Urology Services Inquiry

Oral Hearing

Day 28 – Wednesday, 1st March 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

INDEX

	PAGE
Mrs. Vivienne Toal, sworn Examined by Mr. Wolfe KC	3
Lunch adjournment	78
Mrs. Vivienne Toal Examined by Mr. Wolfe KC (Cont'd)	79

THE INQUIRY RESUMED ON WEDNESDAY, 1ST MARCH 2023 AS FOLLOWS:

CHAIR: Good morning, everyone.

10:00

Mr. Wolfe.

MR. WOLFE KC: Good morning, Chair. Your witness this morning is Ms. Vivienne Toal. I think she wishes to be sworn.

10:00

MRS. VIVIENNE TOAL, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS:

1 Q. MR. WOLFE KC: It's Mrs. Toal?

A. It is, yes. 10:01

2 Q. Good morning, Mrs. Toal.

A. Good morning.

3 Q. Thank you for coming to the Inquiry to give evidence. In advance of today you have provided the Inquiry with a Section 21 statement, which is 49 of 22. If you 10:01 could just look at the cover page and the last page. WIT-41007. You're familiar with that. You can see the legend in the top right-hand is telling us that an addendum witness statement was received by the Inquiry, and I'll come to that in a moment. You're familiar 10:02 with that. That's your first witness statement?

A. Yes, that's right.

4 Q. We'll go to the last page, WIT-41148. The page numbering tells us that it is a substantial piece of

work. It runs to some 150 pages or so. We can see, if we scroll down, your signature, dated 25th July 2022.

Would you like to adopt that witness statement, subject to the changes in your addendum, as part of your evidence to the Inquiry?

A. Yes, please.

5 Q. Then the addendum, which came into us on Monday morning. It's dated 24th February of this year. WIT-91883. You recognise that? 10:03

A. Yes, I do.

6 Q. The signature is at 86 in that sequence, 91886. You recognise that's your signature?

A. Yes.

7 Q. You wish to adopt that as part of your evidence? 10:03

A. Yes, please.

8 Q. This statement deals with a number of things. It makes a number of changes, perhaps minor in nature in a couple of respects, one more significant description of your involvement in another case of a doctor in difficulty. 10:03

A. Yes.

9 Q. It provides some updated material in regard to MHPS training?

A. Yes. 10:04

10 Q. And in regard to how data relating to MHPS investigations is shared with the Trust Board?

A. That's right. That's correct.

11 Q. Those two latter elements are of some significance.

We'll look at those in the course of this afternoon.

You are currently Director of Human Resources and Organisation Development for the Southern Trust; is that correct? 10:04

A. That's correct. Yes.

12 Q. You took up that role on a permanent basis on 21st September 2016?

A. That's correct.

13 Q. It's right in the middle, I suppose, of the Oversight Committee process affecting Mr. O'Brien; isn't that right? 10:04

A. Yes, that's correct. The process commenced when I was Acting.

14 Q. You were Acting Director, if I can just shorten it to HR without injury to your full job title? 10:05

A. That's fine.

15 Q. You were Acting Director of HR from 15th August; isn't that right?

A. That's correct, yes. 10:05

16 Q. You had been employed in what we sometimes refer to as the Legacy Trust. That was one of the legacy Trusts, I suppose, Craigavon Health and Social Services Trust which was to, with other Trusts, morph into the Southern Trust following the review of public administration in Northern Ireland? 10:05

A. Yes, it was like Craigavon Area Hospital Group Trust, yes.

17 Q. You had been employed in that Trust from 1998 and had

held a number of human resources type posts in that Trust?

A. That's correct.

18 Q. If we just pull up your witness statement briefly, in ease of the pen of the Panel members. WIT-41015. We can see that you graduated from Queen's University in 1996 BSc Honours in Business Administration Computer Science, later studied for a postgraduate diploma in Human Resource Management with the University of Ulster. Then scrolling down, you set out those posts, starting as a clerical officer but very quickly moving into specific HR professional roles in the Legacy Trust; isn't that right? 10:06 10:06

A. That's right. Yes.

19 Q. In assuming the Directorship role in September 2016 you succeeded Mr. Kieran Donaghy? 10:07

A. That's correct, yes.

20 Q. Your job description for your present role, which you've now held for seven years, is at WIT-41171. If we pull up one line of what is a fairly detailed description of your role. 10:07

"You will provide specialist HR advice to the Trust Board, share corporate responsibility for the governance of the Trust, and compliance with legal requirements and contribute fully to the development, delivery, and achievement of the Trust's Corporate Plan, which will be responsive to the needs of the population in line with performance targets established 10:08

by the HSCB."

You are at the top of the HR pyramid within the Trust; is that right?

A. Yes. 10:08

21 Q. You lead that Directorate?

A. Yes.

22 Q. You report to the Chief Executive?

A. That's right.

10 23 Q. You attend the Trust Board? 10:08

A. Yes, I'm in attendance, yes.

24 Q. There is, just briefly if we could look at it, a structure or an organigram which relates, I think, to 2016. Maybe you could help us with that. WIT-41185. Yes, that was the picture in 2016 and that's your role 10:09 at the top of the tree?

A. That's right.

25 Q. A number of your staff members were to have some roles in matters that we'll discuss today. Siobhán Hynds, she was your most -- I think you described her as one 10:09 of your most or your most experienced practitioner in the area of working with doctors in difficulty; is that fair?

A. In terms of Siobhán's role in legacy Newry and Mourne Trust she would have had experience with medical 10:09 staff there. I would have said around 2016, however, her experience was in employee relations which was more on the non-medical side. But, yes, prior to that, in legacy days she would have had involvement with medical

staff, yes. In terms of --

26 Q. Just to remind ourselves, she was to be the HR input into the investigation which was led by Dr. Chada?

A. Yes. That's right.

27 Q. Zoe Parks -- we see her name frequently. She had a role in some of the matters we'll be discussing today? 10:10

A. Yes.

28 Q. Where did she -- she sits on the medical staffing side of the division? 10:10

A. That's right. Yes. Our medical staffing service was led, or is led by Zoe Parks. That sat alongside the other Heads of Service roles, so Head of Resourcing, Head of Employee Relations, etcetera, then Zoe would have been Head of Medical Staffing. All medical staffing matters would have gone through the medical staffing side of HR. 10:11

29 Q. It sounds like a fairly specific role by contrast with some of the other HR roles.

A. Yes. 10:11

30 Q. What's within her portfolio?

A. I suppose it's an integrated unit now. I mean certainly when I came into post we tried to bring together all of the aspects of medical staffing so it would include terms and conditions. It would have included the sort of systems management for job planning to support the Medical Director's office. It would have been the employee relations issues. Therefore, MHPS would have come in under that. 10:11 All

contractual issues, resourcing function because the Business Services Organisation did not provide the resourcing function for medical staffing. It sat outside of it, so that comes under Zoe's remit. Also I brought in then our medical locum team in under medical staffing as well. It's a fully integrated unit essentially dealing with all the medical staffing issues.

31 Q. In terms of your role, in addition to HR you have responsibility for the Trust's litigation service? 10:12

A. That's right, yes.

32 Q. That's the full range of litigation, clinical negligence through to public liability?

A. Yes. The operational responsibility lies with me obviously because of the nature of the cases, clinical social care negligence cases there's a really close working relationship with the Medical Director's office. If the interface meetings is to do with the clinical social care negligent cases go through what is now Dr. Austin's office, who is our current Medical Director. So, it's a very close working relationship both with myself as Director of HR for the employer liability cases, etcetera, but also into the Medical Director's office for coroner's cases and the clinical social care negligence cases. 10:13

33 Q. Whistle blowing or raising concerns. If we look at your witness statement to see what you say about that. WIT-41009. You say your remit also includes responsibilities as lead director for raising concerns

under the Trust policy and procedure for raising concerns (whistle blowing) with responsibility for ensuring implementation of the Trust's whistle blowing and arrangements and present bi-annual reports to Governance Committee. You refer to the Trust's 'see something, say something' campaign and your work in relation to that, grow and promote it. What is that campaign and when was it implemented? 10:14

A. We have a regional policy for whistle blowing or raising concerns. It is a policy that has been developed across all HSC organisations, the Department of Health as well led on this piece of work. I just can't quite recall the exact date that the policy came in, but I've had responsibility for this, you know, since I took up post in 2016. Part of what we have been trying to do within Southern Trust is under that campaign around 'see something, say something'. If there is anything that anybody is concerned about, you know, it could be fraudulent matters, it could be Patient Safety matters, any issue, really, that a member of staff would be concerned about, then we encourage people to actually, you know, speak up and raise those concerns. Within the actual policy there will be a number of avenues where individuals could raise those concerns. It could be directly. We encourage directly with line management because that's the quickest and easiest way to try to get something resolved, essentially. But there are other ways, and those are listed in the actual policy. It 10:14 10:15 10:15

could be with me as Director of HR. It could be with the Medical Director. It could be with our Director of Finance if it's a fraudulent related matter, or the Fraud Liaison Officer. There's any number of ways. It also gives individuals options for raising outside of the organisation as other options. Essentially, that's what it is about. If anybody is concerned and they see something, then we encourage them to actually speak up and make sure that those concerns are actually shared with individuals, preferably within the organisation. 10:16

34 Q. Perhaps later today we'll look at some concerns that Mr. O'Brien raised in respect of Patient Safety through his grievance. I want to look at that through the lens than of raising concerns later.

10:17

Could I ask you this? In terms of the issues that have come before this Inquiry, and I know you have been paying close attention to our work, is it fair to say that none of the concerns, whether about Mr. O'Brien's practice or about governance issues in terms of how management have responded to issues or how systems have failed to, perhaps, detect the issues of concern, is it fair to say that none of those kinds of issues have come to you or your part of the system as a raising concern matter or a whistle blowing matter? 10:17

A. That's correct.

35 Q. If it's the case, and obviously we're reasonably immature as an Inquiry in terms of our receipt of evidence, there's more evidence to be received and

we will grow in our understanding of what people knew and what they felt able to say about it. Hopefully this isn't an unfair question. Does it surprise you that more information didn't come into the whistle blowing framework about the concerns that we are now beginning to hear about?

A. I think it shows we have a lot of work to actually do. Does it surprise me? Possibly. I think we were in a situation where so many people knew for so long and, for some reason, those concerns weren't resolved at the earliest possible stage. I think what we have now to do is significantly more work around enabling people to be more comfortable about actually raising concerns. This is a long-term piece of work and it is a journey that we're on to try and ensure that individuals are raising those concerns in the best interests of patient care. It is absolutely an actual journey that we're on around raising that openness, and when there are concerns being raised that people take action. I mean, that is something more down the organisational development side of my role that we absolutely need to pay a significant degree of focus to moving forward.

10:18 10:19 10:19 10:19

36 Q. As we proceed this morning we will come face to face with the notion that it is the Clinical Manager who should take steps within an MHPS process to carry out preliminary enquiries, etcetera.

10:20

A. Yes.

37 Q. That might tell us that it's clinical colleagues, whether management or nonmanagement and, indeed,

nursing colleagues who are best placed to recognise when things aren't going right, when things are going wrong, when there's dangerous risk-taking practice or whatever.

10:20

Thinking back to 2016, and even since that, because these things really come to light ultimately in 2020, how much work was being directed towards nursing and clinicians to apprise them, if you like, of the whistle blowing framework, or other ways of getting concerns into the proper place so they can be actioned?

10:21

A. I think it was dealt with organisationally as opposed to into different staff groups. I think, you know, on reflection what we should have been doing was actually trying to target those different staff groups. The communications would have been going out on a general basis. They would have been a raising concerns week, there would have been a raising concern newsletter, things like that. Back then it was more, I suppose, global communication as opposed to targeted work into those individual areas.

10:21

10:21

I mean, we do have HR business partners that would be aligned to those areas operationally and, I suppose, part of their role would have been to ensure that, you know, policies would have been drawn to the attention of those management teams. But it is fair to say that, from a resource point of view, we didn't have a significant resource, a line to this. So, from that

10:22

perspective we were relying on those sorted of more global communications. I think back then, in terms of, you know, some of the issues around the Mr. O'Brien case, I mean in terms of your question did any of this come to my attention in terms of what we do, what we know now from a whistle blowing perspective, I think back then there was a view, 'well, that's just Mr. O'Brien's way'. Therefore, it seemed sort of -- it got lost. The significance of raising those concerns probably got lost in terms of thinking, 'well, that's just the way he is'. 10:22 10:23

38 Q. Let me turn specifically to the MHPS Framework and spend some time looking at how the local guidelines were developed, just to set this in its fullest context. 10:23

2005 the MHPS Framework was introduced?

A. That's right.

39 Q. 2010 you had a role in, I suppose, overseeing or providing HR commentary into what was to be the development of those local guidelines. Then more recently you've told us, borne out of some lessons learned from the deployment of MHPS and the guidelines to this case, in 2017 some changes were made to the local guidelines; isn't that right? 10:23 10:24

A. That's right.

40 Q. Then, building on that again, there's been work around training for key personnel around MHPS, and you've dealt with that in your addendum statement?

A. That's right.

41 Q. Again, similarly in recent times, new processes for keeping the Board, I think through the Governance Committee --

A. That's correct. 10:24

42 Q. -- apprised of what's going on in any MHPS case. In the course of today we'll probably look at a lot of that.

You tell us in your witness statement that you didn't 10:24 have any formal training on MHPS, either before or after becoming Director of HR; is that right?

A. That's right.

43 Q. I wonder is that a curiosity of being an HR professional, that, as I understand it, the MHPS 10:25 process resides in the HR house, it's owned by that Department; is that right?

A. I think there is a shared responsibility for it, to be honest. I mean, when we look back to 2010 it would have been Dr. Loughran who was the Medical Director at 10:25 that stage who would have been working with Anne Brennan, the senior manager at that point in his office, in terms of trying to look at the development of the Trust guidelines in relation to it. Then I think what happened after that, Mr. Donaghy -- in 10:26 terms of the Director of HR at that stage -- he then asked HR, through Siobhán Hynds and I then, to become involved in looking at that draft and the draft of another individual, Debbie Burns. I think at that

stage it came across into HR and certainly the development of the accompanying guidelines fell within HR. I think that shared responsibility probably is mirrored from a Department of Health point of view, because I think some of the revisions or the planned reviews of MHPS maybe would have started within the Chief Medical Officer's office and then workforce policy or HR lines within the Department of Health then would have had an involvement too. I think, in fairness, it is shared, however in terms of the actual Trust guidelines and working those through, it certainly did come to end up within HROD. 10:26 10:27

44 Q. Why would it be, then, that you wouldn't, as a key HR professional, wouldn't have had any training in the use of MHPS? 10:27

A. I'm not clear that there was training at all for anybody in the organisation prior to 2010. I don't know that, but I don't see any record of training prior to that. Certainly, whenever the guidelines were being developed at that point, Dr. Loughran and Ann Brennan and the Medical Director's office were linking with Dr. Fitzpatrick at that stage from NCAS. I'm not clear what training was provided in the organisation prior to that, if any. 10:27

45 Q. In fact, as we will go on to see -- it's almost ironic -- you were to be part of the team delivering the training on the new guidelines with Dr. Fitzpatrick, we'll see that in the autumn of 2010, in circumstances where, I think everybody agrees that 10:28

there are certain complexities to the MHPS Framework in circumstances where you hadn't had the benefit of training?

A. I think as the years have gone by the complexity, where we have began to understand the complexity of MHPS, possibly not back then. I have to say, it is probably not unusual with maybe like new codes of practice or new legislation, etcetera, that comes in, it is not unusual for HR to not necessarily have specific training on things. We work our way down through new guidance, new legislative responsibilities. You know, we do our own background research, reading, etcetera, but the formality of training might not always be there before we start to develop our own guidance. Certainly it's something I'm very mindful of now, but it wouldn't be completely unusual that that would be the case. 10:28 10:29 10:29

46 Q. Okay. Let's just take a moment to look at the development of the 2010 guidelines and your role in that. Perhaps keeping an eye, in particular, on how the notion of the concept of an Oversight Committee developed. 10:29

Just before we get there, obviously the framework itself had been in place from 2005, and within the framework it provides that there should be a local policy or guideline. 10:30

A. Yes.

47 Q. It takes five years for that development. I know it was Craigavon and other Trusts in 2005, but

Southern Trust forms in 2000 and?

A. Seven.

48 Q. Seven. Is it fair to say that you weren't aware of any local guideline in 2005 after the birth of MHPS?

A. No, I am not aware of any in legacy Trust or Southern Trust. I think when it probably came to light was in 2010. I think the discussions around the Responsible Officer role came in on that date, and I think that's then what, presumably, prompted the conversations within Southern Trust around needing to develop the Trust guidelines. But, no, I don't remember anything prior to that. 10:30 10:31

49 Q. You've told us in your witness statement that Kieran Donaghy, and you've mentioned it already, sent you two review documents, one authored by Anne Brennan, who was, at the time, senior manager in the Medical Director's office? 10:31

A. That's correct.

50 Q. And Debbie Burns, who was Assistant Director in?

A. Performance Improvement, I think, yes. 10:31

51 Q. That's right. You were asked to review that. Let me just pull up Mrs. Burns' paper. Is it fair to say, and I mean no disrespect to Mrs. Brennan's paper, but Mrs. Burns' paper became the kind of prototype or provided the architecture for what was eventually adopted? 10:32

A. Yes, that --

52 Q. Her paper, just to assist you, WIT-41225. The draft, obviously. If we scroll down. We can see at

paragraph 4 about the need for before deciding action is required in relation to poor performance all concerns and reports of potential issues should be screened. If we go to paragraph 5 it explains that a process that's contained within MHPS itself, second bullet point: "An initial verification and assessment of the issues raised should be undertaken by the Clinical Manager of the practitioner", and that is defined as the Clinical Director or Associate Medical Director. 10:33

A. Mm-hmm.

53 Q. "This assessment should be presented to decide on whether an informal or formal investigation is required".

10:33

Then it introduces, at Paragraph 6, the concept of an Oversight Group.

It starts life, as would appear from these tracked changes, as a decision making group. Was it you who came up with the concept of an Oversight Group? 10:33

A. I think Debbie Burns -- and I'm not clear, I cannot recall why Debbie would have been involved in this. I think she worked very closely with Mairéad McAlinden at the time from a performance perspective. It may have been that Mairéad had asked Debbie to try to look at this, but I'm not 100% sure. But it is clear from that document that NCAS -- 10:34

54 Q. Sorry to cut across you, there's other pages, perhaps.

We'll just maybe scroll down.

