Urology Services Inquiry

Oral Hearing

Day 25 – Wednesday, 22nd 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

INDEX

THE HEARING RESUMED ON WEDNESDAY, 22ND FEBRUARY 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. Apologies for the late start. I understand we had some technical difficulties this morning, and it's Wednesday, not Tuesday.

MR. WOLFE KC: Good morning, Chair, Members of the Panel. Your first witness today is Mr. Simon Gibson. I think he wishes to be sworn.

10:27

MR. SIMON GIBSON, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE, AS FOLLOWS:

Q. MR. WOLFE KC: Good morning, Mr. Gibson.

A. Good morning. 10:27

1 Q. You kindly provided the Inquiry with two Section 21 statements which I'm going to bring up to the screen now. The first is Section 21, number 17 of 2022. It's dated 27th June 2022. The first page, if I can show you it, is WIT-23432. I think you are well familiar 10:28 with that document. I'll just scroll through it to the last page and show you your signature. It is WIT-23476. There we go. It's an electronic signature. The question, Mr. Gibson, is do you wish to adopt that Section 21 statement as part of your evidence? 10:28

A. Yes, please.

2 Q. As I've said, you provided a second statement, it's dated 14th July of last year. First page, please, WIT-33908. Before I bring you to the last page you've

proposed some changes to this statement?

A. Mm-hmm.

3 Q. You've kindly provided us with an addendum, which I'll bring you to. Just so I can illustrate to people here and the public what has been done with this document. 10:29 Can we scroll down to WIT-33921, please? Yes. Just highlighting the bottom section.

One of the changes that you notified the Inquiry that you wished to make was in respect of the date on which 10:30 you completed the screening report, which we'll hear more about this morning. It is the fifth and not the seventh. You have indicated you want to make that change to the Inquiry and some other changes, and the Inquiry have annotated your statement accordingly. 10:30 So moving through to the last page of your statement, WIT-33939. Your signature is there, 13th July, as I think I said 14th July earlier, it's 13th July. Do you wish to adopt that statement as part of your evidence? 10:30

A. Yes, please.

4 Q. Finally, by way of preliminary, is your addendum. It is an addendum to this statement 46 of 2022. The Inquiry received it on 20th February. If we can go to it at TRU-320001. There we have it. Scrolling down, 10:31 it sets out the, I think, five or six changes. Over the page, please, which you wish to make to your second Section 21. As I've explained already, the changes that you propose have been annotated into the statement

and I have shown one example of this. Just down the page to your signature then and signed electronically on the 20th. Do you wish to adopt that addendum as part of your evidence?

A. Yes, please. 10:32

5 Q. Thank you. Mr. Gibson, we brought you to the Inquiry today primarily to ask you about your knowledge of the MHPS process which the Trust deployed in respect of Mr. O'Brien's practice. You, as we will hear, had a prominent role as Assistant Director within the 10:32 Medical Director's office in 2016 in conducting a screening report that was used by an Oversight Committee; isn't that right?

A. That's correct.

6 Q. Before we go to all of that, I'll ask you something 10:32 about your career within the Trust, and we'll lightly touch on that.

You came into the Trust, for the first time, in April 2007; isn't that correct? 10:33

A. That's correct.

7 Q. You came in in the capacity of Assistant Director For Surgery and Elective Care?

A. That's correct.

8 Q. Just in ease of the Inquiry's pen, you've told us that 10:33 you've had two roles which have touched upon urology. The first is that first job in surgery and Elective Care. You then had a number of other assistant directorships before taking up a role as assistant

director in the Medical Director's office in April 2016.

A. That's correct.

9 Q. And it's in that last job -- I think you still hold that job, is that right? 10:33

A. I do.

10 Q. In that last job is your second engagement with urology; isn't that right?

A. Yes.

11 Q. Okay. If we could go to your statement, just as I said, in ease of the Inquiry's pen, WIT-23435. I'm just going to scroll slowly down through this. You helpfully set out in tabular form the various jobs that you've had. So just pausing here a moment, this is your assistant directorship in the Surgery and Elective Care role? 10:34 10:34

A. Yes.

12 Q. You set out the specialties, and your role was to operationally manage the surgical services and specialties within the Southern Trust, setting out the specialties, and reporting to the Director for Acute Services; is that correct? 10:34

A. That's correct, yes.

13 Q. Then, scrolling down, you set out the elective targets and then you move to a new role in September 2009, that's the Assistant Director For Best Care, Best Value and Income Generation. And in September 2009 you're handing over the baton, if you like, to Mrs. Trouton who took over from you as Assistant Director in SEC. 10:35

A. That's correct.
14 Q. Scrolling down. Your next role was -- just back up, please -- was as Assistant Director in Medicine and Unscheduled Care, and you held that post for just under three years, two-and-a-half years, isn't that correct? 10:36
A. That's correct.
15 Q. Then, as we see, scrolling down, Assistant Director in the Medical Director's office from April '16, and in that role you reported to the Medical Director --
A. That's correct. 10:36
16 Q. -- who in your time changed from, first, Dr. Wright?
A. Mm-hmm.
17 Q. Then Dr. Khan on an interim basis.
A. That's correct.
18 Q. Dr. O'Kane? 10:36
A. Yes.
19 Q. And latterly, you'll have to help me with that, Dr. Stephen Austin.
A. Dr. Austin.
20 Q. Thank you. Just touching on your role as Assistant Director For Surgery and Elective Care, if we scroll down to WIT-23435. So your job is to operationally manage the surgical services and specialists within the Southern Trust, one of which was urology. 10:36
A. It was. 10:37
21 Q. Isn't the core of your evidence today but I'm just going to ask you for some reflections on that role. You've said within your witness statement that the unit which was urology was understaffed from a medical

perspective. There was a requirement for five consultants to meet the recommendations of BAUS, British Association of Urological Surgeons, but in fact you only had two substantive members of staff and one locum? 10:38

A. That's correct.

22 Q. You've said that had an impact on the ability to fully implement all of the recommendations of BAUS and it was a challenge to deliver on the provision of urological services in terms of delivering on elective targets for 10:38 outpatients, day patients and inpatients.

In terms of the impact on clinicians, the clinicians that you did have, was this a difficult time?

A. Yes, I think it was. I think it was Michael and Aidan 10:38 and Mahmoud, Mehmoud Akhtar, who was the locum. We were very performance driven at that time and we had very firm targets which we had to deliver in terms of the 9 weeks and 13 weeks. I think there was a bit of a demand and a capacity imbalance given the fact that 10:39 the number of consultants against the size of the population within the Southern Trust, yes, I think that was a challenge.

23 Q. At that time, and we're talking 2009 or so, the regional review on Urology Service had just reported. 10:39 You've said in your statement that locally, that is within the Trust, a Steering Group formed. You were part of the project team undertaking an internal review and calculating -- which included as part of your role

calculating the capacity gap, identifying national service standards, recruiting staff, developing a business case. Was it a fairly turbulent time for The Trust in terms of Urology Services?

A. I wouldn't have said turbulent. I mean it was certainly changing. We knew we couldn't stay where we were and we wanted to expand, but I wouldn't have said turbulent. 10:40

24 Q. There was a decision made to relocate the Urology Ward and disperse -- well, the Urology Ward at that time was, as I understand it, based at Ward 2 South. 10:40

A. Yes.

25 Q. Was that reconfigured and patients dispersed to other surgical wards throughout the hospital?

A. I think there was a move from 2 South to 3 South. I can't recall exactly when it was, but there certainly was a move up a floor basically. 10:40

26 Q. Were the consultants consulted on that?

A. I can't recall, to be honest. I think at the same time we were setting up the Thorndale Unit, which was a specific unit to do out-patient procedures and work which maybe didn't require an in-patient or daycare stay, but would have been more than an out-patient consultation. I was involved in setting up the Thorndale Unit and that may have been part of a development of urology services, was to set that up as well. 10:41 10:41

27 Q. Can I ask you to take a look at your witness statement at paragraph 33.1. It is WIT-23455. You talk about

overseeing the quality of services in urology. Here you refer to considering documents such as complaints, SAIs and Datix reports. You then go on to say:

"In essence, performance was a subset of quality. I oversaw the delivery of access targets through the performance metrics as outlined at paragraph 34." 10:42

We can go back there but, in essence, performance -- you seem to be saying performance was judged by reference to compliance with the nine-week and 13-week access targets? 10:42

A. Yes, no question. At that time we were a very performance driven organisation and, to me, the prime focus of the Acute Services in that period was definitely hitting those targets. 10:42

28 Q. When you think about it now, that approach to quality or that emphasis on access, was that not excessively narrow?

A. Yeah, I can see that now. Yeah, absolutely. 10:43

29 Q. Were any other aspects of quality considered or measured?

A. We had a weekly meeting within Acute Services with, kind of, fellow ADs and the Director. We would have taken turn about and we would have looked at HR, governance, and performance. So they would have been considered in the governance section. But my recollection is that the focus was more on performance. 10:43

30 Q. Performance in terms of inpatients, what about

outpatients? Was there an adverse impact on the ability to address the needs of outpatients?

A. The targets were clear for outpatients and inpatients in day cases. The ins and days was 13 weeks and the outpatients was 9. But I would accept the fact that the target for outpatients related to new patients and there was no target for review patients. So when we were trying to achieve the 9-week target, I certainly think the focus would have been on the new patients and I would absolutely concede there were times when maybe the review patients would have been adversely affected, because the focus which was a regionally given target to us didn't take account of review patients. 10:44 10:44

31 Q. What was the problem? Was it a shortage of consultant level and middle grade staff to address the needs of the local population? 10:44

A. It was a supply and demand imbalance. We had a demand for 330,000 patients at that time and we only had two consultants and a locum. They all worked very hard but I just think that it was beyond them to do that. 10:45

32 Q. One of the consultants within urology, as you've indicated, was Aidan, as you said, Mr. O'Brien. Had you many dealings with him?

A. Yes, I did. Yes.

33 Q. In what context? 10:45

A. Usually in terms of hitting the 9-week and 13-week target. We had an away day at Seagoe, I think it was in March 2008, I believe, but I would have met Aidan up on the ward or -- I don't know if Thorndale was open

but in terms of getting the Thorndale up and running on a regular basis, yes, alongside, and it was usually a discussion on targets.

34 Q. When you say a discussion on targets, were you and him reflecting the difficulties in terms of meeting the targets or were you, as the manager, pushing, if you like, the need to get with the targets? 10:45

A. I was cajoling to make sure that the targets were being met, I think is the best way of putting it. I think that was a difficulty because of the supply and demand imbalance. 10:46

35 Q. Within your statement you say, if I can bring it up, WIT-23466. And at 54.2, just scrolling down, you say that:

10:46

"The earliest evidence I have available to me that I first became aware of issues of concern relating to Mr. O'Brien was in April 2008.

There was a Workshop where the issue of triage was discussed and the operational support lead, Sharon Glenny, spoke of delays in obtaining the outcome for Mr. O'Brien's triage of referral letters. I think elsewhere in your statement you emphasised that it was delays in referrals being performed by Mr. O'Brien, not a failure to do them? 10:46 10:47

A. That's correct.

36 Q. You go on to say, if we go down to 23470 in the same statement, WIT-23470. You go on down to the bottom,

please. You talk about it being your recollection that the chasing-up of delayed triage letters did not remedy the concerns as they continually -- they continued periodically up until you handed over responsibility to Mrs. Trouton. You talk about in terms of what could have been done differently, a more formal approach could have been considered rather than what you describe as the "passive informal method" being used. What was that passive informal method? 10:48

A. It would have been either myself or more likely one of the team going up to Aidan and maybe chivvying him along and, you know, seeking his support in getting the referrals triaged. 10:48

37 Q. Were you able to ascertain or diagnose what the problem was that was causing delay? 10:48

A. At the time I think -- I didn't think it was an issue, anything more than simply kind of supply and demand. I think there was a lot of referrals coming in that needed to be triaged. There was also, as you can see further down in that paragraph, the IEAP had come in, it was a new way of working, and Aidan certainly wasn't alone at that time in struggling to hit that kind of target for triage. It was a new way of working that we were asking all of the consultants to comply with and there was -- I can certainly recall two other consultants in different specialties that we had similar conversations with, but at that time they were conversations that rectified and solved the problem. It wasn't as if it was -- Aidan was at that point, on 10:49 10:49

his own, and it wasn't as if the delays were very significant. He would always say, okay, yes, fine, and it would be done within two or three days. The mechanics of the IEAP meant that it was quite a tight turnaround and the fact we were able to hit the target new patients is an indication, you know, that really his delays were no more or no less than some of the other colleagues. 10:49

38 Q. Am I right to detect within the sentence which says in terms of what could have been done differently, a more formal approach could have been adopted. Does that suggest, looking back on matters now, you think a more formal approach ought to have been adopted, notwithstanding what you've said about the new system, it wasn't the major problem, other consultants were slow as well? 10:50 10:50

A. Yes. Knowing now what we know, yes. But I think in the context of that time, if I had gone to my Director and said, 'I'm having difficulties with Aidan in terms of this, I think we should take a formal approach', it wouldn't have been fair without taking half a dozen names at the same time. I don't think I would have got support in taking half a dozen doctors. So early in the process of implementing IEAP down a formal process, I think the response would have been, 'well, keep on going'. 10:50 10:51

39 Q. Would you have at that time known what a formal process would have looked like?

A. No.

40 Q. There was, obviously, as we have heard, a division between medical management and operational management. You were on the operational side.

A. Mm-hmm.

41 Q. Did you work closely with the operational side within the context of urology? Sorry, I should say with medical or professional side in that context? 10:51

A. Yes. I would have had a good close relationship with Eamon, Eamon Mackle, and Michael Young and Robin Brown in Daisy Hill, yes, I would have met them regularly. 10:51 I would like to think we had good working relationships. I didn't perceive any significant tensions at all. We worked well.

42 Q. At no time did you go to them to say, 'triage is a problem'? 10:52

A. I think there may be in my evidence an e-mail that I was sent in October which I then forwarded to Eamon. You know, I would have felt confident in having that discussion with Eamon.

43 Q. Were you surprised in 2016, when you moved to the Medical Director's office, to discover that triage and Mr. O'Brien were still uncomfortable bedfellows, if I could put it like that? 10:52

A. I have to say I wasn't entirely surprised. During the period when I was managing Medicine and Unscheduled Care I would have been at the performance meetings for elected targets, so whilst I wouldn't have been directly involved, I would have been around the table when issues were being discussed, and I'm sure it would 10:52

have come up during that period when Heather was managing. It wasn't as if it came out of left field to me. I would have been aware of ongoing challenges that were periodic in nature, yes.

44 Q. When you took up the role in the Medical Director's office seven years later, you were aware from your experience of sitting at performance meetings that triage was and remained an ongoing issue? 10:53

A. Yes.

45 Q. Just let's look then at your role within the Medical Director's Office. As we noted already, you took up that role in April 2016. Was that part of a natural rotation of moving directors or assistant directors' posts, or is it a case of, I've been in this seat too long, I fancy a change and you apply for the change? 10:53 10:54

A. No, there was - Esther came into post, Esther probably came in in 2015. I think it is reflected more in Heather's statement than mine, she wanted clinical managers in the roles of assistant director. But at that time within medicine it was kind of split between myself and a colleague, Barry Conway. But she wanted kind of a change of manager in that role. And so she asked Anne McVey, who was covering another portfolio at that time, to step into that and then I was offered to take on -- there was nobody really supporting Richard at that time and they invited me to another role. 10:54 10:54

46 Q. Let's just get a snapshot of what's involved with your Assistant Director's role as you set it out in your statement. If we go back to WIT-23433. And

you describe the key functions. We're going to spend a lot of time this morning focusing on what must have been one small element of your job. So help us in terms of what your role was on a day-to-day basis, working to the Medical Director, Dr. Wright? 10:55

A. Well, as you can see there, there was what I would term as four main portfolios of work, with a fifth which wasn't kind of actually in my job description. In terms of medical education, I had responsibility for undergraduate and post-graduate education across both 10:56 site, Craigavon and Daisy Hill with a team on both sites. We had to deliver, we had a contract with the Department of Health held on behalf of Queen's to deliver undergraduate education to medical students. Then we have a close relationship with NIMDTA, the 10:56 Northern Ireland Medical Dental and Training Agency to deliver high-level training to doctors in training on both sites.

With re-validation and appraisal, that was support for 10:56 doctors going through the appraisal and revalidation process.

Research and Development was fairly straightforward. We have quite a strong research and development 10:56 function within the Southern Trust, particularly within cardiology, but more recently within neurology and respiratory, and we have been supporting that. We have been keen to expand that and have been doing so in

recent years.

Then Emergency, Planning, and Business Continuity, it is a corporate role ensuring that the organisation is ready for major incidents or issues such as the pandemic. Then the last one is the one we discussed which isn't formally in my job description, but I put it as a bullet point there because it was something in the first years when Richard was kind of on his own, he didn't have the three deputy Medical Directors that now exist in terms of supporting doctors in difficulty. 10:57 10:57

47 Q. You refer to your job description, the formal job description?

A. Yes.

48 Q. I don't propose opening it but for, the Inquiry's note, it can be found sat WIT-23501. As you say, supporting doctors in difficulty isn't to be found as an item in what is, you know, a fairly comprehensive, formal job description, but you found within a short time of starting within this role that this aspect, that last bullet, supporting doctors in difficulty, became a feature of your role. 10:57 10:58

A. Absolutely, yes.

49 Q. As we shall see, the request from Dr. Wright that you complete a screening report in respect of Dr. O'Brien falls into that category, doesn't it? 10:58

A. It does, indeed. Yes.

50 Q. In terms of whether you felt yourself well equipped to take on the role of supporting doctors in difficulty,

and all of the strands that flow from that, the Trust had a set of guidelines for handling concerns about doctors' performance that were introduced in 2010. There were, from 2005, the MHPS Framework. Let me just focus on those for a moment. 10:59

In terms of the local guidelines, how familiar were you with those at the time when you became involved with assisting Dr. Wright in the context of Mr. O'Brien's practice? 10:59

A. I was aware they existed. I wouldn't claim to know them in great detail.

51 Q. How does it become a situation that you're aware of them but don't know them in detail? How does that arise? 11:00

A. I think it was just a question of -- you know, I started in April. I had been involved in supporting doctors in difficulties in a number of different ways and it was maybe through that that I'd learnt some of the basics. 11:00

52 Q. By the time of August 2016, screening report and all of that, is it fair to say you didn't have a detailed working knowledge of the guidelines?

