Urology Services Inquiry

Oral Hearing

Day 26 – Thursday, 23rd 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.

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THE INQUIRY RESUMED ON THURSDAY, 23RD FEBRUARY 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Ms. McMahon.

MS. McMAHON BL: Madam Chair, members of the Panel, this morning's witness is Martina Corrigan, who is the Head of Service for Urology Services from 2009 to 2021, and I believe she's going to take the oath. 10:01

MRS. MARTINA CORRIGAN, HAVING BEEN SWORN, WAS EXAMINED BY MS McMAHON BL AS FOLLOWS: 10:01

Q. Mrs. Corrigan, thank you for coming along. I know you were here yesterday. Best laid plans. It didn't work out. Apologies for that. Thank you for coming back today. We have this morning until 1 o'clock to get through your evidence. Obviously, because of the duration of your employment and tenure in Urology Services you have quite a significant amount of information that might be relevant to the Inquiry. For the purposes of today, I want to try and concentrate solely on the MHPS period of time and your involvement or your actions in and around that period. If we can both exercise some discipline and try and stick to that, hopefully we'll get everything covered this morning. 10:01 10:02 10:02

As I said, you were the Head of Service, including Urology Services -- I know you covered other part of

the hospital -- from 2009 to 2021 when you changed posts. We'll look at some of your roles since then and your job description. Just in relation to the evidence you have provided so far to the Inquiry, you've sent in four replies to Section 21 Notices? 10:02

A. Yes.

1 Q. Two substantive. One the bulk of the information to the Terms of Reference and the second more substantive in relation specifically to MHPS?

A. That's correct. 10:03

2 Q. And two further replies attaching supplementary documents. I just want to take you to those and ask you if you recognise them, confirm it's your signature and if you'll adopt them as your evidence.

A. Okay. 10:03

3 Q. If we could call up, first of all, the Section 21 reply dated 6th July 2022 at WIT-26146. Do you recognise the front page of that notice 24 of 2022?

A. Yes.

4 Q. If we go to page WIT-26318. There is a signature just at the bottom of that page dated 6th July 2022. Do you recognise that as your signature? 10:03

A. That's correct, yes.

5 Q. Do you wish to adopt that as your evidence today?

A. Yes, please. 10:04

6 Q. The second Notice dated 29th April 2022 is at WIT-39879.

MR. MILLAR BL: Excuse me, Chairman, I'm not seeing anything on the screens here.

CHAIR: If we just take a pause, Ms McMahon. Is this something that is readily sortable?

(Technical difficulties)

10:04

CHAIR: Would you like us to rise so you can check it all out?

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

10:04

CHAIR: Hopefully we'll not have any further technical difficulties and Mrs. Corrigan can finally start giving us some evidence.

7 Q. MS. McMAHON BL: I think we were on to the second Section 21 reply dated 29th April 2022 at WIT-39879. 10:12
That's Notice 40 of 2022. If we go to page 39933. Just to confirm that's your signature. That one is 15th July. I've got the wrong date on my -- so 15th July. The next Notice -- I'll just correct that for my note. You wish to adopt this in your evidence? 10:12

A. Yes, please.

8 Q. The next Notice is WIT-40945. This is a Notice in relation to supplementary documents. We'll come back to that one. We'll try the next one. WIT-41803.

10:13

We'll check the index on those two, but they're documents that came in subject to your main Notices giving us documents that hadn't been -- I think they were discovered later on and provided to the Inquiry.

We'll come back to those. They're not substantive evidence documents, for the purposes of the other Section 21s. In relation to amendments, I understand there are two amendments you wish to make?

A. Yes, please. 10:14

9 Q. The first one is at WIT-26205 at paragraph 20.1(d) where it says:

"Mr. Haynes title should be changed to Clinical Director of General Surgery and Trauma and 10:14 Orthopaedics".

A. Yes.

10 Q. You have put in ENT there?

A. Ayes.

11 Q. The next amendment is at WIT-26306 at paragraph 69.1. 10:14 I think that's six lines down where you've referred to Dr. McAllister and you want to change your reference. There you have written "he was interim AMD" and you want to change that "Dr. McAllister started his role on 29th April 2016 and not in June 2016"? 10:15

A. That's correct.

12 Q. Just a date error there?

A. That's all. Yes.

13 Q. I also know from consultation that you want to make reference later on to a meeting that you had with 10:15 Mr. O'Brien on 25th July 2017?

A. Yes.

14 Q. You haven't referred to that in your statement. We'll deal with that when we get to that point.

A. Okay.

15 Q. Are there any other amendments or corrections that you need to inform us about at this stage?

A. No. Thank you.

16 Q. Thank you. Just as a very brief outline in relation to your role, and for the Panel's note, your occupational history is contained within your Section 21 Notice at WIT-26161. In brief terms, prior to taking up the role as Head of Services in 2009 you worked in various management roles in the Western Health and Social Care Trust and its predecessor Trust? 10:15 10:16

A. That's correct, yes.

17 Q. Just to confirm that you're not clinically quantified?

A. No.

18 Q. Your area of expertise and your undergraduate degree was in Public Policy -- 10:16

A. Yes.

19 Q. -- and Management, and you have an MA in Business Improvement?

A. That's correct, yes. 10:16

20 Q. You started your role for the Trust as Head of Service in September 2009 and you were in that role right up until June 2021?

A. That's right. Yes.

21 Q. I just want to briefly touch on your current role. You're the Assistant Director for the Public Inquiry and Trust liaison since June 2021? 10:16

A. That's correct, yes.

22 Q. I wonder, just in relation to that specific role, if

you could just explain what that role involves?

A. Yes. I suppose I applied for the job and was successful in it in June 2021. At that stage it was to be bringing together evidence and, you know, responses to Section 21s and sort of being the Trust liaison with the likes of the Inquiry. It became apparent that there would be -- and my Director at that stage was Mrs. Trouton, Mrs. Heather Trouton, but it became apparent that there would be a conflict of interest with regard to the fact that I had been working in Urology since 2009 along with Mrs. Trouton, so they appointed a Director, Mrs. Jane McKimm who has never worked operationally with Urology, and also we have Mrs. Margaret O'Hagan, who is an independent adviser for the public Inquiry so that anything -- to make sure there was no conflict of interest, that everything goes through them. Basically, pulling together evidence like your Trust policies and things like that wouldn't have a conflict, but would have worked through it making sure Jane and Mrs. O'Hagan were involved in whatever was going through. But I will be fair to say that really since I took up post and most recently, a lot of my time has been spent trying to prepare for my Section 21s and for today. It's my own personal evidence. I've had no contact with anybody else with regard to their Section 21s apart from if they ask me a specific question about a document that is in the evidence. So it wouldn't have been influencing anybody or anything like that with regards to anybody else's

10:17 10:17 10:18 10:18 10:18

Section 21. I've seen nobody else's. I've been taken totally out of that loop with regards to independence, that there would be no conflict.

23 Q. The Trust have inserted a layer --

A. They have, yes. 10:19

24 Q. -- as it were, of two other individuals in relation to their engagement with the Inquiry because of the unique position that you and Mrs. Trouton are in, where you actually have evidence relevant to the Inquiry in order to ensure that level of independence? 10:19

A. Yes. I was just going to say, I suppose my knowledge then, because at one stage I thought I would better stepping totally back, but it's just the knowledge I had since 2009 just felt it would be relevant, so I've been kept in the post or remained in 10:19 that post, I should say.

25 Q. I think you are probably unique in being the only individual who has been in post for the entire duration and also at the one level, as it were?

A. Yes. 10:19

26 Q. The key level in the middle operationally. Clearly you have lots of information that's relevant. Just in relation to that role, I just want to say a little bit about and discuss with you your responsibilities. Hopefully that will put in context the nature and level 10:20 of your involvement in the MHPS time period and why you were engaged in that.

For the Inquiry's note again, the narrative of your job

description is at WIT-26163. I just want to read from this before I can ask you some more information about it. I'll just read from the second line that's on your screen:

"This role entailed being responsible for the operational management and strategic development of ENT, Urology, Ophthalmology and Outpatients across the Southern Trust. I was responsible for Leadership, Service Provision and Service Development of ENT, Urology, Ophthalmology and Outpatients, and ensuring high quality patient-centred services. I was responsible for achieving service objectives through the implementation of national, regional, and local strategies and access targets. I worked in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Directorate's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources. As a Head of Service I was a member of the division's senior management team and contributed to policy development within the division towards the achievement of its overall objectives." 10:20 10:21 10:21 10:21

You're a member of the senior management team but you don't sit on Board committees; is that right? 10:21

A. I suppose what I mean by that is that it's the division. I would have sat within the Acute Directorate then you have the Surgical and Elective

Care division, so part of that was the Assistant Director and the Heads of Service, along with the Associate Medical Directors and the Clinical Directors. When I say there senior management team, I don't mean sort of your Directors, it's more the next tier down rather than, sort of the Chief Executive and all the other Directors.

27 Q. You reported directly to Assistant Directors?

A. That's correct, yes.

28 Q. In your tenure, who was that? 10:22

A. When I starred in 2009, actually for about two or three days it was Mr. Simon Gibson. Then Simon moved post and it was Heather Trouton from that until 2016. In April 2016 then it was Mr. Ronan Carroll and Mr. Carroll was still my Assistant Director when I left post in 2021. 10:23

29 Q. In relation to Mrs. Trouton and Mr. Carroll, what was the nature of your engagement with them on a daily basis, for example, or weekly basis?

A. On a daily basis I would have been in contact either sort of through e-mail or face to face. I suppose the nature of the job was it just varied from day to day depending on how many, perhaps, meetings we were at. I'm just thinking, for example, in the middle of winter pressures, it would probably have been within every hour because we were needing direction on whether we cancel patients or how we get our emergency departments cleared. I would have worked very closely with both Assistant Directors. 10:23

30 Q. Would you say your lines of communication with them were good? Effective?

A. Very good, yes. Very good, yes.

31 Q. What about the Assistant Directors over the same period of time? Who were they? 10:24

A. When I started it was Ms. Joy Youart but I had no contact with her at all because she had left in December. Then Dr. Gillian Rankin. I just can't remember all the dates just off the top of my head. I think she was 2013. Then it was Mrs. Debbie Burns 10:24 from '13 to '15, and Mrs Esther Gishkori from '15 until '18, I think, to read Melanie McClements from '15 until I left the post in June '21.

32 Q. What was your contact with Directors within the Acute Services? 10:24

A. It varied. Ms. Youart I would never have had any contact with her. Dr. Rankin, I would have had a lot of contact with her because it was during the time of the review of the Urology Services and we would have had regular meetings, particularly on a Monday night. 10:24 Then there would have been meetings ad hocly to do with the review. I also was involved -- Dr. Rankin would have been there at the time that we would have been going through the likes of the issues with regard to the IV antibiotics and the benign cystectomy. 10:25 She would have come to ask for information, for example. She was also involved with me when we were doing an escalation with regards to Mr. O'Brien's triage. We would have weekly meetings to do with

performance with Dr. Rankin, every Tuesday morning, but that would have been with the teams as in each of the divisions, not only Surgery and Elective Care. I would have had quite a bit of contact with Dr. Rankin. The same with Mrs. Burns, I would have had a lot of contact 10:25
with her. Regular meetings. We would have had meetings with regards to if we had, for example, needed more staff on the wards and sort of the whole recruitment process also I would have been very much involved. Mrs. Burns had a very good working 10:26
relationships with the ADs and the Heads of Service. I'm not sure if you were able to come and see sort of the layout of the admin floor, but she would have been down, as we called it, the corner office. Both her and Dr. Rankin would regularly walked into the Head of 10:26
Service if they needed anything, any information. Mrs. Gishkori, I have to say, no, I didn't have any contact with her. She was very clear at the start of her tenure that she expected that any information she needed would come through the ADs as opposed to the 10:26
Heads of Service which takes a bit of getting used to because we would have had an open door policy with the other Directors. If you think about it, from day-to-day, all the stuff that might happen, the AD mightn't be about so you needed to have that 10:26
relationship to go to speak to the Director if you needed, if the AD was on annual leave or maybe offsite in Daisy Hill, or something like that. Finally, Mrs. McClements I had a very good relationship again.

Again open door policy, would have called down to the office and we would have been able to go into her for any issues.

33 Q. You have mentioned a lot of information that we'll deal with when we come back, because you know you will have to come back. I know your counsel has already advised you of that. Just in relation to Mrs. Gishkori, because her tenure is relevant to the period of time for MHPS. I just want to probe that relationship a little bit more, if you don't mind, both in relation to the communication aspects and also any impact her style of management or your style of engagement with her may have had on the culture of dealing with issues as they arose. 10:27 10:27

When you say that her approach was different so that it perhaps wasn't open door that you had been used to, as Head of Service, what impact, if any, did that have on your day-to-day operation or ability to seek help or to make decisions? 10:28

A. Working with the previous Directors it probably did hinder because if you had something -- like you needed to give a heads up on something, for example, the Emergency Department was really, really busy and you needed to know was it okay to open -- you know, bring in extra staff to open a bay, you couldn't go in to her to ask her that. She had always said if you needed to highlight anything to me you just needed to go to one of the other ADs. If Mr. Carroll was not about I would 10:28

go find one of the other ADs I wasn't directly reporting to, for example Mrs. McVeigh, and sort of speak to them. I suppose I sort of got used to it because she had been there for a while but didn't have the same relationship and, you know, didn't feel that I could go to her if I had to escalate something.

34 Q. You mentioned there about having to free up beds or make some operational decisions which presumably directly relate to patient care.

A. Mm-hmm. 10:29

35 Q. If you weren't able to go to Mrs. Gishkori and you had to go to an AD, would that have resulted in, perhaps, delay or, in fact, a decision not being taken about that?

A. It could have, yes. Although the AD normally would have made the decision if she or he couldn't get to the director, you know, talk it through with me. 10:29

36 Q. If it wasn't your direct AD and another one from an ancillary Department, did you assume that they would inform Mrs. Gishkori of the conversation, or was it your view that you were getting your decision signed off, effectively at the level you needed to? 10:29

A. Yes, because if my own AD wasn't about the other AD was able to make the decision, so I would have taken it as their decision. 10:30

37 Q. Is it possible then that decisions made didn't reach the Director, the relevant Director, Mrs. Gishkori?

A. I can't really answer that but it could be possible. I don't know because I don't know sort of what would

have been discussed with Mrs. Gishkori with the ADs.

38 Q. Just from a perspective of how things operated, I know you said that Mrs. Gishkori indicated that there was a line of communication and there was someone between you and her. Is it the case that you wouldn't have felt comfortable just going to her door and rapping the door and saying, 'this situation has arisen. I can't get my hands on an AD, and I need to discuss that'. Was there, in effect, a barrier to you for doing that? 10:30

A. Yes, I felt that. Not with the other Directors. I suppose that was the difference because we said I was there from 2009 to '21. 10:31

39 Q. How was that barrier presented to you? Was it said to you that you shouldn't do this or that you did do it and the response was not welcoming? What was it that happened that made you reluctant or to know that you couldn't do that? 10:31

A. Not long after Mrs. Gishkori started in the role, and I was used to just popping in to the office to her personal assistant, Ms. Stinson, I would have said to Emma, 'are they free?', because you obviously wouldn't just knock the door and then go in, which is what I have done, you know, right from the start. This particular day I just said I just need to give Esther the heads up on something. I knocked the door went in to Mrs. Gishkori. She said, 'I'd prefer this didn't come from you, it came from an Assistant Director. I'm clear that the lines of communication is Heads of Service, Assistant Director to myself'. That was near 10:31 10:32

enough at the start of it. I was a bit taken aback because I had such a good relationship with the other Directors, so I was a wee bit taken aback. In saying that, I would have still been at meetings with her and Mrs. Gishkori would have been in the patient flow team room and was always polite. It wasn't that. It's just when it came to actual, I suppose, decision making. 10:32

40 Q. Do you think that culture, when we look later on at what happened during the period of time '15 to '18, do you think her approach to management had a detrimental impact on governance? 10:32

A. I don't know how to answer in the sense of that I am confident that the governance within the AD to the Head of Service lead nurse level was taken very seriously. Obviously, both Heather and Ronan would have had weekly meetings. They had weekly meetings but one of them was dedicated to governance. I don't know -- like, obviously, there was Acute Governance meeting on the second Friday of the month with the Director and the ADs. 10:33

CHAIR: I think, as I said to Mr. Wolfe yesterday, this is an issue for the Inquiry to determine, rather than the witness.

41 Q. MS McMAHON: Just as you were saying that, I was thinking it might be a better question to ask when you take you to the e-mails you sent during '16, '17 and '18 escalating breaches, and you can answer that in context of anybody replied to you. 10:33

A. Okay.

42 Q. We can do it that way.

Your role in governance, you deal with at WIT-26225 in your witness statement at paragraph 31.1:

10:34

"My role in governance for all my areas was to promote and ensure that there was high quality and effective care offered to all patients and to ensure that services were maintained at safe and effective levels. I can confirm that I didn't have a direct management role regarding the consultants and other clinicians in the Thorndale unit." 10:34

The evidence presented to the Inquiry and from witness statements would seem to indicate that there were two almost separate lines of communication within Urology. One was operationally, and one was the medic side. Would that have been your experience? 10:34

A. That's correct, yes.

43 Q. In some ways those two lines coalesce with you in some respects. Would that be a fair description? 10:35

A. That's fair, yes.

44 Q. On the medic side, and if I include the nursing staff in that, the lead nurses reported to you?

A. Operationally to me and then professionally to the AD, with me not being a nurse or a clinical person. For example, annual leave, and things like that would have been to myself, but anything professionally wise would have went lead nurse then direct to the AD. 10:35

45 Q. The other operational aspects, booking, referrals, people like Katherine Ford, you would have been dealing with that side of the branch of the day-to-day running of the unit?

A. That's right. Yes. Yes. Yes. All the operation clinics, theatre lists, and things likes that, yes. 10:35

46 Q. We will go through it on the next occasion in your evidence, but you have had a significant involvement with matters and issues of concern around Mr. O'Brien's practice from, I think, 2009, almost since you started in the unit? 10:36

A. That's correct.

47 Q. The person in post prior to that in Head of Service was a lady called Louise Devlin?

A. That's correct. 10:36

48 Q. When you started in the Service in 2009, did she give you an indication of her experience with issues arising from the practice of Mr. O'Brien before you took up your substantive post?

A. Louise was responsible for Outpatients as opposed to Urology. The Urology and ENT post was a new post that had been created. But Louise was the other Head of Service then for Trauma and Orthopaedics so we would have shared an office. She advised me of an occasion whenever she'd been in charge of Outpatients been tasked to go to Mr. O'Brien's office to get the some letters that was in his drawer because he was on annual leave. She removed the letters and Ms. Devlin said he came to see her, he was very confrontational and cross 10:36 10:36

with her, and that he said she had no right to remove the letters. She tried to explain that they needed to be added to the patient administrative system at that stage. But she basically said she never really communicated with him again. She had a hard time on that occasion. That was to do with letters in his drawer.

49 Q. Just in general terms, what was your experience and your relationship with Mr. O'Brien from the start of your taking up post? 10:37

A. I have to say I had a very good relationship with Mr. O'Brien. He was a wee bit off with me when we were introduced. I think he just seen me as another manager. But after that initial meeting I have to say I had a very good working relationship with him. 10:38 I suppose I was the person that was able -- I would have been in regular contact with him and all the escalation, et cetera, would have been through myself to him.

50 Q. Again, it is not for today but I just want to take 10:38 a brief trot through the issues that you ultimately had to deal with under the MHPS banner, and your knowledge of them over the years. If we just start with triage. That was something that was first raised with you in 2010 by the booking staff? 10:38

A. That's correct. Yes.

51 Q. The patient notes at home was first escalated to you in 2013?

A. Yes.

52 Q. The issue around non-dictation, again that was first raised in 2014 with you?

A. Yes.

53 Q. The issue of not conforming with booking patients, you don't specify the date but there seems to be correspondence with you and Heather Trouton and other staff on that issue over the years. Then you mention in your statement what you call clinical issues that you weren't aware of around IV fluids, benign cystectomies and an issue around notes being placed in the bin in 2011? 10:39 10:39

A. That's correct, yes.

54 Q. You also were aware of an issue around the allegation that private patients were being given priority towards the end of 2015? 10:39

A. Yes, that's correct.

55 Q. The issue around no access to key worker for Oncology patients. You say that you became aware of that in November 2020?

A. That's correct. 10:39

56 Q. The issue of not following up on results, you say you became aware of that in June 2020?

A. That's correct, yes.

57 Q. The same with the bicalutamide issue?

A. Correct, yes. 10:40

58 Q. We will go in depth into those particular areas on the next occasion when you give evidence. I think it would be a fair summary of all of that to say that there are many, many e-mails, either from you or you're copied

into, in which you raise issues or respond to issues on all of those topics?

A. That's correct, yes.

59 Q. I just wonder if I could ask you, generally, on those issues, given the length of time over which you had an awareness -- you and others had an awareness of varying degrees of concerns around those issues. Was there ever a point from 2010 when it was realised that these had the potential to impact on patient care and safety? 10:40

A. I've had quite a bit of reflection on this. I suppose pre -- the notes at home, the un-triaged, un-dictated, was always classed as being admin issues, wrongly for me now. On reflection, I didn't associate that with Patient Safety up until probably 2016, and it really hit home with me personally whenever, in 2017, I recovered the 783 letters and one of the patients, I think Patient 13 maybe, one of the patients actually was just a couple of weeks younger than my own husband, and the first line of the letter just rang alarm bells with me. Even though I'm not clinical, the fact I worked for 35 years in the Health Service I have sort of picked up some clinical terms. It was that realisation that because of what had been classed as admin was really Patient Safety and, you know, that patient became part of the 2016 -- sorry '17 SAIs. Up until that I would have said they were admin issues. When you read the report it says "admin issues" but it was obviously a Patient Safety, on reflection. 10:41 10:41 10:42 10:42

60 Q. You just mentioned the SAIs. You first became aware of

those in January 2016?

A. 2017. Yes, there was one SAI in 2016.

61 Q. The final reports, you weren't aware of until 2020. They were shared with you --

A. I was aware of Patient 10's SAI because it sort of was what started everything in December '16. But, no, the SAIs, the sort of the five SAIs that came out of the un-triaged I didn't know about until 2020. 10:42

62 Q. You didn't have anything to do with the SAIs, effectively? 10:43

A. No.

63 Q. If we look at the MHPS period, and you deal with that in your second Section 21 Notice. Just for the Panel's note, it's at WIT-39879. There's been a lot of evidence about the MHPS Framework and you tell us in your statement that you didn't know of its existence. When did you first become aware of it? 10:43

A. I became aware of it, I think it was because it was mentioned as sort of from Mrs. Hynds and Mr. Gibson in, probably, the latter end of 2016, December time, when everything, sort of, had come to a head. Pre that, because it isn't part of my responsibility, and I would not have been managing doctors, I never knew -- it's obviously in the Trust policies but I never would have any occasion to read it or need to use it. 10:44 10:44

64 Q. In relation to Trust policies, you also say you weren't aware of the Trust guidelines around doctors?

A. That's correct.

65 Q. It was only discussed with you in the context of MHPS?

A. Yes.
66 Q. The two formal mechanisms, if we could call them that, that were available, you didn't have any awareness of?
A. That's correct.
67 Q. Was it your understanding then, as the Head of Service, that if there were issues with doctors, then those issues were dealt with by other doctors? 10:44
A. Yes.
68 Q. Was that an expectation that you had for those in senior management, the medics in senior management in Urology, that you would have assumed or hoped that they would deal with the issues arising from other medics? 10:45
A. I did, yes. Because I would have had a, again, good relationship with all of my CDs and AMDs and Clinical Lead. Any issues that I would have brought to them, I wouldn't feel that I was cope fit to deal with it. So, yes, I expected that. 10:45
69 Q. You referred in your witness statement the way you considered that things should be escalated or, in your experience, were, at WIT-39882, paragraph 7.1 where you've said: 10:45

"I can confirm that I had not previously implemented or applied the MHPS Framework or Trust guidelines in my role but my understanding, and what I confirm I did during my tenure, was that, if there was a concern with a member of clinical staff highlighted or brought to my attention, I raised with this with either the clinical lead of Urology, which was Michael Young, and/or the 10:45

Clinical Director, Mr. Brown, and/or the Associate Medical Director, which is Mr. Mackle from '09 to '16 Dr. McAllister from April '16 to October '16, and Mr. Haynes from 2017 to 2021, and with your Assistant Directors Mrs. Trouton from '09 to '16, and Mr. Carroll from '16 to '21, and they would have addressed the concerns or issues raised."