A. It is clear that it was following the NCAS 2010 document, and within that NCAS guidance I think that come out in January 2010, which was around, you know, local performance investigations, that in primary care -- not secondary care but in primary care there was a reference to a decision making group. That was obviously linked probably to the size of, sort of like, primary care, maybe GP practices, and things like that. I think that is where maybe some of the confusion there has come in because it was in the context of primary care in that particular NCAS document.

55 Q. If we maybe just pause to let the Inquiry see that. The NCAS guide to which you refer is WIT-41399. As you say, the focus is on primary care. This is an NCAS produced document that came in in 2010.

A. That's correct. Yes.

56 Q. If we just scroll down to 41399, we can see you were making the point that when -- you were making the point that when looking at Mrs. Burns' paper and you're seeing the reference to a decision making group or a DMG, you recognise that --

A. Yes.

57 Q. -- as having an origin, perhaps, in this document.

We see here in handling performance concerns in primary care, NCAS suggests the use of a decision making group supported by a professional advisory group with membership suggestions made for both groups in

a primary care organisation using this structure the DMG would usually make the decision to commission a local investigation or take some other action such as referral to the police, etcetera.

10:37

In this text they're putting the function of making the decision in the hands of the DMG and, ultimately, that's not the path that was followed within your guidelines when introducing the concept of the Oversight Group. Can you just explain that for us? 10:38

A. Yes. A lot of discussions -- I wasn't party to the discussions between Dr. Loughran, Mrs. McAlinden, Kieran Donaghy, but my understanding was that when they looked at Debbie's draft and looked at the decision making group, I don't know who would have said, 'well, 10:38 that's for primary care', but there was obviously something about that concept of some sort of overarching tier that those members of the senior management team wanted to incorporate in. I think that's when it was amended then. You'll see in the 10:38 track changes to the Oversight Group. I think that's the origins of it, but I wasn't party necessarily to those group conversations or certainly at senior management team. But I would have been aware that from, emanating from those discussions the preference 10:39 was to have some sort of tier there, and that's why that was incorporated into my draft of the guidance.

58 Q. We will come in a minute to just look at the guidelines, but the concept of an Oversight Group, as

described in your witness statement, WIT-41052, you say:

"I can recall from discussions with Kieran Donaghy" -- just the top of the page -- "that there was a view from the Chief Executive and Directors that a form of oversight arrangement would be needed to assure consistency of approach, and fairness across MHPS processes. Therefore, the concept of the oversight group was included by me in the Trust guidelines which were eventually published on 23rd October." 10:39 10:40

A. That's right.

59 Q. So, it's all your fault!

The concept, as imagined at that time was, almost by definition, a group comprised usually of the Medical Director, somebody from HR, usually the HR Director, and a person from the Service, so the Directorate, usually the Director. 10:40

A. Yes, that's right. 10:40

60 Q. Would, if you like, sit on a tier receiving information from the Clinical Manager who would have a strong view, if not a decision or a recommendation, on which way to take a performance issue, whether informal, formal, or no action required. We'll look at the fine detail. 10:41

A. Mm-hmm.

61 Q. It was the role of the Oversight Group to ensure that that was done in a way that was consistent, fair, transparent. It was a quality control type function as

opposed to an investigatory screening or decision making function?

A. That's how it was envisaged, yes.

62 Q. It appears to have been realised that there was training requirements around this. You go to WIT-41326. You mentioned this earlier. 24th September 2010. 10:41

"The session is designed to provide an opportunity to explore how we handle performance concerns about doctors and dentists". 10:42

To the best of your recollection, is this the first training that the Trust has brought forward in the area of MHPS and the local framework? 10:42

A. It's the first I'm aware of, yes. I can't say for sure there wasn't anything before that, but it's the first I'm aware of.

63 Q. If we just scroll down. Dr. Fitzpatrick from NCAS attends and yourself and Mrs. Hynds do a piece on the guidance you have just written, or probably a better word is to say you contributed to it and overseen its delivery. 10:43

We spoke about training a little bit earlier in the context of what the NCAS guide says and what the MHPS says. It's recognised by MHPS that there are training requirements in this. Maybe if we just pull up the reference. WIT-18534. At the top of the page it says: 10:43

"Employers must ensure that managers and case investigators receive appropriate training in the operation of formal performance procedures. Those undertaking investigations or sitting on disciplinary or appeal panels must have had formal equal opportunities training before undertaking such duties. The Trust Board must agree what training its staff and its members have completed before they can take part in these proceedings." 10:44 10:44

Training is, perhaps, a difficult issue, Mrs. Toal. If you train somebody today because you think possibly maybe they will have a role as a case manager, as case investigator, and then that doesn't come to pass for four or five years, training is pretty useless or pretty redundant by the time he or she is asked to take on the role. Obviously we know with Mr. Weir and Dr. Khan, when they were asked to take up key roles in the O'Brien investigation, they were without training when they were asked, but it appears that training was hurriedly arranged, and I wonder about the quality of training arranged in those circumstances. Can you offer any reflections on that issue? Was a process of rolling training introduced from 2010? Or how was training handled? 10:44 10:45 10:45

A. Again, I think part of the issue back then was when you look at the session with NCAS, that was being led

by the MD's office. I suppose that's why I wasn't entirely concrete with you in terms of where responsibility for MHPS actually lay at that point, because the Medical Director's office was the office dealing with the set-up of the NCAS training at the medical leadership forum. I think they assumed responsibility for it. 10:46

In terms of, then, the training plan associated with MHPS after that, I'm not sure that was terribly concrete either. Certainly when I look at what we have put in place now and approved through our Trust Board, it certainly wasn't that type of training plan at that point in time. When I look back on the various training interventions at points in time, I mean, we would have had DLS training, the Director of Legal Services under BSO, we had some NCAS training, we had training undertaken internally. So, there's probably various training interventions at various points in time. Was it structured in terms of actually sitting down and saying, 'right, this is what we need to ensure that our people are fully conversant'? No. Therefore, I mean you are absolutely right, I think there is an issue with individuals being trained at a point in time. Thankfully these are not -- I mean formal investigations are not something that happen every day and, therefore, by the time you actually maybe come to being asked to be either a case investigator or a case manager, it could be a significant period of time after 10:46 10:46 10:47 10:47

you have been trained. We do then try to ensure that we have an HR individual aligned to them to ensure that, you know, they are kept right in terms of the actual process. Because we recognise that. I mean, we recognise from a clinician's point of view they are dipping in and out of this. It is not their core business on a day and daily basis. So, that is tricky and it is difficult. 10:48

64 Q. We'll look this afternoon in a little bit of detail at the training programme and framework which has been very recently developed, just a few headlines on that. I can see from the documentation that a training plan has been developed for non-Executive Director. 10:48

A. Yes.

65 Q. For Case Investigator, Case Manager, and there's specific training in relation to, I think it is described as low-level concerns? 10:48

A. Yes. Yes.

66 Q. There appears to be four different packages?

A. Yes. 10:49

67 Q. We'll come to that. Just on this issue. I'm a Clinical Director within that job description while it's comparatively rare that there would be an MHPS formal investigation, but I'm a candidate for being either investigator or case manager should a formal investigation arise. 10:49

A. Mm-hmm.

68 Q. I've been to your bespoke training which you have recently developed but, looking five years ahead, I get

my first brief as case manager. How is that problem of gap in training addressed today or how would you go about that?

A. I suppose we now have, in terms of that training plan, a regularity with it, but, from the perspective of working with somebody. Now the HR manager will be sitting down with them and actually going through, you know, what the actual role is, and they will be there at their elbow trying to, you know, make sure they are worked through the actual process and kept right. It is very much in line with making sure the HR case manager is working very closely with them. That's how we try to close that gap. 10:50 10:50

69 Q. In terms of the guidelines, then, that were developed and the relationship with MHPS, you've explained that -- and this is in your witness statement at WIT-41033. The guidelines were intended to sit alongside and be read in conjunction with MHPS. It was never the intention to replace -- 10:51

A. No. 10:51

70 Q. -- MHPS with Trust guidelines.

In terms of your experience of interacting with the guidelines/MHPS by 2016 when you were Acting Director, and then Director, and you came on to the Oversight Committee, you've referred in your witness statement -- and I don't wish to deal with the substance of these cases in any way -- but you've referred in your witness statement and your recent additional statement to, 10:51

I think, 12 cases where you had some involvement with managing performance issues with doctors, and you've explained the MHPS role for you or for others and your familiarity with that. Is it fair to say that by 2016 you had a good working knowledge of the nuts and bolts of this?

A. I think, on reflection, and probably just when you read down through each of the cases that I have included in my Section 21, I would have been involved in various aspects of it. I think, for me, when I got to 2016, had I carried a case through from beginning to end in that sort of HR advisory role, no. But, yes, I would have been involved in various parts of it, of the actual process. But I think there is a difference between that and being asked to do various aspects of it in comparison with I'm carrying a case from beginning to end, and that's the bit that I think is probably the difference for me.

71 Q. The Inquiry Panel will, no doubt, give some consideration to the 12 examples that you have cited. I think they start at WIT-41034, answer 7, for your note, Chair.

Is it fair to say, then, when we looked at those examples you were advising on aspects of each case or performing a task within each case?

A. That's correct.

72 Q. But not sitting as an Oversight Committee member?

A. That's correct, yes. It might have been a screening

report. It just depended what part of the process I was involved in.

73 Q. You've reflected, in terms of your first knowledge of the issues concerning Mr. O'Brien, and you've told us that you first became aware in late August, or perhaps very early September, in a conversation with Dr. Wright that he had concerns about Mr. O'Brien's administrative practices and that he had been made aware of them earlier in the year but the situation had not improved. 10:54

A. That's correct. 10:55

74 Q. You remember him telling you that he was seeking more information as to the extent of the problem and would speak to you again. Was that a kind of typical conversation between Medical Director's office, and it happened to be you as Acting Director at that point, a Medical Director letting you know about issues going on in his domain which could potentially enter your domain? 10:55

A. I suppose that was the first conversation because that was my first time, really -- apart from the brief period of Acting in February -- that's really my first time being in Headquarters. I mean it came to me to know that next door -- you know, our offices were right next door to each other so there were lots of opportunities for those ad hoc, informal conversations. I didn't find it unusual but, certainly, that was probably the first time that he was giving me that information. But, absolutely, I mean it would not be unusual now, even. I mean the Medical Director is 10:55 10:56

still sitting in the office beside me. We have frequent conversations, corridors, in and out of each other's office. That would be typical now.

75 Q. I suppose I'm raising the point in that way just to explore the nature of that relationship? 10:56

A. Yes.

76 Q. Medical Director who is a clinician and a manager?

A. Mm-hmm.

77 Q. Maybe no longer a clinician generally but a clinical background? 10:56

A. Yes.

78 Q. And will have, I suspect in many cases, accumulated some kind of sense of how to do things correctly procedurally, but you're there or the HR office is there, and should be in close working relationship with 10:57 the Medical Director's office, particularly in issues around clinical performance. Is that fair?

A. I think across a range of issues that is fair. I mean, out of all of the corporate, you know, sides of our senior management team, the Medical Director and the HR 10:57 Director are probably the two that would work most closely together. My team, from an HROD perspective, provide a lot of services to the Medical Director's office. There's lots of opportunities for, you know, fairly collaborative close working. So, absolutely, 10:57 that's not unusual.

79 Q. What you're seeming to suggest here is this was a fairly early high level conversation?

A. Absolutely, yes.

80 Q. Not descending into any detail about the further steps that he was taking?
A. No. It certainly wasn't in any detail but it was an early flag that, you know, there is an issue here.
81 Q. No descending into any detail of the historical background to what was -- 10:58
A. Not that I recall. Absolutely not that I recall.
82 Q. You say -- if I can just bring up WIT-41056, at the top of the page. I'm just alluding to that conversation at the very top of the page. You go on to say that: 10:59

"I believe it was during this conversation that Dr. Wright made me aware that Mr. O'Brien was a friend of Mrs. Roberta Brownlee, who was the Chair of the Southern Trust." 10:59

What was the purpose, as you understood it, of communicating that relationship to you?
A. I think -- I mean timing wise this was -- and I know Dr. Wright alluded to it yesterday, the timing of this was linked to the Chair's 60th birthday party. I was a late invite to that, I suppose because I had only just moved into headquarters, but I was also there, along with my husband. My recall of that was -- I mean he was just saying this could be awkward on the basis that Mr. O'Brien had been at the Chair's party. 10:59 11:00
I don't think it was anything more than that. It was just probably flagging that this is going to be potentially awkward.

83 Q. Going to be potentially awkward because Mrs. Brownlee would be expected to have an opinion on this or a view that she might express? I don't wish to push this artificially too far, but to introduce that into a conversation when first telling you about a concern about Mr. O'Brien that might have to be progressed does appear somewhat odd, do you think? 11:00

A. I'm not sure it's odd but, certainly, obviously with the designation of the Board member, the Chair was going to know about it. It's probably unusual that we'd be in a situation where a consultant where there were concerns about would also have been at the Chair's birthday party. It was just that awkwardness. I don't think it was anything more than that. 11:01

84 Q. You go on in your statement here to say you can recall asking Dr. Wright if Francis Rice, then Chief Executive, knew about the concerns. 11:01

A. Mm-hmm.

85 Q. But you can't recall if Dr. Wright said the Chief Executive had already been informed or that this still needed to be done? 11:01

A. Yes.

86 Q. Is that you expressing the concern 'we definitely discussed the need that the Chief Executive be aware'?

A. Yes. 11:02

87 Q. Just help us with why at this stage, which appears to be a preliminary stage, you're not being told too much about it and you don't know what actions are proposed by Dr. Wright, save that he's going to carry out some

further steps. Why does the Chief Executive need to know anything at this point?

A. I mean, I can recall this, and it is linked to the fact that, from Roberta Brownlee's relationship with Aidan O'Brien. It was more or less just to be flagging that the Chief Executive really needed to know about this.

88 Q. The Chair of the Board should stay out of operational matters; isn't that right?

A. Yes.

89 Q. Was there a concern here, when you reflect upon it, that these conversations mentioning her and the need to alert the Chief Executive, was there a concern that she may not stay out of this operational matter?

A. I'm not sure whether that was in the thinking or not. It was just more the, just the awkwardness of the fact that the Chief Executive, the Chair -- sorry, the Chair was friendly with an individual who we had concerns about. I don't recall that I would have known to be concerned at that stage around whether she would get involved in the minutia of the actual detail of a case. I don't think I would have known enough about that at that stage because I was in an Acting post at that point in time. I don't think I would have been thinking along those lines.

90 Q. If it was any other clinician, the Chief Executive wouldn't need to know at this stage, but because it was Mr. O'Brien who had a relationship, a friendship with Mrs. Brownlee, he did need to know, or it was advisable?

A. I think it was a factor, yes. I think it was a factor. It would be wrong of me not to say that it wasn't.

91 Q. Before we look at the working of this particular Oversight Group, can we go to the 2010 guidelines, please, at TRU-83688? We will just work through them. 11:05 2.1 tells us how to conduct a local performance investigation. It should go through a screening process to identify whether an investigation is ultimately needed. It says in 2.2:

11:05

"Concerns should be raised with the practitioner's clinical manager". This will generally be the clinical director, is that how you understand that, or the associate Medical Director?

A. Yes. For example if it had been the Clinical Director 11:06 then the Clinical Manger would have been the Associate Medical Director. So it allowed for both, essentially.

92 Q. If, however, the concern is expressed to the Medical Director, then certain steps should be followed. He should accept and record the concern but not seek or 11:06 receive any significant detail, rather refer the matter to the relevant clinical manager.

I suppose if we apply that to the Mr. O'Brien situation, the concern has come to the Medical 11:07 Director, Dr. Wright, through the previous Associate Medical Director, Mr. Mackle.

A. Mm-hmm.

93 Q. Mr. Mackle has exited the role and it's the Medical

Director in August 2016 making the running on this and he's told you about that. He's told you, 'there's concerns here and I'm taking further steps'.

2.2 tells us that if this guideline is to be followed, he shouldn't be doing that. It should go to the clinical manager. 11:07

A. That's correct.

94 Q. Is that a fair reading of that?

A. It's very fair. Yes. 11:08

95 Q. Do you have any understanding of the science behind that, or the logic behind that? Why should it come out of the hands of the Medical Director, if it comes to him, and into the hands of the Clinical Manager as part of this screening process? 11:08

A. I think the intention, you know, in terms of the drafting of that was that the Clinical Manager will know the operational detail more so than the Medical Director, and then the Medical Director is named within MHPS around the advisory role and to work in support of the implementation of MHPS. I think it was to try to get it down to the lowest possible level in terms of the individual who would have the actual detail. So that was certainly the intention. 11:09

96 Q. Is it, in other words, the clinical manager is better placed to get to a fuller understanding of the issues on the ground? 11:09

A. Yes.

97 Q. Broadly and deeply what are all these issues about,

what's affecting performance?

A. Yes.

98 Q. It goes on at 2.3. Scrolling down.

"Concerns which may require management under the MHPS Framework must be registered with the Chief Executive". 11:09

It's your understanding, and we know that Dr. Wright and Mrs. Gishkori have a meeting with the Chief Executive, so the issues are brought to the attention of the Chief Executive in this case? 11:10

A. Yes. Yes.

99 Q. 2.4: "The Clinical Manager will immediately undertake an initial verification of the issues raised. The Clinical Manager must seek advice from the nominated HR Case Manager." 11:10

Just on that, if we look at what was actually done, Medical Director asks his Assistant Director, Simon Gibson, to carry out a screening investigation. From what we know there wasn't a nominated HR case manager at this point. This process is setting off without HR input directly to Mr. Gibson, albeit you are there at the Medical Director's side. 11:11

It says at 2.5: "The Chief Executive will be responsible for appointing an Oversight Group for the case". 11:11

I suppose that imagines, does it, that a screening report performed under this process by the Clinical Manager needs to be received by the Oversight Group, and we'll look at the flowchart for that. But, it's the role of the Chief Executive anticipating, or perhaps advised, that an MHPS process might be an option, it's his role to appoint the Oversight Group at the appropriate point.

