had that discussion with him. 15:14
16 314 Q. The logic of that is that what he had no role
17 whatsoever in the decision?
18 A. If he disagreed with it, we would have had to have
19 listened to that. But yes, he was coming with a clear
20 view of what our view was, and it probably would have 15:15
21 been have been quite difficult to disagreed with.
22 315 Q. If the starting question is who made the decision, the
23 Oversight Committee made the decision and Dr. Khan may
24 not have disagreed with it, but he didn't make the
25 decision? The decision was made before he was 15:15
26 appointed.
27 A. The recommendation, yeah. I think this was, as
28 I recall, happening around Christmas and New Year.
29 Things were moving very rapidly at this point and we

1 were focused on keeping patients safe as our main
2 priority. Coordinating the various meetings and
3 conversations was quite challenging over those few
4 weeks, by way of explanation.
5 316 Q. I understand all of that and those are the surrounding 15:16
6 circumstances, but somebody made the decision,
7 notwithstanding that it was Christmas and all of that?
8 A. I mean there's no doubt the Oversight Committee stated
9 their intent and Dr. Khan would have been aware of that
10 when he accepted the role. 15:16
11 317 Q. You directly informed the Chief Executive of the
12 decision?
13 A. Yes.
14 318 Q. As well as the Chair of the Trust Board?
15 A. That's right. 15:17
16 319 Q. Were they separate communications to the communication
17 that happens sometime, I think, later in January, where
18 you go to the Trust Board?
19 A. Yes. I would have met with the Chief Executive in his
20 office probably within hours or within days -- well 15:17
21 probably within hours of this meeting. The Chair,
22 a short time afterwards, whenever I could have -- when
23 she would have been in the Trust, so my recollection is
24 we met in Trust HQ when they were in over that
25 Christmas week at some point. I can't remember the 15:17
26 exact day, but I literally walked into the office and
27 asked to see them.
28 320 Q. Did you see them separately?
29 A. Yes, yes, separately. I don't think they were there at

1 the same time.
2 321 Q. How did they receive the information?
3 A. Mr. Rice was very understanding. He was obviously
4 aware of the ongoing difficulties and understood and
5 was supportive. When I had to see Mrs. -- I have 15:18
6 a mental blank -- Brownlee, she listened quietly and
7 I was aware obviously there was a friendship between
8 Mrs. Brownlee and Mr. O'Brien, but she listened
9 professionally and she agreed she would identify
10 a Trust Board member to act as the designated person, 15:18
11 as was her role, and she was quite understanding.
12 322 Q. The purpose in speaking to them was the formality of
13 informing them that an employee, a clinical employee
14 had been excluded?
15 A. That was one aspect of it. As far as the Chief 15:19
16 Executive, he needed to be aware that it was a formal
17 exclusion or an immediate exclusion of one of his
18 employees and he needed to be aware of the reasons for
19 that, so that was simply a matter of updating him on
20 that. For Mrs. Brownlee it would have been the need to 15:19
21 appoint a designated Board member in the first
22 instance.
23 323 Q. What was the reason for the exclusion?
24 A. We discussed the case with NCAS, who were in agreement
25 with our decision for immediate exclusion. This is not 15:20
26 a formal exclusion. It's an immediate exclusion for
27 a brief period of time, for a few weeks. They agreed
28 that in order to scope the size of the problem, for
29 Mr. Weir to complete his investigation, without any