Was it your expectation that if you brought anything to them that they would tell you what the resulting outcome of that was?

A. It was my expectation. Usually, depending on what the issue was, it would have closed the loop. They would have come back to me on it.

70 Q. Did that happen? 10:46

A. On some things, yes. On others, no.

71 Q. Could you give us examples of the things that it did happen and those that it didn't? If you can recall any at the moment?

A. For example, the notes in the bin that you mentioned, it was escalated to me by the ward sister. I shared it with Mrs. Trouton and Mr. Mackle. Then I know it went to HR, and until the Inquiry started I wasn't aware that there was actually a disciplinary process with regard to that, so I didn't get closed in that loop. 10:47

With regards to other issues that I maybe have raised, say, for example -- I'm just thinking the time I would have raised with regards to un-triaged back in

Dr. Rankin and Mr. Mackle's time, Mr. Mackle did come to me to advise me that he went and spoke to Mr. O'Brien, he had triaged all the letters. I do remember that one distinctly because it was the time he was supposed to be going to a conference in Barcelona and then he had done the triage and didn't get because of the ash cloud. On some occasions, yes, on other occasions, no.

72 Q. Would it be fair to describe that as a bit of an inconsistent approach? 10:48

A. Yes, that would be fair.

73 Q. Do you have any explanation as to why there was that inconsistency? Do you think it was lines of communication with individuals, personalities, or people were busy? Is there any basis for that that you think the Panel would be informed by hearing? 10:48

A. One of the things, sort of thinking about things like this, is I think everybody about, and this process and all, is the confidentiality of it for the doctors. With regards to even all the investigation and then the monitoring and all, which I know we'll talk about, it was all to be kept confidential to protect the doctor. In, for example, the likes of the disciplinary, probably didn't need to know because that's a HR confidential issue between HR and the Consultant. 10:48 10:49 I suppose it depends on the circumstances and nearly feel there was also the busyness of it as well because sometimes you would see the AMDs or the CDs maybe a couple of times in the week and then you mightn't see

them until the next meeting because of their clinical commitments.

74 Q. If we look at the period around November 2015 there was an IR1 raised by Mr. Haynes. I just wanted to ask you the process by which IR1s make their way to the relevant people to have a look at them. If an IR1 is raised where does that go? 10:49

A. If an IR1 is raised it depends on the speciality. For example, Urology, ENT, Opthalmopathy I would be copied in, but it also goes to the governance people. It goes to the Assistant Directors, the Associate Medical Directors for that particular area. Everybody gets -- it's like an e-mail from the IR1 to tell them it's there, you click into it, and you go into the system to read it. For example, if there was things like -- we'd get them for a clinical medical incident, so you would go to the ward, check that out, speak to the staff and that. If it's a fall, then the lead nurses would deal with that. For the likes of Mr. Haynes raising it, that would come to myself, the Associate Medical Director and the Medical -- sorry, Assistant Director. The Assistant Director and then the AMD would actually decide whether it needs to go to screening or not. I don't be involved as a Head of Service in the screening end of things. 10:50 10:50 10:50

75 Q. But you do see IRs as they come?

A. I do.

76 Q. An IR1 can be raised for anything, for example, from notes not being returned up to a patient incident?

A. Correct.

77 Q. If something is put in through the system on an IR1, is that a way in which it is brought to the attention of the hierarchy, if I can put it that way, in a more formal way examine, and a paper trail then is identified? 10:51

A. That's correct, yes.

78 Q. Were you aware of other IR1s being brought to that level on the issues relevant to the MHPS period?

A. No, not leading up to it. IR1s was raised for, ultimately, the five patients who came to harm but that was after the event as opposed to before it. 10:51

79 Q. Did Mr. O'Brien have any IR1s raised for triage?

A. Not that I'm aware, apart from individual ones that Mr. Haynes would have raised. 10:51

80 Q. If that had been done, would that be a way of escalating that problem up in a more formal manner to have it dealt with at an earlier stage?

A. I think it would, yes.

81 Q. The Panel will hear and will know from your statement that you have been involved in, if I can call it, significant informal interventions over the years to try and resolve matters. Would you accept that has been your input into the issues around Mr. O'Brien's practice? 10:52

A. I would accept that, yes.

82 Q. The absence of IR1s, I know the booking staff and the records, there were IR1s raised every time they considered it was appropriate, I think in order to flag

issues, and we'll discuss that. Do you think if the same approach had been taken earlier on on some of the other issues that it might have galvanised people to take action earlier?

A. I suppose the only thing about the IR1s for the notes at home -- I'll be honest, they don't seem to have went anywhere because, obviously, there was the ultimate in January 2017, the amount of notes that came back from home. But the triage, yes, I think potentially, if we had been getting every time there needs to be an escalation, it was just via e-mail as opposed to doing an IR1 about it. 10:53 10:53

83 Q. The reason I ask that question generally is because the Panel is obviously interested to look at the governance systems that were in place, why they weren't used, what happened when they were, and what might have made a difference? 10:53

A. Yes.

84 Q. Apart from the IR1 process and the Datix, obviously the resulting Datix, there doesn't appear to be any other formal way in which the issues that ultimately became subject to MHPS and this Public Inquiry could have been made known through the governance system. Is that a fair description, or do you think there are other ways it could have come through the governance route? 10:53 10:54

A. There is e-mails in the system where people have raised concerns. I think if they had have gone through the IR1 route, that probably would have ultimately led to maybe more SAIs because, like just to put it in

context, one particular day I was looking for an e-mail for evidence for the Inquiry and I had received 375 e-mails that day. You know, so e-mail wasn't the right way of doing things. I think ultimately the IR1 process is the best process to raise it. I suppose the problem with IR1 is it's quite a complicated system and I know when you would have spoken to consultants about raising stuff, they just didn't feel they had the time to actually sit and put all the information in. If it was just to put in what had happened, but you have to go through a number of pages, so I think the learning from this is to make the process a wee bit easier. 10:54 10:55

85 Q. Is the process the same now for passing any concerns along? Is the IR1 system in place at the moment?

A. It's still the IR1, although there seems to be more use of it now than previously. 10:55

86 Q. Is it "one form fits all", whether it's a patient fall or a potentially catastrophic incident?

A. Yes.

87 Q. Is there a way in which that IR1 is graded so if you have 375 e-mails, then that's brought to your attention at the top of the e-mail that this is a significant IR1 as opposed to perhaps one that requires system change rather than patient risk? 10:55

A. It doesn't in the e-mails highlight it. You just read, it gives you a synopsis of what the issue is. You know, you sort of can read it and you automatically -- like, if says a patient fall -- and I'm not underestimating that as not being serious but maybe 10:55

"patient fall" or, you know, "bed sore" or something like that, or somebody nips their fingers in the door, whereas if you start to read through and see there's a significant issue, then you go in and it will be categorised by the author of the IR1, whether its major, minor or catastrophic. 10:56

88 Q. That sounds like a triaging of IR1, is that right?

A. Yes.

89 Q. Who deals with that then?

A. It is part of the governance of the division led by the Assistant Director and either the Associate Medical Director or the CD, and somebody from governance. So governance will bring the cases that has come in as major catastrophic to the meeting and then they will read (as in the group) will read through and determine then if more action is needed. 10:56 10:56

90 Q. In your experience, just before you left post for the Inquiry's information, was it your view that IR1s were effective in both dealing with the issue and responding appropriately in a governance way? 10:57

A. They were effective to a certain extent. But I think the fact that there was never any -- again, going back to what we were saying -- any loop closed. So, for example, if an IR1 went via SAI, if I put in an IR1 today and it actually went as an SAI, most likely wouldn't know that unless it was discussed, you know, because it was me put it in. So I don't know the effectiveness of it for the users because they don't know whether they've put in an IR1 whether -- what the 10:57

ultimate end is of the IR1.

91 Q. So no-one goes back to the staff member and says: "The outcome of the IR1 or training has been identified" or "This is the actual result." It goes into the machine and they don't know what happens? Is that a fair description? 10:58

A. A fair description, yes.

92 Q. Now just back to the MHPS timeframe. In December 2015 there was an issue in relation to clinical letters not being dictated and some of the clinicians drew that to your attention. You spoke to Mrs. Trouton at that time? 10:58

A. That's correct.

93 Q. This was escalated to Mr. Mackle and Mrs Gishkori. That triggers then the January 2016 meeting. Now a lot of information that I'm going to speak through is just really to jump through the chronology but I do want to stop on some points where you have a particular involvement. 10:58

10:58

There was a meeting on the 11th January, I know you're aware of that meeting, that Mr. Wright had with Mrs. Trouton and Mr. Mackle.

A. That's correct.

94 Q. Now this seems to be the start of the process that would lead to MHPS that ended three years later. But Mr. Wright -- did you have much contact with Mr. Wright as Medical Director at that point? 10:59

A. To be fair to Dr. Wright, we would have -- when he took

up post, he was the first Medical Director that actually approached the Heads of Service to say that he would like to attend the speciality meetings so to get introduced to the consultants. So I knew him from his taking up post because I had facilitated him attending a urology and an ENT consultant meeting. But day-to-day dealings or escalations of any issues like that, no, I wouldn't have worked closely with him at all. 10:59

95 Q. Now you weren't at that meeting. Was the contents of the meeting or discussions or outcomes discussed with you afterwards? 10:59

A. They were, yes. It was a discussion where both Mr. Mackle and Mrs. Trouton came to me to say they had had the meeting, I don't recall the actual total conversation, but I do know that they requested me to do a draft letter covering some of the facts and the figures around four areas, four areas un-triaged, review backlog, charts at home and -- I'm taking a blank -- oh, un-dictated letters. 11:00

96 Q. Now, that letter was provided to the Inquiry yesterday?

A. Yes.

97 Q. I know that after consultation, you went and sought that letter and we received a copy yesterday. We have managed to Bates number it and it can be found at TRU-164660 to 164663, for the Panel's note. 11:00

The first page, we can move past that. That's a letter from Ms. Frizell, Solicitor, yesterday sending this to

us. The next page should be your e-mail with, your cover to the draft letter, 164661, on the next page. So that's an e-mail that you have sent on the 18th January 2016 to Mrs. Trouton and Mr. Mackle:

"Dear both,

Apologies for not getting this to you sooner but I wanted to rerun and update the information before including this in the correspondence. I wasn't sure if this was a joint letter but I have put it from a plural perspective, so this may need changed.

Hope it is okay and if there is anything else needed, please do not hesitate to give me a shout."

11:01

11:01

11:02

And you have attached a draft letter. Now there are no notes of the conversations with yourself and Mrs. Trouton and Mr. Mackle.

A. No.

98 Q. But the contents of the letter would seem to indicate that they have given you a steer as to the sort of information not only they want you to cover but the data they would like you to put in the letter?

11:02

A. Yes.

99 Q. I just want to look at some aspects of this. Now the reason why I want to take you through this is because the letter that was subsequently presented to Mr. O'Brien differs from the contents of this letter.

11:02

A. That's right, yes.

100 Q. So this draft, the 18th January 2016, and the ultimate letter handed on 30th March 2016 have been altered, just in detail, and I want to identify that. But did you do another draft of this letter or is this the last draft that you sent to Mrs. Trouton and Mr. Mackle? 11:02

A. This is the last draft I sent. I did update the figures but I didn't do anything with the draft of the letter. That's this last one.

101 Q. We'll look at that in a second. I think you updated the letters on the day of the 30th March, is that right? 11:03

A. That's right. Yes.

102 Q. Okay. So the first part of this, I just wanted to read some of this out, as I say, because it has just been received by the Panel. The first paragraph in that, you speak to un-triaged outpatient referral letters. And you have said: 11:03

"There are currently 253 un-triaged letters outstanding from the period of time when you were on call. These are dating back to November 2014." 11:03

I just want to ask you about that. Where did you get those figures from for this letter? Where was the source of your hard data, as it were, for this correspondence. 11:03

A. For the un-triaged letters, I would have got that from the Referral and Booking Centre, so most likely through Mrs. Robinson. I would have asked her and she would

have provided me with that data.

103 Q. I'm just inquiring if it is possible to put the two letters side by side. It would perhaps make this process a bit easier. The letter that was given to Mr. O'Brien is at TRU-274672. 11:04

I'm trying to find the east way to do this without moving to move back and forward. Perhaps the easiest way at the moment is if I read out the parts that didn't find their way into the final draft, ask 11:05 you the motivation for including them and then we can ask others why they were removed, is that a fair enough thing to do? If we go back to the original. TRU-164662. Okay, back on track.

11:05

So we're under the heading: "Un-Triaged Outpatient Referral Letters". I'll read out the bits that have been left out.

So the second line: 11:05

"We have been advised that whilst the booking centre does not book these patients on to clinics as their date comes up..."

11:06

You had put in your original, which isn't in the ultimate letter:

"There is a clinical issue for us in that we do not

have assurance that these patient letters have been read so as to give an indication on their priority. Therefore, the Trust do not know which waiting list they should actually be on. For example, do they remain on routine? Should they have been updated to "red flag" and "urgent".

Now that information isn't in the original letter. Now when you put that in, you specifically mentioned about there being a clinical issue? 11:06

A. I suppose when I was drafting the letter, really it was under the four headings and the actual information, the data. I just put everything down knowing that when Mr. Mackle and Mrs. Trouton would get it that they would consider it. So it's just one of those things of putting as much in as I possibly could, whenever I was drafting it. 11:06

104 Q. Now the next part of your letter that doesn't find its way in is the line that begins:

11:07

"We have been informed that none of the original 253 letters have not been returned from you to the Booking Centre."

Then the bit that's not in the next letter, the rest of that sentence: 11:07

"The integrated elective access protocol which governs the turnaround time for triage states that this should

be done within 72 hours (although we recognise that this is not always possible, the maximum time to return letters is 1 week). At the moment, the longest un-triaged letter is now 60 weeks."

11:07

Now, again, you will appreciate the next line, and it is a matter for the Inquiry and for the other witnesses to explain why they removed this and if it has any significance or any bearing on the element of risk that you seem to have identified in the body of your text. 11:08
The next part is the next paragraph:

"You will appreciate.."

And almost all of this I think didn't find its way in. 11:08

"...the issue for us is that we do not know what is within these un-triaged letters, as you are the only consultant to have seen these, and whilst we have been given assurances that they will be seen within their 11:08
timescales (therefore not disadvantaged), we are not sure if the priority given by the GP is correct and then from this end the patient is disadvantaged in that their treatment has not been started at an earlier time if that was what had been agreed if the letter had been 11:08
upgraded."

Now I wonder if I could just ask you to talk me through that? Where did you get that information from in

relation to there may be outcome issues for patients?

A. I suppose it's just -- it was just my knowledge that, because I have been working with un-triaged letters -- like, even pre working in the Southern Trust I would have worked as an outpatient manager so I was familiar with the whole concept of referral letters and triage. So I would have known that there was a potential amount of patients that maybe needed to be upgraded, and that's basically where I was coming from. Now when I started in 2009, waiting times were nine weeks for an outpatient appointment. So if the letter wasn't triaged it still would have been seen within nine 9 weeks. Potentially, yes, if there's a cancer patient in it, that wouldn't have been good, but there was always a potential of only nine weeks. Before I left, it was up to four years, I think, the waiting times. So we don't know that somebody in there was graded as a routine would end up as maybe an urgent or a red flag missed if they weren't seen for four years. 11:09 11:09 11:09

105 Q. But even in the drafting of this letter, with your nonmedical background, you realised that that system alone could disadvantage patients? 11:10

A. Yes. Yes.

106 Q. Would it be fair to say that that disadvantage, for you, presented a clinical risk? 11:10

A. Yes.

107 Q. The next part of the letter, it is more the wording, I think. Now the information in boxes was updated for the letter, I think you were asked to update the

figures before sending it through.

A. Yes.

108 Q. Just the second line where you've started the paragraph saying:

"Aidan, we need assurances that there are no patients contained within this backlog are cancer surveillance patients." 11:10

Then you say:

"We have been advised that you have now a separate oncology waiting list."

I just wonder if I could ask you about that sentence was not framed in that way in the ultimate letter. It sounds as if you just found out about a separate oncology waiting list, that may be wrong but certainly reading that at face value, it seems to be the case. Could you explain that? 11:11

A. It used to be all the consultants had a general waiting list that everything went on. Now Mr. O'Brien was Chair of the NICaN and part of Peer Review and part of our oncology DT business meetings. It was advised that we would be better to separate out any patients that were oncology so that they -- because if you think about it chronologically, if you have somebody waiting back to 2013, which I can assure you it wasn't cancer patients, but if you look at that, we have no way of 11:11

knowing how to pick out a surveillance patient. So there was a new oncology list. So it was CAOBUO for Oncology. It meant that when the booking centre were sending for patients they would probably take -- they were instructed to take from that list first for a review clinic. So yes, and that was a fairly new thing, and it went across the Board, all the consultants ended up with an oncology review waiting list.

11:12

109 Q. So that was a way in which it was trying to be effective and targeted?

11:12

A. Yes. Yes.

110 Q. So it was a beneficial approach, was it?

A. It was a beneficial approach, yes.

111 Q. You also say in that paragraph, third line from the bottom:

11:12

"We have no assurances that those patients in the 'older' backlog are not clinically urgent patients."

11:12

Then under: "Patient centre letters and recorded outcomes from clinics", just the last three and a half lines of that first paragraph:

"The lack of a record means that no decision can be made on whether a patient needs to be reviewed, discharged, et cetera, and when they do come to clinic they have to be treated as a new patient because there is no previous information to base decisions on."

11:12

Okay, that's not dictating outcomes. That information wasn't reflected in that way. And then the next paragraph:

11:13

"We have also had it escalated that there are no outcomes recorded from your clinics and as there's no letter dictated, staff are not able to record a decision on the patient."

11:13

Then you have said:

"Example:"

And this wasn't included. 11:13

"Should they be add to a review list, should they be added for urodynamics, flexible cystoscopy, inpatient day procedure or actually discharged back to the GP, I am sure you would agree that this lack of documentation 11:13 is not fair on the patient nor on the admin staff who are trying to manage this."

Then patient notes at home issue, the last two sentences weren't reflected in the final draft: 11:13

"We have been advised that you are being requested a few times a week to bring patient notes in from home. These are needed for clinics, patient admissions or

filing. This is a big governance risk and needs addressed and ceased immediately."

So in your detail in the letter, you have identified both clinical risk and governance risk. There's probably more of a context detail in your draft. Did you ever get any direct feedback on that draft or asked to look at another draft after you sent that through.

A. No. The next thing I had heard was on the 16th March, I think it was, When Heather requested me to update the figures and then on the 30th March, the day that we met with Mr. O'Brien, I got a copy of the final letter, a hard copy, because it was printed off, and I copied it for Mr. Mackle and a copy for Mr. O'Brien. 11:14

112 Q. The 16th March Heather Trouton e-mailed to you -- we don't need to go to this, it's just for the Panel's note -- TRU-277940, and then your e-mail to Mr. Mackle on 30th March is at TRU-282021. Now in that one, you didn't copy Mrs. Trouton in, just Mr. Mackle. Was he the one dealing with the final version? 11:15

A. He was, yes, and I think it was because I think both him and I were going to the meeting, and it's possibly -- because none of us can remember whey it was me, it was possibly Mrs. Trouton must have been on annual leave or something because it was coming up to the end of financial year. So that's probably why I didn't copy her in. 11:15

113 Q. Now Mr. Mackle in his evidence, about the 23rd March letter, seemed to indicate that you principally drafted

that version.

A. The final version?

114 Q. Yes.

A. No, definitely not.

115 Q. We don't have to go to it, it's just for the Panel's note, TRA-02256. So in your mind, this was the last time you had anything to do with the correspondence? 11:16

A. Absolutely.

116 Q. Except for updating the information?

A. Yes. 11:16

117 Q. Now that letter, even though you had updated the information on the 30th March, the version given to Mr. O'Brien was dated the 23rd March?

A. Yes.

118 Q. And you had nothing to do with that either, I presume, had you? 11:16

A. No. No, I didn't.

119 Q. You met with Mr. O'Brien on the 30th March with Mr. Mackle?

A. I did, yes. 11:16

120 Q. Now in relation to that meeting, did you keep a note of that?

A. I didn't. It was actually a very short meeting. I don't even think it lasted 10 minutes. It was whilst both Mr. O'Brien and Mr. Mackle were very courteous to 11:16 each other and talked about the business of the hospital just generally, the meeting was very short and succinct and I think it was just we gave him the letter, Mr. Mackle just gave the headings, he didn't

read the letter in detail. I do recall Mr. O'Brien folded up the letter and asked: "What am I going to do with this?" And I can't recall whether it was myself or Mr. Mackle but I definitely know that we said we had four weeks, we needed a response. Now I do know from reading -- from information in preparation for this that there was a -- Mr. Mackle is supposed to have shrugged his shoulders and rolled his eyes. I honestly can't say if that happened or not, but I could have just been looking at Mr. O'Brien at the time. And I did offer Mr. O'Brien, as I would have always done, if you need any help give me a -- my phrase is, as you can see from e-mails, "give me a shout". 11:17 11:17

121 Q. Just to deal with the shrug issue, that's a contention of Mr. O'Brien's where, when he was asked about what's expected, he was met with shrug of the shoulder and he says that at AOB-1367. That's not your recollection? 11:18

A. No.

122 Q. So going back to your recollection, that's the first time that it had been written in a formal way, the letter to Mr. O'Brien, about issues that had sought to be addressed, at least informally by you over the years? 11:18

A. That I'm of aware, yes.

123 Q. Now the Panel have seen the letter. I don't need to go to it but I don't think it is contentious to say that there's no mention of a plan or timeframes or specific actions that were expected from Mr. O'Brien? 11:18

A. That's correct.

124 Q. Was your understanding of that letter that he was to triage, to get on top of his review backlog, to dictate the letters and not store notes at home?

A. I suppose my view was, yes, that we would get a response back to say that he had done his triage, maybe tell us how he was going to address the review backlog and to let us know that he had returned the charts. I assumed we would get a response back. 11:18

125 Q. At that stage, were you aware that you would have any subsequent oversight of Mr. O'Brien's actions after this point at all? 11:19

A. I wasn't. I didn't think -- wrongly, I didn't follow up on it because I think it was -- in my head it was the Assistant Director and Associate Medical Director who were leading on it. My role was originally just to provide the information, the data, and then ultimately it just happened to be that I attended the meeting with Mr. Mackle because of previous encounters, Mr. Mackle couldn't attend a meeting on his own. So with Heather not being available, it's obviously the reason why I was there. So it was being led by the AD and the MD so I, wrongly, didn't follow up on it. 11:19 11:19

126 Q. Was there any reason why Mrs. Trouton didn't go to the meeting instead of you?

A. I really can't recall why that happened. 11:19

127 Q. Did you know well in advance you had to go to the meeting or was it something that you were informed of just before?

A. I think I was just informed relatively before it,

whether it was that day or the day before, that I had to attend.

128 Q. You've said about previous encounters with Mr. Mackle. Could you just give us some context to that, why he couldn't be alone, as you say, with Mr. O'Brien? 11:20

A. Yes. I'm not aware of the time scales but I think from reflection, it was sort of later on in the evening of a working day, Mr. Mackle, after theatre or clinical, would have popped up on to the admin floor. Again, that's in context of sort of he would walk right round 11:20 from the Director's office right rounds to ourselves. I was in the office on my own, which is why I think it must have been later evening. Mr. Mackle came in, closed the door and put his back against the door and looked visibly shocked and actually looked very unwell 11:20 and said to me: "I've just been accused of bullying. I've just been pulled into an office and been accused of bullying." He didn't tell me which office it was so I know, listening to Mr. Mackle's evidence, he did contact me when the inquiry was announced and said to 11:21 me did I remember who it was. I really don't. I said to him at the time it had to be either Dr. Rankin's office, which was the first one, or Helen Walker who was the AD for HR, before he would have come round to me. He just said: "It has come from down the hill", 11:21 which is what we would call Trust Headquarters and I was more concerned that evening for his actual health. I was trying to get him to sit down and take a glass of water because he was very distressed, and he

definitely said: "I've been accused of bullying by Mr. O'Brien."