A. I think that's a fair comment, yes.

53 Q. The MHPS Framework introduced in 2005, you've held a number of AD roles. In terms of that framework, had it come across your desk in a practical working sense prior to 2016? 11:00

A. No.

54 Q. Were you aware of their existence, the framework?
A. Not before 2000 -- when I joined the medical records office in 2016 I became aware. I went on a case manager's course on 13th August just to really improve my learning and understanding of it. 11:01
55 Q. We can see, if we can bring it up on the screen, WIT-33974. This is your certificate of attendance at a case manager training Workshop delivered by NCAS. Just scroll down. It took place on 30th August '16. If we look at WIT-18500, please? This is -- let me 11:02 check to be sure. This is the MHPS Framework and it defines certain roles.

"Case manager is the individual who will lead the formal investigation. The Medical Director will 11:03 normally act as the case manager but he or she may delegate this role to a senior medically qualified manager in appropriate cases."

You're not medically qualified. You're attending case 11:03 manager training with NCAS in the context of MHPS. Why were you being sent or why did you agree to go to case management training?
A. I think it was simply to get a detailed understanding for my own benefit. I was aware that I would never be 11:03 given the role of a case manager, but just to have support from the Medical Director's office in having a good understanding of the elements of it.
56 Q. I think you've told us in your statement that

subsequently, in 2017, you participated in case investigator training in the context of MHPS?

A. That's correct.

57 Q. Again, the case investigator is normally medically qualified, at least for the purposes of the definitions within MHPS? 11:04

A. That's correct. Yes.

58 Q. Again, was this attendance at training to obtain a better awareness of the role of the investigator?

A. That's correct. Yes. 11:04

59 Q. When you came into the role in the Medical Director's office there had been a very recent development in association with Mr. O'Brien's practice. On 30th March he had met with Martina Corrigan and Eamon Mackle and had been handed a letter dated 23rd March. If we can 11:05 just bring that up on the screen, 23rd March 2016. It is to be found at AOB-00979. That's the letter. The process before your time, the Inquiry has been told, was that Dr. Wright had spoken to Mr. Mackle and it had been agreed that Mr. Mackle would meet with Mr. O'Brien 11:05 and deliver a letter setting out a requirement to deliver a plan to improve on certain aspects of his practice.

First of all, did you see this letter at any time when 11:06 you came to the Medical Director's office?

A. I certainly didn't see it when I started. I can't recall if I saw it in the period of, you know, August to September. I've obviously seen it many times since.

60 Q. In terms, then, then of starting this job in April, was Mr. O'Brien it on your radar? Was this issue of the need for him to compose a plan brought to your attention?

A. In April, no. 11:07

61 Q. At any time before August?

A. No. The first was following Richard's e-mail to Martina, then Martina's response on, I think it was 17 August, that was the first time that Richard kind of briefed me on it. 11:07

62 Q. Okay. So let's just pull up the e-mail that you refer to. TRU-274723. So at the bottom of the page, then we'll scroll up. So 9 August 2016, you have been in post since April:

11:07

"Hi Martina, did we ever make progress with regard to the issues raised re urology which Eamon...".

That is Eamon Mackle:

11:08

"...had been dealing with? Regards Richard."

So that is Richard Wright asking Martina Corrigan, Head of Service, what has been happening since March essentially. 11:08

A. Mm-hmm.

63 Q. In the period between you taking up your role in April and August, were you aware at any time that this issue was on the agenda or was being thought about or being

tracked?

A. I don't recall. No.

64 Q. In terms of your working relationship with Dr. Wright -- I don't wish to sound rude or pejorative, but were you his right-hand man or did he have other staff of your seniority working to him? 11:09

A. There was -- I think there was an AD on the governance side of the house, but in terms of the medical education, medical work for his side of the house, yes, I was his sidekick. 11:09

65 Q. So it is fair to say you worked closely with him, in close physical proximity as well?

A. Well, I didn't have an office. My office, actually, was in Daisy Hill, but, yeah, I mean I did have a very close working relationship with Richard. I had a key 11:09 to his office and quite often would have sat in there when he wasn't there, or sometimes when he was there. I mean no question there is no question that we would have worked closely together, absolutely, that's the truth. 11:09

66 Q. So this issue didn't come on to your agenda prior to August. You have no sense of it being on Dr. Wright's agenda prior to it being raised with you in August. Do you know why the issue re-ignited for Dr. Wright in August? 11:10

A. Well, my -- I heard his evidence that he just was doing some tidying-up when he came to it. But I can't give anything else other than that. I don't know why it suddenly popped back into his head.

67 Q. He, you said, then verbally -- just scrolling down so we can see Martina's response. There we can. She wrote back to him and updated the position on triage review backlog. Scrolling down. And that's how it's left.

A. Mm-hmm.

68 Q. So were these issues then drawn to your attention by Dr. Wright?

A. Yes. So that's -- Richard obviously had a discussion with me. It must have been the following the day because I note that there is a 5 o'clock on the 17th. So the following day is when he must have come to me and said I need you to do, well I think what I termed as a "discrete piece of work". I think I e-mailed Martina the same day and we meet the following Monday.

69 Q. When you use the word "discrete" in that context, do you mean a specific or a particular piece of work, or do you mean a quite confidential, keep this within a few people, piece of work?

A. The latter.

70 Q. The latter. Can I push you on that, what does that mean? Does that mean Dr. Wright didn't want you to go all around the houses calling in information?

A. That's how I would have described it back to you for certain, yes. He didn't want me going into the canteen and asking everybody for what they knew. It was to be quite a controlled, discrete piece of information, just to gather up information with regard to Aidan.

71 Q. We'll come to what the work involved in a moment. You

ultimately -- or you call it a screening report. Is that what Dr. Wright asked for, a screening report?

A. As I recall he asked me for a screening report. I mean I have accepted in my statement that I went beyond my brief in terms of kind of putting in a recommendation and I recognise that was a mistake and shouldn't have been done. But, yes, he was asking for a set of information. 11:12

72 Q. Why did it have to be discreet in the sense of seeking information on the issues from a small number of people as opposed to going all around the houses, as I've put it? 11:13

A. I don't know. I suppose, I mean, I'd been involved in various pieces of work with Richard where he's asked me to have, kind of, discreet discussions. Sometimes it would be more kind of pastoral care, if we have a doctor going through an inquest or litigation or maybe a GMC issue. Quite often I would have met doctors on the QT just to see how they were or if it was involved in maybe a counter fraud case, some of the issues are quite sensitive. So I think that's maybe the context for why he'd asked for it in that way. 11:13 11:13

73 Q. We know you spoke to two people. We'll look at what they told you in a moment. Martina Corrigan?

A. Mm-hmm. 11:14

74 Q. You'll maybe have to help me with the other name.

A. Pamela Lawson, the health records manager.

75 Q. Yes, indeed. But in terms of the narrowness of the work, is it self-evident then that you didn't go to

speak to fellow clinicians or clinical managers?

A. No, I did not.

76 Q. Was that a deliberate policy informed by what Dr. Wright told you to do or was that how you interpreted your brief? 11:14

A. I think it was more that I'd seen the e-mail that had gone between Richard and Martina, and Martina, I knew. I actually appointed Martina. An incredibly competent person in terms of the issues that I had been briefed on. That's why I went to her, because she was best 11:15 placed to, kind of, give the detail of that information that I was looking for.

77 Q. Yes. We'll come to whether that was, I suppose with hindsight or otherwise, an adequate approach to a screening report presently. In terms of what you 11:15 did, it's clear you spoke to two people, none of whom were clinicians.

A. Yes.

78 Q. You wrote to Martina Corrigan. If we can just pull up your e-mail to her. TRU-274722. Bottom of the page, 11:15 please. This is 18th August. As you've said, you're getting down to the work the day after, I think it was, Martina had written to Richard Wright?

A. Yes.

79 Q. He has briefed you. Asked you to commence a discreet 11:16 piece of work -- you have explained what you meant by that -- on issues concerned and actions taken to date. Could you forward relevant information you have on file, and we can meet for initial discussion next week.

Scrolling up the page, she attaches the information that she had already forwarded to Richard. You did meet with her; is that right?

A. Yes. We met on the 21st at 2 o'clock.

80 Q. You also met with -- 11:17

A. Pamela Lawson. I met her on 5th September. I don't know whether that was because of leave. I would imagine, although I have nothing in my calender, but Martina and I would have met a number of times looking at the data. 11:17

81 Q. On 5 September you finalised your report and sent it to Dr. Wright?

A. I did, I sent it in the afternoon, half-past-two.

82 Q. Now, I just want to exam your role and your understanding of that role in the context of MHPS and 11:17 the guidelines, The Trust's local guidelines. If we could have up on the screen, please, WIT-18501. At paragraph 15 it talks about -- this is within the context of an informal approach.

11:18

Paragraph 15 says that:

"The first task of the Clinical Manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. 11:18 As a first step, preliminary inquiries are essential to verify or refute the substance and accuracy of any concerns or complaints.

In addition, it is necessary to decide whether an

informal approach can address the problem, or whether a formal investigation is needed."

Now, within that paragraph, do you recognise any aspect of the role that you were asked to perform for Dr. Wright? 11:19

A. Yes. I suppose it's the preliminary inquiries, it is the gathering together of the information, yes.

83 Q. And the gathering together of the information, did you know, as you were sent out to do the job, that it was with a view to assisting Dr. Wright to decide on next steps? 11:19

A. I can't recall if we had that specific discussion. I think --

84 Q. Or did that come later? Because we know that you were asked to set up an oversight group meeting and contact NCAS, but that comes later? 11:20

A. Yes. I think by the 5th, so on the 5th I gave him the report at half-past-two. I was on leave on the 6th. So we must have had the discussion on the morning of the 7th and I made contact with Jill at NCAS some time before 11:00 a.m. At that time, certainly, yes, but I don't think when I was originally given the brief. 11:20

85 Q. If we could move across to The Trust Guidelines. Sorry, just before we do, you can see the reference in the first line to the role of the Clinical Manager, and we'll come to that in a moment, but it appears from MHPS that the responsibility for carrying out preliminary inquiries lies with a clinical manager. 11:20

A. I'm well aware of that now.

86 Q. TRU-83692, please. This is Appendix 1 of the Trust's guidelines and it describes the screening process. Is it fair to say that -- we'll come to look at your report, and it is described as a screening report. It is not how you describe it necessarily in your correspondence with Mrs. Corrigan but it becomes a screening report. Did you have the guidelines in mind when you adopted that title and wrote the report in the way that you did? 11:21 11:22

A. I probably didn't have that document in mind. I think maybe it would have come from the fact that I was at the NCAS training on 30th August and maybe that would have swayed me in the terms and manner in which I created the report. 11:22

87 Q. The approach here is set out in this flowchart, an issue of concern whether conduct, health or clinical performance is raised. It's raised with the relevant Clinical Manager, and then the Clinical Manager, moving to the right, or the Operational Director informs the Medical Director. That's one route. Another route is a clinical manager -- going down the page -- and HR Case Manager undertake preliminary enquiries to identify the nature of the concerns and assess the seriousness of the issue. 11:23 11:23

If we follow that route, the Clinical Manager and HR Case Manager consult with NCAS and/or Occupational Health Service for any advice when appropriate. Then

the Clinical Manager and HR Case Manager notify the oversight group of their assessment and decision underlining those two words, and the decision may be, and then a list of options, and it is set out, which includes informal remedial action with assistance, and 11:24
input from NCAS, you would recognise from your own report.

So, again, looking at this flowchart, whatever route is adopted, the ball for the preliminary inquiry seems to 11:24
be carried by a clinical manager?

A. Correct.

88 Q. As we can see from the bottom box, it is the clinical manager with the HR case manager who appears on the basis of this process to hold the whip hand in terms 11:25
of, they are delivering a decision to the oversight group. Do you see that?

A. Absolutely. Yes.

89 Q. By contradistinction with the process that you became involved in, there are a number of departures, aren't 11:25
there?

A. Absolutely.

90 Q. You weren't the clinical manager but you were carrying out the preliminary inquiries of the type described here, is that fair? 11:25

A. That's correct, yes.

91 Q. That those preliminary inquiries made it into a screening report, but you weren't making a decision or an assessment, as such, you saw that as being the

role of the oversight group, is that fair?

A. Certainly Richard asked me to gather together the information.

92 Q. First of all, you had training on 30th August with NCAS. Arising out of that training, were you aware that you were tripping over or breaking, if you like, the rules of the process as set out here? Because you weren't a Clinical Manager and you weren't in a position to make a decision? 11:26

A. Yes. Clearly, I mean, Richard asked me to start the piece of work. I commenced the piece of work. I went to the training on the 30th and then finished off. I mean clearly it is easy to see from the training I was on on the 30th that I shouldn't have picked up the piece of work in the first place. Yes. 11:27

93 Q. Maybe we can just formally bring this to the screen. WIT-33938. At paragraph 29.2 you say that: 11:27

"On reflection, I do recognise that the screening of concern stage should have been undertaken by the Clinical Manager rather than myself."

And that your actions were outside the agreed guidelines. You undertook the screening of concern as the Medical Director directly asked you to. You say you felt confident in being able to summarise the issues. Scrolling up. Scrolling down. Top of the page, please. Given that they were administrative in nature, but again, recognising that this was not 11:28

following the correct procedure.

Do you have an understanding, did you have an understanding at the time as to why Dr. Wright asked you to do this job? 11:28

A. Why he asked me? Only that he had asked me to do previous pieces of work with doctors in difficulty. That's the only reason I could give.

94 Q. To be clear, had you ever done a preliminary piece of work within the context of what was to become -- and 11:29 we'll see it at the oversight group meeting on 13th September -- an MHPS process?

A. No, not before that. No.

95 Q. Yes. I'm asking you the question in terms of Dr. Wright's decision to ask you to do it. It appears, 11:29 from the guidelines, that Case Managers, or a Clinical Manager should have been doing this work. Do you understand, or did you have an understanding at the time, as to why a Clinical Manager was not asked to do the work? 11:29

A. No.

96 Q. Had you ever turned out a screening report before?

A. No.

97 Q. Did you receive any advice or instruction on what it should entail, or were you simply invited to gather up 11:30 the concerns?

A. Gather up the concerns, yes.

98 Q. If we look at your statement again, WIT-23463. You assist the Inquiry by saying at 48.2 that:

"A screening report was completed to risk assess through quantification of the impact of the concerns."

Can you help us in terms of what you mean by that? What was being risk assessed? Who was doing the risk assessing? 11:31

A. I was giving the information in the screening report to Richard to allow him to do the risk assessment. I wouldn't have been in a position to consider an assessment of the risks as I'm not clinically qualified. 11:31

99 Q. Those words about "risk assessing through quantification of the impact of the concerns", where do they originate from? 11:32

A. I'm sorry, I don't know what you mean?

100 Q. Who has provided that formula of words? Maybe, just to be clear, maybe I'm not being clear, I see you're puzzled. You say that the screening report was to provide or to be completed to risk assess through the quantification of the impact of the concerns. Is that your understanding of the task that you performed, or is it your understanding of what the screening report that you produced would enable others to do? 11:32

A. Yeah, I think it's the latter. I think it was really just the quantification of the concerns and it was for others to consider the impact and the risk assessment. I was merely, kind of, gathering the data, in essence. 11:33

101 Q. Just briefly stepping through how you conducted your

work. As you said, you met with Martina and you met with Pamela Lawson?

A. Pamela, yes.

102 Q. You also wrote to Mr. Mackle, Mr. McAllister, Mr. Carroll and Mrs. Trouton. That was for the purpose of asking them whether they had heard or received any plans or proposals from Mr. O'Brien since he received the letter in March; isn't that right? 11:33

A. That's correct.

103 Q. Each of them told you that they hadn't received anything? 11:34

A. That's correct.

104 Q. In terms of Mr. McAllister and Mr. Weir, the Inquiry knows that at that time in August of 2016, they had been involved in discussions concerning Mr. O'Brien. If you just pull up on to the screen TRU-281130, please. At the bottom of the page you have written 22nd August asking had anybody heard anything from the 23rd March letter. Scrolling up the page. Marked "strictly in confidence", between Mr. McAllister and Mr. Weir. Mr. McAllister saying: 11:34 11:35

"Please see below. This has come to light subsequent to our discussions on this subject last Thursday. It appears that the boat is missed. I know that you are on leave this week and I'm off for the following two, so I won't get a chance to meet or discuss. Please hold off on attempting to address this issue until the dust settles on the process below." 11:36

Did you know that Mr. McAllister and Mr. Weir were engaged in discussions on how the Aidan O'Brien concerns might be addressed when you wrote to them?

A. No. 11:36

105 Q. Are you surprised that when Mr. McAllister wrote back to you to say he hadn't heard anything from Mr. O'Brien, that he didn't tell you that there was a process in train, even an informal process between himself and Mr. Weir? 11:36

A. I listened to Charlie's evidence yesterday and I know what he said in terms of, I didn't ask him, so he didn't say.

106 Q. I couldn't hear you?

A. Sorry, I listened to Charlie's evidence yesterday and 11:37 Charlie said he didn't tell me because I didn't ask him. My request was more straightforward. I suppose he's technically right, but...

107 Q. How could you ask him what you didn't know?

A. Quite. Yeah. 11:37

108 Q. In the context where you were plainly indicating on behalf of the Medical Director that you had a job to do, should you have been told that clinical management were discussing how they might address the concerns associated with Mr. O'Brien? 11:37

A. If I had of been told it would have been, I wouldn't have been surprised if I was told. It would have been a natural thing to have been said, yeah. I wouldn't have been surprised at that, yes.