What's your understanding in the O'Brien case, or even more generally, about the role of the Chief Executive in terms of appointing the Oversight Group that sat on 13th September? 11:12

A. I think, according to the guidance, it's a very formal appointment, the way that it is documented there. I suppose in practice the formality around that wasn't as outlined in the actual guidance. Again, I suppose, in terms of the actual conversations between Medical Director and Chief Executive, those, again, would be happening in the same way as the conversations between myself and the Medical Director. There are lots of opportunities on Trust headquarters floor to be able to have those. You know, my understanding, I suppose at that stage was, you know, Dr. Wright had already had the conversation with Francis at that stage, Francis Rice, who would have been the Acting Chief Executive, so therefore we moved to a position where an oversight was put in place. The Oversight, in terms of the membership, it didn't really change at all. It 11:13 11:13

depended on the service, obviously, that the concern was housed in, as such. It was always the Medical Director, it was always me as Director of HR, and then because this was Acute Services, it would have been Esther.

100 Q. I suppose the point in putting some kind of formality around appointing an Oversight Group into the hands of the Chief Executive is that it underscores the need for the Chief Executive to have some knowledge, information, so he or she is apprised of what's going on? 11:14

A. Yes. My understanding is Mr. Rice was aware, and that would have been through a conversation with Dr. Wright.

101 Q. In terms of the process, isn't what I've just said probably right; that in all cases the Chief Executive must know what's going on before an Oversight Group is convened? 11:15

A. Yes. In accordance with MHPS it is all concerns need to be raised with the Chief Executive, so there is an awareness. That's what MHPS states. 11:15

102 Q. You set out, obviously correctly, the typical or prescribed membership of the Oversight Group. The role of the Oversight Group is defined, it is for quality assurance purposes and to assure consistency of approach in respect of the Trust's handling of concerns. That, presumably, was a very deliberate scoping out and limiting of the Oversight Group's role. 11:15

A. Yes.

103 Q. On the other hand, it's the clinical manager, 2.6, as

well as the nominated HR case manager who will be responsible for investigating the concerns raised and assessing what action should be taken in response and the possible action could include, and it's set out there, everything from no action required through formal investigation with or without exclusion or restriction. It says, again:

"The clinical manager and the HR case manager should take advice from other key parties such as NCAS, Occupational Health ... in determining their assessment of action to be taken...." 11:16 11:17

I suspect it is not always necessary to go to Occupational Health, it would depend on the case, would it? 11:17

A. Absolutely. Yes. I think in particular Mr. O'Brien was off at the time whenever the immediate exclusion came into play. So he was off absent. But not in every case would we have to make a referral. Certainly if there was an indication that there was a health issue, there's absolutely no doubt Occupational Health would be involved as a support for the individual, but also to help us guide how we handled, you know, whatever part of the process we were in. Sometimes individuals may not be fit to go through an actual investigatory process, for example, and we might need to seek Occupational Health advice in relation to their fitness to do that. There could be various reasons why 11:17 11:17 11:17

we would go, and some cases we may not.

104 Q. The role of NCAS is written into your guidelines. Also, of course, a parent document, it's written clearly into the MHPS document. Is it fair to say that they are, in all cases -- of course there might be exceptional circumstances -- but generally speaking NCAS and the need for advice from NCAS is an inevitable step in the process, particularly where there's some room for debate and need for clarity on the proper pathway? 11:18 11:19

A. Yes. I would agree with that. Yes.

105 Q. From an HR perspective, what do you see as being the role of NCAS and the importance of the services they offer?

A. I suppose from an advisory perspective, first of all, they are there to help guide. I mean, they have extensive experience right across, particularly England and Northern Ireland in relation to sort of guiding managers, clinical managers through the actual process. I think they are a useful sounding Board. Probably back then maybe we weren't, as an organisation, availing of their advice maybe as much as we should have. I think I certainly see a change in that. That's not to say that we didn't contact them, but I think there probably is an acceptance now of their expertise, maybe more so, and how much support they can provide. That's probably the advisory. Obviously from an assessment point of view there's various aspects of their work. Certainly some of the cases that 11:19 11:19 11:20

I outlined in my witness statement, you know, we would have used the services of NCAS to do the performance assessments, behavioural assessments, all of those sorts of things. I think now, just through experience, probably, just the benefit of having that sounding board, and the more people that actually go through to NCAS and seek their advice, they probably see the actual benefit of that more and more.

106 Q. Can I just pick up on something you said in your statement about the various roles at play, particularly the membership of the Oversight Group. If we go to WIT-41052. At paragraph 11.3 you say: 11:21

"The role, definitions for and responsibilities of the Director of HR, Medical Director and the Operational Director in the Oversight Group were not detailed in Appendix 6. They should have been, and on reflection now, if I had sought to document these responsibilities in Appendix 6, this may have led me to consider in more detail the appropriateness of having an Oversight Group at all as part of the Trust's processes for implementing MHPS. This may subsequently have resulted in me having a discussion with Kieran Donaghy back in 2010 when I was involved in drafting the Trust guidelines." 11:21 11:22 11:22

Let me try to unpack that a little. Let's, perhaps, start with Appendix 6 so that we can try to work out what you mean by that. TRU-83701. This is Appendix 6.

You explain the role of the Clinical Manager, the Chief Executive's role. He's to be kept informed of the process throughout. Then the Oversight Group. You say who is to be a member of that, what the role is.

11:23

"They're to be kept informed by the clinical manager and HR case manager as to action to be taken following initial assessment for quality assurance purposes and to ensure consistency of the approach in respect of the Trust's handle of concerns". 11:23

Within Appendix 6 you've clearly defined the role of the Oversight Group. Your statement seems to express something of a regret that you had an Oversight Group, and part of that regret arises out of an omission to 11:24 define the roles of the individual members of the Oversight Group. Do I understand that right?

A. I think it would have been helpful for, you know, each of the participants, as part of the Oversight Group, to have been referred there from a separate point of view. 11:24 Therefore, what does the Operational Director bring? What does the HR Director bring? What does the Medical Director bring? I think it would have been helpful to have done that. I mean my reason for, I suppose, expressing regret around the Oversight Group being part 11:24 of the actual guidance, I think because it was set up in a reactive way and, therefore, it possibly then led to -- well, certainly in the Mr. O'Brien case, because of the lack of the clinical manager being there led to

more of the actual decisions being taken by the Oversight Group. I suppose the way we have it now in relation to that tier that you were referring to, it very much -- we're there to ensure that, you know, processes are implemented at the minute. It is a regular meeting, it's a regular check-in, but the discussion is led by the relevant clinicians and they come expecting to have to report on whether they have any concerns about individuals, they come with the expectation they are to actually feed back. I think it is the reactive nature of us having that oversight group, you know, when there is a concern actually raised rather than how we have it now. 11:25 11:25

107 Q. No doubt you think what you have now is an improvement, but what you had then was fairly well defined, wasn't it? The baton was in the hand of the Clinical Manager to carry out the investigation. 11:26

A. Yes. How it's defined is how it should have worked in practice. The Aidan O'Brien case got off to a really bad start in relation to we didn't follow that. And the lack of the clinician at the very early stages of the process, it just got off to a very bad start on that basis. 11:26

108 Q. Yes. I want to ask you about how that could have happened in a moment. Within your statement you explain the various roles as you saw it. You said: Chief Executive, they weren't involved in appointing an oversight committee but he was kept informed by the Medical Director. 11:27

A. Could I see my statement? Would that be okay?

109 Q. Of course. Of course. WIT-41053. 11(v). No documentation from the Chief Executive's office directly to you about the establishment of any oversight group. Instead the Medical Director would have alerted you to any emerging concerns and would have arranged the establishment of the Oversight Group meeting depending on which of them was available. 11:28

A. Mm-hmm.

110 Q. Then the Medical Director's role is defined. You've said he acted as chair of the Oversight Group. 11:28

Just on that. Dr. Wright considered you to be joint chair of the oversight group. Mrs. Gishkori in her statement describes you as chair. There does seem to be some uncertainty about the chairing role. You saw yourself as a person who provided HR, professional HR advice in relation to the group's responsibilities under MHPS? 11:28

A. Yes. I did not see myself as chair of an oversight group. The nature of the discussions would have been led by the Medical Director because they would have been clinical-type concerns. I mean certainly the case conference was chaired by me, but that was only on the basis that Dr. Wright was actually dialling in, so he wasn't there in the room. It was by teleconference, it was not by videoconference so it just made more sense for me to chair because everybody else was in the room. No, I did not see myself as chair of the oversight. 11:29 11:29

CHAIR: Mr. Wolfe, I'm just wondering, is it -- shortly?

MR. WOLFE KC: Yes, just coming to the end of this section.

111 Q. Pulling up your statement so you can see it. 11 (vii): 11:30

"I understood my role as Director of HR during the oversight meetings and outside of oversight meetings to be primarily a support role to the Medical Director in terms of professional HR advice in relation to their 11:30 responsibilities under MHPS."

In that context and knowing what we now know about how this was dealt with as a matter of procedure, being the HR expert in the room, it was for you to tell 11:31 Dr. Wright, 'this is out with our procedures at almost every stage'. Is that fair?

A. It's fair. I accept that. Yes.

112 Q. You've said, if we just go to WIT-41138. It's a lengthy paragraph and we'll just step through it. 11:31 You say that the lack of clinical management input was problematic, that the Oversight Group was itself driving the decision making in December '16 as opposed to the clinical manager. You've said that while the oversight group's role was defined as quality 11:32 assurance, the absence of the clinical manager at the meetings meant that the Oversight Group determined the actions to be taken. You say that the effect of this, on reflection, was that, contrary to Section 1,

paragraph 15 of MHPS, which outlines that the role of the clinical manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available. What happened instead was the nonmedical Assistant Director, Simon Gibson, took the lead in conjunction, you're assuming, with Mrs. Corrigan and Mr. Carroll. 11:33

Scrolling down. You say the absence of the clinical manager also permitted a divergence from what was the agreed course of action at the oversight meeting on 13th September. The agreed actions were subsequently debated outside the meeting and, as a result, the agreed actions were changed. 11:33

Scrolling down. You say ultimately: 11:33

"I very much regret that those discussions did not happen robustly enough ... and that there was not more focus on ensuring that work commenced urgently after the meeting on 13th September to check if the patients in the backlogs had come to any harm. The issue was further exacerbated by the fact that both Mr. Weir and Dr. McAllister were off on sick leave." 11:34

Before we go to the break, can you help us, Mrs. Toal, in terms of how, given your dedicated role as the HR professional providing advice, knowing, based on your experience, that this wasn't going down the correct 11:34

procedural route and that that was problematic, given the nature of the matters, the clinical issues that were to be investigated, how did that happen and did you intervene to try to stop it from happening?

A. Yes. This is a matter of significant regret for me. 11:35
I suppose the context -- and I mean I'm not offering this as an excuse but it is more by way of, I suppose, explanation around the context at the time. My interview for this post was the following week. I was
Acting. I suppose it had been quite a time gap from me 11:35
being involved in the drafting of those guidelines. Did I have those guidelines at my side when we were having those early discussions? No, and I absolutely regret that. I mean, the process was completely
derailed right from the outset and I should have had 11:36
the guidelines there and I should have been thinking, 'this is not in the actual process'. I can only explain that the rest of what I was probably dealing with and that sort of rabbit in headlights scenario at
that stage, my mind probably on so many other things, 11:36
not least an interview the next week, and my attention was not, probably, from a procedural point of view, where it should have been. That's the only explanation I can offer at this stage. But it's a hard lesson to
learn from on the basis, obviously, patients in the 11:36
middle of all of that.

113 Q. In fairness to your position, you've been reflected in your evidence that you received a fairly high-level briefing, if I can put it in those terms, from

Dr. Wright to say, 'there's a problem here and I'm looking at it'. It doesn't appear on the basis of your evidence that you received more than that. What was happening behind the scenes was that he instructed Simon Gibson to conduct a screening exercise which came to your attention in or about 6th September, and we'll look at that after the break. I suppose at that point a step had been taken out, and a substantial step had been taken by the Medical Director. It is a matter for the Panel to judge, but you're saying that step of appointing Gibson to carry out the screening process was outwith the procedure. 11:37 11:37

A. Yes.

114 Q. That had been taken without you, it seems, being asked to advise on it on the basis of your evidence? 11:38

A. I'm not sure if I knew Simon Gibson was actually doing the screening report at the time Dr. Wright spoke to me. I cannot recall that. But there was a step, whenever the screening report came to me, when Simon brought sent it to me that it should have registered with me. It should have, but it didn't. While I might not necessarily have been made aware by Dr. Wright that he had asked Simon Gibson to do it, I certainly knew at the time the screening report came that it was Simon who had actually prepared that, and that was an opportunity for me -- if it had registered with me -- to say that's not the right process. I should have done that. 11:38 11:38

115 Q. Even at that point it would have been feasible to

reverse gear or at least develop some kind of hybrid involving clinical management?

A. That's correct.

116 Q. That's a fair concession.

We'll leave it at that. 11:39

CHAIR: It's almost 20 to. If we're back then at five to twelve.

MR. WOLFE KC: Very well.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:39

CHAIR: Mr. Wolfe.

117 Q. MR. WOLFE KC: Mrs. Toal, the approach that was adopted in this case, excluding from the process the clinical management and putting the Medical Director's office in the hot seat in terms of conducting the screening process and then taking a decision on that, was that the way things were done generally? I ask that question obviously with the knowledge this was your first involvement with an oversight group meeting, or your first involvement in a process from start to finish, but was it your knowledge or experience that this was how it was done under this Medical Director, if not before that? 11:58 11:58 11:59

A. I probably have maybe little knowledge of Dr. Wright but, certainly, when I look back over some of the cases that I outlined in my Section 21, certainly there would have been clinical managers at those oversight -- not

necessarily all of them but certainly there would have been clinical management input into some of them. I suppose, as well, some of the nature of the concerns, there may have been other people involved. Say, for example, counter fraud and probity services, if they were working alongside the Trust, certainly I know there was one of those cases, we would have had managers involved in that because they would have been involved in the parallel counter fraud and probity case. But I wouldn't say that on every occasion there was no clinical manager input, absolutely not. But would it have been followed to the letter of the guidelines, I'm not sure I could equally say that either. 11:59 12:00

118 Q. We've heard from Dr. Wright in answer to the why question, why did you do it in this way, and his evidence is on the record in terms of whether he took the view that it was a breach of the guidelines. I think his evidence ultimately was rather nuanced around that, but that's a matter for the Panel. 12:00 12:00

A. Mm-hmm.

119 Q. What it seemed to come to from him was, 'listen, I regarded this as a reasonably urgent matter. Mr. Weir and Mr. McAllister, perhaps, were busy practitioners, so it was, I suppose as a matter of expediency, to put this into the hands of Mr. Gibson'. Your observations around that? 12:01

A. I'm not sure I could comment for sure how -- I mean, obviously, Mr. Weir and Dr. McAllister, they are

practising clinicians so therefore inevitably they will be busy. I suppose my experience more recently of clinician involvement, yes, they are busy, but they are required to actually do it. I'm not sure whether Dr. Wright had asked them. I don't believe he did and I don't think he said that. But, other than that, I don't really have any other observations. Yes, clearly he was concerned about it because he had the previous discussion with Heather Trouton and Mr. Mackle. I suppose then at that stage, maybe, because he realised that this hasn't moved forward beyond the 23rd March letter, he maybe had an expectation this needed to be done quickly. 12:02 12:02

120 Q. But you had no discussion with him about the reasons?

A. No. 12:02

121 Q. You didn't challenge him?

A. No.

122 Q. I suppose in light of your earlier evidence, when we reflect back to the reasons why this task is given to the clinical manager, and you outlined it allowed for, I suppose, the input of a person who is clinically on the ground and has an ability to broadly and deeply appreciate the nature of the performance issues and the reasons for them, if that is -- and they were largely my words -- the rationale for this, expediency and the need to do it quickly, would you accept isn't an adequate reason for departing from the Trust's own guidelines? 12:02 12:03

A. Yes, I would accept that absolutely. I suppose the

clinical manager input, not just the clinical expertise and the importance of that. But I think it allows for clinical ownership, you know, in the actual process. I think what we see, probably, in this case, too many people involved and therefore it wasn't necessarily owned by the people that needed to own it. I think that's an important point as well as to why the clinical manager is important in this.

123 Q. What did you understand -- if needs be we'll bring perhaps the flowchart up if it helps you, but I'll ask the question and see how we go. What did you understand the quality assurance role meant? If I, the clinical manager, come to the Oversight Group, this is my decision or view based on this screening report, 'I think we should go for a formal MHPS investigation', is the quality assurance function, does that allow for, 'hold on a minute, I don't think it's appropriate. Have you thought about this?' 12:04 12:04 12:04

A. Absolutely. It allows -- I suppose where we would have knowledge of what has happened, maybe, in other cases, it allows us to sort of, at least, ensure there's a level of consistency. It allows that sort of challenge to be put into the system. I suppose that's maybe -- I'm more reflecting around what I know happens now. If the decision around, you know, from a clinical manager seems a wee bit out of kilter, a wee bit maybe not what you would expect, it allows us to put that sort of question and challenge into that conversation. 12:05 12:05

124 Q. The doctor who is under discussion, what is the

appropriate point to tell him or her that there are issues being discussed both within the organisation, obviously, and externally if you are seeking advice from NCAS? Mr. O'Brien obviously was wholly in the dark about these meetings, the September meeting, the October meeting?

A. Yes.

125 Q. Only on 30th December is he told about this long-running process?

A. Yes. In fairness to the clinician it should be whenever there is a case being discussed. I mean, back in September, you know, I think the appropriate point in time at that stage was to be flagging to him in September that, you know, the Medical Director, Director of HR, you know, and the Operational Director had an awareness of this and there was a screening done. Yes, absolutely, September time, in fairness to the clinician. 12:06

126 Q. Let's move to aspects of the meeting itself and the build up to it. WIT-41559. This is an email which you sent on 6th September. You told us in your witness statement on the night of 6th September after reading this screening report you emailed Wright and Gishkori to see if they were free to discuss a number of issues, and number 2 on your list was Aidan O'Brien potential MHPS case. Do you remember that? 12:07

A. Yes, I do. I do.

127 Q. You're looking to touch base with the colleagues mentioned. What's being suggested, perhaps, as an

informal get together or meeting or discussion, did that ever take place?