129 Q. Just in relation to time frames, we're on to 2016. Do you have any idea when that conversation directly with Mr. Mackle occurred? 11:21

A. I think it was in and around 2011/12. I can't be more precise than that. I know at the time Mr. Mackle's late wife was quite unwell. So I do know it was in and around that time, but I can't be more precise.

130 Q. So just in summary form, he spoke to you directly about an allegation of bullying. His reference to "down the hill" you took to mean headquarters? 11:22

A. Headquarters, Yes, Trust headquarters. Yes.

131 Q. You think it was possibly either Gillian Rankin or Helen Walker who brought the allegation to his attention? 11:22

A. Yes.

132 Q. Now the Panel have heard from Helen Walker that she has no recollection of that but Dr. Rankin will be giving evidence so that can be brought up with her. So that's the context you were saying earlier in your evidence that Mr. Mackle didn't attend meetings alone with Mr. O'Brien? 11:22

A. Yes. And I suppose after that meeting with me there was a decision, which was shared with us all, that Mr. Mackle would take a step back from managing Mr. O'Brien and that it would be Mr. Brown who was the Clinical Director of General Surgery in Daisy Hill would have direct responsibility then in any meetings 11:22

he would take forward.

133 Q. Just having brought up that issue with Mr. Mackle, that allegation that was made, did that become more widely known among staff?

A. I'm sure it did, yes. It would have sort of ruminated through the -- a bit like what Dr. McAllister said, they all talked in theatre to each other so I'm sure that it did, yes. 11:23

134 Q. Did you perceive that as having, or did it have any actual impact on how people dealt with Mr. O'Brien? 11:23

A. I think it did. I think it did, because people knew, as was described by Mr. Mackle, when you sort of try to hit it head-on that something -- an allegation is made that just makes you run scared.

135 Q. I see the time but I wonder if I could just be indulged to just finish off just another couple of sections on this? Now there's nothing in the letter that said it had to be responded to within four weeks but that's the evidence being given to the Inquiry. Did you or anyone else follow up after this meeting with Mr. O'Brien about plans that he had to try to address some of those issues? 11:24 11:24

A. Not directly with Mr. O'Brien, no. Not me, and I assume just looking at everybody else's evidence over this last few days, nobody else did either. 11:24

136 Q. Would it be usual to ask -- to draw to a Consultant's attention concerns around issues of governance and clinical risk and not provide him with some kind of framework of support to address those concerns?

A. I would say yes. I know I offered support, as I always did, but it wasn't formal support.

137 Q. When you say it wasn't formal support, what's the difference between the support you've offered in previous years to the support that you might have offered at this time? 11:25

A. I suppose always my support was sort of informal, you know, but Mr. O'Brien never took up any offers in all the years. He still maybe -- I would say to him, you know, will we spread the likes of the triage maybe out with others or -- he would always still want to do it. Now I do know Mr. Young did help out on two occasions but, you know, Mr. O'Brien had a way of working that was probably inefficient. So it was his way or no way, sort of thing. So it was probably very hard to offer support. But, you know, if we would have been able to sit down, there might have been things like the review backlog, we maybe could had the nurses do a validation on it, for example, the CNSs, clinician nurse specialists. 11:25 11:25 11:26

138 Q. Just at this key point in April 2016 there were staff changes?

A. That's correct.

139 Q. Now those staff changes were as a result of a decision by Mrs. Gishkori, is that right? 11:26

A. That's correct. Yes.

140 Q. Would staff changes have been unusual in your experience or was it something that was routinely done by directors?

A. Well, I had worked from 2009-2016 without any change. I know Mr. Gibson, but that had been done before -- Mr. Gibson and Mrs. Trouton, but that had literally been done before I had taken up post. But, no. And from '16 to 2021, I still had the same AD. So it wasn't normally... 11:26

141 Q. So at this point the two individuals who were tasked by Dr. Wright in dealing with this issue, Eamon Mackle and Heather Trouton, both changed roles?

A. Well, Heather changed roles but Eamon resigned from his role as AMD in April. So that was his choice. 11:26

142 Q. Yes, but they were replaced by other people?

A. Yes, they were.

143 Q. Who had no history with this issue?

A. No, that's correct. 11:27

144 Q. And the Inquiry has heard evidence from Mr. Weir and Mr. McAllister in relation to that. Were you aware of the staff changes at that point?

A. We knew they were happening and I actually didn't know sort of the reason for it until, actually, yesterday Mr. Gibson's -- when he was giving his evidence, actually, had given the reason why the changes -- why Mrs. Gishkori wanted the changes and that she wanted clinical people in the operational AD roles. 11:27

145 Q. Would that have been a significant issue ongoing that a consultant had been given a formal letter? Would that have been something that was pretty significant within the unit at that time from a management position? 11:27

A. It would have been, because it hadn't happened previously.

146 Q. Are you aware if there was any hand-over in relation to that for the people coming into the roles of Mr. Mackle and Mrs. Trouton? 11:28

A. I'm not aware of if there was a hand-over. I did myself, because I was concerned that we didn't have a Clinical Director and Associate Medical Director. Towards the end of April, I updated Mr. Carroll on -- there was a three areas I had to update him on 11:28 clinically-wise.

147 Q. And in your statement at WIT-39890, you have accepted that the change in personnel meant that the letter of 2016 was not followed up as it should have been. Do you think that the change in staff was the only reason 11:28 that it wasn't followed up or was there a general reluctance to follow it up?

A. I think the change of personnel was probably the most -- it was the biggest thing with regard to that because this was the first time since I had started in 11:29 2009 that anybody had actually, you know, addressed it in writing and seemed prepared to take it on. Then I don't know then about the subsequent post holders, whether there was a reluctance there or not.

148 Q. The Panel will be aware while you e-mailed Mr. Carroll, 11:29 nothing really was done until August 2016?

A. Yes.

149 Q. -- in relation to this issue. Because I'm going to move on to that and a new topic, I wonder if that would

be an appropriate time to take a break?

CHAIR: We'll take a break now and come back at quarter to 12.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:40

CHAIR: Ms. McMahon.

150 Q. MS. McMAHON BL: Just before we move on to the rest of the timetable, I know we spoke about Mr. Mackle telling you that it had been alleged about bullying, obviously, 11:48 that's an allegation that Mr. O'Brien denies completely and he can deal with that in his evidence. The other issue we touched upon with the SAIs, and you mentioned about harm coming to patients, obviously that's a matter for other witnesses to deal with, so the 11:48 particular phraseology used wouldn't be accepted by Mr. O'Brien in relation to harm but, as I say, you weren't involved in that. So I'm just putting that on record.

A. Okay. 11:48

151 Q. Now when we talked about Mr. O'Brien had been asked to respond within four weeks, although it's not in the letter --

A. That's correct.

152 Q. -- there is an e-mail to that effect, and again, it's 11:48 just for the Panel's note, 28th April 2016, an e-mail from you to Ronan Carroll at TRU-274671. This is where you inform him of the letter that was given to Mr. O'Brien and you mention that he had been asked to

respond within four weeks but nothing had been received. So just to tie that point up, that's a record of the four-week turnaround being recorded at that point.

A. That's correct, yes. 11:49

153 Q. Now there were steps and stairs along the way later through 2016 and you weren't necessarily involved in a lot of discussions that were ongoing. I don't want to take you to all of the ones that you were involved in because I want to get to the Return to Work Plan and 11:49 your involvement in that?

A. Okay.

154 Q. But I just want to point out a couple of e-mails and I'll give references for the Panel and for core participants to note where your level of involvement 11:49 sat.

There was an e-mail from you on 15th June, it was discussed I think with previous witnesses, to Colin Weir, where you have updated -- you have provided the 11:50 letter of March 16th and just said "as discussed"?

A. Yes.

155 Q. I presume that was on the back of --

A. Yes, it was on the back of -- I do know I updated Dr. McAllister and then he's obviously updated Colin. 11:50 I don't recall the conversation but as you say, I said "as discussed", so he must have asked me for it.

156 Q. And were those conversations, could they be described as a hand-over of the issues that were currently being

aired in relation to Mr. O'Brien?

A. They could be, yes.

157 Q. Again, on 9th August 2016, and the Panel will find this at TRU-274723, Mr. Wright sought an update from you. I'll just quote from that: 11:50

"Did we ever make progress with regard to the issues raised re urology which Eamon had been dealing with?"

This is just in advance of him asking Mr. Gibson to undertake his scoping exercise. Is that the first that you had been directly asked about an update since the meeting with Mr. O'Brien? 11:51

A. Yes, that's the first.

158 Q. You had never thought to follow up from that meeting? 11:51

A. I suppose in my head because there was sort of informal conversations with Dr. McAllister and Mr. Weir that it was being followed up but I personally didn't follow up, and that is a regret that I probably didn't sort of bring it to their attention more, that we needed a response from it. 11:51

159 Q. Well, just to be balanced on that in relation to the evidence you provided, it had been dealt with by Eamon Mackle and Mrs. Trouton?

A. Yes. 11:51

160 Q. You discussed earlier in your evidence that the hierarchy of the medics, dealing with medics, was something that was custom and practice, if I can put it that way, within the unit, and so the people who

replaced those posts, Mr. McAllister, Mr. Weir, was it your expectation they had taken up the mantle in this regard?

A. Yes. Yes.

161 Q. So you provided a letter to Mr. Wright that you had given to Mr. O'Brien on the 30th. There then is a period of time when Mr. Gibson is carrying out his work. There's an oversight meeting then on 13th September. Now did you have any knowledge of the oversight meetings? 11:52

A. No, I had no knowledge of any of them until the December 1st.

162 Q. And you didn't know that they were being planned or that they had happened?

A. No. 11:52

163 Q. Did anyone approach you in advance of the meetings to just get a further update on figures or facts or anything about practice?

A. Well, Simon, Mr. Gibson had actually asked for -- when he met with me with regard to figures -- but it was never in the context that there was an oversight meeting. I assumed it was just from follow-up of Mr. Wright's e-mail. 11:52

164 Q. But Mr. Gibson had informed you that he had been tasked with undertaking the work by Mr. Wright in order to get what could be described as a global view of the situation as it was at that moment in time? 11:53

A. Yes.

165 Q. And did you give him any information to inform his

report or did he just let you know he was doing it?

A. I would have given him some information. Yes, probably give him an update on the situation with regard to the triage, the review backlog and I couldn't do the un-dictated on the chart at home and he did ask a specific question from Ms. Lawson with regards to records, did we know how many charts were at home. I didn't see any responses to that and I didn't respond because it wouldn't be my area of expertise to know that information. 11:53

166 Q. Now when you come back to given evidence, we'll go into some detail about the systems that were in place to give you data and how reliable that data may have been and how you relied on it operationally outside of these issues. But just you've mentioned there, and I think you're probably in a unique position that you can reach out to different parts of The Trust? 11:54

A. Yes.

167 Q. Like Katherine --

A. Katherine Robinson. 11:54

168 Q. Katherine Robinson, I'd just forgotten her surname, apologies?

A. Yes.

169 Q. Asked them for information that was fed in to you obviously to inform you? 11:54

A. Yes.

170 Q. But you touched upon the un-dictated clinics issue and I just wanted to ask you briefly about that. From reading your Section 21 and others, was that

a particularly difficult issue to get proper information on because is it fair to say you don't know what you don't know. If a clinic hasn't been dictated, how do you find that out?

A. I suppose its easier now with digital dictation, but before it used to be the hand-held Dictaphones. So the only person who would probably know if a tape hadn't arrived back with the charts is the secretary. I suppose there would have been -- it was never escalated. And the other thing would have been that the charts needed to come back so the secretary would know there had been no dictation. So it would be very difficult to know. 11:54 11:55

171 Q. So you were dependant on an individual then to alert to the absence of information. 11:55

A. Yes.

172 Q. And you say that's different now with digital dictation. Does that mean that there's a system that flags up the absence of dictation rather than an individual or is there still individual involvement? 11:55

A. There's still individual involvement. I know they are looking at a system to try and -- that when there's a clinical and a patient arrive at the clinician that it automatically flags up there needs to be a letter, but they're looking at the technology of that. The health service system are all full of fire walls so I think it's just trying to get -- and I am not at all and I will never claim to be technically knowledgeable, but I have been advised that it will. But at the 11:56

moment the answer to your question is it still depends on individuals.

173 Q. Is it still -- well, if I can frame the question this way. In your experience, do you see that dynamic or that particular system to be as vulnerable now as it was then? 11:56

A. Not as vulnerable because there is a lot of audits goes on from -- it's a different division, but they will ensure that everybody who has been to a clinic gets a letter. The downfall, and I'm sure we'll get to this, for me, was that there's 10 patients in the clinic and when I asked the question about the dictation, they told me there was 10 letters on the system. But I did spot checks but towards whenever there was a big deviation, when I went in and discovered there was 10 letters, the 10 letters weren't for the 10 patients. It might be one had three letters and one had none. So there is still that vulnerability in the system. And I really -- I know you're hoping to address this, I don't know if anything more has moved on because obviously I haven't been in that post since June '21. 11:56 11:57 11:57

174 Q. We can explore that, the Panel can explore that with other witnesses.

11:57

The other issue about the notes at home, is that another particular issue that requires on reporting from individuals? Notes not being where they should be rather than just being at home with an individual.

A. Yes, the system that we have, the patient administrative system is very, very dependent on human input in the sense of that -- so I have a chart but you come up and lift that chart out of my office. If you don't case note track that chart, it is still, 11:58
accordingly, to me, in my possession. Whilst charts may have been case note tracked out to Mr. O'Brien's office, they might not necessarily -- well, as we know, weren't actually in his office, but people -- and it was a lot in the system and it's only 11:58
now we're discovering how much, but basically if they couldn't find a chart that was case note tracked out of the office, they would go looking for it in the different areas; the ward, outpatients, the secretary's office, and then if it wasn't, we would contact 11:58
Mr. O'Brien and he would bring it but we didn't know the extent of how many charts were at home.

175 Q. Is that system still flawed in that way?

A. It is, yes. There's a business case has been done up for a system called I-Fit that basically barcodes and 11:58
tracks the chart wherever they move around the hospital, but that hasn't been implemented yet. I can't comment on why or whatever, but I do know that they are hoping to move to paperless within Compass say, which is quite imminent. 11:59

176 Q. Thank you for that slight deviation, but it will explain some of the e-mails you subsequently sent during your monitoring of Mr. O'Brien's return to work.

You said you were aware of the 22nd December 2016 Oversight Meeting?

A. That's correct.

177 Q. Were you informed in advance of that, that it was taking place? 11:59

A. No. No. It was after the meeting that I knew about it.

178 Q. Who they you about it afterwards?

A. It would have been Mr. Carroll, the system director.

179 Q. What was the context in which he discussed that with you? 11:59

A. Because there had been a letter received in from the Chair of the Patient 10 SAI which raised issues with regards to non-triage. I am aware now that the 22nd December meeting was called and there were a number of issues raised. Mr. Carroll approached me and Mrs. Clayton to help gather some of that information up. 12:00

180 Q. That was the period between 22nd December and the end of January? 12:00

A. That's correct, yes.

181 Q. You were involved with Mr. Carroll in another scoping exercise, really, to --

A. Yes.

182 Q. Was that to try to fine tune the figures that you wanted to rely on, or? 12:00

A. Yes, to fine tune the un-triaged letters was really sort of towards the end of December up until 30th December. January was more to do with the fact that

the notes had been returned and there was 307 case notes from home, and the fact that there were 783 letters in the drawer, and I think 66 clinics not dictated. It was quite a substantial piece of work had to be done after the December. 12:00

183 Q. All of this work eventually became the preparation for the subsequent MHPS investigation and provided the hard data for that. What's your view as to whether more could have been done in preparation for that investigation or for the areas that were actually 12:01 explored? Do you think that, number one, enough was done to look at what was currently current issues and, number two, do you think it should have gone a little bit wider than what was already known?

A. My personal issue, it should have went a lot further 12:01 because as we know now from 2020, at the time I thought it was quite targeted, small areas looked at. I do believe that outpatient, for example, outpatient dictation should have went to include, ultimately the day case discharges and also the MDT. Dictation wasn't 12:02 only for outpatients only.

I do believe that -- and I can understand why they needed Mr. O'Brien -- wanted to come back to work but I think the investigation should have went on a wee bit 12:02 further, a bit more as, to coin a phrase, deep dive, because if it had been anybody else, in the sense of a nurse or an admin person, potentially wouldn't have been allowed back until the investigation was

completed. But that's my personal view.

184 Q. It's your opinion. What's the basis for that? Why do you think that's the case, that it was, as you have suggested, was treated differently?

A. Like on reflection I think, and it is no criticism of the people that's at the Oversight Meeting, but I think it should have been expanded to be nearly -- and I know the directors is operational, but at the end of the day a director has quite a wide remit. For example, the likes of the systems and processes, whilst I am in, probably, a wee bit of more unique position in that all of my experience has been admin and systems, like the patient administrative system, and case note tracking and my background, outpatients, things like that, most other people wouldn't have the wider view of it. I think more experts or people of specialism in the admin systems should have been brought in and asked, 'is this workable?' 12:02 12:03 12:03

185 Q. We'll talk in a minute about the monitoring and where you say the deficiencies are in that. In this period early January 2017 Mr. O'Brien returned patient notes from home as a result of a request from you. Was that as a direct result of you being asked to do that or was that just part of you identifying that the notes were missing? 12:03 12:04

A. That actually came from Dr. Wright. Dr. Wright requested that he brought all the notes in and left them with me. Mr. O'Brien did contact me and said that they would be leaving them in his office, which is on

the second floor, and he had said that he would be doing it over the weekend of the New Year bank holiday. I arrived in on the Tuesday, I think it was the Monday was the bank holiday, and I went to his office and retrieved the notes from there.

186 Q. This is at TRU-257707 for the Panel's note. There were 307 sets of note returned?

A. That's correct.

187 Q. Including 94 Trust patients who had been seen privately by Mr. O'Brien. Is that just you collecting the notes rather than -- in total numbers, rather than breaking down whether he should have returned them all, or was he able to hang on to some because they were private patients?

A. No. These were actually -- what it was, Mr. O'Brien -- and it was only at that stage in 2017 that I realised that this was happening. He was going to see me as a private patient, for example, on the Saturday, he actually brought my hospital notes home and wrote in the hospital notes of the private consultation. I suppose he needed -- I don't know, Mr. O'Brien will have to be asked. I am assuming he needed the hospital notes to find more information, I don't know. They were NHS notes but for a private patient consultation.

188 Q. There was a process undertaken in relation to un-dictated clinics --

A. Yes.

189 Q. -- that involved the other consultants becoming involved in looking at that?

A. That's correct.

190 Q. That was a process that was not completed. It started in January but not completed until June 2017. That was due to the number of patients involved. Was that something that was passed on to other consultants on top of their own workload to look at, or what way was that organised? 12:06

A. Dr. Wright agreed that they would get a waiting list initiative payment to do them outside of working hours. Obviously we couldn't displace clinical activity because Urology, as we know, their demand capacity is through the roof. But that was outside of hours, so evenings, weekends. 12:06

191 Q. Although that wasn't completed until June 2017, Mr. O'Brien came back to work in the February. 12:06

A. That's correct.

192 Q. In your witness statement, for the Panel's note at WIT-26315, you expressed a view that you don't think that Mr. O'Brien should have been allowed back to work so soon and you called that a mistake. Can you give a bit of context to why you have that view? 12:06

A. It's just back to what I had said previously. This is in hindsight, I didn't say this at the time, but it is a reflection when I was doing my Section 21, I think the investigation should have been a wee bit further. At that stage it hadn't even really started. I think there needed to be more of a -- you know, to extend it to talk to the likes of the people I'm saying there to say what other areas do we need to look at. It was 12:07

a decision made inside a confined group of people without actually expanding it out. It's a bit like everything -- just back to what I said there, you know -- any of the rest that go through disciplinary, they would be properly investigated before allowed back to work. 12:07

193 Q. When you say it was a confined group, who do you think made the decision to allow Mr. O'Brien in?

A. I think from reading, ultimately it was the Case Manager, Dr. Khan. 12:07

194 Q. Did anyone ask your views about the appropriateness of Mr. O'Brien coming back to work, or was that something you wouldn't have expected to be done?

A. No, I wouldn't expect it. I think it was, albeit a senior manager was too junior to make a comment. 12:08

195 Q. You said in your statement at that point that Mr. O'Brien's return to work was not accompanied by a proper plan to manage him. Did you have sight of his Return to Work Plan at that point?

A. The plan was shared with me by Mr. Carroll and Mrs. Gishkori because it had come out from one of the Oversight Meetings. It was the four areas that Mr. O'Brien was to be monitored on as part of his return to work. 12:08

196 Q. When you say that it wasn't a proper plan, I suppose what I'm asking is did you look at the plan and say, 'that's not a proper plan', or did you form that opinion because you were left to try and help implement it? 12:08

A. I think I formed the opinion because I tried to implement it, and I think it should have been, as I said, wider than those four areas.

197 Q. You have specifically said, and you did mention it before but I just want to get a little bit more detail from you. The monitoring arrangements focused on the gaps in his outpatient dictation and outcomes but completely ignored responsibilities towards patients who came in as emergencies or day case. Is that an opinion that you formed on your own knowledge of what was happening or did someone say that to you? 12:09 12:09

A. That's from the findings that I had when I did the exercise in June 2020, when I looked at the emergency patients. The emergency with stents patients and then the elective patients. 12:09

198 Q. When you saw the Return to Work Plan and that sort of detail wasn't included in it, did you express that opinion on anyone or draw it to anyone's attention, that you thought it perhaps wasn't detailed enough?

A. Not at the time, no, because I think the plan came to me as a nearly a fait accompli, just for me to manage it. 12:09

199 Q. By the time you got to June '17 the plan was in place?

A. That's right.

200 Q. Was there ever a suggestion that the plan could have been updated to reflect those findings that there were gaps in, potential deficiencies in oversight? 12:10

A. No.

201 Q. Did you feel that you could have brought that to

anyone's attention, to say, 'well, we may ostensibly be covering this potential lacuna, but the work I have done or the work that's been undertaken shows a vulnerability for emergency and day case patients'?

A. To be honest, I didn't actually look at the ins and the days at that stage. I was concentrating in the midst of a very operationally challenged busy job and trying to make sure that the four areas that I had been tasked with, that I monitored them. In hindsight, yes, I should have thought of that, but I didn't. 12:10 12:11

202 Q. Might it have been something that the medics involved in both the work to prepare for the Return to Work Plan and looking at the work that had completed in June 2017, might it have been something that they noticed and could have adapted the plan to reflect? 12:11

A. Yes. I think because the people that would have been seeing -- as in medics -- would have been seeing patients without that information on them, if they had escalated then we would have known, but nobody every said there was -- at that stage, in between the '17 and, sort of, '19, that there's letters missing. An in-patient discharge wouldn't be so bad because obviously there is electronic discharge from the ward so the juniors would have done that, it would be signed off. It was more to do with the day cases. They weren't dictated on, but nobody every said they were missing. It's one of those things, unless you're told, you don't really -- 12:11 12:12

203 Q. Does it go back to your point that this was an

opportunity at this point to perhaps delve a little bit more deeply into what was happening as regards Mr. O'Brien's practice and also procedures in place? Do you see that as a missed opportunity now?

A. I do, yes. 12:12

204 Q. For the Panel's note the Return to Work Plan can be found at TRU-00732. It was given to Mr. O'Brien at his Return to Work meeting on 9th February with Dr. Khan. How did you end up in the role of monitoring that plan? Can you just explain the process or who spoke to you about it? 12:12

A. It would have come from Mr. Carroll to say it has come from the Oversight Meeting that it needed to be monitored. I suppose I was the best placed to do it because I knew the systems and processes and I worked in Urology so I just done it. 12:13

205 Q. When you say you were the best placed to do that, do you think that was based on a belief at the time that this was an administrative problem?

A. Yes. 12:13

206 Q. Was that something that you were happy to accept given your clear identification of clinical risk issues in your draft letter the previous year?

A. I suppose I accepted it, but I had the knowledge that if there was going to be any issues it would be escalated to medical, as in the CD and the Case Manager, who was also Clinical. But for a medic to actually do the work that I ended up doing for the monitoring, it was probably suited to an admin person 12:13

but with the knowledge that it could be escalated -- which I did -- to the medical.