109 Q. The report itself can be found at TRU-251423. As I've said earlier, it's called a screening report. And you set out the context. The report provides background detail on current status of the issues and provides a recommendation for consideration of the Oversight Committee. Let's look at some of the detail. The first issue is un-triaged outpatient referral letters. Scrolling down please until we see the whole of that paragraph there. Just stop there, thank you. 11:38 11:39

So at March 16th there were 253 un-triaged letters, no plans received, and there were now slightly less, perhaps substantially less, 174 un-triaged letters, but some were dating back 18 weeks. Was that a problem from your perspective? 11:39

A. Yes. I could see that would be a problem, yes.

110 Q. Did you have a sense thinking back to 2009 and what you knew about triage that the problem that you knew then was essentially the same problem only worse in the sense of greater volume? 11:39

A. Well, it was worse in two senses: One, it was a greater volume, but, two, when I was dealing with Aidan it was delayed triage, not un-triaged. So the kind of gravity of the situation was a quantum greater. Because when I would have been going up to him he would 11:40 have said to me, well I would say would have said to him, would you help us out here and get these ones done? He would say yes, okay, and he would have done it. So we never would have got to the sense of being

un-triaged. That would never have been an issue when I was managing him.

111 Q. The information for this came to you from Mrs. Corrigan presumably?

A. Yes. So in terms of all this information, when I set this out I tried to start off with the data from the March 16th letter to give context for the report. And then when I was working with Martina, in that period between the 21st and when I submitted the report on 5 September, it would have been for updating information, she would have been running reports I am sure to gather information together and QA it. 11:40 11:40

112 Q. Were you able, when speaking to her, to get a sense of how this issue had been managed over the six, seven years since you last had direct managerial knowledge of it? 11:41

A. I mean, I don't recall having that discussion directly with her in that period between, kind of, the 21st and the 25th, but I would have known, as others did, that it was an historical issue with regard to Aidan. It had been a periodic challenge that had ebbed and flowed. 11:41

113 Q. Was it your sense that it had always been challenged informally, if challenge is the right word?

A. Yes. 11:41

114 Q. Did you have a view as to the efficacy of informal challenge?

A. The problem existed for years, so, you know, I think there was always going to come a point where the

efficacious nature was deemed ineffective, yes.

115 Q. Issue 2, outpatient review backlog. Here you report 667 patients in his outpatient review backlog dating to 2014. You say that whilst outpatient review backlogs exist with his urological colleagues, the extent and depth of these is not as concerning. 11:42

Is this, again -- is this a volume issue when you are comparing with colleagues or why do you say it is not concerning when it comes to them? 11:42

A. It's a volume issue. I think that, in fairness to Aidan, I think that Michael's, as was referenced yesterday, I think Michael Young's review backlogs were quite high. I don't think Aidan was on his own. It other specialists they were. In terms of extent and depth, the extent is it how far they go back and the depth is how many of them go back that far. You might have somebody that has gone back to 2014, maybe one or two, then the next one might be 2016 or 2015, in between. You might have somebody that has hundreds in 2014. That's what I was trying to allude to there in terms of the extent and depth. 11:43 11:43

116 Q. Notes at home, I can see what you say there. The problem being that if they're at home they may not be available for a patient attending, making the consultation difficult. 11:43

Scrolling down, please

The Trust had a practice of recording, using the

incident reporting system when a chart wasn't available. When you were looking at this in 2016, that formal method of registering the concern had stopped; is that right?

A. That's correct. 11:44

117 Q. Did you gain an understanding of why it had started as a practice and the rationale for that, and why it had stopped as a recording practice?

A. In terms of the rationale for why it started, yes, I was aware of that in terms of -- to give an example 11:44 that I was made aware of back at that time -- was it was a patient going to see a gynaecologist, and he didn't have a set of notes in front of him, so he was starting with a blank piece of paper, the concern being if he had the patient's notes that were with 11:44 Aidan, he or she may have taken a different course of action if they had the full set of notes. Obviously, it's of less relevance now within IECR but as that was developing, that period, I think there was still an issue that there was some concern that maybe previous 11:45 history of the patient's clinical management plans may have been missed.

In terms of your second question, in terms of why it was stopped, in terms of putting it in the IR reporting 11:45 system I don't recall.

118 Q. Issue 4 then was the recording of outcomes from consultants and in-patient discharges. This was not always being done, or not done quickly enough, is that

fair, by Mr. O'Brien?

A. Yes.

119 Q. But you were not able to quantify that because no formal audit had yet been performed?

A. That's correct. 11:46

120 Q. Now, you then proceed to summarise the concerns using the Good Medical Practice Code of the General Medical council. You set that out and you offer the following conclusion that: 11:46

"The report recognises the previous informal attempts to alter Dr. O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr. O'Brien's practice, with Terms of Reference 11:46 centred on whether his current organisational practice may lead to patients coming to harm."

First of all, you seem to be suggesting that based on your research, informal approaches to these issues had 11:46 not been successful and it was necessary to try a more formal approach?

A. That's correct.

121 Q. And you considered that the more formal approach was an external assessment of his organisational practice with 11:47 Terms of Reference focusing on whether those shortcomings would lead to patients coming to harm?

A. That's correct.

122 Q. Now, can you recall what Dr. Wright response to the

report was at the time?

A. I can't, is the honest answer. I know, as I said earlier, I gave it to him. I e-mailed him on the afternoon of the 5th. I was on leave on the 6th. I know that I was in Craigavon on the 7th because I had a meeting with junior doctors that lunchtime. I would have perched on a desk somewhere in the Trust's Headquarters, possibly in Richard's office itself, and we would have had that discussion, but I don't recall what his comments were, no. 11:47 11:48

123 Q. In terms of that recommendation, was it ever discussed?

A. I don't recall. All I recall is Richard asking me to make contact with NCAS on the 7th.

124 Q. Yes. Certainly that recommendation was never taken forward? 11:48

A. No.

125 Q. You have said, and turning to what Dr. Wright said in evidence, which seems to marry with what you have said, that in terms this recommendation was, in essence, you over-extending your role, going beyond your remit seems to be the agreed position between yourself and Dr. Wright. 11:49

I've shown you already the table, the flowchart headed "Screening Process" leading to the need to make a decision which could have, amongst the options, have included an external NCAS process. When you think about this now, the mild criticism attached to your recommendation, the suggestion that you've overreached 11:49

yourself by Dr. Wright, what was a screening report within the context of the guidelines and MHPS to do if it wasn't to produce a decision or a direction, such as you included?

A. I would agree.

126 Q. When you reflect now, was there an confusion on the part of yourself or Dr. Wright in terms of a proper understanding of this process?

A. Yes, I would agree with that, yes. Certainly I think there was confusion from both of us, yes. 11:50

127 Q. In terms of your drafting of the report, the Inquiry is aware that there are two versions of it. I just want to ask you about that. Let me just scroll down a minute, please.

11:51

The version that we are working with would appear to be the version which was shared with Dr. Wright, Mrs. Toal and Mrs. Gishkori, who make up the Oversight Group. If we could turn to WIT-23734. Just go to the bottom of the page, "Summary of Concerns", then on down, please, 11:52 "Conclusion". You can see that this version has the added sentence:

"The options available for this external assessment are provided in Appendix A". 11:52

Then you set out Appendix A, which is a description of the various assessment services or types of assessment that NCAS could carry out. Now we find that version

attached to your Section 21 statement. Can you help us at all in terms of why the version, with the appendix, was created by you and, in turn, why it does not appear to have been sent to members of the Oversight Group?

A. I think, if you scroll up slightly, you will that it is dated 7th September, at the bottom of the page before. 11:53

128 Q. Yes.

A. I think what's happened there is that I've had a discussion with Colin and then, subsequent to that, I've added in that. But maybe, this is conjecture, reflected that this was really overstepping the mark, so it never went anywhere. That's the only logical thing I can think of. 11:53

129 Q. Did anybody tell you at the time that you were overstepping the mark? 11:54

A. No.

130 Q. It's conjecture, what you've just said.

A. Yes.

131 Q. Again, to the best of your knowledge, the suggestion of an NCAS-regulated assessment wasn't discussed. You have no recollection of it being discussed, even at the Oversight Group? 11:54

A. No.

MR. WOLFE KC: It is ten-to-twelve. I have plenty to get through but I think, in ease of everybody, a short break, maybe, to 12 o'clock? 11:54

CHAIR: According to the clock in the chamber it is almost five-to. So let's say ten-past-twelve.

MR. WOLFE KC: Very well.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe.

12:10

132 Q. MR. WOLFE KC: Mr. Gibson, if we could have up on the screen, please, WIT-33922. Before the break we looked at your screening report and what became of your screening report. You explain at paragraph 13.1:

12:11

"When I completed the screening report on 5th September I discussed this report informally with Dr. Wright as Medical Director who wished to convene an Oversight Committee to formally consider this screening report and determine the next steps. The date for this 12:11 Oversight Committee was set for 12th September 2016. To assist the consideration of the Oversight Committee, Dr. Wright requested I seek the advice of NCAS, which I did by telephone on the same day."

12:11

You informally discussed the report. Can you remember anything about that?

A. No, I can't.

133 Q. The fact that you were sent in the direction of NCAS for further advice and the fact that Dr. Wright thought 12:12 that an Oversight Committee should be arranged for the 12th, it was to become 13th September, does that suggest that between you and Dr. Wright you thought that the concerns exhibited in your report were

sufficiently serious to merit further action?

A. I can't say. That would have been Dr. Wright's decision.

134 Q. And he didn't articulate that to you?

A. I can't recall. 12:12

135 Q. You contacted NCAS that day?

A. That's correct.

136 Q. Had you previously had cause to contact NCAS to seek advice?

A. No. 12:12

137 Q. This was your first time in contact with that organisation?

A. In terms of in contact with the organisation, no. Obviously I had been at the training, but in relation to a doctor, that's correct, yes. 12:13

138 Q. What was your understanding of what they could tell you or advise you? You're doing this for the first time. Dr. Wright has told you, go and seek advice. What did you contemplate that might have meant?

A. I was aware of what NCAS can offer because I had been at the training course. In terms of what it might mean, or the phone call that I had with Colin on the 7th, I had no preconceived ideas of how it would go. 12:13

139 Q. In terms of advice, what advice were you seeking?

A. I suppose the question would have been advice on managing Aidan. 12:13

140 Q. It was fairly open-ended?

A. Yes. It was to seek advice. Yes.

141 Q. Dr. Wright, in his witness statement, recalls

communication at that time from Mr. Haynes, that's in or about September, early September 2016, and that this was his prompt to ask you to contact NCAS and to arrange an oversight meeting. Did Dr. Wright discuss with you his communication with Mr. Haynes? 12:14

A. I don't believe so. No.

142 Q. If we can just look, then, at the discussions that you have with NCAS. WIT-53479. This is an internal record made by, it appears, somebody called Jill on 7th September, and she's marking it for the attention 12:15 of Colin, that's Colin Fitzpatrick. Just referring -- going down slightly. He refers to you as Dr. Simon Gibson. That's not how you introduce yourself, is it?

A. No.

143 Q. We'll ask NCAS about that, but perhaps the assumption 12:15 is that people contacting them to seek advice are the medically qualified clinical managers, generally?

A. Yes, I can understand from Jill's perspective, certainly that could well be the case. And certainly Colin would have known that I wasn't a doctor, I would 12:16 have worked with Colin in a previous life before the Trust, so I would have known Colin from years ago and we obviously were together on the course on 30 August, and he would have known then that I wasn't clinically qualified. Whether Jill made an assumption, I just 12:16 don't know.

144 Q. So she records what she describes as the "skeleton details". You can see the summary of concerns set out there. Are you content that they broadly accurately

reflect what you're saying to them, saying to Jill?

A. Yes.

145 Q. Before you then presumably had a conversation with Dr. Fitzpatrick?

A. That's correct. 12:16

146 Q. When you left that conversation with Dr. Fitzpatrick did you leave, and I know it was on the telephone, but did you leave that conversation with a package of advice that you could bring to the Oversight Committee?

A. Yes. I do recall the phone call. Obviously it was the 12:17 first time I had done this so it was kind of -- it did stick in the mind. I remember having the screening report beside me as a script to make sure that I conveyed all the information to Colin. And whilst I haven't been able to find the diary I physically 12:17 wrote in back in 2016, I would have jotted down the advice that he gave me following the phone call.

147 Q. You refer to having the screening report, of which you were the author, beside you as you spoke. As an aide-memoir, presumably? 12:18

A. Yes. I didn't speak to it verbatim, that wouldn't be my style. But certainly I recall knowing that I wanted to convey accurately the detail of the information that Richard had asked me to speak to NCAS about, and I didn't want to miss it by just doing it off the top 12:18 of my head, so I had it beside me and stepped through it. I think it would appear that that's kind of reflected in Colin's letter back to me.

148 Q. You didn't send them the screening report?

A. No. I don't believe so.
149 Q. Did you tell them that you were the author?
A. I don't believe so. No.
150 Q. The letter that you received from Dr. Fitzpatrick, we can find it at AOB-01049. We'll step through this. It is dated 13 September. The Oversight meeting happened that day at 10 o'clock and you tell us in your witness statement that this letter wasn't available for the meeting? 12:19
A. That's correct. This came in at 16:29, I believe. 12:19
151 Q. So Dr. Fitzpatrick reflects that this is a letter he is writing following the discussion with him on 7 September, between you and him, and he sets out the background and your description of the problems: A backlog of 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog. Is that accurate in terms of what you would have said? 12:20
A. It's a fair representation of the screening report in which I say similar. I mean it is not word for word, but it certainly is not inaccurate. 12:20
152 Q. You told him that Mr. O'Brien is very slow to triage referrals, can take him up to 18 weeks, whereas the standard required is less than two days. Again, is that an accurate reflection of what you would have said? 12:20
A. Yes.
153 Q. You told him that he often takes patient charts home and does not return them promptly, often leading to

patient arriving for appointments with no records available. Again a fair reflection of what you would have told him.

"You told me that his note taking has been reported as very poor and on occasions there are no records of consultations". 12:21

Again that's a reflection of what's in the screening report, so presumably you told him that. 12:21

A. That's correct.

154 Q. The last paragraph on the report is: to date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology. I don't think we find that in your screening report, is that fair? 12:21

A. Yes.

155 Q. Again do you think it is fair to say that is something he must have got from you?

A. I do recall having that conversation. I was aware, as I have said, that I wanted to keep the conversation as factual as possible, and as evidence-based, which is why I was looking at the detail and the data that was in the screening report. Then he asked me a very specific question, 'are you aware of any actual patient harm?' And I remember -- it's too dramatic to say I kind of missed a beat, but I was aware of this kind of delayed referred to oncology, but I didn't have anything to hand as evidence or a document that could 12:22 12:22

support that. I was aware that, in terms of NCAS, you have to be as evidence-based, and as fair and as factual as you can be, and yet I was about to raise something for which I had no evidence whatsoever, but I was aware of it. I have to be completely honest, I wasn't aware of the IR1 that Mark Haynes raised in, I think it was late November '15, until his evidence was presented on Day 10 of this Inquiry. I didn't think have that to hand and it wasn't provided to me. The only way I could have got that was through an anecdotal discussion as I was gathering up the information. 12:22 12:23

156 Q. Let me just break that down a little. You, if we take the words of Dr. Fitzpatrick, you have referred him to anecdotal reports of delayed referral to Oncology. Doing the best that you can, what was the source or sources of that anecdotal concern or anecdotal report? 12:23

A. The honest answer is I can't recall. I mean, I had been working with Martina in that period between 21 August and that date, 7 September. I don't recall a conversation with Martina. But I was doing a discrete piece of work, I wasn't having lots of conversations with lots of people. The honest answer to the Panel is I can't recall where that came from. 12:24

157 Q. It doesn't offer much, or any detail perhaps, in terms of the context in which these delayed referrals to Oncology take place. Again, can you help us to break that down a little? In what circumstances were delays to Oncology taking place? 12:24

A. It would be unfair of me to rely on what I have subsequently learned in the last few days, looking at Day 10, because I only just learned that. I have no recollection of the detail behind that at that time.

158 Q. You keep referring to Day 10. Mr. Haynes gave evidence on Day 10. He referred, and I'm not sure I'm going to be able to remember the name of the patient, but we're not going to name the patient out loud in any event, we have a cipher list in front of you. 12:25

A. Yes. 12:25

159 Q. I have a recollection, and maybe you can help me on this, that Mr. Haynes talked about raising an IR1 --

A. That's correct.

160 Q. In respect of a patient?

A. I recall it being Patient 102. 12:25

161 Q. 102.

A. But I think from the evidence bundle attached to the Day 10 transcript of Mark's evidence, yes.

162 Q. Yes. But that is something, that specific case of Patient 102 is not something you would have been aware of as a specific actual case of a problem in respect of referring to Oncology when you had this conversation with Dr. Fitzpatrick? 12:26

A. That's correct. No. I mean the timeline isn't that far out. I mean, Mark submitted it in November '15 and it was escalated through the IR1 in December and March '16, but I have nothing more than that. 12:26

163 Q. Is what you are saying, just so the Inquiry is clear, it's conjectural.

A. Yes.

164 Q. But what you're saying is, in the system at that time, unbeknownst to you, was this case of Patient 102, who had not been referred to oncology, and that is a possible anecdotal, that is possibly the case that was drawn to your attention anecdotally without it being named, is that what you are saying? 12:27

A. That is what I'm saying, that it is conjecture. I have nothing I can back it up with. But that is the only logical place I can come to for that. 12:27

165 Q. We've heard from you already that in terms of the information that you gathered for the purposes of the screening report, you spoke to two people. One was in records, the other had, I suppose, a more rounded understanding of what was going on within urology services because she, that is Mrs. Corrigan, was Head of the service. In terms of the source of these reports, can you say it is more likely than not that Mrs. Corrigan would have told you about this? 12:27

A. I can foresee that being a kind of plausible explanation and I can't think of an alternative one that is as plausible. That's as strong as I can say it, I'm afraid, apologies to the Panel. 12:28

166 Q. The fact that it was known, or perhaps to use a lesser word, suspected, that there were delays in referral to oncology, it is, nevertheless, a source of information or evidence to you, but it didn't make it into your screening report. Why is that the case? 12:28

A. I have reflected on that. I think that maybe I was

being too literal and too narrow in terms of putting that report together in terms of making sure it was, you know, quantifiable evidence that could be backed up with reports. At the time all I had was maybe a conversation over coffee. Again, this is conjecture, 12:29
maybe I thought it was not strong enough to put into the report.