1 impediment and to protect patients until we could
2 reassure ourselves that mechanisms were in place to
3 protect the safety of patients that Mr. O'Brien should
4 stay off work. I appreciate he was actually on sick
5 leave at the same time so in practice it probably 15:20
6 didn't make a lot of difference, but we were aware that
7 he had been coming into work on sick leave, so we
8 wanted to make sure that didn't happen.
9 324 Q. Just to pause there. I have been told that there might
10 be an issue with CaseView. 15:20
11 CHAIR: This has happened previously. Is it affecting
12 everybody or is it just some of the screens? Perhaps
13 it might be appropriate to take a break.
14 MR. WOLFE KC: Yes.
15 CHAIR: It sounds like the same issue we had the other 15:21
16 day. If we can just take ten minutes perhaps and be
17 back at half past.
18
19 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:
20 15:33
21 CHAIR: Not only are we having technical difficulties
22 on Tuesdays but now Thursdays as well. Hopefully they
23 are resolved and we can get back to work.
24 MR. WOLFE KC: Mr. Millar has a theory as to why it's
25 happening which I will share with you later. He has 15:33
26 worked it out. It's beyond me.
27 325 Q. Dr. Wright, this meeting at which these important
28 decisions of formal MHPS investigation on exclusion and
29 appointment of officers to carry forward an MHPS

1 investigation, presumably subject to consultation with
2 them, as you said these decisions were being taken at
3 a time when Mr. O'Brien wasn't in work. There was some
4 suggestion that he was doing some work at home, and
5 I think you indicated that you thought he may have been 15:34
6 in and out, but I don't wish to get into any
7 controversy about that. Whether that's right or wrong,
8 he wasn't in work. This was a meeting taking place
9 without the input of the Director of Acute, albeit her
10 deputy was in attendance. You had no clinical input. 15:35
11 Mr. Haynes wasn't in attendance. Mr. Weir was possibly
12 off sick and Mr. McAllister obviously, Associate
13 Medical Director, had resigned his post, if I put it in
14 those terms. You hadn't obtained NCAS advice in
15 advance of this meeting, although it was to come later. 15:35
16 Was there any particular urgency to act at that time?
17 A. Yes. We now had an SAI report that showed there'd been
18 real significant patient harm, so the balance of taking
19 a gentle softly-softly touch with an individual
20 clinician, albeit wanting to be compassionate and 15:36
21 caring as best you can, has now shifted completely to
22 protecting the public and protecting patients. So,
23 yes, there was an urgency. The Oversight Committee
24 was, as under Trust policy, it wasn't ideal. The
25 Service Director wasn't there but her delegated deputy 15:36
26 was there and it was quorate, and we had authority to
27 do that. So absolutely there was an urgency, and
28 I struggle to see a reason why one wouldn't have
29 proceeded. Obviously I had to discuss the matter with

1 NCAS. I was subject to that and I was subject to the
2 approval of the Chief Executive and, indeed, the Chair.
3 To my mind, there wasn't any reason to delay any
4 further.
5 326 Q. A reason to delay further was that the clinician 15:37
6 concerned wasn't in the workplace, and therefore, if we
7 look at the test set out in the procedures. If we can
8 bring up TRU-83691. It says, this is the appendix to
9 MHPS:
10 15:38
11 "The processes involved in management performance
12 issues move from informal to formal if required due to
13 the seriousness or repetitive nature of the issue, or
14 if the practitioner fails to comply with remedial
15 action requirements, or NCAS referral or 15:38
16 recommendation. The decision following the initial
17 assessment at the screening stage can, however, result
18 in a formal process being activated without having
19 first gone through an informal stage if the complaint
20 warrants such measures to be taken." 15:38
21
22 In this case, Mr. O'Brien hasn't been approached, so
23 there's no question of the practitioner failing to
24 comply with remedial action. Is the determining factor
25 here simply the word about the SAI and its 15:39
26 implications?
27 A. I think that is the main factor.
28 327 Q. But for the fact that you were hearing about the
29 potential of harm arising out of this SAI, you would