A. No. I think there's an email in the system from Emma Stinson. Emma would have been Esther Gishkori's personal assistant. I think there's an email there to advise. Dr. Wright was able to but, from memory, Esther had another engagement immediately after Governance Committee so that was not possible. I think Emma advised on her behalf. 12:08

128 Q. What did you have in mind for that, if it's possible at this remove to comment? You've got a screening report. It's a potential MHPS case. Do you add that comment "potential MHPS case"? 12:08

A. I suppose I knew after reading the report there was potential for that. Again, my recollection of that was, again, probably indicative of the context at that stage and that I knew that there were a couple of ongoing issues, the ED issue, so number 5 around email from Mick McCann re advertising ED consultants. That was around Daisy Hill ED issues that were ongoing at the time. We knew we had issues with escalated rates and consistency rates. There were things, I suppose, I was gathering and I was aware of at that point of time coming into that Acting post. I suppose it was really just an opportunity for the three of us to say, 'right, what are we doing with these?' I think that's really, in terms of -- you know, when I look at that now, what I would have meant at that stage. 12:09 12:09 12:10

129 Q. Can we bring the screening report up, please? We find

that at TRU-251423. Obviously, as you commented this morning, you found it unusual that Simon Gibson was doing this work. He says at the start the context is that the Medical Director sought detailed information on a range of issues relating to the conduct and performance of Dr. O'Brien and this report is to provide the background. I think this report tells us that there had been -- just scroll down. I was going to say that this report -- yes. In March 2016 there had been a documentation of the extent of the triage background. Did you know anything about the initiative that had taken place in March to try to address this issue, in particular the letter that had been given to Mr. O'Brien? 12:11 12:11

A. I think I knew that there was a letter, from recall. I'm not sure I was aware of the detail, and I don't think I was aware of the January meeting. 12:11

130 Q. This is the January meeting between?

A. Sorry, January 16th meeting that Heather Trouton and Mr. Mackle asked to see Dr. Wright as the new Medical Director, really, at that stage, where they were seeking his guidance. 12:12

131 Q. Just scroll through this and go to the last paragraph of the letter. His conclusion is that:

12:12

"Previous informal attempts had been unsuccessful and therefore the report recommends consideration of an NCAS supported external assessment of Dr. O'Brien's organisational practice, with Terms of Reference

focused on whether his current organisational practice may lead to patients coming to harm".

Sorry to have skimmed over that report. Was that the first detailed information to you about what this was all about? 12:13

A. Yes.

132 Q. Was it that conclusion that perhaps led you to suggest in your email to Gishkori and Dr. Wright that potential MHPS. Did you see, perhaps, the writing on the wall as a result of this report? 12:13

A. Yes, I did.

133 Q. In terms of the March process, can you help us in terms of when and, if you can't just say so, you would have become aware of the fact that a letter had been handed to Mr. O'Brien asking him to produce a plan to deal with the issues referred to in that letter? 12:14

A. I can't remember if I knew before 13th September. I just can't recall that at all. I think I knew during the meeting on the 13th that there had been a letter. As I said in my statement, I didn't ask to see that letter, and I should have. 12:14

134 Q. Yes. You've reflected in your statement at WIT-41058 that you don't recall reading a copy of the letter of 23rd March at the meeting, nor do you recall that a copy of the letter was actually available. 12:14

A. No, I don't think so.

135 Q. Did you have a sense of whether what had transpired in March formed any kind of a process, or did you regard

it as, I suppose, a local informal attempt to get to grips with matters?

A. I think I sensed at that stage it was being dealt with operationally, so it was very much local to Acute Services and Surgery at that stage. I don't think I recall thinking that it was an earlier part of any MHPS process or anything like that. I thought it was something fairly local. 12:15

136 Q. The meeting on 13th September, if we could pull up the minutes of that or the record of that? TRU-0026. Is it fair to say that you prepared for that meeting by reading the screening report, but there had been no discussion with the Oversight Committee members prior to coming to the meeting? 12:15

A. I don't recall a discussion. There may have been a corridor conversation or in the sidelines of a meeting. I see the report is in. I don't know. I don't recall anything, certainly, significant outside of 13th September before that. 12:16

137 Q. Did you appreciate before coming to the meeting that NCAS advice had been sought? 12:16

A. I can't say. I really can't say.

138 Q. Obviously with your knowledge of the process, is it fair to say that you would have liked to have thought that NCAS advice had been sought? 12:17

A. Yes. Yes, that's fair.

139 Q. But you didn't direct that yourself?

A. No.

140 Q. Did you come to the meeting, can you recall, with any

clear idea of the direction of travel from your own perspective recognising what the issues were, or did you come to the meeting to listen and contribute and try to reach a consensus?

A. I'm not sure I can recall that I was coming with a predetermined view in my head. That's not something I recall. 12:17

141 Q. In terms of the dynamics of the meeting leading to the decision which is outlined here, the drafting of a letter, a meeting with Mr. O'Brien, and the letter to have certain content, of course, to go through Esther and her team, and the need to inform Mr. O'Brien that there would be a formal investigation if sufficient progress hadn't been made. Yes, that there would be a informal investigation under MHPS. We'll come to that. How did, to the best of your recollection, that decision -- how was that arrived at? Was Dr. Wright leading the charge or was it a group decision? 12:18 12:18

A. I think, from recall, it would have been Dr. Wright who would have been leading the discussion because, well, (1) he had asked for the piece of work, the screening report to be done. He would be familiar with, obviously, the earlier conversations and discussions. He would have been the one involved with Simon in terms of asking him to do that piece of work. My recall of that meeting was working down through the report but it would have been Dr. Wright who would have been leading that part. 12:19 12:19

142 Q. In terms of an HR professional such as yourself coming

to a meeting like that, you've obviously got all of the HR skills and experience, you're being met with, in this context, clinical administrative issues and alleged shortcomings arising out of that. Is your role one of trying to assess the reasonableness or the 12:20
appropriateness, and perhaps the proportionality of the approach that is being debated, or is it more than that? Is it an attempt to get into the substance of the clinical issues themselves? Or do you leave that with the clinicians? 12:20

A. I suppose the proportionality of it, yes, that would be there. Clinically I think it's difficult to do that and that's where it's important from a Medical Director perspective, I mean I would be very much reliant on what they bring to this, which is the kind of clinical 12:21
angle and the clinical expertise. I suppose coming from an HR perspective we wouldn't necessarily always know the details of processes and things like that. That's the benefit of having a variety of views and perspectives. Yes, primarily it is around, you know, 12:21
does this seem a reasonable course of action to be taking.

143 Q. We heard from Mrs. Gishkori that she felt unable to contribute to this meeting in the way that she would have liked. The Inquiry may have gained the impression 12:22
from her that she was uncomfortable with this plan. She expressed to the Inquiry a concern that this kind of plan may not be in the best interests of her service, if Mr. O'Brien was to walk away from something

she possibly regarded as quite hard hitting. Any reflections on that? Can you recall Mrs. Gishkori contributing at all, or do you understand why she might have felt inhibited from contributing?

A. So my recollection of -- well, number one, the tone of the meeting is not something that I recall being difficult or spiky in any kind of way, if I can use that word. It was a discussion. I have no doubt that Esther, although I can't recall, but I have no doubt her coming from an operational perspective may well have been concerned about, you know, from a continuity perspective and impact on the number of the clinicians she would have had there. But we were discussing an informal approach at that stage. And I think my reflections on some of that is around whenever you mention MHPS, even if you're just talking about the informal stage, it is almost like a nuclear button that's hit and not everybody sees MHPS in the way that -- I mean, it is there to try to support an individual. 12:23 12:23 12:24 12:24

So I think what potentially has contributed, maybe, to Esther, on reflection, after the meeting being concerned, it's around the fact that we're in a MHPS process at all, no matter how informal it was. But I don't recall it being a difficult meeting. I don't. In terms of how Dr. Wright Chairs those meetings, he has always been a perfect gentleman. It wouldn't have been a difficult meeting for her to have raised her 12:24

perspective, her view, or her concern, I don't believe.

144 Q. When we look at this note of the meeting and consider it, we can see that it doesn't mention NCAS advice. When you commented on this, I don't need to bring it up on the screen, in your witness statement WIT-14060, you say you that you found it strange that neither the NCAS letter or any NCAS advice was referred to. Now, I'm conscious you said in your statement as well that you only received a copy of the NCAS letter yourself in September 2020 in preparing for this Inquiry, perhaps. Your surprise at not seeing, or your sense of strangeness that you didn't see any reference to NCAS in this record, where does that come from? 12:25 12:26

A. Well, on the basis that Simon Gibson was asked by Dr. Wright to seek NCAS advice. 12:26

145 Q. You know that now, you didn't now, you didn't that pre-meeting.

A. I suppose in terms of my surprise, whenever you look back at this and you look at the notes and you try and you piece it together, I mean it is unusual that there's no reference to NCAS advice in those notes. Albeit, the notes are bullet-point form, they're not detailed notes, and I think that's another learning point. But I think what that may reflect is, if it was discussed, and I would be sure that it was discussed because I find it difficult to understand that Simon having had that conversation with NCAS that there wasn't some reference to it at the actual meeting. But I think because it's not in the notes I'm not sure it 12:26 12:27

featured, obviously, in the discussion, maybe in the detail that it should have. And, certainly, we know that the letter came in, I think, later that day. So anything that Simon would have been discussing would have been as a recollection of what he had discussed and the advice that he had received from NCAS, as opposed to having anything in front of him by way of the letter that NCAS sent back.

146 Q. Would it have jarred with you in the course of the meeting if you had conducted your business without reference to NCAS advice? 12:27

A. That's why, I mean, I would be really surprised if we didn't, you know, if we didn't have some discussion that NCAS advice had been taken. I just find that really odd if it hadn't. But the fact it is not in those notes, I think it's unusual, but possibly indicative of the level of detail that we probably didn't go into at the meeting. 12:28

147 Q. If we just pull up the advice and have your comments on some of the points contained therein. If you go to bring up on the screen AOB-01049. And scroll down, please, to the bottom of the page. 12:28

You've said in your witness statement, Mrs. Toal, that on seeing this advice and seeing that it identified anecdotal reports of delay referral to oncology, you said if this letter had been available at the Oversight Group meeting, this line in particular could and should have served to reinforce the importance of the urgency 12:29

of addressing the concerns and reviewing, if any, actual harm had occurred with patients in the backlogs.

First of all, had you any source or understanding of the source of those anecdotal reports? 12:30

A. No, absolutely none.

148 Q. Have you any sense or understanding of what is meant in this context by "delayed referral to oncology"?

A. Well, in terms of, I suppose, the impact from a patient care and Patient Safety perspective. I suppose that's 12:30 why I was flagging, when I read it, and what I reflected in my statement, you know, that that would have meant potential harm to patients because of that. And I think --

149 Q. But you're unable, sorry to cut across you, you are 12:31 unable to particularise that or provide any greater specificity about the nature of the concern and where it arrived from?

A. No, I'm not.

150 Q. Obviously, and we don't need to bring up the email, I 12:31 think the Panel have already seen the point that this NCAS advice was circulated by Mr. Gibson. The email was sent on 28 September, two weeks after oversight. The reference is WIT-41573. But it wasn't sent to you. It was sent to the other members of the Oversight Group 12:31 and Dr. McAllister. It wasn't discussed at the 10 October oversight?

A. No.

151 Q. This piece of advice didn't feature?

A. No. And I think --

152 Q. What you're telling the Inquiry, I think, is if it had been discussed, if the advice had been discussed, this letter brought forward and the advice discussed, this line would have stuck out like a sore thumb, wouldn't it? 12:32

A. That would be my belief, yes. It should have. It should have stuck out. Yes.

153 Q. And whether it was tittle-tattle, as Dr. Wright suggested it could have been, it required bottoming out, didn't it? 12:32

A. Yes, it required probing. Yeah, it required bottoming out, you're right.

154 Q. It would have been as simple as: Mr. Gibson, you said this to NCAS, what did you mean by it and who told you about it? And a judgment then could have been made about whether further questions were merited outside of the room amongst fellow clinicians perhaps or within the service. 12:33

A. Yes. That's correct. I think there is learning from that in terms of ensuring that at every meeting -- and I think, I mean that's absolutely what we have now in terms of a proper timeline of cases and attachments of NCAS advice and attachments of legal advice, so you have the whole picture when you come to discuss a particular case. That's what was missing here. 12:33

155 Q. Just over the page, please, or down the page. There is reference, just scroll down. Just scroll down further, please. Thank you.

The penultimate paragraph there for Relevant Regulations. There's discussion of a need to provide support encompassing potentially relieving him of theatre duties as part of any plan of remedial action. Can you remember, Mrs. Toal, doing your best, any discussion about how we can assist Mr. O'Brien to progress what we need him to progress? 12:35

A. That was the purpose of involving Colin Weir and Ronan Carroll. At the time to get into the detail of how operationally they would be able to manage and work through an action plan. I don't remember a discussion about theatre duties and, actually, taking him out of theatre to be able to focus on resolving the actual backlog. But, certainly, my recall of what we were asking, and the involvement of both Mr. Weir and Ronan Carroll was operationally under Esther's leadership, to make sure there was a plan, irrespective of how; I mean, I wouldn't have known the ins and outs, necessarily, of how they would have done that, but that was certainly up to operational management along with Colin as Medical Manager to do that. 12:35 12:36 12:36

156 Q. The decision of 13 September was then worked up into a letter to Mr. O'Brien. If we could take a look at that. TRU-251430. You are familiar with this letter? Did you see it when it was produced? 12:37

A. Yes, I was -- I think I was copied into it at the time. So Simon would have drafted it, as he was asked to do, at the Oversight meeting. So I think later that afternoon, from recall, I think I received -- I think

it was the 13th after the Oversight meeting.

157 Q. Did it appropriately reflect what you saw as the way forward?

A. I think there's some wording issues with it. I mean I do reflect in my statement I would have been making amendments to it, but then obviously the alternative plan and alternative discussions around that came after. And when I checked my diary for later that afternoon and the following day, I was back-to-back in particular meetings, so I would have had no opportunity, really, to have made any amendments to it. But, in any event, the letter wasn't going to be sent. But in terms of; I think there is confusion around the informal investigation. 12:38 12:38

158 Q. Tell us about that. Because the Minute that we have looked at talks about an informal investigation under MHPS. 12:38

A. It does.

159 Q. Is it fair to say there is no such concept within MHPS?

A. That's correct. So, it is an informal approach under MHPS. So I think the terminology that clearly we were using around that time was around informal investigation, and that's an error, I suppose, in terms of looking back. But it very much was around an informal approach and I think, first and foremost it was around, so you know, the involvement of Ronan, the involvement of Mr. Weir, in terms of what is in these particular backlogs. And then, secondly, around the action plan, how do we resolve this? How do we resolve 12:39 12:39

it once and for all?

160 Q. Was there to be an investigation?

A. So there was no Investigation Team, so no, because there was no Investigation Team --

161 Q. There was to be an investigation into Mr. O'Brien's performance? 12:40

A. No. It was around what is in these particular backlogs, what's the content of them, and then to work through the Action Plan.

162 Q. So there was to be an Inquiry into or an assessment of what was in these backlogs? 12:40

A. Yes. An "assessment" is probably the better word, as opposed to an "investigation". Because an investigation would have required the appointment of investigators and that certainly was not something that we talked about. 12:40

163 Q. If we could just very briefly go back to the record of the meeting on 13 September please at TRU-00026. These words "formal" and "informal" were bandied about in this context and I just want to take your view on this. There is reference to a formal letter being sent to Mr. O'Brien on 23 March, the letter we discussed earlier. Again, your reflections on that word. Let's see what we can establish here, there was no formal process commenced in March 2016. 12:40 12:41

A. No. No. But I think, again, I think where the "formal" word has come in, it was probably the first time. I think it was the first time that ever anything was documented to Mr. O'Brien. So that's probably why

there is maybe some confusion over the formality. I think there was a level of formality there by putting the concerns on paper.

164 Q. Yes. So, by contrast to what we know had now taken place in previous years of ad hoc communication with Mr. O'Brien to ask him to improve or do certain things, this was putting a degree of formality around a request for the plan on the four issues that had been raised? 12:42

A. Yes.

165 Q. But you're not suggesting, and as far as you're aware, this Minute isn't to be taken as suggestion that you or the organisation with Mr. O'Brien was within, kind of, any formal structure or system or process? 12:42

A. That's right.

166 Q. I'm obliged. Thank you. Now, the next step following the production of this letter which went to Mrs. Gishkori on 13 September was that she engaged with Dr. McAllister and Mr. Carroll to consider an alternative, as it transpired, to what Oversight had produced? 12:42 12:43

A. I think it was Dr. McAllister maybe, not Mr. Carroll, Dr. McAllister, is that what you mean?

167 Q. Well, I'll put it again. What I meant to say was that Mrs. Gishkori, on 14 September, met with Dr. McAllister -- 12:43

A. Yes.

168 Q. And we understand that Mr. Carroll was in attendance.

A. Yes. I think so, yes, apologies.

169 Q. And Mr. Weir may or may not have been. We're not

terribly sure about that, as the evidence stands. But just on that issue, can you remember hearing that an alternative plan was afoot?

A. So Esther, I think it was on the 16th, 15th? I can't remember. So the Oversight was on the 13th. I think then there were discussions on the 14th, and maybe it was the 15th. So there is an email there that basically Esther -- 12:44

170 Q. Let me pull it out?

A. Yes, if you can clarify the date. 12:44

171 Q. TRU-263681. At the bottom of the page.

A. The 15th.

172 Q. You can see that Esther is writing to you:

"Further to our Oversight Committee, two days earlier, I had a meeting with Charlie and Ronan. I mentioned the case that was brought to the Oversight meeting in relation to Mr. O'Brien and the Plan of Action." 12:44

A. Yes.

173 Q. "Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr. O'Brien's performance was of course part of that." 12:45

Moving over the page please:

"Now they both work locally with him. They have plenty of ideas to try out and since they are both relevantly new into post I would like to try their strategy first. I am, therefore, respectfully requesting that the Local 12:45

Team be given three more calendar months to resolve the issues raised in relation to Mr. O'Brien's performance.

I appreciate you highlighting the fact that this long-running issue has not yet been resolved. However, given the trust and respect that Mr. O'Brien has won over the years, not to mention his life-long commitment to the Urology Service which he built up single-handedly, I would like to give my new Team the chance to resolve this in context and for good. This, I feel, would be the best outcome all round." 12:45 12:46

Do you remember what your response to it was, at least internally?