167 Q. You clearly didn't keep it to yourself. It's shared with NCAS and, as we'll see in a moment, the NCAS advice was shared by you with others on the Oversight 12:30
Group, including Dr. Wright. Have you any memory of this particular aspect, delayed referral to oncology, ever arising as a topic of conversation within the various Oversight Group meetings, of which there were several? 12:30

A. No.

168 Q. When you think about it now, albeit that you have a vague memory of the substance of this, someone telling you that there are concerns about delayed referral to oncology surely merited some kind of 12:30
further inquiry, if not formal investigation?

A. Yes. I mean I submitted the letter to Richard, as Medical Director, and to Esther Gishkori, as the Acute Services Director and I don't know what action was taken to it after that in relation to that specific 12:31
line.

169 Q. We know, for example, that your report, your screening report, does not make any reference to private patients and the potential for abuse of the NHS system by

prioritising, or taking out of chronological order, patients who had started as private patients. That information came into the system, if you like, anecdotally when Mr. Haynes reported it after the Oversight Committee meeting in December of 2016, and yet it found its way into the MHPS Terms of Reference for the investigation. Yet something potentially much more serious in terms of Patient Safety is known to you -- not alone you, obviously others in more senior positions -- and yet it appears not to have caused an eyebrow to be raised. Is that a fair way of putting it? 12:32 12:32

A. Yes. I mean, I had forwarded the letter on to Richard and to Esther, and maybe the blame is mine that I should also have specifically flagged it when I forwarded it to them, but I just forwarded the letter. 12:32

170 Q. Just over the next page, please. Dr. Fitzpatrick then -- top of the page, please. Thank you. 12:33

"The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies but to date there has been no obvious improvement." 12:33

Again, is that a fair reflection of what you would have told Dr. Fitzpatrick?

A. Yes, because that would have been the issue that

I raised in the screening report in relation to the discussions that Dr. Rankin and Mrs. Burns had had with him in 2012 and 2014.

171 Q. You are setting the issue in its, I suppose in its long running historical context as opposed to a very recent happening. 12:34

A. Absolutely. Yes.

172 Q. You appear to have discussed various options; is that fair?

A. Yes. 12:34

173 Q. There is a Trust policy in terms of the removal of records. Dr. Fitzpatrick saying this doctor appears to be in breach of the policy. This could lead to disciplinary action, and that would be open to you, but he would suggest asking for compliance. Okay. So is that information that you would have -- that advice, was that likely to have been given to you on the telephone? 12:34

A. Yes. Whilst I don't recall the specifics, I do recall, because I knew this was an important phone call, I had my diary there and I wrote down the advice he gave me into a series of bullet points. Yeah, I see the kind of, the four bullet points, kind of breaking it down, or summarising the four bullet points of advice that he gave. That would have formed in essence what I would have gone to Richard with and briefed him with following the phone call. 12:35 12:35

174 Q. So the possible disciplinary action or, in the alternative, asking for immediate compliance?

A. No. For this one here it would have been I would suggest he is asked to comply immediately with the policy, so that's what I would have led with.

175 Q. Yes. In terms of note taking, he's suggesting an audit might be useful? 12:35

A. Yes.

176 Q. Is that something you would have?

A. The second one was conducting the audit. The third one was the meeting. The fourth one was the query of relieving him of theatre duties. 12:36

177 Q. Sorry, say that again?

A. The fourth bullet point would have been the possibility of relieving him of theatre duties, which is the fourth piece of advice.

178 Q. The four were compliance? 12:36

A. Bring the notes home, do an audit of his charts, meet with Aidan to talk about the review patients and the triage and the possibility of relieving him of theatre duties.

179 Q. Did you appreciate upon leaving this discussion that perhaps a key emphasis of Dr. Fitzpatrick is the significance of Dr. O'Brien's backlog was such that he would require significant support, as is stated here? 12:36

A. Yes.

180 Q. On 28th September you send this advice to Dr. Wright and others. Let me just bring that up on the screen, please. WIT-41573. If you just highlight that. It is now 15 days after the Oversight Meeting and you say that: 12:37

"You will recall that as part of the collation of evidence in relation to the above" -- that's Dr. O'Brien -- "I sought advice from NCAS", which you say was discussed when the oversight committee met.

"The written advice has come in and is attached. Whilst the informal work is underway with Dr. O'Brien, the NCAS advice will be placed on file for reference should we need it at the end of the informal piece of work." 12:38

That is sent to Dr. Wright, Dr. McAllister, Mrs. Gishkori, Emma Stinson.

A. Emma was, at the time, Esther Gishkori's PA, and Dr McAllister was at that point AMD. 12:38

181 Q. Associate Medical Director. Was it sent to Mrs. Toal who was another member of the Oversight Group?

A. No, that was an oversight on my part. I didn't even flag that until she was preparing for the Inquiry, and that it was gone to her. 12:39

182 Q. You refer here to keeping this advice on file pending the completion of the informal work. We'll come on to pick up on that in a moment, but that's a reference to the fact that notwithstanding the Oversight Group's decision on 13th September to pursue an MHPS process, that was overturned and a much more informal approach was suggested and planned. 12:39

A. That's correct.

183 Q. Yes. Let's get into some of that now. Just before we do so, can I just share with you some reflections from Colin Fitzpatrick, Dr. Colin Fitzpatrick who wrote that letter to you. If we can bring up on the screen, please, WIT-53790. If we can scroll down to 12:40
paragraph 8. He is obviously reflecting back on the events of 2016. He says it occurs to him that there were a number of missed opportunities by the Trust in connection with Dr. O'Brien's case. He says initially when Simon Gibson telephoned me on 7th September, 12:40
I recall asking if there were wider concerns with regards to Dr. O'Brien's capability and I was told that there were not. My observation is that Simon Gibson cannot have been fully informed at the time he contacted me because he finds it difficult to believe 12:41
that there were not prior concerns about capability before this call took place. "Anecdotally I understand there are individuals who worked with Dr. O'Brien who had concerns about his capability for a long time. I do not have any documentary evidence that these 12:41
concerns were ever raised formally."

Can I have your response to that, please, Mr. Gibson?

A. I don't recall that element of the conversation is the honest answer. 12:41

184 Q. In what respect? He says he recalls asking you if there were wider concerns?

A. Yes. I don't recall that discussion about wider concerns of capability.

185 Q. Let's examine that. We can see from your screening report what your knowledge of the concerns was, and we can see that in addition to those concerns the record, i.e. Dr. Fitzpatrick's letter includes the additional concern, albeit anecdotal, in terms of referral to oncology. Did you have notice of any concerns beyond that? 12:42

A. Beyond the issues that were in the screening report?

186 Q. Yes, and the oncology anecdotal issue?

A. Not that I recall, no. 12:42

187 Q. Your informant, primarily, for your screening report was Mrs. Corrigan. Did she share any additional concerns with you?

A. Not that I recall, no.

188 Q. In terms of his observation that he finds it difficult to believe that there were not prior concerns about capability before this call took place and that anecdotally he understands that the concerns about his capability -- that is Mr. O'Brien's capability -- existed for a long time. Were you putting it across to him that the concerns that you were mentioning had existed for some time? 12:43 12:43

A. Well, yes. I mean I clearly mention the issues that were going back to 2012 and 2014 and then March 2016. So, yes, I would have -- that's in the screening report and I would have reflected that to Colin, yes. 12:43

189 Q. He categorises -- and I think deliberately, as we'll see in a moment -- prior concerns about capability. Do you understand the word "capability" in this context as

opposed to "conduct" for example?

A. You see, I would take that to mean is Aidan capable of doing a triage of an outpatient? Is he capable of keeping the charts in the hospital? My observation of that is that, yes, if you asked Aidan nicely he would do the triage. It's not that he wasn't capable of doing triage, it's just that he wasn't doing it and was behind in it. To me that's my interpretation of what "capability" means in this context. 12:44

190 Q. Yes. So is it fair to say that based on your knowledge of the working practices of Mr. O'Brien, these weren't capability issues or ability issues, these were something else? 12:44

A. Yes. I think that's a fair summation, yes.

191 Q. What is that something else in your view? 12:45

A. Conduct.

192 Q. We will obviously speak to Dr. Fitzpatrick, but he says that he understands that capability issues or concerns had existed for a long time and his date of knowledge of that will be examined by the Inquiry. Presumably he didn't share that with you at the time of the telephone call? 12:45

A. No. I don't recall that, no.

193 Q. If we can scroll down the page a little and go to -- just a moment -- if we scroll down to paragraph 11, please. We'll read 11 and 13 together. 12:45

He says that: "Once capability concerns were identified there needed to be a clear diagnosis of the

issues and the scope of an investigation defined. That is a stage when the Trust might have taken some wider soundings to be clear it investigated the right issues".

12:46

He says: "Upon being informed of a Serious Adverse Incident and patient harm, I would expect a Medical Director to carry out a soft investigation in relation to wider concerns around clinical capability, which would then inform the terms of reference of any subsequent investigation. This might be considered as another missed opportunity."

12:46

He goes on to say: "The categorisation of the initial concern can make a significant difference to how a case progresses, with a distinction between capacity (with options for assessment and remediation) and conduct (which can lead to a disciplinary). If Simon Gibson did not know about any clinical capability concerns in September 2016, that avenue under the MHPS framework... effectively disappeared."

12:47

12:47

There's a couple of points in there which I wish to explore with you but, again, just on the clinical capacity issues. Dr. Fitzpatrick seems to be categorising these as capability issues in the context of Mr. O'Brien and not conduct?

12:47

A. You mean capability?

194 Q. Capabilities, yes.
A. Sorry. Yes. Because you mentioned capacity.
195 Q. I'm using that interchangeably. But let's stick to capability, so not to confuse you.
A. Thank you. 12:48
196 Q. He says that the circumstances that you describe to him, he seemed to suggest that they are not conduct issues but capability issues. That's not how you understood it?
A. No. 12:48
197 Q. The other issue he addresses is the need for a wider soundings to ensure that the right issues are investigated. You accept that as an operational manager, or non-clinical manager, you were probably not, at least in terms -- you were definitely not, at 12:49
least in terms of the guidelines --
A. Yes.
198 Q. -- and the MHPS process, definitely not the right man for this job.
12:49
Would you accept that a Clinical Manager might have a better sense of the problems that might exist below the surface in the practice of their colleagues?
A. Yes. Absolutely.
199 Q. At no time were you tasked with the job of taking the 12:49
investigation wider than the four items that are reflected in your screening report?
A. No.
200 Q. Do you think there was a missed opportunity to look

more broadly at Mr. O'Brien's practice in 2016?

A. Yes, I do. Yes.

201 Q. Why do you say that?

A. I think that if they'd followed the letter that was written subsequent to the Oversight Meeting on 13th September, I think that would have provided an opportunity to look wider, yes. 12:50

202 Q. That's the letter that you drafted as a result of the decision taken by the Oversight Committee --

A. That's correct. 12:50

203 Q. -- on that date, the 13th? We'll look at that shortly. The Oversight Committee meeting then on the 13th. If we could bring the record of that up, please. It's at TRU-0026. This is the minutes. There are several doctors mentioned in this so we want to be careful. 12:52 13th September meeting, the members of the Oversight Group were Wright, Toal and Gishkori?

A. That's correct.

204 Q. You were in attendance with Malcolm Clegg. What was his role? 12:52

A. Malcolm would be one of our medical HR team members, very good guy. Yes.

205 Q. Who drafted the minutes of this meeting?

A. Malcolm did those ones.

206 Q. Scrolling down to the next page, please? Just take a moment to read the minute. The background is set out of a letter sent to Mr. O'Brien on 23rd March '16. He was asked to develop a plan. No plan has been provided and almost six months have elapsed. A preliminary 12:52

investigation has already taken place on paper. Is that a reference to your screening report?

A. I assume it must be, yes.

207 Q. In view of this, the following steps were agreed. Just before we look at the steps, conscious that your screening report made a particular recommendation, it doesn't feature in the minutes. Conscious that you received oral advice from NCAS, Dr. Fitzpatrick doesn't feature in the minutes. Is that fair? 12:53

A. He certainly doesn't. No. 12:54

208 Q. I pulled up an email earlier in which you indicated to Dr. Wright, and others as you sent them a copy of the NCAS advice, that the advice was discussed by you. "You will recall that I discussed this advice", I think was the words? 12:54

A. That's correct.

209 Q. Did you take this Oversight Committee through the advice provided by Dr. Fitzpatrick?

A. Again, I have to be honest, I have no definite recollection of doing it, but, in my mind, I had been tasked with doing the piece of work over two weeks, which I'd done. I briefed Richard. He asked me to go to NCAS. I did that. I came back, I briefed Richard. Subsequent to that I drafted the letter. The thought that I would have sat there like a wallflower is inconceivable to me. I definitely would have briefed the committee. 12:54

210 Q. In fairness to you, I'll make the point, you said in your email on 28th September "you will recall that

I discussed NCAS device".

A. Yes.

211 Q. Did anybody come back to you and say "oh, no, you didn't"?

A. No. 12:55

212 Q. Let's then just work through what was agreed. You were to draft a letter for Colin Weir and Ronan Carroll to present to Aidan O'Brien. The meeting with Aidan O'Brien should take place next week. What should the letter do? It says here: 12:55

"The letter should inform Aidan O'Brien of the Trust's intention to proceed with an informal investigation under MHPS at this time."

12:56

Just pausing there, are you confident, when you think back now, that it was an informal investigation that was agreed?

A. Yes.

213 Q. "It should also include action plans with a four-week time scale to address the four main areas of his practice that are causing concern", and you set those out. 12:56

Again, notable that there is no reference to the anecdotal problem of referral to oncology. 12:56

A. That's correct.

214 Q. I think I may have asked you but just for complete certainty. Have you any recollection of that issue

being discussed at this Oversight?

A. No.

215 Q. It goes on to say that Esther Gishkori is to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week. What does "go through" mean? 12:57

A. I assume it means sign it off. Just QA it and agree it in terms of consent.

216 Q. Ronan, being Ronan Carroll, her Deputy Director?

A. Ronan Carroll at that time was Assistant Director for Surgery and would have had responsibility for Urology at that time, taking over from Heather on 1st April. 12:57

217 Q. Colin, that's Colin Weir, the Clinical Director?

A. That's correct.

218 Q. Then, going on down: 12:57

"Aidan O'Brien should be informed that a formal investigation may be commenced if sufficient progress has not been made with the four-week period."

12:57

There's nothing there about assisting Mr. O'Brien to achieve the goals that you very much wanted him to achieve, that is coming out of theatre, a suggestion made by NCAS, coming out the theatre duties or providing him, I think the words was he had a need for extensive support or significant support if he wanted to achieve this. 12:58

Can you help us in terms of, first of all, whether the theatre issue or any other form of support for Mr. O'Brien would have been discussed at this meeting?

A. It would have been because it was one of the issues that I would have notated following the meeting with Colin, so I would have raised it alongside raising the other issues. Yes. 12:58

219 Q. Where did that go then in terms of the conclusions that might have been reached?

A. I can't answer that. 12:59

220 Q. Indeed, if you think of all of the advice that was set out by Dr. Fitzpatrick within his letter and which you carried with you, perhaps in a note, certainly in your head, and reflected into this meeting, albeit it's not minuted, did this Oversight Group take on board and accept any of the advice provided by NCAS? 12:59

A. The only observation I could make in terms of the letter that I drafted the same day was that I think two of the issues that are characterised in that letter can be directly mapped back to Colin's letter. We subsequently came in on the 13th so, you know, two of the issues -- in fact three of the issues, but the theatre issue can't be mapped back. 12:59

221 Q. Let's look then at the letter at page TRU-251429. Could I ask your observations on this. One sees and it is perhaps notable when in August Dr. Wright briefs you to carry out your screening report, you immediately that day, or early the next day, write to Mrs. Corrigan? 13:00

A. That's correct.
222 Q. When he asks you to speak to NCAS, you do it either that day -- if you delivered the report on the 5th, but certainly you were speaking to NCAS on the 7th?
A. That's correct. 13:01
223 Q. You are writing this letter 13th September at 14:12 hours, or distributing it, within a couple of hours of the meeting concluding, I would assume?
A. That's correct.
224 Q. The meeting started at 10:00 a.m. Was there a sense, at least from your perspective, of the need to move through these stages very efficiently? 13:01
A. Absolutely. I really thought this was an opportunity to finally get Aidan into a firm and formal process, or informal process. So I was moving at speed to make sure that that momentum wasn't lost. 13:02
225 Q. You address the letter to all but, in particular, to Esther Gishkori saying that -- you're commenting on the targets you're setting within the letter which we'll lack at in a moment, the targets that you're setting for Mr. O'Brien. You say that they are, in essence, achievable but ultimately it's her call operationally? 13:02
A. That's correct.
CHAIR: Was not achievable?
226 Q. MR. WOLFE KC: Just to put this in context, 229 would not be achievable and you're saying we don't want to see him set with a target that he can't reach? 13:03
A. Yes.
227 Q. You've reduced that to something you regard as more

achievable; is that the right way?

A. Yes. I didn't see any benefit in setting him up to fail, to give him something, which in discussion with Martina who is incredibly knowledgeable in urology in terms of outpatients and what maybe could be done, but at the same time not letting it have a tail that would last forever. 13:03

228 Q. Just before lunch, and we'll deal with it very briefly, the letter you sent then is on the next page. If we scroll down. For whatever reason, it's dated 21st September. 13:04

A. I wrote it on the 13th. The reason I dated it on the 21st was the meeting was to take place the week commencing the 19th and there was a period in between time when we were to maybe have a to-ing and fro-ing just to finalise the letter, and I didn't want the letter to go out predated, so I just put a random date in there. The middle of the week commencing the 19th, to make sure it would be there or thereabouts. 13:04

229 Q. Could you help us then as we scroll down to draw out the advice from NCAS that you say is reflected? Do you want me to pause the letter so you can? 13:04

A. Yes. The advice from NCAS related to the four areas. There was the charts at home, which I believe is the next page down, area 3. 13:04

230 Q. Scroll down, please. So the advice from NCAS was either a disciplinary route or tell him to comply immediately?

A. Yes.

231 Q. Is that the option you pick?
A. It's the option that the Oversight Committee picked.
232 Q. Of course. So to be returned within 24 hours?
A. Of the date on this letter, yes.
233 Q. The second issue was one of audit of the outstanding dictations. 13:05
A. No. I think the audit was in regard to area 4, recording outcomes of consultations and in-patient discharges, which is the one that is on the screen there. 13:05
234 Q. Okay.
A. The second paragraph you can see: "A clinical note review will be undertaken of 20 sets of notes to assess your compliance as to this expectation."
235 Q. That's forward looking. It is not auditing what has fallen down in the past? 13:05
A. That's correct.
236 Q. There's to be a meeting with him, and that's what was advised by NCAS; is that fair?
A. That's what NCAS advised, yes. The letter, which would have been presented to Aidan during that week, which would have indicated areas 1 and 2, which are further up on that letter there -- 13:06
237 Q. Scroll up the to the top, please?
A. The meeting would have been the opportunity to discuss those as per NCAS advice. 13:06
238 Q. Yes. Just scrolling on further up the page to the top. The idea of an informal MHPS investigation which could proceed to a formal investigation, that was the

decision of the Oversight Committee?