1 have continued with the process that you'd agreed in
2 September/October, which was, as it worked out, to do
3 nothing until he came back to work?
4 A. Probably. Depending what else happened in the interim,
5 obviously, that probably would be what would have 15:40
6 happened.
7 328 Q. In terms of the exclusion, if we could have on the
8 screen, please, WIT-18499. If we go to paragraph 6.
9 Scrolling on down.
10 15:40
11 "In the vast majority of cases when action other than
12 immediate exclusion can ensure Patient Safety, the
13 clinician should always initially be dealt with using
14 an informal approach. Only where a resolution cannot
15 be reached informally should a formal investigation be 15:41
16 instigated. This will often depend on an individual's
17 agreement with the solutions offered."
18
19 Just dealing with that first line, was this exclusion
20 necessary for Patient Safety reasons? 15:41
21 A. I believe so, until we had scoped the full size of the
22 problem and we had an action plan in place to ensure
23 a safe return to work for Mr. O'Brien. We didn't know
24 when he was going to come back. I mean he had a sick
25 line but he could have been back earlier than planned 15:41
26 and we would have been faced with a situation where we
27 knew of this risk, Mr. O'Brien was back in work walking
28 into theatre to perform an operation and see patients
29 at a clinic and we did not have a robust plan in place

1 to protect the public and I wasn't prepared to have
2 that. It says in the last line of paragraph 6:
3
4 "It is imperative all action is carried out without any
5 undue delay". 15:42
6 329 Q. The fact that Mr. O'Brien was on sick leave?
7 A. That was a factor, but he could come back from sick
8 leave at very short notice, and we had no guarantee he
9 was going to remain on sick leave. This was
10 a difficult decision because it was far from 15:42
11 satisfactory that we were doing this without being able
12 to speak to him in person first. The fact that he was
13 on sick leave was highly unusual, but there was a real
14 possibility he would return to work without the proper
15 protection around to protect both the public and 15:42
16 himself from any further incidents happening. We had
17 to ensure that that did not happen. When we spoke to
18 NCAS after that meeting, they were in agreement with
19 that approach.
20 330 Q. You must speak to NCAS prior to the implementation of 15:43
21 an immediate exclusion?
22 A. Mm-hmm.
23 331 Q. You didn't implement the exclusion until you met with
24 Mr. O'Brien on 30th December; is that fair?
25 A. That is correct. I think that's right, yes. 15:43
26 332 Q. You spoke to NCAS on the 28th, two days before --
27 A. Yes.
28 333 Q. -- the exclusion? After your meeting, you became aware
29 that Mr. Haynes had contacted Mr. Carroll with regard

1 to a private patient concern. If we just deal with
2 that, briefly. AOB-01300. Prior to this intervention
3 from Mr. Haynes, had he ever mentioned to you directly,
4 or through any other source, that you became aware of
5 a concern that Mr. O'Brien may have been giving unfair 15:45
6 advantage to his private patients?
7 A. I don't recall being informed of that before this
8 episode.
9 334 Q. He attaches a letter, and we don't need to open it, but
10 it's a letter from Mr. O'Brien to the patient's GP -- 15:45
11 A. Mm-hmm.
12 335 Q. -- explaining that he's going to bring him into
13 hospital for a TURP. That's summarised in this e-mail
14 and Mr. Haynes asks Ronan Carroll:
15 15:46
16 "Do you think this should be fed into the overall
17 investigation?"
18
19 The impression from there is that Mr. Haynes is aware
20 that there's going to be an investigation, an MHPS 15:46
21 investigation. At that stage, is it appropriate that
22 he should know about that as a Clinical Director or
23 otherwise?
24 A. I think as a medical manager within that team, he would
25 have needed to have known about the fact that 15:46
26 Mr. O'Brien may not be returning, that his colleague
27 will be conducting an investigation. I mean, there
28 would have been legitimate reasons for letting him know
29 about that.