A. I think I was a bit taken aback by it. I probably was concerned that it seemed to be shifting. You know, I did send a letter or an email to Malcolm Clegg. So Malcolm would have been covering for Zoe Parks at this stage. Zoe was Head of medical staffing and she was on maternity leave. So I did sent an email to Malcolm to type up the notes and I referenced something about there appears to be, you know, the goalposts are shifting or changing. 12:46 12:46

174 Q. Yes. I think you said to him we're definitely going to need notes going forward, especially if goalposts keep trying to be changed. 12:47

A. Yes.

175 Q. Can I ask, were notes not routinely kept of these meetings at that time?

A. Yes. Yes. They would have been kept. I suppose I was looking for them sooner rather than later, in fairness.

176 Q. In terms then of what Mrs. Gishkori is saying, she is suggesting that her local managers have a better idea of how to deal with this effectively. She's also putting into the mix a sense that Mr. O'Brien deserves different treatment or perhaps better treatment in light of his considerable background within the organisation. So let's unpack that. 12:47

12:48

We started our conversation this morning, perhaps, by reflecting that it should; thinking on this knowledge of this as better coming from the Service itself, from Clinical Managers on the ground, so is Mrs. Gishkori to be faulted for taking it in this direction? 12:48

A. I think it was the fact that it was taking place outside of it. You know, when I look at, you know, what happened afterwards and, you know, why there was maybe a change in plan, the only thing I can really link this back to was the fact that the terminology of MHPS was being used. 12:49

And I think, you know, from what I'm trying to piece together and what I'm trying to build up by way of a picture, it was the fact that this would have been put to Mr. O'Brien as MHPS and maybe his reaction at that stage and, potentially, the impact from a service point of view I think was probably in the mix. And seeing MHPS as that almost punitive approach as opposed 12:49

to really what it should be, which is around assisting a clinician in terms of bringing their practice back on line or conduct or whatever. So I think it's that view that MHPS just would have been that nuclear option, as such, and the impact and the reaction that might have had.

177 Q. You don't seem concerned clinicians are, Clinical Managers are at least having some input through Mrs. Gishkori's initiative which, as we reflected earlier, not quite in this way but it was their role to have an input having regard to the guidelines. 12:50

A. Absolutely. It's not, I don't necessarily have a difficulty, clearly, in her taking the views of her clinicians. I think it would have been much more helpful if she had done that beforehand, you know, having those discussions before she came down. I think that would have been helpful. 12:51

Actually, when you reflect on what we were asking to be done so that Simon, yes, he would draft the letter, but there needed to be a discussion amongst themselves in terms of: Right, what does this letter need to say? What way are we handling this? So it was very much making sure that operationally that the leaders within the Acute Services Directorate had an involvement. I'm just not sure that we ever anticipated then that the plan would change in the way that it did and the way that Esther then emailed Dr. Wright and I afterwards. 12:51 12:51

178 Q. Of course, if this had been handled in a manner in

keeping would the process, if they had come to the Oversight Committee saying: This is what we know about Mr. O'Brien and this is our plan, the Quality Assurance Role of the Oversight Group would have been able to say, hold on a minute, your plan is too weak or it doesn't deal with matters in quite the way that is needed having regard to, for example, the longevity of the issues or Patient Safety issues? 12:52

A. Yeah, and I reflected that I think in my statement. Yes. 12:52

179 Q. At that time, what was the sense of Patient Safety issues and was the Oversight Group as sensitive to those risks as it needed to have been?

A. No. We weren't as sensitive as we should have been. I think, actually Esther's paragraph there, around, you know, this lifelong commitment, built-up single-handedly, this narrative around him being an excellent surgeon, an excellent clinician, that was the prevailing sort of form at that stage. It probably desensitised us to the risks from an administrative point of view. It was as if they were two separate things and they shouldn't have been. 12:53 12:53

180 Q. I know that, you know, we will maybe come on to your reflections later, but I think we can have a snapshot of that now, I think there's a sense in your reflections that this prevailing narrative about his excellence as a surgeon created a form of a blind spot to more urgent and more effective action. Is that fair? 12:53

A. Very fair.

181 Q. Just your reflections on this. Again, it may well be a complex issue, but we know from other correspondence that the Oversight Group would not have been cited on, that issues relating to the impact of not triaging patients was known to Mr. McAllister and Mr. Weir so that, for example, on that very week, 16 September, Mr. Weir was being asked to give his view on whether a particular case involving Patient 93 was well-handled and whether a Serious Adverse Incident Review should result. 12:54 12:54

There was information, undoubtedly available in the system, that Patient 10 and her SAI was making its way through. That only, of course, came to you in December. But what are we to learn from the fact that the service, in particular Clinical Managers, would have known about those issues I've referred to but it didn't get to the Oversight Committee? 12:55

A. I think its disappointing that, it's more than disappointing that they didn't. I think whenever there is that knowledge, there was a discussion then about what was known. I'm sorry, the discussion about what an alternative plan was. It feels now as if the knowledge was retained within that particular service as opposed to flagging, knowing that there was an oversight, knowing that the Medical Director had an interest in this, to be flagging to him, right okay, this is the totality of what we're dealing with and 12:55 12:56

that sort of level of openness and, therefore, together can we work through how we need to do this? So it was as if, sort of, arms around it, as opposed to opening arms and saying this is what we, you know, what do we need to do about this collectively? 12:56

182 Q. Does it suggest Clinical Managers need to be more responsive in terms of their communication of all of the relevant Clinical and Patient Safety issues to enable the Oversight Group, as it then was, to have an adequate conversation with them with a view to 12:57 determining the proper response?

A. Yes. I suppose a key question that we ask now at any Oversight Group meeting, the monthly meeting, where the clinicians come, will be: Have you any other concerns about any other doctor? And I suppose that question is 12:57 always asked with a view to try to encourage that openness and to try to encourage the sharing of those concerns. So I think it would have been helpful.

183 Q. Just two final points before our lunch break: First of all, you do try to address Mrs. Gishkori in relation to 12:57 this initiative. If we go to TRU-263685. Scrolling down. So this is Dr. Wright telling Esther Gishkori that he has to listen to her opinion before he would concede to any delay in moving forward with the agreed position after oversight, "I would need to see what 12:58 plans are in place".

And you then take up the mantle on that and you say to Esther:

"I'm conscious you go off on leave today. How do you wish to handle Richard's request?".

He explains to you that there had been a meeting with the Chief Executive and that it would eventually be documented. You didn't ultimately see the alternative plan, is that fair? 12:59

A. Yes, that's fair. Yeah, I didn't see it. In me sending that email, I mean "I am conscious you go off on leave today", I did have a concern, I was building a picture potentially, okay, things are shifting a bit. I was concerned that Esther might go off on leave and not have picked this issue up. So that's why I was sending the email first-thing on the 16th. And then by the time then lunchtime comes, the discussion has already been had with the Chief Executive's involvement at that point. So, the discussion, I don't think it was a meeting specifically about this. I think there was a meeting about something else. That's how I'm reading that. And this issue came up. And so, yes, I heard about it afterwards in terms of that email. 12:59 13:00 13:00

184 Q. Finally before lunch, there's an Oversight Group meeting on 12 October. You attended that. That's essentially three weeks after all of this had taken place. Did you have a sense that nothing had been done and the energy, or the urgency, had dissipated from this process? 13:01

A. Well, it was more than a sense that nothing had been done because Esther actually confirmed that Mr. O'Brien

had not been met with. And the discussion around Mr. O'Brien's pending surgery was very much part of that conversation. I suppose Esther being very clear at that point that she didn't want to cause him any distress in advance of it. So, yes, that's my recall of that. And, yes, it's probably fair to say that the urgency, maybe, had been taken out of it. 13:01

185 Q. And your reflection on that, were you comfortable with that, that things could be let lie until he returned from his surgery? 13:02

A. My sense was that they had plans in place to deal with the backlog. I mean that was the overriding, I suppose, concern, really, at that point. And they had plans to deal with those. Did I ask to see what those plans were? No. No I didn't. But that was my sense at the time that actually, and, you know, I suppose looking back, maybe it was easier to deal with this when Mr. O'Brien was not there and they dealt with the backlog. So then, by the time he returned, the backlogs would have been cleared. That's maybe what they were thinking. 13:02 13:03

186 Q. Yes. You've said in your statement WIT-41066, just to have that up on the screen, please:

"I attended the next Oversight Group meeting arranged for 12 October. At that meeting Esther Gishkori advised that Mr. O'Brien was about to commence a period of sick leave for planned surgery at the beginning of November and would be off work for a period of time. 13:03

Esther Gishkori also reported that a meeting with Mr. O'Brien had not yet taken place to speak with him about the concerns regarding his administrative practices and backlog. Esther Gishkori did not wish to speak with Mr. O'Brien in advance of his planned sick leave as she thought it would cause him distress in advance of surgery.

Esther Gishkori gave assurances to Dr. Wright that plans for the backlogs were in place to clear these during his absence. I cannot recall the detail that Esther provided in relation to those plans." 13:04

The assurances were in relation to the backlogs. The Oversight Group didn't receive any assurances that Mr. O'Brien was now conducting triage appropriately, wasn't bringing notes home with him or was appropriately dictating following clinical encounters. 13:04

A. That's correct.

187 Q. Is it fair to say no such assurances were sought and none were given? 13:05

A. I think that's fair to say. Yes.

188 Q. In fact, is it worse than that? It was known that Mr. O'Brien hadn't even been approached on this subject? 13:05

A. That's right.

MR. WOLFE KC: I think we could leave it there for the break.

CHAIR: 2.05, everyone.

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone. Mr. Wolfe.
MR. WOLFE KC: Good afternoon, chair. Good afternoon, Mrs. Toal. 14:08

Just before the break we looked at the events of 10 October, the second Oversight meeting. Just now I want to look at, I had just reached the December Oversight meeting. It seemed to have been a fairly 14:09
quiet period, at least in terms of your involvement and considerations around Mr. O'Brien until December. You were advised on 30 November, you've recalled in your statement, of the SAI concerning Patient 10, and then, on the 6 December you were copied into an email where 14:09
Mrs. Gishkori explains how she is going to handle matters upon Mr. O'Brien's return from his sick leave. If we just briefly look at that at TRU-251827. She is telling Dr. Wright that she has been having conversations in relation to Mr. O'Brien's return to 14:10
work. We thought this would be a good time to set out the ground rules from the start. At that point Colin Weir and Charlie McAllister both off sick. Mark, that's Mark Haynes, wondered if Mrs. Gishkori and he could do this return to work since there are both 14:10
professional operational issues here. She feels this is entirely reasonable.

I suppose you had little option but to reflect, well, that's the only way of doing this. When he comes back to work, the dye having been cast back in September or October?

A. Yes, that's right. 14:10

189 Q. Matters were to change however in late December. You received a telephone call from Simon Gibson, just prior to Christmas followed by an email to invite you to come along to an Oversight meeting on 22 December. Just on that, with Mr. McAllister, and Mr. Weir out of the 14:11 picture for different reasons. You've said that you're not aware who, in clinical terms, Dr. Wright was engaging with and you have said it may have been Mark Haynes, but did you ever hear of any involvement between Dr. Wright and Mark Haynes on issues pertaining 14:11 to Mr. O'Brien?

A. Not that I can recall. No. But I suppose because he was a Urologist he was also a CD. It may have been in my mind, but I'm not sure I had anything concrete, really, to base that on. 14:12

190 Q. But in terms of what is coming in to the Oversight meeting, and we can pull up the record for it, AOB-01280. The driver for this Oversight meeting was Dr. Wright's of the seriousness of the Serious Adverse Incident Review, is that fair? 14:12

A. Yes, that is fair. Yes.

191 Q. The Inquiry is very familiar with this record and this meeting by now. I don't wish to dwell on it on an overall lengthy basis, albeit it was an

important staging post.

Is it fair to say that Dr. Wright was becoming increasingly concerned about Patient Safety?

A. Yes, that is fair to say. Yes. I think the information around Patient 10 was a concern to him. Yes. 14:13

192 Q. I want to ask you to reflect on whether it ought to have taken the case of Patient 10 to put this case on this formal trajectory. If you don't do triage, you risk missing a patient who should be escalated to red flag? 14:13

A. Yes.

193 Q. And you knew in September, from the screening report, the quantity of cases that fell into the non-triaged category. Obviously, Patient 10's case commenced the SAI process with an Incident Report in January of 2016, which you appear to have been unsighted on, and there was this other case I mentioned to you, Patient 93, which was raised but didn't become an SAI. Putting those actual cases to one side, is the logic of the problem not there in front of you, don't do triage, you are going to risk patient health? 14:13 14:14

A. Yes, it seems very obvious now. But, yes, there was obviously potential harm, be it actual in terms of the SAI, but there was potential back then. And, yes, as a group of people we should have; the significance of that should have been in our heads. It should have been, but it wasn't at the level it needed to be. 14:14

194 Q. If we scroll down through this. I just want to take you to what is said about that. So that's the triage issue. Moving down, let's just go to the bottom of the next page, please.

14:15

The consideration of the Oversight Committee is that Mr. O'Brien's administrative practices have led to the strong possibility that patients may have come to harm. You have acknowledged that that is a realisation that could but didn't come earlier. The question becomes: 14:16
Should he return to work? And the analysis is that his continuing administrative practices would continue to harm patients and, therefore, a decision was made to exclude Dr. O'Brien, at that point, for the duration of the formal investigation. 14:16

You said in your witness statement that both yourself and Dr. Wright felt that there was this strong likelihood that his continuing administrative practices could impact on clinical outcomes for patients. 14:16
Therefore, you fully supported the exclusion?

A. Yes, I did. I did. I can't say otherwise. I thought that was the best approach at that stage.

195 Q. As a HR professional, did you work through, in your head at least, whether there were alternatives, viable 14:17
alternatives to this?

A. I suppose the numbers of cases, we didn't have the exact detail at that stage, so we knew that there needed to be quite a bit to work through. I mean

we obviously, from an HR perspective, exclusion or in non-medical terms, a suspension, is sort of your last resort. So, I would have known that at that stage, but this was a case of let's get to grips with what we are dealing with here and so I fully supported it. 14:17

196 Q. We will, of course, hear from Mr. O'Brien in due course. I understand he will express the view and explain that for his patients he was coming back to work, due to come back to work in January. He had lined up theatre, he had lined up clinics. With his 14:18 exclusion there was going to be this adverse effect on his patients. Was that any part of the thinking in December 2016?

A. Well, we knew, I mean clearly that was going to be the implication, that there might be an issue. But it; 14:18 I suppose at this stage from a safety perspective that was the overriding concern. I know there was some discussion, as well, you know, around, you know, the sort of choreography of things. Given that there were patients booked in, how do we deal with those 14:18 particular clinics or whatever? So there was a discussion around, you know, can you let us know when the meeting takes place with Mr. O'Brien so that we can inform the rest of the clinical team. Because I think then they had to put in place, obviously, arrangements 14:19 around cover for patients. That's what my recall, I suppose, would have been at that stage.

But, yes, with a longer term exclusion that would have

gone from immediate to formal perhaps, that would have had an impact on the clinical capacity. But I think at this stage actual safety trumped all of that.

197 Q. We know from consideration of this record of this meeting that there were essentially three issues that were going to move forward into formal MHPS investigation. Private patients was to be added to the list, as was a concern around the actions of management. We'll come to the terms of reference in a moment. 14:19

One of the issues that confronted you in September was the review backlog list and a concern that Mr. O'Brien wasn't dealing with this appropriately. We saw in the October record of Oversight Mrs. Gishkori explaining that during Mr. O'Brien's absence that review backlog was going to be addressed by colleagues, assumedly, and that, as you said before lunch, provided you with a degree of assurance. In terms of Mr. O'Brien's historic performance around this issue, it didn't move forward into the MHPS process as something being worthy of investigation. 14:20 14:20

A. Mm-hmm.

198 Q. The analysis around that or any discussion around that doesn't appear in any record of Oversight. 14:21

A. Mm-hmm.

199 Q. Can you help me to understand whether that just faded away as an issue because the live clinical issue was being dealt with by colleagues, and therefore we don't

need to bother about it any more. Why was it no longer a performance issue to be looked at possibly to determine whether there was a disciplinary issue there?

A. I think, from memory, yes, it was being dealt with by others, but again, my recall on this is that he wasn't the only one in that situation, I think there were others. But my memory is not particularly clear on that aspect. 14:21

200 Q. Do you agree that it being an issue with which the Oversight Group was considering, that we ought to be able to go back to the record to see how that could have been revolved to the satisfaction of the Oversight Group? 14:21

A. Yes, we should be able to follow a paper trail back. Yes, I would agree. 14:22

201 Q. There was a meeting with Mr. O'Brien then on 30 December.

A. Yes.

202 Q. Dr. Wright attended.

A. Yes. 14:22

203 Q. One of your colleagues, Lynne Hainey provided HR input. You wrote to her AOB-01297, on 28 December and asked her to attend that meeting. You use that email, if we scroll down, just to provide her with some of the background. And you're telling her what Mr. O'Brien needed to be advised of. A straightforward question, Mrs. Toal, why were you not in attendance at the meeting with Mr. O'Brien? 14:23

A. I was on annual leave. And Lynne -- so Siobhán Hynds

was on annual leave, I was on annual leave. Then the senior cover for that part of my business was Lynne Hainey.

204 Q. Another development at around that time was the fact that Dr. Wright sought advice from NCAS after the decisions had been taken on 22 December. Is that, in your experience, the appropriate way of doing it or does that put the cart before the horse? In other words, should you seek advice and then bring that to the decision-making table? 14:23 14:24

A. I think with something as significant as this the advice would have been more helpful before the Oversight meeting. I have to say now, because there would be more regular meetings of that tier, you know, in terms of doctors and dentists Oversight, you know, there would be times when, you know, we would say let's just get a bit of NCAS advice in relation to a specific aspect. So it would be a more fluid situation. But I suppose back then in advance of an Oversight meeting, as significant as this, it would have been more helpful to have had it before. Nevertheless, it was attained and we took into consideration NCAS advice in relation to that period of time, you know, to look at the, from a preliminary perspective, to get the preliminary report. So we did take that advice onboard from NCAS. But, yes, it would have been more helpful to have had it before. 14:24 14:25 14:25

205 Q. But it appears that two very important decisions were taken on 22nd December: Exclude and move to formal

investigation.