207 Q. The Inquiry has heard evidence from Colin Weir and Charles McAllister, and the tenure of both of their approaches to dealing with Mr. O'Brien, if I could summarise as saying, they both were reluctant to do that alone. Also they indicated that they felt more comfortable if they had back-up, that there was somebody else involved in the process of overseeing with them. Did you have that sense that you needed that comfort? 12:14 12:14

A. Comfort from? Sorry? The?

208 Q. Somebody else helping you monitor, oversee Mr. O'Brien's practice?

A. I think one of the faults with all of this is that for Oversight and MHPS, it's a very confined group of people. It was discreet. You were told it had to be discreet, confidential, it was very sensitive. It couldn't be spoke outside of the people, nearly on a need-to-know basis. My comfort was I was able to escalate any concerns to Mr. Carroll, my AD, and then my CD. I never would have went direct to Mr. Khan because I wouldn't have seen that in the chain, but would have expected Mr. Weir to pass it on to Dr. Khan. In hindsight, there was a vulnerability there in the sense of -- for me -- because it was nearly on a need-to-know basis and so few of us actually knew. 12:14 12:15 12:15

209 Q. Did you feel any discomfort at the time about having to take this role on alone?

A. The stuff I could do from afar I had no issue with. For example, the electronic triage I was able to do that from my desk. It didn't matter whether I was in the office or at home. The dictation, I got that information from the -- basically Katherine Robinson's team, her service administrators, and that was fine. Private patients was fine as well because I did that monitoring again from my desk. The one that gave me the most discomfort was the case note tracking or the case notes in the office, because that was a physical thing that I had to do that I felt I was sort of -- kind of nearly sneaky doing it because I used to have to go up to Mr. O'Brien's office and it was -- him and I would always have said we're at the opposite ends. I was a morning person and he was a night person. I always would know when I would be in the office at 6, half 6 in the morning the likelihood that he wouldn't be in the office. It just made me uncomfortable. 12:16 12:16 12:16

210 Q. Just so I'm sure of your evidence. Are you saying that you made a point of going to the office when he wasn't there -- 12:16

A. Yes.

211 Q. -- because you just wanted to have a look at the notes?

A. Yes.

212 Q. Was that more to do with the practicalities of two people being in the office at once or did it reflect your discomfort of having to do that job at all? 12:17

A. It reflects my discomfort of having to do the job at all. You know, I go back to Mr. O'Brien and I had

a very good working relationship, so much so that usually it was me who was the person sent to talk to him about any of the issues. I always was happy to do that because I kind of seen that as my role as Head of Service. But I just felt that -- and I know 12:17
Mr. O'Brien probably would have challenged me if he knew when I was in the office. I have since read when I was off on extended sick leave after shoulder surgery that he took exception to some of the staff being in the office looking, counting the notes, what I would 12:17
have done.

213 Q. Part of your strategy in going earlier when he wasn't there was because you didn't want to be -- and correct me if I'm wrong -- there for a confrontation, or if one took place, you didn't want that to happen? 12:18

A. Correct.

214 Q. Would it have been possible for someone else more junior -- I know you are the Head of Service and you have a very significant workload, as the Inquiry will see later on, was there any way possible for another 12:18
more junior member of staff to undertake going to a consultant's office and counting charts, or was there a reason why it was someone of your seniority asked to do that?

A. A very fair point. I suppose, yes, anybody probably 12:18
could have done that, but I think it was back to the need-to-know, trying to keep it confined to a certain amount of people to protect Mr. O'Brien, the confidentially of what was happening. There would have

been very few people -- well, that's my view of it, I don't know what was talked about outside of it, but they wouldn't know the detail of what I was actually doing.

215 Q. Two of the issues that you had to engage in in the oversight of the Return to Work plan, the dictation and the notes, they also would have involved, perhaps, Mr. O'Brien's secretary, the dictation issue? 12:18

A. The dictation issue would but we didn't involve her directly. That would have been through the service administrator. The service administrator have access to the digital dictation, so they didn't even have to ask. They would just be able to go in and look at the clinics and see did the number of letters match up. 12:19

216 Q. They fell foul to the analysis that the number of letters, the number of clinics, and the number of patients weren't reflective of what was outstanding? 12:19

A. Yes.

217 Q. Was that something the secretary might know?

A. She would have known, yes. 12:19

218 Q. Would it have been appropriate perhaps to have gone to her and say, 'what are the clinician numbers?' I know you speak about confidentially, it could have been perceived as an audit across all consultants, which is something the Trust may have considered doing in any event, given your views on the level of analysis they undertook to outstanding work. Would it have been appropriate at any point to go to her and ask directly at source, 'what's the situation with dictation?' 12:19

A. It did happen because there is the e-mail with regards to the backlog report. I know Mr. Gibson was questioned about it yesterday. That originally had been set out for -- it actually was more the purpose for using the secretary's workload to sort of make sure that everybody had an equal amount of work to do. As we know now, that came foul to the fact there was underreporting with respect to Mr. O'Brien. With regards to that they did ask but, as we know now, they weren't given the information. I know she has said since because I've been shared in the e-mail of un-dictated clinics, she just assumed everybody knew that Mr. O'Brien didn't dictate but she didn't report it either. To answer your question the long way round is yes, the secretary would have known and yes the secretary had been asked. 12:20 12:20 12:21

219 Q. There was a return to work meeting with Mr. O'Brien, Mr. Weir and yourself on 9th March 2017. That can be found, just for the Panel's note, at TRU-267952. If we do put that up because I want to refer to a specific part. TRU-267952. This follows up from a meeting on 24th February that you had as well with Mr. O'Brien? 12:21

A. I was off on leave on that actual date. Mr. Weir met him on his own. It was me has done these notes.

220 Q. It says at the top of this: 12:22

"The purpose of the meeting was as a follow on from Mr. O'Brien's return to work meeting that took place with Mr. O'Brien and Mr. Weir on Friday, 24 February."

You were on leave. In advance of this meeting had you spoken to Mr. Weir about expected outcomes after this?

A. I can't recall but I'm assuming we did. We would have met, or we would have spoken about the agenda for what we needed to discuss with Mr. O'Brien. 12:22

221 Q. We don't need to go into the detail of this meeting but what is discussed at this is that Mr. O'Brien gave assurances in relation to outpatient clinics and turn around. Do you recall that? 12:22

A. Yes.

222 Q. He also indicated at that meeting that he didn't want to take on any new patients?

A. That's correct. Yes.

223 Q. Was that the first time that had been raised? 12:22

A. That was the first time it had been raised and I had come back to say that that wasn't possible because, at the end of the day, at that stage five or six consultants, I can't remember how many in post, and to take out on an already growing waiting list that 12:23 Mr. O'Brien, you know, had quite an opinion on that we needed to make sure the people who were on that, advanced triage, enhanced triage, and that we couldn't just stop him from seeing new outpatients. He did say that it was to do with his theatre list being long, but 12:23 in comparison everybody else's was the same. It would have been very difficult to argue that we were taking new patients from him and then not expecting the rest of the team to pick them up.

224 Q. In fact at that meeting it was clarified to Mr. O'Brien that he didn't have the longest waiters I think they're called?

A. The longest waiters, yes.

225 Q. In relation to the review backlogs of that meeting, Mr. O'Brien assured that all patients were on the PAS system? 12:23

A. He did, yes.

226 Q. Did that give you some sort of reassurance that he was up-to-date with reviews, or what was your view when he said that? 12:24

A. I was assured because, understandably, he had spoken to me that this whole process was very stressful, understandably. At that stage he said he was determined to get back on track. That was a verbal conversation outside of the meeting. Him and I walked to the Departmental meeting, I think, together. So, I was assured from that. 12:24

227 Q. He mentions in this as well, and I think you said in your evidence, in your Section 21 you didn't have anything to do with job plans? 12:24

A. That's correct, yes.

228 Q. That was entirely on the medic side. Mr. Weir asked Mr. O'Brien was this fair about the hours he had for dictation at the end of a clinic, and he said nothing about jobs plans was fair. The Inquiry will see evidence and hear evidence in relation to job plans. Would it be fair to say that the job planning issue did seem to take up quite a lot of time and discussion 12:24

among medics?

A. It did, yes. It did. I suppose my only thing thing, just to clarify that, is they would have come to me to say, 'we want to do three outpatient clinics in a week and have you got the accommodation to do that?' But I wouldn't have been agreeing anything apart from that. 12:25

229 Q. If I ask you to look at TRU-251846. This is an e-mail from 8th May 2017. The one is from 5th May from you to Ronan Carroll where you are giving a case update. Well, you're not giving a case update, I think you are providing your update on the oversight? 12:25

A. Yes.

230 Q. In this you said that Dr. Khan wants monthly updates as opposed to weekly, which had been previously; is that right? 12:26

A. That's correct, yes.

231 Q. Was there any reason Dr. Khan asked for the updates to change frequency at that point?

A. I don't know why he asked for that. I think it was because he was getting an e-mail from me every week that there was no issues at that stage. That's only an assumption, sorry. I don't know. 12:26

232 Q. What was your view when he asked for that? Did you feel that that was in any way premature at that point or were you content to go along with that because there had been no particular issues at the Oversight? 12:26

A. I did think it was a wee bit soon, yes. But I did give, and Mr. Carroll asked me to continue doing it weekly, which I did continue to do.

233 Q. Did you copy Dr. Khan and Mr. Carroll into your weekly updates, or just Dr. Khan monthly?

A. Dr. Khan monthly. I didn't with Mr. Carroll because I only started to do it by exception, but I did keep it on my calendar the monthly updates with all the information on it. It is just, as I said earlier, we get so many e-mails, it's just I need to escalate when there's an issue. 12:27

234 Q. When Dr. Khan decided it was by exception, only if there was a problem arising, did that give you any reassurance that that meant if you were to let him know, something would be done about that? 12:27

A. It did, yes.

235 Q. When did you subsequently let him know of concerns, was something done? 12:27

A. Concerns with regards to the charts in the office when it started to -- there were two concerns. First of all, there was a slip in the triage, the length of time of triage, but we had a conversation, Mr. Weir and I had a conversation and we had then had the caveat in on a busy week that as long as it was done by the previous Monday. But I don't know if that was discussed with Dr. Khan or not, but it was definitely with Mr. Weir. Then the one with regards to the charts, it was Mr. Carroll, Mr. Weir, and myself. 12:27 12:28 Again I don't know, even though Dr. Khan would have been informed, I don't know whether he'd asked us to do anything. It was actually on the instructions of Mr. Carroll and Mr. Weir.

236 Q. Did you know Dr. Khan to have done anything when breaches were identified at any stage?

A. No, I don't. I'm not aware.

237 Q. Is that based on your belief that once it went to him it was a matter for him to deal with from the medic side? 12:28

A. Yes.

238 Q. Does that also reflect the tradition, if I can call it that, that you spoke about earlier of when people raise issues, nobody generally comes back to tell them how they was resolved? 12:28

A. That's correct, yes.

239 Q. You not being informed about that was usual practice, I suppose, was it?

A. It was usual practice. Again, I didn't feel it was my place to actually contact him direct. 12:28

240 Q. You didn't feel it was your place to follow up as well?

A. Exactly.

241 Q. I want to take you to a couple of your reports of breaches around at this time. The first one is at TRU-268966. This is an e-mail 21sth June 2017 that you have sent to Mr. O'Brien and you have copied in Mr. Weir: 12:29

"Dear Aidan, as you are aware I have been asked to monitor the points that were discussed with regards to your return to work. 12:29

One of the points was that notes should never be stored offsite and should only be tracked out and in your office for the shortest time possible. I have been monitoring this regularly and noted that the amount of notes in your office has increased, and therefore the length of time they are being kept is increasing."

Then you provided a list of patient names and dates of when notes were missing. You have copied Colin Weir into that. Is that something that might helpfully have gone to Dr. Khan at that point? 12:29 12:30

A. I think it was probably -- my assumption would have been that Mr. Weir would have forwarded it to Mr. Khan. It was one of the first breaches and it was operational. It was me directly contacting Mr. O'Brien, but copying Mr. Weir in. 12:30

242 Q. Would Mr. Weir have been aware that Dr. Khan had changed the procedure for alerts for exception only?

A. He was, yes.

243 Q. If I can ask you to look at TRU-258877. This is another e-mail from Ronan. That is an e-mail to Mr. O'Brien. Move it up so we can see the detail. You have reminded Mr. O'Brien, it seems, from this e-mail, of the terms of the action plan? 12:30

A. Yes. 12:31

244 Q. Which is now the Return to Work and the action plan, same thing, effectively. You have provided him with the detail of that. What prompted that particular e-mail to set that out like that; do you recall?

A. Yes. This is one about the triage. I recall, if we move down, I think there was 30 paper referrals that hadn't been returned. I could monitor the triaged referrals. Still some of the GPS hadn't been using the GP system. I could monitor them. It had obviously been escalated to me from the booking centre that there were still 30 outstanding. 12:32

245 Q. Colin Weir, again, is copied into that, as is Mr. Carroll?

A. That's right, yes. 12:32

246 Q. Do you recall did these e-mails result in a back and forth with you and Mr. O'Brien about his explanation about why, or what was your experience when you did identify potential divergence from the action plan?

A. With regards to the notes, it was a verbal conversation where he said to me he would action any of the notes that were sitting in the office. This one in particular I think from memory he did respond to me. He had said about coming in from leave and he had sent me a long e-mail about the 30 paper referrals and it would be better if he had done a tick box exercise instead of enhanced triage with regards to that. He had sent it and I had forwarded it on to Mr. Carroll, I think, and Mr. Weir. 12:32 12:32

247 Q. You have mentioned two things there and I just want to touch on them briefly, because they will be mentioned again. 12:33

The first one is the idea of enhanced triage.
Mr. O'Brien had a particular view on how triage should be carried out. That was something that he engaged in with you?

A. Yes. 12:33

248 Q. In e-mails?

A. Yes.

249 Q. Your understanding of the way medics should do triage was in accordance with the Trust protocol, effectively, of GP designation and then being reviewed by the 12:33 consultant on call?

A. That's correct, yes.

250 Q. When you were indicating problems with triage you were working from your framework?

A. Yes. 12:33

251 Q. Mr. O'Brien was articulating his adherence to a system he had developed which he considered to be more effective for patient care. Would that be a fair --

A. That's fair, yes. I suppose, just to say, the other consultants did a form of triage or advanced triage 12:34 because of the long waiting times. If they seen somebody that had come in with a stone, they might have sent them for, sort of, a CT scan, they ordered it there and then. They would have done that.
Mr. O'Brien took his enhanced triage a step further in 12:34 that he would potentially ring the patient and go through the detail with the patient on their symptoms. Obviously that then was like an actual scuttle so it took longer. He was counselled, and the rest of the

team said to him he didn't need to do that, just do what they had done.

252 Q. The other consultants worked on an enhanced triage basis only if it was triggered by clinical presentation? 12:34

A. Yes.

253 Q. If I can put it that way. Then they fell back into place with the rest of the expected way of doing things?

A. Yes. 12:35

254 Q. You mentioned again about Mr. Mr. O'Brien being on leave?

A. That's right, yes.

255 Q. Doing some of the catch-up on his admin duties on leave. Was there an expectation from the Trust at all 12:35 that Mr. O'Brien should be doing that while he's on leave?

A. Absolutely not. The amount of times, you know, we would have said, 'but you're on leave, take your leave'. Early on Mr. O'Brien would have said to me, 12:35 'you know, it's my choice. If I do this work outside of working hours, it's the only time I can do it'. I suppose it was like everything else, it nearly became custom and practice. You knew, and you'll see from all the evidence in the e-mails that's been sent in, 12:35 he would come back and say, 'well, I'm on leave tomorrow and I'll address that'. I would have said to him, and I can nearly hear people saying kettle calling pot black, because I'm inclined to do the same thing

when I'm on leave. He would have insisted that it was his choice. For example, Sunday afternoons were spent contacting patients for the following few weeks' theatre lists, but again told not to do it or advised not to do it. Mr. O'Brien had strong views and it was very hard to turn him from them.

256 Q. From the Trust's perspective is there any suggestion that the fact he was having to work on leave was a bit of a warnings sign to the Trust that he just didn't have the capacity to do the work that was expected from him? 12:36

A. From the Trust perspective, no. There was lots of sort of warnings that that was the case, but Mr. O'Brien had more or less the same job plan as everybody else. The expectation was that he should have been able to see less patients, for example, at Outpatients. He should have been able to do it within the allocated time of the job plan if he had listened to the areas that just took him longer. 12:36

12:37

For example, when he did do an outpatient letter it was pages and pages and pages long; great detail but, you know, GPS would have said a paragraph will do. I just want to know what's happening with my patient. Instead of dictating three or four pages, one page would have been fine. 12:37

From the Trust's perspective, again custom and practice, and I've slipped into it as well, I've often

heard people saying, including myself, 'sure, that's just Aidan, that's the way he works'.

257 Q. We will look at AOB-01646. This is Mr. O'Brien's response on 3th July 2017 to your reminder of the terms of the action plan. This gives the Panel an indication of where Mr. O'Brien was coming from in his view of how he could operate as a clinician within the expectations of the action plan. 12:37

This one is dated the 12th and Mr. O'Brien sent an e-mail to you where he's explained his view, but he's also indicated that he finds the e-mail about the action plan and his need to adhere quite demoralising. Do you recall this particular correspondence? 12:38

A. I do, yes. 12:38

258 Q. If I mischaracterise it, because you know more about the background of this that's not written down, so if I mischaracterise either you or your experience with Mr. O'Brien, please just say. He's explained the reasons why he returned referrals. One of the points I want to show is that he makes a point of saying that he takes the time to ensure patients are contacted. You'll see near the bottom of the screen he says: 12:39

"I know how referrals are triaged and returned on time. It is most certainly not by taking the time to ensure that each patient's current state is most appropriately and expeditiously assessed and managed." 12:39

This is the one where he said, the quotation you relied on earlier:

"I personally would have been better off ticking the box being at home on my leave" -- then a redaction -- "should also be at home with persistent colleague awaiting the urgent outpatient appointment." 12:40

Just the tone of the reply to you, if I could just and their styles, if I can put it like that. I don't mean to be pejorative, but you, with your administrative oversight of the action plan, have indicated some divergences or potential breaches of what had been agreed. Mr. O'Brien has come back with clinical data really, and clinical information to patients who are named in order to respond to you. It does read, from this remove, as being very different tones in e-mails. Would that have been your experience of a typical response from Mr. O'Brien? 12:40

A. Normally, at the beginning, Mr. O'Brien, his e-mails would have been always quite courteous and there would have been no sort of -- nothing like this. This is the start of -- and that's why I know that it was a difficult time for him. It just goes back to the bit the part I was monitoring him made me feel uncomfortable because he is basically telling me I know how to triage. I was doing my job. He seen himself doing his job, but he missed the point that he was supposed to return his triage within a given period of 12:40 12:41

time and he still sat with the 30 referrals. This e-mail is a change in tone and, I suppose, going forward this was what I was faced with.

259 Q. Was there an underlying suggestion in this, and I know when we go to your evidence on another day you've said in other Section 21s, the fact that you weren't a medic was an issue for Mr. O'Brien when pressed on his particular practices. You would agree that was reflected in this reply? 12:41

A. Yes, that is reflected in that. On two occasions at least that I recall, Mr. O'Brien did say that to me, 'you're a non-clinical person challenging my clinical decision'. To be fair, the two occasions, I will say that stands out in my mind, on both them occasions I hadn't made the decision on my own, I had spoken to one of his colleagues. It wasn't me as a non-clinical person coming to him, but that was his phrase of terminology to me. 12:42

260 Q. Some of the detail provided in that letter, would it also be fair to say that it is impossible for you to reply to because it is based on his clinical assessment? 12:42

A. Absolutely.

261 Q. And the justification for his actions based on information that either you couldn't possibly know or couldn't comment on, not being a medic? 12:42

A. That's correct. Yes.

262 Q. On reading that reply, and you said this seemed to be a change in tone in the replies, did you think at that

point that you needed assistance with monitoring Mr. O'Brien so that these sorts of responses to your oversight could be dealt with by, for example, one of the medical managers?

A. I did share the e-mail with Mr. Weir and Mr. Carroll and I know as a result of this, we had the meeting -- the meeting that I had forgotten about. So it was led by Mr. Weir. So at that stage I had -- the reason I had passed that on was, number one, Mr. Weir was the case manager but also I knew I needed help with this one. This was something I couldn't deal with on my own. 12:43 12:43

263 Q. We'll go on to that meeting just in a moment. But whose idea then was it -- did you ask for help or when you copied them in, they thought; 'Okay, Martina needs help here' or 'We need to get behind her.' What was the sense of response among your managers to this reply? 12:43

A. Well, there was probably no e-mail response back to this but I do know Mr. Carroll was very supportive and any issues that I would have had with regards to this, I could have spoken to him, and depended on him taking it forward. And I do know then that's when he asked for a meeting to deal with both the slippage in the triage but also the slippage in the amount of notes that was in the deviation that was in the office. 12:44 12:44

264 Q. Just before we go to the meeting on 25th July, there are two references I just want to give the Panel. We don't need to go to the documents; AOB-01652.

That's an e-mail of 19th July 2017, when there is a reduction of 30 notes in the office at that point. So there was compliance. I want to point out these e-mails were the monitoring provided information that Mr. O'Brien was making changes to his practice. Then AOB-01660. That's a reply from Mr. Carroll to that on the same date when he said all notes need to be returned. I think the expectation was that it would get to zero, but there's obviously a movement in the right direction evidenced on those e-mails. 12:45

A. That's right, yes.

265 Q. So the meeting on the 25th, which seems to have been triggered by the tenure of that response, the 25th July 2017, now you haven't referred to that in any of your Section 21s, and that was a meeting with Mr. Weir, with 12:45 yourself, Mr. Carroll, and Mr. O'Brien.

A. That's correct. Yes.

266 Q. Is there any reason why that wasn't included in your original evidence at that meeting?

A. It's just a true -- it's just truly an omission; 12:45 I forgot. And I genuinely had forgotten about that meeting. I usually would pride myself on having a good memory. I do recall at the time speaking to Mr. O'Brien about the notes and he said to me that he was clearing them. Then in my mind, that was it 12:46 sorted. And it was only when I received the transcript of an audio -- a transcript from an audiotape that I remembered the meeting.

267 Q. For the Panel's notes, that's at AOB-56210 to

AOB-56221.

So you're making reference to the fact that Mr. O'Brien recorded this?

A. That's correct, yes. 12:46

268 Q. Did you know it was being recorded?

A. I didn't. No.

269 Q. Do you know if Mr. Weir or Mr. Carroll were aware of it?

A. No, none of us were aware. 12:46

270 Q. Now you became aware of it as a result of the Inquiry?

A. Yes.

271 Q. What was your view or your feeling, knowing that had been recorded without you being aware?

A. Well, there was actually four recordings. Three of them, I was with other colleagues. Initial reaction was quite angry, but I suppose the one that annoys me the most is.... 12:47

272 Q. If you need to take a moment. If you need to stop for a moment, we can do that, just to give you a short break. There's no problem. Do you want to take five minutes. 12:47

A. Yes, thank you.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:47

CHAIR: Ms. McMahon?

273 Q. MS. McMAHON BL: Are you ready to continue?

A. Yes.

274 Q. As a general point, you mentioned that there were several meetings with Mr. O'Brien that had been recorded without your knowledge.

A. That's correct.

275 Q. I just asked you what your views were on that? 12:54

A. That's right. Yes. Sorry about that. I suppose the three with the colleagues, I was angry about, but there was other people in the room with me. The one that annoyed me was on the 9th January when I agreed to meet Mr. O'Brien outside of the hospital. I facilitated 12:54 a meeting in his car when he was handing over the outcome sheets and advised me of the letters in his drawer. So I actually feel quite violated about that, that a colleague would, on a one-to-one basis record me because I don't know what he expected me to say or do. 12:54 The other three meetings, it's very obvious from listening to them that there was an agenda of Mr. O'Brien's because the meeting is steered to the areas that he wanted to talk to us about.

276 Q. Okay. The Panel have those transcribed and they can 12:55 take a view on that.

A. Okay.

277 Q. But that's your view on what you consider to have happened.

A. It is, yes. 12:55

278 Q. I just want to give a list of e-mail references to either potentially what could be construed as breaches of the action plan or compliance with the action plan so the Panel have a note of that and the core

participants are aware that I'm bringing them to the attention of you in your evidence.
The first one is TRU-258891 to TRU-258892. And that's an e-mail of 31st July 2017 when all charts had been removed from the office. So there was no more can compliance, effectively, with the requirements of the plan.