1 336 Q. Yes. If we scroll up the page, I think we can see that
2 you are told about this issue. What was your reaction
3 to seeing that?
4 A. We had put a lot of work -- in years gone past there
5 were a lot of issues with doctors and the management of 15:47
6 their private practice. It was one of the commonest
7 causes for doctors coming before the Oversight
8 Committee. We had put a lot of work into sorting that
9 out, and one of the things we had to do was to
10 institute a training programme for all doctors that 15:47
11 they had to go on, on a regular basis, about good
12 practice when dealing with private patients. So they
13 were all abundantly clear of the rules and, thankfully,
14 as a result of that training programme, the number of
15 those issues had reduced dramatically. It was a case 15:47
16 of prevention being better than cure. This was the
17 first issue that had cropped up on my watch relating to
18 this, and I was very disappointed because I was aware
19 that Mr. O'Brien had been on that training course and
20 would have been well aware of the rules and 15:48
21 regulations. I was suppose just frustration, and
22 disappointment.
23 337 Q. We will see, as we move through the timeline, that this
24 issue becomes a feature ultimately of the Terms of
25 Reference for the MHPS investigation going forward 15:48
26 after it is commented upon in Mr. Weir's report, which
27 was considered on 26th January by the case conference.
28 Leaving that issue to the side, you spoke to NCAS, as
29 I have indicated, on 28th December. They sent you

1 advice on 29th December. If we just look briefly at
2 that, please? AOB-1327, 01327. Again, the background
3 is set out. The background that was set out previously
4 to NCAS when Mr. Gibson spoke to them. The new item is
5 a recent Serious Adverse Incident. This caused concern 15:49
6 that there's potential for patients to be harmed by the
7 ongoing situation. You, Dr. Wright, are awaiting
8 a report on the SAI, but on the information available
9 to date, you feel the Trust will need to undertake
10 a formal investigation. The Trust is also, it says, 15:50
11 considering exclusion.
12
13 Two points there. You've explained to us that the SAI
14 developments was the trigger for formalising the MHPS
15 investigation? 15:50
16 A. Yes.
17 338 Q. That you have clearly told NCAS. The issue of, as
18 they've expressed it, considering exclusion, the minute
19 of the Oversight Group from 22nd December suggests
20 that's a decision that has been made but has yet, 15:51
21 obviously, to be implemented?
22 A. It would always be subject. I mean I was charged with
23 speaking to NCAS and had they disagreed with that
24 decision I would have had to have gone back to the
25 Oversight Committee again to share that view with them. 15:51
26 It was always going to be subject to an agreed way
27 forward with NCAS. If that wasn't explicitly said then
28 that's regrettable, but that would have been clearly
29 understood.

1 339 Q. Let's work through what they are saying to you. They
2 are telling you that this has to be managed in line
3 about your local policy, the guidelines and the MHPS
4 framework. You discussed with them the fact that
5 there's been no noted improvement despite the matter 15:51
6 having been raised with the doctor. Is it entirely
7 fair to say that it has been raised with him, apart
8 from the March correspondence and meeting?
9 A. It was raised with him.
10 340 Q. And that's it? 15:52
11 A. Yes.
12 341 Q. That's what you had in mind?
13 A. Yes.
14 342 Q. The impression might form is that, having spoken to
15 NCAS in September, there have been other efforts to 15:52
16 engage with the doctor when --
17 A. I see how you might take that inference from it. When
18 I read it back I can see where you are coming from
19 there but that wasn't the intention certainly.
20 343 Q. The last two lines suggest that an informal approach is 15:52
21 unlikely to resolve the situation. A more formal
22 approach is now warranted. In your understanding of
23 the letter, is that what you are saying to them or is
24 that what they are reflecting back to you?
25 A. It's a bit of both really. It certainly was what I was 15:53
26 saying to them and that's what they understood,
27 I think, by the conversation.
28 344 Q. Yes. If we scroll over the page then. They advise you
29 that you need robust and specific Terms of Reference

1 and they have to be in line with the guidance. Just
2 within that paragraph, it says:
3
4 "The investigation should not be an unfocused trawl."
5 A. Indeed. 15:53
6 345 Q. The investigation ultimately is conducted pursuant to
7 Terms of Reference, which set out five issues to be
8 explored. Those issues, the fifth of which is
9 a management issue, how do management respond to these
10 issues? The four concerning Mr. O'Brien were issues 15:54
11 that were obvious and well known to you. Was there
12 a need, when you think about it, to engage with
13 clinical colleagues working close to the ground within
14 Urology, to determine whether, on the face of it, there
15 were any other issues of a clinical, administrative or 15:55
16 practice nature that would require further exploration
17 before setting off on the investigative journey?
18 A. I think, knowing where this ended up and knowing how
19 the whole subsequent period worked out, I have given
20 much thought to this, but it would be very irregular to 15:55
21 ask clinical colleagues about how you would investigate
22 one of their colleagues. That would be something that
23 you are breaking all sorts of confidentialities. We
24 were involving the Clinical Director as Case
25 Investigator in a bid to make sure that that ground was 15:56
26 covered, and there was always the potential for the
27 Case Investigator and Case Manager to decide to
28 recommend further investigation, should that be
29 something that they came across. We also have NCAS