A. Yes.

206 Q. First of all, on exclusion, that was a decision reached at that meeting, it wasn't a decision of Dr. Khan?

A. No, the decision was taken at that meeting. I'm clear on that. 14:26

207 Q. Obviously that meeting also, to add a third key decision in principle, it was decided that Dr. Khan would be the case manager and Mr. Weir the case investigator, but those people had to be spoken to. 14:26

A. Yes.

208 Q. To what extent are we to interpret the decisions on exclusion and a formal investigation as being decisions reached, in principle, by the Oversight Group but subject to NCAS advice? 14:26

A. Yeah, I mean at the end of the day if NCAS had provided advice that was contrary to that, I have no doubt that Dr. Wright would have been flagging that. I have no doubt about that. So, yes, I think it would have been subject, obviously, to NCAS. 14:27

209 Q. We'll come to the NCAS, we will have a look at it in a moment. I just want to show you the record for 10th January Oversight meeting. It's at AOB-01363. Mrs. Gishkori attends this meeting. She wasn't able to attend, it seems, the December meeting. If we just scroll down through it. It's fair to say, isn't it, that the NCAS advice wasn't brought to this meeting and wasn't discussed. 14:27

A. Yes. I think that's fair to say. Yes. Yes. It

certainly wasn't brought to the meeting, whether in terms of Dr. Wright's, you know, leading the discussion on the matters, you know, in terms of whether he had that in mind. But I don't recall it being at the meeting. 14:28

210 Q. I don't wish to bring you to any particular part of this record, but it was another important staging post of recording the up-to-date developments on the actions that had been ordered at the December meeting. Adding into the mix the private patients issue that had developed since the last meeting. 14:28

On the issue of the NCAS advice, by this stage the advice was given on 29th December, by this stage there had been a process commenced of developing Terms of Reference. I want to ask you about that in the context of the advice. If you pull up the advice at AOB-01327? Just scrolling down over the next page, please. Go to the bottom of this page, please. Stop there. As for your observations on the last paragraph of that page. The advice is reciting what Dr. Wright is saying and there's an analysis which says that in an informal approach is unlikely to resolve the situation. That advice, we will need to obviously speak to NCAS about this, but the informal approach which was considered in September had never been implemented, isn't that right? 14:29 14:29 14:30

A. That's right. That's right. The thing that Mr. O'Brien would have been aware of would have been the 23rd March letter.

211 Q. Yes.
A. Yes. But he would not have been aware of the discussion in September.
212 Q. We know 23rd March letter, no follow-up with Mr. O'Brien on that. He wasn't cajoled or otherwise directed to deal with that after he received the letter. No support offered, no follow up meeting? 14:30
A. Mm-hmm.
213 Q. Then we have the NCAS advice of 7th September suggesting a number of other informal options. They are not drawn to Mr. O'Brien's attention and the starting gun on those isn't sounded. 14:31

I wonder could NCAS have thought, based on what their understanding, I mean the understanding conveyed to them, I wonder could they have thought this informal approach hasn't worked. That is perhaps an unfair question I am asking you what NCAS might have thought. But it would have been appropriate to tell NCAS, would it not, in specific terms, we haven't actually been able to follow your advice from September, for whatever reason, and we haven't done an informal? 14:31
A. Yeah. It is highly, highly, unlikely that Dr. Wright would have been referring. So, when we see the reference there as per paragraphs 15 to 17 of Section 1 of MHPS, it was highly unlikely that Dr. Wright was referring to that. So there was, in all likelihood, reference to an informal approach. I can't say what Dr. Wright, the terms of which he spoke to, I think it 14:32

was Dr. Lynn at that point, and whether it has got mixed up with the March informal approach. But it's not accurate to say that informal approach is in line with paragraphs 15 to 17 if it's referring to the March one. And certainly, the September one, Mr. O'Brien wouldn't have even been aware of an informal approach at that stage. So there is some muddling and I'm not sure how. 14:33

214 Q. If we can go to the next page, please? You are getting some advice. First of all, can you remember receiving this advice yourself? 14:33

A. No. I don't think I did. Certainly I think it was provided to Lynne Hainey at the time and possibly Siobhán Hynds. If it was provided to Lynne, I think Lynne maybe shared it with Siobhán, or maybe it was provided to both, I just can't recall, but certainly I know both of them would have had it. 14:33

215 Q. Or the process is given some advice in relation to Terms of Reference which NCAS are saying should be robust and specific and in line with the relevant paragraphs of MHPS. It goes on to say: 14:34

"The investigation should not be an unfocused trawl, but we discussed that if there are concerns that patients might not have received appropriate treatment, or if there are patients with inadequate records, then this could be managed separately with an audit look-back to ensure that patients have received the appropriate standard of care." 14:34

I'm just anxious to have your reflections on the whole area of Terms of Reference.

First of all, who did you understand had the job of formulating Terms of Reference? 14:34

A. My understanding of what happened, even in advance of the meeting on 30th December, Simon with Mr. O'Brien, Simon Gibson had started to draft Terms of Reference and also, I think, trying to draft -- to get ahead of it and draft letters, draft notes of what needed to be 14:35 addressed with Mr. O'Brien on the 30th. So, the Terms of Reference then started, I think, to be drafted by Simon at that stage.

216 Q. Was he an appropriate person to give that role to?

A. No. No. No. I don't actually recall an instruction 14:35 for Simon to do it, and he may well have taken it upon himself to actually do it. I think following the NCAS advice that Dr. Wright received, you know, none of that would have been shared with Mr. O'Brien on the day, on the 30th. I think that was on the basis of NCAS 14:36 saying, you know, it's too premature to do that. You know, your Terms of Reference come after. Essentially NCAS advice there, and it is at the top of page there we noted that further preliminary information such as from the SAI and taking account of Dr. 18665's comments 14:36 may be helpful in deciding the scope of the investigation, and therefore the TOR. The drafting of Terms of Reference even in advance of the 30th was too premature.

217 Q. I don't get a sense that, and I asked a similar question to Dr. Wright yesterday, I don't get a sense that there was a sit-down meeting of any description amongst relevant and interested people to commence a considered development of Terms of Reference for this important investigation. 14:37

A. No. And I think where the Terms of Reference will, apart from Simon's work on it, largely from Case Investigator and at that stage Siobhán Hynds, based on what they were gleaning during January, and then further supplemented by their discussion with Mr. O'Brien at the end of January in advance of the case conference. Obviously the Terms of Reference I think took quite a bit of time to work through, and I'm sure you're about to go on to it, but certainly the discussion with Mr. O'Brien, then his letter, where there were a number of points in that letter, which led them to the standing down of Mr. Weir and then Dr. Chada as the Case Investigator. So essentially then those were finalised when Dr. Chada came into post. And probably largely between Dr. Chada and Siobhán Hynds, and with reference to Dr. Khan as the Case Manager. 14:37 14:38 14:38

218 Q. I think I'm right in saying the guidelines are silent on who should be the responsible person or persons for developing the TOR. Do you have a view on who are the appropriate people and at what stage? 14:38

A. Certainly in this case the Terms of Reference, in terms of the stage, to take that part of your question first,

maybe, I think after that preliminary stage during January was the appropriate time to do it. When you look at the NCAS 2010 guidance document around local performance investigations, I think it does refer to the case investigator and the case manager. It might be helpful, maybe, to pull those up. I think there is a reference within that document to the case investigator, case manager.

219 Q. Yes. If we go to WIT-41394. Is this a particular section of that? 14:40

A. If we could go to the contents page of that, it might help.

220 Q. WIT-41396.

A. There's a section about Terms of Reference. Yes, 3.1, which would be on page 12 of that document. 14:40

221 Q. If we go to WIT-41407, please? The Terms of Reference, as finally drafted, should be agreed by the organisation's relevant decision-makers.

A. Yes. It is maybe on down. I hope I've got it reference right. I think it's there. Oh, yes, there it is. So the third line there. Just if you stop it there: The Case Manager and Investigators are appointed to manage and carry out the investigations. Oh, hold on. I am confused on that, actually. I am confused, apologies. 14:41

222 Q. It is not unhelpful to know that, that you are confused, strange as that may sound. It reflects -- and, as I say, your own guidelines don't deal with the issue.

A. Yes.

223 Q. Let's broaden the issue out beyond who should have been doing it. Perhaps the more important issue is the process for doing it and what should be included in a Term of Reference. You receive advice from NCAS, which I read to you, which says that this should not be an unfocused investigation. We can, I suppose, apply some hindsight to know that this MHPS process didn't shine the light at all of the aspects of Mr. O'Brien's practice which were to be regarded by the Trust, at least, as being revealing of shortcomings. 14:42 14:42

A. Mm-hmm.

224 Q. If I can approach the issue of Terms of Reference in that way. Given what you did know across the four issues that were to be investigated ultimately, was there anything in the generality of those issues which might have been symptomatic of other problems in other areas of the practice that were at least worthy of light-touch scrutiny before the Terms of Reference were finalised? 14:42 14:43

A. Yes. I think when we look at it now, the question should have been, so, yes, I suppose there's this reference to you're unfocused trawl and it shouldn't be that. But when you think about the administrative practices of a clinician in one area of the business that we knew about and had been reported from January 16th right through and, as we know, before that, it should have been a question that was asked around his administrative practices in other parts of 14:43

the forest, for want of a better analogy. So if we have issues, if this clinician has issues in this part, could it be that he has issues in this part too? So in that way, you know, when you look back it wouldn't necessarily have been unfocused. It just would have been a sensible thing to do around sensing, do we have a wider problem here administratively?

225 Q. The concern was that the investigation would be unfocused, but what we are presently discussing is the step before that, which is let's come up with Terms of Reference that are focused, but also let's come up with Terms of Reference that are appropriate. That's what we're talking about, I suppose? 14:44

A. Yes.

226 Q. I think probably, upon reflection, you would agree with me that that jump from administrative shortcomings in the areas of his practice that we know about, it's not too clever or complex to say, well, what about -- 14:45

A. What about other parties.

227 Q. -- other aspects? 14:45

A. Yes.

228 Q. If we're learning about this and if the Health Service should learn about this, would you agree that there were other pieces of intelligence, if I could put it that way, that really have been put out on a table and discussed by whoever it was, we are now confused as to who it should have been drafting these Terms of Reference. By that I mean, for example, the remark in the advice from NCAS in September about delays in 14:45

referral to oncology. That should have come back in at that point, shouldn't it?

A. Yes, it should. I suppose that's knowledge of your full patient journey, I suppose, and the administrative processes that work alongside that. It should have been, I think, included in that. 14:46

I think there was also, and I certainly wasn't aware of it, but certainly there was an email around, I think, from a litigation perspective around Mr. O'Brien, I think having emailed Marian Fitzsimons, who was the Litigation Manager at that point in time, around delays in getting some of the information back to the Litigation Department. So there were issues there. And I suppose, again, when you try to join all of those dots together -- 14:46 14:47

229 Q. There was a new complaint in?

A. Yes.

230 Q. I think you probably were aware of that, or certainly some of your colleagues were. Patient 16, if you just want to glance at the cipher list. If we pull up TRU-01366, 23rd December. You can see the name in the attachment line. We're familiar with that SAI which started life as a complaint from the patient's daughter in December of that year, and there is consideration being given there to whether this falls within the SAI process. 14:47 14:48

I raise that simply as another example in order to seek your reflections on maybe what are you doing now, perhaps, that's different when you sit down to compose Terms of Reference to ensure that they are sufficiently broad, without doing injury to fairness or doing injury to the notion that this cannot be so high, wide and handsome that it becomes meaningless.

A. Yes, I think the difference I see now, and probably Dr. O'Kane has brought this difference to it, is the questions around, so what else do we know? What are the complaints? What are the litigation cases? What are the SAIs? So you're on, you know, there's a range of data that you're trying to gather a picture around whether a job plan is in place, an appraisal is in place. It's trying to build a picture outside of just what you are kind of currently dealing with and I think that's helpful.

231 Q. When looking at this and listening to my raising of a potential criticism around how the TR were developed here, do you rely on the hindsight defence to say, 'we simply couldn't have imagined a need for a broader set of Terms of Reference'?

A. No, there were things we should have checked at the time. I don't look at it, oh, you know, now we know what we know. I think there were questions that we should have been asking. There were other problems we should have sensed at the time, and we should have checked those out. For me probably one of the biggest lessons for us as an organisation is around that

problem sensing and how attuned we are to that.

232 Q. Is there any sense that kinds of advice, and we have looked at the language NCAS used, just the culture within which we look at clinical performance, is there any sense of a chill factor that may have existed at that time, may still exist about what employers can properly do when sitting down to investigate? 14:50

A. From experience, I suppose the Terms of Reference are, you know, something that is really important. I still think there is probably something, maybe on reflection, around NCAS advice in terms of this. Because I still think there is maybe a view from NCAS that they need to be quite tight. So that maybe needs to be looked at. 14:51

And back to that point around, I mean the reference that I was flagging there, and, yes, I think there is a bit of confusion, but I have recently sat in on the NCAS Case Manager Training because a number of our new Divisional Medical Directors and Clinical Directors were trained quite recently, and part of that Case Manager Training is the actual Terms of Reference. So I think there's something, there is something there that's worthy of checking. And, I mean, I'm happy to go back to my notes but that was certainly part of the case management training around getting the Terms of Reference right. So it was just something sitting a bit odd with me there. 14:51 14:52

233 Q. If you want to carry that thought away with you and explore it, and the Inquiry, undoubtedly, will be happy

to hear from you if you want to add to that.

A. Yes.

234 Q. Is this around the question of who now would draft the Terms of Reference?

A. The case manager drafts the Terms of Reference. 14:52

235 Q. That's the current position?

A. That is the current position.

236 Q. Does he or she do it, if you like, in the more intelligent way of bringing all of the relevant information into the mix: complaints, SAIs. In other 14:52 words, what's known?

A. Yes. So there would be much more of a, sort of, joined-up approach. From a Medical Director perspective I mean they would have all of that information to hand. I suppose I'm thinking of one 14:53 case in particular, which is our most recent one, which is again back to we drafted Terms of Reference and then we ran the Terms of Reference past NCAS, RPPA (as it is now) and their advice was, 'no, you need to narrow that down quite a bit'. I think there still is that view 14:53 around making sure that they are as tight as they can be.

237 Q. Presumably an organisation or a Trust can have a debate with NCAS and say, 'look, we think this is justified'?

A. Yes. Probably, you know, there's other ways of 14:53 checking things out so it might not necessarily be as part of the investigation, but maybe there needs to be an audit of particular practices that potentially sits alongside that. If there's an issue, then it can form

part of the Terms of Reference at a later stage. So I think we're much more attuned to that at this stage.

238 Q. Two final points on Terms of Reference, please. If we can bring up TRU-267983. This is, as I understand it, the final set of Terms of Reference. Scrolling down. 14:54
Scroll down to the next page, please. We can see that Item 5 is introduced.

Have you any sense of who authored that element and why it was introduced? 14:55

A. So the timeline of that being introduced is after Dr. Chada comes in to the clinical -- the case investigator role. And it is after there has been a piece of correspondence from Mr. O'Brien himself which goes back -- you know, deals with issues as far 14:55
back as March 2016 when he got the letter, when he received the letter from Mr. Mackle and Mrs. Trouton. My awareness of this is as Dr. Chada and Siobhán were trying to work their way through the Terms of Reference, they were picking up on those things what 14:55
was known as far back as March. I think, you know, Mr. O'Brien's meeting as part of that sort of initial preliminary month in January, and also many of his representations that he made, it was becoming clear, you know, there are other issues here that go back as 14:56
far as March '16, and I think that was why that was included. But it definitely came in after Dr. Chada was appointed as case investigator.

239 Q. It would appear she would claim to be the author of it?

A. I heard you say that, yes.

240 Q. She says in her witness statement, WIT-23761, "that it became clear to me" -- that's Dr. Chada -- "that a further Term of Reference needed to be considered. TOR5 was to determine to what extent any of the above matters were known to managers within the Trust prior to December 2016. I believe I added this Term of Reference by mid March 2017." 14:56

Just have your reflections on the propriety of an investigator adding items to the shopping list of matters to be investigated? 14:57

A. You see, I think, leaving aside the fact that we have a changed Case Investigator, if you think about the four-week period in January, which was that sort of four-week preliminary piece where you are gathering more information to help sort of scope out and inform your Terms of Reference, you know, it's not surprising that you're in that period of time and maybe afterwards there will be things that come to light that do need to be added. 14:57 14:57

241 Q. I'm asking more about the propriety of an investigator doing it unmoored to the rest of the process. In other words, could she properly take this investigation into any matter which causes her concern without -- 14:58

A. I think the importance of the discussion with the Case Manager and the relationship that the Case Investigator has with the Case Manager is important in that. So I wouldn't have expected Dr. Chada just to have just

added that in without any discussion or at least the awareness of the Case Manager, Dr. Khan, and I believe that was the case.

242 Q. We will explore that with her. Just one final point on this area: Dr. Wright's statement, you may have heard me ask about this yesterday: 14:58

"The Terms of Reference were agreed by Mrs. Toal and I, after being drafted by Mr. Simon Gibson, after discussion with NCAS in early January. I have been unable to clarify the exact date or details concerning any possible iterations." 14:59

Do you recognise that process of you and him agreeing?

A. No. No, I don't. 14:59

243 Q. There was a case conference on 26 January, you Chaired it. Just in the interests of brevity, I set out a description in your presence yesterday of that process. Would you agree with me that the process is provided for within your guidelines whereby the decision that's on the agenda is whether there's a need to extend exclusion or whether safety, or for other reasons, could allow the practitioner to return? 14:59

A. Yes.

244 Q. And the process is to have a case conference involving a preliminary report from the Case Investigator and a decision to be reached by the Case Manager on that issue? 15:00

A. Yes. That's right. That's right.

245 Q. And that's what was done on 26 January.
A. Yes.
246 Q. If we just pull up the record of that meeting briefly, please. TRU-00037. You Chaired that meeting. You explained to us earlier that Dr. Wright attended remotely? 15:00
A. That's right. That's why I chaired it.
247 Q. Mrs. Gishkori didn't attend and put in her place Anne McVey, who had no prior involvement with this process. You wrote to Mrs. Gishkori in advance of this meeting, isn't that right? 15:01
A. Yes. Yes. She had chaired that with me on Friday.
248 Q. Your concern, if we can just pull up the email, TRU-366455. If we try WIT-367455. I'm not sure we'll be able to find the reference? 15:02
CHAIR: I think there might have been some confusion as to whether you said 2 or 4 at the start of the TRU reference, Mr. Wolfe.
MR. WOLFE KC: 267455? TRU-267445.
A. Yes, that's it. 15:02
249 Q. Let's scroll up so we can see the start of Mrs. Toal's email. You said:

"Esther, this is a very important meeting and requires senior representation from Acute Services. Given 15:03
Ronan's involvement in the parallel process in relation to the scoping of the impact, or actual, or potential on patients, I think it is more appropriate to keep him separate from the oversight committee role in relation

to deputising for you to ensure there is a clear separation in relation to these processes."