TRU-275133 to TRU-275134, and that's a breach of the action plan and a failure to triage. TRU-275148, that's an e-mail of 22nd February 2018, confirmation that triage issue had been resolved again. And TRU-258902, e-mail of 22nd May 2018 where you confirm that the plan has been adhered to, save for triage issues. 12:55 12:56 12:56

A. Yes.

279 Q. Then you had a planned period off sick from the 25th June 2018 that went on a bit longer than was anticipated and you didn't come back to work until 5th November? 12:57

A. That's correct.

280 Q. 2018.

A. That's correct.

281 Q. During your period of absence, did you hand over to anyone on the oversight role regarding the action plan before you went off sick? 12:57

A. I didn't because, originally, it was shoulder surgery from the result of a car accident and I was advised by the consultant I would only be off for about a month.

So a month out of the system is probably not -- it's just like being on annual leave because I have said in my statement to the Inquiry that, you know, monitoring happened every Friday apart from being on leave. So, unfortunately, the surgery turned out to be much more major and I ended up off for 18 weeks. I didn't hand over and, I think, two things there. First of all, it was getting back to the need-to-know basis. My colleagues wouldn't have known the detail of what I was doing, they knew I was doing something with regards to return to work but they wouldn't have known the detail because we had to keep it confidential. 12:57 12:57

282 Q. But given the fact that you were able to do some of this, if I can say remotely?

A. Yes. 12:58

283 Q. We were given information from Katherine Robinson, for example, was that something that Ronan Carroll could have arranged to have sent to him directly?

A. Yes, that could have, yes.

284 Q. So there were aspects of the action plan that could have been followed up without there being any potential breach of confidentially as regards Mr. O'Brien's practices? 12:58

A. Probably.

285 Q. I don't think from the e-mail chains that are available that anyone was monitoring, was that your understanding when you came back? 12:58

A. That's correct, yes.

286 Q. Did you then pick up that in November 2018 when you

came back?

A. For a period of time in October, the two Heads of Service, two of my colleagues, Ms. Clayton and Mrs. Kelly, they would have done monitoring because it would have been brought to light in one of the backlog reports that there had been an issue. I provided the information -- I know I was still off on sick leave, but I still provided the information on what way I would have done the monitoring and they done that for a few weeks until I came back from leave. 12:58 12:59

287 Q. So that was towards the very end of your period of sick leave?

A. It was, yes, it was the last month

288 Q. Now what was your understanding of how long the monitoring period was to last? I know there has been some deviation in understandings. Mr. O'Brien is of the view that it was only to last the duration of the MHPS. Did you understand at any stage, firstly, that it was time bound, the monitoring? 12:59

A. No. 12:59

289 Q. Or that it was to replaced by anything else?

A. No. I just assumed it was going to go on for forever, if you know what I mean. But, no, there was no end time. No end time for me.

290 Q. When did it actually end for you, your role in that? 12:59

A. It didn't. It ended sorted of in around March 2020 but that was due to circumstances of COVID because we didn't have any patients coming in, there was no GP referrals, there was no notes being allowed to move,

everything was quarantined, and then obviously no clinics and no theatre lists. But I had continued up until March 2020 monitoring.

291 Q. Again, for the Panel's note and for core participants, there are e-mails during your absence of breaches. You won't have any information of this but I just want to put it on record. So the first one is an e-mail of the 18th October 2018, TRU-251525 to 251530, TRU-28888, I think that is, three eights. 19th October 2018 e-mail, again about slippages. Then WIT-55773. This is when you are back again, 30th March 2019. That's an e-mail about Mr. O'Brien not triaging. 13:00 13:01

A. Yes.

292 Q. TRU-275324, and that's dated 12th September 2019, an e-mail we escalate to Siobhán Hynds, that Mr. O'Brien is not doing the red flag triaging. 13:01

A. Yes.

293 Q. TRU-275331. That's an e-mail from 5th September 2019 and you e-mail Mr. O'Brien about outstanding dictations. 13:02

A. Yes.

294 Q. TRU-275344 is an e-mail from 16th September 2019 where you've e-mailed Dr. Khan and Siobhán Hynds with updates, including backlog in dictation. Another e-mail on 24th October 2019, WIT-55763, where you have e-mailed Dr. Khan, Siobhán Hynds, Mr. Gibson and Marie O'Kane. At that point, was she the Medical Director? 13:02

A. She was Medical Director, yes.

295 Q. Noting letters not dictated from Mr. O'Brien's clinic.

E-mail of the 6th November 2019 at TRU-275587. E-mail from you to Mr. O'Brien. And you've copied in Mr. McNaboe about the deviations and MDM recommendations not followed up.

A. Yes.

296 Q. Do you recall that? Those give a flavour, both in your absence and when you come back, of issues still arising.

A. That's correct, yes.

297 Q. Just from all your involvement with Mr. O'Brien throughout the years before this more formalised process began or more intensive of him began, do you feel you offered him support as and when necessary to allow him to try to change practices to fit in to what the Trust expected he would do? 13:03

A. I do think I offered it to him. I think, perhaps, sometimes I was, on reflection, possibly, you know a wee bit lenient in that he wouldn't do something and I would go and cajole him, and he would do it. I never would have escalated that because he would have done it. I think I have said in my Section 21, one of the things is I should have been more formal, now in hindsight, because, you know, we ended up where we did. And I would have always said to him, as I said, you know; 'If you need me to do anything, I'm more than happy to help', whether it was printing off letters or, you know, maybe getting some of the other doctors or junior doctors or CNSs to help him out with regards to, perhaps, triage. I think I was more than helpful to

him over the years.

298 Q. Now you have said in one of your statements at WIT-26290, just for the Panel's note, that you felt there was an overreliance on you as you had an already demanding operational day-job and that the system failed when you were on sick leave, seemed to fail when you came back as well, but do you feel that you weren't supported in trying to take on this role as well as all the other things you had to do as Head of Services? 13:05

A. I suppose I'm the sort of person that just says, probably, yes, and just gets on with it. I do think there was always an overreliance on me in the sense that everybody perhaps used the working relationship that I had with Mr. O'Brien to get things sorted rather than people tackle it because we did get on -- we were amicable to each other. I could never change him because he was sort of very set, stubborn in his ways. 13:05

With regards to support, I probably -- it's my own fault, I probably didn't reach out for, you know, to say; "I'm struggling with this", I just did it. I had a demanding job, would have worked easily 15 hours a day, and then on call, acute on-call on top of that, but, you know, always tried to get it done. So from my point of view, I probably didn't reach out and ask for support, but I do think there was an overreliance on me, on reflection. 13:06 13:06

299 Q. The Panel will see from your Section 21, and we'll speak to it again when you come back, you did try to

develop a lot of workarounds, if I use that phrase, to try to resolve issues?

A. Yes, that's correct.

300 Q. Given that they weren't resolved and given the breaches I've just identified as a result of more formal oversight, do you think the governance systems in place were fit for purpose? 13:06

A. On reflection, no.

301 Q. You gave an interview on 15th March 2017 as part of the MHPS process and you indicated in that that you'd always had difficulties with certain parts of Mr. O'Brien's practice since your commencement of your Head of Service role. What was your view on the MHPS process as a whole once it was eventually completed? 13:07

A. The main thing for me out of it is, first of all, it was ongoing. I didn't get any feedback and I don't know, as Head of Service managing directly the Return to Work whether I should have been given some information. I never seen the case determination report until this Inquiry started. There's a number of areas in it, but I think if it had been discussed with even me as the operational person who knew how things worked, there's the admin review, and I know we'll probably touch on that the next time, it was very woolly, it was very wide. I ultimately ended up having to work on it. For me, it went on too long. The determination -- and I know now there was to be another action plan -- was never filtered down. I actually don't think it worked because, as you said, there were 13:07 13:07 13:08

still breaches and we ultimately ended up in 2020 having the issues that we did, that brought us here today.

302 Q. If I can just give the Panel two brief extracts from Section 21, just for your note WIT-39930, at paragraph 24.1 where you have said: 13:08

"The investigation was, in my opinion, a very long, drawn out process and therefore in the time it took to complete it Mr. O'Brien was deviating from good practice in other parts of his practice. In my opinion, because of the length taken to reach a determination it would appear that more patients have been exposed to potential harm." 13:09

13:09

That's just your view on because of the length of the process.

A. Yes.

303 Q. You also said at paragraph 24.2 in relation to Dr. Khan's determination that it was: "Vague and quite wide-reaching, and I feel had been difficult to implement"? 13:09

A. Yes.

304 Q. That's a summary of what you said just previously, but do you think that the process undertaken by MHPS and the outcome on this occasion didn't result in any practical outcomes for you as a manager to make changes to the areas that had been established as being vulnerable? 13:09

A. I agree with that.

305 Q. Just in summary form, for the Panel's note, WIT-26299 to 301, you have set out what you consider to be failings generally --

A. Yes. 13:10

306 Q. -- in your Section 21. You've indicated you felt there was a lack of respect for non-clinical managers in doing this role?

A. Yes.

307 Q. Is it still the situation at the moment? Do you know 13:10 if non-clinical managers are still expected to undertake this kind of oversight and monitoring role?

A. With being out of the role now, the operational role since June 2021, I couldn't comment on that at all.

308 Q. Was it up until that point, June 2021? 13:11

A. Up until that point, yes.

309 Q. You've also said nothing had been done about Mr. O'Brien for years. Just in relation to any potential outside influence, was it your view that there was even the perception that there was an 13:11 influence over how Mr. O'Brien should be treated? Did you have any experience of that, personal experience of that?

A. Not direct experience but, yes, there was a perception. There was the close working relationship with the Chair 13:11 of the Trust Ms. Brownlee, and Mr. O'Brien would have, if you like, name dropped at meetings that he had been out at a dinner the night before, or that he had met her maybe down in Trust headquarters, and that he had

filled her in with regards to the likes of the waiting times in Urology. Because I would say I had another area as well, obviously you know that, opthalmopathy, and ENT, and they have as long a waiting list as Urology, so I just wanted to put that on the record. He would also have, on occasions, just mentioned his legal connections, but they would never have been used in a context of making you persuade not to do something, but the inference was there. 13:12

310 Q. Mr. O'Brien would say that those perceptions of influence were entirely matters for others, that was never a matter for him. Also Ms. Brownlee would reject any suggestion that she in any way advocated for Mr. O'Brien. On one analysis, a consultant speaking to the Chair of a Board about wanting funds may not be that unusual, but I just want to put that context, that slight balance there? 13:12

A. I suppose just to say I had 13 consultants and none of the rest of them ever would have been sort of speaking, as we say, about the Trust Board. 13:13

311 Q. I think we have covered all of the issues, the main issues that are required for the purposes of the MHPS module?

A. Okay.

312 Q. Just while you're here, in relation to that time frame, is there anything you feel we've missed or you might want to say about that process and about your part in it that you haven't already covered in your evidence? 13:13

A. I think I have covered it in most of my evidence

because I took a long time to try and make sure that I went through the years, did a lot of reflection before I put it on paper.

MS. MCMAHON: I have no further questions. The Panel may wish to ask you questions. 13:13

CHAIR: We will have questions for you but we're not going to ask them today.

A. Okay.

CHAIR: We will save them up and spend some time with you in due course. 13:14

A. Okay.

CHAIR: But not day. Thank you very much for coming.

A. Thank you.

CHAIR: It is now a quarter past one. The next witness Mr. Wolfe is taking, I think. It will be a quarter 13:14 past 2.

MS. MCMAHON: Madam Chair, may I clarify to release the witness from her oath or do you want her to remain under oath? It might be some time before she's back and she may want to consult with her legal team. Just 13:14 to confirm if you want to release her from her oath.

CHAIR: If she is happy to take the oath on another occasion I can release her from her oath. We'll have you sworn in again next time.

13:14

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Chair, your witness this afternoon is Mrs. Esther Gishkori. I understand that she wishes to take the oath.

14:23

MRS. ESTHER GISHKORI, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

313 Q. MR. WOLFE KC: Good afternoon, Mrs. Gishkori. Now let's start by looking at the witness statements that you have kindly prepared for the Inquiry in advance of today. The first one is number 7 of 2022. We find the first page. If we can have it up on the screen, please, WIT-23366. You're, of course, familiar with that, Mrs. Gishkori? 14:24

A. Yes.

314 Q. Just scroll through to the last page to see your signature, WIT-23385. I know that you're going to tell me about some corrections in a moment, but subject to anything you wish to correct, do you wish to adopt this witness statement as part of your evidence? 14:24

A. Yes.

315 Q. Then your second statement is number 35 of 2022. First page is WIT-23400. Again, you're familiar with that Mrs. Gishkori? 14:25

A. Yes.

316 Q. We will scroll through to the last page of this statement. It's WIT-23412. You've signed on 27th June. Do you wish to adopt that as part of your

evidence?

A. Yes.

317 Q. Now just before we came in, you mentioned that you had communicated some changes to the Inquiry, or proposed changes. I'm sorry, I'm unsighted on those but can you highlight those for us? 14:25

A. Yes. It was just on an e-mail I sent to Owen yesterday or the day before, and it was in relation to some dates that I think were wrong, just sick leave dates and things. 14:26

318 Q. Okay. We'll perhaps try to adjust that later.

A. Yes. That will do.

319 Q. I think I've explained to you that the expectation is that you might have to come back to give evidence to the Inquiry. 14:26

A. That's okay.

320 Q. But just on the dates of your sickness, and this might be a way of dealing with the issue in the alternative to your e-mail, we have obtained from The Trust some indication of your sickness absence. 14:26

A. Okay.

321 Q. Over the period from 2017 through to 2020. I'll just bring those up on the screen now and ask for your observations. TRU-164659. You can see in the table in the middle of the page the dates of various sickness absence. We're taking the precaution of taking out the reason for your sickness, we've blacked that out on the right-hand column. 14:27

A. Okay.

322 Q. So you can see from that document that the longest periods of sickness were three months in the summer of 2018.

A. Yes.

323 Q. 14th June to 14th September? 14:27

A. Uh-huh.

324 Q. And then going into the following year, you didn't return to work after 6th June.

A. That's right.

325 Q. Yes. 14:27

A. That's right.

326 Q. It says "end date 30 April 2020." But as we'll discuss briefly in a moment, you didn't return to work after the 30th April.

A. That's right. 14:28

327 Q. Are you satisfied that that is an accurate account?

A. Yes, I, am. Perfectly. Thank you.

328 Q. Thank you. Now if we can go to one of your witness statements, WIT-23366. Just scrolling down, please. You are telling us here that you came to work in the 14:28 Southern Health and Social Care Trust in August 2015, isn't that correct?

A. That's right.

329 Q. You took up a job at Director level, isn't that right?

A. That's right. 14:29

330 Q. You were Director of Acute Services?

A. Yes.

331 Q. This was your first job in the Southern Trust?

A. It was.

332 Q. And prior to coming to that role, you'd occupied several roles in the Health Service, particularly with the South Eastern Health and Social Care Trust?
A. That's right.
333 Q. Within your statement, you've described those roles as being across several operational and governance roles and management roles? 14:29
A. That's right.
334 Q. Your employment with the Southern Trust in the Director of Acute Services role ended on 30th April by way of mutual agreement, isn't that correct? 14:29
A. That's right.
335 Q. Now you've said -- just scrolling down the page, please. Can we go to the top of the next page. Your predecessor in the role of Director was Mrs. Debbie Burns? 14:30
A. Yes.
336 Q. You had an opportunity to shadow her on occasions prior to taking up the position?
A. That's right. 14:30
337 Q. But you didn't have a hand-over?
A. No.
338 Q. Does that mean that even though you were shadowing her you didn't have an opportunity to discuss, whether formally or informally, the kinds of issues that you might face in your role as Director? 14:30
A. That's right, yes. I had a chance to shadow Debbie but most of the time she was just going over performance templates with the staff. I didn't really -- she

walked me around the hospital but in terms of the issues that were going on at the time, in terms of, you know, things that were happening, other things that I might have needed to have known, just a formal or an informal hand-over, I didn't have one. The only thing she said to me when she was leaving was: "You'll never stick it." But that was it. Nothing more.

339 Q. Did you enquire as to what she meant by that?

A. I did, yes. Yes.

340 Q. Did she explain? 14:31

A. No. She was moving -- she was staying within the Trust herself, she said, so she didn't want to discuss much more. She was going back to the role I think that she had occupied before she became the Director. So when the Director's post came up, she decided she wasn't going to apply for it and she said it was a very difficult post. She said: "I think you'll find it difficult too." That was all.

341 Q. Yes. And you've described in a summary sense your role. "Mine was an operational role". And you go on in that paragraph to describe it. Do you see there? 14:32

A. Yes.

342 Q. Stepping through this relatively quickly this afternoon, was it a challenging role?

A. Very much so, yes, extremely. 14:32

343 Q. Why did you find it challenging?

A. Well, first of all, as I said before, I was completely new to the job. I didn't know what -- you know, the "elephant in the room" always is; what is the

organisational culture, who's who, what's what, who are the -- I knew nothing about it. But into the bargain I was in charge of seven divisions, probably upwards of 14,000 staff. I honestly turned down more meetings than I attended because I just simply couldn't go to everything that was -- so I just had to juggle, you know, decide at that time, send people in my place if it was important, me go every other month. Things like that. I always tried to communicate as well as I could. I had an excellent secretary, she helped with that. But probably I was expected and did go to about three or four meetings every day. Then after that you had to follow up with the actions, the outcomes of what those meetings were, probably 120 to 200 e-mails were done at home because I just simply couldn't do them. There was never a day when there wasn't some sort of firefighting or an issue. As you can imagine in acute services, it was a very old hospital and that brought all of its own challenging. You know, we had to replace pipes at one point, you know, move patients around, there was always building going on, new pharmacy. It was one of the busiest roles I've ever had and I do note that there are now two people doing that job.

14:33
14:33
14:33
14:34

344 Q. Yes.

14:34

A. So, you know, I assume that the Trust understands how big it was and have put two people into the post of the job. But it was almost as though I was setting myself up for failure because I couldn't do the job properly.

345 Q. Yes.
A. There was always something at the end of the day that you knew hadn't been done. It was always a worry a lot.
346 Q. Did you feel well supported by the staff that you had, whether at Assistant Director level or below, even though you may feel that you were under resourced? 14:34
A. Yes. I would have to say yes. All of my ADs I met on a regular basis, and all of them, as well, were on the admin floor where my office was, so it was very much I could go and find them and seek them out at any time. But all of the information that I got about the Trust came from my Assistant Directors, or the AMDs, or just walking around. But, yes, I did feel supported by my Assistant Director, I would have to say yes. 14:34 14:35
347 Q. Obviously you have, below you in the management chain the ADs, the Assistant Directors?
A. Yes.
348 Q. Then across on the professional --
A. That's right. 14:35
349 Q. -- medical side you have AMDs, CDs and Clinical Leads.
A. Yes.
350 Q. Do you think communication was good both on the operational management side and medical management side? 14:35
A. Yes. The AMDs, again, I met on a regular basis, some of them, and I completely understood some of them couldn't always make the meetings because their clinical job was so busy, so I understood that and took

the hit for that. Sometimes it wasn't just as easy to get them into the room. But any time I went seeking information or asking them for the AMDs were also very supportive. Yes, I would have to say yes.

351 Q. You speak in your witness statement, at paragraph 5 WIT-27300, of having monthly meetings with the Associate Medical Directors? 14:36

A. Yes. The AMDs had a monthly meeting and sometimes they were joined by the AD, depending on what was on the agenda. 14:36

352 Q. What was the focus of those meetings?

A. Mostly anything that was operational. It was a lot to do with waiting lists, and theatre lists, things going on around the hospitals. Too many medical patients in the hospital, and therefore not a lot of time to do the surgery that was planned. We had an orthopaedic ward, for example. The orthopaedic staff didn't like any medical patients in there because of the risk of infection. For bones, you can imagine how hard that would be if someone got -- so there were a lot of operational -- even just the hospital was getting built around all the time, bits added on. Sometimes that encroached on, for example, the Day Procedure Unit or Theatres or Daisy Hill, you know, what would go down to Daisy Hill and what would have to stay because they didn't have laminar flow theatres and they didn't have -- all those operational types of things. 14:36 14:37 14:37

353 Q. Yes.

A. There was plenty.

354 Q. You had two AMDs or three AMDs, but for present purposes I wanted to speak about Mr. Mackle and Mr. McAllister. Mr. Mackle stepped down from his role --

A. He did. 14:38

355 Q. -- in March April of 2016 --

A. Yes.

356 Q. -- to be replaced by Mr. McAllister for a short time. Then there was a gap --

A. That's right. 14:38

357 Q. -- through to the following year before Mr. Haynes took up the role?

A. Yes.

358 Q. In terms of what we are going to be looking at today, and that's performance issues in association with 14:38 a particular clinician's practice, Mr. O'Brien, what would be the meeting or the mode of communication to bring issues around clinical performance affecting the Service to your attention?

A. That would have been brought -- sometimes they would 14:38 have -- it was always brought to the AMD meeting, no matter what that was. I would have recorded it in my red book and whenever we obviously would have needed to take further steps, whatever that may have been, involved probably the Medical Director, very probably, 14:38 the Chief Executive, but depending what the problem and the issue was, we decided at the one-to-one what we would do and how we would take it, if it was brought to me.

359 Q. Yes. Did you find you had a good relationship with both Mackle and McAllister in communication terms?

A. Yes.

360 Q. If there's a caveat to be added to that, may I ask -- I put the two names together but please feel free to -- 14:39

A. Yes. To be fair to both of them, yes, they brought what they believed to be the main issues of their Directorate at that time every month. They didn't hide anything, hopefully.

361 Q. You've said in your witness statement, if you go down to WIT-23369, just the second paragraph there. In terms of the Medical Director it was arranged that you would meet fortnightly but this was difficult to arrange with ongoing time pressures and the meeting did not always take place. 14:39 14:40

A. Yes.

362 Q. The Medical Director, for the purposes of today, I suppose, is Dr. Wright?

A. That's right.

363 Q. Does that suggest that your meetings with him more often than not did not take place fortnightly, or? 14:40

A. Yes. It would be fair to say yes, that is the case.

364 Q. Did that create any particular communication difficulties for you?

A. Yes, it would have. Although Mr. Simon Gibson very often assumed responsibility for Dr. Wright and I assumed that he was delegating the job. Quite often, you know, Simon would have come and asked me for whatever, but it was the very, very difficult for the 14:40

Medical Director. I think at a point in time he worked four days a week only and during those four days, a bit like myself, he had an awful lot of others things to do, so our meetings quite often went on the back burner it is fair to say.

365 Q. You've said at WIT-23370, just at the bottom of the page, please. Maybe it isn't there but I think I've got the -- I can put the point to you in this way. There was no governance team in place when you joined?

A. No. Well, there was one person, one 8B. 14:42

366 Q. Who was that?

A. Her name was Margaret Marshall.

367 Q. When you say no governance team was in place, what does that mean? So within the Acute Directorate --

A. Yes. 14:42

368 Q. -- there was nobody looking at governance issues apart from her?

A. If I can just explain probably what I mean. If you don't mind I'll just explain it through. In my view, governance is actually everybody's business because 14:42 governance runs through all of what all of us do: documentation, standards and guidelines evidence-based practice, risk management, complaints, audit research, all of that is good governance, so it is everybody's business. The governance team for me draws everything 14:42 together. For example, with the Serious Adverse Incident, that would have been reported by the staff on the ground, but the governance team drew together the team to look at that Serious Adverse Incident and, you

know, to report back on it. Or they would have looked at -- I was very keen at looking at trends and patterns, for example, in relation to incidents or near misses, because that will tell you if there's something wrong in an area around one particular person or whatever. When I say a governance team, I mean that that team would have dealt with all of those things being pulled together. Good governance, as I said before, is everyone's business and we should all, everyone who practices, make sure that they deliver good evidence-based practice. 14:43 14:43

369 Q. You've explained in your statement that there was resource available for you to --

A. Yes.

370 Q. -- to fill that gap? 14:44

A. There was. That's right.

371 Q. What exactly did you do?

A. Governance was the only thing that I didn't have an Assistant Director to report to me on, and I felt that was very important because I wanted to keep all of my service the same. So actually Kieran Donaghy, who was the previous Director of Human Resources, told me -- he was very helpful in the beginning, and he told me that Tracey Boyce, who was the Director of Pharmacy, had just done a Diploma in Governance, a postgrad Diploma, I think, I am sorry, it may have been a postgrad, but it was a postgrad, anyway, qualification in Governance and he said: "You know, you should use that as a starting point." So I spoke to Tracy and she was 14:44 14:44

happy enough to do it, based on the fact that hers was a very busy job as well. But she then was able to appoint an 8B and then, more importantly, three Band 7s who did the "legwork", if you like, of the governance team. They were the people who went and gathered the information and brought it together and got the review team sorted out, et cetera. Then there was a team below that of, you know, 4s, 5s, 6s, and they were admin and all those people.