1 here saying the investigation should not be an
2 unfocused trawl. My experience was that was virtually
3 always their advice. They were very against a wide net
4 because you are more likely to run aground in the
5 investigation and it can be considered unfair, so you 15:56
6 need really hard evidence for that. I was confident
7 that the things that we were investigating, we had good
8 grounds to investigate. I was also confident that
9 during the course of an MHPS investigation, should
10 there be other issues of concern arise, they had the 15:56
11 ability to widen the remit as they thought. That's
12 a very long winded answer but it's something I have
13 reflected on extensively. I don't personally believe
14 at this point we had the evidence to widen the net
15 further. I certainly don't think it would have been 15:57
16 appropriate to go asking all his colleagues whether we
17 should be doing that.
18 346 Q. I asked the question because the Inquiry, as I have
19 said at the start this morning, is charged with --
20 A. Yes, I appreciate that. 15:57
21 347 Q. -- various responsibilities within its own Terms of
22 Reference.
23 A. Mm-hmm.
24 348 Q. The public, no doubt, or elements of the public is no
25 doubt thinking, how can you have an investigation under 15:57
26 MHPS, with all the time and resources invested in it,
27 it took two years, give or take, to complete, and not
28 come by all of the answers. The Inquiry has to think
29 about whether, is there something inherent to the

1 process that prevents a deeper or wider excavation at
2 the outset being formally the breadth of the
3 investigation, or is it a question of how
4 practitioners, managers, use the process that inhibited
5 getting any further than what it did? Just your 15:58
6 reflection on that, please?
7 A. There are a lot of issues that would potentially limit
8 the scope of investigation, apart from simply the issue
9 before you. One is resource. It's very difficult to
10 get appropriately trained investigators, Case Managers, 15:58
11 time freed up, because under the MHPS guidance they do
12 need to be clinicians, so they are doing this on top of
13 their busy day jobs, and that, as I am sure you will
14 appreciate, is one of the factors why sometimes MHPS
15 investigations take longer than they should. The 15:59
16 financial resource attributed to them and the
17 administrative support is also an issue. There are
18 also issues of going and doing a wide search, because
19 I have been involved in several of these where you take
20 the ultimate example and you end up with patient 15:59
21 callbacks and reviews of their notes which you have to
22 declare publicly, and there will be a lot of public
23 concern generated for individuals. So you need to be
24 absolutely sure you can justify doing that before you
25 just delve in at the start. The other is the 15:59
26 practicality of just the potential for challenge to the
27 process if you go beyond what you have evidence for
28 investigating. There are lots of reasons why that
29 might be. In this particular case, we were keen to

1 proceed at the outset as fast as we could on the
2 grounds that we were certain we had grounds to
3 investigate, and with the advice and support of NCAS.
4 With hindsight, looking at what happened subsequently,
5 clearly the investigation took far too long for various 16:00
6 reasons. There was a recommendation at the end of it
7 to delve further. So in retrospect, yes, in this
8 particular case it probably would have been good if we
9 had gone further right at the start, but I don't think
10 I had the grounds to do that at this moment in time. 16:00
11 That's my answer.
12 349 Q. Yes.
13 A. But I think if there was different guidance around the
14 situations when that would be appropriate, that would
15 be helpful in terms of when you could go beyond the 16:00
16 immediate Terms of Reference. For instance, if it
17 became clear that someone in this situation where there
18 were multiple layers of patient admin issues, if it
19 became established that that was generally a high risk
20 for clinical concerns as well and there was a hard 16:01
21 evidence base for that, that could be a trigger that
22 you would apply, but I don't think the evidence base,
23 at the time we were doing this, was there for that.
24 350 Q. Say your suspicion is that a clinician isn't dictating
25 after clinical engagements in a particular setting, 16:01
26 should that cause you to be curious about his
27 attendance to administrative-type tasks in other
28 settings?
29 A. We had evidence of failures in different areas of