A. That's correct.

239 Q. Was there any dissent on that decision as it was made at that meeting?

A. I don't recall any, no. 13:07

240 Q. Did Mrs. Gishkori contribute to the meeting?

A. She was there. I have no recollection of her being more or less vocal than anybody else.

241 Q. Can you help us? Because the NCAS advice to you doesn't mention an MHPS-type investigation. Where did 13:07 that idea come from?

A. From the meeting. From the Oversight Committee.

242 Q. Yes, but from who?

A. Oh, gosh, I couldn't recall.

243 Q. Was there any prior discussion with you about it before 13:07 the meeting?

A. No, I don't recall any.

244 Q. In terms of assistance or support to Mr. O'Brien, while the concluding paragraph refers to the availability of, I think, a counselling service -- 13:08

A. Yes.

245 Q. -- or something such as that, there's no specific offer of support to enable him to clear his backlog, for example?

A. That's correct. 13:08

246 Q. Does that suggest that while you may have communicated advice from NCAS on that issue, that that advice was, for whatever reason, disregarded?

A. Well, it's certainly not reflected in the letter.

247 Q. That's an answer that really doesn't address the question. Was it discussed?

A. I don't recall.

248 Q. If it had been agreed you would have put it in the letter? 13:08

A. Absolutely. That letter was the outworking of what the discussion of the Panel was.

MR. WOLFE KC: Okay, I think we can break for lunch.

CHAIR: 2.10, everyone.

13:09

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone.

249 Q. MR. WOLFE KC: We finished off this morning, Mr. Gibson, by looking at the Oversight Committee meeting and what flowed from that in terms of your letter. 14:11

I just want to take you back to something I raised with you this morning. You said that your screening report was completed in order to risk assess through quantification of the impact of the concerns. You go on in your witness statement at WIT-23463 to say: 14:12

"I provided the screening report to allow Dr. Wright, as Medical Director, to consider whether the concerns may have impacted on patient care and safety." 14:12

It wasn't your role to do that, that was information

for the Medical Director. It doesn't appear from the record of the Oversight meeting for 13 September that any discussion of a risk assessment took place nor, for that matter, was there any particular reference to patient care and safety.

Can you help us with this, were the four issues that you identified in your screening report viewed by the Oversight Group as merely administrative on the one part, or were patient care and safety issues realised or considered by the Committee?

A. I can't recall that, to be honest.

250 Q. I think it's a fairly fundamental issue.

A. Yes.

251 Q. What was your own perception?

A. I think, in terms of the charts not being available to other consultants, I thought that that had some potential. I think letters not being triaged was another issue. I listened yesterday to Dr. McAllister in relation to the outpatient review backlog, he described it as a red herring and I can see that now. I don't know what I thought at the time. But, certainly, Aidan wasn't alone in the outpatient review backlog being an issue. Certainly Michael had some and there were some in other specialties as well.

252 Q. Take the outpatient review backlog: The description of that problem in the letter sent to Mr. O'Brien on 23 March, dated 23 March, spoke about Mr. O'Brien maintaining a separate Oncology Waiting List and the

absence of validation of the waiting list backlog left the system, left the Service, not knowing whether patients were at risk. How is that a red herring?

A. I suppose in terms of the context of the way it was described in the screening report, it wasn't described in that way, it was only described in terms of a numerical value. I do recall seeing that in the evidence bundle in relation to the list. I wasn't aware of that in terms of, I didn't see the 23 March letter. I wouldn't have been aware of that at the time. 14:15

253 Q. You did see the March 23rd letter, did you not?

A. Not until later on in the year. I didn't see it in March.

254 Q. Yes, but you saw it before you drafted your screening report, surely? I thought you told us this morning you saw it multiple times? 14:16

A. Yes, I say I saw it multiple times, but when was the first time I saw it?

255 Q. Why would you not have seen it before drafting your screening report? You were in consultation with Mrs. Corrigan, who I understand had been the primary draftsperson of the letter of 23 March. 14:16

A. Yes.

256 Q. Was she not telling you that there was a significant level of concern about this? 14:16

A. I don't recall the detail of the conversation, I just recall that we were gathering together the information.

257 Q. So in terms of patient risk, you can't remember whether

the Oversight Group formed a view on that in September, but you had a view that some aspects of Mr. O'Brien's shortcomings, as you saw them, did hold the potential for patient risk?

A. Yes.

258 Q. In terms of clinical involvement in the decision-making around Oversight, can I just draw your attention to this. The Trust guidelines set out the role of the Oversight Group at paragraph 2.5. If I could bring that up on the screen, please, TRU-83689. And at paragraph -- top of the page. Scroll up slightly, on to the bottom of the next page. Thank you.

We'll start with 2.4: "The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR case manager...".

We had that this morning.

"The Chief Executive will be responsible for appointing an Oversight Group for the case".

"This will normally comprise of the Medical Director, the Director of Human Resources and Organisational Development and the relevant Operational Director."

That's what was done.

"The role of the Oversight Group is for quality assurance purposes and to ensure consistency of approach in respect of the Trust 's handling of concerns".

The decision maker is the Clinical Manager, the Oversight Group is there to ensure a consistent approach and for quality assurance purposes. That's not how it worked in this instance; isn't that right?

A. That's correct. 14:19

259 Q. The Clinical Managers who were closely connected with Urology was Mr. McAllister, he was the Associate Medical Director?

A. Yes, Charlie.

260 Q. Mr. Weir, he was the Clinical Director, both of whom had been recently appointed to their roles in the late spring of 2016? 14:20

A. Yes, that's correct.

261 Q. If they were outside the tent in the sense of not being brought to Oversight Group or consulted on what the Oversight Group was doing, do you consider that that has a negative consequence? 14:20

A. Yes, I can see how that would be. I think that whilst Dr. Wright as Medical Director was medically qualified, I think that Dr. McAllister and Mr. Weir would have been clinically a lot closer and maybe would have been able to give a wider perspective of issues that they may have been aware of that I certainly wasn't, or maybe others weren't as well. Certainly there would be advantages in Colin and Charlie being there, for sure.. 14:20 14:21

262 Q. Yes. The decision was taken by the Oversight Group to conduct an informal MHPS investigation. Mrs. Gishkori was party to that decision, but you became aware shortly after the decision had been taken by Oversight

that a different approach was being contemplated. Can you tell us how you came to know about that?

A. I think I was on leave on the 14th, but I was aware, in terms of the first bullet point, of the action notes from the Oversight Committee that I was to draft the letter. It must have been the second bullet point. Then I was to meet with Ronan and Esther and Colin, top and tail the letter. And given the fact that I was keen that this would have been done quickly, I then made contact with, I think it was Mr. Carroll to find out about the meeting when I came back on the 15th. Ronan said the meeting has been cancelled. So I then went to Emma Stinson, the PA at the time, very competent, and she said that there had been discussion. So at that point, and the email trail is there, but that's when I went back to Richard and said: Has there been a change of plan? 14:22 14:22 14:22

263 Q. Yes, just look at some of those emails. If we go to WIT-34101. You're asking is the meeting not proceeding? 14:23

A. Yes. I think further down, maybe where it starts with...

264 Q. With Ronan saying that Esther has cancelled the meeting?

A. Yes. 14:23

265 Q. Scroll on.

A. So I then check with Mrs. Stinson a couple of hours later. She would have been involved in the diary.

266 Q. The preceding page, 34100. So you communicate with

Dr. Wright on this issue and he replies:

"Classic Esther about-turn after the meeting. I've asked her to outline her plans in detail for us to consider. We haven't agreed to any change yet." 14:24

So this is all by word of mouth and email at this stage?

A. Yes.

267 Q. Is "classic Esther" a form of words you take any particular meaning from? 14:24

A. Yes. I would have understood what he was meaning by that.

268 Q. Just spell out what your interpretation of it would be?

A. Esther. Esther was unique in the Directors that I've worked under. She had a way of working which I wasn't familiar with. She wasn't, maybe, as structured and she wasn't maybe as involved as others and it wouldn't have been, in some ways I wasn't surprised you know that she'd signed-up for something, and then it had changed a day or two later. 14:24 14:25

269 Q. It's this about-turn and we'll see what it looked like in a moment, it seems caused Mrs. Toal to write to Malcolm Clegg to say:

14:25

"We're definitely going to need notes going forward if goalposts keep trying to be changed."

I think Minutes were in the offing already, but that

seems to be an instruction to make sure that the decision of 13 September was minuted. Was there a concern around management at your level and above that Mrs. Ghiskori couldn't be relied upon to tow the party line, or tow the decision in the direction that has been agreed?

A. I think that there was, on occasion, there was levels of indecision in Esther's decisionmaking and behaviour at a Director level, yes.

270 Q. You write to Dr. Wright the next day, perhaps as details around what is in the offing as an alternative to the Oversight are becoming known. If we turn to TRU-251434 and you're saying to Dr. Wright Charlie and Colin must understand the importance of formally recording the meeting. Presumably a meeting with Mr. O'Brien? 14:26 14:27

A. Yes.

271 Q. "Providing quantifiable actions" and "agreeing realistic dates. You say: "Doesn't need 3 months to return charts -- 5 days is generous". 14:27

Can you help us, what was the origin or the trigger for what you have written there?

A. I don't see an email trail where I was provided with the plan of Colin's and Charlie's. Whether or not it was word of mouth with Richard or whether he showed me an email, but it must have come from a discussion I had with Richard and I was reflecting back that I had a level of frustration that we seemed to have Aidan in 14:27

a place where we wanted him in terms of a nice tight process that was quantifiable, time bound, falling into a nice process that, had he followed it, would have been all done and dusted by 12th October, which was the date in the letter, and it seemed to be slipping away from us. Yes, I think that's a reflection there of my frustration of what was unfolding before us. 14:28

272 Q. You plainly thought the alternative that was being put together was counter-productive and not what it needed?

A. It didn't appear to me to be as tight as the letter that I drafted on behalf of the Oversight Committee of 13th September. No. 14:28

273 Q. Were you privy to the fact that Dr. Wright and Mrs. Gishkori met with the Chief Executive, Mr. Rice, that day? I'll show you the email. TRU-263685. Dr. Wright telling Vivienne Toal: 14:29

"I had a meeting scheduled with Francis" -- that's Francis Rice it has been confirmed for us -- "and Esther this morning and this topic came up. Esther agreed in principle to provide the information requested and to ensure that there was a documented meeting with Mr. O'Brien outlining the implications of not getting this sorted within 3 months. Francis was keen to pursue this under those circumstances but not to let it run further than 3 months if still noncompliant." 14:29 14:30

That would suggest, when you talk in your email about

not needing 3 months to return notes, that maybe you had received a flavour of this, whether orally or by email?

A. Yes. I don't recall this being forwarded to me by Richard. So whether or not it was a verbal update or whether he showed me. But, yes, that would be an indication of where that may have come from. Yes. 14:30

274 Q. Was Dr. Wright equally as frustrated with this turn of events?

A. Yes. I think he was. Yes. 14:30

275 Q. In terms of I suppose the power dynamics, to be crude, of the relationships in this context, could Dr. Wright and Mrs. Toal have stood their ground and said, listen, this is the decision of the Oversight Group that you have sent it to, Mrs. Gishkori, now let's get on with it? 14:31

A. I mean that certainly was an option. They could have done that. And I think, I mean I think Richard had a very collegiate style as a manager but if, on this occasion, he had been a bit more dogmatic and said no, that was the decision, we're moving on, we're not going back, I think on this occasion that might have been a better approach, yes. 14:31

276 Q. Would such a dogmatic approach have been, nevertheless, problematic in terms of relationships and, I suppose, the need to have co-operation from Clinical Managers or could he have forced this through? 14:31

A. I mean, yeah, it might have made things difficult but I think he certainly could have forced it through.

Yes, I mean, I think the Medical Director there would have been responsible for that decision and saying, no, this is the way it has to be. I think that could have been done. Yes.

277 Q. Was there, perhaps, a failure to recognise the urgency in the sense of risk-to-patient harm that led Richard Wright and perhaps Francis Rice to fail to stand up to this development? 14:32

A. I don't know if I can answer that. I don't know what was in Richard's and Francis' mind, unfortunately, when they met with Esther. 14:32

278 Q. Have you any view on why, let's call it for convenience, 'Esther's contrary plan', I know it is more than Esther, but just for convenience. Have you any explanation as to why that alternative came to supplant the Oversight Group's decision? 14:33

A. Only from what I read from the emails that Esther wrote on, I think it was the 14th and 15th. She was clear that she wanted to take this forward. That's her clear indication that that's her drive. 14:33

279 Q. Did you appreciate that at that time that Dr. McAllister and Mr. Weir had been asked to consider the circumstances in which Mr. O'Brien had failed to triage Patient 93, if you look at the name? First of all, do you know about the case of Patient 93? 14:34

A. I know about it now in preparing for the Inquiry. I don't recall it at the time, no.

280 Q. That was a case where Mr. Haynes recognised that there was a failure to triage. If triage had taken place the

patient might, and perhaps should have been red flagged to return into the system with, as I understand it, metastatic disease arising out of a prostate primary?

A. Mm-hmm.

281 Q. That wasn't a case you were aware of at the time? 14:35

A. I don't recall that. No.

282 Q. In terms of the approach that was adopted, the plans which were made can be seen at TRU-257641. And they start with Mr. Weir putting something together on the 16th, this is, again, where the three months thing 14:35 comes from. Did you ever see that plan?

A. Only when preparing for the Inquiry. I hadn't seen that before, no.

283 Q. Do you know if Dr. Wright was ever shown that plan?

A. Gosh, no. I wouldn't know if he was shown that or not. 14:36

284 Q. In terms of your role within the Medical Director's office in September 2016 and, subsequently, it didn't come across your desk?

A. No. I don't recall it at all. The reason that I believe that is because as soon as I, in preparing 14:36 for the Inquiry I compared it with the letter of 13 September to get a sense of how close or how far it was from what had originally been planned, and that would have stuck out because it is clear clearly different.

285 Q. Let's just scroll down until we see the end of it. 14:36 Then if we go, and it is amended then by Mr. Carroll, I'm sure you've seen that. If we go up the page to TRU-640. Let's just look at that whole section with the red ink. Just scroll up slightly.

When you compared that plan with what Oversight had agreed and what was referred to in your letter, what was your reflection?

A. I mean, I think, certainly, with the first version, which was Colin's version, was compared to the September 13th letter, quite loose, in my opinion. It didn't have the quantification, the time scales, the detail that was required. I think Mr. Carroll, you know, whilst he was new in this role was very experienced as an AD, and I think he was attempting to put a bit of structure around it, but still, even with those additions and his kind of attempts to look at kind of monitoring processes and putting those in place, it may be still, if you compare it with the 13th, wasn't quite as tight. 14:37 14:37 14:38

286 Q. Thank you for your view on that. The other factor that you might reflect upon was the absence of any form of MHPS investigation in this alternative. Why, in particular, do you think the informal MHPS investigation was important to the Oversight Group? What did that add to the mix? 14:38

A. I think it gave it a structure and it gave it a formality in the terms of the seriousness of it, which I would have assumed wouldn't have missed Aidan in terms of his understanding of where he was. Whereas this was maybe another method of doing what had been tried in March, in 2014, in 2012, and had been unsuccessful. I do take onboard what Dr. McAllister said yesterday that this was a first step and would 14:39

have been worked upon, but as it sat there I think having MHPS as an underpinning element of this would have maybe focused Aidan's attention.

287 Q. Does the fact that this comes with the input of Clinical Managers rather re-emphasise the point that I was making to you earlier that it's important, and it is of course reflected in the MHPS Framework and in the Guidelines, to start with the clinical management input rather than the other way round? 14:39

A. Yes. If you re-ran this again and you had Colin and Charlie at the beginning, then within the context of the MHPS structure, i.e. the way it should be done, I think the end product would have been far better than anything else that had gone. 14:40

288 Q. Hypothetically, one option or one possibility, might have been that Mr. Weir came into the Oversight Group with that plan and the Oversight Group, quality assuring it, said no, that's not good enough, that's not strong enough? 14:40

A. Yes, yes, that theoretically could have happened, or they could have said it was good, but we need to tighten in some of the timescales and quantification and the numbers. 14:40

289 Q. Now, conscious that you didn't see that at the time, there was another Oversight Group meeting on 12 October? 14:41

A. That's correct.

290 Q. If we could just pull up the minute of that, WIT-33928. Sorry, that's your statement. The correct reference is

AOB-01079. Scroll down the page, please. The same people in attendance. It was reported by Mrs. Gishkori that Mr. O'Brien was going for planned surgery in November, was likely to be off for a considerable period. It was noted that Mr. O'Brien had not been told of the concerns following the previous Oversight Committee. It was the noted that a plan was in place to deal with the range of backlog within Mr. O'Brien's practice during his absence. Mrs. Gishkori gave an assurance that when Mr. O'Brien returned from his period of sick leave that the administrative practices identified by the Oversight Committee would formally be discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee. 14:42 14:42 14:43

Now, you didn't see the revised plan, but you knew that the Oversight Group's decision had been placed to one side by the middle of September. Here, we're sitting on 12 October, four weeks had passed, and there were to be another four weeks before Mr. O'Brien goes off for surgery. Have you any sense at all as to why the you urgency which you had appeared keen to inject into the process had completely dissipated? 14:43

A. I don't know why that has happened. Looking back now I'm disappointed because the irony of the fact that the 12 October was the meeting, that was the date at which the process should have been concluded. But here we were going on, yet another plan, for weeks and weeks 14:43

ahead.