372 Q. Can you give us a practical example of a governance shortcoming that existed when you came into post that you were able to solve and pursue a better course as a result of the action that you took? 14:45

A. Well, there was a few that I didn't manage to crack and, to be honest with you, those were important, I felt, but I did speak to the two medical directors in turn. But, for example, when I came in to my position, there were more than 200 Serious Adverse Incidents that hadn't been reported on, more than 200. So this team began very quickly to look at those Serious Adverse Incidents, get teams together. It was difficult because there had to be one of the surgeons or physicians, whoever it was on the team. So by the time I pulled the team together and then they sat, they looked into it and they followed the SAI procedure, and by the time I left, most of those SAIs had been reported on or were being dealt with. I resurrected the Friday morning governance meeting that had been set up by Dr. Gillian Rankin, because it had sort of gone 14:45 14:46 14:46

by the wayside. Actually, governance was one of my passions in both prison healthcare and in the South Eastern Health and Social Care Trust. So I was looking forward to getting on with doing more audits or, you know, taking "near misses" and looking at them and seeing what we could do. But I wasn't able to really get into some of the more enjoyable side of governance, the prevention side of it, because every Friday, the completed SAIs were brought to my governance meetings so, really, that's all we did during the time I was there. But at least it was done. 14:46 14:47

373 Q. Okay. And on the operational side, if we focus on the role of Assistant Director and then below that, within each service, the Head of Service.

A. Yes. 14:47

374 Q. How did information come up from the Service, Urology, to you if there was a problem?

A. The information would have come up -- again, I was very clear, it's not that I wouldn't have spoken to anybody on the team, but I needed it to come through a proper line. The information would have come from the ground to the Head of Service, to the Assistant Director, and then to me. From the medical side the same thing. It would have been probably the Clinical Director to the AMD and to me. In essence, the two people that brought the information to me were the Assistant Director and the AMD. If they weren't there or, you know, somebody else quite often came in. I mean if Ronan Carroll wasn't there, for example, Martina would have stood in. 14:48 14:48

But I don't ever remember, actually, an occasion when it happened. In anaesthetics, for example, or medicine, the Head of Service would have stood in for AMD at times. But that's how it came, how information came.

375 Q. Listening to Mrs. Corrigan's evidence this morning, she was Head of Urology for all relevant periods -- this is page 13 of the current stenography or stenographic reproduction, we may not have it on the screen?

A. Okay. 14:49

376 Q. I'll read it out to you. She says that you were very clear at the start of your tenure that you expected that any information that you needed would have come through the Assistant Directors as opposed to the Head of Service, and that took her a bit of getting used to based on her previous experiences, perhaps with Mrs. Burns and before that. 14:49

A. Yes.

377 Q. She said that she didn't feel that she could go to you if she needed to escalate. Do you recognise that description in terms of the framework of management and communication that you sought to implement? 14:49

A. First of all, I have to say I really am disappointed that she felt she couldn't come to me at any time. However, the only way that I felt that everybody who should know did know was by coming through the Assistant Director. If I can give you an example. If Martina had come in to me and said something to me about urology, and Ronan didn't know, I might have gone 14:50

off and done -- it creates all sorts of problems if you don't follow the proper lines of communication. I got along very well with Martina, and I hope she said that. But in terms of communicate the business of the Directorate, then I did prefer everything to come up through the Assistant Director. I couldn't manage it properly any other way.

378 Q. Yes. When you think back now, do you think that caused any difficulties in terms of your ability to manage?

A. I don't think so. The ADs had, in turn their -- I mean I had meetings separately with my Assistant Directors and a Tuesday afternoon SMT of my own meeting, that was all of my Assistant Directors. The Assistant Directors did the same with their Heads of Service. I cannot -- unless there was something, and I don't remember this happening -- but unless there was something that the Heads of Service didn't feel that the Assistant Director was taking seriously, I would have expected -- but I would always have had them and the Assistant Director in the room and say, 'can we talk this through? What are the barriers to communication?' Communication is one of the biggest issues in the Health Service anyway, you know.

379 Q. You're here today, Mrs. Gishkori, primarily to focus on the issue of the MHPS process.

A. Yes.

380 Q. You've told us in your witness statement, WIT-23407, just to have that up, please, at paragraph 5.

You didn't receive any training on either MHPS or the

Trust guidelines during your time in the Trust?
A. No, I didn't receive any formally training. However, because of my two previous jobs and because I sat on every single consultant interview I was quite -- it was almost like, for want of a better word, osmosis. As I went along in my previous two jobs I understood MHPS. When I went to look at it, it reminded me very much of the previous Leadership and Qualities Framework and the holding to account was actually quite similar, so I kind of was able to grasp it and look at it. The answer to your question is no, I didn't get any training. 14:53 14:53
381 Q. But you had a working knowledge --
A. I did.
382 Q. -- of MHPS and something similar to the Southern Trust's local guidelines from previous work? 14:53
A. That's right. And NCAS too, because the South Eastern Trust were employing GPs at the time, so there was a lot of work in relation to doctors.
383 Q. You used an acronym there N? 14:54
A. NCAS. That's the National Clinical Advisory Service.
384 Q. Yes. We've been calling it NCAS.
A. Sorry.
385 Q. Don't worry. Entirely my fault.
A. Sorry. 14:54
386 Q. You had familiarity with that organisation?
A. Yes, I did.
387 Q. Had you occasion to contact that organisation yourself?
A. I didn't ever contact them but the senior doctor -- and

I notice Colin Fitzpatrick he actually worked with us in prison healthcare, I don't know if it's the same person or not, he would have been the person who dealt with them a lot because he was the lead, but I was always involved with them as well. 14:54

388 Q. When it came to September 2016 --

A. Yes.

389 Q. -- and you were a member of the Oversight Committee, the Oversight Group of the Southern Trust dealing with an issue concerning Mr. O'Brien and, indeed, other clinicians during the meetings but focusing on him today, this wasn't a foreign planet to you. You knew what that MHPS processes involved? 14:55

A. Yes.

390 Q. Had you read the local framework document, the local guideline document produced by the Southern Trust? 14:55

A. Yes. I always --

391 Q. If we could have that up on the screen, please? It is TRU-83685.

A. There was a flowchart I found very useful. I had it here but I don't know where it is. 14:55

392 Q. That's the Trust's guidelines. Did you have a copy of those?

A. The guidelines were there for everyone to see on the Trust's website. I don't know if I had it in hard copy or not, but they were there, yes. 14:56

393 Q. Would it have been something you consulted?

A. Yes.

394 Q. In terms of your awareness of Mr. O'Brien,

Mr. Aidan O'Brien --

A. Yes.

395 Q. -- did you know him before you became employed in the Trust?

A. No. 14:56

396 Q. Starting your employment in August 2015 --

A. Yes.

397 Q. -- did you become aware of him?

A. No, not at all.

398 Q. When do you think was the first time that you became aware of him and of concerns, however those concerns might have been described, with his practice? 14:56

A. Yes. The very first time I became aware of him was in March 2016 at one of the one-to-ones. Heather Trouton and Eamon Mackle were there. 14:57

399 Q. That's March 2016?

A. That's right.

400 Q. I want to test that with you, because other people, you might imagine, have come and give evidence about that and I want to work through that with you. 14:57

A. Okay.

401 Q. We'll get to March 2016.

Could I have up on the screen, please, WIT-12130? At paragraph 425, this is an extract from Mrs. Trouton's Section 21. She's here talking about the concerns such as triage, patient notes held by Mr. O'Brien at home, review backlog. She's being asked did she have discussions with anybody about that. She said: 14:57

"These discussions directly with Mr. O'Brien were primarily via the Head of Urology and ENT but on occasion by Mr. Young, Mr. Brown, Mr. Mackle, Dr. Rankin, Mrs. Burns, Mrs. Gishkori or myself. Following discussion with Mr. O'Brien his practice would improve for a period. However, this improvement was not sustained and through alert systems we would have been alerted to delay, triage, missing notes which was then followed up for action. Review backlog numbers were also constantly monitored." 14:58 14:58

We know from the evidence that we've heard that triage was a problem in late 2015 --

A. Yes. 14:58

402 Q. -- and for several years before that.

A. Mm-hmm.

403 Q. We know from evidence that we've heard that a new issue came on the Services agenda towards the end of 2015 because recently appointed consultant clinicians were discovering that Mr. O'Brien was, on occasions, failing to dictate clinician encounters, those kind of things. Of course, notes at home was seen to be a constant battle. Can you remember, as suggested here by Mrs. Trouton, participating in a meeting with Mr. O'Brien and her to discuss any such issues? 14:59 14:59

A. Never. I never met Mr. O'Brien with Heather Trouton, not ever.

404 Q. Can you remember, prior to March 2016, discussing

issues such as this with Mrs. Trouton?

A. No. I saw on one of the documents that was provided to me that in December 2016 that Heather Trouton had discussed at one of her one-to-ones. But the first time, according to my recollection, and it is five years -- it's a long time ago, Mr. Wolfe, and I hope I'm being correct here, but the first time I remember Mr. O'Brien being discussed was in March 2016. 15:00

405 Q. Can I just deal with that December meeting that you refer to? 15:00

A. Yes.

406 Q. If you go to Mrs. Trouton's statement at WIT-14811. At paragraph 11, please, she says:

15:01

"Following the emerging concern relating to the lack of clinic outcomes recorded on patient centre in 2015 and following verification of this concerned by Mrs. Corrigan, advice was sought by Mr. Mackle from Dr. Richard Wright as to the best next steps. As I recall, it was notification of another concern regarding Mr. O'Brien's administrative practise that prompted a request for a direct meeting with the Medical Director. 15:01

15:01

I also alerted my Operational Director, Mrs. Esther Gishkori, of this latest concern and I have a note of a one-to-one meeting with Mrs. Gishkori which records same."

So that note, if I can just ask for your comments on it, is at TRU-277934. If you can highlight the top section, where it is highlighted in pink, please.

Now this, as you can see, is a note dated 21st December 2015. It is described as a one-to-one with Esther. We have evidence that it's in the hand of Mrs. Trouton and she recalls meeting with you in December to discuss Mr. O'Brien as per that note. Are you saying that meeting didn't take place or you simply don't have recollection of it? 15:02

A. No, no. It is highly possible -- I mean, I had monthly one-to-ones with all of the ADs, of which Heather was one. It is possible that yes, we met. My red books, as you know, weren't able to be retrieved so my one-to-one would have been recorded in it. And all of the other things on Heather's note there I can remember about. So those are things that would have been discussed. But I don't remember that, or plan letter in one month, what did that mean, another letter didn't go to March? I do know that. 15:03

407 Q. Yes. Could we just revise on something you said there. You said the red books have not been retrieved. They have, in fact, been retrieved?

A. Some of them. 15:03

408 Q. Well, quite a number of them, and they've been sent to you for review?

A. Yes.

409 Q. Isn't that right?

A. That's right.
410 Q. Do you think some of them are missing?
A. I think the earlier ones probably later ones were -- you know, with the later ones, 17, 18 especially were the one's that I received but there was no record of that particular one-to-one at the end of December, unfortunately. 15:04
411 Q. Okay. You can't remember the meeting. You don't deny that it took place?
A. Yes, that's right. 15:04
412 Q. You don't deny that these are the kind of issues that were drawn to your attention?
A. Mm-hmm.
413 Q. What subsequently emerged following a January meeting on the evidence that we've received so far between Trouton, Mackle and Wright was the idea that Mr. O'Brien would be met with and asked to produce a plan, a remedial plan to address the shortcomings in his practice. 15:04
15:05
Were you privy to that information --
A. No.
414 Q. -- in January of 2016?
A. No, I was not.
415 Q. The record here from your meeting in 2015 seems to allude to a plan, a letter, with one month to improve? 15:05
A. Yes.
416 Q. Clearly if this note is a contemporaneous note made of that meeting, that is something you were discussing.

Does it not ring any bells to you?

A. No. I'm really sorry but it doesn't. I am being really honest, that really does not ring any bells to me.

417 Q. Can we leave it at this. Would you have thought that a plan from Mr. O'Brien with a period of time to improve was a worthwhile pursuit? 15:05

A. Absolutely. I mean there's there no patient centre letters on triage. Triage is one of the most important part of the urologist's business. If the patients weren't being triaged, what was happening then? That would have rang, as far as I'm concerned, warning bells. I really don't remember -- I'm really sorry but I just don't remember it. 15:06

418 Q. We maybe can't take that much further then. 15:06

A. Yes.

419 Q. You didn't get any feedback from the meeting that they had with Dr. Wright in January?

A. No. Do you mind if I comment on that?

420 Q. Please. 15:06

A. Because the reason is whenever the Oversight Meeting was called in September I wondered why or how, because I thought I was the only one that knew. Heather and Eamon told me in March they were going to write a letter to Mr. O'Brien. Then the next thing I knew or remembered was the September meeting. I wondered how the Oversight Group had gotten to know about it since it was only Heather, Eamon and I that had known. Then I realised that there had been a meeting in January. 15:07

Plus, also, there was an e-mail in February from Richard Wright to me saying he thought --

421 Q. I think we're conflating too many things. Let's structure this a little bit better?

A. Okay. 15:07

422 Q. Let's put January behind us. There had been a meeting between Wright and the two others. You weren't aware of that meeting?

A. No.

423 Q. You weren't aware, you're telling us, of the plan that was hatched at that meeting to meet with Mr. O'Brien, at least at that time? 15:07

A. No.

424 Q. Let me take you forward a step. On 8th February Mrs. Trouton's records show there was a further meeting with you. If we can have TRU-277937 on the screen, please? Down to the highlighted section. Maybe just at the top so you can show the date. This is 8th February. Just to the top, please. 8th February. 15:08

A. Mm-hmm. 15:08

425 Q. "Esther one-to-one". You did have regular one to one meetings with Mrs Trouton?

A. Yes, I did.

426 Q. The note, it says, reading across, an abbreviation for "urology" urol. It says: 15:08

"Apart from review backlog", and the next word might be `working`, that is urology is working apart from the review backlog.

A. Review backlog, yes.
427 Q. Is one way of interpreting that?
A. Yes.
428 Q. But AOB plan.
A. Yes. 15:09
429 Q. Again, it might make sense to suggest to you that following the meeting in January between Trouton and the Medical Directors and Mr. Mackle that this plan was being taken forward?
A. Mm-hmm. 15:09
430 Q. And that she was telling you about that?
A. Mm-hmm.
431 Q. Does that ring any bells?
A. It's funny because -- I'm just having to be honest with you here, I really remember the other things. [redacted] 15:09
[redacted] I remember that distinctly, having a long conversation. CD posts and the ins and days activity. She may have mentioned Mr. O'Brien, trauma, cancel elective activity. If it didn't jump out she may have mentioned it. 15:10
I can't --
432 Q. Let me step forward again.
A. Yes.
433 Q. It's certainly the case that in your opinion at that time the main concern for Urology was the increasing 15:10
waiting lists and the backlog of patients?
A. That's right.
434 Q. To the extent that refers to backlog being the main issue for Urology, that's correct, isn't it?

A. It is.
435 Q. 9th February Dr. Wright sends you an e-mail. It is TRU-657616. Just scrolling down. Mr. O'Brien has written an e-mail talking about his heavy work commitments. Not to overly exaggerate, but he suggesting he's working all day and all night, very little time for rest. 15:11
A. Yes.
436 Q. Then that's copied through to Dr. Wright.
A. Yes. 15:11
437 Q. Then he copies it to you, as you can just see at the top of the page.

"This almost sounds like a cry for help. We should discuss"? 15:11
A. I remember that clearly.
438 Q. There's a picture emerging here --
A. Yes.
439 Q. -- and you don't remember the early parts of it, but information being fed through to you about Mr. O'Brien's performance, the need to address that, and coming from a different angle, perhaps, Dr. Wright telling you about this e-mail. Did you meet with Richard Wright to discuss what was being interpreted as a cry for help? 15:11 15:12
A. Yes. I think Richard and I -- I don't know that we met about that but I do know that the next time we met or thereabouts we did discuss it. I suppose by this stage this slowness, you know -- if I can give you an

analogy. The way I looked at this was -- I called it the speed continuum in my mind. There were people who, when they got under pressure, went very slow and others went very, very fast. That brought its own problems too. I wondered, and I said that to Richard, 'where is he on this?' Because people were saying by now -- as I said to you I didn't know this man at all, but people were saying by now, 'he's just so slow. He goes into theatre all day. He knocks the theatre list off. He's not a team player'. Other people will have seen 14 patients, he'll only have seen 10. But never at any point ever did I ever hear that there was an incident, an accident, an IR1, anything in relation to his practice. It was just the slowness. 15:12 15:13

440 Q. Let's just be careful here because, of course, you did hear about IR1s? 15:13

A. Later on, yes.

441 Q. Yes. The issue here built on top of what you may not remember hearing but certainly it, as it appears brought to your attention by Mrs. Trouton is, can I suggest, a need to assist this -- 15:13

A. Man.

442 Q. -- doctor and provide some support?

A. Yes.

443 Q. You said you can remember speaking to Dr. Wright about it? 15:14

A. Yes.

444 Q. Did anything arrive in practical concrete terms in respect of that or how was it left?

A. I think it was left that Richard was going to meet Mr. O'Brien shortly after 9th February to discuss things through with him. If I can remember right, it was in relation to job planning and he was going to talk to him about job planning and what should be in a job planning plan and SPAs, and how many of those. I think he said would raise that at that particular event or arena. But I didn't have anything from any of my ADs, or come up through Martina or Ronan, or Heather at that point that there was any issues with Mr. O'Brien feeling that he was crying out for help, even though, apparently, he had sent e-mails way before me that he was finding it hard to deal with the workload. I wasn't aware of those. 15:14 15:14

445 Q. What you're saying is you did speak to Mr. Wright about this? 15:15

A. Yes. Yes.

446 Q. It was your understanding that he would take the issue away and deal with it with Mr. O'Brien in the context of job planning? 15:15

A. Job planning.

447 Q. Did you ever receive any feedback to say job planning has been discussed and we found a solution to this problem?

A. No. The next time I remember was the March meeting with Heather and Eamon. That was the next meeting. 15:15

448 Q. Let's move them to the March meeting. If we could have up on the screen an extract from your statement. It is WIT-23372, paragraph 7, please. It seems that what

you're telling us is in February or the beginning of March you met with Trouton and Mackle and they told you they were going to write to Mr. O'Brien --

A. Yes.

449 Q. -- telling him he needed to complete his triage referrals quicker, complete timely dictations and that he needed to be quicker in general? 15:16

A. Yes.

450 Q. Is that how it was expressed to you?

A. Yes. I didn't see the letter. The letter hadn't been written at that point. They were going to write it at that point. They were telling me they were going to write a letter. 15:16

451 Q. What do you mean when you say "I didn't see all of the contents of the letter"? Does that suggest you saw the letter -- 15:16

A. No. It suggests that they told me -- I didn't see the letter at all and I didn't see all of the contents. There was one about a cancer clinic that he had. They told me about the other things that were in the letter except one or two, when I see eventually saw the letter, if you understand what I mean. They told me. I said why don't you just talk to him about it. Eamon said that that had already been tried dating right back to Dr. Rankin, that he was a person who did his own thing, he very much felt as though he was in charge of urology, it was his, as they talked about, baby, he would do what he wanted to do, and he had a very slow style of working. They told me at that point if 15:17 15:17

you were one of his patients you would have been lucky because once you get in to see him he knew the name of your cat, he knew everything about you, but it was the ones who were waiting was the problem. What they were saying was he was a good enough clinician but he really, really had to speed up.

452 Q. Just if we look at TRU-277941. This is a meeting on 21st March.

A. Mm-hmm.

453 Q. It's marked: "One-to-one Esther and Eamon" not, but I understand this is the handwriting of Mrs. Trouton -- 15:18

A. It is.

454 Q. -- who was also at the meeting. If we can scroll it down, please. It says: "Need to get letter to AOB-this week". So do you think this is the meeting that you have referred to in your statement? It's a bit later than the start of March. 15:19

A. Yes. This is the meeting that I'm referring to that I was told that they were going to write to him.

455 Q. Yes. 15:19

A. Yes. That's it.

456 Q. And the letter, let's look at that, AOB-0979. No? Try 00, please. Thank you. Now this is the letter. The note says: "Need to get the letter to AOB-this week". Do you think that was your instruction? 15:20

A. No. That was from Heather and Eamon to say: 'We're going to do this as soon as possible.'

457 Q. Yes. Were they taking ownership of this process?

A. Absolutely.

458 Q. Yes. To what extent did the process interest you?
A. Well, it interested me because going back to governance and all the issues in and around governance, this person was not completing his triages, which is a risk. He wasn't doing his dictations -- which is a big risk. He's the only person who can do dictations, and the charts, et cetera. So I wanted this to be fixed very quickly. And I did say -- I remember saying to them: "But, you know, are you going to sit down with him and discuss..." You know, it's one thing handing someone a letter who is deep down into trouble but it's another thing handing him the letter and sitting with the person to see can you bring them up out of that trouble. That was very important to me that that would happen. 15:21
459 Q. Yes?
A. Yes.
460 Q. So you wanted an assistance or support-based approach?
A. Absolutely, I did.
461 Q. Did you discuss with them what they might look like? 15:22
A. They said that they absolutely would sit down with him. They told me at the meeting that they were going to sit down with him, that they were going to discuss how, you know, how it was possible for this to happen, if he needed any help, if there was anything that they could do. And I said, you know, patient safety comes absolutely first here and if this person needs help then we need to give it, but we need to sort of the problem, whatever the problem is. 15:22

462 Q. Yes. Well, we know what the problem was for the service, don't we?
A. Yes, of course.
463 Q. When did you first see the letter, do you think?
A. Even when it came to the September Oversight Group, the letter wasn't presented there. It was a report from Simon Gibson. 15:22
464 Q. Yes.
A. They called it a screening report, I think.
465 Q. Yes. 15:23
A. The letter itself wasn't presented there.
466 Q. I'm asking you when you first saw that letter?
A. I don't know. Probably, maybe when it came to December and when the SAIs all started to come through. To be honest with you, I don't know when I first saw that letter. 15:23
467 Q. Let's just look at it briefly. It tells that the reader there are currently 253 un-triaged letters dating back a year and a half to December '14.
A. Yes. 15:23
468 Q. Tell me this, were you aware of the data, even if you didn't see the letter at these meetings?
A. Yes. When it came to -- I wasn't aware of the particular data at the March meeting, no, not at all. It was just a letter that was going to this man for being slow. 15:24
469 Q. Can I ask the question another way?
A. Yes.
470 Q. To what extent were you aware of the gravity of the

problem?

A. I became aware of the gravity of the problem in September 2016 when I went to the Oversight Meeting.

471 Q. Although you have two senior managers in front of you at a meeting planning to go to another meeting with Mr. O'Brien -- 15:24

A. Mm-hmm.

472 Q. -- you're not extracting from them any sense of the seriousness of the problem?

A. No. 15:24

473 Q. Why not?

A. Well, Mr. Mackle, I clearly remember Mr. Mackle saying to me, 'we're going to write to Aidan O'Brien because he's slow and he's becoming slower. He is creating havoc within the theatres. He is creating havoc in 15:24 terms of triage. His other colleagues see more patients than him. He phones people up to come in tomorrow to have an operation, nobody knows'. You know, he was just completely not a team member. Honestly, that is all I heard, that type of thing at 15:25 that meeting.

474 Q. You did hear that it was a triage issue?

A. Triage issue, slow.

475 Q. An un-dictated letter issue?

A. No, just slow. 15:25

476 Q. Did you not tell us a moment or two ago --

A. Yes, they did. They told me that he wasn't doing his triages as quickly as he should.

477 Q. Yes. And he wasn't dictating.

A. He wasn't dictating.

478 Q. You regarded those at that time, at that meeting as potentially Patient Safety issues?

A. Yes.

479 Q. Just scroll down. He's telling you about, he's giving you statistics on triage. Then this letter, I am conscious you didn't see it, the backlog figures are there. It is recorded: 15:25

"We are aware that you have a separate oncology waiting list of 286 patients, the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on this list." 15:26

Were you aware of that particular nuance?