1 administrative tasks. It wasn't just one, there were
2 several. I mean, yes, that would alert you to that
3 possibility. However, there are multiple, multiple
4 incidences when clinicians have problems with
5 particular tasks that are addressed that don't end up 16:02
6 in an MHPS investigation that can be remedied fairly
7 quickly and succinctly. This was an unusual case. It
8 wasn't the norm by any means and the circumstances were
9 very unusual. Certain aspects of the behaviour had
10 been tolerated and some would say encouraged by 16:02
11 mechanisms put in within the Trust over a long period
12 of time. There were a lot of complex factors here at
13 work here just beyond the clinician. I'm sure this
14 will be argued about and the public inquiry obviously
15 will come to a view as to whether we should have done 16:03
16 a deeper dive at this point, but my view is at the time
17 I didn't have the evidence to do that, and would have
18 been criticised had I done that.
19 351 Q. Going back to the advice letter, you are told to write
20 to the doctor concerned, Mr. O'Brien, obviously, 16:03
21 informing him of the name of the Case Investigator and
22 designated Board member, and there's correspondence
23 around that.
24 A. Mm-hmm.
25 352 Q. Any objections to the appointment of individuals should 16:03
26 be given serious consideration, and we will look at
27 Mr. Weir who was appointed investigator and then came
28 out of it, and whether that was anything to do with
29 Mr. O'Brien and any submission that he may have made or

1 whether it was nothing whatever to do. We will look at
2 that maybe on the next occasion. We have already
3 looked at the issue of the unfocused trawl and the
4 clear advice that you are receiving. It goes on in
5 that sentence to say: 16:04
6
7 "But we discussed that if there are concerns that
8 patients may not have received appropriate treatment or
9 that there are patients with inadequate records then
10 this could be managed separately with an audit lookback 16:04
11 to ensure that patients have received the appropriate
12 standard of care."
13
14 There was, as I understand it, some look back conducted
15 at other triage cases that then gave rise to a series 16:04
16 of further SAIs?
17 A. Yes, yes. That was after the SAI reported.
18 353 Q. After Patient 10 reported, yes.
19 A. Yes.
20 354 Q. Just on this point. In terms of the record-keeping, 16:05
21 the failure to dictate patient outcomes following
22 clinic, were those files, when returned by Mr. O'Brien,
23 were they all looked at?
24 A. I am not sure I can answer that, to be honest.
25 355 Q. If they are coming back from his home in large numbers 16:05
26 and he is telling you, as we'll see the next time, that
27 at the meeting you had with him, that he would like the
28 opportunity to write up the action that flows from his
29 encounter with the patient, and if he isn't being given

1 the time to do that, surely the Trust must have
2 constructed a process to deal with that?
3 A. The patients were being reviewed by the other
4 clinicians in the Department, who were annotating the
5 notes as they went along. I would need to check. That 16:06
6 was really a matter that was delegated to the
7 operational unit and I wouldn't be au fait with the
8 details of that.
9 356 Q. Right. Just continuing through this, then. The note
10 that: "Further preliminary information such as from 16:06
11 the SAI may be helpful in deciding the scope of the
12 investigation and therefore the Terms of Reference".
13
14 The Terms of Reference were the subject of several
15 iterations, as we will see, before they are finalised 16:07
16 in March. Then they deal with the GMC standard in
17 respect of records. They deal with the issue of
18 occupational health for Mr. O'Brien. It says at the
19 bottom then:
20 16:07
21 "If deemed fit for work they discuss with you the
22 criteria for formal exclusion and the option of an
23 interim intermediary exclusion. The latter would allow
24 for further information to be collated and take account
25 of Dr. O'Brien's comments about the allegations before 16:07
26 deciding whether the reasonable and proper grounds for
27 formal exclusion".
28 A. Yes.
29 357 Q. Arising out of that, you remained of the view that