291 Q. Not to put too fine a point on it, unless there's evidence that I'm not yet aware of, everything would appear to have stopped after Mr. Carroll amended the Colin Weir seven-point plan, or whatever it was? 14:44

A. Yes, that's correct.

292 Q. Was there no drive from the Medical Director's office to say, right, Mrs. Gishkori, and your Service, you have won the battle in a sense with this alternative, now get on with it and let's see the outcome. Did that 14:45 get lost?

A. Well I mean I'm not aware of any communication between Richard and Esther in terms of trying to move this on swiftly, so I think that's a fair comment.

293 Q. Is it perhaps a sense of, well, we have tried our best, 14:45 now it's over to the Service.

A. Well that's where it was sitting at that time. Yes.

294 Q. I think Dr. Wright may have suggested -- I'm not sure if it was conjecture or otherwise, but the man, Mr. O'Brien, was going into hospital in four weeks. 14:45 There's an element of well, we'll leave him alone. Did that come across in any conversation you were involved in?

A. No. I do recall that from -- maybe it was reading his transcripts from Day 23, but at the time I have no 14:46 recollection of that, no.

295 Q. Does it appear to you now that when you think of the informal steps that you became aware of during your screening investigation that had failed to direct or

obtain permanent change, that this was typical of that, another false dawn?

A. Yes. Absolutely.

296 Q. Was there any sense that you were aware of people -- and here I mean Mrs. Gishkori, Mr. McAllister, Mr. Weir -- running scared of Mr. O'Brien for any reason? 14:46

A. No. Well, taking them individually, certainly not Charlie. Dr. McAllister, I would have held him in high regard in terms of his ability and his role as an AMD and I would have been under no illusion that he would have been willing to address any issue with any clinician if it was required of him. I think, from Colin's evidence yesterday, I think Colin maybe did have a bit reticence in tackling Aidan and Esther. I don't know about Esther. 14:47 14:47

297 Q. Was Mr. O'Brien seen to be closely connected with the hierarchy within the Trust?

A. Everybody knew he had a close relationship with Roberta Brownlee, yes. 14:47

298 Q. But you don't know whether this was a factor in the behaviour in September or October, to depart from Oversight?

A. It certainly wouldn't have affected Charlie, that's for certain. I doubt it would have affected Colin. Whether it affected Esther, I would be less certain. 14:48

299 Q. Why do you say you'd be less certain in her case?

A. Roberta kind of directly appointed her.

300 Q. You say in your statement, when reflecting on these

events, and we have asked you about the impression you have formed about the implementation of MHPS, that your primary impression is one of surprise that Mrs. Gishkori decided to move away from the decision of the Oversight Committee to commence the investigation. 14:48

You say that at WIT-33938, paragraph 28.2. You go on to say that Mrs. Gishkori's decision to not follow the decision of the Oversight Committee was a missed opportunity to manage Mr. O'Brien at the time. Do 14:49 you wish to add to that in any way?

A. Only, I think I feel a sense of personal regret for the patients. I'm aware that if we had followed that path of having it all done by 12 October, that would have included the four patients that subsequently became 14:49 part of the SAIs, in terms of their delay being until January/February. So in terms of the actual impact on patient care, that is a huge regret of mine.

301 Q. You've reflected already, I think, this morning, that standing back and looking at this there was a failure 14:50 to follow the steps set out, whether you look at MHPS itself or the local guidelines and, in particular, giving you a role which really didn't belong to an operational manager both in terms of the screening report and contacting NCAS. They were roles, really, 14:50 for a medical practitioner. Do you think, in terms of your experience of matters subsequently, that the Trust has learnt any lessons from this, the way in which this process was handled?

A. There has certainly been huge improvements. I think when Dr. O'Kane came in as Medical Director, I think she saw quite early, in terms of managing doctors in difficulty, that there needed to be a much more structured process and she put that in place in partnership with Vivienne Toal. I think that has been, in my experience, much better because of it. 14:51

So, yes, now I think that Maria saw it almost in advance of this process of the Inquiry starting because I think that the Doctors in Difficulty Oversight Group commenced, I couldn't say when, but certainly not long after she came in to post. It was one of a number of things that she did to bolster. So, yes. 14:51

302 Q. Mr. O'Brien's performance or conduct as a practitioner, his practice, came back on to the radar again formally for the purposes of the oversight group in December of 2016, and you were asked to arrange a meeting for the 22nd of that month. 14:52

If we just turn up the Minute of that please, TRU-251441. Ronan Carroll is standing in the shoes of Mrs. Gishkori on this occasion. You're attending. Mr. Clegg is attending and Tracy Boyce is in attendance. Now, the prelude to this meeting appears to have been a concern raised with Dr. Wright that he shared with you by email on 21 December. Esther Gishkori had telephoned him with regard to worrying developments, as she described it, in connection with 14:52 14:53

Mr. O'Brien and lost notes. You were asked to set up the meeting. As part of that you were asked to make contact with Mr. Haynes. Can you recall that?

A. I don't recall that at the time. I see it in the evidence. I don't recall it. 14:54

303 Q. He was a Clinical Director but not in a relationship with Urology per se.

A. Yes.

304 Q. Why would his input have been considered important, do you know? 14:54

A. I could only speculate that in the absence of Charlie as AMD, that Richard was looking for somebody that was a bit closer to the ground than himself, and just maybe naturally thought of Mark, obviously as an Urologist whilst he didn't have any managerial responsibility at 14:54 that time for that service that he was next in line and maybe just sprung into Richard's head. That's all I can think.

305 Q. Mr. McAllister had been required to step aside in October, I think, or November of that year; isn't 14:55 that right?

A. October 13th.

306 Q. This meeting, if we scroll down, please, considered a number of issues which were outlined. Dr. Boyce, first of all, summarised an ongoing serious adverse 14:55 incident and that was the incident concerning Patient 10; isn't that right?

A. Yes.

307 Q. If you just scroll up the page for a second to the

cover. The context, I should first of all have referred to that. The second line refers to the 13th, a formal investigation being recommended at 13 September. Is that right? Was it a formal investigation or an informal MHPS, certainly if we go back to 13 September -- 14:56

A. I think that's a simple typo. I think that's a typo on my part, it should read "informal".

308 Q. To give it its full description "Informal MHPS Investigation"? 14:56

A. Yes.

309 Q. Is there any doubt about that?

A. No. The 13 September letter is very clear, the last paragraph of the 13th September indicates that.

310 Q. Although in another sense that is a formal investigation, a formality compared to what had been the approach prior to that? 14:57

A. Yes. Well, it's certainly more formal than bringing somebody in for a chat and a cup of coffee, yes.

311 Q. So the issues are being outlined. Issue one, the SAI issue is outlined. And that's, in essence, a triage issue, and Mr. Carroll updates the meeting on the number of outstanding issue. He sets, if we scroll down, an action, which is: 14:57

"A written action plan to address this issue with a clear timeline to be submitted to the Oversight Committee."

Issue 2 is the issue of patient notes:

"Work needs to be done to undertake the volume of those notes which are not properly stored."

14:58

Issue 3 is the issue of dictation. Again, a written action plan is being required. It was agreed to consider any previous incident reports and complaints to identify if there were any historical concerns, and that's left with Mrs. Boyce to pursue. Then, upon consideration, scrolling down, certain decisions were reached.

14:58

"It was agreed by the Oversight Committee that Dr. O'Brien's administrative practices have led to a strong possibility that patients may have come to harm and should he return to work the potential that his continuing administrative practices would continue to harm patients would still exist."

14:58

14:59

Just on that, Mr. Gibson. This entry here seems to reflect a change of impression on the part of the Oversight Committee, at least compared to what was recorded in September. Here there is explicit recognition of harm, or at least potential for harm. Do you know what the trigger for that was?

14:59

A. I would image that it is the input of the SAI that Esther was raising. That was the change.

312 Q. That information, at least in a broad sense, was

available in September in the sense that if a clinician doesn't triage, you're left with the risk that patients are not going to be properly categorised in terms of their symptoms and the risk to their health. And, of course, Patient 10's SAI, commencing with an incident report, started in January of that year, January 16th. Do you think, upon reflection, that this realisation of a risk to patient's health ought to have been better recognised earlier?

A. There's definitely a case to be made that that should have been flagged at the 13 September meeting, yes. If it was known to the people there, absolutely.

313 Q. It was determined here that there would be a formal investigation under MHPS and Mr. O'Brien should be excluded for its duration. That was a decision that was subsequently to be revised in terms of his exclusion. Have you any recollection of why his exclusion was considered necessary?

A. No, I'd have no recollection of that.

314 Q. Beyond this minute?

A. No, nothing. Nothing beyond the minute, no.

315 Q. Dr. Wright seemed to suggest in his evidence that the person to be appointed Case Manager, Dr. Khan, had input into the exclusion decision, almost suggesting that it was Dr. Khan's decision or he had some ownership of it. Is it not plain to your memory that this exclusion decision was subject to NCAS advice a decision of this Oversight Committee at this meeting?

A. Absolutely, yes. It was agreed. The minute is clear.

316 Q. With the decision made to commence a formal investigation, your role became one of servicing some of the initial administrative needs of the process. Is that fair?

A. Yes. Richard asked me to draft up an initial letter and to draft up some Terms of Reference on his behalf, which I then subsequently handed over to Lynne Hainey, who was providing the HR support. I think a draft came through which I think I amended to try to make it more quantifiable and time-bound and statistical in nature. Then once the investigation took off I didn't really have any more involvement after that point. 15:03 15:04

317 Q. Just to pick up on a few points of your involvement: As you said, you drafted some correspondence that you thought would be given to Mr. O'Brien. If we can pick up on that, please, TRU-251447. Let me just check that. So this is the draft, I think, that you put together which you, scroll down through it, scroll down to the next page, so you are setting out, I think, four areas, unreported outcomes. Then, scrolling down, Issue 4, Non-Compliance with Trust Policy in relation to the management of private patients. 15:04 15:05

Now, that's not an issue that was discussed at the Oversight meeting on 22 December. Mr. Haynes had reported in to Mr. Weir that that was a concern, and you were advised of that, is that fair? 15:05

A. Yes.

318 Q. Just in terms of Mr. Haynes' role, was he being kept

abreast of developments in his role as Clinical Director, notwithstanding that he didn't have a role in urology.

A. Not by me. I don't know if Richard spoke to him to keep him updated or Esther, as the Director. But not by me.

319 Q. It would appear that your inclusion of the private patient issue derives from Mr. Haynes' input. Is that fair?

A. Yes, I think that's fair. 15:06

320 Q. An issue arose in relation to whether Mr. O'Brien would be able to work in a private capacity during his period of seclusion, and you made some comments in relation to that. I want to explore that with you. First of all, if we go to a record of the meeting between Dr. Wright and Mr. O'Brien which took place on 30th December. I know you weren't at that meeting, but I just want to draw your attention to the record. AOB-010343. It's said that Mr. O'Brien was made aware of the paragraph in the MHPS documentation relating to exclusion. He queried if he continued to work with private patients. 15:07 15:08

"Dr. Wright suggested that he take advice from his union, but said that as RMO he would discourage this. Dr. Wright suggested that Mr. O'Brien ask his colleagues to review any private patients that he has". 15:08

A message is being given to Mr. O'Brien that Dr. Wright would discourage private work. Is that the way to

interpret that?

A. Yes.

321 Q. That issue was not uncontroversial within the Service. Let me draw your attention to TRU-00113. Mrs. Gishkori is commenting on the issue. She has met with the consultants in urology, this is the context for this email, and a number of questions have arisen which she's directing your way to answer. 15:09

But in relation to one of the queries which concerns Mr. O'Brien's ability during exclusion to work with private patients, she says: 15:09

"Mr. O'Brien is at liberty to do what he wants off Southern Trust premises, but he cannot use the services of The Trust in the carrying out of his own private work." 15:09

You were not of that view, is that fair?

A. Do I reference it further down or above? 15:10

322 Q. Let me draw your attention to this, then. TRU-00112. So this is you answering the series of questions that centre come your way. If we scroll down to No. 4 and your advice, presumably through the Medical Director, is that: 15:10

"In line with the Framework, Mr. O'Brien is not completely at liberty to undertake private practice outside the Southern Trust. As the responsible officer

Dr. Wright advised Mr. O'Brien not to undertake private work during the period of this investigation, and to inform any private providers that he was currently excluded from this main employment. The exception to this is if Mr. O'Brien felt there were any patient safety issues, if this was the case, Mr. O'Brien was advised that he should arrange transfer of care to a colleague."

You then engaged with Ms. Hainey and you asked her, is there merit in referencing the advice given in relation to undertaking private practice in a letter to Mr. O'Brien. 15:11

A. Mm-hmm.

323 Q. Looking at the letter that went to Mr. O'Brien, AOB-1354. If we scroll through to the last page, please. Just stop there. He's told about the four-week exclusion period and it should allow time to determine a clear course of action. Then it said that any decisions will, of course, be communicated to him, and he is referred to the MHPS Framework and the relevant paragraphs. One of those paragraphs deals with the issue of private work during exclusion. Is that as far as it went, Mr. Gibson? There was no explicitly worded caution to Mr. O'Brien about private work? 15:11 15:12 15:12

A. It would appear not in that letter. To be honest, until now I never made the connection between what I put in the red type and it not appearing in that

letter. So, no.

324 Q. Why was that issue considered important by the Medical Director's office?

A. I suppose just to keep a tight control on him.

325 Q. Ultimately you engaged with various Medical Directors, with the Employer Liaison Service of the General Medical Council. Mrs Donnelly, Joanne Donnelly -- 15:13

A. That's correct.

326 Q. -- was at several of those meetings, regularly pressing the Medical Director to clarify whether Mr. O'Brien was able, even despite the lifting of the exclusion, to continue working in a private capacity if the Medical Director couldn't assure himself of the safety of that work. The discussion went as far as a suggestion that Mr. O'Brien should enter into an undertaking to say that he wouldn't perform private work. You remember that? 15:13 15:14

A. I do recall that, yes.

327 Q. Do you know where that issue was left?

A. I don't. I would struggle to know where that one went. 15:14

328 Q. Was he pressed to provide an undertaking?

A. I don't know if Dr. Khan wrote out to him.

I certainly didn't.

329 Q. There was a further Oversight Meeting on 10th January, 2017. If we could pick up on that, please. AOB-01363. Again, you're in attendance at that. In this meeting, scrolling down please, which was essentially a review meeting of trying to work out where the process was at, the fourth issue, if we scroll down, is private 15:15

patients. And it was at this meeting, the issue, not having been discussed at the December meeting, that a decision was made that it was agreed -- just reading the last line:

"It was agreed by the Oversight Committee that this work would be...".

Sorry, that's the wrong line. It says:

"It would appear that there is an issue of Mr. O'Brien scheduling his own patients in a nonchronological manner."

Further information having been received in respect of nine patients. So was it at this meeting that this issue formally entered the process? 15:16

A. Yes, that's correct.

330 Q. The direction of travel here was towards a case conference that took place on 26 January. And these are various steps or various issues that arose on the way to that. Could I ask you about an issue of what appears to have been some confusion and perhaps some ill-will, and perhaps maybe some tension, between yourself and Mrs. Gishkori's office that arose on 20 January. Could we have up on the screen, please, TRU-251505. That's 251505. To the bottom of the page, please. So Mrs. Gishkori is writing to you saying that "Ronan", that is Ronan Carroll was telling her just now

that you'd been in touch to say that Mr. O'Brien will be returning to work. He said that:

"The Investigating Panel has made this decision after a barrister's letter came in to The Trust. Can you update me please? I need to know how the issue of potential harm to patients will be managed should Mr. O'Brien return." 15:18

And she goes on to explain how other issues will be worked through. You respond to that. If we just scroll up please. Just before we read your email, what was that about, can you remember? First of all, what is the barrister's letter and, secondly, had you told Mr. Carroll that Aidan O'Brien was to return to work and that was the decision of the committee? 15:18 15:19

A. The first question, what was the barrister's letter, absolutely no idea. In terms of the second one, is that what I discussed with Ronan? No, whilst I also don't recall I'm referencing the email that I wrote. Richard had asked me if the Oversight Committee decided to allow Aidan back to work, what kind of work could Aidan do if he came back under restriction. He asked me to do another discrete bit of work and try and get from Michael was there any pieces of work he could be doing. 15:19 15:19

331 Q. Michael Young?

A. Michael Young. Sorry. Yes. That's the last sentence on that page that is the screen at the moment.

332 Q. What you said back to Esther is somehow Ronan has managed to completely misinterpret this, so you set out for clarity what you had said.

A. Yes.

333 Q. You explain under MHPS immediate exclusion can only last 4 weeks at which point a decision needs to be made whether to formally exclude. You go on to say: "With regard to the Aidan O'Brien case, this decision needs to be taken by 27th January. To prepare for this Dr. Wright asked you to speak to Dr. Young". 15:20

You did that to ascertain whether he could work independently or with supervision. You haven't yet had that discussion with Ronan and you emphasise no decision has been made. 15:21

Scrolling back up in the direction. Ronan reacts to this. He didn't misinterpret anything. He takes exception to this. But he says:

15:21

"I didn't tell Esther that the decision had been taken to allow Aidan O'Brien to return to work. What I did say was that I just had a conversation with you."

Mr. Gibson: 15:21

"...the content of which was the possibility of a return to work."

Scrolling up the page again. You apologise. Does it appear to you on the basis of that that Mrs. Gishkori had become somehow confused?

A. I think that's a fair reflection. Yes.

334 Q. Then, scrolling further up the page, "Simon, thank you for your apology". Then Mrs. Gishkori writes to you to say she has concerns in relation to you speaking to Mr. Young about anything in relation to this case. However, given the serious misinterpretations between Ronan, you and I: 15:21 15:22

"I think another meeting of the Oversight Committee may be the best next step".

She says: 15:22

"Just so I'm clear, did the Oversight Committee meet since since the letter from Mr. O'Brien's barrister".