A. No, I wasn't, and that was the one bit. When I was provided all those papers I was provided in the core bundles, that was the part of the letter that I don't -- (a) wasn't told about in their meeting, and (b) wasn't told about in September 2016 when we had the oversight, because the screening letter didn't have that in it. 15:26

480 Q. If we scroll down. It's telling you about patient centres and recorded outcomes. This is the dictation issue. 15:26

"Colleagues are frustrated or often frustrated that there's no record of your consultations or discharges

on the patient notes".

Scrolling down. Then "patient notes at home".

Of those issues you were generally aware of the triage issue? 15:27

A. Mm-hmm.

481 Q. Generally aware of the dictation issue.

A. Dictation issue.

482 Q. Generally aware of patient notes at home? 15:27

A. Yes, generally.

483 Q. You knew there was a backlog with review, but you didn't appreciate --

A. No.

484 Q. -- you didn't appreciate that he had a separate oncology waiting list? 15:27

A. It was almost as though -- the thing about urology was, and I suppose in terms of context, there was backlog, you know, in a lot of areas. A lot of the urologists did have waiting lists, but his were way over and above what everybody else's was. Urology in Northern Ireland was a regional problem and needed a regional solution. At no time was there going to be 0, 0, 0 in terms of waiting the whole way down. That was a given. I'm just saying as a background to this. Urology was a big issue in Northern Ireland -- still is, I understand. 15:28 15:28

485 Q. Why do you think these particular issues were being drawn to your attention at this meeting?

A. Mr. Mackle left very soon after the letter was sent and

Heather moved also very soon after the letter was sent. I'm assuming I was being told at that point, you know, there's an issue about this man and here's what we're doing. Although I didn't know, by the way, at the meeting that Mr. Mackle was going to leave so soon as he did. I'm assuming this is a rounding up of business, as it were, in terms of Mr. Mackle.

486 Q. Yes. They went and they had their meeting. Mrs. Corrigan actually attended instead of Mrs. Trouton who was absent that day. 15:29

A. Okay.

487 Q. But Mrs. Trouton shortly left for a new role.

A. That's right.

488 Q. And Mr. Mackle stepped down to be replaced by Dr. McAllister. 15:30

A. That's right.

489 Q. So you left that meeting with the sense that there were patient safety issues, even if you didn't know the granular detail of the letter. You must have been awaiting some outcome from that meeting? 15:30

A. I suppose going back to the very beginning and what we discussed and the burden of the job that I had to do, I absolutely had to delegate work because if I didn't, I couldn't do it all myself and, certainly -- so I delegated as appropriately as I could. And they left my office, they were in my office that day, so when they left my office, I was sure that I had appropriately delegated the task of sitting down with Mr. O'Brien to organise, you know, a way forward. 15:30

Because again -- and I'll say it again -- Mr. O'Brien was -- I didn't know the man at all but everybody had told me he was an excellent clinician, he was very well respected, this man had no "black marks", for want of a better word, against his name. So I knew or I believed that it was possible to sort this, and I felt as though I had appropriately delegated it to them.

490 Q. Yes, but you delegated it, if that's the right word, because they were always taking the initiative and not you, the task that they were to perform was coming from them and they were telling you about it. 15:31

A. Yes.

491 Q. Not delegated in that sense.

A. Well, I didn't write -- I wasn't going to be writing the letter, it was them. 15:31

492 Q. Yes.

A. They came to me with the problem and the solution, if you like. And they agreed to write the letter.

493 Q. Yes. And then they exited stage left? 15:32

A. Yes.

494 Q. Shortly after the meeting, leaving you with the knowledge with the acute services directorate that you have a clinician who has got practise problems that are potentially harmful to patients. 15:32

A. Um-hmm.

495 Q. So did you receive any feedback from that meeting?

A. No, I didn't receive any --

496 Q. Did you seek any feedback from the meeting?

A. I didn't seek any feedback from the meeting but what I did do, because all of my ADs were moving around at that time, and everything was really fluid, but I remember saying to all of my ADs in -- you know, in meeting rooms: "Look, you must hand over whatever is on you're caseload to the AD coming in. You must. You have to. I can't do it and I can't run around finding out before things." So that was a given that everybody who was moving -- and it wasn't a difficult job to do because we were all on the same floor next door to each other, nobody moved rooms. So as far as I was concerned, and given, I suppose, the pressure that I was under, I didn't go seeking anything. No, I didn't. 15:33 15:33

497 Q. Okay. Mr. McAllister, when he took up his role, he wrote to you. If we could have up on the screen, please, WIT-14875, so you're copied into the e-mail, it's 9th May, and Dr. Wright, Ronan Carroll. Item 6, Urology. Obviously there's lots of other issues sketched out there. But the issues that he identifies within urology include the very issues that you are aware from your meeting in March relate to Mr. O'Brien. 15:33 15:34

A. Yes.

498 Q. And at the bottom of the page -- just scroll down to the end of this e-mail, please -- he said: 15:34

"That's what has appeared so far. Basically, a very disturbing picture with significant governance risks. I'd be interested in your thoughts".

And he receives replies from Mr. Carroll and Dr. Wright but we can't find any reply from you.

A. Well, respectfully, a lot of the things that are on that list were ongoing in the directorate. 15:35

499 Q. Yes.

A. I'm not sure that he discovered them all himself. Could we scroll back down?

500 Q. Of course, yes. Do you want to got to the top of the e-mail? 15:35

A. Yeah.

501 Q. Of course.

A. You know, the structure dealing with governance, what we knew and what we are doing and whatever -- mind you, what he's talking about there is the governance within 15:35 medicine.

502 Q. Yes.

A. The monthly meetings with the Clinical Leads, the ADs and Heads of Service. The FY1 rotas were on the agenda all the time. Staff side were always meeting with us 15:35 in relation to that.

503 Q. In a nutshell, a lot of these issues are already on your agenda and were being dealt with?

A. Yes, a lot of them. But I do remember saying to Charlie about urology and I remember him saying: "Yes, 15:36 but Colin and I have got ideas about that." But, again, Charlie McAllister now was the AMD for all of these areas. He had identified the problems.

504 Q. Yes.

A. I knew, Ronan knew, Richard knew, and there was a lot of overlap as well between Richard and I.

505 Q. Just on Mr. O'Brien's issue, Mr. McAllister is putting it on to each of your agendas, perhaps. He obviously has a responsibility as well as AMD and he has answered for that. But in terms of your role, who is being -- you being with this issue from Christmas of the previous year if Mrs. Trouton's account is to be accepted, and you have met with Trouton and Mackle, you know that the meeting has taken place and you know the content, broadly, of the letter that Mr. O'Brien is to receive and has received? 15:36 15:37

A. Yes.

506 Q. But you hadn't sought any feedback from the meeting and you haven't discussed this with Mr. McAllister directly, have you? 15:37

A. Yes, I did. I discussed it with Mr. -- because he came for one-to-ones with me as well and I remember at his first one-to-one, you know, just briefly going down all of the issues here. I mean, the middle grade cover is scant and is unable to provide -- you know, we've known that for a very long time. I think he is writing the obvious down there, to tell you the truth. 15:37

507 Q. But with Mr. O'Brien, you met with Mr. McAllister?

A. Yes, I did. 15:37

508 Q. Spoke about the O'Brien situation?

A. Yes. He said that he and Colin Weir had ideas about how to fix it. And I said: "Well, will you go on ahead and get it fixed really quickly, please, because

it is rumbling on", is the word I used. It wasn't warning bells but it was just rumbling, it was just mentioned here and there, you know.

509 Q. Uh-hmm. Now we get to August and September.

A. Yes. 15:38

510 Q. And you know the issue comes back on the agenda and oversight and all of that, and we'll look at that just now.

A. Okay.

511 Q. How come this issue has gone from March on to an oversight Committee agenda without any action being taken by you to make sure that it was brought to a conclusion as quickly as you wanted it to be brought? 15:38

A. Yes, I think -- you see, are you asking me how it got to the agenda in September? 15:39

512 Q. I'm asking, I suppose, given that the issue was first brought to your attention in December?

A. Yes.

513 Q. You identified it in March as a patient safety issue, at least potentially? 15:39

A. Mm-hmm.

514 Q. It comes on to the agenda in September in an unresolved state. In other words, the better part of nine months have passed and you have a clinician within your Directorate who, apart from a short meeting in March, 15:39 hasn't been spoken to about this in circumstances where he has been asked for a remedial plan and hasn't produced it?

A. Again, I was under the impression that other people

were dealing with it. Heather and Eamon were going to sit down with him and work a plan out. When I spoke to Charlie, it wasn't in May I spoke to Charlie, it might have been slightly later. I'm not going to say a date because I can't remember a date. It was, in my mind, that this particular issue was well within the bounds of being sorted by his CD and AMD and his colleagues in the urology team.

515 Q. At any point before you met Mr. McAllister and Mr. Weir on 14th September 2016, did you receive or seek any feedback from him or from them? 15:40

A. From?

516 Q. McAllister and Weir.

A. They sent out an appeal very shortly after. I spoke to Charlie on the -- just after the -- sorry. Sorry. 15:41

517 Q. What I'm asking you is that you met them after the Oversight Committee meeting on 14th September?

A. I think it was a few days after that.

518 Q. It was 14th September?

A. I brought them into my office. 15:41

519 Q. Yes. We'll come to that.

A. Yes.

520 Q. Before that, at some unspecified point shortly after Mr. McAllister's appointment, you spoke to him?

A. Yes. 15:41

521 Q. He told you that himself and Mr. Weir had plans to sort this out.

A. Mm-hmm. In fact there's e-mails to -- he said at one point to Colin, 'I think we've missed the boat here'.

522 Q. Yes, that's in August?
A. Was that August?
523 Q. That wasn't to you?
A. No. No. That wasn't to me but --
524 Q. What I'm really asking you, Mrs. Gishkori, is you have asked Mr. McAllister to sort this out and sort it out quickly. You can't remember when you asked him to do that, but the question is: did you pursue it with him? Did you seek feedback from him? 'Charlie, what are you doing to sort this out and have you reached a solution?' 15:41 15:42
A. No, because he left very quickly after that as well, after the September.
525 Q. No, you really are missing the point, Mrs. Gishkori.
A. Sorry, I beg your pardon. 15:42
526 Q. Let's think about the period before the Oversight Committee meeting.
A. Okay.
527 Q. The several months between McAllister's appointment in May and the Oversight Committee Meeting in September. That period of three to four months? 15:42
A. Yes.
528 Q. He knows about the O'Brien issue, he knows about the letter?
A. Yes. 15:42
529 Q. You know about the O'Brien issue and you know about the letter.
A. Mm-hmm.
530 Q. You asked him to produce a solution quickly?

A. Mm-hmm.
531 Q. Did you ever go back to him?
A. No.
532 Q. Why not?
A. Again, probably based on how busy I was. You know, the urology issue wasn't the only issue going on at the time, Mr. Wolfe. You have to understand that there was fires all over the place to be put out. You know, retrospect is a very good weapon to have when you are looking back on things, but whenever at the time it was just another one of an awful lot of issues. If I had gone -- you have nine or three or how many issues there, I couldn't have had the time to go back to him and say, 'did you do that, that, that or that'. You know. I had to trust my colleagues, that's what they were there for. I had to trust my AMDs, my ADs, the Clinical Directors below them. They had a job of work to do. I was doing loads -- 15:43 15:43 15:43
533 Q. You also have to manage them, Mrs. Gishkori.
A. Yes. Yes. 15:44
534 Q. You have to, because you're at the top of pyramid, say to them --
A. Operationally, yes.
535 Q. -- you have to say to them, do you not: 'Listen, this is a doctor who appears to be struggling. His struggles are causing potential harm or patient risk. I want this addressed, and I want it addressed quickly, and I want you to report to me with how it has been resolved'. At no point did you receive assurances of 15:44

that nature; is that fair?

A. Only after September Oversight Meeting. That was whenever I really took the issue into my own hands to try and sort it out.

536 Q. Yes. Let's come to September then. 6th September, Mrs. Toal sends you an e-mail? 15:45

A. Mm-hmm.

537 Q. Let's bring that up onto the screen, please. It is at WIT-41560. Scroll down a little, please? Vivienne Toal, 6th September, is writing to you and Dr. Wright. She is saying: 15:45

"There are a number of issues which would be good to touch base on. Could we meet for a hour or so after the Governance Committee on Thursday by any chance?" 15:45

Within that list, number 2, "Mr. Aidan O'Brien - potential MHPS case."

Do you remember that and do you remember touching base, as she puts it, to discuss the O'Brien issue? 15:46

A. Yes, I think it was my secretary had gone back, a full diary, four meetings a day, et cetera, I think I couldn't make this one, I think, was the answer to that. 15:46

538 Q. So you didn't --

A. But we dealt with those at the Oversight meeting.

539 Q. Yes, and this is to set up an informal, it appears "touch base" kind of meeting to consider what's going

to happen, perhaps, with those cases. So it is not the oversight itself I'm asking about.

A. No.

540 Q. But it is giving you information that Mr. O'Brien's case is potentially an MHPS case. Now presumably, having reminded yourself of this e-mail, can you help us, was that the first time you might have appreciated that your colleagues on Oversight were thinking of an MHPS process? 15:47

A. Yes, that would be right. 15:47

541 Q. Yes. You can't remember touching base?

A. It's very possible that we did because that's when sometimes most of the business was done, you know, like gathering people up after a meeting that was organised. You know, it was quick and it happened, everybody was there. So it's very possible that did -- I suppose I need to go back, you know, and.... Please go on. 15:47

542 Q. I'm sorry, are you okay?

A. Yeah.

543 Q. Are you sure? 15:48

A. Yes.

CHAIR: If you do need to take a break, we can.

A. No, it's okay.

CHAIR: In fact, it might be an appropriate time anyway, Mr. Wolfe. It is ten to four now. 15:48

MR. WOLFE KC: I'm in your hands.

CHAIR: We'll take a short break and we will come back again just after 4.00.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe, just during the break, just to be clear, we're not going to sit beyond 5 o'clock today, just so that Mrs. Gishkori knows that and she knows she has to come back anyway. If it makes it any easier, we'll reserve our questions until she returns.

544 Q. MR. WOLFE KC: I may not go up to five o'clock, I'll park at a convenient point in the questions. Now I was asking you just before the break, Mrs. Gishkori, about the e-mail that Vivienne Toal sent on 6th September suggesting that it would be good to touch base on a range of issues, including potentially an MHPS investigation concerning Mr. O'Brien. I think you agreed with me that if you considered that e-mail at the time, that might have been the first occasion in which you would have been aware that an MHPS was in consideration? 16:03 16:03 16:04

A. That is right, yes.

545 Q. What you might not have been aware, and let me ask you about this, was that in advance of this, Mr. Simon Gibson had been tasked with the role of carrying out a screening report or a preliminary investigation into certain issues. When did you first become aware of that or was the need for that discussed with you? 16:04 16:04

A. No. No. The need for that was not discussed with me. The first time I saw this screening report was just in advance of the Oversight Committee and Simon had said that he had been tasked with doing a screening report,

indeed he had given some recommendations in it as well.

546 Q. Yes.

A. So that's when I saw that.

547 Q. Now obviously we'll get to the Oversight Committee, et cetera. 16:05

A. Yes.

548 Q. Now leaving aside the potential for having touched base with Toal and Wright, and you can't remember whether you did or you didn't, and that's your evidence.

A. Yes. 16:05

549 Q. Apart from that potential meeting to touch base, had you ever discussed the circumstances of Mr. O'Brien with, for example, the Medical Director in advance of the oversight meeting?

A. No. 16:05

550 Q. Now 12th September. If we could bring up TRU-257627 and it's coming up to Close of business, I suppose, and Mr. Gibson is sending you the screening report for the oversight committee meeting which is to take place in the morning. 16:06

A. Yes.

551 Q. Let me just pull up what you've said about that in your witness statement. If we go to WIT-23409. And at paragraph 2 at the top of the page -- unfortunately, the questions that you're asked are in a separate 16:06 place.

A. I know.

552 Q. But if I can tell you that you're being asked there when did you first become aware that there would be an

investigation into the performance of Mr. Aidan O'Brien and you say: "I became aware when Dr. O'Brien was listed on the agenda for a meeting of the Oversight Committee. I was not aware prior to attending that meeting. The agenda for the meeting was circulated one day before, but due to a busy work schedule, I had not had sight of the agenda in advance of the meeting."

A. Yes.

553 Q. Can you help us with that? 16:07

A. Yes, it honestly -- you know, Emma would have been saying to me: "Esther, there's your papers", you know, and I would have literally been running down the hill to go to the Oversight Committee, which I think was in Dr. Wright's office in Headquarters. I think Vivienne 16:08 somewhere else had said she had read the papers the night before. I didn't. I did not read them the night before, I read them sort of on the way and then during the meeting, it all started to unfurl and became --you know, I read it as the meeting went along. 16:08

554 Q. I asked you maybe at some length about whether you touched base in the week before.

A. Yes. Yes.

555 Q. It was perhaps with this answer in mind, because this answer that you've given here rather suggests that 16:08 upon -- perhaps even upon arrival at the meeting it was almost a surprise or, certainly, a discovery that Mr. O'Brien was on the agenda. Whereas, you certainly received an e-mail?

A. I did.
556 Q. Or it appears you received an e-mail suggesting that an MHPS for Mr. O'Brien was at least a possibility.
A. A possibility, yes. And all I can say to you is I don't really remember touching base after the governance meeting. I can only tell the truth. 16:09
557 Q. Yes.
A. I can't remember -- I can remember when this whole thing, as they talk about, the alarm bells started to ring and they rang for me in this meeting. 16:09
558 Q. In what sense?
A. Because I read -- I started to read the screening report and everything that was on it and thinking to myself, gosh, you know, Heather and Eamon said they were going to be dealing with this in March. There was a lot of things went through my mind at that meeting, Mr. Wolfe, so... 16:09
559 Q. What were those alarm bells saying to you? Was it: We have failed to deal with this? Was it: This is more serious than I anticipated or can I put a third option to you: I don't like the way this meeting is going? 16:10
A. Well, I neither liked nor disliked it. It was a meeting, there was an agenda, and that was that. For me, it was really about the patients. For goodness sake, we need to get these -- that was it, patients -- you know, I didn't mind who wrote what and who -- you know I went to the school of very hard knocks in certain trusts, but it was the patients. 16:10
560 Q. Okay.

A. I'm okay, just keep going.
561 Q. Take your time.
A. You keep going, honestly, I'm fine.
562 Q. And we will take a break if you want.
A. No, no. We'll be here all night. Please keep going, just ignore them, ignore the tears. Well, you go on ahead! 16:10
563 Q. Before we get to the screening report and the meeting, just another extract from your witness statement and maybe you can help me understand it. I think it's -- yes, just below, paragraph 11. It says: "The concerns had been escalated to the CE". Is that the Chief Executive? 16:11
A. That's the Chief Executive, yeah.
564 Q. Yes. "...before I knew the extent of the problem or that Aidan O'Brien was going to be discussed at an oversight meeting." 16:11
A. Yeah.
565 Q. "Simon Gibson had provided a screening report with recommendations in the conclusion even before the Oversight Committee met. The matter escalated formally after the Oversight Committee meeting. The Chief Executive would have been kept appraised of all matters thereafter by the Oversight Committee generally and the Director of HR." 16:11 16:12

A. Yes.
566 Q. So help me with this because I think we're a little

unsighted on the process here.

A. Okay.

567 Q. You say the concerns had gone to the CE, the Chief Executive, before you knew the extent of the problem. So if we can just maybe think about this in date terms. 16:12

A. Yes.

568 Q. 13th September is the oversight meeting.

A. Yes.

569 Q. Francis Rice was the Chief Executive?

A. Yes, he was. 16:12

570 Q. What is your source of knowledge for thinking that this matter has reached the Chief Executive before it gets to the Oversight Committee?

A. Well, at the Oversight Committee they were saying that the Chief Executive already knew about this and that he 16:12 had -- I mean, I would need to see the minutes but that he had sort of tasked Richard Wright with taking it forward. That's why -- well, I'll tell you about that. I phoned Francis and Richard the next day, so I knew that Francis was aware of it. 16:13

571 Q. Yes, okay. We'll look at perhaps the Trust guidelines, which has a provision for the Chief Executive becoming involved. We'll look at that in a moment. But you're saying that escalated to the CE before you knew the extent of the problem. Is it not fair to say that you 16:13 knew the extent of the problem even before you got the screening report?

A. I believe it's fair to say that I knew about the problem but not the extent of it.

572 Q. So if I could just then, before we formally enter the meeting, I suppose, look at the Trust guidelines. If you can -- the first page for them -- I'll just go to the first page so you can orientate yourself. TRU-83685. I think you told us earlier that they were available to you on the Trust Internet? 16:14

A. Yes, they would have been.

573 Q. If we go to TRU-83688. If we just scroll down a little, please, and stop there. It says that: 16:15

"Concerns that may require management under the MHPS Framework must be registered with the Chief Executive. The Clinical Manager will be responsible for informing the relevant Operational Director." 16:15

There's two points there. This might have been in the mind of whoever informed the Chief Executive.

A. Yes.

574 Q. There had been an issue raised which may require management under MHPS. 16:15

A. Yes.

575 Q. "The Clinical Manager would be responsible for informing it the relevant Operational Director." You were the relevant Operational Director, nobody informed you? 16:16

A. No.

576 Q. In fact, as we read on: "The Clinical Manager", at 2.4, "will immediately undertake a initial verification of the issues raised. The Clinical Manager must seek

advice within Employment Engagement and Relations Department."

You received a screening report, and we'll look at that? 16:16

A. With the agenda. Yes.

577 Q. Yes. It was conducted by Mr. Gibson.

A. That's right.

578 Q. Plainly not a Clinical Manager.

A. No. 16:16

579 Q. Now you appreciated that he was the author of that report, acting under the instructions of the Medical Director?

A. Mm-hmm.

580 Q. Did anybody at any time point out to those gathered around the table at the Oversight Committee that; We've missed a stroke here. The rules of the game, if you like, provide for clinical management input at this stage rather than being led by a nonclinical manager? 16:16

A. The answer to that question is no, nobody did. Plus also -- I mean, I've read this since, of course, in my pack, but I wouldn't have read that in advance of the meeting. But it's just to say to you that, respectfully, Simon Gibson nearly ran the whole thing from the point of view of the Chief Executive's office. Whether he did it under his guidance or whether he just took, respectfully, the ball and ran the whole way up the pitch with it, it seems that that's what he did. So nobody said round the table -- I always challenged 16:17 16:17

Simon, but then I got to the point where I didn't.

581 Q. Okay. In terms of the absence of clinical management at this Oversight Committee meeting, looking back at the issue do you think that was a problem?

A. Yes, I do. Very much so. It's why I contacted the AMD as soon as I went up, because one of the things that you'll find in Health and Social Care nowadays is that there's an awful lot of bureaucracy in it. There's an awful lot of people dish -- the way I looked at it, it was like those blind trying to lead those with 20-20 vision. The people who really knew what should have been happening were the people on the ground. It was always the case with everything. They had the solutions. They always did. But there was a tendency for the bureaucracy in the organisation to just run away with the thing and come up with -- I mean at that meeting there was going to be another letter composed. 16:18 16:18 16:19

582 Q. Yes.

A. Here we go again now. Whereas, and I'm probably jumping on, so I'll wait. 16:19

583 Q. Okay. The structure within the guidelines that you have up in front of you --

A. Yes.

584 Q. -- provide for a Clinical Manager to carry out a preliminary investigation if that's indicates that MHPS -- 16:19

A. Yes.

585 Q. -- might be an issue. The Chief Executive is informed, and then the decision of the Clinical Manager is

notified to the Oversight Committee --

A. Yes.

586 Q. -- which has, as it describes in this document, as a quality control function.

A. Yes. 16:20

587 Q. As opposed to a decision making function.

A. Yes.

588 Q. Did you appreciate that at the time? This Oversight Committee made the decision, as we'll see, to have an informal MHPS investigation as opposed to the Clinical 16:20 Manager.

A. Yes. But, again, that's why I tell you that I tried very hard to bring it back to operational level to have it sorted. Yes, I did appreciate it, is the answer to your question. 16:20

589 Q. Okay. Let's look at the screening report then. You said you read that at the meeting --

A. Yes. Well en route.

590 Q. As best you could?

A. Yes. 16:20

591 Q. It's to be found at TRU-257627. Sorry, it's not. It's TRU-251423. It set out, under a series of issues, Mrs. Gishkori, obviously we don't have the time to go through it. Un-triaged patients, that problem is described and the numbers given, 253 un-triaged 16:21 letters.