1 immediate exclusion --
2 A. Immediate exclusion, yes, for a brief period of time,
3 it's usually for four weeks, to allow assessment. We
4 didn't proceed to formal exclusion at the end of that
5 period. 16:08
6 358 Q. Yes. Then it goes on to deal with the issue of private
7 sector work which came up in your meeting with
8 Mr. O'Brien on 30th December. Again we will have
9 a brief look at that on the next occasion.
10 16:08
11 That was your meeting with NCAS, telephone meeting and
12 the advice received. Just before we leave it for the
13 day, can I ask you this? In terms of the formal MHPS
14 investigation that the Oversight Committee had decided
15 was now necessary, what was the ambition or objective 16:09
16 of that process? What was it designed to do?
17 A. It was designed to determine what were the
18 circumstances that arose in this situation so we could
19 learn from it. It was designed to see if there were
20 issues that would require disciplinary sanctions or 16:09
21 referral to the GMC for Mr. O'Brien himself, clearly,
22 to ascertain if there were any other issues in the
23 background, such as health issues for him. But part of
24 it is to look at the system a practitioner is working
25 in. That's one of the potential strengths of an MHPS 16:09
26 investigation. It doesn't just look at a single issue.
27 It can look at the wider network in which a clinician
28 is working within and nearly always there are
29 significant system factors affecting the performance of

1 any individual doctor. At the end of that we would
2 like to have had Mr. O'Brien at work and working
3 safely, put a system in place that would not allow
4 a similar situation to arise in future, I think.
5 359 Q. Given that many of the issues that were to be 16:10
6 investigated had a certain factual understanding or
7 basis that couldn't be contradicted; for example,
8 triage wasn't being done other than red flag broad
9 generalisation perhaps, but you take my point, that
10 some of these issues couldn't be contradicted, the 16:11
11 notes at home is another example?
12 A. Mm-hmm.
13 360 Q. Were you ultimately left surprised that this
14 investigation took so long to bring to a conclusion?
15 A. I wasn't surprised it took longer than the -- 16:11
16 361 Q. The indicative time?
17 A. -- the indicative time because they virtually can never
18 be completed within the recommended time frame. I was
19 surprised it went on so long, and I know there were
20 multiple factors for that but it wouldn't be unusual 16:11
21 for an MHPS investigation to go on over past six months
22 in my experience. That wouldn't be out of the
23 ordinary. But certainly two years is way beyond the
24 norm.
25 362 Q. Would it have been part of your ambition for the 16:12
26 process, given the patient risk issues involved and
27 with Mr. O'Brien coming back to work, that this process
28 should have been concluded a lot sooner?
29 A. It would have been my ambition, yes, that Mr. O'Brien

1 was being brought back within a controlled framework,
2 if you like, and as long as we were able to receive
3 assurances that that was working and keeping him and
4 the patients safe, the time of the investigation,
5 whilst not terribly satisfactory, was not such a big 16:12
6 issue. The primary concern was to make sure that if he
7 was back at work, he was working in a safe environment,
8 and that's what I strove to attain during the time that
9 I was responsible for it.
10 363 Q. Okay. I think we can leave it for today. We will pick 16:13
11 up on the next occasion to examine whether those
12 ambitions were realised, and we will get through that
13 in the next day. I think we are liaising with
14 Mr. Lunny and the LS team to secure Dr. Wright's
15 re-attendance? 16:13
16 CHAIR: Thank you very much, thank you very much,
17 Dr. Wright, I am sorry you weren't able to get
18 concluded today.
19
20 THE INQUIRY WAS THEN ADJOURNED TO 21ST FEBRUARY 2023 AT 16:13
21 10AM
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