I think it might be on down this page. If we can just scroll down. I think Mrs. Gishkori had, as she describes, an unavoidable prior leave commitment. You were clearly disappointed or concerned that she couldn't attend? 15:03

A. Yes, I was. I think this had been in the diary for a while. It was a significant meeting. And I think I was irked at the time that it was an email like this coming from her PA, that she was happy for the meeting to go ahead in her absence and be updated later. 15:04

250 Q. Obviously she hadn't attended the December meeting.

A. Yes. 15:04

251 Q. That was obviously perhaps a family time leading up to Christmas.

A. Yes, I...

252 Q. Were you concerned about her commitment to the process and her perception of its significance? 15:04

A. I suppose I was piecing a few things together at that point because, you know, when you think back to the change in plan around September, the fact that, you know, Mr. O'Brien hadn't been advised before he went off on sick leave, had less of an issue, I think, I suppose before Christmas because, you know, a lot of people could be off prior to Christmas, some could be off after. That didn't really alarm me. She was there in January in terms of the Oversight meeting then, but 15:05

I thought this one in particular was an important one.

253 Q. Yes. Just in terms of going back to the record of this meeting at TRU-00037, in terms of the business of that meeting, it's right to say, isn't it, that Dr. Khan decided there was a case to answer and he decided in consultation with others that exclusion could be set aside. 15:06

Now, this was to be the last Oversight Committee meeting for this case. There were some decisions taken at this meeting or actions. Sorry, there were decisions that actions needed to be followed. 15:06

A. Yeah.

254 Q. I assume you are familiar with this record. You can scroll through them if you think you need to? 15:06

A. No, I'm fine.

255 Q. But amongst those issues were the need to develop a monitoring plan. There was a need for an urgent job plan, a need for a comparative analysis of Mr. O'Brien's work as compared with his peers, his workload as compared with his peers. There was a need to update NCAS. The investigation was about to commence, so presumably there was a need to track that investigation to some extent. Would you agree with me that any or perhaps all of those issues ought to have led to Oversight follow-up? 15:07 15:07

A. Yes. I think around that time, that's when we were starting to really consider the Oversight Group. I mean certainly what led to the standing down or the

removal of the Oversight out of the 2010 guidance, around that time I think there were some conversations about that. Certainly from a legal advice point of view, I mean we were obviously taking legal advice at that point. We were in the investigation stage and, yes, ideally there should have been the continuation of that sort of tracking process. I think what we went from was removal of an Oversight out of 2010 to not having that sort of tier, that Oversight that actually now we realise the importance of that, the importance of having those regular meetings to track and to ensure momentum is there, to follow through on actions. So I think we've kind of gone from having it to not having it, to actually, really, 'right, this is what we need in order to track'. There have been various stages around that in terms of thought process. 15:08 15:09 15:09

256 Q. If I could just pick up on one of the points that I mentioned? If you go to the bottom of TRU-00038. The bottom of page 39, if you would. Scroll down.

15:09

As regards monitoring, first of all, were you content that it was a safe decision to release Mr. O'Brien from his exclusion?

A. Yes, on the basis that there would be a Return to Work Plan and everything would be monitored and there would, you know, we wouldn't have slippage in those issues. Again, you know, as I said before, exclusion is that worst case scenario and to have someone secluded for that period of time, and a surgeon excluded as well 15:10

around, you know maintenance of skill, clinical skill, and things like that.

257 Q. Presumably that is subject to an effectively monitoring plan being produced?

A. Yes. Absolutely. 15:11

258 Q. And it was agreed that the Operational Team would provide that to members of the Oversight Committee. Did you ever see it and approve it?

A. Yes. I mean we all, to the best of my knowledge, I mean I know I did see it. So I'm assuming Esther and 15:11 Dr. Wright would have seen it. I certainly did. But in terms of the actual detail and the working through from an operational process point of view, Acute Services, the devil in the detail was very much with them in terms of their processes. I don't think I 15:12 would have known how robust it actually was.

259 Q. Is that not the important thing, if you are concerned that you have a clinician who may place patients at risk with his activity, even if it is on the administrative side of the line activity as opposed to 15:12 purely clinical, is it not something that you, as an HR professional and a member of the Oversight team, would need to scrutinise in depth and get appropriate assurances before giving the return to work the green light? 15:12

A. There were other people in this Oversight.

260 Q. Of course. Of course.

A. From my perspective, you know, the importance of others being able to look to see, right, from a clinical

perspective is this okay. Yes, on reflection I probably needed to seek those assurances. But I was reliant on my other colleagues who would have known the actual detail of this.

261 Q. If we could turn to WIT-41147. If we look at paragraph 3, please. You have said: 15:13

"The Return to Work action plan as a means of protecting the public as per MHPS Section 1, paragraph 5, needed to be much more robust, in my view, with greater clarity around reporting and escalation arrangements to the Case Manager and Medical Director. The arrangements should not have been dependent on a single person to monitor". 15:13

15:14

You may be reflecting back there to the slippage that occurred in the summer and autumn of 2018 when Mrs. Corrigan, who was primarily responsible for monitoring and escalating, if escalating was appropriate? 15:14

A. Yes.

262 Q. Are you saying that, upon reflection, much more could have been done by Oversight Group, you and your colleagues, to ensure that the monitoring arrangements were going to be fit for purpose? 15:14

A. Yes. I think the reporting was on an exception basis. So, yes, I think the fact that it was so heavily reliant on Martina Corrigan and then when that person went off, when Martina went off on sick leave, there

was no back-up. So I think that was an issue. It was an exception reporting, actually probably what it should have been was a much stronger line of reporting on a regular basis as opposed to by exception.

MR. WOLFE KC: Chairman, if you intend to take a break this afternoon I suspect in order to complete the witness we might sit, subject to you, of course, to close to five o'clock. 15:15

CHAIR: If we're going to sit on a bit later, I think we should take a break. So 3.30. 15:15

MR. WOLFE KC: Very well.

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MR. WOLFE KC: Chair, just to let the rest of my colleagues know. I have spoken to the witness and to the extent that any witness is content to come a second day, Mrs. Toal is content to come tomorrow again. I just think it might be a bit of a tight squeeze and unfair on the witness, in light of what she has to say across a number of important issues, to try and rush it. I think, subject to you, I think maybe to half four. 15:36

CHAIR: I think no later than half four. It's been a long day. I am sure Mrs. Toal feels it very much and I know she would prefer, as everyone would, not to have to come back tomorrow. It has been a long day for everybody and I think -- 15:37

MR. WOLFE KC: I also appreciate she came yesterday

hoping to get on this afternoon. I'm very grateful to her personally for facilitating us in this way.

263 Q. Just working through some of the other discrete tasks that you had to undertake, Mrs. Toal, to get this process moving, you had to speak to Mrs. Brownlee or contact her to ask her to appoint a non-Executive Director. Could we have up on the screen, please, WIT-41592. Just at the bottom of the page, please, you are telling her: 15:37 15:38

"I am aware that Dr. Wright has spoken to you regarding the immediate exclusion under MHPS of Mr. Aidan O'Brien and the need for a formal investigation.
I would be grateful therefore if a recently MHPS trained NED could be identified as soon as possible to enable this to be communicated to Mr. O'Brien in accordance with the Framework. I will then arrange to meet with the designated NED to brief them on the case." 15:38 15:38

Scrolling back up. This has obviously been forwarded. Is this forwarded to you? Mrs. Brownlee saying "John", that's John Wilkinson:

"I hope you had a quiet and lovely family Christmas. Would you do this for me?". 15:39

This is Mrs. Brownlee maybe forwarding this to John Wilkinson. Sorry for that confusion:

"I would want to explain regarding Mr. O'Brien. Can you let me know and then we can chat first?".

In terms of what you knew about the relationship between Mr. O'Brien and Mrs. Brownlee, that friendship, had you any concern about approaching her in this way? 15:39

A. No. No concern. I mean, it just was part of the process and had to be done. I was aware that Dr. Wright had already spoken to her about it. I think he went in to actually speak to her about it. It was part of the process. 15:39

264 Q. Was this the sum total of your contact with her on the issue. I know you had go to the Trust Board. We'll come to that in just a second. Is that the contact that you had with her on it? 15:40

A. There was one discussion with her, and I don't know why I would have been in her office. Her office is literally just across the corridor from mine. I might have been in for some other reason. It was during January. I don't know a date. She did express to me her unhappiness, I suppose, maybe is a way to describe it, in relation to Mr. O'Brien's exclusion. 15:40

I think it was in the context of this, you know, he's a very hard-working, excellent clinician, that type of language. Those are my words, I'm not quoting her. But my response, I mean it was a very short exchange, and my response to her was, 'these are serious issues, Roberta, and they need to be looked at'. That was the 15:41

sum total of our conversation and she never brought it up with me again.

265 Q. In your view was that an appropriate encounter from her perspective or do you think she shouldn't have touched that issue with you? 15:41

A. No. I don't think she should have touched it with me. No.

266 Q. That's as far as it went, this expression of unhappiness?

A. Yes. She wasn't asking me to do anything. She wasn't. 15:41 There was no instruction or anything like that. It was just to let me know that she was unhappy about it.

267 Q. Is it fair to characterise that she was unhappy, she was letting you know, but there was no pressure on you to change course? 15:42

A. No, and I didn't feel that pressure, to be honest. I just didn't think it was an appropriate thing but it wouldn't -- there was no instruction, nor did I feel a pressure to change the course of where we were heading. 15:42

268 Q. Did any other participant in the process speak to you about any perception of inappropriate approaches from Mrs. Brownlee?

A. No.

269 Q. Thank you. In terms of your contact with the Board, 15:43 can I just bring up -- you went to the Board on 27th January. Can I bring up a draft record and perhaps you can help me to understand how this could have come about. TRU-263865. This is referred to as

a "Draft". Just picking up on the last line:

"Mrs. Toal reported that the immediate exclusion has now been lifted and the consultant is now able to return to work with a number of restrictions in place." 15:44

You've reflected in your witness statement that the use of the word "restriction" in that context is somewhat or was somewhat misleading. Nevertheless, is that the word that would have been used to the Board? 15:44

A. I can't recall. I can't recall. Possibly. Possibly.

270 Q. The position changes in, I suppose, what might be called the final Minute of the authorised record of the Board meeting. If we go to TRU-158980. The word "restriction" changes to "controls". What we're talking about here is the monitoring arrangements. There's no restriction on Mr. O'Brien's practice; isn't that fair? 15:45

A. He was, and I suppose that was my thought, now whether I used the term "restrictions" in the actual Board meeting, but when I was reading it he was still able to do all of those things. It wasn't as if he was restricted from doing certain things, but the controls were there in terms of the Return to Work Monitoring Plan, which was put in place to ensure that he actually did what he was required to do. I suppose that reflects my change, because I didn't see him actually restricted from doing anything in terms of his return. It was more making sure he did what he was required to 15:45

do.

271 Q. You arranged for that change to be made; is that fair?

A. Yes, from memory I think I tracked a change and sent it back to Sandra Judt, who is the Board Assurance Manager. 15:46

272 Q. In terms of Board interaction on this MHPS case, or MHPS in general, at that time you report this in, because, I think, under the rubric you have got to report an exclusion?

A. That's right. That's right. 15:46

273 Q. Thereafter, consideration of any concern relating to Mr. O'Brien within the MHPS process doesn't feature and, indeed, generally the difficulties in bringing the process to an end, even aside from anything to do with Mr. O'Brien's performance, doesn't feature. 15:47

A. No.

274 Q. Is that because the Medical Director's office, your office as HR Director, doesn't think it appropriate because of confidential employment type issues to come back with that, or is it just a practice that wasn't considered? 15:47

A. It was a practice at that stage. I mean, certainly before I took over in terms of this post, I don't believe MHPS cases would have been reported to either the full Board or the Governance Committee. The reporting of this one, from an immediate exclusion perspective, was in under MHPS as that heading under "immediate exclusion". I mean, I suppose what we were mindful of was the actual details. There was the 15:48

designated Board member in terms of Mr. Wilkinson who, as MHPS, would be the one that would be familiar with the case, but other than that there would have been no detail reported. I suppose that was the thinking. That was my understanding and, certainly, practice from before I took the post up there wouldn't have been anything reported through. Now we have subsequently changed that, which I'm sure you'll come on to at some point. You know, there is now an anonymised report that goes through. 15:48 15:49

275 Q. It might be convenient just to deal with it in this context.

A. Sure.

276 Q. If we pull up your Addendum Statement at WIT-91885. Maybe it's not terribly helpful to bring this up. Pull up Answer 6. What you're enclosing with your Addendum Statement Evidence of Case Reports that go to the Board when complete. Let's just look. Yes, I think the safest thing to do is to go to your original statement at WIT-41147, where you explain the current process. 15:49 15:50

You are reflecting the view that greater reporting to the Board of MHPS case data would have added greater accountability into our Trust system. You go on to say that, at that time, Zoe Parks was developing a piece of work in relation to creating an environment where the Board would have an improved visibility of MHPS cases and the template for reporting as that time was currently being developed. What has changed? We'll 15:50

bring up some of the documentation on it and you can talk us through it. For example, if we go to, you have sent us through three reports. September. I'm not sure if it's January or December, and February.

A. Yeah. 15:51

277 Q. If we look at the latest one, February 2023, WIT-91914. What you're telling us, I think, Mrs. Toal, is that this is one of the developments within what might be described as the Reform Initiatives that have been borne out of this case and certain conclusions that 15:52 have been reached by the Trust about the state of governance in various aspects of the organisation. What now goes to the Board that didn't go to the Board back in January 2017, and thereafter?

A. So, a summary of what we do now. Every Doctor and 15:52 Dentist Oversight Group, that's the regular monthly meeting where the Medical Director chairs, I'm there, then there is a slot for each of the Divisional Medical Directors. That's our way of keeping a track on the cases. It is our way of seeking any information from 15:52 Divisional Medical Directors about any doctors that they are concerned about. Okay. It is that regular monthly meeting.

From that meeting then a report is prepared by Zoe from 15:53 Medical Staffing on all of the cases. That could be informal and it could be formal. It is basically a summary of what we talk about at the Doctor and Dentist Oversight Group. That goes to the Medical

Director, but the purpose of that is to update the Chief Executives. Dr. O'Kane, will get from Dr. Austin now, a full report. That's our way, I suppose, of complying with MHPS so that all of the concerns are registered with the Chief. 15:53

278 Q. This is one of those reports?

A. I'm just trying to give you the background, okay?

279 Q. Of course.

A. Then from that the formal cases, so then this report that you see is the reporting of the formal cases to 15:53 our Governance Committee, which is a sub-committee of Trust Board. So it is the formal cases. It doesn't go into all of the informal because the expectation is that the Medical Director, you know, discusses all of those cases with Dr. O'Kane. This gives the Governance 15:54 Committee a summary, essentially, of the formal cases that we're dealing with. I am happy if somebody scrolls down, please, if that's okay. Thank you.

280 Q. Yes. 91915 we can see that in February there are no exclusions in place? 15:54

A. This is our summary cover sheet to the actual report. It just, I mean this gives, I suppose, the headlines to the Governance Committee. In this case it says there are no exclusions in place but there are two doctors currently subject to restrictions. There's one formal 15:55 case actively undergoing investigation and one formal case that's on hold because of PSNI and fraud investigations. It just tries to give an update on a summary position in relation to the cases that we

have.

Then it goes on down to say there are two formal MHPS cases which have concluded, but continue to work through MHPS resolution, so that's obviously the new NCAS, in terms of trying to facilitate return to full practice. We still report those through to the Governance Committee because that allows the Governance Committee to be assured that we have still eyes on those, from an Action Plan point of view and, I suppose, just gives some detail around, I mean in that case, 27991, is around, you know, reintegrate them back into the full remit of their role by March 2023. My expectation at March 2023 is that Dr. Austin and myself are given a report to say we've hit that target, or there's another issue. It just allows us to provide that assurance that we are on top of things. 15:55 15:55 15:56 15:56

281 Q. You set out some, in the bottom of the form, the report, areas of concern, risk and challenge.

A. Yes. We say there, I mean particularly around number 2, it is really just, I mean this is a template, a Board cover template, so within the areas of improvement we say that, we give the assurance there that the designated role, those individuals within those, their training is complete. Then the concern, the risk and the challenge is in and around the actual timescale issue, because we know we have an ongoing issue generally, probably across any NHS organisation around the actual timescale. We very much keep in mind 15:56 15:56

there, we give an explanation as to why, maybe, a timescale hasn't been within the four weeks. Again, it is to try and provide that assurance, we are on top of this, we know what the issues are, and it is, I suppose, a full and open disclosure to our Governance Committee about where we are at and the challenges that we have.

282 Q. Just going further down, there's an attachment behind that?

A. Yes, so the attachment is the full report then. 15:58

283 Q. This gives a fuller breakdown of the two formal cases?

A. Yes. That's right. What we're saying there is at January 2023, so that would have been the January meeting of Oversight. We've had no new formal, no new cases this quarter to report. So we set that out. 15:58 Then we give the update around previous formal cases that have been reported and just give the update. So the actual reference number is there, so that allows us to anonymise. We say the date that the case is opened so that they have full knowledge of that. Just 15:58 a summary of the cases there. We give them the Case Manager, Case Investigator. We indicate the dates that they have been trained and the non-Executive, so that would be the Board member, the designated Board member who has been assigned. We go through the restrictions 15:59 or exclusions. We confirm around NHS resolution involvement, i.e. the former NCAS. GMC as well. So ELA will be your liaison role, again, just to provide the assurance something around that, around GMC. And

if there are any parallel SAI Review processes that are ongoing. So it is really just to try and link all of that. Because obviously later at Governance Committee in terms of Clinical Social Care Governance Report there will be reference to SAIs and those reference numbers. Then the final is around the timescales. 15:59

284 Q. Presumably this goes to Governance Committee --

A. That's right.

285 Q. -- which is a Board committee.

A. Yes. 16:00

286 Q. Then the minutes, as I understand it, of the Governance Committee, and any attached report will go as part of the Trust Board pack --

A. Yes.

287 Q. -- for their monthly meeting? Presumably a Board member would be saying the advantage of this innovation is that it gives the non-execs on the Board greater visibility and the possibility of scrutinising the processing of MHPS cases? 16:00

A. I suppose what it does when you look at MHPS around the assurance that we're adhering to process, it will not give full assurance, but certainly around some of those time scales, and around training that we have Board members allocated, it provides that level of assurance in relation to those particular aspects. 16:00

288 Q. I emphasised that you supplied three months worth of this but I picked one example in the interests of brevity?

A. And they all follow that format.

289 Q. Have you received any feedback to date from the Governance Committee on the use of this format?

A. Yes. Certainly what we're hearing is that it is very helpful. You know, we get quite a bit of engagement from our Board members. Certainly Mrs. McCarten, at the last meeting, was able to say, 'yes, I'm aware of this case. I have made contact with the case investigator to check where things are at'. You know, there's much more engagement. They're starting to see, I think, some of the concerns that are coming through. They are starting to get to grips with some of the issues of time scales and why those might be. The most recent meeting actually there was a discussion around, 'why is it just the formal cases that are being reported through?' I suppose what we were able to confirm at that time was there is a full report in all cases that goes through the Chief Executive, to provide that assurance that that was happening. But what we agreed to do for the next meeting was to ensure that there was, within the cover sheet at least, reference to the number of informal cases on our caseload. That's the type of discussion that we're having. I think, yes, I mean it's helpful and they have a lot more awareness of what we're doing. 16:01 16:01 16:02 16:02

290 Q. Thank you for that and thank you for updating the Inquiry through your Addendum Statement in that respect. 16:02

If I can move onto the role of the non-Executive Director. It touched upon the process of appointing him. You wrote to Mrs. Brownlee who asked specifically for somebody who was trained, presumably you thought it important and she made the selection it seems. You've said in your witness statement, and I would be interested to have your further reflections upon this, this is WIT-41096, that you consider the role of the NED, if I can call it that, within MHPS is not clear in respect of handling of representations about the investigation. 16:03 16:03

MHPS gives no other guidance other than what is included in paragraph 8 of Section 1 of the Framework which is that the NED is to oversee the case to ensure that momentum is maintained and to consider any representations from the practitioner about his or her exclusion or any representations about the investigation. 16:03

16:04

Now, had you any particular concerns about the operation of the non-Executive role in the context of the Mr. O'Brien investigation?