A. Yes.

592 Q. No plan received from Mr. O'Brien.

A. Mm-hmm.

593 Q. Some of those letters, 174, dating back 18 weeks. Alarm bells were starting to ring --

A. Absolutely. Yes.

594 Q. -- when you saw those figures?

A. It did. 16:22

595 Q. That was because of concerns about the impact on patients?

A. Absolutely. And nothing else.

596 Q. Outpatient review backlog.

A. Yes. 16:22

597 Q. Scrolling down. It's described -- you made the point earlier that the letter to Mr. O'Brien referred to a separate oncological review list that Mr. O'Brien seemed to retain.

A. That`s right. 16:22

598 Q. That wasn't mentioned here. Was that your point?

A. That's the point I was trying to make. I didn't see it. I could be wrong.

599 Q. Did you think that significant when you picked up on that point? 16:22

A. Well --

600 Q. I take it you only picked up upon it in preparation for this?

A. Of course. In preparation for this and I found it very significant. If you talk about oncology at all, you're 16:22 talking about patients who have either a very small window of opportunity to be treated and, do you know, even if it's oncology and the patient has secondaries or on a terminal pathway, what about keeping them

comfortable? What about giving them the best option that there is? It just blows my mind to think that patients wouldn't be cared for. That's when I really do lose it, to tell you the truth. But I didn't see this oncology -- even though at a point Mr. O'Brien goes into some sort of big specific convoluted explanation of it, but anyway, for me, to be very simple, I just wanted this sorted as quick as possible. Really. 16:23

601 Q. Then it refers to patient notes at home. We needn't dwell on that. The fact that incident reporting had been used as a method of logging this in the past, that was no longer done. Do you have any view on whether notes at home and the discovery that notes are at home and can't be accessed within the hospital; is that something that should have been recorded as an incident? 16:23 16:24

A. Yes, of course, because, you know, it breaches the Data Protection Act, whatever other -- and Richard was the Responsible Officer for data protection. This is a problem that has been ongoing for a very, very, very many -- I would imagine it was custom and practice years ago. I can remember doctors taking charts home to write notes in and taking them back, long before the legislation came in. When I saw that, even though I was alarmed, I wasn't surprised. But on PAS -- it was hard to know until you'd lost a chart whether it was lost. Do you know what I mean? Until a chart came up that you couldn't find it. I'm not sure if I'm 16:24 16:24

putting that right or not.

602 Q. The fourth issue that's raised is in respect of the recording and the dictation of patient outcomes --

A. Yes.

603 Q. -- following clinical engagements. There had been no formal audit by this stage? 16:25

A. No.

604 Q. Together, I think you're saying, these issues caused you concern?

A. Yes. 16:25

605 Q. Just to scroll to the bottom of the page then. The conclusion reached by, as it appears, Mr. Gibson, is that there's a need for, or he recommends an NCAS supported external assessment of Dr. O'Brien's organisational practice, with Terms of Reference centred on whether there's a risk of patients coming to harm. 16:25

Did you pick up on that recommendation at any point in your thinking at that meeting? 16:26

A. I knew that Richard did make referral to NCAS, as you call it -- I just call it NCAS -- just previously or just after it. As far as I was -- I knew the NCAS flowchart fairly well. Normally what they say is try to resolve this at the lowest possible level. Don't start being convoluted about it if you can get it sorted there and then very quickly with good governance around it so that you can get it done. But Simon made whatever recommendations he wanted, really. 16:26

606 Q. It doesn't appear that that recommendation was accepted at the subsequent Oversight Meeting.

A. Right.

607 Q. Let's look at that now. The Oversight Meeting, as we know, took place on the 13th. If we go to TRU-00026. This is the record of the Aidan O'Brien discussion. By this stage Mr. Gibson had spoken to NCAS and he had received oral advice which was to be committed to writing, was received -- it was dated that day and it wasn't received before the meeting. 16:27 16:28

A. Okay.

608 Q. But it was subsequently shared with you and others.

A. Yes.

609 Q. Do you have a recollection of the NCAS advice being related to the meeting by Mr. Gibson? 16:28

A. Yes, I think so. Did they talk about audit? To audit his practice? I think they said, basically that, you know, we should work together with the clinician to produce the most positive outcome and as soon as possible, I think. More or less they were in that -- and to keep them informed. Yes, I remember seeing the letter, but just now I can't -- 16:28

610 Q. Maybe if we get the chance we'll go to the advice letter.

A. Yes. 16:28

611 Q. You do have a firm memory of advice being related to the meeting?

A. Yes.

612 Q. The outcome of this --

CHAIR: Just to be clear, Mrs. Gishkori, I think there may be some confusion here. Do you remember the advice -- the telephone call being spoken about at the meeting before you saw the letter?

A. No, I don't remember the telephone call being talked about, but I remember seeing the e-mail when NCAS produced the e-mail. Sorry, that was my fault. Sorry. 16:29

613 Q. MR. WOLFE KC: What I was specifically putting to you was this. The written advice from Dr. Fitzpatrick didn't arrive before the meeting? 16:29

A. Yes.

614 Q. It was circulated some two weeks later by Mr. Gibson, on the 28th, I think, or 27th September.

A. Okay.

615 Q. Mr. Gibson has told the Inquiry that at the meeting on 13th September he was able to tell you -- 16:29

A. Me?

616 Q. Not you, the whole meeting. He was able to tell the meeting this is what NCAS have advised, and he took the meeting through, he believes, three or four points that NCAS had mentioned, including, as you point out, the need for an audit of an aspect of Mr. O'Brien's work. 16:30

A. Was it in the minutes? I didn't --

617 Q. It's not in the minutes, that's why I'm asking you. Do you have a memory of the advice or any reference to contact with NCAS being discussed at this meeting? 16:30

A. I'm sorry, I don't.

618 Q. You can't.

A. No.

619 Q. The upshot of the meeting, as we can see in the bullet points, is that Mr. Gibson got the letter which Weir and Carroll would present to Mr. O'Brien at a meeting which would take place within the week or within the fortnight. The letter should inform Mr. O'Brien of the Trust's intention to proceed with an informal investigation under MHPS and it also include action plan with a four-week time scale to address the four main areas of his practice that are causing concern. You, Esther Gishkori, are to go through the letter with Colin Weir, Ronan Carroll and Simon Gibson prior to the meeting, and Mr. O'Brien should be informed that a formal investigation may be commenced if sufficient progress has not been made within the four weeks. 16:30 16:31

Is that a fair record of what was agreed at that meeting?

A. That's what they said, but I thought it was an informal. I think Richard -- maybe I could be wrong. The very last point I felt -- 16:31

620 Q. If you go up to the third bullet point. This letter should inform AOB of the Trust's intention to proceed with an informal.

A. Informal, yes. Of course, I understand.

621 Q. If he doesn't meet the target, a formal investigation would be contemplated? 16:32

A. Yes. Sorry about that, yes.

622 Q. Does that square with your memory?

A. It does.

623 Q. Were you part of the consensus at that meeting that agreed that was the way to go forward?
A. Yes.
624 Q. You paused and thought long and hard about that?
A. Yes, it is a pause. Because I'm sitting there thinking to myself: what happened after the March letter? Where are we with that? Are these dictations still sitting somewhere, you know, from a clinic? Nobody else can do the dictation, only the person who saw the patient. I'm thinking here we are now going to send another letter. How are we going to do that? In my mind I'm thinking, 'but Charlie McAllister told me that he and Colin Weir, who was the CD, were considering ways to deal with it'. That's what I was thinking. But I wasn't brave enough at the meeting to say all of that. Because, I suppose in some ways I wanted to go up and check my e-mails to see had I had an e-mail saying, you know, between March and now. I just still felt that it should be informal as well. You can move on because it's the next bit, I suppose I'm going to say to you now. 16:32 16:32 16:33 16:33
625 Q. Just finish your answer as you wish to answer, Mrs. Gishkori. There's no structure to this particularly.
A. Okay. So I didn't really agree with this particular course of action because I still felt at this point there had been no indication that this man couldn't do his work. No indication of -- as we knew at this point of an incident, an accident, an SAI, any complaints 16:34

even. So I felt he should be made, just as his other colleagues do, I felt he should be made by the CD and the AMD to do it. And I felt it was their job to do. Yes, Martina could have helped, you know, but I wanted to get out of the room and go and find Charlie McAllister and find out what was going on. Honestly.

626 Q. So what did you think was missing? I take your point that you didn't feel brave enough to articulate your real feelings about it. What did you think was missing from this plan of attack? 16:34 16:35

A. So what was going to be in the letter that Simon was going to compose?

627 Q. Sorry?

A. So Mr. Gibson was going to write a letter. What was going to be in that letter? 16:35

628 Q. Yes.

A. Was it appropriate that he wrote the letter?

629 Q. But he was going to be writing the letter and setting out detail on it and you were going to approve it?

A. I just feel that informally -- 16:35

630 Q. What was wrong with this approach?

A. Well, there was still a big bit in relation to the informal process of MHPS. So the Clinical Manager, as you have already said, should be the one who establishes the facts. That didn't happen. Consider 16:36 consultation with the Director HR NCAS, which they did. But then the next bit down is remedial action, i.e. local action plans, which I felt that a local action plan should be, and with the local team as opposed to

Mr. O'Brien getting another letter that now he knew everybody else knew and if he went off sick, what would we do? If he walked out the door, what would we do? How could we get all these dictated. So I wanted to sort it so that the solution involved him. 16:36

631 Q. The solution was going to involve him, was it not, under this approach?

A. Well....

632 Q. And we'll look at the letter in a moment.

A. Yeah, yeah. 16:36

633 Q. But was your problem with the decision that it was going to not only involve a time-tabled requirement for Mr. O'Brien to comply with the requisite standards and clear up the backlog, but was your concern that they were adding onto it an MHPS investigation? 16:37

A. I think my concern was that, clearly, it hadn't been dealt with by the CD and the AMD, and that's where I felt, before we start to send out an informal letter that says you may be excluded -- you know, what it said before, I just wanted it to be dealt with at the lowest possible -- 16:37

634 Q. Let's pull up the letter that was sent to you.

A. Okay.

635 Q. TRU-251429. This is the e-mail that was sent to you, then we go to the letter. It's drafted very quickly after the meeting. 16:37

A. Yes, it is.

636 Q. You are specifically engaged by the content of this.

A. Yes.

637 Q. Mr. Gibson is saying that we've set a target of 70 per month. That is presumably 70 cases every month until the end of December with a view to dealing with the outpatient review backlog. He's saying to you, operationally this is your call. 16:38

A. Mm-hmm.

638 Q. First of all, let's go to the letter. Scroll down the page, please. Did you read the letter when it was sent to you?

A. This letter, yes. It was sent in a draft form. 16:38

639 Q. Yes.

A. Yes. Yes.

640 Q. Did you read it before you went out the next day to meet with Messrs McAllister and Weir?

A. Very possibly. 16:39

641 Q. Yes.

A. Although I don't know, but it came out very soon after the meeting.

642 Q. Yes. It's telling Mr. O'Brien, although, of course, it was never sent, that it's the Trust's intention to 16:39 proceed with an investigation under MHPS. At this stage it will take an informal approach, as outlined within MHPS, but following the outcome of this they may proceed or we may proceed with a formal investigation.

16:39

The informal approach -- skipping the next paragraph -- will consider four areas of his practice and be time bound as indicated below. Each of the areas, un-triaged letters, outpatient review backlog, patient

notes at home, and recording of outcomes, which is to be the subject of 20 sets of notes per month audit.

A. Mm-hmm.

643 Q. He is then told in late October:

"There would be an assessment of your progress against the targets and if there's insufficient progress, this may give rise to a formal investigation". 16:40

The history of this, Mrs. Gishkori, was of informal efforts to address the problems with Mr. O'Brien. If you read the screening report, for example, you would have seen reference to those informal efforts which, over a period of several years, well before your time, had not worked. Here was a rigid time-tabled, targeted plan, but you did not want to use this? 16:40 16:40

A. Can I see the date of that letter, if you don't mind?

644 Q. It's dated 21st September but it was sent on the 13th with a view to it being sent in advance of the meeting with Mr. O'Brien, which was planned for week commencing 19th September. 16:41

A. Okay. Yes. I still think that I'd said -- because we do know that Mr. O'Brien got wind of what Charlie and Colin were going to do and eventually started to go -- he went off sick in -- sorry, let me just go back to what you've asked me, then we'll move on. 16:41

Again here we were with a letter that said, okay, this is informal. After a certain date we're going to make

it formal. You could be excluded. What I knew about him up until --

645 Q. It doesn't mention that.

A. No, it doesn't mention excluded. It said it could be formal. Sorry, can you put it back down? Sorry, I can't. 16:42

646 Q. Do you want to go to the top of the letter?

A. Yes, please. Sorry. Sorry. Thank you.

647 Q. Okay. Is that good for you?

A. Yes. Thank you. Yes. It says: 16:42

"We will be taking an informal approach as outlined within MHPS, but following the outcome of this we may proceed with a formal investigation. The investigation should be seen in the context of the letter written to you on the 23rd where a number of concerns were raised, no plan was provided at that time and concerns still exist". 16:43

Yes, those four areas. Yes, okay. That's fine. 16:43

648 Q. Your concern about that letter was what?

A. My concern about the letter was really just that if I now went by what everybody was saying about Mr. O'Brien, he wouldn't respond very well to someone saying, 'and if this doesn't go well, we're going to be taking a formal approach'. In my mind I was really very concerned about getting his dictations done, number one. 16:43

649 Q. Yes.

A. And who was going to do these.
650 Q. Sorry to cut across you. If you start with the problem.
A. Yes.
651 Q. The problem is these four areas of practice. 16:43
A. Yes.
652 Q. You have indicated to us that as long ago as March you appreciated at least some of those problems as Patient Safety concerns.
A. Yes. 16:44
653 Q. That really rang as an alarm bell when you saw the granular detail --
A. Of it.
654 Q. -- in the screening report?
A. Yes. 16:44
655 Q. Those are the problems that you wish resolved?
A. Yes.
656 Q. Here is a letter which is going to be accompanied with a meeting with Mr. O'Brien setting out a time-tabled call to action. 16:44
A. Mm-hmm.
657 Q. You didn't like this. Why not?
A. It's not that I didn't like it at all, it's just that I felt because I thought he would react better to his own clinical colleagues working with him without 16:44 a letter going out to him. It just was the fact that we were sending another letter, basically. I really had hoped -- that's why I didn't say anything in the meeting, because I really had hoped it would be dealt

with at operational level still. In my mind, may be naive that I was, but I still felt.

658 Q. Notwithstanding the history, you thought it would be better with a clinical level or operational level, Mr. Weir or Mr. McAllister going to him? 16:45

A. Yes.

659 Q. Is that why you approached those two gentlemen the next day?

A. Yes.

660 Q. The next day, 14th September, did you take the initiative of approaching them? 16:45

A. Yes, I did. There must have been a meeting on my floor. You know, my Secretary would have phoned Charlie's secretary and she set Louise up with a meeting or whatever. I think Ronan might have been there too. I remember speaking to Colin at one point but I definitely, definitely spoke to Charlie McAllister who was my direct line that day, and I called him into my office. 16:46

661 Q. Yes. Within the Section 21 statement we've asked you about how you were to relate to certain people in the MHPS process, including the Medical Director? 16:46

A. Yes.

662 Q. You said at WIT-23408 that, as far as the Medical Director -- just at V here. So far as the Medical Director was concerned, your role was to support and respect his decisions on the Oversight Committee. 16:46

A. Yes.

663 Q. You were going to Mr. McAllister and Mr. Weir with

a view to obtaining an alternative view on what had been decided?

A. Yes, I still --

664 Q. -- by the Oversight Committee?

A. Yes, I still respected him and I still -- I mean you can challenge someone still respectfully, which is what I feel I did, both him and Richard -- sorry, Francis Rice. 16:47

665 Q. But you weren't supporting the decision of the Oversight Committee as you suggest is your obligation? 16:47

A. Well, I wasn't -- I respected it but I challenged it, let's just say, as I suppose was my right to do in the meeting. I told you before that for various reasons, I just wasn't that brave to do that and I wanted to check all my facts when I got back up to the office. 16:47 But, you know, I phoned Richard and asked him respectfully, because Charlie and Colin felt it would take three calender months to resolve the whole thing. That's what they felt. Although Simon felt it would take shorter times for some of the things, but that's, 16:48 I suppose, neither here nor there.

666 Q. So your witness statement, let's go to WIT-23409 and just scroll down to (iii). Thank you. You say:

"Following the Oversight Committee, I immediately spoke 16:48 to Charlie McAllister and Colin Weir. Ronan Carroll was also present at the meeting. As both of these individuals were line managers to Aidan O'Brien, I wanted to confirm what information they held in

relation to the problems that I had just been informed of. Charlie informed me that he had received one e-mail from Simon."

That was the request in August, wasn't it, as to whether Charlie had received any of the plans from O'Brien? 16:49

A. Any of the plans from Mr. O'Brien, yes.

667 Q. Charlie suggested a resolution to the problem, which you have outlined further at paragraph 8 above, and that solution was? 16:49

A. The solution was that Mr. O'Brien, who really loved theatre, his theatre sessions and liked being in theatre, Charlie said all that they would have to do to resolve it would be to remove him from his theatre sessions until such times as he had caught up with his admin duties. He said that he and Colin had already looked into it. I don't know if they had spoken to his colleagues, I'm not sure, but he said that it was perfectly doable and he felt that they could do it, it would be safe, effective, and they could do it within three calendar months, he told me. 16:49 16:50

668 Q. Did he see that as a sanction or did he see it as a form of assistance to Mr. O'Brien?

A. Gosh, I would have thought a form of assistance for me and Mr. O'Brien. Like, at the end of the day, it doesn't matter who it was, the patients were right in the middle of this. 16:50

669 Q. Yes.

A. You know. If Mr. O'Brien was assisted in the process, that's fine, but for me, the patients came first and I wanted this thing sorted just as soon as was possible for the patients' sake.

670 Q. Yes. If we go to WIT-23373, please. Just at the top of the page. Again, another perspective on why you approached Weir and McAllister. 16:50

A. Yes.

671 Q. You say:

16:51

"Sensing real and meaningful remedial action was necessary."

A. Yes.

672 Q. You spoke with them and asked if they could suggest an official solution to address Mr. O'Brien's issues with administration and: 16:51

"Being an anaesthetist and having worked in theatre for a long time with Mr. O'Brien, Dr. McAllister said he was almost certain that if Mr. O'Brien was relieved of his theatre lists, until his administration was up to date, he would soon catch up. Mr. O'Brien loved the operating theatre. I understand that he would be prepared to spend all day and into the evening there if he could. If someone else did his lists, he would consider this intolerable and both clinicians thought it would take three calender months to rectify." 16:51 16:51

A. Yes

673 Q. So it was viewed as a form of assistance, he loved theatre so much, he would be unhappy being away from it and he would catch up quickly. Was that the thinking?

A. Yes. You know, I think everybody believed that Mr. O'Brien could do this. I think everybody believed that, you know, he just chose not to do some of his admin. So, I mean, it wasn't a sanction per se but it was a step that was needed in order to resolve a problem. 16:52

674 Q. Yes. Now at this meeting with Weir and McAllister, did you tell them about what had been decided at Oversight? 16:52

A. Yes, I did.

675 Q. Did you tell them that an informal MHPS investigation --

A. Was going to be underway, and I told him there was going to be a letter and that, you know, they were going to set out a template for him to follow, etcetera, yes. I told them about it. Yes, they knew. 16:52

676 Q. Did you tell them that Dr. Wright wished to have Mr. O'Brien excluded? 16:53

A. No, I don't think so. Gosh, no.

677 Q. A moment ago you thought that the letter could --

A. Yes.

678 Q. -- for exclusion?

A. That was -- 16:53

679 Q. Mr. McAllister, I think, has told the Inquiry that you told him that Dr. Wright wished to have or was prepared to have Mr. O'Brien excluded.

A. It was probably discussed at the meeting but, you know,

just in a general terms of discussion, I think, although it's not in the minutes. But I don't know where else I would have got that from. I certainly, even though he was the excluded in the end, it must have been discussed at a point somewhere. Sorry, I don't know where.

680 Q. It wasn't any part of the Oversight Committee's decision to exclude him?

A. No. No, it wasn't.

681 Q. Apart from this plan that was being talked through to remove Mr. O'Brien from his theatre responsibilities, was there any other detail discussed at that meeting about how to carry this forward? 16:54

A. Yes. From what I remember, I think Mr. O'Brien's job plan was due. Yes, job plan. He hadn't had his job plan, and that this was a really good opportunity for Mr. Weir to do his job plan and to discuss the things that we had discussed. Because in a job plan it probably would have been accepted it was going to be -- Colin said he would do it in a nonconfrontational, supportive way, and that they would reach, you know, a mutual decision. That was all part of the conversation. It wasn't just, we're going to exclude him from theatre, that's it, thanks, go. Colin said, I think it was in an e-mail a few days later from Colin that he was going to do it in a supportive way. 16:55 16:55

682 Q. Just finally with this meeting. Can you help us to understand why, emerging from that meeting, you took the view that you would be telling Dr. Wright, 'I don't

wish any longer to support the Oversight Group, the Oversight Committee decision'?

A. I don't think I said I don't wish to support it. What I did was I phoned Richard. I was to have a meeting with Richard and Francis Rice about something else very soon after that. I said to them, and then there was an e-mail I sent, I sent as well. I said respectfully, could we. I asked him if it would be possible for us in Acute to deal with this issue at an operational level. I've spoken to Charlie and Colin Weir, they feel they could resolve the problem in three calender months and would you consider letting us have a go at this? Then the Chief Executive, Francis Rice was brought in as well. His opinion, he said, 'yes, I will let you do this, but no more than three months. At the end of three months, if no progress has been made, then I suppose it was going to go to formal. I don't know. He just said we in Acute would be given no more than three calender months to sort it. 16:56 16:56 16:57 16:57

683 Q. Just to summarise, the Oversight Group plan wanted things resolved against a timetable? 16:57

A. Yes.

684 Q. He was going to be met with, there was going to be an informal MHPS?

A. Yes. 16:57

685 Q. But you left the meeting with McAllister and Weir with a plan to remove him from Theatre?

A. No, they weren't at the meeting, McAllister and Weir.

686 Q. No, the meeting you had with them?

A. Yes.
687 Q. You thought that was going to be a more efficacious and more likely to be fruitful in delivering a solution?
A. I honestly did. I honestly believed in my heart, you know, it made sense. 16:58
688 Q. Was any part of the thinking around this 'Mr. O'Brien and his reputation, and we need to protect him from adverse publicity, perhaps, associated with an MHPS investigation'? Was that part of what was driving this? 16:58
A. I wouldn't say protect him, no. I wouldn't have protected anybody where there was Patient Safety issues. I suppose it would have been a win -- the way I was looking at it, and bearing in mind I didn't know Mr. O'Brien from Adam. I didn't know the man at all, 16:59 but everybody else had told me, even in somebody Neta Chada's report, the patients loved him, everybody thought he was great. He set up the Service himself. He was part of -- he set the Service up. So I'm thinking, well -- and he also was a viable part of the 16:59 team, albeit in Theatre all day long. But, however, he was still very much needed and, don't forget, Urology was in an absolute dire straits in Northern Ireland. Mark Haynes one of our consultants had to go to Belfast on a Friday. Just so -- so all that was in my mind. 16:59
689 Q. Did you have a fear that if the informal MHPS group was adopted that Mr. O'Brien would walk away?
A. I did. I did. I honestly did.
690 Q. And that would impact the Service.

A. Yes.

MR. WOLFE KC: Okay, it's coming up to five o'clock.

CHAIR: I think that's where we'll call it quits for today.

MR. WOLFE KC: Yes. 17:00

CHAIR: I'm sure Mrs. Gishkori will be glad of a break. We will see her again but --.

MR. WOLFE KC: Can we leave it that the Inquiry will consider and liaise with Arthur Cox --

CHAIR: Okay. I'm sorry we can't give you a date today, Mrs. Gishkori. 17:00

A. That's okay. Thank you very much. I don't do very much these days.

CHAIR: We will get back to you before too long.

17:00

THE INQUIRY ADJOURNED TO TUESDAY, 28TH FEBRUARY 2023 AT 10:00