Again, you're none wiser to what the barrister's letter refers to? 15:22

A. No. I think this is where I go to Richard and say, the less said the better, because if you scroll back down again, Esther puts in there "given the serious misinterpretation between Ronan, you and I". I didn't like that because there was no misinterpretation in Ronan and myself, and Esther, there was a misinterpretation by Esther. Ronan gave a clear message to Esther, Esther misinterpreted it and came to 15:22

me, yes, you know, I just thought, bite your tongue.

335 Q. How is the Inquiry, if it considers it relevant, to interpret that little sequence? Does that reflect upon tensions between the Medical Director's office and Mrs. Gishkori? Does it reflect upon some weakness on her part in terms of her ability to interpret basic messages? 15:23

A. I certainly wouldn't agree with the first. I don't think there were tensions. I've worked with Ronan since 2007 and, yes, we've had our spats, but we've always got on and worked well together. I would hold him in high regard. 15:23

In terms of your second comment, I think that's very fair. 15:24

336 Q. Was that your experience of Mrs. Gishkori?

A. Yes.

337 Q. Beyond this? Was she well supported in her work?

A. Sorry, could you repeat?

338 Q. Mrs. Gishkori, was she well supported in her work, do you know? 15:24

A. By whom?

339 Q. By the Trust?

A. I don't know if I can answer that, to be honest. I mean she was well-supported by her ADs, I know that for certain. I know that the ADs that were working under her were working very hard. I actually was under her myself until April '16. 15:24

340 Q. Well you have reflected a concern, if I can put it in

those terms, about how sometimes she related to you and perhaps others on issues with which you were dealing with. What is your assessment of that?

A. Sorry, could you repeat?

341 Q. What is your assessment of that in terms of her work when it related to your work? 15:25

A. Some people you work with you know when the work comes, you know it will be clear, it will concise, it will be a high standard, you would know where you're going, you've got clear direction. I have to say with Esther, on occasion, that she may have been a bit more unstructured, a bit more removed, and certainly different from the other Directors that we'd had before. 15:25

342 Q. I'm asking these questions because it leads to this: Did it, in your view, affect how she managed the Aidan O'Brien situation? 15:26

A. I don't know if I can comment on that. I don't know whether or not it affected how she behaved with the AOB-case. I don't know. 15:26

CHAIR: It may be a decision for the Inquiry, Mr. Wolfe.

343 Q. MR. WOLFE KC: Now, the case conference took place on 26th January. TRU-00037. It is at that meeting, if we scroll down please, slow down there. The Case Investigator was Mr. Weir. He presented a report to this meeting. Scrolling down. It is summarising the key issues, as you can see, the historical attempts to address concerns. Then there's a discussion where 15:27

Mr. Weir is reflecting, I suppose another view of Mr. O'Brien as a good, precise, caring surgeon. Scrolling on down, please. Stopping there. Then Dr. Khan is said to have made a decision:

15:28

"As Case Manager, Dr. Khan considered that there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC, Good Medical Practice, and the decision was agreed by members of the case conference and, therefore, a formal investigation would now commence."

15:28

Do you understand, Mr. Gibson, the process that was followed, taking it back as far as the December Oversight Meeting? Was a decision to conduct a formal MHPS investigation not taken in December prior to the appointment of Messrs Weir and Khan?

15:28

A. Yes, I believe it was. Yes.

15:29

344 Q. So what was this process at this case conference?

A. I'm not sure whether it was a restating of the same decision, or maybe running the same process, but doing it with the right people in the room in terms of the Case Investigator and the Case Manager, running the MHPS process as it should have been run.

15:29

345 Q. Is that how you think it might be interpreted, to give ownership of the process to the two appointees?

A. I think, yes, that's an interpretation. Yes.

346 Q. If you proceed along the line that the decision to commence a formal MHPS investigation was only taken at this meeting by the Case Manager, Dr. Khan, if that's the way to look at it, why were Terms of Reference being drafted before a decision was made that each of the four components, which were later to become five, but each of these four components were to fall within the investigation? 15:30

A. Yes, that's a good point. It would seem, reflecting back now, that there was a bit of a cart before the horse there. 15:30

347 Q. Scrolling down the page then. Scrolling down to the end. It was decided that NCAS would be updated in relation to the case by Dr. Wright. Do you know if that was done? 15:31

A. I don't know if it was done, no. Actually, no, I don't think it was, was it? Because I think, I didn't know then, but I think seeing, I think its either Colin's or Graínne Lynn's evidence to the Inquiry, that they sent a number of update letters and they didn't get responses and they closed it. So I think it possibly is unlikely. 15:31

348 Q. Now, you engaged in drafting aspects of the Terms of Reference and they go through various iterations. Just by way of example, if we go to TRU-251490. You have been sent a draft for comment and possible revision and you have said: 15:32

"I have considered this draft in the context of NCAS

advice, and amended to try and make TOR as specific, focused, and quantitative as possible, by adding in the information presented by Ronan at the 10th January meeting."

15:33

You'll recall that, for example, he provided information about private patients and other figures around the backlog, et cetera.

A. Yes.

349 Q. Then you also say: 15:33

"In particular, the learning from another case in relation to the nonchronological scheduling of patients...".

15:33

Going down to the next page we can see your draft. Scroll down again, please. Yes. So this is your work. Scrolling right down and we get to the fourth, which is the inclusion of private patients. You refer to new advice received by NCAS, received from NCAS in that 15:34 email. Do you know what that is a reference to?

A. Yes. I think, actually, that is poorly worded. I don't know, you may have to scroll back up again.

350 Q. I'm happy to scroll back up again.

A. Yes, could you, please. 15:34

351 Q. Go up to the email, please. I shouldn't have said, was it new advice, I don't think you used that word.

A. No, I think that was most probably my mistake in typing that word "advice". It is mostly in the context of

"NCAS guidance" maybe is a better word. Because I certainly had not got any NCAS advice. We had not received anything. But in terms of guidance, i.e. the training that I had taken back in August, and which was reflected on 13th September, I was trying to then re-reflect into these Terms of Reference to make, as I say there, specific focus in quantitative. So I tried to tighten it as much as I can. 15:34

352 Q. Subsequently the Terms of Reference went through various iterations, the words change here and there? 15:35

A. Yes.

353 Q. But the most substantive change was the addition of an issue concerning management input. If we could turn up TRU-26783. Pull up the right reference.

A. I don't think I was involved in that. 15:36

354 Q. We'll try and find the document.

A. I'm aware of it. I think I know where you're going with this.

355 Q. Yes. In terms of the addition of the --

A. Fifth. 15:36

356 Q. -- fifth factor, which was an investigation into management conduct in association with Mr. O'Brien -- there we have it.

"To determine if any of the above matters were known to line managers within the Trust prior to December 2016 and, if so, to determine what actions were taken to manage the concerns". 15:36

Were you consulted on that one?

A. No.
357 Q. Do you know the origin of it?
A. No.
358 Q. Do you know why that was thought a necessary inclusion in the investigation? 15:36
A. It would only be my speculation but it was a fact that this had been attempted to be managed for many years prior to December 2016 and not particularly successfully, and that was maybe what they were trying to get at in that Terms of reference. But that's my 15:37 speculation.
359 Q. Speculation.
A. Yes.
360 Q. The MHPS investigation launched in or about March or April 2017. You didn't give evidence to that process? 15:37
A. No, I wasn't asked to be a witness to that. No.
361 Q. Your Medical Director continued to be Dr. Wright until he went off on sick leave in or about the start of 2018?
A. That's correct. 15:37
362 Q. He was replaced, at least on an acting up basis or temporary basis by Dr. Khan, who was also the Case Manager in the MHPS process?
A. Yes.
363 Q. He produced an MHPS determination, having received the 15:38 investigation report in or about September or October 2018. Was that discussed with you?
A. No, I don't recall that.
364 Q. At or about the end of that year Mr. Haynes contacted

you in relation to contact that had been made with members of medical staff by Mr. O'Brien and/or members of his family. Can I just draw your attention to this email, please. TRU-251964. Mr. Haynes is writing to you and Dr. Khan: 15:39

"Are you aware of this? Surely this behaviour (phone calls from wife and his son/legal adviser to Mr. Young, below with Mr. Weir) shouldn't happen? How can we (his colleagues) be protected." 15:39

Can you remember receiving that?

A. I'll be honest, I can't remember receiving. I remember viewing it as part of the evidence pack. I'm not sure whether I took any action on that, or Ahmed took that 15:39 forward, I don't recall doing anything directly. So I think Ahmed, as Medical Director, may have done. But I am sure it is in the evidence pack.

365 Q. We understand you may have written to Mr. O'Brien, but you're telling us that you have absolutely no 15:39 recollection of this as an issue at the time?

A. Can you scroll down?

366 Q. Yes, of course. So what Mr. Haynes is copying you in to, for example, Mr. Weir's concerns that --

A. Yes, I do remember that. Yes, I remember that. 15:40

367 Q. If we look at 279201. Dr. Khan, it appears, has written to Dr. O'Brien in terms there that are self-explanatory. Then if we look at the page before that, 279200. Scrolling down, please.

You have written a couple of days later telling Mr. Haynes, Mr. Carroll, that Mr. O'Brien has been contacted and asking has anyone else been approached. Was it considered, to the best of your memory, that the best way to deal with this was at the level of a letter telling him to stop this? Or can you not remember any discussion? 15:41

A. I don't recall any discussion in terms of what alternatives there were, no. 15:42

368 Q. No. An aspect of the return to work arrangements for Mr. O'Brien was, there's various descriptions for this but it was a Return to Work Plan or an Action Plan. That was provided for as part of the lifting of the exclusion. We can see it at TRU-00732. Is that a plan that was solely worked out by the Service, and by that I mean Mrs. Gishkori and Mr. Carroll, or was it something that the Medical Director's office was asked to or was required to take a view on? 15:42

A. I don't recall, to be honest. I may have received a copy, I would have to look. I don't recall. 15:43

369 Q. You had a sense, it seems, based on your drafting of the 13th September letter from 2016 as to the kind of steps that might be required for a robust oversight arrangement? 15:43

A. Mm-hmm.

370 Q. But you have no recollection of becoming involved in this?

A. I don't have any recollection, no.

371 Q. Deviations from the plan were drawn to your attention.
A. In the October of 2018.
372 Q. So in October 2017 you will recall that Mrs. Corrigan, who had been monitoring Mr. O'Brien's compliance with the action plan, had been off work and during her absence Mr. Carroll discovered that there appeared to have been, (A) a failure to monitor Mr. O'Brien during her absence and in those circumstances an apparent failure to comply with what was required of him. Do you remember that being drawn to your attention? 15:44 15:45
A. Yes, I do.
373 Q. You engaged with Mr. Carroll around that issue?
A. I did.
374 Q. Was the Medical Director's office satisfied with the extent to which, or the rigour with which Mr. O'Brien was being monitored? 15:45
A. When Martina went off and it fell down, and certainly I was disappointed, I am sure you'll share the email between Ronan and myself, there was a disappointment that things had slipped. I appreciate that there's multiple priorities on people's time. 15:45
375 Q. Certainly, if you need assistance, we'll bring the email up. It's a series of emails, TRU-251527. TRU-251527. If we start at the bottom of the page, please. And start with Wendy Clayton, with dictation report, and she raises a question about how long certain charts have been in the office. Go on up the page, please. And Ronan Carroll is raising the issue with Michael young and the Associate Medical Director, 15:46

Mr. Haynes, saying that:

"Aidan needs spoken with and asked to address dictation as soon as possible and asked to address notes."

15:47

Going on up the page. Keep going until I see the top of the email. Thank you. So you are copied, or sent this from Mr. Weir, still clinical director, and it is for your "Urgent Consideration". And scrolling down:

15:47

"Mr. O'Brien has accumulated a large backlog of dictated letters and large numbers of charts in his office."

He suggested that he meet, sorry, he is asking for instructions on how to proceed. He can certainly meet him I think it should say:

15:48

"...with Ronan to discuss and record outcome from any meeting with him but I need to know if any sanctions need to be put in place if he has breached any of the review requirements."

15:48

Scrolling back up the page. You say:

15:48

"What is most concerning here is the monitoring and supervision arrangements put in place, which we confirmed to a range of interested parties. If he has a backlog of clinic letters, have these

arrangements fallen down?".

Then scrolling up the page, we'll stop here:

"I think you are stating the obvious" says Mr. Carroll: 15:48

"With Martina having been off since June, overseeing function has not taken place and day-to-day activities were overlooked."

15:49

In that issue, what was going wrong in the Service that when Mrs. Corrigan goes off, the monitoring stops?

A. I don't know if I would be that close to answer that specifically, but I think that within that team there was a relatively small number of managers spread quite 15:49 thin with multiple priorities on their time. I think, as Ronan has said, it was overlooked.

376 Q. Mr. Weir asked whether sanctions needed to be applied. Presumably not a question that you felt comfortable answering, perhaps, but the question was directed to 15:49 you and Dr. Khan.

A. Yes. I was happy to leave Ahmed to answer that one.

377 Q. This was, on the face of it, in late 2018, a deviation from the action plan, and we were to see further deviations in 2019. 15:50

A. Yes.

378 Q. Is it fair to characterise this as nothing was ever done to challenge these deviations other than perhaps back to the informal way of the past?

A. It certainly never -- we started another formal process through MHPS. So, therefore, the only thing that must have been done was the more traditional methods of dealing with Aidan.

379 Q. There was even some uncertainty, it seems, in your mind as to whether the action plan continued to be in force in 2018. Mr. Weir asked the question regarding the outcome of today's meeting -- that was a meeting that took place on 23 October '18. 15:51

15:51

"Can I ask, are we to continue monitoring Aidan O'Brien against the four elements of the action plan?"

You respond to say: "That's a question for Dr. Khan". He says: "Yes, of course we are to continue monitoring". 15:51

Was there some uncertainty about this?

A. In my mind, no. In my mind the action plan -- the monitoring was to continue. I know that I've seen some evidence that Aidan had a different view in terms of when the action plan kind of ceased to exist following the conclusion of the MHPS, but, in my mind, it was clear that it was to continue. 15:52

380 Q. Can I bring you to 2019, and you're right to say Mr. O'Brien, when challenged by, I think, Mrs. Corrigan about a further deviation from the action plan wrote to say that this expired in September 2018. During that year you will have seen from your pack that in May 2019 15:52

Mr. Haynes is saying he's aware of triage not being done. In September 2019 Mrs. Corrigan flags to Mrs. Hynds that Mr. O'Brien is not doing his red flag triage when he's Urologist of the Week. On 16th September of that year she escalates triage and dictation issues to Dr. Khan. In August Mr. Haynes highlights that -- sorry, I should say in October he highlights that dictation from August hadn't been done, two clinics in August. 15:53

That issue comes into your in-tray when Dr. O'Kane asks you to convene a meeting which took place in January 2020. 15:53

A. That's correct.

381 Q. Can you recall that for us, please? 15:54

A. Yes. I think that one of the issues that I know that Mark had, was with the technical nature of how the information was being monitored. I think there's one specific element which is in the email that I write back to Maria, which is towards the end of January. I think it is the 27th maybe. We went through that meeting. There was a delay -- 15:54

382 Q. Maybe just to assist you, we'll pull up your record of the meeting. It was 24th January. I think at WIT-55822. The context for this meeting, I think you set it out in the top of the record. It's in the context of the backlog report; isn't that right? 15:54

A. That's it. Yes.

383 Q. Concerns had been expressed that Mr. O'Brien was

failing to dictate outcomes following clinics and Dr. O'Kane had set you the task of meeting with interested staff for the reasons set out there. To describe in detail the management plan around the backlog report, the expectation around compliance, and the escalation. This is to assist a meeting with Mr. O'Brien to discuss his deviation from the Action Plan.

15:55

You can take it from there, Mr. Gibson. Help us to understand, first of all, what this meeting discussed and what it achieved, if anything, having regard to the concern that Mr. O'Brien was deviating on dictation?

15:55

A. Okay. If you scroll slightly further down on the email. That's fine, thank you. The first two paragraphs really laid out the process as it was defined in terms of undefined workload. In terms of backlogs, I think one of the key sentences is the fourth one in the second paragraph:

15:56

15:56

"It should be noted that one of the reasons this report did not receive regular consideration was that there was some scepticism of the accuracy of this data, as it did not reconcile with the individual's own recollection of behavioural workload."

15:56

In essence, there may have been inaccuracies in the data being provided by the secretarial and audio-typist staff in terms of their data. Therefore, that was

creating a concern. Then overlaid on that was that we discussed at the meeting what is the standard for delivering reasonable timescales for dictation of results or letters after clinics, what is the Trust's standard in relation to that. If you scroll down a bit more please. Thank you. 15:57

384 Q. Just before we go to that, to add a layer or two on that. The clinician dictates or is supposed to dictate following a clinical encounter?

A. Or operation, yes. 15:57

385 Q. That goes to either his medical secretary or the typist pool?

A. Correct.

386 Q. There is something called a backlog report.

A. Mm-hmm. 15:58

387 Q. It is supposed to accurately gather information in respect of output of typing per clinician. It's gathered manually, it's not electronic. But it's supposed to give a sense of where there are gaps or where there are delays in the production of dictation. 15:58

A. Or where there are pressures in terms of, you know, maybe giving support to audio typists or secretaries, that maybe work could be moved around slightly by their supervisors a bit to try and assist, yes.

388 Q. Is there a flaw in the system in that if a doctor doesn't dictate, that won't be known? 15:58

A. That's a fair point. Yes.

389 Q. The standard, you were going to go on to tell us the standard turnaround time. Is the fact simply that

there wasn't one?

A. That's correct.

390 Q. Escalation then I think was the third point?

A. Yes. So it's clear there was no standards identified. There was some question marks in relation to the validity. And then, combining those, there was no process for escalation concerns regarding non-compliance. So that kind of combined to basically say, we have an issue here, which, therefore, would make it challenging to hold Mr. O'Brien to account in terms of his work because of the inherent weaknesses in the system as I described it there. 15:59 15:59

391 Q. Just on that. If we start with the proposition that Mr. O'Brien had been handed a clear, objectively verifiable standard with which to comply with. If we look at the Action Plan that had been set for him. If we go to TRU-00733. Scrolling down, please. It records as an action: 16:00

"An outcome/plan/record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP". 16:01

The paragraph before that:

"The dictation must be done at the end of every clinic and a report, via digital dictation, will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure that all 16:01

outcomes are dictated."