A. I think this is the first case that I can remember that representations were made by a practitioner to the designated Board member and I think the representations that Mr. O'Brien made were quite lengthy. And those questions were asked of Mr. Wilkinson, but I'm not sure he could. I mean we were not clear that he could 16:04

answer those at all. In fact, we were clear that he couldn't answer them is really, I suppose, what I should be saying.

So following some legal advice, then the representations that he made then, we concluded that the first set of representations, and I'm not sure whether I'll get this the right-way-around, but in terms of both sets of representations, one was handled by Dr. Wright as the Medical Director, and one was handled by Dr. Khan as the Case Manager. 16:05

So essentially Mr. Wilkinson probably acted as a bit of a postbox and to ensure that they were responded to. But I'm not convinced, as the designated Board member, whether he would ever have had enough knowledge or involvement in this particular case around, you know, actually validating that those were appropriate responses made. And I think the representations that were made in many respects to Mr. Wilkinson were appropriately handled by the Case Manager or Dr. Wright as the Medical Director and some of them would have been appropriate for Mr. O'Brien to have channelled that way, as opposed to the designated Board member. 16:05 16:06

So I think, because there's probably not an awful lot of guidance in relation to that, in fact, there is no guidance in relation to the types of things, it probably does leave a designated Board member who is 16:06

quite a distance away I suppose from operational issues like this, it leaves them probably unclear as to what their role is.

291 Q. Yes. Mr. O'Brien wrote on 6 March 2017. I'll just pull up the email. AOB-01464. Just on the bottom of the page, please. This is in the context of Mr. O'Brien had written to Mr. Wilkinson and the response that came back came back from Dr. Khan, the Case Manager. Mr. O'Brien's unhappiness, I think, is expressed in the line that: 16:07 16:08

"This way of handling his correspondence implied to me that your role on my behalf does not enjoy an autonomy."

16:08

Now, we can in due course ask Mr. O'Brien about his understanding. But it would seem to suggest in that line that he perhaps regarded Mr. Wilkinson as a man who he could rely on to make representations on his behalf and would have, if you like, the independence to deal with those matters without having to run to the employer, as Mr. O'Brien might perceive it. 16:08

Is there a job of work to do around the understanding of the role of the NED and perhaps to better define the limits of the NED's obligations? 16:09

A. I would agree with that. I mean, it is something that I have passed to the Department in response to the second request for comments around what needed to be

considered as part of a review of MHPS. I mean I think, actually, I had this case in mind whenever I was actually referring or responding to the Department. So I do think that --

292 Q. Let's just bring that up as you mentioned it. WIT-41799? 16:09

A. Yes, so it is to Liz Hynes.

293 Q. I think 2018 the Department had a review that I think it didn't complete, but Your Trust is contributing by making a submission and you wish to add something to the submission around the role of NED. You've said the document is not clear, and that's MHPS, the Framework, assumedly, is it? 16:10

A. Yes. Yes, it is.

294 Q. "The document is not clear and at times we got completely muddled as to what their role actually is and how far they can go when contacted by a doctor through a process." 16:10

I think you've just said, is that related to the O'Brien/Wilkinson experience? 16:11

A. Yes. Absolutely. I think Mr. O'Brien's expectation of the role of the designated Board member was not maybe something that was the same as our expectation.

295 Q. Unmoored from the O'Brien case, and based on your general experience in this area, and knowing perhaps the limitations of NEDs, no matter how enthusiastic or experienced they might be, what would you be telling the Department if they were listening to you? Is the 16:11

appropriate role for a NED in terms of the relationship with the practitioner on one level, and in terms of their relationship with their fellow Board members going in the other direction?

A. Personally, I'm not sure there is a need for it. We certainly don't have it in any other, you know, non-medical staff group. However, I think the issue around maintaining the momentum is important, but I'm not sure that that necessarily has to be the role of a non-Executive. I think there are other ways to ensure that there is momentum maintained and maybe part of that is through the arrangements we have and the reporting through to a Governance Committee or onwards to Trust Board. 16:12 16:12

But I just think that this is something that muddies an actual process. I'm not sure that it is terribly helpful. I think in fairness to a practitioner they might have an expectation, that is that they will step in and actually do something different. 16:13

296 Q. Is the clinician is entitled to have his or her representation through this process?

A. Yes.

297 Q. Again, it might be convenient at this point to draw the Inquiry's attention to the training material which you have recently sent us. There's a specific package now developed for the Trust Board in the context of MHPS; is that right? 16:13

A. Yes. So we have, well, there has been training

undertaken by Director of Legal Services before for a non-Executive, so that's nothing new as such. However, there is more training planned. There's a date in April. The DLS will be there.

16:14

But as part of that and in discussion with our non-Executives we have agreed for a session specifically for the non-Executives who act as designated Board members and that is to deal with the types of representation that practitioners can make to them. Because I think, apart from Mr. Wilkinson, the rest of the non-Executives have had no cases where they have had any representations made. So it is a bit of a mystery to them. So our solicitor is going to try and help dispel that a little bit by trying to describe to them: These are the types of things that you might be asked, and obviously with their support from a legal perspective, they will guide them through that.
I suppose it is to try and demystify that. So that's part of the Board level training.

16:14 16:14 16:15

298 Q. Bring up the document and then you can add anything else to that. WIT-91891. You said Board members have always had some training. What is new about this initiative?

A. Well, it's not that it's necessarily all new, but it is to try; I suppose what we were trying to do there was just to set it out very clearly this will be the expectation. It puts a timeline, I suppose, in terms of, you know, how often. So we have agreed that it

16:15

would be every two years. I suppose it just puts some formality around all of that.

There is a reference there, and I suppose back in September we had started to think about Our Trust Guidelines, you know, revising the 2017 ones. So it was anticipated that that is what we would be including within this training. Now that has been, I suppose, superseded or paused really, essentially, because of the Department's announcement around the review of MHPS and the accompanying guidance in relation to it. We thought it would be prudent to hold on that, but that was around September-time. 16:16 16:16

But it gives you a flavour just in terms of, because it's both DLS and it's also with Trust support. So prior to this it was always DLS but it didn't have the Trust. So that, I suppose, is what is new to this. 16:16

299 Q. The fifth bullet point sets out to deal with the issue of the expectation of roles, responsibilities of a number of people including the designated Board member? 16:17

A. That's right and then just to be very clear around our MHPS reporting to Governance Committee as well.

300 Q. I wonder what the designated Board member is told about the responsibilities if you are expressing some uncertainty about the proper limits of the role. 16:17

A. Yes. And I suppose in this intervening period until the Department, you know, and that task and finish

group that will be looking at image MHPS, all we can go by is what is within MHPS. I suppose the other way to try to supplement that is to give an understanding, actually, of the type of representations maybe that have been made in other cases. Obviously on an anonymous basis from some of the other Trusts, but it is just to try to further that as much as we can at this stage, rather than just sit and wait for a Review of MHPS, which I think is going to take another six months at least. 16:18

301 Q. And the expectation is that this training would be refreshed every two years?

A. Yes. Yes.

302 Q. Now, could you bring up on the screen, please, TRU-267745. Scroll down to the bottom of the page. Thank you, just there. And here Mr. Wright on 21 February, is alluding to a meeting which you had on the previous Friday with him after being approached by John Wilkinson. This concerns an apparent conflict or, potential conflict of interest, on the part of Mr. Weir. So he was the Clinical Director. It was the unanimous view of the Oversight Group in December that he would be appointed in the role of Case Investor. He carried out aspects of that role through January, including the preparation of a preliminary report and a submission to a case conference. 16:18 16:19 16:20

And then, within a month or less than a month, it is being suggested that he had a potential conflict of

interest and Neta Chada is to take his place. What was your understanding of the conflict of interest?

A. So this came about as a result of, I think, the correspondence from Mr. O'Brien by John Wilkinson. And at the start of that, now I think that was the February one, I would be able to confirm that if I saw it. But basically it went back to the origins. 16:20

303 Q. Can I bring that up?

A. Yes, it might help a bit. It went back to March '16.

304 Q. I think it is TRU-01248. So 7 February. You're right to recall that Mr. O'Brien starts the correspondence by reference to the March letter. There was a meeting with Mr. Wilkinson that day as well so far as we understand it? 16:21

A. That's right. That's right. 16:21

305 Q. Yes. You were explaining about the conflict?

A. Yes. So because that had gone back to March and because Mr. Weir was in post after this, so I think Mr. Weir started 1 June '16, and because that was sort of making reference to the fact that there's been a letter that has been issued, the potential conflict was around, well, actually, Mr. Weir, you've been in post from June and essentially you are a witness to this investigation because, if there has been this issue back in March and no progress has been made, then we will need to take your statement in relation to this. 16:21 16:22

So it was as a result of that. We discussed it. I can

remember it clearly because I was on annual leave and I dialled into the call on the Friday afternoon. Our advice at that stage was that, really, Colin Weir was more of an actual witness to this. And therefore, he was asked then to step aside and then we asked Dr. Neta Chada at that point to take up the Case Investigation role. 16:22

306 Q. And obviously he gives evidence to the Chada Investigation.

A. Yes, he does. He does. 16:23

307 Q. Did you understand that his acts or omissions were potentially caught by the fifth Terms of Reference concerning management actions?

A. Yes. It was linked obviously to that. And in all likelihood, now I can't recall exactly, but in all likelihood our legal advice would be flagging it as something to consider as part of the Terms of Reference potentially around that. I'm not entirely clear on that, but certainly it focused the mind on; there are issues dating back to March that will need to be considered here as part of an investigation. 16:23

308 Q. Let me see if I can deal with one final issue this afternoon on the issue of delay. We don't need to go to the document to remind ourselves that the expectation was that an MHPS investigation would be conducted within four weeks. 16:24

Now, I think everyone who has touched these issues has said it never happens in four weeks. It's the

exceptional case that gets through in four weeks. Nevertheless, you would accept, would you, that from a standing start and let's call it in round terms at the start of January, after the Christmas holidays, 2017, through to the end of June 2018 is a staggeringly long time to take with an investigation when many of the primary facts, albeit not entirely uncontroversial, but many of the primary facts had been assembled around triage, notes at home, dictation issues. Not entirely uncontroversial. But many of these issues had been investigated and some data produced. 16:24 16:25

Do you agree that this took far too long?

A. Yes. I do agree. I do agree.

309 Q. Was it, in your mind, inevitably an 18-month process before a report could be handed to Dr. Khan, inevitably in the sense of this is just how long it was going to take because of the issues? 16:25

A. No. I don't think it ever would have been anticipated it would have taken that long. And I think the momentum in the early part of the investigation was there as much, as it could be, with a busy clinician in terms of Dr. Chada, and Siobhán as a senior member of my team and somebody on maternity leave. But it's when it gets to the stage where Mr. O'Brien needs to be contacted around giving his evidence. And in fairness he was a busy clinician. There were patients to be seen. There were patients in clinic. There were patients in surgery. But that's when the significant 16:26 16:26

delays started to happen.

And I suppose my reflection of all of that is that, you know, in many respects Mr. O'Brien was allowed to dictate the actual pace of it throughout when there should have been more control taken of it. So I think right up until, you know, there were attempts even on a Saturday to accommodate Mr. O'Brien. It took a month, probably, you know, to actually get that initial interview with him. He then wouldn't respond to the last issue around the private, or the fourth issue around the private practice. And there was probably a delay there in arranging the next meeting and then a further delay around him trying to focus from an appraisal point of view, which in retrospect, we should have been driving that. That should not have been allowed to enter into the situation. This should have taken priority.

16:27
16:27
16:28

So, I suppose beyond that initial period where the 13 other witnesses were interviewed, it took an inordinate amount of time to get this over the line.
A combination of busy clinical diaries, other priorities, and that lack of kind of driving the process contributed, you know, to all of that. And, you know, for these people this was not the only thing on their agenda. They had other cases, they had other clinical work. But I cannot disagree with you around the inordinate amount of timing.

16:28
16:28

310 Q. Yes. Breaking it down, 13 witnesses were spoken to plus Mr. O'Brien, I believe on two occasions?

A. That's right. Yes.

311 Q. Obviously Dr. Chada has her own day job, her own practice. And it may not work that she can interview 13 witnesses, you know, in a week or whatever. So the Inquiry would acknowledge that there is that frailty there. But 13 witnesses, plus Mr. O'Brien, is capable of being processed within a calender month. Isn't that fair? 16:29

A. I'm not convinced that a calender month would be fair in practical terms when you consider everybody's diary and everybody's clinical commitments. Sometimes they just do not marry up. So I'm not convinced that one calender month is at all realistic whenever you try to marry all of those factors up. When you try to factor in annual leave and you try to factor in other things in terms of clinical practice. Siobhán's other commitments in terms of disciplinary processes, hearings, regional meetings. Logistically, it is really difficult practically. 16:30

312 Q. One of the factors that you suggested was an issue, was that Mr. O'Brien requested at the meeting on 3 August 2017 that he would see evidence around the concern of private patients. In fairness to the clinician who is the subject of investigation, that sort of thing should be pre-empted, shouldn't it? It should be recognised that for him to be able to comment on an allegation, he will need the paperwork. 16:30

A. Yes. I don't think that's an unrealistic expectation and something that I think, yes, could have been pre-empted, could have been provided in advance in a more timely way. I don't disagree with that.

313 Q. The core principle within MHPS is Patient Safety. Was the longevity of this investigation of a potential risk to Patient Safety, or should that be regarded as a general overarching concern in all MHPS cases to move these things along quickly where you have a clinician whose performance is at least questionable? 16:31

A. Yes, I don't disagree with that. I suppose the way we considered that risk was being mitigated was in relation to the monitoring, the Return to Work Plan.

314 Q. Is it fair to say, and we know that you have written emails in, I think it was February of 2017 to Mrs. Heinz asking 'has the letter gone to Mr. O'Brien to bring this to an end', I think is the question you ask. TRU-263969. Dr. Khan is asking a similar type question on 7 February 2018. But reflecting on this now, who should have been driving this or is the answer, well, we just can't touch it because it's an independent investigation? We can't be seen to trample? 16:32

A. Yes. So I think from designated roles' perspective, I think the Case Manager had a role to play. Obviously the designated Board member, part of their role was around ensuring momentum. In fairness to Mr. Wilkinson, there were emails, he was asking. I think the missing part in all of this was actually 16:33

somebody out of all of those, you know, myself, Dr. Khan, the Medical Director, Mr. Wilkinson, actually sitting down and saying: Right, where are we at with this? What's the holdup? And actually taking it by the scruff of the neck and saying what can we do? Where are the blockages? How can we unblock those and get this finalised?

I think the way we are working now in terms of just the regularity of those meetings, the fact that we sit on a Governance Committee. I know before I go in to any Governance Committee, I will know where we are at with those particular cases. Our Board members will know.

315 Q. Sorry, would you expect to be challenged now because there is greater visibility? 16:34

A. Well, I suppose there is even a challenge from the Chair of that Committee, or should be a challenge, in terms of a designated Board member: Do you know where things are at? But I think my experience of things we are seeing now, I mean certainly the last Governance Committee, there was a clear example of one of the non-Executive Directors whose is the designated Board member saying: I have followed this up. I know where things are at. I know we are expecting the report. So I think that has changed quite considerably and I think that is what was missing at the time. In fairness, we shouldn't necessarily have needed it, but I think that provides that safety net for everybody now. 16:33 16:34 16:34 16:35

316 Q. The final question for this afternoon. MHPS,

Section 1, paragraph 29. It is referred to, I think, in your statement, requires a clear audit route be established for initiating and tracking progress of an investigation, its costs and resulting action.

16:35

Is that just not a piece of equipment that you had in place or a piece of the system that was in place at that time?

A. No, I think it was more reactive. It wasn't that proactive monitoring. And even, you know, simple things such as your, you know, your actual pro-forma, your timeline with your attachments on it around; this is the NCAS advice. This is when we referred this to the GMC. You know, there's now that timeline now so that you have everything together and you know where things are at. I think there is more work to be done on the costs and things like that which we need to focus on, but certainly the tracking is absolutely there. 16:36 16:36

317 Q. Yes. Just for the Panel's reference to your statement in that respect, where you said not enough attention was paid to the audit and tracking. WIT-41141 at paragraph 26(vii). 16:36

MR. WOLFE KC: I think we can leave it there for this afternoon and take it up again in the morning at 10 o'clock. 16:37

CHAIR: I'm sorry you have to come back. Your evidence is important so I think we will come back fresh

tomorrow.

We also have Mr. Carroll, I think tomorrow.

MR. WOLFE KC: That's right. Yes. Busy day.

CHAIR: Can you give Mrs. Toal any indication as to how long you might be with her? 16:37

MR. WOLFE KC: Probably another hour.

CHAIR: Okay, thank you, and then we will have some questions. 10 o'clock.

16:37

THE INQUIRY ADJOURNED TO THURSDAY, 2ND MARCH 2023 AT 10:00