Is that not a clear Action Plan to hold Mr. O'Brien to account with? In other words, Mr. Gibson, I'm struggling to understand why this was viewed as so problematic at the meeting on the 23/24 January, when what this plan provided for was instant dictation at or within the clinic and then a digital dictation record on a weekly basis. 16:02

Then, if I can just add to this before getting to the question. If you look at TRU-279849. This is emailed to Dr. Khan from Martina Corrigan escalating the issue in September. I think it's 14th September. Just scrolling down, please. She is able to say, that "Concern 3", that is the dictation issue: 16:03

"...is not adhered to. Mr. O'Brien continues to use digital dictation but I have done a spot check today." 16:03

This is September and she finds the following shortcomings in his dictation, which is a similar email from Mr. Haynes elsewhere in the bundle.
So what were the complications highlighted in your January meeting that were seemingly causing a barrier to engaging with Mr. O'Brien on what should have been a fairly straightforward issue? 16:03

A. I think it was a combination. If we can go back to the email of the lack of standards and --

392 Q. Forgive me. He had been set a clear standard. Regardless of the rest of the world, he had been told get it done. There might have been a more flexible approach with other clinicians, and that's certainly reflected in the January meeting, but that sort of varying standard wasn't the one that was applied to him?

A. Mm-hmm.

393 Q. Isn't that right?

A. That's a good point, yeah. 16:04

394 Q. It is the case -- we can go back to that January record, WIT-55822. If we just go to the last page of it, please, or the last paragraph. Keep going, please. So there's a Conclusion -- stop there. The Conclusion was that: 16:05

"Those present felt that the best way to move this topic forward was for a group of interested staff to agree and describe why this information is being collated? For example, is it largely resource or secretarial workload." 16:06

Is that something, Mr. Gibson, general to the problem --

A. Yes. 16:06

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

A. Absolutely. Yes.

396 Q. Each of these features of the Conclusion are generally system related, how can we improve the system?

A. It was a fairly technical meeting, a system wide technical meeting rather than anything specific.

397 Q. Then, as regards Mr. O'Brien, at the bottom of the page:

16:06

"Considering the processes outlined above in the wider sense of supporting medical staff who have had issues identified, I feel there would be benefits in an urgent discussion regarding the day-to-day management of Mr. O'Brien by his operational line management to ensure that supervision of his administrative duties are being carried out as expected. This would allow an opportunity to identify if there are any concerns starting to emerge, so that appropriate supports can be offered to ensure that concerns do not continue". 16:06 16:07

Just on the dictation issue, was that essentially pushed to one side? We can't grapple with this with Mr. O'Brien because of these technical concerns about the system, notwithstanding the clear identification standard set out in his action plan? 16:07

A. I mean I understand what you're saying in terms of set to one side. Maybe it was we needed to get these issues resolved to allow an easier management of Aidan in terms of this issue. But you're quite right, the standards were set, so maybe he didn't require this level of detail. 16:08

398 Q. Was he ever challenged in respect of the dictation failures which Mr. Haynes and Mrs. Corrigan had

identified in the middle of 2019?

A. I'm not aware.

399 Q. Did this meeting, specifically focused on Mr. O'Brien, ever take place?

A. I'm not aware. 16:08

CHAIR: Mr. Wolfe, I am just conscious of the time. I am just wondering will you be much longer?

MR. WOLFE KC: One more issue.

CHAIR: I think we'll just sit on then, ladies and gentlemen. 16:08

MR. WOLFE KC: Please. Thank you, I appreciate it.

400 Q. You had various interactions with Ms. Donnelly of the GMC?

A. That's correct.

401 Q. I just want to draw your attention to and seek your response on one strand of that. If we go to TRU-161683. You attend with Dr. Wright at a meeting, with Ms. Donnelly, on 8th February '17. At that meeting RW, as we can see here, says that: 16:09

16:09

"An SAI is almost complete and the MHPS investigation is in progress."

This is, as I've said, 8th February 2017. The action associated with this, you can see in the right-hand margin, is to send JD, Joanne Donnelly, a copy of the SAI report as soon as it's received. Now, if we go to the next meeting, TRU-161700. Just scrolling down, please. So the way this works is it recaps on the 16:10

February meeting.

A. It is the next page.

402 Q. We'll go across then, go down, please, to the July meeting.

A. Yes. Halfway down is the important bit. 16:11

403 Q. Sorry, I'm still not seeing it myself.

A. I think maybe -- well.

404 Q. Yes. So at that time, and this is, as I've said, July '17, the SAI investigation in respect of Patient 10 had completed? 16:11

A. That's correct.

405 Q. It had reported by March 2017 --

A. That's correct.

406 Q. ....to the best of my recollection, a second grouped SAI, involving five patients, including Patient 11, 12, 16:11 13, 14 and 15, was about to get underway but had been delayed due to difficulties in obtaining an independent external Chair who ultimately became Dr. Julian Johnston.

A. Yes. 16:12

407 Q. Now, Dr. Wright is telling Joanne Donnelly that the SAI investigation is not yet complete when in fact the investigation that was alluded to at the February 2017 meeting --

A. Was complete. 16:12

408 Q. Was Patient 10's, which had been completed?

A. That is correct.

409 Q. The undertaking to provide Donnelly of the GMC with a copy of the SAI report had not yet been complied

with. Then we have this confusion. Can you explain how that came about?

A. I think confusion is a fairly good summary. I think that the first SAI is ongoing when we meet Joanne in February. It then completes in March. We meet again on 25 July. Joanne asks, well, is the SAI complete? My interpretation, and it is only that based on this, is that Richard is assuming she is talking about the Julian Johnstone SAIs which have only just begun, but actually she is talking about the SAI in February which was just nearing completion. 16:13 16:13

I don't know whether Richard clarified the difference between the two and, in the absence of that clarification, I don't think Joanne would have been aware of the distinction between the first SAI and the second, what I would call "Julian Johnstone SAIs". So he replies and says, oh, we have only just started, Julian Johnson has just been Chaired. Joanne maybe takes that at face value assuming it is the one that was still going on February, and that mistake repeats itself through further meetings with Joanne Donnelly. 16:14 16:14

410 Q. But both yourself and Dr. Wright were well aware that the report you referred to in February, or the SAI you referred to in February carried with it an obligation to get that report to Donnelly when it was available? 16:14

A. Yes.

411 Q. That hadn't been done?

A. Yes. I mean it was down as an action for Richard to

send the report when it was finished. I wasn't aware that that hadn't been done. Then, when we're starting to go to the meeting in June -- sorry, the July meeting on the 27th and the subsequent ones, I'm also assuming that they're referring to the Julian Johnstone SAIs.

412 Q. Can I take you to December 18? There had been a meeting with Ms. Donnelly on 4th December. If we look at TRU-264717. Just scroll down, please. Ms. Donnelly is writing to Dr. O'Kane who had attended with you on 4th December? 16:15

A. That's correct.

413 Q. Ms. Donnelly says:

"I understand that Simon advised that he would forward to me the relevant SAI and MHPS reports." 16:16

That was a week earlier. She has still never been given the SAI report from the previous year and she hadn't been given the MHPS report when it was ready in the summer. She has had to come asking for it. Then 16:16 she's asking for it again because eight days after the meeting you haven't sent it. Was there a tendency to play cat and mouse with the GMC or is that unfair?

A. I think that's unfair in this context in that looking back I know that we had to get it redacted. I know 16:17 that Siobhán Hynds, who was the HR support, had that redacted and handed a copy of that to Dr. Khan's office. I wasn't aware of that and had to, kind of, chase it up, and that's why it took me from the 4th to

the 18th. So that to me was just a question of getting a redacted copy. It came through Siobhan's office. It was hand delivered. I wasn't made aware that it had been hand delivered. Once I chased it, Siobhan told me and I found it and sent it. 16:17

With regard to the SAI, I mean, obviously, at that point the Julian Johnston SAIs were still ongoing and had not been reported. The subsequent SAIs had not been reported either. So I think that relates maybe to 16:18 Joanne's assumption that they were finished when they weren't finished.

I note that in the note of the meeting of 4th December it's noted that I say that the SAIs are completed, but 16:18 I just believe that that is an inaccuracy in her Action Note. Because I wouldn't have said that, because I know they weren't finished their time, and I wouldn't have been that close to the SAIs, in terms of, you know, my portfolio was more on the medical education, 16:18 medical workforce side of the house. So I wouldn't have been that close to it.

414 Q. Did she ever receive Patient 10's SAI?

A. I don't know, is the honest answer.

415 Q. Just, finally, if we could look at what she says when 16:18 she has an opportunity to review the MHPS report. TRU-264716. Scroll down, please.

So she sets out the issues which she thinks are significant arising out of MHPS and she says:

"On the basis of the information you have provided..".

16:19

The second paragraph here or the third paragraph:

"These concerns appear to me to meet the threshold for referral to the GMC as they are allegations of serious and persistent failures." 16:19

She includes, amidst her description, actual harm to at least five patients and potential harm to a large number of patients.

16:19

The Inquiry will have the time to reflect at it's leisure on what is said and what is recorded in the meetings with the GMC. Do you think the GMC was given a full and accurate picture of the concerns in relation to Mr. O'Brien's practice during those meetings in '17 16:20 and '18 before it received the MHPS report?

A. No. Looking at the action notes from the DLA meetings, I think they are quite brief. I think all it says is that the MHPS investigation is ongoing. It doesn't go into any detail. 16:20

416 Q. Was that a deliberate policy for good reasons or bad reasons?

A. I don't think so. I think that maybe there was an assumption that waiting for the report to conclude,

before discussing the outcomes with the GMC, I don't think it was a deliberate attempt to obfuscate or deny information to the GMC. If anything, it was just a conservative approach, maybe.

MR. WOLFE KC: Thank you for your evidence. I have no further questions. 16:21

A. Thank you.

MR. SIMON GIBSON WAS QUESTIONED BY THE INQUIRY AS FOLLOWS: 16:21

CHAIR: Unfortunately there are still a few more questions for you. I'm going to ask Dr. Swart to start.

417 Q. DR. SWART: You have given specific answers to specific things. Mine are more general questions, really. Just to start with, I can understand why Dr. Wright wanted you to do a rapid investigation, for want of a better word, into the issue around the components of the concerns for Mr. O'Brien, but when it came to talking to NCAS, why was it that he asked you to make the phone call to NCAS when it's nearly always a senior clinician who does that? Did you have a discussion with him about that? 16:21

A. I can't recall any specific discussion. I had been at the NCAS training literally the week before. As I said earlier, I had a relationship with Colin from a previous life. I think it was Colin that gave the training on 30th August. 16:22

418 Q. Right.
A. I don't think it was any more complicated than that. In hindsight, obviously, yes, I should have said no, but I was relatively new in post and had developed a good working relationship with Richard; he asked me and I said yes.
419 Q. You were a bit naive to the process at that stage is what you are telling me.
A. There was an element of that, yes.
420 Q. The advice that NCAS gave falls into the category of fairly standard conservative kind of advice. It all seems quite sensible. It wasn't discussed at length at the Oversight Committee, even though you'd some of it in verbally. In fact, no account seems to have been taken of it. Did you have a chance to talk to Dr. Wright about the advice and about his thoughts about it? He was an experienced Medical Director in terms of MHPS and NCAS. What conversations did you have about it?
A. I don't recall the detail. I recall making a note of the issues that Colin had made in terms of suggestion. I then would have gone to Richard and briefed him on those, and then we set up the Oversight Committee. It is, as I said earlier, it is inconceivable it wasn't discussed.
421 Q. It must have been.
A. Yes. Whether it was discussed in the level of detail that subsequently came in the letter of the 13 September, I can't put my hand on my heart, and others

may be able to give their view when they come before you. But it certainly was discussed, it's inconceivable that it wasn't.

422 Q. What is your view about the way the Oversight Committee worked. It was set-up in a certain way. I think we have established that the custom and practice was actually slightly different. 16:24

A. Yes.

423 Q. Did that work as a decision-making Committee?

A. It certainly changed over time. It's a lot stronger now. I think that the due process and the policies are followed to the letter and I think the organisation has learnt from that. But at the time it's clear, after spending a day of this, we can see where the issues were, yes. 16:24

424 Q. So, one of the things that appears to us is that most of the Clinical Managers in the Trust didn't really know anything about the Oversight Committee. It wasn't kind of a recognised structure, which leads me on to ask you about how you interacted with the Clinical Associate Directors and CDs in general. Was there a sense that that group of people were working together with the Medical Director in a senior leadership team. Dr. Wright has described his desire to make that so. What did it feel like to you when you joined that team, not now so much, but at that time? 16:25

A. I felt it was a good team. I suppose I came to it slightly differently because I would have known them in my day job prior to August, because I was managing

medicine, and unscheduled care, and obviously there's a heavy emergency element of care in terms of moving people through the system. So I would have had a lot of contact with the medics.

16:25

So I would like to think I had a good relationship with all the CDs and AMDs. The AMDs did meet monthly and I would have attended those meetings. The CDs, I think, maybe was a bit looser. I think we had, it may have been quarterly meetings with the CDs in general, but I wouldn't say they were consistently held. So that may be something which needed to be looked at.

16:26

425 Q. You reference that three Deputy Medical Directors were appointed, or about to be appointed. What are they covering and how has that changed the dynamic in terms of your role and the AMDs?

16:26

A. Well, certainly I think when Dr. O'Kane came in she realised that the senior medical leadership was light. We had a medic involved in Revalidation and Appraisal with not that many PAs. Damian Scullion he was expanded into that role. Then we had a Deputy Medical Director for Governance and Patient Safety. And then a third for Medical Education/Medical Workforce. And that certainly, I think, strengthened the process in terms of supporting medical staff and then it gave another avenue for the Medical Director to direct work.

16:26

16:27

426 Q. Has that changed your dynamic and your role at all?

A. Well, the one thing is that I would not be as involved

with doctors in difficulty. Because there's a medical doctor, so Aisling Diamond is the Deputy Medical Director for Medical Workforce and I'm aware that she would be involved in issues, a broad range of issues in terms of those kind of issues. So I don't get as closely involved now. 16:27

427 Q. So, as we have been looking at this today and in all the documentation we've seen, it appears as if the Clinical Managers, the Clinician Directors and AMDs were not really involved in the screening report and the decisions thereafter. In fact, they weren't even told about it. 16:28

It also appears that they weren't involved in the Monitoring Plan. Yet they are supposed to be managing the doctors professionally. Now, do you think that was deliberate? Was there an attempt to keep them separate? 16:28

A. No. I would absolutely not think that it was deliberate. I think we've heard much of the blurred lines between operational and clinical management. But, no, certainly in this case you would have heard yesterday, and I would concur completely with Colin in terms of his close relationship with Martina. 16:28

428 Q. I meant in terms of this specific issue, we don't have a Clinical Manager preparing a report for the Oversight Committee, we don't have anybody at the Oversight Committee. We don't have anybody involved in the decision. When the monitoring plans are agreed, none 16:28

of the Clinical Managers know what it is. Can you see how we might think that is a bit odd?

A. Yes, I genuinely don't think that was deliberate, I really don't. I think that was more a failure within the process rather than something more malignant than that. 16:29

429 Q. Going forward, you know, if you have to do all of this again, apart from the things we have already talked about, what do you think the key learning for you personally from this is, from that whole dynamic? 16:29

A. In terms of my learning, is around the importance of communication with all the stakeholders from the very get-go. And that, if you do use and apply the policy properly from the get-go, it has the potential to work.

430 Q. As you look back now, can you see that right from the beginning there was a very clear Patient Safety issue here? 16:29

A. Yes. I can.

DR. SWART: Thank you.

CHAIR: Thank you Dr. Swart. Mr. Hanbury. 16:29

MR. HANBURY: Thank you. I would like to go back when you were formulating your plans for Mr. O'Brien before the MHPS was launched at the end of 2016, there was one thing on the outpatient backlog and your thoughts about 70 patients-a-month being a reasonable. 16:30

A. Oh, yes.

431 Q. If you do the math of 12-a-clinic, that is about an extra clinic and a half a week for an already overwhelmed clinician. How did you think that was

going to work?

A. I mean, it would have been a challenge. It may have meant other things having to be stepped down. I mean, yes, he was a very diligent and hard-working clinician. Thee is no question about that. So I think that once that discussion had been had with him, it would have been a question of sitting down operationally and saying, right, what is your week going to have to look like? What do we have to drop off? It wouldn't have been fair to work him into the ground so there must have been other things that had to be stepped down. 16:30 16:30

432 Q. Or, I guess, getting additional help in?

A. Yes.

433 Q. Thank you. Moving on to your submission to NCAS and the anecdotal delayed referral to oncology. So we have looked at Patient 102, it is an interesting case. It appears that an MDT, having been diagnosed with prostate cancer, it was agreed to be referred to oncology. One of the problems was, he was seen appropriately by Mr. O'Brien the following week, and the dictation was never done. And this was only picked up a year later when he came up and saw Mr. Haynes for follow-up. Mr. Haynes reported this. So my question to you is, why was this anecdotal? Why was this not a robustly looked into case? 16:31 16:31 16:32

A. I suppose because at the time I wasn't aware of that IR1. It only came to my attention during my preparation for this Inquiry. So the only recollection I would have had, was it would have been an informal

discussion with me. None of that was presented to me.

434 Q. Looking back, what should have happened then before it to come to you if it was a failure of identifying --

A. In terms of the incident reporting process, yes, that somehow slipped up somehow, yes. 16:32

435 Q. In retrospect, if that had been happening 2014, that's worrying, would you not agree?

A. Yes.

MR. HANBURY: Thank you. That's all I have.

CHAIR: I will not ask you anything further. Thank you very much for coming along and speaking to us, Mr. Gibson. 16:32

Tomorrow morning then at 10 o'clock. I think we have Mrs. Corrigan; is that correct? 16:33

MR. WOLFE KC: Mrs. Corrigan, at 10 o'clock.

CHAIR: Yes. 10 o'clock tomorrow morning.

THE INQUIRY ADJOURNED TO THURSDAY, 23RD FEBRUARY 2023 AT 10:00 16:33